



Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk

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A Position Paper of the
American College of Physicians

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Abstract

Racial and ethnic minority populations in the U.S. experience disparities in their health and health care that arise from a combination of interacting factors, including racism and discrimination, social drivers of health, health care access and quality, individual behavior, and biology. To ameliorate these disparities, the American College of Physicians (ACP) proposes a comprehensive policy framework that recognizes and confronts the many elements of U.S. society, some of which are intertwined and compounding, that contribute to poorer health outcomes. Identifying and reflecting on the unique challenges and conditions faced by marginalized populations in public policy efforts is essential as part of any comprehensive approach to reducing and eliminating disparities. This ACP position paper provides recommendations to address disparities in coverage, access, and quality of care through expanding Medicaid and insurance marketplace subsidies; funding language assistance and patient navigator services; and supporting physician workforce programs in underserved communities. Specific recommendations are also offered to address issues disproportionately impacting racial and ethnic minority populations, including disparities in maternal mortality rates, Indigenous health, and coronavirus disease 2019 (COVID-19). ACP also calls for policymakers to address disparities in social drivers of health that are associated with disparities in health and health care.

Introduction

In this position paper, the American College of Physicians (ACP) proposes recommendations for addressing specific disparities and issues affecting health and health care that place various racial and ethnic minority populations at disproportionately high risk. These recommendations are made as part of ACP's comprehensive, interconnected, and evidence-based policy framework to address racial and ethnic health disparities. This framework, which is outlined in an accompanying proposal (1), includes 17 recommendations, 10 of which are expanded upon and discussed in more detail in this paper. The companion papers address disparities and discrimination on the basis of race, ethnicity, religion, and cultural characteristics and identities in the context of education and the workforce (2), as well as discrimination and disparities in criminal justice and law enforcement and their impact on health (3). Together, these four papers provide a comprehensive and interconnected policy approach to addressing important issues cutting across clinics, hospitals, schools, universities, prisons, and various other elements of society to achieve ACP's holistic vision to eliminating health disparities.

Racial and ethnic minorities in the U.S. report high rates of discrimination throughout various aspects of society, including employment, housing, education, and health care (4). Experiences of racism and discrimination have been associated with poorer mental, physical, and general health (5). Further, racial and ethnic minorities experience disparities in morbidity, mortality, coverage, and access to and quality of care, which are often exacerbated as a result of disparities in many underlying and reinforcing social drivers of health. Between 2011 and 2014, 21.9% of Hispanic children and adolescents had obesity, the highest prevalence of obesity in the U.S (6). African American men are twice as likely as white men to die prematurely from stroke (7), and African American and Native American/Alaska Native women have higher rates of stroke-related death than Hispanic or non-Hispanic white women (8). Black women are much more likely than White women to die of breast cancer, and the mortality gap is widening as the incidence rate in Black women has caught up to that in White women (9). Racial or ethnic minority children are more likely to develop type 2 than type 1 diabetes and are more likely to develop complications of diabetes and lower limb amputations, which can contribute to disability (10). As recent as 2018, 21.8% of American Indian and Alaska Native

individuals, 19% of Hispanic individuals, 11.5% of Black individuals, and 9.3% of Native Hawaiian and other Pacific Islander individuals were uninsured—the highest rates of all racial and ethnic groups (11). In light of this, ACP strongly believes that recommendations that speak directly to the challenges and realities faced by marginalized populations are necessary as part of a comprehensive and interconnected approach to eliminating disparities in health and health care based on race, ethnicity, religion, and cultural identity and characteristics.

Methods

This position paper was drafted by ACP's Health and Public Policy Committee, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The authors reviewed available studies, reports, and surveys related to health, education, and criminal justice disparities from PubMed and Google Scholar between 1990 and 2020 and relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from ACP's Board of Regents; Diversity, Equity, and Inclusion Committee (DEI); Education Committee (EC); Ethics, Professionalism and Human Rights Committee (EPHRC); and other external experts. The position paper and related recommendations were reviewed and approved by the ACP Board of Regents on 7 November 2020. Financial support for the development of this position paper came exclusively from the ACP operating budget.

Recommendations

- 1. ACP recommends that policymakers consider discrimination and hate against any person on the basis of personal characteristics as a public health crisis.**
- 2. ACP recommends that policymakers address the effect of social drivers of health, like poverty, on the health and health care of those affected, while addressing disparities associated with personal characteristics independent of, or in addition to, socioeconomic status.**
- 3. ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics.**
 - a. Universal health coverage, either through single-payer or public choice model as recommended in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" (12) is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes.**
 - b. Medicaid eligibility should be expanded and Children's Health Insurance Program and Medicaid coverage should be unified in all states so that families are covered under a single program.**
 - c. Insurance marketplace subsidies should be expanded to provide assistance to those in nonexpansion states with incomes too high to qualify for Medicaid and too low to qualify for marketplace premium subsidies.**
 - d. Approaches should be explored to offer coverage for unauthorized immigrants, including allowing them to obtain coverage in the insurance exchange.**
 - e. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for racial and ethnic communities historically underserved and disenfranchised.**

- 4. ACP believes that public policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, and other injustices experienced by Indigenous persons and commit to focused and culturally appropriate policies to address their present reality of injustice, disparities, and inequities.**
 - a. The Indian Health Services (IHS) should become a program with mandatory funding and be equipped with the resources necessary to provide equitable and adequate services to the populations they serve. Funding levels for programs providing health care to Indigenous communities should be at least at parity to other health programs.**
 - b. The definition of "Indian" in the Affordable Care Act should be revised to match the more expansive definitions used by the IHS and Centers for Medicare and Medicaid Services (CMS) to provide benefit and protection to Indigenous people who are not enrolled in a federally recognized tribe.**
 - c. Health and wellness promotion, chronic disease prevention, and other public health interventions addressing morbidities with high incidence in Indigenous communities should be evidence-based, culturally appropriate, community accepted, and respectful of traditional practices and customs.**
 - d. A multidisciplinary approach is necessary to implement culturally appropriate interventions to address the underlying social drivers of health that exacerbate physical, mental, and behavioral health issues and contribute to catastrophic rates of suicide in Indigenous communities. Additional research is needed into the resilience strategies that have bolstered Indigenous communities living in harsh and difficult conditions.**
 - e. Models that provide comprehensive, integrated, culturally appropriate, affordable, and accessible care operated by tribes and native organizations with federal financial support should be encouraged, supported, and expanded as appropriate, and the practices adopted by them should inform policymaking to better serve the health needs of Indigenous persons.**
- 5. ACP believes that physicians and other clinicians must make it a priority to meet the cultural, informational, and linguistic needs of their patients, with support from policymakers and payers.**
 - a. Health literacy among those facing disparities on the basis of personal characteristics must be strengthened in a culturally and linguistically sensitive manner. Funding and support should be made available for clinicians to implement and expand health literacy interventions and adapt their practice to accommodate the cultural, informational, and linguistic needs of their patients.**
 - b. Health care communications must be made in a language the patient understands. Clinicians should be reimbursed by public and private payers for translation services needed in providing care for those with limited English proficiency (LEP) or who are deaf.**
 - c. Patient navigators should be funded and provided to assist patients in navigating the entire spectrum of the health system and to better understand and communicate one's health needs.**
- 6. ACP believes that public policies should reflect the unique effects that country of origin, language, immigration status, workplace, and culture have on health disparities among various distinct communities associated with their personal identities.**
- 7. ACP believes that health care delivery and payment systems should support physician-led, team-based, and patient- and family-centered care that is easily accessible to those affected by discrimination and social drivers of health.**

- 8. ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks, poor environmental health, and climate change, disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.**
 - a. Racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic should be collected and released in a uniform and timely manner at a local and national level. Data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care.**
 - b. Testing, treatments, vaccines, and other resources should be equitably distributed in a transparent manner based on need, especially in historically underserved racial and ethnic minority neighborhoods. These services and supplies should be affordable and accessible regardless of socioeconomic status.**
 - c. The U.S. Department of Labor’s (DOL) Occupational Safety and Health Administration (OSHA) should issue appropriate workplace protections to protect the health and well-being of essential workers during a pandemic.**
 - d. Universal access to family and medical leave that provides a minimum period of 6 weeks of paid leave should be mandated and funded, with flexibility that allows for the caring of family members, as recommended in “Women’s Health Policy in the United States” (13). Legislative or regulatory action at the federal, state, or local level are needed to advance this goal.**
 - e. Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the impact on health of large-scale infectious disease outbreaks and climate change, must be addressed as recommended in “Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health” (14), “Addressing Social Determinants to Improve Patient Care and Promote Health Equity” (15), and “Climate Change and Health” (16).**
- 9. ACP believes that policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk.**
 - a. Ensure access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman’s lifespan, including high-quality and patient-centered preconception, antenatal, delivery, postpartum, and other care and appropriate specialists and subspecialists.**
 - b. Establish maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related or pregnancy-associated death and improving maternal outcomes. MMRCs should have access to necessary data across jurisdictions and implement best practice standards for data collection including consistency and comparability of data.**
 - c. Incentivize health care institutions to undertake safety and quality improvement activities that are shown to be effective in improving maternal and other health.**

d. Cover resources like doulas and patient navigators by public and private payers. ACP supports ongoing research and evaluation of such services in order to demonstrate which models are most effective.

10. ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.

Conclusion

The historically intertwined nature of race, discrimination, and socioeconomic status has translated to numerous disparities in health and health care. Populations facing disparities on the basis of race, ethnicity, religion, and cultural characteristics and identities face their own unique needs and challenges that require tailored, culturally appropriate, community-supported, and evidence-based interventions. Specific issues, like maternal mortality and infectious disease outbreaks, disproportionately impact racial and ethnic minority populations and require intentional policy consideration. While there is no clear panacea to eliminating disparities in health and health care, action must be taken to begin addressing some of the underlying factors we know to be contributing to these disparities. The College contends that implementing targeted recommendations addressing disparities in morbidity, mortality, health literacy, social determinants of health, coverage, and access to and quality of care as part of a comprehensive and interconnected approach is essential to eliminating disparities and discrimination in health and health care.

