REPORT TO CONGRESS ON
RACIAL AND ETHNIC MINORITY HEALTH ACTIVITIES
FOR FISCAL YEARS 2015 AND 2016
AS REQUIRED BY THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148)

FROM THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Acronyms

AAMC	Association of American Medical Colleges
ACF	Administration for Children and Families
ACIP	Asthma Care Implementation Programs
ACL	Administration for Community Living
ADA	Americans with Disabilities Act
AHEC	Area Health Education Centers
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian or Alaska Native
AICH	American Indian Community House
AIDD	Administration for Intellectual and Developmental Disabilities
AIDS	acquired immunodeficiency syndrome
ASPE	Assistant Secretary for Planning and Evaluation
ASPR	Assistant Secretary for Preparedness and Response
ATHS	Alaska Tribal Health System
BMI	body mass index
BUILD	Building Infrastructure Leading to Diversity
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAPUS	Care and Prevention in the United States Project
CBO	community-based organization
CBPR	community-based participatory research
CDC	Centers for Disease Control and Prevention
CEC	Coordination and Evaluation Center
CER	Comparative Effectiveness Research
CHAAMPS	Center for Healthy African American Men through Partnerships
CHAMPS	Cities Combating Hunger through Afterschool and Summer Meal Programs
CHC	community health center
CHEC	Community Health Environment Checklist
CHIP	Children's Health Insurance Program
CHW	community health worker
COPS	Community-Oriented Policing Services
CTA	Call to Action
CLC	cultural and linguistic competency
CPE	Center for Policy and Evaluation
DDTP	Division of Diabetes Treatment and Prevention
DIS	Disparity Impact Statements
CFSAN	Center for Food Safety and Applied Nutrition
CLAS	Culturally and Linguistically Appropriate Services
CLCCHC	Center for Linguistic and Cultural Competency in Health Care
CMS	Centers for Medicare & Medicaid Services
CNSTAT	Committee on National Statistics
COE	Center for Excellence
CPHHD	Centers for Population Health and Health Disparities
CVD	cardiovascular disease

DGA	Dietary Guidelines for Americans
DPC	Diversity Program Consortium
DSME	diabetes self-management education
DTS	Drug Trials Snapshots
EBI	evidence-based intervention
EDC	Everyone with Diabetes Counts
EHR	electronic health records
EPA	Environmental Protection Agency
EPAP	Emergency Prescription Assistance Program
ePHIM	electronic personal health information management
ESF	Emergency Support Function
ESI	early-stage investigator
FDA	Food and Drug Administration
FDASIA	FDA Safety and Innovation Act
FIHET	Federal Interagency Health Equity Team
FNS	Food and Nutrition Service
FPAR	Family Planning Annual Report
FQHC	Federally Qualified Health Centers
FY	fiscal year
GHWIC	Good Health and Wellness in Indian Country Program
HBCU	Historically Black Colleges and Universities
HCOP	Health Careers Opportunity Program
HCUP	Healthcare Cost & Utilization Project
HHS	Department of Health and Human Services
HE-TAP	Higher Education Technical Assistance Project
HINTS	Health Information National Trends Survey
HIT	health information technology
HIV	human immunodeficiency virus
HPSA	Health Professional Shortage Area
HPV	human papillomavirus
HRSA	Health Resources and Services Administration
ICL	Institute for Community Living
IHE	institutions of higher education
IHS	Indian Health Service
IMSD	Initiative for Maximizing Student Development
ISUPS	institutions serving underserved health disparity populations and underrepresented students
LAP	Language Access Plan
LEP	limited English proficiency
LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LRP	Loan Repayment Program
MCN	Migrant Clinicians Network
MDE	medical diagnostic equipment
MEPS	Medical Expenditure Panel Survey
MFFS	Managed Fee for Service

MFP	Minority Fellowship Program
MI	multiple imputation
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MMCO	Medicare-Medicaid Coordination Office
MMWR	Morbidity and Mortality Weekly Report
MOA	memorandum of agreement
MSI	minority serving institution
MSM	men who have sex with men
MYVP	Minority Youth Violence Prevention
NAS	National Academy of Sciences
NCA	National Cooperative Agreement
NCAI	National Congress of American Indians
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCD	non-communicable disease
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCIPC	National Center for Injury Prevention and Control
NCLR	National Council of La Raza
NECHW	New England community health worker
NFLPA	National Football League Players Association
NHIB	National Indian Health Board
NHCHC	National Healthcare for Homeless Council
NHSC	National Health Service Corps
NIDILRR	National Institute for Independent Living and Rehabilitation Research
NIH	National Institutes of Health
NIMHD	National Institute on Minority Health and Health Disparities
NNED	National Network to Eliminate Disparities in Behavioral Health
NPA	National Partnership for Action to End Health Disparities
NRFC	National Football League Players Association
NRNM	National Research Mentoring Network
NSF	National Science Foundation
NSS	National Stakeholder Strategy for Achieving Health Equity
NWDP	National Workforce Diversity Pipeline
NWGHAAD	National Women and Girls HIV/AIDS Awareness Day
NWHW	National Women's Health Week
OAA	Older Americans Act
OAH	Office of Adolescent Health
OASH	Office of the Assistant Secretary for Health
OBHE	Office of Behavioral Health Equity
OCR	Office for Civil Rights
ODPHP	Office of Disease Prevention and Health Promotion
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy
OHE	Office of Health Equity
OIASA	Office of Indian Alcohol and Substance Abuse
OMB	Office of Management and Budget
OMH	Office of Minority Health

OMHHE	Office of Minority Health and Health Equity
OMHRC	OMH Resource Center
ONC	Office of the National Coordinator for Health Information Technology
OPA	Office of Population Affairs
ORA	Office of Regulatory Affairs
OS	Office of the Secretary
OSG	Office of the Surgeon General
OTAP	Office of Tribal Affairs and Policy
OWH	Office on Women's Health
P4C	Partnerships for Care
PACHE	Partnerships to Advance Cancer Health Equity
PAF	Pregnancy Assistance Fund
PATH	Population Assessment of Tobacco and Health
PBHCI	Primary and Behavioral Health Care Integration
PCORI	Patient Centered Outcomes Research Institute
PCFSN	President's Council on Fitness, Sports, and Nutrition
PCMH	patient-centered medical home
PHS Act	Public Health Service Act
PHR	personal health record
PICCI	Partnerships to Increase Coverage in Communities Initiative
PICH	Partnerships to Improve Community Health
PPACA	Patient Protection and Affordable Care Act
PPE	Preconception Peer Educators
PrEP	Pre-Exposure Prophylaxis
PSA	public service announcement
PTOC	Parenting Time Opportunities for Children in the Child Support Program
QDR	Quality & Disparities Report
QPP	Quality Payment Programs
RBHA	Richmond Behavioral Health Authority
RCMAR	Resource Centers for Minority Aging Research
REACH	Racial and Ethnic Approaches to Community Health
RFA	Request for Application
RHEC	Regional Health Equity Council
RIC	Resources for Integrated Care
RMHC	Regional Minority Health Consultant
RHYTTAC	Runaway and Homeless Youth Training and Technical Assistance Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	socioeconomic status
SCHS	Solano County Public Health Services
SDM	Shared Decision Making
SDOH	social determinants of health
SDPI	Special Diabetes Program for Indians
SFSP	Summer Food Service Program
SID	State Inpatient Database
SMAIF	Secretary's Minority AIDS Initiative Funds
SMI	serious mental illness

SOFS	Science and Our Food Supply
SOMH	State Office of Minority Health
SPIRP	Stroke Prevention/Intervention Research Program
STEM	science, technology, engineering, and math
TEC	Tribal Epidemiology Center
TCC	Transdisciplinary Collaborative Centers for Health Disparities Research Program
TCH	Think Cultural Health
TCU	Tribal Colleges and Universities
TKR	total knee replacement
TLOA	Tribal Law and Order Act
TMVIPP	Tribal Motor Vehicle Injury Prevention Program
TPP	Teen Pregnancy Prevention
TRAIL	Together Raising Awareness for Indian Life
TTY	text telephone
UCEDDS	University Centers of Excellence in Developmental Disabilities Education, Research and Service
URM	underrepresented minority
USAPI	U.S. Affiliated Pacific Islands
USDA	United States Department of Agriculture
VA	Veterans Affairs
VDS	Ventanillas de Salud Program

Reporting Requirement

This report responds to the reporting requirement of Section 10334(a)(3) of the Patient Protection and Affordable Care Act (P.L. 111-148), which requires the Secretary of HHS to file a biennial report to Congress on the HHS programs and activities related to minority health and health disparities. Section 10334(a)(3) also requires the heads of each HHS agency to submit to the Deputy Assistant Secretary for Minority Health a report summarizing the minority health activities of each agency. This report summarizes the Department's racial and ethnic minority health activities for FY 2015 and 2016.

REPORT TO CONGRESS ON RACIAL AND ETHNIC MINORITY HEALTH ACTIVITIES FOR FISCAL YEARS 2015 AND 2016

Executive Summary

The transformation of America's healthcare and public health systems provides opportunities to progress toward a nation where everyone can reach their full potential of health. Healthier communities translate into lower healthcare costs, a stronger economy, and a more productive and competitive America. By drawing attention to the environmental, social, and economic conditions that impact health, also known as social determinants of health (SDOH), we are building a stronger foundation for our nation's increasingly diverse population to realize optimal health outcomes. Through this report, the Office of Minority Health (OMH) within the U.S. Department of Health and Human Services (HHS or the Department) provides a summation of ongoing HHS efforts in fiscal years (FY) 2015 and 2016, to reduce health and healthcare disparities and to advance health equity among racial and ethnic minorities and underserved populations.

In FY 2015 and 2016, HHS continued to implement the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan).[1] Initially released in 2011, the HHS Disparities Action Plan was the most comprehensive federal commitment on health disparities and this plan charged all HHS operating and staff divisions to develop HHS policies and programs to reduce health disparities. The HHS Disparities Action Plan was built on applicable law, and leveraged other national initiatives, such as Healthy People 2020 and the National Prevention Strategy. This strategic action plan represented unprecedented coordination and collaboration across HHS divisions and with external partners to achieve the vision of "a nation free of disparities in health and healthcare."

HHS Agency Actions During Fiscal Years 2015 and 2016

- Increased activities and success in reducing disparities in health insurance coverage and access to health care;
- Enhanced strategic planning to drive targeted and collaborative efforts to reduce disparities;
- Increased integration of disparities-related efforts across agencies;
- Increased intra- and interagency collaboration on disparities-related projects and activities;
- Expanded partnerships within HHS and with external partners;
- Increased information sharing with community groups; and
- Improved disaggregated data collection and analysis.

Since the *Report to Congress on Minority Health Activities* for FY 2013 and 2014 was published, the HHS OMH, the National Institute on Minority Health and Health Disparities (NIMHD) of the National Institutes of Health (NIH), the Offices of Minority Health within six HHS agencies, and various other HHS agencies and offices have continued to implement and support

[1] See the HHS Action Plan to Reduce Racial and Ethnic Health Disparities at https://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

programs and policies to reduce disparities in health and healthcare for minority populations.

Major Dimensions of Health Disparities Include:

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

In FY 2015 and 2016, the Department built upon the activities reported in FY 2013 and 2014, including leadership and coordination of national health disparities action plans; community-based participatory research (CBPR); access to quality healthcare for minority and underserved populations; dissemination of a variety of grants; increasing the diversity and cultural competency of the HHS workforce; integration of research and establishment of networks that connect funded institutions, researchers, and the community; participation improvement of racial and ethnic minorities in chronic condition research studies; state leadership and supporting programs to improve the health of, and healthcare for, vulnerable populations across the lifespan; expansion of diverse language-based programs; enhancement of data collection and reporting on health disparities at the national and state levels; access to, and implementation of, health information technology; health literacy; technical assistance and professional training to underrepresented populations; and improvemnet of capacity to address gaps in services.

Most notably, HHS agencies and offices have successfully engaged underserved populations with meaningful disease prevention and health promotion activities, underscoring the objectives of Healthy People 2020, which is a series of evidence-based, national health objectives designed to improve the health of all Americans. A substantial number of activities in FY 2015 and 2016 focused on increasing the diversity of our nation's health workforce. These efforts were designed to substantially increase the diversity and cultural competency of the workforce in order to serve our nation's most vulnerable communities in the future. Increased partnerships with non-government organizations and other stakeholder groups was also a focus for many agencies and offices as they further engaged public- and private-sector partners and stakeholders in collaborative initiatives to improve the health and well-being of racial and ethnic minority populations, as well as all Americans. Technology continued to play a significant role at the forefront of many programs and policies to address health disparities, including investments in health information technology (HIT).

The activities described in this report are important because many of the health barriers that racial and ethnic minorities face are the result of interrelated elements that affect individuals across their lifespan. These SDOH affect daily living in the places that people live, work, learn, and play, and have significant impact on the health outcomes of individuals, communities, and the prosperity of our nation. Addressing these factors, along with an emphasis on prevention and wellness, is a key strategy for reducing disparities and for improving the health of our nation.

Health disparities impart a devastating toll on the productivity and economic growth of our nation, which makes this an issue of importance to all Americans. When people are sick, they miss days from work, which slows productivity and impacts our economy. When people die prematurely, families lose wage earners, which puts a financial strain on households, can push families into poverty, and impact consumer spending. Key findings from a study by the Joint Center for Political and Economic Studies include:

- Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006 (equivalent to $273 billion in 2016); and
- Eliminating health disparities for minorities would have reduced indirect costs associated with illness and premature death, estimated at $1.24 trillion between 2003-2006 (equivalent to $1.47 trillion in 2016).[2,3]

Historically, racial and ethnic minorities have the highest rates of being uninsured, have higher rates of many chronic conditions, and are less likely to receive preventive care and quality healthcare. Through policy and program mechanisms, HHS is working to help end discrimination in healthcare; expand access to coverage; assist in providing healthcare to underserved communities; increase the representation of minorities in the healthcare, public health, and biomedical research workforces; improve health disparities research and data collection; and improve the minority health infrastructure of HHS itself.

The persistent health disparities and the increasing diversity of the nation's population since the publication of the 1985 *Report of the Secretary's Task Force on Black and Minority Health* (i.e., the first comprehensive study of the health status of racial and ethnic minorities conducted by the United States [U.S.] government) drive HHS's commitment to reducing racial and ethnic health disparities. The HHS Disparities Action Plan helped the Department assess the impact of all policies and programs on racial and ethnic health disparities through strategic priorities which align with the Department's Strategic Plan for 2010-2015.[4] These priorities include:

1. **Transform Health Care:** Strengthening the current healthcare system and building a high-value healthcare system requires insuring and/or ensuring access to healthcare for the uninsured, making coverage more secure for those who have it, and improving the quality of care for all populations. The HHS Disparities Action Plan outlined strategies to reduce health disparities by expanding access to health coverage and healthcare and improving primary care services, care coordination, and healthcare quality.
2. **Strengthen the Nation's HHS Infrastructure and Workforce:** There is a critical shortage of primary care physicians, nurses, behavioral health providers, long-term care workers, community health workers (CHWs), and other health professionals in the U.S. With growing diversity, the disparity between the racial and ethnic composition of the healthcare workforce and that of the general population widens.[5] Strategies for strengthening the HHS infrastructure and workforce outlined in the HHS Disparities

[2] La Veist, TA, Gaskin DJ, and Richard P. *The Economic Burden of Health Inequalities in the United States.* Joint Center for Political and Economic Studies; 2009.
[3] See the Inflation Calculator at http://www.in2013dollars.com/2008-dollars-in-2017
[4] See the HHS Strategic Plan: Strategic Plan FY 2010 – 2015 at https://aspe.hhs.gov/pdf-report/hhs-strategic-plan-fy-2010-2015
[5] *Ibid.*

Action Plan involve addressing this shortage, increasing workforce diversity, and improving the cultural competence of health professionals.

3. **Advance the Health, Safety, and Well-being of the American People:** To prevent and control chronic diseases, the HHS Disparities Action Plan outlined strategies to create environments that empower and promote healthy behaviors in minority communities. Creating these environments requires renewed commitment to prevention with an emphasis on strengthening community-based approaches that reduce high-risk behaviors.
4. **Advance Scientific Knowledge and Innovation:** The HHS Disparities Action Plan outlined strategies to increase the availability and quality of data collected and reported on racial and ethnic minority populations; improve patient-centered research in the areas of preventative, screening, diagnostic, and treatment services; and strengthen existing information systems to reduce disparities and improve the quality of health, public health, and biomedical research that will benefit all populations, including racial and ethnic minorities.
5. **Increase Efficiency, Transparency, and Accountability of HHS Programs:** HHS seeks to promote better collaboration and coordination of HHS programs to address racial and ethnic health disparities in an efficient, transparent, and accountable manner. This includes monitoring implementation of the HHS Disparities Action Plan.

The following report highlights HHS programs supporting the reduction of racial and ethnic minority health disparities in FY 2015 and 2016. For this report, the program activities of the various offices are organized by the goals and strategies of the HHS Disparities Action Plan.

Summary of Minority Health Activities

In 1986, Secretary Margaret M. Heckler created the HHS OMH, one of the most significant outcomes of the 1985 *Report of the Secretary's Task Force on Black and Minority Health (Heckler Report)*. The creation of OMH demonstrates the Department's dedication to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. OMH provides tangible support to state offices of minority health, multicultural health- and health equity- focused organizations, community and faith-based organizations, institutions of higher education, tribes and tribal organizations, and scientific and research organizations dedicated to improving the health of racial and ethnic minorities.

OMH continues to lead and coordinate efforts across the government related to policy development and coordination, technical assistance, information exchange, coalition and partnership building, and other activities that address the health needs of racial and ethnic minorities. In addition, the OMH Resource Center (OMHRC), created in 1987, serves as the nation's largest repository of information on health issues specific to African Americans, American Indians and Alaska Natives (AI/AN), Asian Americans, Hispanics, and Native Hawaiians and other Pacific Islanders.

To achieve its mission, OMH has implemented strategies intended to improve the health status of racial and ethnic minority populations. Key OMH strategies include:

- Improving data collection, reporting, and sharing for racial and ethnic minority populations;
- Establishing and strengthening networks, coalitions, and partnerships to identify and solve health problems;
- Developing and promoting policies, programs, and practices to achieve health equity;
- Fostering research and evaluations; and
- Funding demonstration programs at the regional, state, and local level that can contribute to health policy and the effectiveness of strategies for improving health.

Through grants and cooperative agreements, OMH provides support for innovative program models to address health disparities through improvements in public awareness, education, prevention, and service delivery to minority communities. OMH's *Center for Linguistic and Cultural Competency in Health Care and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)* help healthcare providers and organizations provide culturally and linguistically appropriate services to better serve our nation's increasingly diverse communities.

OMH provides executive leadership for the HHS Health Disparities Council, established in 2004 under Secretary Tommy G. Thompson, and oversees implementation of the U.S. Department of HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan). The HHS Disparities Action Plan documented and provided a coordinated framework for the federal government's longstanding commitment to reducing disparities in health and healthcare. OMH coordinated the efforts of Departmental agencies and offices to streamline and institutionalize programmatic and policy efforts, as well as promote integrated approaches and

evidence-based programs, so that all Americans have the chance to live the healthiest lives possible. OMH leads implementation of the HHS Disparities Action Plan to help address health disparities which former Secretary Heckler called an "affront both to our ideals and to the ongoing genius of American medicine." The HHS Disparities Action Plan articulates a set of Departmental priorities, tangible strategies, and high-impact actions to achieve the vision of a nation free of disparities in health and healthcare.

Guided by these priorities, HHS efforts to improve minority health are aligned under the goals and specific strategies of the HHS Disparities Action Plan. In 2015, the Assistant Secretary for Planning and Evaluation and OMH released an Implementation Progress Report which describes some of the major actions and activities that agencies have undertaken to implement the HHS Disparities Action Plan from 2011 - 2014. The Implementation Progress Report is not an exhaustive list of the research, policies, and programs the Department supports to improve minority health, but rather provides examples of important work in this area.[6]

The following sections provide information on HHS programs to reduce disparities in health and healthcare for minority populations during FY 2015 and 2016. Departmental highlights for the reporting period are organized by HHS agency, including the OMH within the Office of the Secretary; NIH's NIMHD; the six operating divisions which each have OMHs; and other HHS agencies implementing minority health-related activities. Each agency's activities are organized by the five HHS Disparities Action Plan goals and their corresponding strategies, and include:

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

Office of the Secretary, Office of Minority Health

Agency Mission: The mission of the OMH is to improve the health of racial and ethnic minorities through the development of health policies and programs that will help to eliminate health disparities. OMH serves as the lead agency for coordinating efforts across the government to address and to eliminate health disparities. It convenes and provides guidance to HHS operating and staff divisions and other federal departments to identify health disparity and health equity policy and programmatic actions. This includes working in close partnership with the Office of the Assistant Secretary for Health (OASH) and the Department's other public health offices. This targeted leadership improves performance through better coordination on cross-cutting initiatives and leveraged resources to reduce health disparities.

OMH has a Regional Minority Health Consultant (RMHC) in each of the 10 HHS regional offices to serve as a focal point and technical resource on minority health issues within each region. In 1990, the RMHCs were established and charged with providing technical assistance to States for the purpose of establishing OMHs throughout the country. Today, the RMHCs serve as an extension of OMH and implement its strategic priorities. They help build networks of consumers and professionals working on minority health issues and provide technical assistance to organizations that serve minority and underserved communities.

[6] See the Implementation Progress Report at https://aspe.hhs.gov/pdf-report/hhs-action-plan-reduce-racial-and-ethnic-health-disparities-implementation-progress-report-2011-2014

OMH Strategic Priorities: OMH focuses on translating core minority health and health disparity programs into strategic activities and policies at the federal, state, tribal, territorial, and local levels. In 2015 and 2016, OMH's three strategic priorities were to:

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

Developed through a Department-wide strategic planning process co-led by the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation (ASPE), the HHS Disparities Action Plan focuses on improving the health status of racial and ethnic minorities across their lifespan. OMH's lead role in providing coordination among the Operating Divisions' Offices of Minority Health and the National Institute on Minority Health and Health Disparities, as well as its partnerships with many of HHS's Staff Divisions and Operating Divisions make it uniquely suited to lead implementation of the HHS Disparities Action Plan.

Another important leadership role for OMH has been the development and implementation of the NPA. The NPA was established to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity using a SDOH framework. It is a multi-sector, multi-level coordinated approach to addressing health equity. The four key implementation components of the NPA are:

1. The Federal Interagency Health Equity Team (FIHET);
2. Regional Health Equity Councils (RHECs);
3. State and Territorial Offices of Minority Health (SOMHs); and
4. National Partners.

The activities and impact of each NPA component are described below, organized by the goals and strategies of the HHS Disparities Action Plan.

One key product of the NPA, the National Stakeholder Strategy for Achieving Health Equity (NSS), was developed based on the input of more than 2,000 stakeholders nationwide who called for collaborative actions to effectively and efficiently address health and healthcare disparities in this country. These stakeholders represented community based organizations; faith-based organizations; the business sector; the public health community; the healthcare workforce; academia; local, territorial, state and tribal governments; and the federal government.

The goals of the NPA and NSS include:

1. **Awareness:** Increasing awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations;
2. **Leadership:** Strengthening and broaden leadership for addressing health disparities at all levels;
3. **Health System and Life Experience:** Improving health and healthcare outcomes for racial, ethnic, and underserved populations;

4. **Cultural and Linguistic Competency:** Improving cultural and linguistic competency and the diversity of the health-related workforce; and
5. **Data, Research, and Evaluation:** Improving data availability and the coordination, utilization, and diffusion of research and evaluation outcomes.

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

In FY 2015 and 2016, OMH played a critical role in supporting initiatives that address health disparities and equity. Racial and ethnic minorities have the highest rates of being uninsured, are less likely to receive preventive care, have higher rates of many chronic conditions, have fewer treatment options, and are less likely to receive quality healthcare. Educational outreach has served to raise the awareness of minority and underserved populations about healthcare coverage and healthcare options and to support increased enrollment of underserved populations in health plans. OMH collaborated with strategic partners and stakeholders to provide information about health plans' benefits and eligibility as well as promote access to healthcare coverage for racial and ethnic minorities and underserved populations.

Highlights of OMH's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

The rationale and goals outlined by the HHS Disparities Action Plan are directly aligned with OMH's mission to improve the health of racial and ethnic minorities through the development of health policies and programs that will reduce health disparities. The section below highlights a sample of OMH programs that address Goals I through IV. Goal V (increasing the efficiency, transparency, and accountability of HHS programs) is addressed in the final section of the report, "Coordination, Integration, and Accountability."

GOAL I: Transform Health Care

During the third open enrollment period for the Health Insurance Exchanges (Exchanges) (October 2015 through February 2016), many of OMH's program activities within Goal I focused on **reducing disparities in health insurance coverage and access to care (Strategy I.A)**.

OMH conducted media outreach during the Open Enrollment period to educate uninsured minority populations about health coverage options offered through the Exchanges by utilizing social and traditional media channels. According to the 2015 OMH report prepared by Radio One, OMH's activities reached more than 20 million users, and an OMH digital/mobile ad campaign (in English and Spanish) helped connect consumers to Healthcare.gov and CuidadoDesalud.gov. The digital/mobile ads were viewed 667,667 times by consumers, which resulted in 4,846 clicks to Healthcare.gov and CuidadoDesalud.gov. An earlier OMH multi-media campaign (Your Coverage Your Care–Working for You) helped educate minority populations about the Centers for Medicare & Medicaid Services' (CMS's) Coverage to Care

initiative.

Through its Partnerships to Increase Coverage in Communities Initiative (PICCI), OMH grantees worked to inform minority populations about coverage options and assisted them with enrollment. During the project implementation period (FY 2014-FY 2016), OMH grantees reported that in-person assistance was provided to 398,218 individuals; 302,437 individuals were reached through community screenings, health fairs, and public meetings; and more than 1.1 million non-English materials were disseminated. OMH also supported 10 Regional Health Equity Councils (RHECs) – regional coalitions that drive action to combat health disparities – that reached more than 6,300 consumers with activities promoting enrollment in healthcare coverage.

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

OMH's work in reducing disparities in healthcare was amplified by two key historic events in FY 2015 and FY 2016: the *30th Anniversary of the Report of the Secretary's Task Force on Black and Minority Health* (*Heckler Report)* in April 2015; and the *30th Anniversary of the HHS OMH* in April 2016. OMH led the commemoration of the 30th anniversary of the *Heckler Report*. This national observance served as an opportunity to call attention to national, state, tribal, territorial, and local efforts toward eliminating health disparities. The activities led by HHS OMH also highlighted the progress we have made as a nation in closing the gaps in health disparities, and the ways in which the *Heckler Report* has served as a driving force for monumental changes in research, legislation, policies and programs to advance health equity. The activities also served as a call to action to highlight the work that needs to be done to address still prevalent disparities. The kick-off event, a Health Equity Summit, was attended by over 800 online and in-person participants and featured remarks by then HHS Secretary Sylvia M. Burwell, former HHS Secretaries Margaret Heckler and Dr. Louis Sullivan, former Surgeon General Dr. David Satcher, former Representative Louis Stokes, and Dr. J. Nadine Gracia, then Deputy Assistant Secretary for Minority Health and Director of OMH. Additional activities and results for National Minority Health Month 2015, with its theme 30 Years of Advancing Health Equity, included:

- Statements and declarations from the President and Members of Congress;
- A series of eight blogs from leaders across HHS, including other OMHs;
- A message from the Secretary;
- Various digital and graphic products;
- Representation and support at eight other anniversary-themed stakeholder events;
- 2,000 media placements and social media interactions related to advancing health equity and National Minority Health Month;
- Over 23 million reached through social media;
- State and regional events; and
- Regional media coverage.

In April 2016, OMH observed the 30th anniversary of the establishment of its office during National Minority Health Month. The OMH 30th anniversary and National Minority Health Month observance, with its 30 Years Accelerating Health Equity theme, reflected the Department's ongoing and collective efforts to achieve a nation free of disparities in health and healthcare. The anniversary built upon the initiatives and campaigns initiated in 2015 during the 30th anniversary of the *Heckler Report*.

OMH led the development and execution of numerous activities to support the 30th anniversary of the establishment of its office. The key activity, the *HHS Health Equity Forum*, was attended by over 1,500 online and in-person participants. Social media reach for this event was 1.4 million and included 150 contributors and 432 tweets. Additional activities and results included:

- A Presidential Message;
- A message from then HHS Acting Assistant Secretary for Health Dr. Karen DeSalvo;
- A video message from then Surgeon General Vivek H. Murthy;
- HHS OMH video announcements and blog posts;
- A dedicated microsite;
- Various digital and graphic products;
- National media interviews and coverage;
- Representation and support at eight other anniversary-themed stakeholder events;
- 300 media placements;
- 209 million unique visitors to www.minorityhealth.hhs.gov; and
- Numerous social media events, including a Health Equity Twitter Chat that consisted of 1,500 tweets by 506 contributors and reached 3.9 million.

GOAL II: Strengthen the Nation's HHS Infrastructure and Workforce

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

The National CLAS Standards addresses the need to **increase the ability of health professions and healthcare systems to identify and address racial and ethnic disparities (Strategy II.A)**. Originally published in 2000, the *National CLAS Standards* provide a blueprint for individuals and health and healthcare organizations to implement culturally and linguistically appropriate services to advance health equity, improve quality, and help eliminate healthcare disparities. OMH updated and released the enhanced *National CLAS Standards* in 2013 and provides national leadership and technical assistance to HHS agencies and external stakeholders to promote the adoption, implementation, and evaluation of the *National CLAS Standards*. Adoption and implementation of the *National CLAS Standards* has helped health and healthcare organizations meet accreditation requirements.

