

110TH CONGRESS
1ST SESSION

S. 1576

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

IN THE SENATE OF THE UNITED STATES

JUNE 7, 2007

Mr. KENNEDY (for himself, Mr. COCHRAN, Mr. OBAMA, Mr. BINGAMAN, Mrs. CLINTON, Mr. BROWN, and Mr. DURBIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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,*

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

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

7 (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.

1 SEC. 2. DEFINITIONS.

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

3 (1) **CULTURAL COMPETENCY.**—The term “cul-
4 turally competent”—

5 (A) with respect to health-related services,
6 means the ability to provide healthcare tailored
7 to meet the social, cultural, and linguistic needs
8 of patients from diverse backgrounds; and

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

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

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

18 (4) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZA-
19 TION; URBAN INDIAN ORGANIZATION.—The terms
20 “Indian”, “Indian tribe”, “tribal organization”, and
21 “urban Indian organization” have the meanings
22 given such terms in section 4 of the Indian Health
23 Care Improvement Act (25 U.S.C. 1603).

24 (5) MINORITY GROUP.—The term “minority
25 group” has the meaning given the term “racial and

1 ethnic minority group” in section 1707 of the Public
 2 Health Service Act (42 U.S.C. 300u–6) (as amended
 3 by section 501).

4 (6) PRACTICE-BASED RESEARCH NETWORKS.—

5 The term “practice-based research network” means
 6 a group of ambulatory practices devoted principally
 7 to the primary care of patients, and affiliated in
 8 their mission to investigate questions related to com-
 9 munity-based practice and to improve the quality of
 10 primary care.

11 (7) SECRETARY.—The term “Secretary” means

12 the Secretary of Health and Human Services.

13 **TITLE I—INCREASING DIVER-**
 14 **SITY AND CULTURAL COM-**
 15 **PETENCY IN THE**
 16 **HEALTHCARE WORKFORCE**
 17 **THROUGH EDUCATION AND**
 18 **TRAINING**

19 **SEC. 101. CULTURAL COMPETENCY AND COMMUNICATION**
 20 **FOR PROVIDERS.**

21 Title II of the Public Health Service Act (42 U.S.C.
 22 202 et seq.) is amended by adding at the end the fol-
 23 lowing:

1 **“SEC. 270. INTERNET CLEARINGHOUSE TO IMPROVE CUL-**
 2 **TURAL COMPETENCY AND COMMUNICATION**
 3 **BY HEALTHCARE PROVIDERS.**

4 “(a) ESTABLISHMENT.—Not later than 1 year after
 5 the date of enactment of the Minority Health Improve-
 6 ment and Health Disparity Elimination Act, the Sec-
 7 retary, acting through the Deputy Assistant Secretary for
 8 Minority Health, shall develop and maintain an Internet
 9 Clearinghouse within the Office of Minority Health to as-
 10 sist providers in improving the health and healthcare of
 11 racial and ethnic minority groups, with the goal of—

12 “(1) increasing cultural competency;

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

16 “(3) improving healthcare quality and patient
 17 satisfaction;

18 “(4) reducing medical errors and healthcare
 19 costs; and

20 “(5) reducing duplication of effort regarding
 21 translation of materials.

22 “(b) INTERNET CLEARINGHOUSE.—Not later than 1
 23 year after the date of enactment of this section the Sec-
 24 retary, acting through the Deputy Assistant Secretary for
 25 Minority Health, and in consultation with the Director of

1 the Office for Civil Rights, shall carry out subsection (a)
2 by—

3 “(1) developing and maintaining, through the
4 Office of Minority Health, an accessible library and
5 database on the Internet with easily searchable,
6 clinically-relevant information regarding culturally
7 competent healthcare for racial and ethnic minority
8 groups, including Internet links to additional re-
9 sources that fulfill the purpose of this section;

10 “(2) developing and making templates for vis-
11 ual aids and standard documents with clear expla-
12 nations that can help patients and consumers access
13 and make informed decisions about healthcare, in-
14 cluding—

15 “(A) administrative and legal documents,
16 including informed consent and advanced direc-
17 tives;

18 “(B) clinical information, including infor-
19 mation pertaining to treatment adherence, self-
20 management training for chronic conditions,
21 preventing transmission of disease, and dis-
22 charge instructions;

23 “(C) patient education and outreach mate-
24 rials, including immunization or screening no-
25 tices and health warnings; and

1 “(D) Federal health forms and notices;

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

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

7 “(5) facilitating access to such documents, in-
8 cluding distribution in both paper and electronic for-
9 mats;

10 “(6) providing technical assistance to healthcare
11 providers with respect to the access and use of infor-
12 mation described in paragraph (1) including infor-
13 mation to help healthcare providers—

14 “(A) understand the concept of cultural
15 competence;

16 “(B) implement culturally competent prac-
17 tices;

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

21 “(D) understand and apply Federal guid-
22 ance and directives regarding healthcare for ra-
23 cial and ethnic minority groups;

24 “(E) obtain reimbursement for provision of
25 culturally competent services;

1 “(F) understand and implement
 2 bioinformatics and health information tech-
 3 nology in order to improve healthcare for racial
 4 and ethnic minority groups; and

5 “(G) conduct other activities determined
 6 appropriate by the Secretary;

7 “(7) providing culturally appropriate dissemina-
 8 tion strategies to provide educational materials to
 9 patients, representatives of community-based organi-
 10 zations, and the public with respect to the access
 11 and use of information described in paragraph (1),
 12 including—

13 “(A) information to help such individ-
 14 uals—

15 “(i) understand the concept of cul-
 16 tural competence, and the role of cultural
 17 competence in the delivery of healthcare;

18 “(ii) work with healthcare providers to
 19 implement culturally competent practices;

20 “(iii) provide options for providers
 21 and consumers to promote increased un-
 22 derstanding of health literacy and self-
 23 management concepts, as well as the bene-
 24 fits of improved provider-patient commu-
 25 nications; and

1 “(iv) understand the concept of low
 2 health literacy, and the barriers it presents
 3 to care; and

4 “(B) if determined appropriate, materials
 5 and information identified by community-based
 6 organizations, including other non-profit organi-
 7 zations, that are beneficial in assisting
 8 healthcare providers and patients in making de-
 9 cisions regarding health, healthcare, and patient
 10 recovery; and

11 “(C) other material determined appro-
 12 priate by the Secretary; and

13 “(8) supporting initiatives that the Secretary
 14 determines to be useful to fulfill the purposes of the
 15 Internet Clearinghouse.

16 “(c) DEFINITIONS.—The definitions contained in sec-
 17 tion 2 of the Minority Health Improvement and Health
 18 Disparity Elimination Act shall apply for purposes of this
 19 section.”.

20 **SEC. 102. HEALTHCARE WORKFORCE COMPOSITION AND**
 21 **PLACEMENT.**

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

1 **“SEC. 793. HEALTHCARE WORKFORCE, EDUCATION, AND**
 2 **TRAINING.**

3 “(a) IN GENERAL.—The Secretary, acting through
 4 the Administrator of the Health Resources and Services
 5 Administration and the Deputy Assistant Secretary for
 6 Minority Health, shall establish a database that can
 7 produce aggregated and disaggregated statistics on health
 8 professional students, including applicants, matriculates,
 9 and graduates.

10 “(b) REQUIREMENT TO COLLECT DATA.—

11 “(1) IN GENERAL.—Each health professions
 12 school described in paragraph (2) that receives Fed-
 13 eral funds shall collect race and ethnicity data, pri-
 14 mary language data, and where feasible, other health
 15 disparity data pursuant to subsection (d), con-
 16 cerning the students described in subsection (a), as
 17 well as intended geographical site of practice and in-
 18 tended discipline of practice for graduates. In col-
 19 lecting race and ethnicity data, a school shall—

20 “(A) at a minimum, use the categories for
 21 race and ethnicity established by the Director of
 22 the Office of Management and Budget in effect
 23 on the date of enactment of the Minority
 24 Health Improvement and Health Disparity
 25 Elimination Act; and

1 “(B) if practicable, collect data on addi-
2 tional population groups if such data can be ag-
3 gregated into the minimum race and ethnicity
4 data categories.

5 “(2) HEALTH PROFESSIONS SCHOOL.—A health
6 professions school described under this paragraph is
7 a school of medicine or osteopathic medicine, public
8 health, nursing, dentistry, optometry, pharmacy, al-
9 lied health, podiatric medicine, or veterinary medi-
10 cine, or a graduate program in mental health prac-
11 tice.

12 “(c) REPORTING.—Each school or program described
13 under subsection (b), shall, on an annual basis, report
14 data on race and ethnicity and primary language collected
15 under this section to the Secretary for inclusion in the
16 database established under subsection (a). The Secretary
17 shall ensure that such disparity data is reported to Con-
18 gress and made available to the public.

19 “(d) HEALTH DISPARITY MEASURES.—The Sec-
20 retary shall develop, report, and disseminate measures of
21 the other health data referenced in section 793(b)(1), to
22 ensure uniform and consistent collection and reporting of
23 these measures by health professions schools. In devel-
24 oping such measures, the Secretary shall take into consid-

1 eration health disparity indicators developed pursuant to
2 section 2901(c).

3 “(e) USE OF DATA.—Data reported pursuant to sub-
4 section (c) shall be used by the Secretary to conduct ongo-
5 ing short- and long-term analyses of diversity within
6 health professions schools and the health professions. The
7 Secretary shall ensure that such analyses are reported to
8 Congress and made available to the public.

9 “(f) CULTURAL COMPETENCY TRAINING.—The Sec-
10 retary shall mandate the collection and reporting of data
11 from health professions schools regarding the extent to
12 which cultural competency training is provided to health
13 professions students, that may include the duration, con-
14 tent and timing of the training, and conduct periodic as-
15 sessments regarding the preparedness of such students to
16 care for patients from racial and ethnic minority groups.

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

22 “(h) PARTNERSHIP.—The Secretary may contract
23 with external entities to fulfill the requirements under this
24 section if such entities have demonstrated expertise and
25 experience collecting, analyzing, and reporting data re-

1 quired under this section for health professional stu-
 2 dents.”.

3 (b) NATIONAL HEALTH SERVICE CORPS PRO-
 4 GRAM.—

5 (1) ASSIGNMENT OF CORPS PERSONNEL.—Sec-
 6 tion 333(a)(3) of the Public Health Service Corps
 7 (42 U.S.C. 254f(a)(3)) is amended to read as fol-
 8 lows:

9 “(3)(A) In approving applications for assign-
 10 ment of members of the Corps, the Secretary shall
 11 not discriminate against application from entities
 12 which are not receiving Federal financial assistance
 13 under this Act.

14 “(B) In approving such applications, the Sec-
 15 retary shall—

16 “(i) give preference to applications in
 17 which a nonprofit entity or public entity shall
 18 provide a site to which Corps members may be
 19 assigned; and

20 “(ii) give highest preference to applica-
 21 tions—

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

1 “(II) from entities described in clause
 2 (i) that primarily serve racial and ethnic
 3 minority groups with annual incomes at or
 4 below twice those set forth in the most re-
 5 cent poverty guidelines issued by the Sec-
 6 retary pursuant to section 673(2) of the
 7 Community Services Block Grant Act (42
 8 U.S.C. 9902(2)).”.

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

12 (A) in subsection (a)—

13 (i) by redesignating paragraphs (1),
 14 (2), and (3) as paragraphs (2), (3), and
 15 (4), respectively; and

16 (ii) by striking “shall—” and insert-
 17 ing “shall—

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

20 (B) by striking “subsection (a)(1)” each
 21 place it appears and inserting “subsection
 22 (a)(2)”.

23 (3) CONFORMING AMENDMENT.—Section
 24 338I(c)(3)(B)(ii) of the Public Health Service Act
 25 (42 U.S.C. 254q–1(c)(3)(B)(ii)) is amended by

1 striking “section 333A(a)(1)” and inserting “section
2 333A(a)(2)”.

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

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

6 (1) by striking subsection (a) and inserting the
7 following:

8 “(a) IN GENERAL.—The Secretary shall make grants
9 to, and enter into contracts with, public and nonprofit pri-
10 vate health or educational entities, including designated
11 health professions schools described in subsection (c), for
12 the purpose of assisting the entities in supporting pro-
13 grams of excellence in health professions education for
14 underrepresented minorities in health professions.”;

15 (2) by striking subsection (b) and inserting the
16 following:

17 “(b) REQUIRED USE OF FUNDS.—The Secretary
18 may not make a grant under subsection (a) unless the des-
19 ignated health professions school agrees, subject to sub-
20 section (c)(1)(C), to use the funds awarded under the
21 grant to—

22 “(1) develop a large competitive applicant pool
23 through linkages with institutions of higher edu-
24 cation, local school districts, and other community-

1 based entities and establish an education pipeline for
2 health professions careers;

3 “(2) establish, strengthen, or expand programs
4 to enhance the academic performance of underrep-
5 resented minority in health professions students at-
6 tending the school;

7 “(3) improve the capacity of such school to
8 train, recruit, and retain underrepresented minority
9 faculty members including the payment of such sti-
10 pends and fellowships as the Secretary may deter-
11 mine appropriate;

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

16 “(5) facilitate faculty and student research on
17 health issues particularly affecting racial and ethnic
18 minority groups, including research on issues relat-
19 ing to the delivery of culturally competent healthcare
20 (as defined in section 270);

21 “(6) establish and implement a program to
22 train students of the school in providing health serv-
23 ices to racial and ethnic minority individuals through
24 training provided to such students at community-
25 based health facilities that—

1 “(A) provide such health services; and

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

4 “(7) provide stipends as the Secretary deter-
5 mines appropriate, in amounts as the Secretary de-
6 termines appropriate; and

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

10 (3) in subsection (c)—

11 (A) by amending paragraph (1) to read as
12 follows:

13 “(1) DESIGNATED SCHOOLS.—

14 “(A) IN GENERAL.—The designated health
15 professions schools referred to in subsection (a)
16 are such schools that meet each of the condi-
17 tions specified in subparagraphs (B) and (C),
18 and that—

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

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

23 “(iii) meet each of the conditions
24 specified in paragraph (4); or

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

3 “(B) GENERAL CONDITIONS.—The condi-
4 tions specified in this subparagraph are that a
5 designated health professions school—

6 “(i) has a significant number of
7 underrepresented minority in health pro-
8 fessions students enrolled in the school, in-
9 cluding individuals accepted for enrollment
10 in the school;

11 “(ii) has been effective in assisting
12 such students of the school to complete the
13 program of education and receive the de-
14 gree involved;

15 “(iii) has been effective in recruiting
16 such students to enroll in and graduate
17 from the school, including providing schol-
18 arships and other financial assistance to
19 such students and encouraging such stu-
20 dents from all levels of the educational
21 pipeline to pursue health professions ca-
22 reers; and

23 “(iv) has made significant recruitment
24 efforts to increase the number of underrep-
25 resented minority in health professions in-

1 dividuals serving in faculty or administra-
 2 tive positions at the school.

