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Implementation of the National Partnership for Action to End Health Disparities: A Three-Year Retrospective

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ABSTRACT

In April 2011, the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) launched the National Partnership for Action to End Health Disparities (NPA) to increase the effectiveness of efforts to eliminate health disparities by coordinating partners, leaders, and stakeholders committed to action. At its core, the NPA is an experiment in collaboration that relies heavily on those on the front line who are actively engaged in minority health work at multiple levels. It gives them the responsibility of identifying and helping to define core actions, new approaches, and new partnerships that ultimately will help to close the health gap in the United States. This paper provides a retrospective examination of the NPA's creation and development of health equity coalitions at the federal and regional levels and its establishment of strategic national partnerships to move a health equity agenda forward. The article explores how the development of this infrastructure has, in turn, led to the implementation of actions and activities to address health disparities. The article concludes with a reflection on emerging opportunities for improvement and ways forward to continue the initiative's evaluation and secure its sustainability.

Keywords: health equity, coalition, collaboration, social determinants of health

INTRODUCTION

With the launch of the National Stakeholder Strategy for Achieving Health Equity (NSS or National Stakeholder Strategy) on April 8, 2011, the National Partnership for Action to End Health Disparities (NPA) moved from development into its early implementation phase. After the launch of the NSS, the NPA began building health equity coalitions to support the implementation of the NPA: (1) the Federal Interagency Health Equity Team (FIHET) and (2) the Regional Health Equity Councils (RHECs). The FIHET was established to provide federal leadership to the NPA by convening leaders within federal agencies to end health disparities by building capacity for equitable policies and programs, cultivating strategic partnerships, and sharing relevant models for action. The 10 RHECs correspond to the 10 U.S. Department of Health and Human Services' (HHS) public health service regions and serve as bodies to coordinate region-specific activities and initiatives as part of the NPA. RHEC members collaborate to address health disparities in their geographic areas, work to establish partnerships, leverage resources, infuse NPA goals and strategies into policies and practices, and share stories and successes with broader constituencies. RHECs are composed of individuals from the public, private, and nonprofit sectors, including state and local government agencies, healthcare providers and systems, health plans, businesses, academic and research institutions, and foundations. The NPA also began to establish targeted partnerships with individual organizations across sectors to further its aim to address health disparities—formally known as "national partner" organizations.

The NPA and these stakeholders are driven by five primary goals in their efforts to end health disparities: (1) Increase awareness of significant health disparities, their impact on the nation, and actions that are necessary to improve health outcomes for racial, ethnic, and underserved populations; (2) Build leadership capacity across sectors and organizational levels to address health disparities; (3) Improve health system and life experience outcomes for racial, ethnic, and underserved populations; (4) Improve cultural and linguistic competency, and the diversity of health-related workforce; and (5) Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes. The NPA's ability to achieve these goals has been dependent on the continued strengthening of the internal infrastructure that has been built since 2011 (FIHET, RHECs, and national partnerships) and the development of new multisector partnerships across different levels (federal, national, regional, state, and local). This paper provides a retrospective look at the development of the FIHET and RHECs as well as national partners and their pursuit of actions and accomplishments to achieve the NPA's goals.

METHODS

The evaluation of the NPA was initiated in 2012 and has been guided by five key assessment questions to help determine the extent of its progress thus far, which are:

1. How does the multilevel/multisector structure support actions that contribute to the elimination of health disparities?
2. How do leaders in the public, private, nonprofit, and community sector effectively engage in collaborative, efficient, and equitable working partnerships to eliminate health disparities?
3. What are the identifiable actions that are being implemented at the community, state, tribal, regional, and national levels that relate directly to the 5 goals and 20 strategies in the National Stakeholder Strategy?

4. How much of the work to end health disparities is integrated into stakeholder strategies and mainstream systems (e.g., healthcare quality improvement, public and community health improvement, economic and community planning and development) in and beyond the health sector?
5. What are the promising practices and strategies that contribute to ending health disparities?

As an evaluation strategy, a mixed-methods evaluation was designed to document the ongoing implementation and progress of NPA stakeholders, identify lessons learned, provide insights regarding the components of the NPA that should be sustained or modified, and discern the initiative's accomplishments and early outcomes. Given these objectives, each fiscal year the evaluation team has conducted interviews with key stakeholders, including representatives from all 10 RHECs, the FIHET, NPA national partner organizations, and NPA state and local stakeholders. The evaluation team also surveyed RHEC and FIHET members and representatives from state/territorial health departments and offices of minority health. In addition, the evaluation team has analyzed various stakeholder documents to corroborate findings and add richness to the descriptions of NPA actions and accomplishments reported by stakeholders through interviews and surveys.

RESULTS

The NPA was designed to bring together a set of complementary stakeholder groups that act as cooperative partners for addressing health disparities. The approach was grounded in the belief that addressing the social determinants of health that lead to health disparities necessitates a multisectoral, multitiered strategy that involves a variety of stakeholders.

This section assesses the extent to which this multilevel infrastructure is working, based on stakeholder members' perceived efficacy, and provides supporting evidence by describing partnerships that have formed to date.

