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Improving Multicultural Health in the United States  
White Paper

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### Definitions

Comprehensive care- primary, preventive, specialty, and urgent care combined

Environmental racism- intentionally locating hazardous waste sites, landfills, incinerators, and polluting industries in communities inhabited mainly by African-American, Hispanics, Native Americans, Asians, migrant farm workers, and the working poor

Health literacy- the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions

Multi-cultural care- linguistically and culturally competent care made available to the population in need

Non-Latinos (NLs) / Non-Latino white - People who do not identify as Latino / white people who do not identify as Latino

Persistent organic pollutants- petroleum-based environmental contaminants used in agriculture and industrial processing

Prevention-based care- health care that aims to improve health literacy of patients and assistance accessing resources for health

Primary prevention- policy and governance that supports development of healthy environments in which community members have access to clean air, water, food, open space, and a reliable source of culturally sensitive care

Universal health care- universal (open to all regardless of citizenship), multi-lingual, and single-payer care providing comprehensive, prevention-based health care

Health care work force diversity- variance in the race/ethnicity of providers and staff such that it is in equal proportional to the whole population

### Legend for sidebars and text boxes



**Inequalities in focus**- Statistics spotlighting disease and access-based health inequities



**Bright ideas** - Examples of programs that promote best practices for equity in health care



**Key findings** - Outcome-based examples from case studies



**Selected quotes** - Excerpts from literature and case-study interviews

## Executive summary

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In the United States, inequalities in health care have a particularly negative impact on minority populations. This report targets ways to transform the health care system in order to improve the health and wellness of people of all backgrounds, races, and ethnicities, with a specific focus on Latino<sup>1</sup> and African American populations. Access-related factors such as the cultural competency of medical professionals and preventive care are highlighted. The purpose of this report is threefold and includes: 1) a review of research on racial inequalities in health care; 2) case studies of programs that work to increase access to culturally competent and comprehensive health care; and 3) an outline of policy recommendations aimed to correct deficiencies in the health care system.

Program data were gathered from organizations (n=14) in the U.S. that serve uninsured multi-cultural populations. Most organizations care for a mix of people who are uninsured or receive public insurance. Top health concerns identified by organizations include diabetes, asthma, cardiovascular disease, multi-cultural care, STD/HIV care, dental care, prenatal care, cancer, hypertension, mental health care, and needing a usual source of care, affordability of pharmaceuticals, pediatric care, smoking cessation, substance abuse, violence, and pesticide-related exposure. Organizations spotlighted in this report for offering best practices to eliminate health inequalities met the criteria of operating in one or more of the following topic areas: community health educator training, multi-cultural care and services, multi-cultural physician training, workforce diversity scholarships, assistance navigating the health care system, rural care, regulatory advocacy, transparency in health care, protection of the uninsured, community pollution monitoring, and the greening of the health care industry.

Following are general recommendations to improve and equalize the health care system in order to better serve people of all cultural backgrounds in this country.

**Diversity and staffing among health care professionals.** Establishing the link between education and appropriate health care is the first area of priority. African American and Latino health care professionals are lacking in the United States, in part because of the overall lower levels of education and access to education experienced by these groups. Yet it has been demonstrated that more African American, Latino, and other minority ethnicity health care professionals are necessary for the complete and competent care of these populations, in great part because they provide culturally and linguistically appropriate treatment and advice. Increased access and funding for low-income and minority ethnicity populations to receive a medical education is the primary issue in need of attention. In this regard, two key policy recommendations are to promote 1) affirmative action in medical education and 2) the training of health care professionals and administrators to speak Spanish or a language other than English and the provision of cultural sensitivity training. In addition, available resources should be used to provide funding for minority ethnicity students to pursue degrees in health care fields.

**Quality changes to improve health care.** Improving the safety of patients and affordability of care are measures needed to achieve equality in the health care system. Medical error rates in the United States are high enough to list the health care system itself as a major cause of death. Affordability of care is a primary concern among the uninsured, who are vulnerable to medical debt, as well as for the publicly insured, who often suffer insufficient medical coverage. Immediate policy action should require health care sites to monitor patient safety and establish a systems-level approach to help prevent medical error. Policy action is recommended to raise public insurance to the level of providing comprehensive health care and services regardless of ability to pay or language spoken. An effective approach would build administrative changes into the system to streamline enrollment in public assistance programs and increase efficiency while reducing program costs and enrollment barriers (e.g. language access). Public

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<sup>1</sup> TRPI uses the terms Latino and Hispanic interchangeably to refer to individuals who trace their origin or ancestry to the Spanish-speaking parts of Latin America and the Caribbean.

assistance programs currently operate under a racially segregated care model and are an area in need of systems-level improvements. Resources available should help ensure secure sources of support for community-based clinics that provide comprehensive public health services and community health educator training.

**Prevention for healthy environments.** Finally, in order to improve the overall quality of health of minority populations, a system of primary prevention must be integrated to decrease dependence on emergency care and the need for medical intervention in the first place. A variety of social inequalities that can be considered “stressors” result in the poor quality of health experienced by people of color, the poor, and the uninsured. Women and children are particularly vulnerable to toxic exposure during the reproductive life stage. In addition, a lack of adequate housing, public transportation, open spaces, clean environments, security of food and water, and social services conspire to inhibit the ability of human bodies to overcome stressors resulting from environments contaminated with toxic chemicals such as air pollution, gas stations, toxic dumps, and processed food and alcohol. The key public health policy recommendation is to fund primary prevention initiatives including anti-pollution measures and public services. Investments required to ensure long-term improvements and equality in health care access include policies and practices to 1) protect and develop communities with open spaces, sidewalks, public schools, public transportation, school/community clinics, and 2) to prevent harmful entry of toxic waste, fast food, alcohol, and petrol establishments into communities. The savings and benefits gained by funding such community resources likely would far outweigh the \$30 billion in U.S. health care costs in a system that has failed to adequately address high mortality rates, medical errors, and a diseased population.

## I. Review of health care inequalities faced by multi-cultural populations

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### Introduction

Access to health care coverage and the quality of coverage is low in the United States despite spending more per capita on health care than any other country in the world. The United States ranks 37 out of 191 countries in terms of life expectancy and child mortality, according to the World Health Organization (2000). With nearly 50 million uninsured, fewer U.S. residents are guaranteed coverage compared to other industrialized nations. Even individuals with coverage do not necessarily experience the positive health outcomes typically associated with access to health care. On the contrary, people of color in the United States experience disproportionately poorer health outcomes regardless of income or insurance status.

In addition to health status, race/ethnicity is a predictor of many things in this country including education level, income, and incarceration rate. Factors such as race, income, and parents' education all weave together to create unequal access to educational attainment and health.

Unequal access to health care is a critical issue faced by minority ethnicity adults, adolescents, and children, and it is the focus of this report. The term "health inequality" is broadly used to describe factors that limit access to health care as well as the higher mortality rate, greater burden of disease, and other adverse conditions among minority ethnicity populations compared with Non-Latinos.

Minorities are a growing part of the population and compose the majority of those without health insurance. In 2000, minorities accounted for approximately one-third of the population, according to the U.S. Census Bureau. Latinos are the largest subgroup (12.5%), followed by African Americans (12.3%), and Asian Americans (3.6%) (U.S. Census Bureau, 2000). Minority ethnicity populations are projected to grow considerably in the first half of this century. The Census Bureau projects that by the year 2035, there will be 75 million Latinos comprising 20 percent of the population. By 2070, it is estimated that more than half of the population will be minorities, establishing a "minority majority" society for the first time in the United States (U.S. Census Bureau, 2002).<sup>2</sup>

People of color consistently experience poorer health outcomes compared to other groups in the country. Racial, ethnic, linguistic, or other minority patients here tend to have higher morbidity rates than white, English-speaking patients (Betancourt et al., 2002; Collins & Fund, 2001; Collins & Hughes, 2002; Doty, 2003; Doty, 2002; Hughes, 2002; Perot, 2001). African Americans and Latinos experience discrimination based on their race/ethnicity with regard to all factors determining health outcome. Simply being African

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### *Inequalities in focus*

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#### *HIV/AIDS (DHHS, 2007)*

- Racial and ethnic minorities accounted for almost 70 percent of newly diagnosed cases of HIV and AIDS in 2002. More than 90 percent of babies born with HIV belonged to minority groups.
- HIV/AIDS is spreading at a rapid rate in the Hispanic community. Hispanics accounted for around 20 percent of AIDS cases in 2002, despite making up only 14 percent of the U.S. population.
- Hispanics were 60 percent more likely than whites to be diagnosed with AIDS. Hispanics also were almost three times more likely to die of AIDS than their white counterparts in 2001.
- More than 54 percent (14,398) of HIV/AIDS diagnoses in 2002 were African Americans. African Americans are 1 times more likely to die of AIDS than whites.
- AIDS is the leading cause of death in African American women aged 25-34 and the third leading cause of death in African American men in the same age group.

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<sup>2</sup> U.S. Census Bureau figures traditionally underestimate Latino population projections due to inter-marriage among acculturated residents.

American or Latino in the United States leads to a greater likelihood of poor health outcomes. Studies have demonstrated the persistent nature of race/ethnicity-based healthcare inequalities by examining health outcome and healthcare quality and controlling for a variety of factors including insurance status, income, age, severity of conditions, payer source, or other characteristics unrelated to healthcare need (Mayberry et al., 1999; Gaskin & Hoffman, 2000; Weinick et al., 2000; IOM, 2002).

Besides socioeconomic characteristics and racial discrimination, other factors that limit access to health care include language barriers, source of usual care, inadequate insurance coverage, ineligibility/enrollment barriers to public programs, undocumented immigration status, and barriers to primary prevention such as nutritious food, a clean environment, and education (Committee on Pediatric Workforce, 2004).

Based on their past and present health outcomes, the two groups at most risk are African Americans and Latinos. They have less access to health care, and the quality and outcomes of the care they receive are consistently worse than those of Non-Latino whites (Cunningham & Cornelius, 1993; Cornelius et al., 1991; Ford & Cooper, 1995; Carlisle & Shapiro, 1995).

Hispanics are the largest minority ethnicity group in the United States, growing from 9% of the population in 1990 to 12.5% in 2000 (U.S. Census, 2000). Hispanic is a term describing a heterogeneous population consisting of many racial, ethnic, and cultural entities that mainly share the Spanish language. (Williams, 2007). Latino also is a term used to describe this group and refers to Spanish-speaking people from Latin American countries such as Mexico, Puerto Rico, and Cuba. In this report, the terms Latino and Hispanic are used interchangeably in reference to this diverse group recognizing that these terms, while over-generalizing a diverse group, are useful for the sake of discussion only.

African Americans comprise a minority ethnicity group of concern because they have been subjected to a racially biased health care system since their ancestors were brought to the U.S. as slaves. African Americans fare worse in nearly all measures of health compared with Non-Latinos Americans. Health statistics on morbidity, mortality, and longevity have consistently shown that African Americans have lower outcomes compared with Non-Latinos in nearly all categories of disease and illness. Death and complication rates are higher for African Americans than for NL-Americans, and recovery rates tend to be lower. Though overall life expectancy improved during the 20th century for all groups, it remains lowest for African Americans (Miniño, 2006).

