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Plan to address health disparities and promote health equity in New Hampshire

The State Plan Advisory Work Group

Plan to Address Health Disparities and Promote Health Equity in New Hampshire

Prepared for the

New Hampshire
Health & Equity Partnership

by

The State Plan Advisory Work Group

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Executive Summary

In 2010, the Endowment for Health, the Foundation for Healthy Communities, the NH Institute for Health Policy and Practice, the NH Minority Health Coalition, and the NH Department of Health and Human Services (DHHS) Office of Minority Health and Refugee Affairs (OMHRA) established the NH Health and Equity Partnership to examine issues relating to the health of New Hampshire's racial, ethnic and linguistic minorities. This new public-private partnership identified the need for a clear plan to guide its work. The ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire*** outlines strategic priorities for the NH Health and Equity Partnership. The scope and implementation of the plan is not limited by the resources of State Government, nor by the capacity of a single person, agency or organization. This plan is a call to action for organizations and community members to join the NH Health and Equity Partnership to implement this agenda across multiple sectors. Summary recommendations include:

Access to Care

- Expand access to high quality and affordable healthcare.
- Promote an integrated, holistic health perspective to include the physical, mental and oral.
- Develop community members' health literacy and capacity to navigate the healthcare system.
- Support efforts to improve providers' capacity to serve diverse populations.
- Improve the education that providers receive on patient-centered, culturally responsive care.
- Advocate for funding streams tied to culturally and linguistically appropriate healthcare.
- Diversify the healthcare workforce to better reflect the populations served.

Environments Where We Live, Learn, Work and Play

- Increase opportunities for physical activity, access to healthy foods, and safety in neighborhoods in which minorities live, learn, work and play.
- Expand transportation options and improve use of existing options.
- Improve early childhood development and school-based programs' cultural effectiveness.
- Expand accessibility and effectiveness of education and training opportunities for minorities.
- Encourage employers and labor unions to dedicate resources to recruitment, training and retention of racial, ethnic and linguistic minorities for staff and leadership positions.
- Support initiatives that encourage minority groups to build networks.

Awareness and Promotion of Health Equity

- Educate and involve partners outside the health sector who impact where we live, learn, work and play in improving health and equity.
- Incorporate concepts of civic and social responsibility in health and equity discourse.
- Identify and pursue funding opportunities to support the priorities of this plan.
- Encourage public, private and nonprofit organizations to prioritize and budget for health equity.
- Build and maintain a collaborative public-private partnership structure to implement the plan.
- Influence and create public policy that supports health and equity.

Data

- Establish NH DHHS guidelines and policy for the collection of race, ethnicity and language data as a model for other agencies and organizations.
- Identify resources for electronic data system improvements and quality assurance.
- Train collectors and submitters of race, ethnicity and language data to use NH DHHS policy.
- Educate the public about the collection of race, ethnicity and language data.
- Work with data stewards to stratify their data to identify disparities.
- Develop an equity index reflecting data from health and other sectors.

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

- World Health Organization

"The conditions in which many clinical encounters take place—characterized by high time pressure, cognitive complexity, and pressures for cost containment—may enhance the likelihood that these processes will result in care poorly matched to minority patients' needs. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity. Further, financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities' ability to obtain quality care."

Unequal Treatment:
Confronting Racial and Ethnic Health Disparities in Health Care
- Institute of Medicine 2003

I. Introduction

In 2010, the Endowment for Health, the Foundation for Healthy Communities, the NH Institute for Health Policy and Practice at the University of New Hampshire, the NH Minority Health Coalition, and the NH Department of Health and Human Services (DHHS) Office of Minority Health and Refugee Affairs (OMHRA) initiated a public-private partnership, the NH Health and Equity Partnership, to identify priorities for action to work towards health equity for racial, ethnic and linguistic minorities in New Hampshire (NH). Representatives of these organizations and other stakeholders formed a State Plan Advisory Work Group responsible for developing a clear plan to guide its work. The ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire*** outlines strategic priorities for the NH Health and Equity Partnership. The work group developed this plan using a collaborative planning process involving diverse public, private and nonprofit stakeholders. The goal was to define statewide priorities and prepare recommendations to advance health equity for NH's minority communities. The scope and implementation of the plan is not limited by the resources of State Government, nor by the capacity of a single person, agency or organization.

The ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire*** considers health equity within the broad framework of social determinants such as education, housing, employment, environment, and other factors that influence health status and access to quality health care for individuals and communities. By addressing health disparities at their source we will improve health and health care for minority communities and for the general population statewide.

What Are Health Disparities?

Not everyone in the United States enjoys the same health opportunities. Studies show that minority populations often experience poorer than average health and health outcomes—they are more likely to die as infants, have higher rates of diseases and disabilities, and have shorter life expectancies. The Federal Office of Minority Health defines health disparities as "the persistent gaps between the health status of minorities and non-minorities in the United States."[1] In 2003, an Institute of Medicine Report, ***Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care***,[2] helped to raise national awareness about health disparities. Unfortunately, eight years later disparities still persist. For example:

> Infant mortality rates are twice as high for black babies as they are for white babies, and

> Hispanic women are twice as likely to have cervical cancer as white women.[3]

Health disparities have been well documented on a national level. While they are not as clearly documented in NH, there is enough evidence that they do exist. For example, statewide studies by the NH Minority Health Coalition show dramatic differences in health insurance coverage by race, with 89% of non-Hispanic Whites reporting having coverage in 2002, and only 62% of African descendants and 38% of Latinos reporting health insurance coverage.[4] The Coalition also found racial and ethnic disparities in weight and weight control, as well as prevalence of hypertension.

[1] U.S. Department of Health and Human Services, National Partnership for Action, "Health Disparities," available at http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=13#top. Accessed online October 2010.

[2] Smedley BD, Stith AY, Nelson AR, eds. ***Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*** Washington DC: National Academies Press; 2003.

[3] Mead H, Cartwright-Smith L, Jones K, Ramos C, Woods K, Siegel B. ***Racial and Ethnic Disparities in U.S. Health Care: a Chartbook***. New York, NY: The Commonwealth Fund; 2008.

[4] New Hampshire Minority Health Coalition. ***Disparities in Health: A Growing Reality for New Hampshire***. Issue Paper 1. Manchester, NH: September 2004.

What Factors Influence Health?

Barriers in access to health care and differences in the quality of care received certainly contribute to health disparities. Overcoming cultural and linguistic barriers, especially, are critical to accessing high quality health care. However, health is not merely the result of medical or clinical care but the sum of what we do as a society to create the conditions in which people can be healthy.[5] Other factors are now recognized as being equally, if not more important in determining one's health and health status including income and poverty status, education, employment and working conditions, housing quality, and environmental features including access to healthy food choices, walkable streets, and safe neighborhoods. This complex array of social, cultural, and environmental factors that impact one's quality of life are called social determinants of health, and they contribute significantly to health disparities. Figure 1 illustrates these diverse factors, or social determinants, that impact health. It is the combined differential experiences in access to health care, quality of healthcare, individual health behaviors, and social determinants that result in inequalities in health for racial, ethnic and linguistic minority populations.

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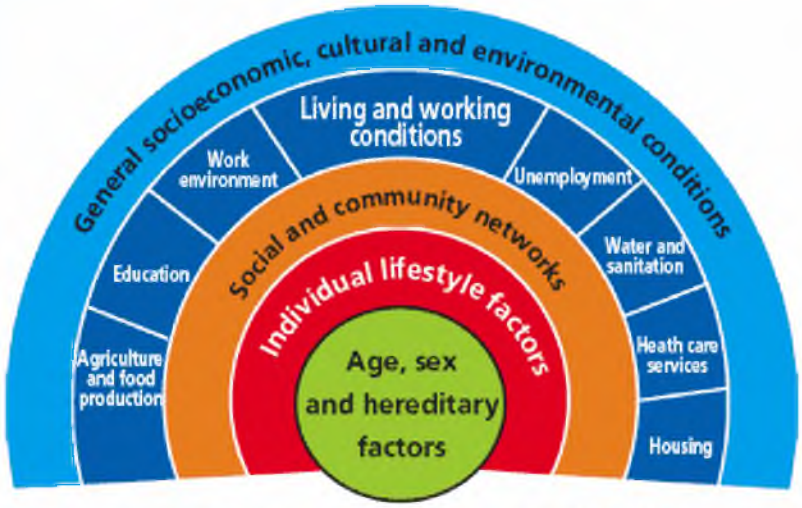

FIGURE 1. **Factors that Determine Health**[6]

Why Does NH Need A Plan?