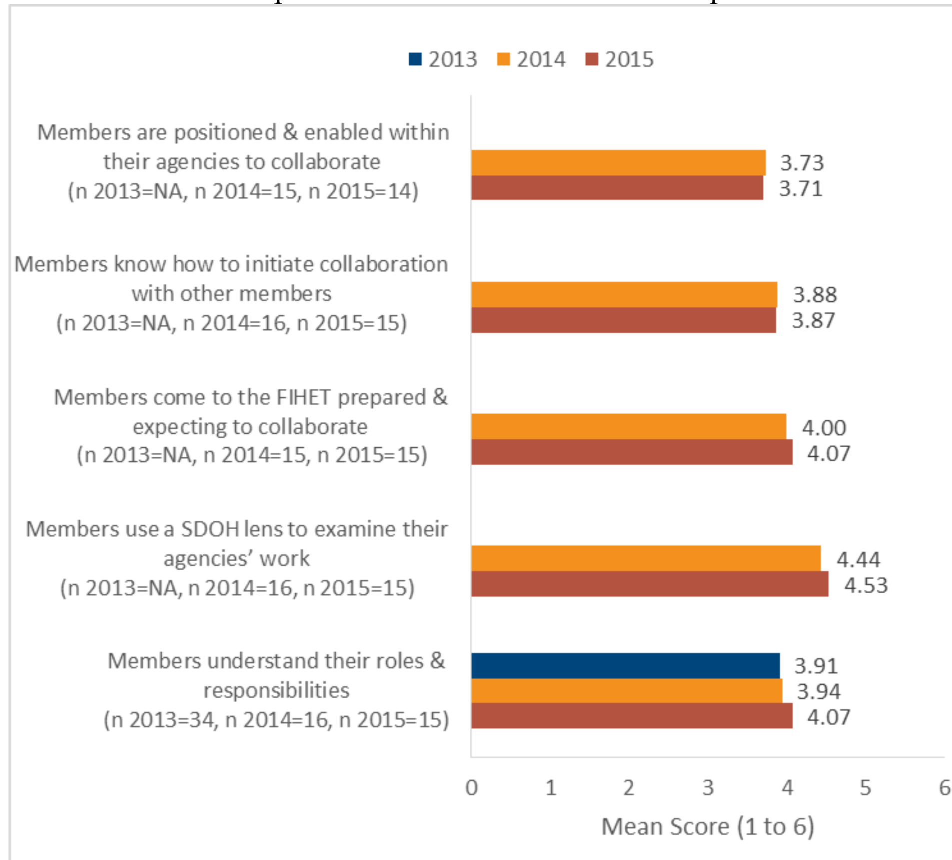
Building and Strengthening Health Equity Coalitions at the Regional and Federal Levels

Coalition Membership. The characteristics, skills, attitudes, and beliefs of coalition members can contribute to, or detract from, the ability of a coalition to function as a body and achieve its intended goals (Anderson-Butcher & Ashton, 2004; Appleton-Dyer, Clinton, Carswell, & McNeill, 2012; Cottrell & Parpart, 2006; D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; deJong, 1996; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Gray, 2004; Kegler, Rigler, & Honeycutt, 2010; Lawson, 2004; Mattessich & Monsey, 1992; Mattessich, Murray-Close, & Monsey, 2001; Nowell, 2009; Ross et al., 2010). Similarly, formal and informal leadership permeates all elements of collaboration and is a critical element for an effective coalition (Ansari, Oskrochi, & Phillips, 2009; Appleton-Dyer et al., 2012; Brown, Feinberg, & Greenberg, 2012; DeCarolis, 1999; Donaldson, 2005; Kegler et al., 2010; Willumsen, 2006).

Since its creation in 2011, the FIHET has built a membership from across 12 federal agencies with the goal of developing a cohort of federal staff with the skills, knowledge, and authority needed to serve as health equity champions within their agencies. Members are typically nominated by their agencies' or programs' leadership to serve on the group. Since 2013, FIHET members have *somewhat agreed* on average that FIHET members understand their roles and responsibilities as FIHET members, and the mean score has increased over time (see Figure 1). FIHET members have also *somewhat agreed* or *agreed* that FIHET members have used a social determinants of health (SDoH) lens to examine their agencies' mission and work as a result of participation on the FIHET. Further, FIHET members have tended to *somewhat agree* that FIHET

members come to the FIHET prepared and expecting to collaborate with other members and agencies. Nonetheless, they have been less likely to *agree* that FIHET members know how to initiate collaboration with other FIHET members and that FIHET members are positioned and enabled within their individual agencies to initiate collaborative projects with other FIHET members and agencies.

