

## H.R. 3090 Health Equity and Accountability Act of 2009

Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 1. Expanding Access to Affordable Health Coverage

	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Insurance Market Reforms</b>	<ul style="list-style-type: none"> <li>• Not specified.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>Individual Role</b>	<ul style="list-style-type: none"> <li>• Not specified.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>Employer Role</b>	<ul style="list-style-type: none"> <li>• Not specified.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>State Role</b>	<ul style="list-style-type: none"> <li>• Not specified.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>Federal Government Role</b>	<ul style="list-style-type: none"> <li>• Provide federal reimbursement for language services (e.g., interpreter/translation services) offered to individuals with limited-English proficiency (LEP) under Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP).</li> <li>• Wave the 5-year continuous residence eligibility requirement for lawfully present individuals to receive hospital benefits under Medicare Part D.</li> <li>• Provide Medicaid payments for services delivered to non-citizens of the U.S. if they meet state eligibility requirements and are: lawfully present; under the age of 21; or pregnant.</li> <li>• Provide parity Medicaid payments for U.S. Territories.</li> </ul>	<ul style="list-style-type: none"> <li>• Patients who face language barriers are less likely than others to have a usual source of medical care and to receive preventive services.<sup>2</sup> Extending reimbursement for language services under public insurance programs is important for eliminating language barriers in access to care and improving safety and quality of care for the nation's 24 million residents with LEP.<sup>3</sup></li> <li>• Lawfully present immigrants face considerable barriers to obtaining health care coverage, including tight eligibility requirements for public insurance programs and limited employer-sponsored health insurance. As a result, they are less likely to have insurance than citizens and account for approximately 21% of the total uninsured population.<sup>4</sup> Extending Medicaid payments for lawfully present immigrants and eliminating the 5-year eligibility requirement for Medicare Part D would reduce this insurance disparity and improve access to care for nearly 22 million immigrants residing in the US.<sup>5</sup></li> <li>• Current policies place caps on the amount of federal funds allotted to Medicaid programs of U.S. territories. For example, the 2008 average federal per-month expenditure for a beneficiary in the U.S. was \$330, compared to \$20 in Puerto Rico.<sup>6</sup> Increasing federal support for U.S. Territory Medicaid programs to State rates could potentially improve access to health care, in particular to diagnostic, preventive, and treatment services necessary to combat high burden diseases—e.g., HIV/AIDS in Puerto Rico.<sup>7</sup></li> </ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

*Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities*

<b>Federal Credits and Subsidies to Individuals</b>	<ul style="list-style-type: none"><li>• Not specified.</li></ul>	<ul style="list-style-type: none"><li>• Not applicable.</li></ul>
<b>Federal Credits and Subsidies to Employers</b>	<ul style="list-style-type: none"><li>• Not specified.</li></ul>	<ul style="list-style-type: none"><li>• Not applicable.</li></ul>
<b>Financing</b>	<ul style="list-style-type: none"><li>• Not specified.</li></ul>	<ul style="list-style-type: none"><li>• Not applicable.</li></ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 2. Expanding Access to Health and Medical Care

	Summary	Implications for Racial/Ethnic Minorities
<b>Expanding Availability of Care</b>	<ul style="list-style-type: none"> <li>Support the development of health care facilities in U.S. Territories and Hawaii.</li> </ul>	<ul style="list-style-type: none"> <li>Health care facility expansions are likely to improve access to care for underserved populations in U.S. Territories and Hawaii if they explicitly take into account community health and health care needs (e.g., limited bed capacity or shortage of specialty/tertiary services).</li> </ul>
<b>Public Health and Prevention</b>	<ul style="list-style-type: none"> <li>Develop screening guidelines for minority patients that are at increased risk for chronic disease and cancer. Disease priorities include hypertension, diabetes, cardiovascular disease, asthma, and HIV/AIDS.</li> <li>Establish lung cancer mortality as a national public health priority and implement a Lung Cancer Mortality Reduction Program to reduce lung cancer mortality by at least 25% by 2015.</li> <li>Expand the Minority HIV/AIDS Initiative to increase access to HIV/AIDS prevention and treatment services among racial/ethnic minorities and strengthen community-based HIV prevention programs.</li> <li>Provide grants to support education and outreach initiatives to promote positive health behaviors in women and children, targeting in particular, nutrition, physical activity, and tobacco use.</li> <li>Expand efforts to eliminate racial/ethnic disparities in diabetes and improve access to preventive services through research and the development of preventive programs.</li> <li>Launch educational programs to inform health care professionals and the public about persisting racial/ethnic health disparities and strategies to reduce them.</li> </ul>	<ul style="list-style-type: none"> <li>Racial/ethnic minorities are generally less likely to receive preventive screenings than whites.<sup>8</sup> While screening guidelines, tailored to minorities, have the potential to increase screening rates, their impact is likely to be minimal in the absence of a usual source of care.<sup>9</sup></li> <li>Lung cancer is the leading cause of cancer mortality among American men and women. African Americans are 12% more likely to develop lung cancer and 37% more likely to die from the disease than whites.<sup>10</sup></li> <li>African Americans are nearly ten times as likely, and Hispanics are more than three times as likely as whites to have HIV/AIDS.<sup>11</sup> Therefore, expanding access to HIV/AIDS prevention, treatment and community-based programs is especially important for preventing and improving the health and quality of life of minorities with HIV/AIDS.</li> <li>Racial/ethnic minorities have higher obesity rates than whites.<sup>12</sup> This disparity is particularly pronounced among African American and Hispanic girls ages 12-19, who are more than twice as likely to be obese than their white counterparts.<sup>13</sup> While whites have historically had higher smoking rates than minorities, American Indian/Alaska Native women are much more likely to smoke than white women.<sup>14</sup> Furthermore, research suggests disparities in health knowledge around dangers of smoking.<sup>15</sup> Health education and outreach efforts, particularly if culturally and linguistically tailored, have the potential to reduce disparities in smoking among minorities.</li> <li>African Americans, Hispanics and American Indians/Alaska Natives are two times more likely to have diabetes than whites, and between 1980 and 2008, the prevalence doubled among African American men and increased by 60% among African American women.<sup>16</sup> Expanding research and preventive program development will be important to eliminating these disparities and improving the early screening, treatment, and management of diabetes among minorities.</li> <li>Eliminating racial/ethnic health disparities will require public awareness and political will to secure appropriate resources for disparity reduction initiatives. Public perception surveys indicate that the majority of Americans are unaware of racial/ethnic disparities in health. These</li> </ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