Every resident in NH shares the same concerns for health, housing, education, employment, and quality of life. Some populations struggle because they do not have adequate opportunities to maintain optimum health. We succeed as a state when we ensure opportunity for all, including the opportunity for health and well-being. By applying our ingenuity, we can make better use of our limited resources, progress towards solving health disparities, and develop programs and services that are fairly distributed and accessible

[5] Institute of Medicine. ***The Future of Public Health***. Washington, DC: National Academy Press, 1998.

[6] Dahlgren G, Whitehead M. ***Policies and strategies to promote social equity in health.*** Stockholm: Institute for Future Studies; 1991.

across all communities. Developing a ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire*** will focus our collective efforts to promote initiatives and policies that can help make our communities healthier places to live, learn, work and play for all.

Historically, NH's population has been predominantly white, of European or Canadian descent; however the state has been transitioning over the past two decades to reflect an increasingly diverse population base. The immigrant population is also increasing, with Latinos/Hispanics being the state's largest minority group. Between 2000 and 2008 the State's foreign-born population increased by 26%.[7] However, not all racial, ethnic and linguistic minorities are recent immigrants. NH is also home to individuals who are deaf, African Americans, Native Americans, and multi-racial or multi-ethnic children and families. Each of these groups experience unique forms of marginalization and exclusion from mainstream opportunities to create healthy lives. The plan identifies strategies that recognize these unique challenges, while promoting health and equity for all minority groups.

A ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire*** will serve as a guiding document for a variety of organizations and coalitions, some of whom have been working to eliminate health disparities for years. The plan builds off the work of past efforts to address disparities in NH (described in detail below). While much has already been accomplished, continued collaboration will be critical to achieve systemic change. Now is the time to focus the energy of these groups by improving collaboration. The plan also clearly presents these issues for a wide audience, including new leaders and stakeholders who have not worked on these issues in the past. This plan will help to engage new partners as issues of health and equity gain momentum and importance in NH.

Past Efforts to Address Disparities in NH

The NH Minority Health Coalition

In 1993, Sandra Hicks led a small group of concerned citizens interested in improving health for NH's growing population of racial and ethnic minorities, to form the New Hampshire Minority Health Coalition (NHMHC). A statewide organization, the NHMHC's mission is to "identify underserved populations in the state with barriers to accessing appropriate health care, to advocate for adequate and appropriate services, and to educate and empower these populations to be active participants in their own health."

By 1995, the organization had six volunteer board members and one paid staff member who delivered HIV prevention services. In 2001, it grew to a staff of approximately twenty after receiving Center's for Disease Control and Prevention (CDC) funding to improve the health of African Descendent and Latino communities in Hillsborough County, as part of the Racial and Ethnic Approaches to Community Health (REACH) 2010 initiative. This project engaged numerous community-based organizations, state and local agencies, local companies and private residents representing diverse, underserved minority communities concerned about the appropriate delivery of health care services to these communities.

Today, NHMHC continues its direct-service work to address disparities through a bi-lingual and bi-cultural *Bright Start* Home Visiting Program for at-risk new and expectant moms, outreach to expand access to mammograms, and an HIV prevention program, all in Manchester. Additionally, the NHMHC has had a

[7] U.S. Census Bureau Population Estimates Program, ***2005-2009 American Community Survey 5-Year Estimates***, "New Hampshire Fact Sheet," Available at: http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&geo_id=&_geoContext=&_street=&_county=&_cityTown=&_state=04000US33&_zip=&_lang=en&_sse=on&pctxt=fph&pgsl=010. Accessed online February 2011.

longstanding statewide presence by conducting cultural competency trainings across NH, and playing a lead role in minority health advocacy in NH since its inception. The NHMHC currently holds positions on the leadership team for NH Voices for Health, and on a legislative commission looking at the State's Child Health Insurance Program. NHMHC is also the lead organization for the Boston Public Health Commission's REACH Across the US Center of Excellence in Eliminating Disparities (CEED) funded Legacy Project to address disparities within African descendent communities in NH.

The Medical Interpretation Advisory Board

In 2001, a diverse group of stakeholders assembled to serve in an advisory capacity for several grant-funded projects aimed at improving the ability of healthcare providers to provide communication access. This group grew into the Medical Interpretation Advisory Board (MIAB) and has overseen the implementation of several successful initiatives since its inception. Initially, Southern NH Area Health Education Center and the NH Minority Health Coalition partnered to provide medical interpretation training for foreign language interpreters and cultural competency training for healthcare providers. To date, approximately 365 medical interpreters have been trained in 42 languages. At the same time, Lutheran Social Services developed the Language Bank as a referral service for healthcare providers to find trained interpreters in appropriate languages. Today the Language Bank and other organizations provide trained medical interpreters for thousands of medical encounters in NH each year.

While supporting these initiatives, MIAB recognized the need for additional research and programs beyond the scope of these projects. Grant funding enabled research that resulted in the report, ***Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers***, authored by the Access Project and Cultural Imperative. The results of that research, as well as anecdotal stories from deaf, hard of hearing (D/HH), and limited English proficient (LEP) patients, and the MIAB's shared experiences with the existing service delivery system served as the impetus for a strategic planning process focused on increasing access to quality healthcare for limited English proficient and deaf and hard of hearing populations in NH by improving communication access in medical encounters. This process engaged new participants and provided the opportunity for shared learning between representatives of the deaf and hard of hearing community and communities for whom English is not a primary language. The Advisory Board grew into a coalition and a strategic plan was completed in 2005. Between 2005 and 2010, the MIAB convened three large statewide conferences on culturally and linguistically appropriate healthcare for healthcare providers. Reassessment of the MIAB Strategic Plan in 2009 -2010 revealed a desire by MIAB coalition participants to address a broader set of barriers to health beyond communication access. This began the MIAB's journey to involvement in statewide planning to address health disparities and promote health equity.

The NH Office Of Minority Health And The Diversity Task Force

In October 1999, the NH Department of Health and Human Services (DHHS) created the NH Office of Minority Health (OMH), demonstrating its commitment to improving access to DHHS services and developing strategic, focused efforts to improve the health of NH's minority communities. DHHS considers the activities and impact of OMH to cut across all of DHHS' services, as demonstrated by the fact that OMH reports directly to the Commissioner's Office. Since its inception, OMH has employed a broad vision and partnership structure to improve minority health in NH. OMH has also participated in regional initiatives with the other New England states to promote health equity, linking its policy and programmatic priorities to those defined by the Federal Office of Minority Health and by the community members for whom it advocates.

Since 1998, DHHS has relied on input and feedback from members of the Diversity Task Force (DTF) to help guide its work. The DTF functioned first as an advisory committee to DHHS and OMH, and over time expanded to encourage participation from ethnic minority leaders and community members in the work of OMH. Together, OMH and the DTF worked on issues such as improving communication access, training staff on cultural competency, mediating challenges to refugee and immigrant integration, disseminating information to minority groups, and addressing health disparities. In 2009-2010, the group began to use a wider framework to look at issues of equity across sectors, mirroring the social determinants of health framework described in this plan. OMH has expanded its programs over the past year to include NH's refugee resettlement program (reflected in its new name, the Office of Minority Health and Refugee Affairs, OMHRA), and a healthcare workforce training initiative. As one of the organizations leading the development of the plan, OMHRA is committed to its implementation and will represent DHHS in the NH Health and Equity Partnership.

