

IMPORTANT FAX

Date: 10-14-97

FAX TO: Vice President Al Gore

202-456-7028

or 202-456-2461

FROM:

ANN ORICK



P6/b(6)

RE: Thank you for your letter on the
K-25 Site, Oak Ridge, TN Health Issue.

This fax contains 4 pages including cover sheet.

ANN ORICK

P6/b(6)

Tuesday Oct 14, 1997

Vice President Al Gore
The White House

Dear Vice President Gore:

I just wanted to thank you for your letter in response to my many faxes on the K-25. Oak Ridge, Tennessee, Health Concerns. I have tried to reach you now for 25 months regarding this problem because people are so very sick. I am hopeful that we may have a statement from the Democrats and the Administration before others take the lead and establish a helping hand of support for the Tennessee people.....that's why I have continually written to you.

Secondly, I felt I also needed to let you know that Senators and Representatives from other states may be first to bring this matter to the attention of Congress in Washington. On Friday I met with students from the University of Tennessee Sociology Dept. and they have decided to take this on as a project. This means that numerous people will be reached in the near future with this problem and one of the first activities these students are undertaking is to call members of the Senate and House to gain support for the ill and seek

environmental help in forcing DOE to properly clean up Oak Ridge. They are students of journalism, law, etc., and are eager to make a difference in the world. I see this as having major media appeal, and these students want this to go international. Before they met with me on Friday, they had already called the White House (who promptly told the students they did not know of any such problem and had not been contacted - where's all my letters and faxes?), and several Senators that some of them had worked for during the summers the past couple years. One person has promised to make his "one minute speech" on the floor on a Monday morning on this topic. I hate to see elected officials from other states taking the floor to introduce to the nation and the world Tennessee's problems. Don't you want to take the lead position here? You should be the person most interested in what's happening in your state to your people.

Now I have alerted you, and pray that you take these notices seriously. We desperately need help, and our preference is with you and we hope we are first on your list of priorities too. I am still asking for a personal meeting with you so that I can show you first hand someone who is really very ill, has medical proof, has documents obtained from DOE showing their consistent pollution with toxic and radioactive contaminants to the area, and to beg you to help us make DOE accountable for a proper and safe clean-up and continued jobs for the unaffected, trained workers so that the economy does not suffer further due to DOE's actions. Don't you feel like DOE should be accountable for

what they have caused to happen here, and that the people should not have to suffer medically or financially because of them? Please step in and help us now. We are very sick. Please grant me a meeting to discuss our problems. I have already met in Washington with Sen. Thompson's people, and met in Knoxville with Sen. Bill Frist just a couple of weeks ago. I have two letters stating my request for a meeting with Sec. of Energy Pena is in the Office of Scheduling and Logistics and I will be notified of that soon.

Again for your letter, I sincerely thank you, and hope that it is the beginning of a correspondence that can end up in one of the greatest solutions to any problem you have seen since becoming a Vice President of a great country, or a former Senator for a great state.

Thank you.....



Ann Orick

P6/b(6)

Breast cancer

Mastectomy file

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WASHINGTON, DC 20515-0701
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NEW HAVEN, CT 06810
(203) 562-3718
KILLINGWORTH/CLINTON
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STRATFORD
(203) 378-8008

185 co-sponsors
house.



CHIEF DEPUTY WHIP
COMMITTEE ON NATIONAL SECURITY
SUBCOMMITTEE:
MILITARY PROCUREMENT
MILITARY PERSONNEL

UNITED STATES
HOUSE OF REPRESENTATIVES
ROSA L. DELAURO
30 DISTRICT, CONNECTICUT

Rep. -
only
11

Daschle →
410-sponsors.
18-19.
Kim Conover

January 27, 1997

Roukama → Susan Molinari

Mr. Rahm Emmanuel
Assistant To the President
Director of Special Projects
The White House
1600 Pennsylvania Ave, NW
Washington, D.C. 20502

↳ 48 hr - not a specific time
Dr.
→ Breast Reconstructive
→ 2nd follow up

Dear Rahm:

Last week I spoke with you about working with the White House on legislation guaranteeing minimum hospital stays for women undergoing mastectomies and lymph node dissections.

You requested information on how many women would be affected by this legislation. Attached is a fact sheet that outlines estimates of how many women are enrolled in managed care organizations and how many women undergo mastectomies.

Please contact Lissa Topel in my office at 225-3661 if you have any questions.

Thank you for your help.

Internet petition

Sincerely,

Rosa L. DeLauro
ROSA L. DeLAURO
Member of Congress

Type in experience

RLD/lt

Attachments

Hearings
health-related

Press conference

bill
Commerce

Research

Times

→ Pediatric Labeling
Info at event
day of / day after

**Facts on the Number of Women Affected
by the DeLauro-Dingell-Roukema
Breast Cancer Patient Protection Act**

- o According to the Group Health Association of America, approximately 51 million Americans were enrolled in HMOs in 1994. According to the American Association of Health Plans, in 1994, approximately 53 percent of HMO enrollees were women. Therefore, approximately 27 million women were enrolled in HMOs in 1994.

- o An HCIA study, cited in a November 6, 1996 Wall Street Journal article, estimates that 110,400 mastectomies were performed on breast cancer patients in 1995.

- o In 1995, HCIA estimates that 8,390 mastectomies (7.6 percent) were done on an outpatient basis. In 1991, HCIA estimates that only 1.6% of all mastectomies were done as outpatient surgery.

- o The American Cancer Society estimates that 180,200 women will be diagnosed with breast cancer in 1997; another 43,900 will die from the disease this year.

DRAFT

THE WOMEN... THEIR STORIES

Judy Willis

In September of 1994, Judy Willis of Virginia underwent a bilateral mastectomy with expander implants (implants that are gradually filled with saline as the wounds heal). She was admitted into the hospital around 1:00 pm and released from the hospital at around 8:00 am the next day (19 hours later)-- without even getting a meal! She had not been told that she would be released that soon. In fact, the doctor told her that she would probably be in the hospital for a few days. Her sister was very surprised when Judy told her to come pick her up that early the next day.

She was discharged 19 hours after being admitted, and sent home with 3 drainage tubes sticking out of her chest. She had to empty and measure the fluid draining out. She had little use of her arms (women have to do exercises to regain mobility), which made this task very difficult to perform. She could not get out of bed on her own and going to the bathroom was also difficult - cooking meals were out of the question.

For Judy Willis, undergoing an outpatient mastectomy was both physically and emotionally devastating. She knows that others in her health plan have undergone the same treatment and she wants it to stop.

Sharon Faucher

In February of 1996, Sharon Faucher of Connecticut was admitted to the hospital for a mastectomy at 8:00 a.m. Since outpatient surgery is defined as a hospital stay of 23 hours or less, by 6:00 a.m. the next morning, 22 hours later, a nurse woke her up and told her that she should get dressed because she was being discharged. She had been given morphine for her pain, so she could barely stand. She also had been vomiting. She asked to stay, but the nurse told her she had to leave.

She left with drainage tubes and bandages. No oncology nurse was sent to talk to her about her surgery. No wheelchair was sent to carry her out of the hospital. On her way home from the hospital, less than 24 hours after her surgery, she vomited three times.

Sharon hopes that no woman ever has to endure the physical and emotional pain she went through after such a humiliating experience.



PRESS RELEASE

VIEWERS STAND WITH LIFETIME TELEVISION AND LINDA ELLERBEE AGAINST "DRIVE-THROUGH" MASTECTOMIES

More Than 10,000 Viewers Sign Network's Internet Petition on Lifetime Online: Names And Numbers to Be Sent to Congress

ANAHEIM, CA., December 12, 1996 – In a span of two weeks, more than 10,000 viewers of LIFETIME Television have responded to journalist/breast cancer survivor Linda Ellerbee's commentary on "drive-through" mastectomies currently being debated among politicians, medical professionals and health maintenance organizations (HMOs). The Ellerbee short segment premiered on Sunday, Nov. 24, on "Perspectives on Lifetime," the Network's award-winning vignette series.

In the 60-second segment, which has aired only once each day, Ellerbee argues that a mastectomy is more complex than "getting a tooth pulled." However, she tells viewers how some health care groups are treating mastectomies with outpatient treatment, a controversial step for such a physically and emotionally challenging procedure. Ellerbee urges viewers and on-line users to sign an on-line petition at www.lifetimetv.com which will be sent to congressional representatives to lobby for a law mandating a 48-hour hospital stay. The spot will air through December 8.

Amy Langer, Executive Director of the National Alliance of Breast Cancer Organizations (NABCO) said, "NABCO, along with breast cancer survivors across the country, applaud Lifetime's efforts to alert their viewers of this alarming trend and urge them to participate in this petition."

Meredith Wagner, LIFETIME's Senior Vice President of Public Affairs said, "It is extremely rewarding to know that so many of our viewers and online users are responding to our outreach efforts. Lobbying for legislation that will keep women well cared for after breast surgery is not a typical effort for a cable network to take, but it is something that Lifetime feels is crucial for the health of women nationwide."

LIFETIME Television is available on more than 8,300 cable systems and alternative delivery systems nationwide, serving 66.7 million households. Learn more about LIFETIME Television on the Lifetime Online web site at <http://www.lifetimetv.com>.

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Contact: Brett Henne, LIFETIME Television 212/424-7120



NABCO

NATIONAL ALLIANCE
OF BREAST CANCER
ORGANIZATIONS

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Nancy Brinker
Rose Kushner
Ruth Spear

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December 23, 1996

Hon. Rosa DeLauro
United States Congress
House of Representatives
436 Cannon House Office Building
Washington, DC 20515

Dear Congresswoman DeLauro:

Thank you for your leadership in initiating Federal legislation protecting women from inappropriate post-mastectomy hospital stays under managed care. As the leading non-profit information resource on breast cancer and a network of 375 organizations across the country, the National Alliance of Breast Cancer Organizations has been increasingly concerned about the impact that managed care will have on the treatment and quality of life of women with breast cancer and their families.

In recent conversations with Lissa Topel, we mentioned that Lifetime Television has also taken a stand on this issue. Lifetime has been working with NABCO and other breast cancer organizations for the past three years as the network has become active in the fight against breast cancer. As the enclosed press release dated December 12 explains, more than 10,000 Lifetime viewers have signed an on-line petition expressing concern about "drive through" mastectomies.

After Congress reconvenes, NABCO and Lifetime would like to explore ways to join with you in calling attention to the issue, perhaps including the delivery of the 10,000 petitions at a press event. Please contact my office to discuss your thoughts on next steps, including the involvement of your Congressional colleagues and other national organizations.

Information about NABCO is enclosed, along with the Lifetime press release. I'll look forward to your call, and wish you a happy and healthy New Year.

Very truly yours,

Amy S. Langer
Executive Director

encls.
cc: Kim Calder, NABCO
Marcy Haley, Lifetime
Lissa Topel

TELEFAX TRANSMITTAL

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 Director, National Institutes of Health
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DATE: April 9, 1998

TO: Sarah Bianchi
Office of Policy Development
Executive Office of the President

FAX NUMBER: 202-456-⁷⁴³¹~~5557~~

PHONE NUMBER: 202-456-5560

NUMBER OF PAGES (INCLUDING COVER PAGE): 4

[] PLEASE CALL TO CONFIRM RECEIPT. THANK YOU.

REMARKS: Ms. Bianchi -

Attached is information regarding NIH
investment in minority-related research
and research training. Please give this material
to Chris Jennings as soon as possible.

