The Affordable Care Act & Racial and Ethnic Health Equity Series

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Public Health and Prevention Programs for Advancing Health Equity

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Preface

Data, research and experience have demonstrated longstanding and extensive disparities in access to, quality and outcomes of care for racially, ethnically and linguistically diverse patients and communities in the U.S. health care system, despite efforts to address them. While lack of health insurance is a well established and major contributor to these disparities, children and adults from diverse racial and ethnic heritage often face significantly poorer care and health outcomes than White patients even when insured.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (together the Affordable Care Act or "ACA") offer an unprecedented opportunity to bridge this divide. While expanding health insurance is a centerpiece in achieving this goal, the ACA includes dozens of provisions intended to close these gaps in quality and outcomes for racially and ethnically diverse and other vulnerable populations. In so doing, the new law provides important incentives and requirements to create a more equitable health care system by expanding the number of health care settings nearer to where people live and work, increasing diversity among health professionals, and addressing language and culture in delivery of services through innovative, clinical, and community-based approaches. But taking this vision and its well intentioned goals to reality in the short and longer-term will determine ultimate effectiveness and success.

The Texas Health Institute (THI) received support from the W.K. Kellogg Foundation and The California Endowment to monitor and provide a point-in-time portrait of the implementation progress, opportunities, and challenges of the ACA's provisions specific to or with relevance for advancing racial and ethnic health equity. Given the ACA was intended to be a comprehensive overhaul of the health care system, we established a broad framework for analysis, monitoring, and assessing the law from a racial and ethnic health equity lens across five topic areas:

- Health insurance and exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

This report is one of five THI has issued as part of the *Affordable Care Act & Racial and Ethnic Health Equity Series*, and it focuses specifically on provisions in the ACA addressing ***Public Health and Prevention Programs for Advancing Health Equity.***

Executive Summary

I. Introduction

The United States spends more on health care than any other industrialized nation, yet this greater spending does not translate to better health or life expectancy. In 2009, the U.S. spent more than twice the average of industrialized countries on health care, yet the U.S. ranked 27th among 34 industrialized nations in terms of life expectancy. Health care spending in the U.S. is also steadily growing as a percentage of the economy and estimates affirm that this growth is "largely attributable to preventable conditions…More than 85 cents of every dollar spent on health in the U.S. are spent on the treatment and management of chronic diseases, such as those caused by preventable conditions related to obesity and tobacco use." Only 3% of the nation's health care dollars is spent on disease prevention.

Compounding these trends are health disparities—which also contribute to unnecessary and preventable medical expenditures. According to the Agency for Healthcare Research and Quality's most recent report on disparities, while quality is improving, access and disparities are not. Healthy People 2010, a comprehensive framework developed by the U.S. Department of Health and Human Services, included two overarching goals, one of which was to eliminate health disparities. However, in an assessment of its progress toward achieving this goal published in 2010, it was found that there is much work still to be done. In fact, a significantly larger number of health indicators showed an increase in disparity rather than a decrease in disparity.

The enactment of the Affordable Care Act (ACA) in 2010 offered a unique opportunity to create a more equitable, high quality health care system focused on prevention, with its commitment to establishing the Prevention and Public Health Fund and numerous other programs on community health and prevention. The purpose of this report is to provide a point-in-time status on the implementation of the ACA's 11 key provisions for advancing racial and ethnic health equity in public health and prevention. In particular, the report describes opportunities presented by the new law for bridging longstanding disparities in health and health care through prevention and public health, offering details on emerging programs, best practices, and resources. Challenges, barriers, and important priorities moving forward are also discussed to assure that equity remains core and central to any prevention and public health strategy.

II. Methodology

We utilized a multi-pronged, qualitative design to monitor and assess the implementation progress, opportunities, and challenges of the ACA's 11 public health and prevention provisions with explicit mention of or major implications for racially and ethnically diverse communities. These provisions were categorized into three priority areas and organized as follows:

1. **Public Health Initiatives for Children and Adolescents**
   - Maternal, infant, and early childhood home visiting programs (§2951)
   - Personal Responsibility Education (§2953)
   - Funding for Childhood Obesity Demonstration Project (§4306)

2. **Community Health and Prevention**
    - National Prevention, Health Promotion and Public Health Council (§4001)
    - Prevention and Public Health Fund (§4002)
    - Clinical and Community Preventive Services (§4003)
    - Community Transformation Grants (§4201)

3. **Chronic Disease Programs Targeting Diverse Populations**
    - Oral healthcare prevention activities (§4102)
    - Indian health care improvement (§10221)
    - Young women's breast health awareness and support of young women diagnosed with breast cancer (§10413)
    - National Diabetes Prevention Program (§10501)

For each topic area, we reviewed: peer-reviewed literature and national reports; emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. Findings on progress, opportunities, and challenges identified through our review were synthesized with information and perspectives obtained through a series of key informant interviews with numerous thought leaders, experts, and community advocates in the field.

