

**A RECOMMENDATION REPORT FROM
THE HHS ADVISORY COMMITTEE ON MINORITY HEALTH (ACMH)**

**Ensuring that Health Care Reform
Will Meet the Health Care Needs of
Minority Communities and
Eliminate Health Disparities**

**A Statement of Principles and
Recommendations**

July 2009

Submitted to

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Minority Health**



**Ensuring that Health Care Reform Will Meet the Health
Care Needs of Minority Communities and Eliminate
Health Disparities**

***A Statement of Principles and Recommendations U.S.
Department of Health and Human Services Advisory Committee
on Minority Health (ACMH)***

Submitted

**Through
Garth Graham, MD, MPH,
Deputy Assistant Secretary for Minority Health
To
Kathleen Sebelius, Secretary,
U.S. Department of Health and Human Services**

July 2009

Advisory Committee on Minority Health: Section 1707 of the Public Health Service Act, as amended, by the Minority Health and Health Disparities Research and Education Act of 2000, P. L. 106-525 authorizes the establishment of an Advisory Committee on Minority Health. The Committee also is governed by provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees. The Act directs the Advisory Committee on Minority Health to advise the DHHS, through the Deputy Assistant Secretary for Minority Health, on improving the health of racial and ethnic minorities and on the development of the program activities of the Office of Minority Health.

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“Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.”

Dr. Martin Luther King Jr. at the 2nd National Convention of the Medical Committee for Human Rights on March 25, 1966

Executive Summary

Health and health care disparities have disproportionately affected minority communities across the US health care system. In 2003, the Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, urged that eliminating disparities become a national priority. Despite this call to arms, the 2008 National Healthcare Disparities Report (NHDR) shows that health disparities are actually increasing in many areas and remain unchanged in others. For example, the proportion of new AIDS cases was 9.4 times as high for Blacks as for Whites and three times as high for Hispanics as non Hispanics. Minority communities (i.e., Blacks, Hispanics, American Indians/Alaskan Natives, some Asian Americans and Native Hawaiians and Other Pacific Islanders) continue to be vulnerable communities who are disproportionately poorer, and disproportionately uninsured or underinsured. Minority communities continue to experience disproportionately higher morbidity and mortality rates for disabling chronic diseases such as diabetes, kidney disease, heart disease, and cancer. Well-regarded research suggests that 83,000 deaths each year are attributable to racial and ethnic health disparities.

The unprecedented economic downturn in the latter half of 2008 combined with the increasingly dire effects of high health care costs for both businesses and individuals have set in motion unique/concerted efforts to achieve meaningful health care reform in 2009. Meaningful health care reform offers the potential to improve the health status in minority and vulnerable communities, and to reduce/eliminate health disparities. But, if the past is not to be the prologue, then health care reform must *intentionally* establish the strategies necessary to ameliorate and ultimately to eliminate minority health disparities. Otherwise, the myriad challenges of health care reform could mean that minority health priorities receive insufficient consideration.

Every strategic aspect of health care reform currently being considered, from health insurance coverage to health care access to patient-centered comprehensive services to expanding primary care providers to improving quality of care by improving health care provider training also has the potential to ameliorate health disparities and improve the health of minority communities. *Consequently, the Advisory Committee on Minority Health (ACMH) asserts that every such health care reform proposal/strategy must be assessed/evaluated regarding its implications and impact for ameliorating health disparities and improving the health of minority communities.*

To facilitate this necessary/critical scrutiny, the ACMH proposes 14 Principles to provide the necessary evaluative criteria. These principles encompass scientifically well-

established areas of health care policy and health care reform including the need for a diverse health care workforce, equitable access to comprehensive health care coverage and services, the key roles of public health and the safety net, and the need for transparent, accessible, and comprehensive data systems. The ACMH urges application of the following 14 Principles to ensure that health care reform will meet the health care needs of minority communities, and create the impetus and infrastructure to eliminate health disparities/inequities.

The ACMH also proposes three overarching Recommendations to facilitate/support application of the 14 Principles.

A Diverse Health Care Workforce with Diverse Executive Leadership and Governance

Principle 1: The development of a health care workforce that is truly representative and reflective of the communities served is vital for health care reform to achieve its full potential to serve a diverse and growing minority population and to create an affordable and sustainable health care system that produces good health outcomes.

Principle 2: The development of diverse executive leadership and governance bodies of the health care system is essential for implementing effective health care reform that meets the needs of a diverse minority population and ensures/works for the elimination of health disparities/inequities.

Principle 3: Accrediting and licensing agencies must include strong and robust requirements/benchmarks and oversight processes for ensuring the provision of patient-centered, culturally and linguistically sensitive/competent care in all health care settings. These benchmarks must ensure a diverse health care workforce with diverse executive leadership and governance.

Principle 4: Health care professional schools must be affordable and must reflect the diverse communities they serve. Their curricula must promote a trans- and multi-disciplinary, team-oriented, and community-responsive approach to teaching, training, mentoring, and matriculating in order to ensure the availability of primary care health care providers necessary to implement comprehensive health care reform.

Equitable and Sustainable Access to Comprehensive and Affordable Health Care Coverage and Services

Principle 5: High quality health care coverage that is affordable and comprehensive must be equally accessible to all individuals regardless of nativity or citizenship, age or health history. Coverage should be portable to eliminate gaps in coverage due to transitions in employment or life circumstance. Minority and vulnerable communities are

disproportionately affected by lack of coverage and access and the consequences of poor health status.

Principle 6: A redesigned health care system must be patient-centered and promote a medical home or more broadly a health home for everyone. To improve access for minority and vulnerable communities, financing and reimbursement policies must incentivize and ensure that all persons residing in the US have a health home that emphasizes prevention, primary care, chronic care management and care coordination, and providing patient-centered, culturally and linguistically sensitive/competent care.

Principle 7: Health care reform must support the enhancement and availability of a wide range of community-based interventions and programs that are responsive to diverse populations, in particular, minority and vulnerable communities. Coordination of patient-centered, culturally and linguistically sensitive/competent care across primary care and medical specialties and sub-specialties must be encouraged through financing and reimbursement systems.

Principle 8: While health care reform must create a financially sustainable health care system, new or revised financing and reimbursement policies must not adversely and/or disproportionately affect minority and vulnerable communities. Indeed, such financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status.

Preserve the Safety Net, Focus on Community Engagement and the Social Determinants of Health, Promote Partnerships with Public Health

Principle 9: A robust safety net must be maintained to insure that vulnerable and minority populations do not fall through the cracks. Minority and vulnerable communities are those who not able to access affordable health care coverage and/or services and thus disproportionately rely on the safety net, e.g., children in immigrant families, low-income parents, low-wage working adults with no children, some lawfully residing residents, and undocumented residents in the U.S.

Principle 10: Health care reform must include minority communities as key stakeholders to provide direct input as to how health care should be structured and delivered. Strong and active minority and vulnerable community engagement is the essential foundation for establishing successful strategies to eliminate health disparities that include meaningful prevention strategies and that account for/address the social determinants of health (SDOH).

Principle 11: The public health infrastructure must be strengthened to assure that its primary functions and activities are responsive to a diverse population, especially minority and vulnerable communities, and account for/address the social determinants of health (SDOH). Health departments must have the ability to hold their agencies

accountable for health disparities as well as the capacity to deal/work with diverse populations in public health emergencies. Minority and vulnerable communities represent a particular challenge/responsibility for public health because these communities disproportionately lack access to health care and health homes.

Data Systems Ensure Comprehensive Capacity and Multi-Dimensional Accountability for Eliminating Disparities as well as Achieving Reform

Principle 12: The developing area of Health Information Technology (HIT) must support the delivery of a continuum of patient-centered, culturally and linguistically sensitive/ competent care that is seamless and coordinated. HIT through its data-collection must be used for quality assurance and improvement aimed at eliminating health disparities/inequities. HIT must go beyond the hospital to include community-based providers and programs that serve minority and vulnerable communities.

Principle 13: Data collection strategies must be designed to recognize, measure, evaluate, and address the social determinants of health (SDOH) within the context of the health care system and strategies to improve health outcomes, promote quality assurance, and eliminate health disparities/inequities. SDOH includes environmental influences such as poor housing, unsafe neighborhoods, lack of access to fresh foods, and polluted environments as well as personal behaviors.

Principle 14: Data collection strategies, including information on quality, performance, and outcomes, must be transparent and consistent with the benchmarks for eliminating health disparities/inequities as established by the Secretary of HHS or by the federal Health Equity Commission. Measures relevant to and informative of minority and vulnerable communities have been disproportionately absent from data collection and measurement strategies – this situation must be corrected.

The Advisory Committee on Minority Health makes three overarching Recommendations to ensure that the foregoing 14 Principles for Minority Health Equity are effectively incorporated into health care reform activities so that health care reform will meet the needs of minority communities and create the impetus and infrastructure to eliminate health disparities:

Recommendation 1: The Administration and the Congress shall take steps to develop and establish a Federal Health Equity Commission (akin to the Federal Civil Rights Commission) that will focus on eliminating health disparities in the US. The Health Equity Commission will provide the stature and clout demonstrably necessary to begin to achieve sustained progress toward the elimination of health disparities/inequities.

Recommendation 2: In the meantime, all health care reform commissions, committees, and working groups – whether federal or state or local governmental and legislative, public or private think-tank/NGO, must take steps to include sub-committees that address health disparities/inequities, minority health equity, and workforce diversity. It is equally important that these entities take meaningful steps to ensure diversity reflective of communities served in their leadership, membership, and staffing.

Recommendation 3: The 14 Principles for including Minority Health Equity in Health Care Reform must be thoroughly considered/addressed in writing by all entities described in Recommendation 2. These reports must be delivered to the Secretary of US Health and Human Services and the Federal Health Equity Commission.

**Ensuring that Health Care Reform Will Meet the Health Care
Needs of Minority Communities and Eliminate Health
Disparities**

A Statement of Principles and Recommendations

U.S. Department of Health and Human Services

Advisory Committee on Minority Health (ACMH)

FULL REPORT

Statement of 14 Principles and Three Recommendations Designed to Ensure that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Eliminate Health Disparities

“Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.”

