NLWJC - Kagan
DPC - Box 051 - Folder-003

Race-Race Initiative Policy: Health

Race Init Policy-health

BR/EK
You asked for a race & consumer idea. Here is CPSC's.
Tom

U.S. Consumer Product Safety Commission
Washington, DC 20207

Vulnerable Populations and Product Hazards

Fire
Each year, 3,800 people die from residential fires in the U.S. The risk for blacks is roughly twice as high as the risk for whites. Older housing stock and no or few smoke detectors are often the cause of this increased risk.

Old Cribs
Each year, 50 babies die in old, hazardous cribs. These cribs do not comply with CPSC safety standards. Low-income people may re-use older cribs. The hazards of old cribs include strangulation related to corner posts and missing or inadequate spacing of slats; and broken or missing hardware causing cribs to collapse.

Charcoal/Carbon Monoxide
Each year, 25 people die from carbon monoxide caused by burning charcoal indoors. Almost half of these deaths occur to ethnic minorities, particularly Hispanics and Asians. Differences in cultural practices, where charcoal may have been burned indoors, may be responsible for this. CPSC's new mandatory label for charcoal uses a pictogram (as well as words) to warn that charcoal must not be burned inside homes, tents, or vehicles.

CPSC's Use of Radio to Target Vulnerable Populations

Public Service Announcements -- In 1995 and 1996, CPSC produced radio public service announcements about product hazards and safety tips specifically addressed to Native Americans, Latinos, and African Americans. A unique set of radio spots for African Americans was composed and performed by singer/songwriter Marvin Matthews; these safety messages were done in rhythm & blues, gospel, urban contemporary, and jazz formats so they could fit "seamlessly" with the musical formats of targeted radio stations. Millions of listeners heard these radio spots.

Radio Actualities -- In 1998, CPSC plans to offer recorded safety messages ("actualities") through a toll-free number so radio stations can easily record and use these stories in their programs. The recorded messages will provide important product hazard warnings and safety messages for radio news directors to incorporate in their broadcasts. Targeted stations will be invited to call CPSC's toll-free number to get these messages for re-broadcast.

Race Init Policy - health

David Campt
08/07/98 10:34:36 AM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP, Christopher C. Jennings/OPD/EOP

cc: See the distribution list at the bottom of this message
Subject: race and health

HEALTH.W

As you may have heard from Elena Kagan and Josh Gotbaum following our meeting on race initiative related policy and budget issues on Tuesday, PIR recently had a meeting on race and health that was wonderfully organized by folks over at HHS. As it turned out, the same day there was a meeting on environmental justice organized by the Council on Environmental Quality. For a number of reasons, both meetings are summarized in the same letter from John Hope Franklin to the President, which is attached.

In any case, Dennis Hayashi and Marilyn Gaston from HHS, who were involved in arranging the meeting, have had a chance to look at this letter, which is now going through our standard process of review by the Advisory Board. We would also like to get your input as soon as possible, by Wednesday next week. As you review the letter, please keep two things in mind:

1) The letter encourages the POTUS efforts for universal health care, which have met with Congressional resistance. Our rationale for the inclusion of this idea was that it does not embarrass the President if the Board, which was designed to have an independent voice, calls for policies that the President believes in, but about which he must make on-going political calculations.

2) Similarly, the President appointed an outside Advisory Board so that it would have the freedom to make recommendations that push the policy envelope harder. So are the recommendations from this Board -- whose focus is on racial justice -- sufficiently bold, given the scope of the nation's health-related disparities? Are there other recommendations that you would propose we include to provide the President with additional leverage in recommending policy or budget ideas for FY2000 and beyond?

Thank you so much for your time and attention. We look forward to getting your input ASAP.

Message Copied To:

Judith A. Winston/PIR/EOP
Lin Liu/PIR/EOP
Elena Kagan/OPD/EOP
Joshua Gotbaum/OMB/EOP
Julie A. Fernandes/OPD/EOP

President William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

I am very pleased to provide you with an overview of two recent meetings on issues related to racial disparities in health. One of these sessions was held on July 10 in Boston, Massachusetts, on the subject of Race and Health. The second session concerned environmental justice and related health issues; it took place on July 10-11 in Los Angeles, California. In this letter, I will describe the issues that were raised during the Boston meeting, describe the Los Angeles meeting, and present recommendations for your consideration. In addition, I will highlight in an attachment the outcomes from the Los Angeles meeting, which focus on the federal response to local concerns. Reports on these two meetings are being included in this one letter because of their related public health issues. In the environmental justice field, minority and low-income communities suffer disproportionately from environmental and public health concerns.

Meeting on Race and Health

The Boston meeting on Race and Health was sponsored for the Advisory Board by the Department of Health and Human Services. Dr. David Satcher, the Surgeon General of the United States, provided the keynote address; William Winter, Thomas Kean, and Judy Winston joined me at the session. The meeting provided us with many heartbreaking illustrations of the continuing disparities in health and health care. In addition, the meeting included an extensive discussion of models that work to improve health and health care access.

The gaps in health and health care access for people of color are well documented and merit Presidential attention for two reasons. First, on the most basic measure of fairness, America should not be a society where babies of different racial backgrounds have significantly different life expectancy. If our nation is committed to the proposition that all people are created equal, our most basic indicators of life and health should reflect this principle.

As important, the gaps in health and health care access undermine the vision of a nation moving towards One America. We received information about the fact that a higher portion of minorities than whites are medically uninsured and/or live in medically under-served areas; we learned that purposeful or even unintended discrimination by providers that can result in unnecessary suffering and/or death; we learned that providers often do not understand the ways that cultural influences affect themselves and their patients as they deliver medical services. At the same time, we learned that the medical establishment is disproportionately white, and that the portion of physicians who are black, Latino, and American Indian is dropping, even as these groups' percentage of the total population is growing. These trends and their negative effect on the lives and health of people of color are barriers in our path toward racial justice and One America.

Summary of Race and Health Panel Discussion

Most panelists at this meeting were community service providers or health advocates who were knowledgeable about difficulties in access to health care. The meeting did not include medical researchers, who might have highlighted the most recent scientific controversies about whether differences in genetics or biology might account for some portion of health disparities. Rather, our panelists focused on what appear to be race-related differences in the access to health care, which have significant implications for health status. They focused on the various types of barriers to equitable health care access that tend to result in people of color receiving less and/or lower quality medical treatment than whites. I will illustrate some of these causes below.

<u>Structural Inequities</u>

In the course of our work through the year, we have heard a good deal of testimony about disparities in employment, income, and wealth between people of color and whites. These disparities have significant implications for access to health care. For example, 14 percent of white adults were medically uninsured, compared to 21 percent of African American adults and 35 percent of Hispanic adults. Because of poverty, minorities are more likely to be insured by Medicaid, which often affects the terms of care provided to them by managed care organizations. Furthermore, minorities are more likely than whites to live in areas that are medically under served; the minority representation in these areas is nearly three times their portion of the U.S. population. Put more plainly, because of difficulties in accessing the health care system that are largely related to disparities in employment, income and wealth, people of color receive medical treatment less frequently and at later stages of health problems than whites. This contributes to higher rates of illness, suffering, and death.

Discrimination by Providers

During the course of the Initiative, we have discussed how many people have stereotyped views of others and sometimes discriminate against them, often without knowing they are doing so. Participants during the Boston meeting discussed the fact that health care providers -- doctors, nurses, clinic attendants, and others -- are as subject to this regrettable behavior as anyone else. These panelists also discussed how these differences in treatment can result in people's medical treatment being unnecessarily delayed, sometimes with very serious consequences for their life and health.

Cultural Competency of Providers

The panelists told us that in addition to structural inequities and provider discrimination, a significant factor in racial disparities in health care access are the differences in language and/or culture that can exist between the provider and the patient. Several of our participants discussed the need for providers becoming more culturally competent, so they can be capable of delivering effective medical care to people of different cultures than their own. To some extent, becoming culturally competent means addressing the barriers in language between the providers and the clients, and not merely working around them or soliciting the assistance of untrained (and sometimes non-adult) interpreters. However, it is important to recognize that cultural competence is relevant not just when providers and clients speak different languages, but also in cases when they both speak the same language, but come from different cultural backgrounds. In many health care settings, patients are confronted with providers who do not recognize or respect their patients' culturally-influenced values and beliefs, which often affect their attitude toward the provider's advice. In many cases, these cultural differences undermine the necessary cooperation between providers and clients, which results in the medical services being much less effective.

Lack of Minority Providers and Researchers

People of color are very under-represented within the ranks of physicians, which represent the most senior level of the health provider hierarchy. This under-representation has significant implications for health care access, largely because physicians of color are more likely to treat Medicaid or uninsured patients. For this reason and others, it also appears that minority physicians are more likely to see patients of color than other physicians. Unfortunately, after years of increases, the enrollment of black, Latino, and American Indian students in medical schools is declining. The gaps in minority enrollment in medical schools has a negative effect not only on health care for minorities, but also on the racial inclusivity of the topics, methodologies, and patients involved in health research.

Meeting on Environmental Justice

The environmental justice meeting on July 11 was convened by the White House Council on Environmental Quality (CEQ) and the Race Initiative. It was the first of a series of meetings intended to highlight these issues at the community level, and to spur Federal agencies to respond. The meeting was held in South Central Los Angeles and focused on environmental justice concerns in that community. This meeting was part of a broader interagency effort intended to further Executive Order 12898, which you issued in February 1994 and which directed Federal agencies to identify and address any disproportionate and adverse effects of their programs and activities on minority and low-income communities.

The Los Angeles meeting proved to be an effective forum for a dialogue within the Los Angeles community and for defining an agenda for Federal action. The format for the meeting, which was developed through a planning committee comprised of community leaders, state and local officials, and CEQ and Congressional staff, included opportunities for community presentations as well as small-group meetings with senior policy officials from the departments of Agriculture, Commerce, Housing and Urban Development, Interior, Justice, Transportation, and the Environmental Protection Agency. Advisory Board member Angela Oh and two senior Initiative staff attended the meeting.

The meeting was preceded by a bus tour on June 10, in which local residents provided the Federal officials with vivid illustration of their environmental and health concerns in the Long Beach and Huntington Beach areas. Earlier that day, administration officials met with business community leaders, with a separate meeting held with state and local officials.

Summary of Environmental Justice Dialogue

The community participants in the Los Angeles meetings were highly aware of immediate health threats in their community, and highly frustrated with the limited assistance or attention they have received from all levels of government. Initial presentations by community leaders focused on air quality and public health; exposures of children to toxic emissions from facilities in close proximity to residences and schools; related siting and land use issues; transportation impacts; economic development; water quality; and environmental justice claims under Title VI of the Civil Rights Act of 1964.

All of these topics included three overarching complaints that are typical of environmental justice concerns in low-income and minority communities across the country. There is a strong view that these communities have not been accorded their appropriate priority in government programs, funding, and enforcement activities; that these communities lack an effective voice or opportunity to participate in the governmental decisions concerning the environment and public health that most directly affect them; and that these communities are too often the dumping ground when facilities that may present public health or environmental risk are sited, leading to multiple and cumulative exposures of residents in these communities to sources of risk. These concerns were particularly evident in discussing the following four topics.

Public Health Threats to Children

Residents of the community presented a number of compelling stories concerning the exposure of children to toxicities in schools that are too close to facilities using industrial processes that emit or threaten release of toxic chemicals. Residents complained about a number of schools in the area where there had been repeated closures or hospitalizations of children due either to routine chemical emissions or catastrophic accidents. There were compelling and graphic descriptions of the health impacts to children, strongly expressed concerns about potential health threats from consumption of contaminated fish and from other sources, and complaints about the lack of needed health services to identify significant health threats.

Siting and Land Use

Siting and land use were central issues throughout most of the discussion, and the community felt strongly that the Federal government should assume greater responsibility in siting and zoning decisions that may give rise to environmental justice concerns. A number of community groups expressed the need for buffer strips and other approaches to ensure that schools and residences are separated from industrial plants or other sources of toxic emissions.

These same residents repeatedly emphasized the need to encourage economic development that could provide new jobs and new vitality to the community. A number of areas were identified where sites with known or suspected contamination, owned by insolvent or defunct owners, were blights on the community and impediments to economic development cleanup because of the lack of either public or private funds for cleanup.

Transportation Impacts

South Central Los Angeles is being shaped by a number of major transportation projects, and there are strong concerns about the impacts these projects may have on the community. In particular, community groups registered concern about the extension of Highway 710, which was recently approved by Secretary Slater, the Alameda Corridor improvement project, and the proposed expansion of the Los Angeles Airport. Community concerns included the health effects of increased diesel traffic congestion in and surrounding residential communities, increased airport noise and fumes, and the possible excavation of contaminated soils as work of the Alameda Corridor Project begins.

Access to Decision Making

There was a high degree of frustration about the lack of a single point of contact for residents to seek help when confronted with public health and environmental threats. A number of community residents voiced concern about the lack of coordination among Federal agencies, as well as between Federal agencies and counterparts in state and local government. These concerns were coupled with a high degree of suspicion that the attention focused on the community for purposes of this meeting would evanesce after the meeting, and that there would be little in the way of accountability or follow-up in responding to the concerns the community was raising.

Recommendations

Representatives from federal agencies made a number of commitments to address the concerns of the local community with respect to environmental justice. These commitments are highlighted in an attachment.

With respect to the Race and Health meeting, one of the most striking findings from the meeting is that health professionals already have a very good understanding of the most effective strategies for closing gaps in health care access, which will in turn close gaps in health. This consensus stands in contrast other policy areas where experts often disagree about the best strategies for closing race-related disparities. Our recommendations reflect these consensus strategies from health care experts:

1. *Continue advocating for broad-based expansions in health insurance coverage.* We recommend that you continue your efforts to expand medical insurance coverage to all Americans. To the extent that you are successful, your efforts to expand coverage generally will help close racial disparities, because minorities tend to be disproportionately represented in demographic groups with limited or no insurance. For example, universal health insurance coverage could be thought as disproportionately helping Latinos, blacks, and American Indians, since these groups are over-represented in the ranks of the uninsured.

2. *Continue advocacy of increased health care access for under served groups.* The demographic differences and physical isolation of communities of color create the potential for closing health disparities by developing programs that are aimed at increasing the health care access of specific under served groups, but are not aimed at specific racial populations. For example, because minority groups comprise a higher portion of the child population than the adult population, a successful effort to increase children's access to health care would likely help close the gaps in access between whites and people of color. Similarly, other efforts to target specific populations with major gaps in health care access, (for example, public housing tenants or migrant farm workers), would have a similar effect of closing gaps in health care access by race.

3. *Increase funding for existing programs targeted to undeserved and minority populations.* In addition to broader health initiatives, there are opportunities to strengthen programs that are dedicated to helping the under served and minorities increase their access to health care. A few simple numbers help illustrate the point. According to HHS, there are about 43 million people who live in medically under-served areas in the United States. About 10 million of these have adequate health care access through medical insurance. Nevertheless, there remains a gap of about 33 million people -- disproportionately minorities -- who live in under served areas and have insufficient access to health care.

   Some of this gap in health care is being met by programs that have a proven track record in helping under served and minority populations receive access to care. For instance, community health centers (CHCs) specifically target poor and minority communities to provide both preventative and ameliorative care. In addition, there are several HHS programs that increase minority representation in the health professions and/or directly place providers into under-served areas. Such programs include the disadvantaged faculty loan repayment, general practice dentistry residency, physician assistant training, advanced nurse education, preventative medicine residency, and the National Health Service corps (NHSC). Community health centers, the National Health Service Corps, and the Indian Health Service currently provide health services to about 10 million people, leaving about 23 million people in medically under-served with no access to care.

   Funding by the Health Resources and Services Administration of the CHCs and the NHSC has remained constant over the last several years, even as the population of the medically under-served is increasing. The Indian Health Service, which fulfills a very old promise to this segment of the population, is reported by many as under-funded as well. In order to close racial disparities in health care access, we recommend significant increases in funding for the Indian Health Service, community heath centers, the National Health Service Corps, and other HHS programs with a track record of placing providers in under-served areas.

4. *Enhance financial and regulatory mechanisms to promote culturally competent care.* There are some existing controls that influence the delivery of health services that may affect efforts to provide culturally competent care. Specifically, current regulations for Medicaid reimbursements often do not reflect the additional difficulties of serving non-English speaking client populations. As a result institutions that use interpreters to foster clear, confidential communication between providers and non-English speaking patients are often not re-imbursed for this expense. If providers could be fully reimbursed when such expenses are needed, they would more likely provide

such services and improve access to care.

In addition, the CHCs function as very important laboratories for increased understanding about the importance and complexities of culturally competent care. However, current funding mechanisms do not support non-patient hours so that practitioners can dissect and publish their lessons learned for the benefit of other providers serving ethnic populations.

Our recommendation is that the appropriate agencies review the Medicaid reimbursement procedures and the CHC funding mechanisms with the specific goal of changing regulations that unduly impede the expansion and increased understanding of culturally competent services.

5. *Emphasize importance of cultural competence to institutions training health providers.* HHS should encourage medical training institutions and accrediting associations to require that students receive some training in cultural competency. Although the federal government does not directly accredit medical training institutions, these institutions and the organizations that accredit them are likely to be responsive to strong encouragement about cultural competency from the federal government.

I would like to take this opportunity to express the appreciation of the entire Advisory Board on Race for the splendid leadership taken by the Department of Health and Human Services and the Council on Environmental Quality for their respective meetings. Both of the meetings were considered first rate by those in attendance. In addition, HHS published a short booklet for the meeting that provides an excellent overview of many of the important issues. It is attached for your review.

My best wishes.

Yours truly,

John Hope Franklin
Chair

Attachment: Federal Commitments to Respond to Community Concerns

The dialogue during the Los Angeles meeting with the community resulted in a concrete, focused set of commitments by Federal officials to investigate and take appropriate steps to address public health and environmental concerns identified over the course of the two days, as well as a consensus that, with appropriate follow-up, this model of community-based meetings could provide an effective means of addressing environmental justice concerns in other communities. The federal commitments were as follows:

1. *A coordinated Federal response.* Community interest in a mechanism to work more effectively with Federal, state, and local instances will be addressed initially through an interagency task force focused on the South Central Los Angeles. This task force, established for a trial period of six months and comprised of representatives from each of the agencies participating in the meeting, will be chaired by the Regional Administrator of EPA. This mechanism will provide the communities with one-stop access to the Federal government, while providing the agencies a forum for coordinated, collaborative efforts to respond to community concerns.

2. *Immediate responses to public health threats.* A number of commitments that the Federal agencies made in the context of the meeting were to investigate or address immediate public health and environmental threats in the community, including potential exposures to public health and environmental threats in schools and from consumption of contaminated fish. Federal agencies also committed to a meeting between agency officials and community groups to provide the community with an opportunity to specifically identify facilities or other sources of public health or environmental threats that they believe are appropriate for investigation and appropriate enforcement action.

3. *Access to Decision making.* Federal agencies need to improve community access to decision makers across the board, and the commitments made in Los Angeles provide illustrative (but not necessarily complete) examples of how this can be done. The meeting for the community to identify enforcement priorities, and a commitment by the Regional Administrator of the Federal Highways Administration to a meeting where the community can air concerns about the Alameda corridor project, may provide the first steps to more routine communication of this type in the region.

4. *Technical assistance and training.* Communities of color often lose access to significant sources of Federal assistance, or fail to secure the full protection of Federal law, because of a lack of technical capability to apply for funding or enforce their rights. Stronger efforts by Federal agencies are needed. As

a result of the Los Angeles meeting, the Department of Transportation committed to providing more technical assistance to the community in applying for transportation enhancement funding and highway safety programs already available to the community, community training by the Department of Housing and Urban Development (HUD) on community participation in the Community Development Block Grant process, and joint EPA-HUD training for the community on Title VI of the Civil Rights Act of 1964.

5. *Accountability and Follow-up.* Mechanisms for accountability and follow-up response to community concerns are highly important. A precise list of the Administration's initial commitments will be reviewed by the community, there will be further dialogue with the community, with other interested constituencies, and with state and local officials on the broader concerns that are not fully addressed by these commitments. Progress in meeting the commitments made to the Los Angeles community will be monitored closely by CEQ and by agency officials in Washington. CEQ will reconvene the interested community representatives and Federal officials in October.