Background and Rationale

1. ACP recommends that policymakers consider discrimination and hate against any person on the basis of personal characteristics as a public health crisis.

Marginalized minority groups have long faced discrimination, inequality, and inequity in the U.S. A survey of Americans found widespread experiences of discrimination, particularly against those who are Muslim, Black, Hispanic, LGBTQIA, and Jewish (17). Racism affects all aspects of life, including housing, access to proper nutrition, education, employment, and both mental and physical health. In a review of the literature, Williams et al identified numerous pathways racism and discrimination impacts health, including “reduced access to employment, housing and education and/or increased exposure to risk factors... adverse cognitive/emotional processes and associated psychopathology; allostatic load and concomitant patho-physiological processes; diminished participation in healthy behaviors...and/or increased engagement in unhealthy behaviors...and physical injury as a result of racially-motivated violence” (18). Racism has been significantly related to poor overall health; the relationship between racism and poor mental health was twice as large as the correlation between poor physical health and racism (5). Repeated exposure to overt and covert discrimination has negative impacts on health due to increased stress response. This overacting physiological and psychological stress response can lead to mental and physical illnesses, such as depression, psychological distress, and high blood pressure. Additionally, this constant stress increases risks for engaging in risky coping mechanisms such as substance abuse (19).

Bias and violence targeted toward religious and cultural minorities, such as Jewish and Muslim communities, have been on the rise in recent years. A 2020 survey of Jewish Americans found 54% have experienced or witnessed an act

of anti-Semitism in the past 5 years, 63% felt less safe than they did a decade ago, nearly half have heard and witnessed verbal and physical harassment in public for public displays of Judaism, and 22% have had their place of worship vandalized, damaged, or defaced (20). Recent acts of anti-Semitism have included unprovoked attacks against Orthodox Jews on the streets of New York; the 2017 "Unite the Right" Neo-Nazi rally in Charlottesville, Virginia; the 2018 attack on the Pittsburgh Tree of Life synagogue; and the 2019 attack on the Chabad of Poway synagogue in Poway, California (21,22,23). Another survey noted Americans had more negative opinions toward Islam than any other religion and 69% believed Muslims in the U.S. face discrimination (24). While Islamophobia existed before the terrorist attacks of 11 September 2001, anti-Muslim beliefs, policies, and attacks increased in frequency and intensity since then (25). In April 2020, the beginning of the holy month of Ramadan, a Missouri mosque was set on fire, which caused over \$1 million worth of damage and displaced several families living in the building, only one of the many reports of attacks targeted toward Muslim places of worship in recent years (26). Trends of Islamophobia have also impacted non-Muslims, like Hindus and Sikhs, who may be perceived to be Muslim because of race, facial hair, or other religious dress (27,28).

The Department of Health and Human Services' (HHS) Healthy People 2020 initiative identifies violence, discrimination, and racism as key environmental and community determinants that impact one's health (29), all of which racial and ethnic minority communities are disproportionately impacted by. Violence, high rates of injuries and deaths from firearms, and racism especially harm the health of Black, Indigenous, and Latinx persons. Racial and ethnic minorities are exposed to violence at a rate higher than White persons (30), are at greater risk for more physically harmful forms of violence, and hence are at greater risk of experiencing harm to health as a result (31). Violence induced stress at early ages has been shown to hinder brain development, impact learning, and result in deteriorated states of behavioral, mental, and physical health (32). Exposure to violence has also been associated with substance abuse, risky sexual behavior, and unsafe driving habits (33), as well as higher rates of self-reported coronary heart disease, fair or poor physical health, frequent mental distress, heavy drinking, and smoking (31). A meta-analysis of the literature on racism and health found that experiences of racism were associated with diminished mental health, including depression, anxiety, and stress, that particularly impacted Asian American persons and Latinx persons, as well as diminished general and physical health (5). Another review of the literature found associations between experiencing discrimination and unhealthy behaviors, declines in utilization of care, and nonadherence to medical regimens (34). Violence, discrimination, and racism contribute to disparities in injury, disease, and death (35) in racial and ethnic minority communities and must be recognized and addressed as social drivers of health.

ACP believes that action and policies should be directed and prioritized to address the unique circumstances of those at greatest risk, including Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race, ethnicity, or cultural identity and characteristics; Muslim, Jewish, Hindu, Sikh people, and other religious groups; lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA) people; immigrants regardless of status; individuals with a mental or physical disability; and other marginalized groups. In "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health" (14) and "Lesbian, Gay, Bisexual, and Transgender Health Disparities" (36), ACP strongly affirms that individuals must not be discriminated against on the basis of where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated;

and whether they have intellectual or physical disability. In the paper “Racism and Health in the United States” (37), ACP condemns the harm experienced by Black, Indigenous, Latinx, and other persons affected by discrimination because of their race or ethnicity as a result of racism and discrimination and opposes the racist actions and policies perpetuating inequities in medicine and throughout society. Additionally, the College commits to being an antiracist organization in order to address structural sources of injustice.

2. ACP recommends that policymakers address the effect of social drivers of health, like poverty, on the health and health care of those affected, while addressing disparities associated with personal characteristics independent of, or in addition to, socioeconomic status.

Poverty is strongly associated with poorer health in the U.S. for all races. Between 2001 and 2014, those in the top 5% of income earners saw their life expectancy increase by roughly 2.5 years, whereas those in the bottom 5% saw virtually no change (38). Those making less than 100% of the federal poverty line are 5 times as likely to report poor or fair health than those making more than 400% of the federal poverty line (39). Those who are in poverty have higher rates of heart disease, hypertension, and stroke (40). Poverty can impact health through increased barriers to coverage and accessing care, higher rates of behavioral risk factors, and other community factors including increased exposure to environmental pollutants, limited access to fresh foods, and inadequate places to exercise (41). While poverty and other socioeconomic factors have been shown to be a significant social driver of health for all populations, Black people and Indigenous people experience structural racism that contributes to poorer health that is independent of, and in addition to, the impact of poverty. Policies must expressly recognize that Black and Indigenous people living in poverty are disproportionately harmed by the combined impact of racism and poverty.

There is a growing recognition among health equity research of the role of intersectionality in amplifying disparities produced by social drivers of health experienced by those most marginalized in society (42,43). Intersectionality is “a theoretical framework that posits that multiple social categories (for example, race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)” (44). Within an intersectional framework, disparities in social drivers of health like poverty, housing, and educational attainment produce disparities in health and health care for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race, ethnicity, or cultural identity and characteristics and can have a compounding effect at the intersection of various characteristics of personal identity. For example, a gay non-White male is more likely to not have health insurance than a straight non-White male and a gay White male (45). Special consideration must be given to the intersection of these varying characteristics of personal identity in addressing disparities in health related to race, ethnicity, religion, and cultural characteristics and identities.

As called for in the ACP paper “Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health” (14), the College supports greater investment in research, public health infrastructure, and policy interventions to address social drivers of health. Additionally, ACP recommends, in its paper “Addressing Social Determinants to Improve Patient Care and Promote Health Equity” (15), that policymakers integrate a “health in all policies” approach in policymaking and community planning and allocate adequate funding for government agencies and social service providers to reduce health disparities and address social drivers of health.

- 3. The American College of Physicians believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate impact on those at greatest risk because of their personal characteristics.**
- a. Universal health coverage, either through single-payer or public choice model as recommended in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" (12) is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes.**
 - b. Medicaid eligibility should be expanded and Children's Health Insurance Program and Medicaid coverage should be unified in all states so that families are covered under a single program.**
 - c. Insurance marketplace subsidies should be expanded to provide assistance to those in nonexpansion states with incomes too high to qualify for Medicaid and too low to qualify for marketplace premium subsidies.**
 - d. Approaches should be explored to offer coverage for unauthorized immigrants, including allowing them to obtain coverage in the insurance exchange.**
 - e. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for racial and ethnic communities historically underserved and disenfranchised.**

Coverage

Having adequate health coverage is closely associated with one's access to care and well-being. Compared to those who are insured, uninsured individuals are three times less likely to visit a doctor or health professional regarding their health (46). Uninsured individuals are less likely to have a regular source of care; more likely to forgo care or prescription drug treatment due to cost; less likely to receive preventive services like cancer screenings, blood pressure and cholesterol checks, Pap smears, and blood sugar screenings; and more likely to forgo follow-up care for a chronic condition than those with public or private coverage (47,48). With lower rates of follow-up cancer screenings (49), uninsured patients are at higher risk for being diagnosed with disease or cancer at later stages and have higher mortality rates than those who are insured (50,51,52). When uninsured patients do seek hospital care, they receive fewer diagnostic and therapeutic services and experience higher rates of mortality compared to those who are insured (50,51,53,54). Hence, ensuring adequate coverage for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race, ethnicity, or cultural identity is one of many actions needed to reduce disparities in health outcomes.

While the Patient Protection and Affordable Care Act (ACA) greatly decreased the coverage gap, additional measures are needed to achieve universal coverage and eliminate persistent disparities in coverage. As the overall population has seen a decrease in the uninsured rate since the ACA was implemented, racial and ethnic minorities have experienced some of the largest gains but still have higher uninsured rates compared to White persons (11). In one analysis, American Indian and Alaska Native persons had the highest uninsured rates of all racial and ethnic groups. Between 2013 and 2018, the uninsured rate dropped from 30.4% to 21.8% for American Indian and Alaska Native persons, while it dropped from 18.1% to 9.3% for Native Hawaiian and Other Pacific Islander persons and from 12.3% to 6.8% for Asian American persons (11). Another analysis during this same time period found that the uninsured rate dropped from 24.4% to 14.4% for Black adults and from 40.2% to

24.9% for Hispanic adults (55). This has coincided with a reduction in the Black-White disparity gap (9.9 points in 2013 to 5.8 points in 2018) and the Hispanic-White disparity gap (25.7 points to 16.3 points). However, the coverage gains from the ACA have stalled and uninsured rates have even slightly increased since 2016 (56), suggesting that further action beyond those taken in the ACA is necessary to achieve full coverage and eliminate coverage disparities.