### **Factors contributing to health inequalities**

The well-documented disparities in minority health care are persistent and increasing. The 2006 National Health Disparities Report found that for all health care measures examined, minorities not only received worse care but the difference was getting worse rather than improving – this was particularly the case for Latinos and the poor (AHRQ, 2006). For both African Americans and Latinos, examples of a declining quality of health care included preventive services, treatment of acute illness, management of chronic disease and disability, timeliness, and patient centeredness. For Latinos, a lack of health insurance and a usual source of care were getting worse. For the poor, not having a usual source of care and experiencing delays in care were getting worse (AHRQ, 2006). Table 1 contains key recurring themes covering inequalities in health care access among minority populations.

### ***Inequalities in focus***

#### ***Cancer (DHHS, 2007)***

- Overall, African Americans are more likely to develop cancer than persons of any other racial or ethnic group, and have the highest cancer death rate than any other racial or ethnic group.
- For Hispanic women, the incidence of cervical cancer is two and half times higher than the rate of NL-whites.

**Table 1.** Factors and evidence of health inequalities among minority ethnicity populations

Factor	Relevant evidence and areas for improvement
<b>Unaffordable care resulting in poor health</b>	The National Longitudinal Mortality Study reported that 24% and 34% of Latino men and women, respectively, earned <\$10,000 per year, compared with 12% and 18% of Non-Latino men and women (Sorlie et al., 1993). Multivariate analyses of selected health outcomes using seven independent variables showed low family income to be significantly associated with greater odds of a child’s suboptimal health status (Flores et al., 1998).
<b>Insufficient coverage and care provided through public assistance</b>	Latino and African American beneficiaries of Medicaid are more than one-and-a-half times more likely to be in only fair to poor health than Non-Latino beneficiaries. In 1995, Non-Latino Medicare beneficiaries were one-and-a-half times more likely than African-American beneficiaries and twice as likely as Latino beneficiaries to have additional coverage through an employer-sponsored health plan. Non-Latinos also were three times as likely to have the additional private “Medical coverage” (Smedley et al., 2003).
<b>Racially segregated public assistance health care</b>	Care provided through Medicare is segregated by race. Physicians who treat black patients are less likely to be board certified than those who treat white patients and are more likely to report that they face difficulties obtaining high-quality subspecialty referrals, diagnostic imaging, and non-emergency hospital admission for their patients (Bach et al., 2004).
<b>Employment in industries with low rates of job-based coverage</b>	Latinos generally have the least access to health care and a lower rate of insurance coverage than do Non-Latinos and African Americans, regardless of income level. Latinos experience the lowest rates of job-based health care coverage. In California, more than 2.3 million non-elderly adults – 41% of the population – lacked health insurance (LIF, 2008).
<b>Insufficient children’s coverage</b>	In a cross-sectional survey of parents of children (n=203) coming to the pediatric Latino clinic at an inner-city hospital, parents cited the following barriers to health care: language problems (26%), long waiting time at the physician’s office (15%), no medical insurance (13%), and difficulty paying medical bills (7%) (Flores et al, 1998).
<b>No usual source of care</b>	Over a 20-year period from 1977-1996, Latinos, when compared with other race/ethnicities, experienced considerable increases in the probability of lacking a usual source of care (from 19.9% to 29.5%), even when controlling for differences in income and health insurance coverage (Weinick et al., 2000).
<b>Lack of workforce diversity</b>	Latinos, African Americans, Native Hawaiians and Other Pacific Islanders (NHOPIs), and American Indians/Alaska Natives are underrepresented among U.S. physicians, composing 12.6%, 12.1%, 0.1% and 0.7% of the U.S. population and 5%, 4.5%, 0.03%, and 0.2% of the physician population, respectively; see figure 1 (AHRQ, 2006).
<b>Staff shortages</b>	In an analysis of 51 communities in California, the lowest physician-to-population ratio occurred in areas of poverty that had high proportions of both African American and Latino residents (Komaromy et al., 1996).
<b>Limited multi-language proficiency among health care</b>	In 2006, the U.S. Department of Health reported that nearly half of individuals with limited English proficiency do not have a usual source of care (USDHHS). In a survey of physicians (n=1,364) practicing in 13 urban areas in California, there were only 48 Spanish-speaking primary care and 29 specialist physician equivalents available for every 100,000 Spanish-speaking limited English proficiency (LEP) patients on Medicaid. There

Factor	Relevant evidence and areas for improvement
<b>professionals</b>	were even fewer Spanish-speaking physician equivalents available for uninsured Spanish-speaking LEP patients; see Table 2 (Yoon et al., 2004).
<b>Lack of preventive care resulting in a high mortality rate</b>	Among Spanish-speaking subpopulations, those of Mexican origin reported the lowest rates of advice to quit smoking (42.4%) and the highest rates of delayed care for illness or injury (24.1%) and uninsurance (31.1%) (USDHHS, 2006). Hispanics accounted for around 20 percent of AIDS cases in 2002, despite making up only 14 percent of the U.S. population. Hispanics are 60 percent more likely to be diagnosed with AIDS than whites. Hispanics were also almost three times more likely to die of AIDS than their white counterparts in 2001.
<b>Environmental justice</b>	Race has been found to be the most significant variable associated with the location of hazardous waste sites and the greatest number of commercial hazardous facilities were located in communities with the highest composition of racial and ethnic minorities (Commission for Racial Justice, 1987).
<b>Racially/ ethnically segregated work force with high exposure to environmental contaminants</b>	Latinos compose 83.6% (108,940 of 130,364) of the farm worker population in California and are exposed to dangerous nerve-inhibiting organophosphate pesticides, 178,000 pounds of which are sprayed each year in California on artichokes, oranges, almonds, peaches, olives, broccoli, lettuce, cauliflower, corn, cabbage, and Brussels sprouts. On the national scale, the EPA report that in 2004, more than 759,000 farm workers were exposed to 640,000 pounds of methamidophos on potatoes, cotton, tomatoes, California alfalfa and 700,000 pounds of ethoprop on potatoes, sugarcane, and tobacco (methamidophos and ethoprop also are organophosphate pesticides) (USEPA).

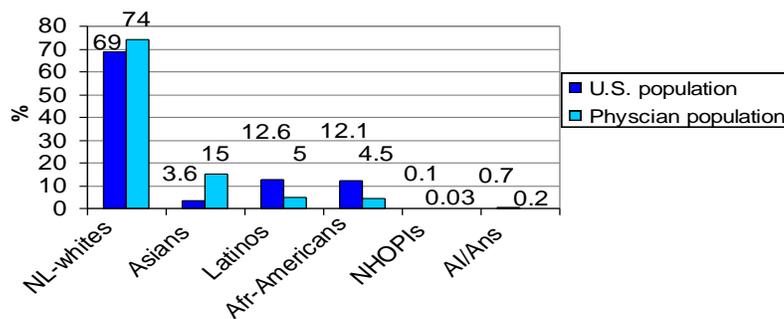
## II. Building a new system of health care

Access to appropriate and effective health care is limited or less effective as a result of the education and social issues considered in the following section of this report. A lack of insurance, unaffordable care, and a lack of a usual source of care often cited as primary factors resulting in higher rates of death and disease among minority ethnicity populations. At the root cause of insufficient health care is a racially/ethnically segregated work force and barriers to higher education creating an insufficient health care system. The racially and ethnically segregated nature of the U.S. work force leaves those working in fields such as (e.g. the service industry and agriculture) without access to employer-based health care. In addition, limited access to higher education results in a lower-than-average income, which in turn makes health care and insurance coverage difficult to afford. Without equal access to higher education, the health care workforce does not reflect the diversity of the population.

### Diversity and staffing among health care professionals

The diversity of the U.S. population is not reflected in the national health care work force. Non-Latinos and Asian Americans are overrepresented in the U.S. physician population, for example. Non-Latinos comprise 69% of the U.S. population and 74% of the physician population; Asian Americans comprise 3.6% of the U.S. population and 15% of the physician population. Latinos, African Americans, Native Hawaiians and Other Pacific Islanders (NHOPIs), and Native Americans/Alaska Natives are underrepresented in the U.S. physician population, composing 12.6%, 12.1%, 0.1% and 0.7% of the U.S. population and 5%, 4.5%, 0.03%, and 0.2% of the physician population, respectively (AHRQ, 2006); see Figure 1.

**Figure 1.** U.S. population versus physician population by race/ethnicity in the U.S. <sup>1</sup>



<sup>1</sup>Agency for Healthcare Quality and Research (2006). "The National Healthcare Disparities Report, 2006." The U.S. Department of Health and Human Services. Rockville, Maryland.

In addition to the lack of diversity, there are overall shortages in health care professionals to the extent that federally designated "Health Professional Shortage Areas" (HPSAs) exist throughout the country. Approximately 20% of the U.S. population currently lives in a HPSA, the. Criteria include (1) exceeding a specified population-to-practitioner ratio representing shortage and (2) over-utilized, excessively distant, or otherwise inaccessible resources.

Shortages in physicians result in critically low physician-patient ratios in poor communities of color. In an analysis of 51 rural and urban California communities, researchers found that lower physician-to-population ratios occurred in areas of poverty and in places that had high proportions of both

African American and Latino residents, regardless of income level (Komaromy et al., 1996). Table 2 illustrates differences in the patient profiles of physicians of various races and ethnicities. Though doctors of color tend to take a full patient load, a significant shortage of health care providers remains a problem that is in part born of a lack of minorities entering the health care profession.

**Table 2.** Patient profiles by physicians' race/ethnicity<sup>1</sup>

Patient characteristics	Physician race/ethnicity		
	<u>Latino</u>	<u>African American</u>	<u>NL-white</u>
Proportion of residents from underserved minority groups	Significantly higher	5 times higher	Standard for comparison
Proportion of patients of physicians' own race/ethnicity	3 times higher	6 times higher (42.9% more)	Standard for comparison
Percent publicly insured	24%	45%	18%
Percent uninsured	9%	3%	6%

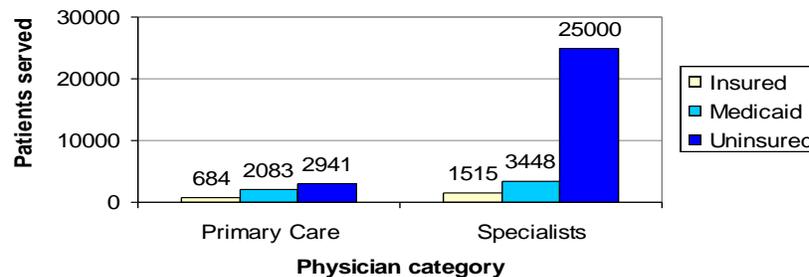
<sup>1</sup> Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, Bindman AB (1996). "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations." *N Engl J Med*;334:1305-1310.

**Quality changes to improve health care**

A lack of culturally competent care due to a lack of diversity in the A major issue that results from lack of diversity in the health care workforce is the lack of culturally competent care including poor communication. The U.S. Department of Health and Human Services identified culture and communication as major barriers to health care in a 2003 report (AHRQ). In a follow-up report in 2006, Central and South Americans reported the highest rates of patient-provider communication problems (18%) and nearly half of individuals with limited English proficiency (LEP) reported that they do not have a usual source of care (AHRQ, 2006).

In 2001, a survey was conducted of physicians (n=1364) practicing in 13 urban California counties. Results showed that only 26% of primary care and 22% of specialist physicians reported fluency in Spanish. Yet the need is clear for more Spanish-speaking physicians to serve limited English proficiency (LEP) patients, as demonstrated in Figure 2 (Yoon et al., 2004).