OMH's *Center for Linguistic and Cultural Competency in Health Care (CLCCHC)* supported the launch of a new, free e-learning program for *Promotores de Salud* and began development of an e-learning program for behavioral health professionals. Think Cultural Health (TCH), the

flagship initiative of the CLCCHC[7] was established to advance health equity at every point of contact through developing and promoting culturally and linguistically appropriate services. In FY 2016, TCH awarded approximately 157,000 continuing education credits in five free e-learning programs (for physicians, nurses, disaster response personnel, oral health professionals, and promotores de salud). The cumulative total for these e-learning programs from their inception to the end of September 2016 was 945,204 continuing education credits awarded. The foregoing data are gathered from user registrations which are required of each user of the e-learning programs. The data are then aggregated and checked against a spreadsheet pulled directly from the database of each on-line education program. This method helps ensure the accuracy of the numbers. The continuing education credits earned through the TCH e-learning programs can be applied to licensure requirements for health professionals. The TCH website underwent a complete redesign in 2016 to improve the website's user experience and usability, including mobile platforms. OMH conducted a two-part webinar series on the *National CLAS Standards* in FY 2016; the first hosted 1,215 participants and the second hosted 1,508 participants.

OMH also leads efforts to **promote the use of Promotores de Salud and CHWs (Strategy II.B)** as trusted members of their community to provide health education and outreach, help community members navigate the healthcare system, and improve the quality of patient-provider interactions in clinical settings. OMH coordinates the *HHS Promotores de Salud Initiative*, launched in April 2011, with the goals of recognizing the important contributions of promotores in reaching vulnerable, low-income, and underserved members of Latino populations and promoting increased engagement of promotores to support health education and prevention efforts and access to health insurance programs.

One of the NPA's emerging priority areas is strengthening the nation's network of CHWs as a critical part of the disease prevention and health promotion workforce to identify and meet the needs of underserved communities. With the help of the *Regional Health Equity Councils (RHECs)*, which correspond geographically to the 10 HHS regions, the NPA seeks to achieve impactful progress toward regional and national recognition of the value of CHWs in community health promotion and healthcare delivery. Moreover, the NPA's Cross-RHEC CHWs Coalition supports activities to expand the role of CHWs and to develop sustainable business models in order to reimburse CHWs for primary prevention services. In FY 2015-2016, RHEC activities promoting the use of CHWs and *Promotores de Salud* occurred in four regions; some examples of the activity include:

- RHEC I co-hosted a CHW summit with the *New England CHW (NECHW) Coalition* in March 2016 to discuss challenges that CHWs face and identify opportunities to collaborate and work toward better addressing these challenges. This collaboration will help create guiding principles and shared values to align shared work and priorities of the NECHW Coalition;
- RHEC V hosted a *Collaborative Forum for Community Health Workers to Advance Health Equity Summit* to foster collaboration among CHWs in Wisconsin communities;
- RHEC IX developed three CHW information briefs; and

[7] See more on the CLCCHC at https://www.thinkculturalhealth.hhs.gov

- RHEC IX developed a CHW database, which includes information on existing CHW programs, populations served, services offered, language capacity, CHW collaborators, funding sources, and CHW websites.

OMH, through its *OMHRC,* supports OMH's commitment to promoting and training *Promotores de Salud* and CHWs through training and technical assistance programs; some examples of these programs include:

- *Improving Community Health in the Rio Grande Valley*: A 1.5-day capacity building training event focused on understanding healthcare benefits and federal funding. Fifty Promotores and CHWs attended, as well as five local organizations serving 300-500 families;
- *Sacramento Promotores Training*: A 1.5-day training for 35 Spanish-speaking and 25 English-speaking CHWs. Topics included PPACA and behavioral health, as well as healthcare coverage and resources; and
- *CHW Training for Immigrant and Refugee Populations*: Using the OWH's CHW leadership curriculum, over 50 CHWs were trained in three locations (Seattle, Denver and New York). Participants received training on community leadership and cultural health beliefs of specific immigrant/refugee populations. CHWs who participated in the program reported feeling improved confidence to expand their scope and work with immigrant clients.

OMH also has a leadership role in initiatives to **increase the diversity of the healthcare and public health workforces (Strategy II.C)**. The NPA addresses educating youth and emerging leaders about the SDOH and health disparities and aims to increase their knowledge through practical learning opportunities. By partnering with higher education centers as well as minority serving institutions (MSI) through the *Youth National Partnership for Action*, OMH can prepare youth leaders to become future leaders and practitioners, and engage emerging professionals as partners in health equity work. Moreover, through the development and implementation of a *Youth Health Equity Model of Practice*, OMH is currently building the evidence base and infrastructure to support the design, implementation, and evaluation of health workforce policies, and capturing and sharing the information needed to develop appropriate health policies and programs for engaging young adults. OMH is identifying and matching emerging leaders with partner organizations to address emerging priorities in the field. The intent is also to infuse technology and innovation into established organizations and coalitions that have worked to address health equity for years. Current partners in this initiative include Morehouse School of Medicine, Marshall University, West Virginia State University, the Hispanic Association of Colleges and Universities, Hispanic-Serving Health Professions Schools, the Association of American Indian Physicians, the National Council of Asian Pacific Islander Physicians, and the National Council of Urban Indian Health.

NPA activities supporting programs for students to increase racial and ethnic diversity in public health and biomedical sciences professions, include:

- Establishing a high school summer course in New Britain, Connecticut;
- Forming the Youth Health Equity Council at University of Colorado;
- Developing a semester-long training offered by Marshall University to high school students;
- Offering a three-week training to undergraduate and Masters students at Morehouse School of Medicine;

- Recruiting youth to participate in Raices, an environmental justice youth project geared toward Latino/a students in rural Idaho; and
- Placing undergraduate, graduate, and doctoral students (18 students) with diverse organizations around the U.S. to complete short-term (8-10 weeks), in-the-field health equity projects.

OMH also supports the Department's commitment to diversify the healthcare and public health workforces through the *OMHRC*. In FY 2015 and FY 2016, OMHRC provided training and technical assistance programs in workforce diversity, including the *Higher Education Technical Assistance Project (HE-TAP)* and its sub-projects such as *Improving Latino Student Success in the Health Professions* event. Through HE-TAP, OMHRC works with faculty from institutions of higher education (IHE), especially MSIs, to improve their ability to receive research dollars and encourage students to participate in science, technology, engineering, and math (STEM). In FY 2015, university faculty and federal partners presented in four regional meetings on increasing enrollment of students in STEM and improving faculty access to federal resources. Each 2.5-day meeting hosted approximately 85 participants, with 349 total participants attending the four meetings. Ninety-five percent of participants felt the program improved their understanding of federal funding opportunities and how to work with their university sponsored program offices. In FY 2016, a total of three intense capacity building trainings were conducted at MSIs. A total of 71 persons were trained, representing 29 IHEs, of which 13 were MSIs (five Historically Black Colleges and Universities (HBCU), six Hispanic serving institutions (HSI), two Tribal Colleges and Universities (TCU) as well as two Black serving institutions and one emerging HSI. Evaluations were overwhelmingly supportive, with an average satisfaction rating of 98.87 percent.

OMH continues to demonstrate leadership in promoting workforce diversity through its *National Workforce Diversity Pipeline (NWDP)* grant program. NWDP seeks to address health disparities among racial and ethnic minorities by supporting networks of institutions focused on establishing pipeline programs that increase minority and disadvantaged high school and undergraduate students' awareness of and application to healthcare, behavioral health, and STEM education programs. In 2016, NWDP grantees reported serving more than 4,300 students.

GOAL III: Advance the Health, Safety, and Well-being of the American People

The majority of OMH's key program activities within Goal III are focused on **increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. In collaboration with a range of federal, national, state, tribal, territorial, academic, community, and faith-based partners, OMH supports the development, implementation, and assessment of evidence-based interventions (EBIs) to close the modifiable gaps in health, longevity, and quality of life among racial and ethnic minorities, as well as and disadvantaged populations. OMH has also played a significant role in collaborating with other Departmental and federal agencies in response to public health crises.

OMH has several programs that focus on outreach and education campaigns regarding preventive benefits in relation to specific conditions and/or populations. *Million Hearts®* is a national initiative to prevent one million heart attacks and strokes by 2017. This initiative brings

together communities, health systems, non-profit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke. OMH has provided technical assistance across HHS and external partners to enhance the impact of programmatic and policy work aimed at reducing disparities in cardiovascular disease (CVD) outcomes, including smoking cessation and blood pressure management.

OMH held a webinar as part of the *Tobacco-Free College Campus* initiative in Region III to recognize the role of HBCUs in eliminating tobacco use on their campuses and adopting 100 percent tobacco- and smoke-free policies. Other efforts in Region III included a partnership with *The Truth Initiative*, where the RMHC provided technical assistance to HBCUs and helped secure funding for tobacco-free activities.

OMH partnered with the Arkansas State OMH on the *Arkansas Minority Barber & Beauty Shop Health Initiative.* The mission of this initiative is to increase public awareness of heart disease and stroke, and ultimately empower racial and ethnic minorities to better understand hypertension prevention and management. Program objectives emphasize screening, education, and referral to care. The program also incorporates the *Million Hearts®* ABCS of clinical prevention (i.e., aspirin therapy, blood pressure control, cholesterol management, and smoking cessation) in its efforts. In FY 2016, the initiative conducted three educational and screening events for 446 participants. One hundred thirty-two participants (approximately 30 percent) were referred to care according to the results of their hypertension, cholesterol, diabetes and Body Mass Index (BMI) screenings. There was also a significant increase in knowledge and awareness relative to blood pressure, cholesterol, diabetes, and the signs of heart attack or stroke based upon participants' pre- and post-test results.

An OMH initiative, the *Walgreens/HHS Influenza Voucher Initiative*, a public-private partnership in the form of a Co-Sponsorship Agreement, was first established between Walgreens, Inc. and HHS during the 2010-2011 influenza season. The primary purpose of this agreement is to assist uninsured racial and ethnic minorities in obtaining an annual influenza vaccination. In each successive year of the initiative, the number of individuals receiving an influenza vaccination has increased from 4,395 vaccinated during the 2010-2011 influenza season to 332,137 vaccinated during the 2015-2016 influenza season. This initiative utilizes community and faith-based organizations, CHWs, and other entities in concert with local Walgreens pharmacies to identify and host influenza vaccination events in traditionally under-vaccinated communities. For the 2015-2016 influenza season, the program reached nearly 2,600 zip codes. For the 2016-2017 influenza season, vouchers were made available in English, Spanish, Vietnamese, and Chinese; the; the U.S. Virgin Islands also joined this initiative. These vouchers help ensure that the most vulnerable populations receive and benefit from this preventive service and promote health literacy in populations' primary languages.

Influenza Season	Free Influenza Vaccinations
2015-2016	335,092
2014-2015	326,323
2013-2014	252,538
2012-2013	168,681
2011-2012	52,851
2010-2011	4,395

Through OMHRC, OMH provided additional support to communities through social media marketing and training programs to organizations and institutions that support the health of

communities of color throughout the U.S. and its territories. Examples include a social media marketing campaign raising awareness of issues related to viral hepatitis and human immunodeficiency virus (HIV), and the *Preconception Peer Educators (PPE)* training program. OMHRC's recent implementation of HIV and viral hepatitis social marketing campaigns supported increased awareness of the co-infections of HIV and viral hepatitis, and increased HIV testing and viral hepatitis screening with referral to care for minority and hard-to-reach communities. Approximately 240,000 racial or ethnic minority individuals are expected to receive information on the co-infection of viral hepatitis and HIV, and 2,000 screenings/testings are expected to be provided. Campaigns are expected to continue past the end of the funding period (September 2017). OMHRC also partnered with colleges and universities to implement the PPE program. The PPE program was developed to raise awareness among college students about infant mortality and its causes. The PPE program applies a peer education curriculum to equip college students with targeted health messages that they can spread throughout their campuses and communities. Trained PPEs champion these health messages to reduce infant mortality rates with a focus on at-risk populations. As of FY 2016, approximately 2,200 students were trained as PPEs.

In FY 2015, OMH began implementation of the *Community Health Data: A Pilot Demonstration Project to Model Collaboration between Local Agencies to Facilitate Data Access and Utilization*. This project is expected to produce several tools, including a research-informed framework for organizing and maintaining community data collaboratives, a capacity assessment tool for partners, and a technical assistance tracking system. Through the creation and piloting of a framework to guide the development and maintenance of data collaboratives, OMH seeks to grow the capacity of community collaboratives to access, use, and share data to inform strategies to reduce health disparities in communities. The final document will provide a framework for local efforts to come together around data-driven priorities.

OMH also supports collaborative community-based projects to promote healthy behavior and decrease health disparities among youth and young adults. These programs feature collaboration among a range of partners, including IHEs (including MSIs), primary and secondary schools, community organizations and institutions, and the community at large. The *Youth Empowerment Program* addresses unhealthy behaviors in minority at-risk youth (ages 10-18) and provides them with opportunities to learn skills and gain experiences that contribute to more positive lifestyles and enhance their capacity to make healthier life choices. During FY 2015 and FY 2016, more than 12,000 at-risk minority youth,their families, and community stakeholders engaged in cultural activities, summer programming, college preparation, community service, mentoring, financial literacy sessions, and internships.

Additionally, OMH funds the *Minority Youth Violence Prevention: Integrating Public Health and Community Policing Approaches (MYVP)* program, in partnership with the Department of Justice, Office of Community Oriented Policing Services (COPS Office). The program supports program interventions developed through adaptations, refinements, and modifications of promising violence prevention and crime reduction models that are tailored to at-risk minority male youth (ages 10-18) and integrate a problem-solving approach, such as the Center for Disease Control and Prevention's (CDC) problem-solving model or the COPS Office's Scanning, Analysis, Response and Assessment problem-solving model. Outcomes for the

MYVP program in Year 1 (September 2014-August 2015) included:

- Direct services to over 2,900 youth;
- Family services to 661 individuals;
- 128 linkages to supportive services;
- More than 20 community education events for 1,448 participants; and
- Mentoring/recreational activities to 2,000 youth.

The MYVP program in Year 2 (September 2015-August 2016) provided:

- Direct services to over 3,000 youth;
- Family services to 1,401 individuals;
- More than 70 community education events for 4,278 participants; and
- Mentoring/recreational activities to 2,704 youth.

OMH also supports Goal III by **conducting and evaluating pilot tests of health disparity impact assessments of selected proposed national policies and programs (Strategy III.B.)**. The NPA addresses five key emerging priority areas, one of which is promoting the integration of health equity in policies and programs. OMH provides leadership and coordination for the *FIHET*, a coalition of 12 federal agencies, including 18 HHS staff and operating divisions, that works across sectors to reduce health disparities by building capacity for equitable policies and programs, cultivating strategic partnerships, and sharing relevant models for action under the NPA implementation structure. FIHET membership includes the Department of Transportation, Department of Education, Department of Veterans Affairs (VA), Department of Defense, and Department of Agriculture. In FY 2015-2016, FIHET activities that adopted a "health in all policies" approach included:

- Piloting a health equity mapping project with six FIHET agencies;
- Convening a roundtable of federal government representatives and foundation leaders in health and economic development on cross-sector collaboration;
- Developing and led 16 webinars as part of an *Equity in All Policies Series* to promote innovative programs across the nation that result in more health equitable outcomes in health and the SDOH, and that can be replicated by others in their own communities;
- Initiating a new partnership with the National Indian Health Board (NIHB) to develop a framework for assessments related to the public health accreditation process based on the SDOH;
- Conducting an unpublished study of federal and non-federal leaders on approaches, barriers/challenges, and successes associated with cross-sector collaboration, and convened a roundtable of federal government representatives and foundation leaders in health and economic development on cross-sector collaboration; and
- Conducting activities to build the capacity of federal leaders on the team to promote equitable policies and programs. Activities included establishing a common understanding of core health equity concepts, such as the difference between equality and equity, the meaning of an equity lens, and evaluating case studies to apply the equity lens to a program, function, or policy.

OMH partnered with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Behavioral Health Equity in its *Review of Disparity Impact Statements:*

Analysis of Findings.[8] SAMHSA and OMH worked together to review data collection tools and approaches for assessing and monitoring grantee disparity impact statements. A final report, *Review of Disparity Impact Statements: Analysis of Findings*, summarized the review and analysis of a sample of the agency's disparity impact statements. Select findings from the final report included:

- Thirty-three disparity impact statements were analyzed from the four grant programs participating in the 2012 pilot of the Disparity Impact Strategy;
- While documenting disparities was an initial challenge for grantees, addressing *National CLAS Standards* appeared to be less challenging for the grantees. Most grantees understood the cultural and linguistic needs of their populations and already had plans in place to address those needs; and
- The disparity impact statements most frequently identified Hispanic or Latino and Black or African American as the populations of focus; sex, sexual orientation, and gender identity were less frequently used to describe the populations of focus.

OMH also supported the Depatment's response to the *Zika virus public health crisis*. In March 2016, OMH began collaborating with the Office of the Assistant Secretary for Preparedness and Response (ASPR), the Office of Population Affairs (OPA), the CDC, the Office of Intergovernmental and External Affairs, the White House Office of Public Engagement, and the Puerto Rico Department of Health on various activities designed to raise awareness of, and educate the public on, the impact of and prevention of the Zika virus infection. The primary focus of OMH's engagement was to ensure bilingual materials (Spanish/English) were culturally and linguistically appropriate for the intended audience and that they were written in plain language. Through that work, OMH developed several resources to ensure that Latino communities in the U.S. mainland and the U.S. territories of Puerto Rico and the Virgin Islands have the necessary information to know about the Zika virus, the methods of transmission, its health implications, and both personal and vector control-related prevention techniques. OMH developed Zika virus resources web pages in English and Spanish. OMH also collaborated with ASPR and OPA to translate a factsheet on pregnancy, stress management, and the Zika virus into Spanish; review translated content; and provide translation support for men's health fact sheets included in the OPA toolkit for healthcare providers serving pregnant women and men of reproductive age. In December 2016, OMH and Puerto Rico's Center on Social Innovation held a Zika Spanish-language roundtable in Puerto Rico entitled *El Zika: Retos, soluciones y recursos para los municipios, comunidades e individuos*. This discussion brought together community leaders to share their work in response to the outbreak of the Zika virus on the island as models for community members and leaders, organizations, healthcare providers, and others to take action to protect themselves and their communities from mosquitos that carry the Zika virus.

During 2016, OMH played a significant role in responding to the *Flint water crisis*. OMH provided input and counsel to the HHS Flint Recovery team, including assisting on the ground with community outreach and relationship building through OMH's RMHC for HHS Region V and other OMH staff. OMH, through its resource center, also funded radio and mobile ads as part of the week-long (July 18-25, 2016) *Care for Flint campaign* to raise awareness of the

[8] Substance Abuse and Mental Health Services Administration. *Review of Disparity Impact Statements: Analysis of Findings*. Substance Abuse and Mental Health Services Administration; 2016.

availability of new expanded health coverage, mental health services, and nutrition support services. The campaign, which included local partners, helped lead to increased visits to Flintcares.com (from 328 to nearly 3,500); 3,000 views of the American Sign Language public service announcement; and distribution of 5,000 handouts and 13 community-based events. OMHRC supported the Flint community through technical assistance and capacity building. A September 2016 grant-writing webinar had 375 attendees. In October 2016, OMHRC also conducted a 2.5-day Vision, Design, Capacity training for community-based organizations, providing training on constructing a responsive proposal for funding.

GOAL IV: Advance Scientific Knowledge and Innovation

Many of OMH's program activities within Goal IV focused on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)** and **conducting and supporting research to inform disparities reduction initiatives (Strategy IV.B)**. OMH, through OMHRC, oversees *The Knowledge Center*, which develops and maintains public access to the nation's largest repository of information on health issues specific to minority groups. The repository of minority health literature is accessible to the public through an online database of information. This collection is in the process of being digitized, with the goal of providing the general public with increased direct access to health-related literature and statistical reports. This searchable database is publicly accessible and was searched 24,864 times in FY 2015 and 26,902 times in FY 2016. The collection was 58 percent digital in FY 2015 and 61 percent digital in FY 2016.

OMH partners with state and territorial offices of minority health and tribal organizations through the *State Partnership Initiative* to address some of the most significant health disparities within each state, territory or tribal organization. The purpose of this program is to demonstrate that partnerships in which state offices of minority health/health equity (or other state entities with a similar function) and state health agencies, or tribes and tribal health agencies/organizations play a significant role, can efficiently and effectively improve health in selected geographical hotspots and address health disparities that affect minorities and disadvantaged populations. FY 2015 was the first year of the five-year project period. During the first year, grantees completed Health Disparities Profiles for one to three Healthy People 2020 Leading Health Indicator topics, focusing on health disparities among racial and ethnic minority populations, and crafted plans to reduce these disparities. Each year, each program will implement innovative evidence-based practices to reduce these disparities and update its Health Disparities Profiles on the selected leading health indicator topics to document its progress.

OMH funded the *AI/AN Health Disparities Partnerships Program* to strengthen the capacity of Tribal Epidemiology Centers (TECs) and Urban Indian Health Programs (UIHPs). Under the AI/AN Health Disparities Program, AI/AN grantees collect, manage, and disseminate health data to increase awareness of health disparities impacting American Indian or Alaska Native populations in designated tribal regions. Examples include conducting an analysis and disseminating crash and motor vehicle safety data for tribal communities in Arizona in order to reduce injuries and deaths from motor vehicle accidents; and working to increase child immunization rates. Additionally, grantees' results have been published so that others may replicate their programs, such as *Native Generations: A Campaign Addressing Infant Mortality*

among Urban American Indians/Alaska Natives from the Seattle Indian Board, published by the *AI/AN Mental Health Journal* in its August/September 2016 issue. Grantees have also improved coordination and utilization of research and outcome evaluations in programs addressing health disparities by improving data collection on AI/AN populations. For example, through linking and proper coding of existing cancer data, the Northwest Portland Area Indian Health Board reported that its identification of misclassified data resulted in a 2.7 percent increase in the number of AI/AN records in the Northwest Tribal Registry.

OMH partnered with the National Science Foundation (NSF) and the Committee on National Statistics (CNSTAT) of the National Academies of Sciences (NAS) on the *Improving Data Collection on Criminal Justice System Involvement in Population Health Data Programs*, which included a 2-day workshop to identify measures to assess criminal justice involvement as a social determinant of health and indicator for health status in population-based health data collections. The workshop had 60 participants and featured eight presentations from subject matter experts, including five representatives from the federal government with expertise in population health data collection. A workshop summary was released in December 2016.[9]

OMH also partnered with OASH's Office of Disease Prevention and Health Promotion (ODPHP) and CDC's National Center for Health Statistics (NCHS) to collaborate on the development of the *Health Disparity Data Tool*, a web-based data tool to summarize health disparities as well as changes in disparities over time for measurable population-based Healthy People 2020 objectives. This tool provides detailed comparisons by population groups (e.g., by sex, race and ethnicity, educational attainment, or family income) for each of the latest available data points for measureable Healthy People 2020 objectives. The health disparities tool was launched in March 2015 and is periodically updated.[10] The tool serves as an important resource for policy and research on health disparities, helping to advance health equity and supporting health in all policies work.

Regional Minority Health Consultants

OMH's RMHCs work in the 10 HHS Regional Offices to help build networks of consumers and professionals working on minority health issues. The RMHCs engage in activities and initiatives to support HHS health disparities initiatives and to help support state and local efforts to reduce health disparities. This report highlights some activities and initiatives that were implemented in the regions to support HHS, OASH, OMH, and Regional Health Administrator priorities.

Highlights of RMHCs' Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

RMHCs supported initiatives to **reduce disparities in health insurance coverage and access to**

[9] See the Workshop Summary at http://sites.nationalacademies.org/dbasse/cnstat/improving_collection_of_criminal_justice_indicators/index.htm
[10] See the Health Disparity Data Tool at https://www.healthypeople.gov/2020/data-search/Search-the-Data

care (Strategy I.A). For example, Region V implemented the *Health Insurance Marketplace Enrollment and Medicaid Expansion* initiative to identify and recruit entities to support enrollment events. The RMHCs participated in key national, regional, state, tribal, and community-based events providing technical assistance and delivering speeches throughout the region. The RMHCs facilitated meetings with enrollment assisters and stakeholders to conduct information sessions and provide assistance during enrollment events. RMHCs disseminated relevant information around the healthcare law and how to use healthcare coverage to over 900 regional stakeholders.

The *4th US Conference on African Immigrant and Refugee Health – Rethinking Integration, Challenges, and Empowerment,* held in New York, NY (Region II), was developed to offer a multi-disciplinary platform, grounded in the SDOH framework, to further understand the obstacles that stand in the way of optimal health in African immigrant and refugee communities in the U.S. Over 120 participants (federal, state, and local community-based partners, health and public health, social work, behavioral health professionals, students, community members) were able to learn and problem solve around issues causing disparities in African immigrant health.

The *Adolescent Health Collaborative Webinar* on access to primary care, also held by the Region II RHMC, provided an overview of three community programs that increased the availability of culturally appropriate and sensitive teen primary care practice. More than 70 attendees across the region, most of whom serve disadvantaged and vulnerable populations, learned about model programs for teens.

During the *Flint Water Crisis*, the *Minority Health Summit* was hosted in Region V, which assisted states in developing regional recommendations for regional health priorities and initiatives for minority populations. This activity increased participation and representation of racial and ethnic minority populations in meetings and events (e.g., regarding the water crisis and Medicaid expansion in Flint).

The Region VI RHMC participated in a RHEC council meeting to discuss plans for development and release of the *2016 Blueprint on Health Equity*. This blueprint on health equity targeted minority populations in Region VI.

The Region VII RHMC is researching efforts to engage university officials in discussions around inclusion of cultural competency and CLAS within medical curricula. The initiative targeted several states, including Missouri, Iowa, Kansas, and Nebraska. This initiative increased awareness of the *National CLAS Standards*.

RMHCs also supported initiatives to **reduce disparities in the quality of healthcare (Strategy I.C)**. The Region II RMHC partnered with regional staff from the Office on Women's Health (OWH) to ensure inclusion of racial and ethnic minority perspectives in the *National Women's History Month Program – Working to Form a More Perfect Union Honoring Women in Public Service and Government*. The program highlighted women's history of public service through portraying the history and legacy of Rosie the Riveter and included presentations regarding *Empowering Women with Federal Government Programs*. Other presentations addressed opportunities in health, public health and STEM fields. The Region II RMHC also shared

career-focused resources on internships, fellowships, and career development for students to achieve their personal and professional goals and become role models for future generations. This RMHC activity raised awareness of healthcare workforce issues specific to women and promoted the diversification of the healthcare workforce to include women of color.

The Region IX RMHC monitored one of the *National Prevention Partnership Awards* projects which aimed to increase the use of high-value bundled services, including breast, cervical, and colorectal cancer screening; influenza and pneumococcal vaccinations; and cholesterol tests among older adults who are racial and ethnic minorities. The primary targeted populations are Black or African American and Hispanic or Latino living in south Los Angeles, California. The full implementation of this initiative is underway.

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

RMHCs support initiatives to **increase the ability of all health professions and healthcare system to identify and address racial and ethnic health disparities (Strategy II.A)**. RMHCs engaged in activities and initiatives to increase the adoption and implementation of the *National* among students in health professions schools and health providers. Additionally, the Region VII RHMC provided training on the *National CLAS Standards*. As a result, there was an increase in awareness of the *National CLAS Standards* and *Think Culture Health* website in Region VII.

RMHCs also **promoted the use of Promotores de Salud and CHWs (Strategy II.B)** through presentations on the role of CHWs and Promotores de Salud in addressing health disparities and the engagement of CHWs and Promotores de Salud in health service delivery systems. The Region IX RHMC implemented *The Role of Promotoras in the Community Interacting with Families with Substance Use Situations Skill Building Training*. The objective of the training was to strengthen the knowledge of Yolo/Sacramento County Promotoras of healthcare coverage benefits; cultural considerations when assessing the needs of families in need of behavioral and mental health resources; and federal initiatives and resources that can build their capacity to conduct health promotion and disseminate reliable health information to their communities. The trainings meet the cultural and linguistic needs of Promotores de Salud, and the skills building training was conducted in Spanish and English.

The Region II RHMC, in partnership with regional staff from OWH and the Administration for Children and Families (ACF), co-hosted the *Federal Strategic Planning Meeting to Combat Human Trafficking*. The purpose of this meeting was to *discuss anti-trafficking efforts and identify areas fo*r collaboration among Region II federal partners, state, territorial, and municipal government agencies, human trafficking prevention networks, and non-profit organizations from New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands. The success of the program resulted in continuing work to train community professionals and raise awareness of human trafficking in partnership with other local, state, and federal agencies and departments.

The Region IX RMHC also implemented initiatives to **increase the diversity of the healthcare and public health workforces (Strategy II.C)**. Region IX Office of Pacific Health provided extensive technical assistance to U.S. Affiliated Pacific Islands (USAPI) nursing leaders at a

meeting convened by the USAPI Nursing Education Directors. Nursing Education Directors and leadership at USAPI healthcare organizations and hospitals are seeking to address impending critical nursing and allied health workforce shortages. The implementation of this initiative is underway.

GOAL III: Advance the Health, Safety, and Well-being of the American People

RMHCs worked to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. For example, the Region VII RMHC developed and implemented a summit with discussion on viral hepatitis C and the effects among tribal communities. Additionally, regional onsite meetings with state offices of minority health were held to enhance engagement between these offices and to discuss a strategic collaboration for FY 2017 that would significantly impact minority health. The Region VII RMHC also held a public health summit addressing the opioid epidemic and how to collaboratively address the issue in this particular region. Over 65 healthcare professionals, state officials, public health advocates, faith and community-based organizations, and community health workers participated in this event.

