

Discovering the Full Spectrum of Cardiovascular Disease Minority Health Summit 2003 Report of the Advocacy Writing Group

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The US population is exceptionally rich in cultural diversity, and that diversity is increasing rapidly. Nearly 33% of the US population self-identifies as a member of a racial or an ethnic minority.¹ Trends in US Census data for the past 30 years point to the continual increase in the number of diverse groups. Roughly 1 million immigrants enter the United States each year; by 2000, there were >32 million immigrants. Some regions are extraordinarily diverse: For example, in Los Angeles County, Calif, 140 nationalities have been documented.² In terms of future population trends, Latinos, Asians, and their subgroups will at least double, if not triple, in population size by the year 2050.² Likewise, people of predominantly African descent and Native Americans will show marginal increases in population size. The number of individuals who claim membership in at least 2 ethnic groups will increase 10% by 2050, and racial/ethnic minorities will constitute >50% of the US population.²

The aging of the “baby boom” population segment of the United States, which is defined as people born between 1946 and 1964, will create increasing numbers of cases of cardiovascular diseases (CVD) and escalating demand for screening and treatment services. A broad (eg, World Health Organization) definition of health as physical, mental, and social well-being must guide advocacy efforts to define policy and programmatic strategies to eliminate racial/ethnic disparities in CVD because healthcare practices and policies do not sufficiently address racial/ethnic disparities in health status.³ In fact, most of the determinants of health status fall outside the healthcare sector.^{3a} This point is graphically demonstrated in the framework for a comprehensive public health strategy

presented in *A Public Health Action Plan to Prevent Heart Disease and Stroke*, released in April 2003.^{3b}

The purpose of this article is to set an advocacy and action agenda for research and service efforts with regard to disparities in CVD. In endeavoring to systematically explore and delineate these efforts, the authors use 3 categories of prevention: primary, secondary, and tertiary.⁴ It should be recognized, however, that these efforts extend well beyond the clinical encounter to embrace a variety of regulatory, policy, and practice changes in sectors outside health care and even health services. Primary prevention strategies are those that ameliorate the root causes of disease before its development, those that are mainly population based. Secondary prevention aims at detecting disease or disease precursors early, when intervention is most effective. Tertiary prevention involves aggressive treatment and rehabilitation strategies, which halt or slow disease progression, restore function, and limit disability. The categories are used only as a way of organizing a fairly complex body of material and are to some extent not mutually exclusive and overlapping.

A number of overarching issues or needs may be identified that cut across these prevention categories and that must be addressed in concert with categorically specific approaches to eliminate disparities:

1. Recognizing and embracing cultural diversity, both within and between racial/ethnic groups
2. Ensuring cultural competence and language access in communications at every level, through health researcher/administrator/care provider training

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3. Facilitating multisectoral partnering and related investment and community-development strategies to increase community capacity for health promotion and healthcare service delivery
4. Directing attention to the obesity and diabetes epidemics as contributing disproportionately to current and future increases in CVD disparities, while retaining a core focus on significant causes of preventable mortality, such as tobacco use
5. Expanding data collection and surveillance to ensure access to important quantitative and qualitative information about a broad range of racial/ethnic communities to identify and develop tailored intervention strategies for areas of high disease risk and burden, including disaggregating data on these communities to better understand and address intra-ethnic variations
6. Clarifying and highlighting the federal governmental role in addressing disparities
7. Mounting efforts to build trust between health professionals and underserved communities
8. Recognizing and investigating the link between stress and CVD risk behaviors and disease outcomes

Overarching Needs

Recognizing and Embracing Cultural Diversity

“Minority” communities are not monolithic. Geography is one lens through which the diversity within racial/ethnic groups may be viewed. The Chinese community in New York City, for example, is different from that in San Francisco. Native American people are distributed among >500 tribes across the nation, with ≈200 in Alaska alone. Geography and national origin collectively demonstrate that although a national community of Latinos exists on some level, variations may be seen between the cultures of Mexican Americans in Arizona and New Mexico, Cubans in Miami, Puerto Ricans in New York City, and Dominicans in New York City. Socioeconomic status provides another lens through which diversity may be scrutinized both within and across groups. Although socioeconomic clustering of members of a given racial/ethnic group exists, substantive socioeconomic variations may be observed among various subgroups. For example, the overall poverty rate in 1990 was 14% for Asians but 25% for Vietnamese, 43% for Cambodians, 64% for Hmong, and 35% for Laotians.⁵