<b>Support for the Health Care Safety Net</b>	<ul style="list-style-type: none"><li>• Provide grants to support health care facilities that serve a substantial number of uninsured, underinsured, racial/ethnic minorities and individuals with LEP.</li><li>• Allow for community health centers (CHCs) to contract with federally certified rural health clinics to provide primary care services to individuals eligible for reduced or no-cost care.</li><li>• Provide support for Critical Access Hospital (CAH) improvements.</li></ul>	misconceptions are strongest among whites. For example, research shows that whereas 57% of African Americans are aware of racial disparities in life expectancy, only 43% of whites are aware. <sup>17</sup> <ul style="list-style-type: none"><li>• Support for an integrated health care safety net that includes CHCs, public hospitals, and not-for-profit health care facilities is important for expanding access to care at all levels—primary, secondary and tertiary—for low-income and racial/ethnic minorities.</li><li>• Creating links between CHCs and rural health clinics could help low-income rural populations access needed care at minimal or no cost.</li><li>• CAHs serve as a vital source of care for rural and geographically isolated communities.</li></ul>
<b>Community Strategies</b>	<ul style="list-style-type: none"><li>• Support Health Empowerment Zones consisting of cooperative partnerships between state, local, non-profit, and community entities to reduce health disparities through community-based programs.</li><li>• Provide grants to support multi-sector community health initiatives to reduce racial/ethnic health disparities.</li></ul>	<ul style="list-style-type: none"><li>• Support for Health Empowerment Zones and targeting disparities reduction offer the opportunity to expand engagement of minority communities in improving their health and well being as well as significantly expanding the potential to address transportation, nutrition, environment and other priorities frequently not seen as central to medical care, but essential for improving health.<sup>18</sup></li></ul>
<b>Regional Strategies</b>	<ul style="list-style-type: none"><li>• Encourage utilization of Medicare's telemedicine services across state lines by allowing for multistate practitioner practices.</li><li>• Provide grants for initiatives to improve the health of residents living in areas along the U.S.-Mexico border. Program priority areas include maternal and child health, primary care, preventive services, and community health workers (CHWs) or <i>promotoras</i>.</li><li>• Establish a Rural Health Quality Advisory Commission to identify objectives and strategies for improving quality and eliminating gaps in rural health care systems.</li><li>• Provide grants to develop integrated health care networks in rural areas and reduce health disparities in the Delta Region.</li><li>• Establish Rural Community Hospital Program and increase payments for inpatient and outpatient services delivery at qualifying hospitals.</li></ul>	<ul style="list-style-type: none"><li>• Telemedicine services have great potential to improve access to clinical expertise and specialty care services in rural and medically underserved areas.<sup>19</sup></li><li>• Over 500,000 individuals live in <i>colonias</i> in the rural area along the U.S.-Mexico border, the vast majority being Hispanic. These unincorporated communities generally have poor infrastructure, limited access to health care services, and poor health status. CHWs and <i>promotoras</i> are key resources for reaching and improving the health of these communities.<sup>20</sup></li><li>• Almost two-thirds of rural counties are classified as health professional shortage areas, and minority-majority counties are even more likely to have this designation.<sup>21</sup></li><li>• Limited access to health care among minorities in rural areas exacerbates racial/ethnic health disparities. Approximately 19% of African Americans in urban areas report having poor/fair health status, compared to 29% of those in remote rural areas.<sup>22</sup> Efforts to identify gaps in rural health care systems, coordinate services of existing health care providers, and increase payments to providers in rural areas could potentially improve access to care for this population.</li></ul>