Figure 1: FIHET Member Perceptions of the FIHET's Membership

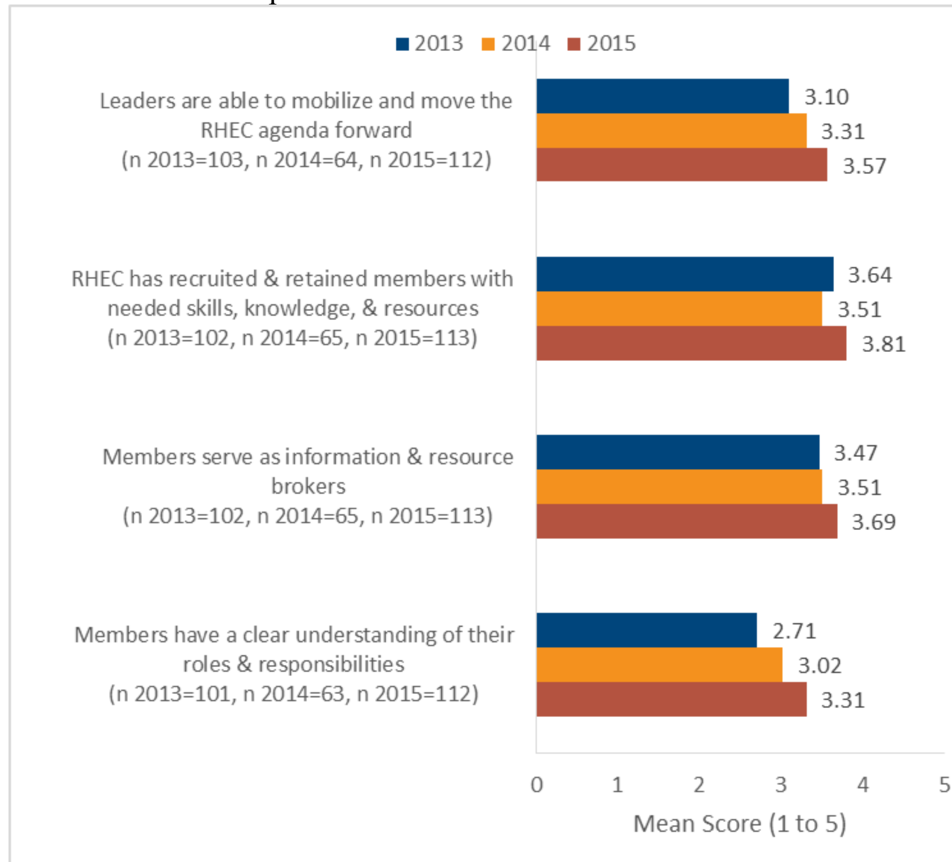


Source: 2013, 2014, and 2015 FIHET Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Somewhat disagree, 4-Somewhat agree, 5-Agree, and 6-Strongly agree. The first four items in the figure were not included in the 2013 questionnaire and therefore data is not available for that year.

The RHECs have developed a group of members from the public, private, and nonprofit sectors that have the skills and abilities needed to implement activities to address health disparities and serve their regions. RHEC members have *agreed* that the RHEC has recruited and retained members that have the skills, knowledge, and access to resources needed to implement planned activities. Over time, RHEC members have tended to *agree* that they have a clear understanding of their roles and responsibilities in implementing the RHEC's blueprint for action and workplan (see Figure 2). They also have tended to *agree* that the RHEC and its members serve as information and resource brokers and consultants (e.g., sharing data, technical assistance, best practices) to non-RHEC organizations in order to support the sustainability, effectiveness, and growth of efforts to reduce health disparities. Gradually, RHEC members have increased in the extent to which they

agree that RHEC leaders—RHEC co-chairs and subcommittee chairs—are able to mobilize and move the RHEC agenda forward.

Figure 2: RHEC Member Perceptions of the RHECs'



Source: 2013, 2014, and 2015 RHEC Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Neither disagree nor agree, 4-Agree, and 5-Strongly agree

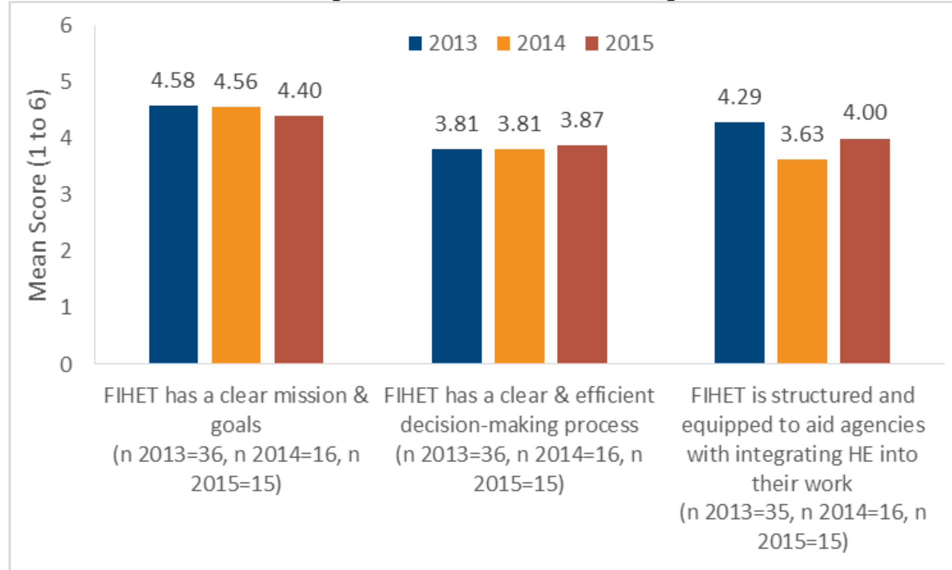
Membership

Purpose, Process, and Organization. The selection and articulation of a coalition's goals and objectives is a critical step in establishing the coalition's identity, sense of purpose, and strategic direction (Anderson-Butcher & Ashton, 2004; Cottrell & Parpart, 2006; D'Amour et al., 2005; Erwin & Rainforth, 1996; Foster-Fishman et al., 2001; Gajda & Kolib, 2007; Nowell, 2009). In addition, to achieve these goals and objectives, a coalition must establish a structure and processes by which the coalition goes about its work (Appleton-Dyer et al., 2012; Cheney & Osher, 1997; Cottrell & Parpart, 2006; Cropper, 1996; D'Amour et al., 2005; Donaldson, 2005; Gajda & Kolib, 2007; Harper et al., 2004; Nowell, 2010; Trickett & Espino, 2004; Wolff, 2001).