**Figure 2.** Number of patients per Spanish-speaking physician for three limited English proficiency populations in 13 urban areas of California<sup>1</sup>



<sup>1</sup> Yoon, JK, Grumbach K, Bindman A (2004). "Access to Spanish-Speaking Physicians in California: Supply, Insurance, or Both." *Am Board Family Med*;17:165-172.

*“Many of the residents believed that limited English proficiency families under their care ‘never’ or only ‘sometimes’ understood their child’s diagnosis, medications, discharge instruction, or follow-up plan. Eighty percent admitted to avoiding communication with such families.”*  
(Burbano-O’Leary et al., 2003).

In a questionnaire of residents (n=59) from an urban, university-affiliated children’s hospital that serves a population in which 10%–20% have limited English proficiency (LEP), most of the staff (40 of 59) reported speaking little or no Spanish. Many resident physicians thought LEP families under their care “never” or only “sometimes” understood their child’s diagnosis (21 of 40), medications (11 of 40), discharge instructions (17 of 40), or follow-up plan (16 of 40). Eighty percent

(32 of 40) admitted to avoiding communication with such families (Burbano-O’Leary, 2003).

Miscommunication between caregivers and patients contribute to the relatively high rate of complications, misdiagnoses, and deaths associated with the U.S. health care system. In a cross-sectional survey of parents of children (n=203) coming to the pediatric clinic serving a Latino population at an inner-city hospital, parents who spoke little or no English reported that medical staff who could not Spanish led to adverse health consequences for their children, including poor medical care (8%), misdiagnosis (6%), and prescription of inappropriate medications (5%) (Flores et al., 1998).

In addition, the U.S. medical system is the leading cause of death and injury in the United States. The term iatrogenic is used to describe inadvertent deaths resulting from medical treatment and diagnostic procedures including errors in medical and surgical procedures and unnecessary hospitalizations. Death from iatrogenic events is 783,936, exceeding the 2004 coronary heart disease annual death rate of 451,326 and the annual cancer death rate of 553,888 (Table 3) (AHRQ, 2004).

Adverse drug reactions (ADRs) are one type of medical error researchers have examined. System-level failures were found to be the cause of adverse drug reactions 75% of the time—in disseminating pharmaceutical information, in checking drug dosages and patient identities, and making patient information available. Dosage errors in particular were primarily due to the physician’s lack of knowledge about the drug or patient (Leape et al., 1995). In a study of two tertiary care hospitals, researchers found that errors in ordering medications accounted for more than one-half (56%) of preventable ADRs while errors in administering medication accounted for 34% of preventable ADRs (Bates et al., 1995).

**Table 3.** Estimated annual cost of medical interventions

<u>Condition</u>	<u>Deaths</u>	<u>Cost</u>	<u>Citations</u>
Adverse drug reactions	106,000	\$12 billion	Lazarou et al., 1998; Suh et al., 2000
General medical error	98,000	\$2 billion	Thomas et al., 1999; Thomas et al., 2000
Bed sores	115,000	\$55 billion	Xakellis, 1995; Barczak et al., 1997
Infection	88,000	\$5 billion	Weinstein, 1998; MMWR, 2000
Malnutrition	108,800	----	Burger et al., 2000
Outpatient care	199,000	\$77 billion	Starfield, 2000; Weingart, 1996
Unnecessary procedures	37,136	\$122 billion	HCUP, 2006
Surgery-related	32,000	\$9 billion	AHRQ, 1976; Leape, 1989
<b>TOTAL</b>	<b>783,936</b>	<b>\$282 billion</b>	

## Primary prevention for healthy environments

Minority ethnicity populations tend to receive lower quality care, particularly when it comes to preventive care. Patients with less education consistently receive less health advice from doctors (AHRQ, 2006). Minorities are less likely to receive appropriate preventive services, such as breast and cervical cancer screening and immunizations. Even when African American women get prenatal care, they are less likely than whites to receive amniocentesis, ultrasound, and counseling on tobacco and alcohol use. In addition, physicians who treat black patients are less likely to be board certified than those who treat white patients; they also are more likely to report difficulties obtaining high-quality subspecialty referrals, diagnostic imaging, and nonemergency hospital admission for their patients (Smedley et al., 2003).

Minority ethnicity children receive less care and counseling compared with non-minority children. A cross-sectional study comparing well-child visits (WCVs) of minority and non-minority children found WCVs were shorter for Latino children than for Non-Latino or African American children and Non-Latino children were more likely to receive preventive counseling than were African American or Latino children (72% vs. 61% vs. 61%, respectively;  $p=0.01$ ) (Cook et al., 2006).

In addition to a lack of preventive services, minority populations also face environmental injustices that negatively impact their health. Populations of color are exposed to a disproportionate number of toxins through work and living environments contaminated with pollution and industrial chemicals, further contributing to their disease burden. In a study examining environmental injustices, approximately three out of every five African American and Latino lived in communities with one or more toxic waste sites. More than 15 million African-Americans, more than 8 million Hispanics, and about 50 percent of Asian/Pacific Islanders and Native Americans lived in communities with one or more abandoned or uncontrolled toxic waste sites (Bullard, 1993).

Examination of disease by race and ethnicity consistently shows that U.S. immigrants become less healthy the longer they live here. In a recent study, Latinos in California were found to be healthier in terms of mental health, asthma, and blood pressure compared to the general population, but differences disappeared the longer they lived in the United States (Taningco, 2007). Ultimately, Latinos in the U.S. experience a higher risk for diabetes mellitus, tuberculosis, HIV/AIDS, alcoholism, cirrhosis, cancer, and death from violence compared to the general population (Kaiser, 1996). Living in this country places Latinos and most immigrant populations at particular risk for diseases they would not be likely to experience in their countries of origin. Moreover, the low-income population would likely experience fewer diseases if they received adequate preventive advice, experienced fewer financial burdens, and were exposed to fewer environmental stressors. So, though race ethnicities may suffer from different diseases, all health-disparities-related diseases are environmental diseases. That is, diseases related more to place and access to care than to biology or genetics. A most urgent priority across all sectors of society is to create healthy environments with equal access to resources for a healthy life.

### *Inequalities in focus*

#### ***Adverse Drug Reactions*** (IOM, 2000; Lazarou, 1998; Gurwitz et al., 2000)

- Over 2 million ADRs occur each year resulting in 44,000 to 98,000 preventable deaths.
- ADRs are the 4<sup>th</sup> leading cause of death in the U.S. ahead of lung disease, diabetes, AIDS, pneumonia, and automobile deaths.

### III. Case studies: Organizations improving access to multicultural health care

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#### Background and rationale

Data for this report was collected from organizations in five cities and several small communities with large Latino populations across the United States. The goal was to examine innovations in the health care system that increase access to health care for Latinos and other minority ethnicity populations. Organizations were selected for offering innovative health care solutions to help meet the needs of the uninsured in their areas; in each case, health conditions, needs, and policies were studied to understand the organizations' relationships with their multi-cultural communities.

Formative research was conducted to identify organizations that directly or indirectly provide affordable, culturally competent, primary, and preventive care to minority ethnicity populations. Organizations were identified through associations, networks, funding agencies, reports, and government/non-government based entities that support the elimination of health inequalities. A wide range of organizations were contacted to include the perspective of clinics, health centers, hospitals, coalitions, forums, non-profits, and health management organizations. Racial and ethnic diversity in the United States also was analyzed to identify growth areas for Latinos and other minority ethnicity populations. Based on geo-demographic data and interview requests, locations in California, Arizona, Texas, Delaware, and Michigan were included in the study.

Most counties with the greatest Latino population growth were in the south and west, including 369 counties that passed a 5% population threshold between 1990-2004. Due to the concentration of Latinos in these parts of the country, California, Texas, and Arizona were three of the five states included. These states each have more than one million immigrants and have long been major ports of entry. Immigrants account for more than one in six people ( $\geq 15\%$ ) in California and Texas. California is the state with the highest proportion of immigrants; more than 27% of California residents were foreign-born in 2005 (Frey, 2006).

Latino growth centers overlap with overall U.S. population growth areas. Growth of minority populations is highest in large metropolitan areas (population  $> 500,000$ ). Seven out of 10 African Americans, nearly eight out of 10 Latinos, and almost nine out of 10 Asians live in large metropolitan areas, but fewer than six out of 10 Non-Latinos live in cities (Frey, 2006). California and Texas also are centers of "melting pot metros," which is a metropolitan area in which more than one minority population exceeds the national average. The 18 areas nationwide are heavily concentrated in the west including eight in California (including Los Angeles and San Francisco), one in Arizona (Phoenix), and two in Texas (Dallas and Houston). Several rural areas in Texas, California, and Arizona also were included to capture a population profile in less populous areas. See Table 4 for site specific indicators.

**Table 4.** Demographic statistics of selected sites

<b>Location</b>	<b>Indicators of diversity</b>
<b>California</b>	California has the largest Latino population of any state (>13 million) and 30% of all Latinos in the United States. California ranks among the last (48 <sup>th</sup> ) in Latino population growth (18.2%) (U.S. Census, 2000).
Los Angeles and the Inland Empire (Riverside-San Bernardino-Ontario)	The Los Angeles metro area has the largest Latino population of any city in the U.S. with more than 5.5 million composing 43.2% of the population in 2004. Los Angeles is ranked eighth for African Americans at 947,351 (7.3%), and it has the largest Asian population of any metro area with more than 1.7 million (13.2%). Los Angeles and the Inland Empire had the first and second largest population gains in Latinos (over 435,000 and 333,527 respectively) between 2000 and 2004. In the past two decades, the Latino population in the Inland Empire has increased by 324%; with more than 1.2 million Latino residents, the area is now the sixth largest Latino metropolitan area in the nation (Frey, 2006).
San Francisco Bay Area	San Francisco-Oakland-Fremont is a melting pot metro and has the third largest Asian population in the country at 879,495 Asians composing 21.2% of the population (Frey, 2006). It also had the second most declines in the white Non-Latino population from 2000-2006 (94,650) (Frey, 2006).
Watsonville	Latinos made up 33,254 of 44,265 (75.0%) of the population in Watsonville compared with 35.9% in California (U.S. Census, 2000).
<b>Texas</b>	Nearly 8.4 million Hispanics reside in Texas, 19% of all Latinos in the United States. The Texas Latino population is the second largest in the nation, and Latinos compose a significant share (50%+) of population growth ranked 42 <sup>nd</sup> state in the nation between 2000 and 2006 (Frey, 2006). Of 196 rural counties in Texas, 24 have no physicians, and most are federally designated medically underserved areas, with many containing designated health professional shortage areas (Texas Department of State Health Services, 2007).
Dallas-Ft. Worth	Dallas-Ft. Worth is ranked seventh in Latino population in the country with more than 1.4 million, composing 25% of the population. It is also the second fastest growing metropolitan area in terms of minority populations with a 32.8% increase in minority populations from 2000 to 2004. Dallas-Ft. Worth had the third-largest gains of Latinos (>290,000), seventh-largest of Asians (>49,000), and third-largest of African Americans (>74,000). Dallas-Ft. Worth has the tenth-largest African American population 789,807 (13.9%) (Frey, 2006).
Brownsville	91.3% of the Brownsville population is Latino (127,535 of 139,722) compared with 35.7% in Texas (U.S. Census, 2000).
<b>Arizona</b>	Arizona's Latino population is the sixth-largest in the nation. Nearly 1.8 million Latinos reside in Arizona, 4% of all Latinos in the United States. Arizona had a Hispanic population growth of 42.7% (ranked 23 <sup>rd</sup> state in nation) between 2000 and 2006 (Frey, 2006).
Greater Phoenix	Greater Phoenix (including Tempe, Mesa, and Glendale) is ranked seventh among U.S. metropolitan areas in population growth of Latinos. It accounted for 52% (215,784) of overall population growth between 2000 and 2004. Phoenix had the second-highest gains of all metro areas in African American population (19.2%) between 2000 and 2004 (Frey, 2006).
Nogales & Casa Grande	In Nogales, 19,539 people (93.6% of the population) are of Latino origin, and in Casa Grande, 32,855 people (39.1%) are of Latino origin.
<b>Delaware</b>	Delaware had a Hispanic population growth of 42.7% (ranked 18 <sup>th</sup> state in nation) between 2000 and 2006 (Frey, 2006). Sussex County, Delaware is a medically underserved area and suffers a health professional shortage. Only 5 percent of practicing physicians in Sussex are of Hispanic origin and 1 percent of African-American origin, though both of those populations in Sussex are the fastest growing populations in the state (Delaware Health Care Commission, 1999).

