

**REPORT TO CONGRESS
ON MINORITY HEALTH ACTIVITIES
AS REQUIRED BY THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148)**

**FROM THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
OFFICE OF MINORITY HEALTH
FOR THE FISCAL YEARS 2013 AND 2014**



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Acronyms

ACA	Affordable Care Act
ACF	Administration for Children and Families
ACL	Administration for Community Living
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/Alaska Native
ASPE	Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
CAH	Critical Access Hospital
CBPR	Community-based Participatory Research
CDC	Centers for Disease Control and Prevention
CER	Comparative Effectiveness Research
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Records
FDA	Food and Drug Administration
FIHET	Federal Interagency Health Equity Team
FQHC	Federally Qualified Health Centers
HBCU	Historically Black Colleges and Universities
HHS	Department of Health and Human Services
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
LEP	Limited English Proficiency
MSI	Minority Serving Institution
NCHS	National Center for Health Statistics
NHSC	National Health Service Corps
NHPI	Native Hawaiian and Pacific Islander
NIH	National Institutes of Health
NIMHD	National Institute on Minority Health and Health Disparities
NPA	National Partnership for Action to End Health Disparities
NSS	National Stakeholder Strategy for Achieving Health Equity
OAH	Office of Adolescent Health
OASH	Office of the Assistant Secretary for Health
OBHE	Office of Behavioral Health Equity (Substance Abuse and Mental Health Services Administration)
OCR	Office for Civil Rights
ODPHP	Office of Disease Prevention and Health Promotion
OHE	Office of Health Equity (Health Resources and Services Administration)
OMH	Office of Minority Health
OMHHE	Office of Minority Health and Health Equity (Centers for Disease Control and Prevention)

ONC	Office of the National Coordinator for Health Information Technology
OS	Office of the Secretary
OWH	Office on Women’s Health
PCOR	Patient Centered Outcomes Research
PCFSN	President’s Council on Fitness, Sports, and Nutrition
PHS Act	Public Health Service Act
PHR	Personal Health Record
RFA	Request for Application
RHEC	Regional Health Equity Council
RMHC	Regional Minority Health Consultant
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Socioeconomic Status
SOMH	State Offices of Minority Health

Executive Summary

New advances in medicine and medical technologies have provided Americans with the potential for longer, healthier lives more than ever before. However, persistent and well-documented health disparities continue to exist among racial and ethnic minorities and underserved populations. Through this report, the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS), provides a summation of ongoing HHS efforts to reduce health and health care disparities and to advance health equity among racial and ethnic minorities and underserved populations.

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act, includes a number of provisions designed to improve the health of racial and ethnic minorities and other underserved or vulnerable populations by addressing many of the factors that have long been associated with health disparities, including expanding access to affordable, quality health coverage. Within the health care law, there are also specific requirements that address minority health issues: (1) transfer of the Office of Minority Health to the Office of the Secretary; (2) establishment of individual Offices of Minority Health within the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA); and (3) redesignation of the National Center on Minority Health and Health Disparities to an institute (the National Institute on Minority Health and Disparities, or NIMHD) within the National Institutes of Health.

Section 10334(a)(3) of the Affordable Care Act requires that a report be submitted to Congress not later than one year after enactment, and biennially thereafter, describing the activities carried out under sections 1707 and 1707A of the Public Health Service Act as amended (PHS Act). On March 23, 2011, the Department of Health and Human Services (HHS) submitted its first Report to Congress that provided information on HHS' programs and activities on minority health and health disparities, establishment of the individual Offices of Minority Health, redesignation of the National Center on Minority Health and Health Disparities, and actions undertaken to promote cohesive and coordinated minority health and health disparities activities. In 2013, HHS submitted a second report, which summarized HHS minority health activities for fiscal years 2011 and 2012.

This Report responds to the reporting requirement of section 10334(a) of the Affordable Care Act and provides an update to Congress on HHS programs and activities related to minority health. This report summarizes HHS minority health activities for fiscal years 2013 and 2014.

Significant progress has been achieved in implementing the provisions of the Affordable Care Act that address health disparities. Since the first 2011 Report to Congress on Minority Health Activities, all of the individual Offices of Minority Health have been established. The leadership

of AHRQ, CDC, CMS, FDA, HRSA, NIMHD and SAMHSA have appointed permanent directors of their respective Offices of Minority Health.

Since the Report to Congress on Minority Health Activities for fiscal years 2011 and 2012, the HHS Office of Minority Health, the National Institute on Minority Health and Health Disparities, the individual Offices of Minority Health within six HHS agencies, and various other HHS agencies and offices have carried out programs and developed policies to reduce disparities in health and health care for minority populations. These activities have included: leadership and coordination of national health disparities action plans; community-based participatory research; access to quality health care for minority and underserved populations; dissemination of community grants; increasing the diversity and cultural competency of the health and human services workforce; integration of research and establishment of networks that connect funded institutions, researchers, and the community; improving the participation of racial and ethnic minorities in chronic condition research studies; strengthening state leadership and supporting programs to improve the health and health care for vulnerable populations across the lifespan; expanding diverse language-based programs; improving data collection and reporting on health disparities at the national and state levels; increasing access to and implementation of health information technology; improving health literacy; providing technical assistance and professional training to underrepresented populations; and building capacity to address gaps in services.

HHS Agency Actions During Fiscal Years 2013 and 2014

- Increased activities and success in reducing disparities in health insurance coverage and access to health care;
- Enhanced strategic planning to drive targeted and collaborative efforts to reduce disparities;
- Increased integration of disparities related efforts across agencies;
- Increased intra- and interagency collaboration on disparities related projects and activities;
- Expanded partnerships within HHS and with external partners;
- Increased information sharing with community groups;
- Improved data collection and translation of findings to diverse audiences; and
- Improved program monitoring and assessment, and use of findings to for quality improvement.

Under the leadership of Health and Human Services Secretary Sylvia M. Burwell, the U.S. Department of Health and Human Services is implementing the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan). Initially released in 2011 and the first of its kind for the Department of Health and Human Services, the HHS Disparities Action Plan is the most comprehensive federal commitment on health disparities and charges all HHS operating and staff divisions to heighten the impact of HHS policies and programs to reduce health disparities. The HHS Disparities Action Plan builds on the foundation of the Affordable Care Act and leverages other national initiatives such as Healthy People 2020 and the National Prevention Strategy. This strategic action plan represents an unprecedented time of coordination and collaboration across the Department and with external partners, guided by a clear road map, to achieve the vision of “a nation free of disparities in health and health care.” The Department remains committed to eliminating health disparities and advancing health equity. In accordance with the Affordable Care Act section 10334(a)(3), the following Report highlights HHS agencies and their programs dedicated to minority health and health disparities in fiscal years 2013 and 2014.

Background

In 1985, the U.S. Department of Health and Human Services (HHS) released the *Report of the Secretary's Task Force on Black and Minority Health*, a landmark report documenting the extent of health disparities among minorities in the United States. Also known as the *Heckler Report*, it called such disparities “an affront both to our [nation’s] ideals and to the ongoing genius of American medicine.” In the decades since the release of that report, much has changed—including significant improvements in health and human services throughout the nation. Nevertheless, health and health care disparities have persisted. Beyond the heavy burden that health disparities represent for the individuals and communities affected, there are additional societal and economic burdens borne by the country as a whole.

Many of the health barriers that racial and ethnic minorities face are the result of interrelated elements that affect individuals across their lifespan. These factors, also known as social determinants of health, influence the health and well-being of individuals and communities. Addressing these factors, along with an emphasis on prevention and wellness, is a key strategy for reducing disparities and for improving the health of our nation.

Since minority health issues were elevated as a national issue, HHS has taken significant action to continue to address health disparities among racial and ethnic minorities and underserved populations. Through policy and program mechanisms, HHS is working to end discrimination, expand access to coverage, provide health care to underserved communities, increase the representation of minorities in the health care, public health, and biomedical research workforces, improve health disparities research and data collection, and is working within the department itself to improve the minority health infrastructure.

Major Dimensions of Health Disparities Include:

- Disparities in health insurance coverage;
- Disparities in access to health care;
- Disparities in the quality of care provided;
- Inability of providers to recognize and address disparities;
- Disparities in levels of health;
- Disparities in data collection;
- Disparities in resources allocated to address disparities, such as research into the causes of disparities, solutions to differences in health outcomes; and
- Disparities in social determinants of health, such as economic stability, level of education, access to health care, geographic location and the environment.

The Impact of the Affordable Care Act on Health Disparities

Historically, not all Americans have had equal access to health care, including behavioral health or oral health services. Racial and ethnic minorities have the highest rates of being uninsured and have higher rates of many chronic conditions, and are less likely to receive preventive care and quality health care.

Enacted in March 2010, the Affordable Care Act makes health insurance more affordable and provides better access to quality health care for all Americans. Because of the Affordable Care Act, approximately 24 million people are expected to gain health insurance by 2017, with an

additional 12 million people gaining coverage under Medicaid.¹ Already the Affordable Care Act is making a difference, and millions of Americans are benefiting from the provisions of the law, including minority and underserved populations.

Since October 2013, we have reduced the number of uninsured Americans by 14.4 million,² with millions of Americans enrolling in coverage through the Health Insurance Marketplace and millions more gaining coverage through the expansion of Medicaid and the Children's Health Insurance Programs (CHIP). As of the first quarter of 2015, 14.1 million had gained health insurance since the start of the initial open enrollment period for the Marketplace, with 4.2 million Latinos and 2.3 million African Americans (ages 18-64) gaining coverage.³ Since the first quarter of 2015, the uninsured rate dropped by 12.3 percentage points among Latinos and 9.2 percentage points among African Americans in the 18-64 year old age group. Approximately 5.7 million young adults gained coverage from 2010 through March 4, 2015, dropping the young adult uninsured rate by 7.4 percent during that time.

Ending Insurance Discrimination

Under the Affordable Care Act, insurance companies can no longer deny coverage and are prohibited from engaging in discrimination based on a pre-existing condition. Insurance companies also can no longer put a lifetime dollar limit on coverage or cancel coverage by finding an accidental mistake on paperwork. These are important consumer protections for all individuals, including racial and ethnic minorities who suffer disproportionately from many chronic diseases.

In November 2014, implementing provisions in the Affordable Care Act, HHS issued final regulations requiring group and individual health plans to provide benefits for mental health and substance use disorders equivalent to those provided for physical health conditions.⁴ Ensuring parity in benefits provided for behavioral health conditions will help to address disparities experienced by many underserved and vulnerable populations.

Affordable Insurance Coverage

The Affordable Care Act expands access to affordable health insurance coverage. Racial and ethnic minorities constitute one-third of the nation's population, but constitute more than one-half of the nation's uninsured. Young adults, who have had some of the highest rates of being uninsured, can now stay on their parents' health plans until the age of 26, and by 2013 more than

¹ Congressional Budget Office's March 2015 Estimates of the Effects of the Affordable Care Act on Health Insurance Coverage. (2015). Retrieved July 2015 from:

<https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>

² U.S. Department of Health and Human Services *ASPE Issue Brief, October 31, 2014*.

http://aspe.hhs.gov/health/reports/2014/InsuranceEstimates/ib_InsuranceEstimates.pdf

³ U.S. Department of Health and Human Services. Health Insurance Coverage and the Affordable Care Act, May 2015. Retrieved from: http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

⁴ U.S. Department of Health and Human Services [Press Release] Administration issues final mental health and substance use disorder parity rule. Retrieved July 2015 from:

<http://www.hhs.gov/news/press/2013pres/11/20131108b.html>

3 million young adults had gained health insurance coverage⁵. Americans of all ages are benefitting from the preventive health care services provided at no cost as part of the essential health benefits mandated under the Affordable Care Act. No-cost health care services that are now available include immunizations; cancer screenings, well-woman visits; depression screening; and counseling for obesity.

During the second open enrollment period (November 15, 2014 to February 15, 2015, including Special Enrollment Period activity through February 22, 2015), a total of 11.7 million individuals had signed up for or were automatically re-enrolled in individual market health coverage through HealthCare.gov or a State-based Marketplace.⁶ In the 37 states using the HealthCare.gov platform, nearly 8 in 10 consumers had the option of obtaining coverage for \$100 per month or less after any applicable financial assistance to lower their monthly premiums. The state-based and federal Marketplaces have provided individuals, families, and small businesses (those with 100 or fewer employees) access to affordable, high-quality health plans.

As of 2014, under the Affordable Care Act all plans offered inside and outside of the Health Insurance Marketplace are required to offer items and services referred to as essential health benefits. Any private health insurance plan offered through the Marketplace must, at a minimum, offer these services. Additionally, states choosing to expand their Medicaid program must offer these essential health benefits to those newly eligible for Medicaid. These essential health benefits are available to all eligible individuals, regardless of pre-existing conditions, and include items and services within the following ten categories: ambulatory patient services; hospitalization; pregnancy, maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive services; and pediatric services.

**Table 1. Expansion in Insurance Coverage as a Result of the Affordable Care Act⁷
Estimated Number of Individuals Affected**

Benefit	African Americans	American Indians/ Alaska Natives	Asian Americans and Pacific Islanders	Latinos	Effective Date
Persons Who Newly Have Insurance Coverage (Ages 18-64)	2.3 million	N/A	N/A	4.2 million	As of Q1 2015
Number of Americans Estimated to be Newly Covered for Expanded Preventive Services Under the Affordable Care Act	7.8 million	0.5 million	4.3 million	8.8 million	As of June 2014

⁵U.S. Department of Health and Human Services Health Insurance Coverage and the Affordable Care Act (May 2015). Retrieved July 2015 from: http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

⁶ “Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report” (March 2015). Retrieved from: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

⁷ U.S. Department of Health and Human Services Health Insurance Coverage and the Affordable Care Act (May 2015). Retrieved from: http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf

Preventive Care

The Affordable Care Act helps to reduce disparities by making preventive care more affordable and accessible. The law requires health plans to cover certain preventive services, such as blood pressure and cholesterol screening, mammograms and Pap smears, and vaccinations, with no cost-sharing (e.g., copayment, coinsurance or deductible). Millions of elderly and disabled Americans with Medicare also have access to many preventive services with no cost-sharing, such as an annual wellness visit and cancer screenings.

Health Care Providers for Underserved Communities

The Affordable Care Act increases funding for community health centers, which provide comprehensive, high-quality preventive and primary health care. In 2013, of the 21.7 million people treated at community health centers supported by the Health Resources and Services Administration (HRSA), more than half of the patients were racial and ethnic minorities. According to 2013 Uniform Data System, 1,202 health center grantees with 9,208 sites served 21.7 million patients (62 percent of whom are members of racial and ethnic and minority groups) through 86 million patient visits supported by 156,817 personnel. Community health centers have received funding to create new health center sites in medically underserved areas, to expand preventive and primary health care services, and to support major construction and renovation projects.

Diversity and Cultural Competency of the Workforce

Numerous studies indicate that racial and ethnic minority health care providers are more likely to practice in medically underserved areas and provide health care to large numbers of minorities who are uninsured or underinsured.^{8,9,10,11} Increasing the diversity and cultural and linguistic competency of the public health and health care workforces are important strategies to address health and health care disparities. Investments through the Affordable Care Act and the American Recovery and Reinvestment Act of 2009 have helped to more than double the number of clinicians in the National Health Service Corps (NHSC), a network of primary care providers who practice in underserved and vulnerable communities, from 3,600 to nearly 8,900 in fiscal

⁸ Komaromy, M., Grumbach, K., Drake, M., Vranizan, K., Luri, N., Keane, D. & Bindman, A. B. (1996). The role of Black and Hispanic physicians in providing health care for underserved populations. *New England Journal of Medicine*, 334, 1305-1310.

⁹ Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender and partnership in the patient-physician relationship. *Journal of the American Medical Association*, 282(6), 583-589.

¹⁰ The Affordable Care Act helps African Americans. (n.d.). *The White House*. Retrieved from:

http://www.whitehouse.gov/sites/default/files/docs/the_aca_helps_african_americans_fact_sheet_0.pdf.

¹¹ Community Health Centers and the Affordable Care Act: Increasing access to affordable, cost effective, high quality care. (2010). *Healthcare.gov*. Retrieved from:

<http://www.healthcare.gov/news/factsheets/2010/08/increasing-access.html>.

year 2013.¹² The NHSC provides scholarships and loan repayment to medical students and primary care physicians, as well as other health professionals, in exchange for a commitment to practice in an underserved area. HRSA reports that in fiscal year 2014, the program resulted in 9.7 million patients being served by NHSC clinicians and in 9,200 scholarship and loan repayment agreements to place NHSC clinicians in communities with limited access to care. The Affordable Care Act also strengthens cultural competency training for health care providers.

Improved Data Collection and Reporting Standards

The goal of section 4302 of the Affordable Care Act is to improve efforts to reduce disparities through the standardization, collection, analysis, and reporting of data on health and health care disparities. In accordance with section 4302(a), HHS adopted new data standards for the collection of race, ethnicity, sex, primary language, and disability status for self-reported data collected from population-based health surveys on October 31, 2011. Section 4302(b) requires the collection of data on these five demographic characteristics in Medicaid and the CHIP. Secretary Burwell submitted the *Report to Congress Improving the Identification of Health Care Disparities in Medicaid and CHIP* in November 2014.¹³ This report documents HHS' progress in implementing approaches for identifying, collecting, and evaluating data on health care disparities in Medicaid and CHIP, including recommendations for improvement. HHS has made progress in addressing health care disparities in Medicaid and CHIP by updating data-collection systems and tools; stratifying performance measures by demographic characteristics; developing new measures specific to populations of interest; and promoting data sharing, collaboration, and analyses.

Provisions within the Affordable Care Act to Strengthen the Department of Health and Human Services Minority Health Infrastructure

The Affordable Care Act includes provisions that specifically improve efforts by HHS to address minority health and reduce health disparities. These include the transfer of the Office of Minority Health within the Office of the Secretary (OS), the redesignation of the National Institute on Minority Health and Health Disparities within the National Institutes of Health (NIH), establishment of Offices of Minority Health (OMH) within six HHS agencies, and development of measures to evaluate the effectiveness of activities aimed at reducing health disparities.

¹² U.S. Department of Health and Human Services Health Resources and Services Administration. Fiscal year 2016 Justification of Estimates for Appropriations Committee. Retrieved July 2015 from: <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>.

¹³ U.S. Department of Health and Human Services. (November 2014). Report to Congress Improving the Identification of Health Care Disparities in Medicaid and CHIP. Retrieved from: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc-2014.pdf>

Reauthorization of the HHS Office of Minority Health

The Affordable Care Act authorized appropriations for the HHS Office of Minority Health (OMH) through 2016. The law retains and strengthens existing authorities for improving minority health and the quality of health care minorities receive, and for eliminating health disparities. The Affordable Care Act also requires that OMH “submit a report” to Congress on minority health “activities carried out during the preceding two fiscal years” that evaluate the “extent to which such activities have been effective in improving the health of racial and ethnic minority groups.”¹⁴ These authorities form the basis for the OMH activities that are reported below.

Elevation of the HHS Office of Minority Health

HHS issued a change of reporting structure for the Deputy Assistant Secretary for Minority Health to report directly to the Secretary and be administratively supported by the Assistant Secretary for Health. The Deputy Assistant Secretary for Minority Health serves as the Director of the HHS Office of Minority Health and as principal advisor to the Secretary for health program activities that address minority populations, develops policies for the improvement of health status of minority populations, and coordinates all Public Health Service minority health activities.¹⁵

Establishment of Six Individual Offices of Minority Health

The leadership of the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA) each created an Office of Minority Health within their agency as required by Section 10334 of the Affordable Care Act (Section 1707A of the PHS Act). The heads of the agencies also appointed a director for their respective Office of Minority Health who would report directly to them. Funding reserved from each agency’s appropriation is to be utilized to carry out minority health activities, including staffing for the office.

All of the above named agencies have appointed permanent directors who meet regularly with the Deputy Assistant Secretary for Minority Health and who provide important leadership and coordination within their agencies on minority health and health equity.

Redesignation of the National Center on Minority Health and Health Disparities

The Affordable Care Act redesignated the National Center on Minority Health and Health Disparities within the National Institutes of Health (NIH) to an Institute. Among other responsibilities, the National Institute on Minority Health and Health Disparities (NIMHD) “coordinates all research and activities conducted or supported” by NIH on minority health and

¹⁴ 42 U.S.C. § 300u–6(f); Retrieved from: <https://www.law.cornell.edu/uscode/text/42/300u-6>

¹⁵ 78 FR 59699 (September 27, 2013); Retrieved from: <https://federalregister.gov/a/2013-23680>.

health disparities. The NIMHD also is authorized to “plan, coordinate, review, and evaluate research and other activities conducted or supported by the institutes and centers” of NIH.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan)

The persistence of health disparities and the increasing diversity of the nation’s population since the publication of the *Heckler Report* prompted HHS to strengthen its commitment to reducing racial and ethnic health disparities. The HHS leadership realized the pressing need to develop a national plan that would focus specifically on addressing health inequities that stemmed from social, economic, and environmental disadvantages that disproportionately affect racial and ethnic minorities.

Released in April 2011, the HHS Disparities Action Plan not only responds to the input of stakeholders around the nation, but it also capitalizes on new and unprecedented opportunities in the Affordable Care Act to benefit diverse communities.

This comprehensive plan leverages key provisions of the Affordable Care Act. With the HHS Disparities Action Plan, the Department is committed to continuously assessing the impact of all policies and programs on racial and ethnic health disparities through several priorities, goals, and strategies. These include:

1. **Transform Health Care** – Strengthening the current health care system and building a high-value health care system requires insuring the uninsured, making coverage more secure for those who have it, and improving the quality of care for all populations. The HHS Disparities Action Plan outlines strategies to reduce health disparities by expanding access to health coverage and improving primary care services, care coordination, and health care quality.
2. **Strengthen the Nation’s Health and Human Services Infrastructure and Workforce** – There is a critical shortage of primary care physicians, nurses, behavioral health providers, long-term care workers, community health workers, and other health professionals in the United States. With growing national diversity, the disparity between the racial and ethnic composition of the health care workforce and that of the population widens. Strategies for strengthening the health and human services’ infrastructure and workforce outlined in the HHS Disparities Action Plan involve addressing this shortage, increasing workforce diversity, and improving the cultural competence of health professionals.
3. **Advance the Health, Safety, and Well-Being of the American People** – To prevent and control chronic diseases, the HHS Disparities Action Plan helps to create environments that empower and promote healthy behaviors in minority communities. This requires renewed commitment to prevention, with an emphasis on strengthening community-based approaches to reducing high-risk behaviors.
4. **Advance Scientific Knowledge and Innovation** – The HHS Disparities Action Plan outlines strategies to: increase the availability and quality of data collected and reported on racial and ethnic minority populations; improve patient-centered research in the areas of prevention, screening, and diagnostic and treatment services; and strengthen existing

information systems to reduce and improve the quality of health, public health, and biomedical research that will benefit all populations including racial and ethnic minorities.

