HHS Action Plan to Reduce Racial and Ethnic Health Disparities

A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE

Introduction and Background

Medical advances and new technologies have provided people in America with the potential for longer, healthier lives more than ever before. However, persistent and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive. Health disparities — differences in health outcomes that are closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play. This document provides a brief overview of racial and ethnic health disparities and unveils a Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities ("HHS Disparities Action Plan").

> "It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone."
>
> – Kathleen G. Sebelius, Secretary, Health & Human Services

The HHS Disparities Action Plan complements the 2011 National Stakeholder Strategy for Achieving Health Equity, a product of the National Partnership for Action ("NPA Stakeholder Strategy"). The NPA Stakeholder Strategy reflects the commitment of thousands of individuals across the country in almost every sector. It resulted from a public-private collaboration that solicited broad community input with the assistance of state and local government and Federal agencies. The NPA Stakeholder Strategy proposes a comprehensive, community-driven approach to reduce health disparities in the U.S. and achieve health equity through collaboration and synergy. Now, this first-ever HHS Disparities Action Plan and the NPA Stakeholder Strategy can be used together to coordinate action that will effectively address racial and ethnic health disparities across the country. Furthermore, the HHS Disparities Action Plan builds on national health disparities' goals and objectives recently unveiled in *Healthy People 2020*, and leverages key provisions of the Affordable Care Act and other cutting-edge HHS initiatives.

With the HHS Disparities Action Plan, the Department commits to continuously assessing the impact of all policies and programs on racial and ethnic health disparities. Furthermore, the Department can now promote integrated approaches, evidence-based programs and best practices to reduce these disparities. Together, the HHS Disparities Action Plan and the NPA Stakeholder Strategy provide strong and visible national direction for leadership among public and private partners. While the Department respects and recognizes the critical roles other Federal departments play in reducing health disparities, this action plan focuses on HHS initiatives.

Overview of Racial and Ethnic Health Disparities

The societal burden of health and health care disparities in America manifests itself in multiple and major ways. In one stark example, Murray et al show a difference of 33 years between the longest living and shortest living groups in the U.S.[5] Another study, *The Economic Burden of Health Inequalities in the United States,* by the Joint Center for Political and Economic Studies, concludes that "the combined costs of health inequalities and premature death in the United States were $1.24 trillion" between 2003 and 2006.[6] Such health disparities arise from both biologic factors and social factors that affect individuals across their lifespan. Regarding the latter, the World Health Organization (WHO) defines these "social determinants of health" as the conditions in which people are born, grow, live, work and age that can contribute to or detract from the health of individuals and communities.[7] Marked difference in social determinants, such as poverty, low socioeconomic status (SES), and lack of access to care, exist along racial and ethnic lines. These differences can contribute to poor health outcomes.[8]

Individuals, families and communities that have systematically experienced social and economic disadvantage face greater obstacles to optimal health. Characteristics such as race or ethnicity, religion, SES, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.[9] While this HHS Disparities Action Plan focuses primarily on health disparities associated with race and ethnicity, many of the strategies can also apply across a wide array of population dimensions. For example, expanding healthcare access, data collection, and the use of evidence-based interventions will contribute to health equity for vulnerable populations that are defined by income, geography, disability, sexual orientation or other important characteristics.

The Burden of Racial and Ethnic Health Disparities: Major Dimensions

The leading health indicators have demonstrated little improvement in disparities over the past decade, according to recent analyses of progress on *Healthy People 2010* objectives. Significant racial and ethnic health disparities continue to permeate the major dimensions of health care, the health care workforce, population health, and data collection and research.

Disparities in Health Care: The Institute of Medicine's (IOM) landmark 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* identifies the lack of insurance as a significant driver of healthcare disparities.[11] Lack of insurance, more than any other demographic or economic barrier, negatively affects the quality of health care received by minority populations. Racial and ethnic minorities are significantly less likely than the rest of the population to have health insurance.[12] They constitute about one-third of the U.S. population, but make up more than half of the 50 million people who are uninsured.[13]

Members of racial and ethnic minority groups are also overrepresented among the 56 million people in America who have inadequate access to a primary care physician.[14] Minority children are also less likely than non-Hispanic White children to have a usual source of care.[15]

Since 2002, the annual Agency for Healthcare Research and Quality (AHRQ) National Health Disparities Reports (NHDR) have documented the status of healthcare disparities and quality of care received by racial, ethnic and socio-economic groups in the United States.[16] The NHDR documented that racial and ethnic minorities often receive poorer quality of care and face more barriers in seeking care including preventive care, acute treatment, or chronic disease management, than do non-Hispanic White patients.[17] Minority groups experience rates of preventable hospitalizations that are, in some cases, almost double that of non-Hispanic Whites.[18] African Americans have higher hospitalization rates from influenza than other populations.[19] African American children are twice as likely to be hospitalized and more than four times as likely to die from asthma as non-Hispanic White children.[20]

Major efforts to provide quality health care to racial and ethnic populations occur through both long-standing safety net programs, such as the Health Resources and Services Administration (HRSA)-funded Community Health Center Program, and new initiatives such as those aimed at increasing meaningful use of health information technology by primary care providers. The Community Health Center Program provides vulnerable populations access to comprehensive, culturally competent, quality primary healthcare services. Of the nearly 19 million patients currently served through these HRSA-funded community health centers, 63 percent are racial and ethnic minorities and 92 percent have incomes below the federal poverty level.[21]

Disparities in the Nation's Health and Human Services Infrastructure and Workforce*:* The 2004 IOM report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce,* underscores the significant differences in the racial and ethnic composition of the healthcare workforce compared to the U.S. population.[22] More recently, the American Association of Medical Colleges reported that in 2008, Hispanics made up approximately 16 percent of the U.S. population, but accounted for less than 6 percent of all physicians.[23] African Americans accounted for a similar proportion of the U.S.'s population, but just over 6 percent of physicians[24].

Racial and ethnic minorities are more likely than non-Hispanic Whites to report experiencing poorer quality patient-provider interactions, a disparity particularly pronounced among the 24 million adults with limited English proficiency.[25] Diversity in the healthcare workforce is a key element of patient-centered care. The ability of the healthcare workforce to address disparities will depend on its future cultural competence and diversity.

In addition to cultural competency and diversity issues, shortages of physicians and other health professionals in underserved areas significantly affect the health of racial and ethnic minorities. HRSA's

National Health Service Corps (NHSC) invests in the healthcare workforce by placing health professionals in Health Professional Shortage Areas to care for underserved populations. Currently, 7,000 NHSC clinicians provide healthcare services in underserved areas in exchange for loan repayment or scholarships: approximately 33 percent of these clinicians are minorities and half serve in community health centers.[26]

Disparities in the Health, Safety, and Well-Being of the American People*:* All people should have the opportunity to reach their full potential for health. Yet, those who live and work in low socioeconomic circumstances (which disproportionately include racial and ethnic minorities) often experience reduced access to healthy lifestyle options and suffer higher rates of morbidity and mortality as compared to their higher-income counterparts.[27] The recently released Centers for Disease Control and Prevention (CDC) report, *Health Disparities and Inequalities,* demonstrates that African American, Hispanic, Asian American and American Indian and Alaska Native populations suffer higher mortality rates than other populations.[28] Cardiovascular diseases, for example, account for the largest proportion of inequality in life expectancy between African American and non-Hispanic Whites. Childhood obesity affects racial and ethnic minority children at much higher rates than non-Hispanic Whites, driving up rates of associated diabetes.[29]

Addressing disparities at the population level involves both new and well-established efforts. For the past decade, the CDC's Racial and Ethnic Approaches to Community Health (REACH) program has empowered residents to seek better health, helped change local healthcare practices, and mobilized communities to implement evidence-based public health programs to reduce health disparities across a broad range of health conditions. More recently, as part of the American Recovery and Reinvestment Act (ARRA) and with additional funds from the Affordable Care Act, the 50 CDC-funded Communities Putting Prevention to Work (CPPW) programs are supporting statewide and community-based policy and environmental changes in nutrition, physical activity, and tobacco control, directly targeting factors that may harm people's health.

These recent efforts join well-established programs to provide comprehensive child development services to economically disadvantaged children and families. Specifically, the Administration for Children and Families' (ACF) Head Start program promotes the social and cognitive development of children by providing educational, health, nutritional, social and other services to enrolled children and families. The Head Start program helps parents make progress toward their educational, literacy, and employment goals, and engages them in their children's learning. Most recent data indicate that racial and ethnic minorities make up 79 percent of the population served by Head Start, making this program a critical vehicle for addressing the social determinants of health disparities.[30] And the National Institutes of Health (NIH) has woven innovative pilot projects into the Healthy Start setting as a strategy to address the disproportionate burden of asthma among minority children and children living in poverty. These projects serve as models for developing healthy learning environments to introduce health and asthma self-management skills to children and their families.

