A national partnership for action to end health disparities in the United States

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Executive Summary

In its effort to achieve health equity, the United States joins other countries that are also confronting the problem of ending health disparities. Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Health disparities are persistent and pervasive in America, affecting its racial and ethnic minorities, other at-risk populations, and those of low socioeconomic and educational status. The vision for a healthier America was the force that brought together thousands of community and government leaders to develop the National Partnership for Action to End Health Disparities (NPA). Although efforts to address health equity began prior to the NPA, those efforts were carried by specific organizations and sectors (e.g., local health departments, universities, health systems, philanthropy, etc.).

Efforts to end health disparities are inherently a comprehensive community and systems change effort. The NPA is about change: why there should be change, who should effect the change, and the strategies that can be applied to implement change. The changes needed to achieve health equity in the United States can take place only with the cooperative effort of individuals at all levels of public and private enterprise. The NPA is the first national, multi-sector, community- and partnership-driven effort on behalf of health equity—with government leading the way.

The development of the NPA was sponsored by the U.S. Department of Health and Human Services and its Office of Minority Health through a sequence of activities that included regional meetings for community and stakeholder leaders throughout the country, a national public commentary period, and numerous levels of review, analysis, and content refinement by a range of experts. More than 2000 individuals participated on behalf of community- and faith-based organizations; businesses; healthcare and insurance industries; academia; city/county, state, tribal, and federal governments; and other sectors.

The NPA’s prime product, the National Stakeholder Strategy for Achieving Health Equity, offers a set of 20 community-driven strategies to end health disparities in the United States and to achieve
health equity though collaboration and synergy. It was released nationally on 8 April 2011 simultaneously with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (represents the federal commitment for health equity and a response to the strategies recommended in the National Stakeholder Strategy for Achieving Health Equity). Together the two documents offer new strategies and a mechanism for new partnerships aimed at closing the health gap for the nation’s racial, ethnic, and underserved communities.

Comprehensive change takes time, significant resources, and the efforts of many partners. Beyond financial and human capital, these efforts also require wide-ranging coordination, transparency, and commitment. The NPA is forging a new path for which there is no prior roadmap. Although early in its implementation, the NPA has already made a difference in the way partners frame their work, individually and collectively. Partners are beginning to use NPA goals and, ultimately, these actions translate into positive opportunities for communities. A key lesson learned is that the NPA achieves a momentum for change as it creates a national forum and strategy for cooperation.

**Problem**

The United States is among the richest countries in the world, yet disparities in health and healthcare continue to exist for many of its vulnerable populations. These persistent and pervasive disparities carry a high societal burden in terms of the loss of valuable resources (e.g., financial capital, healthy children and families, workforce capacity and capability, and social compassion).

Throughout its existence America has welcomed people of many nations and cultures to its shores. With this rich diversity comes a wide range of experience with health and healthcare disparities. Examples of these are outlined in Exhibit 1. These disparities have been extensively documented over time, most notably in the 1985 Report of the Secretary’s Task Force on Black and Minority Health (an early and influential federal effort); the 2002 congressionally-mandated report on healthcare disparities from the Institute of Medicine; the yearly (since 2003) federal National Healthcare Disparities Report and National Healthcare Quality Report; and Healthy People 2020, America’s master blueprint for health, among other sources.

Federal standards designate racial categories as White; African American or Black; Asian; American Indian or Alaska Native; and Native Hawaiian or Pacific Islander; and ethnic categories as Hispanic and non-Hispanic. However, these represent broad categories. Statistically significant data are often
not available for the diversity of smaller subpopulations in the United States. Grouping of data can mask and significantly underestimate the health and healthcare disparities that exist for subpopulations. Underestimates of health or socioeconomic status adversely affects awareness of health disparities—with a corresponding lost opportunity to focus on prevention, healthcare, research, and other efforts. As a result, the populations affected by inadequate or inaccurate data collection continue to suffer from poorer health outcomes. It is not only racial and ethnic minorities that suffer from health-related disparities, but also other underserved populations, such as those in certain geographic areas, individuals with disabilities, LGBT populations, and those of low socioeconomic and educational status (see Exhibit 1).