Community-Based Organizations

To complement the more formal institutions and organizations described above, NH has an active sector of community-based organizations and networks led by and comprised of racial, ethnic and linguistic minorities. These include, but are not limited to organizations representing Africans, African Americans, Bhutanese, Latinos/Hispanics, Native Americans, Vietnamese, deaf and hard of hearing individuals, and others. Individually, these organizations and networks have had varying degrees of success at establishing formal non-profit status or advocating on behalf of their constituents. Many of these organizations function with very limited staff and resources, and they often end up competing for funding and visibility.

However, despite these constraints, NH's small community-based organizations have consistently improved the lives of their constituents and encouraged resiliency and self-advocacy in their communities. Members rely on these organizations and their leaders for assistance with transportation, interpretation, navigating health and social service systems, interpreting cultural norms, accessing education and employment, and many other needs. In essence, these organizations creatively and effectively fill the gaps where more formal services are lacking. Recommendations in the plan draw from the expertise of these leaders and organizations and aim to fill more of these gaps. The strength of the NH Health and Equity Partnership will lie in the participation of all interested community-based organizations, so that the knowledge, interests and needs of NH's minority community members are incorporated at all stages throughout the process.

II. Methods

The Plan to Address Health Disparities and Promote Health Equity in New Hampshire was developed through a highly collaborative, participatory process during the summer and fall of 2010. The planning process included two phases. Each phase provided important input from the full range of resources and stakeholders to identify priority issues and recommendations for eliminating health disparities and promoting health equity in NH.

Phase I

Phase I funding was provided by the Endowment for Health for the NH Institute for Health Policy and Practice to conduct an ***Assessment of Race, Ethnicity and Language Data Collection in New Hampshire Public Health Data Sets***.[8] Researchers surveyed data stewards of NH public health data to see how closely these data sets align with data collection guidelines and recommendations from the U.S. Office of Management and Budget (OMB) and the Institute of Medicine (IOM). This assessment, which documents current public health data collection in NH, was completed and released in September 2010.

Phase II

Phase II funding was provided by the NH Office of Minority Health and Refugee Affairs (OMHRA) to identify the priority needs to be addressed in a plan. Altarum Institute was contracted to provide coordination and technical support to the State Plan Advisory Work Group's activities in achieving these goals. To inform the work group's efforts and decision making processes in the planning process, Altarum reviewed studies and reports produced by diverse stakeholder organizations; conducted a review of other state minority health plans; and engaged stakeholders in focus groups and key informant interviews to identify needs, gaps, priorities and strategies for addressing health disparities experienced by racial, ethnic and linguistic minority populations in New Hampshire. The qualitative findings are included in the report, ***Towards Development of a State Plan to Reduce Health Disparities and Promote Health Equity in New Hampshire: Summary of Qualitative Findings from Focus Groups and Key Informant Interviews.***[9] Phase II data sources include:

Reports and Study Review. Several public and nonprofit organizations have previously conducted and released studies, and provided recommendations related to health issues and their social determinants in NH's minority communities. Some reports address the concerns of specific localities, while others address broader, statewide concerns. The Phase I results were also reviewed to guide development of the plan.

Review of Other State Plans. Other state minority health plans were reviewed, and telephone interviews and online plan retrieval were conducted to provide an understanding of their scope, content and formats. The State Plan Advisory Work Group considered other states' experiences developing and implementing their plans as part of the planning process.

[8] Schreiber J, Costelly A. ***Assessment of Race, Ethnicity and Language Data Collection in New Hampshire Public Health Data Sets.*** Durham, NH: University of New Hampshire, NH Institute for Health Policy and Practice; September 2010. Available at: www.nhhealthpolicyinstitute.unh.edu/pdf/Assessment.pdf

[9] Pooler J, Korda H. ***Towards Development of a State Plan to Reduce Health Disparities and Promote Health Equity in New Hampshire: Summary of Qualitative Findings from Focus Groups and Key Informant Interviews.*** Altarum Institute; September 2010.

Focus Groups and Key Informant Interviews. Four focus groups and 17 key informant interviews were conducted by Altarum Institute and members of the State Plan Advisory Work Group to obtain input on what is currently being done within the context of serving racial, ethnic, and linguistic minorities and addressing social determinants of health; how health is defined and the supports and challenges individuals face in being healthy; and what should be considered in creating the statewide plan. A variety of stakeholders participated including health care providers, health department officials, community members, and public service officials, among others. Fields represented include: law enforcement, transportation, legal assistance, employment and labor, faith-based, environmental services, deaf and hard-of-hearing, health care providers, foundations, and agriculture.

Phase III

Phase III, funded by the Endowment for Health and OMHRA, will offer an opportunity for interested partners and community members to become more engaged as the plan is implemented. In early 2011, ad hoc work groups will form around the four priority areas outlined in the plan, and by May 2011 work plans with a 2 year scope will be developed for each priority area. As a living document, this plan will guide the work of the NH Health and Equity Partnership for at least 5 years, and progress towards the objectives will be monitored by a steering committee.

III. Priority Areas and Recommendations

The State Plan Advisory Work Group reviewed diverse inputs in the development of priority areas and recommendations for the Plan to Address Health Disparities and Promote Health Equity in New Hampshire. The need for an in-depth review process emerged due to the fact that the recommendations below are not discrete and isolated. Instead, they overlap and will be implemented simultaneously. For example, educational attainment is linked to economic stability and access to a living wage. However, certain populations do not have equal access to a quality education. Therefore many of the recommendations cited in this plan under the topic of access, such as improving cultural competency education and training, or improving transportation systems, can be applied to education and employment topics, not solely health topics. Furthermore, by using an integrated, holistic perspective of health that includes physical, mental and oral health, the recommendations in this plan can be viewed as addressing the overall health and wellness of individuals and our society. Using a social determinants of health framework, success in one area of this plan will serve as a catalyst for action in other areas, and all successes will help to eliminate health disparities for minority populations statewide.

In October 2010, preliminary recommendations were shared for additional input and comment with a larger stakeholder audience at a public feedback forum. The final recommendations below are the result of this highly collaborative process. They are applicable across private, nonprofit and public sector organizations and represent the commitment of the NH Health and Equity Partnership to advancing health equity for racial, ethnic, and linguistic minorities statewide. The Partnership supports, encourages and promotes implementation of these recommendations, described below.

1. Access to Care

NH's growing diversity challenges the healthcare system to adapt to meet a broad spectrum of new, often unrecognized or unknown needs. The patient-centered care each healthcare organization strives to offer requires a high level of sensitivity and responsiveness. At the same time, requirements to provide interpreters and culturally responsive care have increased. Given the high cost of U.S. healthcare, providers face real challenges in their efforts to provide high quality healthcare to the state's entire population. At the same time, NH is home to a complex healthcare system. Even when individuals are insured, they often have to advocate for themselves or follow complicated directions to navigate the system, receive test results, locate specialists, or care for all aspects of their mind and body. In this context, achieving high quality health poses unique and complex challenges for minority populations and providers.

Economic Barriers

Economic barriers to accessing care are significant. Many individuals lack adequate health insurance, even when employed, or rely on Medicaid if they are eligible. Recent immigrants, here in the U.S. less than five years are not eligible for public health insurance, unless they are granted special status like refugees or asylees.[10] Of those eligible for Medicaid, many are not enrolled in this publicly funded health program. Nearly half of all non-citizen immigrants are uninsured, a rate that is nearly three times higher than U.S.-born citizens.[11]

[10] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, Pub.L. 104-193, 110 Stat. 2105, enacted August 22, 1996).

[11] Ku, L. ***Why Immigrants Lack Adequate Access to Health Care and Health Insurance.*** Washington, DC: Migration Policy Institute, September 1, 2006.

