



A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

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ABSTRACT: This report provides state policymakers with a menu of policy interventions that have been implemented to address disparities in minority health and health care. The authors divide these state and local programs into those targeting infrastructure, management, and capacity, and those targeting specific health conditions. Based on their review, the authors identified eight key needs that state and national policymakers will need to consider: consistent racial/ethnic data collection; effective evaluation of disparities-reduction programs; minimum standards for culturally and linguistically competent health services; greater minority representation within the health care workforce; expanded health screening and access to services (e.g., through expanded insurance coverage); establishment or enhancement of state offices of minority health; involvement of all health system stakeholders in minority health improvement efforts; and creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

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EXECUTIVE SUMMARY

The 2002 report of the Institute of Medicine, *Unequal Treatment*, documents deep and pervasive disparities in health and health care for racial and ethnic minority populations in the United States. The National Disparities Initiative, launched in 1998 to eliminate these racial and ethnic disparities by 2010, was important for acknowledging health disparities and for lending the problem a greater and more appropriate moral urgency.

A national strategy to achieve a public health goal most often requires the involvement of the states. Many states now sponsor specific health programs that help members of racial and ethnic minorities, but health disparities as such have not been a high-level issue. Elevating the importance of the discussion is essential, however, for the creation of new interventions. Policy advances in states frequently lead to policy innovation at the federal level as well.

This report was developed to give state policymakers a menu of policy interventions that would address minority health disparities. The authors divide proposed interventions into two broad categories: State Infrastructure and Capacity and Health Conditions. The first covers management and capacity issues necessary to address the broad range of disparities; the second addresses disease and other health-specific issues needing state intervention.

The section Health Conditions includes all six components of the National Disparities Initiative, along with other categories where there are disparities. In State Infrastructure and Capacity, categories were selected through consultation with a National Advisory Panel of state officials and other experts familiar with the disparities issue. This agenda is not proposed as exhaustive or all-inclusive and is intended to provide state policymakers with an array of potential policy initiatives that may be pursued individually or as components of broader, omnibus legislative efforts. Not all interventions and proposals described herein are appropriate for every state, though all are worthy of consideration.

Each category in the agenda includes a description of research defining the problem, examples of promising practices currently in operation in states and localities, and policy recommendations for state policymakers. Below is a summary of key policy recommendations for each category of the agenda.

State Infrastructure and Capacity

Cultural and linguistic competency. States can develop standards tailored to community needs, collect data to identify service needs, finance interpreter services, and increase the supply of minority health providers. Los Angeles County, California, and the Department of Social and Health Services of Washington State have been active in the setting of standards for cultural and linguistic competency. Legislated requirements for translation and interpreter services are embodied in California's Dymally-Alatore Bilingual Services Act and Kopp Act.

Data. States have a critical role in fostering collection, analysis, and use of minority health data for the identification and amelioration of disparities. Some state surveillance systems' racial and ethnic classifications, however, are very narrow. Some states still categorize all racial and ethnic groups as black or white only. The accepted national standard for data collection is the race and ethnicity categories in the Office of Management and Budget's Directive 15.

Elderly. States can help minority elderly by promoting broader availability of home- and community-based services and by assisting income eligible seniors to qualify for full Medicaid or Medicaid-financed coverage of Medicare cost sharing. New Jersey's Senior Gold Program is an example of the prescription drug assistance programs created by some states to aid seniors who are ineligible for Medicaid. As the states revise these programs in light of the 2003 Medicare prescription drug act, the unmet needs of minority elderly should be addressed.

Insurance coverage. More than half of U.S. uninsured belong to racial and ethnic minorities. For them, Medicaid and State Children's Health Insurance Programs make available important and otherwise unobtainable coverage. States should expand eligibility, encourage take-up, and eliminate administrative obstacles to promote wider coverage.

Primary care. States can expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations. California's Physician and Surgeon Incentive Licensing Program helps physicians establish practices in underserved localities. The California legislature requires the regents of the University of California to maintain data and report about recruitment of medical students from underserved areas, and the university system's Community-Based Health Professions Education Partnership Program encourages the development of undergraduate medical and other health professional clerkships in primary care combining health education, human services, and

community involvement. Research and development on local health networks is the subject of work by the federal Department of Health and Human Services' Agency for Healthcare Research and Quality and the Bureau of Primary Health Care.

Purchasing. States can use their extensive purchasing power to require data collection and reporting, mandate consumer satisfaction surveys, and require specific health interventions. California includes nondiscrimination clauses in its Medicaid managed care contracts. New Jersey's contracts include requirements that health plans create provider networks that can accommodate the language needs of enrollees. Colorado requires that its contractors offer culturally competent health care services.

Regulatory approaches. States can influence professionals, institutions, and health plans by using licensure and other regulatory requirements to address provider and facility shortages in minority communities. Providers applying for certificates of need in New Jersey have to demonstrate that they are improving health care access for persons from poorly served communities.

State infrastructure. States can help minority health offices reduce disparities by ensuring that these offices have adequate financial resources (many are channeling revenue from the Tobacco Settlement), limit staff turnover, foster good relations with other state agencies, legislative and/or regulatory grounding, access to data, and clear performance measures. Legislatures in Arkansas, California, Connecticut, and Florida have given strong backing to minority health commissions and offices. Ohio has a stand-alone Commission on Minority Health, and the legislatures of Indiana and Oklahoma have assigned these responsibilities to their state health departments.

Workforce development. States can foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection, and using Graduate Medical Education funds more creatively. The Health Resources and Services Administration operates several programs to encourage workforce diversity; the Association of American Indian Physicians has a mentoring program; the Minority Medical Education Program is an effort led by the Association of American Medical Colleges; and New York developed a Minority Participation in Medical Education grant program.

Health Conditions

Asthma. States can address disparities in asthma rates by improving research, surveillance, monitoring, and evaluation. States can encourage standardization of care, support

environmental interventions, and encourage collaborative approaches among providers, payers, school systems, families, public health authorities, and others. California has been active with several programs: an Office of Binational Border Health, which focuses on the Mexico–California border region; the California Asthma Public Health Initiative; and the California Asthma Among the School Aged project. Illinois, New Jersey, and New York also have asthma public health programs for at-risk populations.

Cancer. States can implement screening and prevention programs targeted toward minority communities and can integrate attention to minorities in their comprehensive cancer control plans. Successful programs include a Breast and Cervical Cancer Early Detection program in Mississippi, and the Real Men Checkin’ It Out prostate cancer initiative of South Carolina’s Office of Minority Health.

Cardiovascular disease. States can enhance the ability of providers to control hypertension in persons who are at risk, encourage provider/community prevention partnerships, and target resources to populations disproportionately affected by cardiovascular disease. The University of Arkansas for Medical Sciences, Maine’s Bureau of Health, and Illinois’s Department of Public Health Stroke Task Force are among many examples cited in the main body of this paper.

Diabetes. States need comprehensive approaches to reduce risk factors for diabetes, promote early diagnosis, and improve quality of care and self-management practices. States can require insurers to provide coverage for diabetes treatment (46 states had such laws as of October 2002); other programs currently active are the CDC-funded New York Diabetes Control Program and North Carolina’s Project DIRECT.

HIV/AIDS. States need multifaceted efforts to prevent the spread of HIV/AIDS, including education and outreach for minority communities; states may consider needle and syringe exchange programs, which reduce transmission without increasing illicit drug abuse. During 2003 Florida’s state legislature directed the Department of Health to develop HIV/AIDS programs to help minority communities, including pregnant women and prison inmates; California statute mandates an HIV/AIDS initiative and New Jersey’s health and senior services department supports community-based HIV prevention projects.

Immunization. States can research gaps in rates and services, as well as improve minority surveillance; states can use childhood immunization programs as a model for adult programs and consider specific funding sources such as premium taxes. Federal/state

partnerships include the Racial and Ethnic Adult Disparities in Immunization Initiative, launched in 2002 by Health and Human Services, and Vaccines for Children, sponsored through the Centers for Disease Control immunization program. South Carolina created public service announcements, which it ran on minority-oriented radio stations, to encourage vaccination against influenza and pneumonia. Other state outreach and adult and child immunization efforts are described.

Infant mortality. States can increase access to prenatal care for at-risk parents, establish home visitation programs for at-risk communities, conduct appropriate SIDS education in minority communities, and initiate healthy baby education campaigns. The American Academy of Pediatrics' program, Back to Sleep, has helped reduce SIDS rates nationwide. The National Institute of Health worked with community partners to extend the reach of Back to Sleep to African Americans. California has added multiple languages to its SIDS awareness programs to reach Chinese, Vietnamese, Spanish, Arab, Thai, Croatian, and Laotian communities.

Injury prevention. States can develop injury surveillance systems that gather race and ethnicity data. Successful interventions include mentoring programs to reduce violence, alcohol reduction efforts, smoke detectors, drowning prevention, and pedestrian safety. New York's Harlem Hospital Injury Prevention Program is an example of a successful injury-prevention intervention. A smoke alarm giveaway in Oklahoma City contributed to a reduction in fire injuries there, and in Elmira, N.Y., pre- and postnatal home visits by nurses to at-risk mothers helped produce a range of local health improvements.

Mental health. States need to improve the accessibility and delivery of mental health services to minorities, especially through culturally and linguistically competent community-based providers, as well as prevention initiatives. Interpreter mandates, such as those created by the Illinois Mental Health Hispanic Interpreter Act, are valuable. So are such partnerships as the Youth and Family Centers in Dallas schools, which help to integrate physical and mental health care. Model legislation for states has been written into the National Alliance for the Mentally Ill Omnibus Mental Illness Recovery Act.

Obesity, physical activity, and tobacco use. States can set up prevention and education programs to reach minorities, should create environments conducive to physical exercise, and can adopt CDC tobacco guidelines. Numerous state programs, such as Rhode Island's Obesity Prevention and Control program and North Carolina's Healthy Weight initiative work to encourage healthy weight and good nutrition among their clientele. A Cross-Cultural Workgroup on Tobacco in Washington state identifies populations most affected

by smoking. Other laws in many states prohibit tobacco products or tobacco advertising at or even near schools.

Oral health. States can encourage fluoridation of local water supplies, increase outreach to parents, sponsor school-based education programs, improve access with mobile and school-based clinics, and enhance community/migrant health center infrastructure. Programs to widen the use of dental sealants, such as ones that bring dental services to elementary schools, have proven their value in Ohio and Connecticut. Other states (Pennsylvania, Washington, Delaware) have worked to extend dental insurance or increase reimbursement rates under Medicaid to help people see dentists or encourage dentists to widen their practices to the underprivileged.

Key Themes and Findings from the State Disparities Agenda

The 20 categories included in the State Disparities Agenda cover a wide swath of state policies and programs. Eight key needs arise for state policymakers, and those who seek to craft omnibus or multifaceted legislation to address disparities would do well to ensure that any proposal addresses these eight needs:

Better and more consistent data collection. Assessing and reducing disparities depend on accurate and timely data. Yet major inadequacies in data collection hamper efforts within individual states and hinder efforts to understand differences among states. At the extreme, some state surveillance systems still categorize all racial and ethnic groups as black or white only. The accepted national standard for data collection relies on the categories included in the Federal Office of Management and Budget's Directive 15 (revised October 30, 1997): American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; white; and ethnic group: Hispanic or Latino. States should also collect and report health data on the racial and ethnic subgroups that reside there, and they should initiate strategies to identify gaps in available data for small population groups.

Effective evaluation of programs. The initial intention of this project was to identify best practices among state programs, statutes, regulations, and initiatives, but the researchers soon confronted a shortage of research assessing and documenting effectiveness. We abandoned the term "best practices" for the more ambiguous "promising practices." Practices are identified as promising based on case studies and other reports, as well as recommendations made by researchers, policy experts, and state officials. Our inability to find best practices prompts our recommendation that researchers and public officials work together to evaluate the effectiveness of disparities interventions and to document and publicize those programs and policies that yield positive results. Equally

important is the need to identify interventions that do *not* work so that resources can be channeled productively.

Emphasize stronger cultural and linguistic competence in all disparities reduction activities. Culturally and linguistically appropriate services are health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to appropriately respond to the attitudes, feelings, or circumstances of individuals or groups sharing a common and distinctive racial, national, religious, linguistic, or cultural heritage. Language and cultural barriers have been found to increase health costs. States need to develop minimum standards for culturally and linguistically competent health services; undertake data collection and research on successful practices; support education, training, and development of a more competent workforce; and monitor and enforce the effectiveness of implemented programs. In all of these priority areas, states need support from the federal government and foundations.

Workforce development programs and improvement to the cultural competence of all health care professionals. Although Latinos, African Americans, and American Indian/Alaska Natives account for 25 percent of the U.S. population, they account for only 6 percent of practicing physicians and less than 14 percent of registered nurses. White physicians and dentists are far less likely than their minority colleagues to practice in federally designated shortage areas, to see minority patients, and to accept Medicaid patients. Racial concordance of patient and provider is associated with greater participation in care, higher patient satisfaction, and greater adherence to treatment. States have undertaken many initiatives to improve the “pipeline” of minority practitioners, but states need to expand and improve efforts to diversify the health care workforce, and they need assistance in identifying best practices.

Health screening and access to services (insurance). Many state, county, and local public health authorities identify illnesses among their disadvantaged residents through health screening services, and then have no resources or ability to provide treatment. The majority of the nation’s 43 million uninsured are racial and ethnic minorities. Lack of health insurance coverage has been identified as the single most important factor in explaining differences between the health status of African Americans and Hispanics versus whites.¹ Unfortunately, the recent state fiscal crisis has caused the loss of public insurance coverage for about 1.6 million lower-income Americans.² States that want to reduce or eliminate disparities have no choice but to confront inequities in the availability of affordable and decent health insurance.

Focus on creating and/or improving state minority health offices and infrastructure. Thirty-five states and territories have a designated office, commission, council, or advisory panel on minority health. These entities advise state policymakers about disparities and other gaps, and develop strategies, programs, and solutions. Still, there are no commonly accepted standards, core competencies, or minimum infrastructure requirements for state minority health offices. Successful offices have: adequate financial resources; low turnover; close working relationships with other key state agencies; statutory or regulatory grounding; access to good data on disparities and minority health; and operate with clear performance measures. A promising combination in a state is an office of minority health as well as a standing commission that involves major state stakeholders (legislative, executive, and nongovernmental).

Involve all health system stakeholders. Issues related to minority health and health disparities can be easily pigeon-holed so that policymakers have only limited exposure to them. Yet any effective strategy requires the full engagement of state governments—including executive and legislative branch leaders—and the broader health sector—including hospitals, physicians, community health centers, nurses, home health providers, the public health community, community-based organizations, and more. An effective strategy must also engage the broader public through community-based public education activities and programs.

Finally, we include a recommendation directed not to state policymakers but to national policymakers and national health sector leaders, including organizations of health philanthropy:

Create a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities. As important as states are in developing a winning strategy to eliminate disparities, they cannot carry out this mission alone. The federal government already plays a critically important role in supporting state-based activities. It is also important for the nongovernmental sector, working nationally, to encourage and support state-based efforts to eliminate disparities. We propose the establishment of a national coordinating council on state activities. Such a group can serve a number of critical purposes, including:

- Conducting and supporting research on best practices;
- Developing strategies to advise states;
- Publicizing nationally the strategies of states confronting disparities successfully;
- Educating state officials and other state stakeholders on developments in reducing or eliminating disparities.

A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

INTRODUCTION

The elimination of racial and ethnic disparities in health care emerged as a prominent concern in segments of the health policy community in 1998. That year, President Bill Clinton and his Surgeon General, Dr. David Satcher, articulated as a goal eliminating disparities in six health categories by 2010. The willingness of President George W. Bush to continue this initiative has given it bipartisan credibility, as has the public support of Senate Majority Leader Bill Frist. Substantial, unprecedented attention is being devoted to this issue by many policymakers, public officials, health professionals, health services researchers, and community organizations. National organizations, such as the federal Agency for Healthcare Research and Quality and the American Public Health Association, have made this issue a priority. The Institute of Medicine's release of *Unequal Treatment* in 2001 authoritatively validated the issue's importance.³

Six years into the initiative, the elimination of racial and ethnic health disparities has not yet attained the status and priority necessary to improve the health and well being of tens of millions of Americans. Although many public officials embrace the disparities issue as a legitimate public concern, legislative proposals are few, and none has resulted in significant, new public resources. Indeed, serious cutbacks in Medicaid and other public health activities between 2001 and 2004 have led to losses in coverage and health promotion programs.⁴ Paralleling the lack of frontline legislative policy initiatives at the federal level is a lack of high-priority legislative initiatives in the states. As of this writing in early 2004, there is little reason to believe that any of the six goals set by President Clinton and Dr. Satcher in 1998 will be achieved by 2010.

Where does this conclusion leave the disparities agenda? In brief, progress in educating and sensitizing policy and political elites about the issue has not yielded policy gains sufficient to achieve substantial improvements. The value of these gains should not be underestimated or diminished, but it is time to assess the progress of policies addressing this important national goal. This paper focuses on states' role in advancing the disparities elimination policy agenda.

States As Catalysts for Policy Change

In the U.S. political system, the role of the 50 state governments and the territories is often underappreciated. Nearly every major health policy initiative considered by the

Congress in the last 10 to 15 years was first devised, tested, and improved through state experimentation. These include prescription drug coverage for seniors, insurance coverage for needy children, small-group and nongroup insurance market reform, comprehensive health system reform, genetic discrimination in insurance, managed care patient rights, and more.

In these and other examples, federal action was (or will be) more authoritative and comprehensive than most state efforts. Nevertheless, federal action was informed in each case by experimentation and innovation at the state policy level. In many cases—such as children’s health insurance expansion—passage of federal legislation triggered a further round of state expansion and experimentation. The innovation dynamic swings in both directions.

To be sure, federal impediments to state experimentation have been roadblocks to reform, especially the Employee Retirement Income Security Act of 1974, which prohibits states from passing laws that regulate employer-provided health coverage. Medicaid functions as both a roadblock and an enabler; federal rules of participation have often inhibited state reforms, yet the powerful engine of federal financial participation has advanced opportunities for reforms in access to care that states could never have financed on their own.

For the issue of eliminating racial and ethnic health disparities, the federal/state dynamic holds important lessons. Demonstrating that disparities elimination is a feasible and attractive issue at the state level will encourage federal legislators to devise and more actively promote policy initiatives to give this issue the attention and support it needs and deserves. Using state innovation as a deliberate trigger to encourage federal activity may, in turn, engender a more substantial wave of state experimentation.

Understanding Disparities As a Policy Issue

First and foremost, the national effort to eliminate racial and ethnic health disparities is a public health challenge, an initiative to improve the health of populations. Richmond and Kotelchuck propose a useful model to conceptualize the process by which public health knowledge translates into public health action and policy.⁵ Three ingredients are necessary: the knowledge base; the social strategy to accomplish change; and the political will to support change (and to generate resources needed to produce change). One or two of these ingredients are not sufficient—all three are needed. We can use this model both to assess progress to date and to identify potential strategies to move the issue forward.

The knowledge base is the scientific and administrative database upon which to make decisions. Since publication of the Heckler Report on Black and Minority Health in 1985, increasing attention has been paid to disparities in health status and health care services provided to racial and ethnic minorities.⁶ The Institute of Medicine's *Unequal Treatment* was confirmation of deep and persistent racial and ethnic health disparities.⁷ In December 2003, the Agency for Healthcare Research and Quality published its first annual national report on disparities⁸ and requires all potential grantees to consider the application of potential research projects to racial and ethnic minorities. A growing and sophisticated body of scientific literature has expanded the knowledge base. There are still many knowledge gaps—notably, about the effectiveness of interventions—but the research enterprise is robust and growing.

Knowledge is essential, yet it is not enough to mobilize public action. Social strategy is the plan by which knowledge and political will are applied. Prior to the 1998 launching of President Clinton's initiative to eliminate disparities, issues related to health status and health care for racial and ethnic minorities were categorized as "minority health." The Clinton/Satcher reframing of minority health issues under the rubric "racial and ethnic health disparities" was a bold and savvy social strategy to raise public awareness and draw attention to long-standing and unattended problems by casting the issue as both urgent and morally imperative. Focusing the strategy on six health conditions and services—adult immunization, cardiovascular health, cancer care, diabetes, HIV/AIDS, and infant mortality—added specificity and accountability. On paper, the knowledge base and social strategy would appear to be on secure ground.

Knowledge and strategy together are insufficient to achieve major public health tasks. Political will is society's desire and commitment to develop and fund new programs or to support or modify existing ones. On the surface, this is where the elimination of health disparities is most difficult to measure. Support from Presidents Clinton and Bush as well as Senator Frist has not been sufficient to mobilize public action and resources to meet the initiative's ambitious goals. No major national legislation has been approved since the 1998 initiative's launch. Disparities elimination is included in the health platforms of the 2004 presidential candidates, yet none of them has mentioned it prominently. The first national report on disparities, which Congress mandated be released by the end of September 2003, was delayed by the Agency for Healthcare Research and Policy without explanation or public outcry. Indeed, the final version of the report, released in December 2003, relabeled disparity as "difference," leaving "no implication that these differences result in adverse health outcomes or imply moral error or prejudice in any way."⁹ In February 2004, U.S. Secretary of Health and Human Services Tommy

Thompson agreed to release the original version of the Disparities Report that includes a more critical assessment of the nation's progress in addressing disparities.

One way to address deficits in political will is to explore alterations and additions to social strategy. For example, initial hopes in the 1960s that federal action on smoking would trigger behavioral change on a national level were undermined by the unwillingness of federal lawmakers to confront the tobacco industry; a shift in social strategy to focus on multiple state and local policies played a key role in precipitating a national transformation in smoking trends.¹⁰ A similar dynamic helped alter public attitudes toward alcohol and drinking and driving. Though these strategies took considerable time to yield returns, the results now appear irreversible.

An alteration in the social strategy to eliminate racial and ethnic health disparities could place greater emphasis on the role of state and local governments. This is not to suggest that state and local governments have been inactive, in fact, this paper will enumerate a range of activities in all 50 states. Still, it is difficult to find any state official—legislator, executive, minority health officer—who would characterize disparities elimination as a high-level policy priority. Programs at the state and local health department level cannot be confused with high-level policy development and prioritization.

One challenge is the lack of an action agenda. Focus groups conducted with state legislators as part of this project indicate an interest and desire to be more active. But public policymakers need concrete policies and program ideas to champion, and state officials say they do not receive many proposals. At the state level, disparities may be an issue where political will exists for a social strategy that has not yet been sufficiently formed.

This project's purpose is to begin crafting a state policy agenda for the elimination of racial and ethnic health disparities—to provide guidance and advice for state policymakers and policy experts, to expand the knowledge base in their states, and to develop comprehensive social strategies. We do not presume to advise state officials on political will—that is their domain.

Prior Research on State Disparities

Four significant previous reports—by the National Academy for State Health Policy,¹¹ the National Health Law Program,¹² the Association of State and Territorial Health Officers,¹³ and the Office of Minority Health¹⁴—evaluated state-level activities to address racial and

ethnic health disparities. Each report examined aspects of the systems, competencies, relationships, and resources to eliminate disparities and to assess the effectiveness of various practices. Common obstacles to eliminating disparities identified by the reports include:

- lack of accurate data to measure and document progress;
- shortages of minority-targeted health programs;
- limited technical assistance to improve the quality of health care professionals;
- inadequate funding or lack of funding priorities;
- cultural and language barriers;
- data collection limitations;
- the increase in the number of languages spoken;
- demographic changes;
- geographic isolation; and
- patient/client apathy.