Dr. Martin Luther King Jr. at the 2nd National Convention of the Medical Committee for Human Rights on March 25, 1966

Consequences of the History of Disparities in US Health Care System

Health and health care disparities have disproportionately affected minority communities across the US health care system. In 2003, the Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, urges that eliminating disparities become a national priority. Despite this call to arms, the 2008 National Healthcare Disparities Report (NHDR) shows that health disparities are increasing.¹ Minority communities (i.e., Blacks, Hispanics, American Indians/Alaskan Natives, some Asian Americans and Native Hawaiians and Other Pacific Islanders) continue to be vulnerable communities disproportionately poorer, and disproportionately uninsured or underinsured. Minority communities continue to disproportionately experience higher morbidity and mortality rates for disabling chronic diseases such as diabetes, kidney disease, heart disease, and cancer.² Well-regarded research suggests that 83,000 deaths each year are attributable to racial and ethnic health disparities.³

The US has a long history of inequities in health care yet the scientific study of health care disparities is a relatively new field.⁴ Publicity and public concern regarding health care disparities have increased dramatically in the last ten years. Federal and state governments, leading health care foundations and major employers have called attention to disparities in treatment and outcomes and to the urgent need to develop effective interventions. Some federal initiatives, such as the Healthy People 2010 initiative, explicitly target reduction in disparities. Today, 13 of the nation’s 48 state offices of minority health specifically identify “disparity reduction” or “equity” in their name,⁵ and industries from hospitals to health insurance companies are working to ameliorate disparities by investing substantial resources in quality improvement efforts for all Americans.⁶

Even with the increased attention and advances in the quality of care, persistent racial and ethnic health disparities continue to plague the US health care system. Hundreds

of studies have documented substantial gaps in access, quality of care and health outcomes by race, ethnicity, socioeconomic status, and gender.⁷ Notable examples include surgical outcomes, access to ambulatory services, and outcomes for heart disease and certain cancers.⁸ African-American women are 67 percent more likely to die when diagnosed with breast cancer.⁹ Hispanics with HIV are almost 30 percentage points less likely to receive protease inhibitors during treatment;¹⁰ poor individuals score lower on 11 of the 17 core measures of quality care than high-income individuals;¹¹ African Americans wait two times as long for kidney transplantation.¹² Women are less likely to receive evidence-based testing and treatment for heart disease than men.¹³

“Asian American and Pacific Islander women have low rates of cancer screening including mammograms and Pap tests. According to Kagawa-Singer and Pourat (2000), in the United States, 26% of Chinese, 21% of Japanese, 28% of Filipinos, 50% of Koreans, and 68% of Asian Indians (all over the age of forty) had never had a mammogram. Furthermore, one fifth of Asian American women (over the age of eighteen) have never had a Pap test, and among those who have, one out of seven have not had the test within the past three years.”¹⁴

When mortality rates are used as the indicator of health outcomes, American Indians and Alaska Natives face a disadvantage, relative to Whites, at each stage of the life span, with persistent disparities in infant mortality, life expectancy, and mortality from a variety of conditions including chronic diseases.¹⁵ There is also sufficient evidence of disparities in health care financing, access to care, and quality of care to conclude that American Indians and Alaska Natives are disadvantaged in the health care system.¹⁶

The *National Healthcare Disparities Report, 2008* (NHDR) produced by the Agency for Healthcare Research and Quality (AHRQ) provides in its introductory section a succinct but powerful description of the state of health care for minorities and other vulnerable groups in the US:

Disparities persist in health care quality and access - For AI/ANs, 75% of the core measures that could be tracked over time improved (gap decreased). For Blacks and Asians, 60% of the core measures used to track access remained unchanged (gap stayed the same) or got worse (gap increased). For Hispanics, 80% of core access measures remained unchanged or got worse. For poor populations, 57% of core access measures remained unchanged or got worse. *Magnitude and pattern of disparities are different within subpopulations* - Improvements in preventive care, chronic care, and access to care have led to the elimination of disparities for some priority populations in areas such as mammograms, smoking cessation counseling, and appropriate timing of antibiotics. At the same time, many of the largest disparities have not changed significantly. *Some disparities exist across multiple priority populations* - In addition to the variable distribution of disparities evident across priority populations, in some cases several different populations experience the same gaps in care as other populations due to poor quality overall or populations experiencing similar barriers.”

According to a new study by the Kaiser Family Foundation, and a decade after US Surgeon General David Satcher called for the elimination of racial disparities in health, women of color in every state continue to fare worse than white women on a variety of measures of health, health care access and other social determinants of health. The June 2009 report -- *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* -- documents the persistence of disparities on 25 indicators between white women and women of color, including rates of diseases such as diabetes, heart disease, AIDS and cancer, as well as insurance coverage and health screenings. Women of color fared worse than white women on most measures and in some cases the disparities were stark. National statistics mask substantial state-by-state variation in disparities. The report moves beyond national figures to quantify where disparities are greatest, providing new information to help determine how best to combat the problem. The analysis also provides new state-level data for women that are often difficult to obtain.¹⁷

Urgent Need for Minority Health to Inform Health Care Reform Deliberations

The unprecedented economic downturn in the latter half of 2008 combined with the increasingly dire effects of high health care costs for both businesses and individuals have set in motion unique/concerted efforts to achieve meaningful health care reform in 2009. Meaningful health care reform offers the potential to improve the health status in minority and vulnerable communities, and to reduce/eliminate health disparities. But, if the past is not to be the prologue, then health care reform must *intentionally* establish the strategies necessary to ameliorate and ultimately to eliminate minority health disparities. Otherwise, the myriad challenges of health care reform could mean that minority health priorities receive insufficient consideration.

Given this context, the US Department of Health and Human Services (DHHS) Advisory Committee on Minority Health (ACMH) at its February, 2009 meeting determined that the focus of its present work should be on health care reform from the perspective of improving access and quality of health care for minority and vulnerable communities. The aim of the ACMH is to encourage and support legislative and programmatic health care reform strategies that are guided by key principles and recommendations intended to improve the state of minority health in the US by eliminating disparities.

The ACMH acknowledges the work of the DHHS Office of Minority Health, AHRQ and all the collaborating DHHS agencies for programs, initiatives and resources developed and implemented to address health disparities. Their efforts have moved the field forward and informed/shaped health care policy and practice to benefit all communities.

At this particular time, however, significant national interest in, and momentum towards, health care reform calls for structuring a health care system that incorporates knowledge and expertise for addressing health disparities as integral elements. Every

strategic aspect of health care reform currently being considered, from health insurance coverage to health care access to patient-centered comprehensive services to expanding primary care providers to improving quality of care by improving health care provider training also has the potential to ameliorate health disparities and improve the health of minority communities. *Consequently, the Advisory Committee on Minority Health (ACMH) asserts that every such health care reform proposal/strategy must be assessed/ evaluated regarding its implications for ameliorating health disparities and improving the health of minority communities.*

To facilitate this necessary/critical scrutiny, the ACMH proposes 14 Principles to provide the necessary evaluative criteria. These principles encompass scientifically well-established areas of health care policy and health care reform including the need for a diverse health care workforce, equitable access to comprehensive health care coverage and services, the key roles of public health and the safety net, and the need for transparent, accessible, and comprehensive data systems. The ACMH recently completed work on proposing a national multi-component policy strategy for reducing disparities by promoting patient-centered culturally and linguistically sensitive/competent health care.¹⁸

The ACMH urges application of the following 14 Principles to guide the development of health care reform so that addressing health disparities becomes integral to the process of improving access to quality health care and to improving the health status of all communities. This process will also ensure that health care reform will meet the health care needs of minority communities, and create the impetus and infrastructure to eliminate health disparities/inequities. The ACMH also proposes three overarching Recommendations to facilitate/support application of the Principles.

A Statement of Principles Designed to Ensure that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Create the Impetus to Eliminate Health Disparities

A Diverse Health Care Workforce with Diverse Executive Leadership and Governance

Principle 1: The development of a health care workforce that is truly representative and reflective of the communities served is vital for health care reform to achieve its full potential to serve a diverse and growing minority population and to create an affordable and sustainable health care system.

Principle 2: The development of diverse executive leadership and governance bodies of the health care system is essential for implementing effective health care reform that meets the needs of a diverse minority population and ensures/works for the elimination of health disparities/inequities.

Principle 3: Accrediting and licensing agencies must include strong and robust requirements/benchmarks and oversight processes for ensuring the provision of patient-centered, culturally and linguistically sensitive/competent care in all health care settings. These benchmarks must ensure a diverse health care workforce with diverse executive leadership and governance.

Principle 4: Health care professional schools must be affordable and must reflect the diverse communities they serve. Their curricula must promote a trans- and multi-disciplinary, team-oriented, and community-responsive approach to teaching, training, mentoring, and matriculating in order to ensure the availability of primary care health care providers necessary to implement comprehensive health care reform.

Equitable and Sustainable Access to Comprehensive and Affordable Health Care Coverage and Services

Principle 5: High quality health care coverage that is affordable and comprehensive must be equally accessible to all individuals regardless of nativity or citizenship, age or health history. Coverage should be portable to eliminate gaps in coverage due to transitions in employment or life circumstance. Minority and vulnerable communities are disproportionately affected by lack of coverage and access and the consequences of poor health status.

Principle 6: A redesigned health care system must be patient-centered and promote a medical home or more broadly a health home for everyone. To improve access for minority and vulnerable communities, financing and reimbursement policies must incentivize and ensure that all persons residing in the US have a health home that emphasizes prevention, primary care, chronic care management and care coordination, and providing patient-centered, culturally and linguistically sensitive/competent care.

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Principle 8: While health care reform must create a financially sustainable health care system, new or revised financing and reimbursement policies must not adversely and/or disproportionately affect minority and vulnerable communities. Indeed, such financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status.

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Principle 10: Healthcare reform must include minority communities as key stakeholders to provide direct input as to how health care should be structured and delivered. Strong and active minority and vulnerable community engagement is the essential foundation for establishing successful strategies to eliminate health disparities that include meaningful prevention strategies and that account for/address the social determinants of health (SDOH).

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Data Systems Ensure Comprehensive Capacity and Multi-Dimensional Accountability for Eliminating Disparities as well as Achieving Reform

Principle 12: The developing area of Health Information Technology (HIT) must support the delivery of a continuum of patient-centered, culturally and linguistically sensitive/ competent care that is seamless and coordinated. HIT/HIE through its data-collection must be used for quality assurance and improvement aimed at eliminating health disparities/inequities. HIT/HIE must go beyond the hospital to include community-based providers and programs that serve minority and vulnerable communities.

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The Advisory Committee on Minority Health makes three overarching Recommendations to ensure that the foregoing 14 Principles for Minority Health Equity are effectively incorporated into health care reform activities so that health care reform will meet the needs of minority communities and create the impetus and infrastructure to eliminate health disparities:

Recommendation 1: The Administration and the Congress shall take steps to develop and establish a Federal Health Equity Commission (akin to the Federal Civil Rights Commission) that will focus on eliminating health disparities in the US. The Health Equity Commission will provide the stature and clout demonstrably necessary to begin to achieve sustained progress toward the elimination of health disparities/inequities.

Recommendation 2: In the meantime, all health care reform commissions, committees, and working groups – whether federal or state or local governmental and legislative, public or private think-tank/NGO, must take steps to include sub-committees that address health disparities/inequities, minority health equity, and workforce diversity. It is equally important that these entities take meaningful steps to ensure diversity reflective of communities served in their leadership, membership, and staffing.

Recommendation 3: The 14 Principles for including Minority Health Equity in Health Care Reform must be thoroughly considered/addressed in writing by all entities described in Recommendation 2. These reports must be delivered to the Secretary of US Health and Human Services and the Federal Health Equity Commission.

Discussion of the 14 Principles for Minority Health Equity

A Diverse Health Care Workforce with Diverse Executive Leadership and Governance

Principle 1: The development of a health care workforce that is truly representative and reflective of the communities served is vital for health care reform to achieve its full potential to serve a diverse and growing minority population and to create an affordable and sustainable health care system.

Principle 2: The development of diverse executive leadership and governance bodies of the health care system is essential for implementing effective health care reform that meets the needs of a diverse minority population and ensures/works for the elimination of health disparities/inequities.

Principle 3: Accrediting and licensing agencies must include strong and robust requirements/benchmarks and oversight processes for ensuring the provision of patient-centered, culturally and linguistically sensitive/competent care in all health care settings. These benchmarks must ensure a diverse health care workforce with diverse executive leadership and governance.

Principle 4: Health care professional schools must be affordable and must reflect the diverse communities they serve. Their curricula must promote a trans- and multi-disciplinary, team-oriented, and community-responsive approach to teaching, training, mentoring, and matriculating in order to ensure the availability of primary care health care providers necessary to implement comprehensive health care reform.