3 “(C) CONSORTIUM.—The condition speci-
 4 fied in this subparagraph is that, in accordance
 5 with subsection (e)(1), the designated health
 6 profession school involved has with other health
 7 profession schools (designated or otherwise)
 8 formed a consortium to carry out the purposes
 9 described in subsection (b) at the schools of the
 10 consortium.

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

20 (B) by amending paragraph (2) to read as
 21 follows:

22 “(2) CENTERS OF EXCELLENCE AT CERTAIN
 23 HISTORICALLY BLACK COLLEGES AND UNIVER-
 24 SITIES.—

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

5 “(B) USE OF GRANT.—In addition to the
 6 purposes described in subsection (b), a grant
 7 under subsection (a) to a designated health pro-
 8 fessions school meeting the conditions described
 9 in subparagraph (A) may be expended—

10 “(i) to develop a plan to achieve insti-
 11 tutional improvements, including financial
 12 independence, to enable the school to sup-
 13 port programs of excellence in health pro-
 14 fessions education for underrepresented
 15 minority individuals; and

16 “(ii) to provide improved access to the
 17 library and informational resources of the
 18 school.

19 “(C) EXCEPTION.—The requirements of
 20 paragraph (1)(C) shall not apply to a histori-
 21 cally black college or university that receives
 22 funding under this paragraph or paragraph
 23 (5).”; and

24 (C) by amending paragraphs (3) through
 25 (5) to read as follows:

1 “(3) HISPANIC CENTERS OF EXCELLENCE.—

2 The conditions specified in this paragraph are
3 that—

4 “(A) with respect to Hispanic individuals,
5 each of clauses (i) through (iv) of paragraph
6 (1)(B) applies to the designated health profes-
7 sions school involved;

8 “(B) the school agrees, as a condition of
9 receiving a grant under subsection (a) of this
10 section, that the school will, in carrying out the
11 duties described in subsection (b) of this sec-
12 tion, give priority to carrying out the duties
13 with respect to Hispanic individuals; and

14 “(C) the school agrees, as a condition of
15 receiving a grant under subsection (a) of this
16 section, that—

17 “(i) the school will establish an ar-
18 rangement with 1 or more public or non-
19 profit community-based Hispanic serving
20 organizations, or public or nonprofit pri-
21 vate institutions of higher education, in-
22 cluding schools of nursing, whose enroll-
23 ment of students has traditionally included
24 a significant number of Hispanic individ-

uals, the purposes of which will be to carry
out a program—

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

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

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

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

“(A) with respect to Native Americans,
each of clauses (i) through (iv) of paragraph
(1)(B) applies to the designated health profes-
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 Native Americans; 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 private institutions of higher edu-
13 cation, including schools of nursing, whose
14 enrollment of students has traditionally in-
15 cluded a significant number of Native
16 Americans, the purpose of which arrange-
17 ment will be to carry out a program—

18 “(I) to identify Native American
19 students, from the institutions of
20 higher education referred to in clause
21 (i), who are interested in health pro-
22 fessions careers; and

23 “(II) to facilitate the educational
24 preparation of such students to enter

1 the designated health professions
2 school; and

3 “(ii) the designated health professions
4 school will make efforts to recruit Native
5 American students, including students who
6 have participated in the undergraduate
7 program carried out under arrangements
8 established by the school pursuant to
9 clause (i) and will assist Native American
10 students regarding the completion of the
11 educational requirements for a degree from
12 the designated health professions school.

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

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

18 “(B) that the health professions school in-
19 volved has an enrollment of underrepresented
20 minorities in health professions significantly
21 above the national average for such enrollments
22 of health professions schools.”; and

23 (4) by striking subsection (h) and inserting the
24 following:

25 “(h) FORMULA FOR ALLOCATIONS.—

1 “(1) ALLOCATIONS.—Based on the amount ap-
2 propriated under section 106(a) of the Minority
3 Health Improvement and Health Disparity Elimini-
4 nation Act for a fiscal year, the following subpara-
5 graphs shall apply as appropriate:

6 “(A) IN GENERAL.—If the amounts appro-
7 priated under section 106(a) of the Minority
8 Health Improvement and Health Disparity
9 Elimination Act for a fiscal year are
10 \$24,000,000 or less—

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

16 “(ii) and available after grants are
17 made with funds under clause (i), the Sec-
18 retary shall make available—

19 “(I) 60 percent of such amount
20 for grants under subsection (a) to
21 health professions schools that meet
22 the conditions described in paragraph
23 (3) or (4) of subsection (c) (including
24 meeting the conditions under sub-
25 section (e)); and

1 “(II) 40 percent of such amount
2 for grants under subsection (a) to
3 health professions schools that meet
4 the conditions described in subsection
5 (c)(5).

6 “(B) FUNDING IN EXCESS OF
7 \$24,000,000.—If amounts appropriated under
8 section 106(a) of the Minority Health Improve-
9 ment and Health Disparity Elimination Act for
10 a fiscal year exceed \$24,000,000 but are less
11 than \$30,000,000—

12 “(i) 80 percent of such excess
13 amounts shall be made available for grants
14 under subsection (a) to health professions
15 schools that meet the requirements de-
16 scribed in paragraph (3) or (4) of sub-
17 section (c) (including meeting conditions
18 pursuant to subsection (e)); and

19 “(ii) 20 percent of such excess
20 amount shall be made available for grants
21 under subsection (a) to health professions
22 schools that meet the conditions described
23 in subsection (c)(5).

24 “(C) FUNDING IN EXCESS OF
25 \$30,000,000.—If amounts appropriated under

1 section 106(a) of the Minority Health Improve-
2 ment and Health Disparity Elimination Act for
3 a fiscal year exceed \$30,000,000 but are less
4 than \$40,000,000, the Secretary shall make
5 available—

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

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

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

20 “(iv) after grants are made with
21 funds under clauses (i) through (iii), any
22 remaining excess amount for grants under
23 subsection (a) to health professions schools
24 that meet the conditions described in para-

graph (2)(A), (3), (4), or (5) of subsection
(c).

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

“(i) not less than \$16,000,000 for
grants under subsection (a) to health pro-
fessions schools that meet the conditions
described in subsection (c)(2)(A);

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

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

“(iv) after grants are made with
funds under clauses (i) through (iii), any
remaining funds for grants under sub-

1 section (a) to health professions schools
2 that meet the conditions described in para-
3 graph (2)(A), (3), (4), or (5) of subsection
4 (c).

5 “(2) NO LIMITATION.—Nothing in this sub-
6 section shall be construed as limiting the centers of
7 excellence referred to in this section to the des-
8 ignated amount, or to preclude such entities from
9 competing for grants under this section.

10 “(3) MAINTENANCE OF EFFORT.—

11 “(A) IN GENERAL.—With respect to activi-
12 ties for which a grant made under this part are
13 authorized to be expended, the Secretary may
14 not make such a grant to a center of excellence
15 for any fiscal year unless the center agrees to
16 maintain expenditures of non-Federal amounts
17 for such activities at a level that is not less
18 than the level of such expenditures maintained
19 by the center for the fiscal year preceding the
20 fiscal year for which the school receives such a
21 grant.

22 “(B) USE OF FEDERAL FUNDS.—With re-
23 spect to any Federal amounts received by a cen-
24 ter of excellence and available for carrying out
25 activities for which a grant under this part is

1 authorized to be expended, the center shall, be-
2 fore expending the grant, expend the Federal
3 amounts obtained from sources other than the
4 grant, unless given prior approval from the Sec-
5 retary.

6 “(i) EVALUATIONS.—

7 “(1) ADVISORY COMMITTEE.—

8 “(A) IN GENERAL.—Not later than 90
9 days after the date of enactment of the Minor-
10 ity Health Improvement and Health Disparity
11 Elimination Act, the Secretary shall establish
12 and appoint the members of an advisory com-
13 mittee composed of representatives of govern-
14 ment agencies, including the Health Resources
15 and Services Administration, the Office of Mi-
16 nority Health, and the Indian Health Service,
17 community stakeholders and experts in identi-
18 fying and addressing the health concerns of ra-
19 cial and ethnic minority groups, and designees
20 from health professions schools described in
21 subsection (b).

22 “(B) DUTIES.—The advisory committee
23 shall develop and recommend performance
24 measures with which to assess, based on data to
25 be compiled by recipients of grants or contracts

1 under this section or section 736, 737, 738, or
2 739, the extent to which the program described
3 in this section and sections 736, 737, 738, and
4 739 has met the purpose of this part. The advi-
5 sory committee shall submit such recommenda-
6 tions to the Administrator of the Health Re-
7 sources and Services Administration not later
8 than 6 months after the appointment of the ad-
9 visory committee.

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

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

3 “(A) IN GENERAL.—The Administrator of
4 the Health Resources and Services Administra-
5 tion shall collect data on an annual basis from
6 recipients of grants or contracts under this sec-
7 tion or section 736, 737, 738, or 739 on the
8 performance measures established under para-
9 graph (1).

10 “(B) BIENNIAL MEETING.—The Adminis-
11 trator of the Health Resources and Services Ad-
12 ministration shall convene a meeting of the ad-
13 visory committee established under paragraph
14 (1) not less than twice per year. At the meet-
15 ing, the advisory committee shall recommend
16 any necessary changes to such performance
17 measures to improve data collection and short-
18 term evaluation with respect to the programs
19 carried out under this section or section 736,
20 737, 738, or 739, and provide technical assist-
21 ance as necessary.

22 “(3) UPDATES.—The Administrator of the
23 Health Resources and Services Administration shall
24 determine whether to incorporate the recommended
25 changes as described in paragraph (2)(B) and pro-

1 vide technical assistance as necessary. The Adminis-
 2 trator shall not penalize a current recipient of a
 3 grant or contract under this section or section 736,
 4 737, 738, or 739 for failing to comply with the re-
 5 vised data collection or performance measure re-
 6 quirements if the recipient demonstrates an inability
 7 to provide additional data mandated under the re-
 8 quirements.

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

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

20 **“SEC. 742. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
 21 **GREE PROGRAMS.**

22 “(a) COOPERATIVE AGREEMENTS.—The Secretary
 23 shall award cooperative agreements to accredited schools
 24 of public health, schools of allied health, and public health
 25 programs to design and implement a degree program over

1 the Internet (referred to in this section as an ‘online de-
2 gree program’).

3 “(b) APPLICATION.—To be eligible to receive a coop-
4 erative agreement under subsection (a), an accredited
5 school of public health, school of allied health, or public
6 health program shall submit an application at such time,
7 in such manner, and containing such information as the
8 Secretary may require.

9 “(c) PRIORITY.—In awarding cooperative agreements
10 under this section, the Secretary shall give priority to any
11 accredited school of public health, school of allied health,
12 or public health program that serves a disproportionate
13 number of individuals from racial and ethnic minority
14 groups.

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

18 “(1) Limiting enrollment to individuals who
19 have obtained a secondary school diploma or a rec-
20 ognized equivalent.

21 “(2) Maintaining significant enrollment and
22 graduation of underrepresented minorities in health
23 professions.”.

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

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

5 “The definition contained in section 738(b)(5) shall
 6 apply for purposes of this part, except that such definition
 7 shall also apply in the case of references to ‘underrep-
 8 resented minority students’, ‘underrepresented minority
 9 faculty members’, ‘underrepresented minority faculty ad-
 10 ministrators’, and ‘underrepresented minorities in health
 11 professions’.”.

12 **SEC. 104. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
 13 **SHIP PROGRAM.**

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

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

18 (2) by redesignating section 770 as section 771;

19 and

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

21 **“SEC. 770. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
 22 **SHIP PROGRAM.**

23 “(a) IN GENERAL.—The Secretary may make grants
 24 to eligible schools to award scholarships to eligible individ-
 25 uals to attend the school involved, for the purpose of ena-

1 bling the individuals to make a career change from a non-
 2 health profession to a health profession.