III. Implementation Progress

This section describes the implementation progress, opportunities, challenges, and road ahead for 11 provisions in the ACA critical to advancing racial and ethnic health equity in public health and prevention. These provisions are discussed in context of the aforementioned three topic areas.

A. Public Health Initiatives for Children and Adolescents

Children from diverse racial and ethnic heritage experience persistent and pervasive disparities across multiple health and health care measures when compared to their White counterparts. Comprehensive policy reforms proposed to ameliorate the excess burden of poor health among diverse children have gone beyond ensuring health insurance coverage to advocating for services such as: health and nutrition counseling for pregnant women and infants; home visiting for at-risk families; and multi-sector strategies that promote behavior change at the individual, institutional, and community levels. At least three key provisions in the ACA intend to improve health outcomes for racially and ethnically diverse children and adolescents. This section provides a review and update on implementation progress of these provisions:

Maternal, infant, and early childhood home visiting programs. Section 2951 of the ACA intends to strengthen maternal, infant, and early childhood home visiting programs, support service coordination for at-risk populations, and improve outcomes for families through the provision of comprehensive services. Grants are authorized for states to deliver maternal, infant, and early childhood home visiting programs with the goals of reducing child abuse, neglect and injuries, and improving health outcomes such as infant health, child development as well as improving parenting skills and school readiness. The Health Resources and Services Administration (HRSA) awarded funding in FY 2010 to FY 2013 for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. All programs are targeted to vulnerable and at-risk

families and in addition several programs plan to explicitly tailor services to improve outcomes among diverse racial and ethnic groups or individuals with cultural or linguistic differences.

Political challenges have confronted states as they seek to implement MIECHV programs under the ACA. For example, Florida stood to receive $31.3 million over five years in total grant funding for MIECHV. However, action was thwarted by the state's legislature, which eventually rejected the funding due to general opposition to the ACA. Next steps for advancing minority health status in MIECHV programs are to ensure that approved evidence-based home visiting programs include cultural competency components. It is also important to ensure that race/ethnicity data are collected whenever possible to assure reporting explicitly integrated measures assessing impact for diverse populations.

Personal Responsibility Education. Section 2953 of the ACA authorizes an adolescent Personal Responsibility Education Program (PREP) offering support for abstinence and contraception learning initiatives to prevent pregnancy and sexually-transmitted diseases. The program is required to incorporate culturally-appropriate information into program activities, with $75 million allocated for each of the years FY 2010 to FY 2013 to 46 states. Based on a review of brief program descriptions, all grantees describe goals around reducing rates of teen pregnancy, HIV, and STIs among at-risk groups. Several program descriptions (29) mention their intent to target racially and ethnically diverse teens. However, the abstinence-only programs, as described in the law, do not require specific tailoring for diverse youth which may limit their focus and effectiveness among youth from diverse racial, ethnic, and socioeconomic backgrounds.

Childhood Obesity Demonstration Projects. Section 4306 of the ACA amends the Social Security Act by appropriating $25 million for grants to conduct childhood obesity demonstration projects in FY 2010 to FY 2014. On September 29, 2011, CDC announced the three grantees that received funding to establish a Childhood Obesity Demonstration Project. A fourth grantee received funds to evaluate the interventions and share best practices and successes. All three of the funded entities with demonstration projects to reduce childhood obesity target racially and ethnically diverse and/or low-income children. Results of the demonstration projects, to be released in 2015, will inform federal, state, and local policy, and are expected to provide important next steps for curbing the childhood obesity epidemic among underserved children. However, future legislation will be required to continue and expand on this initiative, leaving uncertain broader intervention reach.

B. Community Health and Prevention Initiatives

Racially and ethnically diverse populations have much to gain from the newly established priorities put forth by the ACA to address the underlying social and physical determinants of health within communities. Social determinants of health such as education level, socioeconomic status, and neighborhood often differ by race and ethnicity. In fact, there is an established link between low socioeconomic status and racial and ethnic disparities in health, with diverse individuals from low-income backgrounds suffering from higher rates of chronic diseases such as obesity and diabetes as well as other conditions. Addressing the current disparities in such determinants through novel national policies and community-level interventions is an important step to achieving true health equity, and the ACA has woven this concept into several of its provisions.