As a cross-agency collaborative, the FIHET has worked to develop a shared purpose among members as well as internal processes, structures, and organization to facilitate its work to promote health equity at the federal level. Over time, FIHET members have *somewhat agreed* or *agreed* that the FIHET has a clear mission and set of goals, although the mean score has decreased sharply during the most recent fiscal year for which data are available (see Figure 3). FIHET members have tended to *somewhat agree* that the FIHET has a clear and efficient decision-making process.

Across years, FIHET members have tended to *somewhat agree* that the FIHET is structured and equipped to aid FIHET agencies with integrating equitable outcomes and health-disparities-related topics into their activities, initiatives, programs, and reports, although the mean score has varied over time.

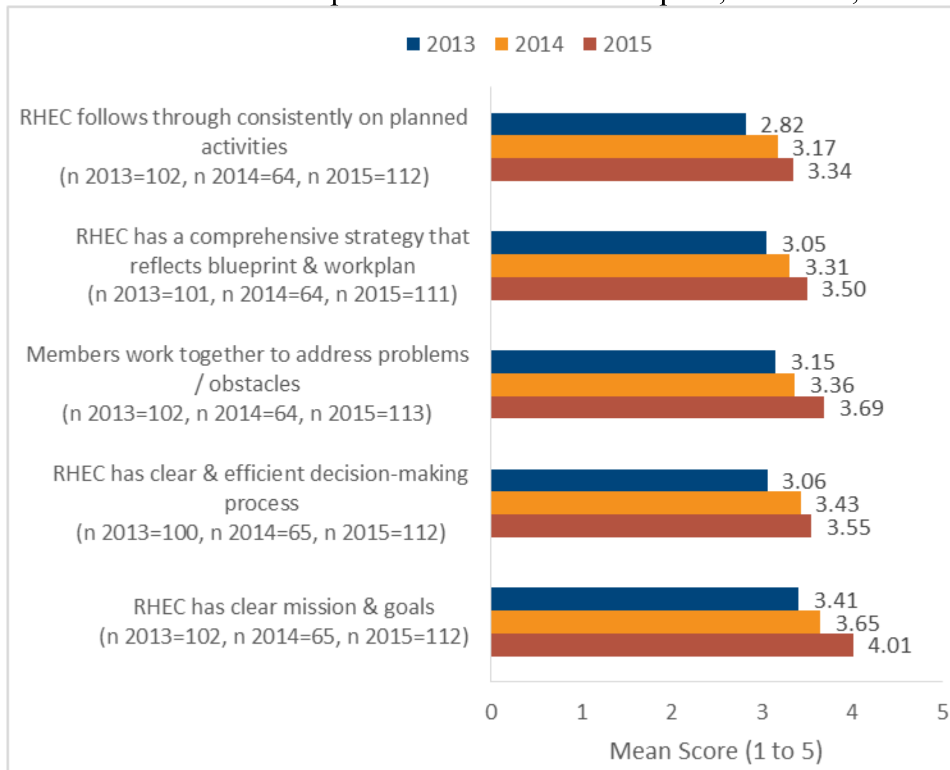
Figure 3: FIHET Member Perceptions of the FIHET's Purpose, Structure, and Processes



Source: 2013, 2014, and 2015 FIHET Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Somewhat disagree, 4-Somewhat agree, 5-Agree, and 6-Strongly agree

The RHECs have established a clear purpose and internal processes for decision-making, planning, and conflict resolution. Over time, RHEC members have increased in the extent to which they *agree* that the RHEC has a clear mission and set of goals, has a clear and efficient decision-making process, and that RHEC members work together to solve shared problems and overcome obstacles to their progress (see Figure 4). RHEC members are volunteers with competing professional and personal responsibilities in addition to their service to the RHEC. The Office of Minority Health (OMH) provides logistic, evaluation and data, and communication, and planning to support RHEC members' efforts. Nonetheless, the need of members to balance RHEC responsibilities with these competing demands has, at times, been a barrier to the execution of planned activities. RHEC members have increased in the extent to which they *agree* that the RHEC has developed a comprehensive strategy that reflects its blueprint for action and workplan. Nonetheless, members continued to *neither agree nor disagree*, on average, that the RHEC follows through consistently on its activities (e.g., outstanding tasks are dealt with in a timely manner), although the mean score has gradually increased.