The reports made similar or overlapping recommendations to improve efforts to combat disparities by forming partnerships or collaborations among government officials, health care providers, and communities. The objectives were to establish reliable funding sources for interpreter services and culturally appropriate health education materials; to conduct reliable data collection and analysis; and to inform, educate, and empower individuals and families about their health. In particular, the National Academy for State Health Policy study noted in its conclusions that strong leadership from executive and legislative branch champions can make a significant difference in producing positive policy outcomes.

Preliminary Findings and Conclusions

Before we developed our State Disparities Agenda, we commissioned four preliminary papers to understand better what has been occurring at the state policy level and to explore how disparities could become a more compelling and frontline policy concern for state officials, particularly state lawmakers.

Ladenheim and Groman used the Health Policy Tracking Service of the National Conference of State Legislatures to assess the level of legislative activity related to health disparities and minority health through 2002.¹⁵ The proportion of bills using the term disparities was “minuscule,” rarely breaking out of single digits. A larger number of bills

dealt with specific aspects of minority health improvement, such as provider recruitment, promotion of culturally competent care, disease-specific programs targeted at specific groups, and support and changes to offices of minority health. Some pieces of legislation specifically target African Americans and a smaller number identifies American Indians/Alaska Natives, while only a few pieces identify Hispanics as the principal beneficiaries. An important limitation to Ladenheim and Groman's research is that much state legislative activity that benefits racial and ethnic minorities is not identified that way. (For example, expansion in subsidized children's health insurance disproportionately helps minority group members and reduces health disparities.) It is likely that much important and effective state policy activity addressing disparities is not categorized that way at all.

State legislators identified this limitation as an important strategic concern in a set of focus groups moderated by McDonough.¹⁶ One group included racially and ethnically diverse legislators who specialize in health policy matters in their respective institutions, while the other consisted of African American legislators who were largely not specialists in health policy. While all participants agreed that disparities elimination is an important and valid public policy concern, a consensus in both groups was that framing policy proposals to help all disadvantaged persons was more effective in winning approval from nonminority colleagues. "I have to use the words 'poor people' or 'working poor' to get support," noted Wisconsin Representative Robert Turner. The other consistent finding was that as of late 2002 the elimination of racial and ethnic health disparities was not a priority issue in any legislative chamber in the nation: "I want to bring a dose of reality to this discussion—disparities is not going to be number one in any of our state legislatures regardless of partisan makeup," said Texas Representative Diane Delisi.

In a third paper exploring the political obstacles faced by legislators and other state policymakers, Stone proposes framing the issue of disparities as a deviation from acceptable and appropriate medical care.¹⁷ The advantages of this approach are that it accords with the paradigm of medicine as a scientific field; it accords with the universal value placed on good health; it defuses the explosive energy often attached to racial politics; it allows policymakers to avoid treating medical care as an ordinary consumer good that would otherwise fall under a market standard of justice; and it permits disparities to be judged as error rather than discrimination, prejudice, or bias. However, there are disadvantages. Most important, it obscures prejudice and discrimination by lumping disparities together with other deviations from the medical need standard.

The fourth paper proposes two new policy frameworks to advance our understanding of state-level disparities and efforts to ameliorate them; first, a Disparity

Index (DI) tool assesses the extent of racial and ethnic health disparities in each state, and second, a Disparity Reduction Profile (DRP) tool to assess the level of state policy program activities to address disparities.¹⁸ The DI facilitates measurement of disparities in a given state by particular disease and other health categories (i.e., cancer, heart disease, HIV, provision of prenatal care, and low birth weight). The DRP measures the level of state effort to eliminate disparities by examining five variables: the existence of a state minority health office, the level and adoption of minority health related legislation filed, the existence of purchasing regulations to address disparities, and the level of detail for race/ethnicity in statistics. Both of these tools are undergoing continuing development and refinement.

These papers show that opportunities exist for states to improve their disparities reduction activities. States have been active, but minority health issues have been back-burner concerns on most state health policy agendas. Part of this relates to the political challenge of addressing minority health concerns as distinct from issues affecting all disadvantaged persons.

Organization and Overview of the State Disparities Agenda

The State Disparities Agenda was developed to help policymakers identify promising strategies for reducing or eliminating disparities. The agenda was developed by a team of health services researchers during 2003.¹⁹ Drafts of each agenda category were shared with specialists; drafts of the entire agenda were shared with state minority health directors. The draft agenda was also shared with attendees at various national conferences during the fall of 2003, including the National Academy for State Health Policy, the Association of State and Territorial Health Officers, and the National Black Caucus of State Legislators.

The agenda is organized into two principal sections: issues related to state infrastructure and capacity and issues related to health conditions (Table 1).

Table 1. State Disparities Agenda: Key Issues Related to State Infrastructure and Capacity

State Infrastructure & Capacity	Health Conditions
Cultural/Linguistic Competency	Asthma
Data	Cancer
Elderly Services	Cardiovascular Disease
Insurance Coverage	Diabetes
Primary Care	HIV/AIDS
Purchasing	Immunization
Regulatory Approaches	Infant Mortality
State Minority Health Infrastructure	Injury Prevention
Workforce Development	Mental Health
	Obesity, Physical Activity, and Tobacco
	Oral Health

Each component of the agenda is divided into three sections: problem statement; promising practices, statutes, regulations, and programs; and policy recommendations. The problem statement provides a brief overview of research documenting the existence of disparities and the consequences of those disparities for individual or population health. The promising practices section highlights programs, statutes, regulations, and other approaches that appear to address the need described in the problem statement. This section is intentionally not titled “best practices” because of the shortage of empirically based evaluations of state disparities initiatives. A major recommendation from this project is the need for rigorous evaluation of disparities reduction efforts. The final section, policy recommendations, is intended to provide guidance to state officials in considering future policy directions and alternatives.

All researchers associated with this project emphasize the degree to which we approached this task with humility. We could have added other categories to the overall agenda, and we could have added much more to each particular category. However, we sought to craft an agenda that would be detailed enough to be useful to policymakers and also accessible.

KEY THEMES AND FINDINGS FROM THE STATE DISPARITIES AGENDA

The 20 categories included in the State Disparities Agenda cover a wide swath of state policies and programs, but there are eight key needs requiring the attention of state policymakers:

- Addressing the need for better and more consistent data collection;
- Effectively evaluating programs to determine which disparities reduction initiatives produce positive results;
- Emphasizing stronger cultural and linguistic competence in all disparities reduction activities;
- Establishing and expanding workforce development programs to increase diversity and to improve the cultural competence of all health care professionals;
- Ensuring access to services as well as screening (lack of health insurance is a major obstacle to reducing disparities);
- Creating and/or improving state minority health offices and infrastructure;
- Involving all health system stakeholders in efforts to reduce disparities.
- Beyond the categories included in the State Disparities Agenda, we include one additional recommendation for national policymakers and leaders:
- Create a national coordinating body to promote state-based activities for eliminating racial and ethnic health disparities.

State policymakers seeking to craft omnibus or multifaceted legislation to address disparities should ensure that any proposal address these eight elements.

Better and more consistent data collection. Accurate and timely data is essential. Yet there are major inadequacies in data collection, hampering efforts within individual states and hindering efforts to understand differences among states. At the extreme, some state surveillance systems still categorize all racial and ethnic groups as only black or white. The accepted national standard for data collection relies on the categories included in the Federal Office of Management and Budget's Directive 15 (revised October 30, 1997): American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; white; and ethnic group: Hispanic or Latino. States should also collect and report health data on racial and ethnic subgroups that reflect the racial and

ethnic makeup within each state, and they should initiate strategies to identify gaps in available data for small population groups.

Determine which disparities reduction initiatives produce positive results. The initial intent of this project was to identify best practices, but the researchers soon confronted the lack of research assessing and documenting the effectiveness of various approaches to addressing disparities. Therefore we abandoned the term “best practices” for the more ambiguous category “promising practices.” Practices are identified as promising based on case studies and other reports, as well as recommendations made by researchers, policy experts, and state officials. We recommend that researchers and public officials work jointly to evaluate the effectiveness of disparities interventions and to document and publicize those programs and policies that yield positive results. Equally important is the need to identify interventions that do *not* work.

Stronger cultural and linguistic competence in all disparities reduction activities. Culturally and linguistically appropriate services are health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to appropriately respond to the attitudes, feelings, or circumstances of individuals or groups sharing a common and distinctive racial, national, religious, linguistic, or cultural heritage. Language and cultural barriers have been found to increase health costs by causing physicians to rely on extensive, costly, and unnecessary tests, resulting in longer treatments, especially for non-English-speaking patients. States need to develop minimum standards for culturally and linguistically competent health services; undertake data collection and research on successful practices; support education, training, and development of a more competent workforce; and monitor and enforce the effectiveness of programs. In all of these priority areas, states need support from the federal government and foundations.

Workforce development programs to increase diversity and improve the cultural competence of all health care professionals. Although Latinos, African Americans, and American Indian/Alaska Natives account for 25 percent of the U.S. population, they account for only 6 percent of practicing physicians and less than 14 percent of registered nurses. White physicians and dentists are far less likely than their minority colleagues to practice in federally designated shortage areas, to see minority patients, and to accept Medicaid patients. Racial concordance of patient and provider is associated with greater participation in care, higher patient satisfaction, and greater adherence to treatment. States have undertaken many initiatives to improve the “pipeline” of minority practitioners, but

they need to expand and improve efforts to diversify the health care workforce, and they need assistance in identifying best practices.

Health screening and access to services (insurance). Many state, county, and local public health authorities have screening programs to identify illnesses among their disadvantaged residents, but then have no resources or ability to provide treatment. The majority of the nation's 43 million uninsured are racial and ethnic minorities. Lack of health insurance coverage has been identified as the single most important factor in explaining differences between the health status of African Americans and Hispanics versus whites.²⁰ As mentioned previously, the recent state fiscal crisis has caused the loss of public insurance coverage for about 1.6 million lower-income Americans. States that want to reduce or eliminate disparities have no choice but to confront inequities in the ability of racial and ethnic minorities to obtain affordable and decent health insurance.

Creating and/or improving state minority health offices and infrastructure. Thirty-five states and territories have a designated office, commission, council, or advisory panel on minority health. These entities advise state policymakers about disparities and other gaps, and develop strategies, programs, and solutions. Still, there are no commonly accepted standards, core competencies, or minimum infrastructure requirements. Successful offices have adequate financial resources, stable staffs, close working relationships with other key state agencies, statutory or regulatory grounding, access to good data, and operate with clear performance measures. A promising combination in a state is an office of minority health as well as a standing commission that involves legislative, executive, and nongovernmental stakeholders.

Involve all health system stakeholders. Issues related to minority health and health disparities can be easily pigeonholed so that policymakers have only limited exposure to them. Yet any effective strategy to reduce or eliminate disparities requires the full engagement of state governments—including executive and legislative branch leaders—and the broader health sector—including hospitals, physicians, community health centers, nurses, home health providers, the public health community, and community-based organizations. An effective strategy must also engage the broader public through community-based public education.

Finally, we include a recommendation directed not to state policymakers but to national policymakers and national health sector leaders, including organizations for health philanthropy:

Create a national coordinating body to promote continuing state activities to eliminate racial and ethnic health disparities. As important as states are, they cannot carry out this mission alone. The federal government already plays a critically important role in supporting state activities. There is also an important role for the nongovernmental sector, working nationally, to encourage and support state efforts. We propose the establishment of a national coordinating council on state activities. Such a group can serve a number of critical purposes, including:

- Conducting and supporting research on best practices;
- Developing strategies to advise states;
- Publicizing nationally the strategies of successful states;
- Educating state officials and other state stakeholders on developments in reducing or eliminating disparities.

State governments have an opportunity to play a vital role and there is much more that states can do. There are many ways that national organizations committed to disparities elimination can support states.

STATE INFRASTRUCTURE AND CAPACITY

CULTURAL AND LINGUISTIC COMPETENCY

The need for cultural and linguistic competence in health care has gained much attention in the past 15 years. Culturally and linguistically appropriate services (CLAS) are health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that have shared a common and distinctive racial, national, religious, linguistic, or cultural heritage.²¹ The Institute of Medicine report also demonstrated that “[R]acial concordance of patient and provider is associated with greater participation in care processes, higher patient satisfaction, and greater adherence to treatment.”²²

CLAS can decrease health care costs. A Kaiser Family Foundation study found language barriers can cause doctors to rely on extensive, costly, and unnecessary tests causing treatment to take 25 to 50 percent longer than treatment for non-English-speaking patients.²³

The Federal Office of Management and Budget’s language services cost-benefit report discussed the benefits of language services, including improving provider–patient communication, thus increasing the rate of accurate diagnosis and patient compliance, and decreasing medical costs by decreasing unnecessary emergency room visits. States can use cultural and linguistic competency programs to decrease costs and errors.

Promising Practices, Statutes, Regulations, and Programs

State Department of Health Initiatives. Los Angeles County is one of the first counties to develop cultural and linguistic competency standards. Due to budget constraints, implementation will be incremental. Standards include creating performance measures, promoting incentives to reward culturally competent practices, supporting staff with necessary skills, knowledge, and tools to support culturally competent practices, promoting recruitment and retention of qualified bilingual staff and staff with diverse backgrounds, and asking facilities and programs to record a patient’s language preference and ensure an interpreter is available if requested. (See <http://www.dhs.co.la.ca.us>.)

In 1991, the Department of Social and Health Services (DSHS) in Washington state initiated an effort to certify medical and social service interpreters and translators working for DSHS. This effort was the culmination of lawsuits and civil rights complaints brought against DSHS for not providing equal access to services for limited English

proficiency (LEP) clients. As part of a consent decree, DSHS agreed to provide (and pay for) interpreters for clients and to ensure the quality of interpreter services via administration of a standardized test. (See <http://www.dshs.wa.gov/msa/ltc/itsvcs.html>.)

State Legislation for Bilingual Services. We have identified three models that states can follow in providing LEP patients their legal right to linguistically competent services. One model is California's Dymally-Alatore Bilingual Services Act, passed in 1973, which requires state and local agencies to provide interpreter services and translated materials. State agencies that furnish information and services to the public must employ qualified bilingual persons in public contact positions to ensure that these services are provided in any non-English language spoken by a substantial number of the people served by the agency. While this law is not specific for health care institutions, it is inclusive of them. Other states could follow similar guidelines and add an enforcement component, the principal weakness of the California law.

California's Kopp Act (California Health and Safety Code 1259) requires general acute care hospitals to make interpreter services available 24 hours a day, to post multilingual notices of the availability of interpreter services, and to record the primary language spoken by each patient.

A Massachusetts statute (Chapter 66 of the Acts of 2000) requires the presence of a competent interpreter in the delivery of certain acute care health services, for example, at acute care hospitals in connection with all emergency room services provided to non-English-speaking patients. Department of Health regulations require designation of interpreter services coordinators, posting notices and signs informing patients of their rights to interpreter services, performing annual language assessments, training interpreters, and refraining from using family members or minors as interpreters. (See <http://www.state.ma.us/legis/laws/seslaw00/sl000066.htm>.)

Medicaid/Medicare Contract Language. California requires state plans and health plans providing Medicaid services to incorporate "structural cultural competence." Plans must establish cultural competence training programs for staff and add staff in order to improve health care access for multiethnic populations. Plans have begun to translate their written materials, improve interpreter access, use community health care workers, and include more minority physicians. The California legislature is considering legislation to codify the Healthy Families and Medi-Cal contract language to prevent requirements from being weakened in the future. (See <http://www.omhrc.gov/clas/cultural1a.htm>.)

Policy Recommendations

1. *State standards.* States can develop minimum cultural and linguistic service standards tailored to their population. The federal CLAS guidelines developed by the Office of Minority Health can be used as a reference. States can also develop guidelines for the use of on-site interpreters, such as 5 percent of population requires on-site interpreter services.
2. *Data collection/research.* State programs may collect race/ethnicity and language preference data for all beneficiaries, members, and clinical encounters. This information should be kept confidential and be used for reporting and monitoring racial and ethnic disparities, quality improvement initiatives, and targeted program development.²⁴ States can also fund research that identifies tools to detect medical errors due to lack of “structural cultural competence,” language barriers, misunderstanding of health education materials, instructions, or signage (e.g., inappropriately preparing for a diagnostic or therapeutic procedure resulting in postponement or delay), and misunderstandings regarding the benefits and risks of procedures requiring informed consent.²⁵
3. *Education.* States can help to ensure an adequate supply of culturally aware providers to promote higher quality and more efficient services. States can require or encourage providers (nurses, dentists, nurse practitioners, physician assistants) to receive cultural competency training prior to receiving a state license. Providers should have knowledge of enhanced risks relating to race, ethnicity, and socioeconomics.
4. *Interpreter services.* Reimbursement for interpreter services is essential. Bilingual staff should be recruited for areas with large proportions of LEP patients. On-site interpreter services can be required, and reimbursed at institutions with significant threshold populations of LEP patients (e.g., whenever more than 15 percent of encounters are with Spanish-speaking patients). Other interpreter services (e.g., remote telephone or simultaneous interpretation) can be encouraged where LEP populations are smaller.
5. *Enforcement/evaluation.* States can evaluate programs to assess their impact on improving outcomes by decreasing disparities. When state agencies do not adhere to minimum standards, patients need access to a grievance process with appropriate interpreters to address their unmet needs.

6. *Workforce diversity.* States need to increase the supply of minority health care providers. Minority providers are more likely to serve in minority communities, thus increasing access for these populations. States need an adequate number of providers who know the values, beliefs, traditions, and cultures of the patients they serve. States should strive to produce a diverse workforce that mirrors its population so that minorities within health care professions are represented at a similar percentage to their representation within the state.

Additional Resources

- Compendium of Cultural Competency Initiatives in Health Care. (See <http://www.kff.org>.)
- Cultural Competency, OMB Benefit-Cost Report Executive Order #13166. (See <http://www.haa.omhrc.gov>.)
- Cultural Competence in Health Care (sponsored by The Commonwealth Fund). (See <http://www.mgh.harvard.edu/healthpolicy>.)
- National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. (See <http://www.omhrc.gov/clas/>.)

DATA

Data are essential for state policymakers, agencies, and private health systems to identify health disparities, plan and justify special initiatives targeted for minority populations, measure progress in eliminating disparities, and make cross-state comparisons. A lack of data on minority groups in a state creates complications for a health department and the statewide health infrastructure. Limited minority health data make it difficult or impossible for health agencies to identify disparities that could adversely affect the health of state residents. Lack of data makes it difficult to justify special initiatives targeted toward minority populations.

Without data on the health conditions of minority groups in the state, it is difficult to measure the progress of state initiatives. According to the National Center for Health Statistics, existing mortality data for white and black populations are accurate but are understated for American Indian/Alaska Natives by 21 percent, for Asian and Pacific Islanders by 11 percent, and for Hispanics by two percent. It is also frequently difficult to produce meaningful data for small population groups. Inadequate and inaccurate data make it difficult to measure disparities now and will increase the difficulty of measuring progress in the future.²⁶

In addition to state data, racial and ethnic data are not routinely collected by health service delivery systems or insurers, in part from confusion over whether such data collection is allowed by federal or state law or regulation. This creates a barrier to performance measurement and clinical quality improvement efforts.²⁷

Promising Practices, Statutes, Regulations, and Programs

Recent efforts to eliminate racial and ethnic health disparities have focused renewed attention on the collection, analysis, and reporting of state data by race and ethnicity.

State Policies on Collecting Racial and Ethnic Data. All 50 states collect vital statistics (e.g., births, deaths, marriages, divorces) by race. The choice of racial categories for which data is collected ranges from black/white only (Alabama) to states such as New York that reference the Federal Office of Management and Budget’s Directive 15 categories cited previously.

The National Health Law Program (NHLP) of California—on behalf of the Office of Minority Health—recently completed the first phase of a major study regarding collection and reporting of racial and ethnic health data by health insurers and managed care plans. Table 2 provides a summary of the state-by-state analyses (available online at <http://www.omhrc.gov/omh/sidebar/datastats13.htm>.)

Table 2. State Policies on Collecting Racial and Ethnic Data²⁸

State Policy	State
States that require the collection of racial, ethnic, or primary language data	SC (race), TX (language)
States that prohibit by statute or regulation the collection of racial and ethnic data in certain contracts	CA, MD, NH, NJ
States whose prior approval processes would require justification for or prohibit the collection of racial and ethnic data on forms	CT, IA, MN, SD, WA
States lacking a policy that protects against discrimination by health insurers or managed care plans on the basis of race, color, or national origin	AL, GA, MS
States whose antidiscrimination protections for health care consumers are uncertain	HI, IN, IA, KS, OK, OR, VT
States lacking protection of confidentiality of medical information or data for non-MCO or -HMO enrollees	AL, CO, DE, DC, FL, GA, ID, IN, IA, KS, KY, LA, NE, NM, OK, PA, SC, SD, UT, WV, WI
Medicaid/SCHIP program and Medicaid managed care practices	State option

Protections Against Misuse or Abuse of Data. In programs or agencies receiving federal assistance, Title VI of the Civil Rights Act of 1964 provides protection from discrimination on the basis of race, color, or national origin. Most states follow the provisions of Title VI or have explicit policies or programs that prohibit discrimination on the basis of race, color, or national origin. The Health Insurance Portability and Accountability Act became effective April 14, 2001; it provides safeguards pertaining to the use and management of private health information.²⁹ HIPAA provides minimum standards to ensure the confidentiality of health information. Every state demands some degree of confidentiality protection for managed care enrollees, but 21 states do not provide similar protections for those who receive health care services through other types of insurance, such as indemnity coverage.

State Health Data Practices. States use many strategies to prevent disease, disability, and premature death. Public health surveillance systems monitor the public's health, identify public health problems, establish priorities, and assign resources. States often encounter problems when they attempt to merge federal requirements for data collection and reporting on race and ethnicity into existing state systems. Some states, such as New York,³⁰ California,³¹ and Massachusetts,³² collect and report health data on racial and ethnic subgroups that reflect the race, ethnicity, and primary language of the groups within that state. Other states, such as Utah³³ and Maine,³⁴ use OMB Directive 15 standards to guide their data collection activities.

Without better and consistent systems for data collection and reporting, states have difficulty prioritizing health problems, as well as initiating and evaluating the efficacy and cost effectiveness of public health programs to eliminate racial and ethnic disparities.

Policy Recommendations

1. The Revised OMB Directive 15 racial and ethnic categories should be adopted by states as the minimum for collecting and reporting health data.
2. The collection, reporting, and tracking of health information by race and ethnicity should be encouraged and supported by public, private, and voluntary health organizations. Such data collection can inform clinical quality improvement efforts, improve program development efforts, and generate interest inside health provider organizations and health plans.
3. States should assess their needs to collect and report health data on their racial and ethnic subgroups.
4. States should initiate strategies to identify gaps in data for small population groups.

ELDERLY SERVICES

Seniors who belong to racial and ethnic minorities face unique challenges. Their private pension and Social Security payments are likely to be lower than those of whites because most had lower wages and salaries during their working years and were more likely to have worked in jobs (such as in agriculture or domestic labor) that were not covered by Social Security or Medicare. If they were adult or elderly immigrants, they may not have worked in the U.S. for very many years. Racial and ethnic minority elderly are more likely to be poor than white elderly (22.4% of black elderly, 18.8% of Hispanic elderly, and 10.3% of Asian/Pacific Islander elderly are poor, compared with 8.9% of white elderly).