Discussion

The 2004 IOM report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*,¹⁹ that complemented *Unequal Treatment*²⁰ called for increased diversity in the health care workforce as part of a comprehensive strategy to reduce health disparities. This report cited that more than 40 percent of Hispanic patients in one survey said that a doctor's ability to speak the patient's language was a significant consideration in choosing a physician and that minority patients are more likely to choose health care professionals from their own ethnic groups and are more satisfied with the care that they receive from them. Evidence indicated that patient-physician communication, trust and understanding increase when patients share the same ethnic, racial, or cultural or primary language background; this improves the accuracy of diagnoses and frequency of patient compliance.

The IOM stressed the impact of the landmark decision in the U.S. Supreme Court ruled in *Grutter v. Bollinger et al.* that it was lawful for the University of Michigan Law School to consider race and ethnicity as one of many factors in the admissions process because the practice was "narrowly tailored" and did not violate the constitutional rights of nonminority applicants. It was in this ruling that Justice Sandra Day O'Connor wrote: "Effective participation by members of all racial and ethnic groups in the civic life of our Nation is essential if the dream of one Nation, indivisible, is to be realized."²¹

This IOM Committee recognized that by 2050 the US may be 50 percent non-white or not primarily English-speaking, and that better patient care will depend on better cross-cultural understanding. The Committee's report cited that African-American physicians in California were five times more likely than their white peers to practice in largely African-American communities while the proportion of African-American physicians to the general population and commensurate with their portion of population is shrinking.

Data from the 2001 Commonwealth Fund Survey indicated that Asian Americans overall (27%) and Asian Americans ethnic subgroups such as Koreans (41%), Chinese (35%), and Asian Indians (28%) were more likely to experience communication difficulties with their provider compared to the general population at 19%.²² Sinkford and Valachovic (2001) have shown that Asian Dentists are more likely to serve other communities of colors than are white dentists and in fact serve a meaningful proportion of black (11.5%) and Hispanic (14.5%) patients.²³

In 2007, Ngo-Metzger and colleagues examined the importance of language concordance between providers and LEP patients as related to health education, interpersonal care, and lower patient satisfaction. Their study of 2,746 Chinese and Vietnamese patients confirmed that "language concordance between providers and patients is still the optimal situation". They also demonstrated that interpreters could have a positive impact in promoting health education although having an interpreter did not substantively mitigate the impact of having a language-discordant provider.²⁴

The IOM Committee discussed these benefits of racial and ethnic diversity among health care professionals: (1) Racial and ethnic minority health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care; (2) Racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health care professionals; (3) Racial and ethnic minority health care providers can help care systems efforts to reduce cultural and linguistic barriers and improve cultural competence; (4) Diversity in higher education/health care professions training settings is associated with better educational outcomes among *all* students."²⁵

The IOM recommended to Health Professions Education Institutions and relevant public and private groups mechanisms to encourage support for diversity efforts with: (1) Additional research and data collection on diversity and its benefits; (2) Efforts to increase broad stakeholders' understanding of and consensus regarding steps that should be taken to enhance diversity among health care professionals; and, (3) The development of broad coalitions to encourage HPEIs, their accreditation bodies, and federal and state sources of health care professions student financial aid to adopt policies to enhance diversity among health care professionals."²⁶

In the Nation's Compelling Interest was followed in the same year by the Sullivan Commission that pointed to the clear, critical need for more health care professionals and support personnel from ethnic or racial minority groups and that such individuals are more likely to serve minority and medically underserved communities.²⁷ Together,

the IOM and Sullivan Commission reports, including their 62 recommendations for action, offered US health care organizations and providers a comprehensive blueprint for achieving diversity and ensuring cultural competency among the workforce.

Responsive and accountable executive leadership is critical for providing quality health care for minority populations and for addressing health disparities. A central finding of the National Public Health and Hospital Institute's (NPHHI) 2004 report to the Department of Health and Human Services' Office of Minority Health, *Serving Diverse Communities in Hospitals and Health Systems*²⁸, is that the infrastructure required to initiate and sustain promising practices and programs to improve diversity and address disparities, especially in the face of severe resource constraints, depends upon the vision, skill and commitment of the organization's leadership and governance. Building this infrastructure requires a style and practice of executive leadership and governance characterized by understanding that workforce diversity and culturally competent care are not separate projects or programs but rather a context for continuous quality improvement of all areas of executive leadership and governance responsibility.

The Joint Commission in its *Hospitals, Language, and Culture* study shows that language and cultural issues have a significant impact on disparities when not addressed by a health care organization and its leadership. The Commission's most recent report, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*²⁹, builds upon *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*³⁰ by providing a framework for hospitals to develop and implement practices for meeting the needs of diverse patient populations. The critical point made by The Joint Commission is that there is no "one size fits all" strategy and that the blueprint for organizational cultural competence is unique for each hospital organization and dependent on the quality of leadership. Without trying to provide all of the answers for meeting the needs of diverse patient populations, The Joint Commission report offers a framework, derived from current practices employed by U.S. hospitals, for executive leaders and governing bodies to think systemically about how they provide health care that is culturally and linguistically appropriate.

Other reports assessing the presence of minorities in the health care professions continue to highlight the importance of increasing this leadership capacity in U.S. hospitals and health care systems for improving access to quality care. The joint study, *A Race/Ethnic Comparison of Career Attainments in Healthcare Management* by the American College of Healthcare Executives (ACHE) and the National Association of Health Services Executives (NAHSE) showed that minorities continue to fall behind whites in several areas of health care management.³¹ Their report provided recommendations to address this inequity but a common theme existed of strengthening networks of minority health care professionals to offer support and strategies for greater career opportunities.

The Puerto Rican Legal Defense and Education Fund (PRLDEF) followed in 2004 with *Condition Critical: The Absence of Latinos among Policy Makers in New York City's Voluntary Hospitals*, which highlighted not only the lack of Latino representation in

hospital administration and boards but also the barriers that minority patient populations face in receiving care.³² Nationally, although Latinos now make up 14 percent of the U.S. population, only 2 percent of hospital chief executives in the U.S. are Latino. Such disparities illustrate how critical it is for the nation that health care organizations recognize and respond to these health care needs. This PRLDEF report spurred the Board of Governors of the Greater New York Hospital Association (GNYHA) to convene a blue ribbon task force on diversity and health care leadership. As a result, the Center for Trustee Initiatives was created in 2005 to help GNYHA-member organizations achieve diversity reflecting *all* minority communities on their governing boards as a critical strategy for advancing quality care for the diverse communities in New York City.

These reports, together with the IOM study and *The Sullivan Report* mentioned above, are a part of the testimony to the obstacles facing minority health care executives and governing body representatives, as well as a challenge to become actively engaged in exploring new avenues for improving community health and the representation of minorities in health care administration and health care professions. Increasing the role of minority executive leadership and governance is a critical element for effective health policy and program development that benefit all U.S. communities.

Effectively engaging the diverse communities served by a healthcare organization requires executive leadership and governance that is representative of, and response to, those communities.³³ Executive leadership that is responsive will view community as a crucial partner in developing and providing quality healthcare – not just as consumers or recipients of healthcare services. The engaged healthcare executive and governing body develop and maintain an open dialogue with the community through interaction with trusted community leaders and members to identify key issues and effective strategies for improving the public’s health and for developing community resources. Current research demonstrates an overall improvement of quality of care for all groups when there is a concerted effort to improve care and to address disparities for minority patients.³⁴ Minority executives often bring this increased awareness and responsiveness to the health care needs of their communities and are instrumental in improving the quality of care for all.

Equitable and Sustainable Access to Comprehensive and Affordable Health Care Coverage and Services

Principle 5: High quality health care coverage that is affordable and comprehensive must be equally accessible to all individuals regardless of nativity or citizenship, age or health history. Coverage should be portable to eliminate gaps in coverage due to transitions in employment or life circumstance. Minority and vulnerable communities are disproportionately affected by lack of coverage and access and the consequences of poor health status.

Principle 6: A redesigned health care system must be patient-centered and promote a medical home or more broadly a health home for everyone. To improve access for

minority and vulnerable communities, financing and reimbursement policies must incentivize and ensure that all persons residing in the US have a health home that emphasizes prevention, primary care, chronic care management and care coordination, and providing patient-centered, culturally and linguistically sensitive/competent care.

Principle 7: Health care reform must support the enhancement and availability of wide range of community-based interventions and program that are responsive to diverse populations, in particular, minority and vulnerable communities. Coordination of patient-centered, culturally and linguistically sensitive/competent care across primary care and medical specialties and sub-specialties must be encouraged through financing and reimbursement systems.

Principle 8: While health care reform must create a financially sustainable health care system, new or revised financing and reimbursement policies must not adversely and/or disproportionately affect minority and vulnerable communities. Indeed, such financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status.

Discussion

In its February 2009 report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* The Commonwealth Fund Commission on a High Performance Health System presents an integrated “system” approach to change that would provide affordable health insurance for all as the foundational support for payment and system reforms.³⁵ The Commission recommends an integrated set of policies to extend coverage to all, and asserts that moving from fractured to continuous insurance coverage would lower insurance administrative costs and provide a foundation for more coherent and effective payment and system reforms.

The Commonwealth Fund is only the latest prominent participant in the health care reform debates to assert that universal and equitable access to quality comprehensive health insurance must be the centerpiece of healthcare reform. Moreover, prominent health care reform stakeholders also agree that universal and equitable access to healthcare insurance will play a critical role in reducing disparities in healthcare and health for minority communities.³⁶ The landmark Institute of Medicine series on health insurance showed conclusively that minority communities are disproportionately uninsured and vulnerable to health crises.³⁷ While the influence of other factors (i.e., the social determinants of health) is compelling, it is clear that universal access to health insurance will greatly reduce health disparities.³⁸ Coverage must be affordable and adequate. High co-payments and deductibles endanger the health of the sick poor by the decrease use of vital inpatient medical services, preventive care and chronic disease management. Continuous enrollment in comprehensive, affordable, and adequate health insurance must ensure that coverage is constant regardless of changes in employment, income, or ability to pay.³⁹

In *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* The Commonwealth Fund Commission on a High Performance Health System also asserts that health care reform must create accountable, accessible, patient-centered, coordinated care by reorganizing and redesigning the fragmented health care delivery system to improve patient experiences.⁴⁰ The health care system must offer the full range of evidence-based patient-centered, culturally and linguistically sensitive/competent health care services, such as (1) prevention and early detection, (2) acute treatment and chronic treatment with access to clinical trials, (3) chronic disease management and palliative care, (4) oral health care services, (5) mental health care services, (6) substance abuse services, (7) rehabilitative, long term and home care, (8) occupational health care, (9) prescription drugs, and (10) preventive and public health measures.