The U.S. Department of Health and Human Services (HHS), the public health system, the medical care system, and the community of stakeholders have struggled with the problem of health and healthcare disparities for many years, in spite of their many successes. New strategies for change were needed and the climate for change was right. In particular: Awareness continues to grow that health disparities are a significant component of healthcare costs. For example, the direct and indirect costs of health inequalities and premature death were estimated at $1.24 trillion between 2003 and 2006. Addressing health disparities is an obvious point of intervention that can provide both financial and ethical payoffs. Minority populations are increasing in number faster than the non-Hispanic White population and are expected to comprise 40 percent of the population by the year 2030. The adverse economic and social impact of not addressing health inequities for minorities costs the loss of economic and human capital. There is a growing constituency for change as awareness increases concerning the social determinants of health; the lack of improvement in health status for minorities and underserved populations; and the financial and social consequences of health disparities. With awareness there has grown a body of health equity stakeholders across all sectors (federal, state, tribal, local, community, faith-based, non-profit, private, academic, and business) that support appropriate policies and actions. Ongoing advances in technology provide a favorable climate for change. For example, many public and private agencies are able to collect, analyze, store, and allow public access to massive amounts of health-related data. The expanding adoption of social networking technology across all sectors of American society offers new opportunities for promoting awareness of disease prevention and health equity messages. In 2010 President Obama signed the Patient Protection and Affordable Care Act, which enacted comprehensive health insurance reforms and which, among other requirements, contains provisions
to improve the federal infrastructure for addressing minority health concerns, the diversity of the healthcare workforce, and others that contribute to health equity. The 2009 *Health Information Technology for Economic and Clinical Health Act* mandates comprehensive adoption of electronic health records.

Exhibit 1: An Overview of Health Disparities in the United States

### Examples of Populations Experiencing Disparities

<table>
<thead>
<tr>
<th>Racial/Ethnic</th>
<th>At-Risk Populations</th>
<th>Social Determinants Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American;</td>
<td>women, infants, children, adolescents, elderly, people with disabilities, rural</td>
<td>low socioeconomic status; low educational attainment</td>
</tr>
<tr>
<td>Asian; American</td>
<td>and urban populations, low literacy individuals, LGBT populations</td>
<td></td>
</tr>
<tr>
<td>Indian or Alaska</td>
<td></td>
<td></td>
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<tr>
<td>Native</td>
<td></td>
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<tr>
<td>Native Hawaiian or</td>
<td></td>
<td></td>
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<tr>
<td>Pacific Islander;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
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</tr>
</tbody>
</table>

### Examples of Well-documented and Prominent Disparities

<table>
<thead>
<tr>
<th>General</th>
<th>Specific¹</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><em>Except as noted, data are from sources reported in the National Stakeholder Strategy</em></td>
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<thead>
<tr>
<th>Disparities in Health</th>
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</thead>
<tbody>
<tr>
<td>infant mortality</td>
</tr>
<tr>
<td>maternal mortality</td>
</tr>
<tr>
<td>cardiovascular disease</td>
</tr>
<tr>
<td>cancer</td>
</tr>
<tr>
<td>HIV/AIDS</td>
</tr>
</tbody>
</table>