Many assume health insurance is not an issue for the elderly because most people over age 65 receive Medicare. There are several important gaps, however. First, Medicare includes cost sharing. Although many seniors purchase supplemental Medicare coverage, many policies are unaffordable for low-income seniors. Also, Medicare does not cover many medical needs; the new Medicare Prescription Drug law, effective in 2006, contains many gaps in coverage that will affect lower-middle-income seniors.³⁵ Second, many minority seniors experience significant difficulties in access to care. African Americans are more likely not to obtain needed care, and, along with Latinos, are more likely to report being unable to see a specialist when needed. Though minority and nonminority elderly have the same Medicare coverage, differences in medical treatment have been documented. Compared with whites, African American Medicare recipients are less likely to receive bypass surgery and influenza immunizations.³⁶ Black Medicare recipients in managed care plans are less likely to receive breast cancer screening, eye exams if diabetic, beta-blocker medication after heart attacks, or follow-up visits after hospitalization for mental illness.³⁷

Medicare does not cover most long-term care services. Compared with non-Latino whites, blacks and Latinos are less likely to use nursing homes and equally likely to use formal, community-based care. Blacks and Latinos are much more likely than whites to rely on informal, at-home care than whites.

Promising Practices, Statutes, Regulations, and Programs

State policy can address Medicare coverage gaps. Many state programs are targeted toward the low-income elderly, which benefits the minority elderly, though this depends on effective outreach and implementation in minority communities.

Very-low-income elderly may be eligible for SSI benefits and associated Medicaid coverage. Elderly with high medical expenses, in the community or in a nursing home,

may qualify for Medicaid coverage through programs for the medically needy (available in 35 states and the District of Columbia) or other Medicaid provisions. Eleven states go beyond the SSI eligibility limit (75% of the federal poverty level [FPL]) and provide full Medicaid coverage for seniors with incomes up to 100 percent of the FPL. State Medicaid programs must cover Medicare Part A and Part B cost sharing and premiums for seniors who are “qualified Medicare beneficiaries (QMB)” (income less than 100% of the FPL) or “specified low-income Medicare beneficiaries (SLMB)” (income between 100% and 120% of the FPL). Federal law has added state payments for Medicare premiums for “qualifying individuals” (QI) with incomes between 120 and 175 percent of the FPL. State implementation differs. Best current practice is full implementation of these options.

Beyond Medicaid, 36 states provide prescription drug assistance for seniors who are ineligible for Medicaid—though the future of these programs is in question with passage of the 2003 Medicare Prescription Drug law. Eligibility for these programs differs significantly across states, ranging from 90 to 300 percent of the FPL. New Jersey’s Senior Gold Program offers eligibility to seniors with incomes to 335 percent of the FPL if single, and 286 percent of the FPL for couples. Drugs are available with a \$15 copayment plus 50 percent of the cost of the drug, with an out-of-pocket coinsurance maximum of \$2,000 for singles and \$3,000 for couples, after which the copayment is limited to \$15. (See <http://www.state.nj.us/health/seniorbenefits/seniorgolddiscount.htm>.)

Policy Recommendations

For the minority elderly, state policy should focus on long-term care use and Medicaid coverage. While some states have developed home- and community-based long-term care services, these programs have not been designed to address disparities in long-term care. State efforts have focused on delivering home and community-based services to those most likely to enter nursing homes (to reduce the use of these services). Because the minority elderly are less likely to use institutional services than whites, they may be less likely to benefit, and because minorities are less likely to use nursing homes and more likely to rely on informal support, home and community-based services need to be consistent with these preferences. Many low-income elderly are eligible for either full Medicaid coverage or Medicaid-financed payment of Medicare cost sharing (QMB, SLMB, or QI eligibility), but have not enrolled. Because minority elderly have lower average incomes than white elderly, these provisions are especially beneficial for them. States should develop efforts to ensure that minority elderly take up these benefits.

Additional Resources

- Rosenbach ML, Lamphere J. (1999). *Bridging the gaps between Medicare and Medicaid: the case of QMBs and SLMBs*. Washington, D.C.: AARP Public Policy Institute.
- Stone J, Yacker HG. (2002). *Prescription drug coverage for Medicare beneficiaries: Medicaid and state pharmaceutical assistance programs*. Washington, D.C.: Congressional Research Service. Available at <http://www.rxpolicy.com/studies/crs31485.pdf>.

INSURANCE COVERAGE

Racial and ethnic minorities are more likely to be uninsured. They are more likely to work in low-wage jobs that do not offer insurance and are more likely to work in part-time jobs or to be unemployed, disrupting ties to employer coverage. Minorities have lower incomes and are less likely to sign up for employer coverage when such coverage requires out-of-pocket premiums (for example, to cover dependents) or to purchase private coverage on their own. Medicaid and the State Children's Health Insurance Program (SCHIP) can fill part of the gap, but many minorities live in states with restrictive eligibility. Even though expanding coverage will not address all disparities, lack of insurance inhibits access to medical services and makes minorities less likely to obtain needed medical care.

Table 3 shows the number of U.S. uninsured in each racial/ethnic group in 2001. More than half of the uninsured Americans—21.4 million—are racial/ethnic minorities. While 11.6 percent of nonelderly whites are uninsured, 20.1 percent of blacks, 34.6 percent of Latinos, 19.1 percent of Asian/Pacific Islanders, and 19.6 percent of American Indians lack health insurance coverage. Although there are important differences in the reasons for lacking health insurance among minority groups, policies to reduce the overall number of uninsured will reduce disparities associated with insurance coverage.

Table 3. Nonelderly U.S. Residents Without Health Insurance, 2001 (millions)

	All Races	White	African American	Latino	Asian/Pacific Islander	American Indian/Alaska Native
All Children and adults under age 65	40.7	19.3	6.4	12.3	2.2	0.6
Children under age 18	8.4	3.3	1.5	3.1	0.4	0.2
Children under age 18, income <200% FPL*	5.8	1.9	1.1	2.4	0.2	0.1
Adults living with children	11.8	4.7	1.7	4.6	0.7	0.2
Adults living with children, income <200% FPL	7.9	2.7	1.2	3.4	0.3	0.1
Adults not living with children	20.4	11.3	3.2	4.6	1.2	0.3
Adults not living with children, income <200% FPL	9.4	4.5	1.7	2.6	0.6	0.1

* Federal poverty level.

Source. Current Population Survey, tabulated by authors.

Efforts to improve coverage focus on program eligibility criteria and program take-up. Eligibility rules set requirements based on income and other characteristics. Medicaid eligibility has been based on having very low income and meeting additional requirements (receipt of welfare, being a child, a member of a family with dependent children, a pregnant woman, elderly, or disabled), although policy is moving away from these categories. Federal law requires Medicaid coverage for children under 6 with family income below 133 percent of the FPL, and all children under 18 with income below 100 percent of the FPL. SCHIP covers children in families with incomes above these levels, with 27 states adopting SCHIP eligibility at 200 percent of the FPL. For adults, federal law requires most states to provide Medicaid coverage for families who would have been eligible for welfare under the pre-welfare reform eligibility standards and to provide transitional eligibility for those losing eligibility because of increased earnings.

Many of those eligible fail to enroll. Because many states have adopted SCHIP eligibility up to 200 percent of FPL, the main issue for uninsured children (5.8 million children, including 3.9 million minority children) concerns barriers to participation. States are beginning to simplify enrollment and enrollment renewal. However, some states have reinstated eligibility barriers, a response to the state fiscal crises between 2002 and 2004. Lower-than-average income, restricted program eligibility, and low program participation are particularly important reasons that relatively few members of racial/ethnic minorities who are members of recent immigrant groups have health insurance.

Promising Practices, Statutes, Regulations, and Programs

Program Eligibility. The best practice is seen in states with high income cutoffs for children's eligibility. Eleven states set SCHIP eligibility above 200% of the FPL: California (250%), Connecticut (300%), Georgia (235%), Maryland (300%), Minnesota (275%), Missouri (300%), New Hampshire (300%), New Jersey (350%), Rhode Island (250%), Vermont (300%), and Washington (250%). For adults, current best practice is found in states that adopted family coverage using Medicaid/SCHIP waivers: Arizona, Hawaii, Minnesota, New Jersey, New York, Oregon, Rhode Island, Vermont, and Wisconsin. Although income cutoffs are lower than for children's coverage, some states provide comparable eligibility for adult family members. Minnesota extends family coverage to those with incomes up to 275 percent of the Federal poverty level. States have received federal waivers to develop these family coverage programs, although in many states these expansions have provided insurance benefits that are less generous than the standard Medicaid benefits package.

Program Take-Up. To improve participation, current best practices embody policy and administrative changes to simplify enrollment burdens for families. The following is a list of these changes (the number of states, including the District of Columbia, that have adopted each change is in parentheses):³⁸

- Eliminating asset tests, which reduces the application burden for families (45 of 51 children's Medicaid programs, 34 of 35 SCHIP programs);
- Adopting presumptive eligibility to allow providers to provisionally enroll recipients based on simplified eligibility questions, pending determination by the state (9 of 51 children's Medicaid programs, 5 of 35 SCHIP programs);
- Adopting self-declaration of income, reducing the burden of documenting income through pay stubs (13 of 51 children's Medicaid programs, 11 of 35 SCHIP);
- Eliminating the requirement for face-to-face interviews, and using mail-in and telephone applications (48 of 51 children's Medicaid programs, 34 of 35 SCHIP programs);
- Establishing 12-month continuous eligibility, which reduces the burden of reapplying every month or quarter (18 of 51 children's Medicaid programs, 23 of 35 SCHIP);
- Reducing or eliminating the requirement that applicants have been uninsured for a minimum waiting period (7 of 35 SCHIP programs have no minimum waiting).³⁵

Policy Recommendations

Future policy is affected by state budgets. Many of the Medicaid and SCHIP expansions, especially for family coverage, are threatened by budget cuts. Some states have begun to restore asset tests and eligibility redeterminations they had simplified or have frozen enrollment in SCHIP. Restricting eligibility entails losing federal matching funds, and will magnify difficulties faced by families who lose private insurance.

Attention should be given to the insurance needs of adults, both those living with children as well as those without children. (For the most part, program expansions have focused on insurance coverage for children.) Among such adults are 7.1 million uninsured minorities living with children, and 9.1 million uninsured minorities who are in households without children.

To facilitate take-up, states can adopt administrative simplifications for adult applicants, and address the lack of information and concerns that make some families hesitant to apply for benefits. Many states disseminate information through public service advertising, use paid outreach workers, and develop partnerships with community and faith-based organizations, businesses, fraternities and sororities, professional organizations, educational institutions, and legal advocacy organizations. (Some are funded by the Covering Kids Initiative, see below.) Even though states may provide grants for outreach, partnerships can be developed with little additional state spending.

To address the needs of immigrants who may be ineligible for federally funded programs, states can use state-generated funds to extend program eligibility to them. Outreach efforts should be tailored to the linguistic needs of these communities and be sensitive to cultural issues. States may also need to address immigration-related legal issues and the lack of trust in government programs found in many immigrant communities.

Additional Resources

- Covering Kids Initiative: <http://www.coveringkids.org/>.
- Maloy, KA, Kenney, KA, Darnell, J, Cyprien, S. (2002). *Can Medicaid work for low-income families?* Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/4032-index.cfm>.

PRIMARY CARE

Racial and ethnic minorities receive worse primary care than whites.³⁹

- Blacks and Hispanics are more likely to identify their usual source of care as a hospital rather than a primary care provider (1.46 and 1.40 times, respectively).
- Twenty-one to 28 percent of minorities waited longer than 30 minutes to be seen by a provider, while 14 percent of whites did so.
- Hispanics were significantly less likely to believe their primary care provider listened to them, compared with whites.
- Asians found it most difficult to make an appointment and were least satisfied with health care staff.

The disparities persist even after adjustments for sociodemographic and health status. Furthermore, although African Americans and Hispanics in managed care plans enjoy greater access to primary care services, the extent of the disparities between ethnic and racial minorities and whites in managed care is similar to disparities in other types of health plans.⁴⁰

In 2000, primary care visits per person were 20 percent lower for Hispanics and 33 percent lower for non-Hispanic blacks, compared with non-Hispanic whites. In addition, ethnic minorities, Medicaid recipients, the uninsured, and rural dwellers were more likely to use community health centers than other health care sites.⁴¹

Promising Practices, Statutes, Regulations, and Programs

Most states have developed programs to provide comprehensive, coordinated primary care services and to increase the number of primary care providers in medically underserved and rural areas.

Education and Workforce Development

Incentive and outreach programs have been used to provide greater access to primary care services. Although these programs have been enacted into law, there is no information available regarding their success at reducing or eliminating racial and ethnic disparities in primary care.

Physician and Surgeon Incentive Pilot Program. The California Division of Licensing of the Medical Board administers a loan program to help correct the unequal distribution of medical practices, in particular, helping licensed physicians and surgeons to establish practices in areas lacking physician services and primary care specialties. The division awards loans on the basis of local need to applicants it determines will establish medical

practices in such areas. (California Business and Professions Code § 2200; <http://www.leginfo.ca.gov/calaw.html>.)

Health Professions Education and Outreach. The Regents of the University of California are required to report to the state legislature regarding efforts to recruit students to schools of medicine, dentistry, and optometry from communities and populations that are underserved so that students will return and practice in these areas. (California Education Code § 92655; <http://www.leginfo.ca.gov/calaw.html>.)

Community-Based Health Professions Education Partnership Program. The University of California established a program to encourage the development of undergraduate medical and other health professional clerkships in primary care combining health education, human services, and community involvement. The goal is to increase the number of medical students who enter residencies in primary care and to increase the number of health professionals who practice primary care in low-income communities and medically underserved areas. The program includes:

- Primary care clerkships;
- Placing nurse practitioners and physician assistants on teams with other health, education, and human services professionals charged with identifying and addressing community health problems;
- Exposing students to a comprehensive array of primary care services;
- Placing students in community or neighborhood primary care clinics in low-income communities;
- Culturally appropriate program governance, staff, and services.

(California Education Code § 92720; <http://www.leginfo.ca.gov/calaw.html>.)

Collaborations and Networks

The Agency for Healthcare Research and Quality (AHRQ) has supported the primary care Practice-Based Research Network (PBRN) since 1993. A PBRN is a network of ambulatory practices devoted to primary care research related to community-based practice. PBRNs produce research findings relevant to clinicians and can be incorporated into everyday practice. In 2000, the AHRQ awarded planning grants to 19 networks to enhance their capacity to conduct research in primary care settings. Each grant supports the development of a plan for the following:

- Establish or improve electronic collection and aggregation of data from individual practices;
- Increase the network's capacity to study the health care of racial and ethnic minority and/or underserved populations;
- Develop methods to assist clinicians in translating research findings into practice;
- Identify potential sources of ongoing support for the network.

(See <http://www.ahrq.gov/research/pbrnfact.htm>.)

An example of a PBRN is the Southern Primary-Care Urban Research Network (SPUR-Net). SPUR-Net evaluates the effectiveness of primary care services delivered to ethnically and socioeconomically diverse populations in the Houston metropolitan area. The network is developing methods to gather and accumulate research data and complete short-cycle research projects. SPUR-Net is composed of five primary care organizations in the Houston area, caring for 800,000 patients annually. (See <http://www.spurnetwork.org/>.)

In 1999, the Bureau of Primary Health Care (BPHC), part of the Health Resources and Services Administration (HRSA), launched a campaign to eliminate health disparities and guarantee 100 percent access to quality health care to underserved Americans by 2010. Through this campaign, Health Disparities Collaboratives were developed to bring community health centers together under the guidance of national experts to improve care with a focus on disease management. Over 350 BPHC-supported health centers have participated in collaboratives focusing on diabetes, cardiovascular disease, asthma, and depression. National, state, and local partnerships have increased access to expertise, computer software, discounted pharmaceuticals and laboratory equipment, community resources for patients, and education resources and materials for participating communities. (See <http://bphc.hrsa.gov/programs/HDCProgramInfo.htm>.)

Rural Florida residents have limited access to health care; what is available suffers from insufficient funding and the difficulty of recruiting and retaining staff. The state established Rural Health Networks, which are networks of rural and urban health care providers and others, to cooperatively plan and deliver health care services. All networks offer public health, primary care (including maternity care), emergency medical care, acute inpatient care, home health care, and outpatient psychiatric and substance abuse services, among others. (Florida Statutes § 381.0406; <http://www.flsenate.gov/statutes>.)

Coverage Expansion

Several states have addressed disparities in accessing and obtaining primary care services attributable to income. By reaching Medicaid recipients these services may indirectly reduce disparities, but large segments of the minority population are not eligible for such benefits.

In 2003 the District of Columbia implemented a Medicaid Section 1115 Demonstration to provide primary and preventive health services to nondisabled adults, between ages 50 to 64, who are not custodial parents or caretakers for children under the age of 19. This group has been shown to have comparatively poorer health status, higher rates of hospitalization, and great research potential. This program includes inpatient, outpatient, and ambulatory medical and surgical services; home health services; hospice services; physical, occupational, and speech therapies; dental services; prescription services; and transportation services. (See <http://cms.hhs.gov/medicaid/1115/dc1115ca.asp>.)

Policy Recommendations

1. States may consider increasing research in such areas as: differences in primary care access among racial and ethnic subgroups; perceptions and interpretations of barriers to care across racial and ethnic groups; and the role of discrimination in impeding access to care. Such research can be initiated by linking academic researchers with state health departments and health care providers who serve minority communities. For example, the National Center for Primary Care at the Morehouse School of Medicine in Atlanta contracts with the Georgia state health department to research issues such as primary care safety nets, Medicaid coverage, and access to care.
2. States can ensure that outreach and education programs as well as established collaborations and networks address health disparities by conducting annual evaluations or creating an external advisory board to monitor progress.
3. States can expand the number of community health centers to increase access, particularly in rural areas, and increase assistance for transportation and childcare by applying for funding to develop Federally Qualified Health Centers designated by the Bureau of Primary Health Care that are developed in “medically underserved areas” (MUA) or in areas with a majority of “medically underserved populations” (MUP).
4. States can reduce financial barriers to primary care and can reorganize health services to strengthen primary care by developing comprehensive, community-based models that integrate prenatal, mental health, and substance abuse services.

Additional Resources

- Practice-Based Research Networks: <http://www.ahrq.gov/research/pbrnfact.htm>.

- Bureau of Primary Health Care: <http://www.bphc.hrsa.gov>.
- CDC's National Center for Health Statistics: office visits: <http://www.cdc.gov/nchs/fastats/docvisit.htm>.
- CDC's National Center for Health Statistics: ambulatory health care data: <http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm>.

PURCHASING

States have underused their extensive purchasing powers to address health disparities. Contract requirements and financial incentives can promote changes by providers and managed care organizations. The potential impact is significant because states purchase a large volume of medical services each year—\$195 billion through Medicaid alone in 2000—in addition to insurance for public employees and those who work in public schools. Other health-related programs, such as those providing mental health services, also involve significant expenditures. The combined power of these programs makes state government the second largest payer in each state (after Medicare).

Promising Practices, Statutes, Regulations, and Programs

Several states have requirements to address disparities in managed care contracts, especially for Medicaid and SCHIP. These requirements reinforce the antidiscrimination requirements of Title VI of the Civil Rights Act, which prohibits health plans from racial or ethnic discrimination and require plans to provide culturally and linguistically appropriate services.

The following are antidiscrimination clauses from a Medicaid managed care contract in California; they prohibit discrimination and set up state agency reviews of discrimination complaints:

3.10 DISCRIMINATION PROHIBITION: The Contractor will not discriminate against Members or Eligible Beneficiaries because of race, color . . . ancestry . . . national origin . . . in accordance with Title VI of the Civil Rights Act of 1964 For the purpose of this Contract, discriminations on the grounds of race, color...ancestry...include but are not limited to the following: denying any Member any Covered Services or availability of a Facility; providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service; the assignment of times or places for the provision of services on the basis of the race, color . . . national origin, ancestry . . . of the participants to be served. The Contractor will take affirmative action to ensure that Members are provided Covered Services without regard to race, color . . . national origin, ancestry . . . except where medically indicated

3.11 DISCRIMINATION COMPLAINTS: The Contractor agrees that copies of all Grievances alleging discrimination against Members . . . because of race, color . . . national origin, ancestry . . . will be forwarded to DHS for review and appropriate action.

(Calif. contract, pp. 18–19, from *Negotiating the New Health System*, 4th ed., http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa196.html.)

New Jersey's contracts require health plans to create provider networks that address the language needs of non-English speakers:

The contractor must ensure that its provider network includes, at a minimum: . . . providers who reflect the ethnic/racial enrollee composition and can accommodate the different languages of the enrollees including bilingual capability for any language which is the primary language of ten percent (10%) or more of the enrolled Medicaid population.

http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa162.html.)

Unfortunately, the benefit to small minority groups is limited by that 10 percent threshold. In addition, there is limited information on the effectiveness of these contract provisions in changing actual practice. (New Jersey contract, from *Negotiating the New Health System*, 4th ed., p. 110)

Another approach requires individual access to interpreter services. In Wisconsin, for example, Medicaid managed care plans have to provide interpreter services for enrollees as necessary to ensure availability of effective communication regarding

treatment, medical history, or health education. (Wisconsin contract, from *Negotiating the New Health System*, 4th ed., p. 33;
http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html.)

Some states require plans to provide information to enrollees about linguistically competent providers. Iowa requires HMOs to inform non-English-speaking enrollees about the availability of providers who speak the same non-English language. (Iowa contract, from *Negotiating the New Health System*, 4th ed., pp. 28–29;
http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html.)

Several states require plans to deliver culturally competent services. Contractors to the state of Colorado, for example, are required to:

- Respect health care attitudes, beliefs, and practices of members related to cultural affiliation;
- When appropriate, contract with diverse providers, to facilitate members' access to culturally sensitive services;
- Train network providers regarding health care attitudes, beliefs, and practices that affect access to and benefit from health care services;
- Evaluate whether culturally sensitive services are being delivered to members.

(Colorado contract, from *Negotiating the New Health System*, 4th ed., pp. 46–50;
http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa167.html.)

Utah addresses minority group linguistic needs by requiring Medicaid managed care plans to provide interpreter services as part of their capitated payments. For recipients covered by fee for service, the state contracts with private organizations for interpreter services. (Contracts were issued through competitive bidding and include refugee assistance and on-site, phone, and written translation in 100 languages. Service is at the request of medical providers or state Medicaid personnel. Federal matching payments are a source of funding.)⁴²

Policy Recommendations

States have imposed data collection and reporting on health plans, using the Health Plan Employer Data and Information Set (HEDIS, detailed at <http://www.ncqa.org>) and other indicators of plan performance. States could require plans to report these measures by race and ethnicity. Plans could perform consumer satisfaction surveys. (The National

Committee for Quality Assurance [NCQA] requires this, though not by race/ethnicity and not all plans participate.) Data collected can include race and ethnicity, allowing plans, agencies, and outside groups to monitor performance and observe how consumer perceptions of health plans differ by race and ethnicity. This may require questionnaires in multiple languages, as has been done in California. These data collection efforts can be used when states initially select plans and later during contract renewal, and they can examine both the extent of plan contracting with minority providers and the perceptions of consumers about a particular plan. External quality review procedures can also be used to monitor plan performance as it affects minority group members.

Managed care plans can also be required to develop interventions targeted at the needs of racial and ethnic groups. For example, Medicaid health plans with a significant number of African American enrollees might be required to develop specific disease-related interventions based on the needs of those enrollees and their communities.