In Region II, the *Men of Color Summit* engaged the community around issues that relate to broadening the horizons and eliminating the achievement gap for young men of color. The summit included a youth panel, a tie ceremony with youth and members of National Pan Hellenic Council fraternities and community partners, and presentations covering a wide range of topics related to mental and physical health, education, conflict resolution, healthy relationships, youth engagement, reentry, mentoring and responsible fatherhood. This event brought attention to programming opportunities and educated over 100 youth.

The Region II RHMC developed the *Federal Strategic Planning Meeting to Combat Human Trafficking* to discuss anti-trafficking efforts and to identify areas for collaboration among Region II federal partners, state, territorial, and municipal government agencies, human trafficking prevention networks, and non-profit organizations from New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands. Individuals who are vulnerable to human trafficking are often from racial, ethnic or sexual minority populations. The success of the program resulted in continuing work to train community professionals and raise awareness of human trafficking in partnership with other local, state, and federal agencies and departments.

The *NOT ON MY WATCH: Combating Opioid Overdose Deaths* program, conducted by the Region IV RMHC, used empirical evidence to describe the burden of prescription opioid and heroin overdose deaths in the U.S. Opioid overdose deaths disproportionately affect racial and ethnic minority populations. In addition, patients from communities of color are often under-treated for pain. The program highlighted ongoing efforts by HHS agencies, non-profit organizations, and community-based organizations to combat the problem and presented a hands-on demonstration to educate individuals on recognizing the warning signs of an opioid or heroin overdose and train individuals on properly administering naloxone to reverse an overdose and save lives.

In Region IX, the RHMC convened a cross-section of stakeholders to explore pooling resources to expand sites implementing *the Summer Food Service Program (SFSP)* in San Joaquin County. Racial and ethnic minority populations experience disparities in access to healthy, safe, and affordable food choices that support healthy eating patterns. As a result of the meeting, seven new summer meal sites and a lead organization were identified for the *Cities Combating Hunger through Afterschool and Summer Meal Programs (CHAMPS) grant*. In August 2016, the Coalition was awarded a CHAMPS grant in the amount of $40,000 to expand participation in the afterschool and summer meal programs. As a result, seven new SFSP sites in San Joaquin County provided SFSP to 200 children age under the age of 18.[11]

To **conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs (Strategy III.B)**, in collaboration with Indian Health Service (IHS) Nashville Area Office and Region II Office of Minority Health, the American Indian Community House (AICH), designed, developed, and implemented, a needs assessment survey to identify healthcare needs and examine existing healthcare systems. The goal of the assessment is to gain a better understanding of, and strengthen health and mental health services for, American Indian and Alaska Native (AI/AN) children, youth, families, and individuals within New York City. This assessment targeted participation from primary care providers, social service providers, juvenile justice officers, teachers, counselors, caseworkers, and other professionals servicing youth and families. Consisting of 27 questions – most with multiple sub-questions and responses – the survey was designed to capture how often AI/AN were seen by various providers, what ailments/conditions were being treated, how many AI/AN were treated, difficulties encountered in treating AI/AN including insurability, and overall awareness of AICH and its programs. The survey was administered from March to April 30, 2015 via mail, electronic survey, and phone. Completion of the survey required approximately 20 minutes. Approximately 480 of the 3,744 providers agreed to participate in the survey. Data analyses and the final unpublished report were developed in June 2015. AICH, IHS and OMH Region II will review the final report and recommendations, and coordinate opportunities for culturally competency/sensitive training specific to AI/AN population and better streamline healthcare services.

GOAL IV: Advance Scientific Knowledge and Innovation

To **increase the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**, the Region VI RMHC conducted presentations on the *CLAS Standards and Health Disparities* to national minority organizations, including the African American Nurses Association and National Association of Hispanic Nurses. A *Kansas City Health Equity* training was also held to discuss the SDOH and its relevance in the greater Kansas City area, as well as meaningful uses of data as they relate to telling the story of inequity.

The Region V RMHC established the *Minority Health Interstate and Tribal Data Quality Workgroup* to address gaps in health status data reports on racial and ethnic minority populations, including American Indians. The Workgroup met monthly and provided an opportunity for representatives from state health departments (i.e., staff who generate health

[11] See more on the Summer Meal Program in California at https://www.cde.ca.gov/ds/sh/sn/summersites.asp

status data reports for OMHs), as well as staff from the Great Lakes Inter Tribal Council Epidemiology Center, InterTribal Council of Michigan and federal agencies to report on activities and initiatives to address gaps in health data on racial and ethnic minority populations. For example, Great Lakes InterTribal Council of Wisconsin Epidemiology Center and Michigan Department of HHS are collaborating on Tribal Behavioral Risk Factor Surveillance System data. The Senior Advisor to the HHS Deputy Assistant Secretary for Minority Health reported on the OMH *American Indian and Alaska National Behavioral Risk Factor Surveillance System Tribal Oversample Project*. The Region VII RMHC also provided grants writing training for tribal communities in several states, including Missouri, Iowa, Kansas, and Nebraska. As a result, several barriers and challenges were identified.

National Institutes of Health's National Institute on Minority Health and Health Disparities

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

Scientific research to improve minority health and reduce health disparities is led by the NIMHD. To achieve its mission, NIMHD conducts and supports research on minority health and health disparities, promotes and supports the training of a diverse research workforce, translates and disseminates research information, and fosters innovative collaborations and partnerships. In addition, the PPACA elevated the NIMHD as an institute at NIH and charged it with the responsibility to plan, coordinate, review, and evaluate all minority health and health disparities research activities conducted and supported by NIH.

Highlights of NIH's Fiscal Year 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

The mission-driven program activities of NIH primarily fall within two key areas identified in the HHS Disparities Action Plan: (1) foster workforce and infrastructure development and (2) provide leadership and direction to programs designed to improve the health of the nation by conducting and supporting biomedical research. As noted below, many of the programs focus on both areas. The NIH highlighted programs, projects, and initiatives for FY 2015 and FY 2016 support Goals II and IV of the HHS Disparities Action Plan.

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

NIH plays a critical role in **increasing the diversity of the healthcare and public health workforces (Strategy II.C)**. Initiated in 2001, *Partnerships to Advance Cancer Health Equity (PACHE)* is supported through the National Cancer Institute's (NCI) Center to Reduce Cancer Health Disparities. PACHE provides institutional awards for the development of partnerships between institutions serving underserved health disparity populations and underrepresented students (ISUPS) and NCI-designated Cancer Centers. These partnerships conduct cancer and cancer health disparities research, develop and implement cancer research experiences and research education for scientists and students, and disseminate cancer advances to underserved communities. Objectives of the program include:

- Increasing the participation of ISUPS in the nation's cancer research and research training enterprise;
- Producing more competitive grant applications, including those that support underrepresented scientists;
- Increasing research capacity at institutions serving underserved health disparity populations and underrepresented students;
- Increasing involvement and effectiveness of cancer centers in research and training related to underserved populations;
- Developing more effective research, outreach, and education programs that will have an impact on underserved health disparity populations; and
- Enhancing research in cancer health disparities at cancer centers.[12]

In FY 2016, NIH supported 51 awards (24 partnerships) through the PACHE program. These partnerships conducted 58 research projects, including supporting pilot projects to allow investigators to explore new areas of research. Fifty percent of the projects conducted basic research, 40 percent were population research, and 10 percent conducted translational research. Forty percent of all research projects (23 projects) focused on cancer health disparities. The cancer types studied were breast, prostate, lung, colorectal, cervical, and pancreatic, and HPV-associated cancer, while about 10 percent of projects involved study of other cancer types. These research projects serve as a valuable research training vehicle for scientists/early-stage investigators (ESIs), including those from populations underrepresented in the biomedical research workforce. Seventy-one ESIs, the majority of whom were from a MSI (72 percent), made significant contributions to the research as investigators/co-investigators or research scientists. This research activity produced 97 peer-reviewed publications, of which ESIs contributed nearly a quarter. During FY 2016, partnership Principal Investigators (PIs), co-PIs and ESIs leveraged more than $37 million in funds from other awards, including NIH research project grants, grants from other agencies, and foundations (such as the NSF).[13]

The *Enhancing the Diversity of the NIH-Funded Workforce* is a unique program intended to

[12] See more on the Cancer Center Program at https://grants.nih.gov/grants/guide/pa-files/PAR-17-095.htmlhttps://grants.nih.gov/grants/guide/pa-files/PAR-17-095.html

[13] See more on the PACHE Program at https://www.cancer.gov/about-nci/organization/crchd/diversity-training/pache

develop, implement, assess, and disseminate innovative and effective approaches to engaging, training, and mentoring students; enhance faculty development; and strengthen institutional research training infrastructure to enhance the participation and persistence of individuals from diverse backgrounds, including those from underrepresented groups, in biomedical research careers. The program, also referred to as the Diversity Program Consortium (DPC), consists of three integrated initiatives: Building Infrastructure Leading to Diversity (BUILD); the National Research Mentoring Network (NRMN); and the Coordination and Evaluation Center (CEC).

The BUILD initiative grants experimental training awards to undergraduate institutions to implement and study innovative approaches to engage and retain students from diverse backgrounds in biomedical research and prepare students to become future contributors to the NIH-funded research enterprise. BUILD awards are intended to impact student, faculty, and institutional levels and contribute to broader transformational impact through the dissemination of effective interventions and strategies to diversify biomedical research. The NRMN is developing a national network of mentors and mentees from all biomedical disciplines relevant to the NIH mission to provide mentorship, professional development, mentor/mentee training, networking, and resources to individuals from the undergraduate to early career faculty levels. The CEC coordinates activities and will evaluate the efficacy of the training and mentoring approaches developed by BUILD and NRMN awardees. The findings will have implications for recruiting, training, and mentoring diverse groups nationwide, and the CEC will disseminate effective approaches to the broader research training and mentoring communities.

The DPC grants were funded in FY 2014 and are in the third year of a five-year grant funding period. In FY 2015 and FY 2016, BUILD targeted three levels of interventions: students; faculty; and the 10 BUILD institutions.[14] The student-level interventions focused on research training, building scientific identities, and exposure to scientific approaches relevant to health disparities. The faculty interventions included mentor training, grant writing activities, and financial resources for pilot research projects. Institutional development included financial support for the enhancement of research capacity and infrastructure. To date, there are approximately 500 BUILD scholars and 400 students that have participated in summer research experiences. NRMN has approximately 2,000 mentees registered and 1,200 mentors, who are part of its membership and reach. NRMN has trained 225 junior scientists in the art of grant writing. CEC has facilitated consortium-wide evaluation plans, as well as developed and deployed a data tracker tool that will be used to facilitate the data collection efforts and provide a real-time view of the consortium's progress; data analysis is expected to begin in January 2017.

The *Initiative for Maximizing Student Development (IMSD)* is a student development program for institutions with research-intensive environments. The goal of the program is to increase the number of students from diverse backgrounds, including those from underrepresented groups in biomedical research, who complete Ph.D. degrees in these fields. The program offers an opportunity to develop new or expand existing effective academic developmental programs, including student research internships, to prepare these students for competitive research careers and leadership positions in the biomedical sciences.

Evaluation activities for *IMSD* programs focus on: (1) assessing the overall impact of the

[14] See the list of BUILD institutions at https://www.nigms.nih.gov/training/dpc/pages/build.aspx

program on the institution's baseline numbers and efforts to accomplish the goal of diversifying the institutional pool of students that complete Ph.D. degrees in biomedical sciences; and (2) measuring improvement over time in the overall program outcomes, as well as intermediate outcomes, such as effectiveness of activities or other interventions. NIH supports up to $3,000 for evaluation support per IMSD program.

In FY 2015, the program was funded at $25,167,672 and is currently supporting 533 undergraduate students and 370 Ph.D. students in about 50 institutions around the country. Data comparing underrepresented minority (URM) student numbers and key academic milestones before and after implementation of IMSD practices support the program's effectiveness. For example, at Brown University, these practices include developing strategic partnerships with selected undergraduate institutions; providing a personalized education program of student support and skill-based modules to supplement discipline-based course work; and transforming institutional culture by engaging faculty in supporting diversity-related goals and practices. Program components are broadly applicable as best practices for others seeking to improve URM recruitment and achievements of graduate students traditionally underrepresented in the sciences. IMSD is one of many diversity focused training programs at NIH, all of which are evaluated for effectiveness in meeting program goals through individual progress reports and during the peer-review process for renewals. All such training programs undergo periodic evaluations to determine whether the program goals of enhancing the diversity of the biomedical research workforce are being met. The following metrics are tracked:

- Institution types represented;
- Geographical distribution of programs;
- Demographics of trainees;
- Trainee degree completion rates;
- Time-to-degree;
- Scientific accomplishments of trainees; and
- Trainee career outcomes.

GOAL III: Advance the Health, Safety, and Well-being of the American People

NIH focuses on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. The *Asthma Empowerment Collaborations to Reduce Childhood Asthma Disparities* program includes two phases that support studies to create and evaluate Asthma Care Implementation Programs (ACIP) for children at high risk for poor asthma outcomes. Each ACIP consists of interventions targeting four different areas that influence the health of children with asthma: (1) medical care; (2) family; (3) home; and (4) community. The first phase awards are ongoing, allowing nine investigator teams to conduct a community needs assessment to ensure that the ACIP they create will meet the needs of children and their families in specific communities. NIH has also released a funding opportunity announcement seeking applications for clinical trials to assess eligible ACIPs with awards expected to be made in summer 2017.

These planning grants will allow investigators to identify their community's needs by engaging with stakeholders. In FY 2015 and FY 2016, investigators took a variety of approaches to engage the relevant stakeholders (e.g., schools, tribal authorities, payors, care providers, parents/

caregivers, and potential collaborators) in their communities. Many of the investigators plan to publish their work to describe the best practices that arose from their information gathering methods and the information gained. Specific examples of barriers to care that investigators learned about included teachers' reluctance to use technology to communicate with care providers and parents; the variability within and among parents' transportation needs; and school policies regarding use of inhalers at school. As expected, each community studied had specific needs and strengths that were identified during these planning grants.

The *Transdisciplinary Collaborative Centers for Health Disparities Research Program (TCC)* supports regional coalitions of academic institutions, community organizations, service providers and systems, government agencies, and other stakeholders focused on priority areas in minority health and health disparities. Collaboration at the regional level provides opportunities for institutions and organizations to achieve a broader reach than is possible with isolated local efforts by combining expertise and resources. At the same time, it fosters applied research that is uniquely responsive to specific population-based, environmental, sociocultural, and political factors that influence health within a particular region. The program supported 14 different TCCs with 19 grants in FY 2016, totaling $35,797,765. TCC program grants focus on health policy research, SDOH, men's health research, precision medicine research, and chronic disease prevention research. In FY 2015 and FY 2016, the TCCs have supported research and coalition building across the U.S. For example, the National Transdisciplinary Collaborative Center for African American Men's Health developed the *Center for Healthy African American Men through Partnerships (CHAAMPS),*[15] a collaborative center to develop, implement, and evaluate interventions to improve African American men's health through research, outreach, and training. This TCC also hosted a panel discussion on "Public Health Solutions: Reducing Violence Against African American Males", which was broadcast on Minnesota Public Radio in March 2016[16] and attended by 150 community members.

The *Population Assessment of Tobacco and Health (PATH) Study*[17] is a nationally representative, longitudinal cohort study of tobacco use and how it affects the health of people in the U.S. Tobacco use disproportionately affect racial and ethnic minority populations. The PATH Study provides an empirical evidence base for developing, implementing, and evaluating regulations governing tobacco products by measuring the behavioral and health effects associated with changes in tobacco control regulations. The PATH Study began in October 2011 and is one of the first collaborations between the NIH and Food and Drug Administration (FDA) since Congress granted FDA the authority to regulate tobacco products. The overarching goals of the PATH Study are to develop a population-based, multi-year evidence base that supports FDA in fulfilling its mission under the Tobacco Control Act to regulate tobacco products. The study uses household-based audio computer-assisted self-interviewing techniques to collect annual and/or biennial data on tobacco-product use; nicotine dependence; knowledge, attitudes, beliefs, and risk perceptions related to the use of tobacco products; health status, conditions, and outcomes; contextual and familial influences; and more. About 46,000 people ages 12 years and older are participating in the PATH Study. Some of them use tobacco; others do not. Interviewers meet with each person once a year for at least three years. Data in the first wave

[15] See more information on the CHAAMPS Center at http://chaamps.com
[16] See the discussion recording at http://www.mprnews.org/story/2016/03/29/violence-as-public-health-issue
[17] See more information on the PATH Study at: https://pathstudyinfo.nih.gov/UI/HomeMobile.aspx.

were collected from September 2013 to December 2014. In FY 2015 and FY 2016, the study invited select participants to take part in additional study activities. To date, PATH Study adult prevalence estimates have shown similar results to nationally representative surveys.[18] While cigarette smoking is the most prevalent form of tobacco use, there is a large diversity of products being used, especially among youth. Other tobacco products used included cigars, e-cigarettes, and hookah. About four in 10 youth and adult tobacco users use multiple types of tobacco products. For both adults and youth, use of a flavored tobacco product first is associated with an increased likelihood of being a current tobacco user.

GOAL IV: Advance Scientific Knowledge and Innovation

NIH plays a critical role in **increasing the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. The *All of Us* Research Program, formerly known as the Precision Medicine Initiative Cohort Program, is a participant-engaged, data-driven program supporting research at the intersection of lifestyle, environment, and genetics to produce new knowledge with the goal of developing more evidence-based and effective ways to improve health literacy, prolong health, and treat disease. The *All of Us* Research Program plans to engage a group of one million or more participants in the U.S. The program will enroll participants from diverse social, racial, ethnic, ancestral, geographic, and economic backgrounds, from all age groups and health statuses. Information from the program will be a broad, powerful resource for researchers working on a variety of important health questions. A central priority of the program is to capture the diversity of the U.S. and engage communities that have been underrepresented in biomedical research. Importantly, the program will focus not just on disease but also on ways to increase an individual's chances of remaining healthy throughout life. The FY 2016 budget for this program was $130 million and is currently being implemented.[19]

Large medical centers, health centers, academic institutions, private-sector companies, patient advocacy organizations, the VA, and other federal agencies are all active participants in this initiative.

Planned evaluation and performance measures include:

- Enrolling diverse communities: The program seeks to emphasize the representation of individuals that have historically been underrepresented in biomedical research. *All of Us* is establishing its goals for the communities it intends to reach and from which it will seek participants. Targeted engagement materials and approaches will be developed with diverse stakeholders to reach different communities and work with the enrollment sites to evaluate these approaches, ensuring diverse communities are being engaged and enrolled.
- Retaining diverse communities: Program population diversity will be regularly evaluated through enrollment numbers and participant retention across the life of the program. The program will accomplish this by leveraging real-time online tools. The program will also assess withdrawal rates and look for indicators that might predict early withdrawal, especially in relation to individual communities.

[18] *Ibid.*
[19] See more on the All of Us Research Program at https://allofus.nih.gov/

Informed by the September 2015 report of a working group of the Advisory Committee to the NIH Director, the program has begun building the infrastructure and capacity to support this large-scale research platform, keeping to the program's core values. In 2016, a Data and Research Center, Participant Technologies Center, Biobank, and Health Care Provider Organizations network, including FQHCs and VA, were funded and are now working as a consortium to develop the full platform.

To understand the obstacles to and opportunities for engaging and retaining potential participants in the program, many efforts have been ongoing to capture individual perspectives about all aspects of the program. Among these efforts, 60 interviews were conducted in 2016 with potential participants across four locations: Nashville, Pittsburgh, Los Angeles, and Miami. In addition, 60 small group discussions with more than 500 people were held around the country. To further understand the interests and needs of the full range of communities that the *All of Us* Research Program hopes to engage in the study, study messaging, online modules, and study survey questions will be tested in communities that reflect the full diversity that the program aims to capture.

A major focus of NIH is to **conduct and support research to inform disparities reduction initiatives (Strategy IV.B)**. When completing the horizon-scanning activities that are crucial to identifying future scientific directions, experts work to ensure that biomedical advances benefit all Americans, including those from historically underserved and underrepresented populations. Such concerns underscored the work of the National Cancer Institute's (NCI) *Cancer Moonshot*[SM] Blue Ribbon Panel (BRP), a collaboration between experts across the country and NCI scientists. The BRP, under the leadership of the National Cancer Advisory Board (NCAB, an NCI Federal Advisory Committee), conducted its assessment in 2016, culminating in a report delivered to NCAB in September 2016 that provided recommendations on the overall vision, scientific goals, and strategic approaches that NCI should pursue through the Cancer Moonshot. Prominent leaders and stakeholders within the cancer research community identified ten scientific priorities that could contribute to accelerating progress for all cancer patients. These recommendations span the continuum of cancer research from basic to clinical to population science, with cross-cutting themes of focus, including minority health and health disparities.[20]

In December 2016, Congress enacted and the President signed Public Law 114-255, the 21st Century Cures Act. Section 1001 of this Act contains the Beau Biden Cancer Moonshot, authorizing a total of $1.8 billion during the next seven fiscal years for cancer research at the NIH's NCI. The Further Continuing and Security Assistance Appropriations Act 2017, also signed into law in December 2016, appropriated the first $300 million for Beau Biden Cancer Moonshot research.

The Cancer Moonshot aims to improve cancer care for all populations as well as reduce health disparities in populations that have increased risks. Partnerships for Cancer Moonshot are occurring across academia, industry, and the public and private sectors. Partnerships are diverse and include federal agencies working to enhance cancer care, public-private partnerships to

[20] See more on the Moonshot Cancer Initiative at https://www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative

accelerate cancer therapies, and academic partnerships to support new research.

The Cancer Moonshot Blue Ribbon Panel identified ten transformative research recommendations, summarized below: Across all of these initiatives are the cross-cutting themes of reducing health disparities, increasing data sharing, and creating new collaborations and partnerships

- Establish a network for direct patient involvement
- Create a translational science network devoted exclusively to immunotherapy
- Develop ways to overcome cancer's resistance to therapy
- Build a National Cancer Data Ecosystem
- Intensify research on the major drivers of childhood cancers
- Minimize cancer treatment's debilitating side effects
- Expand use of proven cancer prevention and early detection strategies
- Mine past patient data to predict future patient outcomes
- Develop a 3-D cancer atlas
- Develop new cancer technologies

The *Stroke Prevention/Intervention Research Program (SPIRP)* supports 10 health disparities research projects at four regional centers in the U.S. Ongoing projects include clinical trials, cost effectiveness research, epidemiology, implementation research, and systems change science. Education and training programs are embedded within the SPIRPs with the goals of improving diversity and mentorship in neurology research training programs and addressing disparities in stroke care with healthcare professionals. One example of these projects is *Shake, Rattle, and Roll*. This cluster-randomized pragmatic trial aims to help participants "shake" the salt habit, "rattle" the intensity of current blood pressure management, and design the interventions with the goal of being able to adapt and "roll" them out to other appropriate clinics. The primary aim is to determine if either diet/lifestyle coaching or intensified blood pressure management by physician/system change protocols improve hypertension control and reduce the disparity in control rates. Each SPIRP project's evaluation measures are unique. Overall, the 10 SPIRP projects have completed (or nearly completed) enrollment and were in a follow-up period in FY 2015 and FY 2016. Three projects are currently in the analysis phase. Community partnerships and implementation science have been important components of all the SPIRP projects, and progress in individual projects toward impacting health disparities is promising. For example, analysis of the *Shake, Rattle, and Roll trial* was conducted in FY 2016 and results will be disseminated in FY 2017. Implementation of the new hypertension protocol has the potential to reduce disparities in hypertension control in California.

Beginning in 2010, the *Centers for Population Health and Health Disparities (CPHHD)* have focused on bringing together transdisciplinary teams to address health disparities and inequities among various racial and ethnic minorities using multi-level, multi-discipline, and multi-factorial approaches. Areas of emphasis include advancing understanding of development and progression of cancer and other related co-morbidities that contribute to health disparities, developing new or improved intervention or prevention approaches to reduce health disparities and increase health equity, and advancing understanding of the multifactorial causes of health disparities and health inequities. The CPHHD program ended in FY 2015 and research supplements were provided during FY 2016. These centers increased understanding of the

persistence of health disparities, and began to identify approaches to address these inequities as well as challenges and successes in developing transdisciplinary teams and comprehensive intervention models for addressing health disparities. The CPHHD program launched a project to promote data harmonization to facilitate secondary data analysis and promote collaborations across various populations and outcomes. In the second round of funding, the NIH established 10 new centers to advance understanding of SDOH and health disparities by bringing together scientists across multiple disciplines and theoretical models from a variety of research traditions to facilitate the development of comprehensive models of how various social, economic, cultural, environmental, biological, behavioral, physiological, and genetic factors affect health outcomes and distribution in populations. Interventions focused on improving population health and reducing health disparities, including provision of better neighborhood resources (e.g., walking areas, better food choices), education on physical activity and nutritional choices, increasing health screening for early detection and treatment, and improving policy at institutional (e.g., clinics and hospitals) and local levels to improve access and utilization of care. Through these interventions, the centers showed improvement in health outcomes and lessened disparities. Recent successes include research publications on multilevel approaches to addressing cancer health disparities and disparities in hospital financing.

The National Institute on Aging supports the *Resource Centers for Minority Aging Research (RCMAR)*.Their mission is to address the national priority of reducing health disparities with special emphasis on health disparities in an aging population. The RCMARs create an infrastructure that works to increase the number of researchers focusing upon the health and well-being of minority elders, and enhance diversity in the professional workforce by mentoring diverse academic researchers for sustained careers in minority elder health-related research. Through pilot funding and collaborative research, the RCMARs also advance research on health disparities among older adults. The RCMAR program has recruited a highly diverse cadre of researchers. Examples of novel research findings emerging from the RCMAR programs include research that has documented inequalities in the incidence of dementia among different racial and ethnic groups in the U.S.[21] and research that has found that Black veterans served by the U.S. Veterans Health Administration have lower all-cause mortality and lower incidence of coronary heart disease than Black individuals in the general U.S. population who typically experience higher mortality rates.[22]

Agency Offices of Minority Health

Agency for Healthcare Research and Quality

Agency Mission: The mission of the Agency for Healthcare Research and Quality (AHRQ) is to produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable; and to work within HHS and with other partners to make sure that the evidence is understood and used.

Office of Minority Health Mission and Function: AHRQ's OMH is located within the Office of

[21] See one RCMAR research study publication at https://www.ncbi.nlm.nih.gov/pubmed/26874595?dopt=Summary
[22] *Ibid.*

Extramural Research, Education, and Priority Populations, and it leads AHRQ in its efforts to achieve measurable improvements in the quality, equity, and outcomes of healthcare for priority populations. The OMH Director reports to the Director of AHRQ and works with the Senior Advisor for Minority Health. During the 2015-2016 period, responsibilities of the OMH Director and Senior Advisor for Minority Health included:

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

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

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

Highlights of AHRQ's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

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

GOAL I: Transform Health Care

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

To **reduce disparities in health insurance coverage and access to care (Strategy I.A)**, a partnership with Wake Forest School of Medicine and its Outpatient Department Medicine Clinic, with Community Partners HealthNet, and with a network of 18 clinics serving 25 rural

North Carolina counties, created an *electronic Personal Health Information Management (ePHIM)* project to improve the ability of low-income African American, American Indian, Latino, and White older adults living in rural and urban communities to use information technology applications for ePHIM. This project has three specific aims: (1) document the ePHIM experience, knowledge, perceived needs, and perceived risks of low-income minority and White older adults living in rural and urban communities; (2) delineate the actual use of ePHIM by low-income minority and White older adults living in rural and urban communities; and (3) delineate differences in perception, belief, and experience in using ePHIM between patients and caregivers who use ePHIM, as compared to those who do not use ePHIM. By delineating the factors that facilitate or limit the use of ePHIM, this project increases the ability to access, manage, and understand personal health information, thereby enabling individuals to become better consumers and participate more fully in making healthcare decisions.

AHRQ partnered with Indiana University-Purdue University Indianapolis, in collaboration with criminal justice, clinical, and public health agencies serving Marion County, Indiana to conduct a research project that identified *Opportunities to Reduce STI/HIV Disparities among Recent Offenders*. The specific aims are to describe if, when, where, and for what purposes recent offenders present for clinical care in the one year after arrest or release from incarceration, compared to the non-offender population during a one-year period, and assess the quality of sexually transmitted infection (STI)/HIV care among recent offenders with at least one clinical encounter in the year after arrest or release from incarceration. As a result of this research, the information gained from the study will have implications for intervention and prevention efforts and may be used to increase and improve STI screening, treatment, and prevention in clinical settings to help curb rates of STI/HIV among recent racial and ethnic minority offenders in the post-incarceration period.

AHRQ also partnered with Wayne State University to conduct an *eHealth Activity among African American and White Cancer Survivors* study that addressed the multiple and often overwhelming needs of cancer survivorship as data show that survivors do not engage in a wide range of eHealth activity. The study's abstract states that eHealth may be generally described as the use of Internet-based and mobile technologies to assess, monitor, and improve health.[23] This study examines the HIT and personal health information management practices of cancer survivors, and uses data to develop design principles to guide the development and design of a HIT tool to support cancer survivorship. These data will guide the development of survivor-centered design principles that will inform the development of a software application prototype that will facilitate access to digital cancer survivorship resources.

AHRQ partnered with the University of Chicago to create a *Partnership for Healthier Asians* that examined the effectiveness and sustainability of a dissemination model that leverages national initiatives as well as targeted assessment of local resources and needs for Asian Americans in the Chicago metropolitan area. The development of innovative approaches to disseminate evidence-based health information among vulnerable populations is urgently needed to eliminate disparities in health across groups. As a result, this study built upon evidence-based resources to culturally tailor and adapt the information for community context and reach.