- Black infants die at rates 2.4 times that of White infants.
- The maternal mortality rate for Blacks is 3 times that of Whites; and is nearly 6 times higher for women over 35 years compared to those under 20 years of age.
- Compared to Whites, the incidence of HIV/AIDS is higher for Blacks, Native Hawaiians and Pacific Islanders, and Hispanics (8.9 times, 4.0 times, 3.4 times, respectively).
- Compared to the general population deaths from tuberculosis, alcohol, motor vehicle accidents, and diabetes are higher for
<table>
<thead>
<tr>
<th>Disease</th>
<th>American Indians and Alaska Natives (6 times, 6.1 times, 3.1 times, and 2.8 times, respectively).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Compared to adults (35 and older), youths ages 18-25 are more than 4 times more likely to use illicit drugs and more than 2 times more likely to binge drink alcohol.</td>
</tr>
<tr>
<td></td>
<td>• Disabled persons, women, children, the elderly, the homeless, and minorities disproportionately experience exposure to violence. Disabled youths ages 12-19 experience violence at nearly twice the rate as those without a disability.</td>
</tr>
<tr>
<td></td>
<td>• The poor are 2.5 times more likely to have untreated tooth decay than the not poor.</td>
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<tr>
<td></td>
<td>• Asians, Native Hawaiians, and Pacific Islanders account for over half of chronic Hepatitis B cases.</td>
</tr>
<tr>
<td></td>
<td>• Blacks, Asians, Pacific Islanders, and Hispanics have stomach cancer mortality rates that are 1.5 times that of Whites. Cancer is the leading cause of death for Asians and Pacific Islanders.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Other Health Disparities</th>
<th>Disparities in Health Care²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Compared with residents of large city suburbs, residents of rural areas had worse care for about 40% of access measures and 30% of quality measures.</td>
</tr>
<tr>
<td></td>
<td>• Compared to non-Hispanic Whites, Hispanics had worse care for 83% of access measures and 56% quality measures.</td>
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<tr>
<td></td>
<td>• Compared to high-income individuals, the poor had worse care for 100% of access measures and 83% quality measures.</td>
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<tr>
<td></td>
<td>• The poor are 4.7 times more likely to not have health insurance than are those with high income.</td>
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<tr>
<td></td>
<td>• Although 25% of Americans live in rural areas, only 10% of doctors practice in those settings.</td>
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²These data are from the 2010 National Healthcare Disparities Report
### Healthcare Workforce Disparities

- minority representation in the healthcare workforce;
- workforce shortages in geographic locations;
- availability of culturally and/or linguistically competent providers

<table>
<thead>
<tr>
<th><strong>Healthcare Workforce Disparities</strong></th>
<th><strong>Disparities in Data Collection</strong></th>
</tr>
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<tbody>
<tr>
<td>• Only 21% of medical school graduates plan to practice in underserved areas.</td>
<td></td>
</tr>
<tr>
<td>• Hispanics represent about 15% of the population but comprise only 5% of physicians, 5-7% of nursing, dental, and medical school students, and 4% of medical school faculty.</td>
<td></td>
</tr>
<tr>
<td>• Blacks represent about 13% of the population but comprise only 3.5% of physicians, 6-7% of dental and medical school students, and 3% of medical school faculty.</td>
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<tr>
<td>• Mortality rates for American Indian and Alaska Native populations have been underestimated due to the miscoding of race on death certificates.</td>
<td></td>
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<tr>
<td>• U.S.-born African Americans, and Black immigrants from Sub-Saharan Africa, South America and the Caribbean may be grouped together under the category of “Black.”</td>
<td></td>
</tr>
<tr>
<td>• Asians, Asian sub-groups, Native Hawaiians, and Pacific Islanders may be grouped together under the category of “Asian” or “Asian/Pacific Islander.”</td>
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</table>

### Examples of Significant U.S. Publications that Address Disparities (including those above)

In order to close the health gap for the nation’s racial, ethnic, and underserved communities in a climate that was ripe for change, the federal Office of Minority Health (OMH) within HHS sponsored the development of the National Partnership for Action to End Health Disparities (NPA). Its goal was to mobilize and connect individuals and organizations from across the country to create a nation in which all people have an equal opportunity to reach their full health potential. Given the broad range of disparity populations and needs within the United States, it has become increasingly clear that government agencies and private constituencies working alone within their own sectors are inadequate for solving the problem of health disparities. The driving force of the NPA is the conviction that a nationally-based strategy is needed—one that relies on multiple layers of partnerships across sectors in order to leverage resources and talent. The NPA’s strategic importance is based on its identity as a public/private partnership that includes the combined efforts of governments, academia, institutions, businesses, humanitarian and faith-based organizations, and individuals working across the entire spectrum of public, private, community, and individual enterprise. The NPA is designed to address a wide breadth of inequities. However, it does so through a common set of goals and strategies that all of its stakeholders can adapt to their specific situations, partnerships, and resources.

