

110TH CONGRESS
1ST SESSION

H. R. 3333

To amend the Public Health Service Act to improve the health and healthcare of racial and ethnic minority groups.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 2007

Mr. JACKSON of Illinois (for himself, Mr. WICKER, Mr. THOMPSON of Mississippi, Mr. PICKERING, Mr. LEWIS of Georgia, Mr. ROGERS of Alabama, Mr. STARK, Mr. KIRK, Mr. DAVIS of Alabama, Mrs. DRAKE, Mr. CONYERS, Mr. BURGESS, Mr. BOYD of Florida, Mr. FORBES, Ms. JACKSON-LEE of Texas, Mr. ALEXANDER, Ms. KILPATRICK, Mr. WAMP, Ms. WATSON, Mr. ENGLISH of Pennsylvania, Mr. SCOTT of Virginia, Mr. LATOURETTE, Ms. NORTON, Mr. BONNER, Mr. SERRANO, Mr. BOOZMAN, Mr. GUTIERREZ, Mr. TIBERI, Ms. WATERS, Mr. MARCHANT, Mr. DAVIS of Illinois, Mr. LOBIONDO, Mr. BISHOP of Georgia, Mr. TIAHRT, Mr. FATTAH, Mrs. EMERSON, Mr. MEEK of Florida, Mr. LATHAM, Mr. BUTTERFIELD, Mr. BOUSTANY, Ms. SCHAKOWSKY, Mr. RENZI, Mr. ORTIZ, Mr. JONES of North Carolina, Ms. WOOLSEY, Mr. WALSH of New York, Ms. LEE, Mr. GINGREY, Mr. JOHNSON of Georgia, Mr. LAHOOD, Mr. RODRIGUEZ, Mr. REGULA, Mr. AL GREEN of Texas, Mr. SHAYS, Mr. COOPER, Mr. HOBSON, and Mr. REYES) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to improve the health and healthcare of racial and ethnic minority groups.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
 3 “Minority Health Improvement and Health Disparity
 4 Elimination Act”.

5 (b) TABLE OF CONTENTS.—

Sec. 1. Short title; table of contents.

Sec. 2. Definitions.

TITLE I—INCREASING DIVERSITY AND CULTURAL COMPETENCY
 IN THE HEALTHCARE WORKFORCE THROUGH EDUCATION AND
 TRAINING

Sec. 101. Cultural competency and communication for providers.

Sec. 102. Healthcare workforce composition and placement.

Sec. 103. Workforce training to achieve diversity.

Sec. 104. Mid-career health professions scholarship program.

Sec. 105. Cultural competency training.

Sec. 106. Authorization of appropriations; reauthorizations.

TITLE II—PROMOTING HEALTH AND HEALTHCARE AWARENESS
 AND ACCESS

Sec. 201. Care and access.

Sec. 202. Authorization of appropriations.

TITLE III—RESEARCH TO REDUCE AND ELIMINATE HEALTH
 DISPARITIES

Sec. 301. Agency for healthcare research and quality.

Sec. 302. Genetic variation and health.

Sec. 303. Evaluations by the Institute of Medicine.

Sec. 304. National Center for Minority Health and Health Disparities reauthor-
 ization.

Sec. 305. Authorization of appropriations.

TITLE IV—DATA COLLECTION, ANALYSIS, AND QUALITY

Sec. 401. Data collection, analysis, and quality.

TITLE V—LEADERSHIP, COLLABORATION, AND NATIONAL
 ACTION PLAN

Sec. 501. Office of Minority Health.

6 **SEC. 2. DEFINITIONS.**

7 In this Act and the amendments made by this Act:

8 (1) CULTURAL COMPETENCY.—The term “cul-
 9 turally competent”—

1 (A) with respect to health-related services,
2 means the ability to provide healthcare tailored
3 to meet the social, cultural, and linguistic needs
4 of patients from diverse backgrounds; and

5 (B) when used to describe education or
6 training, means education or training designed
7 to prepare those receiving the education or
8 training to provide health-related services tai-
9 lored to meet the social, cultural, and linguistic
10 needs of patients from diverse backgrounds.

11 (2) HEALTH DISPARITY POPULATION.—The
12 term “health disparity population” has the meaning
13 given such term in section 903(d)(1) of the Public
14 Health Service Act (42 U.S.C. 299a–1(d)(1)).

15 (3) HEALTH LITERACY.—The term “health lit-
16 eracy” means the degree to which an individual has
17 the capacity to obtain, communicate, process, and
18 understand health information (including the reg-
19 ister and language in which the information is pro-
20 vided) and services in order to make appropriate
21 health decisions.

22 (4) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZA-
23 TION; URBAN INDIAN ORGANIZATION.—The terms
24 “Indian”, “Indian tribe”, “tribal organization”, and
25 “urban Indian organization” have the meanings

1 given such terms in section 4 of the Indian Health
2 Care Improvement Act (25 U.S.C. 1603).

3 (5) MINORITY GROUP.—The term “minority
4 group” has the meaning given the term “racial and
5 ethnic minority group” in section 1707 of the Public
6 Health Service Act (42 U.S.C. 300u–6) (as amended
7 by section 501).

8 (6) PRACTICE-BASED RESEARCH NETWORKS.—
9 The term “practice-based research network” means
10 a group of ambulatory practices devoted principally
11 to the primary care of patients, and affiliated in
12 their mission to investigate questions related to com-
13 munity-based practice and to improve the quality of
14 primary care.

15 (7) SECRETARY.—The term “Secretary” means
16 the Secretary of Health and Human Services.

1 **TITLE I—INCREASING DIVER-**
 2 **SITY AND CULTURAL COM-**
 3 **PETENCY IN THE**
 4 **HEALTHCARE WORKFORCE**
 5 **THROUGH EDUCATION AND**
 6 **TRAINING**

7 **SEC. 101. CULTURAL COMPETENCY AND COMMUNICATION**
 8 **FOR PROVIDERS.**

9 Title II of the Public Health Service Act (42 U.S.C.
 10 202 et seq.) is amended by adding at the end the fol-
 11 lowing:

12 **“SEC. 270. INTERNET CLEARINGHOUSE TO IMPROVE CUL-**
 13 **TURAL COMPETENCY AND COMMUNICATION**
 14 **BY HEALTHCARE PROVIDERS.**

15 “(a) ESTABLISHMENT.—Not later than 1 year after
 16 the date of enactment of the Minority Health Improve-
 17 ment and Health Disparity Elimination Act, the Sec-
 18 retary, acting through the Deputy Assistant Secretary for
 19 Minority Health, shall develop and maintain an Internet
 20 Clearinghouse within the Office of Minority Health to as-
 21 sist providers in improving the health and healthcare of
 22 racial and ethnic minority groups, with the goal of—

23 “(1) increasing cultural competency;

1 “(2) improving communication between
2 healthcare providers, staff, and their patients, in-
3 cluding those patients with low health literacy;

4 “(3) improving healthcare quality and patient
5 satisfaction;

6 “(4) reducing medical errors and healthcare
7 costs; and

8 “(5) reducing duplication of effort regarding
9 translation of materials.

10 “(b) INTERNET CLEARINGHOUSE.—Not later than 1
11 year after the date of enactment of this section the Sec-
12 retary, acting through the Deputy Assistant Secretary for
13 Minority Health, and in consultation with the Director of
14 the Office for Civil Rights, shall carry out subsection (a)
15 by—

16 “(1) developing and maintaining, through the
17 Office of Minority Health, an accessible library and
18 database on the Internet with easily searchable,
19 clinically-relevant information regarding culturally
20 competent healthcare for racial and ethnic minority
21 groups, including Internet links to additional re-
22 sources that fulfill the purpose of this section;

23 “(2) developing and making templates for vis-
24 ual aids and standard documents with clear expla-
25 nations that can help patients and consumers access

1 and make informed decisions about healthcare, in-
2 cluding—

3 “(A) administrative and legal documents,
4 including informed consent and advanced direc-
5 tives;

6 “(B) clinical information, including infor-
7 mation pertaining to treatment adherence, self-
8 management training for chronic conditions,
9 preventing transmission of disease, and dis-
10 charge instructions;

11 “(C) patient education and outreach mate-
12 rials, including immunization or screening no-
13 tices and health warnings; and

14 “(D) Federal health forms and notices;

15 “(3) ensuring that documents described in
16 paragraph (2) are posted in English and non-
17 English languages and are culturally appropriate;

18 “(4) encouraging healthcare providers to cus-
19 tomize such documents for their use;

20 “(5) facilitating access to such documents, in-
21 cluding distribution in both paper and electronic for-
22 mats;

23 “(6) providing technical assistance to healthcare
24 providers with respect to the access and use of infor-

1 mation described in paragraph (1) including infor-
2 mation to help healthcare providers—

3 “(A) understand the concept of cultural
4 competence;

5 “(B) implement culturally competent prac-
6 tices;

7 “(C) care for patients with low health lit-
8 eracy, including helping such patients under-
9 stand and participate in healthcare decisions;

10 “(D) understand and apply Federal guid-
11 ance and directives regarding healthcare for ra-
12 cial and ethnic minority groups;

13 “(E) obtain reimbursement for provision of
14 culturally competent services;

15 “(F) understand and implement
16 bioinformatics and health information tech-
17 nology in order to improve healthcare for racial
18 and ethnic minority groups; and

19 “(G) conduct other activities determined
20 appropriate by the Secretary;

21 “(7) providing culturally appropriate dissemina-
22 tion strategies to provide educational materials to
23 patients, representatives of community-based organi-
24 zations, and the public with respect to the access

1 and use of information described in paragraph (1),
2 including—

3 “(A) information to help such individ-
4 uals—

5 “(i) understand the concept of cul-
6 tural competence, and the role of cultural
7 competence in the delivery of healthcare;

8 “(ii) work with healthcare providers to
9 implement culturally competent practices;

10 “(iii) provide options for providers
11 and consumers to promote increased un-
12 derstanding of health literacy and self-
13 management concepts, as well as the bene-
14 fits of improved provider-patient commu-
15 nications; and

16 “(iv) understand the concept of low
17 health literacy, and the barriers it presents
18 to care; and

19 “(B) if determined appropriate, materials
20 and information identified by community-based
21 organizations, including other non-profit organi-
22 zations, that are beneficial in assisting
23 healthcare providers and patients in making de-
24 cisions regarding health, healthcare, and patient
25 recovery; and

1 “(C) other material determined appro-
2 priate by the Secretary; and

3 “(8) supporting initiatives that the Secretary
4 determines to be useful to fulfill the purposes of the
5 Internet Clearinghouse.

6 “(c) DEFINITIONS.—The definitions contained in sec-
7 tion 2 of the Minority Health Improvement and Health
8 Disparity Elimination Act shall apply for purposes of this
9 section.”.

10 **SEC. 102. HEALTHCARE WORKFORCE COMPOSITION AND**
11 **PLACEMENT.**

12 (a) IN GENERAL.—Part F of title VII of the Public
13 Health Service Act (42 U.S.C. 295j et seq.) is amended
14 by inserting after section 792 the following:

15 **“SEC. 793. HEALTHCARE WORKFORCE, EDUCATION, AND**
16 **TRAINING.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Administrator of the Health Resources and Services
19 Administration and the Deputy Assistant Secretary for
20 Minority Health, shall establish a database that can
21 produce aggregated and disaggregated statistics on health
22 professional students, including applicants, matriculates,
23 and graduates.

24 “(b) REQUIREMENT TO COLLECT DATA.—

1 “(1) IN GENERAL.—Each health professions
2 school described in paragraph (2) that receives Fed-
3 eral funds shall collect race and ethnicity data, pri-
4 mary language data, and where feasible, other health
5 disparity data pursuant to subsection (d), con-
6 cerning the students described in subsection (a), as
7 well as intended geographical site of practice and in-
8 tended discipline of practice for graduates. In col-
9 lecting race and ethnicity data, a school shall—

10 “(A) at a minimum, use the categories for
11 race and ethnicity established by the Director of
12 the Office of Management and Budget in effect
13 on the date of enactment of the Minority
14 Health Improvement and Health Disparity
15 Elimination Act; and

16 “(B) if practicable, collect data on addi-
17 tional population groups if such data can be ag-
18 gregated into the minimum race and ethnicity
19 data categories.

20 “(2) HEALTH PROFESSIONS SCHOOL.—A health
21 professions school described under this paragraph is
22 a school of medicine or osteopathic medicine, public
23 health, nursing, dentistry, optometry, pharmacy, al-
24 lied health, podiatric medicine, or veterinary medi-

1 cine, or a graduate program in mental health prac-
2 tice.

3 “(c) REPORTING.—Each school or program described
4 under subsection (b), shall, on an annual basis, report
5 data on race and ethnicity and primary language collected
6 under this section to the Secretary for inclusion in the
7 database established under subsection (a). The Secretary
8 shall ensure that such disparity data is reported to Con-
9 gress and made available to the public.

10 “(d) HEALTH DISPARITY MEASURES.—The Sec-
11 retary shall develop, report, and disseminate measures of
12 the other health data referenced in section 793(b)(1), to
13 ensure uniform and consistent collection and reporting of
14 these measures by health professions schools. In devel-
15 oping such measures, the Secretary shall take into consid-
16 eration health disparity indicators developed pursuant to
17 section 2901(c).

18 “(e) USE OF DATA.—Data reported pursuant to sub-
19 section (c) shall be used by the Secretary to conduct ongo-
20 ing short- and long-term analyses of diversity within
21 health professions schools and the health professions. The
22 Secretary shall ensure that such analyses are reported to
23 Congress and made available to the public.

24 “(f) CULTURAL COMPETENCY TRAINING.—The Sec-
25 retary shall mandate the collection and reporting of data

1 from health professions schools regarding the extent to
2 which cultural competency training is provided to health
3 professions students, that may include the duration, con-
4 tent and timing of the training, and conduct periodic as-
5 sessments regarding the preparedness of such students to
6 care for patients from racial and ethnic minority groups.

7 “(g) PRIVACY.—The Secretary shall ensure that all
8 data collected under this section is protected from inap-
9 propriate internal and external use by any entity that col-
10 lects, stores, or receives the data and that such data is
11 collected without personally identifiable information.

12 “(h) PARTNERSHIP.—The Secretary may contract
13 with external entities to fulfill the requirements under this
14 section if such entities have demonstrated expertise and
15 experience collecting, analyzing, and reporting data re-
16 quired under this section for health professional stu-
17 dents.”.

18 (b) NATIONAL HEALTH SERVICE CORPS PRO-
19 GRAM.—

20 (1) ASSIGNMENT OF CORPS PERSONNEL.—Sec-
21 tion 333(a)(3) of the Public Health Service Corps
22 (42 U.S.C. 254f(a)(3)) is amended to read as fol-
23 lows:

24 “(3)(A) In approving applications for assign-
25 ment of members of the Corps, the Secretary shall

1 not discriminate against application from entities
2 which are not receiving Federal financial assistance
3 under this Act.

4 “(B) In approving such applications, the Sec-
5 retary shall—

6 “(i) give preference to applications in
7 which a nonprofit entity or public entity shall
8 provide a site to which Corps members may be
9 assigned; and

10 “(ii) give highest preference to applica-
11 tions—

12 “(I) from entities described in clause
13 (i) that are federally qualified health cen-
14 ters as defined in section 1905(l)(2)(B) of
15 the Social Security Act; and

16 “(II) from entities described in clause
17 (i) that primarily serve racial and ethnic
18 minority groups with annual incomes at or
19 below twice those set forth in the most re-
20 cent poverty guidelines issued by the Sec-
21 retary pursuant to section 673(2) of the
22 Community Services Block Grant Act (42
23 U.S.C. 9902(2)).”.

1 (2) PRIORITIES IN ASSIGNMENT OF CORPS PER-
 2 SONNEL.—Section 333A of the Public Health Serv-
 3 ice Act (42 U.S.C. 254f–1) is amended—

4 (A) in subsection (a)—

5 (i) by redesignating paragraphs (1),
 6 (2), and (3) as paragraphs (2), (3), and
 7 (4), respectively; and

8 (ii) by striking “shall—” and insert-
 9 ing “shall—

10 “(1) give preference to applications as set forth
 11 in subsection (a)(3) of section 333;” and

12 (B) by striking “subsection (a)(1)” each
 13 place it appears and inserting “subsection
 14 (a)(2)”.

15 (3) CONFORMING AMENDMENT.—Section
 16 338I(c)(3)(B)(ii) of the Public Health Service Act
 17 (42 U.S.C. 254q–1(c)(3)(B)(ii)) is amended by
 18 striking “section 333A(a)(1)” and inserting “section
 19 333A(a)(2)”.