A multicultural approach in which cultural differences between and within racial/ethnic groups are recognized, valued, respected, and accommodated has recently become a widely embraced value within the fields of medicine and public health; however, it is extremely challenging to develop and cultivate multiculturalism in practice.^{5a-5d} In general, individuals are categorized or placed within one specific culture that may contribute ethnocentric attitudes and values. Ethnocentrism tends to elevate one group’s way of doing things as the optimal or solitary yardstick by which other perspectives are judged. In the mainstream of medicine and public health, ethnocentrism usually is manifested in Eurocentrism, in which the perspectives of the dominant or majority group, whites of European descent, define the standard. Ethnocentrism can impede the progress of medical and public health efforts because the “one size fits all” model

may exclude others from appropriate and available services, programs, and policies.^{3a}

Ensuring Cultural Competence and Language Access

Ensuring linguistic competence is vital to the provision of good health care. One study found that even when they are insured, Spanish-speaking Latino populations find it more difficult to obtain access to health care. For example, 20% of Spanish-speaking and 16% of English-speaking Latinos had not visited a doctor in the previous 2 years, as compared with <10% of non-Latino whites and blacks.⁵ Moreover, Latinos lacking English-language proficiency face significant barriers to care, especially if they are uninsured. Two thirds (66%) of uninsured Spanish-speaking Latinos did not have a regular doctor, as compared with 37% of uninsured whites and 44% of uninsured blacks.⁶ Nearly half (45%) of the Spanish-speaking Latino population without insurance reported problems in communicating with their doctors, as compared with fewer than one third of uninsured whites (28%) and blacks (30%).⁶ This problem is greatly magnified in Asian and other populations with great diversity in language.^{5b}

Reading/writing literacy and health literacy are related challenges across racial/ethnic minority populations, given their lower levels of formal education on average, particularly in printed materials. Thus, priority needs to be given to providing health education/promotion messages and other communications that are, to the extent feasible, not only authoritative but also user friendly and culturally relevant.⁷

Beyond language access in medical settings, diversity in representation and inclusiveness are central to engaging and involving racial/ethnic minority populations.^{3a} Diversity in representation ensures that staff and membership on decision-making committees are representative of the community. Diversity ensures the presence of racial/ethnic minority populations; people of different economic strata, religious affiliations, sexes, and gender preferences; and special interest groups that may be affected by the decisions being made. Diversity in this context is a representative construct that reinforces heterogeneity and the principles associated with equal access to care.

Diversity in representation should be wedded to the corollary construct of inclusiveness. Inclusiveness encompasses involvement in planning and decision-making processes. Representation gets people to the table, but it does not in and of itself ensure high-quality involvement in the process. Transparency, community involvement from the onset of the endeavor, and shared resources and involvement in decision making are features of inclusive processes. Despite the inefficiency and lengthiness of these processes, inclusivity is a foundation for a truly ethical process and helps ensure collective responsibility and ownership of the established objectives, goals, and strategies for achieving them.^{3a}

Cultural competence refers to the appropriate tailoring of the content of research and service applications and encompasses a range of materials and activities, including research questionnaires or protocols, health education materials such as public service announcements or patient education brochures, and outreach and promotional strategies, programs,

and policies.^{7a} In essence, cultural competence ensures that an activity is responsive to a particular population and will more likely be efficacious when matters of competency are addressed.^{3a} Culture expresses the values and attitudes of a community and helps shape behavior. For example, values that shape gender roles dramatically influence how change can occur in family settings. Cultural context expresses the day-to-day realities that a community confronts (eg, high rates of unemployment, unsafe neighborhoods, substandard educational institutions). Achievement of cultural competence is nevertheless problematic because of the absence of a thorough treatment of the concept in the literature. A recent comprehensive review of cultural competence concluded that no one has yet developed a core comprehensive approach to thinking about and implementing cultural competence in health care at multiple levels and from multiple perspectives.⁸

Facilitating Multisectoral Partnering to Increase Community Capacity

An emphasis on community capacity building may provide unique means by which to promote health, healthcare access and quality, and environmental change to encourage healthier lifestyle practices. Voluntary nonprofit organizations need to define ways in which they can collaborate, especially with existing regional and national organizations that target and serve communities of color (eg, churches, community health centers, immigrant services organizations, social services agencies). In spite of the scarcity of “evidence-based” information related to communities of color, immediate community intervention is necessary. The use of qualitative research in doing so will generate much-needed in-depth information on how to change community attitudes, environments, and practices, and will facilitate the conduct of relatively low-cost research at a time when the emphasis on cost constraint is considerable.⁹

The specific danger with regard to comprehensive collaborative initiatives based on “best practices” is the relative absence of an evidence base for communities of color¹⁰ and the inattention given to serious efforts related to disparities. Indeed, a dilemma of the public health field, particularly in regard to the issue of disparities, is its traditional focus on the individual.^{10,11} Partnerships will necessarily have to confront the challenge of addressing population health despite the inherent associated complexity and challenge.