Similarly, coverage rates for children have generally increased since the implementation of the ACA but have stalled in recent years, with American Indian and Alaska Native (13.2%) and Hispanic (8.2%) children experiencing the highest rates of uninsurance (57). Nearly 68% of the children who remain uninsured are actually eligible for coverage under Medicaid or the Children's Health Insurance Program (CHIP); however, knowledge gaps and perceived difficulties with enrollment have created barriers in getting uninsured children enrolled in these public programs (58).

One mechanism to reducing the uninsured gap, particularly for those who are lower income, is through public programs like Medicaid and CHIP. Under the ACA, states are provided the opportunity to expand Medicaid eligibility to those making under 138% of the federal poverty level (FPL) and receive additional federal funding to offset most of the costs. This was done to bridge the gap for those who traditionally made too much to qualify for Medicaid but not enough to afford other coverage. As of 2020, 38 states and the District of Columbia have expanded Medicaid eligibility under the ACA, and these states have had greater success in reducing racial and ethnic disparities in coverage and Black persons in expansion states are more likely to be insured than White persons in nonexpansion states (56,59). Between 2013 and 2018, the Black-White coverage gap decreased from 8.4 points to 3.7 points, while the Hispanic-White coverage gap decreased from 23.2 points to 12.7 points in expansion states. Currently, the median income limit to qualify for nonexpansion states is 40% of FPL and nearly all prohibit childless adults from qualifying (60). As 46% of all Black persons and 36% of all Hispanic persons in the U.S. live in nonexpansion states, expanding Medicaid eligibility in the remaining holdout states could have a meaningful impact on coverage for racial and ethnic minorities (56).

Premium subsidies made available under the ACA for marketplace exchange plans provide another avenue for decreasing coverage disparities. Under the ACA, premium subsidies in the form of tax credits are provided to those who obtain insurance on an ACA marketplace exchange and make between 100% and 400% of FPL. Of the 28 million nonelderly adults who remain uninsured, 33% are eligible for financial assistance through the marketplace (61). However, compared to White persons, uninsured Black persons are more likely to fall in the coverage gap in nonexpansion states—where they do not qualify for Medicaid but do not make enough to qualify for the marketplace subsidies (11).

Unauthorized immigrants, a population that is primarily made up of racial and ethnic minorities, have been consistently left out of legislative efforts to expand coverage. Nearly a quarter of those uninsured in the U.S. are noncitizens (62) and Hispanic persons and Asian American persons are less likely than White persons to be eligible for coverage as they comprise a larger share of those who are noncitizens (11). Migrant workers, many of whom may be unauthorized immigrants, tend to work more dangerous jobs with fewer workplace protections, placing them at particular health risk (63). While authorized noncitizen residents are eligible for marketplace subsidies and can qualify for Medicaid after a 5-year waiting period, unauthorized immigrants are ineligible to receive federally funded health care or purchase insurance through the ACA exchange. As a result, nearly 45% of unauthorized immigrants and 23% of authorized immigrants are uninsured (64). Those with Deferred Action for Childhood Arrivals (DACA) status, who were brought to the U.S. as children, are ineligible for federal health programs but are able to access employer-sponsored insurance or some state programs (65). Further, research has found that fears around immigration enforcement has resulted in a reduction in the utilization of health and nutrition programs and services for qualified

US-born children who are citizens (66,67). Expansion of public charge rules, which considers use of public non-cash benefits programs as a negative factor in permanent residency or temporary visa applications, resulted in 14% of immigrants not utilizing public programs, including 42% that reported avoiding participating in Medicaid/CHIP (68). A lack of policy to provide coverage to unauthorized immigrants remains one of the biggest obstacles in achieving the goal of universal coverage.

ACP has long supported the goal of providing access to high-quality care through achieving universal coverage. In the ACP paper "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" (12), the College recommends a transition to a new single-payer or public choice system that covers essential benefits; ensures sufficient access to care; and is not dependent on one's place of residence, employment, health status, or income.

Quality

Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race, ethnicity, or cultural identities have also reported lower quality of care received. Both Black persons (68.7%) and Asian American/Pacific Islanders (64.5%) are less likely than White persons (72.8%) to rate their care as high-quality, with experiences of discrimination being negatively associated with quality (69). Black patients with breast cancer have lower 5-year survival rates, are less likely to receive treatment, and had longer time from diagnoses to treatment compared to White patients (70). Additionally, Black women receive lower rates of locoregional therapy, hormonal therapy, and chemotherapy while Hispanic women receive lower rates of hormonal therapy, even after adjusting for insurance and socioeconomic status (71). Findings from the 2018 National Healthcare Quality and Disparities report issued by the Agency for Healthcare Research and Quality (AHRQ) show that while quality of care disparities have improved overall since 2000 for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race, ethnicity, or cultural identity, many disparities persist, particularly for uninsured and low-income minorities. Black persons, American Indian and Alaska Native persons, and Native Hawaiian and Pacific Islander individuals received poorer care for 40% of quality measures compared to White persons, while Hispanic persons performed worse on 35% and Asian American persons on 27% of measures. Between 2000 and 2017, disparities improved for only 5 measures for Hispanic persons, 4 measures for Black persons, 2 measures for American Indian and Alaska Native persons and Asian American persons, and 1 measure for Native Hawaiian and Pacific Islander persons (72).

Access

As a result of discriminatory housing policies and residential segregation, racial and ethnic minorities often live in communities that are lacking access to hospitals and other health care resources and professionals (73). One analysis of the geographical distribution of primary care physicians found that ZIP codes with a majority of African American persons were 67% more likely to be a primary care physician shortage area compared to ZIP codes with a majority of White persons. The more segregated an African American neighborhood was, the more likely it was a shortage area (74). In California, the supply of physicians was found to be inversely related to the proportion of Black and Hispanic residents in an area (75).

As affirmed in ACP's paper "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health" (14), the College strongly believes that all Americans must have access to high-quality health care regardless of their race or ethnicity or where they live and that actions should be taken to ensure an adequate supply and distribution of physicians and other health professionals to meet the needs of underserved

rural and urban populations. ACP also believes that physicians have an ethical obligation to “work toward ensuring access to health care for all persons; act to eliminate discrimination in health care; and help correct deficiencies in the availability, accessibility, and quality of health services,” and to address disparities in care as a result of personal characteristics (76).

4. ACP believes that public policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, and other injustices experienced by Indigenous persons and commit to focused and culturally appropriate policies to address their present reality of injustice, disparities, and inequities.

- a. The Indian Health Services (IHS) should become a program with mandatory funding and be equipped with the resources necessary to provide equitable and adequate services to the populations they serve. Funding levels for programs providing health care to Indigenous communities should be at least at parity to other health programs.**
- b. The definition of “Indian” in the Affordable Care Act should be revised to match the more expansive definitions used by the IHS and Centers for Medicare and Medicaid Services (CMS) to provide benefit and protection to Indigenous people who are not enrolled in a federally recognized tribe.**
- c. Health and wellness promotion, chronic disease prevention, and other public health interventions addressing morbidities with high incidence in Indigenous communities should be evidence-based, culturally appropriate, community accepted, and respectful of traditional practices and customs.**
- d. A multi-disciplinary approach is necessary to implement culturally appropriate interventions to address the underlying social drivers of health that exacerbate physical, mental, and behavioral health issues and contribute to catastrophic rates of suicide in Indigenous communities. Additional research is needed into the resilience strategies that have bolstered Indigenous communities living in harsh and difficult conditions.**
- e. Models that provide comprehensive, integrated, culturally appropriate, affordable, and accessible care operated by tribes and native organizations with federal financial support should be encouraged, supported, and expanded as appropriate, and the practices adopted by them should inform policymaking to better serve the health needs of Indigenous persons.**

Those indigenous to the United States, including American Indians and Alaska Natives, make up as much as 1.7% of the population and are concentrated in the western United States. Roughly 78% of American Indian and Alaska Native people reside outside federally recognized tribal areas, whereas 60% live in metropolitan areas (77). American Indian and Alaska Native people have experienced historical structural inequalities, including land seizure, forced relocation, and other forms of discrimination, that have contributed to disparities in access to health care, poorer health outcomes, increased morbidities and mortality, and higher rates of poverty and incarceration compared to the rest of the country (78). Conversations around health care for American Indian and Alaska Native people must be respectful and responsive to the unique challenges, culture, traditions, and values of Indigenous people (79).

Indigenous communities have a life expectancy that is 5.5 years lower than the average American life expectancy and experience disparities in mortality and disease (80). Alcohol use, diabetes, cancer, chronic disease, accidents, and injury pose a particular health concern. One study found the unintentional injury death rate was 2.4 times higher for American Indian and Alaska Native people than White persons, ranging from 1.4 to 3 times higher for vehicle accidents,

poisoning, and falls (81). Rates for intentional injury, including homicide and suicide, were 2 times higher (82). American Indian and Alaska Native people are nearly three times more likely than White persons to be diagnosed with diabetes and 2.5 times more likely to die from diabetes (83). They also have the highest rates of cardiovascular disease of all groups and die from heart disease at a rate twice of that of the general population (82). Colon cancer and lung cancer, which may be associated with higher rates of tobacco use (84), are experienced at higher rates, and American Indian and Alaska Native individuals present with later stages of cancer, suggesting the need for targeted cancer screening interventions (85). Alcohol-related death rates are more than six times that of the general population (86) and hospitalization rates are 78% higher (82). Additionally, American Indian and Alaska Native people die at higher rates from HIV, kidney cancer, influenza, and pneumonia, and experience death rates larger than White persons for almost every cause of death (82,87). These disparities have been attributed to poor social determinants of health, social and economic inequities, and barriers to accessing care.