20 **SEC. 103. WORKFORCE TRAINING TO ACHIEVE DIVERSITY.**

21 (a) CENTERS OF EXCELLENCE.—Section 736 of the
 22 Public Health Service Act (42 U.S.C. 293) is amended—

23 (1) by striking subsection (a) and inserting the
 24 following:

1 “(a) IN GENERAL.—The Secretary shall make grants
2 to, and enter into contracts with, public and nonprofit pri-
3 vate health or educational entities, including designated
4 health professions schools described in subsection (c), for
5 the purpose of assisting the entities in supporting pro-
6 grams of excellence in health professions education for
7 underrepresented minorities in health professions.”;

8 (2) by striking subsection (b) and inserting the
9 following:

10 “(b) REQUIRED USE OF FUNDS.—The Secretary
11 may not make a grant under subsection (a) unless the des-
12 ignated health professions school agrees, subject to sub-
13 section (c)(1)(C), to use the funds awarded under the
14 grant to—

15 “(1) develop a large competitive applicant pool
16 through linkages with institutions of higher edu-
17 cation, local school districts, and other community-
18 based entities and establish an education pipeline for
19 health professions careers;

20 “(2) establish, strengthen, or expand programs
21 to enhance the academic performance of underrep-
22 resented minority in health professions students at-
23 tending the school;

24 “(3) improve the capacity of such school to
25 train, recruit, and retain underrepresented minority

1 faculty members including the payment of such sti-
2 pends and fellowships as the Secretary may deter-
3 mine appropriate;

4 “(4) carry out activities to improve the informa-
5 tion resources, clinical education, curricula, and cul-
6 tural and linguistic competence of the graduates of
7 the school, as it relates to minority health issues;

8 “(5) facilitate faculty and student research on
9 health issues particularly affecting racial and ethnic
10 minority groups, including research on issues relat-
11 ing to the delivery of culturally competent healthcare
12 (as defined in section 270);

13 “(6) establish and implement a program to
14 train students of the school in providing health serv-
15 ices to racial and ethnic minority individuals through
16 training provided to such students at community-
17 based health facilities that—

18 “(A) provide such health services; and

19 “(B) are located at a site remote from the
20 main site of the teaching facilities of the school;

21 “(7) provide stipends as the Secretary deter-
22 mines appropriate, in amounts as the Secretary de-
23 termines appropriate; and

1 “(8) conduct accountability and other reporting
2 activities, as required by the Secretary in subsection
3 (i).”;

4 (3) in subsection (c)—

5 (A) by amending paragraph (1) to read as
6 follows:

7 “(1) DESIGNATED SCHOOLS.—

8 “(A) IN GENERAL.—The designated health
9 professions schools referred to in subsection (a)
10 are such schools that meet each of the condi-
11 tions specified in subparagraphs (B) and (C),
12 and that—

13 “(i) meet each of the conditions speci-
14 fied in paragraph (2)(A);

15 “(ii) meet each of the conditions spec-
16 ified in paragraph (3);

17 “(iii) meet each of the conditions
18 specified in paragraph (4); or

19 “(iv) meet each of the conditions spec-
20 ified in paragraph (5).

21 “(B) GENERAL CONDITIONS.—The condi-
22 tions specified in this subparagraph are that a
23 designated health professions school—

24 “(i) has a significant number of
25 underrepresented minority in health pro-

1 fessions students enrolled in the school, in-
2 cluding individuals accepted for enrollment
3 in the school;

4 “(ii) has been effective in assisting
5 such students of the school to complete the
6 program of education and receive the de-
7 gree involved;

8 “(iii) has been effective in recruiting
9 such students to enroll in and graduate
10 from the school, including providing schol-
11 arships and other financial assistance to
12 such students and encouraging such stu-
13 dents from all levels of the educational
14 pipeline to pursue health professions ca-
15 reers; and

16 “(iv) has made significant recruitment
17 efforts to increase the number of underrep-
18 resented minority in health professions in-
19 dividuals serving in faculty or administra-
20 tive positions at the school.

21 “(C) CONSORTIUM.—The condition speci-
22 fied in this subparagraph is that, in accordance
23 with subsection (e)(1), the designated health
24 profession school involved has with other health
25 profession schools (designated or otherwise)

1 formed a consortium to carry out the purposes
2 described in subsection (b) at the schools of the
3 consortium.

4 “(D) APPLICATION OF CRITERIA TO
5 OTHER PROGRAMS.—In the case of any criteria
6 established by the Secretary for purposes of de-
7 termining whether schools meet the conditions
8 described in subparagraph (B), this section may
9 not, with respect to racial and ethnic minorities,
10 be construed to authorize, require, or prohibit
11 the use of such criteria in any program other
12 than the program established in this section.”;

13 (B) by amending paragraph (2) to read as
14 follows:

15 “(2) CENTERS OF EXCELLENCE AT CERTAIN
16 HISTORICALLY BLACK COLLEGES AND UNIVER-
17 SITIES.—

18 “(A) CONDITIONS.—The conditions speci-
19 fied in this subparagraph are that a designated
20 health professions school is a school described
21 in section 799B(1).

22 “(B) USE OF GRANT.—In addition to the
23 purposes described in subsection (b), a grant
24 under subsection (a) to a designated health pro-

1 fessions school meeting the conditions described
2 in subparagraph (A) may be expended—

3 “(i) to develop a plan to achieve insti-
4 tutional improvements, including financial
5 independence, to enable the school to sup-
6 port programs of excellence in health pro-
7 fessions education for underrepresented
8 minority individuals; and

9 “(ii) to provide improved access to the
10 library and informational resources of the
11 school.

12 “(C) EXCEPTION.—The requirements of
13 paragraph (1)(C) shall not apply to a histori-
14 cally black college or university that receives
15 funding under this paragraph or paragraph
16 (5).”; and

17 (C) by amending paragraphs (3) through
18 (5) to read as follows:

19 “(3) HISPANIC CENTERS OF EXCELLENCE.—

20 The conditions specified in this paragraph are
21 that—

22 “(A) with respect to Hispanic individuals,
23 each of clauses (i) through (iv) of paragraph
24 (1)(B) applies to the designated health profes-
25 sions school involved;

1 “(B) the school agrees, as a condition of
2 receiving a grant under subsection (a) of this
3 section, that the school will, in carrying out the
4 duties described in subsection (b) of this sec-
5 tion, give priority to carrying out the duties
6 with respect to Hispanic individuals; and

7 “(C) the school agrees, as a condition of
8 receiving a grant under subsection (a) of this
9 section, that—

10 “(i) the school will establish an ar-
11 rangement with 1 or more public or non-
12 profit community-based Hispanic serving
13 organizations, or public or nonprofit pri-
14 vate institutions of higher education, in-
15 cluding schools of nursing, whose enroll-
16 ment of students has traditionally included
17 a significant number of Hispanic individ-
18 uals, the purposes of which will be to carry
19 out a program—

20 “(I) to identify Hispanic students
21 who are interested in a career in the
22 health profession involved; and

23 “(II) to facilitate the educational
24 preparation of such students to enter
25 the health professions school; and

1 “(ii) the school will make efforts to
2 recruit Hispanic students, including stu-
3 dents who have participated in the under-
4 graduate or other matriculation program
5 carried out under arrangements established
6 by the school pursuant to clause (i)(II) and
7 will assist Hispanic students regarding the
8 completion of the educational requirements
9 for a degree from the school.

10 “(4) NATIVE AMERICAN CENTERS OF EXCEL-
11 LENCE.—Subject to subsection (e), the conditions
12 specified in this paragraph are that—

13 “(A) with respect to Native Americans,
14 each of clauses (i) through (iv) of paragraph
15 (1)(B) applies to the designated health profes-
16 sions school involved;

17 “(B) the school agrees, as a condition of
18 receiving a grant under subsection (a) of this
19 section, that the school will, in carrying out the
20 duties described in subsection (b) of this sec-
21 tion, give priority to carrying out the duties
22 with respect to Native Americans; and

23 “(C) the school agrees, as a condition of
24 receiving a grant under subsection (a) of this
25 section, that—

1 “(i) the school will establish an ar-
2 rangement with 1 or more public or non-
3 profit private institutions of higher edu-
4 cation, including schools of nursing, whose
5 enrollment of students has traditionally in-
6 cluded a significant number of Native
7 Americans, the purpose of which arrange-
8 ment will be to carry out a program—

9 “(I) to identify Native American
10 students, from the institutions of
11 higher education referred to in clause
12 (i), who are interested in health pro-
13 fessions careers; and

14 “(II) to facilitate the educational
15 preparation of such students to enter
16 the designated health professions
17 school; and

18 “(ii) the designated health professions
19 school will make efforts to recruit Native
20 American students, including students who
21 have participated in the undergraduate
22 program carried out under arrangements
23 established by the school pursuant to
24 clause (i) and will assist Native American
25 students regarding the completion of the

1 educational requirements for a degree from
2 the designated health professions school.

3 “(5) OTHER CENTERS OF EXCELLENCE.—The
4 conditions specified in this paragraph are—

5 “(A) with respect to other centers of excel-
6 lence, the conditions described in clauses (i)
7 through (iv) of paragraph (1)(B); and

8 “(B) that the health professions school in-
9 volved has an enrollment of underrepresented
10 minorities in health professions significantly
11 above the national average for such enrollments
12 of health professions schools.”; and

13 (4) by striking subsection (h) and inserting the
14 following:

15 “(h) FORMULA FOR ALLOCATIONS.—

16 “(1) ALLOCATIONS.—Based on the amount ap-
17 propriated under section 106(a) of the Minority
18 Health Improvement and Health Disparity Elim-
19 nation Act for a fiscal year, the following subpara-
20 graphs shall apply as appropriate:

21 “(A) IN GENERAL.—If the amounts appro-
22 priated under section 106(a) of the Minority
23 Health Improvement and Health Disparity
24 Elimination Act for a fiscal year are
25 \$24,000,000 or less—

1 “(i) the Secretary shall make available
2 \$12,000,000 for grants under subsection
3 (a) to health professions schools that meet
4 the conditions described in subsection
5 (c)(2)(A); and

6 “(ii) and available after grants are
7 made with funds under clause (i), the Sec-
8 retary shall make available—

9 “(I) 60 percent of such amount
10 for grants under subsection (a) to
11 health professions schools that meet
12 the conditions described in paragraph
13 (3) or (4) of subsection (c) (including
14 meeting the conditions under sub-
15 section (e)); and

16 “(II) 40 percent of such amount
17 for grants under subsection (a) to
18 health professions schools that meet
19 the conditions described in subsection
20 (c)(5).

21 “(B) FUNDING IN EXCESS OF
22 \$24,000,000.—If amounts appropriated under
23 section 106(a) of the Minority Health Improve-
24 ment and Health Disparity Elimination Act for

1 a fiscal year exceed \$24,000,000 but are less
2 than \$30,000,000—

3 “(i) 80 percent of such excess
4 amounts shall be made available for grants
5 under subsection (a) to health professions
6 schools that meet the requirements de-
7 scribed in paragraph (3) or (4) of sub-
8 section (c) (including meeting conditions
9 pursuant to subsection (e)); and

10 “(ii) 20 percent of such excess
11 amount shall be made available for grants
12 under subsection (a) to health professions
13 schools that meet the conditions described
14 in subsection (c)(5).

15 “(C) FUNDING IN EXCESS OF
16 \$30,000,000.—If amounts appropriated under
17 section 106(a) of the Minority Health Improve-
18 ment and Health Disparity Elimination Act for
19 a fiscal year exceed \$30,000,000 but are less
20 than \$40,000,000, the Secretary shall make
21 available—

22 “(i) not less than \$12,000,000 for
23 grants under subsection (a) to health pro-
24 fessions schools that meet the conditions
25 described in subsection (c)(2)(A);

1 “(ii) not less than \$12,000,000 for
 2 grants under subsection (a) to health pro-
 3 fessions schools that meet the conditions
 4 described in paragraph (3) or (4) of sub-
 5 section (c) (including meeting conditions
 6 pursuant to subsection (e));

7 “(iii) not less than \$6,000,000 for
 8 grants under subsection (a) to health pro-
 9 fessions schools that meet the conditions
 10 described in subsection (c)(5); and

11 “(iv) after grants are made with
 12 funds under clauses (i) through (iii), any
 13 remaining excess amount for grants under
 14 subsection (a) to health professions schools
 15 that meet the conditions described in para-
 16 graph (2)(A), (3), (4), or (5) of subsection
 17 (c).

18 “(D) FUNDING IN EXCESS OF
 19 \$40,000,000.—If amounts appropriated under
 20 section 106(a) of the Minority Health Improve-
 21 ment and Health Disparity Elimination Act for
 22 a fiscal year are \$40,000,000 or more, the Sec-
 23 retary shall make available—

24 “(i) not less than \$16,000,000 for
 25 grants under subsection (a) to health pro-

1 fessions schools that meet the conditions
2 described in subsection (c)(2)(A);

3 “(ii) not less than \$16,000,000 for
4 grants under subsection (a) to health pro-
5 fessions schools that meet the conditions
6 described in paragraph (3) or (4) of sub-
7 section (c) (including meeting conditions
8 pursuant to subsection (e));

9 “(iii) not less than \$8,000,000 for
10 grants under subsection (a) to health pro-
11 fessions schools that meet the conditions
12 described in subsection (c)(5); and

13 “(iv) after grants are made with
14 funds under clauses (i) through (iii), any
15 remaining funds for grants under sub-
16 section (a) to health professions schools
17 that meet the conditions described in para-
18 graph (2)(A), (3), (4), or (5) of subsection
19 (c).

20 “(2) NO LIMITATION.—Nothing in this sub-
21 section shall be construed as limiting the centers of
22 excellence referred to in this section to the des-
23 ignated amount, or to preclude such entities from
24 competing for grants under this section.

25 “(3) MAINTENANCE OF EFFORT.—

1 “(A) IN GENERAL.—With respect to activi-
2 ties for which a grant made under this part are
3 authorized to be expended, the Secretary may
4 not make such a grant to a center of excellence
5 for any fiscal year unless the center agrees to
6 maintain expenditures of non-Federal amounts
7 for such activities at a level that is not less
8 than the level of such expenditures maintained
9 by the center for the fiscal year preceding the
10 fiscal year for which the school receives such a
11 grant.

12 “(B) USE OF FEDERAL FUNDS.—With re-
13 spect to any Federal amounts received by a cen-
14 ter of excellence and available for carrying out
15 activities for which a grant under this part is
16 authorized to be expended, the center shall, be-
17 fore expending the grant, expend the Federal
18 amounts obtained from sources other than the
19 grant, unless given prior approval from the Sec-
20 retary.

21 “(i) EVALUATIONS.—

22 “(1) ADVISORY COMMITTEE.—

23 “(A) IN GENERAL.—Not later than 90
24 days after the date of enactment of the Minor-
25 ity Health Improvement and Health Disparity

1 Elimination Act, the Secretary shall establish
2 and appoint the members of an advisory com-
3 mittee composed of representatives of govern-
4 ment agencies, including the Health Resources
5 and Services Administration, the Office of Mi-
6 nority Health, and the Indian Health Service,
7 community stakeholders and experts in identi-
8 fying and addressing the health concerns of ra-
9 cial and ethnic minority groups, and designees
10 from health professions schools described in
11 subsection (b).

12 “(B) DUTIES.—The advisory committee
13 shall develop and recommend performance
14 measures with which to assess, based on data to
15 be compiled by recipients of grants or contracts
16 under this section or section 736, 737, 738, or
17 739, the extent to which the program described
18 in this section and sections 736, 737, 738, and
19 739 has met the purpose of this part. The advi-
20 sory committee shall submit such recommenda-
21 tions to the Administrator of the Health Re-
22 sources and Services Administration not later
23 than 6 months after the appointment of the ad-
24 visory committee.

1 “(C) NOTIFICATION.—Not later than 30
2 days after the submission of the recommenda-
3 tions, the Administrator of the Health Re-
4 sources and Services Administration shall re-
5 view the recommendations and establish per-
6 formance measures described in subparagraph
7 (B), and the Administrator shall notify recipi-
8 ents of grants or contracts under this section or
9 section 736, 737, 738, or 739 of the new per-
10 formance measures and make requirements re-
11 lated to the performance measures publicly
12 available both on the website of the Administra-
13 tion and as part of any notifications of awards
14 released to entities receiving the grants or con-
15 tracts.

16 “(2) DATA COLLECTION AND ANNUAL EVALUA-
17 TIONS.—

18 “(A) IN GENERAL.—The Administrator of
19 the Health Resources and Services Administra-
20 tion shall collect data on an annual basis from
21 recipients of grants or contracts under this sec-
22 tion or section 736, 737, 738, or 739 on the
23 performance measures established under para-
24 graph (1).

1 “(B) BIENNIAL MEETING.—The Adminis-
2 trator of the Health Resources and Services Ad-
3 ministration shall convene a meeting of the ad-
4 visory committee established under paragraph
5 (1) not less than twice per year. At the meet-
6 ing, the advisory committee shall recommend
7 any necessary changes to such performance
8 measures to improve data collection and short-
9 term evaluation with respect to the programs
10 carried out under this section or section 736,
11 737, 738, or 739, and provide technical assist-
12 ance as necessary.

13 “(3) UPDATES.—The Administrator of the
14 Health Resources and Services Administration shall
15 determine whether to incorporate the recommended
16 changes as described in paragraph (2)(B) and pro-
17 vide technical assistance as necessary. The Adminis-
18 trator shall not penalize a current recipient of a
19 grant or contract under this section or section 736,
20 737, 738, or 739 for failing to comply with the re-
21 vised data collection or performance measure re-
22 quirements if the recipient demonstrates an inability
23 to provide additional data mandated under the re-
24 quirements.

1 “(4) ACCOUNTABILITY.—The Administrator
 2 shall review and take into consideration performance
 3 measurement data previously collected from recipi-
 4 ents of grants or contracts under this section or sec-
 5 tion 736, 737, 738, or 739 when deciding to renew
 6 the grants or contracts of such recipients.”.