## **Methods and analysis**

Organizations across the United States were identified for improving health care access for uninsured and publicly insured minority ethnicity populations. A total of five metropolitan areas and three rural communities were included. Key stakeholders from health care organizations (health practitioners, policy makers and community-based representatives) participated in interviews about their organization. Semi-structured interviews lasted approximately 20-40 minutes and covered health insurance status, health conditions, unmet health needs or challenges in serving their populations, and policies as they relate to the Latino and African American communities in each geographic location. Interview data were analyzed to determine the similarities and differences of health policy issues raised by various stakeholders, as well as the geographic differences of the health needs of the Latino and African American communities. Data are included here for addressing key issues of uninsured Latino communities. Finally, access to health care is presented in its national context in order to provide solutions that concerned stakeholders can implement.

Notes from interviews were analyzed, and are presented here as individual case studies describing program innovations and populations served. Other data collected on health insurance status, health conditions, unmet health needs or challenges in serving a population, and policies are presented in tabular format. Data on ranking of policy priorities were combined to present the highest priority areas and also to maintain anonymity of responses.

## Results

**Table 5.** Case study profiles

Type of organization	Patient population (approximate uninsurance rate)*	Health issues of most concern	Factors that perpetuate inequalities	Innovative and successful programs	Policy recommendations
Publicly funded HMO (Wilmington, DE)	50% Latino, 30% AA, 20% NL-white (100%)	diabetes, hypertension, asthma, reproductive health	-lacking access to comprehensive health services, workforce diversity -barriers to enrollment in public programs	-community health educators and system navigators -expanded safety net of care to reduce use of emergency services	-train providers of color -provide incentives to practice in rural areas -eliminate requirement for proof of citizenship and a birth certificate to enroll in public programs imposed by the Federal Deficit Reduction Act -streamline enrollment in public programs
Federally qualified clinic (Detroit, MI)	Latino & AA (75%)	diabetes awareness and prevention	-long waiting list for clinic services	-community-based pollution monitoring	-community healthy food policy -train more health care providers -streamline enrollment in public programs
Federally qualified clinic (Brownsville, TX)	>18,000 Latinos (62%)	diabetes, hypertension, heart disease, asthma	-provider shortages	-multi-cultural physician education -bilingual care and health education -community-based pollution monitoring	-universal health care
Federally qualified clinic (Ft. Worth, TX)	>6,000 Latinos (80%)	diabetes, high blood pressure, obesity	-lacking access to specialty care -provider shortages	-universal primary and preventive health care	-train more health care providers
NGO physician association (Tempe, Arizona)	>15,000 Latinos (100%)	diabetes Alzheimer's cardiovascular disease	-lack of multi-lingual access and affordable care	-annual health fairs with volunteer physicians -scholarships for Latino health professionals -community health	-federal funding with state and county matching programs for community-based care

Type of organization	Patient population (approximate uninsurance rate)*	Health issues of most concern	Factors that perpetuate inequalities	Innovative and successful programs	Policy recommendations
				education through the Spanish media	
Privately funded women's clinic (San Francisco, CA)	>3,500 Latino and AA patients (95%)	mental health, violence, primary care, urgent care, oral health	-mistrust around women's care providers, insurance, and cost of care -medial debt	-community health training and empowerment -free women's health services for vulnerable populations	-universal health care -medical payer rates -access to interpretation services
Federally qualified clinic (San Francisco Bay Area, CA)	>3,000 Latino and Native Americans (68%)	substance abuse, heart disease, diabetes	-lack of access to affordable, primary care -barriers to enrollment in public programs	-city-wide universal health care for residents	-maintain flexibility and affordability of public assistance programs
Federally qualified clinic (Watsonville, CA)	>14,000 Latino patients (24%)	-reproductive disease, diabetes, obesity, and heat and pesticide-related disease	-exposure to dangerous conditions in farming -barriers to enrollment in public programs	-community-based pollution monitoring -expanded hours for farm workers -safety net health care	-county and state-level support of community-based clinics
Privately funded university hospital (Los Angeles, CA)	Children of minority ethnicities (varies)	asthma, heart disease, mental health, cancer	-lacking culturally competent care and comprehensive care	-patient navigators/advocates who assist mental health patients link to primary and mental health services	-culturally competent care and services
HMO (East Los Angles)	Mostly Latino and AA (90%+ are publicly insured)	diabetes, obesity, asthma, hypertension, reproductive	-lacking cultural competent care and preventive medicine	-demonstration site for provision of bilingual care	-streamline enrollment into public assistance programs

Type of organization	Patient population (approximate uninsurance rate)*	Health issues of most concern	Factors that perpetuate inequalities	Innovative and successful programs	Policy recommendations
		health			
NGO (California)	11 million Latinos in CA	most work is regulatory	-lacking work force diversity and bilingual care -consumer abuses in health care	-empowerment training -interpretation services -regulatory advocacy	-single payer health care -full children's coverage -bilingual and culturally appropriate care
NGO (California)	2,800 community leaders across California (n/a)	mental health, children's health, work force diversity, prevention	-lack of language access prescription drugs	-grassroots empowerment of community leaders	-language access and reimbursement services -bilingual prescription drug labeling -school-based health centers -full children's coverage
NGO (U.S. and California)	Latinos nationwide: 35 million (~33%); Latinos in California: 11 million (~39%) <sup>1</sup>	varies by area but generally includes chronic disease	-lacking transparency in health care costs and language access -lack of workforce diversity	-establishment of collaboratives and civic engagement activities -leadership development and advocacy training for Latinas	-single-payer universal health care -streamline enrollment in public assistance -language access and reimbursement services -workforce diversity -community health educators -comprehensive sex education in public schools
HMO collaborative (U.S.)	11 national health plans covering >87 million members	diabetes, birth outcomes	-lacking access to multi-lingual care	multi-lingual prevention-based programs	-inclusion of Medicaid contractual components e.g. prevention, ensuring ethnic diversity among providers, and improving outreach to target population

\*AA=African American

<sup>1</sup>Kaiser Family Foundation. June 2003. *Facts: Race, Ethnicity and Medical Care.*

## Individual Case Summaries

### The Community Health Access Program Wilmington, DE

#### Population

Population includes patients ineligible for public assistance up to 200% Federal Poverty Level. If eligible for public assistance, patients are enrolled. Medicaid is available to adults at 100% of the federal poverty guideline and children at the 200% level, but CHAP is designed to include adults up to 200% of poverty. Program participants include approximately 50% Latino, 30% African American, and 20% Non-Latino depending on the geography.

#### Program innovations

Community action: *Volunteer care providing primary and preventive care*

With a state-funding mechanism, CHAP provides a safety net for impoverished adults and children who do not qualify for public assistance and also assists those eligible for public assistance to apply. Using the Medical Society's Volunteer Initiative Program (VIP), 500 volunteers participate, half primary care and half specialty care, and agree to take on patients at discounted rates or pro bono. CHAP provides eligibility screening so there is no additional administrative burden on clinics. After enrollment in CHAP, patients select a medical care clinic for primary care and are linked with volunteer physicians. CHAP patients also are linked to pharmaceutical patient assistance programs.

#### Key Findings

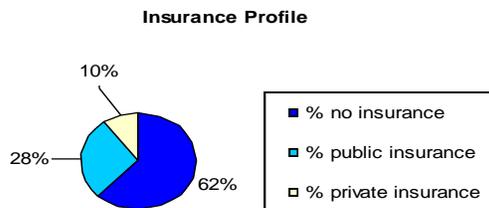
**The Community Health Access Program:**  
*Safety net health care reduces dependence on emergency services*

Preventive medicine including disease screenings has effectively prevented unnecessary use of emergency services. CHAP participants are three times less likely to visit the emergency department compared with self-reported use at enrollment, data corroborated by random sample of chart review.

### Brownsville Community Health Center Brownsville, TX

#### Population

Provides comprehensive primary and preventive care to a 99% Latino population in a rural area.



#### Best programs & practices

#### Frontera de Salud

*Universal health care and multi-cultural physician training*

Provides free care to the “working poor,” those who cannot afford insurance but earn too much for Medicaid and are too young for Medicare, and who rely on publicly and chronically under-funded clinics for their health care.

Founded by a group of medical students, an all-volunteer organization of health care professionals in-training at the University of Texas. This year, they will implement a new Integrated Community Health Elective for physicians in family or internal medicine residency training programs.

## Program innovations

Community action: *Volunteer care providing primary and preventive care*

Affordable and bilingual primary and preventive care are offered to the rural Latino population served at this public clinic. It operates in part thanks to their partnership with Frontera de Salud, an all-volunteer group of healthcare professionals-in-training that operate weekend clinics to provide examinations and physician referrals, as well as cancer, diabetes and hypertension screenings, and focused healthcare counseling. They also hold monthly ‘special clinics’ that provide gynecological exams, a well-woman check-up, and counseling. On a typical Saturday, thirty gynecology patients are seen.

Community action: *Pollution monitoring & action networks*

As a HEAN Partner, the center is involved in environmental justice efforts (see “Best programs & practices” text box).

Community outreach: *Health education*

Frontera students also conduct diabetes education classes. Twenty-five patients typically attend the classes where they are familiarized with the nature, symptoms, and complications of diabetes, and given specific recommendations to alleviate diabetic complications.

Community outreach: *Rural care*

On Sunday, Frontera travels to the community center of Iglesia San Felipe in Cameron Park, an impoverished neighborhood just outside the Brownsville city limits. Services there include blood pressure and blood glucose monitoring stations, depression and domestic violence screenings, a diabetic foot assessment station, and counseling stations to serve individuals whose exams raise suspicion of cardiovascular and/or diabetic disease. On a typical Sunday, Frontera screens and counsels 25-40 patients, of whom 2-5 require referral to the Brownsville Clinic.

## Salud Para la Gente –Watsonville, CA

### Population

The uninsured population in Watsonville numbers 14,589, and consists mainly of farm workers and their families, including a large Mixteco speaking population from Oaxaca.