Transportation

Transportation for many minorities, especially new refugee and immigrant arrivals and deaf or blind individuals, is yet another barrier to care. Availability of public transit is extremely limited in NH, especially in rural parts of the state, and poses a particular burden on low-income individuals.

Oral Health

Integrated care, sometimes referred to as "putting the mouth and mind back in the body," is essential for ensuring healthy individuals. Oral health is an important component of general health and well-being. Like many low-income NH residents, minority populations experience severe problems accessing dental care. Even where dental care is available, insurance coverage often is not, and out-of-pocket costs are beyond the means of many low-income minorities. Additionally, language access and medical interpreters are underutilized in oral health care due to financial obstacles.

Mental Health

Like oral health, mental health is also an important component of general health and wellbeing. Refugees and immigrants have experienced dislocation, either forced or voluntary, from their countries of origin, and may experience stress due to migration and acculturation. Some are survivors of torture and/or trauma and may require specialized treatment with culturally competent mental health providers. Children who are deaf or hard of hearing are at particular risk for physical abuse or sexual abuse.[12] The isolation of being limited English proficient (LEP) or deaf in an English speaking culture is a cause for stress and a challenge for maintaining mental health. Barriers to mental health for these populations include the cost of services, lack of parity in mental health insurance coverage, a lack of trained providers, lack of interpretation, and ineffective outreach and treatment methods due to the impact of diverse cultural norms. Cultural stigma regarding mental illness also creates a significant barrier to care for many minority persons in need of assistance.

Cultural Barriers And Health Literacy

While many people face economic and geographic barriers to accessing health care and health, minorities face additional social and cultural barriers. Cultural norms and low health literacy are common impediments to minorities' access to all types of healthcare. The Institute of Medicine reports that nearly half the population in the United States has difficulty understanding and using health information.[13] According to the American Medical Association, poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and race."[14]

> *Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. Health literacy varies by context and setting and is not necessarily related to years of education or general reading ability.*[15]

While low health literacy is common, health care providers commonly presume their patients possess basic health literacy skills. This can be compounded for racial, ethnic and linguistic minorities who may interpret symptoms of illness differently, or may have greatly varying levels of formal academic instruction. LEP and deaf and hard of hearing individuals may also find it challenging to understand what their provider is saying due to differing exposures to mainstream media and culture.

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[12] Shah R, Lotke M. "Hearing Impairment: Follow-up". ***eMedicine*** by WEB MD: Updated September 10, 2010. Available at http://emedicine.medscape.com/article/994159-followup. Accessed online December 2010.

[13] Institute of Medicine. ***Health Literacy: A Prescription to End Confusion.*** Washington, DC: National Academy Press; April 8, 2004.

[14] American Medical Association. ***Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs.*** JAMA; Feb 10, 1999.

[15] National Network of Libraries of Medicine. "Health Literacy". Available at: http://nnlm.gov/outreach/consumer/hlthlit.html. Accessed online February 20, 2011.

Communication Barriers

Effective communication between the patient and the healthcare provider is critical to the delivery of quality health care and is required by Federal regulations. LEP and deaf and hard of hearing patients who face communication barriers delay seeking care, are less likely than others to have a usual source of medical care, receive preventive services at reduced rates, and have an increased risk of nonadherence to medication and treatment.[16] Such barriers impair discussions of symptoms and treatment alternatives, resulting in misdiagnoses or poor treatment decisions. Communication barriers also impede the understanding of and adherence to treatment plans and therapies. Medical interpreters, when assessed and trained, can help in bridging this critical communication gap between provider and a LEP patient.[17] To improve these communication barriers, Title VI of the Civil Rights Act mandates language access for limited English speakers and Title III of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act mandate communication access for individuals who are deaf or hard of hearing. Despite these mandates and efforts to expand communication access, the availability of foreign language and ASL/English interpreters in medical settings in NH is still limited.

Workforce Diversity

Lack of diversity in the healthcare workforce can add additional hurdles to communication and cultural understanding during the medical visit. Benefits of a diverse healthcare workforce include improved access to care, greater patient choice and satisfaction, and improved adherence to treatment, as well as strengthening the cultural competence of the health system.[18, 19]

> *There already is strong evidence that ethnic minority physicians are more likely to provide care for ethnic minority and socioeconomically disadvantaged patients. There is a strong link between race and ethnic concordance (and language concordance) and the quality of patient–physician communication, other health care processes, and some patient outcomes. This link makes it all the more important to increase ethnic diversity among health professionals, enabling ethnic minorities to have improved access to care and better experiences with health care.*[20]

[16] Flores G. Perspective: Language barriers to health care in the United States, ***New England Journal of Medicine 2006***; 355:229-231 July 20, 2006. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp058316.

[17] Robert Wood Johnson Foundation. "Importance of Language Services." June 4, 2008. Available at: http://www.rwjf.org/qualityequality/product.jsp?id=28822. Accessed online December 2010.

[18] Cohen JJ, Gabriel, BA, Terrell, C. The case for diversity in the health care workforce, ***Health Affairs***, 2002, 21(5):90-102

[19] Health Resources and Services Administration. "The Rationale for Diversity in the Health Professions: A Review of the Evidence," Washington, DC: U.S. Department of Health and Human Services; October 2006.

[20] Cooper LA, Powe NR. D***isparities In Patient Experiences, Health Care Processes, And Outcomes: The Role Of Patient–Provider Racial, Ethnic, And Language Concordance.*** The Commonwealth Fund; July 2004.

Access to Care - Key Points

- Access to affordable and quality healthcare disproportionately affects minority populations.
- Integrated care is essential for ensuring healthy individuals. This will require changes to physical, mental and oral healthcare systems.
- Federal regulations require that healthcare providers ensure effective communication with their patients, but there is limited funding available to support providers in this effort.
- Culturally responsive care and improved health literacy can greatly improve health out
- There is evidence to support the belief that a diverse health care workforce results in improved access, satisfaction and outcomes, such as adherence to treatment.

Access to Care - Recommendations

Healthcare Access

> Expand access to high quality and affordable healthcare.
  - o Expand access to health insurance coverage.
  - o Develop high quality patient centered health care for all.
  - o Address transportation needs to enable access to healthcare service providers.

> Promote an integrated, holistic health perspective to include the physical, mental and oral.

> Develop community members' health literacy and capacity to navigate the healthcare system.

Cultural Competence

> Support efforts to improve providers' capacity to serve diverse populations.
  - o Require training on cultural competence and on all forms of discrimination as part of training, licensure, and continued credentialing of all health professionals.
  - o Promote culture change within healthcare organizations to improve the delivery of culturally responsive care.

> Improve the education that providers receive on patient-centered, culturally responsive care.

Communication

> Advocate for funding streams tied to culturally and linguistically appropriate healthcare.
  - o Support efforts to improve organizations' capacity to serve linguistic minorities.
  - o Work to improve access to ASL/English interpreters in medical settings.

Workforce Diversity

> Diversify the healthcare workforce to better reflect the populations served.
  - o Expand the pool of diverse healthcare workers through proven practices such as pipe line initiatives and utilizing the skills of foreign-trained health workers.

2. Environments Where We Live, Learn, Work and Play

The economic, social and environmental conditions individuals experience on a day-to-day basis play a significant role in shaping their health and quality of life. Factors related to individual and community health status that challenge most NH residents—finding a job or housing in troubled economic times, finding transportation options—also affect minority populations, often to a greater extent. It is the combination of factors related to where we live, learn, work and play that set the stage for health and well-being.

Environments Where We Live

Our built environment, defined as "*the physical structures and infrastructure of communities*" can directly impact our health. The Prevention Institute explains, "*The designated use, layout and design of a community's physical structures including its housing, businesses, transportation systems, and recreational resources affect patterns of living (behaviors) that, in turn, influence health.*"[21] In NH, affordable housing is often out of reach for many low-income minorities. Minority populations are spatially concentrated, with greatest diversity in urban cores.[22] Many of these areas have less resources, poorer schools, higher crime rates, fewer safe places for children to play outside, and limited access to healthy food. These low-income communities are more likely to face environmental hazards and inadequate infrastructure to support a healthy lifestyle.

