Epilogue

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In 1985, the Report of the Secretary's Task Force on Black and Minority Health was published (*1*) after the federal government convened the first group of health experts to analyze racial/ethnic health disparities among minorities. This analysis, also known as the Heckler report, revealed higher illness and death rates among minorities. The year 2015 marks the 30th anniversary of the Heckler Report and presents an opportunity to evaluate and continue to improve minority health at the national, state, tribal, territorial, and local levels.

Since 1985, the United States has made considerable progress in understanding the effects of health disparities across diverse populations. Populations affected by health disparities experience systematic social or economic discrimination and exclusion that affect health adversely (*2*). Health disparities have been associated with race/ethnicity, socioeconomic status, sex, age, sexual orientation, and geographic location (*3*). CDC has documented evidence of these disparities in several publications. The CDC health disparities and inequalities reports, published in 2011 (*4*) and 2013 (*5*), included such topics as social determinants of health, environmental hazards, health care access, mortality and morbidity, behavioral risk factors, and preventive health services.

To complement the health disparities reports, in April 2014, CDC published an initial report on related strategies to reduce these disparities, which included interventions for childhood vaccinations, motor vehicle crashes, HIV, and tobacco use (*6*). This supplement provides information on additional selected interventions that are increasing colorectal cancer screening; improving health-related quality of life for persons with disabilities; and reducing youth violence, hepatitis A, risk for HIV infection, and asthma attacks. The supplement also describes community-driven, participatory approaches to increase access to healthy foods (*7*). The purpose of these periodic reports is to evaluate and report on interventions and strategies that reduce health disparities while continuing to document them (*5*), highlight effective and promising strategies to eliminate health disparities (*6*), and document new models and expanded collaborative efforts to achieve health equity.

More work remains to be done. Data can be disaggregated by population subgroups, as demonstrated by the Hispanic health Vital Signs report released by CDC in May 2015 (*8*). In addition, evidence should continue to be gathered regarding what works to improve minority health, reduce health disparities, and move the nation toward health equity. For example, the national health profile for lesbian, gay, bisexual, and transgender (LGBT) persons, or sexual minority populations, is largely undocumented and therefore not well understood. The 2011 Institute of Medicine report (IOM) on the health of LGBT persons is one of the first national assessments of health disparities in this population (*9*). This IOM report documented that LGB youths are at increased risk for suicidal ideation, suicide attempts, and depression and noted that small studies suggest the same might be true for transgender youths. In addition, the IOM report indicates that rates of smoking, alcohol consumption, and substance abuse might be higher among sexual minority populations. Expanding the collection of sexual orientation and gender identity data in large national data sets and conducting studies to determine the efficacy of targeted interventions to address health disparities can increase awareness among public health practitioners and health care providers of the magnitude of health disparities experienced by these populations, as well as the potential for remedying them.

This 2016 supplement on strategies for reducing health disparities describes focused public health actions that range from individual counseling to engaging community health workers to developing clinical, community, and environmental health connections (*7*). These actions address numerous health concerns disproportionately affecting particular populations, such as hepatitis A disease (*10*), HIV infection (*11*,*12*), colorectal cancer screening (*13*), youth violence (*14*), and pediatric asthma (*15*). This supplement also includes reports related to health self-management among persons with disabilities (*16*) and American Indian/Alaska Native communities rebuilding the traditional food system using traditional ecological knowledge about health (*17*).

Programs described in these reports raise questions and describe interventions that can help strengthen the evidence base for reducing health disparities. For example, two articles describe interventions that depend on community health workers (CHWs) and lay health advisors (LHAs) (*12*,*15*).

Since the 1960s, CHWs and LHAs have been recognized as an effective strategy to address disparities among minority populations (*18*). CHWs and LHAs are effective, in part, because they share the same cultural background and speak the same language as the population they serve, they are aware of indigenous health beliefs that influence healthy or unhealthy behaviors, and they understand barriers to health care experienced by their community. They can act as intermediaries between community members and health care providers, which increases use of health care and preventive health care screenings, increases adoption of recommended behavior changes, and reduces health care costs (*19*).

In a 2015 article on health equity, the authors argue for a health care system that promotes health equity (*20*). Health services that focus on health equity would identify specific communities at risk, collect meaningful data to understand local needs and priorities, make progress, and conduct ongoing assessments of health outcomes. Programs designed to build health equity are likely a smart investment as more payment systems adapt to reward better patient outcomes. Meaningful involvement of CHWs and LHAs is an example of the type of intervention that this report asserts is necessary for achieving health equity. Questions raised by two of the CHW and LHA programs described in this supplement include the following: What additional intervention research is needed to ensure the sustainability of CHW and LHA approaches? Which efforts are necessary to identify and provide requisite training and professional development? How can CHWs and LHAs be meaningfully involved in the design and implementation of culturally appropriate interventions, including culturally appropriate evaluation strategies (*12*,*15*)? Overall, how can CHWs and LHAs contribute to programs that advance health equity?

The published evidence on implementation science, program and policy evaluation, and performance management in public health practice is substantial and growing. Public health professionals can bolster the impact of strategies for reducing health disparities, disseminate and tailor these strategies to reach more communities, and determine how to expand these strategies for even greater impact by rigorously applying lessons learned from these efforts (*21*). Collaborating with affected communities, policymakers, and the health care system, health disparities can be reduced. Working together with multiple sectors that influence health outcomes, public health professionals can pursue health equity.

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ISSN: 2380-8950 (Print)