National Prevention, Health Promotion, and Public Health Council. Section 4001 authorizes the establishment of the National Prevention, Health Promotion and Public Health Council, a federal interagency group established by the President. The Council is charged with: coordinating federal efforts in health promotion, prevention, and wellness; developing a national prevention strategy; and making recommendations to the President and Congress regarding federal health priorities. In June 2011, the National Prevention Council, comprised of 17 federal agencies and headed by the U.S. Surgeon General, released the *National Prevention Strategy*. The Strategy emphasizes that optimal health should come not only from the medical care received in hospitals and clinics, but should also be addressed through improvements in clean air and water, nutritious foods, and safe recreation areas, homes, and work places.

The *National Prevention Strategy* outlines five recommendations to achieve the strategic direction of eliminating health disparities: ensure a strategic focus on communities at greatest risk; reduce disparities in access; increase capacity to identify and address health disparities; support research to identify effective strategies to eliminate health disparities; and standardize and collect data to better identify health disparities. In June 2012, The National Prevention Council released its Action Plan enumerating goals around the outlined strategy. However, sustainability remains a major concern due to continued financial constraints, as do efforts to encourage collaboration between multiple federal agencies.

Prevention and Public Health Fund. Section 4002 of the ACA authorizes the HHS Secretary to transfer funds, beginning in FY 2010, to HHS programs for prevention, wellness, and public health activities intended to both improve health and control health care costs. The first year of funding was primarily spent on infrastructure and workforce (69%), mainly for primary care workforce development. In FY 2011 and FY 2012 most financial assistance was dedicated to community prevention (40%), which includes Community Transformation Grants, Racial and Ethnic Approaches to Community Health (REACH), and tobacco prevention. In FY 2013 funding was reduced across all categories, representing "significant reductions to critical programs and services aimed at community prevention, immunization, substance abuse and mental health and health equity." However, the Fund's support was reduced by $6.25 billion from the original amount over nine years beginning in FY 2013—a decline that the 2013 sequestration increased by $51 million. And in April 2013, $453.8 million was used to supplement insurance enrollment activities for the ACA's Health Insurance Marketplaces. These financial reductions and diversions call into question whether the Public Health and Prevention Fund will be able to achieve its goal of significantly reducing rates of chronic disease and controlling health care costs.

Community Transformation Grants. Section 4201 of the ACA authorizes the HHS Secretary to award grants to state and local government agencies as well as community-based organizations to reduce rates of chronic disease and address health disparities through community-level prevention programs. Activities under the grants are intended to focus primarily on several community improvement strategies including: ensuring healthier school environments; building infrastructure to promote active living and improve safe food access; encouraging healthy food options at restaurants; and implementing strategies to improve determinants of health underlying racial and ethnic disparities. In 2011, CDC awarded $103 million for 35 implementation grants and 26 capacity-building grants. In addition, $4 million were awarded to six networks of community-based organizations. During FY 2012 $70 million was awarded to 40 communities with fewer than 500,000 people. Approximately two-thirds of current grantees address populations experiencing health disparities. However, as with a number of other ACA provisions budget constraints have

led to reductions that may thwart fuller realization of intended goals: the FY 2013 budget allocated $80 million less than the President requested in 2012.

Clinical and Community Preventive Services Task Force. Section 4003 of the ACA amends the Public Health Service Act to clarify the role of two previously established prevention task forces. AHRQ's Preventive Services Task Force is authorized to review research and evidence for clinical preventive services, including effectiveness, appropriateness, and cost-efficiency. The Task Force is charged with developing new recommendations based on this review as well as updating previous preventive recommendations for the health care community, with findings to be published and disseminated through the Guide to Clinical Preventive Services. The Task Force also evaluates programs for how well they apply to racially, ethnically, and socioeconomically diverse populations. The Task Force's first and second reports to Congress highlight ways in which communities are implementing its recommendations, provide updated recommendations and findings, and reveal current research gaps and future priorities including those related to advancing health equity. The Community Preventive Services Task Force now includes addressing health disparities through evidence-based research among its priorities. However, its 2011 progress report did not include any systematic reviews related to health equity and since the publication of that report the group has only performed one systematic health equity-related review.

C. Chronic Disease Programs for Diverse Populations

Preventable chronic conditions and, rates of chronic disease are among the major health challenges facing the nation—a concern and priority reflected throughout many ACA provisions. As such, the ACA has established a number of national campaigns targeting costly and preventable health conditions. And, as this focus is of critical importance for racially and ethnically diverse populations who suffer disproportionately from these diseases, the ACA has included explicit language to tailor programs and initiatives in diabetes, cancer, and oral health disease for these populations.