Figure 4: RHEC Member Perceptions of the RHECs' Purpose, Structure, and Processes

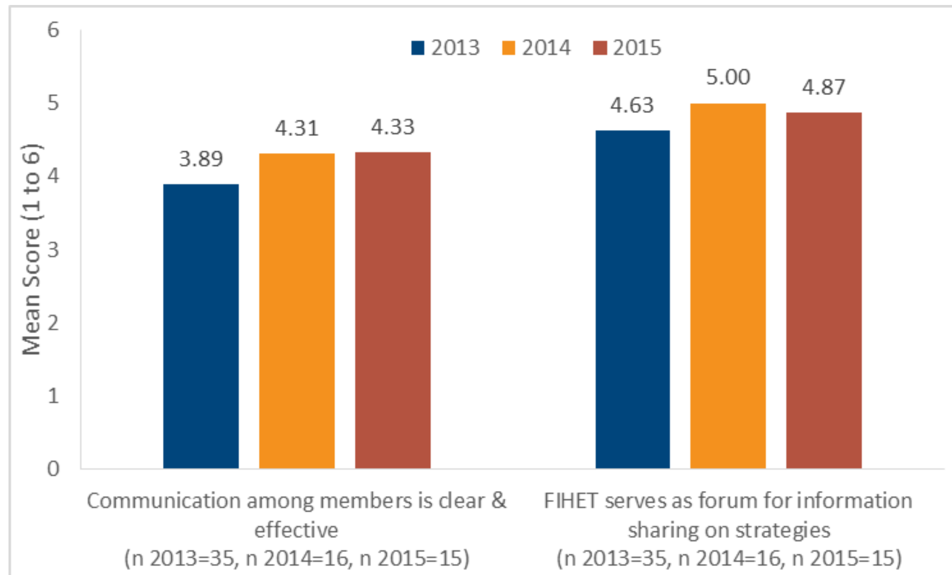


Source: 2013, 2014, and 2015 RHEC Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Neither disagree nor agree, 4-Agree, and 5-Strongly agree

Communication and Collaboration. The development of channels for formal and informal communication and collaboration between coalition members is an important factor in a coalition's ability to implement its plan of action and parallel activities outside of the coalition's workplan that align with the coalition's overall goals (Appleton-Dyer et al., 2012; Boyd & Peters, 2009; Cross, Dickman, Newman-Gonchar, & Fagan, 2009; Foster-Fishman et al., 2001; Harper et al., 2004; Kegler et al. 2010; Luke et al., 2010; Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; Willumsen, 2006).

The FIHET has become a forum for members to share information about their activities related to health equity and a venue for cross-agency collaboration and relationship building. Over time, FIHET members have tended to *somewhat agree*, on average, that communication among FIHET members is clear and effective (see Figure 5). FIHET members have tended to *agree*, however, that the FIHET serves as a forum for members to share information with each other about strategies and actions to end health disparities, promote equitable outcomes, and achieve health equity. With respect to interagency collaboration, 58% (n=36), 37% (n=25), and 48% (n=24) of FIHET members stated that they collaborated with another FIHET member's agency as a result of their participation in the FIHET during 2013, 2014, and 2015 respectively and most of this collaboration was limited to information sharing. About 84% (n=25), 90% (n=10), and 58% (n=24) of FIHET members stated that their participation in the FIHET had strengthened their relationships with other federal agencies during 2013, 2014, and 2015 respectively.

Figure 5: FIHET Member Perceptions of Communication and Information Sharing



Source: 2013, 2014, and 2015 FIHET Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Somewhat disagree, 4-Somewhat agree, 5-Agree, and 6-Strongly agree

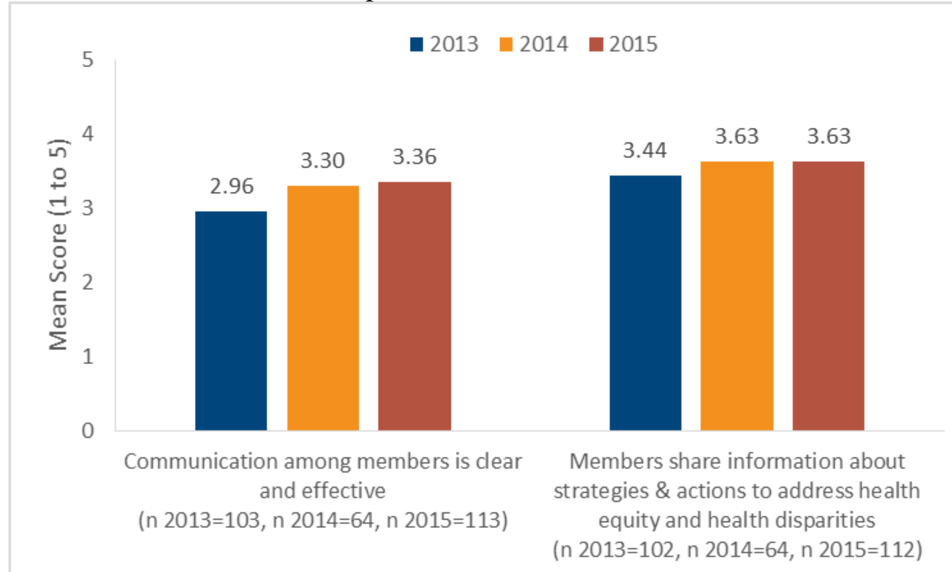
During 2015, the FIHET and its leadership sought to increase members' ability to define linkages between their missions and health equity, serve as equity champions within their agencies, and collaborate. FIHET members engaged in a leadership and professional development process to increase their tools and knowledge needed to engage in cross-agency collaboration and work to change or influence policies and programs within their agencies. FIHET members engaged in facilitated discussions to help FIHET members learn how to apply a health equity lens to their day-to-day work and the work of their agencies. In addition, FIHET members participated in an activity to identify core federal functions (whether primary research, policy making, grant making, data collection, etc.), and discussed opportunities and challenges to promoting health equity through three of the identified core functions (i.e., research, policy, and partnerships). This process was intended to help FIHET members understand how health equity is relevant to the core activities of federal government agencies, initiate discourse about promoting health equity within the context of core functions of FIHET member agencies, and enable members identify alignment in agency functions and thus find opportunities for collaboration.