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

7 “(c) USE OF FUNDS.—Amounts awarded as a schol-
 8 arship under this section may be expended only for tuition
 9 expenses, other reasonable educational expenses, and rea-
 10 sonable living expenses incurred in the attendance of the
 11 school involved.

12 “(d) DEFINITIONS.—In this section:

13 “(1) ELIGIBLE SCHOOL.—The term ‘eligible
 14 school’ means an accredited school of medicine, os-
 15 teopathic medicine, dentistry, nursing, pharmacy,
 16 podiatric medicine, optometry, veterinary medicine,
 17 public health, chiropractic, allied health, a school of-
 18 fering a graduate program in behavioral and mental
 19 health practice, or an entity providing programs for
 20 the training of physician assistants.

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

1 **SEC. 105. CULTURAL COMPETENCY TRAINING.**

2 Part B of title VII of the Public Health Service Act
3 (42 U.S.C. 293 et seq.), as amended by section 104, is
4 amended by adding at the end the following:

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

6 “(a) IN GENERAL.—The Secretary, acting through
7 the Administrator of the Health Resources and Services
8 Administration and in collaboration with the Office of Mi-
9 nority Health and Agency for Healthcare Research and
10 Quality, shall support the development, evaluation, and
11 dissemination of model curricula for cultural competency
12 training for use in health professions schools and con-
13 tinuing education programs, and other purposes deter-
14 mined appropriate by the Secretary.

15 “(b) CURRICULA.—In carrying out subsection (a),
16 the Secretary shall collaborate with health professional so-
17 cieties, licensing and accreditation entities, health profes-
18 sions schools, and experts in minority health and cultural
19 competency, community-based organizations, and other
20 organizations as determined appropriate by the Secretary.
21 Such curricula shall include a focus on cultural com-
22 petency measures and cultural competency self-assessment
23 methodology for health providers, systems and institu-
24 tions.

25 “(c) DISSEMINATION.—

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

5 “(2) EVALUATION.—The Secretary shall evalu-
6 ate adoption and the implementation of cultural
7 competency training curricula, and facilitate inclu-
8 sion of cultural competency measures in quality
9 measurement systems as appropriate.”.

10 **SEC. 106. AUTHORIZATION OF APPROPRIATIONS; REAU-**
11 **THORIZATIONS.**

12 (a) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated—

14 (1) such sums as may be necessary for each of
15 fiscal years 2008 through 2012, to carry out the
16 amendments made by sections 101 and 102 of this
17 title (adding sections 270 and 793 to the Public
18 Health Service Act);

19 (2) \$45,000,000 for fiscal year 2008 and such
20 sums as may be necessary for each of fiscal years
21 2009 through 2012, to carry out the amendments
22 made by section 103(a) (relating to centers of excel-
23 lence in section 736 of the Public Health Service
24 Act);

1 (3) such sums as may be necessary for each of
 2 fiscal years 2008 through 2012, to carry out the
 3 amendments made by section 103(b) (adding section
 4 742 to the Public Health Service Act);

5 (4) such sums as may be necessary for each of
 6 fiscal years 2008 through 2012, to carry out the
 7 amendments made by section 104(b) (adding section
 8 770 to the Public Health Service Act); and

9 (5) such sums as may be necessary for each of
 10 fiscal years 2008 through 2012, to carry out the
 11 amendment made by section 105 (adding section
 12 743 to the Public Health Service Act).

13 (b) REAUTHORIZATIONS.—The following programs
 14 are reauthorized as follows:

15 (1) EDUCATIONAL ASSISTANCE IN THE HEALTH
 16 PROFESSIONS REGARDING INDIVIDUALS FROM DIS-
 17 ADVANTAGED BACKGROUND.—Section 740(c) of the
 18 Public Health Service Act (42 U.S.C. 293a(c)) is
 19 amended by striking the first sentence and inserting
 20 the following: “For the purpose of grants and con-
 21 tracts under section 739(a)(1), there is authorized to
 22 be appropriated \$60,000,000 for fiscal year 2008
 23 and such sums as may be necessary for each of fis-
 24 cal years 2009 through 2012.”.

1 (2) SCHOLARSHIPS FOR DISADVANTAGED STU-
2 DENTS.—Section 740(a) of the Public Health Serv-
3 ice Act (42 U.S.C. 293a(a)) is amended by striking
4 “\$37,000,000” and all that follows through
5 “through 2002” and inserting “\$51,000,000 for fis-
6 cal year 2008, and such sums as may be necessary
7 for each of fiscal years 2009 through 2012”.

8 (3) LOAN REPAYMENTS AND FELLOWSHIPS.—
9 Section 740(b) of the Public Health Service Act (42
10 U.S.C. 293a(b)) is amended by striking
11 “\$1,100,000” and all that follows through “through
12 2002” and inserting “\$1,700,000 for fiscal year
13 2008, and such sums as may be necessary for each
14 of fiscal years 2009 through 2012”.

15 (4) GRANTS FOR HEALTH PROFESSIONS EDU-
16 CATION.—Section 741 of the Public Health Service
17 Act (42 U.S.C. 293e) is amended in subsection (b),
18 by striking “\$3,500,000” and all that follows
19 through the period and inserting “such sums as may
20 be necessary for each of fiscal years 2008 through
21 2012.”.

1 **TITLE II—PROMOTING HEALTH**
 2 **AND HEALTHCARE AWARE-**
 3 **NESS AND ACCESS**

4 **SEC. 201. CARE AND ACCESS.**

5 Part P of title III of the Public Health Service Act
 6 (42 U.S.C. 280g et seq.) is amended by adding at the end
 7 the following:

8 **“SEC. 399R. ACCESS, AWARENESS, AND OUTREACH ACTIVI-**
 9 **TIES.**

10 “(a) DEMONSTRATION PROJECTS.—The Secretary
 11 shall award multiyear contracts or competitive grants to
 12 eligible entities to support demonstration projects de-
 13 signed to improve the health and healthcare of racial and
 14 ethnic minority groups through improved access to
 15 healthcare, patient navigators, primary prevention activi-
 16 ties, health promotion and disease prevention activities,
 17 and health literacy education and services.

18 “(b) ELIGIBILITY.—In this section:

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

22 “(2) ORGANIZATION.—The term ‘organization’
 23 means—

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

25 “(B) an academic institution;

1 “(C) a State health agency;

2 “(D) an Indian Health Service hospital or
3 clinic, Indian tribal health facility, or urban In-
4 dian facility;

5 “(E) a nonprofit organization, including a
6 faith-based organization or consortium, to the
7 extent that a contract or grant awarded to such
8 an entity is consistent with the requirements of
9 section 1955;

10 “(F) a primary care practice-based re-
11 search network; and

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

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

17 “(A) includes—

18 “(i) individuals who are representa-
19 tives of organizations of racial and ethnic
20 minority groups;

21 “(ii) community leaders and leaders of
22 community-based organizations;

23 “(iii) healthcare providers, including
24 providers who treat racial and ethnic mi-
25 nority groups; and

1 “(iv) experts in the area of social and
 2 behavioral science, who have knowledge,
 3 training, or practical experience in health
 4 policy, advocacy, cultural or linguistic com-
 5 petency, or other relevant areas as deter-
 6 mined by the Secretary; and

7 “(B) is located within a federally- or State-
 8 designated medically underserved area, a feder-
 9 ally designated health provider shortage area,
 10 or an area with a significant population of ra-
 11 cial and ethnic minorities.

12 “(c) APPLICATION.—An eligible entity seeking a con-
 13 tract or grant under this section shall submit an applica-
 14 tion to the Secretary at such time, in such manner, and
 15 containing such information as the Secretary may require,
 16 including assurances that the eligible entity will—

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

20 “(2) collaborate with appropriate community
 21 organizations and include meaningful community
 22 participation in planning, implementation, and eval-
 23 uation of activities;

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

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

5 “(5) evaluate the effectiveness of activities
6 under this section, within an appropriate time
7 frame, which shall include a focus on quality and
8 outcomes performance measures to ensure that the
9 activities are meeting the intended goals, and that
10 the entity is able to disseminate findings from such
11 evaluations;

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

14 “(7) demonstrate coordination between public
15 and private entities; and

16 “(8) assist individuals and groups in accessing
17 public and private programs that will help eliminate
18 disparities in health and healthcare.

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

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

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

5 “(3) a community-based consortium as de-
6 scribed in subsection (b)(3)(A);

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

9 “(5) an Indian tribe, tribal organization, or
10 urban Indian organization; and

11 “(6) other health systems that—

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

15 “(B) provide care or treatment for a sub-
16 stantial number of patients who are uninsured,
17 are receiving assistance under a State program
18 under title XIX of the Social Security Act, or
19 are members of vulnerable populations, as de-
20 termined by the Secretary;

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

23 “(D) provide an assurance that amounts
24 received under the grant or contract will be
25 used to implement strategies that address pa-

1 tients’ linguistic needs, where necessary, and re-
 2 cruit and maintain diverse staff and leadership;
 3 and

4 “(E) provide an assurance that amounts
 5 received under the grant or contract will be
 6 used to support quality improvement activities
 7 for patients from racial and ethnic minority
 8 groups.

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

12 “(1) address health disparities in the United
 13 States-Mexico Border Area, as defined in section 8
 14 of the United States-Mexico Border Health Commis-
 15 sion Act (22 U.S.C. 290n–6), relating to health dis-
 16 parities in the areas of—

17 “(A) maternal and child health;

18 “(B) primary care and preventive health,
 19 including health education and promotion;

20 “(C) public health and the built environ-
 21 ment;

22 “(D) oral health;

23 “(E) behavioral and mental health and
 24 substance abuse;

1 “(F) health conditions that have a dis-
2 proportionate impact on racial and ethnic mi-
3 norities and a high prevalence in the Border
4 Area;

5 “(G) health services research;

6 “(H) environmental health;

7 “(I) workforce training and development;

8 or

9 “(J) other areas determined appropriate by
10 the Secretary;

11 “(2) implement the best practices in disease
12 management, including those that address primary
13 prevention and co-occurring chronic conditions, as
14 defined by the public-private partnership established
15 under section 918(b), that target patients with low
16 health literacy, and, as feasible, incorporate health
17 information technology;

18 “(3) evaluate methods for strengthening the
19 health coverage and continuity of coverage of migra-
20 tory and seasonal agricultural workers, as such
21 terms are defined in section 330(g), and workers in
22 other industries with traditionally low rates of em-
23 ployer-sponsored health insurance; and

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

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

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

13 **“SEC. 399S. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
 14 **HAVIORS.**

15 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
 16 laboration with the Director of the Centers for Disease
 17 Control and Prevention and other Federal officials deter-
 18 mined appropriate by the Secretary, may award grants to
 19 State or local governments, Indian tribes (including Alas-
 20 ka Native villages), tribal organizations, or urban Indian
 21 organizations, to promote positive health behaviors for ra-
 22 cial and ethnic minority populations, especially in medi-
 23 cally underserved communities.

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

4 “(1) to educate, guide, and provide outreach in
5 a community setting regarding health problems prev-
6 alent among racial and ethnic minority populations,
7 especially in medically underserved communities;

8 “(2) to educate, guide, and provide experiential
9 learning opportunities that target behavioral risk
10 factors including—

11 “(A) poor nutrition;

12 “(B) physical inactivity;

13 “(C) being overweight or obese;

14 “(D) tobacco use;

15 “(E) alcohol and substance use;

16 “(F) injury and violence;

17 “(G) risky sexual behavior;

18 “(H) mental health problems;

19 “(I) poor oral health;

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

23 “(4) to educate and provide outreach regarding
24 enrollment in health insurance including the State
25 Children’s Health Insurance Program under title

1 XXI of the Social Security Act, Medicare under title
2 XVIII of such Act and Medicaid under title XIX of
3 such Act;

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

6 “(6) to educate and refer racial and ethnic mi-
7 norities to appropriate healthcare agencies and com-
8 munity-based programs and organizations in order
9 to increase access to quality healthcare services, in-
10 cluding preventive health services; or

11 “(7) to educate, guide, and provide home visita-
12 tion services to improve maternal and child health
13 outcomes.

14 “(c) APPLICATION.—

15 “(1) IN GENERAL.—Each State or local govern-
16 ment, Indian tribe (including Alaska Native vil-
17 lages), tribal organizations, or urban Indian organi-
18 zations that desires to receive a grant under sub-
19 section (a) shall submit an application to the Sec-
20 retary, at such time, in such manner, and accom-
21 panied by such information as the Secretary may re-
22 quire.

23 “(2) CONTENTS.—Each application submitted
24 pursuant to paragraph (1) shall—

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

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

9 “(C) contain an assurance that the appli-
10 cant will evaluate the effectiveness of commu-
11 nity health worker programs receiving funds
12 under the grant;

13 “(D) contain an assurance that each com-
14 munity health worker program receiving funds
15 under the grant will provide services in the cul-
16 tural context most appropriate for the individ-
17 uals served by the program;

18 “(E) contain a plan to document and dis-
19 seminate project descriptions and results to
20 other States and organizations as identified by
21 the Secretary; and

22 “(F) describe plans to enhance the capac-
23 ity of individuals to utilize health services and
24 health-related social services under Federal,
25 State, and local programs by—

1 “(i) assisting individuals in estab-
 2 lishing eligibility under the programs and
 3 in receiving the services or other benefits
 4 of the programs; and

5 “(ii) providing other services as the
 6 Secretary determines to be appropriate,
 7 that may include transportation and trans-
 8 lation services.