National Diabetes Prevention Program. Section 10501 of the ACA establishes a national diabetes prevention program for high-risk adults. The provision is designed to disburse grants to model sites for community-based diabetes prevention and includes support for training and outreach for intervention instructors as well as monitoring and evaluation conducted. On October 9, 2012, the CDC awarded $6.75 million to six organizations to expand the National Diabetes Prevention Program. Grantees are expected to work with both employers and public and private health insurance companies to coordinate performance-based reimbursement to organizations implementing these programs. Of the six grantees at least five have incorporated strategies to target racially and ethnically diverse individuals at higher risk for diabetes through recruitment initiatives, culturally competent program goals, or as part of the organization's vision. However, while authorized in FY 2010 and FY 2011, appropriations were not forthcoming until FY 2012, with future funding uncertain.

Breast Cancer Education Campaign. The Education and Awareness Requires Learning Young (EARLY) Act was passed as part of the ACA as section 10413. It provides funding through the CDC for a breast cancer education campaign for young women, under age 40, to improve knowledge of: breast health among women of all racial, ethnic, and cultural backgrounds; risk factors for breast cancer such as familial, racial, ethnic, and cultural background; and evidence-based early detection strategies, among others. As part of this provision, the CDC established the Advisory

Committee on Breast Cancer in Young Women to guide the CDC in its development of policies and programs related to breast cancer awareness among young women. As part of this provision, the CDC has supported seven organizations targeting young women diagnosed with breast cancer, with two programs specifically addressing racially and ethnically diverse populations. Notwithstanding progress in implementation, concerns have arisen around the efficacy and appropriateness of such a campaign and best strategies around prevention of breast cancer among young women. Most notably, some leading cancer researchers have voiced concerns about the appropriateness of a widespread campaign, especially as breast cancer occurrence among women younger than 40 years is relatively rare.

Support for Prevention Programs for American Indians and Alaska Natives. Section 10221 of the ACA makes the reauthorization of the Indian Healthcare Improvement Act permanent as well as authorizes new programs within the Indian Health Service (IHS) to increase the types of services available for American Indians and Alaska Natives. These efforts are intended to reduce preventable illnesses, with an emphasis on diabetes, substance abuse, and suicide. The changes made by the ACA include improvements in the health care delivery system under IHS. For example, the law now authorizes hospice, long-term, and home-based care and authorizes the training of more American Indian and Alaska Native health care providers through the Community Health Representative program. However, progress has been slow especially with little to no appropriations for many programs.

National Oral Health Campaign. Section 4102 of ACA authorizes a five-year public education campaign targeting prevention and education in oral health through the CDC. The campaign stresses the importance of reaching certain vulnerable populations such as children, pregnant women, the elderly, and racial and ethnic minorities, and includes language specifying that services be provided in a culturally and linguistically appropriate manner. Grants to all 50 states for school-based dental sealant programs and improved data collection for oral health activities have been authorized by the ACA, but not funded. The CDC is using current funding to implement these activities among 19 states; however, without new appropriations CDC has been unable to fund additional states. Additionally, the five-year national oral health education campaign with a focus on health disparities authorized under the law, has not received any appropriations to date. While the CDC Division of Oral Health continues to support infrastructure for oral health activities with its current budget, without funding for expansion of activities authorized under the ACA or complementary public education campaigns and disease management initiatives, it will be difficult to achieve the broad results in reducing gaps in oral health care experienced by vulnerable communities.

IV. Public Health and Prevention: Emerging Opportunities and Challenges for Advancing Equity

Our review has found that public health and prevention provisions have stressed evidence-based models and outcomes, cross-sector collaboration, and assisting community-based organizations, with several provisions specifically including health equity among their priorities. Support for such initiatives occurs by authorizing dollars to extend programs already in existence, allowing them to expand in their efforts to reach diverse and vulnerable populations. At the same time, the ACA authorizes and funds several novel programs focusing on disease priorities and diverse

populations. However, effective implementation is contingent upon appropriations and sustainable funding.

The ACA opened new doors for advancing public health and prevention, particularly to address the underlying social, economic, and physical factors which affect how diverse individuals and families access health care, the quality of care they obtain, and health status and healthy living. However, the path to realizing these opportunities has been challenging. In this context, at least three key dynamics with implications for public health, prevention, and health equity have emerged following the advent of health care reform.