**Context**

As is common throughout the world, the social determinants that primarily contribute to America’s health disparities are poverty; racial/ethnic minority status; and lack of education, economic opportunity, and access to healthcare resources. These determinants are often related to patterns of social disadvantage or exclusion. Thus, the NPA defines health disparity as a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion. The primary groups which the NPA focuses on are racial and ethnic minorities, geographic populations, the disability community, and LGBT populations—within the context of the populations and disparities noted in Exhibit 1. These groups were chosen based on input from the thousands of individuals that participated in developing the NPA.
The NPA’s five central goals are: 1. Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations; 2. Strengthen and broaden leadership for addressing health disparities at all levels; 3. Improve health and healthcare outcomes for racial, ethnic, and underserved populations; 4. Improve cultural and linguistic competency and the diversity of the health-related workforce; and 5. Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes. Four crosscutting, fundamental principles are central to the NPA: leadership through community engagement; the value of working via partnerships, the necessity of cultural and linguistic competency to meet the needs of all communities, and the requirement of non-discrimination in actions, services, leadership, and partnerships.

The formation of the NPA stands squarely within the context of the democratic values of the United States. That is, policies are established and action is taken with input from public and private stakeholders. Governments at all levels have a role in working for the health and well being of its citizenry; organizations have a role; states and citizens have rights. In a matter as critical as advancing health equity, the NPA offers a forum for sharing ideas and resources, an opportunity for partnerships on behalf of strategic action, and above all, a collaborative approach to problem solving.

OMH sponsored the planning and development of the NPA. However, a fundamental value of the NPA is its lack of dependency on an influx of government spending. The expectation is that OMH and other government agencies will act as catalysts for change by leveraging their existing partnerships and resources. In this way they act as models for other NPA constituencies and partners. Partnerships emphasize the pooling and efficient use of resources, mobilization of talents, and use of diverse approaches in order to avoid duplication of efforts and fragmentation of services. Partnerships promote sharing of human and material resources, finances, and time in order to strategically leverage funding and talent in an era of scarcity and limitation.

**Planning**

The formation of the NPA was based on the voices of nearly 2,000 leaders who overwhelmingly supported broadening the national dialogue about health disparities from the more traditional disease-focused approach to a more systems-oriented approach that addresses crosscutting, multilevel issues. These perspectives were gathered via a multi-year, multi-layered, community-based process that was
sponsored by OMH. This process emphasized a "bottom up" approach. The intent was to change the paradigm of strategy development by vesting individuals—particularly those at the front line of fighting health disparities—with identifying and helping to shape core actions for a coordinated national response. Thus one of the earliest planning activities was a series of countrywide regional conversations, which included “community voices” meetings, with representatives from minority groups and organizations, American Indian and Alaska Native tribes, community organizations, faith-based organizations, health care providers and organizations, state and local public health agencies and organizations, academia and research, and health systems. The process continued with increasing input from groups representing policy makers, business, rural and border health populations and others interested in health equity. This included analysis, input, and content refinement from a National Visionary Panel of experts as well as a National Consensus Meeting for late-stage review and refinement of content. A Federal Interagency Health Equity Team (FIHET) was established to provide guidance. Its members are representatives of HHS and the federal departments of Agriculture, Commerce, Defense, Education, Housing and Urban Development, Justice, Labor, Transportation, and Veterans Affairs, as well as from the Environmental Protection Agency and the Consumer Products Safety Commission. The process also included a six-week national public comment period.