[23] See more on the eHealth Activity among African American and White Cancer Survivors Study at http://grantome.com/grant/NIH/R01-HS022955-01A1

To **reduce disparities in access to primary care services and care coordination (Strategy I.B)**, the *Primary Care Medical Home and Preventive Service Use in Latino Immigrants* research project is a joint partnership between AHRQ and the Oregon Health and Science University to provide valuable information for medical providers and policy makers as they attempt to finance, organize, and provide routine preventive healthcare for low-income individuals in U.S. communities. This research has three main aims: (1) compare the rate of preventive service utilization in low-income, recent Latino immigrants with Latino non-immigrants and non-Hispanic Whites within a large network of FQHCs and FQHC look-alike clinics; (2) test the impact of provider continuity on the utilization of recommended preventive services in low-income Latino immigrants; and (3) test the impact of team-based care on the utilization of recommended preventive services in low-income Latino immigrants. CHCs will benefit from this information as they provide preventive healthcare with limited resources. The researchers have completed several quantitative analyses on the access to, and use of, preventive services by low-income Latino patients in the network of community health services (these analyses have resulted in multiple manuscripts) and conducted data collection. They will next perform data analysis with the goal of submitting two more manuscripts.

AHRQ also partnered with the Palo Alto Medical Foundation Research Institute to implement a *Culturally-adapted Diabetes Prevention Program intervention* that demonstrated that an intensive lifestyle intervention that reduced the incidence of type 2 diabetes by 58 percent among high-risk adults. The findings will be of value to clinicians, patients, and other decision makers considering effective obesity and diabetes prevention programs for the millions of Mexican-Americans who carry a disproportionate diabetes burden. The findings also have high potential for real-world applicability and impact on Mexican-American minority health and policies aimed to eliminate health disparities. Furthermore, the findings will be of value to several national health initiatives, such as the National Diabetes Prevention Program and Million Hearts®. The researchers have made significant progress in achieving the objectives of culturally adapting the *Group Lifestyle Balance intervention* for Latino patients. They plan to meet established goals for recruitment, screening, baseline assessments, and randomization; follow-up assessments; data and safety monitoring and quality control; and publications.

AHRQ is partnering with the National Asian American Pacific Islander Mental Health Association, Asian American Center on Disparities Research, and Asian American Psychological Association to conduct a three-year research conference agenda on *Integrated Care for Asian Americans, Native Hawaiians, and Pacific Islanders: Making Research Work to Improve Our Health*. It is important to conduct this type of research as Asian Americans, Native Hawaiians, and other Pacific Islanders are either missing from research altogether or are identified as other or merely Asian American. Findings from this research have important implications for development of culturally and linguistically appropriate care, development of policies, and redefining training efforts to improve the current workforce. This conference is very inclusive and will bring together researchers, community members, service providers, policy makers, and other stakeholders.

AHRQ is also partnering with New York University to conduct a *Language Barriers and Post-Acute Outcomes in Home Care: A Mixed Methods Analysis* study that focuses on improving

patient-provider communication for limited English proficiency (LEP) patient populations, reducing racial and ethnic health disparities, improving care for vulnerable populations, improving post-hospital discharge processes, and addressing patient safety across the healthcare system. The specific aims of the study are to compare the 30-day all-cause readmission among LEP patients recently discharged from the hospital who receive home care services from a language concordant nurse with those who do not, and explore how patients and providers describe the impact of language barriers on home healthcare services utilization and implementation, including the service transition from hospital to home care. Results from this study will have policy and research implications for the organization and management of care coordination for LEP patients. The researchers are conducting data collection/analysis and drafting manuscripts. Additionally, they have established the goal of submitting at least three abstracts to professional conferences based on early findings from the study.

AHRQ is partnering with the University of Chicago to carry out a *Reducing Healthcare Disparities with Shared Decision Making* study. The specific aims of the project are to: (1) systematically review key issues in shared decision making around paradigmatic conditions or situations for racial and ethnic minority populations, children, older persons, surrogate decision makers, men who have sex with men (MSM), and transgender individuals; (2) obtain input and feedback from diverse stakeholders (including organizations, community groups, healthcare delivery systems, clinicians, and patients) representing minority populations and under-resourced settings around desired shared decision making interventions; and (3) develop tools to help stakeholders implement and evaluate Shared Decision Making (SDM) interventions in minority populations in under-resourced settings. The study answers important basic questions critical for reducing disparities through SDM. Stakeholder input is expected to determine (1) desired content, presentation of data, and process for SDM; (2) adaptation to traditional media, social media, and health IT (HIT); (3) priorities for development and implementation of SDM products; and (4) contextual factors affecting SDM, such as design of clinic, incentives, and implementation issues. Literature reviews are anticipated to cover (1) diverse patient populations across race and ethnicity (e.g., African American, Asian American, Latino), sexual minority populations, age (e.g., children, adults, older persons), assistive and surrogate decision makers, and those with communication challenges to SDM (e.g., LEP and limited health literacy); (2) types of decisions; and (3) tools that may influence SDM. The researchers have conducted data collection and performed data analysis for aims 1 and 2, and plan to continue these research activities for aims 2 and 3.

To **reduce disparities in the quality of healthcare (Strategy I.C)**, AHRQ is partnering with Rhode Island Hospital to conduct *A Patient-Centered Medical Home (PCMH) Needs Assessment on Sexual Health Disparities in Young Women of Color* that will utilize a mixed-methods needs assessment with PCMH providers and young women of color to understand the needs and barriers to quality sexual and reproductive healthcare (on provider and patient levels). The PCMH is a potential vehicle to reduce the sexual and reproductive health disparities of young women of color, and this study provides an understanding of needs and barriers to quality healthcare services in the PCMH setting. Research has identified barriers that maintain health disparities in healthcare, in particular provider (e.g., lack of training and skills) and patient (e.g., perceived discrimination) level barriers as well as patient-provider communication barriers (e.g., discomfort with sexual health communication).

AHRQ is partnering with the University of Texas Health Science Center at Houston, Harvard University, and HealthPartners to create a study on *Measuring Occurrence of and Disparities in Dental Clinic Adverse Events* that will further knowledge regarding the epidemiology of threats to patient safety within ambulatory dental settings and also examine if the incidence varies by populations. Importantly, the investigators also propose matching dental events with medical records to address challenges resulting in fragmented care for safety events. This developmental project will greatly raise awareness of the importance of patient safety in dentistry and will catalyze a novel line of dental clinical, quality improvement, and health economics research.

In partnership with the University of Texas Health Science Center at Houston, the *Evidence-Based Dissemination for Mammography Adherence in Safety Net Communities* project actively disseminated the evidence-based intervention (EBI) through a unique breast health collaborative with a wide membership of FQHC, supported implementation through training, and evaluated the adoption, implementation, sustainment, and effectiveness of the intervention. Breast cancer and death due to breast cancer disproportionately affect racial and ethnic minority populations, and FQHCs play a significant role in providing healthcare access to racial and ethnic minority and other underserved women. The project contributes to research on dissemination and implementation and also assesses the additional cost each FQHC will incur to implement and sustain the mammography appointment. This cost analysis will provide valuable data to all FQHCs in the country beyond the immediate impact of the project in the limited geographic area. As of FY 2016, the researchers have performed the initial phases of data collection.

Also, AHRQ will partner with the Alaska Native Tribal Health Consortium, Alaska Tribal Health System (ATHS), and Alaska Federal Health Care Access Network to conduct the *Evaluation of the Impact of Telemedicine on Management of Rheumatoid Arthritis* study. This study addresses an important problem by evaluating the impact of video teleconference rheumatology follow-up visits on access to care for rural patients and quality of care. This project evaluates an intervention that has been implemented in the ATHS but has the potential for generalizability to other populations with geographic or other barriers to access to rheumatologists. As more patients embrace technology to meet their healthcare needs, the demand for telemedicine is expected to grow. Therefore, the results will expand and update existing knowledge of HIT research in this area.

GOAL IV: Advance Scientific Knowledge and Innovation

AHRQ plays a critical role in **increasing the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. With the *National Healthcare and Disparities 2015 Report,* AHRQ has reported on healthcare quality and disparities for racial and ethnic minority populations for the 13th year in a row (https://nhqrnet.ahrq.gov/inhqrdr/). The *National Healthcare Quality and Disparities Report* and its companion chartbooks are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. In part they draw on measures from AHRQ's *Healthcare Cost & Utilization Project (HCUP),* a family of healthcare databases that bring together the data collection efforts of state data organizations, hospital organizations, private data organizations, and the federal government to create a national information resource

of encounter-level healthcare data. While the 2015 *National Healthcare Quality & Disparities Report* (QDR) report shows progress nationwide in access to and affordability of care, the State Snapshots[24] reveal substantial variations across states and sizable disparities related to race, ethnicity, income, and other factors.

AHRQ and its contractor Truven Health Analytics, in collaboration with CDC's NCHS and Truven Health Analytics, also utilized HCUP data to analyze racial disparities in sepsis-related in-hospital mortality. The study found that sepsis-related mortality rates adjusted for patient characteristics were higher for all minority groups than for white patients. After adjusting for hospital characteristics, sepsis mortality rates in 2013 were similar for White, Black, and Hispanic patients but remained elevated for Asian, Pacific Islander, and other racial and ethnic patients. A manuscript of these results has been accepted for publication in *Critical Care Medicine*.

The study on the *Effects of Missing Data Strategies on Disparities Research Results in HCUP State Inpatient Databases (SIDs)* will look at making the SID a more useful and reliable resource for the study of racial disparity. The two multiple imputation (MI) approaches employ state-of-the art methods to investigate the impact of missing data on analyses that look at the disparities in healthcare quality associated with variables that typically have missing data. The methods used should translate to other fields of research. Based on the simulation, the researchers selected the optimal MI method for imputation. As a result, MI datasets will be generated as a companion to the SID that will allow users to perform analysis using existing software for complete data for a wide range of substantive research questions. They use imputed SID data to conduct musculoskeletal healthcare disparities research. The application is to determine whether race is a risk factor for a set of adverse outcomes after total knee replacement (TKR) and whether racial disparities exist in utilization of TKR. Upon completion of the project, the results of the study can be disseminated to the general public as well as research communities.

The *National Healthcare Quality and Disparities Report* and its companion chartbooks also draw on more than 60 measures from AHRQ's *Medical Expenditure Panel Survey (MEPS)* conducted by AHRQ. The MEPS is a set of large-scale surveys of families and individuals, and their medical providers, across the United States. Additionally, the MEPS includes a nationally representative survey of employers. MEPS, which is the most complete source of data on the cost and use of healthcare and health insurance coverage, contributes to these reports and chartbooks. All of the MEPS data produced for the reports and available from the MEPS website have separate data available for the five OMB standard race categories of White, Black or African American, Asian, and Native Hawaiian or other Pacific Islander, as well as other races. MEPS also collects more detailed Asian race categories in compliance with the 2011 HHS Affordable Care Act Data Collection Standards. The Report also draws on data from AHRQ's HCUP project and includes State-specific estimates for selected AHRQ Quality Indicators (QIs) based on HCUP data.

[24] See the National Healthcare QDR Report's State Snapshots at http://www.ahrq.gov/news/qdr.html

Centers for Disease Control and Prevention

Agency Overview: The CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

CDC increases the health security of our nation. CDC saves lives and protects people from health threats. To accomplish its mission, CDC conducts critical science and provides health information that protects the nation against expensive and dangerous health threats, and responds when these arise.

CDC and CMS co-led Million Hearts®, an HHS initiative intended to prevent one million heart attacks and strokes in the United States over the course of 5 years (2012 through 2016). Working alongside 120 official partners, 20 federal agencies, and all 50 states and the District of Columbia, Million Hearts® aligned efforts across the country to prevent CVD using a select set of evidence-based public health and clinical strategies. The Million Hearts® team developed evidence-based tools that were disseminated through this network of partners. A sample of tools disseminated over FY15 and FY16 include:

- Self-Measured Blood Pressure Monitoring Action Steps for Clinicians;
- Hypertension Control Change Package for Clinicians;
- Medication Adherence: Action Steps for Health Benefit Managers;
- Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians;
- Protocol for Identifying and Treating Patients Who Use Tobacco;
- Hypertension Prevalence Estimator Tool;
- Self-Measured Blood Pressure web page;
- Undiagnosed Hypertension web page; and
- HIT web page.

Through an annual competition, Million Hearts® recognized 48 Hypertension Control Champions that have achieved blood pressure control rates at or above 70 percent in FY 2015-FY 2016. Million Hearts® enlisted the support of faith-based communities through the 100 Congregations program, in which congregations designated one member to serve as a Million Hearts® advocate and resource for heart health information. In FY 2015, Million Hearts® conducted *Healthy is Strong*, a communication and education initiative targeting African American men aged 40-65 to increase their awareness that cardiovascular disease is preventable. Million Hearts® also funded national partners through cooperative agreements to address key aspects of Million Hearts®, especially hypertension control. The Million Hearts®-funded projects included:

- a learning collaborative focused on integrating public health and healthcare efforts to improve hypertension (Association of State and Territorial Health Officials);
- a Community Hypertension Models project in which YMCA staff were trained as Health Heart Ambassadors to educate patients with hypertension how to use self-measured blood pressure monitors and record their readings (YMCA of the USA); and

- a pilot project examining quality improvement strategies and tools to improve detection and control of hypertension in community health centers serving populations disproportionally burdened with high blood pressure (National Association of CHCs).

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

- Reframing the elimination of health disparities as an achievable objective;
- Facilitating the implementation of policies across CDC that promote the elimination of health disparities;
- Assuring implementation of proven strategies across CDC programs that reduce health disparities in communities of highest risk;
- Advancing the science and practice of health equity; and
- Collaborating with national and global partners to promote the reduction of health inequalities.

CDC carries out the following activities to achieve these goals:

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

Highlights of CDC's Fiscal Years 2015 through 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

The CDC implements relevant projects to **reduce disparities in access to primary care services and care coordination (Strategy I.B)**. The CDC supports community health programs to improve many health conditions in clinical settings. Through the *National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)*, the CDC prioritizes efforts to link community programs to clinical services to ensure people with, or at high risk for, chronic diseases have access to the resources they need to prevent or manage these diseases. For example, the NCCDPHP carries out the *Partnerships to Improve Community Health (PICH)* and *Racial and Ethnic Approaches to Community Health (REACH)* programs. These two programs focus on improving and sustaining management of chronic conditions through community-clinical linkages. Such connections between community and clinical sectors can improve population health as well as support patient needs and care. The PICH and REACH programs are implemented nationwide in local governments, public health offices, and hospital and health systems, as well as with community-based organizations and tribal organizations. For instance,

to reduce diabetes, the Solano County community partners launched a series of National Diabetes Prevention Program classes. These classes are offered in a variety of settings across the county including churches, parks, and clinics. Solano County Public Health Services (SCPHS) is using community linkages to help residents of Solano County better manage chronic conditions. As reported to CDC by SCPHS, Solano County's adult diabetes rate is 11.9 percent, which is higher than the California (9.9 percent) and the national (9.3 percent) rates. The county also offered 12 classes for the Chronic Disease Self-Management Program, a scientifically supported program using education and behavioral interventions that support patients' active management of their condition in their daily life. Primary care providers can refer patients to these classes via a referral system developed in partnership with Community Medical Centers, Inc. (i.e., FQHCs). By September 2015, over 42,000 residents had increased access to clinical and community linkages that help people manage chronic conditions.

GOAL II: Strengthen the Nation's HHS Infrastructure and Workforce

The CDC's activities also focus on **increasing the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities (Strategy II.A)**. The CDC *SDOH Website*[25] serves as a single place for accessing CDC resources for SDOH data, tools for action, programs, and policy. Currently, the website is accessed by people in public health, community organizations, and healthcare systems to address SDOH inequity, reduce health disparities, and improve community well-being. The *2016 Summary Report* covering from January 1, 2016 to December 31, 2016 showed 398,729 hits, while a summary report since the site was launched showed that between November 2015 and December 31, 2016, there have been 466,328 hits.

The brief document titled *"Ten Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities"*[26] demonstrates at-a-glance how addressing SDOH inequities is part of every one of the 10 essential public health services and therefore a critical part of public health practice. This publication was developed in collaboration with the CDC's *State, Tribal, Local and Territorial Subcommittee*, a 15-person Federal Advisory Committee of state, tribal, local, and territorial health officers/representatives.

The *Strengthening and Diffusing the Non-Communicable Disease (NCD) Collaborative in the USAPI* program engages local trainers to implement an evidence-based strategy using the Chronic Care Model to systematically strengthen NCD healthcare quality and outcomes, focusing on diabetes preventive care across health systems in the region. The goal of the NCD Collaborative is to reduce health disparities in chronic disease risk factors and morbidity/mortality, targeting community-clinic linkages, environmental transformation, surveillance/monitoring, and policy.

The *Diabetes Prevention – State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke* was developed and implemented to prevent obesity, diabetes, and

[25] See the CDC SDOH Website at www.cdc.gov/socialdeterminants
[26] See this CDC document at https://www.cdc.gov/publichealthgateway/publichealthservices/pdf/Ten_Essential_Services_and_SDOH.pdf

heart disease and stroke (through control of high blood pressure), and to reduce health disparities in these areas among adults. These efforts are supported through state/jurisdiction level leadership, coordination, and technical assistance to selected communities. The program targets low SES and racial ethnic populations experiencing a disproportionate burden of type 2 diabetes and high blood pressure, resulting in heart disease and strokes. Some of the states participating in the program include California, Hawaii, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Utah, Virginia, and Washington.

The CDC also seeks to **promote the use of Promotores de Salud and CHWs (Strategy II.B)**. The *Public Health Law Research Collaboration for Cardiovascular Disease Control-CHW Case Study* is a comparative case study conducted to inform decision makers about effective strategies and potential challenges to state-level actions and organizing structures relevant to CHW certification. Cardiovascular disease disproportionately affects racial and ethnic minority populations. Given their linguistic and cultural connection to the communities they serve, CHWs are believed to be effective in supporting cardiovascular disease control in communities of color. The study seeks to capture information related to the strategies, activities, and partnerships states are using to implement multiple types of CHW certification structures; barriers, facilitators, and unintended consequences associated with implementation of various structures guiding CHW certification; cost and resource estimates from each state related to the development, implementation, and support of pertinent CHW certification activities; and contextual factors thought to influence implementation as well as mediating processes believed to influence outcomes. This project will result in technical assistance materials containing detailed narrative descriptions of the implementation processes in each state, costs of implementation under each approach, summarized outcome information linked to adoption and implementation of CHW certifications, and organizing structures. The process performance measures are expected to be available on December 31, 2017.

The *Cardiovascular Disease: Interventions Engaging Community Health Workers* program focuses on conducting an effectiveness review and economic review on interventions that engage CHWs to prevent CVD. Cardiovascular disease disproportionately affects racial and ethnic minority populations, and CHWs can be effective in cardiovascular disease control. Thus, the Community Guide will complete the reviews and develop a Community Preventive Services Task Force finding and recommendation summary. The program targets patients from the 50 states, Washington DC, and Puerto Rico with an increased risk of CVD. The Community Preventive Services Task Force recommends interventions that engage community health workers to prevent CVD.[27] There is evidence of effectiveness for interventions that engage CHWs in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for CVD. There is also evidence of effectiveness for interventions that engage CHWs for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors, such as physical activity, healthy eating habits, and smoking cessation, in patients at increased risk for CVD.

[27] See more on the Cardiovascular Disease: Interventions Engaging Community Health Workers Program at https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health

Similarly, the *Diabetes: Interventions Engaging Community Health Workers* program is developed to conduct an effectiveness review and economic review on interventions that engage CHWs to prevent diabetes. Diabetes disproportionately affects racial and ethnic minority populations. The Community Preventive Services Task Force recommends interventions engaging CHWs for diabetes prevention based on sufficient evidence of effectiveness in improving glycemic control and weight-related outcomes among people at increased risk for type 2 diabetes. Some evidence suggests interventions adapted from the U.S. Diabetes Prevention Program (Diabetes Prevention Program Research Group 2002, NIDDK 2016) reduce rates of progression to type 2 diabetes, though more research is needed. Interventions engaging CHWs for diabetes prevention, which are typically implemented in underserved communities, can improve health, reduce health disparities, and enhance health equity.

GOAL III: Advance the Health, Safety and Well-being of the American People

The CDC focuses on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. The CDC program *Reducing Motor Vehicle-Related Injuries and Deaths Among American Indians and Alaska Natives* has worked with tribes to improve American Indian and Alaska Native (AI/AN) motor vehicle safety, and is currently expanding technical assistance to tribes through an Inter-Agency Agreement with the *Federal Highway Administration Tribal Technical Assistance Program*. This partnership allows CDC to provide technical support, training, and other activities intended to reduce motor vehicle-related fatalities and injuries in Indian Country and to reach up to 37 percent of the 567 federally recognized tribes in the United States. In 2016, CDC published a *Tribal Motor Vehicle Injury Prevention Best Practices Guide*[28] that includes lessons learned from previous CDC activities with tribes. This guide summarizes the burden of motor vehicle crash injury and death for the AI/AN community, and provides recommended strategies with examples from Indian Country to increase seat belt use, increase child safety seat use, and reduce alcohol-impaired driving. The National Center for Injury Prevention and Control (NCIPC) previously funded 12 tribes through CDC's *Tribal Motor Vehicle Injury Prevention Program (TMVIPP),* intended to increase seatbelt and child safety seat use and decrease alcohol impaired driving. The foci of technical assistance were on implementing evidence-based strategies, building partnerships, evaluating interventions, identifying funding opportunities, providing training, and developing culturally competent outreach to AI/AN communities. This program helps fill the technical support gap identified by tribes that were funded by federal programs. Statistical injury reports and atlases will: (1) more accurately reflect the state of injury inequity present for AI/AN; (2) give tribes information on which to draw conclusions; (3) provide a reliable source of injury data to inform programs; and (4) serve as a foundation for improving injury-related policy, strategic planning, and expenditure decisions at the tribal, state, and national levels.

The CDC is also collaborating with the Indian Health Service's *TECs* to improve data collection, reporting, and research related to suicide and unintentional injuries among AI/ANs, including motor vehicle crash-related injuries. Three TECs (Albuquerque Area Southwest TEC, Albuquerque, New Mexico; Navajo TEC, Window Rock, Arizona, and Oklahoma Area TEC,

[28] See the Tribal Motor Vehicle Injury Prevention Best Practices Guide at https://www.cdc.gov/motorvehiclesafety/pdf/native/tmvip_best-practices_guide_2016-a.pdf

Oklahoma City, Oklahoma) are being funded by NCIPC's Division of Unintentional Injury Prevention, beginning in September 2016. The program targets children under the age of six (6) years old living at or below the poverty line, children of some racial and ethnic groups, and children living in older housing.

Furthermore, the CDC has implemented the *Promotion and Measurement of Safe and Sustainable Water Services in Indian Country* program. In August 2015, the *Indian Health Service (I) Division of Sanitation Facility Construction* asked for CDC's assistance with creating safe and sustainable water services in Indian Country. IHS is providing funding to CDC for specialized scientific expertise not readily available within IHS. CDC is overseeing and supporting the work of the National Tribal Water Center to enhance community efforts for the creation of safe and sustainable water service. Examples include developing teaching materials and techniques to promote usage of treated water and support of water treatment infrastructure. CDC is also developing hazard, exposure, and health outcome measures that demonstrate the effectiveness of individual and community water and sanitation infrastructure in AI/AN populations. In addition, the CDC and IHS are in the early stages of a project to help tribes improve their drinking water programs using the 10 Essential Environmental Health Services.

The Congressional FY 2015 budget provided $15.5 million to CDC's *Healthy Homes and Lead Poisoning Prevention Program*. The funding builds on past success in reducing children's blood lead levels through blood lead surveillance and primary prevention of high blood lead levels by targeting resources to reduce or eliminate lead sources to children at highest risk for exposure. Beginning in FY 2014, CDC is funding 29 state health departments, five local health departments, and Washington, DC through three-year, competitive, cooperative agreements. The funds provide support for surveillance activities in states, counties, and cities with the most concentrated and persistent lead poisoning issues. For FY 2015, there was a 35 percent decrease in children's blood lead levels by race and a 28 percent decrease by poverty level.[29] These blood lead surveillance data are essential for local non-profit organizations and social service agencies, housing and health code enforcement, early childhood education programs, and other public health and educational activities to protect children living in the highest risk housing, buildings, and neighborhoods by directing housing rehabilitation and health education activities.

The *Good Health and Wellness in Indian Country Program (GHWIC)* is CDC's largest single investment in Indian Country and is a 5-year program funded at $16 million in 2015. GHWIC supports a coordinated, holistic approach to healthy living and chronic disease prevention, and reinforces the work already under way in Indian Country to make healthy choices and lifeways easier for AI/AN. The long-term goals of the program are to reduce rates of death and disability from tobacco use, reduce the prevalence of obesity, and reduce rates of death and disability from diabetes, heart disease, and stroke. GHWIC works in all of NCCDPHP's four action areas or domains: (1) epidemiology and surveillance, (2) environmental approaches, (3) healthcare system interventions, and (4) community programs linked to clinical services. The 12 tribes funded by GHWIC use community-chosen and culturally adapted policies, systems, and environmental improvements to achieve GHWIC's long-term goals. Eleven tribal organizations provide leadership, technical assistance, and resources to more than 100 other tribes and tribal

[29] See more on the National Health and Nutrition Examination Survey at https://www.cdc.gov/nchs/nhanes/index.htm

organizations in their IHS areas and to GHWIC-funded tribes. Eleven TECs serve tribes, villages, and tribal organizations in each IHS area to evaluate GHWIC interventions, to demonstrate tribe and area-level impact. One TEC, the Urban Indian Health Institute, coordinates the national evaluation by providing support and expertise to other TECs, tribal organizations, tribes, and CDC. The GHWIC program seeks to reduce rates of death and disability from tobacco use by 5 percent; reduce the prevalence of obesity by 3 percent; and reduce rates of death and disability from diabetes, heart disease, and stroke by 3 percent. CDC anticipates that specific data of progress toward outcomes will be available at the end of the 2019 calendar year.

The *Preventive Health and Health Services Block Grant* provides all 50 states, Washington, DC, two American Indian tribes, and eight U.S. territories with funding to address their unique public health needs in innovative and locally defined ways. This program gives grantees the flexibility to use funds to respond rapidly to emerging health issues and fill funding gaps in programs that deal with leading causes of death and disability. The Kickapoo Tribe in Kansas continues to promote physical activity to members of the Boys & Girls Club of the Kickapoo Tribe for youth aged 5-21. The tribe's major health objective (Healthy People 2020: Physical Activity Objective #5) is to increase the proportion of adolescents who participate in daily school physical education. As part of the results, the Kickapoo Tribe has developed and implemented an afterschool program that promotes physical activity through the use of sports, games, and cultural teachings and has coordinated activities with various tribal, national, state, and local entities that promote the overall health and well-being of tribal members.

GOAL IV: Advance Scientific Knowledge and Innovation

The CDC also seeks to **increase the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. Through the *Hispanic Health Vital Signs* and *African American Health Vital Signs*, the CDC examines health risks and leading causes of death in the U.S. among these particular populations. It showed that health risks can vary by Hispanic subgroup and nativity and confirmed the importance of monitoring and developing interventions to improve the health of Hispanic sub-populations. Program outcomes were made available through the publication of a *Morbidity and Mortality Weekly Report (MMWR)* on May 5 2017.[30]

The CDC publishes the MMWR to address several health-related issues and to inform and provide health-related recommendations to public health professionals. In February 2016, the *MMWR* supplement titled *"Strategies for Reducing Health Disparities — Selected CDC-Sponsored Interventions, United States, 2016"* highlighted health challenges and disparities that minority populations in the U.S. are currently facing. For instance, this report examined health promotion and diabetes prevention among AI/AN communities.

[30] See the MMWR at https://www.cdc.gov/mmwr/volumes/66/wr/mm6617e1.htm?s_cid=mm6617e1_w

Centers for Medicare & Medicaid Services

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

By law and program design, many CMS activities are handled by third parties. The states play a major role in administering the Medicaid and CHIP programs. In addition, state survey agencies inspect hospitals, nursing homes, and other healthcare facilities to confirm compliance with Medicare and Medicaid health and safety standards. Medicare contractors process claims, provide technical assistance to providers, and answer beneficiary questions. Quality Improvement Organizations conduct a wide variety of programs to support and improve healthcare quality pursuant to the Social Security Act and contracts with CMS.

In its 2013 Strategic Roadmap, CMS identified four goals: (1) better care and lower costs through improvement, (2) prevention and population health, (3) expanded healthcare coverage, and (4) enterprise excellence.[31] Several of the objectives in the roadmap linked to CMS's goals relate to health disparities:

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

CMS also served with CDC as the co-lead of the Million Hearts® initiative, whose goal was to prevent one million heart attacks and strokes by 2016. CMS activities and products related to Million Hearts®, *From Coverage to Care*, stratified data, and the *Mapping Medicare Disparities Tool*, are described below.

Office of Minority Health Mission and Function: The CMS OMH is commited to improving the health of vulnerable populations, and offers a comprehensive source of information on eliminating health disparities and improving the health of all minority populations, including racial and ethnic minorities, people with disabilities, sexual and gender minorities, and those living in rural areas. The mission of CMS OMH is to ensure that the voices and the needs of the populations it represents are present as the agency is developing, implementing, and evaluating

[31] See the CMS 2013 Strategic Roadmap at https://www.nadona.org/wp-content/uploads/2016/05/CMS-Strategy.pdf.

its programs and policies. Through its efforts, CMS OMH seeks to have all CMS beneficiaries attain their highest level of health and to eliminate disparities in healthcare quality and access.

CMS OMH serves as the principal advisor and coordinator to the agency for the needs of minority populations, including racial and ethnic minorities, people with disabilities, members of the lesbian, gay, bisexual, and transgender community, individuals with limited English proficiency, and rural populations. Consistent with the goals of CMS, CMS OMH carries out the following duties:

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

Highlights of CMS's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

CMS's overall commitment to strengthening and modernizing its programs to provide access to high-quality care and improved health at lower cost directly informs the CMS OMH's commitment to ensuring all CMS beneficiaries achieve their highest level of health and to eliminating disparities in healthcare quality and access.