Continued challenges to funding public health and prevention. The provisions under review present with varying levels of funding concerns and challenges. Some programs, such as the National Diabetes Prevention Program and the Indian Healthcare Improvement Act, were extensions of existing efforts and will continue with or without the additional support provided by the ACA, although they may not live up to their full potential due to the limited or partial funding appropriated. Other provisions have received mandatory funding, have not been subjected to funding cuts, and are well on their way to achieving stated goals. These initiatives include the maternal and child home visiting program and grants for personal responsibility education. One provision, the oral health prevention campaign, however, has made no progress to date as no funds have been appropriated. The Prevention and Public Health Fund was intended to provide more continuous financial support to public health initiatives as, in the past, federal funding was provided by category, and this new fund was intended to move away from that approach. However, questions remain as to whether the fund will fulfill its purpose. While new funding streams are a promising start to improving population health and eliminating health disparities, it appears that budget deficits, cuts to the Prevention and Public Health Fund, and sequestration continue to challenge public health programs funded through the ACA. As local and state departments that have received ACA funding struggle to fulfill their general required duties and objectives, priorities in health disparities may remain on the sidelines.

Need for more evidence-based outcomes related to public health interventions. Data collection and evaluation have presented long-standing challenges in efforts to document effectiveness of population health programs, especially those related to health disparities. Frequently, public health departments and other organizations involved in public health interventions use different tools and measures to collect data and report progress. Many public health programs have had difficulty, for example, correlating investment with a decline in tobacco use. Instead, public health practitioners are more likely to track progress of process measures such as awareness of messaging and characteristics of persons reached. Furthermore, sharing and disseminating lessons learned and evidence-based practices resulting from state-based initiatives has historically been handicapped due to the lack of a centralized system or process to collate information, results and data. In addition, limited timeframes to demonstrate improvement for broad health outcomes for diabetes, obesity or other conditions often prove challenging. This theme of varying measures and outcomes also stood out in our analysis of the law's public health and prevention provisions. The evaluation and efficacy of such programs should be consistent across programs, including measuring improvement in health disparities. The ACA's enhancement of the Community Preventive Services Task Force presents as a potential avenue to moving toward an enhanced and more standardized assessment of community health interventions, including those that will benefit diverse populations.

Enhanced emphasis on partnership development and community-based prevention. The fusion of a "health in all policies" approach and an increased focus on prevention at the community level holds much promise for significant progress toward health disparities. However, many key informants have reported that public health practitioners frequently "work in silos" hindering the scope and breadth of their work. Previously, federal funding for public health has not typically emphasized collaboration and was often provided through rigid categories. Provisions within the ACA aim to increase the importance of establishing partnerships across public health, communities, and other sectors, as well as promoting flexibility in targeting goals for improved health. Challenges for new partnerships in public health include the difficulty in measuring and assessing the health impact of non-health policies. For non-health agencies, collecting baseline data and projecting impacts of a policy on health are both notably challenging tasks, especially in terms of training and supporting staff to conduct such activities. The successful implementation of a "health in all policies" approach will help to reduce the fragmentation of funding for different programs and break down the "silo effect" among different agencies to promote health and equity. When results are integrated across sectors and partnerships are formed to acknowledge the connection between health and other non-health policies, it will minimize the perceived effect of separate programs churning out stand-alone results. As new policies promoting eliminating health disparities are being implemented, the expected challenges such as bureaucratic barriers and battles for territory have emerged, but it is perhaps the more unforeseen challenges that have gained attention and presented the most severe threat to the ACA's successful implementation. A mixture of financial pressures, political opposition and rising rates of chronic disease stand as road blocks to ensuring these policies and programs move forward quickly and effectively.

V. Moving Forward: Strengthening Public Health & Prevention to Advance Health Equity

Investment in public health and prevention, particularly in the context of addressing the overarching determinants of health, are core to advancing and achieving health equity. As noted, despite the ACA's intent and support, the full realization of the law's public health and prevention objectives have generally been stalled by a combination of factors from political opposition to federal budget cuts including sequestration, and declining state and local budgets. The Prevention and Public Health Fund, in particular, has felt the brunt, serving more as a "safety-net" fund to support and sustain existing workforce and public health programs rather than being used to invest in new and novel public health and prevention initiatives. Still, the Fund did establish the Community Transformation Grant program, among others, which is intended to support community-level initiatives targeting the social, economic, and physical determinants of health. Our review of the ACA's related provisions has identified at least four priorities that may assist in elevating its prominence and assuring that equity is core and central to any public health and prevention strategy:

Leveraging ACA's Health Care Delivery Investments to Support Public Health & Prevention and Reduce Disparities. Public health and prevention are integral to many dimensions of equity embedded in the ACA. As such, the Act includes numerous other equity opportunities that can feature, integrate, and otherwise address public health and prevention related priorities. Outcomes of integrating these goals and strategies may add both value to the provision intent and help expand recognition of their importance in addressing patient and population health. There are at least three examples among ACA's many relevant provisions

where public health and prevention can both benefit from and enhance program objectives around equity: Community Health Needs Assessments (CHNAs); medical homes; and initiatives supported through the CMS Innovation Center. The ACA's requirement for all nonprofit hospitals to conduct a CHNA to maintain their tax-exempt status offers a unique opportunity to integrate assessment indicators related to prevention, community health, and equity as well as build and foster unique collaborations for system-wide interventions. Medical homes, or partnerships between the patient, family and primary care provider in collaboration with other specialty areas, are also supported in the ACA, and offer an avenue for advancing equity and prevention. Many of these programs integrate cultural and linguistic competence into care service, prevention, and health promotion. The CMS Innovation center offers additional opportunities for aligning prevention-focused activities with the objective of advancing equity.

Encourage the Explicit Recognition and Integration of Health Equity Where Absent in Public Health and Prevention Provisions of the ACA. Health equity, disparities reduction, and cultural and linguistic priorities are clearly cited as priorities among a number of the ACA's public health or prevention related programs. For example the personal responsibility education grants identify the need for providing culturally appropriate education. However, the majority of provisions do not explicitly mention or cite the need to address racially and ethnically diverse communities. For example, grants for the childhood obesity demonstration projects, diabetes prevention and the maternal and child home visiting programs describe the need to target "at risk" communities and individuals but do not state a focus on diversity or the need for culturally appropriate services. For these and other provisions, specifically recognizing the role and importance of addressing health equity will elevate its importance and likely encourage initiatives that address the needs of diverse patients and communities. Should opportunity be available at the policy level, equity language should be included in federal rules, regulations, and guidance, funding announcements, or charter for related taskforces and committees. At the programmatic level, explicitly integrating racial and ethnic health equity priorities into public health and prevention may involve one or more of many concerted actions, such as infusing equity into program goals and objectives, addressing workforce diversity, and assuring culturally and linguistically appropriate outreach and education, among others.

Develop Incentives to Encourage Cross-Sector Collaboration. Addressing the social and economic dynamics that influence and determine health should be considered a core aim in eliminating health inequalities. Multiple sectors, including public health, the community, social service organizations, and the health care delivery system should develop flexible roles and responsibilities and integrate services and goals for improved population health. Comprehensively assessing health effects of non-health policies such as zoning regulations, housing permits, transportation and business initiatives is likely to be a central task. Public health expertise and experience can assist by providing, tracking and analyzing data to demonstrate progress toward strategic goals. Related incentives, in the form of new payment models and structures and a shared financial target, will motivate different sectors "to engage in the difficult work of building effective partnerships based on shared goals, information systems, innovations in the use of human resources, and cross-sector leadership." And while the shared goal of improved population health alone is an important priority, successful cross-sector collaboration can also include opportunity for participating agencies to elevate their own status and influence.

Incorporate Enhanced CLAS Standards into Public Health and Prevention Initiatives. The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services

(CLAS) in 2013 comes at a pivotal point in efforts to redress longstanding disparities and advance health equity. Building on the original standards issued in 2000, its expanded scope spans a broad range of activities central to enhancing prevention efforts and promoting public health, including: improving quality and safety; engaging communities; meeting standards and accreditation requirements; and justifying the business case through a set of identified actions ranging from governance, leadership, and workforce to communication, language assistance, and engagement as well as continuous improvement and accountability. The CLAS standards are intended to serve as a set of guiding principles for health care organizations serving diverse populations. At the same time, specific standards may have special relevance for public health and prevention, including the six focused on: responsiveness to cultural and language needs; use of trained personnel in interpretation and employing a variety of strategies in communication; actively engaging communities; developing and using relevant, valid data; and conducting as well as acting on findings from health assessments.

VI. Conclusion

The Affordable Care Act holds considerable promise for elevating the importance and, in turn, the contribution of public health and prevention to improving the nation's health. Moreover, many of the provisions discussed in this report directly or implicitly reflect the law's intent to advance health equity as part of the public health and prevention agenda. At the same time, given the goal of reaching and insuring new populations and supporting innovative programs aimed at addressing the needs of vulnerable individuals, this era of health care reform offers the chance to broaden knowledge and understanding around the role and value of public health and prevention in improving the nation's health. In particular, the intended initiatives offer new if not unique opportunities to improve the health of diverse and other vulnerable children and adults, including those with chronic conditions, while opening doors for engaging communities and forming partnerships with other service sectors.