The NPA planning period culminated with the 8 April 2011 release of the National Stakeholder Strategy for Achieving Health Equity (“National Stakeholder Strategy”), which provides a detailed analysis of health and healthcare disparities and 20 strategies for common action, each of which aligns with one of the five NPA goals. Each of the 20 strategies has a corresponding set of objectives, measures, and potential data sources that, in toto, offer a starting plan of action that can be adapted to the needs and resources of any organization or partnership working to reduce health disparities.

In conjunction with the launch of the National Stakeholder Strategy, HHS simultaneously released its first ever HHS Action Plan to Reduce Racial and Ethnic Health Disparities (“HHS Disparities Plan”), which will be renewed annually. The HHS Disparities Plan is a federal response to the National Stakeholder Strategy and a pledge of the government’s accountability in supporting health equity. With it, HHS broadcasts its commitment to integrated approaches, evidence-based programs, and strong and visible national direction for leadership among public and private partners on behalf of health equity. The 2011 twin launch of these complementary community and federal documents—and their ongoing
Implementation among community stakeholders nationwide and within HHS—mark the beginning of widespread public/private cooperation and coordination aimed at achieving health equity.

The NPA promotes and strengthens collaboration across multiple sectors, and at federal, regional, state, and community levels through three components: 1) the National Stakeholder Strategy and related documents such as the HHS Disparities Plan; 2) Specific Blueprints for Action (aligned with the National Stakeholder Strategy) for selected populations and for each of 10 geographic regions; and 3) targeted initiatives that will be undertaken by partners across the public and private sectors in support of the NPA.

The policy tools and organizations that will move implementation of the National Stakeholder Strategy include the legislative mandates of the Affordable Care Act and other laws; the longstanding relationship between OMH and the state offices of minority health (SOMH); the minority health-promoting mechanisms that already exist throughout HHS and other government departments; partnerships with public health entities that facilitate the engagement and education of policymakers at the state level (e.g., the National Conference of State Legislatures, the Association of State and Territorial Health Officials, the National Association of State Offices of Minority Health); partnerships with entities that educate the business sector to embrace health equity as a financially profitable policy (e.g., the National Business Group on Health); and organizations which work to improve the health and well-being of geographic populations (e.g., the National Rural Health Association).

**Implementation**

One of the most challenging steps in achieving any significant goal is to move from ideas to action—from planning to implementation. Thus, the existence of the NPA does not in and of itself lead to the achievement of its intended outcomes. Success will be dependent upon the ability to implement and assess progress for the National Stakeholder Strategy; the HHS Disparities Plan and other related federal documents; the Blueprints for Action; and the targeted initiatives that will be undertaken by partners across the public and private sectors. Implementation has been a critical concern of the NPA. An initial implementation framework has been developed by a diverse group of stakeholders and was refined through the NPA development process previously described. It is grounded in the key concepts of leadership, ownership, partnership, capacity, and communication. Implementation will be operationalized through voluntary multi-sector, multi-level councils that provide leadership, ensure
continued information flow, and galvanize action at the federal, national, regional, state, tribal, and local levels.

**A communications plan** is a key component of implementation and evaluation. The NPA communication plan focuses on (1) increasing awareness among key audiences of the significance of health disparities, their impact on the nation, and the actions necessary to achieve health equity; (2) helping partners promote and address the goals by making them a priority, and by sharing information within their individual networks to broaden diffusion of information; (3) ensuring cohesion in all communications and coordination between and among the multi-sector, multi-level councils and their partners, and fostering effective communication and sharing of information by creating dynamic feedback loops between the councils to share relevant activities, policies, emerging issues, priorities, and evaluation/best practices.