**H.R. 3090 Health Equity and Accountability Act of 2009**

*Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities*

**Table 3. Cost Containment**

		Summary	Implications for Racial/Ethnic Minorities
<b>Containing Drug Costs</b>	<ul style="list-style-type: none"> <li>• Not Specified.</li> </ul>		<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>Reducing Fraud, Waste and Abuse</b>	<ul style="list-style-type: none"> <li>• Not Specified.</li> </ul>		<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
<b>Information Technology</b>	<ul style="list-style-type: none"> <li>• Conduct a study of the utilization of health information technology (HIT) in medically underserved areas to identify barriers to implementation and the impact of HIT on quality and containing health care costs.</li> <li>• Provide grants to support HIT to advance best practices for collecting data on health disparities.</li> <li>• Provide grants to facilitate the adoption of HIT in rural areas.</li> </ul>		<ul style="list-style-type: none"> <li>• The use of HIT for standardizing medical records, claims and health care quality data has potential for reducing preventable errors and administrative inefficiencies. HIT can also be especially useful for standardizing the collection and monitoring of racial/ethnic disparities data in health care. However, the expansion of HIT use in health care will require expanded training to ensure that health care providers possess sufficient knowledge and skills to utilize HIT tools appropriately.</li> </ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

**Table 4. Quality Improvement**

	Summary	Implications for Racial/Ethnic Minorities
<b>Data Collection and Public Reporting</b>	<ul style="list-style-type: none"> <li>• Establish Epidemiological Centers to collect data and monitor the health status of Native American tribes. The Centers will also evaluate the effectiveness of service delivery systems, make recommendations accordingly, and assist in identifying health priority areas.</li> <li>• Provide grants to Tribal entities to conduct epidemiological studies of local Native American communities.</li> <li>• Improve quality of care for patients with low-health literacy by supporting research that aims to understand the correlation between health literacy, health status, and health care.</li> <li>• Also See <i>Table 5: Collecting Data on Disparities in Quality of Care.</i></li> </ul>	<ul style="list-style-type: none"> <li>• Native Americans face persisting disparities on various public health status, outcomes and service indicators.<sup>23</sup> They suffer disproportionately from a range of chronic and acute illnesses, such as diabetes, mental health disorders, alcoholism, tuberculosis, and pneumonia and are significantly more likely to die from many of these conditions—e.g., Native Americans are nearly eight times more likely to die from alcoholism and over six times more likely to die from tuberculosis.<sup>24</sup> Establishing epidemiological centers and supporting epidemiological studies by Tribal entities will be important for collecting robust data to monitor and reduce disparities as well as evaluate and improve the quality of services provided to Native Americans.</li> <li>• Nearly 87 million U.S. adults have low-health literacy—defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions”—and recent research suggests that these individuals generally have poorer health status, are less likely to use preventive care, more likely to be hospitalized and to experience poor outcomes.<sup>25</sup> Supporting research on this topic offers an opportunity to build an evidence-base to develop effective strategies to improve health status, access to care, and quality for individuals with low-health literacy.</li> </ul>
<b>Care Coordination and Disease Management</b>	<ul style="list-style-type: none"> <li>• Provide grants to develop and modify existing disease management programs for patients with low-health literacy.</li> </ul>	<ul style="list-style-type: none"> <li>• Health literacy is often cited as a strong predictor of knowledge about chronic disease and management.<sup>26</sup> Tailoring existing disease management programs for individuals with low-health literacy has the potential to improve knowledge and understanding about disease conditions and proper management, and ultimately to improve health status and quality of life for these populations.</li> </ul>
<b>Promoting Evidence-Based Practices</b>	<ul style="list-style-type: none"> <li>• Support the Agency for Healthcare Research and Quality (AHRQ) to administer grants that research the effects of workforce diversity on quality of care across multiple domains, such as cultural competence, efficiency of care, patient satisfaction, and patient outcomes.</li> <li>• Establish Office of Minority Affairs within the Food and Drug Administration (FDA) to increase minority participation in clinical trials and encourage data collection, analysis, and dissemination of racial/ethnic differences in treatment outcomes.</li> <li>• Require federally supported Comparative Effectiveness Research (CER) to be disaggregated by race/ethnicity to identify differences in treatment outcomes among subpopulations.</li> </ul>	<ul style="list-style-type: none"> <li>• Increasing the racial/ethnic diversity of the health care workforce is often cited (through observational studies) as central to creating a more culturally competent health care system and reducing disparities in health and health care.<sup>27</sup> However, empirical evidence is still largely lacking. Grant support through AHRQ will offer an opportunity to undertake rigorous research to examine the benefits of workforce diversity on health care quality and outcomes as well as promote innovation and widespread implementation of proven programs and policies for expanding health professions diversity.</li> <li>• Racial/ethnic minorities, in particular African Americans, are often under-represented in clinical trials, resulting in insufficient data to assess</li> </ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