- 5. Increase Efficiency, Transparency, and Accountability of HHS Programs** – HHS seeks to promote better collaboration and coordination of HHS programs to address racial and ethnic health disparities in an efficient, transparent, and accountable manner. This involves monitoring the HHS Disparities Action Plan.¹⁶

The HHS Disparities Action Plan offers a comprehensive commitment to addressing disparities related to insurance coverage, quality of care, workforce diversity, population health, research, and data collection. It is a clear example of how leaders at the highest levels have committed to making health equity a priority. It is also an example of how agencies throughout the Department are leveraging resources to eliminate health disparities.

By mobilizing HHS around these goals, the HHS Disparities Action Plan moves the country closer to realizing the vision of “a nation free of disparities in health and health care.”

Report Requirement

The Affordable Care Act requires the leaders of HHS agencies to report on minority health activities within their agencies:

“Not later than one year after the enactment of this section, and biennially thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared.”

The information contained in this report responds to the requirement in the Affordable Care Act (P.L. 111-148) at Section 10334(a)(3) by highlighting information from agencies on their activities. HHS programs and activities on minority health and health disparities in fiscal years 2013 and 2014 include specific activities of the HHS Office of Minority Health, individual Offices of Minority Health established by the Affordable Care Act, the National Institute on Minority Health and Health Disparities, and various other HHS agencies and offices. This report also addresses HHS’ strategies for ensuring cohesive and coordinated minority health and health disparities activities and for assessing performance.

Through full implementation of the HHS Disparities Action Plan, the Department promotes integrated approaches, evidence-based programs, and promising practices to reduce these disparities. For this report, the program activities of the various offices are organized by the goals and strategies of the HHS Disparities Action Plan. Use of this framework illustrates and institutionalizes the Department’s commitment to assessing the impact of all policies and programs on racial and ethnic health disparities.

¹⁶ Koh, H. K., Graham, G., & Glied, S. (2011). Reducing racial and ethnic disparities: The action plan from the Department of Health and Human Services. *Health Affairs*, 30(10), 1822-1829.

Summary of Minority Health Activities

The HHS Disparities Action Plan articulates a set of Secretarial priorities, tangible strategies, and high-impact actions to achieve the vision of “A nation free of disparities in health and health care.” Four overarching Secretarial priorities foster coordination and transformation of the existing programs and new investments included in the HHS Disparities Action Plan. The cross-cutting priorities include:

1. **Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities** – Successful implementation of this priority across HHS influences and transforms agenda setting, data collection, and public health/clinical guidelines and practice.
2. **Increase the availability, quality, and use of data to improve the health of minority populations** – Effective data collection, analysis, and utilization are fundamental to the department’s efforts to understand the causes of health disparities, design effective responses, and evaluate progress in reducing disparities. As called for by the Affordable Care Act, HHS developed and adopted new data collection standards for race, ethnicity, sex, primary language, and disability status. The HHS Disparities Action Plan also outlines strategies to ensure public access to data and identify high-need/disparity areas and align HHS investments accordingly.
3. **Measure and provide incentives for better health care quality for minority populations** – Racial and ethnic minorities often have higher rates of disease and reduced access to high quality health care services than non-Hispanic Whites. Providing incentives for quality care in these populations is critical for improving patient outcomes and creating a health care system that promotes equity. The HHS Disparities Action Plan calls for agencies to refine performance measures, develop cross-departmental and interagency collaborations, and expand health disparities projects to provide incentives to improve health care quality.
4. **Monitor and evaluate the Department’s success in implementing the HHS Disparities Action Plan** – HHS is committed to ensuring program integrity, effective program performance, and responsible stewardship of federal investments. The HHS Health Disparities Council is charged with overseeing the HHS Disparities Action Plan implementation and assists with coordinating minority health activities across HHS. Ongoing oversight by the Council identifies areas for collaboration across HHS to conduct joint health and health care disparities programs.

Guided by these priorities, HHS efforts to improve minority health are aligned under the goals and specific strategies of the HHS Disparities Action Plan.

The following sections provide information on HHS programs to reduce disparities in health and health care for minority populations during fiscal years 2013 and 2014. The departmental activity highlights for the reporting period are organized by HHS agency, including the Office of Minority Health (OMH), National Institute on Minority Health and Health Disparities (NIMHD), the six individual Offices of Minority Health, and other HHS agencies implementing related

activities. Each agency's activities are organized by the five HHS Disparities Action Plan goals and their corresponding strategies, and include:

- A description of the mission of the agency or office; and
- A summary of key activities addressing minority health and health disparities.

NOTE: Highlighted projects are generally in full or partial implementation unless otherwise noted; therefore, process and/or outcome evaluation data may not be available at this time.

Office of the Secretary, Office of Minority Health (OMH)

Agency Mission: The mission of OMH is to improve the health of racial and ethnic minorities through the development of health policies and programs that will help to eliminate health disparities. OMH serves as the lead agency for coordinating efforts across the government to address and to eliminate health disparities. OMH convenes and provides guidance to HHS operating and staff divisions and other Federal departments to identify health disparity and health equity policy and programmatic actions. This targeted leadership improves performance through better coordination on cross-cutting initiatives and leverages funds to reduce health disparities.

OMH accomplishes its work through coordination of HHS health disparity programs and activities; assessing policy and programmatic activities for health disparity implications; building awareness of issues impacting the health of racial and ethnic minorities; developing guidance and policy documents; collaborating and partnering with agencies within HHS, across the federal government, and with other public and private entities; funding demonstration programs; and supporting projects of national significance.

OMH programs address disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care. OMH's core functions are to:

- Promote the collection of health data by racial, ethnic, and primary language categories and strengthen infrastructures for data collection, reporting, and sharing;
- Work to increase public awareness of the major health problems of racial and ethnic minorities and factors that influence health through collaborations and partnerships;
- Establish and strengthen networks, coalitions, and partnerships to identify and solve health problems;
- Develop and promote policies, programs, and practices to eliminate health disparities and achieve health equity;
- Foster research, demonstrations, scientific investigations, and evaluations aimed at identifying and addressing health disparities; and
- Fund demonstration programs that can inform health policy and the effectiveness of strategies for improving health disparities.

OMH also has a Regional Minority Health Consultant (RMHC) in each of the 10 HHS regional offices to serve as a focal point and technical resource on minority health issues within each region. The RMHCs help build a network of consumers and professionals working on minority health issues. In addition, the RMHCs work with State and Territorial Offices of Minority

Health and provide technical assistance to organizations that serve minority and underserved communities.

OMH Strategic Priorities: OMH focuses on translating core minority health and health disparity programs into strategic activities and policies at the federal, state, tribal, territorial, and local levels. OMH's three strategic priorities are to:

- Support the development and implementation of the provisions of the Affordable Care Act that address health disparities and equity;
- Lead the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan); and
- Coordinate the National Partnership for Action to End Health Disparities (NPA).

In fiscal years 2013 and 2014, OMH played a critical role in supporting and implementing the provisions of the Affordable Care Act that address health disparities and equity. Racial and ethnic minorities have the highest rates of being uninsured, are less likely to receive preventive care, have higher rates of many chronic conditions, have fewer treatment options, and are less likely to receive quality health care. Educational outreach serves to raise the awareness of minority and underserved populations about the Affordable Care Act and to support increased enrollment of underserved populations in health plans. OMH collaborated with strategic partners and stakeholders to increase the understanding of health plans, benefits, and eligibility as well as increase enrollment in the Health Insurance Marketplace for racial and ethnic minorities and underserved populations.

OMH leads and oversees the implementation of the HHS Disparities Action Plan. Launched in April 2011, the HHS Disparities Action Plan is the most comprehensive federal commitment on health disparities reduction and charges all HHS operating and staff divisions to heighten the impact of HHS policies and programs to reduce health disparities. Developed through a department-wide strategic planning process led by the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation (ASPE), the HHS Disparities Action Plan is focused on improving the health status of racial and ethnic minorities across their lifespan.

Another important leadership effort for OMH has been the development and implementation of the NPA. The NPA was established to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity, using social determinants of health framework. There are four key implementation components of the NPA:

1. **Federal Interagency Health Equity Team (FIHET)** – An interagency federal team composed of 12 federal agencies and departments that identifies opportunities for federal collaboration, partnership, coordination, and/or action on efforts that are relevant to the NPA and provides leadership and guidance for national, regional, state, tribal, territorial, and local efforts that address health equity.
2. **Regional Health Equity Councils (RHECs)** – Led by and each composed of up to 35 non-federal members, the 10 RHECs are regional coalitions that drive regional action

around common issues and leverage federal, regional, state, tribal, territorial, and local resources to combat health disparities.

3. **State and Territorial Offices of Minority Health** – The state and territorial offices of minority health lead state and territorial efforts in implementing health disparity or health equity plans in alignment with the NPA and developing strategic partnerships.
4. **National Partners** – National partners include community and faith-based organizations, professional societies, government agencies, national non-profit organizations, advocacy groups, foundations, corporations, businesses, industry groups, and academic institutions that support the NPA by advancing the goals of the NPA within their organization’s mission and operations and through leveraging resources and strategic partnerships.

A key product of the NPA, the National Stakeholder Strategy for Achieving Health Equity (NSS) was developed based on the input of more than 2,000 leaders and advocates from across the United States who called for collaborative actions to effectively and efficiently address health and health care disparities in this country. These leaders and advocates represented community-based organizations, faith-based organizations, the business sector, the public health community, the health care workforce, academia, as well as local, territorial, state, tribal, and federal governments.

The goals of the NPA and its NSS include:

1. **Awareness** – Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations;
2. **Leadership** – Strengthen and broaden leadership for addressing health disparities at all levels;
3. **Health System and Life Experience** – Improve health and health care outcomes for racial, ethnic, and underserved populations;
4. **Cultural and Linguistic Competency** – Improve cultural and linguistic competency and the diversity of the health-related workforce; and
5. **Data, Research, and Evaluation** – Improve data availability and the coordination, utilization, and diffusion of research and evaluation outcomes.

Together, the HHS Disparities Action Plan and the NSS provide visible and accountable federal leadership while also promoting collaborations among communities, states, tribes, the private sector, and other stakeholders to more effectively reduce health disparities and achieve health equity.

Highlights of OMH’s Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

The rationale for and goals outlined by the HHS Disparities Action Plan are directly aligned with OMH’s mission to improve the health of racial and ethnic minorities through the development of health policies and programs that will eliminate health disparities. The section below highlights a sample of OMH programs that address goals I through IV. Goal V (increasing the efficiency,

transparency, and accountability of HHS programs) is addressed in the final section of the report, “Coordination, Integration, and Accountability.”

Goal I: Transform Health Care

During the first two open enrollment periods for the Health Insurance Marketplace (October 2013 through February 2015), many of OMH’s program activities within Goal I focused on **reducing disparities in health insurance coverage and access to care** (Strategy I.A).

Traditional Media - OMH’s traditional media outreach focused on reaching minority consumers with information about enrollment. This included a radio and digital media campaign in English and Spanish to increase health insurance coverage during the special enrollment period and to expand health literacy in minority communities through the CMS “From Coverage to Care” program. This targeted campaign reached over 4 million people in the Washington, DC; Miami; Houston; and Galveston border areas during the period that it ran in October 2014. OMH also conducted interviews with radio and other outlets in key markets throughout the country.

Social Media - OMH connected with minority communities through social media platforms, promoting OMH-created infographics that encouraged consumers to sign up for coverage to our network of tens of thousands of active followers. OMH also regularly participated in Google Hangouts, Twitter Chats and other social media activities in English and Spanish about enrollment and “From Coverage to Care.” Other health awareness campaigns provided a platform to publicize opportunities for coverage through the Marketplace and Medicaid, including Twitter chats during Minority Health Month in April (7 million reached), Men’s Health Month in June (7 million reached), Minority Mental Health Month in July (3 million reached) and Hispanic Heritage Month in Sept.-Oct., among others.

Professional Outreach - OMH promoted information, tools and resources to support organizations engaged in enrollment activities and outreach via the OMH website (which receives 56,000 unique views monthly) and through weekly and monthly newsletters (which reach over 25,000 people, mostly health and service professionals.)

The *Regional Health Equity Councils (RHECs)* of the National Partnership for Action to End Health Disparities supported the efforts of the Affordable Care Act to remove barriers to coverage based on health status, particularly for racial and ethnic minorities who have disproportionately higher rates of chronic disease. Supporting outreach activities in four regions, RHECs engaged approximately 3,250 consumers eligible for coverage under the

Affordable Care Act in seven states, with almost 50 percent expressing intent to enroll in coverage. Technical assistance from OMH was used to support their data collection activities through the development of a tool that the RHECs and their partners used to assess the impact of

Project Impact: NPA/RHEC ACA Outreach and Enrollment Activities

Supporting the Affordable Care Act outreach activities in four regions, Regional Health Equity Councils (RHECs) engaged approximately 3,250 consumers eligible for coverage under the ACA in seven states, with almost 50% expressing an intent to enroll in coverage.

their outreach efforts. Specific examples of events include:

- A Health Insurance Marketplace training forum co-sponsored with CMS;
- A statewide conference with Public Housing Authorities to reach low income populations on the Affordable Care Act benefits;
- A Community Forum and Expo on the Affordable Care Act with more than 250 attendees, translated in four additional languages (Chinese, Korean, Hindi, and Tagalog);
- An educational session for 622 attendees from all five racial and ethnic minority groups across Michigan on general policies and procedures for implementation of the Affordable Care Act; and
- Twenty-seven Affordable Care Act presentations to a diverse range of organizations including business associations, HIV planning groups, health service advisory councils, parole boards/programs for the re-entry population, churches, and local departments of health.

Many of OMH's program activities within Goal I also focused on **reducing disparities in access to primary care services and care coordination** (Strategy I.B) and **reducing disparities in the quality of health care** (Strategy I.C). Programs often focus on specific racial or ethnic minority populations and demonstrate OMH's commitment to establishing and strengthening networks, coalitions, and partnerships to identify and reduce health disparities.

OMH, through its *Office of Minority Health Resource Center (OMHRC)*, continues to increase public awareness of health disparities that impact racial and ethnic minority communities, and to educate consumers about important health policies that can have impact on their lives, including the Affordable Care Act. In FY 2014, OMHRC helped to expand OMH's public awareness efforts by leveraging social media to help increase youth enrollment in the Health Insurance Marketplace. An innovative series of social media marketing ads with youth appeal encouraged people under 25 to get covered, and the ads were shared widely across social media and by our partners, including the White House, Native News Online and Robert Wood Johnson Foundation. During National Minority Health Month 2014, OMHRC organized a Twitter relay event with over 20 public and private sector partners to promote prevention, best practices, and health resources to a range of consumers. The impact of this social media outreach was a potential reach of over 56 million people on Twitter.

Through OMHRC, OMH also increased outreach to minority populations by leveraging broadcast, print and online media to conduct public information, health promotion and public education campaigns through earned (free) media outreach. News stories placed in traditional and minority media resulted in free media exposure valued at over \$1 million. Through media outreach, health education messages on prevention, information on obtaining health insurance through the Health Insurance Marketplace and public education messages on how to utilize new health insurance coverage was conveyed to more than 800 million viewers in 2014.

Goal II: Strengthen the Nation’s Health and Human Services Infrastructure and Workforce

Program activities for OMH within Goal II focus on several key strategies outlined in the HHS Disparities Action Plan to build the capacity of the health and human services infrastructure and workforce to eliminate health disparities.

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) addresses the need to **increase the ability of health professions and health care systems to identify and address racial and ethnic disparities** (Strategy II.A). Originally published in 2000, the National CLAS Standards provide a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services to advance health equity, improve quality, and help eliminate health care disparities. OMH updated and released the enhanced National CLAS Standards in 2013 and provides national leadership and technical assistance to HHS agencies and external stakeholders to promote the adoption, implementation, and evaluation of the National CLAS Standards. OMH has conducted studies related to the identification and adoption of the National CLAS Standards in health care. One organization that has incorporated the National CLAS Standards into its hospital accreditation standards is the Joint Commission, which recently released 2015 Standards for the Hospital Accreditation Program.¹⁷ Several of the Standards’ requirements align with the intent and objectives of OMH’s National CLAS Standards. In addition, a partnership between OMH and the National Center for Health Statistics resulted in questions related to the National CLAS Standards being added to the National Ambulatory Medical Care Survey (NAMCS). Two questions assessing cultural competence training and awareness of the National CLAS Standards will be added to the 2015 NAMCS.

OMH’s *Center for Linguistic and Cultural Competency in Health Care (CLCCHC)* supported the launch of a new e-learning program for oral health professionals in FY 2014 and began development of an e-learning program for *Promotores de Salud*. Think Cultural Health (TCH), the flagship initiative of the CLCCHC (see <https://www.thinkculturalhealth.hhs.gov>), was established to advance health equity at every point of contact through developing and promoting culturally and linguistically appropriate services. In FY 2014, TCH registered 29,299 new participants in the four e-learning programs (for physicians, nurses, disaster response personnel, and oral health professionals). The programs awarded approximately 880,000 continuing education credits in FY 2014. This brings the cumulative total of registrants for these e-learning programs since their inception to the end of FY 2014 to 173,440.

To increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities, OMH coordinates and funds the *National Health Education Program on Lupus for Healthcare Providers (NHEPLHP)*. The NHEPLHP program is intended to engage health care providers, educators, and health professions schools in working together to improve lupus diagnosis and treatment through education. The goal of the program is to support

¹⁷ Joint Commission. *A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to the Joint Commission Hospital Accreditation Standards*. July 2014. Retrieved from: <http://www.jointcommission.org/assets/1/6/Crosswalk- CLAS -20140718.pdf>

the development and dissemination of a national lupus health education program to improve diagnosis and treatment for persons with lupus and to reduce health disparities in target populations. The program focuses on practicing physicians, nurses and other allied health professionals and medical, nursing, and other allied health students in training.

The NHEPLHP program has 30 partnerships with colleges and universities. Forty-six live educational events reached 2,739 persons, 6,738 individuals viewed teaching and learning videos, there were 930 curriculum downloads, and there were 8,189 individual visits to the website and 3,284 social outlet visitors. Outreach efforts resulted in the recruitment of 30 additional educators/institutions where curriculum components are now being used in the education of student trainees and other providers. A total of 268 toolkits have been distributed to practitioners and selected dermatologists and nephrologists who are a part of a network of practitioners.

OMH also leads efforts to **promote the use of *promotores de salud* and community health workers (CHWs)** (Strategy II.B) as trusted members of their community to provide health education and outreach, help community members navigate the health care system, and improve the quality of patient-provider interactions in clinical settings. OMH coordinates the *HHS Promotores de Salud Initiative*, which was launched in April 2011, with the goals of recognizing the important contributions of *promotores* in reaching vulnerable, low income, and underserved members of Latino populations and promoting the increased engagement of *promotores* to support health education and prevention efforts and access to health insurance programs. As part of the initiative, OMH chairs the *Promotores Federal Workgroup* and the *Promotores Initiative Steering Committee*, composed of 15 *promotores de salud* from across the nation. The Steering Committee identified the need to continue outreach and enrollment efforts and educate Latinos about the Affordable Care Act. A monthly newsletter was created to maintain communication with the *Promotores Steering Committee* and disseminate resources that focus on the Affordable Care Act, Latino health, and *promotores de salud*.

Project Impact: *Promotores de Salud* and Community Health Workers

- 17 *promotores* were trained in a national certified combined curriculum;
- 237 community members participated in community education sessions conducted by the trained *promotores*; and
- 9 National Council of La Raza affiliates conducted 3-day trainings on conducting environmental scans for 116 *promotores*.

The *Promotores* and CHW programs provided training and technical assistance nationwide to community- and faith-based organizations, health departments, and community stakeholders in the planning, implementation, and evaluation of CHW programs. The objective is to strengthen the capacity of at least 37 agencies nationwide to increase access to and utilization of health care services by low-income and underserved Hispanics and other minority populations. In 2013 and 2014, OMH collaborated with the National Council of La Raza (NCLR), National Hispanic Council on Aging (NHCOA) and Día de la Mujer Latina, Inc. NCLR affiliates implemented and tested curriculum focused on empowering *promotores* by training them how to conduct environmental scans to assess the strengths and needs of the community. NHCOA provided training that empowered older adults and their families to effectively navigate public health and social services. This resulted in Hispanic older adults with chronic diseases having better health

outcomes and allowing them to age at home. Finally, Día de la Mujer Latina developed standard, culturally defined, linguistically appropriate curriculum modules to address the HHS goal of reducing health disparities among vulnerable populations. The collaboration also resulted in the development of a national certified combined curriculum in Spanish and English for Promotores/CHWs/Patient Navigators.

Through the *National Umbrella Cooperative Agreements Program (NUCA)*, OMH seeks to demonstrate that partnerships between Federal agencies and national organizations can efficiently and effectively: 1) improve access to care for targeted racial and ethnic minority populations; 2) address social determinants of health to achieve health equity for targeted minority populations through projects of national significance; 3) increase the diversity of the health-related work force; and 4) increase knowledge base and enhance data availability for health disparities and health equity activities.

OMH partnered with institutions of higher education and health care provider organizations including minority serving institutions, education associations, research centers, and service providers to focus on increasing the diversity of health care and public health workforces. Partners include Harvard Medical School, Morehouse School of Medicine, United Negro College Fund Special Program Corporation, Hispanic Association of Colleges and Universities, Hispanic-Serving Health Professions Schools, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, and the National Council of Urban Indian Health. These collaborative efforts support internships, fellowships, and graduate student and faculty development programs intended to:

- Increase the pool of students from all racial and ethnic backgrounds who are interested in science and health careers;
- Provide opportunities for students to participate in program development and research with public health stakeholders across the country;
- Build leadership capacity among minority professionals and faculty through extensive training in leadership, health systems, health disparities, and health policy; and
- Increase the availability of graduate medical education and the number of culturally, linguistically, and socially competent health care professionals practicing and/or serving in medically underserved urban areas.

Overall, the institutions of higher education and provider organizations delivered services to 2,369 students (middle and high school students); trained 152 physicians, scientists, post-doctoral fellows, faculty and junior faculty in career development; and developed partnerships with more than 100 organizations, colleges and universities, and federal and state agencies.