The Patient Centered Medical Home (PCMH) model is premised on patient-centered primary care and reflects decades of research demonstrating its role in producing improved outcomes at lower costs. Primary care is defined in the PCMH model as comprehensive, first-contact, acute, chronic, and preventive care across the life span, delivered by a team of individuals led by the patient's personal physician. It also encompasses the essential primary care function of care coordination across multiple settings and clinicians.⁴¹

Despite a strong evidence base, primary care faces many challenges. Graduates of US medical schools are not choosing to specialize in primary care, raising concerns about workforce capability in a system with an expanded reliance on primary care. New physicians' decreased interest in primary care careers coincides with increasing indebtedness for medical trainees, the ever-widening gap in salaries between primary care and specialist physicians, an exponential increase in primary care functions, and burnout among practicing physicians called on to deliver more and more services in less and less time.⁴² Implementation of the PCMH model will require infrastructure investment and retooling in the primary care practice. Primary care cannot be addressed in a vacuum; ultimately, the focus should be on rewarding those who contribute to high-quality, cost-effective care across the continuum, regardless of specialty or venue.⁴³

The government must expand and establish new incentives to encourage primary-care practice. In the 1960s, the federal government offered loan repayment programs to primary-care physicians willing to work in community health centers. In the 1970s, federal law funded the training of medical students, residents, and fellows with interest in primary care. Federal support for both of these programs is underfunded and periodically threatened (e.g., recently available funding for community health centers allowed only one in three qualified applications for new health centers to be approved for funding) even as much more generous support for specialist training has been maintained.⁴⁴ Improving the compensation for primary-care practice is another practical option. Primary-care practitioners generally earn much less than specialists; reimbursement rates for their services should be increased. Support should also be increased for research in primary care; this would increase the incentives to practice and also encourage medical schools to contribute to developments in primary care.

Another strategy would be to fund hospital and medical-school training programs in primary care that would place medical students and residents in primary-care practices outside of the hospital.⁴⁵

Minority communities will particularly benefit from a patient-centered culturally and linguistically sensitive/competent care system organized to promote easy patient navigation of accessible personal care *and* to hold providers accountable for high-quality, effective care.⁴⁶ Evidence shows that coordinated care effectively manages costs by managing wellness as well as sickness.⁴⁷ The patient-centered health/medical home is rapidly gaining recognition as a superior way to deliver primary care, particularly for people with complex health care needs. The concept of a Health Home also promotes inclusion of complementary/holistic services – services which have long had particular appeal and effectiveness for minority communities.⁴⁸ Given the prevalence of health disparities, minority communities will particularly benefit from this approach. If health care reform efforts are to reduce/eliminate health disparities, then reform measures must strengthen and reinforce patient-centered culturally and linguistically sensitive/competent primary care through enhanced payment for such primary care services and for the adoption of the health/medical home model.⁴⁹

Community health centers (CHCs) represent the nation's largest single system of comprehensive, primary health care; in 2007, some 7000 CHCs served more than 16 million patients. CHCs are an important source of care for uninsured, publicly insured, and under-insured low-income patients. They serve an estimated one in three low-income persons, one in seven rural Americans, and one in four low-income minority residents. They also provide care to special populations such as nearly 830,000 migrant and seasonal farmworkers and their families, and nearly one million homeless persons. In 2007, 70 percent of all CHC patients had family incomes at or below 100 percent of the federal poverty level, while more than 90 percent had family incomes at or below twice the federal poverty level. CHC patients are also racially and ethnically diverse; in 2007, minority patients comprised half of all health center patients, and one-third of all health center patients were of Hispanic/Latino ethnicity⁵⁰

A 2008 analysis comparing preventive care performance for Medicaid and uninsured patients in health centers and other settings found that even though health center patients were more likely to be lower income, minority, and in poorer health, health centers outperformed other practice settings in the level of preventive care they provided.⁵¹ Efforts to reform the system will likely involve strategies aimed at strengthening the primary health care workforce and shifting health care investments toward primary care, investing in a modern health care infrastructure, reducing health care disparities, and achieving improvements in health care quality while simultaneously fostering greater efficiencies through wiser use of resources. In light of their particularly critical contribution to the health of minority and vulnerable populations, CHCs must play a key role in implementing this broadened concept of health care reform.⁵²

Organizations such as the National Association of Public Hospitals and Health Systems urge that health care reform establish federally-designated Coordinated Care Networks

(CCNs). CCNs would focus on meeting the special needs of vulnerable low income populations under health care reform.⁵³ Complementary to Accountable Care Organizations (ACO), for Medicare beneficiaries and mainstream insured populations. CCNs will offer an opportunity to design, test and implement delivery system reforms targeted specifically on vulnerable, low income, and minorities populations and essential community-wide safety net services. States can play an important role in improving care coordination and case management and strengthening linkages between primary care providers and other child and family service providers to promote and support the healthy development of young children. States can use primary care practice-based strategies, service provider linkage strategies, and systems change and cross-system strategies.⁵⁴

While health care reform must create a financially sustainable health care system, new or revised financing and reimbursement policies must not adversely and/or disproportionately affect minority and vulnerable communities. Indeed, such financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status.⁵⁵ Communities of color experience significant disparities relative to whites in both coverage and access. These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in nonminority communities.⁵⁶

The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs – jobs disproportionately occupied by people of color – tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees.⁵⁷ The Kaiser Family Foundation 2009 Update State Health Facts/Key Health and Health Care Indicators by Race/Ethnicity and State shows the glaring/breathtaking health disparities for minority populations for infant mortality rates, diabetes-related mortality rates, annual AIDS case rate, percent living in poverty, and percent uninsured.⁵⁸

Preserve the Safety Net, Focus on Community Engagement and the Social Determinants of Health, Promote Partnerships with Public Health

Principle 9: A robust safety net must be maintained to insure that vulnerable and minority populations do not fall through the cracks. Minority and vulnerable communities are those who not able to access affordable health care coverage and/or services and thus disproportionately rely on the safety net, e.g., children in immigrant families, low-income parents, low-wage working adults with no children, some lawfully residing residents, and undocumented residents in the U.S.

Principle 10: Health care reform must include minority communities as key stakeholders to provide direct input as to how health care should be structured and delivered. Strong and active minority and vulnerable community engagement is the essential foundation for establishing successful strategies to eliminate health disparities that include meaningful prevention strategies and that account for/address the social determinants of health (SDOH).

Principle 11: The public health infrastructure must be strengthened to assure that its primary functions and activities are responsive to a diverse population, especially minority and vulnerable communities and account for/address the social determinants of health (SDOH). Health departments must have the ability to hold their agencies accountable for health disparities as well as the capacity to deal/work with diverse populations in public health emergencies. Minority and vulnerable communities represent a particular challenge/responsibility for public health because these communities disproportionately lack access to health care and health homes.

Discussion

Safety net organizations have long led the US health care sector in providing quality care to diverse low-income communities through their mission to provide care to all, regardless of ability to pay. Compared to other health care providers nationwide, safety net organizations continue to care for a much higher percentage of individuals from ethnically and racially diverse backgrounds, as well as a greater percentage of individuals with limited English proficiency. Community health centers and public hospitals and health care systems throughout the US have cared for all individuals in their communities, including the uninsured, low-income patients, diverse populations, and those with limited English proficiency. These organizations must continue to play a critical role in expanded coverage and providing specialized care for low-income and minority communities.⁵⁹

While some legislators and policymakers may believe that health care reform may blunt the need for safety net services, the Massachusetts reform experience points to a continuing, and even increased, need for safety net services for low-income and minority patients post health care reform.⁶⁰ Community health centers in Massachusetts continue to play a critical role in caring for newly-insured patients while simultaneously serving as the primary care safety net for uninsured residents.⁶¹ Safety net providers, especially community health centers, continue to be a vital source of care in a post-health care reform world and these providers must be supported by investments in the health care delivery infrastructure, particularly primary care capacity. Safety net health care providers must continue to be: (1) national models in eliminating health disparities; (2) a key resource for primary care and chronic disease management in medically underserved minority and vulnerable low-income communities; and (3) an essential economic engine for local economies.⁶²

Researchers have found that partnerships with community stakeholders can improve availability and quality of health care in under-served neighborhoods. The federal Centers for Disease Control and Prevention (CDC) has long supported innovative community health programs and in 2008 published *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*.⁶³ This workbook reflects the experiences of community organizations and public health practice that have focused on a broad array of conditions affecting health (e.g., housing, access to healthy foods, environmental pollutants) in successfully developing community-based initiatives to promote healthy behaviors. *Promoting Health Equity* offers a practical evidence-based framework for effective community-based initiatives that reflect community priorities and values that consider and account for the social determinants of health (SDOH) in improving community health.⁶⁴

Work funded by the Division of Prevention Research of the CDC to synthesize available knowledge about the effectiveness of community-based interventions to improve population health outcomes led to the development of a conceptual model that links social environmental interventions to health outcomes.⁶⁵ Identified as the *Community's Guide*, the fundamental premise of this model is that access to societal resources determines community health outcomes. Standard of living, culture and history, social institutions, built environments, political structures, economic systems, and technology are all societal resources that populations draw upon to sustain health.⁶⁶

The need to recognize and understand the link between the social determinants of health (SDOH) and health status/health disparities in minority and vulnerable populations is increasingly well-accepted in academic, research and policy circles. The March/April 2005 issue of the leading health policy and health service research journal *Health Affairs* was dedicated to addressing racial and ethnic health disparities.⁶⁷ Excerpts from the Foreword are instructive:

“At the outset, it must be clear that the strategies for eliminating disparities in health care and health status will, by necessity, be different...it is widely known that less than one-quarter of our health status is attributable to health care; rather, our health—or lack thereof—is primarily determined by social factors such as unhealthy practices, poverty, unemployment and underemployment, racism and discrimination, transportation, housing and other neighborhood environmental conditions...Further research and study about community-based approaches to advance health promotion and disease prevention in communities wracked by poverty, racism, and other adverse environmental conditions is critical.”⁶⁸

For several years, numerous peer-reviewed journals have published studies documenting the success of health promotion/health behavior change strategies that incorporate community-oriented strategies and account for the environment-focused multiple determinants of health.⁶⁹ Consensus among leading researchers, policymakers, and public health officials around the world has been coalescing that eliminating health disparities requires addressing the multiple social determinants of

health as well as assuring access to quality medical care services.⁷⁰ Indeed, in light of this accumulating evidence, the World Health Organization established a Commission on Social Determinants of Health in 2005 that has developed SDOH policies to improve the health of the world's most vulnerable populations.⁷¹

In October 2008, the World Health Organization Commission on Social Determinants of Health (CSDH) released its final report *Closing the gap in a generation: Health equity through action on the social determinants of health*. The CSDH was charged to provide support countries and global health partners to address the social factors leading to ill health and inequities. The report concluded that the social determinants of health are known to be among the worst causes of poor health and inequalities between and within countries.⁷² WHO Director-General Dr Margaret Chan said of this report "This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health care services and influence lifestyle choices in the first place." Inequities are killing people on a "grand scale."⁷³

Unfortunately, residential segregation is a notable factor in the US social environment. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. The result too often is that the geographic distribution of health care resources within and across communities results in racially disparate health care: institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities.⁷⁴

In 2001, the Institute of Medicine Committee on Health and Behavior had noted that "*Greater emphasis is needed on public health interventions that involve communities, with the goal of collectively identifying resources, needs and solutions... Individuals and families are embedded within social, political and economic systems that shape behaviors and constrain access to resources necessary to maintain health.*"⁷⁵ Seventy-five percent of health care spending is on preventable diseases that rob millions of Americans of quality life-years and deprive society of productive citizens. Investing in illness and injury prevention is estimated to save billions of dollars spent treating avoidable communicable and chronic diseases.⁷⁶