### Program innovations

Community outreach: *Enrollment assistance in public assistance programs*

Salud Para la Gente has locations throughout the Monterey Bay and school-based health centers where comprehensive primary care is provided through outreach as well as assistance in a public benefit medical program enrollment. Most are unaware of Healthy Kids Program, an insurance program available

### Best programs & practices

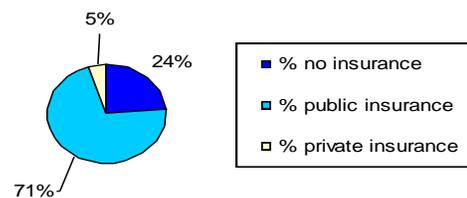
#### **Health and the Environment Action Network (HEAN)**

*Youth empowerment training in environmental justice*

At sites around the country (including three in this study), youth volunteers receive mobile pollution sensors, GPS devices, and video cameras—tools to monitor emissions of carbon monoxide, nitrogen dioxide, and sulfur dioxide in the air and dissolved oxygen and pH levels in water. Participants also record instances of environmental hazards on short videos, map them, and post them online.

After data are collected, HEANs works with local community-based organizations to establish Mobile Action Networks, allowing community members to receive pollution and environmental health updates via text messages to their mobile phones.

Insurance Profile



regardless of documentation, and has more flexible income requirements for those who do not qualify for public programs. They collaborate with migrant Head Start for outreach and education on programs and availability of insurance.

*“As a result of our service to the community, we are now the biggest health care/safety net provider for Watsonville.”*  
– Clinic Supervisor

Universal health care: Free, multi-cultural health care

The main purpose is to provide health care for those who would otherwise use emergency services for health care. At clinics, patient assistance is provided for medication for the uninsured. They partner with the local food bank to provide food, and also provide free/anonymous HIV testing, conduct women’s groups to discuss health issues, STDs, and family planning training, and offer outreach for gay/lesbian youth focusing on HIV prevention. They have expanded clinic hours to farm workers because people often cannot

leave work for preventive care. An important service for farm workers is educating them on heat-related illness and pesticide exposure to ensure they are taking protective steps.

Universal health care: Population and age-relevant care and services

Salud para la Gente also runs the Elder Day Program, an adult day health program providing transportation to elders who need assistance with daily living activities. It is the only program of its type that accepts Medi-Cal (California public insurance).

Community action: Pollution monitoring & action networks

As a HEAN Partner, the center is involved in environmental justice ((see “Best programs & practices” text box above).

## **Latino Issues Forum California**

### **Population**

LIF’s Health Program seeks to enhance and promote the health indicators for the 11 million Latinos in California including low-income, rural, immigrant, and limited-English speaking populations. Their work specifically focuses on increasing access to health care for all Californians, as well as boosting the quality of health care services to meet the unique cultural and linguistic needs of the Latino community. This emphasis on access and quality is intended to reach the uninsured and help implement policy to increase cultural competency.

### **Program innovations**

Accountability: Policy and regulatory advocacy

Latino Issues Forum (LIF) is a non-profit public policy and advocacy institute and is the only Latino organization to advocate through the regulatory process. LIF’s health program specifically focuses on advocacy to increase health access for Latinos in California through legislative, budget and administrative advocacy. Through their legislative advocacy, LIF works closely with the state departments (Health Services, Management Risk Medical Insurance Board, and the Department of Managed Health Care) that administer and oversee these programs to ensure they are effective, efficient, and meeting the needs of Latinos.

Community action: Empowerment training and coalition building

Latinas United for Community Empowerment and Social Justice Project is a leadership development and advocacy training project. LIF works to increase the leadership capacity of local leaders, increase local and statewide networks, and develop health care priorities for Latinas in California.

Universal health care: Multi-lingual health care

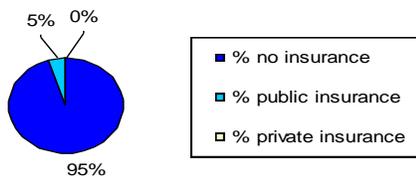
Currently LIF is leading efforts to ensure the strength and efficacy of newly developed regulations requiring commercial health care plans that provide language assistance to the non- or limited-English speaking enrollees. The regulations are a result of legislation signed in 2003 and calling for the Department of Managed Health Care to establish standards for commercial health care plans to develop a plan to provide translation and interpretation services for limited English proficient enrollees.

**Women’s Community Clinic**  
**San Francisco, CA**

**Population**

The Women’s Community Clinic uses an all-women volunteer-based model of care to provide free sexual and reproductive health care and outreach services to Bay Area women and girls. Of the 3,500 women the Clinic serves annually, 8% are Spanish-speaking. The majority of the women the Clinic serves lack health care insurance, lack access to health care, and live below the Federal Poverty Level.

**Insurance Profile**



**Program innovations**

Universal health care: *Free, reproductive care*  
 Access to health care services is a serious concern for San Francisco’s 50,400 uninsured women (San Francisco Health Plan, February 2006). The Women’s Community Clinic is the only free clinic for women in San Francisco. The Clinic builds community capacity by focusing on addressing the needs of their neighborhood through Clinic culture and racial/ethnic representation among the staff, an important part of access to care and mentorship.

Delivery of services on site is focused on sexual/reproductive care. Results of a recent survey conducted with patients indicate that the majority (60%) of young women (aged 25-35) reported a significant amount of health care related debt. In the case of insurance, patients may have been denied insurance in the past because they received abnormal test results or have a preexisting condition. “Poverty and lack of insurance are huge barriers – yet not the only barriers people face in accessing health care,” said Anne Purdy, Communications Director. “Feeling judged, disrespected or rushed prevents many women—especially those with limited resources—from accessing care that could greatly improve their health and well-being.”

Community action: *Empowerment training and employment as a health educator*

***Best programs & practices***

**Western Addition Health Training (WAHT!)**

*Empowerment training in reproductive health*

The Western Addition Health Training Program (WAHT!), is an innovative health careers training and outreach program for African-American women in the Western Addition community of San Francisco. WAHT! was launched specifically to address the health care needs in the Western Addition, a predominately African-American neighborhood in San Francisco. WAHT! uses a multi-faceted approach that incorporates resource and service awareness and delivery in conjunction with education, mentorship, and leadership training. WAHT! is focused on increasing career opportunities for women of color in the health professions while increasing the amount of outreach and services the Clinic provides to Western Addition residents. This is achieved through three main areas of concentration: Health career development and training, Professional mentorship, and Community outreach and collaboration.

*“Feeling judged, disrespected or rushed prevents many women—especially those with limited resources—from accessing care that could greatly improve their health and well-being.”* – Clinic Communications Director

A majority of services are provided by volunteer clinicians and health workers in the Clinic’s Health Worker Program. This volunteer-based model of care allows the Clinic to provide all of services at no cost while simultaneously training the next generation of health care providers. This approach has a lasting effect not only on the women who receive care but also on the women who provide it. The Clinic’s health workers are supported by a community of mentor clinicians and staff who provide hand-on training in women’s health, client-centered counseling and culturally competent care. The Clinic’s health workers emerge as leaders and advocates in the health care field and in their communities, building a values network that expands beyond the Clinic walls. In addition to the Health Worker Program, the Clinic has developed, the Western Addition Health Training Program (WAHT!), now in its pilot year. The WAHT! Program started with 2 program fellows and include three program components: health worker training (which builds off the Health Worker Program and includes health education), professional mentorship, community outreach (see Best practices text box above for a full description).

Community outreach: Homeless and jail outreach services

The mission of the Outreach Program is to work with women who live and work on the street to support their emotional and physical health and well-being. The Outreach Program recognizes the many barriers that women face in accessing culturally appropriate, quality and respectful care and seeks to dismantle these barriers by providing harm reduction based outreach services. The Program is made up of three projects: Street and Single-Room-Occupancy Hotel Outreach, *Ladies’ Night* Drop-in Program, and Health Education Classes in the County Jail. These three projects are linked by the core philosophy of meeting women “where they are” to provide supplies, referrals, information and consistent client-centered support. Services include: distribution of harm reduction and personal hygiene supplies; nutritional support; health and social service referrals; health education information; and program activities which include health education workshops, expressive arts programming and leadership development. The program is comprised of the Outreach Director and 15 outreach volunteers.

## Los Angeles Children’s Hospital

Los Angeles, CA

### Population

The hospital serves ethnically diverse populations in the Los Angeles area and the United States.

### Program innovations

Community action: Reproductive health literacy

The Community, Health Outcomes, and Intervention Research (CHOIR) Program coordinates research designed to reduce children’s health disparities and improve quality of care. One program is a health education course for middle school students about sexual risk reduction; it is the only evidence-based program recognized by the CDC (Clark et al., 2005). This program was developed after finding emerging health care needs of minority youth are not being met resulting in poor health outcomes including higher rates of STDs and less access to prevention services. The researchers also found that 75% of African Americans who have tested HIV positive have had no follow-up. Because insurance is not available through parents, and families have no regular health care provider, this population is more likely to report reliance on emergency services.

*“We found that 75% of African Americans who have tested HIV positive have had no follow-up.”*

– Research Program Director

Community action: Increased access to healthy food and open spaces

In the 2007 Community Diabetes Initiative, investigators at CHOIR partnered with local communities to

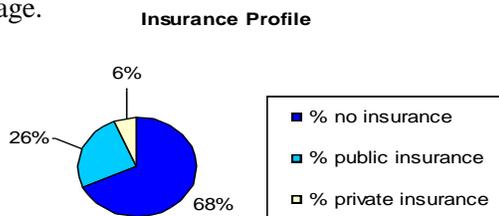
improve available healthy food options and the quality and utilization of local parks. They tallied 190 food outlets in East Los Angeles, nearly half of which were fast-food outlets, with 63 percent of those within walking distance of a school. By comparison, they found 62 grocery stores, only 18 percent of which sold fresh fruit and/or vegetables. Investigators also found that the five community parks within East Los Angeles provide just 0.543 acres of open space per 1,000 residents. Given these and other findings, CHOIR supported the establishment of a farmer’s market in East Los Angeles.

## Native American Health Center San Francisco, CA

### Population

The Native American Health Center is a Federally Qualified Health Center providing care to 3,055 residents of San Francisco and five surrounding counties, including patients in public state and federal insurance and safety net programs.

Approximately one-third of the patient population is Latino and another one-third is Native American; 28% of the patients are served in a non-English language.



### Program innovations

#### Universal health care: City-wide health care

Healthy San Francisco is the first city-wide universal health care program in the United States. The Native American Health Center is one of 10 community clinics, nine Department of Public Health clinics, two free standing clinics, and a hospital that are involved.

#### Universal health care: Multi-cultural care

- Combined medical and dental as well as for HIV+ patients and the homeless.
- Staff speak five languages other than English, including Spanish, Chinese, Korean, Vietnamese, and Tagalog.

### Key Findings

#### Healthy San Francisco

*The first city-wide universal health care program in the country, Healthy San Francisco provides primary and preventive health care to all residents regardless of citizenship status or language spoken. Here, organizers share lessons learned:*

#### Limit enrollment time and transportation burden:

- Enrollment time should be kept to a minimum (under an hour) and enrollment procedures that would require additional travel (e.g. from the clinic to the hospital) should be avoided.

#### Limit enrollment requirements and cost of care:

- Flexibility in medical home - An enrollment requirement to designate a “medical home” may mean services are limited if a patient goes elsewhere.
- Flexibility in timing of care - Currently, if a patient account remains inactive for more than three months, he or she is pushed out of the system and must re-enroll to access care. This is an unnecessary patient and administrative burden.
- Sliding scale fee - Use of a sliding scale fee structure increases likelihood of affordability and is preferable to a set cost of care for all patients.