The *Youth National Partnership for Action (yNPA)*, OMH entered into a Memorandum of Understanding (MOU) with the Stanford University Youth Medical Science Program to provide technical assistance to partners who want to adapt the Public Health Advocacy curriculum for youth enrolled in their program. OMH also entered into an MOU with the Native Hawaiian Health Consortium to adapt the youth Public Health Advocacy curriculum to include culturally appropriate exercises and modules. OMH also supported two pilot presentations for Marshall

University and West Virginia State University, reaching 187 high school students from their Upward Bound and Health care Pipeline programs.

Goal III: Advance the Health, Safety, and Well-Being of the American People

The majority of OMH’s key program activities within Goal III focus on **increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). In collaboration with a range of federal, national, state, tribal, territorial, academic, community, and faith-based partners, OMH supports the development, implementation, and assessment of evidence-based interventions to close the modifiable gaps in health, longevity, and quality of life among racial and ethnic minorities.

The programs focus on **outreach and education campaigns regarding preventive benefits in relation to specific conditions and/or populations**. *Million Hearts®* is a national initiative to prevent 1 million heart attacks and strokes by 2017. The initiative brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke. OMH has provided technical assistance across HHS and to external partners to enhance the impact of programmatic and policy work in reducing disparities in cardiovascular disease outcomes. In FY 2013, OMH and CMS’ Office of Minority Health funded pilot project known as the Million Hearts Stroke Belt Project, which assessed the effectiveness of a six-session stroke prevention program delivered in African-American churches in three high-disparity counties in Alabama. The project recruited 200 participants and showed an improvement in knowledge scores and a reduction in systolic blood pressure measures and weight among the participants.

The *Walgreens/HHS Influenza Voucher Initiative*, a public-private partnership in the form of a Co-Sponsorship Agreement was first established between Walgreens, Inc. and HHS during the 2010 - 2011 influenza season. The primary purpose of the Agreement was assisting uninsured racial and ethnic minorities obtain an annual influenza vaccination. In each successive year of the initiative, the number of individuals receiving an influenza vaccination has increased from 4,395 vaccinated during the 2010 – 2011 influenza season to 252,538 vaccinated during the 2013 – 2014 influenza season. This initiative utilizes community and faith-based organizations, community health workers, and other entities in concert with local Walgreens pharmacies to identify and host influenza vaccination events in traditionally under-vaccinated communities. A new Agreement covering the 2014 – 2015 influenza season was signed in July 2014.

Influenza Season	Influenza Vaccinations
2013 - 2014	252,538
2012 – 2013	168,681
2011 – 2012	52,851
2010 - 2011	4,395

Through its Resource Center, OMH provided additional support to communities through capacity building and technical assistance to organizations and institutions that support the health of communities of color throughout the U.S. and its territories. In FY2013 and 2014, participants from 413 community- and faith-based organizations, departments of health or institutions of higher education, including minority serving institutions participated in dynamic two and three day capacity building or disease specific workshops. Unique achievements include the creation and implementation of the first-of-its kind wellness curriculum that incorporates

Pacific indigenous culture and beliefs, and hosting of a conference examining the health and well-being of African immigrants.

OMH also supports **collaborative community-based projects to promote healthy behavior and decrease health disparities among youth and young adults**. These programs feature

collaboration among a range of partners, including institutions of higher education (including minority-serving institutions), primary and secondary schools, community organizations and institutions, and the community at large. For example, the

Youth Empowerment Program (YEP)

addresses unhealthy behaviors in minority

at-risk youth (ages 10-18) and provides them with opportunities to learn skills and gain experiences that contribute to more positive lifestyles and enhance their capacity to make healthier life choices. The Minority Youth Violence Prevention: Integrating Public Health and Community Policing Approaches (MYVP), a newly funded program in partnership with the Department of Justice, Office of Community Oriented Policing Services (COPS Office) supports this national initiative. The program supports program interventions developed through adaptations, refinements, and modifications of promising violence prevention and crime reduction models that are tailored to at-risk minority male youth (ages 10-18) and integrate a problem solving approach, such as the Center for Disease Control and Prevention (CDC) problem-solving model or the COPS Office “Scanning, Analysis, Response and Assessment (SRA) problem-solving model. These approaches will simultaneously address public health and public safety concerns and be tailored to at-risk minority male youth.

Project Impact: Preventing and Eliminating Disparities Among Youth and Young Adults

The *Youth Empowerment Program (YEP)* reached nearly 73,000 at-risk minority youth and their families; 60 percent of youth cohort participants were female.

OMH activity within Goal III also focused on **conducting and evaluating pilot tests of health disparity impact assessments of selected proposed national policies and programs** (Strategy III.B). As an initial step, the *Federal Interagency Health Equity Team (FIHET) Equity in All Policies Workgroup* promoted adoption of a “health in all policies” approach. The Workgroup supported a panel session at the National Health Impact Assessment conference in Washington, D.C., on ongoing efforts to integrate or consider equity in policies and programs in public, private, health, and non-health sectors. The Workgroup also organized a series of monthly health equity webinars featuring state and local promising practices, including California, Maryland, Massachusetts, Minnesota, and Ohio. A total of 901 individuals participated in the first six webinars. On average, 90 percent of participants agreed their knowledge of strategies for integrating equity in policies and programs increased, and 88 percent of participants agreed they would be able to apply to their work the information learned.

Goal IV: Advance Scientific Knowledge and Innovation

Many of OMH’s program activities within Goal IV focus on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A) and **conducting and supporting research to inform disparities reduction initiatives** (Strategy IV.B). For example, in 2014 OMH:

- Produced the data brief, *Characteristics of Uninsured Males by Race and Ethnicity (Ages 18-64 years)*, to detail socio-demographic information specifically about uninsured men of color and support efforts regarding outreach and enrollment in health insurance coverage for this population.
- Produced a research brief, in collaboration with the Assistant Secretary for Planning and Evaluation (ASPE), *Eligible Uninsured Asian Americans, Native Hawaiians, and Pacific Islanders: 8 in 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid or CHIP*, to detail important demographic characteristics among uninsured Asian Americans, Native Hawaiians, and Pacific Islanders.
- Published the manuscript *Reducing ex-offender health disparities through the Affordable Care Act: Fostering improved health care access and linkages to integrated care*, to describe how new health care coverage opportunities made available by the Affordable Care Act and utilization of integrated health care models may reduce health disparities experienced by ex-offenders.¹⁸

OMH partners with State and Territorial Offices of Minority health through the *State Partnership Grant Program to Improve Minority Health (SPG)* to address data needs within the states regarding health disparities. The purpose of this program is to facilitate the improvement of minority health and elimination of health disparities through the development of partnerships with State and Territorial Offices of Minority Health. The grantees addressed at least one of the three project areas: National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards); the Affordable Care Act; or social determinants of health (three of eight health issues: asthma, cancer, cardiovascular disease and stroke, adult and/or child immunization, diabetes, infant mortality, mental health or obesity/overweight). SPG engaged more than 1,780,460 organizations and consumers in FY 2013 and 5,620,407 in FY 2014.

OMH funds the *American Indian/Alaska Native (AI/AN) Health Disparities Partnerships Program*, which is intended to strengthen the capacity of Tribal Epidemiology Centers (TECs) and Urban Indian Health Programs (UIHPs). Under the AI/AN Health Disparities Program, TECs and UIHPs are provided assistance to collect and manage data more effectively, as well as to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. The AI/AN Health Disparities Program also helps create a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions. The program impacted almost 1,742 individuals in FY 2013 and 2,645 individuals in FY 2014.

OMH is continuing its partnership with CDC's National Center for Health Statistics (NCHS) in support of the *Native Hawaiian and Pacific Islander (NHPI) National Health Interview Survey (NHIS) Project*, which will ultimately collect data on approximately 4,000 NHPI households. The partnership addresses the persistent lack of data for this small size population. This project supports the HHS Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and

¹⁸ Ejike-King, L. & Dorsey, R. (2014). Reducing ex-offender health disparities through the Affordable Care Act: Fostering improved health care access and linkages to integrated care. *AIMS Public Health*, 1(2), 76-83. doi: 10.3934/public health.2014.2.76

Disability Status required by Section 4302 of the Affordable Care Act. OMH worked closely with NCHS in FY 2013 and FY 2014 to support culturally competent outreach and education regarding the study. OMH collaborated with CDC and the White House Initiative on Asian Americans and Pacific Islanders in community outreach and education efforts. Data from the NHPI NHIS are expected to be available in 2015.

National Institutes of Health (NIH) / National Institute on Minority Health and Health Disparities (NIMHD)

Agency Mission: The mission of the National Institutes of Health (NIH) is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and reduce illness and disability. To achieve its mission, NIH provides leadership and direction to programs designed to improve the health of the nation by conducting and supporting biomedical research and activities that foster workforce development. Under this scope, all Institutes, Centers, and the Office of the Director of the NIH support health disparities research. Each strives to, conduct and support intensive research on the factors underlying health disparities; expand and enhance research capacity to create a culturally sensitive and culturally competent workforce; and engage in aggressive, proactive, community outreach, information dissemination, and public health education.

Scientific research to improve minority health and reduce health disparities is led by the National Institute on Minority Health and Health Disparities (NIMHD). To achieve its mission, NIMHD conducts and supports research on minority health and health disparities, promotes and supports the training of a diverse research workforce, translates and disseminates research information, and fosters innovative collaborations and partnerships. In addition, the Affordable Care Act elevated the National Center on Minority Health and Health Disparities to an institute at NIH. The Affordable Care Act also charged NIMHD with the responsibility to plan, coordinate, review, and evaluate all minority health and health disparities research activities conducted and supported by NIH.

Highlights of NIH's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

The mission-driven program activities of NIH primarily fall within two key areas identified in the HHS Disparities Action Plan: (1) fostering workforce and infrastructure development; and (2) providing leadership and direction to programs designed to improve the health of the nation by conducting and supporting biomedical research. As noted below, many of the programs focus on both areas.

NIH highlighted programs, projects, and initiatives for fiscal years 2013 and 2014 support Goals II and IV of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

The NIH conducts several programs to **increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities** (Strategy II.A). For example, NIH's annual *Translational Health Disparities Course* draws a diverse group of health care and public health professionals, researchers, scientists, and members of community- and faith-based organizations seeking research tools to combat health disparities. This competitive, two-week intensive training course held at the National Institutes of Health campus in Bethesda, MD trained nearly 200 students in fiscal years 2013 and 2014. In another example, NIH's *Community Networks Program-Centers (CNP-C)* program is the next generation of the Community Networks Program to Reduce Cancer Health Disparities through Education, Research, and Training. The program established 23 CNP-Cs (six national and 17 regional centers) to conduct evidence-based research through randomized controlled trials to increase knowledge of, access to, and utilization of beneficial biomedical and behavioral procedures related to reducing cancer disparities. The CNP-C includes training of qualified health disparity researchers (particularly new and early stage investigators) in the areas of community-based participatory research (CBPR) and cancer health disparities. The program works with community-based organizations, academic institutions, and HRSA federally qualified health centers. In fiscal years 2013 and 2014, the program conducted 5,593 outreach events nationwide with 206,676 participants.

NIH's *Minority Based Community Clinical Oncology Program (MB-CCOP)* addresses the access to health care component of cancer health disparities by making state-of-the-art cancer clinical trials available to rural residents, racial and ethnic minorities, and other underserved populations. Required to serve a population that is at least 40 percent minority, the participating institutions identify research issues that contribute to cancer care outcomes and provide this information to investigators involved in designing research projects. Cancer centers, community-based oncology groups, and universities came together to engage 1750 providers and conduct 568 clinical trials from June 2013 through May 2014. NIH's *Legacy Project* addresses factors influencing participation in clinical research related to HIV prevention and treatment by people in traditionally underrepresented communities (including African American, Hispanic, and American Indian/Alaska Native communities). Partnerships have been cultivated between NIH's five HIV/AIDS clinical research networks and community-based organizations with the goal of increasing knowledge/awareness of biomedical HIV research in these communities. Results have included capacity building in community-based organizations, development of a project guidance and best practices document for working with American Indian communities, and a study at Historically Black Colleges and Universities to obtain information on HIV/AIDS knowledge, stigma, awareness, and risk among African American college students.

NIH also supports a number of projects to **increase the diversity of the health care and public health workforces** (Strategy II. C). For example, programs within the *Infrastructure Development and Training for Drug Abuse Research* support a range of infrastructure and training activities that focus on: increasing the research capacity of institutions that serve economically disadvantaged students; improving diversity in the scientific research workforce

by supporting and recruiting students, postdoctoral fellows, and investigators from groups that have been shown to be underrepresented in the sciences; providing technical assistance workshops to underrepresented scholars to enhance their scientific writing and grant proposal preparation skills; and providing research training and mentorship to high school and undergraduate students. The programs focus on racial and ethnic minorities, communities with low socioeconomic status, and rural communities. Partners include academic institutions, and the National Hispanic Science Network. This program has provided scientific training opportunities to over 700 early career investigators in fiscal years 2013 and 2014. *NIH's Minority Biomedical Research Support* programs aim to increase the number of faculty, students, and investigators who are members of groups that are underrepresented in the biomedical sciences. These programs include the Support of Continuous Research Excellence, Research Initiative for Scientific Enhancement, and Initiative for Minority Student Development programs. Focused on racial and ethnic minorities, the program partnered with academic institutions to support more than 1,900 undergraduates, masters, and doctoral students in 2013. NIH also partners with the Indian Health Service (IHS) to support the *Native American Research Centers for Health (NARCH)* program. The NARCH initiative supports partnerships between tribes or tribally-based organizations and institutions that conduct intensive, academic-level biomedical, behavioral, and health services research. The NARCH program provides opportunities for conducting research, research training, and faculty development to meet the needs of AI/AN communities. Participants and partners include tribal community colleges and minority-serving institutions that partner with research-intensive universities. The program supported 19 grants in fiscal year 2013 and 20 grants in fiscal year 2014.

Goal IV: Advance Scientific Knowledge and Innovation

NIH supports a range of programs intended to **increase the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). For example, NIH's *Jackson Heart Study (JHS)* was initiated in 1998 as a multi-center investigation of predictors of cardiovascular disease in 5,301 African Americans living in Hinds, Madison, and Rankin Counties surrounding the Jackson, MS metropolitan area. This population-based, longitudinal study exemplifies a unique collaborative model among three institutional partners, the Jackson community, and NIH to uncover the causes of cardiovascular disease, diabetes, and other important diseases in African Americans. NIH has renewed funding for the Jackson Heart Study through 2018. Future research from the study may yield important insights into the

Project Impact: The Jackson Heart Study (JHS)

The JHS is the largest single-site, prospective, epidemiological investigation of cardiovascular disease among African Americans ever undertaken. Ongoing activities will:

- Engage researchers beyond the JHS in collaborative analysis of existing data to produce high quality publications;
- Serve as a training ground for undergraduate and graduate students and early career investigators, as appropriate, to help ameliorate the shortage of minority biomedical researchers;
- Serve as a platform for ancillary studies; and
- Perform community health education activities to disseminate health promotion and prevention messages in the Jackson community.

health of African Americans that can inform the development of targeted interventions to eliminate health disparities.

The *Cancer Surveillance, Epidemiology, and End Results (SEER) Program* and NIH's other major cancer surveys and surveillance systems continue to be authoritative sources of information on cancer incidence, treatment outcomes, and survival in the U.S. SEER data are representative of the demographics of the entire U.S. population. Each year, NIH publishes the statistical cancer data it collects and analyzes, most notably in the Annual Report to the Nation on the Status of Cancer. The report published in fiscal year 2013 included a special feature section on prevalence of comorbidities among Medicare beneficiaries with lung, colorectal, breast, and prostate cancers and how these conditions influence survival. Trends are presented for major racial and ethnic groups. SEER tools for the minority health and health disparities research community include the Health Disparities Calculator (HD*Calc), statistical software designed to generate multiple summary measures to evaluate and monitor health disparities, which allows the user to import SEER data or other population-based health data and calculate any of 11 disparity measurements.

The majority of NIH's program activities within Goal IV focus on **conducting and supporting research to inform disparities-reduction initiatives** (Strategy IV.B), often by fostering innovative, multidisciplinary collaborations to conduct and support intensive research on the factors underlying health disparities and to train diverse researchers.

For example, NIH supports the *Academic-Community Partnerships Initiative*, which is designed to facilitate a series of meetings to build partnerships among academic institutions and community organizations (e.g., schools, faith-based organizations, local health departments) for the purpose of generating collaborative research agendas to address disparate health outcomes. Areas of research emphasis include but are not limited to preterm birth, infant mortality, obesity, health literacy, and violence prevention. Additionally, NIH encourages community engagement as a key component of the *Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN)*. The primary mission of the ATN is to conduct research, both independently and in collaboration with existing research networks and individual investigators, in HIV-infected and HIV-at-risk pre-adolescents, adolescents, and young adults up to age 25 years. There are currently 14 ATN sites across the U.S. Connect-to-Protect® (C2P) is a community prevention protocol within the ATN that has built and continues to foster community trust and engagement, established an extensive and expanding primary prevention research infrastructure, and tested a model of community mobilization that used structural change to produce measurable improved health outcomes in community youth. There are Youth Community Advisory Boards at each site to allow for direct community feedback on the network's scientific agenda.

Project Impact: Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN)

A collaboration between the ATN, CDC, and HRSA established the first of its kind partnership between ATN clinical trial sites and their local health departments. The intent was to improve the identification of youth with undiagnosed HIV infection and, through an ATN outreach expert, link these youth to youth-friendly clinical care. Since 2010 when the collaboration was implemented, 3,300 youth have been identified and approximately two-thirds of them have been linked to care.

NIH's work in Goal IV also attempts to bridge the gap between research and practice through proactive community outreach, information dissemination, and public health education. For example, hearing loss is one of the most common birth disorders in the U.S., and American Indians are two times more likely to have hearing loss and otitis media (infection of the middle ear) than Whites and four times more likely than other groups. Hearing loss has great cultural significance to American Indians due to cultural reliance on the oral communication of knowledge held by elders. The *Safe Passage Study*, which is being conducted by the Prenatal Alcohol and Sudden Infant Death Syndrome (SIDS) and Stillbirth Research Network, includes American Indian populations. This study includes auditory tests of brainstem function. While not a true hearing assessment program, these tests may reveal deficits in auditory conduction and neural processing as well as their association with maternal alcohol intake prenatally and other possible risk factors. The study will also help to improve prevention and intervention strategies that can improve the future health or lives of these high-risk newborns in American Indian populations and increase knowledge about the importance of hearing screening and follow-through for underrepresented groups to ensure improved communication, occupational, and financial outcomes for these children.

NIH is also interested in examining the impact of determinants of health outside of health care, such as the intersection of race, geography, and socioeconomic status (SES). NIH has implemented *Healthy Aging in Neighborhoods of Diversity Across the Life Span (HANDLS)* as a multidisciplinary, community-based, prospective, longitudinal, epidemiologic study examining the influences of race and SES on the development of age-related health disparities among socioeconomically diverse African Americans and Whites in Baltimore, Maryland. This research investigates whether health disparities develop or persist due to differences in SES, differences in race, or their interaction. This study is assessing physical parameters as well as evaluating genetic, biologic, demographic, psychosocial, and psychophysiological parameters of African American and White participants with higher and lower SES over a 20-year period. HANDLS employs mobile medical research vehicles as novel research tools with the goal of improving participation rates and retention among non-traditional research participants.

Individual Offices of Minority Health

Agency for Healthcare Research and Quality (AHRQ)

Agency Mission: AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

Office of Minority Health Mission and Function: AHRQ's Office of Minority Health is located within the Office of Extramural Research, Education, and Priority Populations, and it leads AHRQ in its efforts to achieve measurable improvements in the quality, equity, and outcomes of health care for priority populations. The OMH Director reports to the Director of AHRQ and works with the Senior Advisor for Minority Health. Responsibilities of the OMH Director and Senior Advisor for Minority Health include:

- Reviewing all proposed portfolio and program concepts for grants and contracts presented to the senior leadership team for discussion and approval, to ensure that all programs, projects, and activities have meaningful inclusion of racial and ethnic minority populations; and
- Ensuring that all portfolios (especially patient safety, health information technology, and prevention/care management) increase their focus on priority populations and under-resourced settings of care where a large proportion of racial and ethnic minorities receive health care services.

Recognizing the importance of focusing on racial and ethnic minority health in all of its activities, the Director of the Office of Minority Health is an integral member of the AHRQ Senior Leadership Team. This addition ensures that AHRQ policies, budget decisions, and research agendas address the health care needs of all individuals and communities, including racial and ethnic minorities. The Director of the Office of Minority Health participates in the review, discussion, and approval of research activities carried out across the agency.

In addition, AHRQ has established a Minority Health Network across the agency with representatives from AHRQ offices and centers who are subject matter experts in minority health to ensure their inclusion in the programs, activities, and budget decisions at each of the administrative divisions. Network members offer advice and participate in reviews, discussions, seminars, and other research and program activities initiated by the Office of Priority Populations.

Highlights of AHRQ's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Consistent with its role in generating and disseminating research that provides people with information helps make informed decisions and that improves the quality of health care services, AHRQ's health disparities program activities support improving health care quality and outcomes and reducing disparities in care for priority populations and underserved areas, and align specifically with Goals I and IV of the HHS Disparities Action Plan.

Goal I: Transform Health Care

Program activities for AHRQ within Goal I focus on strategies that support improvements in primary care, create linkages between the traditional health systems and other social services, and explore innovations in health information technology.

To reduce disparities in access to primary care services and care coordination (Strategy I.B), the *Engaging Diverse Patients in Using an Online Patient Portal* project examines diabetes patients' preferences and experiences using electronic health records. The study goals are to: (1) examine whether using these technology systems has an influence on diabetes patients' adherence or appointment-keeping behaviors, and whether this differs among patients from racial and ethnic minority groups; (2) understand the barriers to using these systems as a part of patients' everyday lives; and (3) develop an online training for patients to explain online portal features and how they might use them as a part of their care. The *Design of Health Strategies to Support Collaborative Care in Perinatal Depression Sub-Population(s) Served: Low Income,*

Racial and Ethnic Minorities, Women examines the burden of untreated perinatal depression on public health, which is very large with direct effects on maternal child health outcomes and long lasting effects on health and health care utilization for both mothers and their children. Improving the sustained implementation of the evidence based collaborative care approach to perinatal depression is expected to have large returns on the mental health of the public while reducing the costs of delivering the care.