Disparities in Scientific Knowledge and Innovation*:* The recent IOM Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality report emphasizes that inadequate data on race, ethnicity, and language lowers the likelihood of effective actions to address health disparities.[31] The Office of Management and Budget (OMB) has promulgated minimum standard categories for racial and ethnic data collection by federal agencies. The race categories include: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The ethnicity category includes Hispanic. Enhanced and standardized data on the race, ethnicity, and language spoken by patients and other users of the healthcare system would allow better understanding of the barriers faced by racial and ethnic minority populations. The lack of standards related to data collection remains a challenge for adequately collecting, reporting, and tracking data on health disparities.

New Opportunities to Reduce Racial and Ethnic Health Disparities

The Affordable Care Act

This HHS Disparities Action Plan builds upon the Affordable Care Act – the landmark law signed by President Obama last year – that will bring insurance coverage to more than 30 million people. The Affordable Care Act not only includes provisions related broadly to health insurance coverage, health insurance reform, and access to care, but also provisions related to disparities reduction, data collection and reporting, quality improvement, and prevention. The Affordable Care Act will also reduce health disparities by investing in prevention and wellness, and giving individuals and families more control over their own care. Appendix A provides additional details on the provisions that will affect health disparities. Two important initiatives mandated by the Affordable Care Act are the National Strategy for Quality Improvement in Health Care, which will include priorities to improve the delivery of health care, and the National Prevention and Health Promotion Strategy, which aims to bring prevention and wellness to the forefront of national policy.

HHS Initiatives

In addition to the Affordable Care Act, the Department can leverage other key national initiatives in its effort to reduce racial and ethnic health disparities.

Healthy People 2020[32]*:* One of the four overarching goals of the recently unveiled *Healthy People 2020* initiative is "to achieve health equity, eliminate disparities and improve the health of all groups." Throughout the next decade, the *Healthy People 2020* initiative will assess health disparities in the U.S. population by tracking rates of death, chronic and acute diseases, injuries, and other health-related behaviors for sub-populations defined by race, ethnicity, gender identity, sexual orientation, disability status or special health care needs, and geographic location.

Let's Move![33]: First Lady Michelle Obama launched the *Let's Move!* initiative with the goal of solving the challenge of childhood obesity within a generation. The *Let's Move!* initiative has five key pillars: (1) creating a healthy start in life for our children, from pregnancy through early childhood; (2) empowering parents and caregivers to make healthy choices for their families; (3) serving healthier food in schools; (4) ensuring access to healthy, affordable food; and (5) increasing physical activity. To bring this initiative to the local level, the Secretary, with the First Lady, called on mayors and other local officials to be public leaders of the *Let's Move! Cities and Towns* initiative.

The National HIV/AIDS Strategy[34]*:* Released by the President in July 2010, the National HIV/AIDS Strategy offers a vision that "the United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race and ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."

HHS Strategic Action Plan to End the Tobacco Epidemic[35]*:* Released in November 2010 by the Secretary, this plan is anchored around the four pillars of (1) engaging the public; (2) supporting evidence-based tobacco control policies at the state and local levels; (3) having HHS lead by example; and (4) advancing research, especially in the context of new Food and Drug Administration (FDA) authority to regulate tobacco.

Efforts to Reduce Disparities in Influenza Vaccination[36]*:* The HHS Seasonal Influenza Task Force has launched efforts to maximize vaccinations in targeted racial and ethnic minority groups through coordinated Departmental efforts as well as private-public partnerships.

Interagency Working Group on Environmental Justice[37]*:* Executive Order 12898 directs each federal agency to make achieving environmental justice part of its mission. HHS and other participating agencies are committed to identifying and addressing disproportionately high adverse human health or environmental effects on minority and low-income populations.

HHS Infrastructure

Critical to the Department's success is strengthening its infrastructure to prioritize the challenges of reducing health disparities and to fully implement this HHS Disparities Action Plan. As mandated by the Affordable Care Act, HHS has not only established offices of minority health in six agencies (AHRQ, CDC, FDA, HRSA, Centers for Medicare and Medicaid Services [CMS], and Substance Abuse and Mental Health Services Administration [SAMHSA]), but also elevated the National Center on Minority Health and Health Disparities (now NIMHD) to an institute level at the NIH. Key action steps for these offices include:

1. Enhancing the integration of the missions of offices across the Department to avoid the creation of silos.
2. Aligning core principles and functions with the goals, strategies, and actions presented in the HHS Disparities Action Plan.

Collectively, these entities will improve coordination of health disparity efforts across HHS and build partnerships with public and private stakeholders. The directors of agency offices of minority health and

senior staff in other key agencies will constitute the HHS Health Disparities Council overseen by the Assistant Secretary for Health. The Council will serve as the venue to share information, leverage HHS investments, coordinate HHS activities, reduce program duplication, and track progress on the strategies and actions of the HHS Disparities Action Plan.

In addition, HHS will reinvigorate and reaffirm its continuing commitment by:

- Promoting closer collaboration between operating and staff divisions to achieve a more coordinated national response to health disparities;
- Coordinating more effectively its investments in research, prevention, and health care among HHS agencies and across the federal government;
- Developing improved mechanisms to monitor and report on progress toward achieving the vision of the HHS Disparities Action Plan; and
- Facilitating public input and feedback on Departmental strategies and progress.

Partnerships with Other Federal Departments

To help ensure successful implementation of the HHS Disparities Action Plan, the Department will collaborate with the Federal Interagency Health Equity Team (FIHET). FIHET seeks to facilitate activities of the NPA between federal agencies to increase the efficiencies and effectiveness of policies and programs at the local, tribal, state and national levels. This team, which includes representatives of the Departments of Agriculture (USDA), Commerce (DOC), Education (ED), Housing and Urban Development (HUD), Labor (DOL), Transportation (DOT), and the Environmental Protection Agency (EPA), can collectively address the broad range of social determinants of health.

Vision and Purpose

In November 2010, Secretary Kathleen Sebelius charged HHS with developing a Department-wide action plan for reducing racial and ethnic health disparities. This HHS Disparities Action Plan was developed through a collaborative, Department-wide process that actively engaged all HHS agencies. The action plan emphasizes approaches that are evidence-based and will achieve a large-scale impact. The action plan will be operational across HHS immediately.

The vision of the HHS Disparities Action Plan is:

"A nation free of disparities in health and health care."

The HHS Disparities Action Plan proposes a set of Secretarial priorities, pragmatic strategies, and high-impact actions to achieve Secretary Sebelius's strategic goals for the Department. The five goals from the HHS Strategic Plan for Fiscal Years (FY) 2010-2015 provide the framework for the HHS Disparities Action Plan.[38] They are:

I. Transform health care;
II. Strengthen the nation's Health and Human Services infrastructure and workforce;
III. Advance the health, safety, and well-being of the American people;
IV. Advance scientific knowledge and innovation; and
V. Increase the efficiency, transparency, and accountability of HHS programs.

The actions presented in this HHS Disparities Action Plan represent mainly new efforts beginning in FY 2011 and beyond. The actions are also intended to be carried out with current agency resources, so that implementation can proceed without delay. This plan will also serve as guidance for future development, subject to the availability of resources. The following pages outline the strategies and actions, with further background provided in the two appendices. Appendix A highlights the new opportunities in the Affordable Care Act to reduce health disparities. Appendix B summarizes other relevant efforts begun prior to FY 2011 that also serve to create the strong foundation for the HHS Disparities Action Plan. Implementation of the actions will be led either by a single agency or co-led by agencies working in partnership.

This HHS Disparities Action Plan begins with the Secretarial priorities then presents the goals, strategies, and actions.

Overarching Secretarial Priorities

Implementation of the HHS Disparities Action Plan will uphold four overarching Secretarial priorities to assure coordination and transformation of both existing programs and new investments. These priorities aim to:

1. **Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.** HHS leadership will assure that:
    a. All staff and operating divisions will review their strategic plans, communications, programs, and regulations to assure that the goals, strategies, and actions in the HHS Disparities Action Plan are included to the fullest extent possible.
    b. Every staff and operating division will assess its current and future capacity to support this HHS Disparities Action Plan, and will realign resources to best meet the goals.
    c. Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.