Race init policy - health
and
AIDS - African Americans

STATE OF EMERGENCY
Monday, May 11th
Congressional Black Caucus
10:00 AM to 1:00 PM
The Capitol, Room HC 8

On Monday, May 11, 1998, the Congressional Black Caucus will hold a meeting to request that President Clinton declare a "State of Emergency" in HIV and AIDS among African Americans. We ask that you join us for this historic meeting. Let the Caucus know that you support this emergency request. The meeting will be from 10:00 AM to 1:00 PM in The Capitol, Room 6 or 9. The Capitol is in Washington, DC, you should go to the House Wing which is on the Independence Avenue side of the Capitol.

The African American community is facing a State of Emergency in the face of HIV/AIDS. According to the Centers for Disease Control and Prevention (CDC), every hour, seven (7) Americans are infected with HIV, three (3) of them are African Americans. A total of 240,000-325,000 African Americans are infected with HIV and 92,200 African Americans are living with AIDS. An alarming 1 in 50 African American men and 1 in 60 African American women are infected with HIV.

This State of Emergency demands sound national policy and proactive national and community based leadership. In a country which is the leader in HIV/AIDS research and care, it is unconscionable and intolerable that African Americans are: less likely to know their HIV status, more likely to be diagnosed late in disease progression, less likely to have access to doctors with HIV/AIDS experience and the state of the art HIV/AIDS care, and less likely to be prescribed, and to take the new and promising combination drug therapies.

We come together on May 11th, to work with the Congressional Black Caucus as they request that President Clinton declare a "State of Emergency" in HIV and AIDS among African Americans. All agencies of the federal government must garner their collective expertise and resources to address this crisis now and be held made accountable for closing the health outcomes disparities. We recommend that the Secretary of Health and Human Services provide a report on how the agencies (including but not limited to NIH, HRSA, HCFA, CDC, SAMHSA) whose departments are responsible for HIV/AIDS related prevention, health care and research, plan to close the gap by the year 2000. The plan should delineate the specific goals and objectives, time frames for implementation and completion, and the funding allocated to meet the objectives.

Furthermore, federal funds must be directed to follow the epidemiological trends in the epidemic, and new resources must be allocated to address emerging needs and to close the gaps in services. We are especially concerned about women, adolescents, gay men and injection drug users. The response to the HIV/AIDS epidemic must be integrated with many challenges facing our community, such as poverty, teen preganacy, STDs, unemployment, addiction, homelessness, access to health care, disproportionately high rates of incarceration, and the list goes on. The following strategies must be must be planned and implemented immediately:

1) A large scale, culturally appropriate, public information and education campaign targeted to African Americans, to educate people about the benefits of knowing their HIV status; to promote HIV counseling, and voluntary HIV testing; and to promote voluntary partner counseling, notification and referral services. The overall goals of this campaign are to reduce further transmission of HIV/AIDS and to promote early intervention and treatment for those who have already contracted the virus.

2) A large scale public information and educational campaign to dispel the shame and stigma associated with HIV/AIDS and promote the understanding of HIV/AIDS treatments. To further promote the understanding that disease management and treatment can increase the length and quality of life for people living with HIV/AIDS.

3) A comprehensive plan to address the HIV prevention, care, treatment and support service needs of African American gay men. African American gay men have been disproportionately affected by HIV/AIDS, yet in many regions of the country there is a lack of services to address their specific needs.

3) A comprehensive plan and the allocation of the necessary funds to ensure that every person in this country with HIV/AIDS has access to the state of the art HIV care, treatment with effective combination drug therapies, and treatment for opportunistic infections. We can no longer stand watching only a select few benefit from the enormous national investment in HIV/AIDS research, prevention, treatment and care.

4) A comprehensive and coordinated plan to address HIV/AIDS and substance abuse by increasing resources for the expansion of culturally appropriate and gender specific drug prevention and treatment programs; and the integration of HIV prevention and primary HIV health care into drug prevention and treatment services.

5) Overturn the ban and allow Federal funding of needle exchange programs. By leaving states and localities to fund these programs on their own, the federal government is effectively denying this lifesaving intervention to thousands of Americans at risk for HIV/AIDS.

6) A comprehensive plan, and the allocation of sufficient funding, to conduct clinical research on the effect of HIV treatment in minority populations. This needs to include a greater focus on the effect of HIV therapy on concomitant medical conditions that are of high incidence within the African American community. Further, this plan should also address the current rates of inclussion of people of color into clinical trials, and the need to establish more African American investigators in HIV related research.

Join us, the AIDS epidemic is not over, especially not in African American communities. We need your voices, we need your support, and we need your outrage. We must act swiftly if we are to save the lives of our friends, family members and partners.

initiative
Race policy ~~initiative~~ – health

Sarah A. Bianchi 11/25/97 05:31:12 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc:
Subject: race and health

We decided that John Callahan was going to send us a new version of the spending updated to reflect the passbacks. But we agreed Chris would go ahead and talk to Josh about the need for more money -- outside of the grant program.

We are also going to talk to NIH about getting them to focus some of their outreach/campaign dollars on minority outreach -- as they receive the vast portion of discretionary funding.

We are talking to Bill Corr again about other things necessary to plan the event tomorrow. As always, I am sure we will be filled with confidence.

Chris and I have already talked to Julie, OPL and the race commission about pulling together an outreach meeting when we get back from Thanksgiving.

sb

First page to Chris:

Race policy ~~init~~ - health

Did HHS ever respond to the particulars of this memo? Should we press any of them? Or are they already incorporating them into their next, more specific document?

MEMORANDUM

October 3, 1997

TO: Bill Corr Elena

FR: Chris Jennings and Sarah Bianchi

cc: Elena Kagan

Attached are few suggestions you may want to consider for possible new increases and initiatives in the areas the Secretary has identified as having significant racial disparities. We would like to set up a meeting this week to discuss these ideas in addition to the options that you have been considering.

CARDIOVASCULAR DISEASE AND STROKES. The HHS initiative to begin to address the race-oriented disparities in cardiovascular diseases are clearly worth doing. We believe that we should consider building on your recommendations by initiating a national prevention effort to educate both the public and health providers as to how best reduce the incidence of this disease. It may be useful to consider a multifaceted initiative to increase awareness about prevention, particularly among Native Americans, African-Americans, and Hispanics. Based on preliminary discussions with the American Heart Association and others, an initiative such as the one outlined below could make a substantial impact:

- **A Nationwide Education Campaign.** This campaign -- which could have an special emphasis to target minority communities -- would educate health providers and high risk populations about how to prevent cardiovascular disease and stroke. It would stress the importance of keeping blood pressure under control, the need for physical activity, and reducing tobacco use. It could include PSAs and other national-based efforts (such as the President or the Secretary launching healthy heart walks in major cities) as well community-based efforts based on successful outreach models (such as "Search Your Heart" -- a church-based heart health program for African-Americans run by the American Heart Association);

- **Coordinated Cardiovascular Efforts in Every State.** Another aspect of this initiative could include funding for state or local health departments to begin a cardiovascular outreach program, just as many of them have efforts to reduce infant mortality, AIDS, and other major health problems. With this new stable source of funding, state and local health departments could bring together community-based organizations and coordinate state and local prevention activities;

- **Special Grants for Enhanced Prevention Efforts in Certain High Risk Communities.** These grants, similar to Healthy Start Grants for infants, would fund enhanced efforts in a select number of communities with a particularly high incidence of heart disease. In these selected areas HHS would partner with community-based efforts and local institutions to develop a multi-faceted approach to reduce cardiovascular disease and stroke.

CANCER

Breast and Cervical Cancer Prevention. We agree with your strategies for reducing the incidence and mortality for breast and cervical cancer, including increasing public education campaigns to address the benefits of mammography and improving access to optimal care for minority women. As you note, the CDC breast and cervical screening program currently helps address these goals by providing screening to low-income women, and over 40 percent of the women currently screened by this program are minorities. We would be interested in considering expanding this program to screen thousands more low-income minority women. This expansion could also include new education efforts about prevention and the importance of mammography and cervical screening.

Other Cancer Initiatives. We recognize the Secretary's rationale for health areas this initiative should target. However, we believe it is worth pursuing some other cancer initiatives that have the potential to reduce racial disparities. Within the White House, there is increasing interest in cancer-focused interventions, which may provide rationale for expanding our efforts in this area.

I. New National Effort to Reduce Deaths from Colorectal Cancer

Problem: Colorectal cancer is the third most commonly diagnosed cancer for both men and women and the second leading cause of cancer deaths. African-Americans are more likely to be diagnosed with it and more likely to die from it and mortality trends indicate that the gaps between blacks and whites are widening. Experts from NIH, CDC, and the American Cancer Society have come to a unified conclusion that screening for colorectal cancer does reduce mortality. These conclusions have led to new screening recommendations, which at this time are not widely known by health providers or the public at large. There is also not currently a screening initiative for this type of cancer for low-income Americans as there is for breast and cervical cancer.

New Colorectal Education and Screening Initiative. We believe that a major outreach effort, similar to the one the Department has led to encourage mammography screening, would be extremely beneficial. A major screening program for low-income and high-risk populations -- similar to the one for breast and cervical cancer at the CDC -- combined with a national campaign to educate the public and health care providers about the importance of screening would encourage more Americans to get screened for this cancer. This initiative would not only be an important component of the race and health initiative but would also be a new screening program which demonstrate that HHS is keeping cancer prevention efforts in line with the most up-to-date medical research.

II. Improving minority participation in clinical trials

Problem: There are large disparities in the number of minorities participating in many cancer clinical trials, particularly prevention and screening trials. Minorities are less likely to be aware of the benefits of such trials or to have access to them. For some cancers, such as prostate cancer, there is also a problem of participation in treatment trials. For example, prostate cancer mortality and incidence rates are much higher among African-Americans than whites.

National Efforts to Encourage Minorities to Participate in Clinical Trials. Some possible options to increase the participation among minorities in clinical trials might include working through the Clinical Trial Education Initiative at the National Institutes of Health or through the Louis Sullivan Black Leadership Initiative on Cancer or through other education efforts to increase participation in these trials. We also interested in discussing special initiatives, through the NIH or elsewhere to encourage African-American men to participate in clinical trials for prostate cancer research.

III. Biomedical Research for Minorities

Problem: While we are aware that NIH and others do carefully consider the appropriate level of minority-related research, there is longstanding concerns in the minority community about the level of emphasis of biomedical research on minority-related concerns.

National Conference on the Status of Biomedical Research for Minorities. We are interested in your thoughts on whether it would be appropriate to call for a meeting or conference on the status of biomedical research for minorities or on ways to better involve minorities in existing biomedical research. While we well understand that scientists should make decisions about what kind of clinical trials or other biomedical research gets funded, if there are new projects or research initiatives that NIH is launching, we believe it might be useful to consider ways to highlight them.

DIABETES. We are pleased that the Department's FY 1999 budget request includes a $16 million increase for diabetes programs at the CDC. We are interested in how this new funding can best be used to reduce the burden of diabetes among minorities, what initiatives you are considering for this new funding, and how best to highlight them. We understand that twenty percent of CDC's new funding would go to the National Diabetes Education Program which would have an emphasis on targeting minority communities. We believe that this new HHS increase, in addition to the $30 million per year for Native Americans through grants distributed by the Secretary in the FY1998 budget, has the potential to make a substantial contribution to reduce the problem of diabetes among minorities.

EXPAND INFANT MORTALITY PREVENTION ACTIVITIES AND SIDS CAMPAIGN. We agree that expanding the Healthy Start Program, as mentioned in your memo, to target new minority communities would be one effective way of moving forward in this area. We are unclear whether new dollars would be necessary for this expansion. We are also interested in discussing other areas that promote these goals. We are also interested in expanding the "Back to Sleep" campaign, which you also mention in your memo with a special target to minorities, including targeting local communities, churches, grandparents, and other outreach efforts.

AIDS. We agree with the goals outlined in your memo, particularly with regard to increasing the percentage of minorities who are aware of their HIV serostatus and receive early access to primary care and other treatment. Consistent with these goals, we are interested in a demonstration that we recently learned the Department is considering as part of a potential response to the Vice President's request to have HCFA look into the feasiblity of an AIDS Medicaid expansion. The proposed demonstration would implement a targeted outreach to high risk and HIV populations as well as a focused coordination of care effort across all programs treating HIV patients in a number of selected cities. We are also interested in discussing whether it makes sense to increase treatment programs such as ADAP, with a special emphasis on minority populations.

IMMUNIZATIONS. We do not have any specific suggestions in these areas, but are interested in ideas the Department has in ways to reduce the disparities. While we have made substantial progress in increasing immunization rates among children, we are interested in discussing specific initiatives that would meet your goals of increasing immunization rates for adults. We are also interested in discussing whether it is necessary to pursue new ways to better target minority children.

Race Init Policy - health

Jennifer M. Palmieri
11/03/97 07:52:30 PM

Record Type: Record

To: Christopher C. Jennings/OPD/EOP
cc: Sylvia M. Mathews/WHO/EOP, Elena Kagan/OPD/EOP, Stephanie S. Streett/WHO/EOP
bcc:
Subject: Re: health and race

Thanks for the update. From our viewpoint -- Dec. 15 and 18 are available as possibilities. (Dec. 12 and 19th are not).
Christopher C. Jennings

Christopher C. Jennings
11/03/97 07:12:07 PM

Record Type: Record

To: Sylvia M. Mathews/WHO/EOP
cc: Elena Kagan/OPD/EOP, Jennifer M. Palmieri/WHO/EOP
Subject: Re: health and race

We called a meeting with HHS today to discuss the substance and timing of the race and health announcement. We informed them of the need for a one month delay.

The downside of waiting until December is that we may miss out on announcement some FY '98 grants targeted to minority communities that must be released in November. However, HHS (and Elena and I) understand the difficulties of President's hectic schedule and we are now on track to produce a good event in December.

FYI, you should know that the Secretary is out for the first part of the month. The dates that work best for her are Dec. 12, 15, 18, or 19. What do you think about this timeframe?

cj

Race Init Policy - Health

10-21 Race + Health

1. How we talk about this.

what's new: Pres committing himself ~~b~~ to a very ambitious goal.

Yr 2000 goals are interim step.
This is different

Then - what we'd be doing new in FY98 + beyond.

Lots of action - new or subst expansions from FY 97.

EG. Infant mortality - ^{2} in FY 98 and FY 99 bud pro

major expansion of Healthy Start program

New commitments of resources - targeting now

Proposal for 99 - wrap this up.

major new initiative on STDs + minority communities

on Diabetes -

Including enrollment / for clinical trial - targeted toward minority enrollments.

demons that Dept is thinking in creative new way to target these communities

[illegible]:

2. Budget 99

30 communities would pick 1 goal - over 5 yrs -

w/ additional $ 5 locs for each goal

first - measure / then - dev action steps

5 yrs - dramatically reduce -

then use knowledge universally -

so these function as pilot projects -

do a number of diff things - see what works

Communities will understand better how to address other
racial disps by focusing on ones

Many of these are not strong technology-focused. Much on
the msg side – relatively inexpensive

Also note: starts at local community.
Try to go to more
But do it community-by-community.

All this is on top of national
expansions/↑s

360 over 5 years.

III. Outreach w/ minority community
Spoke to about a dozen leaders.
Gen'l ag. That these 6 goals are imp.
Encouraged HHS to take broader look –
access to health care / systemic concerns
Lots of concern – not just black/white
including Hisp/Asians

CJ: Data collection? Do we have anything to say?
Some of the $ has to go there
Have to find out what's going on in indiv
communities.

Rollout strategy? – Could use more work w/ orgs.
Now probably too tight
CJ: Need great rollout for Congress.

Race Init Policy – Health

WR - Min - WR reform
ED - 2EOs
Health
Adoption -

DPC [illegible] other Teams

HHS NEWS

DRAFT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

EMBARGOED FOR RELEASE: 4 p.m.
Thursday, October 16, 1997

Contact: CDC Press Office
(202) 639-3286

VACCINATION LEVELS FOR MINORITY CHILDREN AT ALL-TIME HIGH
PARTNERSHIP EFFORTS HELPING TO CLOSE THE IMMUNIZATION GAP

Disparity at an all-time low

[illegible]

The CDC *MMWR* reported today that vaccinations for minority children in the United States have reached record high levels and met or exceeded most of the 1996 national immunization goals. In the United States today, vaccination levels are nearly the same for preschool children of all racial and ethnic groups, narrowing a gap that was estimated to be as wide as 26 percentage points a generation ago.

[illegible]

For children living at or above the poverty level, all of the 1996 national immunization goals were met or exceeded in the five racial and ethnic groups. However, vaccination coverage levels for children living below the poverty line were as much as 13 percentage points lower than the coverage levels for children living at or above the poverty level.

"These are compelling findings. We've shown that when Americans put their mind to it, and are equipped with adequate resources, gaps in health care for minority children can be narrowed," said Health and Human Services Secretary Donna E. Shalala. "Although our immunization partners around the nation should be exhilarated by this progress, disparity continues. We must continue to reach out to our neediest families to ensure all children have equal access to life-saving vaccines."

In 1993, the United States launched the Childhood Immunization Initiative (CII) to increase the number of preschool children protected through routine vaccination. Goals were set to vaccinate at least 90 percent of U.S. children for most vaccines by 1996, and for all recommended vaccines by 2000.

According to CDC's National Immunization Survey, the 1996 goals for diphtheria, tetanus, pertussis vaccine (DTP) and hepatitis B vaccine were met or exceeded for African-American, Hispanic, American Indian/Alaskan Native, and Asian/Pacific Islander children. The goal for polio vaccines was met or exceeded for all groups except Hispanic and American Indian/Alaskan Native children who were within one percentage point of the goal. For *Haemophilus influenzae* type b vaccine (a vaccine that protects against meningitis), all groups met or exceeded the goal, except for Hispanic children, who were within one point of the 90 percent goal. The measles vaccine goal was exceeded for all except for Hispanic, African-American and American Indian/Alaskan Native children, who were within three percentage points of the goal.

Among children living below the poverty level, the goal for hepatitis B vaccine was met in all five racial and ethnic groups. The DTP goal was met in all groups except Asian/Pacific Islander children. For individual vaccines, the vaccination coverage levels across the racial ethnic groups for children living below the poverty level were up to 13 percentage points lower than children living at or above the poverty level.

However, minority children still lag behind white children when overall vaccination rates are compared. While 79 percent of white children have received the full series of vaccinations by age 2, only 74 percent of African-American children and 71 percent of Hispanic children are fully vaccinated against childhood disease. Overall, the rate is 78 percent, up from 55 percent in 1992, but still short of the 90 percent goal for the year 2000.

"The relatively small gaps in coverage for each vaccine among the racial/ethnic groups reflect positively on the nationwide efforts to increase vaccination levels. State and local health departments and many community and professional organizations have partnered to improve immunization levels among minority children," said Dr. David Satcher, director, Centers for Disease Control and Prevention. "Each day in the United States, some 11,000 children are born. Parents and our immunization partners everywhere must continue their work to improve immunization levels."

The National Immunization survey is the first national survey measuring vaccination coverage for five racial and ethnic groups and is the first national survey to report coverage for children of Hispanic, American Indian/Alaskan Native, and Asian/Pacific Islander origin.

"Every parent wants the best for their children's health. These data tell us that we have reached a new milestone for public health -- the virtual achievement of the 1996 goals for children in these five racial and ethnic groups," said Jose Cordero, M.D., acting director of CDC's National Immunization Program. "This is the first time, CDC has reported national immunization levels by racial and ethnic category. The National Immunization Survey is a critical tool in monitoring public health status for children of all populations."

The CII was launched in August 1993. This initiative is working to increase and sustain infant immunization rates by: (1) improving the quality and quantity of immunization services; (2) reducing vaccine costs for parents; (3) increasing community participation, education and partnerships; (4) improving systems for monitoring diseases and vaccination; and (5) improving vaccines and vaccine use.

Parents and health care providers can learn more about vaccines and the diseases they prevent through CDC's National Immunization Information Hotline: 1-800-232-2522 for information in English or 1-800-232-0233 for information in Spanish. Information on childhood immunization is also available via the internet at http://www.cdc.gov/nip/home.htm.