The *Home Modifications: Access, Funding and Effectiveness* focused on the elderly, individuals with disabilities, inner-city, low income, minorities, and rural populations. This research addresses how home modifications are a low-cost intervention that can reduce rates of in-home falls and fall-related injuries, and subsequently delay or prevent institutionalization among older adults. The results of this work will inform evidence based practice, reduce unnecessary costs associated with emergency room use, hospitalization and institutionalization, and promote improved quality of care by identifying socioeconomic disparities in access to these devices. *A First Look at Patient Centered Medical Home (PCMH) for Minority Veterans: Implementation and Utilization* study is making important contributions to the evidence base on characteristics of facilities serving large proportions of racial and ethnic minorities, interventions that differentially benefit racial and ethnic minorities, and effectiveness of the PCMH. This is the first study to characterize the effects of a PCMH model of care for individuals of racial and ethnic minority groups.

To **reduce disparities in the quality of health care** (Strategy I.C), AHRQ is partnering with the Eisenberg Center to create *Effective Health Care (EHC) Program/Spanish Language Guides* that provide useful background information such as benefits and risks for different health conditions. The work targets Hispanic populations throughout the U.S. These guides are used at AHRQ conferences, seminars, presentations, and can be ordered through the AHRQ publications clearinghouse. AHRQ is also partnering with the Hispanic Health Coalition of Georgia, Mississippi Gulf Coast Black Nurses Association, North Carolina Office of Minority Health and Health Disparities, Indiana Office of Minority Health, and GoodHealthTV to conduct the *EHC Program, Regional Partnership Development Offices (Regional Offices)*. This project highlights AHRQ's establishment of regional outreach headquarters in Atlanta, Georgia; New York, New York; Chicago, Illinois; Denver, Colorado; and, Dallas, Texas. Dissemination activities helped to ensure consumer/community groups and health care providers serving target populations had access to the EHC Program's evidence-based resources.

Project Impact: EHC Program/Spanish Language Guides

- In fiscal year 2013, five Spanish-language guides were translated in the following areas: developmental delays; Attention Deficit Hyperactivity Disorder (ADHD); autism; mental health; and renal disease.
- In fiscal year 2014, 13 guides were produced in the following areas: cancer; functional limitations and physical disabilities; brain and nerve conditions; genitourinary conditions; obesity; infectious diseases; and HIV/AIDS.

AHRQ is partnering with Wayne State University to conduct the *Text Messaging to Improve Hypertension Medication Adherence in African Americans* study. This research is one of the first theoretically driven text message interventions for improving medication adherence specifically among African Americans. This health intervention is a highly innovative, scalable,

and adaptable technological infrastructure that can be applied to other public health concerns. This study targets African Americans and elderly, racial and ethnic minorities in the state of Michigan. AHRQ is also partnering with Massachusetts General Hospital to conduct the *Virtual Patient (VP) for Improving Quality of Care in Primary Healthcare* study. A VP is an interactive computer simulation used in health care education that provides a virtual representation of a patient encounter for learning and assessment. This project explores the use of a VP in primary care to assist providers in building their clinical capacity to accurately diagnose and treat trauma-related medical and mental health problems in patients from traumatized refugee, disadvantaged, and racial and ethnic minority populations.

Goal IV: Advance Scientific Knowledge and Innovation

AHRQ plays a critical role in **increasing the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). The *National Quality and Disparities Reports and State Snapshots* provide annual updates of national data on the quality of health care and status of health care disparities in the U.S. The State Snapshots provide state-specific health care quality information, including strengths, weaknesses, and opportunities for improvement. Analyses from the national reports are used by researchers, policymakers, and educators to better understand health care quality and disparities in their state,

AHRQ's *Quality Measurement, Evaluation, Testing, Review and Implementation Consortium (Q-Metric)* focuses on developing new and enhancing existing pediatric measures, developing or enhancing cross-cutting methodologies (e.g., to allow for data capture and sharing via health IT and to identify and compare racial and ethnic, socioeconomic, and special health care need disparities), and engaging user groups. Topic measures include sickle cell disease, Body Mass Index (BMI) documentation and follow-up measures, availability of services, pediatric sepsis, and imaging in children with headaches and seizures.

AHRQ also plays a critical role in **conducting and supporting research to inform disparities-reduction initiatives** (Strategy IV.B). Personalized health care is a coordinated, strategic approach to patient care that broadly applies the concepts of systems biology and personalized, predictive, preventive, and participatory care (known as prospective health care or P4 medicine). AHRQ is involved in several personalized health care activities. The *Translating Team Science into Primary Care: Patient Centered Outcomes Research (PCOR)* on teamwork in federally qualified health centers (FQHCs) project is designed to use PCOR to translate and apply team science to primary care delivery. Specifically, the project will train a health services researcher to acquire the necessary PCOR skills through mentoring, coursework, and experience to collaboratively refine, pilot, and evaluate the patient-team communication model within FQHCs. The project is designed to develop and hone study design and analytical methods for evaluating the effect of a personalized health care intervention on health care utilization and patient-reported outcomes among patients with chronic daily headache.

AHRQ is also involved in the promotion of community-based participatory research (CBPR). The *Enhancing Quality and Access to Lifestyle Counseling and Health Behavior Change in Racial and Ethnic Minorities - A Practice-Based Research Network Dissemination and Implementation Demonstration Project* is a demonstration project using a CBPR approach. This

project will target practice-based research network primary care practices in South Carolina, Georgia, Tennessee, Virginia, Maryland, Mississippi, Colorado, and Iowa. For Phase I, a primary objective is to identify preferences and priorities for lifestyle modification and health behavior change counseling among patients and primary care providers. For Phase II the goal is to disseminate the evidence on effective strategies identified during Phase I to Primary Care Practices Research Network (PPRNet) health care providers and patients, and then work with and engage these stakeholders to identify evidence-based strategies they would like to adopt and implement. The demonstration project was initiated in March 2014 and is currently implementing activities for Phase I. Researchers are preparing an evidence synthesis review.

The Chicago, Illinois based *Reducing Healthcare Disparities with Shared Decision Making Sub-Population(s) Served: Lesbian, Gay, Bisexual, Transgender (LGBT) MSM (men who have sex with men), WSW (women who have sex with women) and Ethnic and racial minorities (African American, Latino, Asian American/Pacific Islander)* is a three-year project led by a team of expert investigators in the field of shared decision making. This study aims to reduce health care disparities in the LGBT community across different racial and ethnic minority groups and selected health conditions important to these populations. Some of the specific areas of study include gender transitions, anal cancer screening, Pre-exposure Prophylaxis, Hepatitis C, and Intimate Partner Violence. In the first phase of the project researchers are conducting systematic reviews of the key issues surrounding shared decision making in minority LGBT populations. The systematic review will inform the next steps to conduct qualitative interviews beginning in 2015. This project will highlight the specific needs of this community and guide the research community to address health care disparities reduction through shared decision making.

AHRQ is partnering with the University of Nebraska Medical Center to conduct the Feasibility of *Touch Screen Computer Based Breastfeeding Educational Support* study. This project will explore acceptance of a bilingual, interactive, touch-screen patient education and motivation tool (PEMT). The goal of the PEMT is to improve breastfeeding knowledge and self-efficacy, and improve partial and exclusive breastfeeding rates among Hispanic rural women. The educational material will be delivered using a variety of multimedia formats and will include combinations of audio, text, images, and video.

Centers for Disease Control and Prevention (CDC)

Agency Overview: CDC works 24/7 to keep Americans safe, healthy, and secure and helps keep America competitive through improved health. To deliver on that mission, CDC works with partners to create the expertise, information, and tools that people and communities need to protect their health – through health promotion; prevention of disease, injury, and disability; and preparedness for new health threats. Collaborative activities include:

- Monitoring health;
- Detecting and investigating health problems;
- Conducting research to enhance prevention;
- Developing and advocating sound public health policies;
- Implementing prevention strategies;
- Promoting healthy behaviors;

- Fostering safe and healthful environments; and
- Providing leadership and training.

Office of Minority Health Mission and Function: CDC's Office of Minority Health and Health Equity (OMHHE) aims to accelerate CDC's health impact in the U.S. population and to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified as at-risk for health disparities. OMHHE's priority goals include the following:

- Reframe the elimination of health disparities as an achievable objective;
- Facilitate the implementation of policies across CDC that promote the elimination of health disparities;
- Assure implementation of proven strategies across CDC programs that reduce health disparities in communities of highest risk;
- Advance the science and practice of health equity; and
- Collaborate with national and global partners to promote the reduction of health inequalities.

CDC carries out the following activities to achieve these goals:

- Monitor and report on the health status of vulnerable populations and the effectiveness of health protection programs;
- Initiate and maintain strategic partnerships with governmental, non-governmental, national, and regional organizations to advance science, practice, and workforce for eliminating health disparities; and
- Provide leadership for CDC-wide policies, strategies, action planning, and evaluation to eliminate health disparities.

Highlights of CDC's Fiscal Years 2013 through 2014 Activities (Categorized by the HHS Disparities Action Plan)

Consistent with its role in creating the expertise, information, and tools that people and communities need to protect their health, CDC's health disparities program activities align with Goals II-IV of the HHS Disparities Action Plan. The majority of CDC's program activities focus on advancing the health, safety, and well-being of the American people (Goal III).

Goal I: Transform Health Care

One of the major CDC programs under Goal I is the *HHS Million Hearts®*. Launched in September 2011, the HHS Million Hearts® is a public-private partnership focused on preventing one million heart attacks and strokes by 2017 (please see the Office of the Secretary, Office of Minority Health section for additional detail about the broader initiative). CDC's involvement in fiscal years 2013 and 2014 included the following:

- The CDC Foundation partnered with CDC’s Division for Heart Disease and Stroke Prevention and Million Hearts® to develop a public education campaign focused on increasing the awareness of the preventability of heart attacks and strokes to empower and activate patients to take control of their heart health. The pilot project is targeting populations at highest risk first – primarily African American men in the southeastern United States - Clayton County, GA, and Richland County, SC.
- CDC also developed the *Million Hearts® Hypertension Control Challenge* to identify providers that worked with their patients to achieve hypertension control rates at or above 70%. Nine winners were announced in 2014. Together they cared for 8.3 million patients, of which 3.4 million had hypertension, and collectively achieved a control rate of about 80%.
- CDC also focused on reducing health disparities in the quality of health care including efforts focused on smoking and tobacco cessation. These include conducting research on the use and effectiveness of tobacco quitlines by persons with mental illness (persons with mental illness are at increased risk of tobacco use), collaborating with FDA on a publication addressing disparities in tobacco use among U.S. adults, producing a policy toolkit to tackle disparities in smoking, and establishing and promoting (through CDC’s Tips Campaign) a Spanish-language national quitline portal number, 1-855-DEJELO-YA, which links callers to Spanish language quitline services in their state. CDC is also funding a national Asian quitline service, which provides culturally appropriate tobacco cessation assistance in the Chinese, Korean, and Vietnamese languages that are promoted as part of the Tips campaign.

Project Impact: Million Hearts Hypertension Control Challenge

- Nine winners were announced in 2014;
- Providers cared for 8.3 million patients, of which 3.4 million had hypertension; and
- Awardees collectively achieved a control rate of about 80%.

Goal II: Strengthen the Nation’s Health and Human Services Infrastructure and Workforce

Several of CDC’s key program activities within Goal II focus on **increasing diversity of health care and public health workforces** (Strategy II.C). For example, the *CDC Undergraduate Public Health Scholars Program* consists of internship opportunities that create a public health workplace experience to increase student interest in public health with a particular focus on minority health issues. The full program spans 10 weeks during the summer and provides opportunities for up to 200 undergraduate students. Students are placed at state and local health departments, hospitals, community-based organizations, and at CDC. Students receive mentored educational and professional development experiences. The 2013 program engaged 199 students, and 162 mentors; the 2014 program engaged 195 students and 185 mentors.

Goal III: Advance the Health, Safety, and Well-Being of the American People

Many of CDC’s program activities in Goal III focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). Each program supports the development, implementation, and

assessment of evidence-based interventions to close the modifiable gaps in health, longevity, and quality of life among racial and ethnic minorities.

Community Transformation Grants (CTG), which had been supported by the Prevention and Public Health Fund created by the Affordable Care Act, enabled 107 awardees to design and implement community-level prevention programs that placed special emphasis on reaching people who experience the greatest burden of death, disability, and suffering from chronic conditions. The CDC Community Transformation Grants Program implemented, evaluated, and disseminated evidence-based community preventive health activities. Funded communities worked across multiple sectors to reduce heart attacks, cancer, and strokes by addressing a broad range of risk factors and conditions including poor nutrition and physical inactivity, tobacco use, and others. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, these grants improved health, reduced health disparities, and controlled health care spending.

Project Impact: Focusing on Where People Live, Learn, Work, and Play

By focusing on the health of individuals and communities, *Community Transformation Grant* program grantees:

- Provided 24 million people with increased access to systems or opportunities that support control of high blood pressure and of high cholesterol;
- Increased access for 29 million people to physical activity opportunities;
- Increased access for 40 million people to environments with healthy food or beverage options; and
- Increased access for 20.6 million to smoke-free or tobacco-free environments.

The *Racial and Ethnic Approaches to Community Health (REACH) Program* focuses on comprehensive strategies to reduce chronic disease disparities and improve health among racial and ethnic priority populations. REACH partners use community-based, participatory approaches to identify, develop, and disseminate effective strategies for addressing health disparities in chronic diseases and related risk factors. In fiscal year 2013, CDC funded six national partners to work with over 75 community-based organizations across the country to apply evidence- and practice-based strategies to reduce health disparities and support communities in designing and implementing culturally appropriate initiatives. CDC also forward funded (two-year funding) two demonstration project awardees to apply strategies to prevent obesity and hypertension and increase the evidence for programs effective in addressing racial and ethnic priority populations. In fiscal year 2014, financed in part by Prevention and Public Health Funding, CDC funded 49 governmental agencies, community-based nongovernmental organizations, tribes and tribal organizations, Urban Indian Health Programs, and tribal and intertribal consortia for REACH 2014. They are working to reduce tobacco use and exposure, improve nutrition, increase physical activity, and improve access to chronic disease prevention, risk reduction, and management opportunities.

Through the *National Influenza Vaccination Disparities Partnership (NIVDP)* and the *Grassroots Communication and Social Marketing to Promote Influenza Immunization to Disparate Populations*, CDC builds partnerships at the grassroots level and across private and public sectors. The primary goal of the four-year program, which started in 2011, is to develop long-term partners and promote cross collaboration between community leaders, private sector organizations (e.g., pharmacy chains and health plans), and public sector organizations (medical

associations, community-based organizations, and state and local public health departments) to help reduce the impact of influenza among Hispanic, African American, and AI/AN populations. By the end of the 2012-2013 program year, there were over 680 NIVDP partners in 95 markets serving the target populations, including other ethnic groups in hyper-growth areas.

With *A Comprehensive Approach to Good Health and Wellness in Indian Country*, financed solely by Prevention and Public Health Funding, CDC initiated a new five-year project aimed at preventing heart disease, diabetes, stroke, and associated risk factors in American Indian tribes and Alaska Native villages through a holistic approach to population health and wellness. Awardees are using effective community-chosen and culturally adapted public health interventions to reduce commercial tobacco use and exposure, improve nutrition and physical activity, increase support for breastfeeding, increase health literacy, and strengthen team-based care and links between community resources and clinical services. Of the 22 awards, half are supporting tribes directly, and the other half are supporting tribal organizations to provide leadership, technical assistance, training, and resources to tribes and villages in their Indian Health Service (IHS) Administrative Areas.

CDC's [National Program of Cancer Registries \(NPCR\)](#) supports central cancer registries in 45 states, the District of Columbia, Puerto Rico, and the U.S. Pacific Island Jurisdictions. These data represent 96 percent of the U.S. population. NPCR documents new cancer cases within each state, and identifies minority groups that experience health disparities in cancer. This information aids in state cancer planning. Together, CDC's NPCR and the National Cancer Institute's (NCI's) Surveillance, Epidemiology and End Results (SEER) Program collect data for the entire U.S. population. This national coverage enables researchers, clinicians, policy makers, public health professionals, and members of the public to monitor the burden of cancer, evaluate the success of programs, and identify additional needs for cancer prevention and control efforts at national, state, and local levels.

CDC's [National Comprehensive Cancer Control Program \(NCCCCP\)](#) provides seed money, structure, and support for developing and implementing Comprehensive Cancer Control (CCC) plans in all 50 states, several tribes, and U.S. Associated Pacific Islands and territories. CCC is a collaborative process through which a community pools resources to reduce the burden of cancer that results in risk reduction, early detection, better treatment, and enhanced survivorship. CDC's Comprehensive Cancer Control Program funds Cancer Control Coalitions in all 50 states, the District of Columbia, seven tribes and tribal organizations and seven U.S. territories. NCCCCP promotes health equity within the work of the cancer coalitions through activities including identification of existing data resources to measure disparate disease burden of cancer and related adverse conditions; tracking progress in eliminating health disparities using periodic status reports; and conducting health disparities research.

The Childhood Obesity Research Demonstration (CORD) Project seeks to determine whether approaches in the community that support healthy behaviors, including reducing childhood obesity risk factors, and improving utilization of preventive services such as screening and counseling, can improve underserved children's risk factors for obesity. Based on an integrated systems model of primary care and public health, CORD addresses four key components: health

care systems and organizations, community health workers, preschools (early care and education centers), schools, and communities.

In 2011, CDC awarded a three-year cooperative agreement to the National Institute for Children’s Health Quality (NICHQ). NICHQ, in close partnership with Baby-Friendly USA, launched Best Fed Beginnings, a nationwide effort to help hospitals improve maternity care practices and increase the number of Baby-Friendly designated hospitals in the United States. Eighty-nine hospital teams – made up primarily of teams from states where the need for improving access to Baby-Friendly designated hospitals was greatest – participated in the 22-month learning collaborative. Participating hospitals used quality improvement methods to make improvements to maternity care practices in pursuit of the Baby-Friendly designation. The recruitment and enrollment process focused on the significant disparity in breastfeeding initiation among African-American mothers. In the end, 88 percent of the hospitals that joined the NICHQ collaborative served non-Hispanic African-American populations and 100 percent served Medicaid/CHIP insured populations greater than the national average.

With funds from CDC, the National Association of City and County Health Officials (NACCHO) is funding 63 local health departments to establish local peer and professional breastfeeding support and provide lactation training for healthcare professionals targeting communities with majority African American or other underserved populations. A Community of Practice portal was developed for the Breastfeeding Support Network (BSN) to facilitate management of project activities, distance learning, information sharing among partners, and LHD and CBO collaborations.

Centers for Medicare & Medicaid Services (CMS)

Agency Overview: As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation’s health care system to provide access to high quality care and improved health at lower cost. The Agency’s primary programs are Medicare, Medicaid and the Children’s Health Insurance Program (CHIP). With the enactment of the Affordable Care Act, CMS recently assumed certain responsibilities for regulating the private health insurance market. CMS establishes policies for program eligibility and benefits consistent with current law, processes over one billion Medicare claims annually, matches state expenditures with federal funds for Medicaid and CHIP, ensures health care quality, and safeguards public funds from fraud, waste and abuse. CMS is one of the largest purchasers of health care in the world and maintains the nation’s largest collection of health care data.

By law and program design, many CMS activities are handled by third parties. The states separately administer the Medicaid and CHIP programs and inspect hospitals, nursing homes and other health care facilities to confirm compliance with health and safety standards. Medicare contractors process claims, provide technical assistance to providers, and answer beneficiary questions. Quality Improvement Organizations conduct a wide variety of programs to support and improve health care quality.

In its 2013 Strategic Roadmap, CMS identified four goals: (1) better care and lower costs through improvement, (2) prevention and population health, (3) expanded health care coverage,

and (4) enterprise excellence. Several of the objectives in the Roadmap linked to CMS' goals relate to health disparities:

- Targeting quality improvement interventions to areas and population with the greatest identified need;
- Identifying gaps in the use of preventive benefits, community-based services, outreach, and education; and
- Helping consumers access understandable health information that they may use to apply for and find health care coverage that they can afford and best meets their needs.

Office of Minority Health Mission and Function: The CMS OMH is committed to improving the health of vulnerable populations, including racial and ethnic minorities, people with disabilities, and lesbian, gay, bisexual and transgender (LGBT) individuals. The mission of the CMS Office of Minority Health is to ensure that the voices and the needs of the populations it represents are present as the Agency is developing, implementing, and evaluating its programs and policies. Through its efforts, the CMS Office of Minority Health seeks to have all CMS beneficiaries attain their highest level of health, and seeks the elimination of disparities in health care quality and access.

The CMS OMH serves as the principal advisor and coordinator to the agency for the special needs of minority and disadvantaged populations. Consistent with the goals of CMS, the CMS Office of Minority Health carries out the following duties:

- Provides leadership, vision and direction to address HHS and CMS Strategic Plan goals and objectives related to improving minority health and eliminating health disparities;
- Leads the development of an agency-wide data collection infrastructure for minority health activities and initiatives;
- Implements activities to increase the availability of data to monitor the impact of CMS programs in improving minority health and eliminating health disparities;
- Participates in the formulation of CMS goals, policies, legislative proposals, priorities, and strategies as they affect health professional organizations and others involved in or concerned with the delivery of culturally and linguistically appropriate quality health services to minorities and disadvantaged populations;
- Consults with HHS Federal agencies and other public and private sector agencies and organizations to collaborate in addressing health equity; and
- Establishes short-term and long-range objectives and participates in the focus of activities and objectives in assuring equity of access to resources and health careers for minorities and disadvantaged populations.

Highlights of CMS' Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

CMS' overall commitment to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost directly informs the CMS OMH's commitment to ensuring all CMS beneficiaries achieve their highest level of health and

eliminating disparities in health care quality and access. Program activities support Goals I-V of the HHS Disparities Action Plan.

Goal I: Transform Health Care

CMS’ work in this area focuses on **reducing disparities in health insurance coverage and access to care** (Strategy I.A), **reducing disparities in access to primary care services and care coordination** (Strategy I.B), and **reducing disparities in the quality of health care** (Strategy I.C). Several CMS activities help to identify gaps in the use of preventive benefits, community-based services, outreach, and education and to target quality improvement interventions to areas and populations with the greatest identified need. Table 3 and the text that follows highlights some key outreach and education activities in fiscal years 2013 and 2014.