2. **Increase the availability, quality, and use of data to improve the health of minority populations.** Strong surveillance systems must monitor trends in health and quality of care measures, as well as patient-centered research activities. HHS will:
    a. Ensure that data collection standards for race, ethnicity, sex, primary language, and disability status are implemented throughout HHS-supported programs, activities, and surveys.
    b. Assure public access to data that is appropriately disaggregated and de-identified in order to promote disparities research and assure that data on race and ethnicity in federally supported programs, activities, or surveys is routinely reported in a format that is available for external analysis. This is consistent with the HHS Open Government Initiative.
    c. Identify and map high-need/disparity areas and align HHS investments to meet these needs. One example of this action is the Value-Driven Health Disparities Collaboration Project, which will use data to map and accelerate comprehensive planning to coordinate local disparities reduction activities. Working with

health plans and local health systems, this demonstration project will conduct local assessments and map "hot spots" of particular chronic conditions, health concerns, or factors known to contribute to ill health. The project will also identify gaps in services, programs, funds, and/or actions to effectively address the "hot spots" and take advantage of opportunities to promote healthier lifestyles. It will also establish ongoing partnerships with the community and private sector to reduce health disparities.

d. Develop a system of public reporting of preventable hospital admissions by race and ethnicity (non-Hispanic White, African American, Hispanic) for dually eligible (Medicare/Medicaid) beneficiaries by hospital and state, with presentation of the data as unadjusted and adjusted relative risk ratios.
e. Publicly display aggregately collected Medicaid and Medicare quality measurement data in new ways that call attention to racial and ethnic disparities.

3. **Measure and provide incentives for better healthcare quality for minority populations.** Racial and ethnic minorities often receive poorer quality of care and face more barriers to seeking care than non-Hispanic Whites.[39] Providing incentives for quality care in these populations is critical for improving patient outcomes and creating a high-value healthcare system that promotes equity. HHS will:
    a. Implement through CMS an initiative that sets measures and provides incentives to improve health care quality, particularly for vulnerable populations. This effort will assess and refine current or new measures of chronic disease burdens for racial and ethnic minorities, such as heart attack, renal failure, stroke, hypertension, and diabetes. CMS will review current measures including those used in hospital value-based purchasing, Hospital Compare, Home Health Compare, Children's Health Insurance Program (CHIP) Pediatric Quality Measures Programs, and other special payment models.
    b. Develop cross-departmental and inter-agency collaborations between CMS, HRSA, AHRQ, SAMHSA, and Indian Health Service (IHS) to provide incentives for improvements of health care quality. For example, SAMHSA will collaborate with CMS to support the development of measures and incentives related to the racial and ethnic health burden of depression.
    c. Expand health disparities projects, including a CMS initiative to reduce avoidable hospital admissions for people dually eligible for Medicare and Medicaid, racial and ethnic analyses of CMS Survey and Claims Data, and Quality Improvement Organization Disparities Special Initiatives addressing diabetes self management training, patient safety, and clinical pharmacy services.

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 funds. Regular reviews of progress will determine not only when goals are being reached, but also when refining or changing direction is necessary.
    a. Identify cross-cutting areas for collaboration across agencies and offices to conduct joint health and healthcare disparities research.
    b. On a biannual basis, Office of the Assistant Secretary for Health/Office of Minority Health (OASH/OMH) and Assistant Secretary for Planning and Evaluation (ASPE) will review and report results of Agency Head progress made under this plan. Agencies and offices will refine strategies for improving the timeliness and quality of results.
    c. On a biannual basis, review progress on Departmental efforts to improve coordination in the administration of grants, contracts, and intramural research that address reduction of disparities. Reduce duplication, align, or leverage resources where appropriate, and eliminate administrative burdens that limit efficient use of resources.

Goal I: Transform Health Care

Transforming the current healthcare system and building a high-value healthcare system requires insuring the uninsured, making coverage more secure for those who have it, and improving quality of care for all. The 2010 Affordable Care Act offers the potential to meet these goals and address the needs of racial and ethnic minority populations. Specific provisions, such as those supporting improvements in primary care, creating linkages between the traditional realms of health and social services, as well as ongoing investments in health information technology, can transform health care and reduce disparities.

Strategy I.A: Reduce disparities in health insurance coverage and access to care. Racial and ethnic minorities have far lower rates of health insurance coverage than the national average, with approximately two of every five persons of Hispanic ethnicity and one of every five non-Hispanic African Americans uninsured.[40] Removing barriers to coverage based on health status through the Affordable Care Act will offer an unprecedented opportunity for access to care, particularly for racial and ethnic minorities who have disproportionately higher rates of chronic disease.

Actions:

▸ **I.A.1** **Increase the proportion of people with health insurance and provide patient protections in Medicaid, CHIP, Medicare, Health Insurance Exchanges, and other forms of health insurance.** The Affordable Care Act: (1) allows those with pre-existing conditions (first children and eventually everyone) to gain and keep coverage; (2) ends lifetime limits on care; (3) covers preventive services recommended with an A or B by the U.S. Preventive Services Task Force (USPTF) in Medicare and private health plans; and (4) promotes coverage of preventive services recommended with an A or B by the USPTF in Medicaid.

- Medicaid coverage will be expanded to individuals under age 65 with incomes up to 133 percent of the federal poverty level by 2014, including individuals who are not pregnant or are without dependent children. Grants to community-based and non-profit organizations, local governments, tribes, and states will support outreach activities and enrollment of children who are currently uninsured but eligible for Medicaid and CHIP. Such activities will have a focus on reducing disparities in coverage for racial and ethnic minorities and those experiencing language barriers.
- Each Health Insurance Exchange will offer grants to organizations to establish navigator programs, which will raise awareness of the Health Insurance Exchange and draw diverse populations to gain access to coverage through the

Health Insurance Exchange. Navigators will provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.

- Enrollment procedures will be streamlined to facilitate linkage of children and families to health insurance and human service programs by building on the existing Express Lane Eligibility. Linking enrollment of children and families in CHIP and Medicaid to enrollment in human service programs will improve the access and availability of both health care and human services for underserved populations. (Express Lane agencies are identified by a Medicaid or CHIP program as entities that have the authority to determine program eligibility).
  Lead/Participating Agencies: CMS, ACF, HRSA, IHS, SAMHSA, USDA
  Timeline: FY 2011-2014

Strategy I.B: Reduce disparities in access to primary care services and care coordination. Access to timely and needed primary healthcare services continues to be a major challenge for racial and ethnic minorities.[41] The actions below will expand primary care services and invest in training primary care providers. A special effort will be made to expand primary care and increase care coordination for migrant and seasonal farm workers, people experiencing homelessness, and residents of public housing.

Actions:

▸ **I.B.1 Increase the proportion of persons with a usual primary care provider and patient-centered health homes.**

- HRSA will award 350 New Access Point grant awards to support new health center service delivery sites in medically underserved areas. Doing so will improve comprehensive, culturally competent, primary and preventive health care services. Funds will not only expand such services (including oral health, behavioral health, pharmacy, and/or enabling services) at existing health center sites, but will also support major construction and renovation projects at community health centers nationwide.
- HRSA will expand its NHSC by placing more primary care providers in communities with designated health professional shortage areas. Physicians, nurse practitioners, and dentists will receive payments that help satisfy their educational loans in return for providing health care in underserved communities.
- Community-based health teams will establish agreements with primary care physicians and other health care professionals to improve care coordination through patient-centered health homes. This involves coordination of disease

prevention services, management of transitions between healthcare providers, and improvement of connectivity to a usual source of primary care.

- HRSA will expand its health center quality initiative that provides technical assistance and resources to health centers to: (1) become nationally recognized as health homes; (2) adopt and meaningfully use health information technology; (3) track clinical control of blood pressure and clinical management of diabetes; and (4) track reductions in racial and ethnic disparities in low birth weight child births.
  Lead/Participating Agencies: HRSA/CMS, ACF, CDC, SAMHSA
  Timeline: Starting in FY 2011

Strategy I.C: Reduce disparities in the quality of health care. The quality of care received by racial and ethnic minorities continues to be suboptimal, as demonstrated by the 2010 NHDR core indicators of quality care in preventive care, acute treatment, and chronic disease management.[42] The actions below will enhance the quality of care provided to racial and ethnic minorities by removing barriers to the timeliness, patient-centeredness of care, and the equitable use of evidence-based clinical guidelines.