Health care services are delivered to American Indian and Alaska Native people through a patchwork of federal, state, local, tribal, and private programs. A majority of American Indian and Alaska Native people receive coverage and care through private payers or non-Indian Health Service (IHS) programs, like the Veterans Health Administration or Medicare. At the federal level, IHS, an agency of HHS, provides direct care to roughly 1 million members of American Indian and Alaska Native tribes (82). The IHS has 26 hospitals, 55 health centers, and 21 health stations throughout the country that receive over 5.2 million outpatient visits and 15,000 inpatient admissions and provide mostly primary and emergency care services and prescription drug coverage but also some ancillary and specialty services (80). It operates as an integrated health system at the federal level, sharing infrastructure like health information technology with 12 administrative regions. Tribes are also eligible to establish their own health systems and receive federal funding for them, which serve more than 1.1 million patients through more than 17 hospitals and 493 outpatient centers. Additionally, 41 nonprofit Urban Indian Health Programs receive federal funding to provide care to American Indian and Alaska Native people residing in urban areas (88).

The Alaska Tribal Health System is a tribal health system that serves the unique needs of Alaska Native people based on a model of self-determination (89). Throughout the state of Alaska, there are more than 200 federally recognized tribes that span across 586,412 square miles of land, much without road access, making remote villages difficult and expensive to reach and provide goods and services. As a result, tribal health organizations are often the only provider in an area and manage over 99% of health programs in the state. Under the Alaska Tribal Health Compact, tribal organizations are authorized to establish health programs and receive funding from the federal government. Tribes or consortiums of tribes that sign onto the compact are represented by the Alaska Native Health Board, which serves as an advocate for Alaska Native health issues (90). The Alaska Native Tribal Health Consortium (ANTHC) and the Southcentral Foundation (SCF) co-manage the Alaska Native Medical Center, a hospital serving Alaska Native people in Anchorage, while several hospitals outside of Anchorage are operated by other regional tribal organizations. Through the Community Health Aide Program (CHAP), over 550 community-based, trained aides serve more than 170 rural villages throughout the state and serve as the first point of contact in many villages, providing primary care, preventive, and screening services as well as making referrals to higher levels of care as needed (91). Given its success in expanding access to care in rural and underserved areas, IHS announced its intention to launch its own nationwide program modeled after the Alaska program (92).

The Southcentral Foundation (SCF) is another success story from the Alaska system that can serve as a model for Indigenous health care. Up until 1982, IHS-managed health care in southcentral Alaska was marked with long wait

times and impersonal, reactive, disjointed, and inconsistent care. SCF was established by the Cook Inlet Region Incorporated as a nonprofit organization to provide health services to Alaska Native people living in the southcentral Alaska region, including Anchorage (89). SCF utilized listening sessions, focus groups, and in-depth interviews to redesign the health care delivery system to center it around a mission and vision that aligned with the health needs of the Alaska Native community it served, including the incorporation of traditional healing services and the centering of self-determination. A patient-centered medical home model was utilized to promote continuity of care and the building of relationships with primary care physicians, with same-day access to appointments and integrated case managers, behavioral health, psychiatrists, midwives, and pharmacists (93).

Aside from programs directly serving the community, the passage of the ACA also provided the opportunity for increased coverage and access to care for American Indian and Alaska Native people. More than 9 in 10 American Indian and Alaska Native people had incomes that qualified them for coverage expansions (94). The ACA created exemptions for American Indian and Alaska Native persons from paying the annual penalty for being uninsured, paying most cost sharing for plans obtained through the marketplace exchange, and the ability to enroll in or change plans outside of the open enrollment period. However, the ACA uses a definition of American Indian and Alaska Native persons that is different from and narrower than the definition that is used in other federal programs like Medicaid, CHIP, and IHS (95). The ACA limits these benefits to American Indian and Alaska Native people who are enrolled members of a federally recognized tribe or shareholder in an Alaska Native regional or village corporation. By doing so, those who are considered nonenrolled American Indian and Alaska Native people and who have otherwise historically been able to utilize IHS services are prevented from utilizing the benefits granted under the law. A legislative fix is needed to streamline the definition of American Indian and Alaska Native people across federal programs in order to provide consistent access to health care programs.

While IHS is an important tool in addressing health disparities of American Indian and Alaska Native people, it is not without its shortcomings. Concerns have been raised about funding disparities between IHS and other federal health programs like VHA, Medicare, and Medicaid (96). In 2017, per capita spending for IHS was \$4,078, compared to \$8,109 for Medicaid, \$10,692 for VHA, and \$13,185 for Medicare. Unlike Medicare and Medicaid, IHS is a discretionary program, meaning the program faces spending caps, funds must be allocated during the annual appropriations process, and the funding level does not automatically adjust based on the number of people served. In addition to federal funding, IHS is also authorized to obtain revenue from external private and public payers for care provided within the system and collects about \$700 million a year from CMS (82).

IHS facilities primarily provide primary and emergency care services. For specialty care and other services not provided within the IHS system, care is contracted out to private providers and paid through the IHS Purchased/Referred Care (PRC) program. To be eligible for PRC, a patient must meet eligibility requirements like exhausting all other available health resources and living on a federally recognized reservation or designated PRC delivery area. IHS classifies PRC requests as one of five priority levels based on urgency and critical need, typically reserving funding for requests classified as the highest of priority levels (97). As a result of IHS' limited and fixed funding, not all PRC requests are approved. While federal appropriations for the PRC program increased from \$801 million in 2013 to \$929 million in 2017, the number of deferred or denied requests increased from 283,020 to 354,446 (96).

IHS also suffers from significant vacancy rates for positions, including physicians, nurses, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacists. The agency has a 25% vacancy rate throughout the system, ranging from 13% to

31% depending on the geographic area, and an estimated turnover rate of 46%, which negatively affects access and quality of care, ability to build trust with the community, and employee morale (80,98). A report by the Government Accountability Office found that retention challenges are a result of the rural location of many facilities and include insufficient housing and below-market salaries (80). Certain areas deemed isolated hardship posts face high rates of crime and violence; pollution; isolation; scarce goods and services; and a lack of schools, opportunities, and entertainment, which contribute to the vacancies and turnover. For facilities in tribal areas, housing is often difficult to find for those who are non-American Indian and Alaska Native or not married to someone who is.

Quality of care provided at IHS facilities is also a concern and may contribute to health disparities. One study found IHS ranks below the 25th percentile among Medicare and Medicaid plans nationally for mammography and retinopathy screening (99). In some facilities, inspectors from CMS found violations that were grounds for a loss of Medicare reimbursements, resulting in one hospital being kicked out of the program and assessed temporary suspensions. Numerous cases have been reported of inadequate and untimely care that have resulted in preventable death (84).

Despite the shortcomings of health programs targeted toward American Indian and Alaska Native people, some programs and initiatives have seen some success, including telehealth efforts. With much of the population located in rural and isolated areas, it is often time-consuming and cost-prohibitive for patients to travel to see specialists. Telehealth and broadband communications play an important role in filling those gaps and financial and technical assistance should be provided for deploying tribal broadband services. The Alaska Tribal Health System has utilized telehealth to service over 250 sites throughout the state, a majority of which are small villages with less than 300 residents. This program utilized a "store and forward" approach to expand telehealth to areas without broadband service. Following the implementation of telehealth for audiology and ear, nose, and throat services in Nome, the percentage of patients who had to wait more than 5 months for an appointment decreased from 47% to 3% (100). Within the federal IHS system, the Tele-Behavioral Health Center of Excellence provides behavioral health services through synchronous video communications. These are the only behavioral health services in some communities and the telehealth components make it easier to recruit qualified professionals (80). Patients utilizing telebehavioral health were more than 2.5 times more likely to keep their video appointment than in-person appoints (100).

Given the unique challenges that disproportionately burden American Indian and Alaska Native communities, IHS has implemented targeted programs to alleviate these disparities. The IHS Injury Prevention Program partners with tribal leadership to develop programs to prevent injuries and deaths from vehicle accidents, firearms, and suicide, which contributed in part to the reduction in unintentional injury rate (82). The College supports firearm safety and violence prevention interventions as discussed in "Reducing Firearm Injuries and Deaths in the United States" (101). Another program, the Special Diabetes Program for Indians, awards grants to federal, tribal, and urban sites for innovative diabetes prevention and treatment activities. By targeting the local level, the program aims to empower tribal communities to achieve community support and participation through ownership. As a result of this approach, 63% of awardees promote traditional diets, 92% undertake culturally appropriate public awareness campaigns, and 51% utilize traditional approaches like storytelling and talking circles. The grants facilitated the establishment of infrastructure needed for offering population-based diabetes care including increased use of a diabetes registry, dedicated diabetes clinics, weight management programs, and nutrition education services. During the first 10 years of implementation, both mean hemoglobin A_{1c} and low-density lipoprotein cholesterol were meaningfully reduced. Eight-year risk for diabetes and 10-year risk for coronary heart disease were also reduced while

lowered blood pressure, blood glucose, and cholesterol and the promotion of healthy lifestyles were achieved (82). Given the health disparities that remain in American Indian and Alaska Native communities, additional targeted and culturally appropriate programs are necessary to improve Indigenous health. As recommended in "Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs" (102), ACP believes that with high rates of alcohol and substance use in Indigenous communities, policymakers should evaluate the impact of the criminalization of these disorders and implement alternatives to criminal penalties to mitigate the disproportionate burden of incarceration. ACP commits to further developing focused and culturally appropriate policy approaches needed to address the social and health issues that disproportionately burden Indigenous communities.

5. ACP believes that physicians and other clinicians must make it a priority to meet the cultural, informational, and linguistic needs of their patients, with support from policymakers and payers.