Thank you very much.

[The original will be delivered via courier today.]

NIH INVESTMENT IN RESEARCH AND RESEARCH TRAINING
PROGRAMS RELATED TO MINORITIES

The NIH investment in research and research training programs related to the minority populations in the U.S. is about \$1.5 billion. Of this, about \$115 million supports research training in the preparation of minorities for careers in biomedical research. Examples are: 1) the Minority Access to Research Careers Program for undergraduate student training in research and minority and predoctoral faculty fellowships; 2) the Bridges to the Future Program for students to make the transition from two-year to four-year colleges and from Master's degree granting to doctoral degree granting programs; 3) support for minority high school, college, graduate and postdoctoral students by supplemental funds to regular research grants; and 4) a program within NIH for loan repayment scholarship funds for undergraduate, graduate and medical students, as well as postdoctoral trainees studying AIDS.

Support for research activities performed by minority investigators and their students totals about \$136 million. Under the Minority Biomedical Research Program, research is performed by faculty and students at academic institutions having a significant number of minority students [Historically Black Colleges and Universities (HBCUs); Hispanic Serving Institutions (HSIs) having an enrollment of at least 25% Hispanic students; and institutions in inner cities and some other geographic areas in which a large number of minority students are enrolled].

Support for Research Centers at Minority Institutions is about \$32 million and includes special funds for construction at these institutions. The total funds provided to HBCUs will be about \$86 million and to HSIs about \$69 million in FY1998.

Funds for research related to diseases or conditions that inordinately affect the minority populations of this country are provided by the Institutes and Centers and total over \$2 billion. These funds are particularly directed to studies of breast, prostate and lung cancer, cardiovascular disease, hypertension, diabetes, stroke, sickle cell disease, sudden infant death syndrome and infant mortality.

The Office of Research on Minority Health serves as a focus of coordination of the activities of all the NIH Institutes and Centers and is described in the attached Fact Sheet. The Office is responsible for the Minority Health Initiative, which provides about \$70 million a year for projects supported by the Institutes and Centers. These include perinatal studies and interventions to improve infant mortality rates, the effects of alcohol on the fetus, adolescent alcohol use, lead poisoning in children, research on HIV infection in adolescents, studies of asthma in minority children, auditory and visual impairments in minority children, and many others.

The NIH is committed to ensuring that all Americans have equal access to good health and that all scientists have the opportunities to compete fairly for research funds.

April 1998

NATIONAL INSTITUTES OF HEALTH

OFFICE OF RESEARCH ON MINORITY HEALTH

What is meant by "minority health?"

"Minority health" refers to the morbidity and mortality of African-American, Hispanic, Asian/Pacific Islander, and Native American citizens of this country.

Why conduct research on "minority health?"

Minorities at all stages of life suffer poorer health and higher rates of premature death than the majority population. With some conditions, such as asthma and AIDS, a good deal is known about why minority populations are the hardest hit, but less about how to reduce the disproportionate burden of these illnesses. With other conditions, such as lupus and certain cancers, it is still unclear why minorities are disproportionately affected. Supporting research that attempts to fill these gaps in basic health knowledge is paramount in the quest to uncover new scientific knowledge that will lead to better health for all Americans.

Eliminating the disproportionate burden of ill health and disability among minority Americans will also benefit the Nation economically. More people will be fit to work, gaining economic independence and contributing to the Nation's productivity and competitiveness.

Why does NIH need a designated office—Office of Research on Minority Health (ORMH)?

NIH is committed to solving the research questions that result from the disparity of health status among Americans. In addition, NIH recognizes that if the United States hopes to maintain its international pre-eminence in scientific research in the 21st century, it needs

to draw future generations of scientists from a more diverse pool of people than have been drawn to science in the past.

The establishment of ORMH by the Congress emphasizes the obligation of NIH in solving these problems and facilitates the effort by supplying the necessary focal point within the Office of the Director, NIH.

What is the mission of the ORMH?

The NIH ORMH has a twofold mission:

- To support and promote biomedical research aimed at improving the health status of minority Americans across the lifespan, and
- To support and promote programs aimed at expanding the participation of underrepresented minorities in all aspects of biomedical and behavioral research.

How will ORMH accomplish its goals?

The ORMH works in partnership both with grassroots organizations in minority communities and with the scientists and program experts in the NIH institutes, centers, and divisions (ICDs). ORMH does not offer research/training support directly to the community. Rather, it supports studies and programs as pilot projects managed by the ORMH's partner ICDs. Projects that receive support are subject to rigorous scientific scrutiny and to ongoing assessment. It is intended that projects that demonstrate effectiveness will ultimately become part of the partner ICD's research portfolio, freeing ORMH funds to support new pilot projects in other areas of need.

ORMH

**"FILLING THE
GAPS IN
THE HEALTH
RESEARCH
NEEDS OF
AMERICANS"**

NATIONAL
INSTITUTES OF
HEALTH

Office of
Research on
Minority Health

What has ORMH accomplished so far?

The Minority Health Initiative (MHI) was launched in 1992 and funded at \$58 million in Fiscal Year 1995. This is the rubric under which a series of multi-year research studies and a set of training programs are being funded. These efforts are targeted to address the disparity in minority health across the lifespan and increase the participation of minorities in biomedical research. This agenda was formulated based on the recommendations of a Fact Finding Team comprised of 53 distinguished citizens who assimilated information and ideas from nearly 1,000 representatives of the biomedical community around the country.

Phase I of an Assessment of NIH Minority Research/Training Programs has been completed, and Phase II is underway. The entire assessment will conclude with Phase III by the end of Fiscal Year 1997.

A working relationship with the community has been established through consultations and conferences, the most recent of which was the National Conference on Minority Health Research and Research Training held in Chicago in 1994.

What work remains to be done?

In addition to continuing to identify and fill the gaps in health research and research training support that must be filled to ensure that the health needs of all Americans are met, ORMH is committed to:

- Promoting the inclusion of minorities in research study populations
- Enhancing the capacity of the minority community to participate in addressing its health problems
- Increasing collaborative research and research training programs between minority and majority institutions
- Improving the competitiveness and number of well-trained minority scientists applying for NIH research funding
- Developing an ongoing assessment tool for minority programs at NIH and a coordinated information system to link these programs.

For more information please contact:

John Ruffin, Ph.D.
Associate Director for
Research on Minority Health
National Institutes of Health, Rm 260
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Bethesda, MD 20892-0164
301-402-1366

April 1996

ORMH

NATIONAL
INSTITUTES OF
HEALTH

Office of
Research on
Minority Health

Full Report
at Health

Minority Americans Face Barriers to Good Health

By Rep. Louis Stokes

By the 21st century, minorities are expected to be nearly 50 percent of the US population. Especially at a time of concern over the impact of welfare reform, Medicaid and Medicare reform, and potential budget cuts for other federally funded health programs, it is increasingly essential that the nation make improving the health status of minorities one of its top priorities.

In recent years, we have seen unprecedented advances in biomedical research, the diagnosis of disease, and the delivery of health care services. However, African-Americans, Hispanic-Americans, Native Americans, and those of Asian/Pacific Islander heritage have neither fully nor equally benefited from these new discoveries.

Rather, minority Americans continue to face historical barriers to good health, such as poverty, poor nutrition, and lack of access to quality health care, which has severely compromised their health status.

To help effectively address the shocking disparities in the status of minority health, I have introduced H.R. 1895, the Disadvantaged and Minority Health Improvement Amendments Act of 1997. This important legislation, which has been referred to the House Commerce Committee, reauthorizes programs authorized by the Disadvantaged Minority Health Improvement Act of 1990.

That law was enacted in response to the Health and Human Services Secretary's 1985 task force report on black and minority health. This report identified six causes of death directly linked to 80 percent of all deaths among African-Americans and other minorities. As such, the report verified what many minority health professionals across the nation had known for years: that African-Americans and other minorities suffer from disproportionately higher rates of some cancers, diabetes, cardiovascular diseases and stroke, chemical dependency, homicide and accidents, and infant mortality.

The 1990 law created a statutory authority for the office of minority health within HHS. It also authorized several HHS minority-targeted health professions training and education programs.

Since the 1985 report, AIDS has been identified as an additional cause of poor health

African-Americans and other minorities suffer from disproportionately higher rates of some cancers, diabetes, cardiovascular diseases and stroke, chemical dependency, homicide and accidents, and infant mortality.

among minority men and women. In fact, recent reports by the Centers for Disease Control and Prevention indicate that AIDS incidence is rising fastest among African-American women, having doubled from 1990 to 1994.

The trends for AIDS incidence among minority children is equally disturbing. In fact, the CDC recently reported that in 1995, 58 percent of reported children with AIDS were non-Hispanic blacks and 23 percent were Hispanic.

In addition, in spite of the relative decrease in AIDS mortality among the general population, this disease remains the leading cause of

death among African-American and Hispanic-American men and women between the ages of 25 and 44. This dire situation perpetuates the growing disparity in minority health.

Together, these diseases factor very heavily into the estimated 70,000 excess deaths that African-Americans suffer every year. These are deaths that would not occur if minorities' life expectancy and death rates were the same as whites. The poor health status of African-Americans and other minority Americans is further compounded by the fact that African-Americans and other minorities are less likely to have adequate health care coverage, more likely to receive less aggressive care, and more likely to suffer worse health outcomes.

It is quite evident that the need for the enactment of the Disadvantaged and Minority Health Improvement and Amendments Act of 1997 is as urgent now as it was in 1990. An update of the HHS Secretary's 1985 report reveals that the gap in disease morbidity and mortality between whites and African-Americans, Hispanic-Americans, and other minorities is widening.

For example, recent studies show that African-Americans suffer nearly double the rate of infant mortality of whites; 29 percent of all AIDS cases in the United States occur among African-Americans and 16 percent among Hispanic-Americans; African-Americans and Native Americans incur a disproportionately high rate of some cancers, diabetes, hypertension, and stroke compared with other non-whites; Hispanic-Americans are twice as likely to suffer from diabetes compared with the general population; and the injury death rate for Native Americans is very high.

The fact that 33 percent of Hispanic-Americans and 22 percent of African-Americans do not have health insurance coverage, compared with 14.5 percent of whites, only exacerbates this critical situation.

The crisis in the status of minority health is also exacerbated by mounting concern about the severe under-representation of minorities in the health professions and the fact that there has been very little growth in the number of minorities attending medical school.

While recent reports predict a general over-supply of physicians and other health care providers, this is not the case for minority health care professionals. African-Americans and Hispanic-Americans make up 12 and 9 percent of the US population, respectively. Yet they represent only 3.2 percent and 4.4 percent of the nation's practicing physicians.

Similarly, African-Americans represent nearly 8 percent of nurses, less than 5 percent of physician assistants, and one percent of dentists in the country, and Hispanic-Americans represent less than 5 percent of the nation's nurses.

These data are critical because studies have shown that African-American and other minority health care professionals are much more likely to serve the most vulnerable populations among us — the poor and the underserved urban and rural communities. The shortage of minority physicians, nurses, dentists, and other health professionals impedes the delivery of health care services to the underserved and further jeopardizes their health status.

The lack of minority representation in the health professions is linked to factors such as poverty and the lack of access to quality education. The dismantling of affirmative action and issues of minority student admittance, retention, and graduation from medical school and other health training programs are other factors.