Actions:

▸ **I.C.1** **Improve the quality of care provided in the Health Insurance Exchanges.** Health plans participating in the Health Insurance Exchanges, new private, competitive health insurance markets for individuals and small employers to be established by 2014, will implement a quality improvement strategy using financial and non-financial incentives to promote activities to reduce disparities in health and health care. Activities may include language services, community outreach, cultural competency training, health education, wellness promotion, and evidence-based approaches to manage chronic conditions.
Lead/Participating Agencies: CMS
Timeline: FY 2011-2014

▸ **I.C.2** **Improve outreach for and adoption of certified electronic health record (EHR) technology to improve care through the Regional Extension Centers program and other federal grant programs**. Racial and ethnic minority communities will be specifically targeted for EHR outreach and adoption through federal and private sector partnerships with HHS agencies, the National Health Information Technology Collaborative, and other health organizations. The soon-to-be released "HHS Health Information Technology (HIT) Plan to End Health Disparities" will promote HIT interagency collaborations and disseminate best practices to improve care provided in underserved

racial and ethnic communities through the use of technologies such as telehealth, electronic health records, clinical tools, and personal health records.
Lead/Participating Agencies: ONC, CMS, OASH/OMH, HRSA, NIH
Timeline: Starting in FY 2011

I.C.3 **Develop, implement, and evaluate interventions to prevent cardiovascular diseases and their risk factors.** Heart attacks and strokes are the leading causes of premature death for racial and ethnic minorities. This initiative will focus multiple efforts on the prevention of cardiovascular diseases and their risk factors. HHS will implement interventions that will range from quality of care improvement opportunities to potential reimbursement incentives for policy and health system changes. This initiative will involve working both with minority providers and providers serving minority populations.
Lead/Participating Agencies: CDC, AHRQ, CMS, HRSA, NIH, OASH, ONC,
Timeline: Starting in 2011

I.C.4 **Increase access to dental care for children in Medicaid and CHIP.** 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 coverage and access to oral health services. Specifically, this initiative seeks to increase by 10 percent the rate of children up to age 20 enrolled in Medicaid or CHIP who receive any preventive dental service and the rate of enrolled children ages six to nine who receive a dental sealant on a permanent molar tooth. The initiative includes working with states to develop oral health action plans, strengthening technical assistance to states and tribes, improving outreach to dental healthcare providers, increasing outreach to beneficiaries and partnering with other relevant governmental agencies and private sector organizations.
Lead/Participating Agencies: CMS, ACF, CDC, HRSA, OASH/OMH
Timeline: Starting in 2011

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

Strengthening the nation's health and human services infrastructure involves addressing the critical shortage of primary care physicians, nurses, behavioral health providers, long-term care workers, and community health workers in the U.S. With growing national diversity, the disparity between the racial and ethnic composition of the healthcare workforce and that of the U.S. population widens as well.

Strategies to address the gaps in workforce diversity and shortages includes expanding the use of healthcare interpreters to overcome language barriers, improving the quality of patient-provider interactions in clinical settings, improving cultural competence education and training for health care professionals, and increasing racial and ethnic diversity in the healthcare workforce.[43]

Strategy II.A: Increase the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities. Racial and ethnic minorities, and especially people whose primary language is not English, are more likely to report experiencing poorer quality patient-provider interactions than non-Hispanic Whites.[44] The actions below will address this disparity and optimize patient-provider interactions.

Actions:

▸ **II.A.1 Support the advancement of translation services.**

- **Promote the healthcare interpreting profession as an essential component of the healthcare workforce to improve access and quality of care for people with limited English proficiency.** In partnership with national organizations for certification of interpreters, HHS will improve quality of care for people with limited English proficiency. This includes promoting the knowledge, skills, and abilities required for healthcare interpreting, educating individuals about the pathways into the healthcare interpreting profession, and establishing an accessible online national registry of certified interpreters to allow healthcare facilities and providers to quickly identify certified interpreters. Collaborations with community colleges will develop effective training programs that help build the profession of healthcare interpreters and deliver credentialing examinations for healthcare interpreters.
- **Improve language access in Medicaid**. This initiative will pilot test software for a web-based enrollment system that enables Medicaid staff to interview non-English speaking or low-literacy applicants, and help those applicants to apply for Medicaid and

CHIP benefits. This will allow a higher federal matching rate for state administrative costs dedicated to translation/interpretation services, including American Sign Language or Braille. This initiative will also encourage states to: employ staff members to provide translation or interpretation functions; pay for direct translator/interpreter support to medical providers; translate brochures, commercials, radio and newspaper advertisements, and other promotional material into other languages; and provide interpretation hotlines for Medicaid and CHIP recipients.
Lead/Participating Agencies: OASH/OMH, CMS, HRSA
Timeline: Starting in FY 2011

▸ **II.A.2 Collaborate with individuals and health professional communities to make enhancements to the current National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).** The CLAS Standards, released in 2000, represent the first national standards for culturally competent healthcare service delivery. These standards will be updated, via a CLAS Standards Enhancement Initiative. Improvements will be informed by the responses received throughout the recently ended public comment period and three previously held regional public meetings. HHS will maximize public input, stakeholder dialogue, and subject matter expertise to ensure that the enhanced CLAS Standards serve the health needs of populations experiencing health disparities.
Lead/Participating Agencies: OASH/OMH, SAMHSA
Timeline: Starting in FY 2011

Strategy II.B: Promote the use of community health workers and Promotoras. While Health Insurance Exchanges and expansions in Medicaid created by the Affordable Care Act offer much promise for racial and ethnic minorities, targeted efforts are necessary to ensure that they are enrolled and receive the health benefits for which they are eligible. Promotoras are individuals who provide health education and support to their community members. Community health workers and Promotoras can provide enrollment assistance and serve as critical liaisons between community members and health and human services organizations.[45]

Actions:

▸ **II.B.1 Increase the use of Promotoras to promote participation in health education, behavioral health education, prevention, and health insurance programs.** This initiative includes: establishing a National Steering Committee for Promotoras; developing a national training curriculum and uniform national recognition for them; creating a

national database system to facilitate recruitment and track training and certification of Promotoras; and supporting and linking Promotoras' networks across the Nation. As part of ACF's Head Start Program, Promotoras and community health workers can help parents effectively navigate the healthcare system and manage health care for their children.
Lead/Participating Agencies: OASH/OMH, ACF, CDC, CMS, HRSA, SAMHSA
Timeline: Starting in FY 2011

- **II.B.2 Promote the use of community health workers by Medicare beneficiaries.** This initiative will promote the use of community health workers as members of interdisciplinary teams and multi-sector teams. Enabling payment of community health workers as members of diabetes self-management training teams, for example, improves the provision of health care, health education, disease prevention services, and connection to health homes will be enhanced. These workers will improve patients' diabetes self-management skills in many ways including the provision of plain language health-related information in non-clinical community settings.
  Lead/Participating Agencies: CMS, CDC, HRSA, IHS, OASH
  Timeline: Starting in FY 2011

Strategy II.C: Increase the diversity of the healthcare and public health workforces. Numerous studies have shown racial and ethnic minority practitioners are more likely to practice in medically underserved areas and provide health care to large numbers of racial and ethnic minorities who are uninsured and underinsured. This strategy includes actions to increase the diversity of the health care and public health workforces to address the compelling need for reductions in healthcare disparities.[46]

Actions:

- **II.C.1 Create a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions.** Create an undergraduate pipeline program to increase racial and ethnic diversity in the health professions. This initiative will fund a national program to provide early educational opportunities for undergraduate students from health disparity populations to encourage careers in public health and biomedical sciences.
  Lead/Participating Agencies: CDC, NIH
  Timeline: Starting in FY 2011

- **II.C.2 Increase education and training opportunities for recipients of Temporary Assistance for Needy Families (TANF) and other low-income individuals**

for occupations in healthcare fields through Health Profession Opportunity Grants (HPOG) program. HPOGs aim to improve the work readiness and employment outcomes for low-income workers and TANF beneficiaries. The ACF's Offices of Family Assistance and Refugee Resettlement will promote linkages between the HPOG grantees and refugee communities to offer the training programs. Training programs can include home care aides, certified nursing assistants, medical assistants, pharmacy technicians, emergency medical technicians, licensed vocational nurses, registered nurses, dental assistants, and health information technicians. Graduates of the training programs receive an employer- or industry-recognized certificate or degree.

Lead/Participating Agencies: ACF

Timeline: Starting in FY 2011

II.C.3 Increase the diversity and cultural competency of clinicians, including the behavioral health workforce.