- a. Health literacy among those facing disparities on the basis of personal characteristics must be strengthened in a culturally and linguistically sensitive manner. Funding and support should be made available for clinicians to implement and expand health literacy interventions and adapt their practice to accommodate the cultural, informational, and linguistic needs of their patients.**
- b. Health care communications must be made in a language the patient understands. Clinicians should be reimbursed by public and private payers for translation services needed in providing care for those with limited English proficiency (LEP) or who are deaf.**
- c. Patient navigators should be funded and provided to assist patients in navigating the entire spectrum of the health system and to better understand and communicate one's health needs.**

Health Literacy

Health literacy refers to one's capacity to understand and process health information in order to make health decisions and can be independent of educational attainment. Health literacy can impact adherence to treatment plans and make it difficult to understand prescription labels, forms, bills, appointment slips, discharge information, and other medical documents. Research has found that physicians tend to overestimate patients' health literacy and understanding of instructions while patients tend to be unaware of their health literacy and overestimate their ability to recall health information (103). Hispanic persons, Black persons, and American Indian and Alaska Native persons have the lowest average health literacy scores of all groups (104). Further analysis of this data found that lower health literacy scores for African Americans and Latinx persons than White persons persisted after accounting for social factors, with foreign-born Latinx persons having lower scores than native-born (105). Those with LEP may also have poorer health literacy. One study of emergency room patients found that 74% of Spanish-speaking patients had less than adequate health literacy scores, compared to 7% of English-speaking patients (106). Factors like poverty, education, age, disability, and insurance status have also been associated with health literacy (107).

A review of the literature found that low health literacy was associated with more hospitalizations and use of emergency care, lower rates of mammography screenings and influenza vaccination, misadherence of medication treatment plans, difficulty in understanding health communications and labels, and poorer health status and higher mortality rates among the elderly (108). One study found that Black persons were more likely than White persons to not follow

physician provided medication instructions and had lower health literacy (109). Other studies have found similar associations between race/ethnicity and treatment adherence for patients with HIV and rheumatoid arthritis (110,111).

There is limited evidence regarding the effectiveness of targeted interventions for low health literacy. Approaches like isolating information or presenting important information first, using the same denominators for treatment risk and benefit information, using higher numbers to indicate better quality, using icons to accompany numbers, and adding video to verbal narratives have shown some success in improving comprehension of medical information (112). For the primary care setting, Hersh et al recommend the use of easy-to-understand nonmedical language, avoiding assumptions in literacy levels, breaking down information and presenting in smaller pieces, confirmation of understanding, and using written materials with graphics to accompany verbal instructions (103). The teach-back method, in which a patient repeats back instructions to gauge comprehension, has also been found in some studies to be effective in improving comprehension (113). Patient navigators are another tool to assist those with low health literacy navigate the complexities of the health care system, coordinate care, and confront things such as selecting an insurance plan, paperwork and applications, and language barriers. Patients who utilize patient navigator services reported increased satisfaction, reduced anxiety, and fewer disruptions in care and were more likely to complete treatments (114).

Technology-based solutions that provide patients access to clinical notes are becoming increasingly popular as a tool to share information, improve understanding of one's health, and encourage care compliance (115). However, these tools may actually create more disparities accessing this type of patient engagement and informational resource for populations with less technology access, LEP, low digital literacy, functional illiteracy, and low health literacy. Some research suggests those with low health literacy reported they were less likely to use health information technology tools and found them less useful and easy to use (116).

LEP

More than 350 languages are spoken in the U.S. with Spanish, Chinese (including Cantonese, Mandarin, and others), Tagalog, and Vietnamese being the most common (117). As of 2016, roughly 15% of adults in the U.S. spoke a language other than English at home, or 22% including noncitizen residents (118). Additionally, Black, Hispanic, and other racial and ethnic minority groups are disproportionately represented among the 8.3 million individuals in the U.S. who are functionally illiterate (119). Those with LEP receive lower-quality care as a result of communication barriers, cultural differences, and structural barriers and biases (120). An analysis of adverse incident reports found that 49% of patients with LEP endured physical harm compared to 29.5% of English speakers (121). Patients with LEP were less likely to receive full informed consent documentation (122) and more likely to report difficulties understanding medical situations, medical labels, and bad reactions (123). A meta-analysis of admissions data found that patients with LEP stayed in the hospital 6% longer than English-speaking patients and had longer average hospital stays for unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement (124). Patients facing linguistic barriers may also misunderstand diagnosis and treatment options, improperly follow treatment instructions, and have poor comprehension of care plans (125).

Patients with language-discordant physicians reported worse interpersonal care and less health education, although use of a clinic interpreter mitigated some of these effects (126). A review of the literature highlights the effectiveness of interpretation services on improving care for patients with LEP. Access to trained professional interpreters is associated with improved patient satisfaction, quality of care, and outcomes. When informal interpreters are used, such as

family members or unqualified interpreters, more errors occur (127). Use of interpreter services was also associated with receiving more preventive services, more office visits, and the filling of more prescriptions (128).

Title VI of the 1964 Civil Rights Act, through Executive Order 13166, requires health “providers” who receive federal funds to adhere to guidance requiring meaningful access to services for those with LEP. Section 1557 of the ACA includes additional requirements protecting the right to accessing health care in one’s preferred language and requires the use of qualified medical interpreters. The HHS guidance requires covered health programs and providers, including those receiving federal funds, administered by HHS, or established under the ACA, to provide language assistance services that are free to patients, timely, and accurate (129). However, interpretation services are often unavailable and compliance with existing law is not strongly enforced (120). One study found that roughly 40% of patients with LEP received language interpretation services upon admission and discharge (130). Another study found that only 57% of patients with LEP had an interpreter present with the physician upon admission and 60% during the hospitalization; these numbers drop to 17% and 14% when limited to professional interpreters (131). Interviews with internal medicine and emergency medicine residents found that in hospitals where interpreter services were available, they were not used due to time constraints, hassle, and convenience of using alternatives like family members and institutional normalization (132).

While an important tool in ensuring quality care for patients, providing interpreter services can be costly, particularly for smaller physician practices. Some estimates place the cost at around \$45-\$150 per hour for in-person services, \$1.25-\$3.00 per minute for telephone services, and \$1.95-\$3.49 per minute for video services (129), while others at around \$279 per patient per year (128). Medicaid and CHIP in 14 states and the District of Columbia will cover the use of interpreter services for beneficiaries, whereas others, like Arizona, require contracted managed care organizations to offer interpretation services free of charge. Additional efforts are needed to increase public and private funding of interpretation services to ensure adequate access to all patients with LEP.

Culturally Aware Care

The cultural awareness of clinicians involves awareness of discrimination, cultural beliefs around medicine, and use of complementary and alternative medicine. Cultural competence in physicians is associated with better medication adherence rates, patient-centered communication, and positive health outcomes (133). Both a majority of health care professionals (134) and minority patients (135) believe that cultural understanding and knowledge is important in effectively providing health care services. In one focus group study conducted to develop a culturally appropriate coronary heart disease patient education program for medically underserved South Asian immigrants, researchers found that an effective program should understand the explanatory models that influence health and disease prevention within the target community and incorporate them into the targeted message, acknowledge the heterogeneity within the target community, address the various factors that impact the community’s health behaviors, and engage the community throughout the process to ensure they are receptive (136).

Culturally appropriate interventions have shown some success in reducing cancer screening among minority communities. In Minneapolis, HealthPartners convened a focus group to strategize messaging around colonoscopy exams to address racial disparities in colorectal cancer screenings, finding that minority patients were concerned about the invasiveness and inconvenience of the traditional colonoscopy. After changing messaging around the traditional colonoscopy and promoting alternative home screens, the percentage of racial and ethnic minority patients who were eligible and completed a screening increased from 43% to 70%, while the minority-White gap decreased from 26

points to 8 points. To address similar disparities in Latinx communities, Kaiser Permanente conducted ethnographic research that identified concerns with taking off from work and found treating, as opposed to finding, cancer to be a more effective message. After publishing photo novellas to promote colorectal cancer screenings and changing messaging, among other initiatives, screening rates increased from 66% to 73%, and the Latinx-White gap decreased from 5 points to less than 3 points (137).

In 2012, The Joint Commission published standards on patient-centered communication that emphasize the importance of focused care for patients with LEP and cultural competency (138). HHS's Office of Minority Health also published National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to offer a framework for physicians and other health professionals to achieve health equity (139).

In the paper "Language Services for Patients with Limited English Proficiency", ACP emphasizes the need for language services in order to improve health care services, recommends the establishment of a national clearinghouse to provide translated documents and patient education materials, and calls for federally-funded insurance programs to reimburse physicians for language services and the time involved in administering them (140). The College has also highlighted the need for health literacy efforts and calls for materials to reflect the linguistic and cultural characteristics of patients in its paper "Patient Safety in the Office-Based Practice Setting" (141).

6. ACP believes that public policies should reflect the unique effects that country of origin, language, immigration status, workplace, and culture have on health disparities among various distinct communities associated with their personal identities.

The Latinx community is one of the largest, fastest-growing, and most heterogeneous minority groups in the U.S. The diverse ranges of English proficiency, immigration status, country of origin, and number of generations spent in the U.S. within the community poses the need for interventions specific to the unique disparities faced by Latinx persons of various backgrounds and circumstances. Of the roughly 60 million Latinx persons in the U.S., 62% are of Mexican origin, 10% Puerto Rican, 4% Cuban, 4% Salvadoran, 3% Dominican, and 3% Guatemalan. Of the remaining, 6% have South American origins and 3% other Central American countries (142). Hispanic persons have higher rates of poverty and lower rates of high school completion compared to White persons and the highest rates of uninsurance of any group (143). Given the lack of insurance, Hispanic persons have less access to care, receive fewer preventive care services than White persons, and more frequently delayed care due to cost concerns (143). Hispanic persons have higher rates of diabetes and obesity and higher death rates from diabetes, chronic liver disease and cirrhosis, essential hypertension and hypertensive renal disease, and homicide than White persons (143). Despite generally poorer social determinants of health and access to care, Hispanic persons have a higher average life expectancy (144), lower all-cause death rates, and lower death rates for 9 of the 15 leading causes of deaths compared to White persons (143). Researchers have attributed this to healthier behaviors among newer immigrants, better eating habits, lower smoking rates, and stronger social networks (145).