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

12 “(1) propose to target geographic areas—

13 “(A) with a high percentage of residents
 14 who are eligible for health insurance but are
 15 uninsured or underinsured; and

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

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

21 “(3) have documented community activity and
 22 experience with community health workers.

23 “(e) COLLABORATION WITH ACADEMIC INSTITU-
 24 TIONS.—The Secretary shall encourage community health
 25 worker programs receiving funds under this section to col-

1 laborate with academic institutions. Nothing in this sec-
2 tion shall be construed to require such collaboration.

3 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
4 NESS.—The Secretary shall establish guidelines for assur-
5 ing the quality of the training and supervision of commu-
6 nity health workers under the programs funded under this
7 section and for assuring the cost-effectiveness of such pro-
8 grams.

9 “(g) MONITORING.—The Secretary shall monitor
10 community health worker programs identified in approved
11 applications under this section and shall determine wheth-
12 er such programs are in compliance with the guidelines
13 established under subsection (f).

14 “(h) TECHNICAL ASSISTANCE.—The Secretary may
15 provide technical assistance to community health worker
16 programs identified in approved applications under this
17 section with respect to planning, developing, and operating
18 programs under the grant.

19 “(i) REPORT TO CONGRESS.—

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

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

3 “(A) A description of the programs for
4 which grant funds were used.

5 “(B) The number of individuals served
6 under such programs.

7 “(C) An evaluation of—

8 “(i) the effectiveness of such pro-
9 grams;

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

11 “(iii) the impact of the programs on
12 the health outcomes of the community resi-
13 dents.

14 “(D) Recommendations for sustaining the
15 community health worker programs developed
16 or assisted under this section.

17 “(E) Recommendations regarding training
18 to enhance career opportunities for community
19 health workers.

20 “(j) DEFINITIONS.—In this section:

21 “(1) COMMUNITY HEALTH WORKER.—The term
22 ‘community health worker’ means an individual who
23 promotes health or nutrition within the community
24 in which the individual resides—

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

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

5 “(C) by enhancing community residents’
6 ability to effectively communicate with
7 healthcare providers;

8 “(D) by providing culturally and linguis-
9 tically appropriate health or nutrition edu-
10 cation;

11 “(E) by advocating for individual and com-
12 munity health, including oral and mental, and
13 nutrition needs; and

14 “(F) by providing referral and follow-up
15 services.

16 “(2) COMMUNITY SETTING.—The term ‘commu-
17 nity setting’ means a home or a community organi-
18 zation located in the neighborhood in which a partic-
19 ipant resides.

20 “(3) MEDICALLY UNDERSERVED COMMUNITY.—
21 The term ‘medically underserved community’ means
22 a community identified by a State—

23 “(A) that has a substantial number of in-
24 dividuals who are members of a medically un-

1 derserved population, as defined by section
2 330(b)(3); and

3 “(B) a significant portion of which is a
4 health professional shortage area as designated
5 under section 332.

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

11 **“SEC. 399T. GRANTS FOR RACIAL AND ETHNIC AP-**
12 **PROACHES TO COMMUNITY HEALTH.**

13 “(a) PURPOSE.—It is the purpose of this section to
14 provide for the awarding of grants to assist communities
15 in mobilizing and organizing resources in support of effec-
16 tive and sustainable programs that will reduce or eliminate
17 disparities in health and healthcare experienced by racial
18 and ethnic minority individuals.

19 “(b) AUTHORITY TO AWARD GRANTS.—The Sec-
20 retary, acting through the Centers for Disease Control and
21 Prevention, in consultation with the Office of Minority
22 Health, shall award grants to eligible entities to assist in
23 designing, implementing, and evaluating culturally and
24 linguistically appropriate, evidence-based and community-

1 driven sustainable strategies to eliminate racial and ethnic
 2 health and healthcare disparities.

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

5 “(1) represent a coalition—

6 “(A) whose principal purpose is to develop
 7 and implement interventions to reduce or elimi-
 8 nate a health or healthcare disparity in a tar-
 9 geted racial or ethnic minority group in the
 10 community served by the coalition; and

11 “(B) that includes—

12 “(i) at least 3 members selected from
 13 among—

14 “(I) public health departments;

15 “(II) community-based organiza-
 16 tions;

17 “(III) university and research or-
 18 ganizations;

19 “(IV) Indian tribes, tribal organi-
 20 zations, urban Indian organizations,
 21 national or regional Indian organiza-
 22 tions, or the Indian Health Service;

23 “(V) organizations serving Native
 24 Hawaiians;

1 “(VI) organizations serving Pa-
2 cific Islanders; and

3 “(VII) interested public or pri-
4 vate healthcare providers or organiza-
5 tions as deemed appropriate by the
6 Secretary; and

7 “(ii) at least 1 member from a com-
8 munity-based organization that represents
9 the targeted racial or ethnic minority
10 group; and

11 “(2) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require, which shall
14 include—

15 “(A) a description of the targeted racial or
16 ethnic populations in the community to be
17 served under the grant;

18 “(B) a description of at least 1 health dis-
19 parity that exists in the racial or ethnic tar-
20 geted populations, including infant mortality,
21 breast and cervical cancer screening and man-
22 agement, cardiovascular disease, diabetes, child
23 and adult immunization levels, HIV/AIDS, hep-
24 atitis B, tuberculosis, asthma, or other health

1 priority areas as designated by the Secretary;
2 and

3 “(C) a demonstration of a proven record of
4 accomplishment of the coalition members in
5 serving and working with the targeted commu-
6 nity.

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

17 “(e) NONDUPLICATION.—Funds provided through
18 this grant program should supplement, not supplant, ex-
19 isting Federal funding, and the funds should not be used
20 to duplicate the activities of the other health disparity
21 grant programs in this Act.

22 “(f) TECHNICAL ASSISTANCE.—The Secretary may,
23 either directly or by grant or contract, provide any entity
24 that receives a grant under this section with technical and

1 other non-financial assistance necessary to meet the re-
 2 quirements of this section.

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

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

15 **“SEC. 399U. GRANTS FOR HEALTH DISPARITY**
 16 **COLLABORATIVES.**

17 “(a) PURPOSE.—The Secretary, acting through the
 18 Administrator of the Health Resources and Services Ad-
 19 ministration, shall award grants to eligible entities to as-
 20 sist in implementing systems of primary care practices to
 21 eliminate disparities in the delivery of healthcare and im-
 22 prove the healthcare provided to all patients.

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

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

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

10 “(A) Diabetes.

11 “(B) Asthma.

12 “(C) Depression.

13 “(D) Cardiovascular disease.

14 “(E) Cancer.

15 “(F) Preventive health, including
16 screenings.

17 “(G) Perinatal health.

18 “(H) Patient safety.

19 “(I) Oral health.

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

22 “(K) Other areas as designated by the Sec-
23 retary.

24 “(c) NONDUPLICATION.—Funds provided through
25 this grant program should supplement, not supplant, ex-

1 isting Federal funding, and the funds should not be used
 2 to duplicate the activities of the other health disparity
 3 grant programs in this Act.

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

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

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

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

17 “(b) HEALTH ACTION ZONE INITIATIVE PRO-
 18 GRAM.—

19 “(1) IN GENERAL.—The Secretary shall award
 20 Health Action Zone Initiative Program grants to
 21 State and local public health agencies and Indian
 22 tribes and tribal organizations of eligible commu-
 23 nities. Each grant shall be funded for 5 years.

24 “(2) ELIGIBLE COMMUNITIES.—

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

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

11 “(i) overall burden of disease and
12 health conditions;

13 “(ii) accessibility to and availability of
14 health and economic resources;

15 “(iii) proportion of individuals from
16 racial and ethnic minority groups; and

17 “(iv) other factors as determined ap-
18 propriate by the Secretary.

19 “(3) AGENCY COLLABORATION.—The Secretary,
20 in collaboration with the Deputy Assistant Secretary
21 for Minority Health, the Director of the Centers for
22 Disease Control and Prevention, the Administrator
23 of the Health Resources and Services Administra-
24 tion, the Director of the Indian Health Service, the
25 Director of the Centers for Medicare & Medicaid

1 Services, the Director of the Substance Abuse and
2 Mental Health Services Administration, and heads
3 of other Federal agencies as appropriate, shall deter-
4 mine, with respect to the Health Action Zone Initia-
5 tive Program—

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

11 “(B) current programmatic and research
12 initiatives in which eligible communities may
13 participate;

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

16 “(D) mechanisms to facilitate joint appli-
17 cation, or establish a common application, to
18 multiple grant programs, as appropriate.

19 “(4) APPLICATIONS.—

20 “(A) IN GENERAL.—The State and local
21 public health agencies of eligible communities
22 shall jointly submit an application to the Sec-
23 retary at such time, in such manner, and ac-
24 companied by such information as the Secretary

1 may require, including a strategic plan that
2 shall—

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

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

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

12 “(iv) identify Federal funding needed
13 to support the proposed activities; and

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

17 “(B) COMMUNITY ADVISORY BOARD.—

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

23 “(ii) MEMBERS.—

24 “(I) COMMUNITY.—The majority
25 of the members of a community advi-

1 sory board under clause (i) shall be
2 individuals that will benefit from the
3 activities or services provided by the
4 grants under this section.

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

16 “(iii) DUTIES.—A community advi-
17 sory board shall—

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

21 “(II) assist in the evaluation of
22 such activities; and

23 “(III) prepare an annual report
24 that describes the progress made to-
25 wards achieving stated goals and rec-

1 ommends time lines and future
2 courses of action.

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

8 “(A) promote disease prevention and
9 health promotion for racial and ethnic minority
10 groups;

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

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

21 “(D) coordinate and integrate community-
22 based activities including education, city plan-
23 ning, transportation initiatives, environmental
24 changes, and other related activities at the local

1 level that help improve public health and ad-
 2 dress health concerns;

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

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

10 “(G) assist eligible communities in meeting
 11 Healthy People 2010 objectives; and

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

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

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

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

1 **“SEC. 399W. OUTREACH.**

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

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

11 “(1) A State or local government.

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

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

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

20 “(5) An elementary or secondary school.

21 “(c) DEFINITION.—In this section:

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

25 “(A) a health program operated by the In-
26 dian Health Service, an Indian tribe, tribal or-

ganization or urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

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

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

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

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

“(i) is exempt from or not subject to Federal income tax, or is owned by an entity or entities exempt from or not subject to Federal income tax; and

“(ii) enrolls not less than 75 percent of its members in a plan or program funded in whole or in part under a Federal, State, or local healthcare program (other

1 than a program for government employ-
 2 ees); and

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

15 “(2) INDIANS; INDIAN TRIBE; TRIBAL ORGANI-
 16 ZATION; URBAN INDIAN ORGANIZATION.—The terms
 17 ‘Indian’, ‘Indian tribe’, ‘tribal organization’, and
 18 ‘urban Indian organization’ have the meanings given
 19 such terms in section 4 of the Indian Health Care
 20 Improvement Act (25 U.S.C. 1603).

21 “(d) PRIORITY FOR AWARD OF GRANTS.—

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

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

1 “(i) eligible but unenrolled children,
2 including such children who reside in rural
3 areas; or

4 “(ii) racial and ethnic minorities and
5 health disparity populations, including
6 those proposals that address cultural and
7 linguistic barriers to enrollment; and

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

11 “(i) safety net hospitals, defined as
12 hospitals with a low income utilization rate
13 greater than 25 percent (as defined in sec-
14 tion 1923(b)(3) of the Social Security Act
15 (42 U.S.C. 1396r-4(b)(3)));

16 “(ii) federally qualified health centers
17 as defined in section 1905(1)(2)(B) of the
18 Social Security Act with the ability to es-
19 tablish and lead a collaborative partner-
20 ship;

21 “(iii) community-based consortiums as
22 described in section 399R(b) (3)(A) and
23 (4);

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

1 “(v) Indian tribes, tribal organiza-
 2 tions, or urban Indian organizations;

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

5 “(vii) faith-based organizations or
 6 consortia.

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

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

20 “(a) IN GENERAL.—The Secretary shall award a
 21 grant to fund the Delta Health Initiative Rural Health,
 22 Education, and Workforce Infrastructure Demonstration
 23 Program for the purpose of addressing longstanding,
 24 unmet health needs in the Mississippi Delta, including
 25 health education, access and research, and job training.

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

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

7 “(2) solicit and fund proposals from local gov-
8 ernments, hospitals, healthcare clinics, academic in-
9 stitutions, and rural public health-related entities
10 and organizations for research development, edu-
11 cational programs, healthcare services, job training,
12 planning, construction, and the equipment of public
13 health-related facilities;

14 “(3) have experience working with federally
15 qualified health centers and local health depart-
16 ments; and

17 “(4) have experience in diabetes education and
18 management, promoting healthy communities, health
19 education, and wellness.

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

22 “(1) an academic health and research center;

23 “(2) at least 2 regional universities;

24 “(3) a school of nursing; and

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

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

12 **SEC. 202. AUTHORIZATION OF APPROPRIATIONS.**

13 There are authorized to be appropriated—

14 (1) such sums as may be necessary for each of
15 fiscal years 2008 through 2012, to carry out section
16 399R of the Public Health Service Act (as added by
17 section 201);

18 (2) \$52,000,000 for fiscal year 2008, and such
19 sums as may be necessary for each of fiscal years
20 2009 through 2012, to carry out section 399T of the
21 Public Health Service Act (as added by section 201);
22 and

23 (3) such sums as necessary for each of fiscal
24 years 2008 through 2012, to carry out sections

1 399S, 399U, 399V, 399W, and 399X of the Public
 2 Health Service Act (as added by section 201).