- Require follow-up investigations on the effects of drugs on minority populations if there is evidence that there may be a disparity in outcomes based on race/ethnicity.
- Support Centers of Excellence (COE) Program through the designation of public hospitals and health systems serving large numbers of minority patients. Centers will design, implement, and evaluate programs targeting the health care needs of racially, ethnically, and linguistically diverse populations.
- Support projects to develop models to reduce disparities in the early detection and treatment of cancer, improve the quality of life for individuals living with cancer, and eliminate disparities in cancer screening rates.

the effectiveness and safety of medication and treatment among these groups.<sup>28</sup> Efforts to increase minority participation in clinical trials and assess the effectiveness and difference in outcomes for interventions will be important for improving quality and reducing medical and medication errors among minority patients. As identified in a report recently provided to the President and Congress by HHS, CER that focuses on racial/ethnic differences in procedural outcomes has potential to reduce health disparities at the national level, especially among minority populations who suffer a disproportionately high burden of chronic disease.<sup>29</sup>

- Launched in 2002 by the National Center on Minority Health and Health Disparities, the CEO program provides support to minority serving research institutions to develop and test strategies to reduce health disparities.<sup>30</sup> Extending support to non-traditional research entities and institutions disproportionately serving minorities, such as public hospitals, is likely to promote the development of disparity reduction initiatives which span multiple domains.
- Lack of preventive screenings contributes to disparities in cancer death rates, which are 25% higher for African Americans than whites for all cancers combined.<sup>31</sup> Programs which reduce cultural and economic barriers to preventive screenings have great potential to reduce racial/ethnic cancer disparities.<sup>32</sup>
- Efforts to reduce discriminatory practices in health care settings and ensure compliance with Title VI are dependent upon reliable and consistent reporting mechanisms. Previous compliance efforts have shown that such attempts are most successful when reimbursement is tied to reporting.<sup>33</sup>
- The Civil Rights Commission is a bi-partisan and independent federal entity responsible for making recommendations on civil rights issues. Charging the Commission to explicitly address issues pertaining to health disparities and the prison population could encourage policies and programs to reduce disparities by improving the health of this population and their communities.<sup>34</sup>

#### Civil Rights Enforcement and Legal Action

- Amend Title XXXI of the Public Health Services Act to establish an Office of Health Disparities within the Department of Health and Human Services (HHS) to oversee health programs and activities receiving Federal assistance and ensure compliance with Title VI of the 1964 Civil Rights Act, which prohibits discrimination on the basis of race, ethnicity, or national origin.
- Amend the 1983 Civil Rights Commission Act to address the activities of health care and correctional facilities in eliminating racial/ethnic health disparities.

## H.R. 3090 Health Equity and Accountability Act of 2009

Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 5. Infrastructure Support for Reducing Racial/Ethnic Disparities