- HRSA will develop a plan for targeted recruitment of students from backgrounds that are underrepresented in the healthcare workforce. Activities will include implementing innovative strategies to encourage student interest in primary care and application to the NHSC scholarship program. In addition, HRSA will develop new approaches for reaching minority health professions students before they enter the job market through the loan repayment program. HRSA will assess the results of targeted efforts to expand outreach, mentorship, partnership, and recruitment practices.
- Through the newly funded Center for Integrated Health Solutions (CIHS) that works with higher-education institutes, SAMHSA will grow a diverse workforce to provide services in integrated primary care and behavioral health settings for vulnerable populations. CIHS will strengthen the capacity and skills of practitioners working in integrated care settings to better address the needs of racial and ethnic minority populations.
- Utilizing its National Network to Eliminate Disparities in Behavioral Health (NNED), SAMHSA will launch two new Communities of Practice for providers. This includes accessing virtual training and technical assistance to implement evidence-based behavioral health interventions focused on trauma and trauma-related disorders geared to minority populations.
- Through its Historically Black Colleges and Universities (HBCU) Center for Excellence, SAMHSA will increase the diversity of the workforce by training teams of clinicians, faculty, and students from HBCUs on best practices in behavioral health promotion, screening, and intervention. The Behavioral Health Policy Academy and related virtual events will serve as the primary venue for

capacity development across 105 HBCUs.
Lead/Participating Agencies: HRSA, NIH, SAMHSA
Timeline: Starting in FY 2011

II.C.4 **Increase the diversity of the HHS workforce.** The Office of Human Resources recently launched the Hispanic Initiative focused on the hiring, recruitment, and retention of Hispanics into the HHS workforce as the Department lags behind many agencies in the percentage of Hispanics that make up its workforce. Utilizing a multi-faceted approach, HHS will continually track Hispanic employment and recruitment efforts and conduct quarterly meetings to monitor progress. HHS is pursuing implementation of the Hispanic Serving Institution Fellowship Program, developed with the Hispanic Association of Colleges and Universities (HACU), which would provide HHS professional rotations for Hispanic academics working in the education and science field. HHS is also working with HACU to provide internships to college students in an effort to connect HHS with young Hispanic professionals at the start of their careers. HHS is also developing a Toolkit for managers and supervisors to provide guidance on methods of outreach, recruitment, and retention of Hispanics and other underrepresented populations in the HHS workforce. HHS recently signed a Memorandum of Understanding (MOU) with five Hispanic-serving organizations to establish a framework for cooperative initiatives. HHS and these organizations are phasing in a variety of programs over the coming year to increase Hispanic employment in HHS occupations.
Lead/Participating Agencies: ASA, all other HHS Agencies
Timeline: Starting in FY 2011

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

Advancing the health, safety, and well-being of the American people has special relevance for racial and ethnic minorities who fare far worse than their non-Hispanic White counterparts across a broad range of health indicators.[47] Creating environments that promote healthy behaviors to prevent and control chronic diseases and their risk factors requires renewed commitment to prevention, with an emphasis on strengthening community-based approaches to reduce high-risk behaviors.

Strategy III.A: Reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies. The actions under this strategy include the implementation of both universal and targeted interventions to close the modifiable gaps in health, longevity, and quality of life among racial and ethnic minorities.

Actions:

▸ **III.A.1 Build community capacity to implement evidence-based policies and environmental, programmatic, and infrastructure change strategies.**

- Through the Affordable Care Act, the CDC Community Transformation Grants Program will implement, evaluate, and disseminate evidence-based community preventive health activities. The goal is to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base for effective prevention programming. Funded communities will work 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. While the program is designed to reach the entire population, special emphasis is placed on reducing health disparities and reaching rural and frontier areas.
  Lead/Participating Agencies: CDC
  Timeline: Starting in FY 2011

▸ **III.A.2 Implement an education and outreach campaign regarding preventive benefits.**
The campaign will be a national public-private partnership to raise public awareness of health improvement across the lifespan supported by the Affordable Care Act. The campaign will reach racial and ethnic minority populations with messages on the importance of accessing preventive services to relevant to nutrition, physical activity, and tobacco use.
Lead/Participating Agencies: CDC, CMS, HRSA, IHS, SAMHSA
Timeline: Starting in FY 2012

III.A.3 Develop, implement, and evaluate culturally and linguistically appropriate evidence-based initiatives to prevent and reduce obesity in racial and ethnic minorities.

- HRSA will sponsor a Healthy Weight Learning Collaborative to disseminate evidence-based and promising clinical and community practices to promote healthy weight in communities across the nation.
- The Childhood Obesity Research Demonstration Project, led by CDC, will develop, implement, and evaluate multi-sectoral and multi-level interventions for underserved children aged two to 12 years and their families. The project uses an integrated model of primary care and public health approaches to lower risk for obesity in racial and ethnic minority communities.
  Lead/Participating Agencies: CDC, HRSA, ACF, AHRQ, CDC, NIH
  Timeline: Starting in FY 2011

III.A.4 Reduce tobacco-related disparities through targeted evidence-based interventions in locations serving racial and ethnic minority populations.
Reducing smoking prevalence among racial and ethnic minorities will require programs and interventions that are both culturally relevant and evidence based**.** Efforts will include tobacco-free policies, quitline promotion, and counseling and cessation services in sites such as public housing, community health centers, substance abuse facilities, mental health facilities, and correctional institutions.
Lead/Participating Agencies: OASH/OMH, CDC, FDA, ACF, HRSA, IHS, NIH, SAMHSA, OASH/OWH
Timeline: Starting in FY 2011

III.A.5 Increase education programs, social support, and home-visiting programs to improve prenatal, early childhood, and maternal health. HRSA's Maternal, Infant, and Early Childhood Home Visitation program aims to meet the diverse needs of children and families in at-risk communities, particularly underserved minority women and their families with limited social support networks. Eligible entities can implement effective home-visiting services -- including coordination and referrals to other community services -- that can lead to improved outcomes in prenatal, maternal, newborn, and child health and development; parenting skills; school readiness; and family economic self sufficiency. These services can also lead to reductions in crime, domestic violence, and parental substance abuse.
Lead/Participating Agencies: ACF, HRSA, OASH/OPA, SAMHSA
Timeline: Starting in FY 2011

▸ **III.A.6 Implement targeted activities to reduce disparities in flu vaccination.** This initiative will improve vaccination rates in racial and ethnic minority communities. These activities, building on demonstration efforts in the 2010-2011 flu season, will include working with the private sector (pharmacy chains, health plans, and others), medical associations, community-based organizations, and state and local public health departments to increase the availability of flu vaccine and communicate a common set of messages about the seriousness of flu and the safety of the vaccine.
Lead/Participating Agencies: OASH/NVPO, OASH/OMH, CDC, ACF, CMS, FDA, HRSA
Timeline: Starting in FY 2011

▸ **III.A.7 Implement targeted activities to reduce asthma disparities.**

- **Implement the Coordinated Federal Initiative to Reduce Asthma Disparities.** This interagency initiative, part of the President's Task Force on Environmental Health Risks and Safety Risks to Children, will promote best practices in asthma care to reduce disparities. These practices include: implement HHS clinical practice guidelines; link public and private stakeholders at the community level to deliver comprehensive, consistent, and integrated programs; optimize the tracking and targeting of populations disproportionately affected by childhood asthma; and develop a coordinated research agenda on asthma prevention and decreasing asthma severity.
- Measure and promote better asthma care for racial and ethnic minorities through Medicaid and CHIP demonstration grants to states. Activities will support environmental interventions, nontraditional asthma educators, and testing of core asthma measures.
  Lead/Participating Agencies: NIH, AHRQ, CDC, CMS, HRSA, and all other HHS agencies
  Timeline: Starting in FY 2011

Strategy III.B: Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs. Entities ranging from local health departments, national foundations, the World Health Organization, and several countries, are conducting health impact assessments on proposed policies and programs. Health disparity impact assessments have the potential to inform policymakers of likely impacts of proposed policies and programs on health and healthcare disparities among racial and ethnic minorities, and to reduce disparities through improving new policies and programs.

Actions:

- **III.B.1 Adopt a "health in all policies" approach.** Develop, implement, and monitor strategies addressing health disparities by engaging other key federal departments, the private sector, and community-based organizations to adopt a "health in all policies" approach, including a health impact assessment for key policy and program decisions.
  Lead/Participating Agencies: OASH/OMH, All HHS Agencies
  Timeline: Starting in FY 2012

- **III.B.2. Evaluate use of health disparity impact assessment for proposed policies and programs.** HHS will collaborate with national foundations to conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.
  Lead/Participating Agencies: OASH/OMH, All HHS Agencies
  Timeline: Starting in FY 2012

Goal IV: Advance Scientific Knowledge and Innovation

While scientific advances have improved the longevity and quality of life for people in America, these gains have not been experienced equally by racial and ethnic minorities.[48] Advancing scientific knowledge and innovation can improve patient-centered research in the areas of prevention, screening, diagnostic and treatment services, and strengthen existing information systems to reduce and improve the quality of health, public health, and biomedical research. These efforts must benefit all populations.

Strategy IV.A: Increase the availability and quality of data collected and reported on racial and ethnic minority populations. The capacity of HHS to identify disparities and effectively monitor efforts to reduce them is limited by a lack of specificity, uniformity, and quality in data collection and reporting procedures. Consistent methods for collecting and reporting health data by race, ethnicity, and language are essential.