Community-building and development initiatives engaging and supporting grassroots community-based organizations on issues of neighborhood revitalization, housing quality, environmental justice, full employment, crime reduction, and public education and recreation infrastructure rebuilding and maintenance are critical to a disparities agenda that seeks long-term solutions.

Directing Attention to the Obesity and Diabetes Epidemics

Although nearly all other Healthy People 2010 indicators are moving in healthful directions (narrowing disparities), obesity and diabetes rates are accelerating in an unhealthy direction (with widening disparities).¹² Obesity has reached epidemic proportions, with nearly 2 in 3 US adults now

classified as overweight.^{13–16} The economic costs of obesity and sedentariness are considerable and are estimated to approach those of tobacco at \$117 billion annually.^{17–21} The projected societal health, productivity, and economic toll of the obesity epidemic, in the context of the aging and increasing ethnic diversification of the US population, have made addressing the epidemic a national priority.^{22–24} Racial/ethnic minority populations have higher levels of overweight and obesity and have experienced greater increases during the past decade than have white populations.^{9,10} For example, among women 40 to 59 years old, 79% of Mexican Americans and 82% of black Americans are overweight as compared with 61% of whites.¹³ These statistics on prevalence of overweight are implicated in substantive racial/ethnic disparities in chronic disease morbidity and mortality^{12,13,25} and are rooted in less healthy physical activity and eating patterns.^{27,30}

The burgeoning obesity and diabetes epidemics offer an unprecedented opportunity to develop a multilevel, multisectoral framework for change to address the increasingly “obesogenic” US environment.^{28,29} A public–private sector base of support must be built around such a framework to advance the sort of aggressive public policy that is necessary for success, with similarities to and differences from that mounted for tobacco control.^{26,27}

Expanding Data Collection and Surveillance

Data collection and analyses for surveillance and monitoring are core functions of governmental public health practice; however, methodological limitations must be confronted in matters related to disparities. The public health infrastructure has the capability of monitoring aggregate racial/ethnic groups, particularly with regard to the categories defined by the US Census Bureau.³¹ The problem is that disparities often are not visible at the aggregate level of an entire racial/ethnic community. For example, although the smoking prevalence for Latinos (23%) is below that of whites (27%), the rate for Puerto Ricans is 30%.²⁶ It is critical that surveillance and monitoring protocols be in place to allow for tracking small populations. If the protocols are not in place, then these communities will not be defined as having a problem and resources will not be targeted toward the development of appropriate interventions. This issue is particularly germane to Asian American/Pacific Islander, Latino American, and Native American populations, but it is not irrelevant for blacks, including US-born, slave-descendant, and African and Afro-Caribbean populations. For example, government should invest in expanded surveillance to provide risk behavior and disease prevalence estimates for smaller geographic areas (eg, ZIP codes or census tracts).^{32a} These sources of evaluation data extrinsic to a particular project that capture secular trends and presumably intervention effects would decrease the burden of intervention research participation on community-based organizations and local health departments, allowing them to focus on the service missions that motivate their involvement.³³

Surveillance and monitoring protocols do not provide for a comprehensive assessment of qualitative data. Indeed, qualitative indicators remain poorly defined; however, effective

programs and services depend on the ability to measure and evaluate and then integrate an understanding of these indicators into intervention-development efforts. The ability to measure an array of indicators, both qualitative and quantitative, for a multiplicity of racial/ethnic communities is central to the elimination of disparities in health.