Additional Resources

- Rosenthal J, Kaye N, Flowers L. (2002). State purchasing and regulation of health care services: a snapshot of strategies to reduce racial and ethnic health disparities. Portland, ME: National Academy for State Health Policy. (See <http://www.nashp.org>.)
- George Washington University Center for Health Services Research and Policy. (2003). *Negotiating the new health system: contract language from state managed care contracts*. (4th ed.). (See http://www.gwu.edu/%7Echsrp/Fourth_Edition/.)
- California Endowment. (2003, April). *Improving access to health care for limited English proficient health care consumers: options for federal funding for language assistance services*. (See http://www.calendow.org/pub/frm_pub.htm.)

REGULATORY APPROACHES

States regulate health care facilities, providers, insurers, and managed care organizations. This authority—including certificate of need, provider licensure, and managed care regulation—can be used to address health disparities.

Certificate of need requirements mandate that providers, such as hospitals or nursing homes, apply to state agencies in order to expand their facilities or make major investments in capital equipment. The facility must give the agency information to show the expansion will serve community needs. Many states have dropped these regulatory procedures over the last two decades, but several states continue to review and approve or disapprove applications from providers.

States also set licensing requirements for physicians and other health care professionals, and in recent years, states have adopted legislation to regulate managed care organizations, establishing appeal procedures for treatment decisions, permitting consumers greater access to specialists, altering contracts between providers and managed care plans, and requiring plans to collect and make available data on plan performance.

Promising Practices, Statutes, Regulations, and Programs

The New Jersey certificate of need requirement reads that providers will “show how the proposed project shall promote access to low-income persons, racial and ethnic minorities, women, disabled persons, the elderly, and persons with HIV infections and other persons who are unable to obtain care.” (New Jersey certificate of need requirements, section 8:33-4:10(a); <http://www.state.nj.us/health/hcsa/hcsadmin.htm>.)

Each applicant must give detailed information on how the proposed service will meet the needs of medically underserved groups, how the service will be accessed, and the amount of charitable service. Concerning health disparities, applicants must document the “means for assuring effective communication between the staff . . . and non-English-speaking people,” and supply information on their compliance with “State and Federal regulations requiring provision of uncompensated care, community services, or access by minorities and handicapped persons . . . (including the existence of any civil rights access complaints against the applicant).” (New Jersey certificate of need requirements, section 8:33-4:10(a)(8) and (3).)

Policy Recommendations

Although there is also uncertainty about the impact of certificate of need requirements on access to services and utilization for minority patients, states that still have certificate of need requirements can use them to address disparities in two ways.

First, states can use the certificate of need process to collect data from providers on minority access and utilization. These data can be used to encourage facility expansion in underserved minority communities and to identify facilities where minority patients receive different levels of service compared with white patients. This information can aid in the development of interventions and new approaches to address treatment-related disparities.

Second, by granting certificates of need selectively, states can explore opportunities to foster the location of services in facilities that deliver a high volume of these services. Often, quality of care is better when high-volume providers deliver it. The consolidation of services can improve quality of care for all patients and can benefit minority group

members. (Along with all other patients, they will receive higher quality care from high-volume providers, and service consolidation will make it less likely that minority patients will receive care from different providers and in different facilities than white patients.) Service consolidation has the potential to reduce de facto racial and ethnic segregation of health care. This assumes minorities will not encounter discrimination when attempting to use services at these facilities, and that focusing services in particular facilities will not impose additional access burdens (such as longer travel times to obtain services) or create other cultural or linguistic difficulties. Policymakers must be careful to ensure that service consolidation leads to improved care for minorities and does not impose new burdens on their communities.

States have not used provider licensure and managed care regulation to address racial/ethnic disparities. Through both types of regulation, states can monitor complaints about discrimination concerning access and treatment.

The literature on medical treatment of racial and ethnic minorities has demonstrated important differences in service use for those with the same insurance coverage and even within managed care plans. States can develop data reporting requirements for managed care organizations to monitor access and treatment decisions that affect minorities. To improve the quality of care, states can also require that reporting of medical errors include information on patient race/ethnicity that would allow for the identification of adverse impacts on minorities. Finally, states that monitor nonprofit community benefits can include minority access and utilization as one of the items monitored and as a community benefit that needs to be preserved when providers propose conversion from nonprofit to for-profit status.

Additional Resources

- Rosenthal J, Kaye N, Flowers L. (2002, April). *State purchasing and regulation of health care services: a snapshot of strategies to reduce racial and ethnic health disparities*. Portland, Me.: National Academy for State Health Policy. (<http://www.nashp.org>.)
- The American Health Planning Association provides links to certificate of need websites maintained by the states: <http://www.ahpanet.org/websites.html>.

STATE INFRASTRUCTURE

Thirty-five states and territories have a designated office, commission, council, or advisory panel on minority health. Many of the other states use public health analysts, special projects officers, or other means to coordinate health disparities

activities. These offices, commissions, councils, and advisory groups inform state policymakers and leaders about gaps and disparities and develop corrective strategies, programs, and solutions.⁴³ State minority health entities serve as points of contact for government and nongovernmental agencies and community-based organizations. There are no commonly accepted standards, core competencies, or minimum infrastructure requirements for state offices of minority health. Some states describe their state minority health infrastructure as a “patchwork quilt,” where the minority health entities provide the “essential threads” to keep different pieces of the quilt together.⁴⁴

Promising Practices, Statutes, Regulations, and Programs

State offices of minority health are strongest when:

- They are formally supported by the state government through legislative or regulatory initiatives. (In Arkansas, the combination of an independent commission [reporting directly to the governor’s office] and an Office of Minority Health [located within the health department] is a foundation for development of the state’s minority health infrastructure.)
- They have a statewide plan, statewide advisory groups, task forces, or commissions committed to eliminating health disparities.
- They involve other state and private-sector minority health programs and coalitions.
- They include initiatives sponsored by the academic community and the faith community. Florida created a grant program called Reducing Racial and Ethnic Health Disparities: Closing the Gap, which stimulates development of community and neighborhood projects to improve the health outcomes of racial and ethnic populations. (Fla. Stat. § 381.7352; http://www.flsenate.gov/statutes/index.cfm?App_mode=Display_Statute&URL=Ch0381/ch0381.htm.)
- They build strong links between themselves, the minority community, and the state health department. (In Connecticut an Advisory Council links the Office of Multicultural Health to the community and the Health Director.)

State minority health offices are least effective when they:

- Lack financial resources;

- Have recurrent staff turnover;
- Are isolated from other state agencies and from relevant divisions within the health department;
- Lack legislative or regulatory grounding of minority health initiatives;
- Lack data on health disparities and performance measures.

Minority Health Commissions or Offices

Arkansas. The Arkansas Minority Health Commission has 12 members who have actively participated in health issues for minorities or have special knowledge or experience with minority health issues. (Arkansas Stat. Ann. § 20-2-102: 1991.)

California. The state of California declares that the health status of California's racial and ethnic communities is poor relative to the health status of the white population. The Office of Multicultural Health was established to close the gaps in health status and access to care among the state's diverse racial and ethnic communities. (California Health and Safety Code § 150-152; <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=00001-01000&file=150-152>.)

Connecticut. The Office of Multicultural Health, established as part of the state's Department of Public Health, is responsible for improving the health of all state residents by eliminating differences in disease, disability, and death rates among ethnic, racial, and cultural populations. (Connecticut Gen. Stat. § 19a-4j: 1998; <http://www.cga.state.ct.us/2001/pub/Chap368a.htm>.)

Florida. The Florida Commission on African American Affairs, part of the Executive Office of the Governor, develops strategies and plans to address the economic, social, educational, health, and welfare needs of Florida's African Americans. (Florida Statutes § 14.27; http://www.flsenate.gov/statutes/index.cfm?App_mode=Display_Statute&URL=Ch0014/ch0014.htm.)

Legislation Addressing and Coordinating Activities Against Health Disparities

Indiana. The state health department is developing and implementing a state structure to address health disparities. Its tasks include monitoring minority health progress; funding minority health programs, research, and other initiatives; staffing a minority health hotline; developing and implementing a program to increase the awareness of health and social service providers to the needs of minorities; and implementing culturally and linguistically

appropriate disease prevention programs. (Ind. Code § 16-46-11-1; <http://www.in.gov/legislative/ic/code/title16/ar46/ch11.html>.)

Ohio. The act establishing the stand-alone Commission on Minority Health includes a plan to distribute a share of national tobacco settlement revenue to the Health Priorities Trust Fund through 2012.

Oklahoma. The state required the department of health to conduct a study of all services and programs for minority health, rural health, social initiatives, and elder care, and to make recommendations to eliminate overlapping and duplicative services. (1993 Okla. Sess. Laws, Chap. 269.)

Legislation Addressing Funding for Minority Health Activities

Pennsylvania. The state established a fund for minority health that uses tobacco settlement monies. (Pa. Act No. 77; <http://www.legis.state.pa.us/WU01/LI/BI/BT/2001/0/SB1454P2044.HTM>.)

Minnesota. The state commissioner of health has been directed to establish a program to close the gap in the health status of American Indians and populations of color in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence. Minnesota also appropriates funds for health and human services related to Indian health and racial and ethnic disparities in infant mortality and tuberculosis. (Minn. Stat. § 145.928, <http://www.revisor.leg.state.mn.us/stats/145/928.html>; § 145.9268, <http://www.revisor.leg.state.mn.us/stats/145/9268.html>.)

Policy Recommendations

States should make sure that their offices of minority health:

1. are sufficiently anchored in statute or regulation to operate effectively;
2. involve a wide array of stakeholders inside and outside government;
3. have adequate financial resources to meet their goals and objectives;
4. operate with clear performance measures;
5. have adequate data and data systems to evaluate state progress in meeting minority health needs;

6. take full advantage of resources available through hospitals and other providers, academic institutions, and other potential partners; and
7. operate within the structure of a statewide plan to address disparities.

Additional Resources

National Conference of State Legislatures. (2003). Minority health legislation: minority, health commissions, and offices of minority health. (Updated September 2003.) (See <http://www.ncsl.org/programs/health/disparity.htm>.)

WORKFORCE DEVELOPMENT

Latinos, African Americans, and American Indian/Alaska Natives account for 25 percent of the U.S. population but represent only 6 percent of practicing physicians. Eighty-six percent of registered nurses are white, while whites account for about 69 percent of the U.S. population.⁴⁵ Compared with majority colleagues, minority physician residents are twice as likely to practice in federally designated shortage areas, three times more likely to see minority patients, and accept a greater proportion of Medicaid patients.⁴⁶ Minority dentists are more likely to practice in minority communities but are a small proportion of the dental workforce.⁴⁷ The IOM's *Unequal Treatment* noted that "racial concordance of patient and provider is associated with greater participation in care processes, higher patient satisfaction, and greater adherence to treatment."⁴⁸ A diversified workforce leads to decreased racial and ethnic differences in health and healthcare outcomes.

Many of the programs described in this section are focused on the physician workforce and can be extrapolated to other disciplines. Workforce diversity within all health professions (dentists, nurses, pharmacists, physicians, nurse practitioners, and physician assistants) is necessary to better serve our diverse nation.

Promising Practices, Statutes, Regulations, and Programs

Increasing Medical School Admissions and Recruitment. Minnesota approved legislation to increase workforce diversity by proactively recruiting within underserved communities. The University of Minnesota–Duluth School of Medicine uses a federal Area Health Education Center Program grant to plan, develop, and operate area health education center programs. Each program seeks to recruit minorities and increase awareness of health careers among minority and other students in medically underserved areas of the state.⁴⁹

Increasing the Pipeline. The Health Resources and Services Administration of the U.S. Department of Health and Human Services runs programs to increase workforce

diversity. State health departments can run similar programs through public high schools, universities, and medical, nursing, dental, and pharmacy schools. HRSA programs include:

- Health Careers Opportunity Program. This program helps students from disadvantaged backgrounds develop the skills necessary to enter health professions (<http://bhpr.hrsa.gov/diversity/hcop/default.htm>).
- HRSA's Centers of Excellence. These aid health-professional training programs, to enlarge minority applicant pools (<http://bhpr.hrsa.gov/diversity/coe/default.htm>).
- Minority Faculty Fellowship Program. This assists health-professional training institutions to increase the number of underrepresented racial and ethnic minorities serving on their faculties (<http://bhpr.hrsa.gov/diversity/mffp/default.htm>).

The Health Resources and Services Administration runs a program to support and increase diversity in nursing by providing opportunities for individuals from disadvantaged backgrounds to obtain scholarships or stipends, get help with pre-entry preparation, and participate in retention activities.

American Indian/Alaska Natives are among the most underrepresented groups in medicine. More American Indian health professionals are needed to bring culturally competent care to American Indian populations. The Association of American Indian Physicians (AAIP) has a mentoring and shadowing program serving American Indian high school and undergraduate students wanting to enter health professions. States can fund programs looking to increase the pipeline.⁵⁰

The Minority Medical Education Program (MMEP) led by the Association of American Medical Colleges sponsors students from diverse backgrounds for a six-week education program at medical schools. The program introduces students to the medical school curriculum and helps them prepare for the application process. (See <http://www.aamc.org/diversity/start.htm>.)

New York developed a Minority Participation in Medical Education grant program in 1996 to encourage minority participation in medicine. Funds were used to recruit and mentor minority faculty and to recruit junior and senior high students to science. Participants were tracked to see where they decided to practice. The program is no longer funded, but it can serve as a model to other states.

Increasing Culturally Competent Workforce Capacity. California law permits Mexican and Caribbean licensed physicians and dentists to practice in community health centers in

medically underserved areas. The law creates the Licensed Physicians and Dentists from Mexico Pilot Program and authorizes a three-year nonrenewable license.

The Charles Drew University of Medicine and Science, located within a predominantly African American and Latino area of Los Angeles, recruits and educates health professionals who will serve in underserved communities. (See <http://www.ucop.edu/cprc/medmigration.pdf>.)

Policy Recommendations

1. States can create opportunities to diversify the applicant pool for health professional schools and programs. States can improve the pipeline of minority students by beginning mentoring and educational efforts at earlier grades and in younger populations.
2. States can create post-baccalaureate programs at state schools, offering minority residents the opportunity to return to school and get the training they need to apply for health professional jobs. Classes can be targeted to minority and underserved populations, diversifying the applicant pool for health professional schools.
3. Finally, states with historically black medical schools and Hispanic-serving health-professional schools can work with these schools to diversify the workforce. The Health Resources and Services Administration works with historically black medical schools to increase the number of physicians working with the underserved. (See <http://www.hrsa.gov/OMH/HBMSassessment.htm>.)
4. States can develop incentive programs to increase the supply of providers working with underserved populations. Many states offer loan repayment opportunities for health professionals. These programs can be tailored to different environments.
5. States can create and fund fellowships and internships for health professionals interested in working with underserved populations. Because minority students are more likely to serve in these communities, these initiatives diversify the health workforce.
6. States can use data collection systems to monitor workforce diversity and the adequacy of training and recruitment programs. States can tailor interventions to areas that have shortages of minority health professionals.
7. States can use Graduate Medical Education (GME) funds to encourage residency programs and teaching hospitals to increase diversity.

Additional Resources

Web sites for workforce development:

- HRSA: <http://www.hrsa.gov>.
- Association of American Medical Colleges, diversity page:
<http://www.aamc.org/diversity/start.htm>.
- American Medical Student Association. Diversity in Medicine Resources page:
<http://www.amsa.org/div/divres.cfm>.

HEALTH CONDITIONS

ASTHMA

Between 1980 and 1996, the number of Americans with asthma increased 74 percent, to an estimated 14.6 million. Though asthma affects people at all socioeconomic levels, ages, races, and ethnic groups, children and low-income and minority populations continue to have substantially higher rates of asthma-related deaths, hospitalizations, and emergency room visits.

According to data for the years 2000 and 2001, the following facts characterize asthma prevalence, health care use, and mortality:⁵¹

- Non-Hispanic blacks were 4 percent more likely to have been diagnosed with asthma than non-Hispanic whites and approximately 30 percent more likely than Hispanics.
- Current asthma prevalence is 10 percent higher among non-Hispanic blacks than non-Hispanic whites and about 40 percent higher compared with Hispanics.
- Non-Hispanic blacks had an asthma death rate 200 percent higher than non-Hispanic whites and 160 percent higher than Hispanics.
- Blacks had an asthma office visit rate 40 percent higher than whites.
- The asthma emergency room visit rate for blacks was 125 percent higher than that for whites.
- The asthma hospitalization rate for blacks was 220 percent higher than for whites.

According to the 2000 U.S. Department of Health and Human Services' *Action Against Asthma: A Strategic Plan for the Department of Health and Human Services*,⁵² the disparity of death rates among children is greater than that among adults, with African American children over four times as likely to die from asthma as white children. In 1996, pediatric hospitalizations for asthma were estimated to be five times higher for children in lower-income families.

Asthma prevalence among disadvantaged and minority children is disproportionately high in the inner city. Those living in lower socioeconomic conditions, particularly in inner cities, are at greater risk of being exposed to high levels of environmental allergens and irritants that cause asthma attacks. Poor housing and

environmental conditions make it difficult to control exposure to the dust mites, cockroach particles, cat and dog dander, and mold that exacerbate asthma.

Promising Practices, Statutes, Regulations, and Programs

Limited state policy activity has concentrated on developing initiatives to address racial and ethnic disparities in asthma. While some initiatives address disparities in asthma, more needs to be done, particularly to improve environmental conditions. Several states have addressed income disparities in obtaining quality asthma services. Many states have implemented general initiatives, such as allowing medications in school, housing assessments for allergens or irritants, and surveillance and disease management programs. In 2002, 14 laws in eight states focused on target populations most affected by asthma. Of these, only several focus on racial and ethnic populations. Only one statute involved the issue of housing conditions and childhood asthma: Rhode Island passed a law stating that asthma is a housing-related health problem.

Initiatives to Address Racial and Ethnic Disparities in Asthma

Asthma Information Program. The Illinois Department of Public Health developed and implemented an asthma information program targeted at population groups at high risk of asthma. These target groups include but are not limited to African Americans, Hispanics, the elderly, children, those exposed to environmental factors associated with high risk of asthma, and those with a family history of asthma. (20 ILCS § 2310/2310-337; <http://www.legis.state.il.us/legislation/ilcs/chapterlist.html>.)

Asthma Resource Directory. The New Jersey Office of Minority Health and the New Jersey Minority Health Network on Asthma developed an asthma resource directory. This directory is part of a comprehensive asthma outreach, education, and training program that provides information on organizations that offer asthma services in three cities—Newark, New Brunswick, and Trenton. The information in the directory was compiled through a search of local, state, and national resources. The directory includes information about each individual organization including the type of organization and specific asthma outreach and education services available. (See <http://www.state.nj.us/health/commiss/omh/asthma/>.)

Advisory Group. California established an Office of Binational Border Health through the Department of Health Services to facilitate cooperation between health officials and health professionals in California and Mexico, to reduce the risk of disease in the California border region. This includes reducing the risk of childhood asthma along

the U.S.–Mexico border, where the hospitalization rates have increased since 1989. (California Health and Safety Code § 475; <http://www.leginfo.ca.gov/calaw.html>.)

Collaborative Efforts. The California Asthma Public Health Initiative, funded by the California Department of Health Services' Chronic Disease Control Branch, is an initiative to improve the quality of life for children and adults with asthma through implementation of programs and policies in asthma education, management, and prevention. The initiative is focused on eliminating disparities in asthma practices and outcomes through coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations, and academic institutions. (See <http://www.dhs.cahwnet.gov/ps/cdic/cdcb/Medicine/Asthma/>.)

Another example is the California Asthma Among the School Aged project (CAASA), directed by the Integrating Medicine and Public Health project, a collaborative program of the California Department of Health Services and the University of California, San Francisco's Institute for Health and Aging. The goal is to improve health outcomes for school-aged children with asthma and to reduce health disparities by linking improved clinical care to the community. The project uses continuous quality improvement techniques, community health workers as links between health services and patients and families, and local organizations involved in the well-being of children to increase knowledge and awareness of asthma among providers and to improve the delivery of asthma care. The project conducts at least one home visit for environmental assessment and parent/family education. (See <http://arcc.ucsf.edu/caasa/>.)

General Statewide Initiatives

New York Healthy Neighborhoods Program. This statewide initiative, sponsored by the Department of Health, seeks to reduce the number of hospitalizations for asthma. Interventions include asthma trigger education, dust control measures, installing pillow and mattress covers, using bleach for mold and mildew removal and control, and eliminating or restricting smoking in housing units. Public health workers determine if the interventions remain in effect and evaluate the residents' medical status, emergency department visits, and quality of life. (See http://www.health.state.ny.us/nysdoh/asthma/ny_action.htm.)

Medications in Schools. Illinois is one of several states that allows students with asthma to possess and use medications while in school, while at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school

activities while on school property.

(105 ILCS § 5/22-30; <http://www.legis.state.il.us/legislation/ilcs/chapterlist.html>.)

Surveillance and Disease Management. California law established the Reduction of Asthma Through Assessment, Intervention, and Evaluation project. Through this program, the Department of Health Services (1) analyzes and assesses morbidity and mortality data, current patterns of medical care and population-based health services, interventions and other related activities, and the extent of the burden on the state's resources; (2) surveys factors known to worsen asthma, including cockroach allergens and molds, in order to estimate the relative importance of these factors in the state; (3) identifies populations most affected by asthma; (4) offers public and professional education to disseminate the most current information on asthma; (5) ensures that projects are scientifically based and practical; and (6) establishes and maintains a surveillance and intervention program for the prevention of asthma. (California Health and Safety Code § 104316-104321; <http://www.leginfo.ca.gov/calaw.html>.)

Medicaid Disease Management Pilot Program. Texas law requires the Department of Health to develop a Medicaid disease management pilot program for children's asthma. The program is implemented in counties with a high incidence of children's asthma and a high rate of hospital emergency room care for the treatment of children's asthma. (Texas Gov't Code § 531.021912; <http://www.capitol.state.tx.us/statutes/statutes.html>.)

Policy Recommendations

1. States can improve research on asthma by:
 - Following changes in rates of disease in different locations or populations to target health services and public health programs; helping evaluate the effectiveness of intervention efforts; and providing insight into risk factors.
 - Monitoring environmental exposures and their impact on illness and disability.
 - Evaluating effectiveness of intervention and prevention programs.
 - Understanding disparities in asthma rates, particularly those tied in to environmental, socioeconomic, cultural, and genetic factors.
2. States can establish standardization of care through statewide implementation of the National Heart, Lung and Blood Institute's *Guidelines for the Diagnosis and Management of Asthma*, which emphasize assessment and monitoring of symptoms; control of environmental factors to limit exposure to allergens and other triggers; use of appropriate medication; and education of the patient and family in asthma care.

3. States can support more comprehensive environmental interventions (i.e., National Cooperative Inner City Asthma Study) to reduce the levels of indoor allergens, such as cockroaches, house dust mites, and mold, and reduce asthma morbidity. (See <http://www.niehs.nih.gov/airborne/research/secondary.html>.)
4. States can improve environmental management of asthma by improving public housing and addressing poor housing. States can also promote education in schools, workplaces, public housing, childcare and youth programs, and other community institutions including outreach to school personnel, workplace supervisors, and housing officials.
5. States can develop and support formal collaborations between school nurses, patients, and physicians, such as the Asthma Action Plan sponsored by the Massachusetts Health Quality Partners. The initiative helps pediatricians, parents, and school nurses to manage pediatric asthma by enhancing communication to assist in daily management and to respond quickly to attacks.