Table 3. CMS Outreach and Education Events

Outreach and Education Focus	Total Events	FY 2013 Events	FY 2014 Events	African American	Asian Pacific Islander	Hispanic Latino
General Affordable Care Act	4142	2510	1632	1427	1009	1706
Medicare	859	826	33	279	274	306
Health Insurance Marketplace	223	28	195	53	53	117
Patient Safety	3	1	2	1	1	1
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program	479	348	131	76	79	97
Quality Improvement	22	17	5	10	2	10
Preventive Services	30	15	15	11	8	11
Million Hearts Initiative	5	5	0	3	1	1
Totals	5763	3750	2013	1860	1427	2186

The CMS OMH is conducting the *From Coverage to Care (C2C) Initiative* in partnership with 11 other federal agencies. C2C assists people with new health care coverage to understand their benefits, and to connect with appropriate primary care and preventive services. The primary communities served by this program are newly insured and consumers with continuing coverage under Medicaid, CHIP, Marketplace, and other health insurance plans. The toolkit, “Roadmap to Better Care and a Healthier You,” was developed and includes eight steps to help consumers and health care providers be informed about the diverse benefits available through their coverage and how to use it appropriately to access primary care and preventive services. A 10-part video series was also developed to help those with new health care coverage make the most of their coverage, and raise awareness about the importance of getting routine primary care and regular preventive care. The C2C Roadmap is also available in Spanish, Chinese, Korean, Vietnamese and Haitian Creole with videos available in English and Spanish.

As a result of *Navigator Grants in Federally-facilitated and State Partnership Marketplaces*, grantees and their staff serve as an in-person resource for individuals who want additional assistance in shopping for and enrolling in plans in the Health Insurance Marketplace. CMS has provided grants to more than 100 national organizations and businesses to help individuals learn about the health care coverage available in the Marketplace. Navigators are trained to provide unbiased information in a culturally competent manner to consumers about health insurance, the new Health Insurance Marketplaces, qualified health plans, and public programs including Medicaid and the Children's Health Insurance Program (CHIP). Target populations include African American, American Indian/Alaska Native, Hispanic/Latino, disabled, urban and rural communities.

Through the CMS *Improving Cardiovascular Health and Reducing Cardiac Disparities* program Quality Improvement Organizations (QIOs) work with clinical providers and beneficiaries in collaboration with key partners and stakeholders to improve the cardiovascular health of racial and ethnic beneficiaries in support of the Million Hearts® initiative's goal to prevent one million heart attacks and strokes by 2017. The program focuses on Medicare and dually eligible African American, Hispanic, Latino, Asian, Pacific Islander beneficiaries. Gender specific resources are provided and rural beneficiaries are targeted. The program has served 504 clinical participants. Results include the following: 1,934 beneficiaries have been reached; six sessions of "Heart Health 101" have been completed; 15,000 bookmarks with blood pressure and heart health education have been distributed via the Pharmacy Bookmark Project; 3,021 beneficiaries received blood pressure screenings at various sites; 60 graduated from the American Heart Association's "Check, Change, Control" program; a tool and guide were developed for race, ethnicity, language data collection; Health Hubs have been created in libraries; YouTube videos created; and a Health Ministry Toolkit was created.

The *Partnership for Patients (PfP)* program engages hospital networks in adopting effective quality improvement approaches for reducing disparities in patient health outcomes and readmissions. In December 2013, new requirements were added to Hospital Engagement Network (HEN) contracts through option year funding. As a result, HENs are now required to engage their hospital network in reducing health care disparities. Currently, the PfP HENs engage hospitals adopting a number of approaches for reducing health care disparities, including but not limited to adopting the National CLAS Standards, patient data collection standardization and utilization for identifying and addressing disparities in patient health outcomes, and leadership engagement. The PfP also established an internal Health Equity Initiative team and has created a health care disparities resource folder on the Community of Practice website. Lastly, strategic partnerships with federal agencies including the Office of the Assistant Secretary for Health (OASH), the Indian Health Service, and the Department of Veterans Affairs to implement initiatives, were established to further support PfP aims, including a pilot project with HENs to inform OASH on best approaches for reducing disparities in adverse drug effects.

Goal II: Strengthen the Nation’s Health and Human Services Infrastructure and Workforce

In the effort to **increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities** (Strategy II.A), the *CMS Strategic Language Access Plan* is part of CMS’ ongoing commitment to ensure that limited English proficient individuals (LEP) have equal access to CMS programs and activities. The program provides translated documents for LEP individuals in several languages, including Arabic, Armenian, Chinese, Farsi, French, German, Greek, Haitian Creole, Italian, Korean, Polish, Portuguese, Russian, Spanish, Tagalog and Vietnamese languages. As a result of the Language Access Plan, oral interpretation assistance is currently offered in over 200 languages across all CMS programs. Multilingual services are provided through oral interpretation and written translation. Programs are being expanded and policies are being implemented to ensure individuals with limited English proficiency have equal access to CMS programs and activities.

The goal of *Everyone with Diabetes Counts (EDC)* is to improve health literacy of Medicare beneficiaries with diabetes. EDC achieves this goal by recruiting and facilitating the completion of diabetes self-management education (DSME) classes, decreasing disparities in recommended monitoring of diabetes measures, and facilitating the building of sustainable community-based diabetes education programs to serve individuals with disabilities (blind and low vision). The program serves Medicare beneficiaries who are minorities, underserved, and/or those who reside in rural populations. Special innovation projects were funded in West Virginia, New York, and Texas.

Project Impact: Everyone with Diabetes Counts

- 6,400 beneficiaries completed diabetes self-management education (DSME) classes;
- 55 physician practices, representing over 100 individual physicians, participated;
- 600 community-based sites were utilized to host DSME classes;
- 9 clinics became certified diabetes centers, with an additional 9 in various stages of completing this process; and
- Clinic results include:
 - Blood pressure: 23.5% of beneficiaries in poor control pre-DSME showed improvement post-DSME
 - HbA1c: 50% of beneficiaries in poor control pre-DSME showed good improvement post-DSME
 - Lipids: 64.8% of beneficiaries improved to good control, showing substantial improvement post-DSME.

Goal III: Advance the Health, Safety, and Well-Being of the American People

A key example of CMS’ efforts to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A) is CMS’ collaboration with HHS OMH and the Center for Faith-Based and Neighborhood Partnerships on the *100 Congregations For Million Hearts*, which solicit the support and action of faith-based organizations (FBOs) to help prevent cardiovascular disease by

focusing on hypertension control. Member congregations are asked to establish relationships with local experts and resources, disseminate national messaging, and connect congregants to individualized monitoring strategies (including a mobile app and blood pressure tracking wallet cards). Through increased clinical community linkages, the program has resulted in better reporting and increased attention on hypertension by communities and providers, increased self-monitoring by individuals with hypertension, development of sustainable educational programming about heart health, and creation of a growing network of Million Hearts and FBOs. There are several congregations representing sub-populations participating in 100 Congregations that include racial and ethnic minorities and women.

Goal IV: Advance Scientific Knowledge and Innovation

Under Goal IV, CMS' primary program activities focus on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). For example, CMS is using Census data to evaluate Medicare race and ethnicity data. CMS obtains Medicare and Medicaid beneficiary enrollment records including race and ethnicity data from external sources and has limited ability to collect data directly from beneficiaries. This study, conducted with the U.S. Census Bureau, evaluates the degree to which CMS race and ethnicity data and imputation models match Census self-reported values. In addition, CMS is using the *Medicare Current Beneficiary Survey to Assess and Improve Quality by Measuring and Reporting Health Disparities in Vulnerable Populations* project to develop measures to enable identification of beneficiaries who have Limited English Proficiency and LGBT populations. The project allows for an oversample of Hispanic and Asian beneficiaries and is creating a public use data file, which is optimized for disparities researchers.

The CMS OMH is conducting a series of projects to improve quality and data reporting to support Strategy IV.A, including the following:

- *Improving Quality by Measuring and Reporting Health Disparities in Vulnerable Populations* is a multi-year project to develop measure(s) of the provisions of Culturally and Linguistically Appropriate Services (CLAS). This project will also explore and disseminate CLAS best practices, improve the reporting of race and ethnicity by health plans, explore disparities in quality, and provide actionable information on these subgroups of Medicare beneficiaries. This project will also serve LEP and LGBT populations.
- *Stratified Analysis and Reporting of Racial and Ethnic Disparities* project focuses on the analysis, reporting, display, and dissemination of existing Medicare Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems quality measures stratified by race and ethnicity. This project will provide information for CMS and its stakeholders and partners that will be useful for targeting quality improvement activities and resources; monitoring health plan performance; and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategies.
- *Planning, Designing, Implementing and Evaluating Programs: Reducing Health Disparities through Quality Improvement* project features an environmental scan and needs assessment to analyze health disparities and then design, implement and

evaluate culturally and linguistically appropriate interventions to address health care gaps, identify health care equity best practices and inform existing federal and state policies and efforts to reduce health disparities, including providing support to Quality Improvement Organizations (QIOs). Health IT will be utilized as a foundational component of this effort. The program will focus on Medicare and dual-eligible beneficiaries experiencing health care disparities due to race, ethnicity, limited English proficiency, sexual orientation and gender identity, geography or disability.

CMS is also **conducting and supporting research to inform disparities-reduction initiatives** (Strategy IV.B). For example, populations with LEP consistently experience suboptimal health outcomes directly related to language barriers. To date, no research studies have provided a national, statistical evaluation of CLAS compliance with regard to language assistance for populations with LEP. The *Geography Matters* project offers the first national analysis of perceptions of provider communication in areas with higher proportions of people with LEP by examining the relationship between people with LEP and hospital communication quality scores.

Evidence suggests that disparities exist in electronic health record (EHR) adoption and use. Some patients and providers who do not adopt EHRs experience lower reimbursement rates, have poorer health literacy rates, and less effective patient–provider interactions compared to those adopting EHRs nationally. For the *Barriers to EHR Adoption and Use* project, CMS conducted a series of analyses to understand and support participation in the Medicare and Medicaid EHR Incentive Programs by Eligible Providers (EPs), Eligible Hospitals (EHs), and Critical Access Hospitals (CAHs). The goal of the research is to gather and summarize the barriers to EHR participation faced by EPs, EHs, and CAHs, and their needs for support.

Goal V: Increase Efficiency, Transparency, and Accountability of HHS Programs

CMS has engaged in various initiatives to increase the efficiency, transparency, and the accountability of HHS Programs, including:

- Outreach and education to help health care professionals and systems transition to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). In fiscal year 2014, CMS was involved in 5 related outreach activities directed to minority populations; one was directed to African American populations, and four to Hispanic and Latino populations.
- Outreach and education about fraud and abuse activities across the country. CMS was involved in nine outreach activities in fiscal year 2013 and seven in fiscal year 2014. Out of these events, seven were directed to African American populations, one to Asian and Pacific Islander Americans, and eight to Hispanic and Latino populations.
- Release of a two-year funding opportunity announcement designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid. CMS selected 27 states to participate in this grant program.

Food and Drug Administration (FDA)

Agency Mission: FDA is charged with protecting the public health by ensuring the safety, effectiveness, and security of human and veterinary drugs, biological products, and medical devices; ensuring the safety of foods, cosmetics, and radiation-emitting products; and regulating tobacco products. Specifically, FDA is responsible for advancing public health by:

- Helping to speed innovations that make medicines and devices safer and more effective;
- Providing the public with the accurate, science-based information they need to use medicines, devices, and foods to improve their health;
- Regulating the manufacture, marketing, and distribution of tobacco products to protect the public and reduce tobacco use by minors; and
- Addressing the Nation's counterterrorism capability by ensuring the security of the supply of foods and medical products.

Office of Minority Health Mission and Function: The FDA's Office of Minority Health (OMH) advances the agency's regulatory mission in addressing the reduction of racial and ethnic health disparities and in achieving the highest standard of health for all. The FDA OMH provides leadership and direction to:

- Strengthen FDA capacity to address minority health and health disparities across the agency through coordinated leadership on regulatory actions and decision making;
- Promote effective communication and the dissemination of information to the public, in particular to underserved, vulnerable populations; and
- Improve and strengthen the research and the evaluation of sub-population data associations with race and ethnicity.

Highlights of FDA's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Plan to Reduce Health Disparities)

The FDA OMH's goals of coordinated leadership, effective communication and information dissemination to the public, and improved health disparities research align with Goals I-V of the HHS Disparities Action Plan.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

In the effort to **increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities** (Strategy II.A), FDA's OMH precepts pharmacy students who express an interest in minority health and apply to the *Pharmacy Student Experiential Program* as part of their elective rotation. Students gain enhanced regulatory science skills/knowledge for application towards addressing health disparities. OMH has precepted four minority pharmacy students, two of which are from minority-serving institutions (MSIs). FDA also issued a report, *Ensuring Access to Adequate Information on Medical Products for All with a Special Focus on Underrepresented Subpopulations, Including Racial Subgroups* in July 2013, under the FDASIA section 1138 Report and Language Access Plan. The agency identified three key areas of need: (1) advancing outreach to minority health professional organizations, (2) increasing use of electronic platforms to reach minority audiences, and (3) developing a language action plan (finalized and submitted

to HHS January 2014), responding to the HHS commitment to language access under Executive Order Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency. Under the FDA Language Access Plan, all consumer updates, drug safety updates are translated into Spanish as well as other languages as needed.

FDA's activities in Goal II that focus on **increasing the diversity of the health care and public health workforces** (Strategy II.C) are conducted through several programs. The FDA Center for Veterinary Medicine develops and implements numerous diversity initiatives within the organization including a recruitment strategy to specifically reach diverse populations at Minority Serving Institutions (MSIs). Targeted student outreach is geared towards students from institutions of higher education to include Minority Serving Institutions, such as Historically Black Colleges and Universities, Predominately Black Institutions, American Indian and Alaska Native-Serving Institutions, and Asian American and Native American Pacific Islander-Serving Institutions. These institutions have included Bowie State University, Tuskegee University, Coppin State University, Howard University, Morgan State University, University of District of Columbia, University of Baltimore, University of Maryland and Oklahoma State University - Main Campus.

FDA OMH's *Summer Student Research Program* is designed for science and mathematics students preparing for future careers in toxicology, regulatory science, or related scientific disciplines. This 10-week summer program in Arkansas provides hands-on research and laboratory experience mentored by FDA scientists. It is open to undergraduate and graduate minority students. This program is run by the FDA's OMH in partnership with FDA's National Center for Toxicological Research. The program funded four students in fiscal year 2013 and three students in fiscal year 2014.

Goal III: Advance the Health, Safety, and Well-Being of the American People

FDA also implements several collaborative research studies and outreach and education initiatives to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A).

The FDA's Center for Drug Evaluation and Research (CDER), Office of Communication (OCOMM) provides Spanish versions of the *FDA Drug Safety Communications* (DSCs). The Spanish DSCs are posted on FDA's website, and the links to these communications are "tweeted" through the "FDA_Drug_Info" twitter account and included in the Office of Special Health Issues' bi-weekly newsletter. Additionally, CDER's OCOMM, Division of Drug Information, has a fee-for-service contract with the Language Line to provide translation services in over 190 languages for non-English speaking callers requesting drug information. The DSC initiative seeks to communicate risk and non-emergency public health information to millions of Spanish-speaking consumers, patients, and health care

Project Impact: Food Safe Families Campaign

- \$78.2 million in donated media;
- \$3.2 million earn media value from blogger outreach/press release pick-up;
- 5 billion impressions;
- 35 percent awareness of campaign messaging;
- 320,000 average monthly website views;
- 11 percent increase in consumers considering use of a food thermometer to be an important step to prevent food poisoning in the home.

practitioners.

The FDA's Center for Food Science and Applied Nutrition manages several campaigns and initiatives. The *Food Safe Families Campaign* was marketed in Spanish specifically to Hispanic media along with media tours including Spanish radio, print, and web materials. The program resulted in \$78.2 million in donated media; \$3.2 million earned media value from blogger outreach/press release pick-up; 5 billion impressions; 35 percent awareness of campaign messaging; 320,000 average monthly website views; 11 percent increase in consumers considering use of a food thermometer to be an important step to prevent food poisoning in the home. The *Read the Label Campaign* is a community outreach campaign that educates Hispanic and African American parents to talk to their kids about the Nutrition Facts label. Resources include tips for using the Nutrition Facts label for kids and a kit for after school programs like Boys and Girls Clubs. The campaign was publicized via multimedia news release, constituent update, Twitter, Facebook, exhibits, and email distribution to public health departments and youth organizations/afterschool programs. The campaign is currently working on establishing partnerships with youth focused/government organizations.

The FDA Office of Women's Health hosts *Pink Ribbon Sunday Mammography Awareness Program* that works to reduce breast cancer health disparities by providing community leaders with free mammography educational materials they can use to inform African American and Hispanic women about the early detection of breast cancer through mammography. The program also helps to raise awareness among minority women about FDA's role in ensuring quality standards for mammography facilities in the U.S. In fiscal years 2013 and 2014, the program disseminated free outreach planning guides, mammography fact sheets in English and Spanish, and mammography outreach cards that direct women to a FDA website where they can search for certified mammography facilities in their area.

The FDA Office of Women's Health also uses the *¡Nunca Más! Novela Series* with four Spanish-language soap operas to educate Hispanic women about safe medication use. Each episode showcases the pitfalls of medication misuse and highlights easy steps women can take to avoid common medication mistakes. The videos are posted on the FDA website and YouTube Channel. DVD copies of the videos and an educational brochure are also available in limited quantity for Hispanic-serving organizations and promoters. A YouTube ad campaign resulted in 1,393,370 total impressions and 5,036 video views in September and October 2013. The combined episode version of the novela series has a total of 21,652 views on the FDA YouTube Channel. The individual episodes have a combined 10,000 views. Website traffic included 4,204 visits in fiscal year 2013 and 2,192 visits in fiscal year 2014.

Goal IV: Advance Scientific Knowledge and Innovation

FDA is conducting a number of efforts to **increase the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). Section 907 of the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA) directed FDA to publish and provide to Congress a report "addressing the extent to which clinical trial participation and the inclusion of safety and effectiveness data by demographic subgroups, including sex, age, race, and ethnicity, is included in applications submitted to the Food and

Drug Administration.” Section 907 also directed FDA to publish and provide to Congress an action plan outlining “recommendations for improving the completeness and quality of analyses of data on demographic subgroups in summaries of product safety and effectiveness data and in labeling; on the inclusion of such data, or the lack of availability of such data, in labeling; and on improving the public availability of such data to patients, health care providers, and researchers” and to indicate the applicability of these recommendations to the types of medical products addressed in section 907. The *FDASIA Section 907 report and Action Plan* were released in August 2013 and August 2014, respectively. Specifically, The FDASIA Action Plan seeks to do the following: (1) data quality to improve the completeness and quality of demographic subgroup data collection, reporting and analysis; (2) subgroup participation to identify barriers to subgroup enrollment in clinical trials and employ strategies to encourage greater participation; and (3) data transparency to make demographic subgroup data more available and transparent.

FDA's efforts to **conduct and support research to inform disparities reduction initiatives** (Strategy IV.B) include the Center for Devices and Radiological Health conducting a *Medical Device Study Evaluation* for patients with skin of color, particularly for patients with Fitzpatrick Skin Types IV, V, and VI, who tend to be Asian, Hispanic, or African American and are considered to have skin types that may be more prone to hypertrophic scarring or keloid scarring. The evaluation aims to study the effect of certain devices on skin of color.

The FDA OMH research and collaboration program has funded pilot projects ranging from advancing safety of transfusions in Sickle Cell Anemia, using bioinformatics to characterize racial differences in triple negative breast cancer, exploring contemporary barriers to participation in clinical trials, to examining health literacy and cultural competency of FDA communications.

Health Resources and Services Administration (HRSA)

Agency Overview: HRSA’s mission is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. HRSA’s goals align with those of the HHS Disparities Action Plan, and focus on (1) improving access to quality care and services, (2) strengthening the health workforce, (3) building healthy communities, and (4) improving health equity. To accomplish its mission and goals, HRSA provides leadership and financial support to organizations in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers, and children. Grantees train health professionals and improve systems of care in rural communities. HRSA also oversees organ, bone marrow, and cord blood donation.

Office of Health Equity Health Mission and Function: The Office of Health Equity (OHE) works to reduce disparities and improve health equity to ensure healthy communities and healthy people. OHE provides leadership on issues related to health equity, health disparities, and cultural and linguistic competency in the following areas:

- Workforce, clinical care, and provider-patient relationships;
- Communication;
- Public health systems (care delivery and integration);

- Strategic agency/organizational partnerships; and
- Health policy.

Highlights of HRSA’s Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

HRSA plays a critical role in implementing the HHS Disparities Action Plan’s focus on improving health and achieving health equity through its commitment to access to quality services, a skilled health workforce, and innovative programs. HRSA’s health disparities activities primarily address Goals I-IV, many of which are explicitly identified in the HHS Disparities Action Plan.

Goal I: Transform Health Care

HRSA supports a range of activities to **reduce disparities in health insurance coverage and access to care** (Strategy 1.A) and to **reduce disparities in access to primary care services and care coordination** (Strategy I.B). For example, the *Health Center Outreach and Enrollment Funding Opportunities*, funded through the Community Health Center Fund under the Affordable Care Act, provided support to health center grantee organizations to hire and train outreach and eligibility assistance workers to assist people nationwide with enrollment into affordable health insurance coverage. In July 2013, \$150 million was awarded to 1,159 health centers to: 1) hire and train outreach and enrollment assistance workers as certified application counselors; 2) conduct in-reach and outreach and assist with the enrollment process; 3) share barriers and successes with state primary care associations (PCAs); and 4) report metrics, successes, and barriers to HRSA quarterly. In December 2013, \$58 million in one-time funding was awarded to 1,158 health centers to increase outreach and enrollment assistance capacity through expanding hours, hiring new or temporary outreach and enrollment assistance workers, purchasing additional outreach and enrollment equipment (e.g., computers, tablets), and/or other allowable activities and costs consistent with the fiscal year 2013 outreach and enrollment supplemental guidance.

Project Impact: Health Center Outreach and Enrollment Funding Opportunities

As a result of this project, Health centers trained over 16,000 outreach and enrollment assisters to provide “in reach” (with currently uninsured health center patients) and “outreach” (to non-health center patients) in their approved service area to raise awareness of affordable insurance options and provide eligibility and enrollment assistance. As of June 30, 2014, health centers have assisted over 6 million individuals in their efforts to become insured.

HRSA also supports a wide range of programs to **reduce disparities in the quality of health care** (Strategy I.C). HRSA funded the *Integration of Oral Health and Primary Care Practice Initiative* to improve access to early detection and preventive interventions by expanding oral health clinical competency of primary care clinicians, leading to improved oral health. HRSA convened three meetings with subject matter experts, primary care practitioners in the safety net setting, and other health professionals from the public and private sectors in 2012, corresponding to the three components of the initiative. A report with HRSA recommendations was published

in 2014 to provide guiding principles and provide a framework for the design of a competency-based, inter-professional practice model to integrate oral health and primary care.