As a candidate, President Barack Obama asserted: "*Simply put, in the absence of a radical shift towards prevention and public health, we will not be successful in containing medical costs or improving the health of the American people.*"⁷⁷ This observation echoed the landmark 2002 IOM report *The Future of the Public's Health* that hailed the traditional role of public health to ensure a basic level of health for the population.⁷⁸ Noting that major improvements in health status and health outcomes have come from population-focused intervention involving social conditions such as improved sanitation, clean drinking water, and slum eradication/infection control, the IOM stated that community good health is related to basic infrastructure quality and social/economic equality.⁷⁹

Emerging policy consensus finds that prevention is crucial to improving health and reducing inequities between racial, ethnic and socioeconomic groups. Strategic investment and implementation of prevention strategies can address the underlying conditions that lead to death, illness, injury, and health inequities in the first place.⁸⁰ Low-income populations and communities of color disproportionately experience worse health and safety outcomes across a broad spectrum of illnesses, injuries, and treatments. To improve health status and equity, proportionately greater attention must be given to a prevention-oriented approach supported by strengthened public health infrastructure.⁸¹ Policies and organizational practices that improve the environments in which people live, work, learn, and play are powerful tools in reducing disparities.⁸²

States through their local public health departments can promote and/or (in most cases) reinvigorate community-based health care planning mechanisms, in which members of the community identify their needs and assist policymakers in planning, implementing, and evaluating the effectiveness of public health systems. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation and implementation of health activities in their communities.⁸³ During the last 10 years, substantial progress has been made in developing the skill sets of and tools available local public health departments to facilitate and support population-based programs designed to improve health equity in vulnerable communities.⁸⁴

Local health departments can support the training of and reimbursement for community health workers, sometimes also known as “lay health navigators” or *promotores*. Community health workers are trained members of medically underserved communities who work to improve community health outcomes by serving as liaisons between community members and health care organizations⁸⁵. In some models, community health workers are trained to teach disease prevention, conduct simple assessments of health problems and help their neighbors and community entities access appropriate health and human resources. Community health worker models are rapidly spreading, as research and practice begin to show improved health outcomes.

Data Systems Ensure Comprehensive Capacity and Multi-Dimensional Accountability for Eliminating Disparities as well as Achieving Reform

Principle 12: The developing area of Health Information Technology (HIT) must support the delivery of a continuum of patient-centered, culturally and linguistically sensitive/ competent care that is seamless and coordinated. HIT through its data-collection must be used for quality assurance and improvement aimed at eliminating health disparities/inequities. HIT must go beyond the hospital to include community-based providers and programs that serve minority and vulnerable communities.

Principle 13: Data collection strategies must be designed to recognize, measure, evaluate, and address the social determinants of health (SDOH) within the context of

the health care system and strategies to improve health outcomes, promote quality assurance, and eliminate health disparities/inequities. SDOH includes environmental influences such as poor housing, unsafe neighborhoods, lack of access to fresh foods, and polluted environments as well as personal behaviors.

Principle 14: Data collection strategies, including information on quality, performance, and outcomes, must be transparent and consistent with the benchmarks for eliminating health disparities/inequities as established by the Secretary of HHS or by the federal Health Equity Commission. Measures relevant to and informative of minority and vulnerable communities have been disproportionately absent from data collection and measurement strategies -- this situation must be corrected.

Discussion

The singular/critical importance of data collection cannot be overemphasized. Data are the fundamental building blocks to determining what factors contribute to creating health care disparities and to designing the strategies to reduce and eliminate these disparities.⁸⁶ Though the presence of disparities in care is well documented, the causes of these disparities are not well understood. A panel of experts convened by the National Academies found that disparities in health care may or may not be due to conscious or unconscious discrimination.⁸⁷ Moreover, disparities in care may be attributed to both organizational or *systems* factors as well as *individual* characteristics of practitioners and patients. Consequently, collecting accurate *and* comprehensive data is of utmost importance—the basic foundation—in working toward eliminating such disparities and improving quality of care.

Data collection has become central to the quality assurance process that can be used to address health disparities. Although disparities and quality are linked, simply improving overall quality of care may not reduce disparities. If data on race, ethnicity, and primary language are available, then disparities in health care can be addressed through a quality of care framework.⁸⁸ Systems reform envisions quality improvement as an organizational responsibility as evidenced by research on diversity faced by hospitals.⁸⁹ A systems approach to reducing racial and ethnic disparities requires performance data that stratify quality-of-care indicators according to patients' race and ethnicity.⁹⁰ Of the 42 quality indicators used in National Healthcare Disparities Report, less than one-half of these measures are available over time for all income, and race/ethnicity groups.⁹¹ This serious deficiency suggests that major changes in data collection and development are necessary to ensure the requisite basis for successful strategies to eliminate health disparities. Disparities in health care can be addressed through a quality of care framework *only if* data on race, ethnicity, and primary language are available. Credible and reliable data collection tools are available/vetted and reliable to support and facilitate these efforts.⁹²

Valid and reliable data are also essential for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific

populations. The capacity to measure and monitor quality of care for various racial, ethnic, and linguistic populations rests on the ability both to measure quality of care in general and to conduct similar measurements across different racial, ethnic, and linguistic groups. According to the report "The Right to Equal Treatment" issued by Physicians for Human Rights, data collection has long been central to the quality assurance process.⁹³

A centerpiece of the current Administration's health care reform strategy involves the use of Comparative effectiveness research (CER) to achieve costs savings by reducing the delivery of ineffective services and to reallocate resources toward effective services. This linchpin of reform will be seriously compromised without adequate comparable data on minority and vulnerable communities. For example, a recent study by the Kaiser Family Foundation shows that women of color in every state continue to fare worse than white women on a variety of measures of health, health care access and other social determinants of health.⁹⁴ The analysis also provides new state-level data for women of many racial and ethnic populations that are often difficult to obtain. In presenting data on Asian American (AA), and Native Hawaiian/Other Pacific Islander (NHPI), the KFF authors note that AA and NHPI are two relatively small but diverse populations. Analyses of AA and NHPI subgroups reveal a more complex picture of health coverage and access to care, one which is clouded by both a lack of data and the reporting of data on AA and NHPI as one group.

The report moves beyond national figures to quantify where disparities are greatest, providing new information to help determine how best to combat the problem and illustrating that national statistics mask substantial state-by-state variation in disparities. For some subgroups, these problems are comparable to the most disadvantaged racial and ethnic group. The authors insist that more and better data are needed to fully understand the needs of these populations and to develop solutions for improved access to and quality health care.⁹⁵

And last, but, certainly not least, another critical data challenge involves emerging communities are increasingly seen as both the settings and key actors as evidence and sharper knowledge emerge concerning the multiple dimensions of the social determinants of health (SDOH). For several years, numerous peer-reviewed journals have published studies documenting the success of health promotion/health behavior change strategies that incorporate community-oriented strategies to improve access to conditions necessary for healthy lives such as healthy foods and safe neighborhoods, and that account for the multiple environment-focused determinants of health.⁹⁶ To support these strategic frameworks for change, innovative approaches to data collection must emerge to identify and quantify the variety of community-based conditions that determine health behaviors.⁹⁷ As discussed earlier, the CDC is already providing notable/effective leadership in this area.⁹⁸ Data collection and measurement strategies must keep pace with and support/inform this work.

Despite two decades of attention, measures/indicators relevant to and informative of minority and vulnerable communities continue to be disproportionately absent from data

collection and measurement strategies. At this critical juncture, we must benchmark and track indicators for all populations by collecting race, ethnicity, and primary language data accurately to monitor quality of care. Expected shortly is an Institute of Medicine report that will provide guidance on standardization of data collection on race, ethnicity, and language. Data collection strategies, including information on quality, performance, and outcomes, must be transparent and consistent with the benchmarks for eliminating health disparities/inequities as established by an entity with sufficient moral stature and legal clout to demand accountability. As discussed below, establishing a Federal Health Equity Commission is required to ensure all necessary steps are taken to reduce/eliminate health disparities.

Discussion of Recommendations to Implement 14 Principles

The Advisory Committee on Minority Health makes three overarching Recommendations to ensure that the foregoing 14 Principles for Minority Health Equity are effectively incorporated into health care reform activities so that health care reform will meet the needs of minority communities and create the impetus and infrastructure to eliminate health disparities:

Recommendation 1: The Administration and the Congress shall take steps to develop and establish a Federal Health Equity Commission (akin to the Federal Civil Rights Commission) that will focus on eliminating health disparities in the US. The Health Equity Commission will provide the stature and clout demonstrably necessary to begin to achieve sustained progress toward the elimination of health disparities/inequities.

Recommendation 2: In the meantime, all health care reform commissions, committees, and working groups – whether federal or state or local governmental and legislative, public or private think-tank/NGO, must take steps to include sub-committees that address health disparities/inequities, minority health equity, and workforce diversity. It is equally important that these entities take meaningful steps to ensure diversity reflective of communities served in their leadership, membership, and staffing.

Recommendation 3: The 14 Principles for including Minority Health Equity in Health Care Reform must be thoroughly considered/addressed in writing by all entities described in Recommendation 2. These reports must be delivered to the Secretary of US Health and Human Services and the Federal Health Equity Commission.

“Health is the place where all the social forces converge....the fight against disparities in health is also one against the absence of hope for a meaningful future.”¹⁹⁹

In 2003, the Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, established a clear roadmap to eliminate health disparities. Despite this compelling call to arms, and the issuance of numerous and compelling reports on health disparities by other prestigious entities, the gaps in health status remain the same or are worsening with shocking consequences. A recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, then over 880,000 deaths would have been averted.¹⁰⁰ The Institute of Medicine estimated that 18,000 people die prematurely each year because they lack health insurance – the black/white mortality rate has not improved in 60 years, and that the annual cost to the nation of the poorer health and shortened life spans attributable to uninsurance is between \$65 and \$130 billion.¹⁰¹ Because people of color are disproportionately represented among the uninsured, these numbers carry a greater burden in minority communities.¹⁰² Moreover, minority communities are disproportionately affected by conditions adverse to health including living in unhealthy environments with fewer health care facilities, fewer health care professionals and less emphasis on general wellness.¹⁰³

In light of this disheartening history, we recommend and urge the establishment of a Federal Health Equity Commission. In accordance with Dr. Martin Luther King's piercing observation that injustice in health is the most shocking and most inhumane inequality, the Health Equity Commission will effectively elevate health disparities issues to the status of civil rights issues, and recognize that in the US all people have the inalienable right to an equal opportunity for a healthy life.¹⁰⁴

The legislative history of the Civil Rights Commission shows a remarkable similarity in context and goals to the blueprint for change outlined by the IOM. The Civil Rights Commission was created by the Civil Rights Act of 1957 in response to a recommendation by an ad hoc President's Committee on Civil Rights. In calling for a permanent commission, that Committee stated: "In a democratic society, the systematic, critical review of social needs and public policy is a fundamental necessity. This is especially true of a field like civil rights, where the problems are enduring, and range widely [and where] ... a temporary, sporadic approach can never finally solve these problems. Nowhere in the federal government is there an agency charged with the continuous appraisal of the status of civil rights, and the efficiency of the machinery with which we hope to improve that status.... A permanent Commission could perform an invaluable function by collecting data.... Ultimately, this would make possible a periodic audit of the extent to which our civil rights are secure.... [The Commission should also] serve[] as a clearing house and focus of coordination for the many private, state, and local agencies working in the civil rights field, [and thus] would be invaluable to them and to the federal government."¹⁰⁵ A permanent Commission on Civil Rights should point all of its work toward regular reports which would include recommendations for action in ensuing periods. It should lay plans for dealing with broad civil rights problems.... It should also investigate and make recommendations with respect to special civil rights problems.¹⁰⁶

The charge for the Health Equity Commission will include at least (1) develop and analyze recommendations for improving the health of racial and ethnic minorities and vulnerable low-income communities, and (2) monitor and regularly review progress in achieving a diverse health care workforce. The achievement of minority health equity requires that health care reform be built on workforce diversity. The Federal Health Equity Commission should have the status and scope of responsibilities and authorities comparable to the Federal Civil Rights Commission. This approach also shifts the focus away from the list of health disparities to the desired outcomes and implied action strategies, and means that key components for change and achieving goals include the leadership and involvement of communities.