Actions:

▸ **IV.A.1 Implement a multifaceted health disparities data collection strategy across HHS.** This initiative will:

- Establish data standards and ensure federally conducted or supported health care or public health programs, activities, or surveys collect and report data in five specific demographic categories: race, ethnicity, gender, primary language, and disability status as authorized in the Affordable Care Act;
- Oversample minority populations in HHS surveys;
- Develop other methods for capturing low-density populations (Native Americans, Asian Americans and Pacific Islanders) when oversampling is not fiscally feasible;
- Use analytical strategies and techniques, such as pooling data across several years, to develop estimates for racial and ethnic minority populations;
- Publish estimates of health outcomes for racial and ethnic minority populations and subpopulations on a regular, pre-determined schedule;
- Improve public access to HHS minority data and promotion of external analyses; and
- Develop and implement a plan for targeted special population studies, internally or through research grant funding announcements and contracts.

This initiative will also address gaps in subpopulations traditionally missed by standard HHS data collection activities.

Lead/Participating Agencies: ASPE/Data Council, AHRQ, CDC, CMS, OASH/OMH, all other HHS Agencies

Timeline: Starting in FY 2011

Strategy IV.B: Conduct and support research to inform disparities reduction initiatives. Health disparities research can inform initiatives to improve the health, longevity, and quality of life among racial and ethnic minorities by bridging the gap between knowledge and practice.

Actions:

▸ **IV.B.1 Develop and implement strategies to increase access to information, tools, and resources to conduct collaborative health disparities research across federal departments**. Bringing together various federal departments to pool government resources and expertise to utilize and disseminate health disparities research results will accelerate efforts to address social determinants of health in multiple settings. This initiative will develop coordinated research protocols and Memoranda of Agreement to facilitate collaboration across departments and agencies.
Lead/Participating Departments/Agencies: HHS/NIH, DOE, DOL, ED, EPA, USDA, VA
Timeline: Starting in FY 2011

▸ **IV.B.2 Develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations.** Patient-centered outcomes research informs healthcare decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. By working collaboratively with research and healthcare institutions, HHS can develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations. Targeted health conditions will include diabetes mellitus, asthma, arthritis, and cardiovascular diseases including stroke and hypertension.
Lead/Participating Agencies: NIH, AHRQ, ASPE, OASH/OMH
Timeline: Starting in FY 2011

▸ **IV.B.3 Promote community-based participatory research (CBPR) approaches to increase cancer awareness, prevention, and control to reduce health disparities.** The NIH is supporting various CBPR approaches that integrate the complex and multi-level determinants of health to reduce the burden of disease such as cancer, cardiovascular diseases, and diabetes within communities. This initiative will fund new cooperative agreements through the existing National Cancer Institute (NIH/NCI) Community Networks Program centers to increase knowledge of, access to, and utilization of biomedical and behavioral procedures for reducing cancer disparities. Such efforts range from prevention through early detection, diagnosis, treatment, and survivorship in

racial and ethnic minorities and other underserved populations. The Centers also provide an opportunity for training health disparity researchers (particularly new and early-stage investigators) in CBPR approaches and cancer health disparities.
Lead/Participating Agencies: NIH
Timeline: Starting in FY 2011

▸ **IV.B.4** **Expand research capacity for health disparities research.** This initiative will support efforts to expand faculty-initiated health disparities research programs and improve the capacity for training future research scientists. Through extending infrastructure like the NIMHD Research Infrastructure in Minority Institutions Program, HHS will support researchers to study health disparities to improve the scientific infrastructure needed to find solutions.
Lead/Participating Agencies: NIH, HRSA, OASH/OMH
Timeline: Starting in FY 2011

▸ **IV.B.5** **Leverage regional variation research in search of replicable success in health disparities.** Studies of systems where racial and ethnic minorities receive the highest quality of care and have the best health outcomes can reveal important tools to improve health disparities. Thorough research may reveal the specific mechanisms that solve this recalcitrant issue. HHS will support researchers who search for successful models and identify effective solutions to address health disparities.
Lead/Participating Agencies: NIH, AHRQ
Timeline: Starting in FY 2011

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

Promoting better collaboration and streamlining efforts can improve the efficiency of HHS programs. Addressing racial and ethnic health disparities in an efficient, transparent, and accountable manner will require better coordination and integration of the minority health infrastructure and programs. Using transparent measures can help the Department hold itself accountable. Other HHS open-government activities such as the Community Health Data Initiative — a major new public-private effort to help people understand health and healthcare performance in their communities and to spark and facilitate action to improve performance — will promote local application of measures.

▶ **Streamline grant administration for health disparities funding**. The Department will improve the coordination of the administration of grants that address health disparities by identifying effective ways to implement processes that simplify grant administrative activities for communities, community-based organizations, tribes, and states. This will include moving toward standardizing grantee reporting requirements, developing common metrics to reduce inefficiencies, and identifying opportunities to leverage investments.

▶ **Monitor and evaluate implementation of the HHS Disparities Action Plan.** To assure accountability and a clear focus on performance and outcomes, HHS will employ a multi-level monitoring and evaluation approach to track progress on implementation and outcomes of the HHS Disparities Action Plan. Goal, strategy and action-level indicators will be assessed. At the **goal level**, HHS will monitor disparities data to assess the extent to which progress is being made in the five goals. At the **strategy level**, HHS will undertake program evaluations to assess the extent to which changes in strategy-level objectives are correlated with action steps. At the **action level**, HHS will track performance data to determine the extent to which actions are completed and assess the timeliness of completion. Collectively, these evaluation activities will help us to understand our progress toward achieving the vision of the HHS Disparities Action Plan.

▶ **Goal-Level Disparities Monitoring and Surveillance**. To monitor the nation's overall progress toward achieving desired changes in disparities indicators, HHS will annually track progress on measures selected from multipurpose national data systems such as population-based surveys to track progress. These measures will reflect the goals of the HHS Disparities Action Plan, *Healthy People 2020* disparity objectives, and Affordable Care Act provisions. Measures will be publicly accessible and will provide timely updated information. HHS data systems will be used to provide data for these measures. Measures are listed in Appendix C.

Strategy-Level Evaluation. HHS will work with lead agencies to develop an evaluation plan for relevant actions within the HHS Disparities Action Plan. Evaluations will focus on the extent to which outcomes from implemented actions are correlated with desired strategies and changes. For example, HHS may conduct an evaluation to assess whether the creation of specific payment structure incentives by Health Insurance Exchanges have improved health outcomes among racial and ethnic and low-income populations.

These evaluation efforts will build upon existing monitoring and evaluation infrastructures. Each agency of the Department routinely conducts evaluations designed to assess the process, outcomes, and effectiveness of its own programs based on what aspects of disparity are targeted. Efforts are made to ensure all programs have measurable objectives that can be used to direct program activities and measure the benefits accruing to the target populations. To this end, the agency may directly collect data in the process of administering the program relating to performance. It may also conduct special evaluation studies to assess program outcomes and impacts. All monitoring and evaluation is designed in full recognition that in addition to actions outlined in the plan, changes in disparities are also related to ongoing efforts at various levels in government and private sector organizations, including efforts that address social determinants of health.

Action-Level Monitoring. HHS will routinely monitor agency and office progress in completing actions within the HHS Disparities Action Plan. As a part of this process, HHS will utilize existing performance measures, such as Government Performance and Results Act (GPRA) measures, and other program performance monitoring data systems. Additional performance metrics may be identified to allow HHS to identify barriers to action success and assess overall progress on HHS Disparities Action Plan implementation.

Conclusion

This HHS Disparities Action Plan in support of the *National Stakeholder Strategy* will accelerate national momentum toward reducing racial and ethnic health care disparities. The Affordable Care Act represents the most significant federal effort to reduce disparities in the country's history. By building on the Affordable Care Act and shaping the Department's health disparities reduction activities around the Secretary's priorities, the Department will lead by example. Through the release of this Action Plan, the Department commits to the vision of a nation free from disparities in health and health care for racial and ethnic minority populations.

References

[1] Institute of Medicine (IOM). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press; 2002.

[2] U.S. Department of Health and Human Services (HHS). Office of Disease Prevention and Health Promotion, Healthy People 2020: Rockville, MD. Available at: www.healthypeople.gov

[3] National Partnership for Action. National Stakeholder Strategy for Achieving Health Equity; 2011.

[4] U.S. Department of Health and Human Services (HHS). Office of Disease Prevention and Health Promotion, Healthy People 2020: Rockville, MD. Available at: www.healthypeople.gov

[5] Murray CJL, Kulkarni SC, Michaud C, Tomijima N, Bulzacchelli MT, et al. (2006) Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States. PLoS Med 3(9): e260. doi:10.1371/journal.pmed.0030260. Doonan MT, Tull KR. Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate. Milbank Quarterly. 2010 March; 88(1): 54-80.