> ***"Our zip code may be more important to our health than our genetic code."***
>
> - Robert Wood Johnson Foundation Commission To Build a Healthier America

Cultural barriers can also come into play when minorities seek safe and healthy environments in which to live. For example, there are few housing systems appropriate for deaf and hard of hearing senior citizens. New England Homes for the Deaf in Massachusetts offers assisted living facilities for this population. However, NH has no assisted living facility of this kind, so many deaf and hard of hearing seniors end up being placed in nursing homes.

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[21] Aboelata M. ***The Built Environment and Health: 11 Profiles of Neighborhood Transformation.*** The Prevention Institute. July 2004.

[22] Johnson K. ***The Changing Faces of New Hampshire: Growing Diversity.*** Carsey Institute, UNH: Presentation to N.H State Advisory Committee of U.S. Civil Rights Commission, 9/20/2010.

Lack of transportation is an element of the built environment that is a frequent challenge for low-income minorities. The state's limited availability of public transportation poses problems for many of NH residents, especially those in rural communities. The transportation system effectively limits access to healthcare providers and facilities as well as access to employment and education options.

Environments Where We Learn

Experts agree that early interventions put youth on the right path for academic success. Academic success *"will ensure socioeconomic attainment over the life course, which will ensure better health outcomes."*[23] Dr. Anthony Iton, a disparities expert at the California Endowment, said,

> ***"It's the early childhood experience: preschool education and high quality K-12 education that gives every kid the opportunities, should they so choose, to go onto college, a vocational school or to a living wage job."***[24]

Access to education and minorities' experience in the educational system impact their ability to create a healthy and successful future. Public school education in NH is designed to meet the needs of the mainstream population. Social, cultural and linguistic barriers that minorities face in schools effect academic performance and increase dropout rates. Data collected by the Gallaudet Center for Assessment and Demographic Studies indicate that most deaf students ages 17 and 18 read on a third or fourth grade level.[25] Ethnic minorities also reported a lack of a welcoming environment, and the difficulty their children face at school.

> ***"We have very intelligent children, but they cannot keep up with the stress. It is so stressful to be in school."*** - Focus group participant [26]

Publicly funded, center-based comprehensive early childhood development programs are effective in preventing cognitive delay and increasing readiness to learn, and have direct impacts on health. Dr. William Dow, a health economist and policy expert at the University of California, Berkeley said, *"My best guess based on the research literature is that improving education for the current generation of kids is the most promising path for reducing disparities by the next generation."*[27]

[23] Williams D, as quoted in ***Ask the Experts Forum #3 Myths About Health Inequities,*** California Newsreel: May 6, 2008. Available online at www.unnaturalcauses.org. Accessed online December 2010.

[24] Iton A, as quoted in ***Ask the Experts Forum #3 Myths About Health Inequities,*** California Newsreel: May 6, 2008. Available online at www.unnaturalcauses.org. Accessed online December 2010

[25] Allen TE. Who are the deaf and hard-of-hearing students leaving high school and entering postsecondary education? 1994. Available at: http://research.gallaudet.edu/AnnualSurvey/whodeaf.php . Accessed online December 2010.

[26] Pooler J, Korda H. ***Towards Development of a State Plan to Reduce Health Disparities and Promote Health Equity in New Hampshire: Summary of Qualitative Findings from Focus Groups and Key Informant Interviews.*** Altarum Institute; September 2010.

[27] Dow W, as quoted in ***Ask the Experts Forum #3 Myths About Health Inequities,*** California Newsreel: May 6, 2008. Available online at www.unnaturalcauses.org. Accessed online December 2010.

Environments Where We Work

Struggles of daily life and the need for economic stability were cited most often by focus group respondents as barriers to health and health care access.[26] Minority populations, especially newly-arrived refugee and immigrant groups, often find themselves further disadvantaged as they search for employment in new and different majority cultures. Many approach the job market with limited education and training, foreign education that does not easily transfer to the United States job market, or few options for well paying jobs with health care coverage and other benefits. Even for minorities that do have equivalent education and professional training, challenges to finding a job in these tough economic times are often augmented due to discrimination, which was also named as a barrier. For example, some focus group participants and key informants reported that businesses are not as likely to hire racial and ethnic minorities, even though they may possess the same skills and education as non-minority job candidates.

Social Inclusion

Improving the environments where we live, learn, work and play for minorities in NH will greatly enhance the health of these populations and of our communities as a whole. However, addressing each factor independently can require intensive resources and political will. A more comprehensive and cohesive way to approach improving our neighborhoods and the health of our communities is by working towards social inclusion.

> ***"Social inclusion is based on the belief that we all fare better when no one is left to fall too far behind and the economy works for everyone. Social inclusion simultaneously incorporates multiple dimensions of well-being. It is achieved when all have the opportunity and resources necessary to participate fully in economic, social and cultural activities which are considered the societal norm."***[28]

When minority groups arrive in a new environment, it takes time for the new arrivals as well as the current residents to adjust to their diversifying community. Minorities can experience exclusion or isolation, as well as various forms of discrimination. Therefore, they may be more likely to remain disengaged in their community or to create a separate community of their own. Citing his research on the impact of immigration on social capital, Harvard Professor Robert Putnam describes this phenomenon.

> ***"The short run effect of being around people who are different from us is to make all of us uncertain – to hunker down, to pull in, to trust everybody less. Like a turtle in the presence of some feared threat, we pull in."***[29]

Initiatives focused on inclusion and integration are essential to address this short-term problem. The long-term integration of minorities into communities has an opposite effect. As minorities establish themselves in a community and become more engaged in civic life, trust increases on all sides. Minorities are able to create wider social networks, generating a sense of belonging, which contributes to improved mental health and well-being. The other residents also benefit as their fear decreases, and as they expand their own networks, learning to benefit from the skills, knowledge and cultural differences brought by their new neighbors.

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[28] Boushey H, Fremstad S, Gragg R, Waller, M. ***Social Inclusion for the United States.*** London, England: Center for Economic and Social Inclusion; April 2007.

[29] Interview with Robert Putnam, March 2008. Available at: http://www.hks.harvard.edu/news-events/publications/insight/democratic/robert-putnam. Accessed November 2010.

Immigrants are not the only minorities to face challenges related to isolation. Less than 20% of individuals who are deaf communicate with their families conversationally.[30] Deaf and hard of hearing people put isolation at bay, gain confidence, and maintain better health through organizations that serve them such as the Hearing Loss Association of America (HLAA), the NH Association of the Deaf (NHAD), Northeast Deaf and Hard of Hearing Services (NDHHS), the National Association of the Deaf (NAD), and the NH Registry of Interpreters for the Deaf (NHRID).

> ***"These organizations need to be an integral part of any system to remove barriers to healthy lifestyle and healthcare."*** - Key Informant[26]

All individuals benefit from opportunities to build social networks, or social capital. Formal and informal groups such as ethnic associations and the deaf and hard of hearing organizations cited above offer forums where minorities can create positive connections with like-minded community members. However, to truly build healthy, socially inclusive communities, opportunities must also be created for networking between groups, or what Putnam defines as "bridging social capital." Rather than cementing homogenous groups, bridging social capital means forming bonds across diverse social groups.[31] These diverse networks generate opportunities for individuals to make contacts that lead to educational opportunities, employment, friendships, healthy activities, and the creation of shared goals among community members. Initiatives to help minorities bridge social capital, or build their networks, will create healthier and more inclusive communities.