Notwithstanding the intent of the law and its public health and prevention provisions, much remains uncertain. Shortfalls in appropriations, state budget restrictions, the lack of a stronger efficacy evidence base and historically low priority given to these programs threaten significant progress. Other current uncertainties around the rollout of the ACA's marketplaces and ultimate acceptance of the law's vision and principles may have a spillover effect that may inhibit fuller realization of public health and prevention goals. Nonetheless, the ACA has created the occasion for breaking new ground in advancing public health priorities. Time and intent will determine whether the hoped for goals are achievable.

I. Introduction

The United States spends more on health care than any other industrialized nation, yet this greater spending does not translate to better health or life expectancy. In 2009, the U.S. spent $7,960 per capita on health care, more than twice the average of industrialized countries ($3,233),[1] yet the U.S. ranks 27th among 34 industrialized nations in terms of life expectancy.[2] Health care spending in the U.S., as a proportion of the economy, is steadily growing. Whereas in 1980, health care represented 9% of the Gross Domestic Product (GDP), by 2011, it represented 17%, and it is expected to grow to more than one-fifth by 2021.[3] Economic estimates affirm that this growth in spending is "largely attributable to preventable conditions…More than 85 cents of every dollar spent on health in the U.S. are spent on the treatment and management of chronic diseases, such as those caused by preventable conditions related to obesity and tobacco use."[4] Only 3% of the nation's health care dollars is spent on disease prevention.[5]

Compounding these trends are health disparities—which also contribute to unnecessary and preventable medical expenditures. As Thomas LaVeist and colleagues uncovered in a seminal report in 2009, the combined costs of health inequalities and premature death in the U.S. were $1.24 trillion between 2003 and 2006.[6] The report concluded that "eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006." However, according to the Agency for Healthcare Research and Quality's most recent report on disparities, despite initiatives to improve health for vulnerable populations, "quality is improving, access and disparities are not improving."[7] Healthy People 2010, a comprehensive framework developed by the U.S. Department of Health and Human Services, included two overall goals, one of which was to eliminate health disparities. However, in an assessment of its progress toward achieving this goal published in 2010, it was found that there is much work still to be done. In fact, a significantly larger number of health indicators showed an increase in disparity rather than a decrease. The authors concluded:

Figure 1. Disparities in Chronic Disease and Prevention

- Rates of age-adjusted advanced stage breast cancer are consistently higher among African American women than White women, and the rate is increasing among African American women since 2007.[1]
- In years 2000 to 2007, African American women had significantly higher breast cancer death rates than White women.[2]
- In years 2000 to 2005, Hispanic adults with obesity were less likely to receive advice about healthy eating from a health care provider than Whites.[3]
- In 1998 and 2003, Hispanics were less likely than Whites to have their blood cholesterol measured.[4]
- In years 2001 to 2008, African Americans had higher rates of hospital admission for congestive heart failure than Whites.[5]
- In 2007, the rate of HIV was almost eight times higher among African Americans than Whites.[6]

Sources: 1-5. 2010 National Healthcare Quality and Disparities Reports. February 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr10/qrdr10.html
6. http://www.cdc.gov/nchhstp/healthdisparities/AfricanAmericans.html

> Overall, in the area of disparity reduction, there is not much good news. According to our analysis, not much progress has been made, to date, in moving toward the reduction and ultimate elimination of disparities in health. However, it is still early, and to date, limited resources have been devoted to the elimination of disparities in health. Furthermore, there is reason for optimism with health system reform still ahead of us.[8]

Figure 1 offers examples and data reflecting the persistent and severe racial and ethnic disparities in chronic disease and prevention.

Purpose and Rationale

The purpose of this report is to provide a point-in-time status update on the implementation of ACA's provisions for advancing racial and ethnic health equity in public health and prevention. As such, this report describes the opportunities presented by the new law, along with emerging experiences, challenges, and lessons learned with implications for addressing and integrating diversity and equity across public health and prevention. Embedded within this report are emerging programs, best practices, and resources that are intended to assure that racial and ethnic health equity is central to any public health and prevention initiative.

Eleven public health and prevention provisions with an explicit focus on or with considerable implications for racially and ethnically diverse populations were reviewed for this report. These include:

- Section 2951: Maternal, Infant, and Early Childhood Home Visiting Programs;
- Section 2953: Personal Responsibility Education;
- Section 4001: National Prevention, Health Promotion and Public Health Council;
- Section 4002: Prevention and Public Health Fund;
- Section 4003: Clinical and Community Preventive Services;
- Section 4102: Oral Healthcare Prevention Activities;
- Section 4201: Community Transformation Grants;
- Section 4306: Funding for Childhood Obesity Demonstration Project;
- Section 10221: Indian Health Care Improvement;
- Section 10413: Young Women's Breast Health Awareness and Support of Young Women Diagnosed with Breast Cancer; and
- Section 10501: National Diabetes Prevention Program

Organization of Report

This report is organized into the following four sections:

I. ***Introduction:*** This section provides an overview of the goals, objectives, target audience, and value and use of this report. It also describes the *Affordable Care Act &Racial and Ethnic Health Equity Series* in greater depth.