7 (b) COOPERATIVE AGREEMENTS FOR ONLINE DE-
 8 GREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND
 9 SCHOOLS OF ALLIED HEALTH.—Part B of title VII of
 10 the Public Health Service Act (42 U.S.C. 293 et seq.) is
 11 amended by adding at the end the following:

12 **“SEC. 742. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
 13 **GREE PROGRAMS.**

14 “(a) COOPERATIVE AGREEMENTS.—The Secretary
 15 shall award cooperative agreements to accredited schools
 16 of public health, schools of allied health, and public health
 17 programs to design and implement a degree program over
 18 the Internet (referred to in this section as an ‘online de-
 19 gree program’).

20 “(b) APPLICATION.—To be eligible to receive a coop-
 21 erative agreement under subsection (a), an accredited
 22 school of public health, school of allied health, or public
 23 health program shall submit an application at such time,
 24 in such manner, and containing such information as the
 25 Secretary may require.

1 “(c) PRIORITY.—In awarding cooperative agreements
2 under this section, the Secretary shall give priority to any
3 accredited school of public health, school of allied health,
4 or public health program that serves a disproportionate
5 number of individuals from racial and ethnic minority
6 groups.

7 “(d) REQUIREMENTS.—Awardees shall use an award
8 under subsection (a) to design and implement an online
9 degree program that meets the following conditions:

10 “(1) Limiting enrollment to individuals who
11 have obtained a secondary school diploma or a rec-
12 ognized equivalent.

13 “(2) Maintaining significant enrollment and
14 graduation of underrepresented minorities in health
15 professions.”.

16 “(c) DEFINITION.—Part B of title VII of the Public
17 Health Service Act (42 U.S.C. 293 et seq.) is amended
18 by inserting after the part heading the following:

19 **“SEC. 735A. APPLICATION OF DEFINITION.**

20 “The definition contained in section 738(b)(5) shall
21 apply for purposes of this part, except that such definition
22 shall also apply in the case of references to ‘underrep-
23 resented minority students’, ‘underrepresented minority
24 faculty members’, ‘underrepresented minority faculty ad-

1 ministrators’, and ‘underrepresented minorities in health
2 professions’.”.

3 **SEC. 104. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
4 **SHIP PROGRAM.**

5 Subpart 2 of part E of title VII of the Public Health
6 Service Act (42 U.S.C. 295 et seq.) is amended—

7 (1) in section 770, by inserting “(other than
8 section 771)” after “this subpart”;

9 (2) by redesignating section 770 as section 771;
10 and

11 (3) by inserting after section 769 the following:

12 **“SEC. 770. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
13 **SHIP PROGRAM.**

14 “(a) IN GENERAL.—The Secretary may make grants
15 to eligible schools to award scholarships to eligible individ-
16 uals to attend the school involved, for the purpose of ena-
17 bling the individuals to make a career change from a non-
18 health profession to a health profession.

19 “(b) APPLICATION.—To receive a grant under this
20 section, an eligible school shall submit to the Secretary
21 an application at such time, in such manner, and con-
22 taining such information as the Secretary may require.

23 “(c) USE OF FUNDS.—Amounts awarded as a schol-
24 arship under this section may be expended only for tuition
25 expenses, other reasonable educational expenses, and rea-

1 sonable living expenses incurred in the attendance of the
2 school involved.

3 “(d) DEFINITIONS.—In this section:

4 “(1) ELIGIBLE SCHOOL.—The term ‘eligible
5 school’ means an accredited school of medicine, os-
6 teopathic medicine, dentistry, nursing, pharmacy,
7 podiatric medicine, optometry, veterinary medicine,
8 public health, chiropractic, allied health, a school of-
9 fering a graduate program in behavioral and mental
10 health practice, or an entity providing programs for
11 the training of physician assistants.

12 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
13 individual’ means an individual who is an underrep-
14 resented minority who has obtained a secondary
15 school diploma or its recognized equivalent.”.

16 **SEC. 105. CULTURAL COMPETENCY TRAINING.**

17 Part B of title VII of the Public Health Service Act
18 (42 U.S.C. 293 et seq.), as amended by section 104, is
19 amended by adding at the end the following:

20 **“SEC. 743. CULTURAL COMPETENCY TRAINING.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Administrator of the Health Resources and Services
23 Administration and in collaboration with the Office of Mi-
24 nority Health and Agency for Healthcare Research and
25 Quality, shall support the development, evaluation, and

1 dissemination of model curricula for cultural competency
2 training for use in health professions schools and con-
3 tinuing education programs, and other purposes deter-
4 mined appropriate by the Secretary.

5 “(b) CURRICULA.—In carrying out subsection (a),
6 the Secretary shall collaborate with health professional so-
7 cieties, licensing and accreditation entities, health profes-
8 sions schools, and experts in minority health and cultural
9 competency, community-based organizations, and other
10 organizations as determined appropriate by the Secretary.
11 Such curricula shall include a focus on cultural com-
12 petency measures and cultural competency self-assessment
13 methodology for health providers, systems and institu-
14 tions.

15 “(c) DISSEMINATION.—

16 “(1) IN GENERAL.—Such model curricula
17 should be disseminated through the Internet Clear-
18 inghouse under section 270 and other means as de-
19 termined appropriate by the Secretary.

20 “(2) EVALUATION.—The Secretary shall evalu-
21 ate adoption and the implementation of cultural
22 competency training curricula, and facilitate inclu-
23 sion of cultural competency measures in quality
24 measurement systems as appropriate.”.

1 **SEC. 106. AUTHORIZATION OF APPROPRIATIONS; REAU-**
2 **THORIZATIONS.**

3 (a) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated—

5 (1) such sums as may be necessary for each of
6 fiscal years 2008 through 2012, to carry out the
7 amendments made by sections 101 and 102 of this
8 title (adding sections 270 and 793 to the Public
9 Health Service Act);

10 (2) \$45,000,000 for fiscal year 2008 and such
11 sums as may be necessary for each of fiscal years
12 2009 through 2012, to carry out the amendments
13 made by section 103(a) (relating to centers of excel-
14 lence in section 736 of the Public Health Service
15 Act);

16 (3) such sums as may be necessary for each of
17 fiscal years 2008 through 2012, to carry out the
18 amendments made by section 103(b) (adding section
19 742 to the Public Health Service Act);

20 (4) such sums as may be necessary for each of
21 fiscal years 2008 through 2012, to carry out the
22 amendments made by section 104(b) (adding section
23 770 to the Public Health Service Act); and

24 (5) such sums as may be necessary for each of
25 fiscal years 2008 through 2012, to carry out the

1 amendment made by section 105 (adding section
2 743 to the Public Health Service Act).

3 (b) REAUTHORIZATIONS.—The following programs
4 are reauthorized as follows:

5 (1) EDUCATIONAL ASSISTANCE IN THE HEALTH
6 PROFESSIONS REGARDING INDIVIDUALS FROM DIS-
7 ADVANTAGED BACKGROUND.—Section 740(c) of the
8 Public Health Service Act (42 U.S.C. 293a(c)) is
9 amended by striking the first sentence and inserting
10 the following: “For the purpose of grants and con-
11 tracts under section 739(a)(1), there is authorized to
12 be appropriated \$60,000,000 for fiscal year 2008
13 and such sums as may be necessary for each of fis-
14 cal years 2009 through 2012.”.

15 (2) SCHOLARSHIPS FOR DISADVANTAGED STU-
16 DENTS.—Section 740(a) of the Public Health Serv-
17 ice Act (42 U.S.C. 293a(a)) is amended by striking
18 “\$37,000,000” and all that follows through
19 “through 2002” and inserting “\$51,000,000 for fis-
20 cal year 2008, and such sums as may be necessary
21 for each of fiscal years 2009 through 2012”.

22 (3) LOAN REPAYMENTS AND FELLOWSHIPS.—
23 Section 740(b) of the Public Health Service Act (42
24 U.S.C. 293a(b)) is amended by striking
25 “\$1,100,000” and all that follows through “through

1 2002” and inserting “\$1,700,000 for fiscal year
2 2008, and such sums as may be necessary for each
3 of fiscal years 2009 through 2012”.

4 (4) GRANTS FOR HEALTH PROFESSIONS EDU-
5 CATION.—Section 741 of the Public Health Service
6 Act (42 U.S.C. 293e) is amended in subsection (b),
7 by striking “\$3,500,000” and all that follows
8 through the period and inserting “such sums as may
9 be necessary for each of fiscal years 2008 through
10 2012.”.

11 **TITLE II—PROMOTING HEALTH**
12 **AND HEALTHCARE AWARE-**
13 **NESS AND ACCESS**

14 **SEC. 201. CARE AND ACCESS.**

15 Part P of title III of the Public Health Service Act
16 (42 U.S.C. 280g et seq.) is amended by adding at the end
17 the following:

18 **“SEC. 399R. ACCESS, AWARENESS, AND OUTREACH ACTIVI-**
19 **TIES.**

20 “(a) DEMONSTRATION PROJECTS.—The Secretary
21 shall award multiyear contracts or competitive grants to
22 eligible entities to support demonstration projects de-
23 signed to improve the health and healthcare of racial and
24 ethnic minority groups through improved access to
25 healthcare, patient navigators, primary prevention activi-

1 ties, health promotion and disease prevention activities,
2 and health literacy education and services.

3 “(b) ELIGIBILITY.—In this section:

4 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
5 tity’ means an organization or a community-based
6 consortium.

7 “(2) ORGANIZATION.—The term ‘organization’
8 means—

9 “(A) a hospital, health plan, or clinic;

10 “(B) an academic institution;

11 “(C) a State health agency;

12 “(D) an Indian Health Service hospital or
13 clinic, Indian tribal health facility, or urban In-
14 dian facility;

15 “(E) a nonprofit organization, including a
16 faith-based organization or consortium, to the
17 extent that a contract or grant awarded to such
18 an entity is consistent with the requirements of
19 section 1955;

20 “(F) a primary care practice-based re-
21 search network; and

22 “(G) any other similar entity determined
23 to be appropriate by the Secretary.

1 “(3) COMMUNITY-BASED CONSORTIUM.—The
2 term ‘community-based consortium’ means a part-
3 nership that—

4 “(A) includes—

5 “(i) individuals who are representa-
6 tives of organizations of racial and ethnic
7 minority groups;

8 “(ii) community leaders and leaders of
9 community-based organizations;

10 “(iii) healthcare providers, including
11 providers who treat racial and ethnic mi-
12 nority groups; and

13 “(iv) experts in the area of social and
14 behavioral science, who have knowledge,
15 training, or practical experience in health
16 policy, advocacy, cultural or linguistic com-
17 petency, or other relevant areas as deter-
18 mined by the Secretary; and

19 “(B) is located within a federally- or State-
20 designated medically underserved area, a feder-
21 ally designated health provider shortage area,
22 or an area with a significant population of ra-
23 cial and ethnic minorities.

24 “(c) APPLICATION.—An eligible entity seeking a con-
25 tract or grant under this section shall submit an applica-

1 tion to the Secretary at such time, in such manner, and
2 containing such information as the Secretary may require,
3 including assurances that the eligible entity will—

4 “(1) target populations that are members of ra-
5 cial and ethnic minority groups and health disparity
6 populations through specific outreach activities;

7 “(2) collaborate with appropriate community
8 organizations and include meaningful community
9 participation in planning, implementation, and eval-
10 uation of activities;

11 “(3) demonstrate capacity to promote culturally
12 competent and appropriate care for target popu-
13 lations with consideration for health literacy;

14 “(4) develop a plan for long-term sustainability;

15 “(5) evaluate the effectiveness of activities
16 under this section, within an appropriate time
17 frame, which shall include a focus on quality and
18 outcomes performance measures to ensure that the
19 activities are meeting the intended goals, and that
20 the entity is able to disseminate findings from such
21 evaluations;

22 “(6) provide ongoing outreach and education to
23 the health disparity populations served;

24 “(7) demonstrate coordination between public
25 and private entities; and

1 “(8) assist individuals and groups in accessing
2 public and private programs that will help eliminate
3 disparities in health and healthcare.

4 “(d) PRIORITIES.—In awarding contracts and grants
5 under this section, the Secretary shall give priority to ap-
6 plicants that are—

7 “(1) safety net hospitals, defined as hospitals
8 with a low income utilization rate greater than 25
9 percent (as defined in section 1923(b)(3) of the So-
10 cial Security Act (42 U.S.C. 1396r-4(b)(3)));

11 “(2) a federally qualified health center as de-
12 fined in section 1905(l)(2)(B) of the Social Security
13 Act with the ability to establish and lead a collabo-
14 rative partnership;

15 “(3) a community-based consortium as de-
16 scribed in subsection (b)(3)(A)

17 “(4) safety net health plans that are in coordi-
18 nation with local health centers;

19 “(5) an Indian tribe, tribal organization, or
20 urban Indian organization; and

21 “(6) other health systems that—

22 “(A) by legal mandate or explicitly adopted
23 mission, provide patients with access to services
24 regardless of their ability to pay;

1 “(B) provide care or treatment for a sub-
2 stantial number of patients who are uninsured,
3 are receiving assistance under a State program
4 under title XIX of the Social Security Act, or
5 are members of vulnerable populations, as de-
6 termined by the Secretary;

7 “(C) serve a disproportionate percentage of
8 patients from racial and ethnic minority groups;

9 “(D) provide an assurance that amounts
10 received under the grant or contract will be
11 used to implement strategies that address pa-
12 tients’ linguistic needs, where necessary, and re-
13 cruit and maintain diverse staff and leadership;
14 and

15 “(E) provide an assurance that amounts
16 received under the grant or contract will be
17 used to support quality improvement activities
18 for patients from racial and ethnic minority
19 groups.

20 “(e) USE OF FUNDS.—An eligible entity shall use
21 such amounts received under this section for demonstra-
22 tion projects to—

23 “(1) address health disparities in the United
24 States-Mexico Border Area, as defined in section 8
25 of the United States-Mexico Border Health Commis-

1 sion Act (22 U.S.C. 290n–6), relating to health dis-
2 parities in the areas of—

3 “(A) maternal and child health;

4 “(B) primary care and preventive health,
5 including health education and promotion;

6 “(C) public health and the built environ-
7 ment;

8 “(D) oral health;

9 “(E) behavioral and mental health and
10 substance abuse;

11 “(F) health conditions that have a dis-
12 proportionate impact on racial and ethnic mi-
13 norities and a high prevalence in the Border
14 Area;

15 “(G) health services research;

16 “(H) environmental health;

17 “(I) workforce training and development;

18 or

19 “(J) other areas determined appropriate by
20 the Secretary;

21 “(2) implement the best practices in disease
22 management, including those that address primary
23 prevention and co-occurring chronic conditions, as
24 defined by the public-private partnership established
25 under section 918(b), that target patients with low

1 health literacy, and, as feasible, incorporate health
2 information technology;

3 “(3) evaluate methods for strengthening the
4 health coverage and continuity of coverage of migra-
5 tory and seasonal agricultural workers, as such
6 terms are defined in section 330(g), and workers in
7 other industries with traditionally low rates of em-
8 ployer-sponsored health insurance; and

9 “(4) identify, educate, and enroll eligible pa-
10 tients from racial and ethnic minorities and other
11 health disparity populations into clinical trials.

12 “(f) REPORT.—Not later than 3 years after the date
13 an entity receives a contract or grant under this section
14 and annually thereafter, the entity shall provide to the
15 Secretary a report containing the results of any evaluation
16 conducted pursuant to subsection (c)(5).

17 “(g) DISSEMINATION OF FINDINGS.—The Secretary
18 shall, as appropriate, disseminate to public and private en-
19 tities, including Congress, the findings made in evalua-
20 tions described under subsection (f).

21 **“SEC. 399S. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
22 **HAVIORS.**

23 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
24 laboration with the Director of the Centers for Disease
25 Control and Prevention and other Federal officials deter-

1 mined appropriate by the Secretary, may award grants to
2 State or local governments, Indian tribes (including Alas-
3 ka Native villages), tribal organizations, or urban Indian
4 organizations, to promote positive health behaviors for ra-
5 cial and ethnic minority populations, especially in medi-
6 cally underserved communities.

7 “(b) USE OF FUNDS.—Grants awarded under sub-
8 section (a) may be used to provide support to community
9 health workers—

10 “(1) to educate, guide, and provide outreach in
11 a community setting regarding health problems prev-
12 alent among racial and ethnic minority populations,
13 especially in medically underserved communities;

14 “(2) to educate, guide, and provide experiential
15 learning opportunities that target behavioral risk
16 factors including—

17 “(A) poor nutrition;

18 “(B) physical inactivity;

19 “(C) being overweight or obese;

20 “(D) tobacco use;

21 “(E) alcohol and substance use;

22 “(F) injury and violence;

23 “(G) risky sexual behavior;

24 “(H) mental health problems;

25 “(I) poor oral health;

1 “(3) to educate and provide guidance regarding
2 effective strategies to promote positive health behav-
3 iors within the family;

4 “(4) to educate and provide outreach regarding
5 enrollment in health insurance including the State
6 Children’s Health Insurance Program under title
7 XXI of the Social Security Act, Medicare under title
8 XVIII of such Act and Medicaid under title XIX of
9 such Act;

10 “(5) to promote community wellness and aware-
11 ness;

12 “(6) to educate and refer racial and ethnic mi-
13 norities to appropriate healthcare agencies and com-
14 munity-based programs and organizations in order
15 to increase access to quality healthcare services, in-
16 cluding preventive health services; or

17 “(7) to educate, guide, and provide home visita-
18 tion services to improve maternal and child health
19 outcomes.