###

Race Init Policy - Health

FY 1999 President's Initiative on Race
Department of Health and Human Services
($ in thousands)

Budget Activity by OPDIV	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6
	Infant Mortality	*Breast and Cervical Cancer*	*Heart Disease and Stroke*	*Diabetes*	*AIDS*	*Immunization*
	Eliminate Disparities in infant mortality rates, including death from Sudden Infant Death Syndrome (SIDS).	Eliminate Disparities in breast and cervical cancer screening and management.	Eliminate disparities in heart disease and stroke.	Eliminate Disparities in diabetes-related complications.	Reduce disparities in AIDS case rates among racial/ethnic populations through increased knowledge of HIV serostatus and improved access to early medical treatment.	Eliminate disparities in child and adult immunization rates.
FDA						
HRSA						
Health Centers	312,701					
NHSC Recruitment Program	28,347					
NHSC Field	13,884					
Nurse Practitioner/Midwife	5,638					
MCH Block Grant	241,706					
Healthy Start	170,982					
Rural Health Outreach grants	11,361					
Ryan White:						
Early Intervention - Part C	34,351					
Pediatric HIV/AIDS - Part D	40,000					
Family Planning	218,452					
Tobacco/Substance Abuse			1,000			
Lower Extremity Amputation Prevention				100		
Emergency Relief - Part A					466,686	
Comprehensive Care - Part B					578,954	
Early Intervention - Part C					99,568	
Pediatric HIV/AIDS - Part D					40,000	
Education and Training Centers - Part F II (a)					17,287	
Dental Services - Part F II (b)					7,500	
Childhood and Other Immunization						1,600
IHS						
Model Diabetes Program (24 Tribal Sites)				8,151		
Viral Hepatitis and H. Influenza Type B (Hib) Immunization Program in Alaska					1,369	
CDC						
HIV/AIDS	28,876				66,000	
Sexually Transmitted Diseases	16,565					
Immunization						342,145
Heart Disease & Health Promotion			30,700			
Diabetes & Other Chronic Disease				8,600		
Environmental Disease Prevention	15,948					
Breast & Cervical Cancer Prevention		70,000				
Infectious Diseases	7,607					
Epidemic Services	6,606					
Health Statistics	7,052					
NIH						
	127,000	41,000	216,000	125,000	311,000	64,000
SAMHSA						
Knowledge Development and Application					20,300	
Targeted Capacity Expansion					1,000	
Substance Abuse Block Grant					55,122	
Program Management					580	
ACHPR						
Crosscut	4,800	2,600	2,450	2,500	2,300	
Specific to Goal	3,970	0	500	733	2,300	
HCFA						
Multi-City Mammography Project		1,000				
TOTALS BY GOALS	$1,295,848	$114,600	$250,650	$145,084	$1,669,966	$407,745

DRAFT

PRESERVATION PHOTOCOPY

Healthy ~~Start~~ Life

What Is It?

- A **Presidential Initiative** to significantly reduce disparities in health status among racial and ethnic minorities.
  - Establish projects in **30 communities**--cities, counties, neighborhoods, or rural regions-- to create coalitions/innovative strategies.
  - Community-based participation linking health and social service providers, and educational, civic and religious organizations.

Healthy ~~Start~~ Life

Goal

- Provide communities flexibility to eliminate specific health disparities. Examples:
  - Infant mortality rates, including SIDS;
  - Breast and cervical cancer screening and management;
  - Heart disease and stroke;
  - Diabetes - related complications;
  - AIDS case rates through HIV serostatus knowledge and early medical treatment; and
  - Child and adult immunization rates.

Healthy ~~Start~~ Life

Use Healthy Start Model

- Builds on the successful Healthy Start community-based solutions to infant mortality.
- Utilizes a community-driven systems development approach to focus on specific health disparities.
- Funds a wide variety of governmental, private and tribal grantees.
- Maximizes existing resources, changes environments, integrates services, and engages communities in taking ownership of goals.

Healthy ~~Start~~
Life

Principles

- **Innovation** in service delivery
- **Community/Individual Commitment** to goals and objectives
- **Increase Access** to health and social services
- **Integration** of complex prevention, treatment and educational services
- **Multi-Agency Participation** to facilitate incorporation of related existing programs.

Healthy ~~Start~~ Life

Data Collection & Evaluation

- Significant emphasis on the collection of baseline data
- Central evaluation of Healthy ~~Start~~ Life impact
  - Over time
  - Across targeted communities

Healthy ~~Start~~ Life

Federal Commitment

- Provide **$360 million over 5 years** to create 30 community-based coalitions.
- Provide funding priority in existing grant programs for *Healthy ~~Start~~ Life* communities.
- Expand biomedical and behavioral research to identify factors contributing to disparities.
- Establish performance measures in existing Federal programs to eliminate health disparities.
- Provide access to experts, technical assistance and training.

Healthy Start-Life Initiative

What Is it?

Background:
Despite significant progress in the overall health picture of the nation, as reported in *Health, United States*, there are continuing disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians and Alaska Natives and Asians and Pacific Islanders compared to the U.S. population as a whole. Demographic changes are expected to heighten this problem if a successful intervention is not launched.

There continues to be challenges in addressing the health concerns of the rapidly growing racial and ethnic minority populations in this country:

- There is a lack of access to care. Minority populations lack insurance, over use emergency rooms, and as a nation we lack sufficient trained professionals who are most likely to serve minority populations.

- There is a lack of policies and programs which specifically address identified health care needs of minority populations. Despite disproportionate disparities in morbidity and mortality outcomes, our systems for services are not designed to address this disparity.

- There is a lack of prevention efforts "marketed" specifically to minority populations.

- There is a lack of national data on minority populations, and in particular information about subpopulations continues to be severely deficient.

Initiative:
The *Healthy Start-Life* Initiative would establish 30 targeted communities to significantly reduce health disparities among racial and ethnic minorities. This initiative would be a comprehensive targeted strategy within a defined area to enhance access to services and change health outcomes through a more tightly coordinated continuum the preventive, medical, social, educational, civic and religious organizations. This Initiative will build on the successes of the Healthy Start model and the Minority Community Health Coalition Demonstration Grant Program.

- Communities -- Through a national competition, we would provide communities with the resources, primarily "glue money ", intended to enable the development of coalitions. Providers, consumers, educators, and other community organizations would come together at the same table in order to maximize existing resources to achieve more together than could be achieved alone. These resources would be used to develop community needs assessments, reach out to minority populations, integrate services delivery systems and build partnerships.

    -- Definition of Community -- A city, county, neighborhood or rural region with a definable and significant health disparity among racial and ethnic minorities.

Goal

The *Healthy Start-Life* initiative will provide communities with the flexibility to address specific health disparities which most impact on their community. The Department has selected six health problem areas as examples of disparities communities may choose to address:

- **Infant mortality** -- Per 1,000 live births: Total 7.2; White 6.0; Black: 14.2
- **Breast and cervical cancer** -- Breast screening for women ≥ 50 years of age: Total 56%; White 56%; Black 56%; Cervical Screening for women ≥ 18 years: Total 77%; White 76%; Black 84%
- **Heart disease and stroke** -- Mortality rates per 100,000 Heart: Total 108; White 105; Black 147; Stroke: Total 26.7; White 24.7; Black 45.0
- **Diabetes** -- End Stage Renal Disease per 1,000 persons with diabetes: Total 3; White 2.4; Black 5.2
- **AIDS case rates** -- per 100,000: Total 31.4, White 16.2; Black 115.3
- **Child and adult immunizations** -- Adults age 65+: Influenza: Total 55%; White 57%; Black 39%; Pneumococcal: Total 30%; White 31%; Black 15%

These focus areas are drawn from the health objectives for the nation, Health People 2000. The targets to reduce these disparities have been established in collaboration with the major national organizations that are active in addressing health concerns for the affected populations. The six focus areas will receive priority attention because achieving these goals will make an important contribution to improving the health of racial and ethnic minorities.

In the process we will use targeted strategies and resources to address these problem areas. The *Healthy Start-Life* Initiative will contribute materially to our longer term objective of substantially eliminating disparities in health status by the year 2010.

Use Healthy Start Model

There has been tremendous support for the "process" we used in developing the Healthy Start communities and their coalition building strategies to prevent and reduce infant mortality. We want to bring the lessons learned and the valuable experiences gained in designing these demonstration projects to support communities to develop sustainable solutions to the problems or minority health disparities.

We intend to create community driven systems, through seeking commitment and participation of community leaders, health care and social services providers, and other civic and religious organizations. We want to provide opportunities for community capacity building through coalitions to significantly reduce racial and ethnic health disparities.

We would entertain a wide variety of eligible governmental, private, and tribal entities as ***Healthy Start Life*** grantees who demonstrate a commitment and strategy for addressing a specific health disparity. We would also require the commitment and endorsement of State governments to ensure the success of the project.

We are also building on the experience of the Office of Minority Health's Minority Community Health Coalition Demonstration Grant Program. These were small one-year grants, renewable up to 3-years, with specific focuses on interventions-tobacco use cessation, hepatitis B, TB, etc.

Like Healthy Start and the Minority Community Health Coalitions, ***Healthy Start Life*** would maximize existing resources. Many programs remain categorically focused around immediate goals and reducing or preventing disparities among racial and ethnic minorities is not perceived as their charge. ***Healthy Start Life*** coalitions bring these programs to a shared table to invest in a vision which may exceed their individual goals. At the table, all stakeholders would begin to perceive a clear benefit in making efforts to utilize their existing resources--marshaling non-monetary strategies--to overcome turf issues, bureaucratic procedures and discrimination.

Healthy Start History:

- As of FY 1997, HRSA has a total of 60 Healthy Start grantees and has spent a cumulative total of $556 million. The demonstration program began in FY 1991 with 15 communities which had exceptionally high infant mortality rates receiving a total of $25 million in planning funds. The program was expanded in FY 1994 to seven additional communities. In FY 1997, HHS has begun the replication phase of the Healthy Start program and awarded 40 new grants to implement successful infant mortality reduction strategies developed by the original grantees.

- Some of our successes have been:

  -- In Pittsburgh, decreases in low birthweight births 6.5% compared to 12.8%.
  -- In Philadelphia, project experienced 30.8% reduction using alcohol during pregnancy.

-- In Washington, DC, births to adolescents declined 11%; in Philadelphia 14%.
-- New York reported a 40% reduction in infant mortality in the project catchment area, resulting in a 24% citywide decline.
-- In Baltimore, case management techniques reduced substance abuse, inappropriate weight gain, and under utilization of prenatal care, resulting in lower rates of low birthweight births, poor pregnancy outcomes, and reductions in infant mortality.

Principles

The *Healthy Start Life* initiative will be based on five principles:

- **Innovation** in service delivery -- We must encourage innovative and flexible solutions developed at the local level to address specific community needs. Are more cardiovascular screenings important? Do people need dietary assessments? Are referrals to other health agencies hampered by turf battles? Is more information needed on how sexually transmitted diseases are prevented? Is transportation a barrier? Are local institutions culturally insensitive?

- **Community/Individual Commitment** to goals and objectives -- Success is largely contingent on the community/individual "buy-in". We need to give people the practical tools to improve their lives. Service delivery systems will be demand driven as communities actively involve themselves in determining needs/goals/objectives.

- **Increase Access** to health and social services -- To improve the health outcomes of racial and ethnic populations we need a wide variety of responses that can best be enhanced by coalition building. For example, we need to expand prenatal services; increase the proportion on minority women having mammograms, clinical breast exams, and Pap tests; increase AIDS counseling and testing and early access to primary care, increase adult immunizations.

- **Integration** of complex prevention, treatment and educational services -- Minority populations at risk are unable or unwilling to navigate a complex web of providers and agencies in order to get their needs met. We must strive to make systems work together to meet consumers needs. Through integrating systems we can more efficiently and effectively engage hard-to-reach minority populations in a broader range of health and preventive services.

- **Multi-Agency Participation** to facilitate incorporation of related existing programs -- There are a vast number of participants out there with resources, networks, and experience -- Community Health Centers, Ryan White Care providers, Maternal and Child Health Clinics, Family Planning Clinics, Public Health Departments, immunization clinics, State Offices of Minority Health, National Minority Health Network, Regional Minority Health Consultants, Area Agencies on Aging, Medicaid State Agencies, etc.

Data Collection & Evaluation

Data collection and evaluation serves many purposes, including the determination of current activities; review of past activities in order to better implement future plans; and as a basis to make modifications and redirections of existing policies and practices.

Healthy Start Life initiative will be evaluated in an attempt to attribute changes in health status to the specific activities as opposed to intervening variables. Especially important is measuring organizational variables such as participation and decision-making process and support in each community, degree of coordination among providers, and provider or site-specific structure and incentives will be examined, as well as the level of client satisfaction.

The 30 communities themselves will be responsible for ongoing evaluation of progress toward achievement of the goals they have articulated. The processes of implementation, evaluation, changes and reevaluation are an integral component of good management and would be an essential part of the initiative.

Federal Commitment

The ***Healthy Start Life*** initiative would make a total of $360 million to 30 communities over the next 5 years. This "glue money" would permit the creation of a community coalition with initial planning and subsequent operational stages. We would assume:

- Providing a total of $12 million over 5 years to each of the 30 communities.
- Funding for Year One would be a $1 million planning grant.
- Funding for Year Two would grow to $2 million, further planning and initial implementation.
- Funding for the Years Three thru Five would average $3 million annually as the projects become operational.

In existing grant programs, HHS would give priority for funding increases to projects in ***Healthy Start Life*** communities.

NIH, AHCPR, and CDC will direct an increasing level of attention to research promoting improvement in the health status of minorities throughout their lifespan and expand participation of underrepresented minorities in all aspects of biomedical and behavioral research. Since 1992, there has been a Minority Health Research Initiative--$63 million this year--with a large part of the research focused based on recommendations of consensus conferences. Minority educators, research scientists and community organizations have been welcomed into this priority setting process to help reduce the gap in minority research and training. ***Healthy Start Life*** community coalitions would be a welcome addition to this research initiative.

All of our agencies and programs are in the process of developing comprehensive Government Performance and Results Act (GPRA) plans. Many programs have focused and drawn on the health objectives of the nation, Healthy People 2000, which include targets for reducing disparities among racial and ethnic minorities. We will focus heightened attention to these racial disparity goals in our GPRA plans.

As Federal partners, we will provide access to experts--Federal and elsewhere--to assist communities in their coalition building process. Technical assistance is often a critical component, as is training. We will provide multiple points of access to the communities in gaining the knowledge and skills they need to be successful. Part of the modest grant to these communities, would be available to facilitate the training and technical assistance needs of the coalitions.

Race Init Policy - Health

Eliminating Disparities in Health

In support of the President's Initiative on Race, the Department of Health and Human Services has identified six areas in which racial and ethnic minorities experience serious disparities in access to health services and in health status. The leadership and resources of the Department will be committed to achieving significant reductions in these disparities by the Year 2000, with the ultimate goal of eliminating these disparities. Through this effort, we will contribute to meeting three of the five central goals of the President's Initiative on Race:

- educate the nation about the facts surrounding the issue of race
- promote a constructive dialogue to confront and work through the difficult and controversial issues surrounding race
- find, develop and implement solutions in critical areas such as health care for individuals, communities, corporations and government at all levels.

A national focus on health disparities is needed given the compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities between populations in the United States. Indeed, despite significant progress in the overall health of the nation, as documented in *Health, United States*, the annual report card on the health status of the American people, there are continuing disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians and Alaska Natives and Asians and Pacific Islanders as compared to the U.S. population as a whole. The demographic changes that will unfold over the next several decades heighten the importance of addressing the issue of disparities in health status: Groups that currently experience poorer health status will increase as a proportion of the total population. Therefore, the future health of the American people will be substantially influenced by our success in improving the health of racial and ethnic minorities.

It is particularly important that the Department and the nation focus on the issue of disparities in access to services and health status as major changes unfold in the systems through which care is financed and delivered. Indeed, one of the Department's strategic goals for the next six years is to improve the quality of health care, with particular attention given to the problem of disparities in access to quality services. However, it is important to note that improvements in prevention and clinical services can only partially address the difficult, complex and often controversial issues surrounding racial and ethnic disparities in health status. Education, income and other socioeconomic factors play a large role in influencing health outcomes. The Department's programs to improve the economic security of low-income families and communities will be important contributors to improving the health status of low-income populations--populations that are disproportionately composed of racial and ethnic minorities. We look forward to collaborations with other federal departments, states and the private sector to address the broader determinants of health.

The Department has selected six health problem areas to address as part of the President's Initiative on Race: infant mortality, breast and cervical cancer, heart disease and stroke, diabetes, AIDS case rates, and child and adult immunizations. These focus areas are drawn from the health objectives for the nation, *Healthy People 2000.* The targets to reduce these disparities have been established in collaboration with the major national organizations that are active in addressing health concerns for the affected populations. The six focus areas will receive priority attention because achieving these goals will make an important contribution to improving the health of racial and ethnic minorities. In the process we will also learn how to more effectively target strategies and resources to address other problem areas. This exercise will contribute materially to our longer term objective of substantially eliminating disparities in health status by the year 2010.

To achieve the goals of the President's Initiative on Race will require a reexamination and re-energizing of existing efforts within the Department. The Department must redouble its efforts to assure that the needs of its customers are identified and addressed, and that Departmental efforts are communicated as effectively as possible. The Department must broaden and strengthen its partnerships with state and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations--those who have the greatest access to and knowledge of the community. Finally, the Department must ensure that adequate monitoring efforts are carried out, and that local and national data necessary for determining priorities, and designing programs are available.

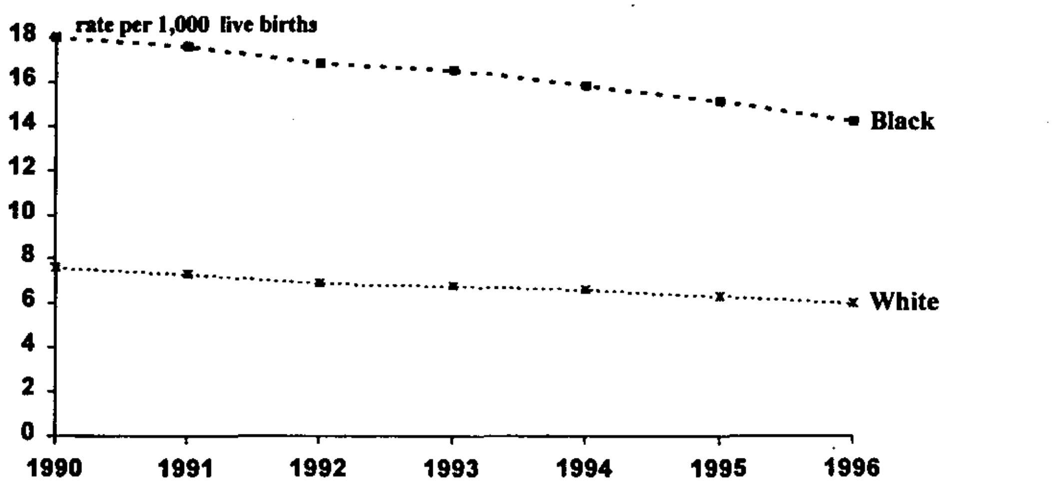
The Department has set forth an action plan for the next twelve months aimed at achieving progress towards the six goals. In addition, the Secretary and the Assistant Secretary for Health will conduct strategic assessments for each of the six goals over the next year to assess whether the Department and the nation are doing the right things to assure that the goals are met, and to begin a broad national dialogue to identify the most effective actions to achieve progress in these six areas, and by extension the other areas of disparity that must be addressed in the long term.

GOAL 1

Eliminate disparities in infant mortality rates, including death from Sudden Infant Death Syndrome (SIDS)

There are substantial racial and ethnic disparities in infant morbidity and mortality rates in the United States. Our goal is to continue progress in reducing overall morbidity and mortality rates, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the greatest disparity in infant mortality, which is among blacks whose rate is nearly 2 ½ times as great as whites, by at least 20% from their 1996 rate by the Year 2000. We will also work to reduce infant mortality rates among American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians whose rates are also above the national average. These are our goals under *Healthy People*--the nation's health objectives.

Infant Mortality Rates for the United States by Race, 1990-1996.