GOAL I: Transform Health Care

CMS seeks to **reduce disparities in health insurance coverage and access to care (Strategy I.A)**. *CMS's call centers* support over 200 languages and text telephone (TTY). In FY 2015, the Medicare and Exchange language lines together handled 198,129 calls. The Medicare Call Center took 22,000 TTY calls and the Exchange Call Center took 18,000 TTY calls. Also, the Exchange Call Center received a total of 2,778,519 Spanish calls and the Medicare Call Center a total of 844,594 Spanish calls, which are answered by CMS's bilingual representatives. Adjustments to Spanish staffing at the Exchange Call Center during Open Enrollment reduced wait times from 1 minute 22 seconds to 26 seconds. The Experian call center continued to offer a language line to assist with ID proofing questions and issues.

Health Insurance Exchange Navigators help consumersas they look for health coverage options through the Exchange, including completing eligibility and enrollment forms. Navigators must

have expertise in eligibility and enrollment rules and procedures; the range of qualified health plan options and insurance affordability programs; the needs of underserved and vulnerable populations; and Exchange privacy and security standards. Navigators serve a number of vulnerable and underserved populations, including, but not limited to:

- The uninsured and those newly-eligible for health insurance;
- Consumers with disabilities;
- Consumers with mental illness, substance abuse, and co-occurring disorders;
- Consumers with HIV/AIDS;
- Individuals and families affected by sickle cell disease;
- Consumers who are homeless, live in low-income housing, or live in rural or urban areas;
- Consumers who are socially isolated;
- Consumers who are immigrants or refugees;
- Migrant workers;
- Farmers;
- The Lesbian, Gay, Bisexual, Transgender, Queer and other (LGBTQ+) community;
- Individuals with LEP;
- Consumers with low literacy or low health insurance literacy;
- Veterans;
- Consumers with low incomes;
- Part time workers;
- The self-employed;
- Consumers losing employer-sponsored coverage after layoffs;
- Pre-Medicare retirees;
- Former inmates;
- "Young invincibles;"
- Graduating students;
- New mothers;
- Children;
- Consumers encountering gang relations/affiliations;
- Fishermen and their families;
- Consumers from Compact of Free Association countries;
- The Hmong population; and
- African Americans, Hispanics or Latinos, Asians, Native Hawaiians or Other Pacific Islanders, American Indians, Alaska Natives, Haitians, Creoles, Arab Americans, South Asians, and other racial and ethnic minorities.

In FY 2015, Navigator assistance was available to consumers in 2,330 of 2,471 counties across 34 states with Exchanges operated by HHS. More than 221,000 consumers were assisted with Health Insurance Exchange applications, millions of consumers benefited from Navigator outreach, and millions of consumers learned about their coverage options as a result of Navigator outreach and education efforts. In FY 2016, Navigator assistance was available to consumers in 2,268 of 2,401 counties across 34 states with Exchanges operated by HHS and more than 176,000 consumers were assisted with Health Insurance Exchange applications. FY 2016 funds were awarded to Navigator grantees on September 2, 2016.

In FYs 2015 and 2016, CMS made certain *language access/plain language educational materials* available in 15 languages on Medicare.gov. English and Spanish notices are mailed to low-income subsidy beneficiaries. Medicare.gov is also available in Spanish. Products in languages other than English and Spanish have extremely low usage rates. CMS plans to increase promotion of the availability of the translated materials. Also, CMS will focus distribution on partners and stakeholders instead of direct-to-consumer through English or Spanish websites.

CMS makes a broad range of educational Health Insurance Exchange materials available in 14 languages. The Health Insurance Exchange paper family application was translated as a job aid into 33 languages. All English and Spanish notices include taglines in the top 15 languages. CMS also offers links from the HealthCare.gov footer to information in 15 languages.

CMS regulations are designed to ensure all individuals are able to access information about and to apply for Medicaid and CHIP. Regulations require that Medicaid and CHIP applications, all supplemental forms, including renewal forms, and state Medicaid agency websites must be in plain language and accessible to individuals with LEP and people with disabilities. State Medicaid agencies must provide reasonable accommodations, including assistance with applications and renewals, at no cost.

Many newly insured individuals belong to vulnerable or minority populations and may not have experience with the healthcare system. To **reduce disparities in access to primary care services and care coordination (Strategy 1.B)**, the *From Coverage to Care Initiative*, developed by CMS, helps consumers understand their health coverage and connect to primary care and the preventive services that are right for them so people can live a long and healthy life. In FY 2015, the initiative provided 2.5 million printed informational resources ordered by 3,000 organizations, had 20,000 downloads from its website, and held regular webinars reaching variety of community partners.

The CMS *Medicare-Medicaid Coordination Office (MMCO)* is dedicated to ensuring that beneficiaries dually enrolled in both Medicare and Medicaid have access to seamless, high-quality healthcare including the benefits to which such individuals are entitled under the Medicare and Medicaid programs. The programs within this office impact racial and ethnic minority populations by facilitating access to quality healthcare. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO continued to support the *Resources for Integrated Care (RIC).* RIC develops and disseminates technical assistance and actionable tools based on successful innovations and care models. Through this resource, CMS has supported the identification, expansion, and dissemination of best practices in the following technical assistance areas: behavioral health, disability competent care, geriatric competent care, member engagement and long-term services and supports. For example, during 2015 and 2016, RIC provided eight continuing education opportunities for providers caring for individuals with Alzheimer's disease and related dementias; more than 3,000 providers attended these trainings. In 2016, RIC also partnered with eight managed care organizations to participate in a learning collaborative to advance access to disability competent care.

CMS launched the *Medicare-Medicaid Financial Alignment Initiative (FAI)* to better align Medicare and Medicaid benefits and to improve beneficiary experience, quality, and cost of care. Enrollment has grown steadily since the first demonstrations began operations in 2013. Under this Initiative, more than 450,000 Medicare-Medicaid enrollees in 13 states were receiving coordinated care, including primary, acute, behavioral health and long-term supports and services through either a capitated or managed fee-for-service (MFFS) model as of FY 2016. While results are forthcoming for most demonstrations, early results from the first two demonstration years combined for the Washington State MFFS model demonstration indicated $67 million in gross Medicare savings.[32] The FAI evaluation also includes OMH-funded focus groups conducted in a number of states, designed to examine the experiences of subpopulations of demonstration enrollees. Results of early focus groups conducted in Massachusetts and Washington suggested that enrollee satisfaction with healthcare services, including provider relationships, did not appear to vary along racial or ethnic lines.[33]

The *Everyone with Diabetes Counts (EDC)* program is targeting Medicare beneficiaries within racial and ethnic minority populations and geographically underserved rural communities. The goal of this program is to improve the health literacy of Medicare beneficiaries with diabetes. EDC achieves this goal by recruiting and facilitating the completion of diabetes self-management education (DSME) classes, decreasing disparities in recommended monitoring of diabetes measures, and facilitating the building of sustainable community-based diabetes education programs to serve individuals with disabilities (e.g., blind and low vision). The current program led by Quality Innovation Network-Quality Improvement Organizations began on a nationwide basis (expanded from efforts in various states) in August 2014 and will continue through July 2019 under the current contracts. The EDC program is measuring changes in the participants' clinical measures and perceived ability to self-manage diabetes as a result of receiving community-based DSME.

GOAL II: Strengthen the Nation's HHS Infrastructure and Workforce

CMS also seeks to **increase the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities (Strategy II.A)**. The *CMS Equity Plan for Improving Quality in Medicare* released in September 2015 charted a five-year strategy to support CMS stakeholders in their work to reduce disparities, improve health and quality outcomes, and reduce costs for Medicare beneficiaries nationwide. The strategy's goals include (1) expanding the collection, reporting, and analysis of standardized data; (2) evaluating disparities impacts and integrate equity solutions across CMS programs; (3) developing and disseminating promising approaches to reduce health disparities; (4) increasing the ability of the healthcare workforce to meet the needs of vulnerable populations; (5) improving communication and language access for individuals with LEP and persons with disabilities; and (6) increasing

[32] Wilkin J, Zhao L, Trapnell T, Simms A, Nussbaum A, Morley M, et al. *Report for Washington managed fee-for-service (MFFS) final demonstration year 1 and preliminary demonstration year 2 Medicare savings estimates: Medicare-Medicaid Financial Alignment Initiative*. Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Innovation; 2017.
[33] Anderson W, Greene A, Ormond C, Booth M, Fralich J, Gattine E, et al. *Issue Brief: Special Populations Enrolled in Demonstrations under the Financial Alignment Initiative. Centers for Medicare & Medicaid Services,* Centers for Medicare & Medicaid Innovation; 2017.

physical accessibility of healthcare facilities. Areas where CMS made progress on the CMS Equity Plan for Improving Quality in Medicare are detailed in CMS' Year 1 Progress Report on the plan,[34] and select progress is included in relevant sections of this report.

GOAL III: Advance the Health, Safety, and Well-being of the American People

CMS is also committed to **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. Racial and ethnic minority populations experience disparities in access to quality dental care. In 2015, CMS sought to improve oral health among children enrolled in Medicaid and CHIP, including racial and ethnic minority children, by focusing assistance on the nine lowest performing states in child oral health quality to improve access, effectiveness, and value. For FY 2015, states reported, on average, a nearly 1.5 percentage point increase in the number of children ages one (1) to 20 receiving a preventive dental service. Nationally, the number of children ages one (1) to 20 receiving a preventive dental service increased by more than one percentage point.

CMS also sought to empower providers and health care organizations to work locally to **reduce disparities in population health by increasing the availability and effectivness of community-based programs and policies (Strategy III.A).** Through FY2015-2016, CMS OMH produced resources to help health care providers, health systems, health plans, and health care quality improvement organizations and networks implement culturally and linguistically tailored services and programs that are proven to reduce disparities. CMS OMH produced quality improvement tools for health plans including a resource guide and targeted intervention to support health plans embedding health equity in local community-based programs, including colorectal cancer screening programs.[35,36] CMS OMH also produced tools for hospitals including a guide to help hospitals reduce hospital readmissions among racial and ethnic minorities and other underserved communities.[37]

To support **conducting and evaluating pilot tests of health disparity impact assessments of selected proposed national policies and programs (Strategy III.B),** CMS OMH developed the *CMS Disparities Impact Statement*,[38] a tool designed to help organizations systematically identify and take steps to address disparities. This tool uses a plan-do-study-act quality improvement framework and provides CMS and external CMS stakeholders a means to systematically assess the disparities impact on CMS programs and policies. In FY2015-2016, CMS sought opportunties to apply a health equity lens and assess disparities impacts across several programs. CMS OMH and CMMI worked to assess the impacts of health disparities

[34] See more in the CMS Equity Plan Progress Report (October 2016) at https://www.cms.gov/files/document/cms-equity-plan-progress-report-oct-2016.pdf.
[35] See more on the Building an Organization Response to Health Disparities resource guide at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
[36] See more on the Targeted Intervention for Colorectal Cancer Screening at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Targeted-Interventions-Colorectal-Cancer-Screening.pdf
[37] See more on the Guide to Reducing Disparities in Readmissions at https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf
[38] See more on the CMS Disparities Impact Statement at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

within models including the CMMI *Accountable Health Communities model*, which included a scored Health Resource Equity Assessment as a component of its application package, and worked with model evaluation teams to embed aspects of disparities assessments in program evaluation. CMS OMH and CCSQ also worked together to assess where *Quality Improvement Network-Quality Improvement Organizations (QIN-QIO)* and *Hospital Engagement Networks' (HEN)* Statements of Work included opportunities to better understand disparities impacts within these programs. Importantly, CMS also examined the current state of health quality measures addressing the provision of Culturally and Linguistically Appropriate Services (CLAS) and disparities, characterized gaps in existing measures and their implementation, and identified measurement opportunities to address these gaps among racial and ethnic minorities, people with limited English proficiency, people with low health literacy, people with disabilities, and sexual and gender minorities.

GOAL IV: Advance Scientific Knowledge and Innovation

To **increase the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**, CMS has collected *Medicare Part C and D Performance Data Stratified by Race and Ethnicity*. The database presents Healthcare Effectiveness Data and Information Set and CAHPS scores for different racial and ethnic groups at the level of individual Medicare contracts and is intended to be used to improve quality and accountability. For the first time, all Medicare Advantage Plans can use data to identify health disparities in populations that they serve. The information provided by this database is not used to evaluate care through the Medicare Advantage and Part D Star Ratings program, nor is it used for payment purposes.

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

The CMS OMH has designed an interactive map, the *Mapping Medicare Disparities* Tool,[39] to increase transparency and accountability by identifying areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. It provides an excellent starting point for researchers to understand and investigate geographic and racial and ethnic differences in health outcomes. The tool has had thousands of unique hits, and received the CMS *"Dedication to Transparency to Better Serve the American Public Award."*

Food and Drug Administration

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

[39] See more on the CMS Mapping Medicare Disparities interactive data visualization tool at https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities

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

OMH Mission and Function: The FDA OMH advances the agency's regulatory mission to promote and protect the health of diverse populations through research and communication of regulatory science that address health disparities. The FDA OMH provides leadership and direction to:

- Improve regulatory science by increasing the amount of clinical trial data available on racial and ethnic minorities; improve the data quality to determine how minorities react to medical products; and increase transparency and access to available data;
- Strengthen FDA's ability to respond to minority health concerns; and
- Promote health and safety communication to minority populations who often experience low health literacy and/or have limited English proficiency.

Highlights of FDA's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Plan to Reduce Health Disparities)

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

GOAL I: Transform Healthcare

FDA hosts a seminar series: *"Health Equity: Moving Upstream to Address Disparities"* to promote discussions on relevant issues to keep reviewers abreast of new and emergent scientific issues related to public health and how these apply to the Agency's mission. The Scientific Rounds: *"Comparative Effectiveness Research - The Patient-Centered Outcomes Research Institute: What is it, How it Works, Why it Matters to FDA: PCORI's Addressing Disparities Program"* was also presented to stimulate dialogue among FDA's scientists and researchers.

GOAL II: Strengthen the Nation's HHS Infrastructure and Workforce

FDA seeks to promote the use of community health workers and promotoras (Straetgy II.B) though recruitment efforts at job fairs held in conjunction with academia, local employers, and military support organizations, such as the *Wounded Warrior Project*.

FDA advertises in multiple online journals, on professional associations/society websites, and on sites that include hard to reach and diverse populations. The agency also uses a Delegated Examining Recruitment tool to recruit diversified multi-level candidates utlizing USAJobs as well as more proactive outreach to difficult to hire groups such as medical officers, pharmacists,

regualtory counsel, and others; through job fairs, social media and other professional recruitment outlets (Strategy II.C).

FDA seeks to increase the diversity of the healthcare and public health workforces (Strategy II.C) through its *Pathways Program* which recruits talented candidates through the Summer Intern, Year Round Intern, and Recent Graduate programs. FDA also works with organizations such as TRANSCEN and minority serving institutions to recruit diverse applicants. During FY 2015, OMH participated in the *Pathways Internship Program* which lead to the selection and subsequent hiring of a full time FDA OMH employee.

FDA OMH precepts pharmacy students who apply to the *Pharmacy Student Experiential Program* and express an interest in minority health and as part of their elective rotation. Students gain enhanced regulatory science skills and knowledge to address health disparities. During FY 2015 and FY 2016, FDA OMH precepted seven students, several of whom went on to present abstracts/posters at national conferences, enroll in additional degree-granting programs, and/or enter residencies.

The *National Center for Toxicological Research* (*NCTR) Summer Student Research Program* is a 10-week summer program for undergraduate and graduate students interested in toxicology, regulatory science, or related scientific disciplines, and provides hands-on research and laboratory experience mentored by FDA scientists. For FYs 2015 and 2016, FDA OMH funded five students from Minority Serving Institutions (MSIs).

The *Satcher Health Policy Leadership Fellowship Program* is a 10-month multidisciplinary training program designed to provide physicians and post-doctoral professionals with the specific knowledge, skills, and experiences to prepare them for leadership roles promoting and implementing policies and practices to reduce disparities and advance health equity. FDA OMH funded two fellows that have gone on to enter a postdoctoral fellowship and/or obtain an adjunct instructorship at Morehouse School of Medicine.

The FDA *Fellowship in Genomic Medicine and Health Disparities* is a two year experience that provides regulatory-focused training in genomic medicine and clinical molecular genetics towards addressing the need for inclusion of diverse populations in health-related research for precision medicine. The postdoctoral fellow for 2015 and 2016 published research findings and presented abstracts and posters at multiple national conferences.

GOAL III: Advance the Health, Safety and Well-being of the American People

FDA plays a key role in **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**.

In September 2016, FDA OMH, in partnership with the University of Miami Office Of Research Compliance and Quality Assurance, hosted the *FDA Clinical Trials Symposium: Improving Clinical Research in the Age of Precision Medicine*. The symposium sought to further OMH efforts to implement sustainable and tangible solutions to improve minority participation in clinical trials and focused on scientific, regulatory, and ethical aspects of clinical trials, as well as

quality assurance practices. More than 420 members of the research community attended the 2-day event.

The *"Fresh Empire" Campaign to Reduce Tobacco Use Among African American, Hispanic, and Asian/Pacific Islander Youth* is a targeted and culturally relevant public education campaign to reduce tobacco use among at-risk and underserved African American, Hispanic, and Asian/Pacific Islander youth who identify with hip hop culture. The campaign is currently running in 36 markets and refreshes its creative content regularly. To date, the campaign has reached 90 percent of its target audience an average of 15 times per quarter.

The goal of the *Campaign to Reduce Tobacco Use Among American Indian & Alaska Native Youth* is to develop a targeted and culturally relevant campaign to reduce commercial tobacco use among at-risk and underserved AI/AN youth.

The *Population Assessment of Tobacco and Health (PATH) Study*[40] is a nationally representative, longitudinal cohort study of tobacco use and how it affects the health of people in the U.S. Tobacco use disproportionately affect racial and ethnic minority populations. The PATH Study began in October 2011 and is one of the first collaborations between the NIH and Food and Drug Administration (FDA) since Congress granted FDA the authority to regulate tobacco products. Spanning the country, participants include those who self-identify as Black or African American, AI/AN, Asian, Native Hawaiian or other Pacific Islander, or Hispanic or Latino descent. Participants include approximately 46,000 people over ages 12. The overarching goals of the PATH Study are to develop a population-based, multi-year evidence base that supports FDA in fulfilling its mission under the Tobacco Control Act to regulate tobacco products. The PATH Study provides an empirical evidence base for developing, implementing, and evaluating regulations governering tobacco products by measuring tobacco use and health and the behavioral and health effects associated with changes in tobacco regulations. Data in the first wave were collected from September 2013 to December 2014. Waves 2, 3,and 4 were launched in FY 2014, FY 2015, and FY 2016 respectively.

The *Read the Label Campaign* is a community outreach initiative targeting Hispanic and African Americans that teaches parents how to talk to their kids about the nutrition facts label, provides tips for using the Nutrition Facts label for kids, and includes an after school kit for programs like Boys and Girls Clubs.

"Beware of Some Dietary Supplements and Non-prescription Drugs Because They Harm You" was FDA OMH's multilingual campaign in partnership with the Office of External Affairs and the Office of Regulatory Affairs (ORA) health fraud division. The initiative was tailored for Asian Americans and Hispanics to be cautious when importing dietary supplements and other non-prescription drugs because they could be misbranded or contaminated. The campaign included an article and a public service announcement (PSA) video that was translated into multiple languages (i.e., Chinese, Korean, Tagalog, Vietnamese, and Spanish).

FDA, in collaboration with the National Science Teachers Association, has created the *Science and Our Food Supply (SOFS): Investigating Food Safety from Farm to Table*, an innovative,

[40] See more information on the PATH Study at: https://pathstudyinfo.nih.gov/UI/HomeMobile.aspx.

interactive supplementary curriculum for use in middle level and high school science classes. FDA OMH has continuously funded multiple teachers that work in underserved communities for this annual, weeklong professional development program that provides an in-depth orientation to a curriculum that focuses on the science behind food production and safety. Since 1999, 718 middle and high school teachers have completed the program and subsequently trained an additional 14,000 teachers. Over 75,000 SOFS kits have been distributed nationwide.

The Center for Food Safety and Applied Nutrition (CFSAN) and ORA exhibited and presented at 24 local and regional health organization meetings focusing on 44 CFSAN nutrition and food and cosmetics publications in English and Spanish.

GOAL IV: Advance Scientific Knowledge and Innovation

FDA OMH led the development of the *FDA Action Plan To Enhance the Collection and Availability of Demographic Subgroup Data*. During FY 2015 and FY 2016, FDA worked to implement action items in the plan, grouped into three identified priorities: (I) improve data quality and completeness; (II) increase clinical trial subgroup participation; and (III) increase demographic subgroup data transparency and availability.

To improve data quality (priority I), the agency released two FDA guidance documents "*Collection of Race and Ethnicity Data in Clinical Trials*" and "*Evaluation and Reporting of Age, Race, and Ethnicity Specific Data in Medical Device Clinical Studies*." Both documents provide clear and detailed guidance to FDA staff and regulated industry on important inclusion-related clinical trial data issues. FDA also updated its MedWatch forms for reporting of adverse events to now include fields for race and ethnicity.

As part of addressing its second priority (increasing clinical trial diversity), FDA declared 2016 the *Year of Clinical Trial Diversity* to make a strong push to improve representation of diverse groups in clinical trials to include minorities, women, and elderly. Activities included an ongoing a series of PSAs, print and online health education materials such as brochures, infographics, a toolkit, webinars, and social media. Three public stakeholder meetings were also held:

1) In April 2015, the National Academies of Sciences, Engineering, and Medicine and FDA hosted a joint meeting *Strategies for Ensuring Diversity, Inclusion, and Meaningful Participation in Clinical Trials: A Workshop*. More than 100 participants attended online and in-person, and a formal publication detailing the workshop's proceedings was released in April 2016.
2) In December 2015, FDA OMH and the Johns Hopkins University Center for Excellence in Regulatory Science and Innovation held a joint workshop *Clinical Trials: Assessing Safety and Efficacy for a Diverse Population,* to advance the understanding of the importance of diversity in clinical trials and to discuss methods for the design, conduct and analysis of trials that allow for the assessment of the effects among population subgroups. More than 400 persons attended online and in-person.
3) In February 2016, FDA hosted the public meeting *Enhancing the Collection, Analysis, and Availability of Demographic Subgroup Data* to provide a public update on the

implementation of the FDA Safety and Innovation Act (FDASIA) 907 Action Plan. Over 200 participants attended online and in-person.

To increase data transparency and availabilty (Priority III), FDA launched two major efforts: *Drug Trials Snapshots (DTS)* and the *FDA Language Access Plan (LAP)*.

DTS publishes, in clear, consumer-friendly plain language, demographic data (sex, race, ethnicity, and age) from clinical trials that supported FDA approval of new molecular entities and original biologics. More than 100 DTS have been published since the launch of the program.

The LAP is an initiative to identify the needs of people with limited English proficiency and to provide meaningful access to language-assistance services. Part of Executive Order 13166 and the FDASIA Section 1138, FDA OMH leads the implementation of this effort. The FDA OMH also created the first LAP Volunteers Group to ensure translated information for limited English proficient consumers/patients is accurate, culturally sensitive, and in plain language. Currently, the program has over 80 volunteers that speak over 19 languages.

In 2016, FDA OMH hosted the "*LAP Multilingual Workshop.*" The widely attended event provided detailed methods and tools to educate communication experts on best practices on how to develop, engage, and deliver information for English-learner populations.

FDA also works to **increase the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. Historically, there has been a lack of minority participation in clinical trials, which creates challenges with research data truly representing the national population. The *Efficient and Effective Clinical Trial Recruitment Planning/Clinical Trials Transformation Initiative* recognizes that recruitment is a critical factor that can determine the success or failure of a clinical trial while recognizing the staggering number of clinical trials that continue to fail to meet recruitment goals despite previous efforts. The initiative, in which FDA OMH plays a pivotal role, seeks to move recruitment planning upstream and parallel to the clinical trial design process to ensure trial feasibility.

The FDA OMH Research and Collaboration Program works with FDA centers and external partners/universities to support research studies that inform minority health and address health disparities. A sampling of OMH-sponsored/supported research projects/initiatives ongoing in FY 2015 and FY 2016 include:

- *Safer Labeling of Pediatric Medications: Reducing Literacy-related Health Disparities among Chronically Ill Adolescents;*
- *Integrated Analysis of microRNA Expression and Copy Number in Triple Negative Breast Cancer of African American Women;*
- *Immunogenicity of recombinant coagulation factors: Pharmacogenetic determinants: Race based differences in clinical outcomes with respect to immunogenicity of FVIII and FIX:*
- *Hemoglobin Oxidative Toxicity and Control in Sickle cell Disease; and*
- *Racial/Ethnic Differences in Drug Disposition and Response: Review of Recently Approved Drugs.*

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

In the *Reduce Tobacco Related Disparities by Increasing Evidence-Based Targeted Enforcement of FDA Tobacco Regulations Nationwide* program, FDA contracts for tobacco retail compliance check inspections to be conducted within the states and territories to ensure compliance with the tobacco provisions of the Federal Food, Drug, and Cosmetic Act and tobacco product regulation provisions that restrict youth access to regulated tobacco products. The retail compliance check program is expected to educate retailers about the dangers of tobacco use and to reduce youth access to tobacco products while the surveillance program is designed to reduce the marketing of tobacco product to youth, including racial and ethnic minority populations.

The *DASH-demographics (DASH-D) Program* is a relational database that compiles demographic subgroup information (e.g., race, ethnicity, age, sex) on patient participation in clinical trials for CDER approved new drugs from 2014-present. The database is an easily accessible and reliable source of demographic subgroup information to support greater transparency in accordance with FDASIA Section 907.

Health Resources and Services Administration

Agency Overview: The Health Resources and Services Administration (HRSA) is the primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. HRSA's programs provide healthcare to people who are geographically isolated and economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers and their families, and those in need of high-quality primary healthcare. HRSA also supports the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in healthcare delivery. HRSA oversees organ, bone marrow, and cord blood donation. It compensates individuals harmed by vaccination and maintains databases that protect against healthcare malpractice, waste, fraud, and abuse.

Office of Health Equity Health Mission and Function: The Office of Health Equity (OHE) aims to ensure that health equity is realized in communities throughout the United States. Central to this mission is OHE's effort to engage with HRSA's Bureaus and Offices to promote health equity leadership and issues in HRSA policies and programs as they affect diverse vulnerable and disadvantaged populations. This is achieved through three impact areas:

- Health equity policy coordination for vulnerable and underserved populations;
- Internal, external, and community partnerships to improve health equity; and
- Health equity solutions (training and operations).

Highlights of HRSA's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

HRSA plays a critical role in implementing the HHS Disparities Action Plan's focus on improving health and achieving health equity through its commitment to access to quality services, a skilled health workforce, and innovative programs. HRSA's activities to address

health disparities primarily relate to Goals I-IV, many of which are explicitly identified in the HHS Disparities Action Plan.

GOAL I: Transform Health Care

HRSA supports a range of activities to **reduce disparities in health insurance coverage and access to care (Strategy I.A)** and **to reduce disparities in access to primary care services and care coordination (Strategy I.B)**. Racial and ethnic disparities in health insurance coverage exist. *The Health Center Program* addressed these disparities in FY 2016 by providing funds to health centers to support adding more than 7,000 outreach and eligibility assistance workers to assist people nationwide with enrollment into health insurance coverage.

HRSA also supports a wide range of programs to **reduce disparities in the quality of healthcare (Strategy I.C)**. Racial and ethnic minority populations experience disparities in healthcare quality. HRSA has sought to address these disparities by funding the *PCMH Supplemental Funding Opportunity* to assist health centers to make the necessary practice changes intended to achieve, expand, and/or optimize PCMH recognition. In FY 2016, 246 health centers were awarded this one-time funding, totaling $8.6 million, to provide assistance with improving the quality of care and patients' and providers' experience of care through the PCMH healthcare delivery model.

The *FY 2016 Quality Improvement Awards* are provided to high-performing health centers nationwide as well as those health centers that have made significant quality improvement gains in the past year to expand access to care, improve care quality and outcomes, increase comprehensive care delivery in a cost-effective way, promote health equity, and support health centers in maintaining or achieving patient-centered medical home recognition. Health centers will use these funds to expand current quality improvement systems and infrastructure and improve primary care service delivery in the communities they serve. In FY 2016, HRSA awarded over $100 million in Quality Improvement Awards to over 1,300 health centers. Over 60 percent of patients served in health centers funded by HRSA's Health Center Program were racial or ethnic minorities.

HRSA funded the *National Cord Blood Inventory* program ($10.4 million) for the collection and maintenance of genetically diverse, high-quality umbilical cord blood units for inclusion in the National Cord Blood Inventory. This effort includes adding minority cord blood units to the inventory to ensure access to compatible cord blood for transplantation for minority populations.

GOAL II: Strengthen the Nation's HHS Infrastructure and Workforce

HRSA also plays a key role in **increasing the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities (Strategy II.A)**. Through a National Cooperative Agreement (NCA) with HRSA, the *Migrant Clinicians Network (MCN),* provides training and technical assistance to clinicians serving underserved migratory and seasonal agricultural workers and their families, who tend to be racial and/or ethnic minorities. The MCN also serves as a professional home for clinicians serving

agricultural workers. The MCN's clinical and health services team provides both onsite and distance technical assistance. Services include consultation on clinic systems and intensive training to new chief medical officers and other new clinical leaders. The MCN provides health centers with assistance in the following competencies: risk management; workforce development (e.g., recruitment and retention of primary care providers); PCMH initiatives; and related protocols and procedures. Other initiatives are focused in the following areas: environmental and occupational medicine, pesticide awareness, and education on worker's compensation for health centers.