20 “(c) APPLICATION.—

21 “(1) IN GENERAL.—Each State or local govern-
22 ment, Indian tribe (including Alaska Native vil-
23 lages), tribal organizations, or urban Indian organi-
24 zations that desires to receive a grant under sub-
25 section (a) shall submit an application to the Sec-

1 retary, at such time, in such manner, and accom-
2 panied by such information as the Secretary may re-
3 quire.

4 “(2) CONTENTS.—Each application submitted
5 pursuant to paragraph (1) shall—

6 “(A) describe the activities for which as-
7 sistance is sought under this section;

8 “(B) contain an assurance that, with re-
9 spect to each community health worker pro-
10 gram receiving funds under the grant, such pro-
11 gram will provide training and supervision to
12 community health workers to enable such work-
13 ers to provide authorized program services;

14 “(C) contain an assurance that the appli-
15 cant will evaluate the effectiveness of commu-
16 nity health worker programs receiving funds
17 under the grant;

18 “(D) contain an assurance that each com-
19 munity health worker program receiving funds
20 under the grant will provide services in the cul-
21 tural context most appropriate for the individ-
22 uals served by the program;

23 “(E) contain a plan to document and dis-
24 seminate project descriptions and results to

1 other States and organizations as identified by
2 the Secretary; and

3 “(F) describe plans to enhance the capac-
4 ity of individuals to utilize health services and
5 health-related social services under Federal,
6 State, and local programs by—

7 “(i) assisting individuals in estab-
8 lishing eligibility under the programs and
9 in receiving the services or other benefits
10 of the programs; and

11 “(ii) providing other services as the
12 Secretary determines to be appropriate,
13 that may include transportation and trans-
14 lation services.

15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Secretary shall give priority to applicants
17 that—

18 “(1) propose to target geographic areas—

19 “(A) with a high percentage of residents
20 who are eligible for health insurance but are
21 uninsured or underinsured; and

22 “(B) with a high percentage of families for
23 whom English is not their primary language;

1 “(2) have experience in providing health or
2 health-related social services to individuals who are
3 underserved with respect to such services; and

4 “(3) have documented community activity and
5 experience with community health workers.

6 “(e) COLLABORATION WITH ACADEMIC INSTITU-
7 TIONS.—The Secretary shall encourage community health
8 worker programs receiving funds under this section to col-
9 laborate with academic institutions. Nothing in this sec-
10 tion shall be construed to require such collaboration.

11 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
12 NESS.—The Secretary shall establish guidelines for assur-
13 ing the quality of the training and supervision of commu-
14 nity health workers under the programs funded under this
15 section and for assuring the cost-effectiveness of such pro-
16 grams.

17 “(g) MONITORING.—The Secretary shall monitor
18 community health worker programs identified in approved
19 applications under this section and shall determine wheth-
20 er such programs are in compliance with the guidelines
21 established under subsection (f).

22 “(h) TECHNICAL ASSISTANCE.—The Secretary may
23 provide technical assistance to community health worker
24 programs identified in approved applications under this

1 section with respect to planning, developing, and operating
2 programs under the grant.

3 “(i) REPORT TO CONGRESS.—

4 “(1) IN GENERAL.—Not later than 4 years
5 after the date on which the Secretary first awards
6 grants under subsection (a), the Secretary shall sub-
7 mit to Congress a report regarding the grant
8 project.

9 “(2) CONTENTS.—The report required under
10 paragraph (1) shall include the following:

11 “(A) A description of the programs for
12 which grant funds were used.

13 “(B) The number of individuals served
14 under such programs.

15 “(C) An evaluation of—

16 “(i) the effectiveness of such pro-
17 grams;

18 “(ii) the cost of such programs; and

19 “(iii) the impact of the programs on
20 the health outcomes of the community resi-
21 dents.

22 “(D) Recommendations for sustaining the
23 community health worker programs developed
24 or assisted under this section.

1 “(E) Recommendations regarding training
2 to enhance career opportunities for community
3 health workers.

4 “(j) DEFINITIONS.—In this section:

5 “(1) COMMUNITY HEALTH WORKER.—The term
6 ‘community health worker’ means an individual who
7 promotes health or nutrition within the community
8 in which the individual resides—

9 “(A) by serving as a liaison between com-
10 munities and healthcare agencies;

11 “(B) by providing guidance and social as-
12 sistance to community residents;

13 “(C) by enhancing community residents’
14 ability to effectively communicate with
15 healthcare providers;

16 “(D) by providing culturally and linguis-
17 tically appropriate health or nutrition edu-
18 cation;

19 “(E) by advocating for individual and com-
20 munity health, including oral and mental, and
21 nutrition needs; and

22 “(F) by providing referral and follow-up
23 services.

24 “(2) COMMUNITY SETTING.—The term ‘commu-
25 nity setting’ means a home or a community organi-

6 “(A) that has a substantial number of in-
7 dividuals who are members of a medically un-
8 derserved population, as defined by section
9 330(b)(3); and

“(4) SUPPORT.—The term ‘support’ means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

18 "SEC. 399T. GRANTS FOR RACIAL AND ETHNIC AP-
19 PROACHES TO COMMUNITY HEALTH.

•HR 3333 IH

1 “(b) AUTHORITY TO AWARD GRANTS.—The Sec-
2 retary, acting through the Centers for Disease Control and
3 Prevention, in consultation with the Office of Minority
4 Health, shall award grants to eligible entities to assist in
5 designing, implementing, and evaluating culturally and
6 linguistically appropriate, evidence-based and community-
7 driven sustainable strategies to eliminate racial and ethnic
8 health and healthcare disparities.

9 “(c) ELIGIBLE ENTITIES.—To be eligible to receive
10 a grant under this section, an entity shall—

11 “(1) represent a coalition—

12 “(A) whose principal purpose is to develop
13 and implement interventions to reduce or elimi-
14 nate a health or healthcare disparity in a tar-
15 geted racial or ethnic minority group in the
16 community served by the coalition; and

17 “(B) that includes—

18 “(i) at least 3 members selected from
19 among—

20 “(I) public health departments;

21 “(II) community-based organiza-
22 tions;

23 “(III) university and research or-
24 ganizations;

1 “(IV) Indian tribes, tribal organi-
2 zations, urban Indian organizations,
3 national or regional Indian organiza-
4 tions, or the Indian Health Service;

5 “(V) organizations serving Native
6 Hawaiians;

7 “(VI) organizations serving Pa-
8 cific Islanders; and

9 “(VII) interested public or pri-
10 vate healthcare providers or organiza-
11 tions as deemed appropriate by the
12 Secretary; and

13 “(ii) at least 1 member from a com-
14 munity-based organization that represents
15 the targeted racial or ethnic minority
16 group; and

17 “(2) submit to the Secretary an application at
18 such time, in such manner, and containing such in-
19 formation as the Secretary may require, which shall
20 include—

21 “(A) a description of the targeted racial or
22 ethnic populations in the community to be
23 served under the grant;

24 “(B) a description of at least 1 health dis-
25 parity that exists in the racial or ethnic tar-

1 geted populations, including infant mortality,
2 breast and cervical cancer screening and man-
3 agement, cardiovascular disease, diabetes, child
4 and adult immunization levels, HIV/AIDS, hep-
5 atitis B, tuberculosis, asthma, or other health
6 priority areas as designated by the Secretary;
7 and

8 “(C) a demonstration of a proven record of
9 accomplishment of the coalition members in
10 serving and working with the targeted commu-
11 nity.

12 “(d) SUSTAINABILITY.—The Secretary shall give pri-
13 ority to an eligible entity under this section if the entity
14 agrees that, with respect to the costs to be incurred by
15 the entity in carrying out the activities for which the grant
16 was awarded, the entity (and each of the participating
17 partners in the coalition represented by the entity) will
18 maintain its expenditures of non-Federal funds for such
19 activities at a level that is not less than the level of such
20 expenditures during the fiscal year immediately preceding
21 the first fiscal year for which the grant is awarded.

22 “(e) NONDUPLICATION.—Funds provided through
23 this grant program should supplement, not supplant, ex-
24 isting Federal funding, and the funds should not be used

1 to duplicate the activities of the other health disparity
2 grant programs in this Act.

3 “(f) TECHNICAL ASSISTANCE.—The Secretary may,
4 either directly or by grant or contract, provide any entity
5 that receives a grant under this section with technical and
6 other non-financial assistance necessary to meet the re-
7 quirements of this section.

8 “(g) DISSEMINATION.—The Secretary shall encour-
9 age and enable grantees to share best practices, evaluation
10 results, and reports using the Internet, conferences, and
11 other pertinent information regarding the projects funded
12 by this section, including the outreach efforts of the Office
13 of Minority Health and the Centers for Disease Control
14 and Prevention. Such information shall be publicly avail-
15 able, and posted on the Internet website of relevant gov-
16 ernment agencies.

17 “(h) ADMINISTRATIVE BURDENS.—The Secretary
18 shall make every effort to minimize duplicative or unneces-
19 sary administrative burdens on grantees.

20 **“SEC. 399U. GRANTS FOR HEALTH DISPARITY**
21 **COLLABORATIVES.**

22 “(a) PURPOSE.—The Secretary, acting through the
23 Administrator of the Health Resources and Services Ad-
24 ministration, shall award grants to eligible entities to as-
25 sist in implementing systems of primary care practices to

1 eliminate disparities in the delivery of healthcare and im-
2 prove the healthcare provided to all patients.

3 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
4 a grant under this section, an entity shall—

5 “(1) be a federally qualified health center as de-
6 fined in section 1861(aa)(4) or 1905(l)(2)(B) of the
7 Social Security Act with the ability to establish and
8 lead a collaborative partnership; and

9 “(2) submit to the Secretary an application, at
10 such time, in such manner, and containing such in-
11 formation as the Secretary may require, which shall
12 include plans to implement collaboratives in one or
13 more of the following areas:

14 “(A) Diabetes.

15 “(B) Asthma.

16 “(C) Depression.

17 “(D) Cardiovascular disease.

18 “(E) Cancer.

19 “(F) Preventive health, including
20 screenings.

21 “(G) Perinatal health.

22 “(H) Patient safety.

23 “(I) Oral health.

24 “(J) Finance and redesign of health cen-
25 ters to implement planned care.

1 “(K) Other areas as designated by the Sec-
2 retary.

3 “(c) NONDUPLICATION.—Funds provided through
4 this grant program should supplement, not supplant, ex-
5 isting Federal funding, and the funds should not be used
6 to duplicate the activities of the other health disparity
7 grant programs in this Act.

8 “(d) TECHNICAL ASSISTANCE.—The Secretary may,
9 either directly or by grant or contract, provide any entity
10 that receives a grant under this section with technical and
11 other non-financial assistance necessary to meet the re-
12 quirements of this section.

13 “(e) ADMINISTRATIVE BURDENS.—The Secretary
14 shall make every effort to minimize duplicative or unneces-
15 sary administrative burdens on grantees.

16 **“SEC. 399V. HEALTH ACTION ZONES.**

17 “(a) PURPOSE.—The Secretary shall establish the
18 Health Action Zone Initiative demonstration program to
19 support comprehensive State, tribal, or local initiatives to
20 improve the health of racial and ethnic minority groups.

21 “(b) HEALTH ACTION ZONE INITIATIVE PRO-
22 GRAM.—

23 “(1) IN GENERAL.—The Secretary shall award
24 Health Action Zone Initiative Program grants to
25 State and local public health agencies and Indian

1 tribes and tribal organizations of eligible commu-
2 nities. Each grant shall be funded for 5 years.

3 “(2) ELIGIBLE COMMUNITIES.—

4 “(A) IDENTIFICATION.—The Secretary
5 shall develop, after opportunity for public re-
6 view and comment, and implement a metric for
7 identifying and notifying eligible communities
8 pursuant to subparagraph (B), and report such
9 findings to Congress and the public.

10 “(B) ELIGIBILITY.—Eligible communities
11 shall be communities that are most at risk, or
12 at greatest disproportionate risk, for adverse
13 health outcomes, as measured by—

14 “(i) overall burden of disease and
15 health conditions;

16 “(ii) accessibility to and availability of
17 health and economic resources;

18 “(iii) proportion of individuals from
19 racial and ethnic minority groups; and

20 “(iv) other factors as determined ap-
21 propriate by the Secretary.

22 “(3) AGENCY COLLABORATION.—The Secretary,
23 in collaboration with the Deputy Assistant Secretary
24 for Minority Health, the Director of the Centers for
25 Disease Control and Prevention, the Administrator

1 of the Health Resources and Services Administra-
2 tion, the Director of the Indian Health Service, the
3 Director of the Centers for Medicare & Medicaid
4 Services, the Director of the Substance Abuse and
5 Mental Health Services Administration, and heads
6 of other Federal agencies as appropriate, shall deter-
7 mine, with respect to the Health Action Zone Initia-
8 tive Program—

9 “(A) core goals, objectives and reasonable
10 time lines for implementing, evaluating and sus-
11 taining comprehensive and effective health and
12 healthcare improvement activities in eligible
13 communities;

14 “(B) current programmatic and research
15 initiatives in which eligible communities may
16 participate;

17 “(C) existing agency resources that can be
18 targeted to eligible communities; and

19 “(D) mechanisms to facilitate joint appli-
20 cation, or establish a common application, to
21 multiple grant programs, as appropriate.

22 “(4) APPLICATIONS.—

23 “(A) IN GENERAL.—The State and local
24 public health agencies of eligible communities
25 shall jointly submit an application to the Sec-

1 retary at such time, in such manner, and ac-
2 companyed by such information as the Secretary
3 may require, including a strategic plan that
4 shall—

5 “(i) describe the proposed activities
6 pursuant to paragraph (5);

7 “(ii) report the extent to which local
8 institutions and organizations and commu-
9 nity residents have participated in the stra-
10 tegic plan development;

11 “(iii) identify established public-pri-
12 vate partnerships, and State, local, and
13 private resources that will be available;

14 “(iv) identify Federal funding needed
15 to support the proposed activities; and

16 “(v) report the baselines, methods,
17 and benchmarks for measuring the success
18 of activities proposed in the strategic plan.

19 “(B) COMMUNITY ADVISORY BOARD.—

20 “(i) IN GENERAL.—In order to receive
21 a Health Action Zone Initiative Program
22 grant under this section, an eligible com-
23 munity shall have a community advisory
24 board.

25 “(ii) MEMBERS.—

1 “(I) COMMUNITY.—The majority
2 of the members of a community advi-
3 sory board under clause (i) shall be
4 individuals that will benefit from the
5 activities or services provided by the
6 grants under this section.

7 “(II) REPRESENTATIVES.—A
8 community advisory board shall in-
9 clude representatives from the State
10 health department and county or local
11 health department, community-based
12 organizations, environmental and pub-
13 lic health experts, healthcare profes-
14 sionals and providers, nonprofit lead-
15 ers, community organizers, elected of-
16 ficials, private payers, employers, and
17 consumers.

18 “(iii) DUTIES.—A community advi-
19 sory board shall—

20 “(I) oversee the functions and
21 operations of Health Action Zone Ini-
22 tiative Program grant activities;

23 “(II) assist in the evaluation of
24 such activities; and

1 “(III) prepare an annual report
2 that describes the progress made to-
3 wards achieving stated goals and rec-
4 ommends time lines and future
5 courses of action.

6 “(5) USE OF FUNDS.—An eligible community
7 that receives a grant under this section shall use the
8 funding to support activities to achieve stated core
9 goals and objectives, pursuant to paragraph (3),
10 which may include initiatives that—

11 “(A) promote disease prevention and
12 health promotion for racial and ethnic minority
13 groups;

14 “(B) facilitate partnerships between
15 healthcare providers, public and health agen-
16 cies, academic institutions, community based or
17 advocacy organizations, elected officials, profes-
18 sional societies, and other stakeholder groups;

19 “(C) enhance the local capacity for health
20 data collection and reporting in a manner that
21 can be aggregated and disaggregated to en-
22 hance understanding of the racial and ethnic di-
23 versity of the Health Action Zone;

24 “(D) coordinate and integrate community-
25 based activities including education, city plan-

1 ning, transportation initiatives, environmental
2 changes, and other related activities at the local
3 level that help improve public health and ad-
4 dress health concerns;

5 “(E) mobilize financial and other resources
6 from the public and private sector to increase
7 local capacity to address health issues;

8 “(F) support the training of staff in com-
9 munication and outreach to the general public,
10 particularly those at disproportionate risk for
11 health and healthcare disparities;

12 “(G) assist eligible communities in meeting
13 Healthy People 2010 objectives; and

14 “(H) aid eligible communities in providing
15 employment, and cultural and recreational re-
16 sources that enable healthy lifestyles.

17 “(6) EVALUATION.—The Secretary, directly or
18 through contract, shall conduct and report an eval-
19 uation of the Health Action Zone Initiative Program
20 that shall be available to the public.

21 “(7) SUPPLEMENT NOT SUPPLANT.—Grant
22 funds received under this section shall be used to
23 supplement, and not supplant, funding that would
24 otherwise be used for activities described under this
25 section.

1 “(c) PUERTO RICO.—For purposes of this section,
2 the term ‘State’ includes Puerto Rico.