3 **TITLE III—RESEARCH TO RE-**
 4 **DUCE AND ELIMINATE**
 5 **HEALTH DISPARITIES**

6 **SEC. 301. AGENCY FOR HEALTHCARE RESEARCH AND**
 7 **QUALITY.**

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

11 **“SEC. 918. ENHANCED RESEARCH WITH RESPECT TO**
 12 **HEALTHCARE DISPARITIES.**

13 “(a) ACCELERATING THE ELIMINATION OF DISPARI-
 14 TIES.—

15 “(1) STRATEGIC PLAN.—The Secretary, acting
 16 through the Director, and in collaboration with the
 17 Deputy Assistant Secretary for Minority Health,
 18 shall develop a strategic plan regarding research
 19 supported by the agency to improve healthcare and
 20 eliminate healthcare disparities among racial and
 21 ethnic minority groups. In developing such plan, the
 22 Secretary shall—

23 “(A) determine which areas of research
 24 focus would have the greatest impact on
 25 healthcare improvement and elimination of dis-

1 parities, taking into consideration the overall
2 health status of various populations, dispropor-
3 tionate burden of diseases or health conditions,
4 and types of interventions for which data on ef-
5 fectiveness is limited;

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

8 “(C) solicit public review and comment
9 from experts in healthcare, minority health and
10 health disparities, health services research, and
11 other areas as determined appropriate by the
12 Secretary;

13 “(D) incorporate recommendations from
14 the Institute of Medicine, pursuant to section
15 303 of the Minority Health Improvement and
16 Health Disparity Elimination Act, as appro-
17 priate;

18 “(E) complete such plan within 12 months
19 of enactment of the Minority Health Improve-
20 ment and Health Disparity Elimination Act;
21 and

22 “(F) update such plan and report on
23 progress in meeting established goals and objec-
24 tives incorporating recommendations from the
25 Institute of Medicine as described in section

1 303(b) and (c) of the Minority Health Improve-
 2 ment and Health Disparity Elimination Act not
 3 less than every 2 years and include in annual
 4 performance budget submissions, an update of
 5 progress in meeting plan goals and objectives;

6 “(G) ensure coordination and integration
 7 with the National Plan to Improve Minority
 8 Health and Eliminate Health Disparities, as de-
 9 scribed in section 1707(c) and other Depart-
 10 ment-wide initiatives, as feasible; and

11 “(H) report the plan to the Congress and
 12 make available to the public in print and elec-
 13 tronic format.

14 “(2) ESTABLISHMENT OF GRANTS.—The Sec-
 15 retary, acting through the Director, and in collabo-
 16 ration with the Deputy Assistant Secretary for Mi-
 17 nority Health, may award grants or contracts to eli-
 18 gible entities for research to improve the health of
 19 racial and ethnic minority groups.

20 “(3) APPLICATION; ELIGIBLE ENTITIES.—

21 “(A) APPLICATION.—To receive a grant or
 22 contract under this section, an eligible entity
 23 shall submit to the Secretary an application at
 24 such time, in such manner, and containing such
 25 information as the Secretary may require.

1 “(B) ELIGIBLE ENTITIES.—To be eligible
2 to receive a grant or contract under this sec-
3 tion, an entity shall be a health center, hospital,
4 health system, community clinic, university,
5 community-based organization, or other health
6 entity determined appropriate by the Secretary,
7 that—

8 “(i) by legal mandate or explicitly
9 adopted mission, provides patients with ac-
10 cess to services regardless of their ability
11 to pay;

12 “(ii) provides care or treatment for a
13 substantial number of patients who are un-
14 insured, are receiving assistance under a
15 State program under title XIX of the So-
16 cial Security Act, or are members of vul-
17 nerable populations, as determined by the
18 Secretary;

19 “(iii) serves a disproportionate per-
20 centage of patients from racial and ethnic
21 minority groups;

22 “(iv) provides an assurance that
23 amounts received under the grant or con-
24 tract will be used to implement strategies
25 that address patients’ linguistic needs,

1 where necessary, and recruit and maintain
 2 diverse staff and leadership; and

3 “(v) include a focus on community-
 4 based participation in research and dem-
 5 onstrations, as well as research analysis,
 6 interpretation, solutions and partnerships
 7 for patients from racial and ethnic minor-
 8 ity groups.

9 “(C) PREFERENCE.—Consortia of 3 or
 10 more eligible entities, particularly those entities
 11 that partner with health plans, shall be given a
 12 preference for grant or contract funding.

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

16 “(A) prioritize the translation of existing
 17 research into practical interventions for improv-
 18 ing health and healthcare and reducing dispari-
 19 ties;

20 “(B) target areas of need as identified in
 21 the strategic plan pursuant to subsection (a)(1),
 22 the National Healthcare Disparities Report
 23 published by the Agency for Healthcare Re-
 24 search and Quality, the Unequal Treatment:
 25 Confronting Racial and Ethnic Disparities in

1 Health Care Report, and other relevant reports
 2 by the Institute of Medicine, and other reports
 3 issued by Federal health agencies;

4 “(C) include a focus on community-based
 5 participatory research solutions and partner-
 6 ships as appropriate;

7 “(D) expand practice-based research net-
 8 works (primary care and larger delivery sys-
 9 tems) to include networks of delivery sites serv-
 10 ing large numbers of minority and health dis-
 11 parity populations including—

12 “(i) public hospitals and private non-
 13 profit hospitals;

14 “(ii) health centers;

15 “(iii) health plans;

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

18 “(v) other sites as determined appro-
 19 priate by the Director.

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

24 “(A) develop outreach and training pro-
 25 grams for healthcare providers with respect to

1 the practical and effective interventions that re-
 2 sult from research programs carried out with
 3 grants or contracts awarded under this section;
 4 and

5 “(B) provide technical assistance for the
 6 implementation of evidence-based practices that
 7 will improve health and healthcare and reduce
 8 disparities.

9 “(b) REALIZING THE POTENTIAL OF DISEASE MAN-
 10 AGEMENT.—

11 “(1) PUBLIC-PRIVATE SECTOR PARTNERSHIP
 12 TO ASSESS EFFECTIVENESS OF EXISTING DISEASE
 13 MANAGEMENT STRATEGIES.—

14 “(A) IN GENERAL.—The Secretary shall
 15 establish a public-private partnership to iden-
 16 tify, evaluate, and disseminate effective disease
 17 management strategies, tailored to improve
 18 healthcare and health outcomes for patients
 19 from racial and ethnic minority groups. Such
 20 strategies shall reflect established healthcare
 21 quality standards and benchmarks and other
 22 evidence-based recommendations.

23 “(B) PARTNERSHIP COMPOSITION.—The
 24 partnership’s members shall include the fol-
 25 lowing:

1 “(i) Representatives from the fol-
2 lowing:

3 “(I) The Office of Minority
4 Health.

5 “(II) The Centers for Disease
6 Control and Prevention.

7 “(III) The Agency for Healthcare
8 Research and Quality.

9 “(IV) The Centers for Medicare
10 and Medicaid Services.

11 “(V) The Health Resources and
12 Services Administration.

13 “(VI) The Indian Health Service.

14 “(VII) The Substance Abuse and
15 Mental Health Services Administra-
16 tion.

17 “(VIII) The Office of Behavioral
18 Health.

19 “(IX) Other agencies as des-
20 ignated by the Secretary.

21 “(ii) Representatives of health plans,
22 employers, or other private entities that
23 have implemented disease management
24 programs.

1 “(iii) Representatives of hospitals;
 2 community health centers; large, small, or
 3 solo provider groups; or other organiza-
 4 tions that provide healthcare and have im-
 5 plemented disease management programs.

6 “(iv) Representatives of national mi-
 7 nority advocacy organizations, as well as
 8 community-based representatives who have
 9 been involved with establishing, imple-
 10 menting, or evaluating health promotion,
 11 disease prevention and disease manage-
 12 ment programs.

13 “(v) Other individuals as designated
 14 by the Secretary.

15 “(C) PARTNERSHIP DUTIES.—

16 “(i) IN GENERAL.—Not later than 18
 17 months after the date of enactment of the
 18 Minority Health Improvement and Health
 19 Disparity Elimination Act, the partnership
 20 shall release a best practices report with
 21 respect to disease management practices,
 22 with a particular focus on the following:

23 “(I) Self-management training.

1 “(II) Increasing patient partici-
 2 pation in and satisfaction with
 3 healthcare encounters.

4 “(III) Helping patients use qual-
 5 ity performance and cost information
 6 to choose appropriate healthcare pro-
 7 viders for their care.

8 “(IV) Interventions outside of a
 9 traditional healthcare environment, in-
 10 cluding the workplace, school, commu-
 11 nity, or home.

12 “(V) Interventions utilizing com-
 13 munity health workers and case man-
 14 agers.

15 “(VI) Interventions that imple-
 16 ment integrated disease management
 17 and treatment strategies to address
 18 multiple chronic co-occurring condi-
 19 tions.

20 “(VII) Other interventions as
 21 identified by the Secretary.

22 “(2) REPORT.—

23 “(A) IN GENERAL.—Not later than Sep-
 24 tember 30, 2010, the partnership shall submit
 25 to the Secretary and the relevant committees of

1 Congress a report that describes the extent to
2 which the activities and research funded under
3 this section have been successful in reducing
4 and eliminating disparities in health and
5 healthcare in targeted populations.

6 “(B) AVAILABILITY.—The Secretary shall
7 ensure that the report is made available on the
8 Internet websites of the Office of Minority
9 Health, the Agency for Healthcare Research
10 and Quality, and other agencies as appro-
11 priate.”.

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

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

18 (a) IN GENERAL.—The Secretary shall ensure that
19 any current, proposed, or future research and pro-
20 grammatic activities regarding genomics include focus on
21 genetic variation within and between populations, with a
22 focus on racial and ethnic minority populations, that may
23 affect risk of disease or response to drug therapy and
24 other treatments, in order to ensure that all populations
25 are able to derive full benefit from genomic tests and

1 treatments that may improve their health and healthcare.

2 The Secretary shall encourage, with respect to racial and

3 ethnic minority populations, efforts to—

4 (1) increase awareness, access, availability, and
5 utilization of genomic tests and treatments;

6 (2) determine and monitor appropriateness of
7 use of genomic tests and treatments;

8 (3) increase awareness of the importance of
9 knowing one's family history and the relationships
10 between genes, the social and physical environment,
11 and health; and

12 (4) expand genomics research that would help
13 to—

14 (A) improve tests to facilitate earlier and
15 more accurate diagnoses;

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

19 (C) increase the effectiveness of drugs,
20 particularly for diseases and conditions that dis-
21 proportionately affect such populations; and

22 (D) augment the current understanding of
23 the interactions between genomic, social and
24 physical environmental factors, and their influ-
25 ence on the causality, prevention, control, and

1 treatment of diseases common in such popu-
2 lations.

3 (b) GENETIC VARIATION, ENVIRONMENT, AND
4 HEALTH SUMMIT.—

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

21 (2) PARTICIPATION.—The Summit shall in-
22 clude—

23 (A) representatives from the Federal
24 health agencies, including the National Insti-
25 tutes of Health, the Centers for Disease Control

1 and Prevention, the Office of Minority Health,
2 the Food and Drug Administration, the Health
3 Resources and Services Administration, the
4 Centers for Medicare & Medicaid Services, the
5 Substance Abuse and Mental Health Services
6 Administration, and additional agencies and de-
7 partments as determined appropriate by the
8 Secretary;

9 (B) independent experts and stakeholders
10 from relevant industry and academic institu-
11 tions, particularly those that have demonstrated
12 expertise in both genomics and minority health
13 and serve a disproportionate number of racial
14 and ethnic minority patients; and

15 (C) leaders of community organizations
16 and Indian tribal epidemiology centers that
17 work to reduce and eliminate health disparities.

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

23 (A) an appropriate description of human
24 diversity, incorporating available information on
25 genetics, for use in genomic research and pro-

grams operated or supported by the Federal Government;

(B) guiding ethics, principles, and protocols for the inclusion and designation of racial and ethnic minority populations in genomics research, particularly clinical trials programs operated or supported by the Federal Government;

(C) ways to increase awareness of, access to, and utilization of effective pharmacogenomic and other genetic screening and services for racial and ethnic minority populations;

(D) research opportunities and funding support in the area of genomic variation that may improve the health and healthcare of minority populations;

(E) ways to enhance integration of Federal Government-wide efforts and activities pertaining to genetic variation, environment, and health; and

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

(c) PHARMACOGENOMICS AND EMERGING ISSUES

ADVISORY COMMITTEE.—

1 (1) IN GENERAL.—The Secretary, under section
 2 222 of the Public Health Service Act (42 U.S.C.
 3 217a), shall convene and consult an advisory com-
 4 mittee on issues relating to pharmacogenomics (re-
 5 ferred to in this subsection as the “Advisory Com-
 6 mittee”).

7 (2) DUTIES.—

8 (A) IN GENERAL.—The Advisory Com-
 9 mittee shall advise and make recommendations
 10 to the Secretary, through the Commissioner of
 11 Food and Drugs and in consultation with the
 12 Director of the National Institutes of Health,
 13 on the evolving science of pharmacogenomics
 14 and inter-individual variability in drug re-
 15 sponse, as it relates to the health of racial and
 16 ethnic minorities.