	Summary	Implications for Racial/Ethnic Minorities
<b>Collecting Data on Disparities in Quality of Care</b>	<ul style="list-style-type: none"> <li>Amend Title XXXI of the Public Health Services Act to require programs receiving support from HHS to: collect data on race, ethnicity, primary language, and sexual orientation; utilize the data to detect disparities between sub-populations; and annually report findings to the HHS Secretary, Office of Civil Rights Director, and specific Congressional committees.</li> <li>Provide grants to minority serving institutions to collect, analyze, and report data on racial/ethnic health disparities.</li> <li>Require the Social Security Administration to collect data on race, ethnicity, and primary language.</li> <li>Revise HIPAA standards to require reporting on race, ethnicity, and primary language.</li> <li>Require health professions schools receiving federal funds to collect data on race, ethnicity, and language proficiency to establish a publicly available national database on health professions students.</li> </ul>	<ul style="list-style-type: none"> <li>Expanding requirements to report data by race/ethnicity and primary language, in addition to grants for minority serving institutions to collect such data, will allow for monitoring of the status and progress in reducing health disparities and help identify areas in health care services and public health programs needing improvement.</li> <li>Analysis of data to detect disparities between racial/ethnic sub-populations will provide information on the health status and specific needs of immigrant populations and the approximated 100 different ethnic groups with populations over 100,000 living in the US.<sup>35</sup></li> </ul>
<b>Cultural Competence and Language Assistance</b>	<ul style="list-style-type: none"> <li>Require all Federal health-related agencies to develop and implement a plan to eliminate racial/ethnic disparities which includes direct responses to key national disparity reports (e.g. the Institute of Medicine's (IOM) <i>Unequal Treatment</i>).</li> <li>Require all federal health-related agencies to develop and implement a plan to improve language access services for individuals with LEP through staff training, assessment of the quality of language access services, and translating materials.</li> <li>Contract with IOM to produce a report on federal efforts to provide linguistically appropriate health care to individuals with LEP. The report is also to include promising practices and guidelines for culturally and linguistically appropriate services and a description of the impact of language services on health care quality and costs associated with their provision.</li> <li>Promote national standards on culturally and linguistically appropriate services within organizations by implementing strategies to recruit, retain, and promote individuals with the ability to provide culturally and linguistically appropriate services and ensuring opportunities for cultural competence training education among staff.</li> <li>Require the Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct a Geo-Access study to identify areas with shortages of mental health service providers and assess the capacity of existing providers to deliver culturally and linguistically</li> </ul>	<ul style="list-style-type: none"> <li>The landmark 2002 report <i>Unequal Treatment</i> provides a comprehensive overview of the status of racial/ethnic disparities in health and health care, their potential sources of origin, and subsequent recommendations for disparity reduction initiatives.<sup>36</sup> A requirement for all federal health-related agencies to develop and implement a strategic plan to eliminate disparities would bridge evidence-based research and practice. However, coordination of disparity reduction plans between Federal agencies would be critical to the success of such a requirement.</li> <li>A requirement for federal health-related agencies to improve language access services would benefit the nation's 24 million residents with LEP.<sup>37</sup></li> <li>Integrating cultural competence at the organizational-level can assist in de-institutionalizing racism and guide program/service development and evaluation.</li> <li>Racial and ethnic minorities are more likely to encounter geographic and financial barriers to mental health services than whites. Minorities also have less trust in mental health services and are more likely to avoid treatment due to fear of being stigmatized within their communities.<sup>38</sup> A Geo-Access study to assess the extent of these barriers could inform resource allocation and the development and implementation of culturally and linguistically appropriate programs to increase mental health service utilization and ultimately improve mental health of minorities.</li> </ul>

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

appropriate services.

- Establish individual Offices of Minority Health within all agencies of the Public Health Service to evaluate programs as they relate to minority groups and make recommendations to heads of agencies.
- Establish an Office of Minority Health within the Centers for Medicare & Medicaid Services (CMS) to develop and implement plans to reduce health disparities by improving the quality of health care for minority beneficiaries of CMS programs.
- Authorize the Secretary of Education to provide states with grants to assess the need for English as a Second Language (ESL) programs and to integrate them with job training.

- Established in 1986 by the U.S. Department of Health and Human Services, the HHS Office of Minority Health (OMH) advises the Secretary and Office of Public Health and Science on policies and programs to reduce and eliminate racial/ethnic disparities in health and health care. Establishing similar offices within all federal health-related agencies would be instrumental to integrating priorities pertaining to minorities into all health-related programs and reducing longstanding disparities in health and health care.
- Improving language proficiency of individuals with LEP, particularly English language reading comprehension skills, has great potential to improve access and quality of care as well as disease management.<sup>39</sup> ESL programs could be most beneficial to a growing elderly immigrant population. It is estimated that 14% of the 65+ population speak a language other than English at home, more than a third of whom have LEP.<sup>40</sup> This population is likely to grow over the next 20 years in the US as elderly, Hispanic and Asian populations are projected to increase.

#### Health Workforce Diversity

- Require HHS to submit bi-annual reports on workforce diversity to the Committees on Health, Education, Labor, and Pensions (HELP) and Energy and Commerce. Reports are to contain information on grants administered, current status of diversity in the health care workforce, and strategies to achieve workforce parity.
  - Provide grants to evaluate barriers as well as programs to achieve workforce diversity.
  - Support the development of a national working group on workforce diversity comprised of representatives from various agencies across sectors (e.g. OMH, consumer organizations, and health professions) to review and identify successful workforce diversity programs and strategies.
  - Provide grants to institutions with a demonstrated commitment to workforce diversity to implement, expand, and evaluate workforce diversity programs, such as scholarships, fellowships, loan repayments, and mentorships.
  - Increase workforce diversity by expanding programs that support students from disadvantaged backgrounds in entering and completing health professions training programs.
  - Establish a technical clearinghouse on workforce diversity within OMH to provide information on the importance of workforce diversity, data on minority representation in the health care workforce, model practices and programs, and information on scholarship and grants for underrepresented populations.
- The racial/ethnic composition of the health care workforce does not reflect the diversity of the nation, a disparity which is likely to grow as the nation becomes increasingly diverse. For example, while Hispanics comprise approximately 12% of the U.S. population, they account for less than 4% of all physicians. African Americans comprise a relatively similar proportion of the nation's population but only 5% of physicians in the health care workforce.<sup>41</sup> Monitoring workforce diversity, supporting grant programs and providing incentives for training health professionals from diverse backgrounds could help to increase workforce diversity and improve quality of care and access to preventive services in underserved minority communities.
  - A national clearinghouse containing workforce diversity data, planning tools and grant information would help to reduce duplication and encourage networking and collaboration across organizations to pool information and resources to diversify the health care workforce.