Clarifying and Highlighting the Federal Governmental Role in Addressing Disparities

The National Institutes of Health and the Centers for Disease Control and Prevention are charged by the US Congress with addressing the underrepresentation of minorities in research at every level. Racial/ethnic minority communities derive fewer benefits from government and private research investment and advances in various ways. This challenge can be confronted by such approaches as cultivating “cultural insider” researchers, who may better inform hypothesis development and interpretation of results, culturally grounding intervention approaches,³⁴ and recruiting and retaining study subjects from historically understudied groups; ensuring participation by racial/ethnic minorities in all funded prevention and treatment trials in sufficient numbers to permit ethnic-specific analyses; and dedicating funding for research projects that target understudied and underserved populations that are experiencing excess disease risk or burden. Examples of desirable models include the National Cancer Institute’s Minority Training Program in Cancer Control Research³⁵; partnership grants between major research institutions and minority-serving institutions; the Centers for Disease Control and Prevention’s Racial and Ethnic Approaches to Community Health (REACH) program; the National Institute of Neurological Disorders and Stroke’s Specialized Neuroscience Research Programs at Minority Institutions; the National Heart, Lung, and Blood Institute’s ethnically targeted diabetes and heart disease intervention trials; and the National Institute of Neurological Disorders and Stroke’s Stroke Prevention/Intervention Research Program.

Mounting Efforts to Build Trust Between Health Professionals and Underserved Communities

Efforts must be mounted to build and rebuild trust with members of underserved and understudied communities—between providers and patients, between researchers and prospective study participants, and between scientific experts and the public they inform and serve. Inclusiveness in the process of intervening, as described previously, is an important step toward accomplishing this goal; however, an equally critical aspect of this rebuilding effort must examine and expose the link between noncompliance with medical recommendations and mistrust resulting from experiences of bias and discrimination.³⁶ In addition, the historical exploitation of underserved communities by researchers for scientific advancement at the expense of research “subjects” (eg, the Tuskegee Syphilis Study) is a part of the folklore in these communities.^{37,38} These issues must be regularly addressed from the outset of collaborative ventures, with sharp distinctions drawn between past and proposed efforts (eg, explicit articulation of the mutual benefits of participation).³⁹ Community-based participatory research models⁴⁰ are evol-

ing that recognize the necessity of community direction and partnerships in public health intervention for long-term effectiveness.

Recognizing and Investigating the Link Between Stress and CVD Risk Behaviors and Disease Outcomes

The link between stress and CVD risk behaviors and disease outcomes must be recognized and investigated. Although a certain amount of stress is inherent in the human condition and compatible with optimal human functioning (ie, eustress), experiences of discrimination, institutionalized racism and oppression, interpersonal violence, and socioeconomic marginalization create distress that compromises human development and self-actualization.⁴¹ Distress is associated with depression and anxiety disorders, as well as subclinical fatigue, frustration, poor concentration, impatience, and unwillingness to delay gratification, conditions that interfere with intimacy, supportive social and professional relationships, and childrearing. In addition, racial/ethnic minority individuals are disproportionately likely to be impoverished, undereducated, and unemployed/underemployed, which creates challenges to meeting basic survival needs that influence values and produce competing priorities.⁴² Both distress and economic disadvantage adversely affect engagement in preventive behaviors (eg, tobacco avoidance, optimal nutrition, regular physical activity), disease-screening behaviors, and appropriate treatment seeking and compliance.^{42a}

The overarching issues described broadly and conceptually above capture the inequities that produce racial/ethnic disparities in CVD risk and burden and potential solutions. More detailed and content-specific strategies for addressing these disparities follow. These strategies are encompassed in 3 sections based on their broad focus on primary, secondary, or tertiary prevention.

Primary Prevention Strategies

Shifting Focus of Intervention to Include Organizational Practice and Legislative Policy Change: The Case for Obesity Prevention and Control

The culturally competent education of individuals and families is certainly a foundation of primary prevention; however, relatively little sustainable weight-related lifestyle change has been produced by individually targeted interventions,^{43–47} even among comparatively affluent and highly motivated volunteer samples. This failure has been largely attributed to a pervasive postmodern environment that promotes sedentaryness and excessive food consumption, particularly of the highly palatable but nutrient-poor variety.^{48,49}

Societal structures, eg, schools, workplaces, worship venues, must share with individuals and families in the high cost of adopting and maintaining a fit lifestyle in the “obesogenic” or obesity-producing^{28,48} environment in the United States. Against the backdrop of limited resources and substantial environmental barriers to healthy eating and active living, intervention strategies must work within existing societal structures to cultivate leadership for and modeling of change.