Six FIHET member agencies (and one non-FIHET organization) engaged in a health equity mapping process to identify the linkages between health disparities and the agencies' core functions, goals, and priorities. The agencies also engaged in identifying how the organizations were applying an equity lens to their work and how they could improve their use of a health equity lens as well as identifying opportunities to partner with other agencies doing comparable work or with comparable priorities. A detailed discussion of the FIHET health equity mapping activity and findings from a participating program at the US Department of Agriculture is published in this supplement (Nweke, Ryan, & Williams, 2017).

Similar to the FIHET, the RHECs have become a forum for members to share information across organizational, community, and state lines about their activities and strategies related to health equity and have developed into a venue for cross-agency collaboration and relationship building. RHEC members have increased in the extent to which they *agree* that members share information about strategies and actions in their organizations or communities to end health

disparities and achieve health equity (see Figure 6). They have also increased in the extent to which they *agree* communication among RHEC members is clear and effective.

Figure 6: RHEC Member Perceptions of Communication and Information Sharing



Source: 2013, 2014, and 2015 RHEC Member Surveys
Notes: 1-Strongly disagree, 2-Disagree, 3-Neither disagree nor agree, 4-Agree, and 5-Strongly agree

As the RHECs have solidified themselves as functioning regional collaboratives they have extended their collaboration across regions in areas of mutual priority and interest. Cross-RHEC groups have evolved over the last two years in response to cross-cutting health disparities and health equity issues that span not just a single RHEC but various regions and organizations. The American Indian and Alaska Native Caucus was created to plan and implement cross-RHEC activities and work on American Indian and Alaskan Native concerns. The cross-RHEC Oral Health Equity Workgroup formed to address oral health disparities issues across regions. The cross-RHEC Community Health Workers Workgroup serves to provide a forum for activities related to community health workers (CHWs).

Translating Coalition Building and Strengthening into Action to Address Health Disparities and Promote Health Equity

As the RHECs and FIHET have developed their capacity to function effectively as health equity coalitions, they have undertaken collaborative projects designed to address health disparities at the federal, state, and community levels. These activities fall under the overarching umbrella of the NPA's 5 goals and 21 strategies outlined in the NSS. This section describes major actions and accomplishments of NPA stakeholders with a focus on the most recent full year of activity, 2015.

Hosting webinars and events. NPA partners and stakeholder groups developed several informational and educational webinars as a means to increase awareness and knowledge of key issues, strategies for promoting health equity in programs and policies, and trends related to health equity and health disparities. During 2015, the RHECs, FIHET, and OMH hosted 14 webinars that reached a total of 1,886 attendees. On average, 92% of respondents to webinar assessment questions reported that they were satisfied with the webinars and 88 percent reported they had

improved knowledge or understanding in key topic areas covered by the webinar as a result of attending the event. Webinar participants reported that they intended to apply and share the information provided during the webinars to enhance their work to reduce health disparities or address the social determinants of health, including advocacy, direct services, policy development, collaboration, research, education, and training.

Creating publications on health disparities and health equity. NPA stakeholders have prioritized raising awareness and education through publications related to health disparities and health equity topics. During 2015, RHECs developed 12 publications as part of their NPA activities, an increase from six publications in 2014. RHECs' publications included six factsheets on topics related to health disparities, three reports that summarized health disparity trends in the regions, two proclamations for Minority Health Month, and an infographic describing the connection between education and health.

Providing Affordable Care Act outreach and education to underserved populations. The NPA has prioritized the education of uninsured and underinsured consumers about the benefits of the health insurance provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA). During 2015, RHECs worked directly with eight organizations to host 184 outreach and education events that were attended by 13,498 people. RHECs IV, V, VI, VII, VIII, and IX worked with eight organizations to implement 97 events focused on educating participants about how to enroll in health coverage that were attended by 6,487 people. RHECs IV, V, VII, and VIII worked with six organizations to implement 87 events focused on educating participants about how to use their health coverage that were attended by 6,651 people.

Engaging youth and emerging professionals. One of NPA's five goals is strengthening and broadening leadership for addressing health, and it identifies youth as a target audience for awareness building and leadership development. NPA stakeholders have worked to prepare young people to become future leaders and practitioners by educating them about health disparities and the social determinants of health, and engaging youth in health equity work. RHEC I conducted workshops during summer 2015 and established partnerships to educate youth about the significance of health disparities and health equity. RHECs II and VIII began building infrastructure to increase youth and emerging professional participation in planning and supporting RHEC activities. RHEC III hosted a conference targeting representatives from Historically Black Colleges and Universities to develop their capacity to develop minority health professionals. RHECs I, III, IV, VI, VII, VIII, and IX provided placements for 14 emerging professionals who participated in the Youth National Partnership for Action (yNPA) Summer Health Equity Fellowship.