Though African-Americans, Hispanic-Americans, and Native Americans make up more than 22 percent of the nation's total population, they earn only 9.8 percent of all bachelor's degrees in the biological and physical

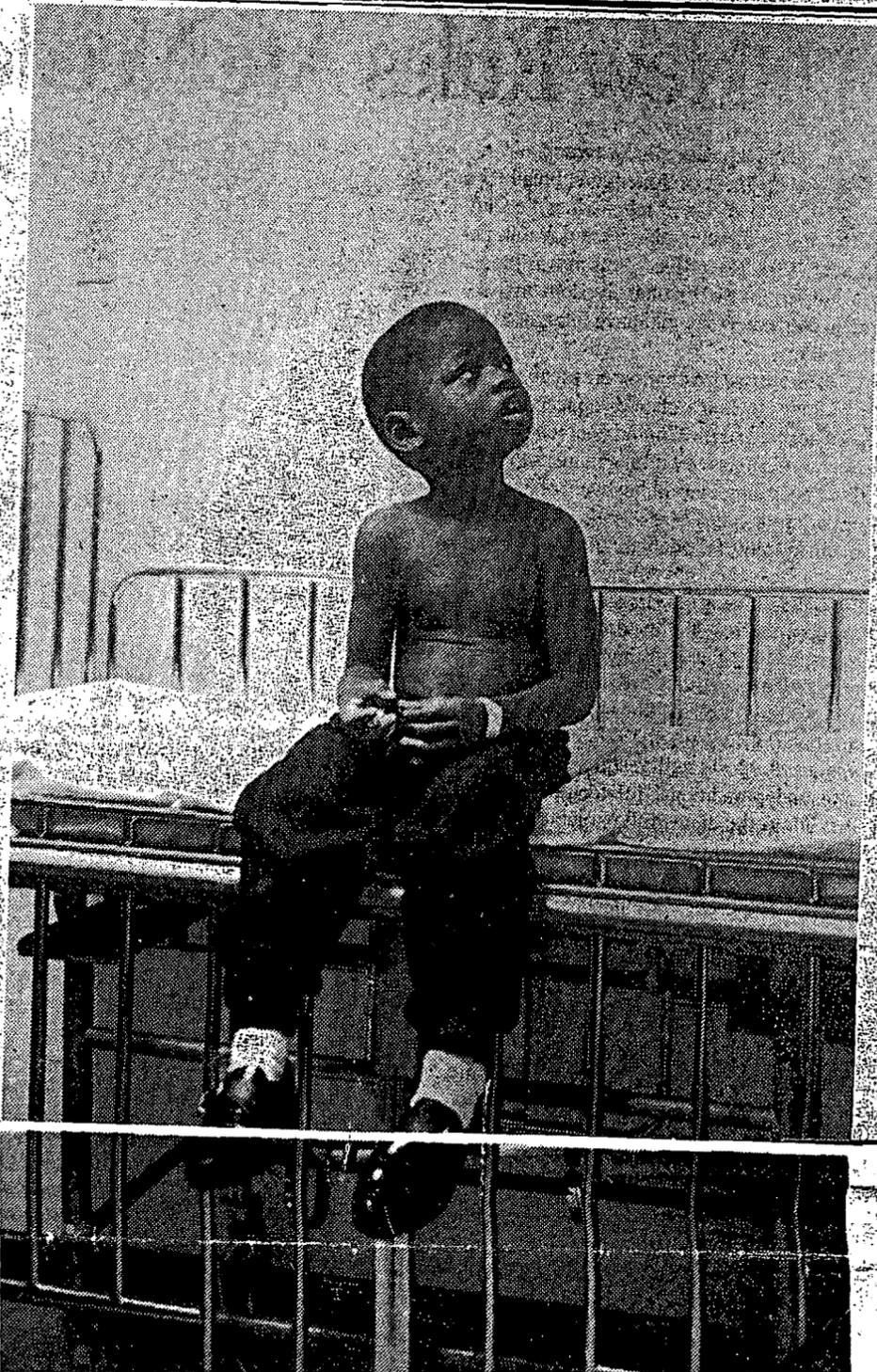


Photo by Impact Visuals

According to Rep. Louis Stokes, poverty, poor nutrition, and lack of access to quality health care severely compromise the health of minority Americans.

sciences. Thus, the pool of minority applicants for competing health professions training programs is entirely too small to serve the nation's growing needs.

Enter H.R. 1895. This legislation reauthorizes the health professions loans, scholarships, and fellowships for disadvantaged students; the Minority Centers of Excellence; the

The crisis in the status of minority health is also exacerbated by mounting concern about the severe under-representation of minorities in the health professions.

HHS office of minority health; and the National Institutes of Health office of research on minority health programs.

The Disadvantaged Assistance Programs reauthorized by this measure are the only federal initiatives designed to address shortages of health professionals from diverse populations and geographic areas. These programs provide critical support to ensure that the poorest of students can be physicians, dentists, pharmacists, veterinarians, and other health professionals. Scholarship support for disadvantaged students is often the only means by which they can attain a health professions education.

The Minority Centers of Excellence program was established to strengthen the nation's capacity to educate minority students. This program provides special support to historically black health professions schools and

institutions that serve Hispanics and Native Americans. These are institutions that have a history of training a majority of the nation's minority health professionals. They also have a legacy of serving as the primary resource for health care for minority and underserved populations.

The contributions of Meharry Medical and Dental Colleges, Xavier School of Pharmacy, Tuskegee University School of Veterinary Medicine, Morehouse School of Medicine, Howard University College of Medicine, and the other participating institutions are particularly important. These institutions seek to meet the needs of the underserved in spite of the fact that they suffer severe financial difficulties. Without them, the status of minority health in America would be even more compromised.

H.R. 1895 also reauthorizes and extends the duties of the NIH office of research on minority health to include the planning, coordination, and evaluation of research and other activities conducted or supported by the agencies of the NIH.

The office of research on minority health provides support for biomedical research that is focused on improving the health status of minorities and for programs that are focused on expanding the participation of underrepresented minorities in biomedical and behavioral research. The work of this office is vital to the effort to identify and fill the gaps in health research that must be filled to ensure that the health needs of all Americans are addressed.

Each of the programs reauthorized by the Disadvantaged Minority Health Improvement Amendments Act of 1997 is essential to the effort to improve the status of minority Americans and is critical to strengthening the health of the nation.

Rep. Louis Stokes (D-Ohio) is the ranking member of the Appropriations subcommittee on VA, HUD and Independent Agencies.

ONE AMERICA IN THE 21ST CENTURY

The President's Initiative on Race

On June 14, 1997, President Clinton announced an effort to lead our nation toward becoming one America in the 21st century. He outlined the following goals for the Initiative:

- to develop policies that can make a real impact on closing the gap in economic opportunity, education, health care, housing, crime and the administration of justice;
- to recruit leaders and encourage community efforts (i.e. promising practices), all over the country, that bring people together across racial lines;
- and to raise the issue of race on the national agenda through dialogue that educates the American public.

Highlights of Progress

- **Increased Civil Rights Enforcement.** In his FY 99 budget, the President proposed \$602 million, the largest single increase (16 percent) for the enforcement of civil rights laws in nearly two decades. The cornerstone of this initiative is a \$37 million (15 percent) increase for the EEOC. Through a combination of the increased use of mediation, improved information technology and an expanded investigative staff, the EEOC will reduce the average time it takes to resolve private-sector complaints from over 9.4 months to 6 months and reduce the backlog of cases from 64,000 to 28,000, by the year 2000.
- **Enforcement Against Housing Discrimination.** To respond to the increase in reported cases of serious fair-housing violations, HUD will double the number of civil rights enforcement actions by the year 2000. In addition, HUD has committed \$15 million to 67 fair-housing centers around the country to assist in combating housing discrimination this year.
- **Getting Good Teachers into Underserved Areas.** Responding to the need for a diverse and excellent teaching force, the President proposed a \$350 million program to attract talented people of all backgrounds to teach at low-income schools across the nation. The funding also will be used to improve dramatically the quality of training given to future teachers. This new program will help bring nearly 35,000 outstanding new teachers into high-poverty schools in urban and rural areas over the next five years.
- **Hispanic Education Action Plan.** Nearly one in three Hispanics between 25 and 29 years old left school without a high school diploma or a GED. To correct this situation, President Clinton announced an unprecedented \$600 million in the FY 99 budget to help Latino youngsters master the basics of reading and math. The funding will also pay for programs to help them learn English, stay in school, prepare for college and, ultimately, succeed in college.
- **Creating "Education Opportunity Zones."** The President proposed \$1.5 billion, over five years, to bolster reform efforts by high-poverty urban and rural school districts that demonstrate both a commitment to and a track record in improving educational achievement. Funds will be used to improve accountability, turn around failing schools, recognize outstanding teachers, deal with ineffective ones and expand public school choice.
- **Reducing Class Sizes and Modernizing Schools.** The President has proposed a \$12.4 billion initiative, over 7 years, to help local schools reduce class size in grades 1-3, from a national average of 22 to 18. Through the program, local schools will be able to hire an additional 100,000 well-prepared teachers. In addition, to address the crucial issue of school construction, the President proposed federal tax credits to pay interest on nearly \$22 billion in bonds to build and renovate public schools, largely in the 100-120 school districts with the greatest number of low-income children.

- **Tapping the Potential of America's Urban and Rural Communities.** The President's budget includes \$400 million for a new Community Empowerment Fund (CEF) that is expected to leverage an estimated \$2 billion in private-sector loans to help communities invest in businesses and create jobs -- as many as 280,000 jobs when projects are completed. In addition, the President's budget provides \$150 million per year for 10 years to fund 15 new urban Empowerment Zones (EZs) and \$20 million per year for 10 years to fund five new rural EZs. These funds will encourage comprehensive planning to create economic opportunity and revitalize distressed areas.
- **Increased Capital to Minority Businesses.** The Small Business Administration (SBA) has set a goal of providing an estimated total of \$1.86 billion in loans to African-American small business over a 3-year period and \$2.5 billion worth of loans to Hispanic-owned businesses by the year 2000. In addition, the SBA and the "Big Three" US automakers struck an agreement that will increase subcontracting awards to minority businesses by nearly \$3 billion over the next three years -- a 50 percent increase from current levels.
- **Eliminating Ethnic Health Disparities.** This new initiative sets a national goal of eliminating by the year 2010, longstanding disparities in the health status of racial and ethnic minority groups. Currently, for example, African Americans suffer from diabetes at 70 percent higher rates than white Americans, while Native Americans suffer from diabetes at nearly three times the average rate. Vietnamese women suffer from cervical cancer at nearly five times the rate of white women, and Latinos have two to three times the rate of stomach cancer as white Americans. The President announced a five-step campaign -- led by Surgeon General and Assistant Secretary for Health Dr. David Satcher -- to mobilize the resources and expertise of the Federal government, the private sector and local communities.
- **Fighting Hate Crimes.** On November 10, 1997, the President and Attorney General Janet Reno hosted the first-ever White House Conference on Hate Crimes, which featured many experts and law enforcement officers from around the country.
- **Highlighting Promising Practices.** The Race Initiative is compiling information on "promising practices," ideas from communities and organizations that are working to help bring people together as one America. Calling attention to this work, on June 3, the President attended the convention of City Year, a promising practice that brings together teams of diverse young people to work on community projects, thus helping break down racial barriers. To date, 150 promising practices have been identified and listed on the Race Initiative website, and the list continues to grow.
- **Efforts Involving American Indians.** The Board has made a special effort to include American Indians and Alaska Natives in its work. Indians participated as panelists at Advisory Board meetings that discussed stereotypes, poverty, labor, housing and higher education issues. The Board has held separate meetings with tribal leaders in Phoenix, Santa Fe and Denver. In addition, the Administration successfully fought back proposed legislation that would have ended sovereign immunity for tribes and, in May, the President issued an executive order strengthening government-to-government relationships between the tribes and the US.
- **Sparking Dialogue.** The Race Initiative has prompted innumerable conversations about race around the country, highlighted by an April "Month of Dialogue." From April 6-9, 600 colleges and universities participated in a "Campus Week of Dialogue," organizing hundreds of race-related events across the nation. On April 30, 41 governors, 22 mayors and over 100 YWCAs participated in special "Statewide Day of Dialogue" events.
- **Studying Race:** In May, the President's Initiative on Race announced that the National Research Council (NRC), the research arm of the National Academy of Sciences, will coordinate studies by prominent researchers on a range of topics related to race, including demographic trends. The work will include findings on whites, blacks, American Indians, Hispanics and Asian Pacific Americans. The project will culminate with a major research conference in October in Washington D.C.