3 **“SEC. 399W. OUTREACH.**

4 “(a) IN GENERAL.—The Secretary, in collaboration
5 with the Office for Minority Health, the Centers for Medi-
6 care and Medicaid Services, the Indian Health Service,
7 and the Health Resources and Services Administration,
8 shall establish a grant program to improve outreach, par-
9 ticipation, and enrollment by eligible entities with respect
10 to available healthcare programs.

11 “(b) ELIGIBILITY.—In this section, the term ‘eligible
12 entity’ means any of the following:

13 “(1) A State or local government.

14 “(2) A Federal health safety net organization.

15 “(3) A national, local, or community-based pub-
16 lic or nonprofit private organization.

17 “(4) A faith-based organization or consortia, to
18 the extent that a grant awarded to such an entity
19 is consistent with the requirements of section 1955
20 relating to a grant award to non-governmental enti-
21 ties.

22 “(5) An elementary or secondary school.

23 “(c) DEFINITION.—In this section:

1 “(1) FEDERAL HEALTH SAFETY NET ORGANI-
2 ZATION.—The term ‘Federal health safety net orga-
3 nization’ means—

4 “(A) a health program operated by the In-
5 dian Health Service, an Indian tribe, tribal or-
6 ganization or urban Indian organization (as
7 those terms are defined in section 4 of the In-
8 dian Health Care Improvement Act (25 U.S.C.
9 1603);

10 “(B) a federally qualified health center, as
11 defined in section 1905(l)(2)(B) of the Social
12 Security Act, with the ability to establish and
13 lead a collaborative partnership;

14 “(C) a safety net hospital, defined as a
15 hospital with a low income utilization rate
16 greater than 25 percent (as defined in section
17 1923(b)(3) of the Social Security Act (42
18 U.S.C. 1396r–4(b)(3)));

19 “(D) a covered entity described in section
20 340B(a)(4);

21 “(E) a safety net health plan defined as a
22 managed care organization that—

23 “(i) is exempt from or not subject to
24 Federal income tax, or is owned by an en-

1 tity or entities exempt from or not subject
2 to Federal income tax; and

3 “(ii) enrolls not less than 75 percent
4 of its members in a plan or program fund-
5 ed in whole or in part under a Federal,
6 State, or local healthcare program (other
7 than a program for government employ-
8 ees); and

9 “(F) any other entity or a consortium that
10 serves children under a federally funded pro-
11 gram, including the special supplemental nutri-
12 tion program for women, infants, and children
13 (WIC) established under section 17 of the Child
14 Nutrition Act of 1966 (42 U.S.C. 1786), the
15 head start and early head start programs under
16 the Head Start Act (42 U.S.C. 9831 et seq.),
17 the school lunch program established under the
18 Richard B. Russell National School Lunch Act
19 (42 U.S.C. 1751 et seq.), and an elementary or
20 secondary school.

21 “(2) INDIANS; INDIAN TRIBE; TRIBAL ORGANI-
22 ZATION; URBAN INDIAN ORGANIZATION.—The terms
23 ‘Indian’, ‘Indian tribe’, ‘tribal organization’, and
24 ‘urban Indian organization’ have the meanings given

1 such terms in section 4 of the Indian Health Care
2 Improvement Act (25 U.S.C. 1603).

3 “(d) PRIORITY FOR AWARD OF GRANTS.—

4 “(1) IN GENERAL.—In making grants under
5 subsection (a), the Secretary shall give priority to—

6 “(A) eligible entities that propose to target
7 geographic areas with high rates of—

8 “(i) eligible but unenrolled children,
9 including such children who reside in rural
10 areas; or

11 “(ii) racial and ethnic minorities and
12 health disparity populations, including
13 those proposals that address cultural and
14 linguistic barriers to enrollment; and

15 “(B) eligible entities that plan to engage in
16 outreach efforts with respect to individuals de-
17 scribed in subparagraph (A) and that are—

18 “(i) safety net hospitals, defined as
19 hospitals with a low income utilization rate
20 greater than 25 percent (as defined in sec-
21 tion 1923(b)(3) of the Social Security Act
22 (42 U.S.C.1396r-4(b)(3)));

23 “(ii) federally qualified health centers
24 as defined in section 1905(1)(2)(B) of the
25 Social Security Act with the ability to es-

1 tablish and lead a collaborative partner-
2 ship;

3 “(iii) community-based consortiums as
4 described in section 399R(b)(3)(A) and
5 (4);

6 “(iv) safety net health plans that are
7 in coordination with local health centers;

8 “(v) Indian tribes, tribal organiza-
9 tions, or urban Indian organizations;

10 “(vi) other health systems that as de-
11 scribed in section 399R(d)(5); or

12 “(vii) faith-based organizations or
13 consortia.

14 “(2) TEN PERCENT SET ASIDE FOR OUTREACH
15 TO INDIAN CHILDREN.—An amount equal to 10 per-
16 cent of the funds appropriated under section 202(3)
17 of the Minority Health Improvement and Health
18 Disparity Elimination Act to carry out this section
19 for a fiscal year shall be used by the Secretary to
20 award grants to health programs operated by the In-
21 dian Health Service, an Indian tribe, tribal organiza-
22 tion, or urban Indian organization (as those terms
23 are defined in section 4 of the Indian Health Care
24 Improvement Act (25 U.S.C. 1603)) for outreach to,
25 and enrollment of, children who are Indians.

1 **“SEC. 399X. DELTA HEALTH INITIATIVE.**

2 “(a) IN GENERAL.—The Secretary shall award a
3 grant to fund the Delta Health Initiative Rural Health,
4 Education, and Workforce Infrastructure Demonstration
5 Program for the purpose of addressing longstanding,
6 unmet health needs in the Mississippi Delta, including
7 health education, access and research, and job training.

8 “(b) ELIGIBILITY.—To be eligible to receive a grant
9 under this section, an entity shall—

10 “(1) include a nonprofit alliance of not less
11 than 4 academic institutions that have a history of
12 collaboration, along with their State Hospital Asso-
13 ciation and 2 community-based organizations;

14 “(2) solicit and fund proposals from local gov-
15 ernments, hospitals, healthcare clinics, academic in-
16 stitutions, and rural public health-related entities
17 and organizations for research development, edu-
18 cational programs, healthcare services, job training,
19 planning, construction, and the equipment of public
20 health-related facilities;

21 “(3) have experience working with federally
22 qualified health centers and local health depart-
23 ments; and

24 “(4) have experience in diabetes education and
25 management, promoting healthy communities, health
26 education, and wellness.

1 “(c) DEFINITION.—In this section, the term ‘alliance’
2 means an entity composed of—

3 “(1) an academic health and research center.

4 “(2) at least 2 regional universities.

5 “(3) a school of nursing; and

6 “(4) a strong economic development entity, as
7 determined by the Secretary.

8 “(d) FEDERAL INTEREST IN PROPERTY.—With re-
9 spect to funds used under this subsection for construction
10 or alteration of property, the Federal interest in the prop-
11 erty shall last for a period of 1 year following completion
12 or until the Federal Government is compensated for its
13 proportionate interest in the property use changes or the
14 property is transferred or sold, whichever time period is
15 less. At the conclusion of such period, the notice of Fed-
16 eral interest in such property shall be removed.”.

17 **SEC. 202. AUTHORIZATION OF APPROPRIATIONS.**

18 There are authorized to be appropriated—

19 (1) such sums as may be necessary for each of
20 fiscal years 2008 through 2012, to carry out section
21 399R of the Public Health Service Act (as added by
22 section 201);

23 (2) \$52,000,000 for fiscal year 2008, and such
24 sums as may be necessary for each of fiscal years
25 2009 through 2012, to carry out section 399T of the

1 Public Health Service Act (as added by section 201);
 2 and

3 (3) such sums as necessary for each of fiscal
 4 years 2008 through 2012, to carry out sections
 5 399S, 399U, 399V, 399W, and 399X of the Public
 6 Health Service Act (as added by section 201).

7 **TITLE III—RESEARCH TO RE-**
 8 **DUCE AND ELIMINATE**
 9 **HEALTH DISPARITIES**

10 **SEC. 301. AGENCY FOR HEALTHCARE RESEARCH AND**
 11 **QUALITY.**

12 (a) IN GENERAL.—Part B of title IX of the Public
 13 Health Service Act (42 U.S.C. 299b et seq.) is amended
 14 by adding at the end the following:

15 **“SEC. 918. ENHANCED RESEARCH WITH RESPECT TO**
 16 **HEALTHCARE DISPARITIES.**

17 **“(a) ACCELERATING THE ELIMINATION OF DISPARI-**
 18 **TIES.—**

19 **“(1) STRATEGIC PLAN.—**The Secretary, acting
 20 through the Director, and in collaboration with the
 21 Deputy Assistant Secretary for Minority Health,
 22 shall develop a strategic plan regarding research
 23 supported by the agency to improve healthcare and
 24 eliminate healthcare disparities among racial and

1 ethnic minority groups. In developing such plan, the
2 Secretary shall—

3 “(A) determine which areas of research
4 focus would have the greatest impact on
5 healthcare improvement and elimination of dis-
6 parities, taking into consideration the overall
7 health status of various populations, dispropor-
8 tionate burden of diseases or health conditions,
9 and types of interventions for which data on ef-
10 fectiveness is limited;

11 “(B) establish measurable goals and objec-
12 tives which will allow assessment of progress;

13 “(C) solicit public review and comment
14 from experts in healthcare, minority health and
15 health disparities, health services research, and
16 other areas as determined appropriate by the
17 Secretary;

18 “(D) incorporate recommendations from
19 the Institute of Medicine, pursuant to section
20 303 of the Minority Health Improvement and
21 Health Disparity Elimination Act, as appro-
22 priate;

23 “(E) complete such plan within 12 months
24 of enactment of the Minority Health Improve-

ment and Health Disparity Elimination Act;
and

“(F) update such plan and report on progress in meeting established goals and objectives incorporating recommendations from the Institute of Medicine as described in section 303(b) and (c) of the Minority Health Improvement and Health Disparity Elimination Act not less than every 2 years and include in annual performance budget submissions, an update of progress in meeting plan goals and objectives;

“(G) ensure coordination and integration with the National Plan to Improve Minority Health and Eliminate Health Disparities, as described in section 1707(c) and other Department-wide initiatives, as feasible; and

“(H) report the plan to the Congress and make available to the public in print and electronic format.

“(2) ESTABLISHMENT OF GRANTS.—The Secretary, acting through the Director, and in collaboration with the Deputy Assistant Secretary for Minority Health, may award grants or contracts to eligible entities for research to improve the health of racial and ethnic minority groups.

1 “(3) APPLICATION; ELIGIBLE ENTITIES.—

2 “(A) APPLICATION.—To receive a grant or
3 contract under this section, an eligible entity
4 shall submit to the Secretary an application at
5 such time, in such manner, and containing such
6 information as the Secretary may require.

7 “(B) ELIGIBLE ENTITIES.—To be eligible
8 to receive a grant or contract under this sec-
9 tion, an entity shall be a health center, hospital,
10 health system, community clinic, university,
11 community-based organization, or other health
12 entity determined appropriate by the Secretary,
13 that—

14 “(i) by legal mandate or explicitly
15 adopted mission, provides patients with ac-
16 cess to services regardless of their ability
17 to pay;

18 “(ii) provides care or treatment for a
19 substantial number of patients who are un-
20 insured, are receiving assistance under a
21 State program under title XIX of the So-
22 cial Security Act, or are members of vul-
23 nerable populations, as determined by the
24 Secretary;

1 “(iii) serves a disproportionate per-
2 centage of patients from racial and ethnic
3 minority groups;

4 “(iv) provides an assurance that
5 amounts received under the grant or con-
6 tract will be used to implement strategies
7 that address patients’ linguistic needs,
8 where necessary, and recruit and maintain
9 diverse staff and leadership; and

10 “(v) include a focus on community-
11 based participation in research and dem-
12 onstrations, as well as research analysis,
13 interpretation, solutions and partnerships
14 for patients from racial and ethnic minor-
15 ity groups.

16 “(C) PREFERENCE.—Consortia of 3 or
17 more eligible entities, particularly those entities
18 that partner with health plans, shall be given a
19 preference for grant or contract funding.

20 “(4) RESEARCH.—The research funded under
21 paragraph (2), with respect to racial and ethnic mi-
22 nority groups, shall—

23 “(A) prioritize the translation of existing
24 research into practical interventions for improv-

1 ing health and healthcare and reducing dispari-
2 ties;

3 “(B) target areas of need as identified in
4 the strategic plan pursuant to subsection (a)(1),
5 the National Healthcare Disparities Report
6 published by the Agency for Healthcare Re-
7 search and Quality, the Unequal Treatment:
8 Confronting Racial and Ethnic Disparities in
9 Health Care Report, and other relevant reports
10 by the Institute of Medicine, and other reports
11 issued by Federal health agencies;

12 “(C) include a focus on community-based
13 participatory research solutions and partner-
14 ships as appropriate;

15 “(D) expand practice-based research net-
16 works (primary care and larger delivery sys-
17 tems) to include networks of delivery sites serv-
18 ing large numbers of minority and health dis-
19 parity populations including—

20 “(i) public hospitals and private non-
21 profit hospitals;

22 “(ii) health centers;

23 “(iii) health plans;

24 “(iv) an Indian tribe, tribal organiza-
25 tion, or urban Indian organization; and

1 “(v) other sites as determined appro-
2 priate by the Director.

3 “(5) DISSEMINATION OF RESEARCH FIND-
4 INGS.—To ensure that findings from the research
5 described in paragraph (4) are disseminated and ap-
6 plied promptly, the Director shall—

7 “(A) develop outreach and training pro-
8 grams for healthcare providers with respect to
9 the practical and effective interventions that re-
10 sult from research programs carried out with
11 grants or contracts awarded under this section;
12 and

13 “(B) provide technical assistance for the
14 implementation of evidence-based practices that
15 will improve health and healthcare and reduce
16 disparities.

17 “(b) REALIZING THE POTENTIAL OF DISEASE MAN-
18 AGEMENT.—

19 “(1) PUBLIC-PRIVATE SECTOR PARTNERSHIP
20 TO ASSESS EFFECTIVENESS OF EXISTING DISEASE
21 MANAGEMENT STRATEGIES.—

22 “(A) IN GENERAL.—The Secretary shall
23 establish a public-private partnership to iden-
24 tify, evaluate, and disseminate effective disease
25 management strategies, tailored to improve

1 healthcare and health outcomes for patients
2 from racial and ethnic minority groups. Such
3 strategies shall reflect established healthcare
4 quality standards and benchmarks and other
5 evidence-based recommendations.

6 “(B) PARTNERSHIP COMPOSITION.—The
7 partnership’s members shall include the fol-
8 lowing:

9 “(i) Representatives from the fol-
10 lowing:

11 “(I) The Office of Minority
12 Health.

13 “(II) The Centers for Disease
14 Control and Prevention.

15 “(III) The Agency for Healthcare
16 Research and Quality.

17 “(IV) The Centers for Medicare
18 and Medicaid Services.

19 “(V) The Health Resources and
20 Services Administration.

21 “(VI) The Indian Health Service.

22 “(VII) The Substance Abuse and
23 Mental Health Services Administra-
24 tion.

1 “(VIII) The Office of Behavioral
2 Health.

3 “(IX) Other agencies as des-
4 ignated by the Secretary.

5 “(ii) Representatives of health plans,
6 employers, or other private entities that
7 have implemented disease management
8 programs.

9 “(iii) Representatives of hospitals;
10 community health centers; large, small, or
11 solo provider groups; or other organiza-
12 tions that provide healthcare and have im-
13 plemented disease management programs.

14 “(iv) Representatives of national mi-
15 nority advocacy organizations, as well as
16 community-based representatives who have
17 been involved with establishing, imple-
18 menting, or evaluating health promotion,
19 disease prevention and disease manage-
20 ment programs.

21 “(v) Other individuals as designated
22 by the Secretary.

23 “(C) PARTNERSHIP DUTIES.—

24 “(i) IN GENERAL.—Not later than 18
25 months after the date of enactment of the

1 Minority Health Improvement and Health
2 Disparity Elimination Act, the partnership
3 shall release a best practices report with
4 respect to disease management practices,
5 with a particular focus on the following:

6 “(I) Self-management training.

7 “(II) Increasing patient partici-
8 pation in and satisfaction with
9 healthcare encounters.

10 “(III) Helping patients use qual-
11 ity performance and cost information
12 to choose appropriate healthcare pro-
13 viders for their care.

14 “(IV) Interventions outside of a
15 traditional healthcare environment, in-
16 cluding the workplace, school, commu-
17 nity, or home.

18 “(V) Interventions utilizing com-
19 munity health workers and case man-
20 agers.

21 “(VI) Interventions that imple-
22 ment integrated disease management
23 and treatment strategies to address
24 multiple chronic co-occurring condi-
25 tions.

1 “(VII) Other interventions as
2 identified by the Secretary.

3 “(2) REPORT.—

4 “(A) IN GENERAL.—Not later than Sep-
5 tember 30, 2010, the partnership shall submit
6 to the Secretary and the relevant committees of
7 Congress a report that describes the extent to
8 which the activities and research funded under
9 this section have been successful in reducing
10 and eliminating disparities in health and
11 healthcare in targeted populations.

12 “(B) AVAILABILITY.—The Secretary shall
13 ensure that the report is made available on the
14 Internet websites of the Office of Minority
15 Health, the Agency for Healthcare Research
16 and Quality, and other agencies as appro-
17 priate.”.