Since July 1, 2015, 167 individuals have downloaded MCN's *Identifying Migratory and Seasonal Agricultural Workers in Your Clinic tool*. In FY 2016, MCN responded to 90 technical assistance requests related to the identification of agricultural worker patients. The MCN also provided specialized training to health centers to support enrollment in the MCN health network. The health network creates and operates programs that enable patient services, including case management, medical records transfer, follow-up, and interpretation to support care coordination and patient tracking. In FY 2016, MCN trained 35 Health Center Program grantees to enroll patients in the health network for the first time and provided 12 refresher trainings to health centers that have previously enrolled patients in the health network. In FY 2016, 996 patients were provided patient navigation and bridge case management services, and 218 health centers participated in the health network to enroll patients, accept referrals for enrolled patients, and/or send medical records for enrolled patients.

HRSA also seeks to **promote the use of Promotores de Salud and CHWs (Strategy II.B)**. Through a National Cooperative Agreement (NCA) with HRSA, *MHP Salud,* provides training and technical assistance to health centers serving migratory and seasonal agricultural workers and their families to develop and maintain sustainable and effective CHWs and Promotores de Salud programs.

In FY 2016, MHP Salud completed the Health Center Pilot Return on Investment of Promotores programs and has begun development of the Return on Investment Toolkit for health centers based on the findings. The programs served migratory and seasonal agricultural workers and their families, who tend to be racial and/or ethnic minorities. Outcome data was dependent on program aims but included health insurance enrollments and changes in hemoglobin A1C, blood pressure, and weight over time. Preliminary results of the pilot showed:

- One health center's insurance enrollment activities and reduction in avoidable hospitalizations resulted in a total return of $1.68 to $2.43 for every $1 spent during the 2 years of enrollment. The average value of services received by patients was $36.38 for each dollar invested.
- Another health center's education-based program that provided screenings for hypertension and diabetes, using two separate methods of estimating the impact of controlled diabetes, resulted in a return ranging from $1.41 to $1.68 for every $1 invested.

These data demonstrate that with relatively few changes to data collection, and an emphasis on outcomes that can be effectively tracked over time, most programs can find ways to estimate the impact CHWs are having in their communities.

Racial and ethnic minority populations comprise a disproportionate share of the homeless population in the U.S. and experience disparities in access to quality healthcare. Through a NCA with HRSA, the *National Healthcare for Homeless Council (NHCHC)* provides training and technical assistance to strengthen the capacity of health centers to deliver healthcare services to people experiencing homelessness. Multiple activities have been completed by NHCHC related to promoting the use of CHWs, including developing training modules and conducting a workshop titled *"Health Care for the Homeless and Community Health Workers - A Guide to Integrating CHWs into Clinical Practices"* at the NHCHC national conference in June 2016. Workshop participants indicated in survey results that the training was informative and useful.

HRSA also plays a key role in **increasing the diversity of the healthcare and public health workforces (Strategy II.C)**. The *Centers of Excellence (COEs) Program* seeks to increase the supply and competencies of URMs in the health professions workforce by providing grants to health professions schools and other public and non-profit health or educational entities to serve as an innovative resource and education centers for the recruitment, training and retention of URM students and faculty. In the most recent reporting period (academic year 2014-2015), programs and activities supported through the COE program reached 10,503 trainees across the country. Of those, 6,342 were disadvantaged students and 5,878 were URM students. For the URM students, approximately 25 percent of trainees self-identified as Hispanic, 17 percent self-identified as Non-Hispanic Black or African American, 13 percent self-identified as Non-Hispanic AI/AN, and approximately two (2) percent self-identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. COE grantees partnered with 340 healthcare delivery sites to provide 7,700 clinical training experiences to health professions trainees. Approximately 48 percent of these training sites were situated in primary care settings and approximately 63 percent were located in medically underserved communities.

The *Area Health Education Centers (AHEC) Program* aims to enhance access to high-quality, culturally competent healthcare in rural and underserved areas through academic-community partnerships. Through these partnerships, AHECs work to provide training and education to further support distribution, diversity, and supply of the primary care health professions workforce. In the most recent reporting period (academic year 2014-2015), programs and activities supported through the AHEC program reached 405,785 trainees across the country. Of those 180,188 were disadvantaged students and 122,154 were URM students. AHEC grantees partnered with more than 11,000 sites to provide more than 48,100 clinical training experiences to student trainees (e.g., ambulatory practice sites, hospitals, and physician offices). Approximately 67 percent of these training sites were situated in primary care settings and approximately 62 percent were located in medically underserved communities.

The *Health Careers Opportunity Program (HCOP)* aims to provide individuals from disadvantaged backgrounds who desire to pursue a health professions career an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. In FY 2015, HCOP was redesigned to respond to the evolving healthcare workforce needs, while continuing efforts to increase the diversity of the healthcare workforce. The program focuses on specific entry points along a health careers pipeline that begin in the latter years of high school and places increased emphasis on evidence-

informed approaches. It expands its recruitment strategies to include non-traditional students and veterans from educationally and economically disadvantaged backgrounds. In the most recent reporting period (academic year 2014-2015), programs and activities supported through HCOP reached 12,686 trainees across the country. Of those, 9,310 were disadvantaged students and 6,949 were URM students. For the URM students, approximately 28 percent of trainees identified as Hispanic, 22 percent identified as Non-Hispanic Black or African American, approximately three percent identified as Non-Hispanic AI or AN, and less than one (1) percent identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. HCOP grantees partnered with over 280 sites to provide more than 6,000 clinical training experiences for HCOP student trainees (e.g., academic institutions, hospitals, and community health centers). Approximately 46 percent of these training sites were situated in primary care settings and approximately 55 percent were located in medically underserved communities.

To **increase the diversity of the healthcare and public health workforces (Strategy II.C)**, HRSA administers the *National Health Service Corps (NHSC) Loan Repayment and Scholarship Programs*. The NHSC Scholarship Program awards scholarships to health professions students pursuing careers in primary care, in return for their commitment to provide service in a Health Professional Shortage Area (HPSA) upon completion of training. Several NHSC Loan Repayment Programs (LRPs) provide loan repayment of qualifying educational loans for primary care providers who serve at approved sites in HPSAs. The inaugural application cycle for the NHSC Students to Service pilot program, which opened in November 2011, provides loan repayment assistance to medical and other students in their last year of school in return for a commitment to provide primary healthcare services in eligible HPSAs of greatest need. NHSC LRP clinicians include primary care physicians, physician assistants, dentists, dental hygienists, nurse practitioners, certified nurse-midwives, and behavioral and mental health professionals. Expansion of these programs is intended to expand access to primary healthcare services and improve the health of people who live in urban and rural areas where healthcare is scarce. The healthcare workforce is more diverse due to a more than doubling of the number of NHSC obligors in recent years. In FY 2016, African American physicians made up approximately 17 percent of NHSC physicians, and Hispanic physicians make up approximately 18 percent. Among NHSC physicians, African Americans and Hispanics greatly exceed their overall representation of the national physician workforce, where both groups represent only four percent of the national physician workforce.

HRSA also funds the *NURSE Corps Loan Repayment and Scholarship Programs*. The NURSE Corps LRP is a financial incentive program under which individual Registered Nurses (RNs) and Advanced Practice RNs (APRNs), such as nurse practitioners, enter into a contractual agreement with the federal government to serve full-time in a healthcare facility with a critical shortage of nurses in return for substantial repayment of qualifying nursing educational loans. The NURSE Corps Scholarship Program offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment after graduation of at least two years in healthcare facilities with a critical shortage of nurses. The NURSE Corps Scholarship Program award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. In FY 2016, a total of 1,125 NURSE Corps awards (883 LRPs and 242 Scholarship Programss) were made to residents of the 50 states, Puerto Rico, and Washington, DC. In FY 2016, African American nurses represented 16 percent of the NURSE

Corps and exceeded their 12.2 percent share in the national workforce while Hispanic nurses represented 6 percent of the NURSE Corps and nearly matched their 6.6 percent share in the national workforce. As of September 30, 2016, through investments in the NURSE Corps, over 2,000 RNs, including nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, nurse specialists, and other advanced practice nurses are working in communities where they are needed most are providing care. In addition, 83 percent of the NURSE Corps alumni remained at the site where they fulfilled their obligation for at least 2 years beyond the completion of their NURSE Corps service commitment.

GOAL III: Advance the Health, Safety and Well-being of the American People

HRSA works to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)** through the *Health Center Program*. In FY 2016, the Health Center Program supported nearly 1,400 health centers that operate over 10,400 service delivery sites, providing care to nearly 26 million patients in every state, Washington, DC, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. This nationwide network of health centers has created one of the largest safety net systems of primary and preventive care in the country. This program serves medically underserved communities and vulnerable populations as health centers have become the essential primary care provider for America's most vulnerable populations: people living in poverty; the homeless; racial and ethnic minorities; agricultural workers; public housing residents; the geographically isolated; and people with LEP. In addition, health centers advance the preventive and primary medical/healthcare home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Nearly half of all health centers serve rural populations. Furthermore, all health centers must provide enabling services, which help ensure access to primary healthcare services as well as facilitate access to comprehensive health and social services. Over 60 percent of the patients served in health centers are racial or ethnic minorities.

HRSA supports the *Healthy Start Program* to reduce the rate of infant mortality and improve perinatal outcomes through grants to project areas with high annual rates of infant mortality in one or more sub-populations. The program focuses on the contributing factors that research shows influence the perinatal trends in high-risk communities. Through these efforts, the program addresses significant disparities in perinatal health including disparities experienced by Hispanic, American Indian and Alaska Native, African American, Asian, Native Hawaiian or Other Pacific Islander, and immigrant populations or those occurring by virtue of education, income, disability, or living in rural/isolated areas. Communities provide a scope of project services that covers the pre-pregancy, pregnancy, and interconception phases for women and infants residing in their project area. For FY 2016, Healthy Start grantees reported serving 75,463 clients with 3.09 percent who identify as AI/AN, 0.92 percent as Asian, 46.71 percent as Black, 3.65 percent as multiracial, and 14.69 percent as Hispanic or Latino.

HRSA administers the *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program*, in partnership with ACF. The MIECHV program supports voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children living in communities at risk for poor maternal and child health outcomes. In FY 2016, the MIECHV

program served approximately 160,000 parents and children in all 50 states, the District of Columbia, and 5 territories. Of these program participants, 74 percent reported belonging to a racial or ethnic minority. During 2016, the program served 4,184 AI/AN participants. AI/AN participants made up more than 10 percent of total participants in five of the states funded: North Dakota (88 percent); South Dakota (48 percent); New Mexico (38 percent); Montana (16 percent); and, Arizona (10 percent). Total awards of approximately $1.3 million supported tribal sites in FY 2016. The Tribal Home Visiting Program, administered by ACF, has awarded grants to tribes, consortia of tribes, tribal organizations, and urban Indian organizations to develop, implement, and evaluate home visiting programs. There are currently 25 grantees. Tribal grantees have provided a cumulative 54,800 visits to families since FY 2012, with over 19,000 of those in FY 2016. Grantees served 1,749 adult enrollees and 1,730 children in FY 2016.

Substance Abuse and Mental Health Services Administration

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

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

- Reducing the impact of substance abuse and mental illness on populations that experience behavioral health disparities;
- Creating a more strategic focus on specific populations, including racial populations, ethnic populations, and LGBT populations in SAMHSA investments;
- Increasing awareness and access to information regarding behavioral health disparities and strategies to promote health equity;
- Supporting innovative and cost-effective training strategies that contribute to a quality, diverse behavioral health workforce, both within and external to SAMHSA; and
- Using a data-informed quality improvement approach to address racial and ethnic disparities in SAMHSA programs.

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

Office of Tribal Affairs and Policy Function: In FY 2015, SAMHSA established the Office of Tribal Affairs and Policy (OTAP) to lead and support SAMHSA-wide actions intended to facilitate efficient and effective delivery of resources and services to tribal communities through consultation, outreach, education, and engagement of tribes, tribal organizations, federal partners, and other stakeholders. OTAP also supports SAMHSA's efforts to implement the Tribal Law and Order Act of 2010 (TLOA; Title II, P.L. 111-211 codified at 25 U.S.C. Chapter 26). The TLOA of 2010 includes provisions focused on federal coordination of Indian alcohol and substance abuse resources and programs. One of the provisions requires establishment of an interdepartmental memorandum of agreement (MOA) between the Departments of HHS, Interior, and Justice. The MOA was signed by the Secretaries of HHS and DOI and the Attorney General on July 29, 2011. The Office of Indian Alcohol and Substance Abuse (OIASA) is an organizational component of OTAP. Under TLOA guidelines, OIASA coordinates federal partners and provides tribes with technical assistance and resources to develop and enhance prevention and treatment programs for substance use disorders, including the misuse of alcohol.

Highlights of SAMHSA's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

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

GOAL I: Transform Health Care

Primary and Behavioral Health Care Integration (PBHCI) is a program designed to improve the overall wellness and physical health status of people with serious mental illness (SMI) and/or co-occurring substance use disorders (SUDs) by supporting the integration of primary care and preventive physical health services into publicly funded community mental health centers and other community-based behavioral health settings where individuals already receive care. SMI and SUDs disproportionately affect racial and ethnic minority populations. As a result of building the necessary partnerships and infrastructure, grantees are expected to develop or expand their offering of primary healthcare services for people with SMI, including racial and ethnic minorities, resulting in improved health status. Community-based healthcare centers reported on the following infrastructure, prevention, and promotion performance measures on a quarterly basis: policy development, workforce development, financing, organizational change, partnership/collaborations, accountability, types/targets of practices, awareness, training, knowledge/attitudes/beliefs, screening, outreach, referral, and access. PBHCI grantees have

Primary and Behavioral Health Care Integration (PBHCI)

For FY 2015/FY 2016 grantees collected and reported the following health outcomes data to increase access to behavioral healthcare for racial and ethnic minority popupulations who are disproportianatly affected by SMI and SUDs:

- Blood pressure (semiannual)
- BMI (semiannual)
- Waist circumference (semiannual)
- Breath CO (Carbon Monoxide)(semiannual)
- Plasma Glucose (fasting) and/or HgbA1 (annually)
- Lipid profile (HDL, LDL, triglycerides (annually)

demonstrated methods of integrating physical healthcare into specialty behavioral health settings for people with serious mental illnesses. This learning is being incorporated into SAMHSA guidance to the states specific to the block grants, SAMHSA's consultation on the Medicaid health homes program, implementation of the Section 223 program, and into a broader focus on integration across SAMHSA's grant portfolio. PBHCI grantee quarterly reports are used to monitor efforts to address each of the National CLAS Standards. To help promote an organizational environment that promotes Cultural and Linguistic Competency (CLC), many PBHCI grantees require that all staff participate in CLC training. Several grantees have also formed committees specifically to assess the organization's CLC (e.g., CLAS Task Force and Cultural Awareness Leadership Council) in response to the requirement to integrate the National CLAS Standards in their quality-improvement activities. Grantees also routinely provide interpreter services, translated materials, and hire multi-cultural staff.

Examples of PBHCI grantees that are implementing strategies to meet needs of populations in the community include the:

- **Richmond Behavioral Health Authority (RBHA):** RBHA serves a predominately African American population and regularly monitors data to implement strategies such as community health fairs, to decrease potential health disparities experienced by this population related to service access and utilization.
- **Institute for Community Living (ICL):** ICL works with sub-populations to track health disparities in Brooklyn, New York. ICL applies population health principles to monitor the health status by race and ethnicity. Grantee reports indicate statistically significant outcomes. For example, ICL data demonstrates a 10 percent reduction in weight among the Latino and African American populations. During the 2013 PBHCI national grantee meeting, grantees shared their health disparities work via poster presentations. The presentations included information on their sub-population, interventions, successes and challenges, and plans for moving forward.

To **reduce the disparities in the quality of healthcare (Strategy I.C)**, SAMHSA initiated the *Disparities Impact Statements (DIS)* in FY 2012 as a pilot effort, which was expanded to include all new grant programs in FY 2013. The DIS is now institutionalized as a standard practice across SAMHSA's grant-making activities. The HHS Disparities Action Plan outlined goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. The HHS Disparities Action Plan required agencies to continuously assess the impact of their policies and programs on health disparities and assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities, and to assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits. In FY 2016, SAMHSA conducted a study assessing the impact the disparity impact statements had on program implementation and management. The findings indicated implementing disparity impact statements resulted in more strategic attention to vulnerable populations, increased use of data-driven approaches to monitoring the access and use of program resources, and adherence to the National CLAS Standards to support quality healthcare. The analysis revealed that Hispanic or Latino and Black or African American populations were the two racial and ethnic groups most often identified as

disparate populations and Pacific Islander/Native Hawaiian was the racial and ethnic group least often identified as a disparate population. Low income was the most frequently cited social and community characteristic of the disparate subpopulations identified. Program data are used to monitor individual and systemic outcomes.

SAMHSA also supports HIV programs intended to promote equity and reduce disparities. Persons who inject drugs, as well as those with mental illness, are at increased risk for infection with HIV, viral hepatitis and other communicable diseases through risky behaviors, including needle sharing and sexual risk behaviors. Accordingly, SAMHSA supports efforts to prevent and treat substance use and mental disorders and link persons already infected with HIV and/or viral hepatitis to treatment. Populations with and at risk for HIV and viral hepatitis assisted by SAMSHA programs include ethnic/racial minority men and women, lesbian, gay, bisexual and transgender persons and youth, through programs funded by Minority AIDS Initiative funds. SAMHSA has also supported a COE on Behavioral Health for Racial/Ethnic Minority Young MSM and Lesbian, Gay, Bisexual, Transgender (LGBT) Populations. In addition, SAMHSA has developed grants and partnerships with community-based organizations serving minority communities and supported efforts to integrate HIV and viral hepatitis prevention and medical care into mental health and substance use disorder treatment programs. SAMHSA also has supported efforts for organizations to establish and/or enhance partnerships with syringe services programs (SSPs). Such programs are focused on reducing the risk that use of contaminated needles during injection drug use can lead to HIV and viral hepatitis infections.

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

Many SAMHSA program activities focus on **increasing the diversity of the healthcare and public health workforces (Strategy II.C)** by providing fellowships and technical assistance and training opportunities. SAMHSA partners with the Morehouse School of Medicine to implement the *Cooperative Agreement for the Historically Black Colleges and Universities Center for Excellence in Behavioral Health (HBCUs CFE)*, which supports a network of 105 HBCUs throughout the U.S. CFE promotes workforce development through expanding knowledge of best practices, leadership development, and encouraging community partnerships that enhance the participation of African Americans in the substance abuse treatment and mental health professions. The goals of the HBCU-CFE are to promote student behavioral health to positively impact student retention; expand campus service capacity, including the provision of culturally and linguistically appropriate behavioral health resources; facilitate best practices dissemination and behavioral health workforce development; and increase awareness of the early signs of emotional distress and resources for early intervention. Progress reports were submitted by HBCUs for Behavioral Health Capacity Expansion Subawards on March 7, 2016 and final reports were submitted on July 15, 2016. Each report included project outcome evaluation, mental health referrals, and participant exposure to behavioral health messages, among other indicators and performance measures tracked during the project implementation phase to-date. As a result, 6,203 students, 520 staff, 246 faculty, and 203 members of the mental health workforce were trainined in suicide prevention and/or mental health awareness. In addition, 21,923 individuals were exposed to behaviroral health awareness messages through social marketing; 104 communities or organizations implemented mental health training; and 21

schools indicated that they developed products related to the overall project. HBCU-CFE sub-awardees reported disparity impact data in their progress and final reports. These reports include the number of students completing behavioral health internships, number of students, faculty and staff participating in training/educational events, the number of peer educators in behavioral health, and the number of students referred for behavioral health services by race, gender, and sexual orientation. Proposed goals for reaching populations of color and those of specific gender and sexual orientation were exceeded.

The *Minority Fellowship Program (MFP)* is a four-year grant program to reduce health disparities and improve healthcare outcomes for racially and ethnically diverse populations by increasing the number of culturally competent behavioral health professionals available to underserved minority populations in the public and private non-profit sectors. Program efficacy is measured by the number of applicants that applied to the MFP in the past year, by race and ethnicity, gender and school affiliation. A second metric is the number of individuals (and percentage of applicants) who received new MFP Fellowship awards in the past year, as well as those previously admitted, by race and ethnicity and gender. A third measure is the number of MFP Fellows who successfully remained in the MFP during the previous year, by race and ethnicity and gender. Data from this program are pending.

The *National Network to Eliminate Disparities in Behavioral Health (NNED)* is a virtual network, supported by SAMHSA, of community-based organizations focused on reducing disparities and promoting behavioral health equity in racially, ethnically, and culturally diverse communities. As of July 2016, the NNED included 897 partner organizations and 1,285 affiliates representing a total of 3,015 members. In FY 2015 and FY 2016 combined, the *NNEDLearn* annual training provided an opportunity for over 200 NNED members and nearly 50 organizations serving these communities from across the U.S. to learn about and implement within their organization an evidence-based, adapted, and culturally specific behavioral health practice. Six different evidence-based, adapted, and culturally specific behavioral health practices were offered during *NNEDLearn* in FY 2015 and FY 2016. The *NNEDLearn* training model includes both on-site and virtual training components allowing for peer-to-peer exchange among NNED members to occur both in person and virtually.

GOAL III: Advance the Health, Safety, and Well-being of the American People

SAMHSA supports various programs to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. For example, the *NNED* supports information sharing, training, and technical assistance among organizations and communities not receiving SAMHSA grant funding that are dedicated to the behavioral health and well-being of diverse communities. SAMHSA supports community and ethnic-based organizations in addressing behavioral health disparities experienced by racial and ethnic minority populations in underserved communities. *NNEDshare* has been launched as a website optimized for mobile device access and populated with best practices from communities.

Another national initiative, *A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: Jumpstarting an Overdue Conversation* was

developed as part of SAMHSA's efforts to promote behavioral health equity and to support boys and men of color. A four-part toolkit, *Ensuring the Well-being of Boys and Young Men of Color: Factors that Promote Success and Protect Against Substance Use and Misuse*, distills information from the research literature on factors that have been shown either to protect boys and young men of color from substance misuse or to mitigate risks associated with adverse experiences or situations, and factors that have been shown to promote well-being and positive youth development for boys and young men of color in the U.S. The briefs developed for this effort have broad national dissemination, including being available on SAMHSA's website and through the Suicide Prevention Resource Center, the ACF's Runaway and Homeless Youth Training and Technical Assistance Center (RHYTTAC), and the website for Young Minds Advocacy.[41]

Office of the Assistant Secretary for Health

Agency Overview: OASH oversees 12 core public health offices, including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps, as well as 10 regional health offices across the nation and 10 Presidential and Secretarial advisory committees. Of these offices, the former Office for Adolescent Health (OAH), ODPHP, the OPA, the OWH, and the President's Council on Fitness, Sports and Nutrition (PCFSN) conducted activities that are included in this report.

HHS recognizes that public health is undergoing a transformation into a new model of public health, referred to as Public Health 3.0. In this model, public health agencies are building upon their successful interventions by focusing on the SDOH to achieve health equity. In 2016, OASH launched an initiative to lay out the vision for this model of public health, to characterize its key components, and to identify what actions would be necessary to better support the emergence of this transformed approach within public health, with particular attention on advancing community health and well-being.

In January 2016, the U.S. President issued an emergency declaration for the State of Michigan, ordered federal aid to supplement state and local response efforts due to the contaminated water emergency conditions in Flint, Michigan, and designated HHS as the lead federal agency responsible for coordinating federal support for response and recovery efforts in Flint. Flint's population is 56.6 percent African American, and 41.6 percent of Flint's residents live below poverty. To fully leverage HHS's strengths, the HHS response team included the Acting Assistant Secretary for Health, who was the primary interface with state and local public health officials. Two U.S. Public Health Service Commissioned Corps officers also helped with the day-to-day responsibilities in Flint. More than 30 specialized officers from the U.S. Public Health Service Commissioned Corps traveled to Flint to help conduct medical follow-up visits with children who tested positive for high lead levels due to the city's water crisis. The U.S. Public Health Service Commissioned Corps cleared a backlog of approximately 800 blood lead level screening results and prepared test result notifications for parents and the Michigan HHS. The Commissioned Corps is an elite uniformed service with more than 6,700 full-time, highly qualified public health professionals serving the most underserved and vulnerable populations

[41] See more on the Young Minds Advocacy at https://www.ymadvocacy.org/

domestically and abroad.

During 2016, OASH was also involved in Zika virus response activities both in the U.S. mainland and Puerto Rico, whose population is mostly of Hispanic origin, in three pivotal roles:

- **Situational Awareness and Coordination of Efforts:** OASH served in an advisory capacity to the Secretary in the Disaster Leadership Group. OASH also served as a liaison to U.S. blood centers on issues related to safety, supply and cost; and collaborated with FDA and the Biomedical Advanced Research and Development Authority to ensure safety of the blood supply in Puerto Rico and the continental U.S. OASH leadership supported coordination of HHS and interagency activities in the early federal response to Zika virus in Puerto Rico. Associated actions included meetings with members of the governor's team, the Puerto Rico Departments of Health and Emergency Management, community-clinical providers, and academic partners.
- **Education and Outreach:** OASH led the publication of a Zika Toolkit for healthcare providers. Other provider education and outreach included the creation and translation of bilingual (English-Spanish) informational materials (digital, print, social media), promoting the training and use of Promotores and community health workers in Puerto Rico, and other Zika virus outreach activities.
- **Personnel Response:** In 2016, OASH deployed a total of 17 Commissioned Corps to Puerto Rico for the Zika virus response.

Office of Adolescent Health

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

Highlights of OAH's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL III: Advance the Health, Safety, and Well-being of the American People

Great disparities in teen birth rates continue to exist – by age, race and ethnicity, geography, urbanicity, and among vulnerable populations. OAH's program activities focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. OAH managed five national *Teenage Pregnancy Prevention (TPP) Programs*. Teen Pregnancy Prevention (TPP) Program (Tier 1) focuses on the replication of evidence-based programs effective at preventing teen pregnancy, to include that related to racial and ethnic minority populations. In 2015, OAH awarded funding to 58 new grantees to replicate evidence-based programs. The new grants are expected to serve youth across 39 states and the Marshall Islands, in communities where teen birth rates remain high. Grants were awarded in the following categories: Community Capacity Building to Support Replication of Evidence-Based TPP Programs (Tier 1A); and Replicating Evidence-Based TPP Programs to Scale in Communities with the Greatest Need (Tier 1B). Tier

1A programs are funded to help communities build capacity to implement and evaluate programs for populations with teen birth rates well above the national average and with organizations serving youth in juvenile detention and foster care or who are homeless or young parents. Tier 1B programs aim to replicate evidence-based TPP programs to scale in multiple settings in communities where teen birth rates are significantly higher than the national average using a holistic, community-wide approach.

The *Research and Demonstration Projects (Tier 2)* aim to support research and demonstration projects to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy, which disproportionately affects racial and ethnic minority populations. With these programs, OAH reaches adolescents, minority and high-risk adolescent populations, areas with high teen pregnancy rates, and vulnerable and culturally underrepresented youth populations, including youth in foster care or juvenile detention, runaway and homeless youth, and youth who are disconnected from usual service delivery systems. In 2015, OAH awarded funding to 23 new grantees to develop and evaluate new and innovative approaches to prevent teen pregnancy. Grants were awarded in the following categories: Supporting and Enabling Early Innovation to Advance Adolescent Health and Prevent Teen Pregnancy (Tier 2A); and Rigorous Evaluation of New or Innovative Approaches to Prevent Teen Pregnancy (Tier 2B). Tier 2A projects focus on fostering and supporting early technology-based and programmatic-based innovations to develop, test, and refine innovative products, programs, and/or processes to advance adolescent health and prevent teen pregnancy. Tier 2B programs are awarded to develop and rigorously evaluate new and innovative approaches to prevent teen pregnancy, focusing specifically on addressing gaps in the existing evidence base and reducing disparities. For example, grant funds are used to:

- Support pregnant and parenting student services at institutions of higher education;
- Support pregnant and parenting teens at high schools and community service centers;
- Improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking; and/or
- Increase public awareness and education.

As of fall 2015, OAH administered competitive grants to 17 states and three tribal entities to provide expectant and parenting teens, women, fathers, and their families with a seamless network of supportive services. From 2010-2013, OAH provided funding to its first cohort of Pregnancy Assistance Fund (PAF) grantees. Fifteen states and two tribal entities received funding for a 3-year project period. The second cohort of grantees (14 states and three tribal entities) was awarded in July 2013; these grantees are funded for a 4-year project period 2013-2017. The third cohort consisting of three state agencies was awarded in July 2015. OAH is supporting three federal evaluations and conducting a study assessing the sustainability of OAH programs post federal funding.

The *Positive Adolescent Future Study* is testing the effectiveness of programs designed to delay subsequent pregnancies, improve contraception use, and promote school attachment and completion for expectant and parenting teens in three sites (California, Texas, and Washington DC). Additionally, the *Positive Adolescent Futures Evaluation* will include in-depth implementation data collection and analyses for all three sites as well as a follow-up cross-grantee implementation study for the 17 PAF grantees. Reporting will begin in 2017 and

continue through 2019. For the 2013-2017 cohort some results from 2013-2015 include over 24,000 expectant and parenting teens and their families being served, services being offered through 24 distinct programs, most of which combined multiple components to address participants' varying needs. These programs were implemented by 123 provider organizations, including three tribal grantee agencies and 120 other organizations that had received sub-awards from the 14 state grantees. Nearly 50 percent of the youth served by the program are White, 30 percent are African American, and 10 percent are American Indian/Alaska Native. Over 50 percent of all youth served by the PAF program are Hispanic or Latino.[42]

Through the *National Resource Center for HIV/AIDS Prevention among Adolescents*, the OAH supports adolescent service providers with web-based resources, evidence-based research, and training and technical assistance to promote HIV/AIDS prevention among adolescents, in particular adolescents from minority and high-risk populations disproportionately affected by HIV/AIDS. The site offers content specific to African American and Latino adolescents who are engaging in MSM contact; disconnected youth, including those who are runaways, homeless, in detention centers or foster care or not in school; and teens who live in communities with high rates of HIV and STI.