Infant Mortality Rate Baselines:

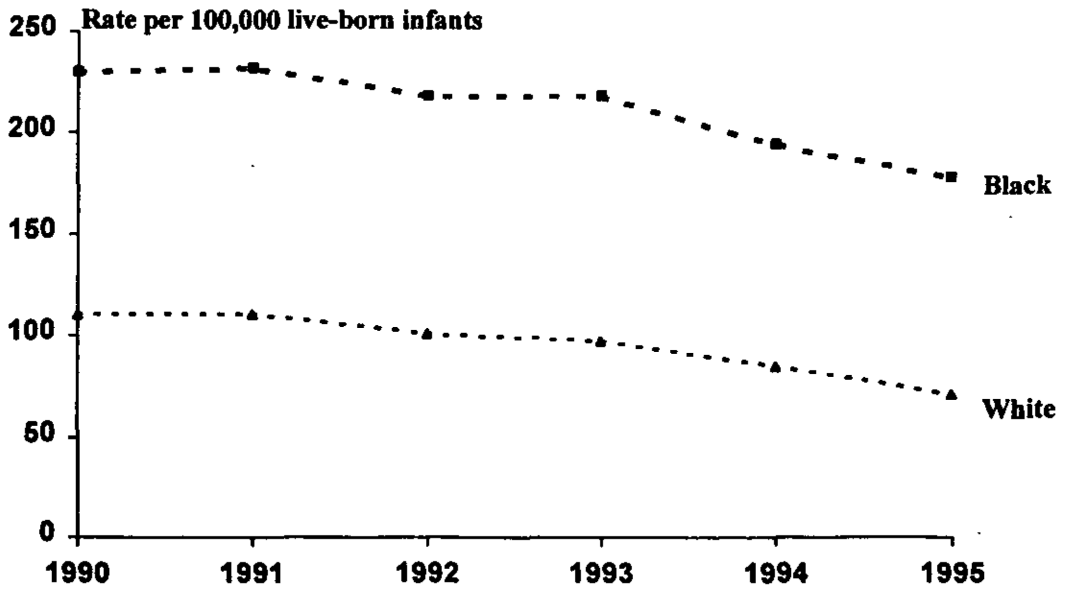
Total: 7.2 per 1,000 live births **(1996 preliminary data)**
Black: 14.2 per 1,000 live births **(1996 preliminary data)**
White: 6.0 per 1,000 live births **(1996 preliminary data)**

Data Source: National Vital Statistics System natality/mortality files, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population, and for white and black subgroups are available nine months after the close of the data year; final data are available 16 months after the close of the data year. Data for other subgroups come from linked data sources and are not available until 21 months after the close of the year (due to inconsistencies in reporting ethnic origin, birth and death files for Hispanic and other minorities that must be linked before accurate statistics can be reported). Linked infant birth and death file data for 1995 will be available this fall for American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians.

Background: Although overall infant mortality rates have been declining, the decline in rates for a number of racial and ethnic groups significantly lags behind the national experience. A major factor in these varied rates is the substantial racial disparity in low birth weight and preterm birth. Much of the decline in overall rates can be traced to research advances, better understanding and treatment of respiratory distress syndrome as well as reductions in deaths due to Sudden Infant Death Syndrome (SIDS). Despite improvements in recent years, SIDS still accounts for approximately 10% of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS, with rates among blacks being two and one half times that of whites, and among some American Indian and Alaska Native populations being three to four times greater. Among blacks the SIDS rate has declined 18 percent between 1993 and 1995, the largest decline ever observed. However, the disparity *between* blacks and whites for SIDS remains large.

Sudden Infant Death Syndrome (SIDS) Rates for the United States by Race, 1990-1995.



Race for infants who died from SIDS was determined by the race of each infant, and race for all live-born infants was determined by the race of the mother.

Sudden Infant Death Syndrome Rate Baselines:

Total: 74.2 per 100,000 live-born infants **(1996 preliminary data)**
Black: 178.6 per 100,000 live-born infants **(1995)**
White: 71.0 per 100,000 live-born infants **(1995)**

Data Source: National Vital Statistics System mortality data, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population are available nine months after the close of the data year; final data that include racial subgroups are available 16 months after the close of the data year.

Strategy for Achieving the Goal

- Provide enhanced prenatal services to low-income pregnant women by building community-based outreach and family-centered infrastructures in communities with high rates of infant mortality, morbidity, and poverty.

- Support a range of biological and behavioral research to better identify the specific factors contributing to the racial and ethnic disparities associated with infant death, preterm delivery, low birth weight, SIDS, and related adverse outcomes.

- Form linkages among public agencies and academic, professional, business and other private entities to address and promote coordinated research and health and social services.

- Promote the recruitment and training of minority researchers and the support of minority institutions that have immediate access and can contribute to the care of high-risk populations.

Action Steps for the Next 12 Months

➪ Increase to 100% the number of States with a plan that addresses infant mortality reduction and the associated racial/ethnic disparities. Emphasis will be placed on increasing the percentage of minority pregnant women receiving prenatal care in the first trimester.

➪ All 50 States will have active "Back to Sleep" or SIDS risk reduction campaigns

➪ Increase to 60 the number of high-risk communities addressing infant mortality reduction, and especially the elimination of disparities in infant mortality rates.

Examples of Programs that Support this Strategy

- **"Back-to-Sleep" Campaign:** Much of the recent decline in the incidence of SIDS is credited to this campaign which recommends that healthy babies be placed on their backs to sleep to help reduce the incidence of SIDS. The campaign will expand efforts to reach minority and ethnic populations. (NIH, HRSA, CDC)

- **Cultural Competence in SIDS Service Delivery Systems:** Complete a Task Force Report by Fall 1997 with recommendations for culturally competent strategies to improve public health campaigns and bereavement services for under served racial and ethnic populations. (HRSA)

- **SIDS-Related Research:** Support research to 1) better understand the physiologic causes of SIDS and why SIDS infants die, 2) develop effective screening tests that can identify infants at risk for SIDS, 3) develop effective pharmacologic therapies for high risk infants; and 4) define specific patterns of risk in racial populations. (NIH)

- **Healthy Start Initiative:** Fund approximately 40 new high-risk communities to implement one or more of the community-based strategies to reduce infant mortality determined to best address the needs of the individual community. (HRSA)

- **State Mortality/Morbidity Review Support Programs:** Support up to five States in their efforts to promote, coordinate, and sustain mortality and morbidity review programs at state and community levels. This will allow States to expand their focus to morbidities and additional population groups. Emphasis will be placed on developing community and state partnerships that utilize the community-based review findings pertaining to service barriers and proposed systems changes to improve racial disparities and other problems associated with poor pregnancy or child health outcomes. (HRSA)

- **Perinatal Research:** Increase identification of risk factors and biological markers for adverse pregnancy outcomes, (e.g., LBW and preterm births), as well as SIDS, among minorities, with the expectation of developing appropriate and effective interventions and treatments for clinical conditions. (NIH, HRSA, CDC)

GOAL 2

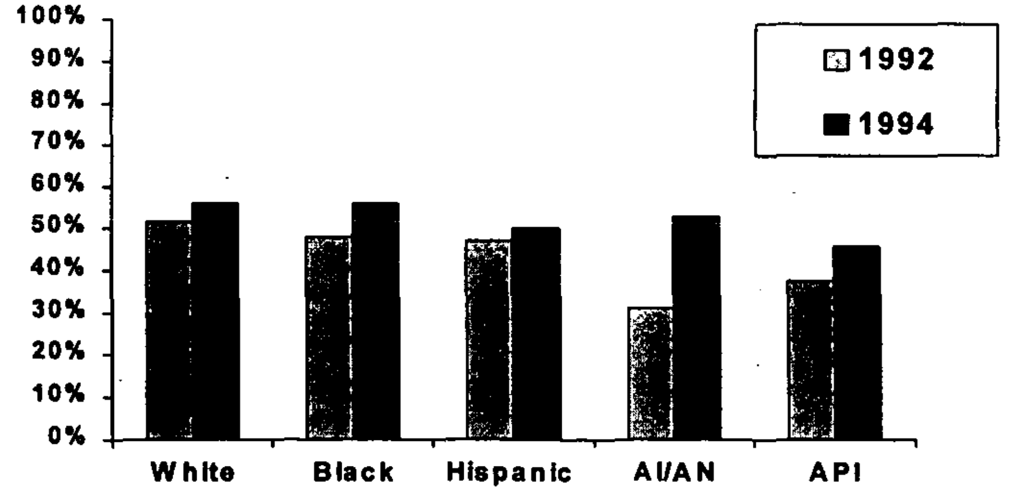
Eliminate disparities in breast and cervical cancer screening and management.

Cancer is the second leading cause of death for all women. Disparities in breast and cervical cancer incidence and death rates occur among various racial and ethnic groups. Screening to detect early disease is critical in the management of these two cancers. Even small changes in the percentage of women screened by mammography and Pap tests can have significant impact on the overall burden of suffering from these cancers. Our goal is to continue progress in getting more women screened for these two cancers at the appropriate age and time intervals, and to eventually eliminate disparities among all racial and ethnic groups in regards to screening and management.

Breast Cancer:

Our goal for the year 2000 for breast cancer screening is to increase to at least 60% those women of all racial or ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the preceding two years. This means we will have to increase the screening rate among white and black women by 7% from their 1994 level, American Indian and Alaska Natives by 13 %, Hispanic women by 20%, and Asian and Pacific Islanders by 30% in order to reach our goal under *Healthy People*--the nation's health objectives.

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, United States, 1992 and 1994.



Breast Cancer Screening Rate Baselines for women ≥ 50 years of age:

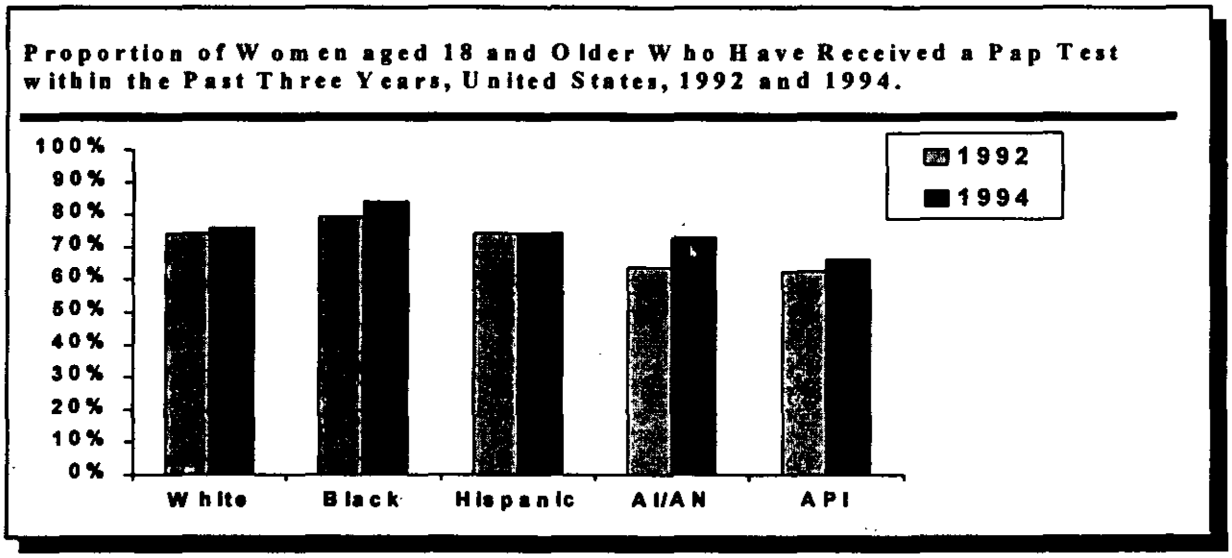
Total: 56 % **(1994)**
White: 56% **(1994)**
Black: 56% **(1994)**
Hispanic: 50 % **(1994)**
American Indian/Alaska Native (AI/AN): 53% **(1994)**
Asian and Pacific Islanders (API): 46% **(1994)**

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Cervical Cancer:

Our goal for the year 2000 for cervical cancer is to increase to at least 85% the proportion of all women aged 18 and older who have received a Pap test within the preceding three years. This is our goal under *Healthy People*--the nation's health objectives.



Cervical Cancer Screening Rate Baselines for women age ≥ 18 years :

Total: 77 % **(1994)**
White: 76% **(1994)**
Black: 84% **(1994)**
Hispanic: 74 % **(1994)**
American Indian/Alaska Native (AI/AN): 73% **(1994)**
Asian and Pacific Islanders (API): 66% **(1994)**

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Discussion: Black women have a 30% greater risk of dying from breast cancer than white women, despite an overall lower risk of acquiring breast cancer in the first place. This higher death rate among blacks is most likely due to later diagnosis and treatment, hence the need for better cancer screening and management among minority populations. Furthermore, the breast cancer death rate *decreased* 10 percent for white women during 1980-1995, while it *increased* 18 percent for black women. These disparities hold true for cervical cancer as well, where the death rates are higher for black (5.2 per 100,000 in 1995) and Hispanic women (3.1 per 100,000) than for the total population (2.5 per 100,000).

Strategy for Achieving the Goal

- Increase public education campaigns to address the benefits of mammography, thereby increasing the proportions of women aged 50-70 who have had a screening mammogram in the prior two years.
- Provide access to optimal care for minority women.
- Establish the Healthy People goal as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 months

- ⇨ Increase in the proportion of minority women 50 to 70 years of age who have had a mammogram and clinical breast exam in the past two years as measured by the 1998 National Health Interview Survey.
- ⇨ Increase the proportion of minority women aged 18 and above who have had a Pap test in the prior three years as measured by the 1998 National Health Interview Survey.
- ⇨ Expand access to screening and treatment to underserved women through the Breast and Cervical Cancer Early Detection Program.

Examples of Programs that Support this Strategy

- **CDC's National Breast and Cervical Cancer Early Detection Program** builds the public health infrastructure for breast and cervical cancer early detection in States through public and provider education, quality assurance, surveillance and partnership development. This program offers free or low-cost mammography and Pap tests to medically under served women, many of whom are minorities. Nearly 1 million screening tests have been performed since the program's inception.

- **The National Cancer Institute** (NCI) is funding twelve regional conferences in FY 1997 on the recruitment and retention of minorities in clinical trials.

- **The Minority Based Community Clinical Oncology Program** which is one of the programs responsible for the proportional representation of blacks and Hispanics in NCI sponsored treatment trials.

- **The National Black Leadership Initiative on Cancer and The National Hispanic Leadership Initiative on Cancer** are important public education programs working in concert with the NCI's Office of Cancer Communication.

- **The National Program of Cancer Registries (NPCR)**, which supports comprehensive, timely, accurate cancer registries in 42 States and the District of Columbia. The NPCR enables reporting of cancer data by age, ethnicity and geographic regions and provides critical feedback to States for tracking cancer trends, targeting and evaluating cancer control interventions, and health resource planning.

- **The Information Action Council of the National Action Plan on Breast Cancer has developed a Bridge to Underserved Populations initiative.** This initiative is exploring a variety of strategies for providing hard-to-reach populations with breast cancer information using the Internet. The IAC convened a series of regional meetings across the country to investigate and develop strategies for bridging the gap between the underserved women and the Information Superhighway. The meetings brought together community based organizations, private organizations, and women from underserved communities. The IAC plans to build partnerships with community based organizations in model pilot projects, that will ensure that underserved women have access to the wealth of information about breast cancer available on the Information Superhighway.

- **The Health Care Financing Administration Medicare Mammography Campaign,** which was launched in conjunction with First Lady Hillary Rodham Clinton and the U.S. Public Health Service's Office on Women's Health, encourages older women to use Medicare's mammography screening benefit.

- **Coverage of Mammography and Pap Smears Under Medicare and Medicaid** - Under H.R. 2015, enacted in August 1997, mammography coverage under Medicare will be expanded to include annual screening mammograms for women over 39, with the cost-sharing waived. Pelvic exams, clinical breast exams, and Pap smears will be covered under Medicare every three years, with annual Pap smears for women at risk of developing cervical cancer and those who have not had negative Pap smear in the past three years. Cost-sharing would also be waived. The Health Care Financing Administration has also sent letters to state Medicaid Directors urging them to provide coverage for annual screening mammograms for women aged 40 and older under Medicaid.

- **HCFA** will continue projects with medical peer review organizations to measure quality of medical practice and assure that all Americans receive the same high quality health care.

- **The Minority Women's Health Initiative** of the PHS Office on Women's Health (OWH) was developed in response to recommendations made during the PHS OWH Minority Women's Health Conference in January 1997. This initiative will target breast cancer in minority women as a top priority.

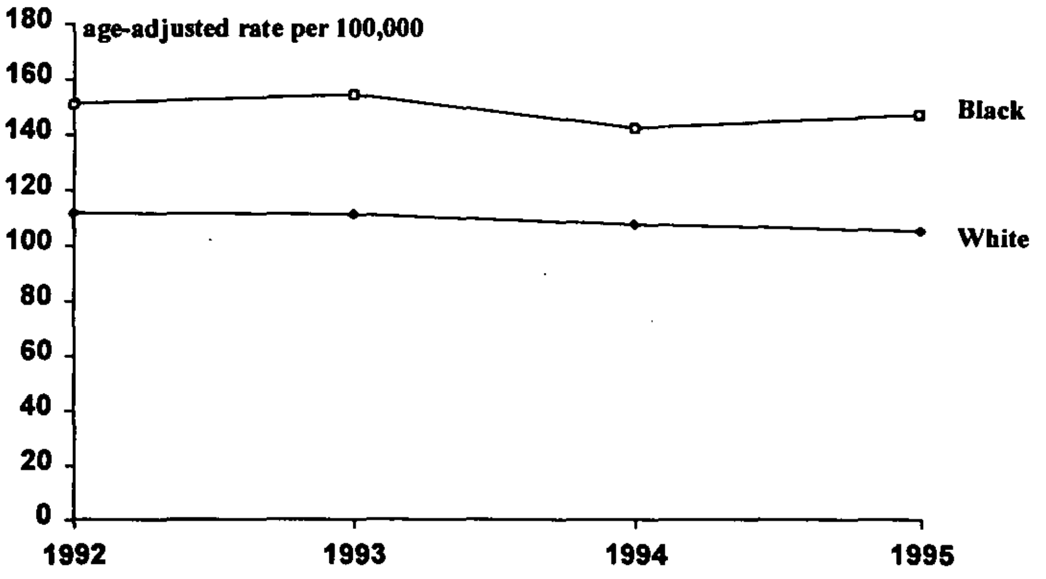
- **The Federal Coordinating Committee on Breast Cancer** will be awarding up to $3 million in fiscal year 1997 to supplement existing programs as well as to support approved but unfunded projects that are targeted towards reducing breast cancer in underserved populations. These funds will be distributed to all agencies of the federal government that carry out breast cancer activities.

GOAL 3

Eliminate disparities in heart disease and stroke

Cardiovascular disease, particularly heart disease and stroke, kills nearly as many Americans as all other diseases combined and is also one of the major causes of disability in the United States. Our goal is to continue progress in reducing the overall death rates from heart disease and stroke, and to eventually eliminate disparities among all racial and ethnic groups. In order to have the greatest impact towards that end, we have set near term goals of reducing the heart disease and stroke mortality rates among blacks by 25% from their 1995 level by the year 2000; these are our goals under *Healthy People*--the nation's health objectives. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1992-1995.



Coronary Heart Disease Mortality Rate Baselines:

Total: 108 per 100,000 persons (age-adjusted) **(1995)**
White: 105 per 100,000 persons (age-adjusted) **(1995)**
Black: 147 per 100,000 persons (age-adjusted) **(1995)**
American Indian/Alaska Natives: 76 per 100,000 persons (age-adjusted) **(1995)**
Asian/Pacific Islanders: 63 per 100,000 persons (age-adjusted) **(1995)**

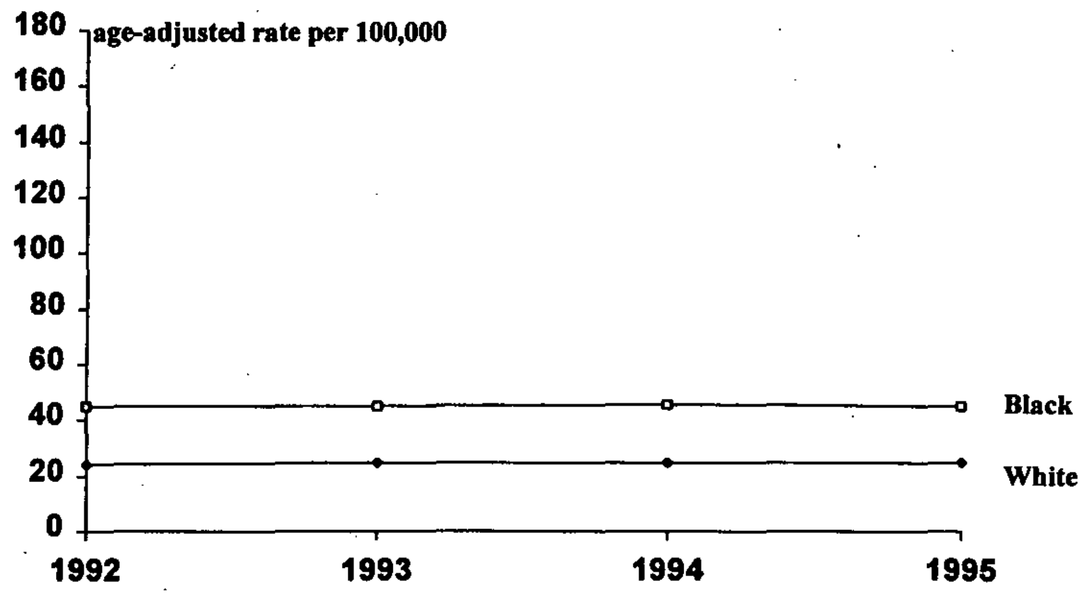
Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Mortality data are collected on minority subgroups; however, denominator data for total Hispanic population requires special data runs from Census to estimate the population sizes as of July 1 of the data year. These data are available approximately 28-30 months following the July 1 date. (1995 data will be available in fall 1997.)