18 (b) ANNUAL REPORTS.—The Secretary, acting
19 through the Director of the Agency for Healthcare Re-
20 search and Quality, shall continue to carry out the report-
21 ing requirements of sections 903(a)(6) and 913(b)(2) of
22 the Public Health Service Act.

23 **SEC. 302. GENETIC VARIATION AND HEALTH.**

24 (a) IN GENERAL.—The Secretary shall ensure that
25 any current, proposed, or future research and pro-

1 grammatic activities regarding genomics include focus on
2 genetic variation within and between populations, with a
3 focus on racial and ethnic minority populations, that may
4 affect risk of disease or response to drug therapy and
5 other treatments, in order to ensure that all populations
6 are able to derive full benefit from genomic tests and
7 treatments that may improve their health and healthcare.
8 The Secretary shall encourage, with respect to racial and
9 ethnic minority populations, efforts to—

10 (1) increase awareness, access, availability, and
11 utilization of genomic tests and treatments;

12 (2) determine and monitor appropriateness of
13 use of genomic tests and treatments;

14 (3) increase awareness of the importance of
15 knowing one's family history and the relationships
16 between genes, the social and physical environment,
17 and health; and

18 (4) expand genomics research that would help
19 to—

20 (A) improve tests to facilitate earlier and
21 more accurate diagnoses;

22 (B) enhance the safety of drugs, particu-
23 larly for drugs that pose an elevated risk for
24 adverse drug events in such populations;

1 (C) increase the effectiveness of drugs,
2 particularly for diseases and conditions that dis-
3 proportionately affect such populations; and

4 (D) augment the current understanding of
5 the interactions between genomic, social and
6 physical environmental factors, and their influ-
7 ence on the causality, prevention, control, and
8 treatment of diseases common in such popu-
9 lations.

10 (b) GENETIC VARIATION, ENVIRONMENT, AND
11 HEALTH SUMMIT.—

12 (1) SUMMIT.—Not later than 1 year after the
13 date of enactment of this Act, the Director of the
14 National Human Genome Research Institute, in col-
15 laboration with the Director of the Office of
16 Genomics and Disease Prevention at the Centers for
17 Disease Control and Prevention, the Director of the
18 Office of Behavioral and Social Science Research at
19 the National Institutes of Health, and the Deputy
20 Assistant Secretary of the Office of Minority Health,
21 shall convene a Summit for the purpose of providing
22 leadership and guidance to Secretary, Congress, and
23 other public and private entities on current and fu-
24 ture areas of focus for genomics research, including
25 translation of findings from such research, relating

1 to improving the health of racial and ethnic minority
2 populations and reducing health disparities.

3 (2) PARTICIPATION.—The Summit shall in-
4 clude—

5 (A) representatives from the Federal
6 health agencies, including the National Insti-
7 tutes of Health, the Centers for Disease Control
8 and Prevention, the Office of Minority Health,
9 the Food and Drug Administration, the Health
10 Resources and Services Administration, the
11 Centers for Medicare & Medicaid Services, the
12 Substance Abuse and Mental Health Services
13 Administration, and additional agencies and de-
14 partments as determined appropriate by the
15 Secretary;

16 (B) independent experts and stakeholders
17 from relevant industry and academic institu-
18 tions, particularly those that have demonstrated
19 expertise in both genomics and minority health
20 and serve a disproportionate number of racial
21 and ethnic minority patients; and

22 (C) leaders of community organizations
23 and Indian tribal epidemiology centers that
24 work to reduce and eliminate health disparities.

1 (3) REPORT.—Not later than 90 days after the
2 conclusion of the Summit, the Director of the Na-
3 tional Human Genome Research Institute shall sub-
4 mit to Congress and make available to the public a
5 report detailing recommendations on—

6 (A) an appropriate description of human
7 diversity, incorporating available information on
8 genetics, for use in genomic research and pro-
9 grams operated or supported by the Federal
10 Government;

11 (B) guiding ethics, principles, and proto-
12 cols for the inclusion and designation of racial
13 and ethnic minority populations in genomics re-
14 search, particularly clinical trials programs op-
15 erated or supported by the Federal Govern-
16 ment;

17 (C) ways to increase awareness of, access
18 to, and utilization of effective pharmacogenomic
19 and other genetic screening and services for ra-
20 cial and ethnic minority populations;

21 (D) research opportunities and funding
22 support in the area of genomic variation that
23 may improve the health and healthcare of mi-
24 nority populations;

1 (E) ways to enhance integration of Federal
2 Government-wide efforts and activities per-
3 taining to genetic variation, environment, and
4 health; and

5 (F) need for additional privacy protections
6 in preventing stigmatization and inappropriate
7 use of genetic information.

8 (c) PHARMACOGENOMICS AND EMERGING ISSUES
9 ADVISORY COMMITTEE.—

10 (1) IN GENERAL.—The Secretary, under section
11 222 of the Public Health Service Act (42 U.S.C.
12 217a), shall convene and consult an advisory com-
13 mittee on issues relating to pharmacogenomics (re-
14 ferred to in this subsection as the “Advisory Com-
15 mittee”).

16 (2) DUTIES.—

17 (A) IN GENERAL.—The Advisory Com-
18 mittee shall advise and make recommendations
19 to the Secretary, through the Commissioner of
20 Food and Drugs and in consultation with the
21 Director of the National Institutes of Health,
22 on the evolving science of pharmacogenomics
23 and inter-individual variability in drug re-
24 sponse, as it relates to the health of racial and
25 ethnic minorities.

1 (B) MATTERS CONSIDERED.—The rec-
2 ommendations under subparagraph (A) shall in-
3 clude recommendations on—

4 (i) the ethics, design, and analysis of
5 clinical trials involving racial and ethnic
6 minorities conducted under section 351,
7 409I, or 499 of the Public Health Service
8 Act or section 505(i), 505A, 505B, or
9 515(g) of the Federal Food, Drug, and
10 Cosmetic Act;

11 (ii) general policy and guidance with
12 respect to the development, approval or
13 clearance, and labeling of medical products
14 for racial and ethnic minorities;

15 (iii) the role of pharmacogenomics
16 during the development of drugs, biological
17 products, and diagnostics;

18 (iv) the understanding of inter-indi-
19 vidual variability in drug response;

20 (v) diagnostics or treatments for dis-
21 eases or conditions common in racial and
22 ethnic minorities; and

23 (vi) the identification of other areas of
24 unmet medical need.

1 (3) COMPOSITION.—The Advisory Committee
2 shall include—

3 (A) experts in the fields of—

4 (i) minority health and health dispari-
5 ties;

6 (ii) genomics;

7 (iii) pharmaceutical and diagnostic re-
8 search and development;

9 (iv) ethical, legal, and social issues re-
10 lating to clinical trials; and

11 (v) bioinformatics and information
12 technology;

13 (B) representatives from minority health
14 organizations and relevant patient organiza-
15 tions; and

16 (C) other experts as deemed appropriate
17 by the Secretary.

18 (4) COORDINATION WITH OTHER ADVISORY
19 COMMITTEES.—The Advisory Committee may con-
20 sult and coordinate with other advisory committees
21 of the Department of Health and Human Services
22 as determined appropriate by the Secretary.

23 (5) RECOMMENDATIONS.—The Advisory Com-
24 mittee shall submit recommendations to the Sec-
25 retary with respect to each of the matters described

1 under paragraph (2)(B) prior to the development of
2 the report by the Secretary as described under para-
3 graph (6).

4 (6) REPORT.—Not later than 180 days after
5 the date of enactment of this Act, the Secretary—

6 (A) shall, acting through the Commissioner
7 of Food and Drugs and in consultation with the
8 Director of the National Institutes of Health,
9 and taking into consideration the recommenda-
10 tions of the Advisory Committee submitted
11 under paragraph (5), submit to the Committee
12 on Health, Education, Labor, and Pensions of
13 the Senate and the Committee on Energy and
14 Commerce of the House of Representatives, a
15 report on the evolving science of
16 pharmacogenomics as it relates to racial and
17 ethnic minorities, including a review of the
18 guidance of the Food and Drug Administration
19 on the participation of racial and ethnic minori-
20 ties in clinical trials; and

21 (B) shall ensure that such report is made
22 publicly available in both paper and electronic
23 formats.

24 **SEC. 303. EVALUATIONS BY THE INSTITUTE OF MEDICINE.**

25 (a) HEALTH DISPARITIES SUMMIT.—

1 (1) IN GENERAL.—Not later than 270 days
2 after the date of enactment of this Act, the Institute
3 of Medicine shall convene a summit on health dis-
4 parities (referred to this section as the “Summit”).

5 (2) PURPOSE.—The purposes of the Summit in-
6 clude—

7 (A) reviewing current activities of the Fed-
8 eral Government in addressing health and
9 healthcare disparities as experienced by racial
10 and ethnic minority populations, and the out-
11 comes of those activities, as practicable; and

12 (B) assessing progress made since the
13 2002 Institute of Medicine National Healthcare
14 Disparities Report and the 2002 Institute of
15 Medicine Unequal Treatment: Confronting Ra-
16 cial and Ethnic Disparities in Health Care.

17 (3) AREAS OF FOCUS.—The Summit shall ex-
18 amine the activities of the Federal Government to
19 reduce and eliminate health disparities, with a focus
20 on—

21 (A) education and training, including
22 health professions programs that increase mi-
23 nority representation in medicine, the health
24 professions, and health-related research careers;

1 (B) aggregated and disaggregated data col-
2 lection and analysis, including successful strate-
3 gies to collect and report data on minority small
4 or sub-populations for whom data are limited;

5 (C) coordination among agencies and de-
6 partments in addressing healthcare disparities;

7 (D) research into the causes of and strate-
8 gies to eliminate health disparities; and

9 (E) programs that increase access to care
10 and improve health outcomes for health dis-
11 parity populations.

12 (4) PARTICIPATION.—Summit participants shall
13 include—

14 (A) representatives of the Federal Govern-
15 ment;

16 (B) experts with research experience in
17 identifying and addressing healthcare dispari-
18 ties among racial and ethnic minority groups;
19 and

20 (C) representatives from community-based
21 organizations, Indian tribal epidemiology cen-
22 ters, and nonprofit groups that address the
23 issues of racial and ethnic minority groups.

24 (5) SUMMIT PROCEEDINGS.—Not later than
25 180 days after the conclusion of the Summit, the

1 Secretary shall offer to enter into a contract with
2 the Institute of Medicine to publish a report summa-
3 rizing the discussions of the Summit and review of
4 current Federal activities to address healthcare dis-
5 parities for racial and ethnic minority groups.

6 (b) NATIONAL PLAN TO ELIMINATE DISPARITIES.—

7 (1) PLAN.—Not later than 2 years after the
8 date of enactment of this Act, the Institute of Medi-
9 cine shall develop an evidence-based, strategic, na-
10 tional plan to eliminate disparities which shall—

11 (A) include goals, interventions, and re-
12 sources needed to eliminate disparities;

13 (B) establish a reasonable timetable to
14 reach selected priorities;

15 (C) inform and complement the National
16 Plan to Improve Minority Health and Eliminate
17 Health Disparities, pursuant to section
18 1707(c)(2) of the Public Health Service Act (as
19 added by section 501 of this Act); and

20 (D) inform the development of criteria for
21 evaluation of the effectiveness of programs au-
22 thorized under this Act (and the amendments
23 made by this Act), pursuant to subsection (c).

24 (2) REPORT.—The Secretary shall offer to
25 enter into a contract with the Institute of Medicine

1 to publish the National Plan to Eliminate Dispari-
2 ties.

3 (c) INSTITUTE OF MEDICINE EVALUATION.—

4 (1) IN GENERAL.—Not later than 3 years after
5 the date of enactment of this Act, the Secretary
6 shall offer to enter into a contract with the Institute
7 of Medicine to evaluate the effectiveness of the pro-
8 grams authorized under this Act (and the amend-
9 ments made by this Act) in addressing and reducing
10 health disparities experienced by racial and ethnic
11 minority groups. In making such an evaluation, the
12 Institute of Medicine shall consult—

13 (A) representatives of the Federal Govern-
14 ment;

15 (B) experts with research and policy expe-
16 rience in identifying and addressing healthcare
17 disparities among racial and ethnic minority
18 groups; and

19 (C) representatives from community-based
20 organizations and nonprofit groups that address
21 racial and ethnic minority health disparity
22 issues.

23 (2) REPORT.—Not later than 2 years after the
24 Secretary enters into the contract under paragraph
25 (1), the Institute of Medicine shall submit to the

1 Secretary and relevant committees of Congress a re-
2 port that contains the results of the evaluation de-
3 scribed under such subparagraph, and any rec-
4 ommendations of such Institute.

5 (3) RESPONSE.—Not later than 180 days after
6 the date the Institute of Medicine submits the report
7 under this subsection, the Secretary shall publish a
8 response to such recommendations, which shall be
9 provided to the relevant committees of Congress and
10 made publicly available through the Internet Clear-
11 inghouse under section 270 of the Public Health
12 Service Act (as added by section 101).

13 (d) HEALTH INFORMATION TECHNOLOGY.—

14 (1) IN GENERAL.—Not later than 180 days
15 after the date of enactment of this Act, the Sec-
16 retary, acting through the Director of the National
17 Library of Medicine and the head of the Office of
18 the National Coordinator for Health Information
19 Technology and in consultation with the Director of
20 the Office of Mental Health and the Director of the
21 Agency for Healthcare Research and Quality, shall
22 offer to enter into a contract with the Institute of
23 Medicine to study and make recommendations re-
24 garding the use of health information technology

1 and bioinformatics to improve the health and
2 healthcare of racial and ethnic minority groups.

3 (2) STUDY.—The study under paragraph (1),
4 with respect to increasing access and quality of
5 healthcare for racial and ethnic minority groups,
6 shall assess and make recommendations regarding—

7 (A) effective applications of health infor-
8 mation technology, including telemedicine and
9 telepsychiatry;

10 (B) status of development of health infor-
11 mation technology standards that will permit
12 healthcare information of the type required to
13 support patient care;

14 (C) inclusion of organizations with exper-
15 tise in minority health and health disparities in
16 the development and implementation of health
17 information technology policies, standards, ap-
18 plications, and monitoring;

19 (D) priority areas for research to improve
20 the dissemination, management, and use of bio-
21 medical knowledge that address identified and
22 unmet needs;

23 (E) educational and training needs and op-
24 portunities to assist health professionals under-
25 stand and apply health information technology;

1 (F) ways to increase recruitment and re-
2 tention of racial and ethnic minorities into the
3 field of medical informatics; and

4 (G) ways to increase and ensure the pri-
5 vacy of health information technology.

6 (3) REPORT.—Not later than 2 years after the
7 Secretary enters into the contract under paragraph
8 (1), the Institute of Medicine shall submit to the
9 Secretary and relevant committees of Congress a re-
10 port that contains the findings and recommendations
11 of this study.

12 **SEC. 304. NATIONAL CENTER FOR MINORITY HEALTH AND**
13 **HEALTH DISPARITIES REAUTHORIZATION.**

14 Section 485E of the Public Health Service Act (42
15 U.S.C. 287c–31) is amended—

16 (1) by striking subsection (e) and inserting the
17 following:

18 “(e) DUTIES OF THE DIRECTOR.—

19 “(1) INTERAGENCY COORDINATION OF MINOR-
20 ITY HEALTH AND HEALTH DISPARITIES ACTIVI-
21 TIES.—With respect to minority health and health
22 disparities, the Director of the Center shall plan, co-
23 ordinate, and evaluate research and other activities
24 conducted or supported by the agencies of the Na-
25 tional Institutes of Health. In carrying out the pre-

ceding sentence, the Director of the Center shall evaluate the minority health and health disparity activities of each of such agencies and shall provide for the timely periodic re-evaluation of such activities.

“(2) CONSULTATIONS.—The Director of the Center shall carry out this subpart (including developing and revising the plan and budget required in subsection (f)) in consultation with the Directors of the agencies (or a designee of the Directors) of the National Institutes of Health, with the advisory councils of the agencies, and with the advisory council established under section (j).