Immigration status is one source of health disparities for Latinx persons. Those with origins from Mexico and Central America comprise roughly two thirds of all unauthorized immigrants in the U.S. (146), and roughly one third of all Latinx persons are immigrants (147). Immigrants receive fewer health care services, lower-quality care, spend less on health care, and pay more out of pocket for their care than nonimmigrants, while those who are unauthorized immigrants have higher rates of uninsurance due to limited access to employer-sponsored coverage, ineligibility for public insurance programs, and high prices for private plans (64,148). The Emergency Medical Treatment and Labor

Act requires emergency departments to treat all regardless of ability to pay or immigration status; however, this incentivizes emergency care over primary care and the lack of a regular source of care results in the delay of necessary services and diagnosis of conditions at more advanced stages and result in issues that are not diagnosed or treated (149). More research is needed on the unique health issues experienced by the unauthorized immigrant community.

Immigration enforcement and the fear surrounding it can also impact one's health through increased stress and discouragement from seeking care. Those in immigration detention experience higher rates of anxiety, depression, and posttraumatic stress disorder than nondetained refugees (150) and Latinx persons are less likely to receive treatment for these issues (151). One study found that following the largest Immigration and Customs Enforcement (ICE) raid at the time at an Iowa meatpacking facility, Latino babies were 24% more likely to be born with a lower birthweight than the year prior; however, this difference did not affect White babies (152). Within immigration detention facilities, human rights groups and journalists have long reported on the poor standards of health care received, including inadequate care resulting in deaths, dangerous and substandard medical practices, delays in emergency responses and requests for care, and underqualified medical staff (153). More than 193 detainees have died in ICE facilities since 2004 (154). An inspection of ICE detention facilities conducted by the Department of Homeland Security (DHS) found moldy bathrooms, food safety issues, a lack of hygiene items, and insufficient medical care (155).

Disparities in health and health behaviors among Latinx persons have also been observed based on country of origin. While smoking rates among Hispanic persons are lower than White persons, Puerto Ricans (21.6%) and Cubans (18.2%) have much higher rates than Mexicans (13%) and Central/South Americans (9.2%). Similar differences in prevalence based on country of origin is observed for cancer, heart disease, and colorectal screening (143). While 17.8% of all Hispanic persons were uninsured in 2017, this number ranged from 27.2% of Central Americans, 19.3% of Mexicans, 13.7% of Cubans, and 7.9% of Puerto Ricans (144). Hispanic persons born in the U.S. have higher rates of smoking, obesity, hypertension, heart disease, and cancer and lower cholesterol rates than foreign-born Hispanic persons (143). Policy interventions addressing health disparities should take into account the differing health issues experienced by those of various national origins.

Employment trends may contribute to poorer health and access to coverage for certain communities. Compared to White persons, Hispanic persons worked in service jobs at a significantly higher rate and professional and managerial jobs at a significantly lower rate, with a median household income gap of \$16,000 (144). Hispanic workers are also disproportionately represented in high-risk jobs like construction, domestic maintenance, repair services, and manufacturing. These types of jobs are less likely to offer adequate employer-sponsored insurance and tend to be more dangerous. Hispanic farm workers had a heat-related death risk factor 3.4 times higher and Hispanic construction workers 1.7 times higher than those of White workers, while Hispanic workers had a death risk factor 1.4 times that of White workers for occupational carbon monoxide exposure (145).

English-language proficiency has been found to be associated with rate of medical errors, clinical outcomes, and quality of care (120). A vast majority of Hispanic persons (72%) speak a language other than English at home—including 86.7% of Central Americans, 78.1% of Cubans, 71.6% of Mexicans, and 59.2% of Puerto Ricans—while nearly 30% reported not being fluent in English (144). For those with LEP, language barriers can result in inaccurate understanding of diagnoses, treatment side effects and risks, and medication instructions, which can inhibit disease management and prevention (149). Ensuring individuals have access to linguistically appropriate services in the medical setting is critical to reducing disparities. One example is the Harborview Medical Center in Seattle, which employs eight cultural mediators to provide interpretation,

health education, case management, and advocacy services to those of various cultural and linguistic backgrounds, 40% of which are Spanish speakers. These mediators take into account age, country of origin, and education level and utilize culturally relevant metaphors to assist patients in understanding their care (145).

Varying cultural backgrounds and beliefs can impact one's experience and engagement with the health care system. Researchers have observed the role of familism among Latinx communities, which can serve as an emotional and financial support network and positively contribute to health (145). Recognizing cultural values like respect and modesty, folk beliefs around illness, and alternative treatments in the clinical setting can help build trust and improve the patient-physician relationship (156). For example, lower rates of postpartum visits were identified at a rural clinic that served a large proportion of Salvadorans, which community interviews attributed to traditional Salvadoran postdelivery quarantining practices. As a result, Salvadoran women were consulted to incorporate a question to the obstetric history form that captures cultural beliefs (145).

The College has longstanding policy pertaining to the intersection of immigration, its impact on health, and racial and ethnic profiling and discrimination. In "National Immigration Policy and Access to Healthcare" (157), ACP affirms that access to health care should not be restricted on the basis of immigration status and children born in the U.S. to parents who are unauthorized immigrants should have the same access to public health programs as any other citizen. ACP also urges policymakers to recognize the public health risks of unauthorized immigrants not seeking care over concerns of immigration enforcement as well as the health consequences to unauthorized individuals and their families of efforts to return unauthorized individuals to their country of origin through arrest, detention, and deportation.

7. ACP believes that health care delivery and payment systems should support physician-led, team-based, and patient- and family-centered care that is easily accessible to those affected by discrimination and social drivers of health.

Alternative payment models and value-based interventions provide a mechanism for reducing health disparities by increasing access to social services and community support. In a fee-for-service system that pays for volume over outcomes, there is little incentive for physicians to address the underlying factors that perpetuate disparities. Through the development and implementation process, new models are able to experiment with and evaluate innovative, targeted approaches to addressing social drivers of health. Alternative payment models like accountable care organizations (ACOs) can help facilitate care coordination and through incentives to control health care spending can implement "culturally competent interventions that address the social, environmental, and behavioral determinants of health—interventions that historically have not been fully embraced given a previous focus on revenue-generating procedures at the expense of a broader notion of public health" (158).

Some states have already begun incorporating social drivers of health into their Medicaid alternative payment models (159). New York's ACOs are required to incorporate at least one social driver of health intervention while in Massachusetts, the Flexible Services Program pays for nutrition and housing supports for some ACO members. Oregon, which in 2012 transferred most of its Medicaid enrollees to ACOs that integrated social drivers of health through the use of a global budget and the funding of social services, saw a 7% reduction in health expenditures and avoidable emergency department visits and improvements in appropriateness of care measures (160). However, racial and ethnic minorities may be significantly underrepresented in these new payment models. One analysis found that while Black persons make up 10.5% and Hispanic persons 8.4% of the overall Medicare population, they only account for 8.5% and 1.6%, respectively, of the Medicare Shared Savings

Program ACO population (161). ACP believes that payers should prioritize inclusion of underserved patient populations in all payment models.

ACP also believes that value-added services, such as performing social drivers of health assessments, behavioral health service assessments, and connecting patients with appropriate services and counseling, should be covered by all payers and included in payments to clinicians.

In the paper “Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms,” ACP recognizes the integral nature of social drivers of health when looking at short- and long-term patient health outcomes and considers value-based payment models an opportunity to combat social drivers of health when properly implemented in a manner that is considerate of administrative burden (162). Managed care payment formulas that incorporate social determinants of health have been found to be more accurate than diagnosis-based payment formulas in allocating funds and reduced underpayments for vulnerable populations (163). Ensuring practices are rewarded for working with underserved populations and Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race or ethnicity, rather than penalized, is critical in fighting health inequities. By reimbursing physicians for providing additional value-added services, such as performing social drivers of health assessments and connecting patients with outside services, underserved populations can receive long-term, high-quality care. Additionally, using a risk-adjusted methodology that includes social drivers of health and comorbid conditions allows physicians to serve patients without being penalized for negative outcomes that are out of their control. Limiting or removing consequences for physicians who work with underprivileged populations ensures these populations have access to necessary health care.

8. ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks, poor environmental health, and climate change, disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.

- a. Racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic should be collected and released in a uniform and timely manner at a local and national level. Data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care.**
- b. Testing, treatments, vaccines, and other resources should be equitably distributed in a transparent manner based on need, especially in historically underserved racial and ethnic minority neighborhoods. These services and supplies should be affordable and accessible regardless of socioeconomic status.**
- c. The U.S. Department of Labor’s (DOL) Occupational Safety and Health Administration (OSHA) should issue appropriate workplace protections to protect the health and well-being of essential workers during a pandemic.**
- d. Universal access to family and medical leave that provides a minimum period of 6 weeks of paid leave should be mandated and funded, with flexibility that allows for the caring of family members, as recommended in “Women’s Health Policy in the United States” (13). Legislative or regulatory action at the federal, state, or local level are needed to advance this goal.**

e. Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the impact on health of large-scale infectious disease outbreaks and climate change, must be addressed as recommended in “Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health” (14), “Addressing Social Determinants to Improve Patient Care and Promote Health Equity” (15), and “Climate Change and Health” (16).