Environments Where We Live, Learn, Work and Play - Key Points

- The neighborhoods we live in, and the context of daily living, directly influence our health and well-being. This includes housing, education, employment, safety and other factors.
- Accessible, affordable transportation is of crucial importance to ensure equality of opportunity to health care, education, housing, employment, and other essentials of daily life.
- Academic success and educational attainment are directly linked to an individual's ability to achieve socio-economic success and well-being.
- Minorities face significant social, cultural and linguistic barriers in school that limit their chances for success
- While NH's minority population is growing, minorities are underrepresented in professional staff and management positions.
- Minorities often face greater challenges in living healthy lifestyles due to social, cultural and environmental factors including discrimination and social isolation.

[30] Shah R, Lotke M. "Hearing Impairment: Follow-up". ***eMedicine*** by WEB MD: Updated September 10, 2010. Available at http://emedicine.medscape.com/article/994159-followup. Accessed online December 2010.

[31] Putnam R. ***Bowling Alone: The Collapse and Revival of American Community.*** New York, NY: Simon and Shuster, 2000.

Environments Where We Live, Learn, Work and Play - Recommendations

Built Environment

- Increase opportunities for physical activity, access to healthy foods, and safety in neighbor hoods in which minorities live, learn, work and play.
  - Assist minority residents in securing housing in safe and accessible neighborhoods.
- Expand transportation options and improve use of existing options.
  - Connect individuals to transportation for health visits, including chronic care treatment.
  - Connect individuals to transportation for job interviews, regular employment, child care, food shopping, ongoing education, and other activities that promote and maintain a healthy lifestyle.

Education and Workforce Development

- Improve early childhood development and school-based programs' cultural effectiveness.
  - Integrate culturally competent programming into early childhood development and school-based programs to improve integration for racial, ethnic and linguistic minorities and their families.
- Expand accessibility and effectiveness of education and training opportunities for minorities.
  - Reach out to and include minority residents in education and training opportunities including post-secondary education and vocational training programs.
- Encourage employers and labor unions to dedicate resources to recruitment, training and retention of racial, ethnic and linguistic minorities for staff and leadership positions.

Social Inclusion

- Support initiatives that encourage minority groups to build networks.
  - Encourage networking and community building within ethnic groups, and deaf and hard of hearing communities to address issues of isolation.
  - Encourage networking and community building between minority groups and the general population to foster integration.

3. Awareness and Promotion of Health Equity

In 2010, America's Health Rankings rated NH the third healthiest state overall in the United States.[32] But given the results of the reports and qualitative inputs examined for this plan, the question is: for whom? It is clear that the benefits of our healthy environment and our healthcare system are not equally distributed and that minorities and low-income individuals in NH face a range of challenges in seeking a healthy lifestyle. Newly arrived refugees and immigrants, as well as local residents of color, regularly experience discrimination and inequity in our communities. This directly impacts their health and ability to achieve well-being. The importance of raising awareness of issues unique to NH's minority populations is increasing in urgency as our population becomes more diverse and as these disparities persist.

Education And Outreach

Focus groups and key informant interviews conducted for the purpose of this plan reflected a lack of awareness of issues unique to racial, ethnic and linguistic minorities by health care providers, service providers and the general public. Due to NH's history as a predominantly white state and our overall image as a healthy place to live, the issues unique to racial, ethnic and linguistic minorities have remained invisible in many programmatic and policy arenas. With increasing awareness, NH's minority populations and the challenges they face will no longer remain invisible. As the diverse, multi-stakeholder, public-private, NH Health and Equity Partnership comes together to implement this plan and gains visibility, issues of health equity will become more commonly understood and will be promoted by a greater range of partners.

Funding

With awareness comes the call for action. Many of the programs and actions needed to promote health equity require funding. Improving access to health care and social services; providing enabling services such as medical interpreters or transportation assistance; enhancing data collection and use will involve additional expenditures or reallocation of program budgets. Health care providers, community organizations, leaders from the private, nonprofit and public sectors, and minority group constituents who provided input to this plan were in general agreement that funding is needed to support and sustain work to eliminate health disparities throughout the state. Stakeholders also asked for assistance finding and pursuing opportunities through grants, partnerships and other means.

Policy And Institutional Change

Promotion of health equity in NH also requires awareness of the social determinants, culture, and environments affecting racial, ethnic and linguistic minorities. The current lack of awareness often results in systematic and structural inequities in minorities' interactions with educational, housing, employment, and health care systems, as well as in health status and health outcomes. Policy and institutional change as well as outreach to key leaders and collaboration across sectors are needed to help ensure a commitment to health equity for minority communities.

[32] America's Health Rankings, ***New Hampshire (2010)***, Available online at http://www.americashealthrankings.org/yearcompare/2009/2010/NH.aspx. Accessed December 2010.

Awareness and Promotion of Health Equity - Key Points

- ► NH is considered the third healthiest state in the U.S., but not all residents experience this healthy status.
- ► Diversity in the NH population is increasing, but many health care providers and other organizations are unaware of the challenges minorities face when accessing their services.
- ► Many public, nonprofit, and private sector organizations within and outside the health sector lack appropriate policies, systems, and processes, to address program and policy issues relating to diversity.
- ► Promoting health equity and meeting the needs of NH's racial, ethnic, and linguistic minorities will require funding; possible approaches include exploring new multisectoral approaches, redirecting budgets, and seeking new grants and funding streams.

Awareness and Promotion of Health Equity - Recommendations

Education and Outreach

> Educate and involve partners outside the health sector who impact where we live, learn, work and play in improving health and equity.
  - o Develop materials and approaches to educate professionals, leaders and decision-makers about cultural competence, the social determinants of health, and health equity.
  - o Encourage collaborations with new partners who influence community-level factors and systems that impact health.

> Incorporate concepts of civic and social responsibility in health and equity discourse.

Funding

> Identify and pursue funding opportunities to support the priorities of this plan.
  - o Coordinate funding initiatives across sectors to focus efforts and avoid duplication, and to address health inequities and social determinants system-wide.

> Encourage public, private and nonprofit organizations to prioritize and budget for health equity.
  - o Examine current operations and budgets to seek ways to promote health equity within existing, routine activities.
  - o When distributing funding throughout the state, require applicants to demonstrate their commitment to health and equity in their response to RFPs.

Infrastructure and Policy

> Build and maintain a collaborative public-private partnership structure to implement the plan.
> Influence and create public policy that supports health and equity.

4. Data

As NH diversifies, it becomes increasingly important to understand and address how racial, ethnic, and linguistic minorities experience health disparities. This necessitates an understanding of differences in health and in factors that affect health including health care, social determinants, and individual behavior. In order to understand and address these variations, we must be able to measure them. This requires common standards for what information is collected, how it is collected, training of data collectors, and how data is utilized. At the same time, public education and engagement is necessary so that minority populations understand the importance of data collection and feel comfortable with supplying the information.

Guidelines and Systems

Data should document, at a minimum, race, ethnicity and language preference. At the federal level, the Office of Management and Budget (OMB) updated guidelines for the collection of race and ethnicity data in 1997, implemented in the Bureau of the Census in the 2000 decennial census, to be adopted by other federal agencies by January 2003. The Institute of Medicine (IOM), in its report, ***Race, Ethnicity and Language Data: Standardization for Healthcare Quality Improvement***, [33] recommended that more granular ethnicity information be collected. The IOM also recommended that information on preferred language and language proficiency be collected to facilitate medical encounters.

In Phase I of the plan development process, the NH Institute for Health Policy and Practice surveyed stewards of NH public health data to see how closely these data sets align with OMB's guidelines and IOM's recommen-dations. The Assessment of Race, Ethnicity and Language Collection in NH Public Health Data Sets revealed there is little standardization in how race and ethnicity data are collected. The report identified the absence of a consistent statewide policy on data collection. A key recommendation is that the collection of race, ethnicity and language data be standardized in a timely and locally sensitive manner.