“(3) COORDINATION OF ACTIVITIES.—The Director of the Center shall act as the primary Federal official with responsibility for coordinating all minority health disparities research and other health disparities research conducted or supported by the National Institutes of Health and shall—

“(A) represent the health disparities research program of the National Institutes of Health including the minority health disparities research program at all relevant executive branch task forces, committees, and planning activities;

1 “(B) maintain communications with all rel-
2 evant Public Health Service agencies, including
3 the Indian Health Service and various other de-
4 partments of the Federal Government, to en-
5 sure the timely transmission of information con-
6 cerning advances in minority health disparities
7 research and other health disparities research
8 between these various agencies for dissemina-
9 tion to affected communities and healthcare
10 providers;

11 “(C) undertake research to further refine
12 and develop the conceptual, definitional, and
13 methodological issues involved in health dispari-
14 ties research and to further the understanding
15 of the cause of disparities; and

16 “(D) engage with national and community-
17 based organizations and health provider groups,
18 led by and serving racial and ethnic minorities,
19 to—

20 “(i) increase education, awareness,
21 and participation with respect to the Cen-
22 ter’s activities and areas of research focus;
23 and

24 “(ii) accelerate the translation of re-
25 search findings into programs including

1 those carried out by community-based or-
 2 ganizations.”;

3 (2) in subsection (f)—

4 (A) by striking the subsection heading and
 5 inserting the following:

6 “(f) COMPREHENSIVE PLAN FOR RESEARCH; BUDG-
 7 ET ESTIMATE; ALLOCATION OF APPROPRIATIONS.—”;

8 (B) in paragraph (1)—

9 (i) by striking the matter preceding
 10 subparagraph (A) and subparagraph (A)
 11 and inserting the following:

12 “(1) IN GENERAL.—Subject to the provisions of
 13 this section and other applicable law, the Director of
 14 the Center, in consultation with the Director of
 15 NIH, the Directors of the other agencies of the Na-
 16 tional Institutes of Health, and the advisory council
 17 established under subsection (j) shall—

18 “(A) annually review and revise a com-
 19 prehensive plan (referred to in this section as
 20 ‘the Plan’) and budget for the conduct and sup-
 21 port of all minority health and health dispari-
 22 ties research and other health disparities re-
 23 search activities of the agencies of the National
 24 Institutes of Health that includes time-based
 25 targeted objectives with measurable outcomes

1 and assure that the annual review and revision
2 of the Plan uses an established trans-NIH proc-
3 ess subject to timely review, approval, and dis-
4 semination;”;

5 (ii) in subparagraph (D), by striking
6 “, with respect to amounts appropriated
7 for activities of the Center,”;

8 (iii) by striking subparagraph (F) and
9 inserting the following:

10 “(F) ensure that the Plan and budget are
11 presented to and considered by the Director in
12 a clear and timely process during the formula-
13 tion of the overall annual budget for the Na-
14 tional Institutes of Health;”;

15 (iv) by redesignating subparagraphs
16 (G) and (H) as subparagraphs (I) and (J),
17 respectively; and

18 (v) by inserting after subparagraph
19 (F), the following:

20 “(G) annually submit to Congress a report
21 on the progress made with respect to the Plan;

22 “(H) creating and implementing a plan for
23 the systematic review of research activities sup-
24 ported by the National Institutes of Health that
25 are within the mission of both the Center and

1 other agencies of the National Institutes of
2 Health, by establishing mechanisms for—

3 “(i) tracking minority health and
4 health disparity research conducted within
5 the agencies and assessing the appropriate-
6 ness of this research with regard to the
7 overall goals and objectives of the Plan;

8 “(ii) the early identification of appli-
9 cations and proposals for grants, contracts,
10 and cooperative agreements supporting ex-
11 tramural training, research, and develop-
12 ment, that are submitted to the agencies
13 and that are within the mission of the Cen-
14 ter;

15 “(iii) providing the Center with the
16 written descriptions and scientific peer re-
17 view results of such applications and pro-
18 posals;

19 “(iv) enabling the agencies to consult
20 with the Director of the Center prior to
21 final approval of such applications and
22 proposals; and

23 “(v) reporting to the Director of the
24 Center all such applications and proposals

1 that are approved for funding by the agen-
2 cies;”; and

3 (C) in paragraph (2)—

4 (i) in subparagraph (D), by striking
5 “and” at the end;

6 (ii) in subparagraph (E), by striking
7 the period and inserting “; and”; and

8 (iii) by adding at the end the fol-
9 lowing:

10 “(F) the number and type of personnel
11 needs of the Center.”;

12 (3) in subsection (h)—

13 (A) in paragraph (1), by striking “endow-
14 ments at centers of excellence under section
15 736.” and inserting the following: “endowments
16 at—

17 “(A) centers of excellence under section
18 736; and

19 “(B) centers of excellence under section
20 485F.”; and

21 (B) in paragraph (2)(A), by striking “aver-
22 age” and inserting “median”;

23 (4) by redesignating subsections (k) and (l) as
24 subsections (m) and (n), respectively;

1 (5) by inserting after subsection (j), the fol-
2 lowing:

3 “(k) REPRESENTATION OF MINORITIES AMONG RE-
4 SEARCHERS.—The Secretary, in collaboration with the Di-
5 rector of the Center, shall determine, by means of the col-
6 lection and reporting of aggregated and disaggregated
7 data, the extent to which racial and ethnic minority groups
8 are represented among senior physicians and scientists of
9 the national research institutes and among physicians and
10 scientists conducting research with funds provided by such
11 institutes, and as appropriate, carry out activities to in-
12 crease the extent of such representation, including devel-
13 oping a pipeline of minority researchers interested in the
14 study of health and health disparities, as well as attracting
15 minority scientists in social and behavioral science fields
16 who can bring their expertise to the study of health dis-
17 parities.

18 “(l) CANCER RESEARCH.—The Secretary, in collabo-
19 ration with the Director of the Center, shall designate and
20 support a cancer prevention, control, and population
21 science center to address the significantly elevated rate of
22 morbidity and mortality from cancer in racial and ethnic
23 minority populations. Such designated center shall be
24 housed within an existing, stand-alone cancer center at a
25 historically black college and university that has a demon-

1 strable commitment to and expertise in cancer research
 2 in the basic, clinical, and population sciences.”;

3 (6) in subsection (l)(1) (as so redesignated), by
 4 inserting before the semicolon the following: “, with
 5 a particular focus on evaluation of progress made to-
 6 ward fulfillment of the goals of the Plan”; and

7 (7) by striking subsection (m) (as so redesign-
 8 nated).

9 **SEC. 305. AUTHORIZATION OF APPROPRIATIONS.**

10 (a) SECTIONS 301, 302, AND 303.—There are au-
 11 thorized to be appropriated such sums as may be nec-
 12 essary for each of fiscal years 2008 through 2012, to carry
 13 out sections 301, 302, and 303 (and the amendments
 14 made by such sections).

15 (b) SECTION 304.—

16 (1) IN GENERAL.—There are authorized to be
 17 appropriated \$240,000,000 for fiscal year 2008,
 18 such sums as may be necessary for each of fiscal
 19 years 2009 through 2012, to carry out section 304.

20 (2) ALLOCATION OF FUNDS.—Subject to sec-
 21 tion 485E of the Public Health Service Act (as
 22 amended by section 304) and other applicable law,
 23 the Director of the Center under such section 485E
 24 shall direct all amounts appropriated for activities
 25 under such section and in collaboration with the Di-

1 rector of National Institutes of Health and the di-
 2 rectors of other institutes and centers of the Na-
 3 tional Institutes of Health.

4 (3) MANAGEMENT OF ALLOCATIONS.—All
 5 amounts allocated or expended for minority health
 6 and health disparities research activities under this
 7 subsection shall be reported programmatically to and
 8 approved by the Director of the Center under such
 9 section 485E, in accordance with the Plan described
 10 under such section 485E.

11 **TITLE IV—DATA COLLECTION,** 12 **ANALYSIS, AND QUALITY**

13 **SEC. 401. DATA COLLECTION, ANALYSIS, AND QUALITY.**

14 The Public Health Service Act (42 U.S.C. 201 et
 15 seq.) is amended by adding at the end the following:

16 **“TITLE XXX—DATA COLLECTION,** 17 **ANALYSIS, AND QUALITY**

18 **“SEC. 3001. DATA COLLECTION, ANALYSIS, AND QUALITY.**

19 “(a) DATA COLLECTION AND REPORTING.—The Sec-
 20 retary shall ensure that not later than 3 years after the
 21 date of enactment of the Minority Health Improvement
 22 and Health Disparity Elimination Act any ongoing or new
 23 federally conducted or supported health programs (includ-
 24 ing surveys) achieve the—

1 “(1) collection and reporting of data by race
2 and ethnicity using, at a minimum, Office of Man-
3 agement and Budget standards in effect on the date
4 of enactment of the Minority Health Improvement
5 and Health Disparity Elimination Act;

6 “(2) collection and reporting of data by geo-
7 graphic location, socioeconomic position (such as em-
8 ployment, income, and education), primary language,
9 and, when determined practicable by the Secretary,
10 health literacy;

11 “(3) if practicable, collection and reporting of
12 race and ethnicity data on additional population
13 groups if such data can be aggregated into the min-
14 imum race and ethnicity data categories; and

15 “(4) collection and reporting of data at the
16 smallest practicable geographic level such as State,
17 local, or institutional levels if such data can be ag-
18 gregated.

19 “(b) DATA ANALYSIS AND DISSEMINATION.—

20 “(1) DATA ANALYSIS.—

21 “(A) IN GENERAL.—For each federally
22 conducted or supported program, the Secretary
23 shall analyze data collected under subsection (a)
24 to detect and monitor trends in disparities in
25 health and healthcare, including those reported

1 under subparagraph (B), for racial and ethnic
2 minority groups at the Federal and State levels,
3 and examine the interaction between various
4 disparity indicators.

5 “(B) QUALITY ANALYSIS.—The Secretary
6 shall ensure that the analyses under subpara-
7 graph (A) incorporate data reported according
8 to quality measurement systems.

9 “(2) QUALITY MEASURES.—When the Sec-
10 retary, by statutory or regulatory authority, adopts
11 and implements any quality measures or any quality
12 measurement system, the Secretary shall ensure the
13 quality measures or quality measurement system
14 comply with the following:

15 “(A) MEASURES.—Measures selected shall,
16 to the extent practicable—

17 “(i) assess the effectiveness, timeli-
18 ness, patient self-management, patient
19 centeredness, equity, and efficiency of care
20 received by patients, including patients
21 from racial and ethnic minority groups;

22 “(ii) are evidence-based, reliable, and
23 valid; and

1 “(iii) include measures of clinical
2 processes and outcomes, patient experience
3 and efficiency.

4 “(B) CONSULTATION.—In selecting quality
5 measures or a quality measurement system or
6 systems for adoption and implementation, the
7 Secretary shall consult with—

8 “(i) individuals from racial and ethnic
9 minority groups; and

10 “(ii) experts in the identification and
11 elimination of disparities in health and
12 healthcare among racial and ethnic minor-
13 ity groups.

14 “(3) DISSEMINATION.—

15 “(A) IN GENERAL.—The Secretary shall
16 make the measures, data, and analyses de-
17 scribed in paragraphs (1) and (2) available to—

18 “(i) the Office of Minority Health;

19 “(ii) the National Center on Minority
20 Health and Health Disparities;

21 “(iii) the Agency for Healthcare Re-
22 search and Quality for inclusion in the
23 Agency’s reports;

24 “(iv) the Centers for Disease Control
25 and Prevention;

1 “(v) the Centers for Medicare and
2 Medicaid Services;

3 “(vi) the Indian Health Service;

4 “(vii) other agencies within the De-
5 partment of Health and Human Services;

6 “(viii) the public through posting on
7 the Secretary’s Internet website; and

8 “(ix) other entities as determined ap-
9 propriate by the Secretary.

10 “(B) ADDITIONAL RESEARCH.—The Sec-
11 retary may, as the Secretary determines appro-
12 priate, make the measures, data, and analysis
13 described in paragraphs (1) and (2) available
14 for additional research, analysis, and dissemina-
15 tion to non-governmental entities and the pub-
16 lic.

17 “(c) RESEARCH.—

18 “(1) DISPARITY INDICATORS.—

19 “(A) IN GENERAL.—The Secretary shall
20 award grants or contracts for research to de-
21 velop appropriate methods, indicators, and
22 measures that will enable the detection and as-
23 sessment of disparities in healthcare. Such re-
24 search shall prioritize research with respect to
25 the following:

1 “(i) Race and ethnicity.

2 “(ii) Geographic location (such as
3 geocoding).

4 “(iii) Socioeconomic position (such as
5 income or education level).

6 “(iv) Health literacy.

7 “(v) Cultural competency.

8 “(vi) Additional measures as deter-
9 mined appropriate by the Secretary.

10 “(B) APPLIED RESEARCH.—The Secretary
11 shall use the results of the research from grants
12 awarded under subparagraph (A) to improve
13 the data collection described under subsection
14 (a).

15 “(2) STRATEGIC PARTNERSHIPS TO ENCOUR-
16 AGE AND IMPROVE DATA COLLECTION.—

17 “(A) IN GENERAL.—The Secretary may
18 award not more than 20 grants to eligible enti-
19 ties for the purposes of—

20 “(i) enhancing and improving methods
21 for the collection, reporting, analysis, and
22 dissemination of data, as required under
23 the Minority Health Improvement and
24 Health Disparity Elimination Act; and

1 “(ii) encouraging the collection, re-
2 porting, analysis, and dissemination of
3 data to identify and address disparities in
4 health and healthcare.

5 “(B) DEFINITION OF ELIGIBLE ENTITY.—
6 In this paragraph, the term ‘eligible entity’
7 means a health plan, federally qualified health
8 center, hospital, rural health clinic, academic
9 institution, policy research organization, or
10 other entity, including an Indian Health Service
11 hospital or clinic, Indian tribal health facility,
12 or urban Indian facility, that the Secretary de-
13 termines to be appropriate.

14 “(C) APPLICATION.—An eligible entity de-
15 siring a grant under this paragraph shall sub-
16 mit an application to the Secretary at such
17 time, in such manner, and containing such in-
18 formation as the Secretary may require.

19 “(D) PRIORITY IN AWARDING GRANTS.—In
20 awarding grants under this paragraph, the Sec-
21 retary shall give priority to eligible entities that
22 represent collaboratives with—

23 “(i) hospitals, health plans, or health
24 centers; and

1 “(ii) at least 1 community-based orga-
2 nization or patient advocacy group.

3 “(E) USE OF FUNDS.—An eligible entity
4 that receives a grant under this paragraph shall
5 use grant funds to—

6 “(i) collect, analyze, or report data by
7 race, ethnicity, geographic location, socio-
8 economic position, health literacy, primary
9 language, or other health disparity indi-
10 cator;

11 “(ii) conduct and report analyses of
12 quality of healthcare and disparities in
13 health and healthcare for racial and ethnic
14 minority groups, including disparities in di-
15 agnosis, management and treatment, and
16 health outcomes for acute and chronic dis-
17 ease;

18 “(iii) improve health data collection,
19 analysis, and reporting for subpopulations
20 and categories;

21 “(iv) modify, implement, and evaluate
22 use of health information technology sys-
23 tems that facilitate data collection, analysis
24 and reporting for racial and ethnic minor-

1 ity groups, and support healthcare inter-
2 ventions;

3 “(v) develop educational programs to
4 inform patients, providers, purchasers, and
5 other individuals served about the legality
6 and importance of the collection, analysis,
7 and reporting of data by race, ethnicity,
8 socioeconomic position, geographic loca-
9 tion, and health literacy, for eliminating
10 disparities in health; and

11 “(vi) evaluate the activities conducted
12 under this paragraph.

13 “(d) TECHNICAL ASSISTANCE.—The Secretary may
14 provide technical assistance to promote compliance with
15 the data collection and reporting requirements of the Mi-
16 nority Health Improvement and Health Disparity Elim-
17 nation Act.

18 “(e) PRIVACY AND SECURITY.—The Secretary shall
19 ensure all appropriate privacy and security protections for
20 health data collected, reported, analyzed, and dissemi-
21 nated pursuant to the Minority Health Improvement and
22 Health Disparity Elimination Act.

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—For the
24 purpose of carrying out this section, there are authorized

1 to be appropriated such sums as may be necessary for
2 each of fiscal years 2008 through 2012.”.

3 **TITLE V—LEADERSHIP, COL-**
4 **LABORATION, AND NATIONAL**
5 **ACTION PLAN**

6 **SEC. 501. OFFICE OF MINORITY HEALTH.**

7 Section 1707 of the Public Health Service Act (42
8 U.S.C. 300u–6) is amended to read as follows:

9 **“SEC. 1707. OFFICE OF MINORITY HEALTH.**

10 “(a) DUTIES.—With respect to racial and ethnic mi-
11 nority groups, the Secretary, acting through the Deputy
12 Assistant Secretary, shall carry out the following:

13 “(1) Coordinate and provide input on activities
14 within the Public Health Service that relate to dis-
15 ease prevention, health promotion, health service de-
16 livery, health workforce, and research concerning ra-
17 cial and ethnic minority groups. The Secretary shall
18 ensure that the heads of each of the agencies of the
19 Service collaborate with the Deputy Assistant Sec-
20 retary on the development and conduct of such ac-
21 tivities.

22 “(2) Not later than 1 year after the date of en-
23 actment of the Minority Health Improvement and
24 Health Disparity Elimination Act, develop and im-
25 plement a comprehensive Department-wide plan to

1 improve minority health and eliminate health dis-
2 parities in the United States, to be known as the
3 National Plan to Improve Minority Health and
4 Eliminate Health Disparities, (referred to in this
5 section as the ‘National Plan’). With respect to de-
6 velopment and implementation of the National Plan,
7 the Secretary shall carry out the following:

8 “(A) Consult with the following:

9 “(i) The Director of the Centers for
10 Disease Control and Prevention.

11 “(ii) The Director of the National In-
12 stitutes of Health.

13 “(iii) The Director of the National
14 Center on Minority Health and Health
15 Disparities of the National Institutes of
16 Health.

17 “(iv) The Director of the Agency for
18 Healthcare Research and Quality.

19 “(v) The National Coordinator for
20 Health Information Technology.

21 “(vi) The Administrator of the Health
22 Resources and Services Administration.

23 “(vii) The Administrator of the Cen-
24 ters for Medicare & Medicaid Services.

1 “(viii) The Director of the Office for
2 Civil Rights.

3 “(ix) The Secretary of Veterans Af-
4 fairs.

5 “(x) The Administrator of the Sub-
6 stance Abuse and Mental Health Services
7 Administration.

8 “(xi) The Secretary of Defense.