Additional Resources

- National Conference of State Legislatures. Asthma: <http://www.ncsl.org/programs/esnr/asthmamain.htm>.
- CDC's National Center for Environmental Health: <http://www.cdc.gov/nceh/airpollution/asthma/default.htm>.
- American Lung Association: <http://www.lungusa.org>.
- Marielena L, Nicholas W, Morton S, Vaiana ME, Genovese B, Rachelefsky G. (2002). *Improving childhood asthma outcomes in the United States: a blueprint for policy action*. RAND. Available at <http://www.rand.org/publications/MR/MR1330/>.

CANCER

Cancer accounted for 61,951 deaths among blacks, 20,233 deaths among Hispanics, 8,813 deaths among Asian or Pacific Islanders, and 1,836 deaths among American Indians or Alaska Natives in 1999. Blacks have a 10 percent higher cancer incidence rate and a 30 percent higher cancer death rate than whites.⁵³ Table 4 compares cancer rates among racial and ethnic subgroups.

Table 4. Cancer Mortality Rates: Age Adjusted, 1999 (per 100,000)

	All Cancers	Trachea, Bronchus, Lung	Colon, Rectum, Anus	Prostate	Breast (rate computed for women only)
White	199.8	56.0	20.6	28.4	26.4
Black	254.4	65.2	28.6	66.5	35.6
Hispanic	126.4	34.9	12.0	12.5	15.4
Asian/Pacific Islander	125.3	28.5	12.2	13.5	13.1
American Indian/ Alaska Native	122.0	22.5	12.8	19.0	15.4

Source. Health, United States, 2001.

Cancer disparities for African Americans are striking. Compared with whites, death rates are 16 percent higher for lung and related cancers, 39 percent higher for colon and related cancers, 134 percent higher for prostate cancer, and 35 percent higher for breast cancer. Alaska Natives have the highest rates of colon and rectal cancers among all subgroups, Korean Americans and Japanese Americans have high rates of stomach cancer, and cervical cancer for Vietnamese women is nearly six times the rate for white women (*Unequal Treatment*, 2003). The burden of higher cancer incidence is magnified by treatment delays and inadequacy for many minorities.

Promising Practices, Statutes, Regulations, and Programs

Many cancer screening, treatment, and prevention programs have been developed for racial and ethnic groups facing disproportionate cancer risks. Some examples follow.

Breast and Cervical Cancer Early Detection Program. This program from the Mississippi Department of Health provides early detection services, including Pap test screening for uninsured women age 18 and older and mammography screening for uninsured women over 50. Screening is provided through health department clinics, health centers, private providers, and contract providers. In coordination with private organizations, the department has implemented an outreach program in 13 Mississippi Delta counties with many African Americans.

(See <http://www.msdh.state.ms.us/msdhsite/index.cfm/13,379,103,61.html>.)

Real Men Checkin' It Out. This program from the South Carolina Department of Health promotes early detection of prostate cancer among African American men through education and outreach. The initiative was developed by the Office of Minority Health using community outreach with African American prostate cancer survivors and using

community-based organizations such as churches, fraternities, and other groups in its implementation. (See <http://www.scdhec.net/omh>.)

Opening Pathways to Cancer Screenings for Vietnamese American Women is a university-based intervention using lay community workers. Modeled on the “Promotora” model used in Hispanic communities, this intervention encourages women in San Francisco to obtain Pap smears and breast exams. About 40 community health workers were recruited, who educate women in small-group settings. Materials in Vietnamese were created, including posters, brochures, other written materials, magnets, and potholders. (See <http://cc.ucsf.edu/news/040301.html>.)

Breast and Cervical Cancer Prevention and Treatment Act of 2000 (PL 106-354) and *American Indian Breast and Cervical Cancer Treatment Technical Amendment Act of 2001 (PL 107-121)*. These two federal laws permit states to expand Medicaid to pay for medical care for women with breast or cervical cancer who are screened through the CDC’s National Breast and Cervical Cancer Early Detection Program. The program provides free breast and cervical cancer screening and diagnostic services for uninsured and low-income women. All states now take advantage of this option. Some states restrict eligibility to the narrowest category of CDC-funded screening services, while 31 have adopted more expansive definitions. (See <http://www.cms.hhs.gov/bccpt/bccptmap.asp>.)

Policy Recommendations

The CDC helps states develop comprehensive cancer control plans. The effort includes technical support, guidance documents, and cooperative agreements with 13 states to create comprehensive plans, and implementation agreements with 14 states plus the Northwest Portland Area Indian Health board. (See <http://www.cdc.gov/cancer/ncccp/contact.htm>.) Plans give explicit attention to cancer risks among minorities. The CDC recommends that representatives of minority and underserved communities be involved in planning. (See <http://www.cdc.gov/cancer/ncccp/elements/index.htm> and <http://www.cdc.gov/cancer/ncccp/index.htm>.)

Screening and detection are important focuses for cancer-related programs. The approach used in the Breast and Cervical Cancer Treatment Act could be extended to other cancers. More effort can be devoted to cancer prevention for minorities by building on lessons learned from efforts for broad population groups, with attention to risks faced by minorities and the use of messages and approaches tailored to their cultural and linguistic needs. Prevention efforts can focus on the social and environmental factors that place minorities at risk of cancer. It is also important that programs address those cancers

with high incidence among minorities that have not been subject to widespread screening programs to date.

Additional Resources

- Association of State and Territorial Health Officials. (2003, March). *Health departments take action: a compendium of state and local models addressing racial and ethnic disparities*. Washington, D.C.: ASTHO. (Available at http://www.astho.org/pubs/0301009_ASTHO_Final.pdf.)
- CDC's National Comprehensive Cancer Control Program: <http://www.cdc.gov/cancer/ncccp/index.htm>.

CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD)—high blood pressure, heart disease, and stroke—is the leading cause of death among men and women across all racial and ethnic groups. Almost 1 million Americans die from the disease each year while another 62 million live with some form of the disease. In 2003, CVD cost the nation \$350 billion in health care expenditures and lost productivity. A limited number of health-related behaviors—notably tobacco use, physical inactivity, and poor nutrition—are responsible for much of the burden of cardiovascular disease.⁵⁴

A disproportionate burden of death and disability from CVD is associated with minority and low-income populations. Evidence suggests strong connections between CVD, high blood pressure, cigarette smoking, physical inactivity, and obesity. Disparities exist in the prevalence of risk factors for CVD. Racial and ethnic groups with higher rates of hypertension tend to develop hypertension at an earlier age and are less likely to undergo treatment. In 2000, 40 percent of all black adults had CVD, compared with 30 percent of white men and 24 percent of white women. When age differences are taken into account, Mexican American men and women also have elevated blood pressure rates. Compared with rates for whites, mortality due to coronary heart disease was 40 percent lower for Asian Americans but 40 percent higher for blacks in 1995, and stroke is the only leading cause of death for which mortality is higher for Asian American males than for white males.⁵⁵

Promising Practices, Statutes, Regulations, and Programs

Nearly every state conducts some cardiovascular health activity. These activities range from general chronic disease initiatives and pilot projects to programs to reduce racial and ethnic disparities among men, women, and children living in geographic areas suffering a disproportionate burden of cardiovascular disease. States recognize that no one entity

alone can be successful in the prevention and management of CVD. States partner with academic, employer, and community organizations to maximize their efforts.

University Partnerships. Through the University of Arkansas for Medical Sciences, Arkansas established the Targeted State Needs Programs, which includes a Minority Health Initiative administered by the Minority Health Commission. This program raises awareness and screens for hypertension. (Arkansas Stat. Ann. § 19-12-114.)

Worksite Partnerships. The Maine Bureau of Health has established high blood pressure programs at work sites that have not taken steps to screen employees, detect and confirm those with elevated blood pressures, refer those with elevations to physicians for diagnosis and treatment, and continue contact with employees to determine progress. (Maine Rev. Stat. Ann. tit. 22, § 1697; <http://janus.state.me.us/legis/statutes/22/title22sec1697.html>.)

Community Group Partnerships. Maine established community-based heart attack and stroke prevention programs to provide public education to schools, community groups, and workplaces about cardiovascular risks, to provide blood pressure and cholesterol screening, referral, and follow-up, and to provide smoking cessation programs for those who want to quit. (Maine Rev. Stat. Ann. tit. 22, § 1699; <http://janus.state.me.us/legis/statutes/22/title22sec1699.html>.)

In Wyoming, a coalition serves as a resource to facilitate state and community level partnerships to improve the cardiovascular health of all Wyoming residents. The coalition comprises state agencies, professional and voluntary groups, community organizations, and interested volunteers. (See <http://wdh.state.wy.us/cvd/coalition.html>.)

Several states have programs bringing together community stakeholders to carry out multiple strategies. Some projects serve the entire state population while others concern specific racial and ethnic groups.

The California Department of Health conducts a multifaceted program for high blood pressure prevention and control. The program coordinates local and state efforts in planning, implementation, and evaluation to improve allocation and utilization of resources. (California Health and Safety Code § 104100-104140.)

Illinois has one of the most comprehensive cardiovascular disease initiatives. In addition to direct health interventions, the Illinois program has provisions to educate the

public and to fund research and treatment. A Stroke Task Force advises the Department of Public Health in setting priorities for prevention and treatment and in implementing a comprehensive statewide public education program on stroke prevention (targeted to high-risk populations and geographic areas with a high incidence of stroke). The task force is directed to submit an annual report to the Governor and the General Assembly by January 1 of each year, beginning in 2003. (Illinois Ann. Stat. ch 20, § 2310-372; <http://www.legis.state.il.us/legislation/publicacts/pubact92/acts/92-0710.html>.)

Illinois has other noteworthy CVD programs based in state law. [Ill. Ann. Stat. ch. 410, § 425/](#) (is the High Blood Pressure Control Act. [Ill. Ann. Stat. ch. 410, § 3/](#) is the Arteriosclerosis Prevention Act. [Ill. Ann. Stat. ch. 105, § 110/](#) is the Critical Health Problems and Comprehensive Health Education Act. [Ill. Ann. Stat. ch. 20, § 2310/2310-370](#) creates grants from the Heart Disease Treatment and Prevention Fund for public and private agencies to fund research regarding causes, prevention, and treatment of heart disease and public education of heart disease. Ill. Ann. Stat. ch. 35, § 5/5070 requires the individual income tax form to allow taxpayers to contribute to the Heart Disease Treatment and Prevention Fund.

The Illinois Employee Wellness Program Grant Act directs the Department of Public Health to make grants to employers to assist them in providing health promotion or wellness services to reduce the prevalence of health risk factors. The services can include aerobic exercise, blood cholesterol screening, fitness and exercise testing, health risk appraisals, blood pressure screening and education, nutrition education, smoking cessation, stress management, and weight loss. ([Ill. Ann. Stat. ch. 30, § 770/.](#))

Policy Recommendations

Many statutes and programs refer to “high-risk populations” or “geographic areas where there is a high incidence of heart disease and stroke” or a “high cardiovascular disease and stroke burden” and rarely refer to elimination of health disparities explicitly. In the absence of valid data on disparities, these general approaches are the most useful methods to address disparities in CVD among racial and ethnic minorities.

Policies most likely to reduce racial and ethnic differences in health status among population groups include collecting and analyzing data for minority populations; requiring programs to target resources to the groups disproportionately affected by cardiovascular disease; creating collaborations among stakeholders; providing adequate resources; and requiring monitoring, evaluation, and reporting of progress.

Additional Resources

- National Conference of State Legislatures. (2003). *Racial disparities in health*. (Updated September 2003.) (See <http://www.ncsl.org/programs/health/disparity.htm>.)
- The burden of chronic diseases and their risk factors: national and state perspectives 2002: <http://www.cdc.gov/nccdphp/burdenbook2002>.
- CDC's Cardiovascular Health Program: <http://www.cdc.gov/cvh/>.

DIABETES

Diabetes is the fifth deadliest disease in the United States and has no cure. Thirteen percent of all African Americans have diabetes and one-third are unaware they have it. African Americans are twice as likely to have diabetes as whites. Twenty-five percent of African Americans between ages 65 and 74 have diabetes. One in four African American women over age 55 has diabetes.

Approximately 105,000 American Indian/Alaska Natives, or 15.1 percent of the population receiving care from the Indian Health Services, have diabetes. American Indian/Alaska Natives are 2.6 times more likely to have diagnosed diabetes than whites of similar age. One Arizona tribe has the highest diabetes rate in the world—50 percent of these adults between ages 30 and 64 have diabetes. Diabetes has reached epidemic proportions among American Indian/Alaska Natives.

Two million or 10.2 percent of all Hispanic Americans have diabetes. The prevalence of type 2 diabetes is twice as high among Hispanics as among whites. Twenty-four percent of Mexican Americans and 26 percent of mainland Puerto Rican Americans between ages 45 and 74 have diabetes. Sixteen percent of Cuban Americans between ages 45 and 74 have diabetes.⁵⁶

Most people do not become aware they have diabetes until they develop one of the life-threatening complications associated with it—heart disease, stroke, high blood pressure, kidney disease, nervous system disease, or dental disease. According to the CDC, 17 million Americans have diabetes, 16 million of those have type 2, and one-third are undiagnosed.⁵⁷

Promising Practices, Statutes, Regulations, and Programs

The CDC-funded New York Diabetes Control Program works with 14 regional community coalitions and three university-based Centers of Excellence to improve diabetes services and access to care and to overcome socioeconomic, cultural, and

language barriers to services. The community and provider interventions have reduced diabetes-related hospitalization rates by 35 percent and decreased lower-extremity amputation rates by 39 percent.⁵⁸

North Carolina's Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together) focuses on the African American community in Raleigh and offers a comprehensive approach to reducing risk factors for diabetes, promoting early diagnosis, and improving the quality of care and self-management practices of patients. Project DIRECT demonstrates that significant changes in preventive care can improve care and reduce diabetes complications. Self-management education can provide special populations, such as African Americans, with necessary tools to manage diabetes more effectively.⁵⁹

As of October 2002, 46 states had laws requiring health insurance coverage for some forms of diabetes treatment. States without laws requiring insurers to cover diabetes treatment were Alabama, Idaho, North Dakota and Ohio. In 2001, laws were signed in Michigan, Montana, Oregon, and Wyoming. During the 2002 session, Georgia and Wisconsin each passed legislation to expand coverage requirements.⁶⁰ Some examples of these laws include the following:

Arizona law requires any contract covering diabetes to include coverage for equipment and medically necessary supplies. (A.R.S. §20-826(P), §20-934 – 1998; <http://www.azleg.state.az.us/ars/20/00826.htm>.)

Since 1998, Colorado law requires that diabetes coverage “shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider.” (§10-16-104 (13); http://www.state.co.us/gov_dir/leg_dir/sess1998/sbills98/sb058.htm.)

Wyoming requires insurers to provide diabetes coverage for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy. (H. 185, now Chapter 142 of 2001; <http://legisweb.state.wy.us/2001/enroll/hb0185.htm>.)

Georgia mandates that insurers cover medically necessary diabetes services, including equipment, supplies, pharmacological agents, and outpatient self-therapy prescribed by a physician. (§ 33-24-59.2.)

Maine requires insurers to provide comprehensive coverage for diabetics. The requirement covers medically appropriate and necessary equipment, insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and outpatient self-management. (Maine Tit 24 §§ 2332-F [nonprofits], 2654 [individual], and 2847-E [group])

Montana law requires group disability insurers to cover outpatient self-management training and education as well as diabetic equipment and supplies: insulin, syringes, injection aids, devices for self-monitoring of glucose-level test strips, visual reading and urine test strips, one insulin pump and accessories to insulin pumps, one prescriptive oral agent used to control blood sugar levels, and glucagon emergency kits. Coverage must include a \$250 benefit per person per year. (H. 406 of 2001; <http://data.opi.state.mt.us/bills/2001/billhtml/HB0406.htm>.)

The Montana Diabetes Prevention and Control Program (DPCP), the Billings Area Indian Health Service (IHS) diabetes program, the urban Indian program, and other tribal and IHS diabetes programs developed a collaborative partnership to identify and reduce the burden of diabetes among American Indians in Montana. This partnership addressed community-based health systems, communications strategies, and surveillance, including the establishment of a surveillance system to monitor trends in diabetes prevalence and quality of care among American Indian youth.⁶¹

The Wisconsin Diabetes Advisory Group (DAG) published *Essential Diabetes Mellitus Care Guidelines* to improve diabetes care through providers and health systems. Over 70 percent of Wisconsin's licensed health plans adopted these guidelines. The Wisconsin Collaborative Diabetes Quality Improvement Project evaluates implementation of the *Guidelines* by sharing resources, population-based strategies, and best practices among collaborators, and by improving diabetes care through collaborative quality improvement initiatives. The collaborators initiated a statewide quality improvement intervention to increase the number of eye exams and improve reporting of exam results and recommendations. This program demonstrates the importance of sharing best practices and effective strategies.⁶²

Policy Recommendations

Successful diabetes programs:

1. Establish systems to document the nature and extent of diabetes-related disparities;

2. Build on expertise in program, science, and policy areas to reduce disparities in diabetes prevention, treatment, and management;
3. Educate the public, health providers, business community, and diabetics;
4. Establish the reduction or elimination of diabetes disparities as a key aim;
5. Identify gaps in diabetes care, for patient access and quality issues;
6. Identify stakeholders and partnerships for prevention and control;
7. Develop, initiate, monitor, and evaluate prevention, treatment, and control strategies in targeted populations;
8. Improve access to quality diabetes care to prevent, detect, and treat complications.⁶³

Additional Resources

- Agency for Healthcare Research and Quality. (2001). *Diabetes disparities among racial and ethnic minorities*. Rockville, Md.: AHRQ. (AHRQ Publication No. 02-P007.) Available at <http://www.ahrq.gov/research/diabdisp.htm>.
- National Conference of State Legislatures. (1998). *State laws mandating diabetes health coverage*. (Updated 2003.) Available at <http://www.ncsl.org/programs/health/diabetes.htm>.

HIV/AIDS

Racial and ethnic minorities, primarily blacks and Hispanics, are disproportionately affected by HIV/AIDS. They represent the majority of new AIDS cases and of those living with AIDS. Of 877,275 AIDS cases reported through 2002, blacks and Hispanics accounted for 40 and 19 percent, respectively, 78 percent of female cases, 79 percent of heterosexual cases, and 82 percent of cases in children. Although blacks and Hispanics represent 12 and 14 percent of the U.S. population, respectively, they accounted for 49 and 19 percent of newly reported cases of AIDS in 2001.⁶⁴ A growing proportion of cases of AIDS are in women, with minority women particularly affected. In 2002, among AIDS cases in black and Hispanic adult and adolescent females, the primary mode of exposure included heterosexual contact and injection drug use. In 2002, the primary mode of exposure for HIV infections among black and Hispanic adult and adolescent females included heterosexual contact (34% and 37%) and injection drug use (9% and 15%).⁶⁵

HIV infection spreads more rapidly among blacks and Hispanics than among any other racial or ethnic group. Currently, most new HIV infections are among blacks (54%) and Hispanics (19%). In 2002, among AIDS cases in black and Hispanic adult and adolescent males the primary mode of exposure included male-to-male sexual contact

(32% and 40%) and injection drug use (19% and 21%). In 2002, for HIV infections among non-Hispanic black and Hispanic adult and adolescent males the primary mode of exposure included male-to-male sexual contact (30% and 42%) and injection drug use (11% and 13%). Among the 24 reported cases of HIV/AIDS in infants born to HIV-infected mothers, 21 cases were among black and Hispanic mothers (87.5%).⁶⁰

Promising Practices, Statutes, Regulations, and Programs

To date, little state activity has concentrated on developing initiatives addressing racial and ethnic disparities in HIV/AIDS. While many initiatives identified below do not specifically address racial and ethnic disparities in HIV/AIDS, they may have a positive impact in reducing disparities. A few states have addressed income disparities in accessing HIV/AIDS services. Such initiatives may have an indirect impact in reducing disparities in HIV/AIDS, but may not include all minorities affected by HIV/AIDS.

Initiatives Addressing Racial and Ethnic Disparities

Florida established a statewide HIV and AIDS prevention campaign directed toward minorities at risk of HIV infection. The campaign includes television, radio, and outdoor advertising; public service announcements; and peer-to-peer outreach. The campaign provides information on the risk of HIV and AIDS and strategies for prevention, early detection, and treatment. The campaign uses culturally sensitive literature and educational materials and promotes development of individual skills for behavior modification. The statute authorized the Department of Health to establish positions for the HIV/AIDS regional minority coordinators and for a statewide HIV/AIDS minority coordinator. The coordinators facilitate efforts to implement and coordinate prevention and treatment programs. (Florida Statutes § 381.0046;

http://www.flsenate.gov/Statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=&URL=CH0381/Sec0046.HTM.

California statute directs funding for pilot AIDS education programs, pilot projects to demonstrate the value of noninstitutional health care services, clinical research, development of an AIDS Mental Health Project, needs assessments, studies, and program evaluations. The statute's intent is to promote community-based programs for preventing HIV infection in all communities where behaviors and prevalence indicate high risk of HIV infection. The statute also encourages local programs to have racial and ethnic minorities take a lead role in developing, implementing, and evaluating all of the activities (education, HIV testing, delivery of care) that are necessary for a comprehensive, culturally sensitive HIV prevention strategy. (California Health and Safety Code § 120800;

<http://www.leginfo.ca.gov/calaw.html>.)

The New Jersey Department of Health and Senior Services supports 31 community-based HIV prevention projects. Among these, 28 target urban, black, and Hispanic men, women, and youth who are at risk of acquiring or transmitting HIV through sexual contact or injection drug use. Four additional projects target migrant farm workers, American Indians, school-based youth, and the black clergy. The initiatives are aimed at meeting the needs of those most at risk. (See <http://www.state.nj.us/health/aids/grantees.pdf> and <http://www.state.nj.us/health/aids/aidsprv.htm>.)

Targeting Specific Populations

These initiatives address HIV rates among specific populations: injection drug users, high-risk pregnant women, and prison inmates. Although these initiatives are not aimed at reducing disparities in HIV/AIDS, they may have a positive impact in doing so.

Outreach Program for Pregnant Women. The Florida Department of Health estimates that 8 out of 10 babies born with HIV are black and 1 in 10 are Hispanic. The Targeted Outreach for Pregnant Women Act (TOPWA) authorizes the Department of Health to establish targeted outreach for high-risk pregnant women who may not seek proper prenatal care, who have substance abuse problems, or who are infected with HIV. The goals are to encourage high-risk pregnant women to be tested for HIV, to link women to medical and other services, and to educate women about the benefits of prenatal care and the use of AZT to reduce the risk of transmitting HIV to their infants. The outreach services are intended to be peer-based, culturally sensitive, and nonjudgmental. As of 2000, 70 percent of women enrolled in TOPWA were black, and 15 percent were Hispanic. (Florida § 381.0045; http://www.faetc.org/PDF/Primary_Care_Guide/30--Resources-for-the-Healthcare-Provider.pdf.)

Assistance to Prison Inmates. According to the Florida Department of Corrections, as of June 2002 the majority of prison inmates were male (94%) and black (53.3%). The Florida Department of Health is required to provide transitional assistance to any HIV-positive inmate, including education on prevention of HIV transmission, a written, individualized discharge plan, and a 30-day supply of HIV/AIDS related medications. (Florida § 945.355 Section 5; http://www.flsenate.gov/Statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=&URL=CH0945/Sec355.HTM.)