Training and Public Education

Improving how data is collected is a priority for identifying, tracking and monitoring health disparities and improvements in health status and health equity. In order to obtain a comprehensive picture of minority health in NH, data on race, ethnicity and language must be collected from stakeholders at various levels of the health care system. These include: State government programs, county and community offices, hospitals and other providers, public and private health benefit plans, and others. Many of these organizations do not

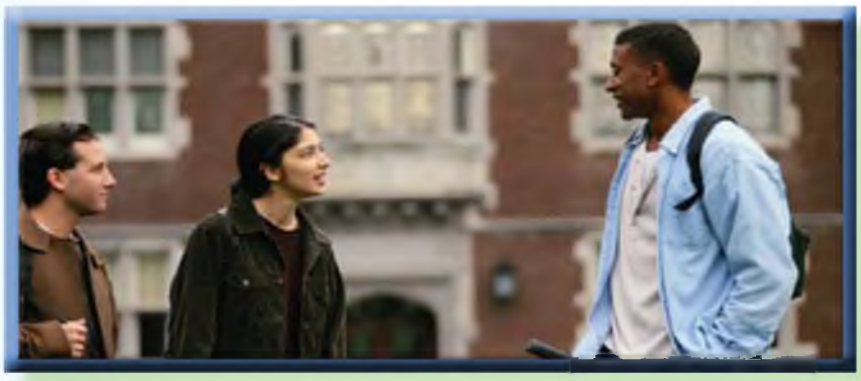
[33] Nerenz David et al. ***Race, Ethnicity and Language Data: Standardization for Healthcare Quality Improvement.*** Washington DC: The National Academies Press; 2009.

provide training on how to gather race, ethnicity or language data. Yet confusion about the social constructs of race and ethnicity persist with data gatherers who are often uncomfortable asking individuals for this information. The report, Assessment of Race, Ethnicity and Language Collection in NH Public Health Data Sets recommends preparing collectors of the data and preparing submitters of the data by training them to a consistent set of guidelines.[34]

Like data gatherers, minority individuals can also experience confusion and often feel uncomfortable when engaged in a conversation about their demographic information. Addressing patient/client concerns can improve the quality of data collected.[35] Clear and consistent education materials should be provided to the public about the collection of race, ethnicity and language data. The education material should include information about why data is collected and how it is essential for quality improvement efforts in healthcare, public health, and other social determinant of health domains. This will ultimately help us address health disparities and promote health equity in New Hampshire.

Data Use

Improving the quality of data collected is only half the challenge. Healthcare organizations, social services agencies, and public health entities must prioritize looking for racial, ethnic, and linguistic based disparities. Stratifying and utilizing the gathered data to identify disparities is necessary to instigate action for change. Monitoring social determinants data, e.g., housing, education, employment, together with health outcomes, is optimal for evaluating our success in achieving health equity for racial, ethnic and linguistic minority populations in New Hampshire. A recommendation from the Assessment of Race, Ethnicity and Language Collection in NH Public Health Data Sets suggests developing data collection and use strategies.[34] Nationwide, other states, governmental entities, and advocacy organizations have developed equity indexes or report cards as a composite summary of these different measures. Such indexes help to make the data accessible to larger groups of people, increasing awareness of disparities, and enabling equity work.



[34] Schreiber J, Costello A. ***Assessment of Race, Ethnicity and Language Data Collection in New Hampshire Public Health Data Sets.*** Durham, NH: NH Institute for Health Policy and Practice; September 2010.

[35] Hasnain-Wynia R, Pierce D, Haque A, Hedges Greising C, Prince V, Reiter J. ***Health Research and Education Trust Disparities Toolkit***. Chicago, IL: Health Research and Educational Trust; 2007. Available online at www.Hretdisparities.org. Accessed on January 31, 2011.

Data - Key Points

- Improving collection of data on race, ethnicity and language is a priority for identifying, tracking and monitoring health disparities and improvements in health equity.
- Health and human service organizations in NH vary in their collection, reporting and utilization of race, ethnicity and language data.
- NH public health data stewards indicated that they would like guidance and more extensive training on the implementation of standards for the collection of race, ethnicity and language.
- There may be some procedural challenges to changing the way that race, ethnicity and language data is currently collected in the public health data sets. Different data sets might require different approaches such as changes in contract language, policy, administrative rules or legislation.
- There are certain limitations on the capacity to collect data because of small sample sizes. Overcoming these limitations may require additional resources to capture information about subgroups.

Data - Recommendations

Guidelines and Systems

> Establish NH DHHS guidelines and policy for the collection of race, ethnicity and language data as a model for other organizations and state agencies.
  - o Collaborate with stakeholders to define a list of relevant ethnicities and languages for the state and develop a system for periodic updates.
  - o Consider adding level of education, literacy level, country of origin, perceptions of experienced and anticipated racism, and data about parent race, ethnicity and language (of children) to guidelines.

> Identify resources for electronic data system improvements and quality assurance.

Training and Education

- Train collectors and submitters of race, ethnicity and language data to use NH DHHS policy.
  - Create a forum for providers and data stewards to communicate and understand the importance of race, ethnicity and data collection
- Educate the public about the collection of race, ethnicity and language data.

Data Use

- Work with data stewards to stratify their data to identify disparities.
- Develop an equity index reflecting data from health and other sectors.
  - Include indicators for social and economic conditions, environmental conditions, employment conditions, health status, behaviors, and health care utilization in order to monitor health equity for minority population

IV. Next Steps for Health Equity in New Hampshire

The NH Health and Equity Partnership established the State Plan Advisory Work Group to develop this ***Plan to Address Health Disparities and Promote Health Equity in New Hampshire***, including recommendations to improve health and access to health care for NH's racial, ethnic and linguistic minorities. This plan and its recommendations were developed to address this charge. Yet, the work and commitment of the Partnership has only begun.

This plan is a call to action for agencies, organizations and individuals across the public, private and nonprofit sectors of the state. Many of these recommendations are directed to stakeholders in the health and health care sectors. However, to truly implement the plan and its vision for health equity, NH will need a broad based community effort that reaches beyond the traditional "health" domain and approaches minority health issues from a multi-sectoral perspective that addresses the social determinants of health: education, housing, employment, and the context and environment of daily living for minority populations.

The State Plan Advisory Work Group invites stakeholders throughout New Hampshire to play their part in bringing this vision to reality.

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Appendix I: Funding

NH Health and Equity Funding Opportunities

The Partnership is eligible to seek funding through two principal channels: 1) Federal and foundation grants available to state governments, through the NH Office of Minority Health and Refugee Affairs, agencies and offices of the NH Department of Health and Human Services; and 2) Federal, state, foundation and corporate grants, contracts and cooperative agreements available to Coalition members and related community-based organizations with 501.c.3 status. The Partnership may also consider collaborating with universities, colleges and research and development organizations to develop funds to eliminate health disparities and support health equity for racial/ethnic and linguistic populations at risk in New Hampshire.

1. Federal and Foundation Grants to State Government Programs

The State of New Hampshire, through its Department of Health and Human Services and the offices and agencies serving racial/ethnic and linguistic minorities, is eligible to apply for funding in support of service delivery and research and demonstration support of pilot programs that address health and health care issues. Funding opportunities range from Prevention Block Grants to Community Health Center service grants, and other public health programs. These opportunities target states and specific communities or organizations in health care and social services areas, as well as housing, education, labor, environment and more. Private foundations may also provide funding for statewide, community and provider-based initiatives.

To most effectively leverage these opportunities, a specific organization or entity should be charged to coordinate identification, distribution and preparation of applications. The NH Office of Minority Health and Refugee Affairs, as the designated state agency for addressing issues of health equity in the state, reports directly to the Commissioner of Health and Human Services, and is well positioned to coordinate fund development within and across the agencies of DHHS. This development would support funding for health-related programs as well as programs that address broader, related social determinants.

Selected key funders by sector are shown below. Information about U.S. Government Grants across all agencies is available at: www.grants.gov. Information about foundation grants is available at: www.foundationcenter.org.