Historical experiences with the 1918 Spanish flu and 2009 H1N1 swine flu outbreak have shown that minority populations and those with LEP do not receive adequate health information and are more likely to transmit disease and die during pandemics (164). While exhaustive and conclusive data are still lacking for the current COVID-19 pandemic, racial disparities are emerging (165). One national analysis of Centers for Disease Control and Prevention (CDC) data found that Latinx and Black residents were three times as likely to contract COVID-19 and two times as likely to die than their White neighbors (166). Another analysis of hospitalization, mortality, and census demographic data found counties with a majority African American population had infection rates three times higher and mortality rates six times higher than those counties with a majority White population (167). In San Francisco, Asian American persons faced the highest mortality rate out of any other group, accounting for 52% of deaths despite only being 34% of the population (168). Native American persons comprised only 8.8% of the New Mexico population but accounted for 60% of deaths (169). Both older and younger racial and ethnic minority patients are impacted at higher rates. At younger ages, a Harvard working paper found 25- to 34-year-old Black patients experienced mortality rates as much as 7.3, Hispanic persons 5.5, and American Indian and Alaskan Native persons 1.4 times that of White persons—disparities that held for almost every age group examined (170). At older ages, an analysis of Medicare claims data found that Black (465/100,000) and Hispanic (258/100,000) beneficiaries had the highest rates of hospitalization (171). For those who do seek out medical care, one analysis of billing data from several states found that Black patients who presented COVID-19 symptoms were less likely to be given a COVID-19 test than White patients (172).

At Massachusetts General Hospital in Boston, 40% of patients with COVID-19 spoke Spanish as their native language (173). Some evidence suggests that those with LEP may be particularly at risk of contracting and spreading the disease due to inadequate translation of public health information and medical services to the patient’s native language (174). There have also been reports of hospitals facing long wait times to obtain translation services, an issue when minutes can mean life or death for the most ill (175). ACP believes multilingual and culturally appropriate public awareness campaigns are needed to ensure best public health practices are followed and testing and treatment services are available to everyone, regardless of their primary spoken or written language.

There is reason to believe that the limited data that has come out does not provide an accurate representation of the full extent of the impact on Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race or ethnicity. This is primarily due to the fact that the piecemeal collection of data at the local, state, and federal levels is incomplete, excludes unconfirmed cases, and obscures racial/ethnic/LEP disparities (165). While some states and municipalities have begun collecting and releasing data on COVID-19 cases at the racial level, the federal government has failed to consistently collect such data in its efforts. In the CDC’s release of data on total U.S. cases, 75% of cases had race and ethnicity as unspecified (176). More than 3 months into the pandemic, 52% of all cases in the U.S. were lacking racial and ethnic data (177). At the state level, half have released some sort of racial and ethnic data on mortality rates while

34 states have released some sort of infection rate data; however, only two states have made testing data by race and ethnicity publicly available (178). Indigenous persons, particularly those residing in federally recognized tribal territory, have faced their own unique challenges in accessing and utilizing health data. Despite having some of the highest mortality rates, roughly half of the states either do not collect information on American Indian and Alaska Native persons or categorize them in a more general “other” racial category (179). Tribal epidemiology centers, which are tribal public health organizations similar to state health departments, have reported being denied access to CDC data that are being made available freely to states. Tribal public health agencies have also run into similar issues at the state level, with state public health agencies refusing to share testing and case information or coordinate on tracing efforts. Furthermore, there is also concern that the existing data exclude those whose symptoms did not meet screening thresholds and those who did not seek care due to lack of trust in the system, uninsurance, worry of medical costs, or lack of paid sick leave. Without complete data, physicians and other health professionals will be ill-equipped with the information they need to make evidence-based decisions and provide targeted care to communities most impacted by the pandemic.

One explanation for COVID-19-related racial disparities is the fact that certain racial and ethnic minority groups have higher rates of chronic disease, such as hypertension, diabetes, obesity, asthma, and cardiovascular disease (180). For instance, diabetes rates among Asian American persons, Hispanic persons, non-Hispanic African American persons, and American Indian and Alaska Native persons are higher than among White persons (181). All of these underlying chronic diseases heighten one’s risk for severe illness from COVID-19, leaving minority communities particularly vulnerable in an environment with inadequate testing and treatment capacities. One analysis found that 34% of American Indian and Alaska Native nonelderly adults and 27% of Black nonelderly adults were at higher risk of serious COVID-19-related illness due to an underlying health issue, compared to 21% for White nonelderly adults (182).

Health status is influenced not only by the health care system, but also by social drivers and the environment in which one is born, works, and lives. It is likely that existing comorbidities do not fully explain COVID-19 disparities and that other factors like structural racism, uninsurance, poor quality of care, food and housing insecurity, workplace risks, and other social drivers of health have contributed to these disparities (165). As some have pointed out, social distancing and working from home are privileges that are not accessible to certain communities and that the aggregate of “higher burden of at-risk comorbidities, the pernicious effects of adverse social determinants of health, and the absence of privilege that does not allow a reprieve from work without dire consequences for a person’s sustenance, does not allow safe practices, and does not even allow for 6-foot distancing” is disproportionately burdening minority communities (183).

- **Location.** Historic redlining, in which lenders and institutions refuse or offer worse terms on mortgages to those in certain neighborhoods based on race, resulted in Black persons settling in segregated and concentrated neighborhoods (184). These neighborhoods are often food deserts and are underserved by medical and financial institutions. In the COVID-19 era, some reports have suggested that these neighborhoods are also located further than neighborhoods with a higher proportion of White residents from the limited number of testing sites in cities throughout the country (185,186). Similarly, Indigenous Americans living on tribal lands have reported inadequate health facilities and COVID-19 testing and care equipment provided by the IHS (187).
- **Environment.** Black individuals are more likely to reside in locations with sources of elevated air pollution, further away from air quality monitoring sites, and closer to toxic waste sites (188). Air pollution can have an impact on respiratory illnesses, which have been shown to exacerbate the effects of COVID-19.

- **Housing.** Racial and ethnic minorities are more likely to reside in densely populated areas while 26% of Black and 27% of Latinx families live in multigenerational homes, compared to 16% of White families (189). Many of the nearly half of Native Americans who live on tribal lands reside in small houses that do not have electricity or running water (187). These crowded settings increase the risk of asymptomatic transfer of COVID-19, particularly from younger people to older at-risk relatives.
- **Transportation.** Black and Latinx individuals are three and two times more likely, respectively, to utilize public transportation than White residents (190). Having to rely on forms of transportation requiring close proximity to other people, as opposed to a personal vehicle, places one at a higher risk of contracting or spreading the virus.
- **Employment.** Racial and ethnic minorities are overrepresented in the frontline “essential” services workforce, placing themselves and their families at risk. For example, Black persons make up 30% of bus drivers and 20% of food service workers, janitors, cashiers, and stockers (191), while also being overrepresented in material moving industries, production, health care support, and personal care and services (189). The meatpacking industry—a majority-minority industry comprised of 44.2% Latinx workers and 25.4% Black workers (192)—has been at the epicenter of new COVID-19 cases, with over 10,000 cases and at least 45 deaths at meatpacking facilities nationwide (193) due to inadequate workplace social distancing and hygiene (194). Many of these industries are known for providing inadequate employer-sponsored insurance coverage and paid leave policies. As called for in “Women’s Health Policy in the United States” (13), ACP supports universal access to paid family and medical leave. Further, the DOL’s OSHA has yet to implement emergency workplace standards in response to the COVID-19 public health emergency (195).
- **Criminal Justice.** Black and Latinx adults are overrepresented in the prison population (196). Seven of the ten largest outbreaks in the country have occurred at correctional facilities and the prison population has an infection rate 2.5 times that of the general population, which has resulted in more than 44,000 cases and 462 deaths (197). Several states, including Nevada and Hawaii, charge copays of \$2-\$5 for physician visits in state prisons, which may pose financial barriers to seeking care given incarcerated individuals typically make between \$0.14 to \$0.63 per hour in prison labor (198). ACP believes that copays for seeking medical care in correctional facilities should be suspended and/or eliminated. As discussed in “Understanding, Addressing, and Ending Disparities and Discrimination in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations” (3), more equitable alternatives to cash bail should be implemented especially during public health emergencies to avoid exposure to crowded jails that function as COVID-19 hotspots.

Aside from illness and impacts on physical health directly caused by COVID-19, there has been increasing COVID-19-related discrimination and violence against minorities. Reports of police encounters by Black men wearing personal protective equipment like facemasks in public have raised concerns about the impact of criminalization on racial health disparities (199). Public officials and others have referred to coronavirus as the “Chinese virus,” stoking hate against Asian American individuals. As a result, Asian American persons have been subject to verbal harassment and physical assaults, and there are concerns some are hesitant to seek medical care to avoid spreading the virus. There are further concerns that consumers may mistakenly believe that business owned and operated by Asian Americans are more dangerous (200). Since the beginning of the COVID-19 public health emergency, more than 2,583 incidents of discrimination against Asian Americans and Pacific Islanders have been reported in the U.S. (201).

9. ACP believes that policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk.

- a. Ensure access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan, including high-quality and patient-centered preconception, antenatal, delivery, postpartum, and other care and appropriate specialists and subspecialists.**
- b. Establish maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related or pregnancy-associated death and improving maternal outcomes. MMRCs should have access to necessary data across jurisdictions and implement best practice standards for data collection including consistency and comparability of data.**
- c. Incentivize health care institutions to undertake safety and quality improvement activities that are shown to be effective in improving maternal and other health.**
- d. Cover resources like doulas and patient navigators by public and private payers. ACP supports ongoing research and evaluation of such services in order to demonstrate which models are most effective.**

Although the worldwide maternal mortality rate has dropped over 40% between 1990 and 2015, the U.S. has seen a nearly 27% increase in pregnancy-related deaths. Women in the U.S. have the highest risk of dying as a result of pregnancy complications among eleven industrialized nations (202) and 3 in 5 pregnancy-related deaths could be prevented (203). Racial and ethnic minority women are much more likely to die due to pregnancy-related complications or health problems, and Black and American Indian and Alaska Native women are at three times the risk of death than White women. Various risk factors have been explored as potential contributors to the issue, including social drivers of health such as lived environment, community, relationships, health and health care, education, income level, age, and preconception health. However, these disparities appear to exist even after controlling for sociodemographic factors (204).