NPA implementation is supported in part by OMH and several contracts managed by OMH to assist with coordinating, monitoring, and sustaining the NPA. Support includes assistance with:

- **Implementation**—coordinating and facilitating council meetings, consulting with leaders and experts, engaging communities, developing content for *Blueprints for Action*, producing tools and materials, working with partners to ensure connection and integration with implementation actions or plans, building partnerships, and providing implementation capacity building support.

- **Communications**—crafting and integrating NPA messages for various audiences, developing communication tools, and helping disseminate NPA information to key audiences in various formats as a means for sharing knowledge about activities, emerging issues, priorities, and evaluation/best practices.

- **Evaluation**—managing and monitoring evaluation activities to ensure that partners connect and contribute to the NPA evaluation; providing capacity building support to communities; and negotiating data use and reporting with agencies who manage data systems relevant to the NPA.

Initial implementation will roll out in stages. **Phase I** involves the activities of the FIHET, FIHET subcommittees, and National Partners. **Phase II** involves the activities of Regional Health Equity Councils, state offices of minority health, and expanded national partnerships with businesses and other communities. **Phase III** involves targeted multi-agency initiatives to minimize duplication and increase effectiveness. Current NPA implementation activities include the following:
**Phase 1—FIHET** includes representation from 12 federal agencies as described above. The purpose of FIHET is to (1) identify opportunities for federal collaboration, partnership, coordination, and/or action on efforts that are relevant to the NPA; and (2) provide leadership and guidance for national, regional, state, and local efforts that address health equity. The FIHET played a critical role in providing feedback on the NPA’s development. Moving into the implementation phase, FIHET has established five subcommittees to develop implementation recommendations linked to the five NPA goals. Each subcommittee has developed work plans outlining its priorities, associated strategies that connect the work of federal agencies, action steps; as well as timelines and intended outcomes for each priority.

**Phase 1—National Partners** work with the NPA to leverage resources, expand its reach and spheres of influence, infuse NPA goals and strategies into organizational policies and practices, and share stories and successes with their broad constituencies. National partners will include community- and faith-based organizations, professional societies, government agencies, national non-profit organizations, advocacy groups, foundations, corporations, businesses of all sizes, industry groups, and colleges and universities. For example,

- **The National Conference of State Legislatures (NCSL)** is a bipartisan organization that serves the legislators and legislative staff of the nation's 50 states, its commonwealths and territories. NCSL works with OMH to help state legislators understand issues related to health disparities and how specific policies either narrow or widen disparities in health care for racial and ethnic minorities.

- **The Association of State and Territorial Health Officials (ASTHO)** recognizes that progress in improving the health of minority populations will require that states have access to information on effective practices as well as resources to assist in the implementation of effective public health policies and programs. ASTHO aims to fill these knowledge gaps, strengthen state leadership, and improve health disparities efforts through various activities under the NPA.

- **The National Association of State Offices of Minority Health (NASOMH)** promotes and protects the health of communities of color, and tribal organizations and nations. Its NPA activities include technical assistance for SOMHs in engaging communities on NPA actions, building awareness, and incorporating or aligning state health disparity and/or health equity plans with NPA goals.
• **National Business Group on Health (NBGH)** is a national, nonprofit devoted exclusively to finding innovative and forward-thinking business solutions to the nation’s most important healthcare challenges. As a NPA partner, NBGH is working to make the case to employers that addressing health disparities is a good financial and business decision.

• **The National Rural Health Association (NRHA)** is a national nonprofit that provides leadership on rural health issues. Its role in the NPA is as a bridge connecting minority and rural health constituencies and needs, building awareness, and addressing actions for border populations.

**Phase II—10 Regional Health Equity Councils** are being launched that will focus on groups of states nationwide. Initial planning meetings were held in four geographic regions prior to the launch of the NPA. The councils will address health disparity improvement actions for their geographic areas and work to leverage resources, infuse NPA goals and strategies into policies and practices, and share stories and successes with broad constituencies. The councils include individuals from the public, nonprofit, and private sectors and they represent communities experiencing health disparities; state and local government agencies; tribes and tribal organizations; healthcare providers and systems; health plans; businesses; academic and research institutions; foundations; and other organizations who focus on specific determinants of health (e.g., environmental justice, housing, transportation, education, etc.).