The following are priorities in shifting the intervention focus to create the structural changes necessary to promote healthy eating and active living in smoke-free environments:

- Encourage the implementation and evaluation of healthy/fit organizational practice guidelines (eg, exercise breaks in meetings and at certain times of the day, prompts to use stairs rather than elevators, walking meetings, healthy food choices when refreshments are served and in vending machines and cafeterias), including as requirements by funding agencies as a condition of grant approval or renewal, to complement current mandates to maintain smoke-free workplaces.^{49,49a}
- Raise awareness of the need for 1 hour each day of high-quality physical education in schools (kindergarten through 12th grade), to include at least 30 minutes of moderate-to-vigorous physical activity, as a legislative priority.⁵⁰
- Promote ways to encourage, regulate, or provide incentives to the food and entertainment industries to recognize their contribution to the obesity epidemic (via advertising, marketing, and promotion of highly palatable, energy-dense but nutrient-poor foods and of sedentary pursuits such as watching television and playing video games to children) and the necessity of their involvement in addressing the epidemic through competitive pricing, aggressive marketing and advertising, and widespread distribution of healthy foods/products.^{51–54}
- Treat access to healthy food and physical activity/recreational opportunities as a public access issue by working to influence local and state governments to create building codes that make climbing stairs as opposed to riding elevators more appealing and accessible; to institute land use/urban planning to integrate green and open spaces, public gardens, and sidewalks/crosswalks; and to initiate conditional-use business permits to balance the distribution of fast food and liquor store outlets with supermarkets and farmers' markets.^{55,56}

Building on Regional Successes While Recognizing “Pockets of Need”: The Case for Tobacco Control

Tobacco control represents one of the major public health successes of the past 2 decades, the result of a progression of efforts from individual-level cessation and uptake-prevention education and counseling to structural changes in product taxation and advertising, local outlet product access and promotion, and restriction of smoking in public facilities. Consistent declines in tobacco consumption and tobacco-related disease burden are evident in states at the forefront of adopting these strategies.^{57,57a} Continued prioritization of tobacco use prevention and cessation efforts is needed, which entails critical review of lessons learned and creative use of opportunities to integrate public health-intervention applications across multiple risk behaviors.⁵⁸

The “pockets of need” for tobacco control services that exist against the backdrop of successful tobacco control efforts overall must be addressed. The most recent available data on tobacco use prevalence for youth and adults indicate that with the notable exception of Native Americans, progress

in reduction continues, but disparities exist across racial/ethnic groups.³² For example, black youth 12 to 17 years old have a smoking prevalence of 7% as compared with 16% for whites and 28% for Native Americans.³² Among adults, prevalence rates in blacks are similar to those in whites (26% versus 27%), but Native Americans have the highest prevalence of any group at 40%.³² The importance of disaggregation of data is affirmed by ethnic differences among Asian Americans/Pacific Islanders. For example, Asian Americans have an overall prevalence of 16%, but Korean Americans and Vietnamese Americans have rates of 27% and 26%,³² respectively. Additional disparities related to socioeconomic status, sexual orientation, and gender persist.^{58a–58c} Improvements in prevalence rates among blacks resulted directly from the national dissemination of culturally tailored materials and successful advocacy efforts against targeted tobacco industry marketing campaigns, which exposed industry manipulation and exploitation.⁵⁹ Research and community development funding should be directed toward addressing ongoing surveillance data gaps, low levels of capacity and infrastructure for grassroots advocacy and advancement of changes in social norms, and underdeveloped interventions or those that lack credible evaluation data.

Secondary Prevention Strategies

Establishing Systems to Monitor Delivery of Health Care to Ensure Access

Access to high-quality health care, particularly in addressing uninsured/underinsured immigrant populations, is critical to any disparities agenda. The “2-tiered medical care system” affects low-income and racial/ethnic minority populations disproportionately. For example, 70% of Latino and 54% of black non-US citizens are uninsured as compared with 30% of white non-US citizens. These racial disparities in access to health insurance have a profound impact on patients' ability to gain access to care. For example, one study found that only 37% of non-US citizen low-income Latinos had seen a physician in the previous year as opposed to 67% of low-income white US-born citizens.¹ Screening and early detection services are particularly compromised by lack of access given the reliance on emergency departments for primary nonemergency care.³⁶

As a result of the 1996 federal welfare reform legislation, low-income immigrants face far greater barriers to gaining access to publicly funded health insurance than do their US-citizen counterparts.⁶⁰ Before 1996, legal immigrants were able to access Medicaid. After 1996, federal reimbursement for Medicaid was radically restricted, and only a few states have made efforts to fill in these federal gaps.⁶⁰ Even in states where it is permissible for immigrants to access care, many immigrants avoid healthcare settings, citing concerns (in many cases misplaced) about compromising their immigration status or being reported to immigration authorities.¹