## H.R. 3090 Health Equity and Accountability Act of 2009

### *Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities*

#### **Patient Navigation**

- Establish a National Center for Cultural and Linguistic Competence in Health Care to carry out activities relating to cultural/linguistic competence, including: translating written materials for health care providers; creating a health information clearinghouse to facilitate the provision of language access services; and a toll-free helpline for individuals with LEP to provide them with information on how to access federally funded health programs (i.e. Medicare, Medicaid, CHIP) and language services.
- Over one-third of children who are eligible for Medicaid, but are not enrolled, are from immigrant families. While recipients of federal funds (i.e. Medicaid providers) are required to provide language appropriate services, many providers are unaware of how to access resources to enable them to do so.<sup>42</sup> A central resource to provide individuals with LEP with enrollment assistance and health care providers with linguistically appropriate resources would improve both access to, and quality of care, for individuals with LEP.

## H.R. 3090 Health Equity and Accountability Act of 2009

Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 6. Social Determinants of Health

	Summary	Implications for Racial/Ethnic Minorities
<b>Interagency Collaboration</b>	<ul style="list-style-type: none"> <li>Provide grants to multi-sector coalitions for environmental health improvement activities that target communities disproportionately exposed to environmental hazards.</li> </ul>	<ul style="list-style-type: none"> <li>Coalition-based approaches to environmental justice can produce systems and policy change by increasing public awareness and mobilizing key stakeholders around an environmental hazard.<sup>43</sup> Such approaches may result in changes to rules and regulations which decrease exposure to environmental risk factors which contribute to chronic diseases (e.g. asthma) that are prevalent in low-income communities.</li> </ul>
<b>Infrastructure Support</b>	<ul style="list-style-type: none"> <li>Codify Executive Order 12898, <i>Federal Actions to Address Environmental Justice in Minority and Low-Income Populations</i>, to ensure that minorities have access to public information on environmental regulations and that minority populations are not disproportionately exposed to environmental health hazards.</li> </ul>	<ul style="list-style-type: none"> <li>Improving knowledge among minority communities about environmental health hazards and regulations is important to safeguarding their health, safety and well-being.</li> </ul>
<b>Data Collection</b>	<ul style="list-style-type: none"> <li>Require the Environmental Protection Agency (EPA) to conduct environmental justice reviews of the impact of their program, policies, and activities for low-income and minority populations.</li> <li>Provide grants to research the relationship between the built environment and factors influencing community health, including physical activity, consumption of nutritional foods, crime, air and water quality, risk of injury, and access to health care services.</li> </ul>	<ul style="list-style-type: none"> <li>The disproportionate burden of adverse environmental exposures on low-income minority communities is well documented. While there is mounting evidence that exposures to environmental toxins produce adverse health effects, additional research is needed to investigate a causal relationship between environmental inequality and racial/ethnic health disparities.<sup>44,45</sup></li> <li>Robust data collection on factors beyond race, ethnicity, and language that are likely to influence and shape health and health care decisions—such as social, economic, and environmental conditions—offer the opportunity to identify associations between health outcomes and social determinants and develop targeted programs to advance health equity.<sup>46</sup></li> </ul>

<sup>1</sup> House Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, Natural Resources, Armed Services, Veterans' Affairs, and Agriculture. (2009). *Health Equity and Accountability Act of 2009*. HR 3090. Retrieved September 22, 2009, from [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3090ih.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3090ih.txt.pdf).

<sup>2</sup> Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62: 255-299.

<sup>3</sup> US Census Bureau. (2007). American Community Survey.

<sup>4</sup> Kaiser Family Foundation. (April 2006). Medicaid and SCHIP eligibility for immigrants. Retrieved September 3, 2009, from <http://www.kff.org/medicaid/upload/7492.pdf>.

<sup>5</sup> US Census Bureau. (2007).

<sup>6</sup> Thorpe, D. (July 20, 2009). U.S. territories want in on health care debate: Inadequate Medicaid funding has profound effect on Puerto Rico AIDS crisis. *Housing Works*. Retrieved September 3, 2009, from <http://www.housingworks.org/news-press/detail/us-territories-want-in-on-health-care-debate/>.

<sup>7</sup> Ibid.