#### Use community and clinical input to design program:

- A well-established clinic consortium in the area that already provides care to underserved populations is the best source to assist in program development. Many clinics in the Healthy San Francisco Consortium are unclear about program operations because they were not involved in their development.

## **Molina Health Care**

### **Long Beach, Riverside, and San Bernardino counties in California**

#### **Population**

The majority of the population is Latino and/or African American and more than 90% are publicly insured through Medicaid, Healthy Families Program, the State Children's Health Insurance Program (SCHIP), and other government-sponsored health insurance programs. In a survey of Molina's providers, 44% report that more than half their patients speak Spanish with about one-third preferring Spanish. Seventy percent of Molina's members are under the age of 21.

#### **Program innovations**

Molina Healthcare is a Health Management Organization that contracts doctors to care for patients who have traditionally faced barriers to quality healthcare. Their southern California locations are Long Beach, Riverside, and San Bernardino counties in California.

##### Universal health care: Demonstration site for multi-cultural care

As an Hablamos Juntos demonstration site in California's Inland Empire (San Bernardino and Riverside counties), Molina will test a fully bilingual 24-hour telephone service that will provide callers with access to member services, medical advice from a qualified nurse or physician, and medical interpreter services.

##### Workforce diversity: Scholarship for Latino medical students

Molina is a major funder of the University of Los Angeles International Medical Graduate Program, which provides student stipends and education costs for Spanish-speaking medical students in exchange for practicing in California's underserved rural and urban communities.

##### Universal health care: Prevention-based care

Programs focusing on prevention currently are being expanded in a partnership with John Hopkins University. The multi-lingual diabetes and obesity management care model operates through various modalities including provider-based, group visits, video education, multi-person care management social workers, and health care workers.

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#### ***Best programs & practices***

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##### **Hablamos Juntos "We speak together"**

*Demonstration sites and physician training for bilingual health care in rural and urban settings*

Hablamos Juntos develops affordable models for health care organizations to offer language services by funding 10 demonstration sites in regions in the United States with new and fast-growing Latino populations.

The Hablamos Juntos sites at UCSF Fresno Center for Medical Education & Research is a medical education and physician training program that has graduated approximately 60 resident physicians annually in one of seven specialties, totaling more than 2,000 physicians to date.

Three important areas for improving communication guide the development of models to break down language barriers:

Bilingual services - Increase the availability and quality of interpreter services for Spanish-speaking patients in health care facilities.

Patient education - Provide useful health care-related materials in Spanish.

Patient navigation - Offer easy-to-understand ways for non-English speaking patients to navigate health care facilities.

## **Arizona Latin-American Medical Association (ALMA)**

**Greater Phoenix, Maricopa County, Nogales, and Casa Grande, AZ  
Population**

Provides services to those who are uninsured, with emphasis on Spanish-speaking uninsured patients. It serves primarily the undocumented population at health fairs, totaling more than 15,000 patients statewide.

### **Program innovations**

Community action: *Volunteer care providing primary and preventive care*

ALMA is a non-profit physician association that began 15 years ago with annual health fairs. The association has 700-1,000 volunteer doctors that serve the Spanish-speaking population in Arizona through health fairs, at which they provide total cholesterol/glucose checks, osteoporosis checks, mammograms, and primary care health exams.

Universal health care: *Free, multi-cultural health care*

Services provided by ALMA doctors are for patients who typically do not have access to doctors or preventive health care. Attendance was 700 in the first year. The next year, it grew to 1,500. In the third year, the health fair was publicized in the Spanish-speaking media in five regions, and attendance jumped to more than 15,000. Due to so many attendees, the program continued expanding, and it also bore two more health fairs in Nogales and Casa Grande, which are very rural areas in critical need of health care providers.

Universal health care: *A usual source of comprehensive care*

In 2006, ALMA began offering *Tarjeta Medica*, a health care program for the Spanish-speaking population. At a discounted rate of \$60 per year per family, services offered include pharmacy, lab, dental, radiology, vision, primary care, specialists, prescription drugs, health screening, urgent care, and prosthetics and orthotics. Participants also receive a bilingual directory of health care providers in the network. People of all ages qualify to purchase this card, including those with preexisting medical conditions. It allows unlimited doctor visits, medicine, and medical exams. Payments made using the card allow patients to save 25-70%.

### ***Best programs & practices***

#### **The Tarjeta Medica**

*Protecting the uninsured from being over-charged*

The Tarjeta Medica program was developed by ALMA in response to the marketing of discount health care cards in Texas and Florida charging the uninsured population \$30-60/month for very limited information about how and where to access health care services. As an alternative to this unaffordable health care, ALMA started issuing the *Tarjeta Medica* in 2006.

### ***Key findings***

#### **The Tarjeta Medica**

*The importance of sustainable funding streams to develop sources of affordable, bilingual care for the uninsured*

As a result of a three-year federal grant to local community health centers, sales of the *Tarjeta Medica* have declined. If the grant funding results in institutionalization of the service, it may be a success, but it is as of yet unclear whether these centers provide affordable bilingual care. Still, it is ALMA's opinion that this grant undermines the local effort of private sector physicians to provide access to health care. After getting the grant, the clinic approached ALMA and requested volunteer physicians to provide care at nearly a pro bono rate. ALMA holds that it could provide comprehensive care without the overhead of community clinics. As such, ALMA intends to continue its efforts until the advent of universal health care.

Community outreach: Health education

ALMA volunteer doctors rotate hosting a Spanish-speaking radio program once a week focusing on disease prevention and health education.

Workforce diversity: Scholarship program for Latino medical students

ALMA raises funds to provide grants to Latino medical students, pharmacists, and RNs to continue their medical educations.

## **Health Access**

### **Sacramento, CA, and the United States**

#### **Population**

Latinos in California and nationwide

#### **Program innovations**

Accountability: Policy and regulatory advocacy

Health Access conducts policy advocacy, works with regulatory agencies, writes laws, get laws sponsored, and testifies for laws. After passage of legislation, it works with state departments (i.e.: health, managed care) and federal departments that administer public insurance programs. It focuses on issues that impact minority communities, mobilizing a coalition of over 200 groups focused on access to quality, affordable health care. Health Access conducts administrative advocacy both in California and nationally as a part of various coalitions. Health Access has three main concerns about the Latino population:

- Accessible health care - The biggest consumer complaint is getting in to see a doctor; the average person with a sick infant does not know if the symptoms indicate an emergency. As such, health care reform is now the organization’s focus in order to provide health care that is accessible, affordable, and transparent.
- Culturally competent care - Cultural and linguistic barriers impede navigation of the health care system, receipt of care, and the understanding and appropriate use of prescription medication.
- Transparency in health care - Health Access protects the uninsured from being overcharged for medical services through (1) a public review process when health insurers propose additional out-of-pocket costs, increases in co-payments, and benefit limitations; and (2) consumer protections for persons enrolled in high-deductible plans to require inclusion of preventive care and limit co-payments to 30% of the cost of care.

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#### ***Best programs & practices***

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#### **Health Care without Harm** *Increasing patient safety and primary prevention*

Health Care without Harm is a social movement to improve patient safety, workplace safety, and environmental safety and sustainability

It is comprised of an international coalition of hospitals and health care systems, medical professionals, community groups, health-affected constituencies, labor unions, environmental and environmental health organizations, and religious groups that work to transform the health care sector and also eliminate toxic chemicals from the health care industry so it is ecologically sustainable and no longer a source of harm to public health and the environment.

## **Best practices for culturally competent and fair care**

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Listed below are practices, novel policies, and exemplary programs identified during this study's research of innovative health care organizations. Best practices were identified by organizations working in one of the areas in need of improvement, areas previously identified in a literature review.

### **Diversity and staffing among health care professionals**

- *Multi-cultural health care*
- *Multi-cultural physician training*
- *Multi-cultural community health educators*
- *Rural care*

A diverse health care workforce with sufficient health care providers will help build a system of care that can provide culturally competent, equitable, and quality services to anyone, regardless of language spoken. This goal – if met – truly will foster universal care. Currently, most health care providers speak only English, but the general population is increasingly multi-lingual. Thus, many best practice care programs are concerned with the delivery of multi-lingual health care services. Solutions in this vein provided by this report appear in the form of affordable, community-based care. Organizations working to increase the number of health care providers who effectively can deliver comprehensive health care services to a local population include the Women's Community Clinic, the Healthy San Francisco Program, Tarjeta Medica, Salud para la Gente, Hablamos Juntos, and Frontera de Salud. Hablamos Juntos and Frontera de Salud also provide multi-cultural physician training. The Women's Community Clinic trains community members to become community health educators reach out to those most in need of care, such as people who are low income, homeless, or who distrust the health care system.

### **Quality changes to improve health care**

- *Patient safety*
- *Transparency in health care*
- *Protection of the uninsured*
- *Regulatory advocacy*

All patients must be treated in a way that ensures patient safety and transparency in the health care process and, to this end, accountability must be maintained. Presently, medical errors are pervasive and among the leading causes of death in the United States. The unaffordable nature of health care was raised repeatedly by organizations in this study. Though few organizations are able to dedicate resources to addressing the regulatory aspects around health care costs specifically, this is some of the most important work taking place to bring equality to health care. Health Access, for example, protects the uninsured from being overcharged for medical services through (1) a public review process when health insurers propose additional out-of-pocket costs, increases in co-payments, and benefit limitations and (2) consumer protections for enrollment in high-deductible plans to require inclusion of preventive care and limit co-payments to 30% of the cost of care.

### **Primary prevention for healthy environments**

- *Community pollution monitoring and action networks*
- *Greening of the health care industry*

Primary prevention is a public health approach that spans the fields of medicine, city planning, resource management, and policy making. Environmental justice emerged from this study as a major aspect of primary prevention in need of attention. In 1987, the United Church of Christ published a nationwide study reporting that race was the most significant factor among variables tested in determining

locations of hazardous waste facilities; a 20-year follow-up study confirmed the same trends were true in 2007. Environmental justice activism works to eliminate such societal inequalities. Best practices in this regard are found in the clinic partners in the Health and the Environment Action Network (HEAN). HEAN conducts pollution monitoring to monitor and mobilize pollution prevention in its communities.

The Community Diabetes Initiative undertaken by the Community, Health Outcomes, and Intervention Research Program by the L.A. Children's Hospital is an excellent example of how community-based partnerships may function to lower diabetes risk by increasing access to healthy food and green spaces.