PRESIDENT'S INITIATIVE ON RACE: June Progress Report Talking Points

Last year, on June 14, the President launched an unprecedented initiative on race to lead the nation in becoming one America in the 21st century.

While the charter for the President's Initiative on Race expires on September 30, the Administration is taking this opportunity to provide a progress report. This winter the President will issue a report to the American people with recommendations for continuing to build on the achievements of this effort.

Meeting our Objectives

At the President's direction, we set out last year to:

- develop national policy initiatives;
- recruit leaders and encourage efforts (i.e. promising practices) aimed at bridging racial divides in local communities across the country; and
- raise the issue of racial reconciliation to the national agenda through dialogue.

Since the Initiative's start, we have:

- developed and implemented new national policies and public/private partnerships;
- sparked hundreds of community-level activities around the country; and
- been the catalyst for dialogue, nationwide, that is destined to have a lasting impact on the national agenda.

Policy Actions. We have undertaken numerous policy actions designed to: close the opportunity gap; improve access to quality education, health care and housing; and reduce racial disparities around crime and the administration of justice.

- The President's FY 99 budget increases funding for the enforcement of existing civil rights laws to \$602 million, the largest increase in enforcement funding in nearly two decades.
- The President's FY 99 budget also includes \$350 million to bring nearly 35,000 outstanding new teachers into high-poverty schools in urban and rural areas, over the next five years.

Promising Practices: This year has given us an opportunity to shine a spotlight on all the existing work being done to bring people of different races together. It's also given us a chance to encourage many new efforts at the grass-roots level. We have witnessed a groundswell of support.

- The President's Initiative led one high school student (Tom Manatos) to organize other local high school students for a town hall discussion on promoting racial harmony within their schools.
- First Lady Hillary Rodham Clinton joined forces with the Boston-based Team Harmony Foundation to discuss ways to prevent prejudice with high school students in Boston and Washington, DC. As a result of the First Lady's events, Team Harmony has had requests to expand its program to New York, Chicago, Atlanta and Los Angeles.

Dialogue. By raising the issue of racial reconciliation to the national agenda, the President's Initiative has been the catalyst for dialogues across the country that have helped educate the American public about the facts surrounding race.

- Close to 600 colleges and universities organized race-related activities on their campuses during the first week of April.
- More than 40 of the nation's governors, 22 mayors and over 100 YWCAs participated in efforts to raise the public's consciousness on race.

We view our work over this year as building not a ceiling, but a foundation for one America. Racial reconciliation is something President Clinton has fought for all of his life. We know that even after our charter expires and the report to the American people is completed this issue will remain a priority on the President's agenda.

PRESIDENT'S INITIATIVE ON RACE -- June Progress Report Qs&As

1Q. Has the President made any decision about extending the Initiative on Race beyond September?

1A. The charter for the Advisory Board expires on September 30th. However, President Clinton has always had a personal commitment to these issues and will continue to commit his time and attention to building one America.

In the meantime, the work of the initiative will continue in several ways. In July, the President will participate in a nationally televised dialogue on race on PBS, with Jim Lehrer. In October, there will be a national research conference convened by the National Research Council. That conference will examine past and current trends among racial and ethnic groups in key areas such as health, education, employment and the administration of justice. It will also identify key gaps in research and data that are needed to promote a clearer understanding of race-related issues. This winter the President will release his report to the American people.

Equally important is the infrastructure that has been created over the past 12 months, which will continue to build on the year's efforts. For example, Cabinet activities will be ongoing and reported to the President every week. The initiative has also generated a cadre of leaders to carry on work at the local level.

2Q. How could you expect the initiative to accomplish anything lasting when it was limited to one year?

2A. This is a very complex issue, and we never said we would solve the race problem in this country in one year. What we have tried to do is help Americans understand that diversity is one of our nation's greatest strengths. We also have tried to energize people to make racial reconciliation a priority in their communities. Finally, we have tried to assess where we are as a nation, and this winter the President will provide all Americans with a blueprint of where we need to go in the 21st century.

3Q. The initiative has been at work for a year now. What's been accomplished?

3A. Since the initiative started we have developed and implemented policies that can make a difference in closing the gap in economic opportunity, education, health care, housing, crime and the administration of justice. We have recruited leaders and encouraged community efforts across the country. We have raised the issue of race on the national agenda.

For example, at the recommendation of the Advisory Board, the President increased the budget to enforce existing civil right laws by \$602 million -- the most significant increase in the last 20 years. This funding will enhance coordination of federal civil rights enforcement and lead to more consistent enforcement of civil rights laws, broader dissemination of best practices and improved data collection.

As another example, the initiative has identified more than 150 promising practices -- national and community-based programs that are working to bridge racial divides and promote racial reconciliation through dialogue and action -- that can be emulated across the country.

4Q. The initiative has been criticized by conservatives for not including their views. Where do conservative voices fit in this dialogue?

4A. From the beginning, we have sought to hear from a wide variety of viewpoints and considered such varied input critical to the initiative's success. We have invited individuals whose viewpoints cover the spectrum, including many conservatives, to participate in initiative events, among them the Akron Town Meeting, a White House meeting with the President and many Advisory Board meetings.

5Q. Critics such as Abigail Therstrom and Ward Connerly have formed a new group called "The

Citizens Initiative on Race and Ethnicity.” Do you view this as an indication that the President’s Initiative has failed in its effort to include conservative voices?

- 5A. The initiative has served as a catalyst for many community groups and citizens of different racial and ethnic backgrounds and different ideologies to come together for constructive dialogues. The Citizens Initiative on Race and Ethnicity is just one positive example of the wide-range of voices that we are reaching.
- 6Q. **There have been reports that the lack of enthusiasm from senior White House officials and subsequent friction between some of those officials and the initiative staff hurt the initiative’s work. How much of that is true?**
- 6A. There is a commitment at all levels of this White House -- starting with the President, Vice President and First Lady -- to this initiative and to tackling, head on, the difficult problems of race in America. The entire staff and Cabinet share the President’s commitment to making the improvement of race relations one of the highest priorities of his second term.
- 7Q. **The American Indian community has sharply criticized the initiative for failing to include an American Indian representative on the Advisory Board. Why was none appointed at the start? And after the issue was raised by that community, why was this oversight not corrected?**
- 7A. The Advisory Board has engaged and will continue to engage American Indians in this initiative. American Indians have been invited to participate in the Advisory Board’s meetings. Board members also have attended special forums to hear specifically from tribal leaders about unique issues that affect Indian country as part of the initiative’s effort to recognize the special government-to-government relationship that exists between the United States and American Indian tribes.
- 8Q. **The initiative never quite picked up momentum. Some have said it got off to a bad start because of a lack of clarity about the board’s mission. What happened?**
- 8A. While the initiative may have gotten off to a slow start, it picked up momentum that has been sustained with the success of recent activities.
- As an example, in April alone over 600 colleges and universities across the nation sponsored forums on race. More than 40 governors and over 20 mayors took part in a statewide day of dialogue on race relations, and the President joined several well-known sports figures in a town hall meeting on race and sports, which was broadcast on ESPN.
- 9Q. **Why hasn’t the initiative taken on the issue of affirmative action since it is clearly the hot button issue on race?**
- 9A. The initiative has made affirmative action one part of the larger dialogue on race because the role of affirmative action continues to be debated across our nation, and we have endeavored to hear from all sides in that debate. However, it is important to note that affirmative action is only one small part of the larger issues of race in our nation.
- In addition, affirmative action is an issue the administration has examined and reported on prior to this initiative. The Administration strongly supports the use of properly constructed affirmative action to remedy discrimination and to promote other compelling interests. We are, however, eager to hear other ideas for ensuring equal opportunity for all American citizens.
- 10Q. **Why didn’t the initiative deal with the apology for slavery issue?**
- 10A. The reaction to a formal apology reflects how deeply this issue continues to reverberate emotionally for a

lot of Americans, both black and white. However, the initiative has made a serious effort to expand the racial dialogue beyond issues of black and white.

One objective of the initiative was to move the country towards recognizing and realizing the full potential of its diversity. We have done that by finding ways in which we can offer real opportunities to Americans who work hard, but who continue to face barriers of discrimination based on race.

11Q. The President said in his commencement address that HE would report to the American people periodically on the work of the initiative. He has only done two town hall meetings for the race initiative in the entire year. What happened?

11A. The President has reported to the American people consistently over the last year through speeches, meetings, press conferences and other events at which he has called on Americans to bridge racial divides. For example, on June 3, the President attended the national convention of the City Year program, a service organization that plays an important role in bringing together people of different races and ethnicities.

From announcing policy that will help close opportunity gaps among the races -- such as recruiting well-trained teachers for under served school districts and involving local prosecutors in crime fighting efforts -- to raising public awareness -- through such activities as a PSA for the Superbowl and an upcoming nationally televised PBS conversation on race -- the President has been at the forefront of this issue all year.

Disparities exacerbated → Public Health

For Adams

PRESIDENT CLINTON ANNOUNCES RACE AND HEALTH INITIATIVE

Today, President Clinton took a bold step forward in improving the health of all Americans by unveiling a comprehensive strategy for significantly raising the health status of America's minority populations. In his weekly Radio Address, the President outlined an ambitious, new health component to his Initiative on Race that will close the gap between whites and minorities in six areas of health where there are serious disparities. The President also announced that U.S. Health and Human Services Secretary Donna E. Shalala will oversee this initiative, which is proposed for five years at \$400 million. The six areas are:

- Infant mortality
- Cancer screening and management
- Cardiovascular disease
- Diabetes
- HIV/AIDS infection rates
- Child and adult immunizations

Clay

David Satcher

Call on committee of print & Satcher committee

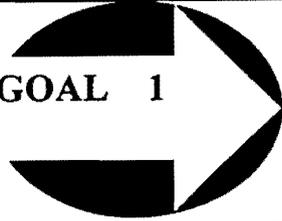
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Letters

CLOSING THE GAPS. Racial minorities historically have not fared as well as whites when it comes to health status. For example, recent data shows the infant mortality rate for black infants is twice that of whites; Indian women die of cervical cancer at twice the rate of non-Indian women; the diabetes prevalence of Hispanics is double that of whites; and Asian-American and Pacific Islander women fare worse than others in breast and cervical cancer screening. The President's plan seeks the elimination of racial disparities in health by the year 2010, which parallels *Healthy People 2010* national health goals for 2010 that President Clinton will unveil two years from now as the nation's health action agenda for the next century. The President has already requested \$80 million in first-year funding for this initiative in the Fiscal 1999 budget. A total of \$50 million would go to enhance programs that address these six areas, and the remaining \$30 million would go to initiate a competitive, community-based grant program to begin studying science-based approaches to eliminating these disparities.