Fund Development Opportunities for the NH Health & Equity Partnership			
Funder	**Opportunity**	**Intended Applicants**	**Comments**
Public Health			
Centers for Disease Control & Prevention (CDC) http://www.cdc.gov	CDC provides funding to states and community programs to address a wide range of public health issues and conditions (e.g., surveillance, diabetes, HIV/AIDS) Minority health programs and resources are provided at: http://www.cdc.gov/omhd/topic/minorityhealth.html		The Preventive Health and Health Services (PHHS) Block Grant gives state grantees the flexibility to prioritize the use of funds to fill funding gaps in programs that deal with leading causes of death and disability, as well as the ability to respond rapidly to emerging health issues including outbreaks of food borne infections and water borne diseases.
Health Resources & Services Administration (HRSA) http://www.hrsa.gov	HRSA provides service grants to states, community organizations and health care providers through the following programs: Bureau of Clinician Recruitment & Service, Primary Health Care (FQHCs), HIV/AIDS, Health Facilities, Health Professions, Healthcare Systems, Office of Health Information Technology, Maternal & Child Health, Office of the Administrator, Organ Transplantation, Rural Health, Special Programs, Tele-Health.		Health Center New Access Points Funded Under the Affordable Care Act of 2010 grant due Nov. 17, 2010 HRSA provides online resources for cultural competency training at: http://www.hrsa.gov/culturalcompetence/
Federal Office of Minority Health (OMH) http://minorityhealth.hhs.gov	OMH provides information on funding opportunities throughout HHS. Site also provides information re: promising practices, tool kits and other resources.		OMH funding site: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=1
Substance Abuse and Mental Health Administration (SAMHSA) http://www.samhsa.gov	SAMHSA provides grants and resources for substance abuse and mental health services prevention, treatment and services programs.	Grants are available to states, health care providers and community programs.	SAMHSA funding opportunities: http://www.samhsa.gov/grants/
Administration for Children & Families (ACF) http://www.acf.gov	ACF provides a range of grants and programs for children, families, refugees, individuals with disabilities and other special populations.	ACF funds state, territory, local, and tribal organizations to provide family assistance (welfare), child support, child care, Head Start, child welfare, and other programs relating to children and families. Actual services are provided by state, county, city and tribal governments, and public and private local agencies. ACF assists these organizations through funding, policy direction, and information services.	
Housing			
U.S. Department of Housing & Urban Development (HUD) http://portal.hud.gov/portal/page/portal/HUD	HUD, through its federal and state offices, provides community development, and affordable housing assistance. For qualifying individuals, help is also available for homelessness, utility bills, housing discrimination and more.		

Education	
U.S. Department of Education http://www.ed.gov	US Department of Education provides formulaic and discretionary grants to organizations, agencies, and individuals. A guide to education programs is available at: http://www2.ed.gov/programs/gtep/index.html?src=fp
Labor/Employment	
U.S. Department of Labor http://www.dol.gov	US Department of Labor provides programs addressing jobs development, labor relations, disability, and more. Grants available to states and organizations are available at: http://www.dol.gov/oasam/grants/prgms.htm
Agriculture/Food & Nutrition	
U.S. Department of Agriculture (USDA) http://www.usda.gov	USDA provides programs, loans and grants to states, community organizations and individuals to support a range of agricultural, education and outreach, food and nutrition programs. Opportunities can be accessed at: http://www.dol.gov/oasam/grants/prgms.htm
Foundations	
Robert Wood Johnson Foundation (RWJF) http://www.rwjf.org	Robert Wood Johnson Foundation supports community initiatives in its program areas: childhood obesity, health insurance coverage, human capital, "pioneer" programs, public health, quality/equality and vulnerable populations. RWJF supports organizations with 501.c.3 status and academic institutions.
W. K. Kellogg Foundation http://www.wkkf.org	W.K. Kellogg Foundation "supports children, families, and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society." The Foundation supports organizations with 501.c.3 status in program areas related to its interests in the areas of educated kids, healthy kids, and secure families through the dual lenses of racial equity and civic engagement.

2. Grants, Contracts and Cooperative Agreements to Partner Organizations

Community-based organizations and coalitions that serve the racial/ethnic and linguistic populations identified in this plan may be eligible to apply for grants, contracts and cooperative agreements to secure funding to advance plan recommendations and programs to address health disparities and their related social determinants. Funding opportunities may address health and health care issues specifically, or related social determinants involving education, housing, environment and more. Many community foundations restrict their giving to specific localities or regions.

Selected key funders by sector are shown below. Information about foundation grants is available at: http://www.foundationcenter.org. Additional resources to support nonprofit organizations in grants and development activities are available through the New Hampshire Center for Nonprofits: http://www.nhnonprofits.org/grantscentral.cfm.

Fund Development Opportunities for Coalition Members and Community Organizations			
Funder	**Opportunity**	**Intended Applicant**	**Comments**
Community Foundations			
New Hampshire Charitable Foundation http://www.nhcf.org	NHCF oversees a portfolio of grant making funds and programs	Non-profit organizations, some individuals	Largest funder of nonprofits in NH; administers Community Impact and Express Grants, and Special Purpose Grants for the Community
Endowment for Health http://ww.endowmentforhealth.org	Children's Mental Health, Economic Barriers to Access, Social & Cultural Barriers to Access, Geographic Barriers to Access	Nonprofit organizations in NH	Statewide conversion foundation
Agnes M. Lindsay Trust http://www.lindsaytrust.org	Funds education, health, dental, recreation	Health & Welfare Organizations including Dental initiatives	Grants $1000-$15,000
Foundation for Seacoast Health http://www.ffsh.org	Infants, Children & Adolescent Programs; Promoting Health and Preventing Disease	Funds health-related programs in Portsmouth and seacoast towns	Conversion foundation; FFSH is only accepting applications for select operating programs
Foundation for Healthy Communities http://www.healthynh.com	Operates several research & program development initiatives: NH Health Access Network, Community Prevention & Treatment Initiatives, Nursing Workforce Partnership, Environmental Health and more.		
Healthy New Hampshire Foundation http://www.hnhfoundation.org	Several grant programs.	See foundation website resources re: independent programs and services available throughout NH http://www.hnhfoundation.org/resources/links.html	Conversion foundation; Mission to evaluate and promote access to quality health and dental insurance coverage and healthy lifestyles for the residents of New Hampshire.

Corporate Funders			
New Hampshire Center for Nonprofits provides a list of local banks and other corporate grant makers in New Hampshire who may provide support for specific community-based initiatives addressing social determinants and health issues affecting minority populations. http://www.nhnonprofits.org/fundingcenter.cfm			
Regional/National Foundations			
Robert Wood Johnson Foundation (RWJF) http://www.rwjf.org	Robert Wood Johnson Foundation supports community initiatives in its program areas: childhood obesity, health insurance coverage, human capital, "pioneer" programs, public health, quality/equality and vulnerable populations. RWJF supports organizations with 501.c.3 status and academic institutions.		
W. K. Kellogg Foundation http://www.wkkf.org	W.K. Kellogg Foundation "supports children, families, and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society." The Foundation supports organizations with 501.c.3 status in program areas related to its interests in the areas of educated kids, healthy kids, and secure families through the dual lenses of racial equity and civic engagement.		
Other			
New Hampshire Department of Health & Human Services http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/default.htm	Wide range of public health & human services, food & nutrition, family support	New Hampshire residents	State-funded programs, limited grant opportunities
United Way of the Greater Seacoast http://www.uwgs.org	Works with partner organizations to provide transportation, health services	New Hampshire seacoast residents	
Monadnock United Way http://www.muw.org	Works with partner organizations to provide a range of community services	New Hampshire Mondadnock region residents	
New Hampshire Healthy Kids http://www.nhhealthykids.com	Low cost health & dental coverage for NH's Uninsured Kids and Teens	Children need not be citizens but must be legal residents	Program does not receive government funding
New Hampshire Children's Trust Fund http://www.nhctf.org	Provides financial assistance, training, technical assistance and evaluation support to community based child abuse and neglect prevention and family support programs in New Hampshire	Parents & families	