## H.R. 3090 Health Equity and Accountability Act of 2009

### Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

- <sup>8</sup> Mead, H., et al. (2008). *Racial and ethnic disparities in U.S. health care: A chartbook*. New York: The Commonwealth Fund.
- <sup>9</sup> The Commonwealth Fund. Usual source of care and receipt of preventive care. Retrieved September 22, 2009, from <http://www.commonwealthfund.org/Content/Performance-Snapshots/Financial-and-Structural-Access-to-Care/Usual-Source-of-Care-and-Receipt-of-Preventive-Care.aspx>.
- <sup>10</sup> American Lung Association. (2007). Lung disease data at a glance: Lung cancer. Retrieved September 22, 2009, from [http://www.lungusa.org/site/c.dvLUK9O0E/b.317181/k.FA6B/Lung\\_Disease\\_Data\\_at\\_a\\_Glance\\_Lung\\_Cancer.htm](http://www.lungusa.org/site/c.dvLUK9O0E/b.317181/k.FA6B/Lung_Disease_Data_at_a_Glance_Lung_Cancer.htm).
- <sup>11</sup> Centers for Disease Control and Prevention. (2007). HIV/AIDS surveillance report, Vol. 19. Atlanta: U.S. Department of Health and Human Services. Retrieved September 22, 2009, from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf>.
- <sup>12</sup> Centers for Disease Control and Prevention. (2009). Differences in prevalence of obesity among black, white and Hispanic adults—United States, 2006-2008. *MMWR*, 58(27): 740-744. Retrieved September 22, 2009, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm>.
- <sup>13</sup> Centers for Disease Control and Prevention. (2009). NHANES Surveys (1976-1980 and 2003-2006). Retrieved September 22, 2009, from <http://www.cdc.gov/obesity/childhood/prevalence.html>.
- <sup>14</sup> Health Resources and Services Administration. (2008). Cigarette smoking. Rockville, MD: US Department of Health and Human Services. Retrieved September 22, 2009, from <http://mchb.hrsa.gov/whusa08/hstat/hb/pages/204cs.html>.
- <sup>15</sup> Reimer, R.A., Gerrard, M., & Gibbons, F.X. (2009). Racial disparities in smoking knowledge among current smokers: Data from the health information national trends surveys. *Psychology & Health*. Retrieved September 22, 2009, from <http://www.informaworld.com/smpp/content~content=a911733362~db=all~jumptype=rss>.
- <sup>16</sup> Centers for Disease Control and Prevention. (2008). Eliminate Disparities in Diabetes. Office of Minority Health & Health Disparities (OMHD) Factsheet. Retrieved September 10, 2009, from <http://www.cdc.gov/omhd/AMH/factsheets/diabetes.htm#40>.
- <sup>17</sup> Lillie-Blanton, M., et al. (2000). Race, ethnicity, and the health care system: Public perceptions and experiences. *Medical Care Research and Review*, 57 (Supplemental 1): 218-235.
- <sup>18</sup> *Health Empowerment Zone Act of 2009*. H.R. 2233. (May 4, 2009). Retrieved July 9, 2009, from <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.2233.IH>.
- <sup>19</sup> Egede, L.E. & Bosworth, H. (2008). The future of health disparities research: 2008 and beyond. *Journal of General Internal Medicine*, 23(5): 706-708.
- <sup>20</sup> Ramos, I.N., May, M., & Ramos, K.S. (2001). Environmental health training of promotoras in colonias along the Texas-Mexico border. *American Journal of Public Health*, 91(4): 568-70.; Zuniga, M.A., et al. (2004). Health status measurement during a household evaluation of an integrated health outreach project targeting Colonia residents in Hidalgo County, Texas. *Abstract AcademyHealth Meeting*. 21: No. 1275, Retrieved September 22, 2009, from <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=103624309.html>.
- <sup>21</sup> Alegría, M., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services*, 53(12):1547-1555. Retrieved September 22, 2009, from <http://www.ncbi.nlm.nih.gov/pubmed/12461214>.
- <sup>22</sup> K.J., Olatosi, B., & Probst, J.C. (2008). *Health disparities: A rural-urban chartbook*. South Carolina Rural Health Research & Policy Centers, Retrieved September 22, 2009, from [http://rhr.sph.sc.edu/report/\(7-3\)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20-%20Distribution%20Copy.pdf](http://rhr.sph.sc.edu/report/(7-3)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20-%20Distribution%20Copy.pdf).
- <sup>23</sup> Office of the General Counsel, US Commission on Civil Rights. (2004). Native American health care disparities briefing. Retrieved September 22, 2009, from <http://www.law.umaryland.edu/marshall/usccr/documents/nativeamericanhealthcare.pdf>.
- <sup>24</sup> Ibid.
- <sup>25</sup> Vernon, J.A., et al. (2007). Low health literacy: Implications for national health policy. Retrieved September 22, 2009, from [http://www.npsf.org/askme3/pdfs/Case\\_Report\\_10\\_07.pdf](http://www.npsf.org/askme3/pdfs/Case_Report_10_07.pdf).
- <sup>26</sup> Williams, M.V., et al. (1998). Inadequate literacy is a barrier to asthma knowledge and self-care. *Chest*, 114(4), 1008-15.
- <sup>27</sup> Beach, M.C., Saha, S., & Cooper, L.A. (2006). The relationship of cultural competence and patient-centeredness in health care quality. The Commonwealth Fund. Retrieved September 23, 2009, from [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/The%20Role%20and%20Relationship%20of%20Cultural%20Competence%20and%20Patient%20Centeredness%20in%20Health%20Care%20Quality/Beach\\_rolerelationshipcultcompatient%20cent\\_960%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/The%20Role%20and%20Relationship%20of%20Cultural%20Competence%20and%20Patient%20Centeredness%20in%20Health%20Care%20Quality/Beach_rolerelationshipcultcompatient%20cent_960%20pdf.pdf).
- <sup>28</sup> King, T.E. (2002). Racial disparities in clinical trials. *New England Journal of Medicine*, 346(18):1400-1402.