[6] Joint Center for Political And Economic Studies. Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations. Washington, DC; 2010.

[7] World Health Organization, Website, Social Determinants of Health, 2009. Available at: http://www.who.int/social_determinants/en/

[8] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[9] U.S. Department of Health and Human Services. National Center on Minority Health and Health Disparities. Social Determinants of Health Initiative. Available at: http://www.nimhd.nih.gov/recovery/goSocialDeterm.asp

[10] Sondik EJ, Huang DT, Klein RJ, Satcher D. Progress Toward the Healthy People 2010 Goals and Objectives. Annual Review of Public Health. April 2010; 31: 271-281.

[11] Institute of Medicine (IOM). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press; 2002.

[12] U.S. Department of Health and Human Services. National Center on Minority Health and Health Disparities. Social Determinants of Health Initiative. Available at: http://www.nimhd.nih.gov/recovery/goSocialDeterm.asp

[13] Smedley BD. Moving beyond access: Achieving equity in state health care reform. Health Affairs. 2008; 27(2): 447-455. DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, Income, Poverty, and Health Insurance Coverage in the United States: 2009, U.S. Government Printing Office, Washington, DC,2010.

[14] National Association of Community Health Centers. Access Denied: A Look into America's Medically Disenfranchised. Washington, DC; 2007.

[15] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics. No Usual Source of Care Among Children. 2007.

[16] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[17] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[18] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[19] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[20] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

▸ REFERENCES

[21] U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System, 2009.

[22] Institute of Medicine (IOM). In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. Washington, DC: The National Academies Press; 2004.

[23] Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2010. Washington, DC; 2010. U.S. Census Bureau, 2008 Current Population Reports.

[24] Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2010. Washington, DC; 2010. U.S. Census Bureau, 2008 Current Population Reports.

[25] U.S. Department of Education. National Center for Education Statistics. The 2003 National Assessment of Adult Literacy. U.S. Census Bureau. Population 5-years or older who speak English "less than very well." 2007. Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[26] U.S. Department of Health and Human Services. Health Resources and Services Administration. Bureau of Clinician Recruitment and Services Management Information System. 2011.

[27] U.S. Department of Health and Human Services. National Center on Minority Health and Health Disparities. Social Determinants of Health Initiative. Available at: http://www.nimhd.nih.gov/recovery/goSocialDeterm.asp

[28] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[29] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[30] U.S. Department of Health and Human Services. Administration for Children & Families. HeadStart Program Fact Sheets. Available at: http://www.acf.hhs.gov/programs/ohs/about/fy2010.htmlInstitute of Medicine (IOM). Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality.

[31] IOM Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press; 2009.

[32] U.S. Department of Health and Human Services (HHS). Office of Disease Prevention and Health Promotion, Healthy People 2020: Rockville, MD. Available at: www.healthypeople.gov. Koh, HK. A 2020 Vision for Healthy People. New England Journal of Medicine. 2010; 362: 1653-1656.

[33] First Lady's Let's Move! Initiative. www.letsmove.gov

[34] National HIV/AIDS Strategy: http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. Implementation Plan: http://www.whitehouse.gov/files/documents/nhas-implementation.pdf

[35] HHS Strategic Action Plan to End the Tobacco Epidemic http://www.hhs.gov/ash/initiatives/tobacco/tobaccostrategicplan2010.pdf

[36] HHS and Walgreens Announce New Effort Aimed at Addressing Health Disparities in Flu Vaccination. Available at: http://www.hhs.gov/news/press/2010pres/12/20101217a.html and www.flu.gov

[37] Interagency Working Group on Environmental Justice. www.epa.gov/compliance/ej/interagency

[38] U.S. Department of Health and Human Services. Strategic Plan for 2010-2015. Available at: http://www.hhs.gov/secretary/about/priorities/priorities.html

[39] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[40] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[41] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

REFERENCES

[42] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[43] Institute of Medicine (IOM). In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. Washington, DC: The National Academies Press; 2004. Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2010. Washington, DC; 2010. U.S. Census Bureau, 2008 Current Population Reports.

[44] Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2008. Rockville, MD; 2009. Available at: www.ahrq.gov/qual/measurix.htm

[45] Kaiser Family Foundation. Optimizing Medicaid enrollment: Perspectives on strengthening Medicaid's reach under healthcare reform. April 2010. Available at: http://www.kff.org/healthreform/upload/8068.pdf

[46] Komaromy M, Grumbach K, Drake M, Vranizan K, Luri N, Keane D, Bindman AB (1996) The role of Black and Hispanic physicians in providing health care for underserved populations. New England Journal of Medicine 334:1305-1310. Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE (1999) Race, gender and partnership in the patient-physician relationship. Journal of the American Medical Association 282(6):583-9.

[47] Centers for Disease Control and Prevention (CDC). CDC Health Disparities and Inequalities Report – United States, 2011. MMWR 2011; 60(Supplement): 1-114.

[48] Institute of Medicine (IOM). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press; 2002

Appendix A: Provisions in the Affordable Care Act that Address Health Disparities

Expanding coverage and access to care: Mechanisms such as *Medicaid expansion (2014)* and *Health Insurance Exchanges (2014)* will give millions of people and small businesses access to affordable coverage. The Medicaid program provided services to an average of 50 million people in 2009; with the expected expansion (2014), the number could potentially increase by 16 million by 2019. Health Insurance Exchanges and new private competitive health insurance markets will help individuals and small employers select and enroll in high-quality, affordable private health plans. These will make purchasing health insurance easier and more understandable. Special efforts should be made to reach target populations and put greater choice in the hands of individuals and small businesses. Additionally, the Affordable Care Act requires health plans and encourages state Medicaid programs to place a strong emphasis on prevention, specifically by encouraging coverage for: i) any clinical preventive service recommended with a grade A or B by the U.S. Preventive Services Task Force (USPTF); and ii) for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). Through the Medicare program, beneficiaries can now receive personalized prevention plans, an initial preventive physical examination, and any Medicare-covered preventive service recommended (grade A or B) by the USPTF.

Nondiscrimination: Section 1557 of the Affordable Care Act extends the application of existing federal civil rights laws prohibiting discrimination on the basis of race, color or national origin, gender, disability, or age to any health program or activity receiving federal financial assistance; any program or activity administered by an executive agency; or any entity established under Title 1 of the Act or its amendments. Entities subject to § 1557 must provide information in a culturally and linguistically appropriate manner in order to comply with the relevant anti-discrimination provisions of Title VI of the Civil Rights Act of 1964 (§ 1557 explicitly references the legal protections of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973).

Data: Section 4302 of the Affordable Care Act contains provisions to strengthen federal data collection efforts by requiring that all federally funded programs to collect data on race, ethnicity, primary language, disability status, and gender.

HRSA Community Health Center Program: The Affordable Care Act expands access to primary health care by investing $11 billion into the HRSA Community Health Center program over the next five years. Together with funds from ARRA, the Affordable Care Act will enable the Community Health Center programs to

nearly double the number of patients served over the next five years. A key component of the health center program will be the implementation of the *New Access Points (NAPs)* grant program. For Fiscal Year 2011, HRSA has committed to support 350 NAPs to increase preventive and primary healthcare services for eligible public and nonprofit entities including tribal, faith-based and community-based organizations. Additional funding of up to $335 million will be available this year for expanded services in existing health centers and $10 million for 125 planning grants to help communities without a health center to develop one. The Community Health Center program provides care to vulnerable populations by assuring access to comprehensive, culturally competent, quality primary healthcare services. Of the nearly 19 million patients currently served through these HRSA-funded health centers, 63 percent are racial and ethnic minorities, and 92 percent are below the federal poverty level.

Health Professional Opportunity Grants (HPOG): HPOG are human service program grants that primarily assist organizations that serve populations with high concentrations of Native American, Hispanic, and African American people. The TANF program provides grants to states to administer a time-limited welfare program to assist needy families in achieving self-sufficiency. Recognizing the need for a larger, well-trained healthcare workforce, HPOG will provide comprehensive healthcare-related training to low-income workers and TANF participants to improve their ability to enter various health professions. To increase their opportunity for success, HPOG will work with community partners to enhance supportive services such as transportation, dependent care, and temporary housing for low-income workers and TANF participants.

Maternal, Infant, and Early Childhood Home Visitation Program: The Affordable Care Act provides support for the Maternal, Infant, and Early Childhood Visitation Program. Home visiting is an effective and relatively low-cost strategy used by public health and human services programs to foster child development and improve prenatal and postnatal health outcomes. The families that benefit from these visits are in communities with concentrations of premature births, low birth-weight infants, infant mortality, poverty, crime and domestic violence, high rates of high school dropouts, substance abuse, and unemployment.