Establishing a Federal Health Equity Commission is required to ensure all necessary steps are taken to reduce/eliminate health disparities. Strategies to stratify quality measurements by race and ethnicity will help the health care system provide three critical functions for all populations served by the health care system: 1) ensure the health of the population: 2) ensure equitable access to health care: and 3) ensure the quality of health care. The Health Equity Commission would have the stature to demand that accounting for and measuring the impact of health disparities inform and undergird the critically important work of the Federal Coordinating Council for Comparative Effectiveness Research.¹⁰⁷

The World Health Organization Committee on Social Determinants of Health underscored the urgent need for ameliorative action on health equity issues in their final report. “Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. Inequities are killing people on a grand scale.”¹⁰⁸

The Health Equity Commission will be a catalyst, as in the civil rights movement, for grassroots mobilization to achieve national and state laws and policies for eliminating health disparities and ensuring equal opportunities for healthy lives for all persons. The Commission will provide the ongoing opportunity for re-examining the standards that govern federal financial assistance to health care entities and health programs. New standards can also incorporate stronger requirements for compliance with Title IV civil rights mandates.

The Health Equity Commission will provide needed leadership for developing a legal and policy framework for expediting progress in reducing health disparities/inequities through a concept that is grounded in civil rights law, related policies, and administrative procedures. Facilitating a structural approach to achieving health as well as health care reform that depends upon community-focused, public health and prevention-oriented, environmentally-sensitive strategies to eliminate health disparities will contribute to both the health of minority communities and the health of the nation. Health reform premised on health equity principles could promote more K-12 science programs in minority-populated areas to lay the foundation for an increasingly diverse health care workforce.¹⁰⁹

The Health Equity Commission would define the benchmarks and prescribe the data collection strategies for monitoring and enforcement. State level minority health commissions would be answerable and accountable to Health Equity Commission. The Health Equity Commission would hold all stakeholders in the health care system accountable for showing that information/data are used and applied to eliminating health disparities. The Joint Commission is already providing substantial guidance to health care organizations about leadership strategies, approaches to data collection and analyses, and strategies for collaborating with external communities that can improve the quality of care for minority communities.¹¹⁰ The Joint Commission intends to develop accreditation standards for hospital culturally competent patient care that incorporate issues such as diversity, culture, language, and health literacy.¹¹¹

Publicly reporting health care access and quality disparities at the institutional (e.g., hospital or health clinic) level is important to ensure that the public and policymakers are aware of when and where health care inequality occurs.¹¹² Once state and federal governments have obtained health care access and quality data by patient demographic data, this information should be publicly reported at the smallest possible level (e.g., hospitals and health centers), to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care and to assist efforts to monitor disparities and take appropriate action to investigate potential violations of law.

The Health Equity Commission will ensure that social and economic inequality among racial and ethnic groups and other marginalized populations is recognized as the most significant underlying factor behind most health status inequality.¹¹³ Racial and ethnic discrimination and segregation perpetuate and deepen these gaps. A comprehensive health care reform plan must address these social and environmental factors. Policies should address providing adequate primary care, health education (including in schools) and preventative care for healthy lifestyles, which will all help control costs. The cumulative effect of unhealthy behaviors and unsafe living environments is poor health outcomes and higher costs.¹¹⁴

A large and growing body of public health research demonstrates that we must improve the social and economic contexts that shape health. As the World Health Organization's report on social determinants of health states, "[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces."¹¹⁵ While *Unequal Treatment* provided an unprecedented focus and a much-needed blueprint for addressing disparities in health care services, the IOM exclusive focus on access to health care services meant that the critical need to recognize, assess, and account for the social determinants of health was not recognized.

Federal efforts should look to a broad range of social and economic policy when crafting strategies to improve and equalize health status for all, and state health agencies should play a leadership role in coordinating these efforts. And states can play a large

role in providing incentives for effort to improve health conditions in a community and more effectively punish acts that weaken community health conditions. Through legal and regulatory strategies championed by the Health Equity Commission, state and federal agencies can reduce environmental health risks and monitor whether and how communities are affected by governmental or commercial activity

Pending the US Health Equity Commission, however, Recommendations 2 and 3 insist that ongoing health care reform efforts must address/account for the barriers and disparities that exist in health care. All health care reform commissions, committees, and working groups – whether federal or state or local governmental and legislative, public or private think-tank/NGO, must take steps now to include sub-committees that address health disparities/inequities, minority health equity, and workforce diversity. The 14 Principles for including Minority Health Equity in Health Care Reform must be thoroughly considered and addressed in writing by these entities. These reports must be delivered to the Secretary of US Health and Human Services

It is equally important that these entities take meaningful steps to ensure diversity reflective of communities served in their leadership, membership, and staffing. Diverse leadership is critical for ensuring that health care reform will account for the health needs of minority and vulnerable communities. Again, these entities must document their efforts and accomplishments in establishing diverse leadership and deliver these reports to the Secretary of US Health and Human Services. Relationships with diverse communities are critical to the success of health care executives as they address maximizing resources and building the trust of communities served.¹¹⁶ Institutions with expertise in medicine, medical education, and research must create new relationships with their service communities where they give up command and control and share resources to build a new accountability with the community.¹¹⁷

ENDNOTES

¹ 2008 National Healthcare Disparities Report ; Agency for Healthcare Research and Quality pages 7-8 ***Magnitude and Patterns of Disparities Differ Among Various Populations*** Improvements in preventive care, chronic care, and access to care have led to the elimination of disparities for some priority populations in areas such as mammograms, smoking cessation counseling, and appropriate timing of antibiotics. At the same time, many of the largest disparities have not changed significantly. The NHDR can be used to identify the most important gaps in care as well as improvements for priority populations. The complete picture of disparities is different for each population. An analysis of each population allows targeting of resources and efforts to improve care and narrow the gaps in care for racial and ethnic minorities and poor populations.

In 2005, the NHDR reported on the biggest gaps that existed in health care quality in America for Blacks, Asians, AI/ANs, Hispanics, and poor populations. Some of the largest gaps reported in 2005 remain the largest gaps in this year's NHDR. For Blacks, large disparities remain in new AIDS cases despite significant decreases. The proportion of new AIDS cases was 9.4 times as high for Blacks as for Whites. Hospital admissions for lower extremity amputations in patients with diabetes and lack of prenatal care for pregnant women in the first trimester are the largest disparities for Blacks observed in the 2008 NHDR.

For Asians, disparities remain in timeliness of care. Asians were more likely than Whites to not get care for illness or injury as soon as wanted. For AI/ANs, disparities remain in prenatal care. AI/AN women were twice as likely to lack prenatal care as White women.^v Also, AI/AN adults were less likely than Whites to receive colorectal cancer screening. For Hispanics, large disparities also remain in new AIDS cases despite significant decreases. The rate of new AIDS cases was more than three times as high for Hispanics as for non Hispanic Whites. For poor people, disparities remain in communication with health care providers. The percentage of children whose parents reported communication problems with their health providers was nearly four times as high for poor children as for high income children. Poor adults were also more than twice as likely not to get timely care for an illness or injury.

The "biggest gaps" are defined as those quality measures with the largest relative rates between Whites and racial and ethnic minorities and between high income and poor individuals. For example, a relative rate of 4.0 means that this population was four times as likely as the White population to be hospitalized for pediatric asthma. This analysis is presented in Table H.1."

² James C, Thomas M, Garfield R, and Lillie-Blanton M. *Key Facts: Race, Ethnicity & Medical Care*. Kaiser Family Foundation, January 2007.

³ Satcher D. What if we were equal? A Comparison of Black-White Mortality Gap in 1960 and 2000. *Health Affairs* 24(2): 459-464 2005

⁴ It was only in 1999 that Schulman et al published the groundbreaking study that brought the issue into public consciousness. Schulman KA, et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*. *NEJM* , 340: 618-626, 1999

⁵ National Conference of State Legislatures, *Minority Health Laws: Commissions and Offices of Minority Health*. Last updated June 2007. See <http://www.ncsl.org/programs/health/mhcommissions.htm> (last accessed: May 7, 2008).

⁶ Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academy Press, 2002.

⁷ Ibid.

⁸ Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2008*. Rockville, MD.

⁹ Joslyn S & West M. *Racial Differences in Breast Carcinoma Survival*. *Cancer*, 88(1): 114-123, 2000.

¹⁰ Stone V, Steger KA, Hirschhorn LR, Boswell SL, et al. *Access to treatment with protease inhibitor (PI) containing regimens: is it equal for all?* *Int Conf AIDS*, 12: 834, 1999.

¹¹ Agency for Health care Research and Quality, *National Healthcare Disparities Report, 2008*. Rockville, MD.

¹² Louis O, Sankar P, Ubel P. *Kidney Transplant Candidates' Views of the Transplant Allocation System*. *J Gen Intern Med*, 12(8): 478-484, 1997.

-
- ¹³ Kim C, Hofer TP, Kerr EA. Review of evidence and explanations for suboptimal screening and treatment of dyslipidemia in women: a conceptual model. *J Gen Intern Med*,18: 854-63, 2003.
- ¹⁴ Tanjasiri, SP, and Nguyen, T. "The Health of Women" in *Asian American Communities and Health*. Eds. Trinh-Shevrin, C, Islam, NS., Rey, MJ., Jossey-Bass, 2009, p. 143
- ¹⁵ Trends in Indian Health 1998–1999. Available at: <http://www.ihs.gov/PublicInfo/Publications/index.asp> 2005.
- ¹⁶ Dixon M, Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*. Washington, DC: American Public Health Association; 2001. Roubideaux Y. *A Review of the Quality of Health Care for American Indians and Alaska Natives*. New York, NY: The Commonwealth Fund; 2004
- ¹⁷ June 2009 Kaiser Family Foundation *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*
- ¹⁸ US Department of Health and Human Services Advisory Committee on Minority Health, A Recommendation Report from the HHS Advisory Committee on Minority Health – *Reducing Health Disparities by Promoting Patient-Centered Culturally and Linguistically Sensitive/Competent Health Care*, submitted to U.S. Department of Health and Human Services Office of Minority Health, Washington, DC; September 8, 2008.
- ¹⁹ Institute of Medicine. Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, Washington, DC: National Academy Press; 2004.
- ²⁰ Ibid.6.
- ²¹ *Grutter v. Bollinger*, 539 U.S. 306 (2003), is a case in which the United States Supreme Court upheld the affirmative action admissions policy of the University of Michigan Law School. The 5-4 decision was announced on June 23, 2003.
- ²² Hughes, DI (2002). *Quality of healthcare for Asian Americans: Findings from The Commonwealth Fund 2001 Health Care Quality Survey*. New York: Commonwealth Fund
- ²³ Sinkford, J. & Valachovic, R. (2001). Financing a dental education: Implications for URMs and the W.K. Kellogg/ADEA Access to Dental Careers (ADC) Grant. Paper presented at the American Dental Education Association, 43rd Annual Deans' Conference, Scottsdale, AZ.
- ²⁴ Ngo-Metzger, Q., Sorkin, DH., Phillips, RS, Greenfield, S., Massagli, MP, Clarridge B., et al (2007). Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. *Journal of General Internal Medicine*, 22 (Suppl.2), 324-330.
- ²⁵ Ibid.19.
- ²⁶ Ibid.19.
- ²⁷ Louis W. Sullivan, *Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Health care Workforce*, funded by the W.K. Kellogg Foundation, Battle Creek, MI; 2004.
- ²⁸ National Public Health and Hospital Institute, *Serving Diverse Communities in Hospitals and Health Systems from the Experience of Public Hospitals and Health Systems*, Washington, DC; 2004.
- ²⁹ Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E, *One Size Does Not Fit All: Meeting the Needs of Diverse Populations*. The Joint Commission, Oakbrook Terrace, IL; 2008.
- ³⁰ Wilson-Stronks A and Galvez E, *Exploring Language and Culture in the Nation's Hospitals: A Report of Findings*. The Joint Commission, Oakbrook Terrace, IL; March 2007.
- ³¹ American College of Health care Executives, Association of Hispanic Health care Executives, Executive Leadership Development Program, Indian Health Service, Institute for Diversity in Health Management, National

Association of Health Services Executives, Foundation of the American College of Health care Executives, *A Race/Ethnic Comparison of Career Attainments in Health care Management*, Chicago; 2002.