**Phase II—State Offices of Minority Health (SOMH)** are actively engaging communities through periodic meetings; developing strategic partnerships, mobilizing networks; improving awareness and communications through different media outlets; and leading states’ efforts in updating health disparity or health equity plans so that they align with the NPA. The SOMHs come together during monthly conference calls to update each other on progress, address challenges, share lessons learned, and consider collective actions.

**Evaluation**

The NPA Evaluation Plan provides a roadmap for determining the effectiveness of NPA strategies and actions. It describes the overall approach, key indicators and measures, data sources, and potential data collection methods. The goal of the evaluation is to ensure the integration and penetration of NPA efforts across sectors (e.g., education, housing, environmental health) and across levels (i.e., federal, national, regional, state, tribal, and community). A logic model was created by a team of expert advisors to illustrate the implementation pathway and anticipated outcomes of the NPA. The model is based on
the assumption that observable changes in the way public and private organizations work across sectors to address the social determinants of health are more likely to occur initially than are observable population-level outcomes. Therefore, the initial focus for evaluation is to determine whether (1) organizational and structural changes have actually been made on behalf of health equity; (2) specific actions have been taken that align with the NPA’s five goals and 20 strategies; (3) public awareness and understanding about social determinants has increased; (4) policy, systems, and other multi-level changes have been initiated; (5) there is an increase in communities’ capacities to address health disparities through the use of data for decisionmaking; and (6) whether promising practices can be identified. Evaluations will also consider the feasibility of developing and using a social determinants health equity index to assess how well the nation is progressing towards improved health outcomes. Even with an optimal social determinants index, it will take several years before observable changes can be expected.

The evaluation plan has identified initial optimal indicators and measures. Some of these measures are already available; others will need to be developed. To the degree possible, evaluation teams will coordinate NPA evaluations with those of other federal entities and with NPA partners in order to minimize duplication and to build on existing data analyses and sources. Evaluation teams will work with OMH leadership to facilitate the development of data-sharing agreements and protocols. Current proposed indicators are as follows:
### Exhibit 2: Current Proposed Evaluation Indicators

**Infrastructure and Partnerships**

Productive and effective health equity councils, including the Federal Interagency Health Equity Team and the national, regional, state, tribal and community health equity councils

Productive and effective NPA Partnerships (e.g., Association of State and Territorial Health Officials, National Conference of State Legislatures, National Business Group on Health, National Association of State Offices of Minority Health)

Vertical (e.g., between state and region) and horizontal (e.g., among states or regions) alignment among national, regional, state, tribal, and local efforts

**Actions**

Multi-sector and multi-level actions

Goal attainment

Alignment between actions and results

Capacity for implementing strategies to end health disparities

**Public Awareness and Understanding**

Awareness of NPA

Awareness of health disparities and understanding of social determinants

News coverage from print, broadcast, and internet news sources on health-related issues affecting underserved and racial and ethnic communities (including mainstream and selected racial and ethnic print news sources)

**Policy, Systems, and Other Multi-level Changes**

Influence of NPA on its partners

Inclusion of health disparities or health equity concepts and language (e.g., social determinants) in mainstream institutions and among broad leadership

Influence of NPA on local, state, and national healthcare-related policies

Influence of NPA on local, state, and national policies, procedures, and practices that address the social determinants of health
Evaluators will select a final list of indicators and measures, as well as the sample of regions, states, and organizations that will be included in the initial evaluation. In general, data collection activities can be summarized into the following types:

- Surveys of the FIHET, Regional Health Equity Councils, and NPA partners;
- Review and analysis of the goals and strategies implemented by the FIHET, Regional Health Equity Councils, and NPA partners;
- Content analysis of NPA partners’ programs, agendas, materials, plans, etc.;
- Interviews with key informants at the federal and national levels and in the regions, states, and tribes that are part of the sample.