## H.R. 3090 Health Equity and Accountability Act of 2009

### *Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities*

---

- <sup>29</sup> Federal Coordinating Council for Comparative Effectiveness. (June 30, 2009). *Research Report to the President and the Congress*. Retrieved July 6, 2009, from <http://www.hhs.gov/recovery/programs/ce/cerannualrpt.pdf>.
- <sup>30</sup> National Center on Minority Health and Health Disparities. NCMHD Centers of Excellence Program. Retrieved September 22, 2009, from [http://ncmhd.nih.gov/our\\_programs/centerOfExcellence.asp](http://ncmhd.nih.gov/our_programs/centerOfExcellence.asp).
- <sup>31</sup> National Cancer Institute. Cancer health disparities. National Institutes of Health. Retrieved September 22, 2009, from <http://www.cancer.gov/cancertopics/factsheet/cancer-health-disparities>.
- <sup>32</sup> Freeman, H.P. & Wingrove, B.K. (2005). *Excess cervical cancer mortality: A marker for low access to health care in poor communities*. Rockville, MD: National Cancer Institute, Center to Reduce Cancer Health Disparities. Retrieved September 22, 2009, from <http://crhd.cancer.gov/attachments/excess-cervcanmort.pdf>.
- <sup>33</sup> Smith, D.B. (1998). Addressing racial inequalities in care: Civil rights monitoring and report cards. *Journal of Health, Politics, Policy, and Law*, 23: 75-107.
- <sup>34</sup> Gaiter, J.L., Potter, R.H., & O'Leary, A. (2006). Disproportionate rates of incarceration contribute to health disparities. *American Journal of Public Health*, 96(7): 1148-1149.
- <sup>35</sup> Brittingham, A. & de la Cruz, P.G. (2004). *Ancestry: 2000*. US Census Bureau. Retrieved June 23, 2009, from <http://www.census.gov/prod/2004pubs/c2kbr-35.pdf>.
- <sup>36</sup> Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine.
- <sup>37</sup> U.S. Census Bureau. (2007).
- <sup>38</sup> US Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved September 22, 2009, from <http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf>.
- <sup>39</sup> Leyva, M.m Sharif, I. & Ozuah, P.O. (2005). Health literacy among Spanish-speaking Latino parents with limited English proficiency. *Ambulatory Practices*, 5(1): 56- 59.
- <sup>40</sup> AARP Policy Institute. Improving access to care among Medicare beneficiaries with limited English proficiency: Can Medicare do more? Retrieved July 6, 2009, from [http://assets.aarp.org/rgcenter/health/i6\\_medicare.pdf](http://assets.aarp.org/rgcenter/health/i6_medicare.pdf).
- <sup>41</sup> Smedley, B.D., Butler, A.S., & Bristow, L.R. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. Washington, DC: Institute of Medicine.
- <sup>42</sup> National Immigration Law Center. (2002). Immigrant-friendly health coverage outreach and enrollment. Retrieved September 22, 2009, from [http://www.nilc.org/immspbs/health/Issue\\_Briefs/Immigrant-Friendly\\_App\\_Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF).
- <sup>43</sup> Nicholas, E.A., et al. (2006). Coalition-based approaches for addressing environmental issues in childhood asthma. *Health Promotion and Practice*, 7:108S-116S.
- <sup>44</sup> Northridge, M.E., et al. (2003). Environmental equity and health: Understanding complexity and moving forward. *American Journal of Public Health*. 93(2): 209-214.
- <sup>45</sup> Brulle, R.J. & Pellow, D.N., (2006). Environmental justice: Human health and environmental inequalities. *Annual Review of Public Health*, 27(3): 3-22.
- <sup>46</sup> Hillemeier, M., et al. (2003). Measuring contextual characteristics for community health. *Health Services Research*. 38(6 Pt 2): 1645-1718.