PARTNERS WITH LOCAL COMMUNITIES. Grants would be made to test interventions and research within up to 30 local communities in the six health areas. The grants will extend for up to five years and will offer the opportunity for demonstrating the effectiveness of specific prevention strategies and clinical intervention. Communities receiving grants would be expected to focus on one of the six priority areas. A departmental steering committee along with a series of panels comprised of experts from HHS, community groups and the health professions will be convened to monitor progress toward the goals and shape strategy to achieve them.

BUILDING ON THE PRESIDENT'S INITIATIVE. The plan unveiled today is part of the historic, year-long Initiative on Race announced by President Clinton last June in which he wants America to start a national dialogue about race and address our racial divisions with constructive dialogue, study and action. The primary purpose of this race and health component is to help minority Americans lead longer, healthier lives, ultimately improving the health of all Americans.

**GOAL 1*****Eliminate disparities in infant mortality rates.******Long-Term Goal***

Eliminate the disparities among racial and ethnic groups in the rate of infant deaths.

Background

Infant death rates among blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for blacks, whose infant death rate (14.2 per 1,000 in 1996) is nearly 2½ times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995.

Among the leading causes of death in infants, the racial and ethnic disparity (expressed as the ratio of the infant mortality rate for black infants to that for white infants, representing the greatest disparity) is greatest in the following: disorders relating to short gestation (preterm birth [PTB]) and unspecified low birthweight (4.1), respiratory distress syndrome (2.8), infections specific to the perinatal period and newborns affected by maternal complications of pregnancy (2.7), and sudden infant death syndrome (SIDS) (2.6). Overall, 13 percent of infants die from disorders relating to short gestation. A much higher incidence of PTB's occurs among black mothers than among white mothers (17.7 compared with 9.7 percent). Underlying factors, such as chronic hypertension and bacterial vaginosis, which have higher incidences among blacks, play a role in PTB's.

SIDS, one of the leading causes of death in infants, accounts for approximately 10 percent of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS. In addition to the greater risk among blacks, the rates are three to four times as high for some American Indian and Alaska Native populations.

Prevention

Racial and ethnic differences in PTB's and SIDS most likely reflect variations in the prevalence of risk factors, including socioeconomic and demographic factors, certain medical conditions, smoking, substance abuse, poor nutrition, psychosocial problems (e.g., stress, domestic violence), quality of and access to health care, and practices such as placing babies on their backs

to sleep to prevent SIDS. We can work toward addressing all of these issues and measure their impact on reducing the rates of infant deaths due to PTB and SIDS. To achieve further reductions in infant mortality and morbidity, the public health community, health care providers, and individuals must focus on the lack of prenatal care available to racial and ethnic minorities.

Women who receive prenatal care in the first trimester have better pregnancy outcomes than women who receive little or no prenatal care. For example, the likelihood of delivering a very low birthweight (VLBW) infant (less than 1,500 grams or 3 lb. 4 oz.) is 40 percent higher among women who receive late or no prenatal care compared with women entering prenatal care in the first trimester. Approximately 95 percent of VLBW infants are born preterm (less than 37 weeks gestation). The risk of early death for VLBW infants is about 65 times that of infants who weigh at least 1,500 grams.

In 1996, the proportion of pregnant women across the Nation receiving prenatal care in the first trimester reached 81.8 percent—a consistent improvement for the seventh consecutive year and up from 75.5 percent in 1989. Yet, one in five pregnant women, or three-quarters of a million women, still did *not* receive timely prenatal care; almost 47,000 women received *no* prenatal care at all. There are substantial racial disparities in the timely receipt of prenatal care. In 1996, 84 percent of white pregnant women, compared with approximately 71 percent of black and Hispanic pregnant women, received early prenatal care. Eliminating these disparities requires the removal of financial, educational, social, and logistical barriers to care.

Near-Term Goals

HHS will seek to reduce infant mortality among blacks (the group with the greatest disparity in terms of infant death rates) by at least 22 percent from the 1996 rate by the year 2000—or from 14.2 per 1,000 to 11.0 per 1,000 live births. We also will work to reduce infant mortality rates among American Indian and Alaska Natives, and Puerto Ricans, whose rates also are above the national average. In addition, we will continue to monitor progress in reducing the SIDS rates for all racial and ethnic groups as an indicator of our progress toward reducing the national infant mortality rate.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$ 2.9 billion in support of these activities in mandatory funding, which includes estimated Medicaid spending, along with an additional \$ 753 million in discretionary funds. The President's FY 1999 budget provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to more clearly identify steps that are needed to encourage and support healthy behaviors by pregnant women and parents of infants, improve the availability and quality of prenatal care, and identify improvements that should be made in HHS programs to enhance their effectiveness in reaching underserved communities.

Research

NIH will support research to better understand the physiologic causes of SIDS and why infants die from this syndrome, develop effective screening tests that can identify infants at risk for SIDS, develop effective pharmacologic therapies for high-risk infants, and define specific patterns of risk in racial and ethnic groups. NIH, HRSA, and CDC will invest in perinatal research to increase identification of risk factors and biologic markers for adverse pregnancy outcomes (e.g., low birthweight and PTB's) and SIDS among minorities, with the expectation of developing appropriate and effective interventions and treatments for these conditions.

Community Demonstration Projects. The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide baseline assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

Action plans shaped by interaction with the target communities and by research findings will be refined over the next 6 to 12 months. However, significant new activities that will advance the goal in the current year and beyond include:

- ***SIDS Outreach.*** NIH will launch a \$1.25 million new outreach effort targeted to racial and ethnic communities. This project will include new media efforts to reach non-English-speaking parents, outreach to health professionals who serve primarily minority communities, and better use of ethnic radio stations to raise parental awareness of what we know about SIDS.
- ***Mississippi Delta Project.*** The 10-county Mississippi Delta region experiences infant mortality rates that are among the Nation's highest as well as a high incidence of other health problems. HRSA will work with community leaders in the Delta region to develop

a comprehensive strategy to improve child and infant health and reduce the overall burden of disease. All of HRSA's bureaus will be involved in a coordinated effort to provide a model for identifying regional health problems and orchestrating a response. Up to \$100,000 for community planning will be awarded by HRSA in late 1997. Based on the findings of the planning process, HRSA will make a substantial increased investment in its programs and will encourage other Federal agencies and foundations to support this underserved area.

- ***State and Local Coordination of Mortality/Morbidity Review Processes.*** HRSA will undertake a series of activities to help States and communities work toward a coordinated system for investigating all infant and child deaths. These reviews use the event of an infant or child death or related adverse outcome (e.g., low weight birth) as a trigger to identify improvements needed in care, services, or broad community resources. Racial disparity, in particular, is a problem commonly identified and worked on in these community-implemented processes. In FY 1998, HRSA will sponsor a meeting of State officials to produce recommendations for the coordination of these activities at the State level. States will be funded to implement State Mortality/Morbidity Review Support Programs that will develop coordinating mechanisms for at least two review processes, and will incorporate review findings into existing assessment and quality improvement methods at State and local levels.
- ***Expansion of Healthy Start.*** On September 1, 1997, HRSA announced \$50.6 million in new Healthy Start awards to 40 high-risk, predominantly minority communities. The Healthy Start program will support implementation of community-devised strategies to reduce infant mortality.
- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. These services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.



Eliminate disparities in cancer screening and management.

Long-Term Goal

Eliminate the disparities among racial and ethnic groups in the rate of cancer screening and management.

Background

Cancer is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites (171.6 vs. 127.0 per 100,000). The death rate for cancer for black men is about 50 percent higher than it is for white men (226.8 vs. 151.8 per 100,000). The death rate for lung cancer is about 27 percent higher for blacks than for whites (49.9 vs. 39.3 per 100,000). The prostate cancer mortality rate for black men is more than twice that of white men (55.5 vs 23.8 per 100,000).

Paralleling the death rate, the incidence rate for lung cancer in black men is about 50 percent higher than in white men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with white men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer.

Prevention

Much can be done to reduce the burden of cancer in the United States through prevention. Lifestyles can be modified to greatly reduce an individual's risk for cancer. Tobacco use is responsible for nearly one-third of all cancer deaths. Evidence suggests that diet and nutrition may be related to 30 to 40 percent of cancer deaths. Additionally, many of the estimated 900,000 skin cancer cases diagnosed each year could be prevented by reducing sun exposure.

For some cancers that we do not yet know how to prevent, early detection can dramatically reduce the risk of death. Breast and cervical cancers, in particular, have proven screening modalities for which screening data, both baseline and continuing, are available. For this reason, the strategy for achieving Goal 2 focuses on breast and cervical cancers. Regular mammography screening and appropriate follow-up can reduce deaths from breast cancer by about 30 percent for

women 50 years of age and older. Screening by Pap test for cervical cancer along with appropriate follow-up care can virtually eliminate the risk of developing this disease.

Despite the considerable gains in screening in the black community, the mortality rate from breast cancer for black women is greater than for white women. Some of the reasons for this disparity include the fact that many women have not yet had a mammogram or a Pap smear, many more are not screened regularly, and still others are screened but have limited follow-up and treatment services available to them. Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, culture, and negative provider attitudes, which negatively affect their health status. Eliminating these differences is critical and will be the focus of attention for the HHS initiative to help identify and understand approaches that have proven successful in some communities. Our focus on tracking breast and cervical cancer will serve as an indicator for assessing our overall efforts to reduce and eventually eliminate disparities in the prevention and management of all cancers.

Near-Term Goals

Breast Cancer: Our goal for the year 2000 for breast cancer screening is to increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding 2 years.

Cervical Cancer: Our goal for the year 2000 for cervical cancer is to increase to at least 85 percent the proportion of all women aged 18 and older who have received a Pap test within the preceding 3 years.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$57 million in support of these activities in mandatory funding, which includes estimated Medicaid and Medicare spending, along with an additional \$112 million in discretionary funds. The President's FY 99 budget includes an additional \$ 5 million each for CDC's Prostate Cancer program and for IHS's Breast and Cervical Cancer Project. In addition, the President's FY 1999 budget also provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to more clearly identify steps that are needed to increase public education campaigns to address the benefits of mammography, increase the proportion of minority women who have had a mammogram and clinical breast exam in the prior two years, as well as a Pap test in the prior three years, and identify improvements that should be made in HHS programs to enhance their effectiveness in reaching underserved communities. The *NCI Office of Special Populations Research* is sponsoring a series of meetings with experts in minority health; meetings in 1997 involved Asian-American and Native American scientist-advocates. Similar discussions with black and Hispanic leaders are scheduled for 1998.