17 (B) MATTERS CONSIDERED.—The rec-
 18 ommendations under subparagraph (A) shall in-
 19 clude recommendations on—

20 (i) the ethics, design, and analysis of
 21 clinical trials involving racial and ethnic
 22 minorities conducted under section 351,
 23 409I, or 499 of the Public Health Service
 24 Act or section 505(i), 505A, 505B, or

1 515(g) of the Federal Food, Drug, and
2 Cosmetic Act;

3 (ii) general policy and guidance with
4 respect to the development, approval or
5 clearance, and labeling of medical products
6 for racial and ethnic minorities;

7 (iii) the role of pharmacogenomics
8 during the development of drugs, biological
9 products, and diagnostics;

10 (iv) the understanding of inter-indi-
11 vidual variability in drug response;

12 (v) diagnostics or treatments for dis-
13 eases or conditions common in racial and
14 ethnic minorities; and

15 (vi) the identification of other areas of
16 unmet medical need.

17 (3) COMPOSITION.—The Advisory Committee
18 shall include—

19 (A) experts in the fields of—

20 (i) minority health and health dispari-
21 ties;

22 (ii) genomics;

23 (iii) pharmaceutical and diagnostic re-
24 search and development;

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

3 (v) bioinformatics and information
 4 technology;

5 (B) representatives from minority health
 6 organizations and relevant patient organiza-
 7 tions; and

8 (C) other experts as deemed appropriate
 9 by the Secretary.

10 (4) COORDINATION WITH OTHER ADVISORY
 11 COMMITTEES.—The Advisory Committee may con-
 12 sult and coordinate with other advisory committees
 13 of the Department of Health and Human Services
 14 as determined appropriate by the Secretary.

15 (5) RECOMMENDATIONS.—The Advisory Com-
 16 mittee shall submit recommendations to the Sec-
 17 retary with respect to each of the matters described
 18 under paragraph (2)(B) prior to the development of
 19 the report by the Secretary as described under para-
 20 graph (6).

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

23 (A) shall, acting through the Commissioner
 24 of Food and Drugs and in consultation with the
 25 Director of the National Institutes of Health,

1 and taking into consideration the recommenda-
2 tions of the Advisory Committee submitted
3 under paragraph (5), submit to the Committee
4 on Health, Education, Labor, and Pensions of
5 the Senate and the Committee on Energy and
6 Commerce of the House of Representatives, a
7 report on the evolving science of
8 pharmacogenomics as it relates to racial and
9 ethnic minorities, including a review of the
10 guidance of the Food and Drug Administration
11 on the participation of racial and ethnic minori-
12 ties in clinical trials; and

13 (B) shall ensure that such report is made
14 publicly available in both paper and electronic
15 formats.

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

17 (a) HEALTH DISPARITIES SUMMIT.—

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

22 (2) PURPOSE.—The purposes of the Summit in-
23 clude—

24 (A) reviewing current activities of the Fed-
25 eral Government in addressing health and

1 healthcare disparities as experienced by racial
 2 and ethnic minority populations, and the out-
 3 comes of those activities, as practicable; and

4 (B) assessing progress made since the
 5 2002 Institute of Medicine National Healthcare
 6 Disparities Report and the 2002 Institute of
 7 Medicine Unequal Treatment: Confronting Ra-
 8 cial and Ethnic Disparities in Health Care.

9 (3) AREAS OF FOCUS.—The Summit shall ex-
 10 amine the activities of the Federal Government to
 11 reduce and eliminate health disparities, with a focus
 12 on—

13 (A) education and training, including
 14 health professions programs that increase mi-
 15 nority representation in medicine, the health
 16 professions, and health-related research careers;

17 (B) aggregated and disaggregated data col-
 18 lection and analysis, including successful strate-
 19 gies to collect and report data on minority small
 20 or sub-populations for whom data are limited;

21 (C) coordination among agencies and de-
 22 partments in addressing healthcare disparities;

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

1 (E) programs that increase access to care
2 and improve health outcomes for health dis-
3 parity populations.

4 (4) PARTICIPATION.—Summit participants shall
5 include—

6 (A) representatives of the Federal Govern-
7 ment;

8 (B) experts with research experience in
9 identifying and addressing healthcare dispari-
10 ties among racial and ethnic minority groups;
11 and

12 (C) representatives from community-based
13 organizations, Indian tribal epidemiology cen-
14 ters, and nonprofit groups that address the
15 issues of racial and ethnic minority groups.

16 (5) SUMMIT PROCEEDINGS.—Not later than
17 180 days after the conclusion of the Summit, the
18 Secretary shall offer to enter into a contract with
19 the Institute of Medicine to publish a report summa-
20 rizing the discussions of the Summit and review of
21 current Federal activities to address healthcare dis-
22 parities for racial and ethnic minority groups.

23 (b) NATIONAL PLAN TO ELIMINATE DISPARITIES.—

24 (1) PLAN.—Not later than 2 years after the
25 date of enactment of this Act, the Institute of Medi-

1 cine shall develop an evidence-based, strategic, na-
 2 tional plan to eliminate disparities which shall—

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

5 (B) establish a reasonable timetable to
 6 reach selected priorities;

7 (C) inform and complement the National
 8 Plan to Improve Minority Health and Eliminate
 9 Health Disparities, pursuant to section
 10 1707(c)(2) of the Public Health Service Act (as
 11 added by section 501 of this Act); and

12 (D) inform the development of criteria for
 13 evaluation of the effectiveness of programs au-
 14 thorized under this Act (and the amendments
 15 made by this Act), pursuant to subsection (c).

16 (2) REPORT.—The Secretary shall offer to
 17 enter into a contract with the Institute of Medicine
 18 to publish the National Plan to Eliminate Dispari-
 19 ties.

20 (c) INSTITUTE OF MEDICINE EVALUATION.—

21 (1) IN GENERAL.—Not later than 3 years after
 22 the date of enactment of this Act, the Secretary
 23 shall offer to enter into a contract with the Institute
 24 of Medicine to evaluate the effectiveness of the pro-
 25 grams authorized under this Act (and the amend-

1 ments made by this Act) in addressing and reducing
2 health disparities experienced by racial and ethnic
3 minority groups. In making such an evaluation, the
4 Institute of Medicine shall consult—

5 (A) representatives of the Federal Govern-
6 ment;

7 (B) experts with research and policy expe-
8 rience in identifying and addressing healthcare
9 disparities among racial and ethnic minority
10 groups; and

11 (C) representatives from community-based
12 organizations and nonprofit groups that address
13 racial and ethnic minority health disparity
14 issues.

15 (2) REPORT.—Not later than 2 years after the
16 Secretary enters into the contract under paragraph
17 (1), the Institute of Medicine shall submit to the
18 Secretary and relevant committees of Congress a re-
19 port that contains the results of the evaluation de-
20 scribed under such subparagraph, and any rec-
21 ommendations of such Institute.

22 (3) RESPONSE.—Not later than 180 days after
23 the date the Institute of Medicine submits the report
24 under this subsection, the Secretary shall publish a
25 response to such recommendations, which shall be

1 provided to the relevant committees of Congress and
2 made publicly available through the Internet Clear-
3 inghouse under section 270 of the Public Health
4 Service Act (as added by section 101).

5 (d) HEALTH INFORMATION TECHNOLOGY.—

6 (1) IN GENERAL.—Not later than 180 days
7 after the date of enactment of this Act, the Sec-
8 retary, acting through the Director of the National
9 Library of Medicine and the head of the Office of
10 the National Coordinator for Health Information
11 Technology and in consultation with the Director of
12 the Office of Mental Health and the Director of the
13 Agency for Healthcare Research and Quality, shall
14 offer to enter into a contract with the Institute of
15 Medicine to study and make recommendations re-
16 garding the use of health information technology
17 and bioinformatics to improve the health and
18 healthcare of racial and ethnic minority groups.

19 (2) STUDY.—The study under paragraph (1),
20 with respect to increasing access and quality of
21 healthcare for racial and ethnic minority groups,
22 shall assess and make recommendations regarding—

23 (A) effective applications of health infor-
24 mation technology, including telemedicine and
25 telepsychiatry;

1 (B) status of development of health infor-
2 mation technology standards that will permit
3 healthcare information of the type required to
4 support patient care;

5 (C) inclusion of organizations with exper-
6 tise in minority health and health disparities in
7 the development and implementation of health
8 information technology policies, standards, ap-
9 plications, and monitoring;

10 (D) priority areas for research to improve
11 the dissemination, management, and use of bio-
12 medical knowledge that address identified and
13 unmet needs;

14 (E) educational and training needs and op-
15 portunities to assist health professionals under-
16 stand and apply health information technology;

17 (F) ways to increase recruitment and re-
18 tention of racial and ethnic minorities into the
19 field of medical informatics; and

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

22 (3) REPORT.—Not later than 2 years after the
23 Secretary enters into the contract under paragraph
24 (1), the Institute of Medicine shall submit to the
25 Secretary and relevant committees of Congress a re-

1 port that contains the findings and recommendations
2 of this study.

3 **SEC. 304. NATIONAL CENTER FOR MINORITY HEALTH AND**
4 **HEALTH DISPARITIES REAUTHORIZATION.**

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

7 (1) by striking subsection (e) and inserting the
8 following:

9 “(e) DUTIES OF THE DIRECTOR.—

10 “(1) INTERAGENCY COORDINATION OF MINOR-
11 ITY HEALTH AND HEALTH DISPARITIES ACTIVI-
12 TIES.—With respect to minority health and health
13 disparities, the Director of the Center shall plan, co-
14 ordinate, and evaluate research and other activities
15 conducted or supported by the agencies of the Na-
16 tional Institutes of Health. In carrying out the pre-
17 ceding sentence, the Director of the Center shall
18 evaluate the minority health and health disparity ac-
19 tivities of each of such agencies and shall provide for
20 the timely periodic re-evaluation of such activities.

21 “(2) CONSULTATIONS.—The Director of the
22 Center shall carry out this subpart (including devel-
23 oping and revising the plan and budget required in
24 subsection (f)) in consultation with the Directors of
25 the agencies (or a designee of the Directors) of the

1 National Institutes of Health, with the advisory
2 councils of the agencies, and with the advisory coun-
3 cil established under section (j).

4 “(3) COORDINATION OF ACTIVITIES.—The Di-
5 rector of the Center shall act as the primary Federal
6 official with responsibility for coordinating all minor-
7 ity health disparities research and other health dis-
8 parities research conducted or supported by the Na-
9 tional Institutes of Health and shall—

10 “(A) represent the health disparities re-
11 search program of the National Institutes of
12 Health including the minority health disparities
13 research program at all relevant executive
14 branch task forces, committees, and planning
15 activities;

16 “(B) maintain communications with all rel-
17 evant Public Health Service agencies, including
18 the Indian Health Service and various other de-
19 partments of the Federal Government, to en-
20 sure the timely transmission of information con-
21 cerning advances in minority health disparities
22 research and other health disparities research
23 between these various agencies for dissemina-
24 tion to affected communities and healthcare
25 providers;

1 “(C) undertake research to further refine
 2 and develop the conceptual, definitional, and
 3 methodological issues involved in health dispari-
 4 ties research and to further the understanding
 5 of the cause of disparities; and

6 “(D) engage with national and community-
 7 based organizations and health provider groups,
 8 led by and serving racial and ethnic minorities,
 9 to—

10 “(i) increase education, awareness,
 11 and participation with respect to the Cen-
 12 ter’s activities and areas of research focus;
 13 and

14 “(ii) accelerate the translation of re-
 15 search findings into programs including
 16 those carried out by community-based or-
 17 ganizations.”;

18 (2) in subsection (f)—

19 (A) by striking the subsection heading and
 20 inserting the following:

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

23 (B) in paragraph (1)—

1 (i) by striking the matter preceding
2 subparagraph (A) and subparagraph (A)
3 and inserting the following:

4 “(1) IN GENERAL.—Subject to the provisions of
5 this section and other applicable law, the Director of
6 the Center, in consultation with the Director of
7 NIH, the Directors of the other agencies of the Na-
8 tional Institutes of Health, and the advisory council
9 established under subsection (j) shall—

10 “(A) annually review and revise a com-
11 prehensive plan (referred to in this section as
12 ‘the Plan’) and budget for the conduct and sup-
13 port of all minority health and health dispari-
14 ties research and other health disparities re-
15 search activities of the agencies of the National
16 Institutes of Health that includes time-based
17 targeted objectives with measurable outcomes
18 and assure that the annual review and revision
19 of the Plan uses an established trans-NIH proc-
20 ess subject to timely review, approval, and dis-
21 semination;”;

22 (ii) in subparagraph (D), by striking
23 “, with respect to amounts appropriated
24 for activities of the Center,”;

1 (iii) by striking subparagraph (F) and
2 inserting the following:

3 “(F) ensure that the Plan and budget are
4 presented to and considered by the Director in
5 a clear and timely process during the formula-
6 tion of the overall annual budget for the Na-
7 tional Institutes of Health;”;

8 (iv) by redesignating subparagraphs
9 (G) and (H) as subparagraphs (I) and (J),
10 respectively; and

11 (v) by inserting after subparagraph
12 (F), the following:

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

15 “(H) creating and implementing a plan for
16 the systematic review of research activities sup-
17 ported by the National Institutes of Health that
18 are within the mission of both the Center and
19 other agencies of the National Institutes of
20 Health, by establishing mechanisms for—

21 “(i) tracking minority health and
22 health disparity research conducted within
23 the agencies and assessing the appropriate-
24 ness of this research with regard to the
25 overall goals and objectives of the Plan;