The *Effectiveness of Teen Pregnancy Prevention Programs Designed Specifically for Young Males* is a collaborative initiative between the OAH and the CDC to support rigorous evaluation of innovative intervention for adolescents and young adults (aged 15-24 years old, primarily African American and Latino) living in the Bronx, Upper Manhattan, South Bronx, NY, and Washington DC to prevent teen pregnancy. As part of this project, motivational interviewing intervention using mobile devices, a father-son intervention delivered in the home, and a group-based intervention delivered in juvenile justice settings are being tested to determine their impact on preventing teen pregnancy.

Office of Disease Prevention and Health Promotion

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

Highlights of ODPHP's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL III. Advance the Health, Safety and Well-being of the American People

ODPHP initiatives aim to reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies. ODPHP plays a vital role in keeping the nation healthy. Thus, ODPHP is responsible for developing goals and objectives to improve the health status of all Americans. Through the *Healthy People 2020* blueprint, ODPHP works to achieve health promotion and disease prevention objectives for the U.S. population, and

[42] The PAF program collects race and ethnicity information as independent items. Racial and ethnicity percentages combined may not sum to 100 percent.

is guided by four overarching goals, including achieving health equity, eliminating disparities, and improving the health of all groups. ODPHP is leading the implementation of Healthy People 2020. The Leading Health Indicators represent a subset of the full complement of the Healthy People 2020 national objectives that are designed to communicate high-priority health issues and actions that can be taken to address them. Each month, HHS produces a *Who's Leading the Leading Health Indicators* e-bulletin or webinar which features an evidence-based example from a community that is working to improve outcomes associated with a specific Leading Health Indicators. At HHS, the Healthy People 2020 Federal Interagency Workgroup guides the implementation of the initiative and includes representatives from about 25 HHS agencies.

The 2015-2020 Dietary Guidelines for Americans (DGA) were released in January 2016. The DGA provides nutrition and dietary information to the general public and informs the development of federal food, nutrition, and health policies and programs. As an evidence-based health policy, the DGA is a critical tool for professionals to help Americans make healthy choices to help prevent chronic disease and enjoy a healthy diet. The 2015-2020 edition includes one of three chapters titled "Everyone has a Role in Supporting Healthy Eating Patterns" devoted to discussing the factors that affect food decisions, including characteristics of individuals and families that can lead to disparities in access to healthy, safe, and affordable food choices that support healthy eating patterns. A series of *Eat Healthy * Be Healthy* workshop videos is being updated to reflect the 2015-2020 DGA and will again be available in English and Spanish. Nearly 11,000 English and over 3,000 Spanish copies based on the 2010 DGA have been distributed nationwide (FY2015- FY2016). An average of 6,625 English and over 800 Spanish downloads per year, including videos (featuring Hispanic and African American couples).[43]

GOAL IV: Advance Scientific Knowledge and Innovation

ODPHP initiatives aim to **increase the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. Over the past two years, ODPHP implemented an initiative titled *"Reducing Racial/Ethnic and Other Disparities in Preventable Health Care-Associated Outcomes."* The purpose of this program was was to identify disparities in readmission based on race, ethnicity, number of chronic conditions, insurance type, and site of care. The findings of the program suggested that all racial and ethnic minority groups had higher odds of readmission to hospitals than did non-Hispanic Whites. Patients discharged from minority serving hospitals had slightly higher odds of readmission. Individuals with two to three of six chronic conditions had increased odds of readmission than patients without chronic conditions. Patients discharged from hospitals with the highest patient-reported satisfaction with medical team communication had lower rates of readmission. When patients of all races and ethnicities were satisfied with medical team communication, hospital readmissions were reduced. Patients with complex chronic conditions, those discharged from minority serving hospitals, and individuals with public insurance were more likely to be re-admitted. Patients had fewer healthcare-associated infections when treated in hospitals with favorable ratings for Hospital Consumer Assessment of Healthcare Providers and Systems measures of patient-provider communication. This finding suggests that patients of healthcare professionals who offer

[43] See more at www.health.gov/dietaryguidelines/workshops

patient-centered, team-based care, with caregivers functioning and communicating effectively with patients, achieve better outcomes and have fewer healthcare-associated infections.

Office of HIV/AIDS and Infectious Disease Policy

Agency Overview: The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) advises the Assistant Secretary for Health on the appropriate and timely development and implementation of policies, programs, and activities related to HIV/AIDS, viral hepatitis, other infectious diseases of public health significance, and blood and tissue safety and availability.

Highlights of OHAIDP's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

OHAIDP supports programs to **reduce disparities in health insurance coverage and access to care (Strategy I.A)**. OHAIDP implemented programs to increase access to care for Black MSM. This particular program aimed to provide in-person assistance following HIV testing to help Black MSM enroll in health insurance in the geographical area of Chicago, Illinois. Specifically, the *Black MSM* program evaluated the intervention's effects on insurance uptake; insurance coverage; and rates of linkage and retention in HIV-related care (HIV treatment, Pre-Exposure Prophylaxis (PrEP)), and other associated health services (e.g., mental health counseling, substance use treatment). Health insurance status, insurance enrollment decision, and housing status were assessed pre- and-post intervention.

OHAIDP also focuses on **reducing disparities in access to primary care services and care coordination (Strategy I.B)**. The *THRIVE Project* strengthened the capacity of health departments, community-based organizations, clinics, behavioral health and social services providers, patient navigators, and others that interface with gay men of color in order to plan, implement, and sustain comprehensive prevention, care, and behavioral health and social service models for gay men of color who are at risk for and living with HIV infection. This project targeted American Indian, Alaska Native, Black or African American, and Hispanic or Latino populations living in different geographical areas, such as Birmingham, Alabama; Baltimore, Maryland; New Orleans, Lousiana; New York City, New York; Philadelphia, Pennsylvania; Norfolk, Virginia; and Washington, DC. The THRIVE project's grantees established their collaborative structures to provide comprehensive HIV prevention and care services to MSM of color, executed contracts with funded Congressional Budget Office partners, and developed monitoring and evaluation plans. CDC submitted an Office of Management and Budget (OMB) package for data collection during FY 2016.

OHAIDP plays an important role in **reducing disparities in the quality of healthcare (Strategy I.C)**. The *Partnerships for Care (P4C)* project was a collaborative effort that OHAIDP has undertaken with CDC and HRSA to expand the capacity of community health centers and health departments and their respective grantees. The purpose of this collaboration was to develop and

implement effective, replicable, and sustainable service delivery models that improve the identification of undiagnosed HIV infection, establish new access points for HIV care and treatment, and improve HIV outcomes along the continuum of care for disproportionately impacted racial and ethnic minority populations living with HIV. The P4C project reached African American and Hispanic or Latino participants in New York, Florida, Maryland, and Massachusetts. Some of the partners involved in this project were the New York State Department of Health, Florida State Department of Health, Maryland State Department of Health and Mental Hygiene, and the Massachusetts Department of Public Health. The program was completed and has undergone final evaluation.

GOAL II. Strengthen the Nation's Health and Human Services Infrastructure and Workforce

OHAIDP **increases the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities (Strategy II.A)**. The *Care and Prevention in the United States Project (CAPUS)* was a 3-year demonstration project with the purpose of reducing HIV-related morbidity, mortality, and related health disparities among racial and ethnic minorities in the U.S. The core program components of CAPUS were the use of surveillance data and other data systems to improve care and prevention; increase HIV testing, linkage to, retention in, and re-engagement with, care and prevention; enhance patient navigation services; address social and structural factors affecting HIV testing, linkage to, retention in, and re-engagement with, care and prevention; and collaborate with community-based organizations (CBOs) to implement activities. This program targeted American Indian, Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian, and Pacific Islander populations in geographical areas, such as Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia. The program is completed and has undergone final evaluation.

OHAIDP **promotes the use of Promotores de Salud and CHWs (Strategy II.B)**. Through the *Improving Access to Care: Using CHWsto Improve Linkage/Retention in Care* program, OHAIDP increased the utilization of community health workers to improve access to healthcare and health outcomes for people living with HIV, especially among Black or African American and Hispanic/Latino populations. The findings of this program provided some insights on the impact of community health workers on improving access to quality healthcare and health outcomes for people living with HIV. Furthermore, the program provided relevant information regarding the association between HIV medical care, retention in HIV medical care, and viral load suppression among persons in HIV medical care.

OHAIDP stresses the importance of **increasing the diversity of the healthcare and public health workforces (Strategy II.C)**. Through the *People Living with HIV Leadership and Training*, the OHAIDP supported leadership training for people of color living with HIV, including developing digital tools to enable people living with HIV to participate on planning bodies, on care teams, in organizations, on boards of directors, and in other leadership positions. There was one national training for HIV-positive transgender women of color, three regional trainings for people of color living with HIV, and one Training of Trainers leadership training for people of color living with HIV.

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

OHAIDP launched *AIDS.gov* to build capacity, increase awareness, provide access to federal resources, and reduce health disparities among racial and ethnic minorities by promoting national goals. In 2016, AIDS.gov launched new pages for the Secretary's Minority AIDS Initiative Fund to highlight annual funding decisions and showcase innovative and promising projects. This website serves diverse monitory populations, including American Indian, Alaska Native, Asian, Black/African American, Hispanic or Latino, Native Hawaiian, and Pacific Islander. Measures to evaluate the use and frequency of use of the various aspects of the pages have been developed. An annual evaluation will conducted to assess the impact of AIDS.gov.

Office of Population Affairs

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

Highlights of OPA's Fiscal Years 2015 through 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL III: Advance the Health, Safety, and Well-being of the American People

OPA runs a few programs that focus on **reducing disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. Through dedicated funding comprised of *Secretary's Minority AIDS Initiative Funds (SMAIF)* and funds from the annual Title X appropriation, OPA supports HIV testing and the integration of HIV/AIDS prevention activities with family planning services in Title X-funded service sites, to include services for racial and ethnic minority populations who are disproportionately affected by HIV/AIDS. Grantees funded in the three-year funding cycle, which began on September 1, 2013, have projects comprised of either a Part A component or a combined Part A and Part B component. Part A projects provide high-impact HIV prevention services integrated with Title X Family Planning Services. Funded activities include opt-out HIV testing, linkages to care for those who test positive, behavioral interventions for HIV prevention through counseling sessions, condom distribution, and STI screening and treatment. Part B projects provide enhanced, bi-directional linkage to care services for individuals who test positive for HIV in a family planning service site. These linkages are between Title X Family Planning service sites and Ryan White-funded HIV medical service sites that are either co-located with a Title X site, or that have an established, collaborative relationship with a Title X service site. Some of the Part B projects also provide family planning services for HIV-positive clients either in the family planning or Ryan White-funded HIV medical service site. Through the grantees, approximately 60 projects were awarded under Part A and 11 projects under Part B. Projects are required to submit semi-annual data on a variety of elements including but not

limited to number of family planning users tested, patient demographics, number of newly diagnosed, and number of HIV-positive clients linked to care. In 2015, the project supported testing for 161,539 unduplicated clients, of which 70,746 identified as American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, or multiracial; and 68,590 of the total clients identified as Hispanic or Latino(a). OPA expects the 2016 data for its Secretary Minority AIDS Initiative Funded HIV projects to be compiled and analyzed by the end of the calendar year. OPA's *Family Planning Annual Report (FPAR),* which includes HIV data for all Title X-funded clinics, will be available in August 2017.

OPA received a new award (FY 2016) from the SMAIF to fund the development and dissemination of an evidence-based algorithm to determine the necessary provision of a range of PrEP services within Title X-funded family planning services projects given their unique circumstances and populations. This project will increase Title X-funded clinics' client awareness of PrEP, boost Title X provider knowledge of the drug, and reduce HIV transmission. The resources provided by the SMAIF-supported project supports communities in which the population is at least 50 percent racial and ethnic minorities with the majority also being underserved or disproportionately impacted by HIV/AIDS, and areas with documented need for HIV prevention services due to elevated or increasing rates of HIV, AIDS, and/or STIs. Monthly progress reports and annual performance reports will be developed as well as an algorithm at the end of the base year. Training materials and pilot testing will be implemented during Year 1. The tool and guidance will be finalized in Year 2.

GOAL IV: Advance Scientific Knowledge and Innovation

OPA focuses on **increasing the availability and quality of data collected and reported on racial and ethnic minority populations (Strategy IV.A)**. Title X-supported service sites are required to report annually on the *FPAR*, an OMB-approved data collection system. The FPAR is the only source of annual, uniform reporting by all Title X Family Planning Services grantees. It provides consistent, national-level data on the Title X Family Planning Program and its users. FPAR data are presented in summary form, which protects the confidentiality of individuals who receive Title X-funded services. Of the 4.0 million family planning users served in 2015, 30 percent self-identified as nonwhite. Thirty-two percent self-identified as Hispanic or Latino, and 13 percent as LEP.

Office of the Surgeon General

Agency Overview: The OSG provides advice and support on issues relating to public health and represents the Secretary and the Assistant Secretary for Health on topics addressing public health practice. In addition, the Immediate Office of the Surgeon General supervises Public Health Service Commissioned Corps activities and advises the Assistant Secretary for Health on policies required for efficient management of the Commissioned Corps. This office does not receive appropriated funds to implement public health programs. However, the office is tasked with providing the most recent evidence-based public health information and translating these findings to the American public.

Highlights of OSG's Fiscal Years 2015 through 2016 Activities (Categorized by the HHS Disparities Action Plan)

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

The OSG serves as command for the U.S. Public Health Service. The Surgeon General is the commanding officer of over 6,700 uniformed, public health and medical professionals stationed in over 800 locations throughout the U.S. and globally to respond to public health emergencies. Officers are assigned throughout government agencies and other locations including vulnerable communities. The Commissioned Corps has responded to public health emergencies like *Hurricane Katrina, the Ebola response, and the Flint Water Crisis*.

GOAL III: Advance the Health, Safety and Well-being of the American People

The *Surgeon General's Call to Action (CTA) to Promote Walking and Walkable Communities* has five goals with related strategies to support walking and walkability in the U.S. Implementation of these strategies will make it easier and safer for people to walk, use a wheelchair, ride a bike, and be physically active in other ways to advance the health and well-being of the American public. The goals of the Call to Action are to:

- Make walking a national priority;
- Design communities that make it safe and easy to walk for people of all ages and abilities;
- Promote programs and policies to support walking where people live, learn, work, and play;
- Provide information to encourage walking and improve walkability; and
- Fill surveillance, research, and evaluation gaps related to walking and walkability.

Walking is an easy and affordable way for most to get physical activity. Walking is also an excellent activity option for older adults as active adults are less likely to suffer falls and able to maintain independent living longer. Unfortunately, community barriers to walking often exist, such as lack of sidewalks or walkable destinations, especially in communities of color. Additional benefits to communities from making walking easier include improving safety, social cohesion, local economies, and reducing air pollution. The CTA calls various sectors to join this walking movement. In addition, the CTA also features information on "rollability" for persons living with disabilities, especially those who use wheelchairs. In partnership with the HHS OMH, the OSG visited Flint, Michigan during the height of the *Flint Water Crisis*. As representatives of HHS, the Surgeon General and OMH Director attended community roundtable meetings with health professionals, faith leaders, and community advocates to address the federal response to the crisis. The Surgeon General hosted a community town hall to hear concerns of residents and leaders in the local community. Officers of the U.S. Public Health Service were deployed to Flint to support clinic test backlogs in the public health department, community engagement and public health education.

The OSG initiated the *Turn the Tide Rx Opioid Addiction Campaign*, which focused on the exponential growth of the opioid addiction problem in the U.S. An important driver of the

opioid epidemic is legally-written prescriptions from doctors, dentists, nurse practitioners and physician assistants. By improving prescribing practices, clinicians can reduce the supply of misused opioids while still treating pain safely and effectively. This national campaign was based on the concept of "prescribers talking to prescribers." The Surgeon General sent a letter to over two million prescribers, urging them to improve prescribing practices, inform their patients about the risks of opioid addiction, and connect people with opioid use disorders to evidence-based treatment. After consulting with the HHS OMH, one of the key messages of this initiative included addressing the under-treatment of pain for patients from communities of color. This message traveled with the Surgeon General to over 13 cities, where he addressed medical schools and hospital system clinicians. During the tour, the Surgeon General visited two historically Black Colleges and Universities: Morgan State University and Meharry Medical College. The Director of OMH served as a co-panelist during the Surgeon General's grand rounds at Meharry Medical College.

The Surgeon General was identified as the principal voice in *Zika Prevention & Education* to address the spread of the Zika virus in the U.S. In response to the challenges identified, especially in the Hispanic community, the Surgeon General traveled to Puerto Rico and Florida, and hosted extensive media and stakeholder conference calls to convey the most up-to-date guidance on the spread of the Zika virus. The *National Council of La Raza (NCLR),* one of the oldest civil rights organizations that represent the interest of Hispanic Americans in the U.S, hosted a national health summit where the Surgeon General shared updates on the Zika virus to community leaders.

Office on Women's Health

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

Highlights of OWH's Fiscal Years 2015 through 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

Many of OWH's activities focus on **reducing disparities in health insurance coverage and access to care (Strategy I.A)**. OWH supported the *HIV Prevention for Women Living with HIV/AIDS* in the Virgin Islands with HOPE, Inc. and in Puerto Rico at the University of Puerto Rico Medical Sciences Campus. Given their location, these programs involved racial and ethnic minority women with HIV/AIDS. Program interventions in the Empowerment Workshops included the recruitment of women at high risk for HIV to participate in risk reduction counseling and HIV testing; and, the unique needs of women living with HIV to improve adherence to treatment, address issues of disclosure and quality of life.

OWH partnered with the HHS Administration for Community Living (ACL) in the creation of the *Community Services Project Development Guide*. *The Community Services Project*

Development Guide includes models for inner-city and rural populations, many of which serve a majority of racial and ethnic older adults. The project is conducted in collaboration with the ACL and it is ongoing.

OWH focuses on **reducing disparities in access to primary care services and care coordination (Strategy I.B)**. OWH also coordinates policy and program development to improve the health and wellness of ethnic and racial minority women. For example, the *College Sexual Assault Policy and Prevention Initiative* is a cooperative agreement that supports organizations working to build the capacity of post-secondary schools to conduct sexual assault prevention activities, to develop improved campus policies aligned with the White House Task Force to Prevent Campus Sexual Assault guidance, and to strengthen campus response efforts. This program impacts a diverse array of campus communities, including post-secondary schools that serve Hispanic, African American, Pacific Islander, AI/AN women in North Carolina, Georgia, Guam, Texas, Kansas, California, Pennsylvania, Indiana, New Hampshire, and Washington, DC. Grantees also collaborate with organizations that bring technical expertise and membership bases with influence in post-secondary education as a resource to foster a collaborative and evidence-based approach to addressing campus sexual assault. The implementation phase of this project is underway.

OWH also focuses on **reducing disparities in the quality of healthcare (Strategy I.C)**. OWH, in partnership with the ACF Office on Trafficking in Persons, developed *SOAR (Stop. Observe. Ask and Respond) to Human Trafficking*, a training for healthcare and social service providers to educate healthcare providers, social workers, behavioral health professionals, and public health professionals about the ways to recognize and respond to human trafficking victims. Individuals who are vulnerable to human trafficking are often from racial, ethnic or sexual minority populations. Trainings were conducted during both in-person and virtual sessions in 2016 in August and September, and attendees were eligible to receive continuing education credits for their participation in the training.

GOAL III: Advance the Health, Safety, and Well-being of the American People

OWH supports several strategies to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. *National Women's Health Week (NWHW)* encourages women to prioritize their health and learn what steps they can take for better health at any age. As part of this initiative, OWH targets health messages to minority women during NWHW. NWHW partners and ambassadors focus their efforts on promoting and educating the public on health disparities in women's health (including heart disease, breast cancer, diabetes, and intimate partner violence). In 2016, more than 4,700 women pledged to be well women. More than 12,900 unique Twitter accounts contributed over 23,000 tweets in support of NWHW and nearly 900 media stories about NWHW appeared.

National Women and Girls HIV/AIDS Awareness Day (NWGHAAD) encourages partners to develop projects and activities that increase awareness about the impact of HIV and AIDS on U.S. women and girls. All women are at risk for HIV, but women of color are disproportionately affected by HIV. African American women made up more than 61 percent of new HIV

infections among women in 2015, but only 14 percent of the female population in the United States. Additionally, Hispanic women made up 15 percent of new HIV infections among women in 2015.[44] For the 2016 NWGHAAD observance, OWH created a set of outreach messages designed to educate African American and Latino women of their disproportionate risk for HIV, how to prevent infection, and highlight HIV testing and counseling resources. In 2016, about 15.8 million people were potentially reached through social media tools. There were 232 million media impressions where almost 200 outlets including 20 TV stations, five daily newspapers and three community newspapers, 15 radio networks and more than 61 blogs and websites covered the observance. Projects focus on increasing awareness by providing various types of prevention, education, and on providing HIV testing and counseling resources.

OWH conducted pilot testing and implementation of the HHS *It's Only Natural: Mother's Love, Mother's Milk,* the only national campaign that addresses barriers identified through formative research to reduce ongoing disparities in breastfeeding. This initiative targeted three states in the South (i.e., Alabama, Louisiana and Mississippi) for intensive education and project implementation because breastfeeding rates have been consistently lower in those states. As a result of this effort, OWH will become better informed on the principles of best practices for breastfeeding promotion and support within African American communities, where rates have consistently remained low.

OWH also coordinates projects with community-based family service centers to improve the health and wellness of ethnic and racial minority women. For example, OWH partnered with The Center for Black Women's Wellness, Inc., Emory University School of Nursing, Open Hand Atlanta, and Community Health and Social Services to conduct the project titled, *Atlanta Partnership for Women's Health—Healthy Women for Healthy Families (HW4HF)*. This project engages primarily low-to-moderate income, Black, English speaking, women of childbearing age in Atlanta, Georgia. The goals of the project are to increase the provision of preventive health services and health promotion services to reduce health disparities among Black women of childbearing age. Results from September 1, 2015 to March 30, 2016 include: (1) 250 clinic days providing primary care and well-women visits to target audience; (2) Cooking Matters Curriculum nutrition workshops (five groups and 86 participants); (3) two Mental Health First Aid Trainings (18 participants); and (4) four stress management support groups (35 participants). From April 1, 2016 to August 1, 2016 the results also include: (1) 120 clinic days providing primary care and well-women visits to target audience; (2) Cooking Matters Curriculum nutrition workshops (three groups and 49 participations); (3) two Mental Health First Aid Trainings (two classes and 22 participants); and (4) four stress management support groups (three group sessions and 15 participants).

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

OWH focused the *In Community Spirit – Prevention of HIV/AIDS for Native/American Indian and Alaska Native Women Living in Rural and Frontier Indian Country Program* to ensure local collaborations to meet the HIV prevention needs of Native women. Programs conducted

[44]CDC. *HIV Surveillance Report, 2015;* vol.27. http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf

culturally and linguistically-appropriate, gender-responsive prevention interventions for Native women that addressed critical HIV/AIDS primary and secondary information which built upon the strengths and contemporary Native cultures. Working with partner agencies and during Native Women Speaking retreats, participants engaged in discussions about intimate partner violence, STI, substance abuse prevention, and the importance of spiritual well-being.

President's Council on Fitness, Sports, and Nutrition

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

Highlights of PCFSN's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL III: Advance the Health, Safety, and Well-being of the American People

PCFSN is implementing key projects to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. PCFSN supports physical activity and nutrition programs in school and community settings. The *I Can Do It, You Can Do It!* program aims to provide access and opportunities for children and adults with disabilities to participate in sports, recreation, and fitness activities as well as learn about healthy eating. Between 2015 and 2016, *I Can Do It, You Can Do It!* exceeded its five-year goal of 100 program sites. Currently, the *I Can Do It, You Can Do It!* Program is implemented in 32 states across 103 sites (K-12 schools, universities, and community-based organizations) impacting over 450,000 individuals with disabilities and their families, including those with racial and ethnic minority backgrounds. Additionally, over 15,000 teachers, graduate students, and other community volunteers have been trained to work with individuals with various physical and cognitive disabilities.

PCFSN is implementing key projects to **reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)**. African American and Hispanic youth have higher rates of overweight and obesity than their White peers. Access to safe places to be physically active contribute to higher rates of obesity and related illnesses in racial and ethnic minority communities. The 2013 Physical Activity Guidelines Midcourse Report revealed that school settings hold a realistic and evidence-based opportunity to increase physical activity among youth. PCFSN supports physical education activities in schools. For example, *Let's Move! Active Schools* is a physical activity and physical education solution that aims to create opportunities for students to be active before, during and after school. PCSFN serves as the federal lead for Let's Move! Active Schools.

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

Other HHS Agencies' Minority Health Activities

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

Administration for Children and Families

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

Highlights of ACF's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL III: Advance the Health, Safety, and Well-being of the American People

ACF **reduces disparities in population health by increasing the availability and effectiveness of community-based programs and policies (Strategy III.A)** Racial and ethnic minority populations experience disparities in access to appropriate health education and quality healthcare. The National Responsible Fatherhood Clearinghouse (NRFC) conducted its quarterly *Fatherhood Buzz event* in January 2015 in a way that supported addressing these disparities. The NRFC partnered with the National Men's Health Network and a variety of national and local collaborators for this event. Utilizing partnerships with CBOs and partners and barbershops, the NRFC's *January Fatherhood Buzz: Healthy Dads, Healthy Families* supported responsible fatherhood by encouraging fathers to "Take Time to Be a Healthy Dad Today." In January 2015, the NRFC worked with 101 barbershops in 24 states and 45 cities to distribute more than 8,000 NRFC tip cards, including 1500 Spanish-only cards. Additionally, the NRFC distributed the Men's Health *Network's Men's Health Facts*, *Real Men Brochures*, and *Kid's Nutrition* materials. Many of the materials were made available to underserved fathers in barbershops in diverse communities. NRFC also partnered with the National Football League Players Association (NFLPA) and community partners at the NFLPA's 18th Annual Collegiate Bowl. They brokered a collaboration that resulted in the NFLPA providing 2,500 free tickets to local fatherhood programs so that fathers and their families could attend the game. As families entered the stadium, the NRFC distributed the above information regarding healthy lifestyles. Along with distributing health and responsible fatherhood materials, the NRFC encouraged

community partners to partner and collaborate with healthcare navigators representing local healthcare exchanges.

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

ACF used its grant-making authority to establish the *Parenting Time Opportunities for Children in the Child Support Program (PTOC)*. This program is a pilot program to give child support agencies grants to develop, implement, and evaluate procedures to establish parenting time orders along with new child support orders. PTOC aims to improve the financial and emotional support of children in the child support system by increasing safe opportunities for them to build relationships with both parents. The parenting time grants focus on providing opportunities to create formal parenting time arrangements at the point of child support order establishment. The goal is to learn more about how the child support program can safely and effectively give families opportunities to establish parenting time orders, thereby improving child well-being overall and related child support outcomes. This ACF initiative targets minority populations in diverse geographical areas living in California, Florida, Indiana, Ohio, and Oregon. These grants ended at the close of FY 2016. ACF expects that final findings would be available approximately in mid FY 2017.

Administration for Community Living

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

Highlights of ACL's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

Many of ACL's program activities within Goal I focus on **reducing disparities in health insurance coverage and access to care (Strategy I.A.)**. All older Americans and their family caregivers are eligible to receive services through the *Older Americans Act (OAA) Programs*. The Administration on Aging within ACL gives specific attention to those individuals who are in the greatest economic and social need, including racial and ethnic minority seniors. OAA programs reach older individuals by way of grants and contracts awarded through the Title III and VI formula grants and Title IV discretionary grants programs. In 2015, OAA Title III programs and OAA Title VI programs were appropriated funding for nutrition and supportive services. Given its mission and the demographics of the aging population, OAA services effectively target services to racial and ethnic minority seniors. Older adults who identify as racial and ethnic minorities are represented at a higher rate than in the general population of older adults; for example, 13.4 percent of OAA consumers identify as African American compared to 10 percent in the older adult population, and 12.2 percent of OAA consumers identify as Hispanics compared to eight (8) percent in the older adult population. OAA Title VI

programs for tribal elders reach more than a quarter of eligible elders with congregate nutrition services, one-fifth with home-delivered nutrition and over 40 percent with supportive services. In 2015, ACL also brought together five technical assistance centers funded under OAA to form the *National Consortium on Aging Resources for Seniors' Equality (Consortium)* to develop and disseminate culturally competent technical assistance and training for the aging network. Racial and ethnic minority populations experience disparities in access to aging services. Therefore, the consortium is charged with assisting the aging network to meet the needs of an increasingly diverse older population, including racial and ethnic minorities. The five-year cooperative agreement to the consortium is providing training and technical assistance to the aging services network to better serve African American, Hispanic, Asian and Pacific Islander, American Indian, Alaska Native, Native Hawaiian, Lesbian, Bisexual, Gay and Transgender (LBGT), and older populations. Each grantee member of the consortium provides a range of training and technical assistance activities relative to its respective target population.