Cross-case study method will be used to analyze the data. This method allows for comparisons across and within selected regions, states, and communities, as well as the combined use of qualitative and quantitative methods. The findings will be compiled into case studies. Each case study will tell the story of what transpired in each of the sample geographic units and will provide insight into the context and circumstances under which changes did or did not take place. Each case study will, in turn, contribute to a national, in-depth case study on the NPA’s effectiveness. Time-series presentations of data will also be conducted in order to show changes.

The evaluation team will submit semiannual reports on its progress, and annual reports that will contribute to the OMH reports to the U.S. Congress. Annual reports will also be provided to the FIHET, Regional Health Equity Councils, NPA partners, and the implementation and communications teams. Reports will be posted on the NPA website and made available and accessible to the public. The evaluation team will facilitate a meeting to reflect and discuss the findings with OMH leadership and staff, the implementation teams, and the communications teams. Meetings will focus on the lessons learned and the implications for iterative strategy improvement and implementation.

**Follow-up and lessons learned**

Efforts to end health disparities are inherently a comprehensive community and systems change effort. The NPA is about change: why there should be change, who should effect the change, and the strategies
that can be applied to implement change. The changes needed can take place only with the cooperative effort of individuals at all levels of public and private enterprise.

Managing and coordinating the magnitude of planning and implementation activities has been one of the greatest challenges of the NPA. That challenge continues as the NPA deliberately plans for further growth with phased and monitored expansion of the number of NPA partners and activities. Past experiences in driving a health equity agenda underscore the lesson that comprehensive efforts take time, significant resources, and the efforts of many partners. Beyond financial and human capital, these efforts also require significant coordination, transparency, and commitment. The growth of the U.S. knowledge base, constituency, and programs for health equity in the past few decades has formed the foundation necessary to initiate and sustain the NPA. Individuals across sectors have committed to participate in NPA activities because of their passion and commitment to its vision and goals.

The NPA represents a grassroots effort to form strategic partnerships and engage communities and organizations on behalf of health equity. As a grassroots effort, all partners have had to “own” the NPA in order for it to survive and thrive. Continued progress is dependent on success in transforming the quality and commitment of stakeholder partnerships. Ideally, individuals and organizations will expand their sharing of resources and spheres of cooperation beyond customary relationships to include partners that can enhance mission capacity and value in new and effective ways. The holistic approach of the NPA to integrate implementation, communication and evaluation activities supports participants as they unite to prioritize common goals, share successful strategies, and move from planning to action. The objective is to advance implementation, communication and evaluation at a pace that maintains their coordination and alignment while also maintaining the engagement of all stakeholders.

The NPA is forging a new path for which there is no prior roadmap. Lessons are learned as actions are planned and executed. Partners and experts are continually encouraged to address new and emerging opportunities. An important lesson has been that an understanding of the social determinants of health does not in itself bring expertise for creating change or forming new relationships and partnerships. Thus, capacity-building opportunities and tools (e.g., educational webinars, targeted messages, and access to experts for consultation, etc.) to facilitate effective participation are being developed.

Although early in its implementation, the NPA has already made a difference in the way partners frame their work, individually and collectively. There is evidence that FIHET member agencies are beginning to
use the NPA goals to develop priorities and scope of activities, which translates into positive opportunities for communities. In addition, FIHET members have consistently engaged and recruited others to join the NPA. Elsewhere there has been an emerging pattern among organizations to work collaboratively and strategically toward common goals. NPA partners are increasing their knowledge about disparities, public/private sector infrastructure and resources for addressing disparities, and how health equity efforts can and should be integrated into the broader national dialogue. A key lesson learned is that the NPA achieves a momentum for change as it creates a national forum and strategy for cooperation.