1 “(ii) the early identification of appli-
2 cations and proposals for grants, contracts,
3 and cooperative agreements supporting ex-
4 tramural training, research, and develop-
5 ment, that are submitted to the agencies
6 and that are within the mission of the Cen-
7 ter;

8 “(iii) providing the Center with the
9 written descriptions and scientific peer re-
10 view results of such applications and pro-
11 posals;

12 “(iv) enabling the agencies to consult
13 with the Director of the Center prior to
14 final approval of such applications and
15 proposals; and

16 “(v) reporting to the Director of the
17 Center all such applications and proposals
18 that are approved for funding by the agen-
19 cies;” and

20 (C) in paragraph (2)—

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

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

1 (iii) by adding at the end the fol-
2 lowing:

3 “(F) the number and type of personnel
4 needs of the Center.”;

5 (3) in subsection (h)—

6 (A) in paragraph (1), by striking “endow-
7 ments at centers of excellence under section
8 736.” and inserting the following: “endowments
9 at—

10 “(A) centers of excellence under section
11 736; and

12 “(B) centers of excellence under section
13 485F.”; and

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

16 (4) by redesignating subsections (k) and (l) as
17 subsections (m) and (n), respectively;

18 (5) by inserting after subsection (j), the fol-
19 lowing:

20 “(k) REPRESENTATION OF MINORITIES AMONG RE-
21 SEARCHERS.—The Secretary, in collaboration with the Di-
22 rector of the Center, shall determine, by means of the col-
23 lection and reporting of aggregated and disaggregated
24 data, the extent to which racial and ethnic minority groups
25 are represented among senior physicians and scientists of

1 the national research institutes and among physicians and
 2 scientists conducting research with funds provided by such
 3 institutes, and as appropriate, carry out activities to in-
 4 crease the extent of such representation, including devel-
 5 oping a pipeline of minority researchers interested in the
 6 study of health and health disparities, as well as attracting
 7 minority scientists in social and behavioral science fields
 8 who can bring their expertise to the study of health dis-
 9 parities.

10 “(l) CANCER RESEARCH.—The Secretary, in collabo-
 11 ration with the Director of the Center, shall designate and
 12 support a cancer prevention, control, and population
 13 science center to address the significantly elevated rate of
 14 morbidity and mortality from cancer in racial and ethnic
 15 minority populations. Such designated center shall be
 16 housed within an existing, stand-alone cancer center at a
 17 historically black college and university that has a demon-
 18 strable commitment to and expertise in cancer research
 19 in the basic, clinical, and population sciences.”;

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

24 (7) by striking subsection (m) (as so redesign-
 25 ated).

1 **SEC. 305. AUTHORIZATION OF APPROPRIATIONS.**

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

7 (b) SECTION 304.—

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

12 (2) ALLOCATION OF FUNDS.—Subject to sec-
13 tion 485E of the Public Health Service Act (as
14 amended by section 304) and other applicable law,
15 the Director of the Center under such section 485E
16 shall direct all amounts appropriated for activities
17 under such section and in collaboration with the Di-
18 rector of National Institutes of Health and the di-
19 rectors of other institutes and centers of the Na-
20 tional Institutes of Health.

21 (3) MANAGEMENT OF ALLOCATIONS.—All
22 amounts allocated or expended for minority health
23 and health disparities research activities under this
24 subsection shall be reported programmatically to and
25 approved by the Director of the Center under such

1 section 485E, in accordance with the Plan described
 2 under such section 485E.

3 **TITLE IV—DATA COLLECTION,**
 4 **ANALYSIS, AND QUALITY**

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

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

8 **“TITLE XXX—DATA COLLECTION,**
 9 **ANALYSIS, AND QUALITY**

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

11 “(a) DATA COLLECTION AND REPORTING.—The Sec-
 12 retary shall ensure that not later than 3 years after the
 13 date of enactment of the Minority Health Improvement
 14 and Health Disparity Elimination Act any ongoing or new
 15 federally conducted or supported health programs (includ-
 16 ing surveys) achieve the—

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

22 “(2) collection and reporting of data by geo-
 23 graphic location, socioeconomic position (such as em-
 24 ployment, income, and education), primary language,

1 and, when determined practicable by the Secretary,
2 health literacy;

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

7 “(4) collection and reporting of data at the
8 smallest practicable geographic level such as State,
9 local, or institutional levels if such data can be ag-
10 gregated.

11 “(b) DATA ANALYSIS AND DISSEMINATION.—

12 “(1) DATA ANALYSIS.—

13 “(A) IN GENERAL.—For each federally
14 conducted or supported program, the Secretary
15 shall analyze data collected under subsection (a)
16 to detect and monitor trends in disparities in
17 health and healthcare, including those reported
18 under subparagraph (B), for racial and ethnic
19 minority groups at the Federal and State levels,
20 and examine the interaction between various
21 disparity indicators.

22 “(B) QUALITY ANALYSIS.—The Secretary
23 shall ensure that the analyses under subpara-
24 graph (A) incorporate data reported according
25 to quality measurement systems.

1 “(2) QUALITY MEASURES.—When the Sec-
2 retary, by statutory or regulatory authority, adopts
3 and implements any quality measures or any quality
4 measurement system, the Secretary shall ensure the
5 quality measures or quality measurement system
6 comply with the following:

7 “(A) MEASURES.—Measures selected shall,
8 to the extent practicable—

9 “(i) assess the effectiveness, timeli-
10 ness, patient self-management, patient
11 centeredness, equity, and efficiency of care
12 received by patients, including patients
13 from racial and ethnic minority groups;

14 “(ii) are evidence-based, reliable, and
15 valid; and

16 “(iii) include measures of clinical
17 processes and outcomes, patient experience
18 and efficiency.

19 “(B) CONSULTATION.—In selecting quality
20 measures or a quality measurement system or
21 systems for adoption and implementation, the
22 Secretary shall consult with—

23 “(i) individuals from racial and ethnic
24 minority groups; and

1 “(ii) experts in the identification and
2 elimination of disparities in health and
3 healthcare among racial and ethnic minor-
4 ity groups.

5 “(3) DISSEMINATION.—

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

9 “(i) the Office of Minority Health;

10 “(ii) the National Center on Minority
11 Health and Health Disparities;

12 “(iii) the Agency for Healthcare Re-
13 search and Quality for inclusion in the
14 Agency’s reports;

15 “(iv) the Centers for Disease Control
16 and Prevention;

17 “(v) the Centers for Medicare and
18 Medicaid Services;

19 “(vi) the Indian Health Service;

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

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

24 “(ix) other entities as determined ap-
25 propriate by the Secretary.

1 “(B) ADDITIONAL RESEARCH.—The Sec-
 2 retary may, as the Secretary determines appro-
 3 priate, make the measures, data, and analysis
 4 described in paragraphs (1) and (2) available
 5 for additional research, analysis, and dissemina-
 6 tion to non-governmental entities and the pub-
 7 lic.

8 “(c) RESEARCH.—

9 “(1) DISPARITY INDICATORS.—

10 “(A) IN GENERAL.—The Secretary shall
 11 award grants or contracts for research to de-
 12 velop appropriate methods, indicators, and
 13 measures that will enable the detection and as-
 14 sessment of disparities in healthcare. Such re-
 15 search shall prioritize research with respect to
 16 the following:

17 “(i) Race and ethnicity.

18 “(ii) Geographic location (such as
 19 geocoding).

20 “(iii) Socioeconomic position (such as
 21 income or education level).

22 “(iv) Health literacy.

23 “(v) Cultural competency.

24 “(vi) Additional measures as deter-
 25 mined appropriate by the Secretary.

1 “(B) APPLIED RESEARCH.—The Secretary
 2 shall use the results of the research from grants
 3 awarded under subparagraph (A) to improve
 4 the data collection described under subsection
 5 (a).

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

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

11 “(i) enhancing and improving methods
 12 for the collection, reporting, analysis, and
 13 dissemination of data, as required under
 14 the Minority Health Improvement and
 15 Health Disparity Elimination Act; and

16 “(ii) encouraging the collection, re-
 17 porting, analysis, and dissemination of
 18 data to identify and address disparities in
 19 health and healthcare.

20 “(B) DEFINITION OF ELIGIBLE ENTITY.—
 21 In this paragraph, the term ‘eligible entity’
 22 means a health plan, federally qualified health
 23 center, hospital, rural health clinic, academic
 24 institution, policy research organization, or
 25 other entity, including an Indian Health Service

1 hospital or clinic, Indian tribal health facility,
2 or urban Indian facility, that the Secretary de-
3 termines to be appropriate.

4 “(C) APPLICATION.—An eligible entity de-
5 siring a grant under this paragraph shall sub-
6 mit an application to the Secretary at such
7 time, in such manner, and containing such in-
8 formation as the Secretary may require.

9 “(D) PRIORITY IN AWARDING GRANTS.—In
10 awarding grants under this paragraph, the Sec-
11 retary shall give priority to eligible entities that
12 represent collaboratives with—

13 “(i) hospitals, health plans, or health
14 centers; and

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

17 “(E) USE OF FUNDS.—An eligible entity
18 that receives a grant under this paragraph shall
19 use grant funds to—

20 “(i) collect, analyze, or report data by
21 race, ethnicity, geographic location, socio-
22 economic position, health literacy, primary
23 language, or other health disparity indi-
24 cator;

1 “(ii) conduct and report analyses of
2 quality of healthcare and disparities in
3 health and healthcare for racial and ethnic
4 minority groups, including disparities in di-
5 agnosis, management and treatment, and
6 health outcomes for acute and chronic dis-
7 ease;

8 “(iii) improve health data collection,
9 analysis, and reporting for subpopulations
10 and categories;

11 “(iv) modify, implement, and evaluate
12 use of health information technology sys-
13 tems that facilitate data collection, analysis
14 and reporting for racial and ethnic minor-
15 ity groups, and support healthcare inter-
16 ventions;

17 “(v) develop educational programs to
18 inform patients, providers, purchasers, and
19 other individuals served about the legality
20 and importance of the collection, analysis,
21 and reporting of data by race, ethnicity,
22 socioeconomic position, geographic loca-
23 tion, and health literacy, for eliminating
24 disparities in health; and

1 “(vi) evaluate the activities conducted
2 under this paragraph.

3 “(d) TECHNICAL ASSISTANCE.—The Secretary may
4 provide technical assistance to promote compliance with
5 the data collection and reporting requirements of the Mi-
6 nority Health Improvement and Health Disparity Elim-
7 nation Act.

8 “(e) PRIVACY AND SECURITY.—The Secretary shall
9 ensure all appropriate privacy and security protections for
10 health data collected, reported, analyzed, and dissemi-
11 nated pursuant to the Minority Health Improvement and
12 Health Disparity Elimination Act.

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—For the
14 purpose of carrying out this section, there are authorized
15 to be appropriated such sums as may be necessary for
16 each of fiscal years 2008 through 2012.”.

17 **TITLE V—LEADERSHIP, COL-**
18 **LABORATION, AND NATIONAL**
19 **ACTION PLAN**

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

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

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

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

5 “(1) Coordinate and provide input on activities
6 within the Public Health Service that relate to dis-
7 ease prevention, health promotion, health service de-
8 livery, health workforce, and research concerning ra-
9 cial and ethnic minority groups. The Secretary shall
10 ensure that the heads of each of the agencies of the
11 Service collaborate with the Deputy Assistant Sec-
12 retary on the development and conduct of such ac-
13 tivities.

14 “(2) Not later than 1 year after the date of en-
15 actment of the Minority Health Improvement and
16 Health Disparity Elimination Act, develop and im-
17 plement a comprehensive Department-wide plan to
18 improve minority health and eliminate health dis-
19 parities in the United States, to be known as the
20 National Plan to Improve Minority Health and
21 Eliminate Health Disparities, (referred to in this
22 section as the ‘National Plan’). With respect to de-
23 velopment and implementation of the National Plan,
24 the Secretary shall carry out the following:

25 “(A) Consult with the following:

1 “(i) The Director of the Centers for
2 Disease Control and Prevention.

3 “(ii) The Director of the National In-
4 stitutes of Health.

5 “(iii) The Director of the National
6 Center on Minority Health and Health
7 Disparities of the National Institutes of
8 Health.

9 “(iv) The Director of the Agency for
10 Healthcare Research and Quality.

11 “(v) The National Coordinator for
12 Health Information Technology.

13 “(vi) The Administrator of the Health
14 Resources and Services Administration.

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

17 “(viii) The Director of the Office for
18 Civil Rights.

19 “(ix) The Secretary of Veterans Af-
20 fairs.

21 “(x) The Administrator of the Sub-
22 stance Abuse and Mental Health Services
23 Administration.

24 “(xi) The Secretary of Defense.

1 “(xii) The Commissioner of the Food
2 and Drug Administration.

3 “(xiii) The Director of the Indian
4 Health Service.

5 “(xiv) The Secretary of Education.

6 “(xv) The Secretary of Labor.

7 “(xvi) The heads of other public and
8 private entities, as determined appropriate
9 by the Secretary.

10 “(B) Review and integrate existing infor-
11 mation and recommendations as appropriate,
12 such as Healthy People 2010, Institute of Medi-
13 cine studies, and Surgeon General Reports.

14 “(C) Ensure inclusion of measurable short-
15 and long-range goals and objectives, a descrip-
16 tion of the means for achieving such goals and
17 objectives, and a designated date by which such
18 goals and objectives are expected to be
19 achieved.