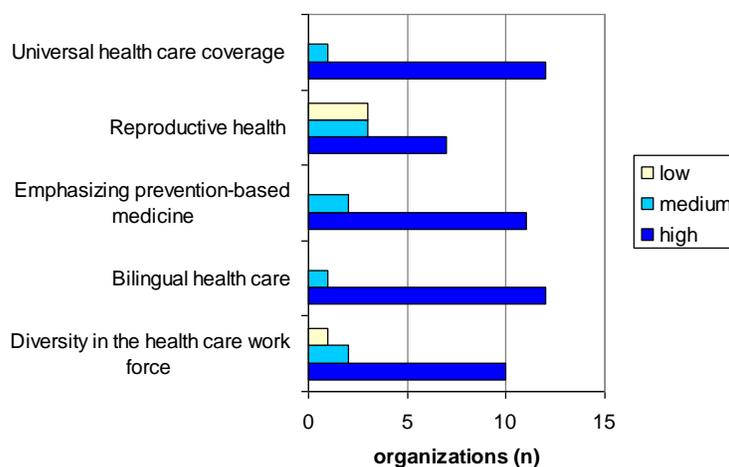
Health Care without Harm works to address environmental justice and health care inequalities by helping to "green" the health care industry thereby eliminating dangers posed to human and environmental health. Health Care without Harm works across all departments of medicine to assist in conversion of health care facilities to sourcing green energy, bio-based chemicals, and healthy food, for example. It also addresses the stressful work environment by targeting reductions in the high rates of medical error and the high number of occupational hazards among health care workers.

## Policy priorities and recommendations

All interviewed stakeholders were asked to prioritize issues regarding increasing health care access for minority populations. The issues presented were taken from the prior literature review.

A total of 13 organizations responded; the only non-respondent belonged to a group dealing primarily with regulatory as opposed to policy issues. Most organizations ranked four of five previously-identified topics as high priority policy areas: universal health care coverage, prevention-based medicine, bilingual health care, and diversity in the health care work force. Though reproductive health is considered an aspect of universal health care coverage and prevention-based medicine, it was listed separately to explore the specificity of this priority. Reproductive health was ranked a high priority among seven organizations and a medium priority by an additional three organizations.

**Figure 3.** Policy priority areas for organizations (n=13)



Results of this study demonstrate that minority populations have medical needs spanning the spectrum of primary, preventive, specialty, and urgent care. Fourteen organizations identified 19 distinct health care needs of concern for their populations. Nine conditions overlap with priority health conditions previously identified in a report of best practices to eliminate health inequalities including 68 national organizations (Jacobson et al., 2007). In addition to the common health concerns identified (diabetes, asthma, cardiovascular disease, cultural competency/multi-lingual care, STD/HIV care, dental, prenatal care, and cancer), areas that need to be addressed by programs working to eliminate health inequalities identified in this study are: hypertension, mental health/depression, usual source of care, affordability of pharmaceuticals, pediatric care, smoking cessation, substance abuse, violence, and pesticide-related exposure. The wider spread of diseases among the organizations in this study (fully illustrated in appendix B), supports previous evidence that race/ethnicity inequalities in health conditions are persistent and increasing. Root causes of this wide array of chronic, environmental, and reproductive diseases are marginal access to care and environmental toxin exposure.

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The right to be healthy is at stake in the discussion of access to health care. A number of racial and ethnic biases in our health care system demonstrate a cyclical pattern in which poor communities and communities of color (regardless of income status) receive deficient, sub-standard, and harmful care. African American and immigrant Latino populations in the United States are particularly at risk for lacking access to regular health care, and may seek unsafe forms of care or procedures in unsafe environments, placing them at further risk. Based on the literature search and case study interviews, it is

suggested that a universal health care system equally accessible to all is the best solution to remediate this situation.

### → Policy recommendation #1: Universal health care

Universal health care is defined as care available to all regardless of language or citizenship. Universal health care is multi-lingual, single-payer, low cost or free, and provide comprehensive care including primary, preventive, specialty, and urgent care. Women and children are especially vulnerable populations to disease during the reproductive life stage. As part of universal health care, reproductive health should be provided with the goal of achieving health literacy on family planning and disease prevention. An adequate health care system also would ensure that health care providers and support staff exist proportional to the population.

### → Policy recommendation #2: Affirmative action in the health care profession

Re-instituting affirmative action is a vital step in building equality into the health care work force as well as providing culturally competent health care for all. Equal access to medical education is extremely critical in ensuring the delivery of culturally competent care. Multi-lingual education of health care providers and medical staff is also an important piece in helping to ensure communication and promote workforce diversity.

A baseline measurement for success in the pursuit of cultural competency is that medical facilities are adequately staffed by people with race/ethnicities proportional to a community's population.

Evidence supporting the reintroduction of affirmative action in health care education comes from a survey of graduating medical students showing more minority physicians go into the types of practices that address the needs of minority populations—primary care in underserved geographic areas, for example. Of graduating students, one-fifth indicated they planned to practice in underserved areas with nearly 51% of Black, 41% of Native American/Alaska Native, and 33% of Hispanic graduating medical students reported intentions to practice in underserved areas. Only 18.4% of Non-Latino-whites reported such plans (Ko et al., 2005). Funding a medical education can prove a major barrier to entry into the medical field, especially for minority groups who have been disenfranchised historically. By expanding programs that fund education in exchange for practicing in underserved areas, federal funding should be provided to ensure full access to medical education without acquiring debt among minority students.

Multi-lingual care and physician training are two needed improvements to medical education. To ensure optimal communication, health care providers and medical staff should be able to communicate directly with patients. Research has shown that although all medical residents (n=40) surveyed about use of hospital interpreters agreed they were effective, 30 of 40 non-proficient residents reported use of hospital interpreters “never” or only “sometimes.” Of these residents, 21 of 40 reported calling on their proficient colleagues “often” or “every day” for assistance (Burbano-O’Leary et al., 2003).

A cultural competency component is also essential in multi-lingual training of health care professionals. Health professions curricula should address issues including but not limited to cultural beliefs, values, behaviors, customs, language (including health literacy), sexual orientation, religious beliefs, disability, socioeconomic status, and other distinct attributes (Williams, 2007).

*“In Obama’s health care plan, there is a major emphasis in automation, transportation, portability, medical records, a variety of strategies to reduce the tremendous expenses and resources wasted from people going to different doctors and tests having to be replicated over and over. A dimension that everyone else leaves out that he talks about is emphasizing federal funding for public health and prevention. He goes beyond improving the delivery system to infusing dollars into the public health system. The private institutions are there to make a profit and are not going to invest money in generalized public health education that doesn’t give them an immediate return on investment. Unless federal government prioritizes this element, it will not happen.”*

-Health Care Organization Director

Presently, a harmful health care system and environmental injustices perpetuate dependence upon health care. The harmful nature of the health care system may be attributed to three aspects: 1) the current system of delivery (medical error); 2) lack of primary prevention and 3) organizational operations that threaten human and environmental health.

**→ Policy recommendation #3: Patient equity and safety in care**

Equity in care entails eliminating practices that provide recipients of public assistance with a lower quality of care. Medical error also needs to be eliminated. At present, few health care sites have a system for reporting medical error. To ensure patient safety, health care sites should establish a systems-oriented approach to patient safety and create a safe environment that supports open dialogue about errors, causes, and strategies for prevention.

**→Policy recommendation #4: Primary prevention and freedom from disease**

Provide broad-based societal infrastructure and development for a public health care system based in primary prevention. The goal of this development is health care available at the community-based and institutional level to the population at large.

**→Policy recommendation #5: Restoration of human and environmental health**

Perhaps the most urgent change needed in health care is to stop being the source of disease. A universal health care system is one aspect of disease prevention and optimal care. A non-polluting health care system is the other essential aspect of a growing a disease-free society. In addition to the quality improvements in medical care discussed above, legislation to restore ecological balance and to eliminate sources of pollution are necessary to attain human and environmental health. Currently the health care industry is the second largest contributor to carbon dioxide pollution (Health Care without Harm, 2008). Beyond the health care industry, all sectors of industry hold responsibility for reducing their dependent upon fossil fuels and toxic chemicals that result in human and environmental damage. Examples of environmental justice legislation previously introduced include toxic waste cleanups in communities of color and a moratorium on the permitting of new toxic chemical facilities (see Appendix E).

**Table 6.** The Health Care Freedom Act: Policy recommendations

<b>Freedom to get educated</b>
<b>→ Policy recommendation #1: Universal health care</b>
Eliminate the requirement imposed by the federal income deficit reduction act for proof of citizenship and a birth certificate to enroll in public assistance programs.
Pass universal health care legislation that provides prevention-based health coverage to all residents through a single payer program. Streamline public assistance programs to ensure enrollment of those eligible.
<b>→ Policy recommendation #2: Affirmative action in the health care profession</b>
Provide public medical education funding for students of minority ethnicities in equal proportion to the entire population.
Require state medical professional boards to collect race/ethnicity and language proficiency data to track the diversity of health care professionals.
Fund development of culturally sensitive programs for use during health care training from premedical education and medical school through residency and Continuing Medical Education.
Fund training of community-based health educators to increase health literacy and assist in health care system navigation.
<b>Freedom from harm and to get well</b>
<b>→ Policy recommendation #3: Patient safety and equality in services</b>
Require health care sites to establish a systems-oriented approach to patient safety and create a safe environment that supports open dialogue about errors, causes, and strategies for prevention.
Require that people receive health care in their language including bilingual prescription drug labeling that requires pharmacies to translate and standardize medication labels.
Require hospitals to bill at the same rate for uninsured as for public insurance programs and to inform beneficiaries that they cannot be over-charged illegally.
Create greater transparency for health care consumers about the rise in health care costs by requiring new standards and a public review process when health insurers propose additional out-of-pocket costs, increases in co-payments, and benefit limitations.
Establish consumer protections for persons enrolled in high-deductible plans; require high-deductible health care plans to cap total out-of-pocket costs for consumers at \$5,000 for individuals and \$10,000 for families.
Establish health care working groups to develop policies and plans that address community health needs and diversity among health care professionals (Williams, 2007).
<b>→ Policy recommendation #4: Primary prevention and freedom from disease</b>
Expand mandatory benefits provided by high-deductible health plans to include preventative care as a mandatory benefit and limit co-payments to no more than 30% of services.
Establish school- and community-based health centers nationwide for the purpose of growing healthy communities.
Fund comprehensive health literacy and sexuality education and ensure that they are meeting the following criteria: medically accurate, unbiased, non-religious based, culturally, linguistically, and age-relevant.
<b>Freedom to be born well and to stay well</b>
<b>→ Policy recommendation #5: Restoration of human and environmental health</b>
Outlaw industrial pollution, pass environmental justice legislation, and implement conversion to use of non-polluting compounds and green chemicals in industries including agriculture, energy, transportation, and health care.

## Conclusion

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The existing health care access problems are pervasive and well-documented. Because minorities represent a rapidly growing proportion of the overall population, the consequences of these problems will become even more pronounced if not addressed through direct action. A key issue relevant to policy makers is the extent to which trends and disparities among racial and ethnic groups cannot be fully explained by socioeconomic factors. A body of research shows that income, health insurance status, and other socioeconomic factors can explain only a portion of the vast disparities documented in minority health care. Immigration status and living environment are additional determinants of child health care coverage and disease risk, for example.

The systemic barriers faced by minority populations are well-characterized. Many barriers faced by Latinos such as no insurance, low income, language/cultural barriers, and immigration status appear to exist at the individual level. However, individual and provider level barriers “reflect larger systemic problems” in rural health care, shortages of physicians, bilingual professionals, qualified medical interpreters, medical error, and threats to patient safety (Casey et al., 2004).

To date, far greater research attention has been given to documenting racial and ethnic disparities in care than in understanding how to build health-creating environments. Almost all factors cited as health care problems among racial/ethnic minority populations are either preventable or remediable. The health care issues faced by minority populations across the United States are universal to uninsured populations and consist most often of diabetes, heart disease, and cancer. Asthma also is frequently cited in this study as a growing health concern among children. The etiology of disease today is diverse because of the increasingly deleterious environment. Considering that the highest disease rates in this country and now also the world are chronic, preventable diseases, it is worth shifting focus to developing drastically different models of agriculture, energy, transportation, and health care—all factors that influence how we relate to our environment.