Syringe and Needle Exchange Programs. Another strategy to reduce disparities in HIV/AIDS is public access to sterile syringes. Many public-health advocates argue that it is not enough to have needle exchange programs; the deregulation of syringes is also needed in order to reduce HIV transmission rates. According to a March 2000 U.S. Surgeon

General's Report, a review of recently published peer-reviewed research on syringe exchange programs shows conclusive evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces HIV transmission and does not encourage the use of illegal drugs.⁶⁶

The Connecticut Department of Public Health is mandated by law to establish needle and syringe exchange programs in health departments of the three cities with the highest number of AIDS cases among IV drug users. This law also raised the limit on needles and syringes distributed per participant from 10 to 30 and requires that first-time applicants receive an initial packet of 30 needles and syringes, educational materials, and a list of drug counseling services. The programs are incorporated into existing AIDS prevention and outreach projects in the selected cities, provide free and anonymous exchanges of needles and syringes, offer education on HIV transmission and prevention measures, and assist participants in obtaining drug treatment services. (Connecticut § 19a-124; <http://www.cga.state.ct.us/asp/menu/Statutes.asp>.)

Programs Addressing Income Disparities

A few states have developed initiatives to address income disparities among HIV/AIDS patients. These initiatives may help the poor and uninsured, but will not necessarily reduce or eliminate racial and ethnic disparities.

The District of Columbia HIV/AIDS 1115 Demonstration project was developed to enhance Medicaid access for low-income HIV-infected individuals by providing Medicaid benefits for the District's HIV-positive population with incomes up to 100 percent of the federal poverty level. The demonstration seeks to provide more effective, early treatment of HIV by making available all Medicaid services, including antiretroviral therapies. In 2002, the District was given approval to contract with selected pharmacy providers in order to distribute HIV-related pharmaceuticals procured under the Federal Supply Schedule to all Medicaid populations as well as demonstration enrollees. (This demonstration was approved for implementation on September 9, 2002. Actual implementation is pending due to budget constraints.) (See <http://www.cms.hhs.gov/medicaid/waivers/dcwaiver.asp>.)

Policy Recommendations

States can improve strategies to develop and implement comprehensive preventive HIV/AIDS efforts, including educational campaigns and outreach programs targeted towards minority populations.

States can increase support and funding for research to test the effectiveness of prevention and treatment interventions, particularly evidence-based practices, among racial and ethnic subpopulations. States can support the inclusion of racial and ethnic minorities in clinical trials to test the effectiveness of new HIV drug therapies.

States should sustain support and funding for needle and syringe exchange programs. More importantly, states should increase efforts to test the effectiveness of such programs among the minority populations who are most in need of such services.

Additional Resources

- National Alliance of State and Territorial AIDS Directors. (2001, March). *Bright ideas 2001: innovative or promising practices in HIV prevention and HIV prevention community planning*. (2nd ed.) Atlanta, GA: Centers for Disease Control and Prevention. (Available at <http://www.cdc.gov/hiv/pubs/brightideas.pdf>.)
- CDC's National Center for HIV, STD, and TB Prevention: <http://www.cdc.gov/hiv/pubs/facts.htm>.
- National Conference of State Legislatures. HIV/AIDS/STDs: <http://www.ncsl.org/programs/health/aidsmainpg.htm>.
- Satcher D. (2000, March). *Evidence-based findings on the efficacy of syringe exchange programs: an analysis of the scientific research completed since April 1998*. Washington, D.C.: U.S. Department of Health and Human Services. (Available at <http://www.dogwoodcenter.org/references/Satcher00.html>.)

IMMUNIZATION

The immunization gap between minority and white populations has narrowed, but overall coverage rates among racial, ethnic, and underserved populations, particularly among adults, are lower than those among the general population.

Recent findings from the National Immunization Survey (NIS) show a significant nationwide increase in coverage for one or more doses of varicella vaccine (VAR) and steady coverage for other vaccines. Still, there is wide variation among states and urban areas covered by the NIS. During 2001, the estimated coverage of the 4:3:1:3:3 vaccine series[†] among states ranged from 82 percent in Rhode Island to 63 percent in New Mexico. Among 28 urban areas, the highest estimate for coverage was 80 percent in Jefferson County, Alabama, and the lowest was 58 percent in Detroit, Michigan. Although U.S. immunization levels for children are at record highs, disparities remain among minority children ages 19 to 35 months. In 2001, coverage levels of the 4:3:1:3:3

series were higher among white children 19 to 35 months of age (79%), compared with non-Hispanic black children (71%), Hispanic children (77%), and American Indian/Alaska Native children (76%).⁶⁷ There also is evidence of smaller “urban pockets” of under-immunized children, a concern because of the potential for outbreaks of vaccine-preventable diseases. Such pockets are crucial targets in the fight to reduce immunization disparities.

Among adults and adolescents overall, vaccination rates continue to rise, but a recent report from the National Foundation for Infectious Diseases identified significant adult immunization disparities for hepatitis B, influenza, and pneumococcal vaccinations.⁶⁸ Of greater concern are immunization rates among persons age 65 years and older that remain significantly lower than the general population. For example, in 2000, 67 percent of older whites received influenza vaccinations, compared with 48 percent of older African Americans and 56 percent of older Hispanics. Disparities for pneumococcal vaccination coverage were greater, with rates of 57 percent for whites, 31 percent for African Americans, and 30 percent for Hispanics.⁶⁹ The percent of adults age 65 years and older who received a pneumococcal vaccination was 24 percent for Hispanics, 35 percent for non-Hispanic blacks, and 60 percent for non-Hispanic whites.⁷⁰

Promising Practices, Statutes, Regulations, and Programs

We identified considerable state activity related to childhood immunizations, but little effort has been made to target urban pockets of under-immunized children and to address disparities in immunization among older minority adults. Several states have targeted high-risk adults, but it is not certain whether these initiatives have any impact on racial and ethnic disparities. Most states have developed immunization registries and tracking systems, educational campaigns, immunization schedule and standards, and standing-order programs that authorize nurses and pharmacists to administer vaccinations. Many states have mandated the administration of vaccines to residents in long-term care and nursing facilities. While these programs will be beneficial in reducing racial and ethnic disparities in immunizations, there remains a need for more state-level initiatives targeted at racial and ethnic minority groups, particularly adults.

Federal–State Partnerships

Racial and Ethnic Adult Disparities in Immunization Initiative (READII). In 2002, HHS launched READII, a new adult immunization initiative to reduce racial and ethnic disparities in influenza and pneumococcal vaccination coverage for adults 65 years of age and older, focusing on African American and Hispanic communities. Through READII, HHS will conduct two-year demonstration projects at five sites to improve influenza and pneumococcal vaccination rates in African American and Hispanic communities. The

HHS project is being implemented by the CDC.
(See <http://www.omhrc.gov/rah/indexnew.htm>.)

The READII project focuses on raising immunization rates among African American elderly in 19 rural Mississippi Delta counties by developing educational activities and increasing access to immunization services. The Mississippi Department of Health is leading in this effort. Partners include local health departments, community organizations, and providers in the 19 counties. The project aims to expand accessibility of immunizations and to promote the effectiveness of immunizations in the elderly population through:

- Provider education and assessment of immunization rates;
- Regional planning meetings involving stakeholders in intervention areas;
- Communication needs assessment and provider surveys to determine perceptions of the target populations and identification of immunization barriers;
- Production of educational materials and public service announcements about influenza and pneumococcal vaccines;
- Increased hiring of nurses to administer vaccinations;
- Promotional events, including many during National Adult Immunization Awareness Week.

(See <http://www.msdh.state.ms.us/msdhsite/index.cfm/14,723,71,html>.)

Vaccines for Children Program. This federal program, sponsored through the CDC National Immunization Program, guarantees vaccine purchase and supply to all states, territories, and the District of Columbia for use by participating providers. The vaccines are given to eligible children without cost to the provider. The program saves parents and providers out-of-pocket expenses for vaccines and provides cost savings to states through CDC vaccine contracts. Children who are eligible to receive vaccines through this program include those under 18 years of age who meet at least one of the following criteria: Medicaid eligible, uninsured, American Indian or Alaska Native, or underinsured.
(See <http://www.cdc.gov/nip/vfc>.)

Education/Outreach Programs

Illinois. An immunization outreach program established under the Department of Health responds to under-immunization of children due to poverty or lack of health insurance;

parents from non-English-speaking cultures where immunizations have not been emphasized; parents not being referred to immunization programs or not having access to public programs; and ethnic and racial disparities in immunization rates. The department can establish permanent, temporary, or mobile sites for immunizing children, including public places such as school grounds or places where parents of children at high risk of not being immunized reside, shop, worship, or recreate. (20 ILCS 2310/2310-255; <http://www.legis.state.il.us/legislation/ilcs/chapterlist.html>.)

South Carolina. The state has targeted racial and ethnic minorities through its immunization program, which developed public service announcements (PSAs) about influenza and pneumococcal vaccines. These PSAs were played on minority radio stations to reach high-risk populations. (See <http://www.partnersforimmunization.org/immunizationprogram.html>.)

Rhode Island. The state has increased outreach to families in pockets-of-need areas through training of parents who are identified leaders in the communities. (See <http://www.partnersforimmunization.org/immunizationprogram.html>.)

Adult Immunization Initiatives

California requires the Department of Health to provide appropriate flu vaccine to local governmental, private, and nonprofit agencies at no charge, so agencies may provide vaccines at accessible locations for all persons 60 years of age or older and to other high-risk groups identified by the U.S. Public Health Service. (California Health and Safety Code § 104900; <http://www.leginfo.ca.gov/calaw.html>.)

Child Immunization Initiatives

Texas. Texas requires its department of health to establish a childhood immunization registry—a single repository of accurate, complete, and current immunization records to aid, coordinate, and promote efficient, cost-effective childhood communicable disease prevention and control. The department may use the registry to notify a parent or guardian by mail, telephone, personal contact, or other means regarding a child due or overdue for an immunization. (Texas Health & Safety Code § 161.007; <http://www.capitol.state.tx.us/statutes/statutes.html>.)

New Mexico. Each individual and group health insurance plan and certificate of health insurance is required to provide coverage for childhood immunizations in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics. (New Mexico Stat. Ann. § 59A-22-34.3; <http://www.state.nm.us/category/governmentnm.html#laws>.)

Rhode Island. Insurance companies and HMOs are taxed on premiums to underwrite vaccine costs. The annual rate of assessment is calculated by the projected costs for the U.S. Public Health Service's Advisory Committee on Immunization Practices' (ACIP) recommended and state-mandated vaccines after the federal share has been determined by the CDC. The assessment is used solely for the "infant-child immunization account." (Rhode Island Gen. Laws § 23-1-146; <http://www.rilin.state.ri.us/Statutes/Statutes.html>.)

Connecticut. The Commissioner of Public Health establishes a standard of care for childhood immunization according to the recommended schedule for immunization of normal infants and children published by the Committee on Infectious Diseases of the American Academy of Pediatrics or the schedule published by the National Immunization Practices Advisory Committee. The immunization program furnishes vaccines at no cost to health care providers; provides the recommended immunization schedule to all parents; assists hospitals, providers, and local health departments in developing and implementing record-keeping and outreach; and assists in the development of a program to assess the vaccination status of children who are clients of state and federal programs. (Connecticut Gen. Stat. § 19a-7f; <http://www.cga.state.ct.us/2003/pub/titles.htm>.)

Policy Recommendations

1. States can research gaps in immunization rates and services for racial and ethnic minority adults and commission pilot studies to assess the effectiveness of immunization outreach programs. There is also a need to increase and improve surveillance data on the immunization of racial and ethnic minority adults.
2. States can use childhood immunization programs as models to implement adult immunization programs, such as adult immunization registries and the standardization of care, by mandating the Adult Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP). (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5140a5.htm>.)
3. More states should consider emulating the law enacted in Rhode Island that, to underwrite vaccine costs for children and adults, taxes insurance companies and HMOs and deposits the proceeds in a separate immunization account.
4. State can implement and evaluate immunization programs in nontraditional settings (e.g., pharmacies, churches, grocery stores), which may be very effective in delivering vaccines to underserved minority populations.
5. More states should mandate funding, implementation, and monitoring of immunization programs such as those found in South Carolina and Rhode Island.

Additional Resources

- CDC's National Immunization Program: <http://www.cdc.gov/nip/default.htm>.
- CDC's Office of Minority Health. *Eliminate disparities in adult and child immunization rates*. (Available at <http://www.cdc.gov/omh/AMH/factsheets/immunization.htm>.)
- National Conference of State Legislatures. Immunizations: <http://www.ncsl.org/programs/health/immuni2.htm>.
- CDC. Healthy People 2010: Immunization and infectious diseases: <http://www.healthypeople.gov/document/pdf/Volume1/14Immunization.pdf>.
- National Foundation for Infectious Diseases: <http://www.nfid.org/>.
- Immunization Action Coalition: <http://www.immunize.org/>.
- National Partnership for Immunization: <http://www.partnersforimmunization.org/>.

INFANT MORTALITY

The United States spends far more on neonatal intensive care than most industrialized countries, but our infant mortality rate is higher. This is partly because other nations emphasize preconception and prenatal care, producing better results. Infant mortality for blacks is almost three times higher than for whites, and the rate for American Indian/Alaska Natives is almost twice as high. The disparity is partially explained by lack of access to care. Early prenatal care is key to decreasing infant mortality disparities. (Causes include congenital anomalies, preterm birth and low birth weight, pregnancy complications, cigarette smoking, teen births, drug and alcohol use, pregnancy nutrition, and repeat pregnancy less than six weeks after birth.) Early culturally and linguistically appropriate prenatal care reduces many infant mortality risk factors.

Sudden Infant Death Syndrome (SIDS) is the leading cause of postneonatal death (after the first 28 days of life). The SIDS rates for African American and American Indian infants are two to three times higher than the rate for whites. Putting infants to sleep on their backs has proven effective for decreasing SIDS; however, African American and American Indian mothers are still more likely than white mothers to put their infants to sleep on their stomachs. (Only 31 percent of African American mothers put their babies on their back; African American parents are more likely to believe stomach sleeping is the best way to reduce SIDS. In this case an information disparity creates a health outcome disparity. Part of the information disparity is lack of access and part is due to the information being presented in a manner that is not culturally and linguistically sensitive.)

Promising Practices, Statutes, Regulations, and Programs

Accessible Prenatal Care. Rhode Island increased access to quality prenatal services by shortening application forms, offering free pregnancy tests, increasing reimbursement to prenatal and obstetrical providers, creating toll-free access to information about counseling services, and conducting outreach campaigns. By improving access and quality of care, the state saved money. A mother who receives cost-effective prenatal care is less likely to bear a child who will require costly intensive care. The number of patients receiving prenatal care increased by 17 percent in seven years, with improved child outcomes. There was a 5 percent decline in low birth weight infants, more children had their first physician visit within two weeks of birth, and more were up to date with immunizations at one year. These are all protective factors against infant mortality.⁷¹

Home Visitation Programs with Prenatal Care. Prenatal care plus home visits show impressive results, including increased use of prenatal care, increased birth weight, increased use of health and community resources, and decreased preterm labor. The Healthy Start program of Connecticut's Department of Health aims to reduce infant mortality with community-based home visitation. Using community resources improves the cultural and linguistic fit of services. The Department of Health and local Healthy Start coalitions run Florida's home visitation initiative as part of a larger governor's initiative. Activities include early maternal and infant outreach, high-risk infant follow-up, parenting skills, and child development. Vermont offers home visitation to all mothers, regardless of insurance status.⁷² Although Vermont is not a diverse state, offering prenatal care to all regardless of insurance will decrease disparities.

SIDS Prevention. The NIH's National Institute of Child Development created an innovative program to address SIDS among African Americans. The American Academy of Pediatrics' Back to Sleep campaign decreased SIDS rates nationwide from over 5,000 to less than 2,500 infant deaths per year. However, SIDS rates and rates of stomach sleeping among African Americans remained two to four times that of white infants. NIH and community partners devised an alternative Back to Sleep campaign aimed at African American communities. Community organizations give Back to Sleep advice in culturally and community sensitive ways. The information kit, developed with community input, has shown success in African American communities. This campaign technique can be used to develop SIDS campaigns for other communities at risk. The key is that all community members are involved in planning.⁷³

In Alameda County, California, SIDS rates remained unchanged in high-risk areas. Case reviews found a high percentage of known risk factors (prone sleeping, nonuse of cribs or bassinets, cosleeping, maternal substance use, and maternal smoking). SIDS

teaching varied in structure, content, and occurrence, and the literature was only available in English. Because of these problems, California diversified their SIDS message by translating educational materials into the community's primary languages: Chinese, Vietnamese, Spanish, Amharic, Thai, Croatian, and Laotian.⁷⁴

Targeted Local Infant Mortality Initiatives. The Northeast Florida Healthy Start, using community groups and state support, developed prevention and intervention strategies tailored to the local experience. Data demonstrated that women of color needed preconception care. They implemented a preconception initiative, the Magnolia Project, to reduce infant mortality in African Americans. The program identifies and improves the preconception health of African American women at risk for poor outcomes. Interventions include improving the medical health of mothers, treating infections, addressing child spacing and family planning issues, improving nutrition, taking folic acid supplements, and addressing any issues that contributed to previous poor pregnancy outcomes.⁷⁰

Policy Recommendations

1. States can expand access to prenatal care for at-risk parents. Funds spent on prenatal care programs can be recouped in nine months with decreased use of expensive treatments for ailing newborns. Expanding Medicaid and CHIP programs to include pregnant mothers also improves access.⁶⁷
2. States can establish home visitation programs for at-risk communities. Programs should begin before birth to alleviate prenatal risk factors for infant mortality including low birth weight, smoking, poor nutrition, and prenatal infections. States need local data to assess disparities, and then target home visitation to these communities. Decreasing spending on costly treatments and reducing the number of mothers requiring welfare recoups expenses. Federal Healthy Start grants can be used to initiate such programs. Community input in developing these programs is crucial.⁶⁸
3. States can conduct effective culturally and linguistically appropriate SIDS education. First, states must have infant mortality data by locality. The CDC has worked with state and local health departments; a critical part of this effort is the CDC's state-based Pregnancy Risk Assessment Monitoring System (PRAMS), which collects data on the health of infants and health and health-related behaviors of pregnant women and new mothers. Using the PRAMS data, states can invite community organizations in high-risk areas to help create appropriate Back to Sleep and other preventive messages.⁶⁹
4. States can initiate other healthy baby campaigns and consumer education projects. Departments of Health should ensure that all educational materials are culturally

appropriate. Indiana offers media campaigning on the following issues: early prenatal care for women as soon as they find out they are pregnant; knowing the signs of preterm labor; smoking cessation during pregnancy; eating well and gaining 25 to 35 pounds during pregnancy; putting babies to sleep on their backs; and taking folic acid prior to pregnancy.

5. States can provide access to substance abuse programs, including smoking cessation. Smoking during pregnancy contributes to adverse birth outcomes, such as spontaneous abortion, stillbirth, fetal death, low birth weight, premature birth, and intrauterine growth retardation. Smoking cessation initiatives decrease the number of low birth weight infants. In 1994, nearly 18 percent of Washington State women smoked during pregnancy, and 70 percent of those women received Medicaid benefits. The smoking rate increased to nearly 25 percent after pregnancy. Washington State created the First Steps program to provide Medicaid-covered health and social services, such as substance abuse education to low-income pregnant women. The state used county smoking rates for pregnant women enrolled in Medicaid to decide where to target its interventions. The project enhanced the interventions offered by providers and supported smoking cessation during and after pregnancy in an effort to reduce low birth weight rates and infants' exposure to environmental tobacco smoke.⁷⁵

Additional Resources

- CDC. Exemplary State Programs. Healthy Mothers Healthy Babies: http://www.cdc.gov/nccdphp/exemplary/healthy_mothers.htm#wi.
- American College of Obstetricians and Gynecologists. National FIMR Program; FIMR Models; SIDS Risk Reduction: http://www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=145.
- Johnson K. (2001, May). *No place like home: state home visiting policies and programs*. (Available at http://www.cmwf.org/publications/publications_show.htm?doc_id=221347)

INJURY PREVENTION

Racial and ethnic disparities exist within the field of injury prevention, both intentional and unintentional. National statistics illustrate the gaps. The firearm death rate for black males ages 15 to 19 is four times that of white males of the same age. The rate for Hispanic males ages 15 to 19 is two and one half times that of non-Hispanic white males of the same age. African Americans and American Indian/Alaska Natives are at greatest risk for injuries from residential fires. The rate of drowning for African Americans is 1.6

times that of whites. The pedestrian fatality rate for Hispanics is 1.7 times higher than for whites; for American Indian/Alaska Natives it is three times higher than for whites. American Indian/Alaska Native women were more likely than any other racial group to report being raped or assaulted.⁷⁶ While the problems are varied, all statistics point to an alarming and persistent trend for racial and ethnic minorities.

Promising Practices, Statutes, Regulations, and Programs

States are beginning to address injury prevention, though few successful projects target minority populations. Lack of program evaluation is a significant obstacle to measuring whether these programs have any effect on reducing disparities. Below are some successful programs addressing intentional and unintentional injuries.

Unintentional and Intentional Injury Prevention

New York: Harlem Hospital Injury Prevention Program (HHIP). Two decades ago, central Harlem had one of the nation's highest rates of childhood injury. HHIP is a hospital-based program that began in 1984 to offer safety education, safe play areas, and interventions to decrease injuries and hospital visits. There are two principal interventions: safe activities/environments (providing after-school activities and cleaning up play areas and school playgrounds) and educational programs. After five years of HHIP, there was a 41 percent decrease in injuries for targeted age groups, a 50 percent decrease in motor vehicle, bike, and serious playground accidents, and a 30 percent decrease in gunshot admissions; within 10 years there was a 55 percent decrease in hospital admissions for major injuries. During this same period, other neighborhoods showed increases in injury statistics. One important reason for the success of the program is that the community was engaged to collect data prior to the intervention, enhancing appropriate interventions. (See <http://www.injuryfree.org>.)

Elmira, New York: Pre/Postnatal Home Visitation. Data demonstrate that pre- and postnatal home visits can decrease violence against children. In Elmira, New York, 15 years of results from a program of home visits show that adolescents born to women who were unmarried and from households of low socioeconomic status who received nurse visits during and after pregnancy reported fewer instances of running away, fewer arrests, fewer convictions and violations of probation, fewer sex partners over a lifetime, fewer cigarettes smoked per day, and fewer days having consumed alcohol. Parents of nurse-visited children report their children had fewer behavioral problems related to alcohol and other drug use. All of the above are risk factors for intentional and unintentional injuries.⁷⁷ Early targeted interventions led to long-term improved outcomes. (See http://www.futureofchildren.org/information2826/information_show.htm?doc_id=70406.)

Fire Prevention

Another disparity arises from fire injuries and deaths. Most interventions target low-income and high-fire areas. Oklahoma created an exemplary program. Data helped determine neighborhoods at highest risk, then officials conducted a smoke alarm giveaway program combined with education and publicity. Oklahoma City saw an 80 percent decrease in annualized injuries per 100,000 in this area compared with an 8 percent decrease in other areas.⁷⁸ Annual fire rates decreased 25 percent as opposed to 18 percent in other areas. Smoke detector giveaways may be an effective strategy to decrease fire related injuries in high-risk areas, which tend to include low-income persons, older housing, and larger numbers of minorities. (See http://www.futureofchildren.org/information2827/information_show.htm?doc_id=69773).