9 “(xii) The Commissioner of the Food
10 and Drug Administration.

11 “(xiii) The Director of the Indian
12 Health Service.

13 “(xiv) The Secretary of Education.

14 “(xv) The Secretary of Labor.

15 “(xvi) The heads of other public and
16 private entities, as determined appropriate
17 by the Secretary.

18 “(B) Review and integrate existing infor-
19 mation and recommendations as appropriate,
20 such as Healthy People 2010, Institute of Medi-
21 cine studies, and Surgeon General Reports.

22 “(C) Ensure inclusion of measurable short-
23 and long-range goals and objectives, a descrip-
24 tion of the means for achieving such goals and
25 objectives, and a designated date by which such

1 goals and objectives are expected to be
2 achieved.

3 “(D) Ensure that all amounts appro-
4 priated for such activities are expended in ac-
5 cordance with the National Plan.

6 “(E) Review the National Plan on at least
7 an annual basis, and report to the public and
8 appropriate committees of Congress on
9 progress.

10 “(F) Revise such Plan as appropriate.

11 “(G) Ensure that the National Plan will
12 serve as a binding statement of policy with re-
13 spect to the agencies’ activities related to im-
14 proving health and eliminating disparities in
15 health and healthcare.

16 “(3) Work with Federal agencies and depart-
17 ments outside of the Department of Health and
18 Human Services as appropriate to maximize re-
19 sources available to increase understanding about
20 why disparities exist, and effective ways to improve
21 health and eliminate health disparities.

22 “(4) In cooperation with the appropriate agen-
23 cies, support research, demonstrations, and evalua-
24 tions to test new and innovative models for—

25 “(A) expanding healthcare access;

1 “(B) improving healthcare quality;

2 “(C) increasing educational opportunity in
3 the field of healthcare; and

4 “(D) increasing the capacity of racial and
5 ethnic minority organizations to improve health
6 and eliminate health disparities.

7 “(5) Develop mechanisms that support better
8 dissemination of information, education, prevention,
9 and service delivery to individuals from disadvan-
10 taged backgrounds, including individuals who are
11 members of racial or ethnic minority groups.

12 “(6) Increase awareness of disparities in
13 healthcare, and knowledge and understanding of
14 health risk factors, and ways to reduce and eliminate
15 health disparities, among healthcare providers,
16 health plans, and the public.

17 “(7) Advise in matters related to the develop-
18 ment, implementation, and evaluation of health pro-
19 fessions education on improving healthcare outcomes
20 and decreasing disparities in healthcare outcomes,
21 with a focus on cultural competence.

22 “(8) Assist healthcare professionals, community
23 and advocacy organizations, academic medical cen-
24 ters and other health entities and public health de-
25 partments in the design and implementation of pro-

1 grams that will improve health outcomes by
2 strengthening the patient-provider relationship.

3 “(9) Carry out programs to improve access to
4 healthcare services and to improve the quality of
5 healthcare services for individuals with low health
6 literacy.

7 “(10) Facilitate the classification and collection
8 of healthcare data to allow for ongoing analysis to
9 identify and determine the causes of disparities and
10 the monitoring of progress toward improving health
11 and eliminating health disparities.

12 “(11) Ensure that the National Center for
13 Health Statistics collects data on the health status
14 of each racial or ethnic minority group pursuant to
15 section 2901.

16 “(12) Support a national minority health re-
17 source center to carry out the following:

18 “(A) Facilitate the exchange of informa-
19 tion regarding matters relating to health infor-
20 mation and health promotion, preventive health
21 services, and education in the appropriate use
22 of healthcare.

23 “(B) Facilitate access to such information.

24 “(C) Assist in the analysis of issues and
25 problems relating to such matters.

1 “(D) Provide technical assistance with re-
2 spect to the exchange of such information (in-
3 cluding facilitating the development of materials
4 for such technical assistance).

5 “(13) Support a center for cultural and lin-
6 guistic competence to carry out the following:

7 “(A) With respect to individuals who lack
8 proficiency in speaking the English language,
9 enter into contracts with public and nonprofit
10 private providers of primary health services for
11 the purpose of increasing the access of such in-
12 dividuals to such services by developing and
13 carrying out programs to improve health lit-
14 eracy and cultural competency.

15 “(B) Carry out programs to improve ac-
16 cess to healthcare services for individuals with
17 limited proficiency in speaking the English lan-
18 guage. Activities under this subparagraph shall
19 include developing and evaluating model
20 projects.

21 “(14) At the discretion of the Director, support
22 a center or program for the improvement of geo-
23 graphic minority health and health disparities to
24 carry out the following for rural disadvantaged mi-
25 nority populations:

1 “(A) Increase awareness on health care
2 issues impacting and effective interventions for
3 these populations.

4 “(B) Increase access to quality healthcare.

5 “(C) Increase access to quality healthcare
6 personnel available to provide services to these
7 populations.

8 “(D) Improve health care outcomes.

9 “(E) Develop a model that can be rep-
10 licated to address national policies and pro-
11 grams to improve the health of these rural dis-
12 advantaged minority communities. This model
13 should include research, health services, edu-
14 cation/awareness, and health information com-
15 ponents, with priority given to existing pro-
16 grams or programs in areas with the most need
17 and have a Community Advisory Board to pro-
18 vide recommendations on projects to benefit the
19 health of minority populations.

20 “(15) Enter into interagency agreements with
21 other agencies of the Public Health Service, as ap-
22 propriate.

23 “(16) Collaborate with the Office for Civil
24 Rights to—

1 “(A) assist healthcare providers with appli-
2 cation of guidance and directives regarding
3 healthcare for racial and ethnic minority
4 groups, including—

5 “(i) reviewing cases that have been
6 closed without a finding of discrimination
7 with the Office of Inspector General and
8 the Office for Civil Rights to determine if
9 there exists a pattern or practice of activi-
10 ties that could lead to discrimination, and
11 if such a pattern or practice is identified,
12 provide technical assistance or education,
13 as applicable, to the relevant provider or to
14 a group of providers located within a par-
15 ticular geographic area;

16 “(ii) biannually publishing informa-
17 tion on cases filed with the Office for Civil
18 Rights which have resulted in a finding of
19 discrimination, including the name and lo-
20 cation of the entity found to have discrimi-
21 nated, and any findings and agreements
22 entered into between the Office for Civil
23 Rights and the entity; and

24 “(iii) monitoring and analysis of
25 trends in cases reported to the Office for

1 Civil Rights to ensure that the Office of
2 Minority Health acts to educate and assist
3 healthcare providers as necessary; and

4 “(B) provide technical assistance or edu-
5 cation, as applicable, to the relevant provider or
6 to a group of providers located within a par-
7 ticular geographic area.

8 “(17) Promote and expand efforts to increase
9 racial and ethnic minority enrollment in clinical
10 trials.

11 “(18) Establish working groups—

12 “(A) to examine and report recommenda-
13 tions to the Secretary regarding—

14 “(i) emergency preparedness and re-
15 sponse for underserved populations;

16 “(ii) development and implementation
17 of health information technology that can
18 assist providers to deliver culturally com-
19 petent healthcare;

20 “(iii) outreach and education of health
21 disparity groups about new Federal health
22 programs, as appropriate, including the
23 programs under part D of title XVIII of
24 the Social Security Act and chronic care
25 management programs under the Medicare

1 Prescription Drug, Improvement, and
2 Modernization Act of 2003 (and the
3 amendments made by such Act);

4 “(iv) leadership development in public
5 health;

6 “(v) the training of behavioral and so-
7 cial science researchers to address health
8 disparities; and

9 “(vi) other emerging health issues at
10 the discretion of the Secretary; and

11 “(B) that include representation from the
12 relevant health agencies, centers and offices, as
13 well as public and private entities as appro-
14 priate.

15 “(b) ADVISORY COMMITTEE.—

16 “(1) IN GENERAL.—The Secretary shall estab-
17 lish an advisory committee to be known as the Advi-
18 sory Committee on Minority Health (in this sub-
19 section referred to as the ‘Committee’).

20 “(2) DUTIES.—The Committee shall provide
21 advice to the Deputy Assistant Secretary carrying
22 out this section, including advice on the development
23 of goals and specific program activities under sub-
24 section (c) for racial and ethnic minority groups and
25 health disparity population.

1 “(3) CHAIR.—The chairperson of the Com-
2 mittee shall be selected by the Secretary from among
3 the members of the voting members of the Com-
4 mittee. The term of office of the chairperson shall be
5 2 years.

6 “(4) COMPOSITION.—

7 “(A) The Committee shall be composed of
8 12 voting members appointed in accordance
9 with subparagraph (B), and nonvoting, ex-offi-
10 cio members designated in subparagraph (C).

11 “(B) The voting members of the Com-
12 mittee shall be appointed by the Secretary from
13 among individuals who are not officers or em-
14 ployees of the Federal Government and who
15 have expertise regarding issues of minority
16 health and health disparities. Racial and ethnic
17 minority groups shall be appropriately rep-
18 resented among such members.

19 “(C) The nonvoting, ex officio members of
20 the Committee shall be such officials of the De-
21 partment of Health and Human Services, in-
22 cluding the Director of the Office of Minority
23 Health and the Office for Civil Rights, and
24 other officials as the Secretary determines to be
25 appropriate.

1 “(D) The Secretary shall provide an oppor-
2 tunity for the Chairman and Ranking Member
3 of the Committee on Health, Education, Labor,
4 and Pensions of the Senate to submit to the
5 Secretary names of potential Committee mem-
6 bers under this section for consideration.

7 “(5) TERMS.—Each member of the Committee
8 shall serve for a term of 4 years, except that the
9 Secretary shall initially appoint a portion of the
10 members to terms of 1 year, 2 years, and 3 years.

11 “(6) VACANCIES.—If a vacancy occurs on the
12 Committee, a new member shall be appointed by the
13 Secretary within 90 days from the date that the va-
14 cancy occurs, and serve for the remainder of the
15 term for which the predecessor of such member was
16 appointed. The vacancy shall not affect the power of
17 the remaining members to execute the duties of the
18 Committee.

19 “(7) COMPENSATION.—Members of the Com-
20 mittee who are officers or employees of the United
21 States shall serve without additional compensation.
22 Members of the Committee who are not officers or
23 employees of the United States shall receive com-
24 pensation, for each day (including travel time) they
25 are engaged in the performance of the functions of

1 the Committee. Such compensation may not be in an
2 amount in excess of the daily equivalent of the an-
3 nual maximum rate of basic pay payable under the
4 General Schedule for positions above GS-15 under
5 title 5, United States Code.

6 “(c) CERTAIN REQUIREMENTS REGARDING DU-
7 TIES.—

8 “(1) RECOMMENDATIONS REGARDING LAN-
9 GUAGE.—

10 “(A) PROFICIENCY IN SPEAKING
11 ENGLISH.—The Deputy Assistant Secretary
12 shall consult with the Director of the Office of
13 International and Refugee Health, the Director
14 of the Office for Civil Rights, and the Directors
15 of other appropriate departmental entities re-
16 garding recommendations for carrying out ac-
17 tivities under subsection (c)(9).

18 “(B) HEALTH PROFESSIONS EDUCATION
19 REGARDING HEALTH DISPARITIES.—The Dep-
20 uty Assistant Secretary shall carry out the du-
21 ties under subsection (a)(7) in collaboration
22 with appropriate personnel of the Department
23 of Health and Human Services, other Federal
24 agencies, and other offices, centers, and institu-
25 tions, as appropriate, that have responsibilities

1 under the Minority Health and Health Dispari-
2 ties Research and Education Act of 2000.

3 “(2) EQUITABLE ALLOCATION REGARDING AC-
4 TIVITIES.—In carrying out subsection (b), the Sec-
5 retary shall ensure that services provided under such
6 subsection are equitably allocated among all groups
7 served under this section by the Secretary.

8 “(3) CULTURAL COMPETENCY OF SERVICES.—
9 The Secretary shall ensure that information and
10 services provided pursuant to subsection (c) consider
11 the unique cultural or linguistic issues facing such
12 populations and are provided in the language, edu-
13 cational, and cultural context that is most appro-
14 priate for the individuals for whom the information
15 and services are intended.

16 “(4) AGENCY COORDINATION.—In carrying out
17 subsection (c), the Secretary shall ensure that new
18 or existing agency offices of minority health report
19 current and proposed activities to the Deputy Assist-
20 ant Secretary, and provide, to the extent practicable,
21 an opportunity for input in the development of such
22 activities by the Deputy Assistant Secretary.

23 “(d) GRANTS AND CONTRACTS REGARDING DU-
24 TIES.—

1 “(1) IN GENERAL.—In carrying out subsection
2 (c), the Secretary acting through the Deputy Assist-
3 ant Secretary, may make awards of grants, coopera-
4 tive agreements, and contracts to public and non-
5 profit private entities.

6 “(2) PROCESS FOR MAKING AWARDS.—The
7 Deputy Assistant Secretary shall ensure that awards
8 under paragraph (1) are made, to the extent prac-
9 ticable, only on a competitive basis, and that a grant
10 is awarded for a proposal only if the proposal has
11 been recommended for such an award through a
12 process of peer review.

13 “(3) EVALUATION AND DISSEMINATION.—The
14 Deputy Assistant Secretary, directly or through con-
15 tracts with public and private entities, shall provide
16 for evaluations of projects carried out with awards
17 made under paragraph (1) during the preceding 2
18 fiscal years. The report shall be included in the re-
19 port required under subsection (g) for the fiscal year
20 involved.

21 “(e) STATE OFFICES OF MINORITY HEALTH.—The
22 Deputy Assistant Secretary shall assist the voluntary es-
23 tablishment and functions of State offices of minority
24 health in order to expand and coordinate State efforts to
25 improve the health of racial and ethnic minority groups.

1 “(1) PRIORITIES.—The Deputy Assistant Sec-
2 retary may facilitate, with respect to racial and eth-
3 nic minority groups—

4 “(A) integration and coordination of State
5 and national efforts, including those pertaining
6 to the National Plan pursuant to subsection
7 (b);

8 “(B) strategic plan development within
9 States to assess and respond to local health
10 concerns;

11 “(C) education and engagement of key
12 stakeholders within States, including represent-
13 atives from public health agencies, hospitals,
14 clinics, provider groups, elected officials, com-
15 munity-based organizations, advocacy groups,
16 media, and the private sector;

17 “(D) development and implementation of
18 accepted standards, core competencies, and
19 minimum infrastructure requirements for State
20 offices;

21 “(E) access to State level health data for
22 racial and ethnic minority groups, which may
23 include State data collection and analysis;

1 “(F) development, implementation, and
2 evaluation of State programs and policies, as
3 appropriate;

4 “(G) communication and networking
5 among States to share effective policies, pro-
6 grams and practices with respect to increasing
7 access and quality of care;

8 “(H) recognition and reporting of State
9 successes and challenges; and

10 “(I) identification of Federal grant pro-
11 grams and other funding for which States could
12 apply to carry out health improvement activi-
13 ties.

14 “(2) RESOURCES.—The Deputy Assistant Sec-
15 retary may provide grants and technical assistance
16 for the voluntary establishment or capacity develop-
17 ment of State offices of minority health.

18 “(3) COLLABORATION.—To the extent prac-
19 ticable, the Deputy Assistant Secretary may encour-
20 age and facilitate collaboration between State offices
21 of minority health and State offices addressing the
22 needs of other health disparity or disadvantaged
23 populations, including offices of rural health.

24 “(4) DEFINITION.—For the purpose of this
25 subsection, ‘State offices of minority health’ include

1 offices, councils, commissions, or advisory panels
2 designated by States or territories to address the
3 health of minority populations.

4 “(f) REPORTS.—

5 “(1) IN GENERAL.—Not later than 1 year after
6 the date of enactment of the Minority Health Im-
7 provement and Health Disparity Elimination Act,
8 the Secretary shall submit to the appropriate com-
9 mittees of Congress, a report on the National Plan
10 developed under subsection (c).

11 “(2) REPORT ON ACTIVITIES.—Not later than
12 February 1 of fiscal year 2009 and of each second
13 year thereafter, the Secretary shall submit to the ap-
14 propriate committees of Congress, a report describ-
15 ing the activities carried out under this section dur-
16 ing the preceding 2 fiscal years and evaluating the
17 extent to which such activities have been effective in
18 improving the health of racial and ethnic minority
19 groups. Each such report shall include the biennial
20 reports submitted under subsection (f)(3) for such
21 years by the heads of the Public Health Service
22 agencies.

23 “(3) AGENCY REPORTS.—Not later than Feb-
24 ruary 1, 2009, and on a biannual basis thereafter,
25 the heads of the Public Health Service shall submit

1 to the Deputy Assistant Secretary a report that
2 summarizes the minority health and health disparity
3 activities of each of the respective agencies.

4 “(g) DEFINITIONS.—In this section:

5 “(1) The term ‘racial and ethnic minority
6 group’ means American Indians (including Alaska
7 Natives, Eskimos, and Aleuts), Asian Americans,
8 Native Hawaiians and other Pacific Islanders,
9 Blacks, and Hispanics.

10 “(2) The term ‘Hispanic’ means individuals
11 whose origin is Mexican, Puerto Rican, Cuban, Cen-
12 tral or South American, or of any other Spanish-
13 speaking country.

14 “(h) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated \$110,000,000 for fiscal year 2008,
17 such sums as may be necessary for each of fiscal years
18 2009 through 2012.”.

○