Research

- NCI will seek to increase recruitment and retention of minorities in clinical trials. NCI and CDC will support research projects and grants that aim to develop, implement, and test means for increasing the participation of women and minority groups as subjects in cancer prevention and screening clinical trials. Differential patterns of cancer rates between population groups require participation by minority groups in clinical trials to ensure that potentially important differences will be accounted for and detected.
- Sexually transmitted diseases disproportionately affect minorities. One type of sexually transmitted disease, human papillomavirus (HPV) infection, has been closely associated with the development of cervical cancer and other genital cancers. The National Institute of Allergy and Infectious Diseases (NIAID) is supporting research to address this problem. NIAID will fund research to develop and evaluate a promising topical microbicide that will inactivate HPV. In addition, NIAID will conduct a Phase I safety trial on an HPV vaccine candidate that has been shown to affect tumor regression in animal models.
- ***Community Demonstration Projects.*** The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide baseline assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

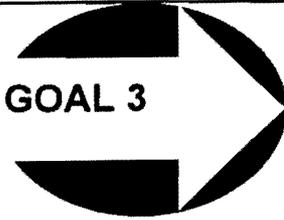
Action plans shaped by interaction with the target communities and by research findings will be refined over the next 6 to 12 months. However, significant new activities in the current year and beyond that will advance the goal include the following:

- ***CDC's National Breast and Cervical Cancer Early Detection Program*** builds the public health infrastructure in States for early detection of breast and cervical cancer through public and provider education, quality assurance, surveillance, and partnership development. This program offers free or low-cost mammography and Pap tests to medically underserved women, particularly women of low income, women 50 years and older, and women of racial and ethnic minorities. Through March 1997, more than 1.3 million screening tests had been performed since the program's inception. This program currently funds breast and cervical cancer screening in all 50 States, the District of Columbia, 5 territories, and 15 American Indian and Alaska Native organizations. In fiscal year 1997, CDC funded 13 national organizations, with a total of more than \$4 million, that target racial and ethnic populations with messages about the importance of breast and cervical cancer screening. The 1998 budget is \$145 million for the National Breast and Cervical Cancer Early Detection Program, which is an increase of \$5.3 million over fiscal year 1997. CDC anticipates that about half of the women served by the program will be members of racial and ethnic minority groups.
- ***Multi-city Mammography Pilot Project***. This 3-year HCFA-funded project will identify effective interventions to increase utilization of Medicare screening benefits among black and Hispanic beneficiaries in six cities. To design the most effective interventions for nationwide application, HCFA seeks a better understanding of certain attitudes and beliefs relative to breast cancer and mammography screening, as well as the health-seeking behaviors of the target audiences. Funding for this activity will be approximately \$1 million per year for the next 3 years.
- ***Breast and Cervical Cancer Education Initiative***. This initiative is designed to provide clear, user-friendly information and advice to women regarding breast and cervical cancers. The initiative encompasses a broad range of issues related to these cancers, including risk factors, screening methodologies, treatment options, and survivorship. The information resources developed for this program are the result of research with black, Hispanic, American Indian and Alaska Native, Asian and Pacific Islander, and white women to assess attitudes and knowledge regarding breast and cervical cancers as well as the sources of health information they rely upon. The resources will be distributed through a variety of means, such as NCI's Cancer Information Service (1-800-4-CANCER) and numerous partnerships including community-based entities. The program provides clear advice to women about when to begin regular mammography

and Pap tests and describes both the benefits and limitations of these tests.

- ***Expansion of Minority Access to Cancer Care and Clinical Trials.*** The Community Clinical Oncology Program is the result of NCI's efforts to ensure that patients treated in their own communities have access to the same quality of cancer care and technologies as patients who receive treatment in major centers. The program has been successful in facilitating the connection of investigators and their institutions with the clinical trials network, encouraging entry into treatment research protocols, and increasing the organization of local-regional cancer programs. A request for application for expansion of the minority-based Community Clinical Oncology Program provides enhanced support for expanding clinical research in minority community settings, thereby bringing the advantages of state-of-the-art treatment and cancer prevention and control research to minority individuals in their own communities as well as increasing the involvement of primary health care providers and other specialists in cancer prevention and control studies. These efforts are particularly critical as blacks have a higher incidence of a number of malignancies and worse overall cancer survival rates compared to the general population. If the results of clinical trials are to be generalized to the entire population, proportional involvement of racial and ethnic minority patients is essential. NCI, with the assistance of CDC, recently added a new minority-enriched screening center to the Prostate, Lung, Colorectal, and Ovarian Trial. The award was made to the University of Alabama at Birmingham and plans are to recruit 5,000 individuals, at least 60 percent black, within 3 years. NCI plans to add a second minority-enriched center in fiscal year 1998, preferably Hispanic in focus.
- ***The National Action Plan on Breast Cancer*** is funding five 2-year pilot projects at approximately \$80,000 each that are designed to link informationally underserved women to breast health information via the Internet.
- ***Prostate Cancer Program.*** The President's FY 1999 budget includes an additional \$5 million for a variety of CDC activities that will: provide support for a limited number of States through a comprehensive cancer control model to address issues related to prostate cancer; conduct surveys to determine knowledge, attitudes, and behaviors of men and health care providers about prostate cancer, prostate cancer screening, and treatment options; initiate the development of a health communication campaign to provide balanced information to patients and health care providers and promote the process of informed decision making regarding prostate cancer screening and treatment options; and enhance capacity to address prostate cancer through epidemiologic and behavioral science research.
- ***Breast and Cervical Cancer Project.*** The President's FY 1999 budget would provide \$5 million to IHS to provide expanded clinical service programs for women for breast and cervical cancer screening and other health related issues. An additional 25,000 women will be served.

- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. These services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.



GOAL 3

Eliminate disparities in cardiovascular disease.

Long Term Goal

Eliminate disparities in cardiovascular disease.

Background

Cardiovascular disease, primarily coronary heart disease and stroke, kills nearly as many Americans as all other diseases combined and is among the leading causes of disability in the United States. Cardiovascular disease is the leading cause of death for all racial and ethnic groups. The annual national economic impact of cardiovascular disease is estimated at \$259 billion as measured in health care expenditures, medications, and lost productivity due to disability and death.

Major disparities exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Compared with rates for whites, coronary heart disease mortality was 40 percent lower for Asian Americans but 40 percent higher for blacks in 1995. Stroke is the only leading cause of death for which mortality is higher for Asian-American males than for white males.

Disparities also exist in the prevalence of risk factors for cardiovascular disease. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. For example, from 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension compared with 25 percent of all men. When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates. Among adult women, the age-adjusted prevalence of overweight continues to be higher for black women (53 percent) and Mexican-American women (52 percent) than for white women (34 percent). Furthermore, the rates for regular screening for cholesterol show disparities for certain racial and ethnic minorities—only 50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past 2 years.

Prevention

The major modifiable risk factors for cardiovascular disease are high blood pressure, high blood cholesterol, cigarette smoking, excessive body weight, and physical inactivity. The greatest

potential for reducing coronary heart disease morbidity, disability, and mortality appears to be in prevention, by addressing these risk factors.

Near-Term Goals

Our goal is to continue progress in reducing the overall death rates from heart disease and stroke and eventually to eliminate disparities among all racial and ethnic groups. To have the greatest impact toward that end, we have set near-term goals of reducing the heart disease and stroke mortality rates among blacks by 25 and 40 percent, respectively, from their 1995 level by the year 2000. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$ 2.2 billion in support of these activities in mandatory funding, which includes estimated Medicaid and Medicare spending, along with an additional \$ 219 million in discretionary funds. The President's FY 99 budget includes an additional \$ 5 million for existing CDC programs devoted to cardiovascular disease. The President's FY 1999 budget also provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to foster efforts by public and private health-related organizations to disseminate and implement current knowledge about prevention and treatment of cardiovascular disease and to define more clearly those populations at increased risk for cardiovascular disease.

Research

Efforts by NIH's NHLBI targeted at eliminating disparities include the following:

- ***Building Healthy Hearts for American Indians and Alaska Natives*** is a pilot project to

test strategies to increase awareness and knowledge of cardiovascular risk factors. It also is designed to develop and implement heart health promotion strategies that address the needs of American Indians and reflect their culture, traditions, lifestyles, and values. Finally, it seeks to promote partnerships and innovative information sharing to help disseminate culturally appropriate messages and materials within indigenous tribal communities and to evaluate the effectiveness and impact of the outreach activities. This 2-year (\$250,000) project is the first in a series of minority health education projects to be designed, developed, and evaluated by members of the target community. Lessons learned from this and the succeeding projects will be used to design larger scale prevention interventions.

- ***Cardiovascular Health for Asians and Pacific Islander American Families*** is an initiative that will be launched in fiscal year 1998 to develop a model cardiovascular outreach program for selected populations of Asian and Pacific Islander Americans. A general approach will be developed that can be tailored to the specific culture, language, and traditional beliefs of the various Asian-American and Pacific Islander subpopulations. Cardiovascular disease is the leading cause of death among these populations. Funding for the project is \$350,000.
- ***Community Demonstration Projects.*** The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide baseline assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

Action plans shaped by interaction with the target communities and by research findings will be refined over the next 6 to 12 months. However, significant new activities in the current year and beyond that will advance the goal include the following:

- ***Eliminate disparities in cardiovascular disease through State-based programs.*** In fiscal year 1998, CDC will initiate an \$8.1 million State-based cardiovascular disease prevention program in States with high rates of cardiovascular disease. The funded States will reflect the disparities in cardiovascular disease rates and will have large ethnic or minority populations. These State programs will determine which groups are most at risk and will direct specific program interventions to reduce risk factors in these populations to levels at or below the general population. This program will result in a national strategy for cardiovascular disease prevention through sustainable State-based programs, outlining effective strategies that States may use to address cardiovascular disease

prevention. An important component of this strategy will be to address the physical activity patterns of minorities by providing worksite, school, and community-based programs to minorities and low-income populations so they have the same opportunities for physical fitness as other Americans.

- ***Reduce tobacco use by youth.*** In an effort to prevent the onset of cardiovascular disease, CDC has initiated an expanded tobacco prevention program targeting young people. CDC will assist States in developing their ability to promote nonsmoking as the norm through widespread policy changes and media messages, preventing the development of nicotine dependence in youth, expanding smoking cessation activities, and protecting nonsmokers from exposure to environmental tobacco smoke. Ethnic and minority groups disproportionately affected by tobacco use will be targeted in this effort. In addition, CDC will fund national organizations to address tobacco use. Several of these organizations provide services and activities to minorities. The 1998 budget includes a \$7 million increase for tobacco prevention activities
- ***NIH will launch a new cardiovascular medical education web site for health care professionals who provide care to black patients.*** The web site will be used by members of the National Physicians' Network. It will report on coronary heart disease in blacks and provide specific treatment information in areas such as blood pressure, cholesterol, and preventive health behaviors and will provide recipes for favorite black dishes that are heart friendly. This \$150,000 web site will be an important resource to physicians and other health care professionals who provide care for black patients.
- ***Cardiovascular Disease Prevention Program (FY 99).*** CDC will use funds requested for FY 99 to support cardiovascular disease prevention programs addressing minority populations in two states. This funding builds on FY 98 CDC of an estimated 6-8 states for cardiovascular disease prevention. The new funds will also be available to the original sites to allow more targeted interventions for minority populations.
- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. These services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.

**GOAL 4*****Eliminate disparities in diabetes.******Long-Term Goal***

Eliminate disparities in diabetes-related complications.

Background

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans. The estimated total direct and indirect costs of diabetes for the United States in 1992 was \$92 billion.

The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world.

Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths. Achieving mortality reduction among high-risk populations will require targeted efforts to reduce cardiovascular risk factors among these groups, which is a focus of our goal on eliminating disparities in cardiovascular disease. Individuals with diabetes, however, face not only a shortened life span, but also the probability of multiple acute and chronic complications, including end-stage renal disease (ESRD), blindness, and lower extremity amputations. All of these complications have the potential to be prevented.