ACL's Center for Policy and Evaluation (CPE) also worked to reduce disparities in health insurance coverage and access to care (Strategy I.A.). CPE staff reviewed and provided feedback on materials in support of CMS Office of Minority Health's Coverage to Care Initiative to ensure that this curriculum is person-centered and consistent with addressing the accessibility needs of minorities with disabilities. Additionally, CPE worked to build awareness of disparities in access to care and network adequacy for individuals with disabilities through identification and dissemination of relevant research. In partnership with CMS OMH and the Medicare-Medicaid Coordination Office, CPE worked to identify and highlight leading state practices in improving transparency and oversight of accessibility features in healthcare networks serving older adults and individuals with disabilities. In anticipation of the U.S. Access Board's adoption of the voluntary accessible medical diagnostic equipment (MDE) standards under Section 510 of the Rehabilitation Act, finalized in early 2017, CPE has also analyzed the need for accessible MDE for older adults and people with disabilities, as well as the business case for providers to procure equipment built in adherence to these standards.

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

The Developmental Disabilities and Bill of Rights Act recognizes the important role that *University COEs in Developmental Disabilities Education, Research and Service (UCEDDs)* play in enhancing the diversity of the workforce, requiring that UCEDDs enhance efforts to recruit and retain underrepresented groups at all levels to respond to the needs of individuals with developmental disabilities and their families. In FY 2015 and FY 2016, the Administration for Intellectual and Developmental Disabilities (AIDD) within ACL funded National Training Initiatives that included diversity fellowships at UCEDDs across the country. The aim was to build the cultural competence capacity of leadership, staff, and governing bodies across the developmental disabilities network, and to increase the number of persons with disabilities from underrepresented groups and disadvantaged backgrounds who benefit from AIDD supported programs. A total of 28 fellows were recruited to participate in the 2015-2016 diversity fellowship programs across 14 funded UCEDDs. In FY 2016, AIDD also supported UCEDDs to establish partnerships with MSIs and community colleges, as well as a consortium of UCEDDs and partners, to develop a diversity training curriculum for the developmental disabilities network. Additionally, AIDD funded efforts to create a new community of practice on disability

for state disability organizations and commissioned a diversity gap analysis of the developmental disabilities networks funded in the states and territories. Information regarding the impact of these new efforts will be available in the coming year.

GOAL IV: Advance Scientific Knowledge and Innovation

Since 1991, the National Institute for Independent Living and Rehabilitation Research (NIDILRR), a Center within ACL, has funded the Americans with Disabilities Act (ADA) National Network, consisting of 10 regional Centers and a Knowledge Translation Center, to provide ADA training, technical assistance, and ADA-related materials to individuals and entities with rights and responsibilities under the ADA, including healthcare facilities and providers. These Centers are available as a resource to provide training and technical assistance to healthcare entities on accessibility requirements as well as ways to ensure that healthcare services and facilities are accessible. Given racial and ethnic minority populations experience disparities in access to aging services, these Centers' services are aligned with the needs of individuals with disabilities who also are racial and ethnic minorities. The ADA National Network services can be accessed through its website (https://adata.org/) or toll free number 800-949-4232.

NIDILRR also funded the development of the Community Health Environment Checklist (CHEC), a suite of objective assessment tools of physical environmental features that enable (or prohibit) persons with disabilities to fully access different types of facilities, including a tool developed specifically to assess doctors' offices. Each facility can be rated from 0 -100, with higher scores indicating better access, along with description of the features that the facility has or does not have. The CHEC can be used by anyone who receives minimal online training.[45]

Indian Health Service

Agency Overview: The IHS conducts activities to raise the physical, mental, social, and spiritual health of American Indian and Alaska Native populations to the highest level. In FY 2015 and 2016, IHS supported a range of vital health programs, services, and activities, including: tribal self-governance, contract health services, tribal management, and contract support; hospitals, health clinics, and facilities construction and maintenance; diabetes, dental health, mental health, alcohol and substance abuse, injury prevention, immunizations, environmental health, sanitation, and health education programs; and, recruitment, retention, and service delivery activities through the Indian Health Professions, Public Health Nursing, and Community Health Representatives programs.

Highlights of IHS's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

Several of IHS's programs focus on **reducing disparities in access to primary care services**

[45] See more on the CHEC at https://enablemob.wustl.edu/DBTAC/WebSurveyStudy/CHEC_SITES.html

and care coordination (Strategy I.B). IHS works to recruit and retain needed health professionals to provide clinical healthcare services in high-priority facilities in AI/AN communities, and to educate, train, and recruit AI/AN people to become health professionals serving Indian communities. The *IHS LRP*, authorized under Section 108 of the Indian Health Care Improvement Act (IHCIA), offers healthcare professionals the opportunity to ease qualified health professions-related student loan debt and help Indian health programs meet the staffing needs of high-priority sites. The LRP provides an initial award for educational loan repayment assistance to qualified healthcare professionals in exchange for a two-year service commitment for full-time clinical practice at an approved Indian health facility. In FY 2015, 1,211 LRP recipient physicians, nurses, dentists, pharmacists, optometrists, podiatrists, and other healthcare professionals served in Indian communities. In FY 2016, a total 1,253 LRP recipients served in Indian communities.

The *Indian Health Service Scholarship Program,* authorized under Sections 103 and 104 of the IHCIA, provides financial support to AI/AN students in health professional education programs. Section 103 scholarships include the preparatory and pre-graduate programs that prepare students for entry into health professions training programs. AI/AN students enrolled in a federal or state recognized tribe are eligible for Section 103 scholarships. Section 104 scholarships include the health professions and allied health professions education and training programs. AI/AN students enrolled in federally recognized tribes are eligible for Section 104 scholarships. AI/AN students accepting a scholarship under Section 104 will incur a service obligation upon completion of their education and training. In FY 2015, a total of 334 students received an IHS scholarship. In FY 2016, a total 296 students received an IHS scholarship.

Many IHS beneficiaries have limited options for healthcare services due to geographic or economic factors. Assisting IHS patients to enroll in Medicare and Medicaid provides the patient with additional options for healthcare services and allows IHS and tribal facilities to bill for Medicare and Medicaid for eligible services. These third-party funds can be used for additional staffing and services at IHS and tribal facilities. In FY 2016, IHS conducted an IHS *Medicaid/Medicare Enrollment Pilot Project* to assist six service units in three IHS areas with Medicare/Medicaid enrollment. This ongoing project has increased Medicare and Medicaid enrollment by five percent in these facilities.

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

IHS administers three *Indian Health Service Grant Programs*, all authorized under the IHCIA, which benefit American Indian and Alaska Native students. *The Quentin N. Burdick American Indians into Nursing Program* helps to increase the number of nurses who deliver healthcare services to Indians. In FY 2015 four universities received grant support and in FY 2016 five universities received grant support to operate the nursing program. *The Indians into Medicine Program* encourages and assists American Indian students to prepare for a career in healthcare. In FY 2015 and FY 2016, three universities received grant support. *The American Indians into Psychology Program* increases psychological services provided to American Indian communities. In FY 2015 and FY 2016, three universities received grant support. Through these three grant programs, IHS is able to expand access to primary healthcare in the fields of

nursing, psychology, and medicine throughout Indian health programs.

GOAL III: Advance the Health, Safety and Well-being of American People

The *Special Diabetes Program for Indians* (SDPI) is a grant program established by Congress in 1997 to provide funds to IHS, Tribal, and Urban Indian (I/T/U) programs for diabetes prevention and treatment services. SDPI is administered by the IHS Division of Diabetes Treatment and Prevention (DDTP) and the IHS Division of Grants Management. There are 301 grant programs in 35 states funded by SDPI. Funding for SDPI is authorized through FY 2023.

I/T/U facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit (Diabetes Audit). The Diabetes Audit is a process to assess care and health outcomes for American Indians and Alaska Natives with diagnosed diabetes, which follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly outcomes at the local, regional, and national levels. Key outcome measures for American Indians and Alaska Natives people with diabetes have shown improvement or maintenance at or near national targets since the inception of SDPI. Examples include:

- **Improving Blood Sugar Control:** Blood sugar control among American Indian/Alaska Native people with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 8.8 percent in 1997 to 8.1 percent in 2016, nearing the A1C goal for most patients of less than eight (8) percent;
- **Improving Blood Lipid Levels:** Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 92 mg/dL in 2016, surpassing the goal of less than 100 mg/dL; and
- **Reducing Kidney Failure:** According to the U.S. Renal Data System, the rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in American Indian/Alaska Native people from 1996 to 2013. This is a much larger decline than in any other racial/ethnic group in the U.S.

The Healthy Lifestyles in Youth Program: *Together Raising Awareness for Indian Life* (TRAIL) is a program supported by the IHS DDTP. DDTP provides funds for obesity prevention activities at Native Boys & Girls Clubs via the Healthy Lifestyles in Youth cooperative agreement with the National Congress of American Indians (NCAI). IHS has worked with NCAI and its partners through this cooperative agreement since 2003 and over 13,000 Native youth have participated since its inception. NCAI provides grant funding to more than 60 Native Boys and Girls Clubs across the country to implement the TRAIL program, an innovative combination of physical, educational and nutritional activities that promote healthy lifestyles in youth 7-11 years of age. There are also self-esteem and prevention activities woven into the program and the importance of teamwork and community service is emphasized. Community and family members participate in activities with the youth and integration of tribal traditions and history related to nutrition, food choices, media influences, and the impact of type 2 diabetes is included. Program test scores for each year consistently indicate increased knowledge about diabetes, increased physical activity/fitness, and increased ability to identify healthier food

options. Program physical activity logs show participating Native American youth collectively perform up to 20,000 hours of physical activity each year. The Boys and Girls Clubs also report annually on the healthy community activity projects that are carried out by TRAIL participants in their local communities.

IHS supports the Community Health Representative (CHR) Program. During FY 2015 and 2016 the program was under the Division of Behavioral Health. IHS recognizes the important contributions of CHRs reaching vulnerable, low-income, and underserved members of American Indian/Alaska Native (AI/AN) populations as a critical part of the disease prevention and health promotion community health workforce. CHRs serve to link the patient to the Indian healthcare system, and improve the quality of patient-provider interactions in clinical settings. CHR services are essential and help prevent avoidable readmissions and emergency department visits. This is accomplished by providing medically-guided home vists, case finding and case management of patients with chronic health conditions such as asthma, diabetes and hypertension. Exported CHR program data in FY 2015 demonstrated that CHRs conducted 246,556 home visits and provided 1,194,171 patient contact/services on a variety of health related conditions. The National CHR Program measures: (1) number of patient contacts; (2) patient contacts for chronic disease services and (3) number of CHRs trained to serve AI/AN communities. FY2015 target measures were exceeded. FY 2016 data reflected meeting 2 out of 3 target measures. This demonstrated increases with number of patient contacts by 11%, and CHR patient contact for chronic disease services increasing by 5%. During FY 2015 and 2016 the CHR program provided a Maternal Child Health Home Visiting Program called Family Spirit to six IHS areas for a total reach of 18 CHR Supervisors, and 70 CHRs.

GOAL IV: Advance Scientific Knowledge and Innovation

The *TEC* program was authorized by Congress in 1996 as a way to provide public health support to multiple tribes and urban Indian communities in each of the IHS areas. TECs are uniquely positioned within tribes, tribal, and urban Indian organizations to conduct disease surveillance, research, prevention, and control of disease, injury, or disability, and to assess the effectiveness of AI/AN public health programs. Some programs have developed innovative strategies to monitor the health status of tribes and urban Indian communities, including the development of tribal health registries and use of sophisticated record linkage techniques to correct existing state data sets for racial misclassification. TECs work in partnership with IHS to provide a more accurate national picture of Indian health status. In FY 2015, the program used the following evaluation measures: health status and monitoring; provide regional profiles; and tribal support–technical training in public health practice. In FY 2016, the program used the following evaluation measures: number of requests for technical assistance, including data requests for Tribal/urban organization, communities, or AI/AN individuals responded to; and number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. In FY 2015, 100 percent of programs met their targets on health status and monitoring, 83 percent of programs met their targets on providing regional profiles, and 100 percent of programs met their targets on tribal support– technical training in public health practice. Reporting relevant to the FY 2016 measures is ongoing.

The IHS publishes several publications on American Indian and Alaska Native populations,

including *Trends in Indian Health* and *Regional Differences in Indian Health*. In FY 2015, *Trends in Indian Health: 2014 Edition* was produced and disseminated online. *Regional Differences in Indian Health* is expected to be published in December 2017 and serves as a key resource for agencies providing public health resources in American Indian and Alaska Native communities.

Office for Civil Rights

Agency Mission: The Office for Civil Rights (OCR) is the HHS agency responsible for enforcing laws that prohibit discrimination based on race, color, national origin, disability, age, sex, religion and exercise of conscience rights by certain health and human services organizations and laws that protect the rights of individuals to access their health information and the privacy and security of that information. OCR supports HHS's efforts to reduce and eliminate unlawful discrimination in healthcare settings through civil rights enforcement, technical assistance, public education and external outreach activities.

Highlights of OCR's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

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

The *Medical School Curriculum Initiative* enhances medical school instruction by helping health professional students appreciate their role in reducing and eliminating unlawful discrimination in healthcare settings. The curriculum, *Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities*, was developed with funding from the National Institutes of Health and the Stanford University School of Medicine and published by the Association of American Medical Colleges (AAMC). In partnership with AAMC's program for aspiring dental and medical school students, OCR presented the curriculum in the summers of 2015 and 2016 to help approximately 2,000 students understand how the equal treatment of patients, including LEP patients, is required by law and necessary to ensure safe and effective healthcare. OCR and AAMC presented the curriculum at Case Western University, Columbia University, Duke University, Howard University, Rutgers University, University of California Los Angeles, University of Kansas, University of Louisville, University of Nebraska, University of Texas, University of Virginia, University of Washington and Yale University.

In July 2016, OCR issued a report on its national compliance review initiative, *Protecting the Civil Rights and Health Information Privacy of People Living with HIV/AIDS*. Focusing on HIV testing, counseling and treatment services, OCR conducted compliance reviews of twelve hospitals in the cities most affected by HIV/AIDS to examine the ways in which hospitals ensure equal access for HIV positive individuals to programs and services, as well as the privacy and security of individuals' health information and their rights with regard to that information. OCR also examined whether the hospitals provided meaningful access to individuals with LEP seeking HIV testing, counseling or treatment services. In sum, OCR evaluated each hospital's policies and practices and found that, while the hospitals under review had implemented some policies and practices to promote equal access to services and EBIs to increase the number of newly diagnosed individuals entering care or remaining in treatment, some barriers remained. The

report summarizes OCR's findings and provides best practices for hospitals serving individuals with HIV/AIDS, including LEP individuals.

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

OCR chairs the *HHS Language Access Steering Committee*, which was established in 2012 to ensure that HHS agencies comply with Executive Order 13166 by providing meaningful access to their programs for individuals with LEP. Through OCR's leadership, the Committee oversees and coordinates ongoing Departmental efforts to improve access for individuals with LEP to programs administered by HHS. In FY 2016, the Steering Committee developed an online learning module to support all HHS agencies in training their employees on competently serving individuals with LEP. This module includes extensive language access reference materials, tools and effective practices to help HHS employees ensure language access, including through effective utilization of telephonic interpretation and document translation services. OCR will continue to work with colleagues across the Department to ensure that all individuals, including those with LEP, have meaningful access to HHS conducted programs and activities, as well as healthcare, health coverage and human services more generally

Office of the Assistant Secretary for Preparedness and Response

Agency Overview: The Office of the ASPR was statutorily authorized under the Pandemic and All Hazards Preparedness Act in the wake of Hurricane Katrina to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters. ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; medical countermeasures advanced research and development and procurement; and grants to strengthen the capabilities of hospitals and healthcare systems in public health emergencies and medical disasters. The office provides federal support, including medical professionals, through ASPR's National Disaster Medical System to augment state and local capabilities during an emergency or disaster.

Highlights of ASPR's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

ASPR's efforts within Goal I focused on **reducing disparities in health insurance coverage and access to care (Strategy I.A)**, **reducing disparities in access to primary care services and care coordination (Strategy I.B)**, and **reducing disparities in the quality of healthcare (Strategy I.C)**. ASPR, in partnership with the FDA, sought to improve access to care through the *Emergency Prescription Assistance Program (EPAP)*.[46] EPAP provides an efficient mechanism for over 70,000 enrolled retail pharmacies nationwide to process claims for certain kinds of prescription drugs, specific medical supplies, vaccines, and some forms of durable medical equipment for eligible individuals in a federally identified disaster area throughout the U.S. and its territories. The program provided 500 fact sheets in English, Spanish and Vietnamese to ASPR regional emergency coordinators and the Federal Emergency Management

[46] See more on the EPAP at www.phe.gov/epap

Agency to distribute in local emergency shelters. The program's website is now available in Vietnamese and Spanish in addition to English and has Vietnamese and Spanish versions for infographic and informational documents for Vietnamese-speaking and Spanish-speaking patients to understand EPAP. The Vietnamese version was translated by ASPR and FDA.

In the wake of a disaster or emergency, ASPR's *Fusion Division* produces demographic reports to support Emergeny Support Function-8 (ESF-8) activations and recovery activities in order to improve access to primary care services and care coordination. The reported characteristics highlight specific needs of communities, including demographic information, such as languages spoken. This past year, Fusion prepared reports, all tailored to the specific sub-populations and geographic areas affected by such a disaster or emergency, for the following locations: the Flint, Michigan water contamination; the Mississippi Valley flooding in late 2015 and early 2016; the Baton Rouge, Louisiana flooding; the Cedar Rapids, Iowa flooding; Zika virus response efforts (languages spoken in at-risk Zika virus states); and the Montana oil spill in late 2015. In the last two years, the Fusion Division has provided 14 reports containing demographic and health disparities information during emergency events to ASPR senior leadership, the Secretary's Operations Center, and Regional Emergency Coordinators. In addition, the reports are posted on the Emergency Management portal for access by all Emergency Management Group members involved in the response.

ASPR also served as the lead during *Flint Water Crisis*. To better serve communities that are LEP and reduce disparities in the quality of healthcare, ASPR coordinated with several other agencies and local groups to develop materials in Arabic and Spanish related to the public health crisis. Examples include:

- United States Department of Agriculture (USDA)/Food and Nutrition Service (FNS) deployed an Arabic-speaking employee to Flint, and she developed a PSA in Arabic;
- USDA/FNS's grantees printed Double Up Food Bucks posters as well as nutrition guidance in Arabic;
- SAMHSA provided copies of the Disaster Distress Helpline flier in Arabic;
- Environmental Protection Agency's (EPA) Spanish-speaking employees developed PSAs and printed materials in Spanish. EPA coordinated with Latinos United for Flint to ensure that the materials were culturally appropriate;
- CDC translated its Rash Study into Spanish. ASPR paid to print 2,000 copies of the Rash Study in Spanish and delivered to local groups. ASPR also paid to print 2,000 copies of HHS's fall Flint Update; and
- Partners distributed fact sheets on federal efforts "by the numbers," results of a rash investigation, nutrition, how to protect health from lead, and how to install water filters on faucets. More than 1,000 of each fact sheet was distributed during community events, distributed to the Flint community recovery working group, national faith leaders, HHS Regional Directors and centers in other agencies, and posted on the community's website.

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

ASPR's efforts within Goal II focused on **increasing the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities (Strategy**

II.A) and **promoting the use of Promotores de Salud and CHWs (Strategy II.B)**. ASPR created and promoted several *Zika fact sheets*, some directly aimed at individuals and others for healthcare providers. These fact sheets were made available in English and Spanish in coordination with the HHS OMH to be made available for dissemination agency-wide, and included topics such as how to avoid Zika virus during trips abroad, five Strategies for Pregnant Women to Manage Stress and Worry during the Zika Virus Disease Outbreak, and Promoting Stress Management for Pregnant Women during the Zika Virus Disease Outbreak: A Resource for Healthcare Providers. ASPR posted fact sheets on mental health for pregnant women and providers in English and Spanish and a blog about mental health for pregnant women in English and Spanish.

ASPR also promotes the inclusion of LEP populations when preparing for and responding to disasters. The fact sheets and blogs posts noted below identify some of the challenges and issues that arise during preparedness, response, and recovery activities related to racial and ethnic minorities.

- Low Literacy Populations and Disaster Communications: 5 Ways to Bridge the Educational Divide - http://www.phe.gov/ASPRBlog/pages/BlogArticlePage.aspx?PostID=190
- Cultural and Linguistic Competency in Disaster Preparedness and Response Fact Sheet - http://www.phe.gov/Preparedness/planning/abc/Pages/linguistic-facts.aspx
- Resources for Serving Persons with Limited English Proficiency http://www.phe.gov/Preparedness/planning/abc/Pages/lep.aspx
- Cultural and Linguistic Competency for Disaster Preparedness Planning and Crisis Response: http://www.phe.gov/Preparedness/planning/abc/Pages/linguistic.aspx
- American Indian & Alaska Native Disaster Preparedness Resource: http://www.phe.gov/Preparedness/planning/abc/Pages/tribal-preparedness.aspx
- Dum Spiro Spero – While I Breathe, I Hope - http://www.phe.gov/ASPRBlog/pages/BlogArticlePage.aspx?PostID=159
- Importance of Cultural and Linguistic Competency in Disaster Preparedness and Response - http://www.phe.gov/ASPRBlog/pages/BlogArticlePage.aspx?PostID=130
- EPAP Activation – Resources in English, Spanish and Vietnamese (several listed at http://www.phe.gov/Preparedness/planning/epap/Pages/default.aspx)
- Joined the HHS OMH Twitter Relay in 2015 that addressed disaster issues, which disproportionately affect minorities.

To promote the use of promotores, ASPR coordinates awareness and outreach campaigns with Mexico through the *Mexican Embassy and the Promotores de Salud networks*. Activities in FY 2015 and FY 2016 included working with the Mexican Embassy and the Mexican Consular Network Ventanillas de Salud Program and national Promotores de Salud networks in community outreach campaigns to increase awareness of immunizations for influenza to prevent a pandemic influenza in the vulnerable and underserved Hispanic communities of the U.S.-Mexico Border. ASPR is a board member on the *Advisory Board of Ventanillas de Salud Program (VDS)*, providing guidance to the prevention and referral programs. VDS served 1,525,504 persons in 2015 and provided a total of 4,555,412 services. ASPR worked with the Mexican Embassy and the Consular Network of Ventanillas de Salud to communicate the risks to pregnant women and families with mothers in childbearing age of the Zika virus, and supported community engagements in Puerto Rico which communicating the risks to pregnant

women and families with mothers in childbearing age of the Zika virus.

Office of the National Coordinator for Health Information Technology

Agency Mission: The mission of the Office of the National Coordinator for Health Information Technology (ONC) is to improve health and well-being of individuals and communities through use of user-friendly information technology providing health data for when and where it matters most. A successful health system relies on interoperable HIT to collect, share, and use information to transform healthcare from volume-based fiscal incentives towards more outcomes-based care that improves accessibility and quality for all individual patients and consumers and empowers them to make more informed and effective choices about the best care and providers for their needs and preferences. ONC's unique technical expertise, statutory authorities, and strong relationships with the private sector make ONC well suited to champion the technical and policy change necessary to achieve the HIT interoperability needed to achieve the enhanced level of patient centered care all Americans deserve.

Highlights of ONC's Fiscal Years 2015 and 2016 Activities (Categorized by the HHS Disparities Action Plan)

GOAL I: Transform Health Care

ONC leads a variety of efforts designed to accelerate nationwide progress toward the interoperable HIT infrastructure on which a transformed, successful health system depends. The *ONC Health IT Certification Program* is a voluntary certification program that provides certification of health IT modules, including electronic health records (EHRs), that meet certain technical standards and form an essential foundation for interoperability. Use of technology certified under the program can help to ensure key data are consistently available to the right person, at the right place, and at the right time. Given that racial and ethnic minorities experience disparities in access to quality of healthcare that can be addressed by HIT, this ONC program is aligned with the needs of racial and ethnic minorities.

GOAL IV: Advance Scientific Knowledge and Innovation

The *ONC HIT Certification Program* supports the availability of certified HIT to meet the needs of clinicians, hospitals and other care providers who are striving to deliver the best care possible for their patients and to succeed in a care and reimbursement system increasingly focused on the outcomes and value of care. The 2015 Edition HIT Certification Criteria (2015 Edition) includes certification criteria that support the capture of a wider range of patient health information, in a structured way that is more granular than may have been the case for some data elements in prior editions or in non-certified HIT. These criteria can help clinicians and organizations capture and use data more effectively to identify opportunities for care improvement for all the patients that they serve. It is a critical step forward in addressing health disparities in the healthcare system and in supporting quality care for all people, regardless of race, gender, sexual orientation, socio-economic background, or behavioral conditions. For example, the 2015 Edition "demographics" certification criterion requires that certified HIT be able to record, change, and access a patient's race and ethnicity according to the OMB and the CDC Race and Ethnicity data standards, and

the CDC Race and Ethnicity code set which includes over 900 concepts for representing race and ethnicity. The structured granular recording of race and ethnicity can help improve care for every individual patient and support health disparity reduction. The criterion also requires certified HIT to be able to record multiple races and/or ethnicities for a patient.[47,48,49,50] Additionally, the 2015 Edition certification criteria includes capabilities to support the standardized exchange of sensitive health information, filtering of clinical quality measure data to help identify health disparities, and the capture of health information from patients. Providers participating in programs requiring the use of certified HIT, such as the Promoting Interoeprability performance category under the CMS-administered Quality Payment Programs (QPP), and participants in Advanced Alternative Payment Models under QPP, are required to use HIT certified to the 2015 Edition of health IT certfication criteria. For providers that are not using up-to-date technology, it may be increasingly difficult for them to meet top performance benchmarks for quality and outcomes of care without the improved structure, granularity, and interoperability of data elements key to delivering the best care to every patient, consistent with the individual's needs and preferences.

Since 2008, ONC has partnered with the AHA to measure the adoption and use of HIT in U.S. hospitals. The *AHA Annual Survey Information Technology Supplement* tracks hospital adoption and use of EHRs and the exchange of clinical data. Results from this survey are used to identify trends in HIT adoption and use among non-federal acute care hospitals. Disparities in EHR adoption have been noted by urban/rural status and hospital characteristics.[51]

ONC has also partnered with the CDC's NCHS to identify trends in HIT adoption and use among office-based physicians through the *National Ambulatory Medical Care Survey: National Electronic Health Records Survey (NEHRS)*, a mail/online survey. Disparities in EHR adoption have been noted by urban/rural status and provider characteristics.[52]

Through an interagency agreement between ONC and the NCI, ONC has supported the *Health Information National Trends Survey (HINTS)*. HINTS collects data about how individuals seek out health information. Results from this survey can be used to identify trends in HIT access and use among individuals. Disparities that might be addressed include race, language, and urban/rural status.[53]

[47] See the ONC Health IT Certification Program at https://www.healthit.gov/policy-researchers-implementers/about-onc-health-it-certification-program
[48] See the 2015 Edition Final Rule: Supporting Care Across the Continuum at https://www.healthit.gov/sites/default/files/2015editioncareacrosscontinuum_10615.pdf
[49] See the 2015 Edition Final Rule: Addressing Health Disparities https://www.healthit.gov/sites/default/files/disparities_and_disabilities_10_8_15.pdf
[50] See the 2015 Edition Final Rule: Expanding Electronic Health Information Access and Exchange at https://www.healthit.gov/sites/default/files/patientengagementconsumerv3_10715_01.pdf
[51] See the Health IT Dashboard at https://dashboard.healthit.gov/index.php
[52] See the Health IT Dashboard at https://dashboard.healthit.gov/index.php
[53] *Ibid.*

Coordination, Integration, and Accountability

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

HHS Health Disparities Council

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

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

Federal Interagency Health Equity Team

The HHS OMH established the FIHET to guide the development of the National Stakeholder Strategy for Achieving Health Equity and implementation of the NPA (additional details on the NPA are provided in the HHS OMH section earlier in this report). The FIHET's composition was specifically tailored to support action across federal agencies whose collective missions address the SDOH. The FIHET is composed of representatives from 12 federal departments and agencies: HHS; Agriculture; Commerce; Defense; Education; Environmental Protection Agency; Homeland Security; Housing and Urban Development; Justice; Labor; Transportation; and VA. The FIHET's goals are to:

- Identify opportunities for federal agency collaboration, partnership, and coordination on efforts that are relevant to the NPA;
- Provide leadership and guidance for national, regional, state, tribal, and local efforts that address health equity; and

- Leverage opportunities for integrating health disparities into their policies, practices, and initiatives.

Conclusion

The U.S. Department of Health and Human Services will continue to lead the implementation of strategic policies and programs whose goals include improving minority health, reducing health disparities, and transforming our healthcare delivery system. In FY 2015 and 2016, significant progress was achieved that will improve the health of racial and ethnic minorities and underserved populations by addressing many of the factors that have long been associated with health disparities. The HHS activities highlighted in this report focused on implementing three key priorities:

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

HHS's actions on minority health represent a comprehensive approach to improving the health of racial and ethnic minority populations and achieving the vision of "a nation free of disparities in health and healthcare."

HHS recognizes that public health is undergoing a transformation, which in 2016 was captured by the framework referred to as *Public Health 3.0*. Public Health 3.0 focuses on the SDOH to achieve health equity. In 2016, the OASH published a Public Health 3.0 Report,[54] summarizing the key findings from five regional listening sessions and presenting recommendations to carry Public Health 3.0 forward, organized in the following five themes for state and local public health offices:

1. Strong leadership and workforce;

[54] See more on Public Health 3.0 at https://www.healthypeople.gov/sites/default/files/Public-Health-3.0-White-Paper.pdf

2. Strategic partnerships;
3. Flexible and sustainable funding;
4. Timely and locally relevant data, metrics, and analytics; and
5. Foundational infrastructure.

Public Health 3.0 focuses on the SDOH to create lasting improvements for the health of everyone in America, and on society working together to ensure the conditions in which everyone can be healthy. One often thinks of the healthcare industry when thinking of health, but building healthy communities requires strategic collaboration across all sectors. These partnerships are key to developing and sharing sustainable resources and to leverage data for action that can address the most urgent community health needs.