Mortality data are collected on Asian/Pacific Islander subpopulations. However, the latest denominator data available from Census for these subpopulations is 1990.

Rates of Stroke Deaths, United States, 1992-1995.



Stroke Mortality Rate Baselines:

- **Total:** 26.7 per 100,000 persons (age-adjusted) **(1995)**
- **White:** 24.7 per 100,000 persons (age-adjusted) **(1995)**
- **Black:** 45.0 per 100,000 persons (age-adjusted) **(1995)**
- **American Indian/Alaska Natives:** 21.6 per 100,000 persons (age-adjusted) **(1995)**
- **Asian/Pacific Islanders:** 25.8 per 100,000 persons (age-adjusted) **(1995)**

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Discussion: The age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Within similarly insured populations such as Medicare recipients, there are significant disparities between blacks and whites in the use of certain diagnostic procedures for heart disease that cannot be explained by differences in the severity of symptoms. Racial and ethnic minorities also have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to be undergoing treatment to control their high blood pressure. Furthermore, the rates for regular screening for cholesterol, another risk factor for heart disease, show disparities for certain racial and ethnic minorities--only 50% of American Indians/Alaska Natives, 44% of Asian Americans, and 38% of Hispanics have had their cholesterol checked within the past two years.

Strategy for Achieving the Goal

- Foster efforts by public and private health-related organizations to disseminate and implement current knowledge about prevention and treatment of cardiovascular disease
- Further explore issues of cardiovascular risk factors to define more clearly those populations that are at increased risk for cardiovascular disease.
- Conduct research to identify genetic determinants of elevated risk.
- Establish the Healthy People goals as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 Months

- ⇨ Evaluate results of the Latino Community Cardiovascular Disease Prevention and Outreach Initiative and use findings for planning a national strategy.
- ⇨ Implement selected program outreach strategies as reflected in the NHLBI Ad Hoc Committee on Minority Populations 5-Year Strategic Plan developed in FY 97.
- ⇨ Initiate a new Asian/Pacific Islander American Cardiovascular Disease Prevention Initiative.
- ⇨ Initiate a new coronary heart disease professional medical education Website for health professionals who provide care to black patients.
- ⇨ Disseminate widely the training materials on cultural competence so that health care providers have information that is relevant to greater patient compliance and better outcomes.

Examples of Programs that Support this Strategy

- **The African American Community Cardiovascular Disease Prevention and Outreach Initiative**, established by the **National Heart, Lung, and Blood Institute (NHLBI)** in 1992. As a part of this initiative, the NHLBI works with the National Medical Association, Association of Black Cardiologists, National Black Nurses' Association, and historically black medical colleges and universities' medical schools to develop and implement community-based cardiovascular disease prevention and education projects for inner-city blacks.

- **The Latino Community Cardiovascular Disease Prevention and Outreach Initiative,** established in 1995 by the **NHLBI**. This initiative is composed of local projects that involve community members in health promotion and disease prevention programs; develop culturally appropriate and language-specific materials; involve existing community organizations and services; use select influential media; and incorporate positive community lifestyles, values, and beliefs. Plans are underway to transition these local projects to a national effort.

- **Building Healthy Hearts for American Indians and Alaska Natives** was established in 1996 by the **NHLBI**. It seeks to increase awareness and knowledge of risk factors for cardiovascular diseases, which account for nearly a quarter of all American Indians and Alaska Native deaths. The initiative develops heart health promotion strategies that address needs and incorporate culture, tradition, lifestyles and values of Native Peoples.

- **The Smoking Cessation Strategies for Minorities Initiative** has been conducted by the **NHLBI** since 1989 to stimulate development of culturally specific smoking cessation and relapse prevention programs for under served minorities. The program developed data on smoking prevalence, acceptability of programs, and incentives that are effective in recruiting and retaining individuals in smoking cessation programs.

- **Improving Hypertensive Care for Inner City Minorities** is a research program initiated by the **NHLBI** in 1993 to develop and then evaluate the feasibility, acceptability, and effectiveness of various methods of maintaining therapy and control of hypertension in inner city minority groups.

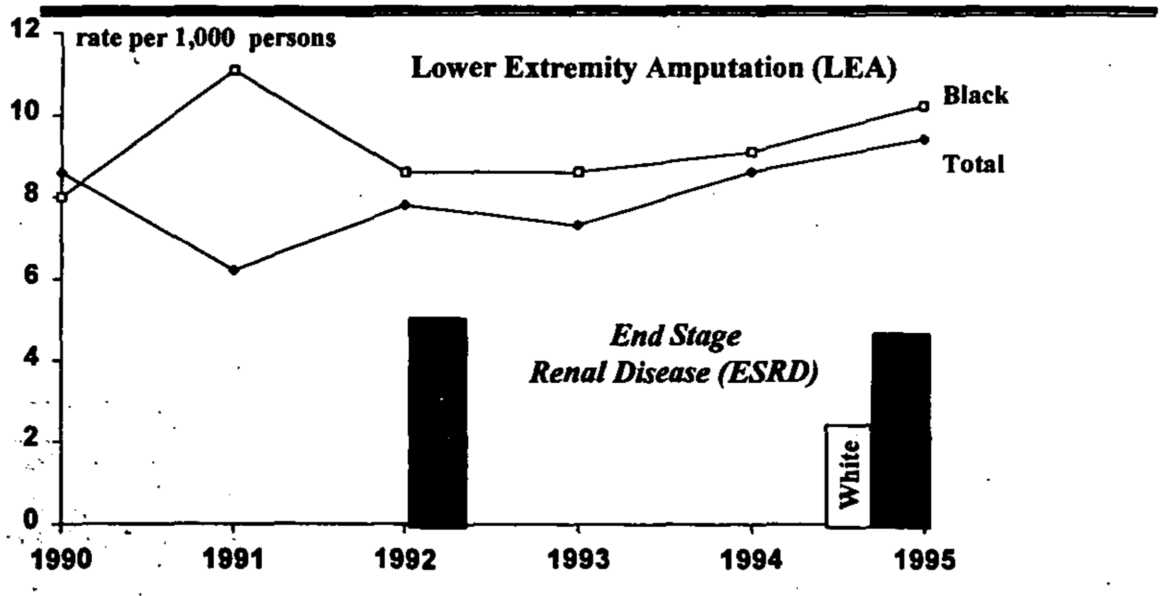
- **The Centers for Disease Control and Prevention's** Division of Nutrition and Physical Activity oversees **WISEWOMAN**, which targets Hispanic women who are 50 years of age or older, do not qualify for Medicaid, and do not have medical insurance. This project, conducted in three states, aims to determine whether a comprehensive program to screen women for cardiovascular disease is feasible and effective, and whether a physical intervention activity is beneficial.

GOAL 4

Eliminate disparities in diabetes-related complications.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting 16 million Americans, with disparities among racial and ethnic groups in the rate of diabetes-related complications. Our goal is to continue progress in reducing the overall rate of diabetic complications among all person with diabetes, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the rate of end stage renal disease from diabetes among blacks and American Indians/Alaska Natives with diabetes by 65% from their 1995 levels by the year 2000. In addition, by the year 2000, we will reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels. These are our goals under *Healthy People*--the nation's health objectives. Rates of diabetes complications among Hispanics are also high; however, existing data do not permit us to monitor diabetes complications among this group. We will develop strategies to reduce diabetes-related complications among Hispanics, and to improve data collection.

Diabetes-related Complication Rates for End-Stage Renal Disease (ESRD) and Lower Extremity Amputation by Race and Ethnicity, United States, 1990-1995.



Lower Extremity Amputation Rate Baselines:

Total: 9.4 per 1,000 persons with diabetes (1995)
Black: 10.2 per 1,000 person with diabetes (1995)

Data Source: Numerator: National Hospital Discharge Survey, CDC, NCHS
Denominator: National Health Interview Survey, CDC, NCHS

Periodicity of data source: Data are currently available on an annual basis, 22 months after close of the data year.

End Stage Renal Disease Baselines:

- **Total:** 3.0 per 1,000 persons with diabetes **(1992-1995)**
- **White:** 2.4 per 1,000 persons with diabetes **(1992-1995)**
- **Black:** 5.2 per 1,000 person with diabetes **(1992-1995)**
- **American Indian/Alaska Native:** 5.4 per 1,000 person with diabetes **(1992)**

Data Source: Bureau of Data Management and Strategy; HCFA Program Statistics; PHS, IHS

Periodicity of Data Source: Data are available on an annual basis; data can be made available 12 months after the close of the data year.

Discussion: While remaining the same or decreasing for whites, prevalence and mortality rates for diabetes among American Indians/Alaska Natives and blacks have been increasing; the prevalence rate of diabetes among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for Puerto Ricans, Mexican-Americans, Cuban-Americans, Native Hawaiians and certain subgroups of Asian Americans. Rates for diabetes-related complications such as end-stage renal disease and amputations are also higher among blacks and American Indians as compared to the total population. Even with similarly insured populations such as Medicare recipients, blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement--signs of poor diabetic control. Complication rates as outcome measures may not be sensitive indicators of progress regarding this ititiative on eliminating racial disparities. We will continue to monitor behavioral practices and health care access issues as indicators of success in acheiving a reduction in disparities. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of glucose, clinic visits, diabetic foot care, dilated eye exams. These measures can be tracked by modifications of some currently available sources that will provide annual data.

Strategy for Achieving the Goal

- Expand research efforts through the NIH that are inclusive of racial and ethnic minorities.
- Establish comprehensive community-directed and community-based efforts to reduce the incidence of Type II diabetes and its complications among American Indians and Alaska Natives.
- Enhance educational efforts for public and provider groups.
- Continue strong partnerships with national and local private sector interests.

Action Steps for the Next 12 Months

- ➩ Develop a major national outreach and consensus intervention initiative to reduce diabetes-associated disease and death, especially in racial and ethnic minorities.
- ➩ Establish cooperative agreements which focus on comprehensive community-directed and community-based efforts to reduce the incidence of type II diabetes, reduce its complications, and lower mortality among minority populations.
- ➩ Implement the Indian Health Service Diabetes Initiative.

Examples of Programs that Support this Strategy

- **National Diabetes Education Program:** Involves both public and private partners to design ways to improve treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately to prevent the onset of the disease.

- **The Diabetes Prevention Program Clinical Trial**: Designed to determine whether type 2 diabetes can be prevented or delayed in at-risk populations. Because type 2 diabetes disproportionately affects minority populations, approximately 50 percent of those enrolled in the DPP will be from those populations.

- **Diabetes Prevention Studies in Minority Populations**: The NIDDK continues to encourage increased research efforts on the disproportionate impact of diabetes in minority populations, including blacks, Hispanics, Asian and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians.

- **National Diabetes Data Group (NDDG)**: The NDDG continues its collaboration with the National Center for Health Statistics in the diabetes component of the Third National Health and Nutrition Examination Survey. The NDDG also is continuing analyses of the diabetes component in the 1989 National Health Interview Survey of the NCHS. In addition, the NDDG recently published *Diabetes in America, 1995*. This important publication is a compilation of epidemiologic and public health data on diabetes, including data about the incidence, prevalence, and impact of diabetes and its complications on minorities.

- The HRSA **Lower Extremity Amputation Prevention (LEAP)** program will expand its partnerships with diabetes associations, pharmceutical corporations, and community groups. Emphasis is on underserved populations, teaching patients to properly test and care for their feet to eliminate causes of amputation.

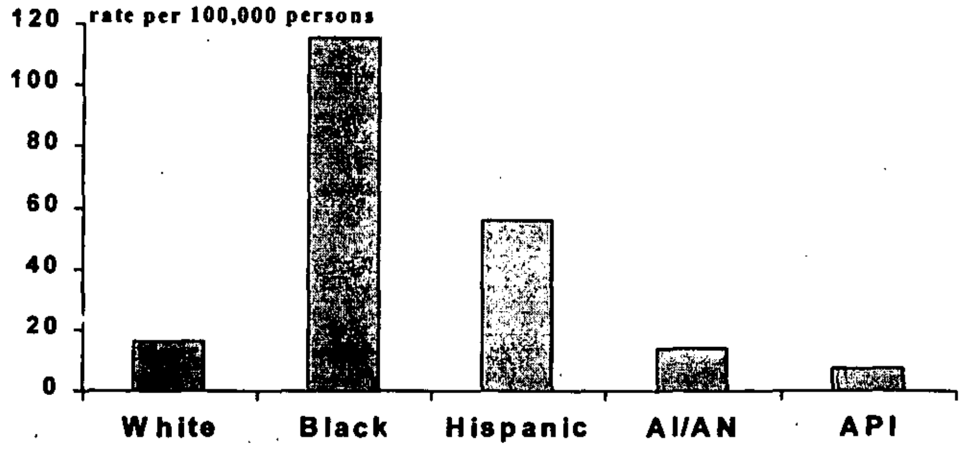
- The Indian Health Service has established 19 model diabetes centers to address the prevention and treatment of Type II diabetes. In 1998, the IHS will begin a 5 year effort to substantively increase its treatment and prevention capacity with funds ($30 million per year) provided by the Budget Reconciliation Act.

GOAL 5

Reduce disparities in AIDS case rates among racial/ethnic populations through increased knowledge of HIV serostatus and improved access to early medical treatment

HIV infection/AIDS has been a leading cause of death for all persons 25-44 years of age for several years regardless of race or ethnicity. Although racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, they account for more than 50 percent of all AIDS cases. Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and assuring access to appropriate health services for all, and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will assure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75% of low income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

AIDS Case Rates in Persons ≥ 13 years of age by Race/Ethnicity, United States, 1996



Adult (≥ 13 years) AIDS Case Rate Baselines:

Total: 31.4 per 100,000 **1996**
White: 16.2 per 100,000 **1996**
Black: 115.3 per 100,000 **1996**
Hispanic: 55.8 per 100,000 **1996**
American Indian/Alaska Native (AI/AN) 14.1 per 100,000
Asian and Pacific Islanders (API) 7.5 per 100,000

Data Source: Adult/Adolescent AIDS Reporting System, CDC

Periodicity of data source: Annual. Data are available three months after the close of the data year.

Pediatric (< 13 years) AIDS Case Rate Baselines:

Total:	1.3 per 100,000	**1996**
White:	0.3 per 100,000	**1996**
Black:	5.7 per 100,000	**1996**
Hispanic:	1.7 per 100,000	**1996**
American Indian/Alaska Native (AI/AN)	0.6 per 100,000	
Asian and Pacific Islanders (API)	0.0 per 100,000	

Data Source: Pediatric AIDS Case Reporting System, CDC

Periodicity of Data Source: Annual. Data are available three months after the close of the data year.

Discussion: Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities. AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 3/4 were among minority populations (50% African American and 24% Hispanic). During 1995-96, AIDS death rates declined 19% for the total U.S. population, while declining only 10% for blacks and 16% for Hispanics. Contributing factors for these mortality disparities include late identification of disease, lack of health insurance to pay for drug therapies, differential access to HIV primary care, and inconsistency in the level of HIV education and experience among physicians treating historically disenfranchised groups. The cost of efficacious treatment, between $10,000-$12,000 per patient per year, is a major hurdle in the effort to assure equitable access to available drug therapies.

Strategy for Achieving the Goal

- Increase the percentage of minority populations that know their HIV serostatus and receive early access to primary care to prevent or delay progression of AIDS.
- Increase the number of racial/ethnic individuals, especially those with high risk factors, who receive counseling and treatment services in public settings.
- Increase access to counseling and testing and therapies that will prevent vertical transmission of HIV between mother and child, with a special emphasis on women of color and their children.

Action Steps for the Next 12 Months

- Continue to work with directly funded community based organizations to target individuals at high risk for HIV infection within racial/ethnic communities to increase counseling, referral services, and access to testing.

- Continue to work with state, city, and territorial health departments to support the HIV Prevention Community Planning process. Through this process, community planning groups work with health departments to develop a comprehensive prevention plan that reflects prioritized needs and is directly responsive to high risk racial/ethnic communities.

- Develop an initiative which creates an epidemiological profile of racial/ethnic communities throughout the country, examines current available programs serving these communities, identifies unmet needs, and develops strategies to address these needs.

- Increase access to prevention and supportive services, and efficacious medications, to assure that individuals from specific racial and ethnic groups receive services in proportion to their representation in the overall epidemic.

- Assure that the composition of the HIV prevention community planning groups reflect the epidemiologic profile of the jurisdiction and increase those groups with linkages to correction and drug treatment facilities.

- Implement the Office of Drug Pricing rebate program for the AIDS Drug Assistance Programs to increase the buying power of Federal, State, and local funds allotted to these programs.

Examples of Programs that Support this Strategy

- The CDC **HIV Counseling and Testing Data System** began operating in 1985 to increase the availability of HIV counseling and testing services for persons who wanted to know their HIV status. Health departments in 65 States, cities, and territories collect information on the characteristics of persons seeking these services. In 1995, nearly 10,000 sites performed nearly 2.4 million HIV tests and reported results to CDC.

- CDC provides financial and technical assistance to **community-based organizations** working to prevent HIV infection, both directly and indirectly through health departments. This program primarily targets high-risk individuals within racial and ethnic communities. CDC also provides funds to National and Regional Minority organizations to identify the prevention needs of community-based organizations that work with racial and ethnic minorities.

- **The Young African-American Men's Study** is a CDC, 2-year formative study to prevent HIV/AIDS in young black men. Data are being collected in Chicago and Atlanta through interviews, observations and group discussions with community leaders, health care providers, and young men who have sex with men.

- HRSA's **AIDS Education and Training Center (AETC)** have a legislative mandate to provide training for minority providers and providers who treat minority populations in appropriate HIV therapeutics.

- The majority of HRSA's **Special Projects of National Significance (SPNS) Program** grants develop new models of HIV care for individuals from minority racial and ethnic populations. The SPNS Program currently is funding support service grants to increase access to HIV/AIDS care and related services for Hispanic populations living on the U.S./Mexico border, urban blacks dually diagnosed with HIV and substance abuse, Native Americans and Alaska Natives who were not accessing HIV services, and Asian and Pacific Islanders in New York City.

- HRSA's **Title III Early Intervention Services Program** provides grant support for outpatient HIV early intervention and primary care services for low-income, medically under served individuals, primarily people of color in existing primary care systems. The objective of these programs is to maximize access to comprehensive and continuing clinical and supportive care for populations that have been disproportionately affected by the AIDS epidemic. Currently, approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.

- HRSA continues to publish **"HIV Care Access Issues"** -- a technical assistance series of reports that identify barriers and strategies to overcome barriers to HIV care among specific population groups, e.g., black, Hispanics, Native Americans, and Asian Americans.

- HRSA's **AIDS Drug Assistance Programs (ADAP)** serve individuals from racial/ethnic minorities in approximate proportion to their cumulative representation in the epidemic to date.