Supporting or developing community health workers. The expanded use and support of CHWs can enhance disease prevention and health promotion, and better meet the needs of underserved communities. RHECs I, V, and IX engaged in projects to support or develop CHWs. RHECs I, V, and IX initiated projects to help support the CHW workforce by identifying funding or other resources, promoting the use of CHWs, and building partnerships with organizations within their regions.

Promoting cultural and linguistic competence. The NPA supports the implementation of the National CLAS Standards through strategies on workforce diversity, cultural competency training, and development of the field of practice. RHECs III, IV, VII, and X completed or initiated activities to promote cultural and linguistic competence. RHEC III worked to compile training resources and identify stakeholders within the region. RHEC IV worked to develop resources to

define cultural competence and identify how states in the region are addressing it. RHEC VII also researched cultural competence definitions and identified training resources. RHEC X worked to develop a guide to best practices and strategies to assist people with limited English proficiency.

Improving data infrastructure and coordination of research and data collection. The FIHET's Data, Research, and Evaluation Workgroup created a Compendium of Publicly Available Datasets as a resource of publicly available data pertinent to research and programs aiming to end health disparities (Federal Interagency Health Equity Team, 2016). RHEC II engaged in the development of a progress report on the collection of health status data in the U.S. Virgin Islands and worked to identify opportunities for improvement. RHEC VII reviewed the health disparities data currently being collected in Iowa, Kansas, Missouri, and Nebraska to identify leading causes of death within the region and convened a meeting of the region's state epidemiologists to discuss how to uniformly collect and report health disparities data across the region. The RHEC also began developing a supplement to the environmental scan focused on heart disease.

Developing Strategic National Partnerships

At its core, the NPA strategy focuses on partnership development and the leveraging of resources to call attention and trigger action to end health disparities. National partners collaborated with OMH to increase the reach and influence of the NPA as well as work to take advantage of emerging opportunities to address health disparities and promote health equity.

Assessing the health equity landscape in state health department chronic disease programs. The National Association of Chronic Disease Directors (NACDD) collaborated with the NPA to identify ways the state health department chronic disease programs can better address health disparities and promote health equity through existing programs. NACDD staff developed and administered a health equity assessment to NACDD members in June 2015. The assessment was designed to assess current funding for and work in health equity, current data collection and analysis, and interest in new data topics, current training, and additional health equity training needs. Sixty-nine respondents from 37 states and territories responded to the assessment; the full results of the assessment are published in this supplement (Pertillar et al., 2016).

Providing technical support for state health departments to help them integrate health equity into their work. Leveraging funding from OMH, the NPA collaborated with the Association of State and Territorial Health Officials (ASTHO) since 2011 to support integration of health equity in programs and policies in state, tribal, and territorial public health departments. Activities under the partnership include but are not limited to: facilitating strategic planning with states, territorial, and tribal health offices; developing, publishing, disseminating, and educating stakeholder groups regarding health equity; and supporting peer-to-peer collaboration and learning across state, territorial, and tribal health agencies. In 2015, ASTHO worked with the Office of Health Equity within the Connecticut Department of Public Health to develop a health equity strategic plan for the entire department under the NPA partnership (Connecticut Department of Public Health 2015).

Addressing health disparities experienced by the American Indian community. OMH also funded collaboration between the NPA and the National Indian Health Board (NIHB) in 2015. This agreement will support specific activities coordinated by the NIHB to educate tribal public health departments on public health accreditation, increase capacity for using the Social Determinants of Health and health equity frameworks in programming within tribal public health departments and in community health needs assessments and planning related to public health accreditation. NIHB and ASTHO have conducted webinars on public health accreditation and

other topics as a means to provide information on topics critical to the terms of the partnership. Key outcomes from this partnership are highlighted in an editorial in this supplement (Ishcomer, 2017).

Educating state legislators and legislative staff about health equity and policy that promote equitable outcomes. Since 2013, the National Conference of State Legislatures (NCSL) as an NPA partner increased the awareness of state legislators and legislative staff about issues critical to improving the health of minority populations using webinars featuring subject matter experts and technical briefs disseminated through their network. Topics addressed under the partnership include changes in the Medicaid, ACA, and other laws and programs and their implications for minority communities, the value of a culturally competent health care workforce, and strategies to improve workforce diversity and promote a culturally competent health care system. Examples of key actions and accomplishments of their work include the development and maintenance of an online, user-friendly legislative tracking system for proposed and enacted bills that impact health disparities; increasing access to electronic resources on the topic of disparities in health for state legislators and legislative staff; and hosting webinars and drafting publications to educate and increase awareness of health disparities and health equity.

Integrating health equity and a health disparities focus into organizational practices. Since 2013, ASTHO focused some of its partnership activities on integrating health disparities and health equity into its organizational strategy, which includes its goals, policies, and practices. The actions and accomplishments of this work include: providing access to electronic resources on health equity, including past ASTHO publications and resources as well as publications and resources from other organizations; developing a health equity strategic map; hosting related webinars for its members and affiliates, and drafting publications to educate and increase awareness of health disparities and health equity; and leveraging their periodic surveys of state and territorial health officials to provide a more complete and accurate picture of the infrastructure within state health agencies to decrease health disparities (Mendoza-Walters et al., 2016).