Prevention

Preventive interventions should target high-risk groups. Rates for diabetes-related complications such as ESRD and amputations are higher among blacks and American Indians compared to the total population. Even among similarly insured populations, such as Medicare recipients, blacks are more likely than whites to be hospitalized for septicemia, debridement, and amputations — signs of poor diabetic control. Scientists are concerned that a number of people in these minority groups develop type 2 (non-insulin-dependent) diabetes in adolescence, and therefore face a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications; for every two persons who are aware of their illness, there is one person who remains undiagnosed.

Although the increasing burden of diabetes is alarming, the good news is that much of this major public health problem can be prevented with early detection, improved care, and diabetes self-management education. Diabetes presents both a challenge and an opportunity for public policy makers, health care providers, community leaders, and individuals with diabetes to apply prevention strategies known to make a significant impact. Recent studies in diabetes have confirmed that careful control of blood glucose levels is a strategy that works for preventing the complications of diabetes. The challenge is to make proper diabetes management part of daily clinical and public health practice.

Near-Term Goals

Therefore, our goal is to monitor progress in reducing diabetes by reducing the overall rate of diabetic complications among all individuals with diabetes and eventually to eliminate disparities among groups. As a major step toward that end, we have set two near-term goals: (1) reducing the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels. Rates of diabetic complications among Hispanics are also high; however, current data do not permit us to monitor diabetic complications among this group. We will develop strategies to reduce diabetes-related complications among all minority groups and to improve data collection.

The rates of diabetes-related complications used as outcome measures are crude indicators of progress in eliminating disparities; however, they are the only outcome measures available consistently on a national basis. We also will monitor behavioral practices and health care access issues as indicators of success. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of blood glucose levels, clinic visits, diabetic foot care, and dilated-eye exams.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$876 million in support of these activities in mandatory funding, which includes estimated Medicaid and Medicare spending, along with an additional \$170 million in discretionary funds. In addition, the President's FY 1999 budget provides an increase of \$5 million to CDC for diabetes education. The President's FY 1999 budget provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to more clearly identify steps that are needed to establish comprehensive community-directed and community-based efforts to reduce the incidence of diabetes and its complications among high-risk minority populations, enhance educational efforts for public and provider groups, and enhance partnerships with national and local private sector interests.

Research

- ***Multicenter Type 2 Diabetes Intervention Trial.*** NIH's National Institute of Diabetes and Digestive and Kidney Diseases is initiating a large, multi-center (25 sites) randomized clinical trial of lifestyle and drug interventions aimed at preventing onset of Type 2 (non-insulin-dependent) diabetes in patients at high risk for developing this disease. Because this form of diabetes disproportionately affects minorities, about 45 to 50 percent of patients recruited will be minorities. Recruitment is under way for the trial, with 1,400 of 4,000 patients recruited. Patients will be followed an average of 4.5 years. The trial not only focuses on minority communities for subjects, but also has an explicit goal to involve minority staff and research investigators. Results from this clinical trial are expected to significantly improve our understanding of how to tailor interventions to the cultural norms and lifestyles of specific communities. The trial is budgeted at \$25 million per year.
- ***Prevention research to improve diabetes prevention in clinical and public health settings.*** CDC conducts applied research that focuses on translating diabetes research findings into clinical and public health settings and program applications. In fiscal year 1998, translational research projects will focus on the following areas in order to help reduce the burden of diabetes among minorities who are disproportionately affected by diabetes: (1) examining Medicaid claims data in order to assess the burden of diabetes among those populations who rely upon Medicaid for health services; (2) determining the economic impact of diabetes, including the costs of early screening and the cost-utility of early intervention; and (3) developing translational research centers within managed care organizations, to study and test strategies aimed at narrowing the gap between observed practices and the stated standards of care for early detection of diabetes, control of the disease, and treatment of major complications, such as eye and foot examinations.
- ***Community Demonstration Projects.*** The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide

baseline assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

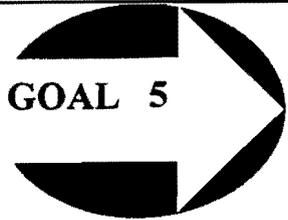
Action plans will be shaped by interaction with the target communities and by research findings and will be refined over the next 6 to 12 months. However, significant new activities in the current year and beyond that will advance the goal include the following:

- ***National Diabetes Education Program (NDEP).*** This is a joint project of the NIH's National Institute of Diabetes and Digestive and Kidney Diseases and CDC's Division of Diabetes Translation (DDT) that involves public and private partners to improve the treatment and outcomes for people with diabetes, to promote early diagnosis and ultimately to prevent onset of the disease. A key milestone will be the early 1998 launching of the NDEP Public Awareness Campaign, which will focus heavily on minority populations. The annual budget for this activity will be \$1.5 - 2.5 million.
- ***Public Health Surveillance.*** CDC will expand public health surveillance activities in support of the collection and analysis of national data and the development of surveillance systems for use at the State, regional, and local levels. Public health surveillance will be used to identify, test, and improve new interventions and to inform policies and procedures on financing preventive services for people with diabetes, including managed care and indemnity plans. Specific systems will investigate the diabetes burden in blacks, American Indians and Alaska Natives, Hispanics, and other high-risk groups.
- ***Diabetes Control Programs.*** The goal of CDC's State-based Diabetes Control Programs (DCP's) is to improve access to high-quality diabetes care for persons with diabetes. In fiscal year 1998, CDC will increase the number of State comprehensive diabetes programs by seven to nine States. The expanded funding will allow the additional States to develop statewide, comprehensive diabetes program activities that target populations that have a disproportionately high risk of diabetes, including blacks, Hispanics, American Indians and Alaska Natives, Asians and Pacific Islanders, and the elderly.
- ***Diabetes Prevention and Treatment Among American Indians.*** The Balanced Budget Act of 1998 authorized grants of \$30 million annually for the next 5 years to provide services for diabetes prevention and treatment in partnership with American Indian tribes, Urban Indian Health Centers, IHS facilities, and other HHS operating divisions (e.g., CDC). The new diabetes programs will have a special focus on children and youth. They will test earlier, community-based interventions in an effort to increase knowledge about primary prevention, such as reducing obesity, promoting health and wellness, and

reducing onset of Type 2 diabetes. In accomplishing these objectives, the new programs will seek to improve linkages between families, public health services, schools, and nutrition programs.

- ***Diabetes Education.*** The President's budget for FY 1999 proposes an additional \$5 million for CDC to develop and implement community-based health education and intervention strategies that are culturally relevant and appropriate, in order to have an impact on reducing the disparities in morbidity and mortality rates for persons with diabetes. CDC also will work closely with its partners, particularly through the National Diabetes Education Program (NDEP), to develop special educational messages, materials, and community-based programs targeted for persons in racial and ethnic minorities.

- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. These services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.

**GOAL 5*****Eliminate disparities in HIV Infection/AIDS.******Long-Term Goal***

Eliminate disparities in the rate of HIV/AIDS infection.

Background

AIDS has disproportionately affected minority populations. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet they account for nearly 54 percent of all AIDS cases. While the epidemic is decreasing in some populations, the *number* of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites.

There are several different HIV epidemics occurring simultaneously in the United States, each of which must address the specific population affected and their associated risk factors. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among black men who have sex with men have increased. In addition, AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 75 percent were among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities.

During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. The cost of efficacious treatment, between \$10,000 and \$12,000 per patient per year, is a major hurdle in the effort to ensure equitable access to available drug therapies.

Inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for high-risk populations. About one-third of persons who are at risk of HIV/AIDS have never been tested. Better prevention strategies are needed that are acceptable to the target community (i.e., they must be culturally and linguistically appropriate), and the capability of organizations serving at-risk populations to develop, implement, evaluate, and fund prevention and treatment programs must be improved. Efforts should include risk reduction counseling, street and community outreach, prevention case management services, and help for individuals at risk in gaining access to HIV testing, treatment, and related services.

To enable HIV-infected persons to benefit from treatment advances, HIV counseling and testing programs in screening and health care settings must better facilitate early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services. Continued emphasis on behavioral risk reduction and other prevention strategies targeted to these populations is still the most effective way to reduce HIV infections.

Near-Term Goals

By the year 2000, through the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act, ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to promote the current standard of clinical care for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$704 million in support of these activities in mandatory funding, which includes estimated Medicaid and Medicare spending, along with an additional \$1 billion in discretionary funds. In addition, the President's FY 1999 budget proposes an additional \$10 million for CDC HIV/STD demonstration projects. The President's FY 1999 budget provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to more clearly identify steps that are needed to: increase the percentage of minority populations who know their HIV serostatus, receive counseling and treatment services, and receive early access to primary care to prevent or delay progression to AIDS. CDC will convene a series of meetings with community planning group members and representatives of minority communities heavily affected by HIV/AIDS to better assess needs and identify priorities for HIV prevention activities. These meetings will include the *1998 HIV Prevention Summit*, a meeting of 800 community planning leaders from across the country. A major theme for the Summit is race, ethnicity, and cultural diversity in HIV prevention activities.

Research

- CDC supports comprehensive research including biologic, epidemiologic, and social issues to develop interventions that can reduce or prevent HIV in racial and ethnic minority populations.
- The National Institute of Allergy and Infectious Diseases (NIAID) is the lead component for AIDS research at NIH. NIAID's AIDS research agenda includes conducting clinical trials that address the specific needs and concerns of minority groups, ensuring that minority patients have access to all clinical trials and communicating AIDS research findings to these communities. In addition, NIAID's Office of Research on Minority and Women's Health encourages research aimed at improving the health of minority populations. The Office also works to increase the effectiveness of outreach and education programs. Through its Office of Communications, NIAID works with community-based organizations to disseminate information about AIDS and NIAID research activities to minority communities. AIDS information is available in Spanish and in low-literacy formats.
- To advance the development of safe, effective HIV vaccine candidates, NIAID will establish a new program called the Strategic Program for Innovative Research on AIDS Vaccines. NIAID will fund an initiative to identify and evaluate innovative strategies to prevent HIV transmission between sexual partners and through intravenous drug use. NIAID will renew the Women's Interagency HIV Study to continue gathering important data on how the epidemic is affecting women, particularly minority women, who make up 80 percent of the program's participants.
- The President's FY 1999 budget would provide an additional \$10 million to enable CDC to address the high prevalence of HIV/STDs in minority populations by directing funds to support six to eight demonstration projects that design, field test, implement, and monitor data and theory-driven targeted interventions. These demonstrations also would enhance community involvement in all aspects of developing, implementing, and evaluating interventions that address the high prevalence of HIV/STDs.
- ***Community Demonstration Projects.*** The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide baseline assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

Action plans shaped by interaction with the target communities and by research findings will be refined over the next 6 to 12 months. However, significant new activities in the current year and beyond that will advance the goal include the following:

- ***HIV community planning.*** CDC will strengthen and refine the HIV prevention community planning process to help develop priorities that specifically address unique community needs, including those of racial and ethnic populations. In addition, CDC will invest \$14 million to strengthen health departments' capacity to provide prevention services, such as counseling, testing, and partner notification services, to those at highest risk, including racial and ethnic minorities.
- ***United States Conference of Mayors HIV/AIDS Prevention Grants Program.*** Using funding provided by CDC, the U.S. Conference of Mayors will soon announce a new round of prevention activities targeting gay and bisexual men and women of racial and ethnic minorities. This grant program is intended to strengthen local capacity for HIV/AIDS prevention activities through the funding of projects involving community-based organizations, local health departments, and others with a role to play in HIV/AIDS prevention. In fiscal year 1998, these grants totaling \$515,000 will be directed to either young (ages 16 to 25) gay and bisexual men of racial and ethnic minorities, gay and bisexual men of racial and ethnic minorities in Southern States, or minority women.
- ***Communities of Color Initiative.*** CDC will develop an initiative, by the end of fiscal year 1998, that will focus on black, Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander communities. This will involve identifying and removing barriers to successful HIV prevention.
- ***HIV/AIDS CARE Grants to States (Ryan White Care Act Title II)—Assuring Access to Drug Therapies.*** Starting with this year's Title II application package, grantees are now required to provide information regarding the extent to which clients of their AIDS Drug Assistance Programs reflect the demographic characteristics of the HIV epidemic in their State. They must discuss any barriers to access for subpopulations and the State's plans to reach and enroll underserved populations in their Drug Assistance Program.
- ***AIDS Education and Training Centers Program (AETC)—American Indian Initiative.*** The American Indian Initiative within HRSA's AIDS Education and Training Centers Program is a collaborative activity with the Indian Health Service, focusing on provider training. This project runs through September 30, 1998, with the Pacific AETC as the main training source. IHS/HRSA have worked with the IHS HIV Center of Excellence in Phoenix, Arizona, to develop a standard curriculum on topics such as cultural competence, acceptability of therapies, and blending of natural/spiritual and holistic medicine. Future training areas include Keams Canyon, Arizona; Navajo Nation; and the

Phoenix Indian Medical Center.