³² Fuentes A, *Condition Critical: The Absence of Latinos among Policymakers in New York City's Voluntary Hospitals*. Puerto Rican Legal Defense Fund, [Public Health Informatics Institute](#), New York; 2004.

³³ Institute of Medicine Diverse Workforce *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, National Academy Press Washington DC 2004

³⁴ Beal A, Doty M, Hernandez S, Shea K, Davis K, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Survey Health Care Quality*, Volume 62, The Commonwealth Fund, New York; June 27, 2007.

³⁵ The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, The Commonwealth Fund, February 2009 Commission recommends these strategies: establishing a national insurance exchange that offers a choice of private plans and a new public plan; requiring everyone to have coverage, with income-related premiums to make coverage affordable; and instituting insurance market reforms that focus competition on outcomes and value.

³⁶ The Robert Wood Johnson Foundation *Racial and Ethnic Disparities in Access to and Quality of Health Care* Princeton 2007

³⁷ Institute of Medicine *Hidden Costs Values Lost Uninsurance in America* Washington DC National Academy Press 2003

³⁸ Lillie-Blanton, Marsha. *Addressing Disparities in Health and Healthcare: Issues for Reform* Testimony before Congress House of Representatives Committee on Ways and Means Health Subcommittee June 10, 2008

³⁹ Rasell ME, *Cost Sharing in Health Insurance -- A Reexamination*. N Engl J Med 1995;332:1164-1168. Newhouse JP, *Free for all? - Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press, 1993.

⁴⁰ The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, The Commonwealth Fund, February 2009 Commission recommends these strategies: establishing a national insurance exchange that offers a choice of private plans and a new public plan; requiring everyone to have coverage, with income-related premiums to make coverage affordable; and instituting insurance market reforms that focus competition on outcomes and value.

⁴¹ Davis, K., Ph.D., Schoenbaum, S.C., M.D., Audet, A.M.J., M.D., *A 2020 Vision of Patient-Centered Primary Care*, *Journal of General Internal Medicine*, October 2005, 20 (10): 953-57

⁴² Lee TH, Bodenheimer T, Goroll AH, Starfield B, Treadway K. Perspective roundtable: redesigning primary care. *N Engl J Med*. 2008;359(20):e24

⁴³ Starfield, B. The Primary Solution Put doctors where they count. *Reforming Health Care* Boston Review, November/December 2005. <http://bostonreview.net/BR30.6/starfield.php> See also Patient-Centered Primary Care Collaborative Web site. <http://www.pcpcc.net/index.php>. PPC-Patient-Centered Medical. National Committee for Quality Assurance Web site. <http://www.ncqa.org/tabid/631/Default.aspx>

⁴⁴ Starfield, B. The Primary Solution Put doctors where they count. *Reforming Health Care* Boston Review, November/December 2005. <http://bostonreview.net/BR30.6/starfield.php>

⁴⁵ Ibid.

⁴⁶ *Reducing Health Disparities by Promoting Patient-Centered Culturally and Linguistically Sensitive/Competent Health Care*. A Recommendation Report from the HHS Advisory Committee on Minority Health (ACMH). Submitted to US Department of Health and Humans Services Office of Minority Health Submitted September 8, 2008.

⁴⁷ American College of Physicians. *Position Paper: The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care*. Philadelphia: American College of Physicians; 2005. Nutting PA, Miller WL, Crabtree

BF et al., Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home, *Annals of Family Medicine*, May/June 2009 7(3):254–60.

⁴⁸ Ibid.46

⁴⁹ Ibid.43. Ibid.34 Ibid.35. Ibid.37.

⁵⁰ Rosenbaum, Sara. Finnegan, B. Shin, P. The Henry J. Kaiser Family Foundation Commission on Medicaid and the Uninsured March 2009 Issue Paper: Community Health Centers in an Era of Health System Reform and Economic Downturn: Prospects and Challenges March 2009

⁵¹ Shin P, Markus A, Rosenbaum A. *Measuring Health Centers against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project*. (United Health Foundation, 2006.) www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/United_Health_Foundation_report_082106.pdf Extensive research into the impact of health centers on pediatric health shows that health center services have led to reductions in community infant mortality rates, an increase in the number of children with a regular source of primary care, and increased use of preventive pediatric care.

⁵² Ibid.50

⁵³ National Association of Public Hospitals and Health Systems and National Association of Community Health Centers, *Letter to U.S. Senate Finance Committee, Washington, DC; May 20, 2009*.

⁵⁴ Johnson, K. and Rosenthal, J., *Improving Care Coordination, Case Management, and Linkages to Service for Young Child: Opportunities for States*, The Commonwealth Fund and the National Academy of State Health Policy, April 2009 http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/April/NASHP_Care_Coordination_April_2009.pdf

⁵⁵ *The Society and Population Health Reader: Volume I Income Inequality and Health* Eds. Kawachi, I., Kennedy, BP, Wilkinson, RG. The New Press New York City. 1999. Ibid. 2 Ibid.37

⁵⁶ Addressing Racial and Ethnic Health Care Disparities Testimony to the House Energy and Commerce Committee, Health Subcommittee Brian D. Smedley, Ph.D. Health Policy Institute Joint Center for Political and Economic Studies

⁵⁷ Ibid. Ibid.55.

⁵⁸ The Kaiser Family Foundation *2009 Update State Health Facts/Key Health and Health Care Indicators by Race/Ethnicity and State*, April <http://www.kff.org/minorityhealth/upload/7633-02.pdf>

⁵⁹ National Public Health and Hospital Institute, *Assuring Health care Equity: A Healthcare Equity Blueprint*, in collaboration with the Institute for Healthcare Improvement with support from the U.S. Department of Health and Human Services Office of Minority Health. Washington, DC; 2008.

⁶⁰ Ibid.53 Public hospitals saw their low-income patient volumes increase as coverage expanded to the uninsured. For community health centers, revenues increased by roughly 14 percent between 2006 and 2007, but costs also climbed 15 percent, even as they grew their patient population by 50,000. These providers serve one-third of the state's remaining uninsured population, up from one-fourth pre-reform. In 2008, the largest Massachusetts safety net hospitals were paid on average 66 percent of their costs for treating low income, Medicaid and uninsured patients.

⁶¹ Ku, L. et al. The Henry J. Kaiser Family Foundation Commission on Medicaid and the Uninsured March 2009 Report: How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform

⁶² National Association of Public Hospitals and Health Systems, *Health Reform Advocacy Information Packet, Washington, DC: 2009*.

⁶³ Promoting Health Equity A Resource to Help Communities Address Social Determinants of Health See FN. 5 <http://www.cdc.gov/NCCDPHP/DACH/chaps/pdf/SDOHworkbook.pdf>

-
- ⁶⁴ The social determinants of health (SDOH) are defined as life-enhancing resources, such as food supply, housing, economic and social relationships, education, and health care, whose distribution across populations effectively determines length and quality of life. The premise of Health People 2010 (HP2010) -- healthy people living in healthy communities -- reflects the widely recognized link between SDOH and health status. See: Brennan Ramirez LK, Baker, EA Metzler M. *Promoting Health Equity A Resource to Help Communities Address Social Determinants of Health*, Atlanta: US Department of Health & Human Services, Centers for Disease Control & Prevention 2008
- ⁶⁵ Anderson, LM et al. The *Community Guide's* Model for Linking the Social Environment to Health, *American Journal of Preventive Medicine*, 2003;24(3S) pp. 12-22. Anderson, LM et al. Methods for Conducting Systematic Reviews of the Evidence of Effectiveness and Economic Efficiency of Interventions to Promote Health Social Environments, *American Journal of Preventive Medicine*, 2003;24(3S) pp.25-31.
- ⁶⁶ Ibid. The *Community's Guide* model identifies these specific social environment factors associated with health outcomes: neighborhood living conditions, opportunities for learning and developing capacity, community development and employment opportunities, prevailing community norms, customs, and processes, social cohesion, civic engagement, and collective efficacy, and programs/services/opportunities that address health promotion, disease and injury prevention and primary/secondary healthcare needs. A similar conceptual framework for examining the community effect on health also appeared in noted health policy journal Bell. J., Standish, M. Communities and Health Policy: A Pathway for Change *Health Affairs* 24(2) March/April 2005.
- ⁶⁷ Racial & Ethnic Disparities *Health Affairs*, 24(2) March/April 2005.
- ⁶⁸ Racial & Ethnic Disparities *Health Affairs*, 24(2) March/April 2005 Foreword authored by Risa Lavizzo-Mourey, President/CEO, The Robert Wood Johnson, William C. Richardson, President/CEO, WK Kellogg Foundation, Robert K. Ross, President/CEO, The California Endowment, and John W. Rowe, Chair/CEO, Aetna,
- ⁶⁹ See, e.g., Bigby, JA et al. A Community Approach to Addressing Excess Breast and Cervical Cancer Mortality Among Women of African Descent in Boston. *Public Health Reports* Vol.118 July-August 2003 338-347. Saegert, S, et al. Healthy Housing: A Structured Review of Published Evaluations of US Interventions to Improve Health by Modifying Housing in the United States, 1990-2001 *American Journal of Public Health* 93(9):1471-1477 September 2003. Srinivasan, S, O'Fallon, LR, Dearry, A. Creating Healthy Communities, Healthy Homes, Health People: Initiating a Research Agenda on the Build Environment and Public Health *American Journal of Public Health* 93(9):1446-1550 September 2003.
- ⁷⁰ US Department of Health and Human Services *Call to action: Eliminating Racial and Ethnic Disparities in Health*, 1998. Schulz, A. et al. Racial and Spatial Relations as Fundamental Determinants of Health in Detroit. *The Milbank Quarterly*, 80(4):677-707, 2002. Marmot, M. Social determinants of health inequalities. *Lancet* 2005; 365:1099-1104.
- ⁷¹ Marmot, M. Social determinants of health inequalities. *Lancet* 2005; 365:1099-1104.
- ⁷² World Health Organization Commission on Social Determinants of Health *Closing the gap in a generation: Health equity through action on the social determinants of health* October 2008
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- ⁷³ Ibid.
- ⁷⁴ Ibid.71
- ⁷⁵ Institute of Medicine. Committee on Health and Behavior: Research, Practice and Policy, Board on Neuroscience and Behavioral Health, *The Interplay of Biological, Behavioral, and Societal Influences* Washington, DC: National Academy Press, 2001.
- ⁷⁶ Prevention Institute <http://preventioninstitute.org/healthdis.html> Health Equity and Community Health. See Also: Ibid.59. The National Steering Committee on Hospitals and the Public's Health is calling on hospitals to fulfill a critical role as collaborators and leaders in recreating the US public health infrastructure and capacity.
- ⁷⁷ Obama '08. Barack Obama's Plan for a Healthy America: Lowering health care costs and ensuring affordable, high-quality health care for all. Available at: <http://www.barackobama.com/pdf/HealthPlanFull.pdf>
- ⁷⁸ Institute of Medicine *The Future of the Public's Health in the 21st Century* National Academy Press 2003. See also Institute of Medicine *The Future of Public Health* National Academy Press 1988.