HRSA has implemented the *Health Literacy Project Targeting Adult and Young Black Men who have Sex with Men (Black MSM)*. The overall goal of this project is to develop opportunities to incorporate health literacy into existing and new HIV service delivery programs targeting adult and young Black MSM. The project includes a web-based training of trainers, creating an on-going cadre of health literacy trainers and a manual for future use. The development and dissemination of brochures allows for opportunities to share information on health literacy and technical assistance resources with HIV service providers and adult and young Black MSM who are living with HIV. This nationwide cross-agency collaboration includes HRSA/HIV AIDS Bureau National Partner Organizations, AIDS.gov, CDC, and SAMHSA.

HRSA has implemented the *U.S.-Mexico Border AETC Steering Team (UMBAST)*. The project supports a consortium of Federal Training Centers to provide quality education, training, and consultation about HIV testing, diagnosis, treatment, linkage, and retention in care in U.S.-Mexico border health centers (especially community health centers), and also addresses health disparities and unmet HIV health care needs along the border. The largest racial and ethnic minority group requiring targeted services in this region is Hispanic/Latino, including migrants. This program collaborates with community health centers, AIDS Education Training Centers (AETCs) supporting U.S. - Mexico Border states, SAMHSA regional Addiction Technology Training Centers, CDC HIV/AIDS Prevention Training Centers, and CDC National Tuberculosis Training Centers.

HRSA also funds the Health Center New Access Point (NAP) Program. Working nationwide with Health Centers, the NAP supplemental funding opportunity provided support to organizations seeking to establish new full-time health center service delivery sites. In September 2013, HRSA awarded \$19 million for 32 new access points. In November 2013, \$150 million was awarded for 236 new access points.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

To increase the **diversity of the health care and public health workforces** (Strategy II.C), HRSA administers the *National Health Service Corps (NHSC) Loan Repayment and Scholarship Programs*. The NHSC Scholarship Program awards scholarships to health professions students pursuing careers in primary care, in return for their commitment to provide service in a Health Professional Shortage Area (HPSA) upon completion of training. The NHSC Loan Repayment Program provides loan repayment of qualifying educational loans for primary care providers who serve at approved sites in HPSAs. The inaugural application cycle for the NHSC Students to Service pilot program opened in November 2011. This program provides loan repayment assistance to medical students (M.D. and D.O.) in their last year of school, in return for a commitment to provide primary health care services in eligible Health Professional Shortage Areas of greatest need. NHSC LRP Clinicians include primary care physicians, physician assistants, dentists, dental hygienists, nurse practitioners, certified nurse midwives, and behavioral and mental health professionals. Expansion of these programs is intended to expand

access to primary health care services and improve the health of people who live in urban and rural areas where health care is scarce. The health care workforce is more diverse due to a more than doubling of the number of NHSC obligors in recent years. African American physicians make up approximately 18 percent of HNSC physicians, and Latino physicians make up approximately 16 percent. Both groups greatly exceed their overall representation of the national physician workforce, where African American physicians represent six percent and Latino physicians represent five percent.

HRSA also funds the *NURSE Corps Loan Repayment and Scholarship Programs*. The NURSE Corps Loan Repayment Program (LRP) is a financial incentive program under which individual registered nurses (RNs) and advanced practice RNs (APRNs) such as nurse practitioners enter into a contractual agreement with the federal government to serve full-time in a health care facility with a critical shortage of nurses, in return for substantial repayment of qualifying nursing educational loans. The NURSE Corps Scholarship Program (SP) offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment payback after graduation of at least two years in health care facilities with a critical shortage of nurses. The NURSE Corps SP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. In fiscal year 2013, 70 percent of NURSE Corps LRP participants who initially received awards in fiscal year 2011 came in for a continuation and committed to work at a critical shortage facility for an additional year. A total Ninety-three percent of NURSE Corps SP participants obtained their baccalaureate degree or advanced practice degree in nursing.

Project Impact: National Health Service Corps Loan Repayment Programs

- In fiscal year 2013, 8,899 NHSC clinicians provided needed health services to more than 9.3 million Americans. The program has more than doubled since 2008, when approximately 3,600 clinicians participated.
- NHSC clinicians also provide needed primary care services to AI / AN populations, with 643 Tribal health programs across the country approved as NHSC services sites as of September 2014. This represents a tenfold increase since 2010, when 60 Tribal health programs served as NHSC sites.

Goal III: Advance the Health, Safety and Well-Being of the American People

To reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A), HRSA has implemented the *Health Center Program*. The Program supports 1,200 health centers that operate over 9,200 service delivery sites, providing care to more than 21.7 million patients in every state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. This nationwide network of health centers has created one of the largest safety net systems of primary and preventive care in the country. Health centers have become the essential primary care provider for America's most vulnerable populations: people living in poverty; the homeless; minorities; agricultural workers; public housing residents; the geographically isolated; and people with limited English proficiency. In addition, health centers advance the preventive and primary medical/health care home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Nearly half of all health centers serve rural populations. Furthermore, all health centers must provide enabling services, which help ensure access to primary health care services, as well as facilitate access to comprehensive health

and social services. Over 62 percent of the patients served in health centers are racial or ethnic minorities. This nationwide program serves medically underserved communities and vulnerable populations and involves Health Center grantees. According to the 2013 Uniform Data System, 1,202 health center grantees with 9,208 sites served 21.7 million patients through 86 million patient visits supported by 156,817 personnel.

HRSA has continued to fund the *Healthy Start Program* to reduce the rate of infant mortality and improve perinatal outcomes through grants to project areas with high annual rates of infant mortality in one or more subpopulations. The program focuses on the contributing factors that research shows influence the perinatal trends in high-risk communities. The purpose of this program is to address significant disparities in perinatal health including disparities experienced by Hispanics, American Indians and Alaska Natives, African Americans, Asian American/Pacific Islanders, and immigrant populations or those occurring by virtue of education, income, disability, or living in rural/isolated areas. Communities provide a scope of project services that covers the pregnancy and interconception phases for women and infants residing in their project area. In fiscal year 2014, HRSA initiated a redesign of the program's framework based on a change in Congressional recommendations, a major evaluation of the program that was completed in 2012, and recommendations from the Secretary's Advisory Committee on Infant Mortality. This redesign of the program's framework requires that all grantees must to use five strategies that have been found to reduce disparities and adverse perinatal outcomes. Grantees are required to undertake specific activities under each strategy: (1) improve women's health, with a focus on access to care; (2) promote quality services, in part through standardization of staff training; (3) strengthen family resilience; (4) achieve collective community impact; and (5) increase program accountability through ongoing quality improvement, performance monitoring, and evaluation.

Goal IV: Advance Scientific Knowledge and Innovation

To increase the availability and quality of data collected and reported on racial and ethnic minority populations, HRSA has implemented *Child Health USA* – an easy-to-use collection of current and historical data on some of the most pressing health challenges facing infants, children their families, and their communities. This HRSA web-based publication uses national data sources to identify and clarify issues affecting the health of children, including population characteristics or social determinants of health, health behaviors, health status, and health care utilization. Analyses are presented by race, ethnicity, and other stratifiers to illustrate health disparities. Many topics feature figures and tables that highlight racial/ethnic disparities. Federal, state and local level policymakers, program managers, and educators can all use the publication as a quick reference tool to identify and address health disparities. The next edition will be released in 2015 and will include drop-down menus to view indicators by demographic stratifiers (i.e. race/ethnicity data where available) with the ability to perform statistical significance testing.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Agency Overview: An important purpose of SAMHSA is to reduce the impact of substance abuse and mental illness on populations that experience behavioral health disparities by

improving access to quality services as well as support that enable individuals and families to thrive, participate in, and contribute to healthy communities. Over the years, SAMHSA has demonstrated that prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment, and recovery support services provides a cost-effective opportunity to advance and protect the nation's health. SAMHSA support states, territories, tribes, communities, and local organizations through grant and contract awards and provides national leadership in promoting the provision of quality behavioral health services.

Office of Behavioral Health Equity Mission and Function: SAMHSA's Office of Behavioral Health Equity (OBHE) coordinates agency efforts to reduce behavioral health disparities for diverse populations by:

- Creating a more strategic focus on racial; ethnic; and LGBT populations in SAMHSA investments; and
- Using a data-informed quality improvement approach to address racial and ethnic disparities in SAMHSA programs.

To address behavioral health disparities for underserved populations, OBHE implements a five-point strategy built around: (1) data; (2) communications; (3) policy; (4) workforce development; and (5) customer service/technical assistance. Each strategy has a work plan with specific objectives, benchmarks, and desired outcomes.

Highlights of SAMHSA's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Secretarial Priorities)

Secretarial Priority 1: Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.

SAMHSA's Office of Behavioral Health Equity developed a data-driven strategy to examine and address disparities in access, service use, and outcomes in SAMHSA grant programs. Grantees are expected to incorporate performance on the disparity measures and adherence to the National CLAS Standards into their quality improvement plans. A revised Request for Application (RFA) language on the disparity impact statement requirement was incorporated into the fiscal year 2012 RFAs for four programs. OBHE worked with these pilot programs to identify lessons learned for consideration in implementation across the 2013 and 2014 grant programs. The disparity impact language was included in 32 new RFAs in 2013 and in 25 new RFAs in 2014.

Assessment and Expansion of Disparity Impact Statements within SAMHSA grants

OBHE incorporated language on disparity impact statements in 2012 RFAs for four programs. They worked with the pilot programs to identify lessons learned for consideration in implementation across the 2013 and 2014 grant programs. As a result, the disparity impact language was included in 32 new RFAs in 2013 and in 25 new RFAs in 2014.

Highlights of SAMHSA’s Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

SAMHSA’s focus on improving access to quality behavioral health services and providing support that enables individuals and families to thrive, participate in, and contribute to healthy communities means that many of its health disparities program activities primarily fall within Goals I-IV of the HHS Disparities Action Plan.

Goal I: Transform Health Care

Several of SAMHSA’s program activities focus on **reducing disparities in health insurance coverage and access to care** (Strategy I.A). They emphasize the need to address behavioral health (i.e., mental health and substance use) conditions and often focus on the integration of behavioral and primary health care. For example, the purpose of the *Outreach and Enrollment of Diverse Populations with Behavioral Health Conditions* is to maximize the enrollment of uninsured/underinsured individuals with behavioral health conditions from diverse populations in Medicaid and the Marketplaces by supporting targeted, culturally and linguistically appropriate outreach, education and enrollment activities, including attention to language access and health literacy issues. Between 2013 and 2014, SAMHSA held 23 webinars (two in Spanish), published 4 enrollment strategy briefs, posted 48 culturally appropriate practices blog posts, held three California events reaching 33 community-based organizations, conducted 12 monthly Community of Learning webinars with 38 Urban Indian Health Organizations (UIHO), performed two peer-to-peer UIHO technical assistance trainings and two on-site trainings, and a hosted a webinar for new immigrants interpreted into five languages all focusing on improving understanding of the Health Insurance Marketplace and enrollment.

The goal of the *Primary and Behavioral Health Care Integration (PBHCI)* program is to improve the physical health status of people with serious mental illnesses (SMI) by supporting communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. By building the necessary partnerships and infrastructure to support this goal, the expected outcome is for grantees to enter into partnerships to develop or expand their offering of primary health care services for people with SMI, resulting in improved health status. In fiscal year 2014, 27,111 consumers were served, of which 56 percent were Black, 26 percent were Hispanic/Latino, nine percent were American Indian, five percent were Asian, two percent were Native Hawaiian, and one percent were Alaska Native.

Project Impact: Primary and Behavioral Health Care Integration (PBHCI)

For the 27,111 participants in FY 14, the program resulted in:

- 19.2% outcome improvement – blood pressure;
- 43% improvement – BMI;
- 30.2% improvement – Breath carbon monoxide (smoking);
- 37.5% improvement – HDL cholesterol and
- 40.5% improvement – LDL cholesterol.

Initiated 2001, the *Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE)* facilitates the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities in states with the highest HIV prevalence rates (at or

above 270 per 100,000). This grant program is part of the Congressional Minority AIDS Initiative and supports the goals of the National HIV/AIDS Strategy. SAMHSA partnered with grantee organizations in selected states and geographic regions around the continental United States to target underserved populations, including racial and ethnic minorities in one or more of the following populations at high risk for HIV or living with HIV: young men who have sex with men (ages 18-29); adult heterosexual women and men; and men who have sex with men (ages 30 and older). In 2013 and 2014, the populations served were predominantly African American (60%), male (64%), age 35 - 54 years old, and 25% Latino. Through 2013, within 11 cities with the highest HIV impact, over 12,000 individuals were screened for behavioral health needs. Of these, 4,217 were referred to other services, and over 4,057 persons were engaged in care under the grant, including mental health, substance abuse treatment and prevention for persons with or at high risk for HIV and behavioral health disorders. HIV testing was provided to over 5,000 persons. For persons in care for 6 months or longer, results by consumer report showed significant improvements in national outcome domains of psychological distress, social connectedness, school/employment, daily functioning, and overall health.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Increasing the ability of all health professions and the health care system to identify and address racial and ethnic health disparities (Strategy II.A) is a critical focus of SAMSHA. For example, the *National Network to Eliminate Disparities (NNED) in Behavioral Health* supports information sharing, training, and technical assistance among organizations and communities dedicated to the behavioral health and well-being of diverse communities. SAMHSA partners with community-based providers and affiliates in the NNED network to target behavioral health service providers and other community-based and ethnic-based multi-service providers, organizations, and entities serving culturally, racially, or ethnically diverse populations. NNEDshare has been launched as a website optimized for mobile device access and populated with best practices from communities. As of July 2014, NNED included 726 partner organizations and 864 affiliates for a total of 2205 members.

SAMHSA also supports a range of programs to increase the capacity and effectiveness of mental health systems and providers serving AI/AN communities. The *Native American Center for Excellence (NACE)* is a national resource center for up-to-date information on AI/AN substance abuse prevention programs, practices, and policies. NACE provides training and technical assistance support for urban and rural prevention programs serving AI/AN populations. The *Tribal Training and Technical Assistance Center* supports comprehensive, broad, focused, and/or intensive training and technical assistance to federally-recognized tribes and other AI/AN communities to address and prevent mental and substance use disorders, suicide, and promote mental health. The Center provides proactive planning/implementation of programming focused on Native children, youth, and their families to: (1) decrease the impact of risk factors, such as poverty, unemployment, racism and historical trauma that contribute to suicide, family disruption, youth violence including bullying, and high-risk substance use; and (2) increase the protective factors, such as strengthening cultural identity, a sense of family and community connectedness, and communication skills, that are linked to the healthy and safe development of AI/AN children and their families. *Circles of Care* was created to provide tribal and urban

Indian communities with tools and resources to plan and design a holistic, community-based, coordinated system of care to support mental health and wellness for children, youth, and families. SAMHSA partners with program grantees to target tribal and urban Indian communities. In fiscal year 2013, six grantees completed the three-year infrastructure grant program and developed their community-based system of care model for children's mental health. In fiscal year 2014, four of the six grantees were awarded a four-year Systems of Care Expansion Implementation grant to implement the model system they developed through three years of the Circles of Care planning. The Circles of Care program was expanded in fiscal year 2014 to fund 11 new grants with increased budgets from the previous cohort. Those 11 tribes and urban Indian centers are currently in the first of three years.

Many SAMHSA program activities focus **increasing the diversity of the health care and public health workforces** (Strategy II.C) by providing fellowships and technical assistance and training opportunities. SAMHSA partners with the Morehouse School of Medicine to implement the *Historically Black Colleges and Universities (HBCU) Center for Excellence*, which supports the network of 105 HBCUs throughout the United States. The Center

promotes workforce development through expanding knowledge of best practices, leadership development, and encouraging community partnerships that enhance the participation of African Americans in the substance abuse treatment and mental health professions. SAMHSA also partners with mental health professional associations for the *Minority Fellowship Program*, which enhances services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, and psychology. Partners include the American Association for Marriage and Family Therapy, American Nurses Association, American Psychiatric Association, American Psychological Association, Council on Social Work Education, National Board for Certified Counselors and Affiliates, and the National Association for Alcoholism and Drug Abuse Counselors.

Project Impact: Historically Black Colleges and Universities (HBCU) Center for Excellence

- 89 organizations or communities have implemented mental health-related training programs;
- 855 students in the mental health and related workforce have been trained in mental health-related practices/activities as a result of the grant; and
- 96 percent of individuals have demonstrated improvement in knowledge/attitudes/beliefs related to prevention and/or mental health promotion.

Goal III: Advance the Health, Safety, and Well-Being of the American People

SAMHSA supports various programs to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). These programs help build community capacity to develop, implement, and evaluation culturally and linguistically appropriate evidence-based interventions.

Another national initiative, *Native Connections*, is designed to prevent and reduce suicidal behavior and substance abuse and promote mental health among American Indian/Alaska Native young people up to and including age 24. This program helps grantees reduce the impact of substance abuse, mental illness, and trauma on AI/AN communities through a public health approach. In addition, this grant builds the capacity of AI/AN communities to support youth and

young adults as they transition into adulthood by facilitating collaboration among agencies. Twenty grants were awarded tribes, which includes technical assistance to the tribes.

The *Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs)* is a substance abuse prevention education and testing program designed to equip and empower MSIs located in communities at the highest risk of substance abuse, HIV and Hepatitis C (HCV) infections with evidence-based methodologies to increase access to comprehensive, integrated substance abuse, HIV and HCV prevention services on their campuses/institutions and surrounding community. The program targets high-risk populations, including African American, Hispanic/Latino, Asian American and Pacific Islander, and American Indian and Alaska Native young adult populations (ages 18-24) on campus and the surrounding communities. In fiscal year 2013, 17,111 individuals received services, 13,579 individuals were tested for HIV, and 60.7 percent of program participants reported a decrease in use of alcohol upon exit from the program. In fiscal year 2014, SAMHSA released a reissue of the MSIs Partnerships with Community-Based Organizations (CBOs) with a new aim to achieve normative and environmental changes to prevent and/or reduce state agency problems as risk factors for the transmission of HIV/AIDS among African American, Hispanic/Latino, Asian American and Pacific Islander, and American Indian and Alaska Native young adult populations (ages 18-24) on campuses, including the surrounding communities. The purpose of both applications is for the MSIs to partner with one or more CBOs to provide integrated substance use disorder, HIV, and HCV prevention programs to these populations and their surrounding communities.

The purpose of the *Targeted Capacity Expansion Program: Substance Abuse Treatment for Racial and Ethnic Minority Populations at High-Risk for HIV/AIDS (TCE-HIV)* program is to facilitate the development and expansion of culturally competent and effective community-based treatment systems for substance use and co-occurring substance use and mental disorders within racial and ethnic minority communities in states with the highest HIV prevalence rates (at or above 270 per 100,000). The expected outcomes for the program include reducing the impact of behavioral health problems, reducing HIV risk and incidence, and increasing access to treatment for individuals with co-existing behavioral health, HIV, and hepatitis conditions. This program ensures that individuals who are at high risk for or have a substance use or co-occurring substance use and mental disorder and who are most at-risk for or are living with HIV/AIDS have access to and receive appropriate behavioral health services.

Goal IV: Advance Scientific Knowledge and Innovation

SAMHSA's *Center for Behavioral Health Statistics and Quality* published three reports based on data from the National Survey on Drug Use and Health (NSDUH) to highlight the special issues and needs of minority populations, including *Need for and Receipt of Substance Use Treatment among Blacks, Hispanic Subgroups Differ in Rates of Substance Use Treatment Need and Receipt* and *Suicidal Thoughts among Asians, Native Hawaiians, or Other Pacific Islanders*. In addition, SAMHSA's NSDUH questionnaire includes the Affordable Care Act Section 4302 HHS data collection standards for race, including the seven categories within the "Asian" response option. Two categories, Guamanian or Chamorro, and Samoan, were added in 2013 to support the full implementation of Section 4302.

Office of the Assistant Secretary for Health (OASH)

The Office of the Assistant Secretary for Health oversees 12 core public health offices – including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps – as well as 10 regional health offices across the nation and 10 Presidential and Secretarial advisory committees. Of these offices, the Office for Adolescent Health (OAH), the Office of Disease Prevention and Health Promotion (ODPHP), the Office of Population Affairs (OPA), the Office of Women’s Health (OWH), and the President’s Council on Fitness, Sports and Nutrition (PCFSN) conducted activities that are included in this report.

Office of Adolescent Health (OAH)

Agency Mission: OAH’s mission is to improve the health and well-being of adolescents to enable them to become healthy, productive adults. OAH coordinates HHS efforts related to adolescent health promotion and disease prevention, and communicates adolescent health information to health professionals and groups, those who serve youth, parents, grantees, and the general public.

Highlights of OAH’s Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal III: Advance the Health, Safety, and Well-Being of the American People

OAH’s program activities for Goal III focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). OAH managed two national

Teenage Pregnancy Prevention (TPP)

Programs. The Tier 1 program is to support the replication of evidence-based program models effective at preventing teen pregnancy. This initiative focuses on the following subpopulations in 37 states and the District of Columbia: adolescents; minority and high-risk adolescent populations; areas with high teen pregnancy rates; and vulnerable and culturally under-represented youth populations, including youth in foster care, runaway and homeless youth, youth with HIV/AIDS, delinquent youth, and youth who are disconnected from usual service delivery systems. OAH provides the Teen Pregnancy Prevention Tier 1 grantees with targeted training and technical assistance (TA) through a variety of mechanisms including a bi-annual conference, individual TA, project directors meetings, webinars, and written guidance. Through the provision of TA, grantees are expected to improve and provide high quality programming to the targeted communities. The

Project Impact: Pregnancy Prevention (TPP) Programs (FY 2013)

- Tier 1 programs served 138,000 youth. Over 60% of the youth served were minority youth. In the first six months of 2014, the program served approximately 65,000 youth. Over 60% of the youth served were minority youth.
- Tier 2 programs served 9,300 youth. Over 60% of the youth served were minority youth. In the first six months of 2014, the program served approximately 4,000 youth. Over 60% of the youth served were minority youth.

Tier 2 program develops, replicates, refines, and tests additional models and innovative strategies for preventing teen pregnancy in collaboration with 19 public and private entity grantee organizations in 13 states and the District of Columbia. There are eight Tier 2 programs specifically designed to test an innovative program that has been designed or tailored for a minority population, including one program for African American youth, one for Alaska Native youth, three for American Indian youth, one for Latino youth, one for Native Hawaiian youth, and one for Haitian American youth.