- ***Minority and other community-based organizations.*** In September 1997, CDC funded 68 new community-based organizations' cooperative agreements for HIV prevention projects. Funding (\$12.2 million) is for minority and other community-based organizations serving populations at increased risk of acquiring or transmitting HIV infection. These community-based organizations joined 26 other organizations, funded several months earlier, which continue prevention programs directed to minority and other populations at high risk of acquiring HIV. A total of 94 organizations will be funded with \$18.7 million to build capacity and skills for HIV prevention in State and local health departments.

- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. These services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.



Eliminate disparities in child and adult immunization rates.

Long-Term Goal

Eliminate disparities in child and adult immunization rates.

Background

The reduction in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past 100 years. Billions of dollars are saved each year through the use of vaccines. Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. Although immunization rates have been lower in minority populations compared with the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. Although coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of underimmunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas with traditionally underserved populations, there is a potential for outbreaks of vaccine-preventable diseases.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older, the fastest growing age group of the population. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Each year, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications.

There is a disproportionate burden of these diseases in minority and underserved populations. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population and the year 2000 targets.

Near-Term Goals

Our goal is to enhance current childhood immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups.

Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent and eventually to eliminate disparities among groups. To reach this goal by the year 2000, we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asians and Pacific Islanders and *quadruple* the 1994 pneumococcal immunization rates among these groups.

Funding

The Department's ongoing investments in consultation, research, and service delivery to address these health conditions and reduce disparities in access and health status are substantial. In fiscal year 1998, we will expend approximately \$880 million in support of these activities, not including services purchased through Medicare and Medicaid programs. The President's FY 1999 budget provides an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities, that will focus on this and the other five goals. It also proposes to increase funding for Community Health Centers by \$15 million to enhance services targeted on reducing disparities.

Strategy for Achieving the Goal

Communication

A structured dialogue involving health care experts and minority communities will be used to more clearly identify steps that are needed to increase provider awareness of the need for timely immunizations, ensure effective vaccine delivery mechanisms, and encourage outreach to all seniors, with special efforts to target minorities.

Research

CDC is conducting a wide range of demonstration projects to show how to sustain and improve immunization rates. For example, CDC is developing State and community-based registries as a cornerstone to support coverage rates and prevent disease outbreaks. CDC, in conjunction with the U.S. Department of Housing and Urban Development, is evaluating various interventions to improve coverage in children living in public housing. Other demonstrations, such as community health networks in large urban areas, are being evaluated to identify approaches to help increase coverage in remaining pockets of underimmunized children. HHS's agency-wide action plan to improve adult immunization rates and reduce disparities among racial and ethnic minorities identifies key steps for agencies to undertake.

Community Demonstration Projects. The President's FY 1999 budget proposes \$30 million for CDC, to award competitive grants to up to 30 communities for the purpose of testing interventions that have shown promise in reducing one of the six identified health disparities. Grantees will be eligible to receive funding over a five-year period to provide baseline

assessment on the health problem in their area, and to implement a community-based trial of specific interventions. Lessons learned from these community demonstrations will be used to improve the design and management of HHS programs that address the six health disparity areas.

Immediate Action Steps

Action plans shaped by interaction with the target communities and by research findings will be refined over the next 6 to 12 months. However, significant new activities in the current year and beyond that will advance the goal include the following:

- ***Targeting underimmunized children.*** CDC is accelerating plans to enhance proven intervention strategies to immunize pockets of underimmunized children. These efforts include specifically targeting immunization training courses to providers of immunization services for minority children. In fiscal year 1998, CDC plans to develop a distance-based training program for major urban areas to train minority health professionals working in inner cities. Approximately \$100,000 will be used to conduct these training sessions.
- ***Targeting underserved geographic areas.*** In September 1997, CDC awarded \$125,000 to the National Medical Association to begin targeted immunization efforts in underserved geographic areas. This activity focuses on physicians who provide services to children who are members of racial and ethnic minorities.
- ***Increasing adult immunizations.*** On September 29, 1997, HHS approved an agencywide plan to improve adult immunization rates and reduce disparities among racial and ethnic minorities. A major objective of this action plan is to increase pneumococcal and influenza immunizations among all adults aged 65 and older and to eliminate disparities among minority populations.
- ***Adult flu and pneumonia vaccination campaign.*** HCFA has just launched a flu and pneumonia vaccination campaign to encourage senior citizens to receive preventive shots paid for by Medicare Part B for these two infectious diseases. The goal is to ensure that at least 60 percent of seniors are receiving a flu shot every year by the year 2000. The campaign includes information provided through direct mail postcards, posters, statement stuffers, cards for clinician/pharmacy stands in English and four other languages, and public service announcements. Special efforts are being made to reach medically underserved groups. HCFA is working with Historically Black Colleges and Universities to involve clergy, family physicians, pharmacies, home health agencies, and others at the community level (such as senior centers, churches, and clubs) to encourage black beneficiaries to get their flu shots annually.

- ***Community Health Centers.*** The President's FY 1999 budget would provide an additional \$15 million to Community Health Centers, that would be dedicated to areas with significant race-based disparities and would provide comprehensive and primary care service access points to serve 150,000 additional low income, underserved and vulnerable patients (65 percent of whom nationally are minorities), in order to further reduce specific health disparities. Some of these services include enabling services such as patient outreach, case management, health education, translation, and transportation; provider and patient education, and the development of strategies to identify and break down the barriers so that easy access to quality health care is available.

THE HHS RACE AND HEALTH INITIATIVE
Top Level

Q. What is HHS' role in the President's Initiative on Race and what exactly is the HHS race and Health Initiative?

A. Our role is to help the President achieve his aim of one America for the 21st century by knocking down barriers that keep minorities from enjoying good health. Our budget includes \$400 million over five years for the HHS Race and Health Initiative. The goal is to reduce health disparities among minorities and non-minorities in six key areas. They are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS infection rates, and child and adult immunization. This is a cross-cutting initiative that addresses health disparities experienced by Hispanics, African-Americans, Native Americans and Asian Americans.

For FY 1999, \$80 million is available. Of that, \$50 million would go to existing HHS public health programs in CDC, HRSA and IHS to better reach minority populations and address their needs in each of the six areas. The grants would be aimed at funding innovative and effective programs that target health disparities, and create successful models for future efforts.

Q. HHS has been accused of picking and choosing which health programs it wants to emphasize, essentially playing favorites with different diseases. Isn't this just another case?

A. We are not playing favorites. We aren't picking and choosing. We pursue all of our education and prevention efforts with great vigor. But closing the gaps that separate minorities from non-minorities is important to our collective health and our future as a nation. It's important to the President, and it's important to the nation.

Q. It was just last year that the President offered a formal apology for the Tuskegee experiment. Isn't this reminiscent of Tuskegee?

A. Absolutely not. This initiative is about education, prevention and treatment. The tragedy of Tuskegee was that people were intentionally deceived and denied treatment that was readily available. We are targeting our education and prevention efforts to help people who are at risk. We're trying to prevent the spread of AIDS and provide effective treatment to those who need it. There is no comparison between our Race and Health Initiative and Tuskegee.

Q. So how are you going to close this gap?

A. We don't know all the answers. For some of these goals, the answers are relatively easy. For example, we've had some success with immunization programs, and so we know what can work in this area. In other areas, like infant mortality, the picture is more complex, and that's where the \$400 million -- particularly the community-based demonstrations -- will move us toward answers. And for a disease like diabetes, the challenge is how to address disparities through basic research -- like looking at NIH for opportunities where we can shed light on racial health disparities through clinical trials and other research tools.

Q. You mentioned some general things. But what are some specific strategies you have either implemented or proposed to close the gaps in terms of access and poverty?

A. We passed Kassebaum-Kennedy legislation to improve the availability of health insurance for working families and their children; we passed a comprehensive \$24 billion Children's Health Initiative Program (CHIP) to give the estimated 10 million uninsured children in this country access to decent health care; and we just asked Congress to work with us to increase health insurance options for Americans age 55-65. Further, the booming economy this Administration has presided over has helped people move up from poverty, with low interest rates, 15 million new jobs, an unemployment rate that is below 5 % and the lowest inflation in 30 years.

New Community Grant Program

Q. Describe the new Community Grant program.

A. The President's Budget proposes an additional \$30 million to begin a five-year, \$150 million demonstration program to test preventive or clinical interventions that show promise of being effective at the community level. The community grant program is in the CDC's proposed budget, however, it will be a Department-wide collaboration.

The intent is to identify preventive and clinical interventions that research suggests will be effective in achieving one or more of the six disparity reduction goals, and then to invite diverse communities to compete to test those models at the community level. The grant will support the core activities, and our Departmental Steering Committee will identify opportunities to augment the basic grant with other discretionary resources.

Q. Is there a research/evaluation component to the grants?

A. Yes, evaluation will play a major role in this project and positive results of the demonstrations will be integrated into ongoing programmatic efforts. This Department-wide research/demonstration component will identify innovative interventions that have been shown to be effective in reducing, and even eliminating, the disparities in health indicators among racial and ethnic minorities. The community-based projects will then determine if the selected interventions can be effective at the community level.

Q. Which groups will be involved in designing and administering these grants?

A. CDC and other HHS agencies will work collaboratively with academic health centers, State and local health agencies, and communities in developing and implementing evaluation of the overall project and of community-based research/demonstrations. Most significantly, there will be widespread consultation with individuals and organizations who have expertise about how the six health disparity areas affect specific racial and ethnic minority communities. These individuals and organizations will be consulted as the Department designs and monitors the demonstration grants. We expect to learn a great deal from these demonstrations that will enable us to reduce and eventually eliminate disparities in these six areas. And, we expect to gain knowledge that will be applicable to our broader undertaking for meeting our Year 2010 goals, and to the redesign and improvement of the Department's current programs.

Q. Can you provide more details about the specific requirements and design of the grants?

A. Over the next 9 months we will work closely with Department agencies, Congress, and organizations and community leaders outside the Department to agree on the most effective design for these demonstration projects.