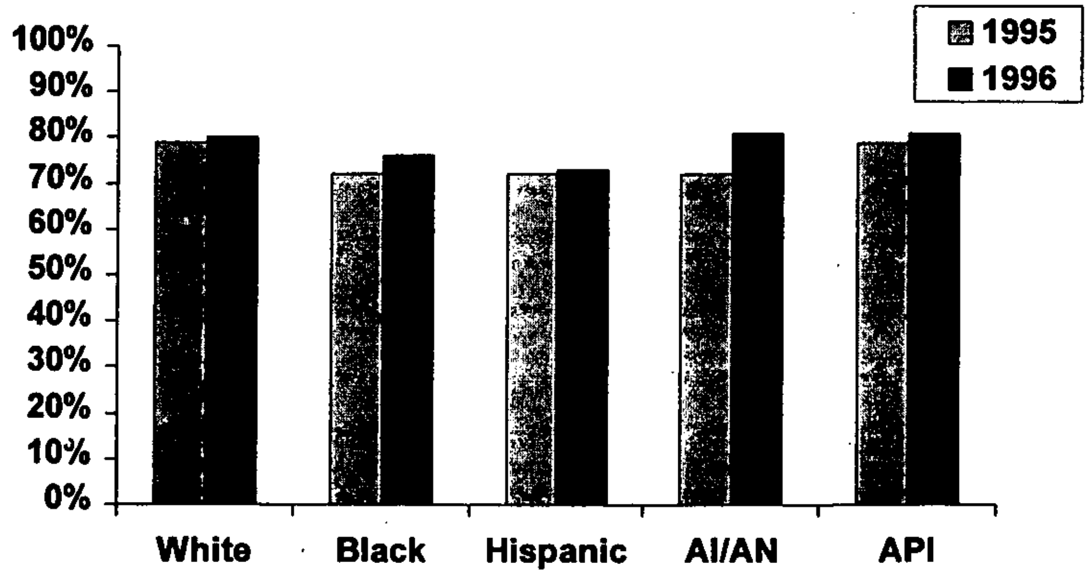
- HCFA estimates that in excess of 50% of people with AIDS, and over 90% of children with AIDS are served through **Medicaid**.

GOAL 6

Eliminate disparities in child and adult immunization rates

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. Although immunization rates have been lower in minority populations compared to the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. Our goal is to sustain current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives.

Childhood Immunization Rates* by Race and Ethnicity, United States, 1995-1996



*Immunization rates reflect those children ages 19-35 months of age who have received 4 doses of DTP (diptheria, tetanus, pertussis), 3 Polio, and 1 MMR (measles, mumps, rubella).

Childhood Immunization Rate Baselines:

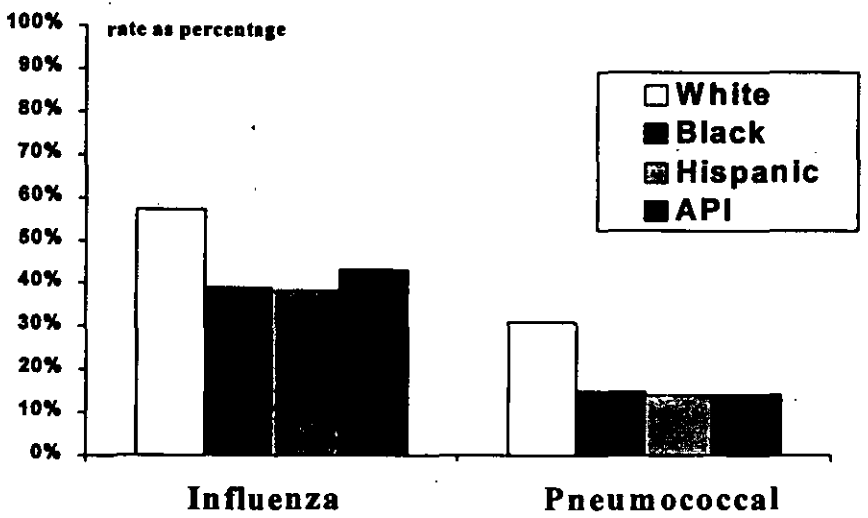
Total: 78 % **(1996)**
White: 80% **(1996)**
Black: 76% **(1996)**
Hispanic: 73 % **(1996)**
American Indian/Alaska Native (AI/AN): 81% **(1996)**
Asian/Pacific Islanders (API): 81% **(1996)**

Data Source: National Immunization Survey, CDC, NCHS

Periodicity of Data Source: Data are reported semi-annually, eight months after the close of the respective data period.

Adult immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. There is a disproportionate burden of these vaccine-preventable diseases in minority and under served populations. Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives. In order to reach this goal, by the year 2000 we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asian and Pacific Islanders and to *quadruple* the 1994 pneumococcal immunization rates among these groups.

Pneumococcal and Influenza Immunization Rates for Persons 65 Years and Older by Race and Ethnicity*, United States, 1994.



*Sample size for American Indian/Alaska Native was too small to quantify

Immunization Rate Baselines for Adults 65 years and older:

Influenza:

Total: 55% (1994)
White: 57% (1994)
Black: 39% (1994)
Hispanic: 38% (1994)
Asian/Pacific Islander: 43% (1994)

Pneumococcal:

Total: 30% (1994)
White: 31% (1994)
Black: 15% (1994)
Hispanic: 14% (1994)
Asian/Pacific Islander: 14% (1994)

Data Source: National Health Interview Survey (NHIS), CDC, NCHS

Periodicity of Data Source: Data will be available annually, approximately six months after the close of the data year. Data have previously been collected as part of supplements, but are currently in the adult core questionnaire. Data collected as part of the core using the new computer assisted personal interview procedure should be available approximately six months following the close of the data year. This system is currently being implemented.

Discussion: Though coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of under-immunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas within traditionally underserved populations, they have the potential to spawn outbreaks of vaccine-preventable diseases. Each year, an estimated 45,000 adults die of influenza, pneumococcal infections and liver cancer due to chronic hepatitis B infection despite the availability of safe and effective vaccines to prevent these conditions and their complications Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the Healthy People Year 2000 targets.

Strategy for Achieving the Goal

Childhood

- The **Childhood Immunization Initiative (CII)** was launched to reduce most diseases preventable by childhood vaccination to zero and to establish a sustainable system to ensure that all 2-year olds receive required vaccines by the year 2000 and beyond. The CII is a comprehensive effort designed to marshal efforts of the public and private sectors, health care professionals and volunteer organizations.

Adult

- Increasing provider awareness of the need for timely immunizations in adults.
- Assuring effective vaccine delivery mechanisms for adults.
- Intensifying vaccine-preventable disease program evaluations, surveillance activities, and investigation of reported outbreaks or unusual occurrences of disease.
- Encouraging outreach to all seniors through Medicare beneficiary education efforts, with special efforts to target minorities.

Action Steps for the Next 12 Months

- ➪ Develop and promote use of software to assess vaccination practices and track vaccinations levels.

- ➪ Increase emphasis on immunizations by supporting collaborative activities to enhance influenza and pneumococcal vaccination levels among Medicare beneficiaries.

- ➪ Develop and test assessment tools for documenting adult immunization levels and practices in Community/Migrant Health Center sites.

- ➪ Continue to support the Department-wide Asian and Pacific Islander Americans (APIA) Action Agenda to ensure that susceptible APIA children and adolescents receive a hepatitis B vaccine series.

- ➪ As directed by the President, hold a national conference for the establishment of State and community immunization registries.

Examples of Programs that Support this Strategy

Childhood

CDC is working with its partners to:

- Develop and implement State and community immunization registries as a cornerstone to increase and sustain vaccination coverage rates to prevent outbreaks of disease.

- Target a range of interventions to address pockets of need in each State or major city.

- Continue implementing proven interventions, such as WIC/Immunization linkages and assessment of coverage levels in provider settings.

Adult

- The DHHS Action Plan for Adult Immunization identifies key steps for each agency to implement to increase adult immunization levels, including efforts targeted at populations with an increased burden of vaccine-preventable diseases.

- The National Coalition for Adult Immunization (NCAI), with about 100 members, cooperates in nationwide informational and educational programs to promote adult immunization activities.

- HCFA's Horizon's Pilot Project targets black Medicare beneficiaries in eight southern States by working with Historically Black Colleges and Universities and HCFA's Quality Improvement Organizations to improve influenza vaccination levels.

- CDC is collaborating with HRSA to conduct a quality improvement project in a limited number of Community/Migrant Health Center (C/MHC) sites targeting adults.

Race initiative-policy-health

Table 7. Deaths and death rates for the 10 leading causes of death in specified age groups, by race and sex: United States, 1995—Con.

[Rates per 100,000 population in specified group. For explanation of asterisks preceding cause-of-death categories, see "Technical notes"]

Rank[1]	Cause of death (*Based on the Ninth Revision, International Classification of Diseases, 1975*), race, sex, and age	Number[2]	Rate[2]
	Black, both sexes, all ages[4]		
...	All causes	286,401	864.2
1	Diseases of heart 390–398,402,404–429	78,643	237.3
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	60,603	182.9
3	Cerebrovascular diseases . . . 430–438	18,537	55.9
4	Human immunodeficiency virus infection . . . *042–*044	17,139	51.7
5	Accidents and adverse effects . . . E800–E949	12,748	38.5
...	Motor vehicle accidents . . . E810–E825	5,423	16.4
...	All other accidents and adverse effects . . . E800–E807,E826–E949	7,325	22.1
6	Homicide and legal intervention . . . E960–E978	10,783	32.5
7	Diabetes mellitus . . . 250	10,402	31.4
8	Pneumonia and influenza . . . 480–487	7,803	23.5
9	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	6,667	20.1
10	Certain conditions originating in the perinatal period . . . 760–779	4,952	14.9
...	All other causes . . . Residual	58,124	175.4
	Black, both sexes, 1–4 years		
...	All causes	1,742	70.3
1	Accidents and adverse effects . . . E800–E949	515	20.8
...	Motor vehicle accidents . . . E810–E825	180	7.3
...	All other accidmicide and legal interE960nE978	192	7.7
3	Congenital anomalies . . . 740–759	168	6.8
4	Human immunodeficiency virus infection . . . *042–*044	124	5.0
5	Diseases of heart 390–398,402,404–429	88	3.6
6	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	86	3.5
7	Pneumonia and influenza . . . 480–487	58	2.3
8	Certain conditions originating in the perinatal period . . . 760–779	35	1.4
9	Anemias . . . 280–285	31	1.3
10	Septicemia . . . 038	22	0.9
...	All other causes . . . Residual	423	17.1
	Black, both sexes, 5–14 years		
...	All causes	1,974	33.4
1	Accidents and adverse effects . . . E800–E949	733	12.4
...	Motor vehicle accidents . . . E810–E825	364	6.2
...	All other accidents and adverse effects . . . E800–E807,E826–E949	369	6.3
2	Homicide and legal intervention . . . E960–E978	216	3.7
3	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	173	2.9
4	Human immunodeficiency virus infection . . . *042–*044	108	1.8
5	Diseases of heart 390–398,402,404–429	85	1.4
6	Congenital anomalies . . . 740–759	78	1.3
7	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	72	1.2
8	Anemias . . . 280–285	40	0.7
9	Pneumonia and influenza . . . 480–487	36	0.6
10	Suicide . . . E950–E959	31	0.5
...	All other causes . . . Residual	402	6.8
	Black, both sexes, 15–24 years		
...	All causes	8,723	159.8
1	Homicide and legal intervention . . . E960–E978	4,060	74.4
2	Accidents and adverse effects . . . E800–E949	1,749	32.0
...	Motor vehicle accidents . . . E810–E825	1,227	22.5
...	All other accidents and adverse effects . . . E800–E807,E826–E949	522	9.6
3	Suicide . . . E950–E959	552	10.1
4	Diseases of heart 390–398,402,404–429	371	6.8
5	Human immunodeficiency virus infection . . . *042–*044	350	6.4
6	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	286	5.2
7	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	104	1.9
8	Anemias . . . 280–285	103	1.9
9	Congenital anomalies . . . 740–759	81	1.5
10	Diabetes mellitus . . . 250	50	0.9
...	All other causes . . . Residual	1,017	18.6
	Black, both sexes, 25–44 years		
...	All causes	41,916	395.5
1	Human immunodeficiency virus infection . . . *042–*044	12,124	114.4
2	Homicide and legal intervention . . . E960–E978	4,856	45.8
3	Diseases of heart 390–398,402,404–429	4,519	42.6
4	Accidents and adverse effects . . . E800–E949	4,457	42.1
...	Motor vehicle accidents . . . E810–E825	2,114	19.9
...	All other accidents and adverse effects . . . E800–E807,E826–E949	2,343	22.1
5	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	3,978	37.5
6	Cerebrovascular diseases . . . 430–438	1,155	10.9
7	Suicide . . . E950–E959	1,117	10.5
8	Chronic liver disease and cirrhosis . . . 571	748	7.1
9	Pneumonia and influenza . . . 480–487	647	6.1
10	Diabetes mellitus . . . 250	624	5.9
...	All other causes . . . Residual	7,691	72.6
	Black, both sexes, 45–64 years		
...	All causes	68,387	1,275.4
1	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	19,402	361.8
2	Diseases of heart 390–398,402,404–429	18,815	350.9
3	Human immunodeficiency virus infection . . . *042–*044	4,075	76.0
4	Cerebrovascular diseases . . . 430–438	3,852	71.8
5	Diabetes mellitus . . . 250	3,000	55.9
6	Accidents and adverse effects . . . E800–E949	2,565	47.8
...	Motor vehicle accidents . . . E810–E825	921	17.2
...	All other accidents and adverse effects . . . E800–E807,E826–E949	1,644	30.7
7	Chronic liver disease and cirrhosis . . . 571	1,615	30.1
8	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	1,473	27.5
9	Pneumonia and influenza . . . 480–487	1,244	23.2
10	Homicide and legal intervention . . . E960–E978	1,002	18.7
...	All other causes . . . Residual	11,344	211.6

See footnotes at end of table.

Table 15. Number of deaths and death rates for the 10 leading causes of death for Hispanic and white non-Hispanic origins, for specified age groups: Total of 49 reporting States and the District of Columbia, 1995

[Rates per 100,000 population in specified group. For explanation of asterisks preceding cause-of-death categories, see "Technical notes." For a listing of reporting States, see "Technical notes"]

Hispanic			
Rank[1]	Cause of death (*Based on the Ninth Revision, International Classification of Diseases, 1975*) and age	Number[2]	Rate[2]
	Hispanic origin, all ages[3]		
...	All causes . . .	94,776	352.3
1	Diseases of heart . . . 390–398,402,404–429	22,403	83.3
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	17,419	64.7
3	Accidents and adverse effects . . . E800–E949	7,784	28.9
...	Motor vehicle accidents . . . E810–E825	4,306	16.0
...	All other accidents and adverse effects . . . E800–E807,E826–E949	3,478	12.9
4	Human immunodeficiency virus infection . . . *042–*044	6,110	22.7
5	Cerebrovascular diseases . . . 430–438	4,992	18.6
6	Diabetes mellitus . . . 250	4,194	15.6
7	Homicide and legal intervention . . . E960–E978	4,009	14.9
8	Pneumonia and influenza . . . 480–487	2,694	10.0
9	Chronic liver disease and cirrhosis . . . 571	2,684	10.0
10	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	2,329	8.7
...	All other causes . . . Residual	20,158	74.9
	Hispanic origin, 1–4 years		
...	All causes . . .	933	36.7
1	Accidents and adverse effects . . . E800–E949	326	12.8
...	Motor vehicle accidents . . . E810–E825	149	5.9
...	All other accidents and adverse effects . . . E800–E807,E826–E949	177	7.0
2	Congenital anomalies . . . 740–759	128	5.0
3	Homicide and legal intervention . . . E960–E978	74	2.9
4	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	68	2.7
5	Human immunodeficiency virus infection . . . *042–*044	35	1.4
6	Diseases of heart . . . 390–398,402,404–429	28	1.1
7	Pneumonia and influenza . . . 480–487	23	0.9
8	Certain conditions originating in the perinatal period . . . 760–779	13	*
9	Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature . . . 210–239	9	*
9	Meningococcal infection . . . 036	9	*
9	Septicemia . . . 038	9	*
...	All other causes . . . Residual	211	8.3
	Hispanic origin, 5–14 years		
...	All causes . . .	1,037	20.5
1	Accidents and adverse effects . . . E800–E949	378	7.5
...	Motor vehicle accidents . . . E810–E825	239	4.7
...	All other accidents and adverse effects . . . E800–E807,E826–E949	139	2.7
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	159	3.1
3	Homicide and legal intervention . . . E960–E978	122	2.4
4	Suicide . . . E950–E959	40	0.8
4	Congenital anomalies . . . 740–759	40	0.8
6	Human immunodeficiency virus infection . . . *042–*044	29	0.6
7	Diseases of heart . . . 390–398,402,404–429	27	0.5
8	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	13	*
9	Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature . . . 210–239	12	*
10	Cerebrovascular diseases . . . 430–438	9	*
...	All other causes . . . Residual	208	4.1

White non-Hispanic			
Rank[1]	Cause of death (*Based on the Ninth Revision, International Classification of Diseases, 1975*) and age	Number[2]	Rate[2]
	White non-Hispanic origin, all ages[3]		
...	All causes . . .	1,856,052	972.5
1	Diseases of heart . . . 390–398,402,404–429	613,933	321.7
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	443,638	232.5
3	Cerebrovascular diseases . . . 430–438	128,961	67.6
4	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	90,914	47.6
5	Pneumonia and influenza . . . 480–487	69,396	36.4
6	Accidents and adverse effects . . . E800–E949	68,328	35.8
...	Motor vehicle accidents . . . E810–E825	31,205	16.4
...	All other accidents and adverse effects . . . E800–E807,E826–E949	37,123	19.5
7	Diabetes mellitus . . . 250	42,671	22.4
8	Suicide . . . E950–E959	25,784	13.5
9	Human immunodeficiency virus infection . . . *042–*044	19,181	10.1
10	Alzheimer's disease . . . 331.0	18,773	9.8
...	All other causes . . . Residual	334,473	175.3
	White non-Hispanic origin, 1–4 years		
...	All causes . . .	3,378	33.9
1	Accidents and adverse effects . . . E800–E949	1,295	13.0
...	Motor vehicle accidents . . . E810–E825	444	4.4
...	All other accidents and adverse effects . . . E800–E807,E826–E949	851	8.5
2	Congenital anomalies . . . 740–759	373	3.7
3	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	306	3.1
4	Homicide and legal intervention . . . E960–E978	156	1.6
5	Diseases of heart . . . 390–398,402,404–429	123	1.2
6	Pneumonia and influenza . . . 480–487	67	0.7
7	Human immunodeficiency virus infection . . . *042–*044	53	0.5
8	Septicemia . . . 038	45	0.5
9	Certain conditions originating in the perinatal period . . . 760–779	34	0.3
10	Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature . . . 210–239	28	0.3
10	Cerebrovascular diseases . . . 430–438	28	0.3
...	All other causes . . . Residual	870	8.7
	White non-Hispanic origin, 5–14 years		
...	All causes . . .	5,090	20.1
1	Accidents and adverse effects . . . E800–E949	2,211	8.7
...	Motor vehicle accidents . . . E810–E825	1,331	5.3
...	All other accidents and adverse effects . . . E800–E807,E826–E949	880	3.5
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues . . . 140–208	633	2.5
3	Congenital anomalies . . . 740–759	295	1.2
4	Suicide . . . E950–E959	239	0.9
5	Homicide and legal intervention . . . E960–E978	190	0.8
6	Diseases of heart . . . 390–398,402,404–429	163	0.6
7	Pneumonia and influenza . . . 480–487	80	0.3
8	Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature . . . 210–239	67	0.3
9	Human immunodeficiency virus infection . . . *042–*044	53	0.2
9	Chronic obstructive pulmonary diseases and allied conditions . . . 490–496	53	0.2
...	All other causes . . . Residual	1,106	4.4

See footnotes at end of table.

Race Initiative policy – health issues

Minority Health Meeting – 8/8/97

Crit: (criteria)
- measurable
- likelihood of success
- cuts across min gps.
- all ages
- other indicators of efforts (than eventual results)

AIDs goal – complicated by needle exchange?

13, 14

Healthy People Consortium – November – Indianapolis –
reducing disparities → group of orgs – establishing goals for nation. Minority health – focused gps.
Day before APHA.
Commitment – attempt to reduce all disparities by yr 2010.