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

23 “(E) Review the National Plan on at least
24 an annual basis, and report to the public and

1 appropriate committees of Congress on
2 progress.

3 “(F) Revise such Plan as appropriate.

4 “(G) Ensure that the National Plan will
5 serve as a binding statement of policy with re-
6 spect to the agencies’ activities related to im-
7 proving health and eliminating disparities in
8 health and healthcare.

9 “(3) Work with Federal agencies and depart-
10 ments outside of the Department of Health and
11 Human Services as appropriate to maximize re-
12 sources available to increase understanding about
13 why disparities exist, and effective ways to improve
14 health and eliminate health disparities.

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

18 “(A) expanding healthcare access;

19 “(B) improving healthcare quality;

20 “(C) increasing educational opportunity in
21 the field of healthcare; and

22 “(D) increasing the capacity of racial and
23 ethnic minority organizations to improve health
24 and eliminate health disparities.

1 “(5) Develop mechanisms that support better
2 dissemination of information, education, prevention,
3 and service delivery to individuals from disadvan-
4 taged backgrounds, including individuals who are
5 members of racial or ethnic minority groups.

6 “(6) Increase awareness of disparities in
7 healthcare, and knowledge and understanding of
8 health risk factors, and ways to reduce and eliminate
9 health disparities, among healthcare providers,
10 health plans, and the public.

11 “(7) Advise in matters related to the develop-
12 ment, implementation, and evaluation of health pro-
13 fessions education on improving healthcare outcomes
14 and decreasing disparities in healthcare outcomes,
15 with a focus on cultural competence.

16 “(8) Assist healthcare professionals, community
17 and advocacy organizations, academic medical cen-
18 ters and other health entities and public health de-
19 partments in the design and implementation of pro-
20 grams that will improve health outcomes by
21 strengthening the patient-provider relationship.

22 “(9) Carry out programs to improve access to
23 healthcare services and to improve the quality of
24 healthcare services for individuals with low health
25 literacy.

1 “(10) Facilitate the classification and collection
2 of healthcare data to allow for ongoing analysis to
3 identify and determine the causes of disparities and
4 the monitoring of progress toward improving health
5 and eliminating health disparities.

6 “(11) Ensure that the National Center for
7 Health Statistics collects data on the health status
8 of each racial or ethnic minority group pursuant to
9 section 2901.

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

12 “(A) Facilitate the exchange of informa-
13 tion regarding matters relating to health infor-
14 mation and health promotion, preventive health
15 services, and education in the appropriate use
16 of healthcare.

17 “(B) Facilitate access to such information.

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

20 “(D) Provide technical assistance with re-
21 spect to the exchange of such information (in-
22 cluding facilitating the development of materials
23 for such technical assistance).

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

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

9 “(B) Carry out programs to improve ac-
10 cess to healthcare services for individuals with
11 limited proficiency in speaking the English lan-
12 guage. Activities under this subparagraph shall
13 include developing and evaluating model
14 projects.

15 “(14) At the discretion of the Director, support
16 a center or program for the improvement of geo-
17 graphic minority health and health disparities to
18 carry out the following for rural disadvantaged mi-
19 nority populations:

20 “(A) Increase awareness on health care
21 issues impacting and effective interventions for
22 these populations.

23 “(B) Increase access to quality healthcare.

1 “(C) Increase access to quality healthcare
2 personnel available to provide services to these
3 populations.

4 “(D) Improve health care outcomes.

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

16 “(15) Enter into interagency agreements with
17 other agencies of the Public Health Service, as ap-
18 propriate.

19 “(16) Collaborate with the Office for Civil
20 Rights to—

21 “(A) assist healthcare providers with appli-
22 cation of guidance and directives regarding
23 healthcare for racial and ethnic minority
24 groups, including—

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

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

20 “(iii) monitoring and analysis of
21 trends in cases reported to the Office for
22 Civil Rights to ensure that the Office of
23 Minority Health acts to educate and assist
24 healthcare providers as necessary; and

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

5 “(17) Promote and expand efforts to increase
6 racial and ethnic minority enrollment in clinical
7 trials.

8 “(18) Establish working groups—

9 “(A) to examine and report recommenda-
10 tions to the Secretary regarding—

11 “(i) emergency preparedness and re-
12 sponse for underserved populations;

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

17 “(iii) outreach and education of health
18 disparity groups about new Federal health
19 programs, as appropriate, including the
20 programs under part D of title XVIII of
21 the Social Security Act and chronic care
22 management programs under the Medicare
23 Prescription Drug, Improvement, and
24 Modernization Act of 2003 (and the
25 amendments made by such Act);

1 “(iv) leadership development in public
2 health;

3 “(v) the training of behavioral and so-
4 cial science researchers to address health
5 disparities; and

6 “(vi) other emerging health issues at
7 the discretion of the Secretary; and

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

12 “(b) ADVISORY COMMITTEE.—

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

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

23 “(3) CHAIR.—The chairperson of the Com-
24 mittee shall be selected by the Secretary from among
25 the members of the voting members of the Com-

1 mittee. The term of office of the chairperson shall be
2 2 years.

3 “(4) COMPOSITION.—

4 “(A) The Committee shall be composed of
5 12 voting members appointed in accordance
6 with subparagraph (B), and nonvoting, ex-offi-
7 cio members designated in subparagraph (C).

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

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

23 “(D) The Secretary shall provide an oppor-
24 tunity for the Chairman and Ranking Member
25 of the Committee on Health, Education, Labor,

1 and Pensions of the Senate to submit to the
2 Secretary names of potential Committee mem-
3 bers under this section for consideration.

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

8 “(6) VACANCIES.—If a vacancy occurs on the
9 Committee, a new member shall be appointed by the
10 Secretary within 90 days from the date that the va-
11 cancy occurs, and serve for the remainder of the
12 term for which the predecessor of such member was
13 appointed. The vacancy shall not affect the power of
14 the remaining members to execute the duties of the
15 Committee.

16 “(7) COMPENSATION.—Members of the Com-
17 mittee who are officers or employees of the United
18 States shall serve without additional compensation.
19 Members of the Committee who are not officers or
20 employees of the United States shall receive com-
21 pensation, for each day (including travel time) they
22 are engaged in the performance of the functions of
23 the Committee. Such compensation may not be in an
24 amount in excess of the daily equivalent of the an-
25 nual maximum rate of basic pay payable under the

1 General Schedule for positions above GS-15 under
2 title 5, United States Code.

3 “(c) CERTAIN REQUIREMENTS REGARDING DU-
4 TIES.—

5 “(1) RECOMMENDATIONS REGARDING LAN-
6 GUAGE.—

7 “(A) PROFICIENCY IN SPEAKING
8 ENGLISH.—The Deputy Assistant Secretary
9 shall consult with the Director of the Office of
10 International and Refugee Health, the Director
11 of the Office for Civil Rights, and the Directors
12 of other appropriate departmental entities re-
13 garding recommendations for carrying out ac-
14 tivities under subsection (c)(9).

15 “(B) HEALTH PROFESSIONS EDUCATION
16 REGARDING HEALTH DISPARITIES.—The Dep-
17 uty Assistant Secretary shall carry out the du-
18 ties under subsection (a)(7) in collaboration
19 with appropriate personnel of the Department
20 of Health and Human Services, other Federal
21 agencies, and other offices, centers, and institu-
22 tions, as appropriate, that have responsibilities
23 under the Minority Health and Health Dispari-
24 ties Research and Education Act of 2000.

1 “(2) EQUITABLE ALLOCATION REGARDING AC-
2 TIVITIES.—In carrying out subsection (b), the Sec-
3 retary shall ensure that services provided under such
4 subsection are equitably allocated among all groups
5 served under this section by the Secretary.

6 “(3) CULTURAL COMPETENCY OF SERVICES.—
7 The Secretary shall ensure that information and
8 services provided pursuant to subsection (c) consider
9 the unique cultural or linguistic issues facing such
10 populations and are provided in the language, edu-
11 cational, and cultural context that is most appro-
12 priate for the individuals for whom the information
13 and services are intended.

14 “(4) AGENCY COORDINATION.—In carrying out
15 subsection (c), the Secretary shall ensure that new
16 or existing agency offices of minority health report
17 current and proposed activities to the Deputy Assist-
18 ant Secretary, and provide, to the extent practicable,
19 an opportunity for input in the development of such
20 activities by the Deputy Assistant Secretary.

21 “(d) GRANTS AND CONTRACTS REGARDING DU-
22 TIES.—

23 “(1) IN GENERAL.—In carrying out subsection
24 (c), the Secretary acting through the Deputy Assist-
25 ant Secretary, may make awards of grants, coopera-

1 tive agreements, and contracts to public and non-
2 profit private entities.

3 “(2) PROCESS FOR MAKING AWARDS.—The
4 Deputy Assistant Secretary shall ensure that awards
5 under paragraph (1) are made, to the extent prac-
6 ticable, only on a competitive basis, and that a grant
7 is awarded for a proposal only if the proposal has
8 been recommended for such an award through a
9 process of peer review.

10 “(3) EVALUATION AND DISSEMINATION.—The
11 Deputy Assistant Secretary, directly or through con-
12 tracts with public and private entities, shall provide
13 for evaluations of projects carried out with awards
14 made under paragraph (1) during the preceding 2
15 fiscal years. The report shall be included in the re-
16 port required under subsection (g) for the fiscal year
17 involved.

18 “(e) STATE OFFICES OF MINORITY HEALTH.—The
19 Deputy Assistant Secretary shall assist the voluntary es-
20 tablishment and functions of State offices of minority
21 health in order to expand and coordinate State efforts to
22 improve the health of racial and ethnic minority groups.

23 “(1) PRIORITIES.—The Deputy Assistant Sec-
24 retary may facilitate, with respect to racial and eth-
25 nic minority groups—

1 “(A) integration and coordination of State
2 and national efforts, including those pertaining
3 to the National Plan pursuant to subsection
4 (b);

5 “(B) strategic plan development within
6 States to assess and respond to local health
7 concerns;

8 “(C) education and engagement of key
9 stakeholders within States, including represent-
10 atives from public health agencies, hospitals,
11 clinics, provider groups, elected officials, com-
12 munity-based organizations, advocacy groups,
13 media, and the private sector;

14 “(D) development and implementation of
15 accepted standards, core competencies, and
16 minimum infrastructure requirements for State
17 offices;

18 “(E) access to State level health data for
19 racial and ethnic minority groups, which may
20 include State data collection and analysis;

21 “(F) development, implementation, and
22 evaluation of State programs and policies, as
23 appropriate;

24 “(G) communication and networking
25 among States to share effective policies, pro-

1 grams and practices with respect to increasing
2 access and quality of care;

3 “(H) recognition and reporting of State
4 successes and challenges; and

5 “(I) identification of Federal grant pro-
6 grams and other funding for which States could
7 apply to carry out health improvement activi-
8 ties.

9 “(2) RESOURCES.—The Deputy Assistant Sec-
10 retary may provide grants and technical assistance
11 for the voluntary establishment or capacity develop-
12 ment of State offices of minority health.

13 “(3) COLLABORATION.—To the extent prac-
14 ticable, the Deputy Assistant Secretary may encour-
15 age and facilitate collaboration between State offices
16 of minority health and State offices addressing the
17 needs of other health disparity or disadvantaged
18 populations, including offices of rural health.

19 “(4) DEFINITION.—For the purpose of this
20 subsection, ‘State offices of minority health’ include
21 offices, councils, commissions, or advisory panels
22 designated by States or territories to address the
23 health of minority populations.

24 “(f) REPORTS.—

1 “(1) IN GENERAL.—Not later than 1 year after
2 the date of enactment of the Minority Health Im-
3 provement and Health Disparity Elimination Act,
4 the Secretary shall submit to the appropriate com-
5 mittees of Congress, a report on the National Plan
6 developed under subsection (c).

7 “(2) REPORT ON ACTIVITIES.—Not later than
8 February 1 of fiscal year 2009 and of each second
9 year thereafter, the Secretary shall submit to the ap-
10 propriate committees of Congress, a report describ-
11 ing the activities carried out under this section dur-
12 ing the preceding 2 fiscal years and evaluating the
13 extent to which such activities have been effective in
14 improving the health of racial and ethnic minority
15 groups. Each such report shall include the biennial
16 reports submitted under subsection (f)(3) for such
17 years by the heads of the Public Health Service
18 agencies.

19 “(3) AGENCY REPORTS.—Not later than Feb-
20 ruary 1, 2009, and on a biannual basis thereafter,
21 the heads of the Public Health Service shall submit
22 to the Deputy Assistant Secretary a report that
23 summarizes the minority health and health disparity
24 activities of each of the respective agencies.

25 “(g) DEFINITIONS.—In this section:

1 “(1) The term ‘racial and ethnic minority
2 group’ means American Indians (including Alaska
3 Natives, Eskimos, and Aleuts), Asian Americans,
4 Native Hawaiians and other Pacific Islanders,
5 Blacks, and Hispanics.

6 “(2) The term ‘Hispanic’ means individuals
7 whose origin is Mexican, Puerto Rican, Cuban, Cen-
8 tral or South American, or of any other Spanish-
9 speaking country.

10 “(h) AUTHORIZATION OF APPROPRIATIONS.—For the
11 purpose of carrying out this section, there are authorized
12 to be appropriated \$110,000,000 for fiscal year 2008,
13 such sums as may be necessary for each of fiscal years
14 2009 through 2012.”.