School Violence Reduction Programs

*School Health Guidelines to Prevent Unintentional Injuries and Violence*⁷⁹ summarizes school health recommendations for preventing unintentional injury, violence, and suicide among young people. The CDC developed these guidelines in collaboration with experts from universities and national, federal, state, local, and voluntary agencies. The guidelines include recommendations related to eight aspects of school health programs:

- A social environment that promotes safety;
- A safe physical environment;
- Health education curricula and instruction;
- Safe physical education, sports, and recreational activities;
- Health, counseling, psychological, and social services for students;
- Appropriate crisis and emergency response;
- Involvement of families and communities;
- Staff development to promote safety and prevent unintentional injuries, violence, and suicide.

States may use this guide as a building block to creating successful interventions.

Policy Recommendations

1. States need statewide injury surveillance systems that include race and ethnicity data. Having this data indicates where disparities lie and gives an idea of which community stakeholders need to be present to create successful interventions.

2. States can initiate home visitation programs, which help to decrease infant mortality, child abuse, welfare rolls, and violent behavior. States can also start mentoring programs, which have shown that a positive adult supervisory role model is a protective factor against violence. Program examples include 100 Black Men of America, and Big Brothers/Big Sisters.
3. States can make reducing alcohol use a priority. A modifiable injury risk factor is alcohol consumption. Targeting efforts to reduce alcohol consumption among youths and others decreases episodes of violence. Emergency room screening and brief alcohol intervention programs have shown promise.
4. States can promote installation of smoke detectors and ensure that all homes have smoke detectors, especially in areas of higher fire rates. One dollar spent on smoke alarms saves \$69 in fire-related deaths.⁸⁰
5. States can promote efforts to prevent drowning. Neighborhood swimming lessons can decrease the incidence of drowning in African American populations.⁸¹ Bodies of water should also be protected by lifeguards or have ways of restricting people who are unable to swim (e.g., fences).
6. Neighborhood interventions have improved pedestrian safety. Interventions include sidewalks, speed bumps, lower speed limits in residential areas, and improved lighting near roadways. Also, family education programs decrease pedestrian accidents. The HHIP program demonstrated a 45 percent decrease in school-age pedestrian injury among the targeted group.⁸²

Additional Resources

- Harborview Medical Center Injury Prevention and Research Center: <http://depts.washington.edu/hiprc>.
- Injury Free Coalition for Kids: <http://www.injuryfree.org>.

MENTAL HEALTH

Overall rates of mental illness among blacks and Hispanics are similar to those of non-Hispanic whites. Differences appear when we assess the prevalence of specific mental illnesses. Blacks are less likely to suffer from major depression and more likely to suffer from phobias than are whites. Adult Mexican immigrants have lower rates of mental disorders than U.S.-born Mexican Americans, while adult Puerto Ricans on the island tend to have lower rates of depression than Puerto Ricans living on the mainland. From 1980 to 1995, the suicide rate among blacks ages 10 to 14 increased 233 percent compared with a 120 percent increase for whites. In 1997, Hispanics had a suicide rate of approximately 6 percent compared with 13 percent for whites.

Blacks, Hispanics, and Asian Americans/Pacific Islanders are overrepresented in high-need populations that are at particular risk for mental illness (people who are homeless, incarcerated, substance abusers, or children in foster care). Blacks represent only 12 percent of the U.S. population, but make up about 40 percent of the homeless population. Nearly half of all prisoners in state and federal jurisdictions, as well as almost 40 percent of juveniles in legal custody, are black. About 45 percent of children in public foster care are black children and adolescents. Blacks are more likely to become victims of serious violent crime than are whites. Substance abuse rates are twice as high for U.S.-born Mexican American men than for Mexican-born men, and seven times higher for Mexican American women than for Mexican-born women. Prevalence rates for current alcohol abuse and/or dependence among American Indian/Alaska Natives have been estimated as high as 70 percent.

Only half of African Americans receive mental health care compared with whites. Among Hispanics with a mental disorder, fewer than 1 in 11 contact mental health specialists, while fewer than 1 in 5 contact general health care providers. Among Hispanic immigrants with mental disorders, fewer than 1 in 20 use mental health specialists, while fewer than 1 in 10 use services from general health care providers. Although data suggest that African Americans may metabolize psychiatric medications more slowly than whites, they often receive higher dosages than whites, leading to more severe side effects, and as a result they stop taking medications at a greater rate than whites with similar diagnoses.⁸³

Promising Practices, Statutes, Regulations, and Programs

There has been moderate state activity with respect to racial and ethnic disparities in mental health. Several states have gone after income disparities, and although not specifically addressing racial and ethnic disparities, these efforts may have a positive impact in reducing them.

Initiatives Addressing Racial and Ethnic Disparities

Interpreter Services. The Illinois Mental Health Hispanic Interpreter Act requires that every state-operated mental health and developmental disability facility where at least 1 percent of total admissions for inpatient or outpatient care consists of recipients of Hispanic descent provide a qualified interpreter at any time such recipient lacks proficiency in the English language. (405 ILCS § 75)

Mental Health and Substance Abuse Programs. California has provided funds to the Department of Mental Health to conduct a pilot project to serve persons from culturally diverse, underserved populations, including clients from the Asian and Pacific Islander

community and the Latino community, who are dually diagnosed with a mental illness and substance abuse problem. (California Welfare and Institutions Code § 4096.7; <http://www.leginfo.ca.gov/calaw.html>.)

Service Standardization and Needs Assessment. California requires the Department of Mental Health to establish service standards to ensure that members of a target population are identified and that services are provided to assist them to live independently, work, and reach their potential as productive citizens. These standards include service plans that contain evaluation strategies that consider cultural, linguistic, gender, age, and special needs of minorities in the target populations. (California Welfare and Institutions Code § 5806; <http://www.leginfo.ca.gov/calaw.html>.)

Community-Based Programs. Many racial and ethnic minorities prefer to receive mental health services through their primary care physicians. This is important because “[c]ommunity health centers as well as other public and private primary health settings provide a vital frontline for the detection and treatment of mental illnesses and the co-occurrence of mental illnesses with physical illnesses.”⁷⁷ Therefore, it is important that mental health services be incorporated into community-level primary care programs.

The California Bronzan-McCorquodale Act organizes and finances community mental health services for those with mental illnesses through locally administered and controlled community mental health programs. Public mental health programs are provided to priority target populations, including all ethnic groups, in systems of care that include factors such as a client-centered approach; coordinated, integrated systems of care; outreach; cultural competence; self-help; and research and evaluation. (California Welfare and Institutions Code § 5600-5623; <http://www.leginfo.ca.gov/calaw.html>.)

Partnerships

The Dallas School-based Youth and Family Centers has a comprehensive school-based mental health care program in the twelfth-largest school system in the nation. This initiative integrates physical and mental health care. The mental health care component creates partnerships with parents and family, treatment and follow-up with teachers, and trains nurses, counselors, and principals to identify problems and make appropriate changes in the classroom tailored to each child’s needs. This program serves 3,000 mostly poor, Hispanic, and black children and families. (See <http://www.mentalhealth.org/publications/allpubs/NMH02-0144/gaps.asp>.)

Expansion of Coverage

California Medi-Cal Specialty Mental Health Services Consolidation Program (1915(b) Waiver).

This program, operated by the Department of Mental Health and the Department of Health Services, contracts with a mental health plan in each county that provides mental health services. The goal of the program is to improve the access to and quality of specialty mental health services for the state's Medicaid beneficiaries. The waiver is implemented statewide and enrollment is mandatory for all Medi-Cal eligible. Services provided under this program include psychiatric inpatient hospital care, rehabilitative mental health services, psychiatry and psychology services, and targeted case management services. (See <http://www.cms.hhs.gov/medicaid/waivers/cawaiver.asp>.)

General Initiatives

National Alliance for the Mentally Ill (NAMI) Omnibus Mental Illness Recovery Act. This is an initiative targeted to state legislatures and governments to build a comprehensive delivery system by replicating evidence-based interventions. This model legislation can be introduced as a single package or as separate initiatives and includes these goals:

- Increasing the participation of consumers and families in planning services;
- Equitable health care coverage;
- Access to newer medications;
- Expanding assertive community treatment programs, including the evidence-based PACT model, a service delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses;
- Creating work incentives for persons with severe mental illness;
- Reducing the use of life-threatening and harmful care (restraints and seclusion);
- Reducing the criminalization of persons with severe mental illness;
- Increasing access to permanent, safe, and affordable housing with appropriate community-based services.

(See <http://www.nami.org/update/reportsnarticles.html>.)

State Planning/Mental Health Block Grants. The Substance Abuse and Mental Health Services Administration (SAMHSA)–Center for Mental Health Services Block Grant program supports comprehensive, community-based systems of care for adults with serious mental illnesses and children with serious emotional disturbances. This is a partnership between federal and state entities to plan and deliver state-of-the-art community-based

mental health services for adults and children. States are required to develop annual plans to address the need for services among special populations, and to encourage partnerships among primary health, dental, mental health, vocational, housing, and educational service providers. (See <http://mentalhealth.samhsa.gov/cmhs/StatePlanning/default.asp>.)

The New York Winds of Change Campaign/Evidence-Based Practice Initiative. The Office of Mental Health (OMH) Winds of Change Campaign is a quality outcomes campaign to promote recovery by adding evidence-based practices—medications, treatments, and services for which there is consistent scientific evidence showing they improve outcomes—to routine mental health settings. The evidence-based practices (EBP) initiative seeks to improve accountability for results, best practices, and coordination of services and programs throughout the mental health system. OMH has identified eight priority EBPs focused on promoting effective practice and recovery for adults with severe mental illness: care coordination, family education, integrated treatment for co-occurring substance abuse and mental health disorders, medication, post-traumatic stress disorder treatment, self-help and peer support services, supported employment, and wellness self-management. (See <http://www.omh.state.ny.us/omhweb/ebp>.)

Policy Recommendations

1. Though consistent scientific evidence shows that some practices are effective in improving outcomes in the lives of individuals with mental illness, states can increase and improve research in these areas by:
 - Including and identifying sizable racial and ethnic minority samples;
 - Examining the efficacy of ethnic- or culture-specific interventions for minority populations and their real-world effectiveness;
 - Identifying mechanisms (e.g., race, ethnicity, age, gender, family history) responsible for differential pharmacological response, and developing and testing potential drug therapies tailored to ethnic and racial minorities.
2. States need to develop strategies to improve the accessibility and delivery of evidence-based treatments to racial and ethnic minorities.
3. States can focus more attention on prevention efforts with the potential to decrease the incidence, severity, and duration of certain mental illnesses.
4. States can increase efforts to develop, expand, and improve mental health services targeted to minority populations. This includes developing comprehensive community-based systems, focusing on providing mental health services through community health centers and agencies, which are often the first point of contact for many racial and ethnic minorities seeking such services.

OBESITY, PHYSICAL ACTIVITY, AND TOBACCO USE

Healthy People 2010 identifies physical activity, weight, and tobacco use as leading indicators of the nation's health during the next 10 years.

In 2001, 31 percent of blacks and 24 percent of Hispanics, compared with 20 percent of whites, were obese.⁸⁴ The prevalence of obesity between 1991 and 2001 rose most among black adults (62% increase) compared with white and Hispanic adults (58% and 49% increases).⁸⁵ In 2002, the age-adjusted prevalence of obesity was highest among black women (40%) and lowest among white women (21%).⁸⁶ Twenty-seven percent of Mexican boys ages 6 to 11 years of age were overweight, compared with 17 percent of black boys and 12 percent of white boys. Black girls were more likely to be overweight (22%) compared with Mexican girls (20%). More than half of black female adults were obese, compared with Mexican females (40%) and white females (31%).

More white adults (35%) were likely to engage in regular leisure-time physical activity than black adults (25%) and Hispanic adults (23%).⁷⁹ Black adults (16%) were most likely to never have been physically active compared with Hispanic adults (11%), white adults (8%), and Asian American adults (9%). White adults (20%) were more likely than Hispanic adults (15%) or black men (14%) to engage in a high level of overall physical activity.

Regarding tobacco use, among the five major racial and ethnic populations, adult smoking prevalence was highest among American Indians and Alaska Natives (34.1%) followed by African Americans (26.7%), whites (25.3%), Hispanics (20.4%), and Asian Americans and Pacific Islanders (16.9%). Cigarette smoking prevalence is higher among white (38.6%) and Hispanic (32.7%) high school students than among African American (19.7%) students.

Promising Practices, Statutes, Regulations, and Programs

Obesity and Physical Activity

State-Based Nutrition and Physical Activity Program. In 2000, the CDC's Division of Nutrition and Physical Activity initiated a program to support state health departments and their partners in developing and implementing nutrition and physical activity interventions to prevent chronic diseases, particularly obesity. States are encouraged to use social marketing approaches to design population-based strategies, particularly policy-level and environmental interventions. During the 2000 and 2001 fiscal years, 12 states won cooperative agreements to fund such programs.

(See http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm.)

The Rhode Island Obesity Prevention and Control program targets children and racial/ethnic minorities, particularly Hispanics, for surveillance efforts and community-based interventions to reduce the prevalence of obesity and type 2 diabetes. The Council, composed of practitioners, researchers, and policymakers, works to reduce disparities in obesity and type 2 diabetes. (See http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm.)

North Carolina's Healthy Weight Initiative focuses on healthy weight, nutrition, and physical activity for children. The initiative's task force developed a plan, *Moving Our Children Toward a Healthy Weight: Finding the Will and the Way*, for children ages 2 to 18, that enhances the state's pediatric nutrition surveillance system. The multilevel approach to reducing the number of overweight and obese children encourages behavioral and interpersonal change and organizational, community, and societal changes necessary to support healthy eating habits and increased physical activity for children, teens, and their families. A pilot intervention in eight counties targets children ages 2 to 5 who are enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or the Child and Adult Care Food Program. (See http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/north_carolina.htm.)

Arkansas law requires every public school student in kindergarten through grade nine to receive no less than one hour per week of physical education training and instruction, which includes no less than 20 minutes of physical activity three times a week for every student who is physically fit and able to participate. The physical education training and instruction is designed to develop behavioral and motor skills that promote a lifelong commitment to healthy physical activity. (Arkansas Stat. Ann. § 6-16-132.)

California established the Safe Routes to School construction program, using federal transportation funds for construction of bicycle and pedestrian safety paths and traffic calming projects. Grants are made to local government based on demonstrated needs; potential for reducing child injuries and fatalities; potential for encouraging increased walking and bicycling among students; identification of safety hazards; identification of current and potential walking and bicycling routes for schools; and consultation and support for projects by school-based associations, local traffic engineers, local elected officials, law enforcement agencies, and school officials. (California Streets and Highways Code § 2333.5.)

Florida established the Healthy Communities, Healthy People program, a comprehensive and community-based health promotion and wellness program to reduce

major behavioral risk factors associated with chronic diseases by enhancing knowledge, skills, motivation, and opportunities for individuals, organizations, and communities to develop and maintain healthy lifestyles. (Florida. Stat. Ann § 381.734.)

Tennessee enacted the Obesity Study and Prevention Act of 2002 to require data collection and analysis regarding the prevention and treatment of obesity, including the effectiveness of existing methods, the effectiveness of alternate methods, the compliance and cooperation of patients, and the reduction in serious problems associated with diabetes. The Department of Health is responsible for submitting an annual report to the state's general assembly. (Tennessee Chapter 658 of the Public Acts of 2002.)

Arkansas lawmakers created the Great Strides Program, which allocates funding for rural communities to establish half-mile to one-mile walking parks. The Tobacco Settlement Proceeds Act was used to fund this grant program. (Arkansas Stat. Ann. § 20-8-302.)

Tobacco

The Washington state Department of Health convened a Cross-Cultural Workgroup on Tobacco to identify populations disparately affected by tobacco use. The membership includes representatives from organizations working with African American, American Indian, Asian American/Pacific Islander, Hispanic, gay-lesbian-transgender, pregnant, low-income, and faith-based populations. Using CDC and state funds, Washington State is developing a strategic plan to identify and reduce tobacco-related disparities and a marketing plan to educate community leaders of diverse populations about the strategic plan and to engage in its implementation.

(See <http://www.cdc.gov/nccdphp/exemplary/tobacco.htm#w>.)

Arizona law prohibits tobacco products at schools and school-related areas. (Ariz. Rev. Stat. Ann § 36-798.04.)

California law prohibits tobacco advertisements within 1,000 feet of any public or private elementary school, junior high school, or high school or public playground. (California Business and Professions Code § 22961.)

Policy Recommendations

1. States can increase research efforts in areas such as the effectiveness and appropriateness of smoking cessation and prevention, nutrition, and physical activity programs among men and women of different racial and ethnic subpopulations. States can ensure that

intervention programs, as well as established collaborations and networks, adequately address disparities by conducting evaluations or creating external advisory boards to monitor their progress.

2. States can implement the CDC's Best Practices for Comprehensive Tobacco Control Programs, an evidence-based guide to help states prevent and reduce tobacco use. The guide describes the key elements for effective state tobacco control programs, including ones for communities, schools, and the entire state. Best Practices also addresses the significance of cessation programs, countermarketing, enforcement, surveillance and evaluation, and chronic disease programs to reduce the burden of tobacco-related diseases. (See <http://www.cdc.gov/tobacco/bestprac.htm>.)

Additional Resources

- CDC's Health topic: nutrition: <http://www.cdc.gov/health/nutrition.htm>
- National Center for Chronic Disease Prevention and Health Promotion: Nutrition and Physical Activity: <http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm>.
- CDC's Tobacco Information and Prevention Source (TIPS): <http://www.cdc.gov/tobacco/index.htm>.
- CDC's Health topic: tobacco: <http://www.cdc.gov/health/tobacco.htm>.
- Healthy People 2010 homepage: <http://www.healthypeople.gov>.

ORAL HEALTH

Low-income children miss 12 times as many days of school due to dental problems as higher-income children. In California, one-half of Asian Americans and African Americans and three-fourths of Latinos do not get the dental care they need. Among minority children, 40 percent of preschoolers and 60 percent of elementary school children do not get the dental care they need. Tooth decay is the most prevalent and preventable childhood chronic disease—five times more common than asthma and seven times more common than hay fever.

Among dentate adults, 48 percent of blacks compared with 28 percent of whites have untreated coronal tooth decay; 20 percent of blacks and 11 percent of whites have untreated root decay; 58 percent of blacks and 52 percent of whites had gingivitis. Socioeconomic status only partially explains these differences.⁸⁷ A survey of 12,349 American Indian and Alaska Native dental patients age 18 and older showed 11 percent with complete tooth loss in individuals 35 and older and 42 percent for patients 65 and older. Tooth loss remains a substantial problem in American Indian and Alaska Native

adults.⁸⁸ Almost 47 percent of all low-income Hispanics and African Americans have untreated tooth decay.

These statistics demonstrate the need for strategies to improve access to dental care for all ages among racial and ethnic minorities.

Promising Practices, Statutes, Regulations, and Programs

School-Based Dental Services

States can improve children's dental health and school attendance by running school-based dental services. A goal of Healthy People 2010 was to have 50 percent of eight year olds treated with dental sealants. (Dental sealants have proven almost 100 percent effective in preventing decay of first and second permanent molars.) Only 23 percent of all eight year olds, 10 percent of African Americans, and 10 percent of Mexican Americans have sealants. School dental clinics increase sealant rates and prevent overall decay.

Ohio. In elementary schools with school-based dental clinics, the rate of children with dental sealants met or surpassed the Healthy People 2010 goal of 50 percent. African American, white, and students of all income levels showed improvements: 52 percent versus 28.2 percent in schools without sealant clinics.

(See <http://www.healthinschools.org/ohiosealant.asp>.)

Connecticut. The state added dental services in 20 of its school-based health centers, mostly in the elementary grades. Some programs decreased tooth decay by 20 percent and decreased the need for urgent dental care by 38 percent. (See

<http://www.ncsl.org/programs/health/CHIPDENT.htm>.)

Expanded Medicaid/CHIP for Dental Services

Pennsylvania. The children's health program uses private insurer reimbursement, billing, and eligibility processes to decrease financial disincentives and administrative barriers to dental care. Pennsylvania's health cards are identical to the ones from private insurers, mitigating provider discrimination and stigma, increasing access to care, and decreasing unmet needs. After 12 months, the percentage of children with a regular source of dental care increased from 51 to 86 percent. The unmet dental treatment needs were reduced from 52 to 10 percent. (See <http://www.ncsl.org/programs/health/CHIPDENT.htm>.)

Washington. The Spokane District Dental Society, Spokane Regional Health District, Washington State Dental Association, Medicaid program, and the University of Washington conducted a pilot program to increase the number of Medicaid children

under age five receiving dental care. Local dental society dentists were trained and certified to receive enhanced Medicaid payments to meet their costs. Eighty-one percent of general dentists and 86 percent of pediatric dentists participated in the program, providing dental care in private offices. The Spokane Regional Health District recruited and enrolled families. University faculty provided specialized training in the care of young children for dentists. In the program's first year, 37 percent of the enrolled children had made at least one dental visit, compared with 12 percent of children not enrolled. While the program did not target minorities, it could be used as a model within minority communities.⁸⁹

Reimbursement

Some dentists refuse Medicaid clients because of low reimbursement. In 1998, Delaware increased reimbursement from 75 percent to 85 percent of usual and customary fees, and decreased administrative burdens on the dentists. Medicaid provider participation increased from 1 provider to over 70 providers in the course of two years. Increasing the number of providers improves access and narrows disparity gaps.

(See <http://www.ncsl.org/programs/health/CHIPDENT.htm>.)

Increasing Capacity and Awareness

Kansas. Kansas improved access to dental care by granting liability immunity to licensed dentists treating the underserved and allowing retired dentists to practice without paying license fees or meeting continuing education requirements. (1996 Kan. Sess. Laws, Chap. 210 (SB 625).)

Vermont. The Tooth Tutor classroom dental health education is for grades K–6. The Vermont Department of Health provides curriculum and all supplies, including a canvas tooth tote, three videos, a large tooth model and demo toothbrush, a storybook for the kindergarten level, toothbrushes for first grade, floss for third grade, a mouth guard sample for fifth grade, and lesson plans for all levels including transparencies, experiments, and parent information. Using community input, states can develop similar programs for targeted communities. (See <http://www.healthinschools.org/sr/states/VT/vtdental.asp>.)

New York. Rochester has a Smilemobile project targeting underserved school-age urban and rural children. School-based, mobile dental trailers and on-site portable clinics create a network of services. Rochester started with 11 sites serving 2,200 children in 1994 and had 37 sites serving 10,000 children in 2000. The program is funded with a mix of Medicaid, CHIP, and grant funding.

(See <http://www.urmc.rochester.edu/Dentistry/EDC/commun.html>.)

Increasing Scope of Practice

Michigan. State law allows dental hygienists to treat patients in an approved dentally underserved program. A dentist must be available in person, by radio, telephone, or telecommunication or on a regularly scheduled basis for review and consultation. (§ 333.16625 (1991).)

Data Collection

New Hampshire. A committee has been established to study the problem of access to dental care for low-income, uninsured, and underinsured people and to make recommendations to improve access to dental preventive and treatment services. (1997 N.H. Laws, Chap. 48 (HB 255).)

Massachusetts. The state charged a special commission on oral health to identify problems in access to dental care for vulnerable populations and to develop policy solutions. The final report of the special commission is available at the commission's website. (See <http://www.oralhealthcommission.homestead.com/files/Report.doc>.)