Bruce - HHS' 1st take at a "racial disparities in health" initiative. Chris and I have some doubts about whether to include AIDS. We also encouraged them to think in terms of focused + concrete presidential announcements on each goal. Chris believes that to make this real, we need to put money behind it, and I basically agree. Chris thinks you and I should get together w/ Frank on how to fund all this race stuff, and I agree with that too. What do you think - should I set up a meeting? Elena

GOAL 1 **Improve infant health for racial and ethnic minorities and eliminate disparities in infant mortality rates among Americans with special attention to Sudden Infant Death rates.**

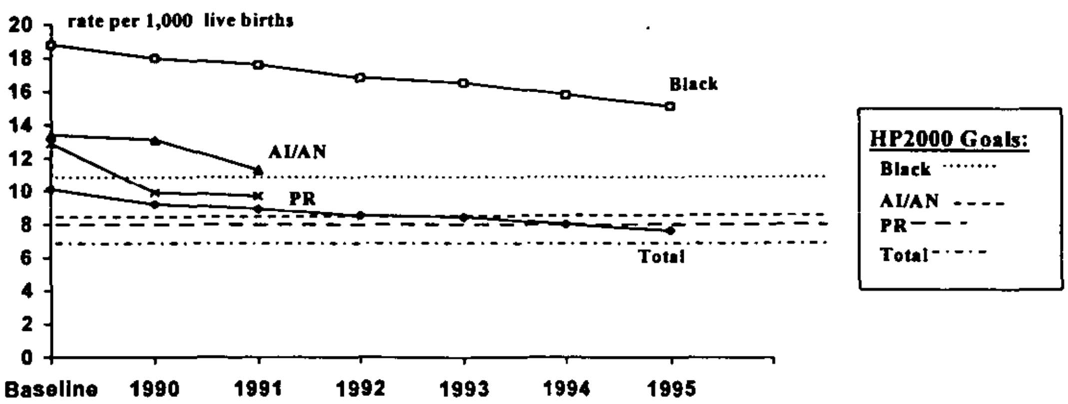
There are substantial racial disparities in infant mortality rates (IMR) in the U.S. For example, in 1993, the IMR was 6.8 per 1,000 live births among whites, as compared with 16.5 per 1,000 live births among blacks.

There are approximately 300 high-risk communities in this Nation in which the infant mortality rate for the population of the respective community as a whole or a racial population group of the community exceeds 1 and ½ times the national infant mortality average. In the vast majority of these communities the infant mortality rate for blacks is 2 to 4 times greater than the corresponding white infant mortality rate.

ea

SIDS continues to be a major cause of infant death with approximately 4,500 to 5,000 infant deaths a year, accounting for approximately 15% of all infant deaths in the first year of life. During the period 1990-1994 the drop in the SIDS rate for Black infants lagged behind that of Whites; the SIDS rate dropped 10.4% for Blacks and 16.7% for Whites. This gap has been widening as he rate for White infants falls faster than that of Blacks.

Infant Mortality Rates for the United States by Race and Ethnicity, 1990-1995.



Race Initiative Policy - health issues

Strategy for Achieving the Goal

The following strategies will be implemented to address the goal to eliminate disparities in infant mortality rates:

- Build community-based and family-centered infrastructure through funding of communities with high rates of infant mortality, morbidity, and poverty;
- Community-driven approach, e.g. FIMR to address local adverse perinatal outcomes, such as low birth weight and infant death;
- Aggressive risk prevention and reduction, e.g. smoking cessation and nutrition intervention;
- Support the development and enhancement of systems of regionalized perinatal care;
- Form linkages among public agencies and academic, professional, business and other private entities to address and promote coordinated health and social services;
- Increase the availability of WIC, nutrition, and Medicaid enrollment;
- Promote recruitment and training of community workers as case management or outreach providers; and
- Conduct national public information and public education campaigns to elevate public awareness of infant mortality and promote early prenatal care and other healthy behaviors.

Success Measures

By the end of FY-98

⇨ Of the approximately 300 high-risk communities, increase to 100 those that have as their goal to eliminate disparities in infant mortality rates.

⇨ Increase to 100% the number of States that will have a plan that addresses infant mortality reduction and the associated racial/ethnic disparities.

⇨ Increase to 40% the number of States promoting communities to employ mortality/morbidity review processes.

⇨ Measure progress on the "Back to Sleep" campaign.

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

14.1: Reduce the infant mortality rate to no more than 7 per 1,000 live births.
14.1a: Reduce the infant mortality rate among blacks: 11 per 1,000 live births.
14.1b: Reduce the infant mortality rate among American Indians and Alaska Natives : 8.5 per 1,000 live births.
14.1c: Reduce the infant mortality rate among Puerto Ricans: 8 per 1,000 live births.

Continuing, New, or Proposed Program Activity

1. Key current, continuing activities of the department which emphasize reducing the disparities targeted by the goal:

- Healthy Start Initiative - continued funding and expansion to new communities. These communities will implement one or more of the identified strategies determined to best address the individual community. In addition to local public information and public education events, the national campaigns will be further enhance public awareness and promotions regarding infant mortality, early prenatal care and healthy behaviors.

- Fetal and Infant Mortality Review - promote fetal and infant mortality review (FIMR) as a methodology used at the community level for assessing, planning, developing, and monitoring the service system and broad community resources that would support and promote the health and welfare of women and children. Infant mortality review uses the event of a fetal or infant death as a trigger to identify improvements needed in the system. Racial disparity has been identified as a problem through many community FIMR projects. A national resource center supports the FIMR process, and provides technical assistance to local projects trying to gain a better understanding of some of the contributing factors to fetal and infant death at the community level, including technical assistance focusing on refining the FIMR process and method for community death reviews.

- Prevention of Perinatal Substance Abuse - Substance abuse during pregnancy - both illicit drugs and tobacco, have been identified as contributing factors to low birthweight. Projects, for example, are being funded that provide technical assistance activities, such as the development of a substance abuse screening document for prenatal providers to identify and provide services to women at-risk during pregnancy.

- Cultural Competence in SIDS Service Delivery Systems - develop cultural competent strategies to improve public health campaigns and bereavement services for underserved racial and ethnic populations.

- SIDS Global Strategy Task Force Project REMI (Representation Increase for Minorities and Indigenous) - It is recognized that in the developed world babies in minority populations continue to die of SIDS at alarming higher rates than in the majority population. A four year commitment just recently began to address these issues including: research; risk reduction; bereavement support; and organizational representation.

2. New activities which could contribute to reducing disparities targeted by the goal:

- Healthy Start program - authorization of the Healthy Start program as a component of Title V of the Social Security Act in lieu of the current funding mechanism under Section 301 of the Public Health Service Act.

- State FIMR Support Programs - from funding 4 states in FY97 increase to an additional 10 states in FY98 to expand FIMR activities within states, as well as develop a community and state partnership which utilizes the FIMR findings as to barriers, proposed systems changes to improve racial disparities and other problems related to poor pregnancy outcome.

- State Coordination of FIMR/Child Fatality Review/SIDS Activities - undertake a series of activities to help states work towards a seamless system for investigating all infant and child deaths. A meeting of state officials will occur in FY98 to propose recommendations for the coordination at the state level of these activities with a workplan of other efforts proposed by this group.

3. Innovative, proposed activities in light of the goal:

- MCH Block Grant programs will be developing program plans that correspond to the performance measures selected for implementation. It is anticipated that the core measures will lead to increasing the percentage of infants born to pregnant women receiving prenatal care and appropriate infant care including access to NICUs. Programmatic efforts will, in the main, focus on initiatives on the racial/ethnic disparities that exist around access to comprehensive infant health services.

- Healthy Start program - expand Healthy Start to include health care for children 0-3 years of age, and promote child care, and develop a national "800" Help Line for child health, care and safety, and preventing child abuse and neglect

- Provide federal funds to support multi-tiered (systems building approach - i.e. Cultural Competency Center for SIDS / Other Infant Death.). A center has been proposed for funding in the FY 1998 Budget.

- Provide federal funds to develop cultural appropriate materials for both risk reduction and bereavement support.

- Provide federal grants to validate and replicate successful risk reduction and bereavement support strategies regarding SIDS and minority populations

- Provide federal grants to support for minority researchers to evaluate the effectiveness of public health campaigns targeted to minority communities.

- Develop training curriculum for effectively providing SIDS related services to minority populations.

- Develop minority specific training programs/strategies using developed curriculum and implement them to improve services to further reduce the rate of SIDS for minority populations.

Key External Factors

Collaborate, coordinate and partner with Federal, State and local, public and private, governmental bodies, and professional, academic, religious and volunteers organizations and other entities.

Collaborate with such organizations as the Secretary's Advisory Committee on Infant Mortality, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, National Perinatal Association, National Medical Association, Healthy Mothers, Healthy Babies Coalition, COSSHMO, Tribal Councils, American College of Nurse-Midwives, American Academy of Family Physicians, other disciplinary groups, NACCHO and other governmental membership groups.

Coordination and Leadership within DHHS

HCFA, CDC, NIH, ACF, ACHPR, IHS, OMH, OPA, SAMSHA;
Outside of DHHS: USDA, HUD

HRSA is lead for this goal.

GOAL 2

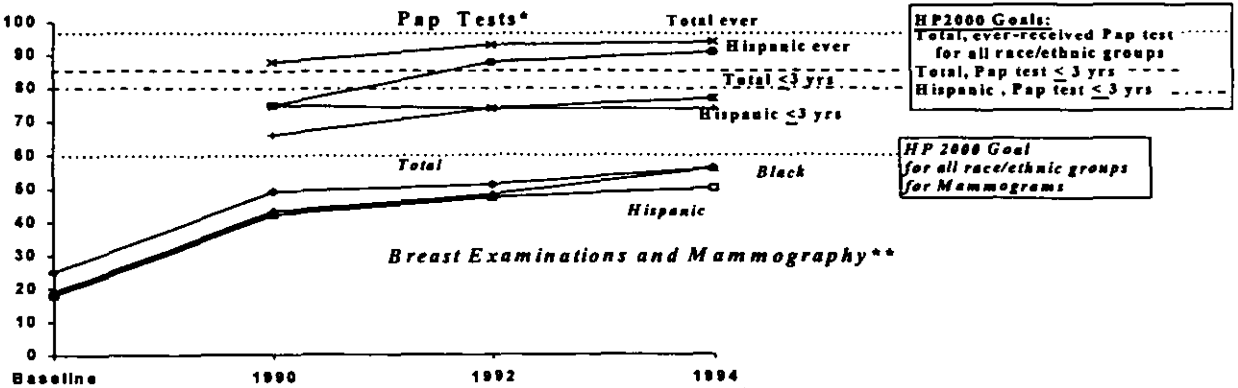
Eliminate disparities in and improve breast and cervical cancer screening and management.

Cancer is the second leading cause of death for most women, and the leading cause of death for Asian and Pacific Islander women.

Breast Cancer. Although black women have a lower risk of breast cancer than white women, their risk of dying from breast cancer is 30% greater-- most likely due to later diagnosis and treatment. While the breast cancer death rate decreased 5 percent for white women during 1980-1992, it increased 16 percent for black women. The overall 5-year survival rate for those diagnosed with breast cancer during 1986-92 was 85 percent for white women; for black women this rate was 70 percent. These disparities exist despite the fact that black and white women over 50 years of age are equally as likely to receive a mammogram (56 percent) during the previous 2 years. This rate is lower for Hispanic women (50%)and Asian and Pacific Islander women (46%). The incidence of breast cancer in Native Hawaiian women is more than 1.5 times greater than in white women.

Cervical Cancer. Death rates from cervical cancer are also higher for black (5.2 per 100,000 in 1995) and Hispanic women (3.1 per 100,000) than for the total population (2.5 per 100,000) Regular screenings for cervical cancer are critical for black and Hispanic women, who are at higher risk for cervical cancer. Only 57 percent of Asian and Pacific Islander women are screened, compared to 77 percent of white women. Major risk factors for cervical cancer are having multiple sexual partners and sexually transmitted diseases.

Pap Test and Mammography Rates Among U.S. Females by Race and Ethnicity, 1990-1994.



* Pap test rates are shown by total and Hispanic populations according to whether the test was ever done and whether the test was performed within the last 3 years.

**Breast examinations and mammography indicates those populations of women 50 years of age and over who have undergone this exam and test in the previous 1-2 years.

Strategy for Achieving the Goal

To be included in final version

Success Measures

To be included in final version

By the end of FY-98

⇨

⇨

⇨

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

16.11: Increase to at least 60 percent those women aged 50 and older who have received a clinical breast examination and a mammogram within the preceding 2 years.
    16.11a: Hispanic women; goal: at least 60 percent
    16.11e: Black women; goal: at least 60 percent

16.12: Increase to at least 95 percent the proportion of women aged 18 and older who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1 to 3 years.
    16.12a: Increase to at least 95 percent the proportion of Hispanic women aged 18 and older who have ever received a Pap test, and to at least 80 percent those who received a Pap test within the preceding 3 years.

Continuing, New, or Proposed Program Activity

The Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program offers free or low-cost mammography screening to women who are minorities, uninsured, low-income, or elderly. The resources devoted to breast cancer screening services have increased from $42 million in FY 1993 to $81 million in FY 1997. The program, which has been operating in an increasing number of states over the past six years has provided screening tests to almost one million medically underserved women. In October, 1996, the program went nationwide, with funding for all 50 states. The Indian Health Service has worked closely with this program to bring mammography services to American Indian/Alaska Native women living on remote reservation sites.

The **National Cancer Institute** sponsored a conference in January 1996 on the recruitment and retention of minorities in clinical trials. NCI will fund seven regional conferences on this topic for FY 1997. In addition NCI will continue research on:

Black/White Differences in Breast Cancer Screening - Research on molecular mechanisms to address Black\White differences in breast cancer screening

Cancer Education for Minority Training and Outreach - Includes new breast cancer RFA - student assistants, pain and outreach education programs

Familial Breast Cancer Resources - Provides an opportunity to do research related to inherited factors.

Minority Efforts in Cancer Centers - Activities targeted to increase research in cancers that affect minorities disproportionately and to promote cancer control research

New Therapeutic Initiative for Minorities - Investigation of improved cancer therapies for minority patients for both major killers (lung, breast, colon, prostate, and cervix) and diseases of higher relative incidence (myeloma, esophageal, gastric & cervical)

The HHS **Office of Minority Health** is funding a cooperative agreement with Albert Einstein Medical Center in Philadelphia, PA, to develop a model community-based cancer outreach program for minorities in high risk, low income, urban communities. The program provides cancer-related health education and screening for breast, cervical, and prostate cancer, and a case management and clinical pathways system to assure that individuals with abnormal screenings receive appropriate treatment and support. Other related activities in OMH include:

Minority Community Health Coalition Demonstration Grant Program supports health risk reduction activities planned and organized by minority community health coalitions.

Bilingual/Bicultural Demonstration Program supports a variety of community-planned efforts to increase health care access for people of different cultural and language backgrounds, particularly Hispanics, Asians, and Pacific Islander communities. Several early detection, screening, and health education programs for cancer have been funded through September 1998.

Key External Factors

To be included in final version

Coordination and Leadership within DHHS

To be included in final version

NIH is lead for this goal.

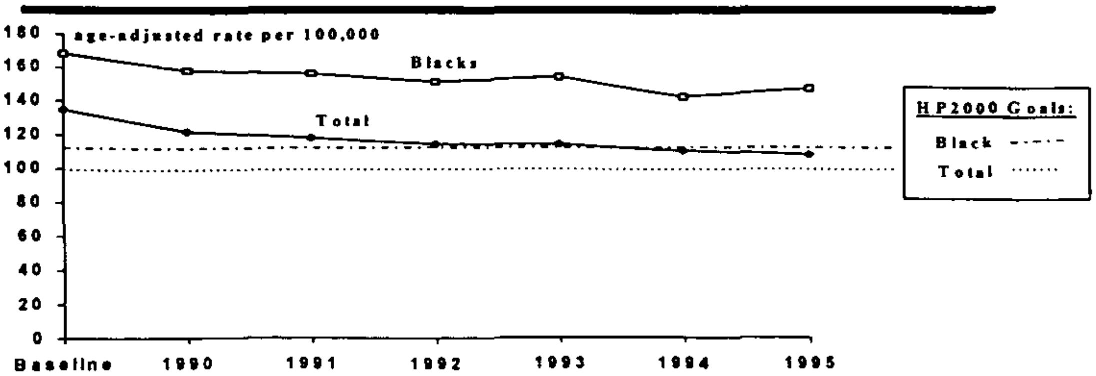
GOAL 3

Eliminate disparities in and reduce cardiovascular disease, including hypertension rates.

Cardiovascular disease, particularly heart disease and stroke, kill as many Americans as all other diseases combined. Cardiovascular disease is also one of the major causes for disability in the United States. The age-adjusted death rate declined for coronary heart disease for the total population by 16 percent from 1987 to 1995. For blacks, the overall decrease was only 8 percent with a slight increase in the age-adjusted death rate between 1992 and 1993. Within similarly insured populations such as Medicare recipients, there are significant disparities between blacks and whites in the use of certain diagnostic procedures for heart disease that cannot be explained by differences in the severity of symptoms.

Many of the risk factors for cardiovascular disease are detectable through regular check ups and modifiable through life style changes and medication: obesity, lack of exercise, smoking, high blood pressure, and high cholesterol. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to be undergoing treatment to control their high blood pressure. For example, during 1988-1994, 32 percent of black males ages 20 to 74 had hypertension compared with 25 percent of all men. When differences of age are taken into account, Mexican American men and women also have elevated rates. Although 54 percent of adults have had their blood pressure checked in the past two years, the rates for regular screening show disparities for certain racial and ethnic minorities--50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their blood pressure levels checked within the past two years.

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1990-1995.



Strategy for Achieving the Goal

To be included in final version

Success Measures

To be included in final version

By the end of FY-98

➪

➪

➪

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

15.1: Reduce coronary heart disease deaths to no more than 100 per 100,000 people.
  15.1a:Reduce coronary heart disease deaths among blacks to no more than 115 per 100,000 people.
15.4: Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control.
  15.4b:Increase to at least 50 percent the proportion of Mexican-Americans with high blood pressure whose blood pressure is under control.

Continuing, New, or Proposed Program Activity

The African American Community Cardiovascular Disease Prevention and Outreach Initiative, established in 1992 by the **National Heart, Lung and Blood Institute**. As a part of this initiative, NHLBI works with the National Medical Association to develop and implement community-based cardiovascular disease prevention and education projects for inner-city Blacks.

The Latino Community Cardiovascular Disease Prevention and Outreach Initiative, established in 1995 by the **NHLBI**. This initiative is composed of local projects that involve community members in health promotion and disease prevention programs; develop culturally appropriate and language-specific materials; involve existing community organizations and services; use select influential media; and incorporate positive community lifestyles, values, and beliefs. Plans are underway to transition these local projects to a national effort late in 1997, if funds are available.

Building Healthy Hearts for American Indians and Alaska Natives was established in 1996 by the **NHLBI**. It seeks to increase awareness and knowledge of risk factors for cardiovascular diseases, which account for nearly a quarter of all American Indians and Alaska Native deaths. The initaitive developes heart health promotion strategies that address needs and incorporate culture, tradition, lifestyles and values of Native Peoples.

The **Centers for Disease Control and Prevention**'s Division of Nutrition and Physical Activity oversees **WISEWOMAN**, which targets Hispanic women who are 50 years of age or older, do not qualify for Medicaid, and do not have medical insurance. This project, conducted in three states, aims to determine whether a comprehensive program to screen women for cardiovascular disease is feasible and effective, and whether a physical intervention activity is beneficial.

Key External Factors

To be included in final version

Coordination and Leadership within DHHS

To be included in final version

NIH is lead for this goal.

GOAL 4

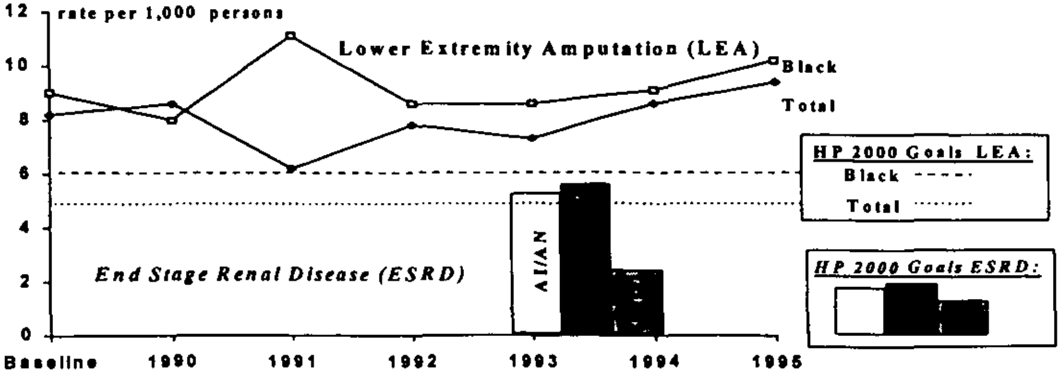
Eliminate disparities in and reduce diabetes-related complications.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting16 million Americans. The Centers for Disease Control and Prevention (CDC) estimates total direct and indirect costs of diabetes is $92 million. While remaining the same or decreasing for whites, prevalence and mortality rates for diabetes among American Indians/Alaska Natives and blacks have been increasing.