Expanding Efforts to Build on Screening Infrastructure of Other Diseases

As discussed previously, the cultivation of effective collaborations at the national, state, and community levels involving service organizations; federal and state agencies; and

community-based, faith-based, and nontraditional minority-led organizations is an essential and vital aspect of the development of effective CVD policy and prevention activities, particularly in underserved communities. For maximal efficacy and impact, additional collaborative development efforts must engage other healthcare and prevention partners that are actively involved in education, detection, and intervention related to other disease prevention and control efforts, such as obesity, cancer, physical activity, and tobacco initiatives, at the national, state, and community levels. These activities often have a significant infrastructure and support network with community- and clinical-level expertise and support. The integration of CVD activities into these networks in a mutually beneficial collaboration offers a unique opportunity for sharing resources (eg, the Centers for Disease Control and Prevention–funded WISEWOMAN projects).⁶¹ Collaborations with service organizations, both those focused on health care and churches and other faith-based entities, offer potential for expanded outreach in underserved communities in addition to their widely recognized roles in these efforts.

Evaluating Systematic Approaches for Intervening in High-Risk Populations

A perennial challenge to screening efforts is the lack of dissemination funding for programs with demonstrated efficacy. Several research projects are under way to further develop and refine effective secondary prevention strategies in faith-based organizations (eg, Project DIRECT).⁶²

Tertiary Prevention/Treatment Strategies

Many of the aforementioned strategies pertain to treatment and tertiary prevention issues. The Institute of Medicine's (IOM) 2002 landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*³⁶ provides a framework for addressing the challenge of gradually eliminating these well-documented disparities. The findings of the IOM should constitute a "wake-up call" for leaders in health care and policy makers nationally and are aptly summarized in the following statement from their report: Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services . . . [s]tudies of racial and ethnic differences in cardiovascular care provide some of the most convincing evidence of healthcare disparities.

Given the findings and recommendations of the IOM report, it is clear that a national strategy to eliminate racial/ethnic disparities in healthcare and treatment settings comprises "the 4 Ps" as areas of focus: health plans (and health systems), health provider awareness, monitoring progress, and public policy advocacy. A summary of the key action steps to mobilize an agenda to address disparities in treatment follows.

Health Plans and Health Systems

Although it is certainly appropriate to view the matter of racial/ethnic disparities in treatment through the lens of civil rights and social justice, the most immediate and sustainable traction is gained by confronting the challenge of disparities

as a quality-of-care issue. It is in this vein that indicators, milestones, and performance standards of progress are defined, tracked, and evaluated by health plans and health systems.^{32a} The IOM's *Crossing the Quality Chasm: A New Health System for the 21st Century*⁶³ underscores the need to strengthen the consistency and quality of care through evidence-based guidelines. As the evidence that culturally competent health care exerts beneficial effects on patient satisfaction and adherence to treatment regimens and reduces costs continues to build, cultural competence will emerge as a core component of quality-improvement efforts. Moreover, the combination of burgeoning healthcare consumer and payer demand for the increased transparency of and accessibility to reliable published information about quality of care in the United States and the skyrocketing healthcare costs faced by the business community and its employees provides fertile ground for confronting disparities in care within health plans and health systems.

In addition to a strengthened emphasis on evidence-based care, health plans and health systems should engage in the following activities:

- Support the use of interpretation services for limited-English-proficiency patients. The demographic reality of racial/ethnic diversity in the United States suggests that health plans and health systems should explore and establish sensible, effective interpretation services that are not cost-prohibitive. Moreover, health plans and systems can educate and remind providers that barriers to interpretation services in the healthcare setting constitute discriminatory practices under Title VI of the 1964 Civil Rights Act.
- Examine the feasibility and fiscal implications of easing immigrant restrictions on access to government health insurance and healthcare programs.
- Expand the use of trained community health outreach workers (also known as "promotoras" and "promotores") to improve care coordination and adherence to treatment regimens in, for example, people with diabetes, asthma, HIV, and heart disease. Patient outcomes can be improved and costly hospitalizations and visits to emergency departments can be avoided in this way.⁶⁴ Health plans and provider systems in some parts of the United States have recently begun to use promotoras and promotores.
- Structure payment systems to provide incentives to entities and organizations to institute practices that reduce disparities in care and treatment. For example, reimbursement systems can be adjusted to promote limb salvage as opposed to lower-extremity amputation. An additional and compelling example emerges from the decreased likelihood of cardiac catheterization, angioplasty, and other invasive cardiac procedures among black patients as compared with the higher levels observed in white patients who present similarly.^{36,65}
- Strengthen data collection efforts (see Monitoring Progress and Data Collection below).