With a competitive award from the Secretary's Minority AIDS Initiative Fund (SMAIF), OAH also supports the *National Resource Center for HIV/AIDS Prevention among Adolescents*, which supports adolescent service providers with web-based resources, evidence-based research, and training and technical assistance to promote HIV/AIDS prevention among adolescents, in particular adolescents from minority and high-risk populations. This initiative is aimed at reaching adolescent service providers and adolescents with an emphasis on minority and high-risk populations through a public website. During 2013, the National Resource Center for HIV/AIDS Prevention among Adolescents (NRC) had a total of 16,186 visitors to the Resource Center website. Of the total visitors, 13,393 were new visitors to the site and 2,675 were returning visitors. There were a total of 35,652 website page views.

Through the Affordable Care Act, OAH also implements and administers the *Pregnancy Assistance Fund (PAF)*. The program allocates funds to 14 states and three Tribal entities to provide pregnant and parenting adolescents, women, fathers, and their families with a seamless network of supportive services to help them complete high school or postsecondary degrees, gain access to health care, child care, family housing, and other critical support. Funds are also used to improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault and stalking. OAH provides extensive training and technical assistance to the grantees through a variety of mechanisms including a bi-annual conference and project directors meetings, individual TA, webinars, and written guidance. OAH also developed an interactive, multi-media resource center website for information on tools to support pregnant and parenting teens, women, and their families. OAH is also conducting a study to evaluate programs for expectant and parenting youth, women, fathers and their families. The *Positive Adolescent Futures Evaluation* will conduct two randomized controlled trials (RCT), and one quasi-experimental design (QED) for impact analyses in three selected sites. Additionally, the evaluation will include in-depth implementation data collection and analyses for all three sites, as well as a follow-up cross-grantee implementation study for the 17 PAF grantees.

OAH partners with and provides funds to CDC Division of Reproductive Health (DRH) for the *Community-wide Teenage Pregnancy Projects*. This initiative is aimed at reducing teenage pregnancy and addressing disparities in teen pregnancy and birth rates. The program is focused on reaching African American and Latino youth ages 15-19. Competitive grants were awarded to eight state and community-based entities for the period of 2010-2015. The focus of the program is to demonstrate the effectiveness of innovative, multicomponent, community-wide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates. OAH and CDC collaborate to provide technical assistance, information exchange, and reporting. In Project Year three, grantees reached over 12,000 youth with evidence-based interventions to

prevent teen pregnancy, an increase of nearly threefold (from 4,304 in 2012 to 12,085 in 2013). Over 60 percent of the youth served were African American or Hispanic youth.

OAH supports a project called *Mobilization for Health: National Prevention Partnership Awards (NPPA) Program Families Talking Together: A family-based teen pregnancy prevention program in Texas*. This grant is designed to establish a national effort to create a network of partnerships and resources to promote health and wellness, educate and train, and establish communication programs to all community populations, regardless of social and economic barriers, race, and ethnicity. As part of this project, the National Campaign to Prevent Teen and Unplanned Pregnancy will partner with the Center for Latino Adolescent Health and Family Health at the New York University's School of Social Work, Healthy Futures of Texas, and the Rio Grande Valley Council to implement Families Talking Together, an evidence-based teen pregnancy prevention program aimed at Latino families with children ages 10-14 year olds. The program will be adapted for delivery by CHWs/*promotores de salud* and include a module on the Affordable Care Act.

Office of Disease Prevention and Health Promotion (ODPHP)

Agency Mission: ODPHP's mission is to lead and mobilize actions to improve health by establishing national health priorities and translating disease prevention and health promotion science into policy, guidance and tools for a healthier nation.

Highlights of ODPHP's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

In April 2014, ODPHP launched an interactive training tool on the Health Literate Care Model (HLCM), a graphic based on the Chronic Care Model, an evidence-based framework developed by the MacColl Institute in 1996. The HLCM calls for health care organizations to address health literacy within all aspects of health care planning and operations and address all patients' ability to navigate and act on health information, regardless of language barriers, socioeconomic factors, and other demographics. The tool serves health care providers and professionals, community leaders, health policymakers, and other stakeholders in improving access to and quality of care for all populations.

Goal III: Advance the Health, Safety, and Well-Being of the American People

Many of ODPHP's activities focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). Key activities include:

- Since Healthy People 2020 was launched in 2010, HHS has produced the *Leading Health Indicators (LHIs)*, a small set of indicators that communicate high-priority health issues and actions that can be taken to address them. Healthy People 2020 identifies and

manages the nation's 10-year goals and objectives for health promotion and disease prevention used to assess the health of the U.S. population on key areas, facilitate collaboration across diverse sectors, and motivate action at the national, state and local levels. Each of the 26 Indicators, organized under 12 broad topics, is associated with a specific Healthy People 2020 objective.

- The *2010 Dietary Guidelines for Americans* utilize consensus, scientific, and medical knowledge to advise the public on ways to improve overall health through proper nutrition and physical activity. They form the basis of federal nutrition policies and programs, providing a vehicle for the government to speak with one voice on nutrition and health. This seventh edition made recommendations for African Americans who reside in the continental U.S. and all U.S. territories, based on scientific evidence related to sodium consumption and blood pressure. Plans are underway for the release of the 2015 Dietary Guidelines for Americans for publication by December 2015. A 2015 Dietary Guidelines Advisory Committee (DGAC) was established to review current science and develop an advisory report. HHS has the administrative lead for 2015; however the release of the Dietary Guidelines policy document is a joint effort by both HHS and the U.S. Department of Agriculture.
- ODPHP launched the series *Eat Healthy • Be Active Community Workshops* in 2012. There are six online workshops that include nutrition and physical activity guidance and feature handouts, video vignettes, and healthy eating tips from the ChooseMyPlate.gov website. State and local community educators, faith-based organizations, public health organizations, and other educators were invited to view and use them for local community training. A total Spanish translation of the complete workshop series was accomplished, with 508 compliance in fiscal year 2014. On September 8, 2014, during National Hispanic Heritage month, the Spanish version of the workshop was released, "Consuma una alimentación saludable - Manténgase activo Serie de talleres comunitarios." Plans for further outreach to more than 5000 community leaders through partnerships with FDA, NIH, and the HHS OMH during fiscal year 2015 are underway.

Goal IV: Advance Scientific Knowledge and Innovation

ODPHP also supports activities that focus on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV. A). For example, *Healthy People 2020* is the blueprint for the nation for achieving health promotion and disease prevention objectives for the U.S. population. Its national objectives are guided by four overarching goals, including: achieve health equity, eliminate disparities, and improve the health of all groups. The nation's public health goals and objectives for 2020 were launched in 2010. The *Healthy People 2010's* goal to eliminate disparities was expanded even further: to achieve health equity, eliminate disparities, and improve the health of all groups. All population-based measures track data for racial and ethnic minorities. At HHS, the Healthy People 2020 Federal Interagency Workgroup was created and includes representatives from approximately 25 HHS agencies as members. Fifty-one states/territories have adopted Healthy People elements in fiscal year 2014.

At the end of fiscal year 2014 ODPHP partnered with CMS, AHRQ, CDC, and HHS OMH to contract with MITRE (a federally funded research and development center) to support the

OASH/ODPHP Disparities Project. Together, over the next three years, they will review current and collect additional data to document disparities in adverse drug reactions, health care-associated infections and other health care-associated adverse outcomes. Their work will ultimately contribute to the creation of a plan to reduce racial and ethnic minority and other disparities in preventable adverse health outcomes.

Office of Population Affairs (OPA)

Agency Mission: OPA administers the Title X program, the only federal program dedicated solely to the provision of family planning and related preventive services. OPA also serves as the focal point to advise the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including family planning, adolescent pregnancy, sterilization and other population issues. OPA operates under the direction of the Deputy Assistant Secretary for Population Affairs.

Goal III: Advance the Health, Safety, and Well-Being of the American People

OPA runs several programs that focus on reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A). Through the Integrate Routine HIV Testing and Linkage to HIV Care and Treatment in Family Planning Services Grants, OPA has funded 18 Title X grantees through the Secretary's Minority AIDS Initiative Fund (SMAIF) and Title X funds. Services include high impact HIV prevention services that include opt-out HIV testing, linkage to care, behavioral interventions through counseling sessions, condom distribution, and sexually transmitted infection (STI) screening and treatment. Applicants with sites serving communities in which racial /ethnic minorities constitute more than 50 percent of the population and demonstrated to be at high risk of HIV infection received \$6,145,910 from SMAIF. An additional \$2 million in OPA funding was awarded communities at high risk of HIV infection but may not have 50% racial and ethnic minority status. From 2010-2013 there were 16,143 first time testers, 1140 positive tests, 98 percent of clients received their results, and 84 percent were linked to care.

Office on Women's Health (OWH)

Agency Mission: OWH's mission is to provide national leadership and coordination to improve the health of women and girls through policy, education, and model programs. OWH achieves its mission by informing and advancing policies, educating the public and professionals, and supporting model programs.

Highlights of OWH's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal I: Transform Health Care

Many of OWH's activities focus on reducing disparities in health insurance coverage and access to care (Strategy I.A). Key activities include:

- During National Women's Health Week, the Office on Women's Health disseminated *ACA Website Information Cards*, 3x5 cards with the Affordable Care Act website information and healthy messages such as encouraging women to eat five fruits and veggies per day and encouraging 30-90 minutes of physical activity every day. In partnership with 18 floral shops and two churches in the Atlanta, GA area, over 3000 cards were distributed, targeting mostly women.
- In fiscal year 2014, OWH allocated funds and granted a limited number of current grantees with established coalitions and partnerships to identify, recruit, and educate underserved and hard-to-reach women about the Health Insurance Marketplace and to assist them in enrollment. These funds aimed to serve American Indian and Alaska Native, African American, and Hispanic women. It is anticipated that the grantees will help enroll approximately 20,000 individuals.
- OWH supports a project called *HIV Prevention for Women Living with HIV/AIDS in the Virgin Islands*. In partnership with HOPE Inc., OWH supports prevention and education projects that will increase access to care, improve knowledge of protective behaviors, and reduce isolation for women in the Virgin Islands living with HIV/AIDS. Similarly, in partnership with the University of Puerto Rico, OWH supports a project called HIV Prevention for Women Living with HIV/AIDS in Puerto Rico targeting Puerto Rican women.

OWH also focuses on **reducing disparities in access to primary care services and care coordination** (Strategy I.B). For example, OWH supports an initiative called HIV Prevention and Support Services for Women Partners of Incarcerated/Recently Released Males. This initiative supports gender-specific demonstration projects for HIV/AIDS continuum of care and prevention services for incarcerated and newly-released women disproportionately impacted by HIV/AIDS. This initiative supports African American women and women of other racial backgrounds.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

OWH supports several strategies to **increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities** (Strategy II. A). In partnership with ACF and OMH Region IV, OWH supports a health and wellness training pilot for health professionals called *Stop. Observe. Ask. Respond to Human Trafficking (SOAR)*. Another project called Trauma Informed Training focuses on providing cultural and sensitivity training for health care professionals who serve women experiencing trauma. OWH also supports the *Improving the Health and Well-Being of Latinas: Tools and Resources for Public Health and Social Service Providers* that serves public health and social service providers who work with Latina women. Two annual events were held to provide tools and information that participants can use when providing education on issues such as the Affordable Care Act and Health Insurance Marketplace, and the impact of health disparities and heart disease.

Goal III: Advance the Health, Safety, and Well-Being of the American People

OWH supports several strategies to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A).

National Women's Health Week (NHHW) encourages partners to develop projects that promote healthy behaviors among women and girls such as engaging in physical activity, making healthy food choices, and receiving preventive screenings. Projects focus on health disparities in women's health by highlighting topics such as heart disease, breast cancer, diabetes care, reproductive health, and intimate partner violence. More than 1800 women pledged to be well women. More than 13,000 unique Twitter accounts contributed over 28,000 tweets in support of NHHW, and nearly 800 media stories about NHHW appeared. *National Women and Girls HIV/AIDS Awareness Day* encourages partners to develop projects that increase awareness about HIV/AIDS in observance of National Women and Girls HIV/AIDS Awareness Day. In 2014, over two million people were reached through social media tools. There were 167,178,052 media impressions where almost 200 outlets including five TV stations, 11 radio stations and more than 130 blogs and websites covered the observance. Projects focus on increasing awareness by providing various types of prevention education and providing HIV testing and counseling.

In Community Spirit - HIV Prevention for Native Women Living in Rural and Frontier Indian Country is a gender-specific HIV prevention education project that integrates the strengths of traditions, values, culture, and spirituality indigenous to the targeted communities. Project Connect is a violence prevention and response initiative that strives to strengthen collaborations between the public health and domestic violence fields. The project has had a significant impact on the selected communities. Each site has identified an increase in women seeking domestic violence materials.

OWH also coordinates education campaigns to improve the health and wellness of ethnic and racial minority women. For example, the *Health and Wellness Initiative for Women Attending Minority Institutions* builds the capacity of the partner institutions to conduct health promotion activities that are gender responsive, culturally and linguistically appropriate, and age appropriate in the areas of HIV/AIDS/STIs, violence against women, mental health, overweight/obesity, nutrition, and overall wellness. This program served African American and Native American women attending universities and colleges in South Carolina, Georgia, Florida, Virginia, Texas, Puerto Rico, Oklahoma, and Washington. MSIs also collaborate with local health service organizations as a resource to foster a culture of health, wellness, and safety for the entire campus community.

OWH also coordinates projects with faith-based communities to improve the health and wellness of ethnic and racial minority women. For example, the *Tri-Regional Faith & Community Health Summit* encourages faith-based organizations to start health ministries within their organization. Summits were held in Regions IV, VI and VII. In another project called *Faith-based Blood Pressure/Glucose Screenings*, OWH partnered with organizations to provide screenings at over 25 churches throughout Kansas City, Missouri.

OWH supports the *It's Only Natural* national campaign that addresses low breastfeeding rates for African American mothers. This campaign was developed in response to the Women's Preventive Services of the Affordable Care Act to provide comprehensive lactation support by trained providers. This campaign aims to serve African American women and families, physicians, nurses and fathers' groups.

President's Council on Fitness, Sports, and Nutrition (PCFSN)

Agency Mission: PCFSN engages, educates, and empowers Americans to adopt healthy lifestyles that include regular physical activity and good nutrition. PCFSN is made up of athletes, chefs, physicians, fitness professionals, and educators who are appointed by the President and serve in an advisory capacity through the Secretary of Health and Human Services. Through partnerships with the public, private, and non-profit sectors, PCFSN promotes programs and initiatives that motivate people of all ages, backgrounds, and abilities to lead active, healthy lives. PCFSN plays a key role in the development of the administration's programmatic priorities, outreach, and awareness efforts to improve the health and quality of life for all Americans.

Highlights of PCFSN's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal III: Advance the Health, Safety, and Well-Being of the American People

PCFSN is implementing key projects to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). PCFSN supports physical education activities in schools. For example, *Let's Move! Active Schools* is a physical activity and physical education solution that aims to create opportunities for students to be active before, during and after school. PCFSN serves as the federal lead for Let's Move! Active Schools. In addition to serving all schools nationwide, Let's Move! Active Schools has targeted outreach to the Native American population through the Bureau of Indian Education and the Let's Move! in Indian Country sub-initiative of the First Lady's campaign. Program partners of Let's Move! Active Schools also provide priority to schools based on need (Title I status). PCFSN is also working with national and local partners to carry out the *Outreach to Native American Communities and Schools* program to engage Native American youth and families in regular physical activity and good nutrition. On September 15, 2014, two President's Council members participated in a Satellite Media Tour for a Rapid City/Pine Ridge/Nebraska/Wyoming television station to draw attention to the importance of healthy lifestyles throughout the school environment. The market reached a large population of AI/AN individuals and families.

PCFSN also supports the *Presidential Youth Fitness Program (PYFP)* whose mission is to provide a model for fitness education that includes use of a health-related fitness assessment, as well as educational and motivational tools, to support educators and empower students to adopt an active lifestyle. The program focuses on professional development for physical educators, using the FITNESSGRAM® health-related fitness assessment, and recognition for students and schools. Program resources are available to all schools across the country. Additionally, a non-

Federal grant program that provides supplemental resources to schools to implement the Presidential Youth Fitness Program provides priority to Title I schools during the application process.

Other HHS Agencies' Minority Health Activities

A number of other HHS agencies carried out programs to reduce disparities in health and health care for minority and vulnerable populations. The following agency-by-agency discussion describes the agency mission, their health disparities activities, and how these efforts are aligned to the HHS Disparities Action Plan.

Administration for Children and Families (ACF)

Agency Mission: ACF fosters health and well-being by providing federal leadership, partnership, and resources for the compassionate and effective delivery of human services.

Highlights of ACF's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

ACF plays a critical role in increasing the diversity of the health care and public health workforces (Strategy II.C) in relation to socio-economic status. Funded by the Affordable Care Act, the *Health Profession Opportunity Grants (HPOG) Program* provides education and training to Temporary Assistance to Needy Families (TANF) recipients and other low-income individuals for occupations in the health care field that pay well and are in high demand. Grantees are required to partner with the State and Local Workforce Investment Board, State TANF Agency, and the State or Federal Office of Apprenticeship. ASPE has also sponsored research to examine retention in high-need areas among NHSC members, by demographic characteristics and by discipline.

Project Impact: Health Profession Opportunity Grants (HPOG) Program

After four years of program implementation, participant data show that 31,900 participants enrolled and received services; 26,100 enrolled in health care occupational training; 17,600 completed training; and 11,600 became employed in the health care sector or occupation since intake.

Goal III: Advance the Health, Safety, and Well-Being of the American People

ACF's activities focused primarily on **reducing disparities in population health by increasing availability and effectiveness of community-based programs and policies** (Strategy III.A). For example, the *Head Start Program* addresses the need to prepare children in low-income families for school, based on the growing evidence of health disparities and of the early onset of achievement disparities between economically disadvantaged children and their more advantaged peers, and the awareness that early health and achievement disparities are linked to long-term negative health, educational, and economic outcomes. In 2013, Head Start served 1,034,000 children and pregnant women in center-based, home-based, and family child care

programs in urban, suburban, and rural communities throughout the nation. Of the total, 37 percent identified as Hispanic or Latino and 29 percent identified as Black or African American. Programs included: Head Start services to preschool children; Early Head Start services to infants, toddlers, and pregnant women; services to families by AI/AN programs; and services to families by Migrant and Seasonal Head Start programs.

The *Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)*, administered by HRSA in partnership with ACF, supports voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. In fiscal year 2014, states reported serving approximately 115,500 parents and children in all 50 states, the District of Columbia, and five territories through the Home Visiting Program. Sixty-seven percent of program participants belonged to a racial or ethnic minority. Under the Tribal MIECHV program, 25 grants have been awarded to tribes, tribal organizations, and urban Indian organizations. In 2014, tribal grantees reported serving approximately 2,800 children and families and tribal grantees have provided nearly 18,000 home visits since the start of the program. Tribal grantees conduct community needs assessments; plan for and implement high-quality, culturally-relevant, evidence-based home visiting programs in at-risk tribal communities; and conduct tribally-driven performance measurement and rigorous evaluation activities.

The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation (MIHOPE) is the legislatively mandated evaluation of the federal MIECHV program. MIHOPE will estimate the impacts of MIECHV on child and family outcomes for different populations using random assessment methodologies and will examine the ability of MIECHV to improve health care practices, eliminate health disparities, and improve health care system quality and efficiency, while reducing costs. More information can be found at www.acf.hhs.gov/programs/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope.

Administration for Community Living (ACL)

Agency Mission: The primary goal of ACL is to increase access to community supports and enhance full participation in the community, while focusing attention and resources on the unique needs of older Americans and people with disabilities. ACL meets its goal with enhanced policy and program support for both cross-cutting initiatives and efforts focused on the unique needs of individual groups such as children with developmental disabilities, adults with physical disabilities, and seniors, including seniors with Alzheimer's Disease.

Highlights of ACL's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal I: Transform Health Care

Many of ACL's program activities within Goal I focus on **reducing disparities in health insurance coverage and access to care** (Strategy I.A.). All older Americans and their family caregivers are eligible to receive services through the Older Americans Act (OAA) Programs. The Administration on Aging within ACL gives specific attention to those individuals who are in

the greatest economic and social need, including racial and ethnic minority seniors. OAA Programs reach older individuals by way of grants and contracts awarded through the Title III and VI formula grants and Title IV discretionary grants programs. In 2014, OAA Title III programs and OAA Title VI programs were appropriated funding for nutrition and supportive services. Given its mission and the demographics of the aging population, OAA services reached 11 percent of the African American seniors, 6.8 percent of Hispanic seniors, 3.0 percent of the Asian American and Pacific Islander seniors, and 1.2 percent of American Indian and Alaskan Native seniors.

ACL has developed the *National Aging Resource Consortium on Racial and Ethnic Minority Seniors (Consortium)* to develop and disseminate culturally competent technical assistance and training for the aging network. During 2013 and 2014, five continuation cooperative agreements were awarded to national minority aging organizations that represent American Indian, Alaskan Native, Native Hawaiian; lesbian, bisexual, gay and transgender (LBGT) and older populations. These organizations are being charged with the assisting the Aging Network to meet the needs of an increasingly diverse older population in a sensitive and efficient manner regardless of sexual orientation.

Assistant Secretary for Planning and Evaluation (ASPE)

Agency Mission: ASPE advises the HHS Secretary on policy development in health, disability, human services, data, and science, and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies, develops policy analyses, and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

Highlights of ASPE's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal I: Transform Health Care

ASPE published three research briefs in 2014 related to the goal of strengthening health care. Each focuses on **reducing disparities in health insurance coverage and access to care** (Strategy I.A) by analyzing the potential impact of the Affordable Care Act on specific racial and ethnic minority communities. The briefs are available online at the following addresses:

- African Americans:
http://aspe.hhs.gov/health/reports/2013/UninsuredAfricanAmericans/ib_UninsuredAfricanAmericans.cfm
- Asian Americans and Pacific Islanders:
http://aspe.hhs.gov/health/reports/2014/UninsuredAANHPI/rb_UninsuredAANHPI.cfm
- Latinos:
http://aspe.hhs.gov/health/reports/2013/UninsuredLatinos/rb_uninsuredLatinos.pdf

In partnership with ACF and HHS OMH, the *Linking Low-Income Men to Medicaid* and the Health Insurance Marketplace program provides states with early guidance on how to enroll low-income men, including low-income men of color, in Medicaid and the Health Insurance Marketplace. This exploratory study focuses on several subpopulations including low-income immigrants and low-income men of color. The first year of research has been completed, and the results of the program are expected to be available in the year 2015.