Population health will only improve with the long-term investment of universal health care. Universal health care is a means of public health whereby primary prevention is funded first and foremost to ensure that the entire population, regardless of language spoken or citizenship, lives in a healthy environment and produces healthy children. Elements of primary prevention work across all levels of society and government to ensure that people reside in homes and environments free of toxins, have a regular source of food and water, enjoy open spaces, and are provided with resources to alleviate any additional stress imposed by societal inequalities. Access to a reliable and trusted source of care for sickness completes the provision of universal health. This is preventive medicine.

In the interim, to eliminate health disparities in the growing Latino population, emphasis must be placed on primary prevention and affordable, bilingual care. Sufficient numbers of health care providers to serve this population will be achieved through the training of the Latino health care workforce using publicly funded bilingual and multi-cultural educational initiatives. Public programs intended to provide health care for the poor should at the very least be highly accessible to the target population including easy enrollment into a support system of multi-cultural care that does not need to be supplemented. Greater accountability in the form of transparency in the health care system also is needed to prevent the uninsured from unscrupulous business practices. The intersection of the environment and human health is the combined policy approach needed to comprehensively address the race/ethnicity-based exposure to disease. Such a direction in policy-making will allow the United States to get from the interim health care situation of an unnecessarily diseased population to the goal of universal health care and healthy environments. It is through the healthy building of our environments and equitable building of our society that we shall grow healthy individuals.

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## **Appendix A. Interviewees & Featured Programs**

### Interviewees

Albert Galvan Health Clinic: Kimberly Mills, Development Coordinator  
Arizona Latin American Medical Association: Adolfo Echeveste, Executive Director  
Brownsville Community Health Center: Emily Albert, Operations Director  
Center for Health Care Strategies: January Angeles, Program Officer  
Community Health and Social Services Center, Inc.: John Carlo, Associate  
Delaware Health Care Commission: Betsy Wheeler, MA, Wheeler & Associations Management Services, Inc., member, & Paula Roy, Executive Director  
Health Access: Beth Abbott, Project Director  
Latino Coalition for a Healthy California: Lupe Alanzo-Diaz, Executive Director  
LA Children's Hospital: Michele Kipke, PhD, Professor, Division Chief, Research on Children, Youth, and Families  
Molina Healthcare, Inc.: Martha Bernadett, MD, MBA, Executive Vice President  
Native American Health Center: Mark Espinoza, Executive Director  
Salud Para la Gente: Christian Pinon, Community Health Outreach Supervisor  
Women's Community Clinic: Carlina Hansen, Executive Director, and Kemi Role, Western Addition Health Training (WAHT!) Program Director

### Featured Programs

Frontera de Salud  
Hablamos Juntos  
Health and Environment Action Network  
Health Care without Harm  
University of California, Los Angeles International Medical Graduate Program

**Appendix B.** Health conditions of most concern in elimination of health inequities

<u>Condition</u>	<u>Organizations</u>	
	<u>n (14)<sup>1</sup></u>	<u>n (68)<sup>2</sup></u>
Diabetes	7	6
Asthma	5	9
Mental health, depression	5	--
Hypertension	4	--
Cardiovascular disease	4	10
Usual source for primary, preventive, and urgent care	3	--
Cultural competency, multi-lingual care	3	15
Affordability of pharmaceuticals	3	--
Pediatric care	3	--
Smoking cessation	2	--
HIV/STD	2	8
Dental	2	6
High risk pregnancies and pregnancy care	1	10
Cancer	1	6
Substance abuse	1	--
Violence	1	--
Pesticide exposure-related illness	1	--

<sup>1</sup>Organizations from this study

<sup>2</sup>Jacobson, 2007

## **Appendix C. Relevant reports and books**

2008: Health Inequalities in the Bay Area

[http://www.phi.org/pdf-library/barhii\\_report08.pdf](http://www.phi.org/pdf-library/barhii_report08.pdf)

2007: Diversity in the Health Professions

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Culturally\\_Compentent\\_Health\\_Systems/Workforce\\_Diversity/AnnobibDraft%20rev%201\\_10%2031%2007.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Compentent_Health_Systems/Workforce_Diversity/AnnobibDraft%20rev%201_10%2031%2007.pdf)

2007: If It's a Pipeline, Why Isn't There More Diversity At the Other End? Framing the Agenda for Health Professions Workforce Diversity

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Culturally\\_Compentent\\_Health\\_Systems/Workforce\\_Diversity/If%20it%20is%20a%20Pipeline%20draft%209-26-07.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Compentent_Health_Systems/Workforce_Diversity/If%20it%20is%20a%20Pipeline%20draft%209-26-07.pdf)

2007: Quantitative Assessment of Selected Health Professions in California

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Culturally\\_Compentent\\_Health\\_Systems/Workforce\\_Diversity/SelectedHealthProfessionsinCA.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Compentent_Health_Systems/Workforce_Diversity/SelectedHealthProfessionsinCA.pdf)

2007: Increasing Diversity of the Health Professions, K-12 Networks of Support

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Culturally\\_Compentent\\_Health\\_Systems/Workforce\\_Diversity/Sections%20I%20and%20II%20K-12%20Networks%20of%20Support1.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Compentent_Health_Systems/Workforce_Diversity/Sections%20I%20and%20II%20K-12%20Networks%20of%20Support1.pdf)

2007: Promising Programs to Eliminate Racial and Ethnic Health Disparities

[http://www.ipa.udel.edu/publications/disparities\\_pgrms\\_summary2.pdf](http://www.ipa.udel.edu/publications/disparities_pgrms_summary2.pdf)

2006: Agency for Healthcare 2006: Research and Quality's Disparities Report: Health Coverage and Access to Care for Hispanics in "New Growth Communities" and "Major Hispanic Centers"

<http://www.kff.org/uninsured/7551.cfm>

2004: In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce

<http://www.nap.edu/openbook.php?isbn=030909125X>

2004: Health Disparities Literature - A compilation from San Francisco State University Center for Health Disparities Research and Training

[http://rimi2.sfsu.edu/resource/Health\\_Care\\_Literature.pdf](http://rimi2.sfsu.edu/resource/Health_Care_Literature.pdf)

2004: Missing Persons: Minorities in the Health Professions

<http://www.aacn.nche.edu/Media/pdf/SullivanReport.pdf>

2003: Kaiser Commission on Medicaid and the Uninsured – Policy Brief

<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22107>

2003: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. Board on Health Sciences Policy, Institute of Medicine. The National Academies Press, Washington D.C.

1985: U. S. Department of Health and Human Services. (1985). Report of the Secretary's Task Force on Black and Minority Health. Executive Summary. Washington, DC: Government Printing Office.

**Appendix D.** Language resources for practicing physicians (Source: California Endowment)

California Academy of Family Physicians

A toolkit and CME course, "Addressing Language Access Issues in Your Practice-A Toolkit for Physicians and Their Staff Members"

[www.familydocs.org/practice-resources/cultural-proficiency.php](http://www.familydocs.org/practice-resources/cultural-proficiency.php)

Kaiser Permanente

A tool to help in providing culturally competent care

[www.familydocs.org/assets/Multicultural\\_Health/CulturalComp\\_Card.doc](http://www.familydocs.org/assets/Multicultural_Health/CulturalComp_Card.doc)

Medical Leadership Council on Cultural Proficiency

A database, searchable by county, of language access services, continuing education resources, and meeting summaries and reports on language access policy and practices

[www.medicalleadership.org](http://www.medicalleadership.org)

The California Health Care Safety Net Institute

More than 30 downloadable resources and publications on language access and cultural competence

[http://www.safetynetinstitute.org/programs/languageaccess\\_resources.html](http://www.safetynetinstitute.org/programs/languageaccess_resources.html)

U.S. Census Bureau

"I Speak" cards with the message "Mark this box if you read or speak (language)," in 38 languages, to help identify a patient's preferred language

[www.usdoj.gov/crt/cor/Pubs/ISpeakCards.pdf](http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards.pdf)

## **Appendix E. Federal legislative activities on environmental justice (Source: U.S. EPA)**

Since the introduction of the first Environmental Justice Act in 1992 by then Senator Al Gore, six additional bills on environmental justice have been introduced. The intent of the bills varies, including identifying and ranking the 100 geographic units with the highest levels of toxic chemicals exposure, preventing certain waste facilities from being constructed in environmentally disadvantaged communities, requiring the Agency for Toxic Substance Disease Registry to collect and maintain demographic data of persons living in communities adjacent to toxic-substance contamination, and establishing an Office of Environmental Justice in the proposed U.S. Department of Environmental Protection. The list below is in numerical order by House then Senate.

### **H.R. 1924 - The "Environmental Equal Rights Act" - Rep. Cardiss Collins**

Introduced on April 29, 1993. No co-sponsors. Referred to the House Energy and Commerce Committee. No hearings have been held. The bill would amend the Solid Waste Disposal Act to allow any citizen in a state to petition to prevent a permit from being issued to a new solid-waste management facilities when it is proposed to be sited in an "economically disadvantaged community."

### **H.R. 1925 - "The Environmental Health Equity Information Act" - Rep. Barbara-Rose Collins**

Introduced on April 29, 1993. Five co-sponsors. Referred to the House Energy and Commerce Committee. No hearings have been held. The bill would require the Agency for Toxic Substance Disease Registry to collect and maintain demographic information on persons living in communities adjacent to toxic substance contamination.

### **H.R. 3425 - "The Department of Environmental Protection Act" - Rep. John Conyers**

Introduced by House Government Operations Committee. The bill would establish an Office of Environmental Justice at the proposed U.S.DEP. It also would establish an Advisory Committee composed of 15 members and appointed for three-year terms with the possibility to be reappointed for one additional term.

### **S. 171 - "The Department of the Environment Act" - Sen. John Glenn**

Introduced January 21, 1993. Seventeen co-sponsors. It passed the Senate May 4, 1993, and was sent to the House on May 5, 1993. One hearing has been held. This bill would establish an Office of Environmental Justice in the proposed Department of Environmental Protection to develop a strategic plan for environmental justice, evaluate environmental policy to protect individuals who have the highest exposure to pollution, report annually on progress in achieving environmental justice, collect health effects data on pollution impacts on individual groups, identify environmental high impact areas, assess health effects from emissions in areas of highest impact.

### **S. 1161 - The "Environmental Justice Act" - Sen. Max Baucus**

Introduced on June 24, 1993. Two co-sponsors. It was referred to the Senate Environment and Public Works Committee. No hearings have been held. A companion bill to H.R. 2105 except that it does not contain the "moratorium" provision.

### **H.R. 2105 - The Environmental Justice Act - Rep. John Lewis**

Introduced in May 1993. Twenty-five co-sponsors. Referred to the House Energy and Commerce, Public Works and Transportation, Education and Labor, and Agriculture committees. No hearings have been held. The bill would require the Environmental Protection Agency within one year of enactment to publish a list ranking from 1 to 100 the geographic units with the highest amounts of toxic chemicals; these will be known as "environmental high impact areas" (EHIA). Impose a moratorium on the siting or permitting of new toxic chemical facilities in EHIA that emit toxic chemicals that cause significant impacts on human health.