Provider Awareness and Action

One of the major recommendations of the IOM is to improve providers' awareness of the reality of disparate health care for

racial/ethnic minorities. The findings, although clearly supported by the evidence, are likely to elicit varying levels of acknowledgment of the problem by health professionals; the IOM forthrightly raised the possibility of bias, prejudice, or stereotyping (or all 3) by providers,³⁶ concluding that additional research was needed to ascertain the root causes of differences in the quality of care provided. Recognizing that few physicians would characterize themselves as racist or biased, the IOM posited that this matter can be confronted only through honest and candid dialogue about the findings, and that health professionals and their associations must be challenged to implement and support structured dialogues that will result in improved awareness of the problem, thoughtful approaches to address it, and ongoing efforts to monitor progress.³⁶

More specifically, health professionals and other care providers can do the following:

- Insist on and support the efforts of institutions of higher learning such as medical, dental, and nursing schools to improve the numbers of underrepresented minorities among health professionals and integrate multicultural education into their training.
- Influence various professional associations to adopt and implement educational and open-dialogue campaigns about the problem of racial/ethnic disparities in health care among their membership. Such discussions should be incorporated into the physician and nursing continuing medical education courses/seminars routinely developed and sponsored by these associations.
- Request that quality-of-care accreditation entities, such as the Joint Commission on Accreditation of Healthcare Organizations, incorporate provider and institutional awareness of disparities in care as performance criteria for institutional reviews.
- Challenge, catalyze, and support the efforts of their own provider institutions or organizations (hospitals, universities, clinics, physician groups) to develop a plan or response to the findings of the *Unequal Treatment* report. Such responses may include the invitation to grand rounds of guest speakers on the issue of disparities, structured and facilitated dialogues about race and racism in health care, or the assemblage of an institutional health-provider task force to develop strategies for action in the clinical care setting.
- Educate elected officials and policy makers at the local, state, and national levels about racial/ethnic disparities in health care and encourage them to address these issues legislatively.

Monitoring Progress and Data Collection

It is critically important that the collection of patient and provider race and ethnicity data be strengthened to glean a better understanding of the factors associated with racial/ethnic disparities in health care. These data collection efforts must be undertaken in a manner that accounts for “the need to protect patient privacy, the costs of data collection, and resistance from healthcare providers, institutions, plans, and patients.”³⁶ Nevertheless, the development and implementa-

tion of data collection strategies organized by race, ethnicity, and (when possible) primary language, the inclusion of racial/ethnic disparities in performance measurement, and the monitoring of progress in the elimination of disparities in health care are critical to achieving improved care.

These data collection efforts, with an emphasis on subpopulation-group data collection, form the foundation of the research that will provide an improved understanding of disparities in health care. Because of the significant numbers of patients and clinical encounters handled by large private-sector health plans, they can play a pivotal role in collecting and organizing data that may lead to the development and implementation of practical solutions in the clinical care setting. Federal and state governments can play a leadership role by supporting and encouraging such data-gathering efforts, working with private- and public-sector providers and their institutions to develop thoughtful approaches to managing issues such as patient privacy, the costs of data collection, and the development of report cards and other indexes to measure progress.