Fifty percent of diabetics are undiagnosed. Racial and ethnic minorities are at greater risk of Type II diabetes (which constitutes 90% of all diabetes) and its complications than the total population. The prevalence rate of diabetes among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for blacks, Puerto Ricans, Mexican-Americans, and Cuban-Americans, Native Hawaiians and certain subgroups of Asian Americans. Researchers are concerned about an alarmingly early age of onset of Type II diabetes, as early as pre-adolescence, reported for certain tribes, Blacks, and Mexican-Americans. Diabetes-related death rates are higher for Blacks, American Indians, Mexican-Americans and Puerto Ricans than for the total population.

Undiagnosed and poorly controlled diabetes increase the likelihood of serious complications from diabetes. Among the most serious complications are cardiovascular disease, diabetic eye-disease and blindness, end-stage renal disease, and foot disease and lower extremity amputations. Rates for diabetes-related complications such as end-stage renal disease and amputations are also higher among Blacks and American Indians as compared to the total population. Even with similarly insured populations such as Medicare recipients, Blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement--signs of poor diabetic control.

Diabetes-related Complication Rates for End-Stage Renal Disease (ESRD) and Lower Extremity Amputation by Race and Ethnicity, United States, 1990-1995.



Strategy for Achieving the Goal

To be included in final version.

Success Measures

To be included in final version.

By the end of FY-98

-
-
-

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

17.10: Reduce the most severe complications of diabetes as follows:
End-stage renal disease to 1.4 per 1,000
Blindness to 1.4 per 1,000
Lower extremity amputation to 4.9 per 1,000
Perinatal mortality among infants of women with established diabetes to 2%
Major congenital malformation among infants of women with established diabetes to 4%
17.10a: Reduce end-stage renal disease due to diabetes among black persons with diabetes to no more than 2.0 per 1,000
17.10b: Reduce end-stage renal disease due to diabetes among American Indians and Alaska Natives with diabetes to no more than 1.9 per 1,000
17.10c: Reduce lower extremity amputations due to diabetes among blacks with diabetes to no more than 6.1 per 1,000

Continuing, New, or Proposed Program Activity

National Diabetes Education Program: Launched in June 1997, this is a joint project of the National Institute of Diabetes & Digestive and Kidney Diseases (**NIDDK**) and the **CDC**'s Division of Diabetes Translation. The program involves both public and private partners to design ways to improve treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately to prevent the onset of the disease.

HHS has proposed a major national outreach and consensus development intervention initiative to reduce diabetes-associated disease and death, especially in racial and ethnic minorities. CDC and NIH would co-lead the initiative; part of the requested funding would be for the **National Diabetes Education Program**

Indian Health Service: A second initiative is proposed by IHS in collaboration with the Assistant Secretary for Planning and Evaluation (ASPE), CDC, NIH, HCFA, AoA, and the

Administration for Native Americans. In FY 1998, the initiative would establish comprehensive community-directed and community-based efforts to reduce incidence of Type II diabetes among American Indiana and Alaska Natives. It will evaluate the effects of promising trial methods in diverse tribal populations and provide newly available pharmaceuticals to prevent and control diabetes and its complications among American Indians/Alaska Natives.

Under a cooperative agreement with the HHS **Office of Minority Health**, the **Association of Asian Pacific Community Health Organization** is examining diabetes among the Asian and Pacific Islander American (APIA) population and is bringing together members of these communities to develop strategies for effectively engaging APIAs in the National Diabetes Education Program. This program seeks to reduce the morbidity and mortality of diabetes and its complications among the APIA communities.

Under a cooperative agreement with the HHS **Office of Minority Health**, The National Council of La Raza has established the **"Latino-Focused National Diabetes Education Program,"** designed to identify and assess the concerns of Latinos regarding diabetes, and develop the capacity of formal and informal Latino leaders to contribute input and participate in the development and implementation of the National Diabetes Education Program to help reduce the burden of diabetes among Latinos.

Key External Factors

To be included in final version.

Coordination and Leadership within DHHS

To be included in final version.

NIH and CDC are co-leads for this goal.

GOAL 5

Eliminate disparities in and improve access to state-of-the-art HIV testing, counseling, health care and support services.

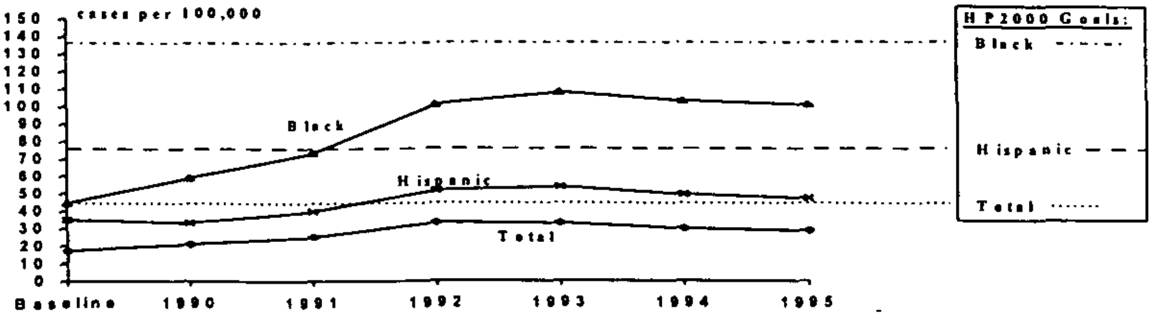
HIV infection is the leading cause of death for all persons 24-44 years of age. Half of the approximately 600,000 AIDS cases diagnosed in the U.S. have died. Racial and ethnic minorities constitute more than 50 percent of all AIDS cases, and more than 75 percent of all AIDS cases in women and children. The *number* of new AIDS cases among Blacks is now greater than the number of new AIDS cases among Whites.

There are a series of HIV epidemics in the U.S., each of which must be addressed differently and specifically. Although the HIV epidemic in White males continues to predominately affect men who have sex with men, injecting drug use and heterosexual contact with an infected injecting drug user plays a larger role in HIV transmission for other groups.

Inadequate detection and referral to follow-up care are major issues for high-risk populations. About 40 percent of persons who are at risk of HIV/AIDS have never been tested. In addition, the rate at which people return for HIV test results is relatively low--less than 40 percent of individuals who take an HIV test at either an anonymous or confidential site return for test results increasing the possibility that HIV-infected individuals will unknowingly transmit the disease. Better screening efforts are needed that are acceptable to the target community (i.e., they must be culturally and linguistically appropriate), and the capability of organizations serving at-risk populations to develop, implement, evaluate and fund programs must be improved.

Minority and majority populations do not benefit equally from efforts to improve treatment. Mainly due to the use of protease inhibitors, AIDS death rates declined 19% for the total U.S. during 1995-96, while AIDS death rates declined only 10% for Blacks and 16% for Hispanics. Contributing factors for these mortality disparities include lack of health insurance to pay for drug therapies, and unwillingness of doctors to prescribe them to individuals who may not comply with treatment regimens. These drugs cost between $10-$12,000 per patient per year.

AIDS Cases in the United States, by Race and Ethnicity, 1990-1995.



Strategy for Achieving the Goal

To be included in final version.

Success Measures

To be included in final version.

By the end of FY-98

- Increasing access to therapies that will prevent vertical transmission of HIV between mother and child.
- Increasing access to efficacious medications for people living with HIV/AIDS.
- Increasing access to supportive services related to HIV/AIDS treatment.

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

18.1: Confide annual incidence of diagnosed AIDS cases to no more than 43 per 100,000 population.

18.8: Increase to at least 80 percent the proportion of HIV-infected people who know their serostatus.

18.13: Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide on site primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases to high-risk individuals and their sex or needle-sharing partners.

Continuing, New, or Proposed Program Activity

Title IV, HIV/AIDS services and access to research for children, youth, women and families, and the Special Projects of National Significance Program co- fund the Women's Initiative for HIV Care and Reduction of Perinatal and HIV Transmission (WIN). This program aims to improve care for women living with HIV and reduce rates of HIV transmission to newborns. Programs serve high percentages of racial and ethnic minorities, in areas such as: Baltimore, New York, Boston, Trenton, Fort Lauderdale, Dallas and Philadelphia.

Through a collaborative effort with the AIDS Education and Training Center program and Title III, HRSA is providing training, as appropriate, to clinicians and support staff serving women of childbearing age (the majority of whom are from minority/ethnic groups) in Title III, Early Intervention Services-funded programs throughout the U.S. and Puerto Rico. In addition, a study is underway to assess the current HIV counseling and testing practices for pregnant women at HRSA funded programs. Results of the study will be available in Fall, 1997. Case studies were also conducted in seven locations around the country that have systems in place to provide a full range of clinical and social services to HIV-positive pregnant women and their infants. Among the findings were that these systems work because of dedicated providers and empowered patients; rural and urban sites are able to provide state-of-the-art care; social services are imperative; and costs are difficult to determine.

Increasing access to efficacious medications for people living with HIV/AIDS is the principal objectives of the AIDS Drug Assistance Program (ADAP) established under Title II of the CARE Act. ADAP is the second largest payor of efficacious medications for people living with HIV, after Medicaid. ADAP programs served 70,000 clients in 1995, nearly 30% were African-American and 27% were of Hispanic descent. Recent reports indicate that new HIV therapies are making a great difference in the lives of people who receive them. The benefits are, however, not uniform. While deaths for men living with AIDS decreased by 22 percent between 1995 and 1996, there was only a 7 percent decrease for women. And the decease for African-Americans was 10 percent as opposed to 28 percent for whites. The new therapies come with a high price tag. The more conservative estimates are that combination anti-retro viral therapy, including the newly approved protease inhibitors, will cost at least $10-12,000 a year per patient.

When other funds, such as private insurance, Medicaid, ADAP or private funds, are not available to a particular client who is in care in an Early Intervention Services (EIS) Program, EIS funds may be used to pay for the medication costs for that client. Approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.

The AIDS Education and Training Center (AETC) have a legislative mandate to provide training for minority providers and providers who treat minority populations. AETCs train a disproportionate number of minority providers in appropriate HIV therapeutics and the literature in this field indicates that minority providers are more likely to treat minority populations.

The majority of Special Projects of National Significance (SPNS) Program grants develop new models of HIV care for individuals from minority racial and ethnic populations. The SPNS Program currently is funding support service grants to increase access to HIV/AIDS care and related services for the following populations: Hispanic Border populations, urban African-Americans dually diagnosed with HIV and substance abuse, Native Americans and Alaska Natives who were not accessing HIV services, and Asian and Pacific Islanders in New York City. Intervention activities include: identification of affected individuals using community agencies and networks, linkage to housing, drug treatment, and education on appropriate HIV treatments.

HRSA through the administration of the Title I HIV/AIDS Emergency Relief grants for eligible metropolitan areas (EMAs) and Title II HIV/AIDS Care grants to States has consistently emphasized assuring access to needed care for all affected racial and ethnic communities. Service data from programs operated under Title I and II of the CARE Act indicate that African- Americans and Hispanics are represented among clients in a higher proportion than their representation in the epidemic. Additionally, the composition of HIV Health Services Planning Councils in Title I communities has been carefully monitored to assure adequate representation of communities of color on these important deliberative bodies.

The Title III Early Intervention Services Program provides grant support for outpatient HIV early intervention and primary care services for low-income, medically underserved individuals, primarily people of color in existing primary care systems. The objective of these programs is to maximize access to comprehensive and continuing clinical and supportive care for populations that have been disproportionately affected by the AIDS epidemic. Currently, approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.

The Title III program continues to fund a project to document existing migration patterns and to coordinate health care services for HIV-positive persons traveling between Puerto Rico and New York - the "**Air Bridge**" project. The goal of this project is to facilitate the continuity of care, referrals for services - many of which are supportive services - and follow up for this targeted population.

HRSA continues to publish "HIV Care Access Issues" -- a technical assistance series of reports that identify barriers and strategies to overcome barriers to HIV care among specific population groups, e.g., African Americans, Hispanics, Native Americans, and Asian Americans.

Key External Factors

To be included in final version.

Coordination and Leadership within DHHS

To be included in final version.

HRSA and CDC are co-leads for this goal.

GOAL 6

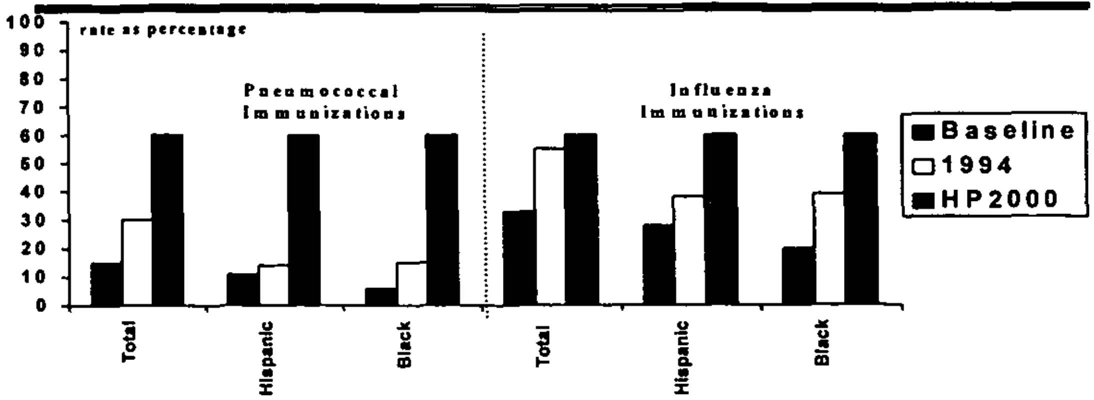
Eliminate disparities in age-specific immunization rates--infants to seniors

Children. Though childhood immunization rates are at an all-time high of 76 percent, approximately 1 million children under age 2 have not received the basic series of shots. Racial and ethnic minority children are especially at risk because they are less likely than white children to be vaccinated. For example, only 84 percent of African American children had received the DTP vaccine series (Diphtheria/Tetanus/Pertussis) in 1994, compared to 91 percent of white children. This is a greater than the disparity in rates between children living in poverty and those not living in poverty. Hispanics, Asians, and Pacific Islanders also are less likely than the total population to have received a tetanus booster during the past ten years.

Hepatitis. African Americans, American Indians/Alaska Natives, Asians, and Pacific Islanders are at increased risk for Hepatitis B. Chronic Hepatitis B infection increases the risk of liver cancer. Yet, about 90 percent of Asian and Pacific Islander children aged 3 to 13 have not received a Hepatitis B vaccine, which is recommended for all children. Hispanics and American Indians/Alaska Natives also are at increased risk for Hepatitis A--a food-borne form of hepatitis.

Adults. The overall cost to society of vaccine-preventable diseases exceeds $10 billion each year for adults alone, not including lives lost. Fewer than 500 children die each year of vaccine-preventable diseases, but 50,000 to 70,000 adults die of influenza, pneumococcal infections, and Hepatitis B. Vaccination levels for pneumococcal pneumonia and influenza among people 65 years and over have increased for African Americans and Hispanics, but the coverage in minority groups remains substantially below the year 2000 target.

Pneumococcal and Influenza Immunization Rates for Persons 65 Years and Older by Race and Ethnicity, United States, 1994.



Strategy for Achieving the Goal

To be included in final version.

Success Measures

To be included in final version.

By the end of FY-98

➪

➪

➪

By Year 2000

Related Healthy People 2000 Special Population Goals and Status:

20.11: Increase basic immunization series among children under age 2 to at least 90 percent.
20.11a: Increase pneumococcal pneumonia and influenza immunizations among blacks age 65 years and older to 60 percent.
20.11b: Increase pneumococcal pneumonia and influenza immunizations among Hispanics age 65 years and older to 60 percent.

Continuing, New, or Proposed Program Activity

The **Centers for Disease Control and Prevention** manages the Clinton Administration's **National Childhood Immunization Initiative**. The FY 1997 budget includes $638 million for vaccine purchase and $354 million for immunization program activities. Funding for childhood immunizations has more than doubled since FY 1993.

> Secretary Shalala launched the initiative in December of 1996 through a bilingual (English/Spanish) public service campaign. There is a bilingual (English/Spanish) childhood immunization phone service that provides general information on immunizations and referrals to local providers.
>
> Minorities are a major target group. CDC has begun creating immunization action plans with areas that have a large minority population. A major goal is to ensure that at least 90 percent of all two-year-olds receive the full series of vaccines by the year 2000.

The **CDCs** proposed activities in the field of adult immunizations include development of effective informational programs for health care providers and the public to motivate target populations; identify barriers to immunization services and develop strategies to increase access to these services; build model state programs for adult immunization, including limited vaccine purchase, in up to 15 project areas; develop and disseminate guidelines and standards for adult immunization practices; enhance surveillance for vaccine coverage, adverse events and vaccine-preventable diseases in adults; and support research on the efficacy, safety and cost effectiveness of vaccines target to adults.

Key External Factors

To be included in final version.

Coordination and Leadership within DHHS

To be included in final version.

CDC is the lead for this goal.

Race Initiative Policy - Health

Jennifer L. Klein
07/08/97 04:39:48 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc: Christopher C. Jennings/OPD/EOP, Sarah A. Bianchi/OMB/EOP
Subject: Racial Disparities in Health Care

You asked me to e-mail information on projects I mentioned in passing:

1. HHS has begun "Horizons: From Strategy to Infrastructure" a collaboration among HCFA, Peer Review Organizations and Historically Black Colleges and Universities to improve the status of African-Americans and other underserved populations in eight southeastern states. A pilot project launched in June will work to improve influenza immunization rates for African-American Medicare beneficiaries.

2. The Medicare Mammography Campaign that was launched by the First Lady has been operating for two years to increase the number of women on Medicare who take advantage of the mammography benefit offered by Medicare. This year the campaign focuses on rates among minority women, which have been particularly low. I am meeting next Monday at 1:30 with Ta Zitans, who is heading this project for HCFA. Anyone want to join me?

Race Initiative -
policy -
health

Chris -
See below.
Elena

HUMAN
RIGHTS
CAMPAIGN

1101 14th Street NW
Washington, DC 20005
website http://www.hrcusa.org
phone 202 628 4160
fax 202 347 5323

AIDS Facts

In the first six months of 1996, AIDS deaths in the United States decreased by 13%, marking the first such decline since the epidemic began in 1981. This decrease is the result of the sustained investment this country has made in HIV/AIDS research, prevention and care. But the need continues to grow. The facts are[1]:

- As of February 28, 1997, 581,429 Americans have been diagnosed with AIDS since 1981: 488,300 (84%) men; 85,500 (15%) women; and 7,629 (1%) children
- 365,000 American lives have been lost to AIDS since 1981; an average of 100 Americans are diagnosed with AIDS daily
- An average of 100 to 150 men, women and children become infected with HIV every 24 hours
- HIV infection remains the leading cause of death among 25-44 year olds, accounting for 19% of deaths in this age group
- One-quarter of new HIV infections in the United States occur among young people under age 21
- In the first six months of 1996, women accounted for 20% of newly reported AIDS cases; in the first six months of 1996, there was a 3% increase in AIDS deaths among women
- In 1985, 233 children were left without parents due to AIDS; in 1995, there were 30,000 children orphaned by AIDS; by the year 2000, this figure is expected to exceed 85,000 children[2]
- Over 76% of women infected with HIV are women of color
- In 1996, people of color accounted for over half (62%) of all adult AIDS cases reported in the United States; African Americans accounted for a larger proportion (41%) of adult AIDS cases than whites (38%) for the first time in the epidemic

EK -
Race
idea
BR

---

[1] Source: Centers for Disease Control and Prevention, 1996

[2] Source: AIDS Project Los Angeles