National Health Service Corps (NHSC): The Affordable Care Act provides $1.5 billion over five years to expand the NHSC. Of note, since the 1970s, the NHSC funds and places health professionals in Health Professional Shortage Areas to provide healthcare services to underserved populations. Currently, 7,000 NHSC clinicians are providing healthcare services in underserved areas in exchange for loan repayment or scholarships, with approximately half of them in health centers. Approximately one-third of these clinicians are minorities.

Prevention and Public Health Funds: Community Transformation Grants: The Affordable Care Act authorizes Community Transformation Grants to state and local governmental agencies, tribes and territories, and national and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, and address health disparities. This program is intended to build on CDC's "Communities Putting Prevention to Work" program.

Promotoras, also known as peer leaders, community ambassadors, patient navigators or health advocates: The Affordable Care Act authorizes promotion of these community health workers uniquely skilled in providing culturally and linguistically appropriate services, particularly in diverse, underserved areas. Community health workers can play a critical role in providing enrollment assistance to racial and ethnic minorities.

Appendix B: Key Opportunities to Advance Health Disparity Reduction Activities at the U.S Department of Health and Human Services

The following healthcare initiatives and prevention programs present a unique opportunity to use innovative approaches to improve and change healthcare practices and policies across the public health system to sharply reduce disparities among racial and ethnic minority populations.

Center for Integrated Health Solutions (CIHS). This Center, co-funded with HRSA, falls within the SAMHSA *Primary and Behavioral Health Care Integration* Program. CIHS is dedicated to addressing the comprehensive care needs of people in or seeking long-term recovery from addiction and mental illness by improving the coordination of healthcare services in publicly funded community settings, and promoting whole health and recovery self management. SAMHSA recognizes that members of underserved racially and ethnically diverse communities are more likely to seek care from a primary care provider than from a community behavioral health provider. CIHS supports primary care providers to enhance their capacity to appropriately screen and refer individuals for behavioral health issues, with emphasis on the potential issues arising from the particular needs of diverse communities.

Communities Putting Prevention to Work (CPPW). As part of the 2009 American Recovery and Reinvestment Act and with additional funds from the Affordable Care Act, the CDC has funded 50 "Communities Putting Prevention to Work" programs committed to reducing chronic diseases related to obesity and tobacco use by implementing effective strategies that develop public health policy and strengthen the community environment to improve and support health.

Culturally and Linguistically Appropriate Services (CLAS). HHS's Office of Minority Health issued national Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) to ensure that all people entering the healthcare system receive equitable and effective care in a culturally and linguistically appropriate manner. The Standards are meant to be inclusive of all populations, but are specifically designed to meet the needs of racial, ethnic, and linguistic populations that experience unequal access to healthcare services. The CLAS Standards on Language Access Services (Standards 4-7) are mandated for all programs receiving federal funds. Many states and healthcare organizations have used the CLAS Standards to help improve the provision of care.

Healthy Weight Collaborative. HRSA funded a Prevention Center for Healthy Weight to launch a first-ever learning collaborative to address obesity in children and families. HRSA's learning collaboratives assist service delivery systems in rapidly moving the best available evidence into practice. The learning collaboratives have shown promise for improving the quality of care and clinical outcomes of underserved populations in community-based settings.

Head Start Program: The Head Start program provides grants to local public and private nonprofit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families. Head Start programs promote school readiness by enhancing the social and cognitive development of children. Efforts include the provision of educational, health, nutritional, social, and other services to enrolled children and families. The Head Start program engages parents in their children's learning and helps them in making progress toward their educational, literacy, and employment goals.

National Network to Eliminate Disparities in Behavioral Health (NNED). This is a network funded by SAMHSA, NIMHD, and foundations to link community-based behavioral health and multi-service organizations serving racial and ethnic minority populations. The NNED supports workforce development, linkages between providers and researchers, and resource and information exchange among these community organizations to improve access to and delivery of evidence-supported quality behavioral health care.

Racial and Ethnic Approaches to Community Health (REACH). REACH, a national multi-level program that has developed innovative approaches that focus on racial and ethnic groups, improves people's health in communities, healthcare settings, schools, and worksites. REACH communities have empowered residents to seek better health, changed local healthcare practices, and mobilized communities to implement evidence-based public health programs that address their unique social, historical, economic, and cultural circumstance. The CDC currently funds 40 communities to implement best practices to reduce health disparities.

Regional Extension Centers. Regional Extension Centers, funded by the ONC to assist more than 100,000 primary care providers in achieving meaningful use of certified electronic health record (EHR) technology, improve care by providing outreach, education, EHR support, and technical assistance. Regional Extension Centers serve local communities around the country, focusing on those healthcare settings that provide primary care services to those who lack adequate coverage or medical care.

Task Force on Environmental Health Risks and Safety Risks for Children. Co-Chaired by HHS and EPA, this Task Force is supported by a Senior Steering Committee constituted of senior representatives of several federal departments, agencies, and White House offices. The Steering Committee has identified asthma disparities, chemical exposures, and healthy settings (where children live, learn, and play) as the three initial priorities for improving coordination of federal efforts and developing interagency collaborations to address environmental health risks and safety risks to children.

Appendix C: Key Disparity Measures

I. Transform Health Care
Measure 1: Percentage of the U.S. nonelderly population (0-64) with health coverage
Measure 2: Percentage of people who have a specific source of ongoing medical care
Measure 3: Percentage of people who did not receive or delayed getting medical care due to cost in the past 12 months
Measure 4: Percentage of people who report difficulty seeing a specialist
Measure 5: Percentage of people who reported that they experienced good communication with their health care provider
Measure 6: Rate of hospitalization for ambulatory care-sensitive conditions
Measure 7: Percentage of adults who receive colorectal cancer screening as appropriate
II. Strengthen the Nation's Health and Human Services Infrastructure and Workforce
Measure 1: Percentage of clinicians receiving National Health Service Corps scholarships and loan repayment services
Measure 2: Percentage of degrees awarded in the health professionals, allied and associated health professionals fields
Measure 3: Percentage of practicing physicians, nurses, and dentists
III. Advance the Health, Safety, and Well-Being of the American People
Measure 1: Percentage of infants born at low birthweight
Measure 2: Percentage of people receiving seasonal influenza vaccination in the last 12 months
Measure 3: Percentage of adults and adolescents who smoke cigarettes
Measure 4: Percentage of adults and children with healthy weight

The indicators will be displayed by race and ethnicity and income.

Appendix D: List of Acronyms

ACF – Administration for Children and Families
ACIP – Advisory Committee on Immunization Practices
AHRQ – Agency for Healthcare Research and Quality
ARRA – American Recovery and Reinvestment Act
ASA – Assistant Secretary for Administration
ASPE – Assistant Secretary for Planning and Evaluation
CBPR – Community-Based Participatory Research
CCHI – Certification Commission for Healthcare Interpreters
CDC – Centers for Disease Control and Prevention
CHIP – Children's Health Insurance Program
CIHS – Center for Integrated Health Solutions
CLAS – Culturally and Linguistically Appropriate Services
CMS – Centers for Medicare and Medicaid Services
CPPW – Communities Putting Prevention to Work
DOC – Department of Commerce
DOE – Department of Energy
DOL – Department of Labor
DOT – Department of Transportation
ED – Department of Education
EHR – Electronic Health Records
EPA – Environmental Protection Agency
FDA – Food and Drug Administration
FIHET – Federal Interagency Health Equity Team
GPRA – Government Performance and Results Act
HACU – Hispanic Association of Colleges and Universities
HBCU – Historically Black Colleges and Universities
HHS – Department of Health and Human Services
HIA – Health Impact Assessment
HIT – Health Information Technology
HPOG – Health Profession Opportunity Grants
HRSA – Health Resources and Services Administration
HUD – Department of Housing and Urban Development
IHS – Indian Health Service
IOM – Institute of Medicine
NAP – New Access Points

NCI – National Cancer Institute
NHDR – National Health Disparities Report
NHSC – National Health Service Corps
NIH – National Institutes of Health
NIMHD – National Institute on Minority Health and Health Disparities
NNED – National Network to Eliminate Disparities in Behavioral Health
NPA – National Partnership for Action
NVPO – National Vaccine Program Office
OASH – Office of the Assistant Secretary for Health
OMB – Office of Management and Budget
OMH – Office of Minority Health
ONC – Office of the National Coordinator of Health Information Technology
OWH – Office on Women's Health
REACH – Racial and Ethnic Approaches to Community Health
SAMHSA – Substance Abuse and Mental Health Services Administration
TANF – Temporary Assistance for Needy Families
USDA – Department of Agriculture
USPSTF – U.S. Preventive Services Task Force
VA – Department of Veterans Affairs
WHO – World Health Organization