Public Policy Advocacy

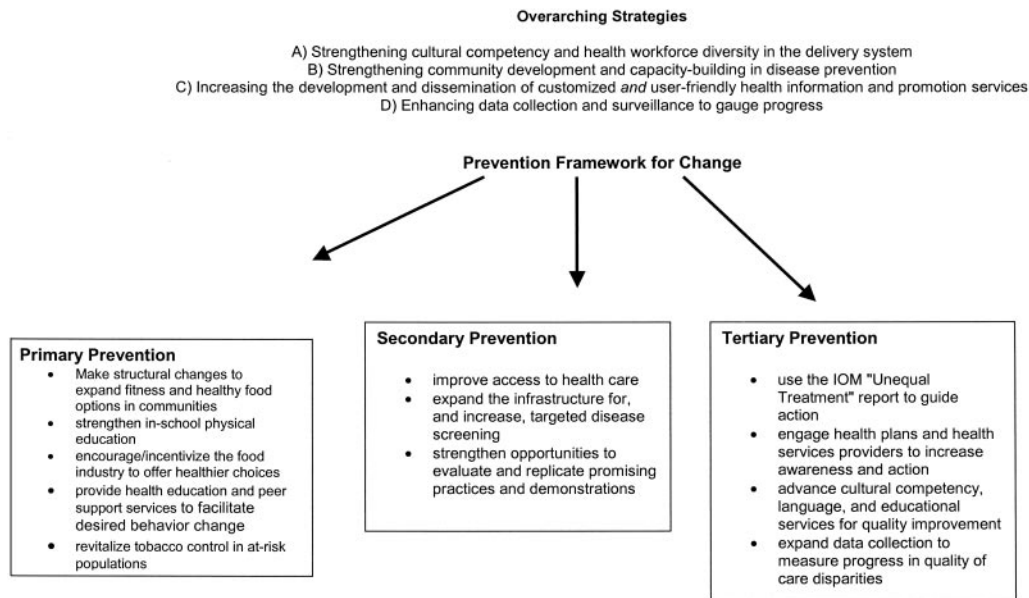
At a minimum, a national public policy strategy should consist of the following:

- Encouragement and/or provision of incentives for data collection and research efforts, with an emphasis on the important roles that federal health agencies such as the Agency for Healthcare Research and Quality, National Institutes of Health, Centers for Disease Control and Prevention, and the Office of Minority Health can play.
- Strengthening of the capacity of the federal Office of Civil Rights (OCR) to educate health providers about the importance of language-access services where the community need exists, as well as increase the ability of the OCR to implement proactive investigative strategies.
- Strengthening of efforts to improve racial/ethnic diversity in the health professions.
- Encouragement of and/or support for the efforts of quality-of-care accreditation bodies to incorporate culturally competent and cross-cultural approaches for health care delivery into standards-of-care-quality into their policies.
- Provision of adequate funding to create incentives for the formation of regional and local public-private partnerships that comprehensively address racial/ethnic disparities in health care.

Conclusions and Implications

The strategies delineated and supported in this article represent the coalescence of current thought about interventions to eliminate disparities in CVD (Figure). Defining and advancing the concepts of diversity, inclusiveness, and cultural and linguistic competence; supporting community development and capacity-building initiatives; developing public-private partnerships to advance policy to alter the “obesogenic,” tobacco-use and low-physical activity environment, highlighting and bolstering federal efforts to eliminate disparities; rebuilding trust between health professionals and underserved communities; and underscoring the link between the distress

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that results from societal oppression and marginalization and CVD risk behaviors and disease outcomes have been identified as cross-cutting needs. Specific primary, secondary, and tertiary prevention strategies for obesity and tobacco use; systems to ensure screening and access to care; and health-care provider and provider organization training, monitoring, and reporting to ensure equity in treatment have been elaborated as an action agenda. As repeatedly noted, the evidence base is fragmented and incomplete; however, the potential for empowering marginalized and disenfranchised peoples and the meaningful societal change inherent in these strategies may be measured by the threat both pose to the status quo and the marshaling of forces to impede their realization.

Action is indicated on many fronts and at many levels of society that influence health status and health care. Ultimately, disparities in health are a reflection and outgrowth of the social injustice that is endemic to US society.⁶⁶ "Minorities" can be defined sociologically as groups of people who are singled out for unequal treatment and who regard themselves as objects of collective inequity, which may contribute to unhealthy lifestyles.⁶⁷ On a macro-level, issues of disparity will not be resolved immediately. Attempts at full redress are laudable but not practical. On a micro-level, excellent models exist for public health success in the United States, driven by sociocultural and physical environmental change (eg, tobacco control, alcohol consumption and driving, and encouragement of breast over bottle feeding of infants). The cultural competence of medical professionals can likewise be increased so that they recognize and embrace cultural differences between and within minority patient populations. Increasing cultural competence within the health services industry, including an appreciation of both racial/ethnic and socioeconomic diversity, can be a powerful social instrument to guide, limit, or constrain human behavior. A social milieu

in which individuals feel that their cultural heritage is acknowledged, valued, and supported can turn the influence of social support, social conformity, and peer pressure toward health promotion in ways that benefit workers and patients. These elements can prove invaluable to a society in which there is impetus and investment to educate; modify behavior; combat social, mental, and physical illness and disease; and promote true physical, mental, and spiritual well-being.

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