While having timely access to accurate and comprehensive data is crucial to identifying and addressing maternal health disparities, the U.S. failed to publish national maternal mortality data between 2007 and 2020 due to concerns about incomplete and incorrect data as data collection practices are not uniform across all states (205). Maternal mortality data are often dependent upon death certificates, standards for which the CDC updates every 10-15 years. Reporting standards were last updated in 2003 to include a checkbox to indicate pregnancy status after years of systematic underreporting (206). These updates, combined with a transition to electronic reporting, resulted in delayed implementation of the revised standards for some states, including several with sizeable Black populations (207). However, even with these changes, there are still doubts about the accuracy of the data. Several national programs including the National Center for Health Statistics (NCHS), Pregnancy Mortality Surveillance System (PMSS), and Pregnancy Risk Assessment Monitoring System (PRAMS) attempt to estimate maternal mortality, but use different measures and methods. At the state level, MMRCs, which analyze maternal deaths and offer recommendations, have been estimated to have reduced maternal deaths by 20% to 50% (208), yet at least 12 states do not have one (209).

Preconception health status can impact adverse birth outcomes and racial and ethnic minority women are susceptible to risk factors, such as obesity, at-risk

drinking, smoking, diabetes, and frequent mental distress. One study found that American Indian and Alaska Native women had the highest rates of four of these risk factors and the highest rate of those with two or more risk factors, while Black women had the highest rate of obesity and Hispanic women had the second highest rate of diabetes (210). Data also suggest the number of prenatal visits is negatively associated with maternal mortality and severe morbidity rates, which racial and ethnic minority women are less likely to obtain, often as a result of social factors like lack of transportation and insurance status. White women are the most likely to seek prenatal care, with 79% obtaining it within the first trimester, whereas African American persons, American Indian and Alaska Native people, and Native Hawaiian/Pacific Islander people less likely, with 64%, 59%, and 55% seeking prenatal care within the first trimester, respectively (211).

Racial and ethnic minority women have also been found to have higher prevalence of chronic diseases, including chronic hypertension, asthma, placental disorders, gestational diabetes, preexisting diabetes, and blood disorders, that in turn result in increased risk for pregnancy-related mortality (212,213). Both Black (214) and Hispanic (215) women have been found to have higher mortality rates from hypertensive disorders of pregnancy compared to White women. Black women also had fatality rates 2.4 to 3.3 times higher for pregnancy complications, including preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage (216).

In addition to health factors, data suggest the quality of the American health system is also failing minority mothers. One national study found that a quarter of hospitals were the site of three quarters of all African American deliveries in the United States, and those hospitals had higher risk-adjusted severe maternal morbidity rates for mothers of all races and ethnicities (213). Hospitals that had more than 50% of their deliveries be of Black mothers performed worse on 12 of 15 delivery-related indicators, including maternal mortality and complicated vaginal and caesarian delivery, compared to hospitals serving more White patients (217).

Providing pregnancy-related support services through doulas has been offered as one potential solution to address maternal mortality disparities and empower and advocate for socially disadvantaged pregnant women (218, 219). One study comparing socially disadvantaged mothers at risk of adverse birth outcomes found that assistance by a doula was associated with a reduction in the likelihood of experiencing a birth complication by the mother (220). While doulas are usually not covered by public or private payers, Oregon, Minnesota, and the District of Columbia cover doula services under their Medicaid program, and New York recently launched a pilot program to reimburse doulas up to \$600 per supported patient (221).

ACP believes that women must have access to affordable, comprehensive, nondiscriminatory health care coverage that includes comprehensive evidence-based care over the course of their lifespans, including access to reproductive health services, as affirmed in Women's Health Policy in the United States (13). In "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health" (14), ACP supports funding and prioritizing policy interventions and actions to reduce the rate of maternal mortality in the United States, especially for Black women. In addition to the recommendations in this position, the College recommends the establishment of maternal mortality review committees or other state or local programs to collect pertinent data, development, and implementation of strategies to prevent pregnancy-related or pregnancy-associated death and improve maternal outcomes; improvement of health care safety; and expansion of postpartum Medicaid eligibility.

10. ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.

Having access to data at the racial level is essential to identifying health trends among certain populations and offering targeted interventions and treatments in order to ameliorate racial and ethnic health disparities. However, there are many challenges and shortcomings to current data collection practices and national standards that pose barriers to effectively using it for these purposes. Given that race and ethnicity are social rather than scientific constructs that lack a uniform understanding and that an individual can identify with more than one race or ethnicity, definitional challenges exist that make them difficult to measure and meaningfully compare in research (222). Individuals may face limited race or ethnicity choices they do not identify with and inadequate sample sizes prohibit reliable estimates of smaller populations. While some data are tracked at the national level, administrative data from insurance claims and medical records, which may include incomplete information, are heavily relied upon for tracking disparities at the state and local levels (223). From the patient perspective, some may be hesitant to answer questions about race and ethnicity over concerns of profiling, discrimination, and subsequent quality of care received, and medical professionals may feel uncomfortable asking intrusive personal questions or feel they do not have the time or resources to do so (224).

At the national level, the U.S. Office of Management and Budget (OMB) has standards on race and ethnicity categorization that the U.S. Census is required to use and is used in research funded by the National Institutes of Health (222). OMB utilizes a two-part question format: respondents can self-identify with five racial categories, including American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White, as well as Hispanic or Latino ethnicity categories. Since 2000, the U.S. Census has allowed respondents to self-identify with more than one race and write in racial identities and in 2020, those who identify as White are requested to also write in their origins. There has been some criticism over the use of such broad racial and ethnicity categories. For example, the Asian category encompasses a vast region of peoples with varying religious and medical beliefs, diets, languages, and traditions and homogenizes a heterogeneous population (224).

In recent years, the U.S. Census Bureau's classification of people with roots in the Middle East or North Africa (MENA) as White has created concern about undercounting and lack of participation in the Census by these communities (225). Historically, those who write in MENA identities had been recoded as White by the federal government, making it difficult for researchers to study the nuanced issues specific to that community (226), including health disparities that may be linked to concerns of discrimination and differing cultural beliefs (227). Arab Americans have higher rates of LEP, poverty, housing instability, state surveillance, and discrimination (228) than the general public and the undercounting of MENA individuals has ramifications on the funding of and ability to target social services to address disparities specific to these communities.

Without adequate data for marginalized communities, it is impossible to know the full extent of the various social, economic, and health issues they face. In "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" (15), ACP calls for additional research into social drivers of health, including an increased effort to recruit disadvantaged and underserved populations into large-scale research studies and community-based participatory studies. Further research and inclusive and coordinated data collection efforts are necessary to better understand the presence of and identify possible solutions for disparities in health, health care, and social drivers of health in communities that face discrimination on the basis of race, ethnicity, religion, and cultural identity.

Appendix: Glossary

Black: The term *Black* is used rather than *African American* to capture the shared and distinct experiences of both those who are descended from enslaved Africans brought to North America who have a long history in the United States as well as others who have more recently immigrated from African, Caribbean, and other countries and who may not as strongly identify with the American identity.

Latinx: Gender-neutral term to refer to those living in the United States who are of Latin American descent, rather than *Hispanic*, which refers to those who share Spanish as a common language. While respecting the views of those who do not prefer to be called Latinx, we conclude that *Latinx* captures power and privilege dynamics in the United States better than *Hispanic*, which would include those of Spanish descent who would identify as White but would exclude those of Brazilian descent and other non-Spanish-speaking Latin American countries. When referencing other sources, we use the descriptors the authors used. We recognize the controversy over the use of *Latinx*: Some argue that the term imposes American and Anglocentric ideals, encompasses a broad and diverse group, is incomprehensible to native Spanish speakers without any fluency in English—some of the very people the term is meant to serve—and is not a term that most persons of Latin American descent identify with. Although an imperfect solution, we choose to use the gender-neutral *Latinx* over *Latino* (in Spanish, many nouns and adjectives are gendered, with nouns ending in -o typically using masculine pronouns) in an effort to be as inclusive as possible.

Social drivers of health: The terms *social drivers of health* and *social determinants of health* are used interchangeably. When discussing the social and economic factors that contribute to health, we prefer to use the term *social drivers of health* to emphasize that these factors are changeable drivers that can be influenced rather than fixed determinants that are immutable. However, given the predominant use of the term *social determinants of health* in the literature, we use that term in this article when referencing other sources that used the term.

Cultural Humility: Self-reflection and self-critique of one's own beliefs, values, biases, and cultures in an effort to increase awareness for others, with an emphasis on openness and readiness to learn.

Racism: Prejudice, discrimination, hate, or bias toward a person or group on the basis of their actual or perceived race/ethnicity. Racism can exist at various levels, from the individual, to the interpersonal, to the institutional, to the structural. It can also manifest in both overt/explicit and covert/implicit manners.

Individual Racism: Privately held biases, beliefs, and actions that perpetuate racism and are often informed by culture.

Interpersonal Racism: Public expressions of racism that arise when interacting with others.

Institutional Racism: Policies and practices within institutions (for example, education or criminal justice system) that, regardless of intent, result in different outcomes for different racial or ethnic groups.

Structural Racism: "Macrolevel systems, social forces, institutions, ideologies, and processes...[that] interact with one another to generate and reinforce inequities among racial and ethnic groups" that can persist even in the absence of interpersonal discrimination and without regard to individual action or intent (23, 24). In this article, *structural racism* and *systemic racism* are used interchangeably.

Anti-Racism: The intentional and conscious effort to take action to oppose racism and racial inequities in all realms of society.

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