Goal III: Advance the Health, Safety and Well-Being of the American People

ASPE's strategies under Goal III focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). ASPE, in partnership with the ACF's Office of Planning, Research, and Evaluation (OPRE), completed a brief on the *Hispanic Healthy Marriage Initiative Grantee Evaluation: Addressing Domestic Violence in Hispanic Healthy Relationship Programs*. The Initiative has provided a comprehensive process and output evaluation of selected ACF Healthy Marriage Grantees that serve Hispanic families from 2007 to 2013. This most recent brief describes how sites addressed domestic violence in the family strengthening and relationship education services they provided. The major finding of the study is that programs treated domestic violence with requisite seriousness and expressed concern about the prevalence and effects of domestic violence in their communities.

Goal IV: Advance Scientific Knowledge and Innovation

ASPE's strategies under Goal IV focus on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). In accordance with section 4302 of the Affordable Care Act, HHS has established data collection standards for race, ethnicity, sex, primary language, and disability status for the Department's population surveys. Notably, the new standards include additional detail for the Asian, Native Hawaiian, and Pacific Islander race categories and for Hispanic ethnicity. In addition, this is the first primary language and disability data collection standard in HHS. The data collection standards also include primary language and disability status. The HHS Data Council, co-chaired by ASPE and AHRQ, lead the Department-wide effort in developing survey data standards and have monitored the implementation of the standards. The data collection standards have been implemented in major HHS population-based surveys with self-reported data.

ASPE has led efforts to develop *HHS' Strategic Framework on Multiple Chronic Conditions* in 2010 to address the needs of those with Multiple Chronic Conditions (MCC), which represent almost one-third of the U.S. population and account for two-thirds of health care spending. To provide information about and build upon these efforts, ASPE recently published a report titled *Research Addressing the HHS Strategic Framework on Multiple Chronic Conditions: Understanding Disparities in Persons with Multiple Chronic Conditions: Research Approaches and Datasets*. It builds on a previous white paper that identified the "long tail" of the MCC distribution: approximately one-third of all Medicare patients have one of the most common combinations of MCC, but another third of all patients have one of two million unique combinations of MCC and account for 79 percent of health care costs. This poses a unique challenge for research because of the small number of persons within each unique combination

of MCC in the “long tail” of the distribution. For disparities research, the challenge is even greater as stratification by race, ethnicity and socio-demographic variables further reduces sample size. The report contributes to meeting the goals outlined by the HHS strategic framework by summarizing the current literature on MCC disparities, describing how the methodological challenges of disparities research are further manifested in MCC research, reviewing promising methods, and assessing the usability of various data systems and datasets for MCC disparities research.

Indian Health Service (IHS)

Agency Mission: IHS conducts activities to raise the physical, mental, social, and spiritual health of American Indians/Alaska Native to the highest level. In fiscal years 2013 and 2014, IHS supported a range of vital health programs, services, and activities including: tribal self - governance, contract health services, tribal management, and contract support; hospitals, health clinics, and facilities construction and maintenance; diabetes, dental health, mental health, alcohol and substance abuse, injury prevention, immunizations, environmental health, sanitation, and health education programs; and, recruitment, retention, and service delivery activities through the Indian Health Professions, Public Health Nursing, and Community Health Representatives programs.

Highlights of IHS’ Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal I: Transform Health Care

Several of IHS’ programs focus on **reducing disparities in access to primary care services and care coordination** (Strategy I.B). IHS works to recruit and retain needed health professionals to provide clinical health care services in high priority facilities in Indian communities and recruit and train American Indian and Alaska Native people to become health professionals serving Indian communities. The *IHS Loan Repayment Program (LRP)*, authorized under section 108 of the Indian Health Care Improvement Act (IHCIA), offers health care professionals the opportunity to ease qualified health professions-related student loan debt and help Indian Health Programs meet the staffing needs of high priority sites. The LRP provides an initial award for educational loan repayment assistance to qualified health care professionals in exchange for an initial two-year service commitment for full time clinical practice at an approved Indian health facility. In fiscal year 2013, a total of 1,312 LRP recipient physicians, nurses, dentists, pharmacists, optometrists, podiatrists and other health care professionals served in Indian communities. In fiscal year 2014, a total 1,229 LRP recipients served in Indian communities.

The *Indian Health Service Scholarship Program* provides financial assistance to AI/AN students in health professional education programs. Three interrelated scholarship programs train the health professional personnel necessary to staff IHS health programs and other health programs serving the Indian people. The Preparatory and Pre-Graduate Scholarship Programs provides financial assistance for AI/AN students from federal or state recognized tribes enrolled in a compensatory or preparatory courses leading to entry into health professional schools. The

Health Professions Scholarship Program provides support for AI/AN students from federally recognized tribes enrolled in health professions or allied health professions education programs. In fiscal year 2013, a total of 384 students in medical, nursing, dental, pharmacy, optometry, podiatry and other health care professional school received an IHS scholarship. In fiscal year 2014, a total 344 students received an IHS scholarship.

IHS also administers three Indian Health Service Grant Programs, all authorized under the IHCIA, which benefit AI/AN students. The *Quenton N. Burdick American Indians Into Nursing Program* helps to increase the number of nurses who deliver health care services to Indians. In fiscal year 2013, four universities received grant support to operate the nursing program. The *Indians Into Medicine Program* encourages and assists Indian students to prepare for a career in health care. In fiscal year 2013, three universities received grant support. The *American Indians Into Psychology Program* increases psychological services provided to Indian communities. In fiscal year 2013, three universities received grant support. Through these three grant programs, IHS is able to expand access to primary health care in the fields of nursing, psychology, and medicine throughout our Indian health programs.

Office for Civil Rights (OCR)

Agency Mission: The mission of OCR is to ensure that people have equal access to and the opportunity to participate in and receive services from all HHS-funded programs without facing unlawful discrimination, and that the privacy and security of their health information is protected. OCR plays a critical role in strengthening the health and human services infrastructure and workforce.

Highlights of OCR's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal II: Strengthen the Nation's Health and Human Services Workforce

OCR plays a critical role in **increasing the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities** (Strategy II. A). During fiscal year 2013, OCR continued implementation of its national compliance review initiative, *Advancing Effective Communication in Critical Access Hospitals*, to support language access programs in rural communities. Title VI of the Civil Rights Act of 1964 (Title VI) requires recipients of Federal funds, such as critical access hospitals (CAHs), to take reasonable steps to ensure meaningful access to their programs and services by individuals who have a limited ability to read, speak, write, or understand English. OCR examined one CAH in each of the 45 states that participate in the CAH Program. OCR reviewed service area data; evaluated language access services policies and procedures; conducted onsite visits; interviewed hospital staff and community stakeholders; provided technical assistance; and secured corrective action when compliance issues were discovered in the hospital's language access program. Each of the CAHs developed a comprehensive language access program, which includes (1) assessments of needs and capacity; (2) interpreter services; (3) translation services; (4) language assistance and grievance policies; (5) notification of the availability of language assistance at no cost to the individual with limited English proficiency (LEP); (6) staff training; (7) assessments of access

and quality of services; (8) stakeholder consultation; (9) digital information services; and (10) compliance with Title VI.

The *Medical School Curriculum Initiative* enhances medical school instruction by helping future medical practitioners appreciate their role in reducing health disparities. The curriculum, *Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities*, was developed in 2004 with funding from the National Institutes of Health and the Stanford University School of Medicine. The curriculum was later published in the Association of American Medical Colleges' (AAMC) MedEdPORTAL, available online at www.mededportal.org/publication/7740. In April 2014, OCR renewed its partnership with the AAMC to reach new audiences by conducting webinars marketing the curriculum to the AAMC's network of universities, faculty and students. During June 2014 through August 2014, OCR introduced the curriculum to 12 medical and dental schools participating in the AAMC's Summer Medical and Dental Education Program (SMDEP). OCR presented a condensed version of the curriculum to nearly 1,000 aspiring dental and medical school students at the following universities: University of Texas–Houston; the University of Virginia; Howard University; Rutgers University; the University of Louisville; Case Western University; University of Nebraska; Duke University; Yale University; Columbia University; University of California–Los Angeles; and the University of Washington.

Goal V: Increase the Efficiency, Transparency and Accountability of HHS Programs

OCR led the *HHS Language Access Steering Committee*, composed of senior level representatives from operating and staff divisions across HHS, in revising the HHS Language Access Plan (LAP). The new HHS LAP was released in February 2013 and establishes the Department's policy and strategy for serving individuals with limited English proficiency (LEP) to ensure they have meaningful access to federally-conducted programs. The 2013 HHS LAP is organized into ten cross-cutting elements which include: (1) assessment of needs and capacity; (2) oral language access services; (3) written translations; (4) policies and procedures; (5) notice of the availability of language assistance at no cost to the individual; (6) staff training; (7) assessment of access and quality; (8) consultations with stakeholders; (9) digital information; and (10) grant assurance and compliance.

The 2013 HHS LAP served as a blueprint for HHS agencies to develop their own agency-specific LAP. OCR provided substantive technical assistance and guidance to agencies, including a Frequently Asked Questions (FAQ) document regarding LAP development, a Resource Guide and Language Access Plan Template, along with consultations and reviews of draft LAPs. These efforts helped agencies produce comprehensive and forward thinking LAPs, which fit the unique circumstances of their programs and activities. Since release of the HHS LAP, 25 operating and staff divisions have developed and are implementing their agency-specific LAPs.

Office of the Assistant Secretary for Preparedness and Response (ASPR)

Agency Mission: ASPR was created under the Pandemic and All Hazards Preparedness Act in the wake of Hurricane Katrina to lead the nation in preventing, preparing for, and responding to

the adverse health effects of public health emergencies and disasters. ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; countermeasures research, advance development, and procurement; and grants to strengthen the capabilities of hospitals and health care systems in public health emergencies and medical disasters. The office provides federal support, including medical professionals through ASPR's National Disaster Medical System (NDMS), to augment state and local capabilities during an emergency or disaster.

Highlights of ASPR's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

ASPR's efforts within Goal II focused on **increasing the diversity of the health care and public health workforce** (Strategy II.B). The *National Disaster Medical System (NDMS)* is a federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to supplement an integrated National medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts. As of May 2014, the NDMS workforce included more than 890 racial and ethnic minorities.

Goal III: Advance the Health, Safety and Well-Being of the American People

ASPR supported several activities to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies** (Strategy III.A). *The Hospital Preparedness Program (HPP)* provides leadership and funding through grants and cooperative agreements to States, territories, and eligible municipalities to improve the resilience and surge capacity of the health care system, thereby enhancing community preparedness for public health emergencies. HPP focuses on building community and regional coalitions of health care providers that aim to enhance the movement of information, resources, and patients across the community so that its health care system that can absorb casualty and incident demands that would otherwise be overwhelming. HPP distributes grants to 62 State and territorial departments of public health to support the building of health care capabilities as described in *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*.

The *ASPR Office of Communications* promotes outreach campaigns to reduce racial and ethnic health disparities to increase the availability and effectiveness of community-based programs and policies for emergency and disaster preparedness, response and recovery activities. The Office of Communications led efforts through new media channels to educate and raise awareness on the need for cultural competency. Activities included a blog on cultural competency training, a blog promoting health equity through emergency preparedness and response published in Huffington Post by the Assistant Secretary, and use of social media to promote cultural

competency. The Office of Communications also promotes HHS-sponsored language access resources, including translated digital materials that are available in multiple languages on the ASPR “Health and Social Assistance” webpage.

Implemented by ASPR, *National Health Security Strategy (NHSS) Implementation Plan* is the Nation’s comprehensive strategy focused on protecting people’s health in case of an emergency. Strategic Objective 1 of the 2014 NHSS (Build and Sustain Healthy, Resilient Communities) supports the reduction of disparities in population health by promoting the availability and effectiveness of community-based programs and policies for building community capacity to implement evidence-based policies and environmental, programmatic, and infrastructure change strategies. The focus is community health resilience – a community’s ability to use its assets to strengthen public health and health care systems and to improve the community’s physical, behavioral, and social health to withstand, adapt to, and recover from adversity.

The HHS Strategic Plan fiscal year 2014-2018 calls for reducing the occurrence of infectious diseases, protecting Americans’ health and safety during emergencies, and fostering resilience in response to emergencies. To address this goal, HHS established the *Public Health Emergency Medical Countermeasure Enterprise (PHEMCE)* to coordinate medical countermeasure (MCM)-related activities occurring across multiple federal departments. The PHEMCE is charged with addressing the production and availability of MCMs to limit potential adverse health impacts on the large and diverse U.S. civilian population. At-risk individuals including those specifically recognized in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), as well as other at-risk individuals with access and functional needs including individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing homelessness, individuals who have chronic medical disorders, and individuals who have pharmacological dependency. ASPR, NIH, and FDA in partnership with the CDC are working to meet this objective by providing support to expanding MCM label indicators to at-risk populations during the development of priority MCMs, including development of alternate formulations as needed. In addition, these agencies include considerations of at-risk individuals’ needs in Strategic National Stockpile formulary analyses.

Goal IV: Advance Scientific Knowledge and Innovation

In fiscal years 2013 and 2014, ASPR sought to **increase the availability and quality of data collected and reported on racial and ethnic minority populations** (Strategy IV.A). The ASPR Fusion Division, by working with the Emergency Management Group Information Cell (EMG InfoCell), develops demographics reports of key community characteristics that can be delivered in advance of notice events (i.e., hurricanes) or immediately after no or little-notice events (i.e., earthquakes or tornados) to help guide federal planning and response operations. The ASPR Fusion Division uses specialized tools and works with partners to provide decision-makers with the information necessary to prepare for emergencies, lead rapid responses, and ultimately save lives. Demographic data generated from ESRI Community Analyst and Behavior Risk Factor Surveillance Survey (BRFSS) includes age, gender, race, languages spoken, households with income below poverty level, households with no vehicles available, health insurance coverage status, medical conditions, adults with health programs requiring

special equipment, and fair or poor health status. These data sources enhance the federal government's capacity to develop strategies to increase access to information related to reducing health disparities in emergency and disaster preparedness, response, and recovery activities.

ASPR also **conducted and supported research to inform disparities and reduction initiatives** (Strategy IV.B) through two research initiatives examining the health and well-being of communities affected by Hurricane Sandy. For the *Sandy Grant program*, ASPR received more than \$11.9 million to support research grants and to aid long-term recovery in areas impacted by Hurricane Sandy. The grants represent the first time HHS has funded evidence based disaster research needed by local communities to support long-term recovery efforts. Several studies funded by the ASPR Sandy Grant program evaluate the status of individual and community resilience among vulnerable populations in socioeconomically disadvantaged, medically underserved, rural, and urban settings with the goal of identifying indicators and/or tools that can assist in disaster recovery for these populations. Research outcomes should inform individual and community recovery in a way that may track with mitigation of health disparities.

Office of the National Coordinator for Health Information Technology (ONC)

Agency Mission: ONC's mission is to improve health and health care for all Americans through use of information and technology. ONC serves as a resource to the entire health system to support the adoption of health information technology (HIT) and the promotion of nationwide health information exchange to improve health care.

Highlights of ONC's Fiscal Years 2013 and 2014 Activities (Categorized by the HHS Disparities Action Plan)

Goal I: Transform Health Care

ONC is working with CMS on the Takoma Project, which improves the quality of dental care for children in Medicaid and CHIP through the development and deployment of dental quality measures for children that can be reported through an electronic health record (EHR). Given the relatively high percentage of racial and ethnic minority children (under the age of 19) with public insurance, this action will help to address disparities in quality of oral health services.

Solo, small group, rural providers, as well as underserved patients and communities have historically faced challenges in health IT adoption and use. ONC's Regional Extension Center (REC) program cuts across and deeply penetrates all health care settings, geography, and specialty, focusing on primary care, rural and underserved providers. RECs provide technical assistance to help these providers adopt and use health IT in meaningful ways so they can improve health care delivery, enhance patient care, and enhance workflow efficiency to drive down costs. Collectively, the RECs have supported 46 percent of the nation's primary care providers, 54 percent of rural providers, and 87 percent of community health centers, demonstrating their effectiveness and ability to support health care providers across all spectrums of the health care continuum.

During 2014, ONC expanded its Communities of Practice (CoPs), where groups of stakeholders with common interests can share knowledge about best practices, lessons learned, and current issues and opportunities in specific health care areas. OPro manages CoPs in a diverse range of areas, ranging from accountable care organizations, Million Hearts, Rural Health to health IT privacy & security to Interoperability to rural health. During 2014, CoPs saw significant increases in CoP membership and activity, with participation from nearly every REC and activities that touched thousands of patients, providers, and communities.

In 2013, ONC initiated a new program of Health IT Fellows to serve as front line liaisons and champions of Health IT adoption and implementation. The Health IT Fellows are providers and administrators representing a wide range of practice setting types, including small practices, large practices, critical access hospitals, rural clinics, and tribal health organizations. Fellows are empowered to work with the local and national community to promote open and productive dialogue around health IT adoption and Meaningful Use. Fellows are chosen because of their demonstrated work as a leader, mentor, and influencer around the use of information technology to deliver better care, in a more cost effective manner, while ultimately improving health outcomes. The Health IT Fellows program enables providers from a diverse set of backgrounds to learn with and from those in the field, and to create conversations whereby they can share best practices/successes with peers facing similar challenges surrounding health IT. In addition, Fellows share their experiences regarding ways providers can leverage health IT to improve the delivery of patient care.

- To date, some of the activity of the Fellows has included: convening meetings around patient engagement, clinical decision support, provider technical assistance tools, and many other Health IT topics
- Developed HIT Fellows collaboration site/forum – www.hitfellows.com
- Objective Reviewer for ONC Funding Opportunity Announcements
- Recognition of Fellows who are or worked with a 2014 Million Hearts Champion

The focus of the REC program, CoPs and Health IT Fellows program has been to help providers in small and underserved practices utilize health IT to reduce disparities and transform the provision of care for all.

Goal IV: Advance Scientific Knowledge and Innovation

ONC conducts, consolidates, and supports research on the adoption, use, safety and challenges of certified health IT (CEHRT) programs in underserved and minority communities. Using data from a variety of sources, the ONC Office of Planning, Economic Modeling and Analysis continues to study the impact of CEHRT in the broader health care community and in key demographic groups such as communities of color and the underserved (<http://dashboard.healthit.gov/index.php>). Findings from these analyses, particularly those focused on the progress of providers located in areas with traditionally underserved populations, inform both CMS and ONC programs and policies for technical assistance in the adoption and implementation of electronic health records for the EHR incentive programs.

Coordination, Integration, and Accountability

HHS is committed to improving coordination, planning, partnership, integration, and evaluation of its health disparities programs as a means to improve the health and health care of racial and ethnic minority populations. Senior HHS leaders have collaboratively developed cross-cutting goals and strategies that serve as the basis for the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan). Two intra- and inter-agency groups in particular (described below) serve to drive programs and policies on minority health within the department, oversee the implementation of the HHS Disparities Action Plan, and improve coordination and collaboration across the department and with other federal agencies.

HHS Health Disparities Council

The HHS Health Disparities Council (Council) is an important, departmental coordinating body on minority health and health disparities. Chaired by the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation, the Council is composed of senior-level representatives from operating and staff divisions across HHS including the Deputy Assistant Secretary for Minority Health, the directors of the individual Offices of Minority Health, and the director of the National Institute on Minority Health and Health Disparities. The HHS Office of Minority Health coordinates the work and activities of the Council. The purpose of the Council is to:

- Oversee the implementation and evaluation of the HHS Disparities Action Plan;
- Coordinate the efforts of HHS operating and staff divisions on a cohesive set of health disparity reduction strategies, creating synergy and efficiencies where appropriate;
- Provide a forum for sharing information related to progress on health disparity reduction plans, successful strategies, and new opportunities to reduce health disparities;
- Serve as a resource to the HHS leadership and operating and staff divisions, providing guidance and support on the development and implementation of policies, programs, and strategic plans that address racial and ethnic health disparities; and
- Leverage the policies, programs, and resources of HHS agencies in support of health disparity reduction goals.

Federal Interagency Health Equity Team

HHS OMH established the Federal Interagency Health Equity Team (FIHET) to guide the development of the National Stakeholder Strategy for Achieving Health Equity and implementing the National Partnership for Action to End Health Disparities (NPA) (additional details on the NPA are provided in the HHS OMH section of the report on p. 14). The FIHET's composition was specifically tailored to support action across federal agencies whose collective missions address the social determinants of health. The FIHET is composed of representatives from 12 federal departments and agencies: Health and Human Services; Agriculture; Commerce; Defense; Education; Housing and Urban Development; Homeland Security; Justice; Labor; Transportation; Veterans Affairs; and the Environmental Protection Agency. The FIHET's goals are to:

- Identify opportunities for federal agency collaboration, partnership, and coordination on efforts that are relevant to the NPA;
- Provide leadership and guidance for national, regional, state, tribal, and local efforts that address health equity; and
- Leverage opportunities for integrating health disparities into their policies, practices, and initiatives.

Conclusion

The U.S. Department of Health and Human Services (HHS) will continue to lead the implementation of strategic policies and programs with the goals of improving minority health, reducing health disparities, and transforming our health care delivery system. In fiscal years 2013 and 2014, significant progress was achieved that will improve the health of racial and ethnic minorities and underserved populations by addressing many of the factors that have long been associated with health disparities. The HHS activities highlighted in this report focused on implementing three key priorities:

- **Affordable Care Act** – Historically, not all Americans have had equal access to health care or similar health outcomes. It is in the nation’s common interest to build a health care delivery system that is better, smarter and healthier – a system that delivers better care and a system that spends health care dollars more wisely. As evidenced by this report, Affordable Care Act implementation efforts across HHS have increased and are demonstrating powerful outcomes in addressing the biggest impediments in health care: affordability, access, and quality. These changes impact all Americans, but are perhaps making some of the biggest changes in the lives of racial and ethnic minorities and underserved populations.
- **HHS Action Plan to Reduce Racial and Ethnic Health Disparities** – The HHS Disparities Action Plan continues to guide HHS’ work, focusing on disparities in access to and quality of care, workforce diversity, population health, research, and data collection. The activities of the past two years continue to demonstrate that leaders at the highest levels have committed to making health equity a priority. They also demonstrate how agencies throughout the Department are collaborating and leveraging resources to eliminate health disparities.
- **National Partnership for Action to End Health Disparities** – HHS efforts to implement the NPA have also demonstrated that, to truly end health disparities, we need to tackle not only health care but also the social determinants of health, the conditions in which people live and work, and where children go to school and play. This community-driven, multi-sectoral, and sustained approach drives intra- and inter-agency collaborations and community partnerships to address factors impacting health such as poverty, access to quality education, transportation, and healthy and safe neighborhoods.

HHS’ actions on minority health represent a comprehensive approach to improving the health of racial and ethnic minority populations and achieving the vision of “a nation free of disparities in health and health care.