Workforce Development

Minority dentists are more likely to practice in minority communities, but represent only a small portion of the dental workforce.⁹⁰ Missouri's Health Access Incentive Fund attempts to address workforce issues. The fund supports loan repayment, liability insurance, and other incentives for dentists who serve persons regardless of their ability to pay. The fund is also used to enhance Medicaid payments to physicians or dentists and to enhance the availability of physician and dental services in shortage areas. (Missouri Ann. Stat. § 191.411. 1; <http://www.ncsl.org/programs/health/oral.htm>.)

Colorado law allows hygienists to bill Medicaid. Maine and Minnesota allow dental hygienists to give primary dental care with supervision. Missouri allows hygienists to perform fluoride treatments, dental sealants, and teeth cleaning. All these laws are recent and have not been evaluated at this time.

Policy Recommendations

1. States can promote water fluoridation. While this is not a direct strategy for reducing racial and ethnic disparities, fluoridation is one of the most effective preventive programs and has proven effective in decreasing cavities for years. (See <http://www.astdd.org/docs/BPAFluoridation.pdf>.)
2. State Medicaid plans can educate minority parents about the importance of oral health, the need for early care to prevent common dental problems, and how to use the dental delivery system. Medicaid can contract with community organizations to create better

cultural fit. Educational programs should be culturally sensitive and given in the language of the various populations. States can help to increase student awareness of oral health and can support creation of mobile school dental clinics.

3. States can experiment with dental-only insurance coverage for those not eligible for Medicaid. The California Children's Dental Health Initiative developed this idea. Children would be covered by governmental dental insurance if they have nongovernmental health insurance but lack dental insurance. Money spent on preventive care saves money over the long term. Children with swollen faces, painful toothaches, and abscessed teeth may end up in emergency rooms. Such an ER visit averages about \$100 for children who may walk out the door with their teeth untouched. Treatments in this setting address infection and pain but not underlying tooth decay.
4. States can also help to improve community health centers and migrant health center dental infrastructure. Incorporating dental services in community health centers increases access to culturally and linguistically competent care. (See <http://www.dentalhealthfoundation.org/topics/children/>.)

Additional Resources

- Dental Health Foundation. Children's dental health resources and materials: <http://www.dentalhealthfoundation.org/topics/children/>.
- National Maternal and Child Oral Health Resource Center: <http://www.mchoralhealth.org/>.
- Center for Health and Healthcare in Schools: <http://www.healthinschools.org/home.asp>.
- Association of State and Territorial Dental Directors: <http://www.astdd.org/>.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number can be found on The Commonwealth Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#323 *The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy* (brochure)

#753 *Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance* (July 2004). Lisa A. Cooper and Neil R. Powe, Johns Hopkins University.

#726 *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals* (May 2004). Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman, Health Research and Educational Trust.

#692 *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race* (December 2003). Lisa A. Cooper, Debra L. Roter, Rachel L. Johnson, Daniel E. Ford, Donald M. Steinwachs, and Neil R. Powe. *Annals of Internal Medicine*, vol. 139, no. 11. In the Literature summary available at http://www.cmwf.org/programs/insurance/cooper_raceconcordant_itl_692.asp.

#690 *Eligibility for Government Insurance if Immigrant Provisions of Welfare Reform Are Repealed* (October 2003). Olveen Carrasquillo, Danielle H. Ferry, Jennifer N. Edwards, and Sherry Glied. *American Journal of Public Health*, vol. 93, no. 10. In the Literature summary available at http://www.cmwf.org/programs/insurance/carrasquillo_immigrantprovisions_itl_690.asp; full article available at <http://www.ajph.org/cgi/reprint/93/10/1680.pdf>.

#682 *Healthcare Workforce Diversity: Developing Physician Leaders* (October 3, 2003). Anne C. Beal, Melinda K. Abrams, and Jolene N. Saul, The Commonwealth Fund. The testimony is available online only at http://www.cmwf.org/programs/minority/beal_sullivancommiss_682.pdf.

#676 *Quality of Care for Children in Commercial and Medicaid Managed Care* (September 17, 2003). Joseph W. Thompson, Kevin W. Ryan, Sathiska D. Pinidiya, and James E. Bost. *Journal of the American Medical Association* (In the Literature summary). This study is the largest comparative analysis of Medicaid and commercial managed care organization performance results to date. The authors demonstrate that Medicaid-insured children enrolled in managed care plans had lower immunization rates and fewer well-child visits than commercially insured children in such plans.

#576 *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (October 2002). Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo. This field report spotlights a diverse group of health care organizations striving to improve access to and quality of care for a growing minority and immigrant population through innovative programs that develop minority leadership, promote community involvement, and increase awareness of the social and cultural factors that affect health beliefs and behaviors.

Quality of Cardiac Surgeons and Managed Care Contracting Practices (October 2002). Dana B. Mukamel, David L. Weimer, Jack Zwanziger, and Alvin I. Mushlin. *Health Services Research*, vol. 37, no. 5. Copies are available from *Health Services Research*, Foundation of the American College

of Healthcare Executives, Publication Services, One North Franklin, Suite 1700, Chicago, IL 60606-3491, Fax: 312-424-0703.

Toward a Systematic Approach to Understanding—and Ultimately Eliminating—African American Women’s Health Disparities (September/October 2002). Carol Hogue. *Women’s Health Issues*, vol. 12, no. 5. Copies are available from the Jacobs Institute of Women’s Health, 409 12th Street, SW, Washington, DC 20024, Tel: 202-863-4990, Fax: 202-488-4229.

Race, Ethnicity, and Disparities in Breast Cancer: Victories and Challenges (September/October 2002). Nina A. Bickell. *Women’s Health Issues*, vol. 12, no. 5. Copies are available from the Jacobs Institute of Women’s Health, 409 12th Street, SW, Washington, DC 20024, Tel: 202-863-4990, Fax: 202-488-4229.

Racial and Ethnic Disparities in Coronary Heart Disease in Women: Prevention, Treatment, and Needed Interventions (September/October 2002). Paula A. Johnson and Rachel S. Fulp. *Women’s Health Issues*, vol. 12, no. 5. Copies are available from the Jacobs Institute of Women’s Health, 409 12th Street, SW, Washington, DC 20024, Tel: 202-863-4990, Fax: 202-488-4229.

Association of Health Literacy with Diabetes Outcomes (July 24–31, 2002). Dean Schillinger et al. *Journal of the American Medical Association*, vol. 288, no. 4. Copies are available from Dean Schillinger, MD, University of California, San Francisco, Primary Care Research Center, Department of Medicine, San Francisco General Hospital, San Francisco, CA 94110, E-mail: dean@itsa.ucsf.edu.

#547 *A Health Plan Report Card on Quality of Care for Minority Populations* (June 2002). David R. Nerenz, Margaret J. Gunter, Magda Garcia, and Robbya R. Green-Weir. In this study, eight health plans participated in a demonstration project designed to determine whether health plans could obtain data on race/ethnicity of their members from a variety of sources and incorporate those data in standard quality of care measure sets, and whether the analyses would show significant racial/ethnic disparities in quality of care within plans, and/or significant differences across plans in quality of care provided to specific groups.

Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care (June 2002). Lisa A. Cooper, Martha N. Hill, and Neil R. Powe. *Journal of General Internal Medicine*, vol. 17, no. 6. Copies are available from Lisa A. Cooper, Welch Center for Prevention, Epidemiology, and Clinical Research, Johns Hopkins University, 2024 East Monument Street, Suite 2-600, Baltimore, MD 21205-2223, E-mail: lisa.cooper@jhmi.edu.

Addressing Racial and Ethnic Barriers to Effective Health Care: The Need for Better Data (May/June 2002). Arlene S. Bierman, Nicole Lurie, Karen Scott Collins, and John M. Eisenberg, *Health Affairs*, vol. 21, no. 3. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#557 *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3 (*In the Literature* summary). The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

#541 *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (May 2002). Mara Youdelman and Jane Perkins, National Health Law Program. This field report profiles a variety of promising programs around the country that provide patients with interpretation services, and also identifies federal, state, local, and private funding sources for such services.

#532 *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care* (March 13, 2002). Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, Harvard School of Public Health/Harvard Medical School. *Journal of the American Medical Association*, vol. 287, no. 10 (*In the Literature* summary). In this article the authors report that among Medicare beneficiaries enrolled in managed care plans, African Americans are less likely than whites to receive follow-up care after a hospitalization for mental illness, eye exams if they are diabetic, beta-blocker medication after a heart attack, and breast cancer screening.

#523 *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (March 2002). Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney. This report, based on the Fund's 2001 Health Care Quality Survey, reveals that on a wide range of health care quality measures—including effective patient-physician communication, overcoming cultural and linguistic barriers, and access to health care and insurance coverage—minority Americans do not fare as well as whites.

#524 *Quality of Health Care for African Americans* (March 2002). Karen Scott Collins, Katie Tenney, and Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of African Americans.

#525 *Quality of Health Care for Asian Americans* (March 2002). Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Asian Americans.

#526 *Quality of Health Care for Hispanic Populations* (March 2002). Michelle M. Doty and Brett L. Ives. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Hispanics.

REFERENCES

- ¹ Hargraves JL, Hadley J. (2003, June). The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. *Health Services Research*. 38(3), pp. 809–829.
- ² Center for Budget and Policy Priorities. (2003). *News release*. Washington, D.C.: Center for Budget and Policy Priorities. Available at <http://www.cbpp.org/12-22-03health-pr.htm>.
- ³ Smedley BD, Stith AY, Nelson AR. (Eds.). (2002). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: Institute of Medicine/National Academies Press. Available at <http://www.nap.edu>.
- ⁴ Center for Budget and Policy Priorities. (2003). *News release*. Washington, D.C.: Center for Budget and Policy Priorities. Available at <http://www.cbpp.org/12-22-03health-pr.htm>.
- ⁵ Atwood K, Colditz G, Kawachi I. (1997). From public health science to prevention policy: placing science in its social and political context. *American Journal of Public Health*. 87(10), pp. 1603–1606.
- ⁶ Heckler M. (1985). *Report of the secretary's task force on black and minority health*. Washington, D.C.: U.S. Department of Health and Human Services.
- ⁷ Smedley BD et al. *Op. cit.*
- ⁸ Agency for Healthcare Research and Quality. (2003). *National healthcare disparities report*. Washington, D.C.: U.S. Department of Health and Human Services. Available at <http://www.ahrq.gov>.
- ⁹ Agency for Healthcare Research and Quality. *Op. cit.* p. 12. Available at <http://www.ahrq.gov>.
- ¹⁰ Kluger R. (1996). *Ashes to Ashes*. New York: Alfred A. Knopf.
- ¹¹ Rosenthal J, Kaye N, Flowers L. (2002). *State Purchasing and Regulation of Health Care Services: A Snapshot of Strategies to Reduce Racial and Ethnic Health Disparities*. Portland, Me.: National Academy for State Health Policy. Available at <http://www.nashp.org>.
- ¹² Youdelman M, Perkins J. (2002). *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*. New York: The Commonwealth Fund.
- ¹³ Association of State and Territorial Health Officers. (2001). *Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health*. Washington, D.C.: Association of State and Territorial Health Officers.
- ¹⁴ Office of Minority Health. (2000). *Assessment of State Minority Health Infrastructure and Capacity to Address Issues of Minority Health*. Available at <http://www.omhrc.gov/omh/sidebar/cossmo/cover.htm>.
- ¹⁵ Ladenheim K, Groman R. (2003). Current state legislative activities related to elimination of health disparities. Washington, D.C.: National Conference of State Legislatures. (Under review.)
- ¹⁶ McDonough J. (2003). State legislators discuss racial and ethnic health disparities. Waltham, Mass.: Heller School, Brandeis University. (Under review.)
- ¹⁷ Stone D. (2003). Reframing the racial disparities issue for state governments. (Under review.)

¹⁸ Gibbs B, Nsiah-Jefferson L, McHugh M, Trivedi A, Prothrow-Stith D. (2003). Reducing racial and ethnic health disparities: an outcome oriented research and policy agenda. Boston, Mass.: Harvard School of Public Health. (Under review.)

¹⁹ Karl Kronebusch, Yale University; Amanda Navarro, University of Texas at Houston; Janet L. Scott-Harris, Heller Graduate School, Brandeis University; and Kimá Taylor, health legislative assistant for U.S. Senator Paul S. Sarbanes (D-Md.).

²⁰ Hargraves JL, Hadley J. (2003). The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. *Health Services Research*. 38(3), pp. 809–829.

²¹ Department of Health and Human Services, Office of Minority Health, National Standards for CLAS; see <http://www.omhrc.gov/clas/>; *Compendium of Cultural Competency Initiatives in Health Care*; see <http://www.kff.org>.

²² Smedley BD et al. *Op. cit.*

²³ *Compendium of Cultural Competency Initiatives in Health Care*; see <http://www.kff.org>.

²⁴ <http://www.cmwf.org/grants>.

²⁵ For information on cultural competence, see <http://www.mgh.harvard.edu/healthpolicy>.

²⁶ COSMOS Corporation. (2000). *Assessment of state minority health infrastructure and capacity to address issues of health disparity*. Developed by COSMOS Corporation under Contract No. 282-98-00127 for the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services. Available at http://www.omhrc.gov/omh/sidebar/cossmo/sec_8_A.htm.

²⁷ Office of Minority Health. (2003). *Assessment of state laws, regulations and practices affecting the collection and reporting of racial and ethnic data by health insurers and managed care plans*. Available at <http://www.omhrc.gov/omh/sidebar/datastats13.htm>.

²⁸ National Health Law Program. *Assessment of state laws, regulations and practices affecting the collection and reporting of racial and ethnic data by health insurers and managed care plans*. Available at <http://www.omhrc.gov/omh/sidebar/datastats13.htm>.

²⁹ <http://www.hhs.gov/ocr/hipaa>.

³⁰ <http://www.health.state.ny.us/nysdoh/omh/faq.htm>.

³¹ <http://www.dhs.ca.gov/home/statistics/>.

³² <http://www.www.state.ma.us/dph/bhsre/resep/resep.htm#raceethnicity>.

³³ <http://www.governor.state.ut.us/dea/publications/race.htm>.

³⁴ <http://www.state.me.us/dhs/bohodr/odrvspge.htm>.

³⁵ Altman D. (2004). The new Medicare prescription-drug legislation. *New England Journal of Medicine*, 350(1), pp. 9–10. Available at <http://www.nejm.org>.

³⁶ Gornick, ME, et al. (1996). Effects of race and income on mortality and use of services among Medicare beneficiaries. *New England Journal of Medicine*, 335(11), pp. 791–799.

³⁷ Schneider, EC, Zaslavsky, AM, Epstein, AM. (2002). Racial disparities in the quality of care for enrollees in Medicare managed care. *Journal of the American Medical Association*, 287(10), pp. 1288–1294.

- ³⁸ Ross DC, Cox L. (2002). *Enrolling children and families in health coverage: the promise of doing more*. Kaiser Commission on Medicaid and the Uninsured. See <http://www.kff.org>.
- ³⁹ Shi L. (1999). Experience of primary care by racial and ethnic groups in the United States. *Medical Care*, 37(10), pp. 1068–1077.
- ⁴⁰ Hargraves JL, Cunningham PJ, Hughes R.G. (2001). Racial and ethnic differences in access to medical care in managed care plans. *Health Services Research*, 36(5), pp. 853–868.
- ⁴¹ Forrest CB, Whelan EM. (2000). Primary care safety-net delivery sites in the United States: a comparison of community health centers, hospital outpatient departments, and physicians' offices. *Journal of the American Medical Association*, 25(16), pp. 2077–2083. Available at <http://www.jama.com>.
- ⁴² Gaufin, J. (2003). Personal communication. California Endowment, 2003.
- ⁴³ National Conference of State Legislatures. See <http://www.ncsl.org/programs/health/disparity.htm>.
- ⁴⁴ COSMOS Corporation. (2000). *Assessment of state minority health infrastructure and capacity to address issues of health disparity*. Developed by COSMOS Corporation under Contract No. 282-98-00127 for the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services. Available at http://www.omhrc.gov/omh/sidebar/cossmo/sec_7_nature.htm#2.
- ⁴⁵ *Closing the Gap*. January/February 2003. Available at <http://www.omhrc.gov/OMH/sidebar/archivedctg.htm>.
- ⁴⁶ <http://www.amsa.org/div/>.
- ⁴⁷ http://www.futurehealth.ucsf.edu/press_releases/dentistshortage.html.
- ⁴⁸ Smedley et al. *Op cit*.
- ⁴⁹ Minn. Stat. § 137.42. Available at <http://www.revisor.leg.state.mn.us/stats/137/42.html>.
- ⁵⁰ *Closing the Gap*. January/February 2003. Available at <http://www.omhrc.gov/OMH/sidebar/archivedctg.htm>.
- ⁵¹ <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm>. Note: Data for health care use outcomes is not available for Hispanic ethnicity. Data for white and black race for these outcomes include persons of Hispanic ethnicity.
- ⁵² <http://www.aspe.hhs.gov/sp/asthma/>.
- ⁵³ Port, JL, Kent M, Altorki, NK. (2002). Early lung cancer detection and treatment strategies. *Surgical Oncology*. 11(4), pp. 191–199.
- ⁵⁴ National Conference of State Legislatures. (2003). *Chronic disease prevention: heart disease and stroke*. Available at <http://www.ncsl.org/programs/health/hrtdis.htm>.
- ⁵⁵ <http://www.raceandhealth.hhs.gov/3rdpgBlue/Cardio/3pgGoalsCardio.htm>.
- ⁵⁶ <http://www.ndep.nih.gov/>.
- ⁵⁷ http://www.cdc.gov/nccdphp/aag/aag_ddt.htm.
- ⁵⁸ <http://www.cdc.gov/diabetes/states/ny.htm>.
- ⁵⁹ North Carolina Department of Health and Human Services: <http://www.ncdiabetes.org>.

- ⁶⁰ National Conference of State Legislatures. (2003). *Diabetes*. Available at <http://www.ncsl.org/programs/health/diabetes.htm>.
- ⁶¹ Montana Department of Public Health and Human Services: <http://www.dphhs.state.mt.us/>.
- ⁶² Wisconsin Department of Health and Family Services: <http://www.dhfs.state.wi.us/>.
- ⁶³ CDC's state-based diabetes prevention and control programs: <http://www.cdc.gov/diabetes/states/index.htm>.
- ⁶⁴ CDC. (2001). *HIV/AIDS Surveillance Report*. 13(2). Available at <http://www.cdc.gov/hiv/stats/haslink.htm>.
- ⁶⁵ CDC. (2001). *HIV/AIDS Surveillance Report*. 13(2). Available at <http://www.cdc.gov/hiv/stats/haslink.htm>.
- ⁶⁶ Satcher D. (2000). *Evidence-based findings on the efficacy of syringe exchange programs: an analysis of the scientific research completed since April 1998*. Washington, D.C.: U.S. Department of Health and Human Services. Available at <http://www.dogwoodcenter.org/references/Satcher00.html>.
- [†] 4:3:1:3:3 series comprises ≥ 4 doses of diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diphtheria and tetanus toxoids and acellular pertussis vaccine; ≥ 3 doses of poliovirus vaccine; ≥ 1 dose of measles-containing vaccine; ≥ 3 doses of *Haemophilus influenzae* type b vaccine; and ≥ 3 doses of HepB vaccine.
- ⁶⁷ Centers for Disease Control and Prevention. (2002). National, state, and urban area vaccination coverage levels among children ages 19–35 months—United States, 2001. *Morbidity and Mortality Weekly Report*, 51(30), pp. 664–666. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5130a2.htm>.
- ⁶⁸ National Foundation for Infectious Diseases. (2002). *A report on reaching underserved ethnic and minority populations to improve adolescent and adult immunization rates*. Available at <http://www.nfid.org/publications>.
- ⁶⁹ U.S. Department of Health and Human Services. (2002). <http://www.omhrc.gov/rah/indexnew.htm>.
- ⁷⁰ Centers for Disease Control and Prevention. (2003). *January-September 2002: National health interview survey*. Available at <http://www.cdc.gov/nchs/about/major/nhis/released200303.htm#4>.
- ⁷¹ Rhode Island Department of Human Services. (2002). *Impact of RIticare on adequacy of prenatal care in the health of newborns: 2002 update*. Available at <http://www.dhs.state.ri.us/dhs/reports/drcimpac00.htm>.
- ⁷² Johnson K. (2001). *No place like home: state home visiting policies and programs*. (Available at http://www.cmfwf.org/publications/publications_show.htm?doc_id=221347.)
- ⁷³ National Institute of Child Health and Development. *Health Information and Media: Back to sleep*. See <http://www.nichd.nih.gov>.
- ⁷⁴ American College of Obstetricians and Gynecologists. National Fetal and Infant Mortality Review Program. *NFIMR Models; SIDS Risk Reduction*. See http://www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=145.
- ⁷⁵ Exemplary State Programs. Healthy Mothers Healthy Babies: http://www.cdc.gov/nccdphp/exemplary/healthy_mothers.htm#wv.

- ⁷⁶ National Center for Injury Prevention and Control. (2001). *Injury Fact Book 2001-2002*. Atlanta, Georgia: Centers for Disease Control and Prevention. Available at http://www.cdc.gov/ncipc/fact_book/factbook.htm.
- ⁷⁷ Olds D et al. (1998). Prenatal and infancy home visitation by nurses: long-term effects of nurse home visitation on children's criminal and antisocial behavior. *Journal of the American Medical Association*, 280(14), pp. 1238–1244. Available at <http://www.jama.com>.
- ⁷⁸ Mallonee S et al. (1996). Surveillance and prevention of residential-fire injuries. *New England Journal of Medicine*, 335(1), pp. 27–31. Available at <http://www.nejm.org>.
- ⁷⁹ <http://www.cdc.gov/mmwr/PDF/rr/rr5022.pdf>. See also *Morbidity and Mortality Weekly* 2001:50(RR-22): pp. 1–46.
- ⁸⁰ Harborview Injury Prevention and Resource Center. Available at <http://depts.washington.edu/hiprc/>.
- ⁸¹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Water Related Injuries*. Available at <http://www.cdc.gov>.
- ⁸² Durkin MS, Laraque D, Lubman I, Barlow B. (1999). Epidemiology and prevention of traffic injuries to urban children and adolescents. *Pediatrics*, 103(6), p. e74.
- ⁸³ U.S. Surgeon General. (2001). *Mental health: culture, race, ethnicity*. Supplement to *Mental health: a report of the Surgeon General* (1999). Available at <http://www.surgeongeneral.gov/library/mentalhealth/cre>.
- ⁸⁴ http://www.cdc.gov/nccdphp/dnpa/obesity/trend/prev_char.htm.
- ⁸⁵ <http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm>.
- ⁸⁶ <http://www.cdc.gov/nchs/nhis.htm>.
- ⁸⁷ Adesanya RM, Drury TF. *Black/white disparities in oral health status of American adults*. Bethesda, Md.: National Institute of Dental and Craniofacial Research/NIH. Available at <http://www.nidr.nih.gov/research/healthDisp/disp-race.pdf>.
- ⁸⁸ National Center for Cultural Competence; Disparities in Oral Health: <http://gucchd.georgetown.edu/nccc/topic3.html>.
- ⁸⁹ Available at <http://www.smileabcd.org>.
- ⁹⁰ http://www.futurehealth.ucsf.edu/press_releases/dentistshortage.html.