⁷⁹ Rosen, G. *A History of Public Health* Baltimore: Johns Hopkins University Press, 1993. The role of public health in assuring community health is consistent with traditional, community-focused role of public health. Noted public health historian Elizabeth Fee in her introduction to George Rosen's *A History of Public Health* wrote: "When the history of public health is seen as a history of how populations experience health and illness, how social economic and political systems structure the possibilities for health or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life." See generally: Hofrichter, R. Ed. *Health and Social Justice Politics, Ideology, and Inequity in the Distribution of Disease A Public Health Reader*. Jossey-Bass San Francisco, CA 2003.

⁸⁰ Prevention Institute and The Joint Center for Political and Economics Studies Health Policy Institute. *Reducing Inequities in Health and Safety through Prevention* March 2009
http://preventioninstitute.org/documents/HealthEquityMemo_031709.pdf

⁸¹ Hofrichter, R. and Bhatia, R. (eds). *Tackling Health Inequities through Public Health Practice: Theory to Action* (Oxford University Press, forthcoming, fall, 2009).

⁸² Prevention Institute <http://preventioninstitute.org/healthdis.html> Health Equity and Community Health

⁸³ Ibid.80.

⁸⁴ Ibid.81.

⁸⁵ Addressing Racial and Ethnic Health Care Disparities Testimony to the House Energy and Commerce Committee, Health Subcommittee Brian D. Smedley, Ph.D. Health Policy Institute Joint Center for Political and Economic Studies

⁸⁶ Issue Brief *Collecting Race, Ethnicity, and Primary Language Data: Tools to Improve Quality of Care and Reduce Health Care Disparities*, HRET, 2005: <http://www.hret.org/hret/publications/content/isbr1105.pdf>

⁸⁷ National Research Council, *Eliminating Health Disparities: Measurement and Data Needs*, Panel on DHHS Collection of Race and Ethnicity Data, Michele Ver Ploeg and Edward Perrin, editors, Committee on National Statistics, Division of Behavioral and Social Sciences and Education (Washington, DC: National Academies Press, 2004),

⁸⁸ Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals, Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman, The Commonwealth Fund, May 2004

⁸⁹ Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey, HRET, 2006: <http://www.hret.org/hret/languageservices/content/languageservicesfr.pdf>

⁹⁰ Ibid.88 Ibid.89

⁹¹ Lillie-Blanton, Marsha. Addressing Disparities in Health and Health care: Issues for Reform Testimony before Congress House of Representatives Committee on Ways and Means Health Subcommittee June 10, 2008

⁹² <http://www.hretdisparities.org/> DISPARITIES TOOLKIT Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007) Health Research and Educational Trust Disparities Toolkit. hretdisparities.org accessed on date. *A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients*, HRET: http://www.hretdisparities.org/hretdisparities_app/index.jsp *A Diversity and Cultural Proficiency Assessment Tool for Leaders*, American College of Health care Executives, American Hospital Association, National Center for Health care Leadership, and Institute for Diversity in Health Management: http://www.aha.org/aha_app/issues/Disparities/index.jsp B. Siegel, M. Regenstein, K. Jones, *Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care*, The Commonwealth Fund, January 2007. *Quality Health Care For Culturally Diverse Populations*, Diversity Rx: <http://www.diversityrx.org/CCCONF/06/index.html>

⁹³ Health Research and Educational Trust (HRET) Making the Case for Collecting Races, Ethnicity and Primary Language <http://www.hretdisparities.org/WhyCMaki-4155.php>

⁹⁴ The June 2009 report -- *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* -- documents the persistence of disparities on 25 indicators between white women and women of color, including rates of diseases such as diabetes, heart disease, AIDS and cancer, as well as insurance coverage and health screenings. Women of color fared worse than white women on most measures and in some cases the disparities were stark.

⁹⁵ Health Coverage and Access to Care Among Asian Americans, Native Hawaiians and Pacific Islanders, Fact Sheet, Ethnicity and Health care, Kaiser Family Foundation, April 2008 .

⁹⁶ See, e.g., Srinivasan, S, O'Fallon, LR, Deary, A. Creating Healthy Communities, Healthy Homes, Health People: Initiating a Research Agenda on the Build Environment and Public Health *American Journal of Public Health* 93(9):1446-1550 September 2003. Saegert, S, et al. Healthy Housing: A Structured Review of Published Evaluations of US Interventions to Improve Health by Modifying Housing in the United States, 1990-2001 *American Journal of Public Health* 93(9):1471-1477 September 2003. Bigby, JA et al. A Community Approach to Addressing Excess Breast and Cervical Cancer Mortality Among Women of African Descent in Boston. *Public Health Reports* Vol.118 July-August 2003 338-347.

⁹⁷ Metzler, M. Social Determinants of Health: What, How, Why, and Now *Prev Chronic Dis* 2007:4(4).

⁹⁸ Ibid.65. Ibid.66. Ibid.67.

⁹⁹ US Department of Health and Human Services *Call to action: Eliminating Racial and Ethnic Disparities in Health*, 1998.

¹⁰⁰ Woolf SH, Johnson RE, Fryer GE, Rust G, and Satcher D. 2004. The health impact of resolving racial disparities: An analysis of US mortality data. *American Journal of Public Health*, 94(12): 2078-2081.

¹⁰¹ Ibid.37

¹⁰² Ibid.80. Racial and ethnic health disparities begin early in the life span and exact a significant human and economic toll. For example: (1) prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States; (2) Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans; (3) Although infant mortality decreased among all races during the 1980-2000 time period, the black-white gap in infant mortality widened; and (4) While the life expectancy gap between the African Americans and whites has narrowed slightly, African Americans still can expect to live 6-10 fewer years than whites, and face higher rates of illness and mortality.

¹⁰³ US Commission on Civil Rights Briefing on Health Disparities June 12, 2009 Testimony by Rubens J. Pamies, M.D., FACP Vice Chancellor of Academic Affairs, Dean of Graduate Studies, & Professor of Internal Medicine University of Nebraska Medical Center, Omaha, Nebraska

¹⁰⁴ Ibid.80 page 2. Every year, hundreds of thousands of people die in the United States from preventable illnesses and injuries. These illnesses and injuries disproportionately impact communities of color and lower wealth communities. 10 Low-income populations and people of color do not experience different injuries and illnesses than the rest of the population; they suffer from the same injuries and illnesses, only more frequently and severely. For example:

- Compared to Whites, American Indians and Alaska Natives are 2.3 times more likely to have diagnosed diabetes, African Americans are 2.2 times more likely, and Latinos are 1.6 times more likely.
- Among African Americans between the ages of 10 and 24, homicide is the leading cause of death. In the same age range, homicide is the second leading cause of death for Hispanics, and the third leading cause of death for American Indians, Alaska Natives, and Asian/Pacific Islanders.
- Homicide rates among non-Hispanic, African-American males 10-24 years of age (58.3 per 100,000) exceed those of Hispanic males (20.9 per 100,000) and non-Hispanic, White males in the same age group (3.3 per 100,000).
- Native Americans have a motor vehicle death rate that is more than 1.5 times greater than Whites, Latinos, Asian/Pacific Islanders, and African Americans.
- Poverty is associated with risk factors for chronic health conditions, and low-income adults report multiple serious health conditions more often than those with higher incomes.
- The average annual incidence of end-stage kidney disease in minority zip codes was nearly twice as high as in non-minority zip codes.

- Premature death rates from cardiovascular disease (i.e., between the ages of 5 and 64) were substantially higher in minority zip codes than in non-minority zip codes.
- Education correlates strongly with health. Among adults over age 25, 5.8% of college graduates, 11% of those with some college, 13.9% of high school graduates, and 25.7% of those with less than a high school education report being in poor or fair health.

¹⁰⁵ Wikipedia US Civil Rights Commission accessed on June 29, 2008.

en.wikipedia.org/wiki/United_States_Commission_on_Civil_Rights

US House Committee on the Judiciary Legislative History of the Civil Rights Commission <http://www.dol.gov/cgi-bin/leave-dol.asp?exiturl=http://judiciary.house.gov/media/pdfs/civilrights.pdf&exitTitle=U.S.%20House%20Committee%20on%20the%20Judiciary%20--Legislative%20History%20of%20the%20Civil%20Rights%20Commission>

¹⁰⁶ Ibid.

¹⁰⁷ <http://www.hhs.gov/recovery/programs/os/cebios.html>

¹⁰⁸ Ibid.72.

¹⁰⁹ Ibid.103

¹¹⁰ Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. One size does not fit all: Meeting the health care needs of diverse populations. Oakbrook Terrace, IL: The Joint Commission; 2008
<http://www.jointcommission.org/patientsafety/hlc>

¹¹¹ Wilson-Stronks A, Galvez E. Exploring cultural and linguistic services in the nation's hospitals: A report of findings. Oakbrook Terrace, IL: The Joint Commission2007. <http://www.jointcommission.org/patientsafety/hlc>
Effective Communication is the cornerstone of patient safety Joint Commission on Accreditation of Health care Organizations: What did the Doctor Say: Improving Health Literacy to Protect Patient Safety. Oakbrook Terrace, IL: 2007

¹¹² Ibid.

¹¹³ Addressing Racial and Ethnic Health Care Disparities Testimony to the House Energy and Commerce Committee, Health Subcommittee Brian D. Smedley, Ph.D.Health Policy Institute Joint Center for Political and Economic Studies

¹¹⁴ Ibid. 80

¹¹⁵ World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*, Final Report of the Commission on Social Determinants of Health, available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

¹¹⁶ The National Forum for Latino Health care Executives, *White Paper: Latino Executive Leadership in the U.S. Health Care Sector*; <http://www.nflhe.org>. Chicago, IL; 2009. The U.S. spends nearly twice as much as other industrialized countries on health care: \$5,711 per person in 2007.¹¹⁶ Hank Hernandez, CEO of Las Palmas Medical Center in El Paso, Texas and former President of the National Forum for Latino Health care Executives (NFLHE), points out: "We should ask ourselves, 'Are these resources being allocated across the whole population – in other words, are all Americans benefiting from this spending?' The answer is no, not everyone is being served. And one way to remedy that inequity is to have hospital executives who reflect and understand the community and can address the needs that the community articulates. That's why we are here."

¹¹⁷ Health Research and Educational Trust, *Report of the National Steering Committee on Hospitals and the Public's Health*, Chicago, IL; 2006.