Developing the next generation of health equity champions and leaders. In 2015, OMH entered into a partnership with Marshall University to offer training on the Social Determinants of Health and health equity to 19 students in its Upward Bound academic programs. OMH also partnered with the Morehouse School of Medicine to offer training to seven students in undergraduate and master's level programs.

Fostering Actions to Address Health Disparities through the Five NPA goals and 20 Strategies

Through diffusion and dissemination of research, information, and strategies, the NPA seeks to mobilize a community-driven approach to combating health disparities. During 2014 and 2015, The evaluation team identified state and local organizations that have used the goals and strategies of the NSS, along with other NPA-related information and materials, as a framework for strategic plans to address health disparities and promote health equity within their states and localities. Organizations we identified include the Arizona Health Disparities Center, Louisiana Department of Health and Hospitals' Bureau of Minority Health Access, Michigan Department of Community Health's Disparities Reduction and Minority Health Section, the Office of Health Equity within the Kentucky Department for Public Health, and the Office of Health Disparities Reduction within the Utah Department of Health. In addition, representatives from the Dayton Council on Health Equity (Dayton and Montgomery County, Ohio) described using the NPA goals and strategies included in the NSS to draft an assessment tool, the NPA Checklist, to assess local organizations' efforts to address health disparities and promote equity.

DISCUSSION

Since its inception, the NPA has evolved from an idea to a strategy, and then on to an infrastructure that supports a growing and vibrant network of individuals who are collectively working to end racial and ethnic health disparities. The NPA's infrastructure now supports a health equity coalition at the federal level as well as health equity coalitions in each of the 10 regions throughout the country. This infrastructure has, in turn, led to a gradual increase in the level of action and activity to address health disparities and promote health equity that can be credited to the NPA. The NPA, however, continues to need maintenance and support for its sustainability over the coming years. As the NPA continues to evolve, stakeholders continue to need specialized technical assistance, especially the regional coalitions, around ongoing and emerging activities such as planning and the creation of partnerships with organizations not currently involved in the NPA. Some of the RHECs have started to develop strategic, cross-sector partnerships that are self-sustaining. For instance, in 2015 RHEC IV developed a relationship with a partner organization that structures food financing initiatives in food desert communities, in which RHEC members serve as a regional advisory body and a means to connect with local organizations in the region. Funds from the partner flow on an annual basis to help support RHEC members on activities related to the partnership. A year earlier, RHEC IV developed a fiscal sponsor partnership with another organization to enable them apply for and receive funding to implement their plan.

The NPA is premised on a model of partnership and collective action. For continuous growth, the NPA must expand its partnership base and invest in fostering collective action among its stakeholders and partners. Onboarding new partners will depend largely on whether potential partners can relate to the mission to achieve health equity. Growth in the partnership base will also be driven by action, progress, and clear benefits of being involved in and contributing to the NPA. It is therefore critical to disseminate the NPA's current strategy, goals, and accomplishments to potential organizations and stakeholders. It is also necessary to strategically identify and engage new sectors and key partners not currently at the NPA table. New partner engagement must be deliberate, and include the process of establishing alignment between partners' missions, programs, priorities and activities, and health equity attainment. In implementing the NPA, vigilance among partners and stakeholders is necessary to ensure that all efforts and activities are centered on equitable outcomes, and viewed through an SDoH lens. The focus on equitable outcomes and the emphasis on the SDoH lens give the NPA unique standing among public efforts aimed at ending health disparities, and should both be applied in partner recruitment, problem formulation, intervention design, and partner engagement for sustainable NPA growth.

CONCLUSION

OMH established the NPA to increase the effectiveness of efforts that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action. The NPA was envisioned as a strategy designed to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity. At its core, the NPA is an experiment in collaboration, which relies heavily on those at the front line who are actively engaged in minority health work at multiple levels, with the responsibility of identifying and helping to define core actions, new approaches,

and new partnerships that will ultimately help to close the health gap in the United States. For the NPA to achieve its objectives, public agencies and private organizations across sectors and levels must change the way they work together in order to focus and align their resources, knowledge, relationships, strategies, and actions to address the social determinants of health. Also, given that the root causes of health disparities are multifaceted, incremental and multisector strategies are required to eventually eliminate disparities and achieve health equity.

The basis for the NPA's strategy is research that focuses on the importance of infrastructure and resources, capacity building, leadership commitment, public awareness, collaboration, and partnerships to efficiently and effectively address complex social problems (Butterfoss, 2007; Butterfoss & Kegler, 2002; Center for Prevention Research and Development, 2006; Minkler, 2005; Wolff, 2001; Zakocs & Guckenburg, 2007). The literature asserts that multi- and cross-sector collaboration will lead to improved capacities and strategies that address the social determinants of health which, in turn, will contribute to a significant reduction in health disparities and the achievement of health equity. Significant reductions in health and healthcare disparities may not be immediately apparent, given the time required to effect such change. It is therefore expected that changes in policies, procedures, and practices as well as social, environmental, and economic conditions that support the elimination of health disparities are more likely to occur first. Thus, as the NPA continues to evolve, it is critical that stakeholders examine how the NPA as a strategy contributes to impacts on specific social determinants that affect health disparities and health equity.

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DISCLAIMER

At the time this work was executed, Onyemaechi Nweke was a staff detail to the Office of Minority Health at the US Department of Health and Human Services. The views expressed are those of the authors and do not reflect the views of the US Environmental Protection Agency.

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