II. ***Methodology:*** The framework and design is discussed in this section, along with specific activities that were undertaken in developing this report.

III. ***Implementation Progress of the ACA's Provisions for Public Health and Diverse Populations:*** This portion of the report offers a thorough synthesis and analysis of information on each provision's legislative context; implementation progress; emerging programs and models; and challenges and next steps.

IV. ***Public Health & Prevention: Emerging Opportunities and Challenges for Advancing Equity:*** This section synthesizes and discusses common and distinct themes that have emerged on implementation progress and describes issues and challenges that must be addressed in the near- and long-term to ensure that programs related to population and public health are designed to effectively address equity and disparities.

V. ***Moving Forward:*** The report is rounded out with a discussion of recommended next steps for ensuring that advancing equity is an integral part of reforming programs for public health and prevention.

Affordable Care Act & Racial and Ethnic Health Equity Series

Series Background and Context

We have been monitoring and analyzing the evolution of health care reform and its implications for reducing disparities and improving equity since shortly after the inauguration of President Obama in 2009. With support from the Joint Center for Political and Economic Studies in Washington, D.C., the project team tracked major House and Senate health care reform bills, identifying and reviewing dozens of provisions with implications for racially and ethnically diverse communities. A series of reports and issue briefs were released, providing a resource for community advocates, researchers, and policymakers seeking to understand and compare the significance and implications of these provisions. Following the enactment of the ACA, a major, comprehensive report—entitled *Patient Protection and Affordable Care Act: Implications for Racially and Ethnically Diverse Populations*[9]—was developed and released in July 2010 describing nearly six dozen provisions in the law core to advancing health equity. The report covered ACA's opportunities and new requirements related to health insurance, the safety net and other points of health care access, workforce diversity and cultural competence, health disparities research, prevention and public health, and quality improvement.

Series Purpose and Objectives

The overall purpose of the *Affordable Care Act & Racial and Ethnic Health Equity Series* is to provide an informative, timely, user-friendly set of reports as a resource for use by health care organizations, community-based organizations, health advocates, public health professionals, policymakers, and others seeking to implement or take advantage of the ACA to reduce racial and ethnic health disparities, advance equity, and promote healthy communities.

The *Series* is funded by W. K. Kellogg Foundation and The California Endowment. The *Series* is intended to:

- Provide a point-in-time snapshot of implementation progress—or lack thereof—of over 60 provisions in the ACA with implications for advancing racial and ethnic health equity, detailing their funding status, actions to date, and how they are moving forward;
- Showcase concrete opportunities presented by the ACA for advancing racial and ethnic health equity, such as funding, collaborative efforts, and innovation that organizations can take advantage of;
- Highlight any threats, challenges, or adverse implications of the law for diverse communities to inform related advocacy and policy efforts; and
- Provide practical guidance and recommendations for audiences working to implement these provisions at the federal, state, and local levels, by documenting model programs, best practices, and lessons learned.

Series Design and Methodology

The project team utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities, and challenges of roughly 60 provisions in the ACA across five topic areas:

- Health insurance exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

For each topic area, the project team conducted a comprehensive review of literature and reports, along with an in-depth assessment of the legislation, emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. To complement research, programs, and policies identified through this review, the team conducted telephone-based interviews with nearly 70 national experts and advocates, federal and state government representatives, health care providers, health plans, community organizations, and researchers in the field. A full list of participants and contributors can be found in Appendix A. Interview questions were tailored to the sectors that respondents represented and were intended to fill important information gaps as well as reinforce themes around emerging progress, opportunities, challenges, and actions not otherwise discussed in written sources. Findings from the literature review, policy analyses, and interviews were synthesized into five topic-specific reports.

Given each report is topic-specific and part of a larger *Series*, every attempt was made to cross-reference subtopics across the *Series*. For example, support for the National Health Services Corps is highlighted under the "Workforce" topic, although it has direct relevance for the "Safety Net" report. Organizing and cross-referencing the reports in this manner was important to streamlining the large amounts of information and ensuring the reports remained user-friendly.

Series Audience and Use

With the latest policy updates and research, complemented by voices and perspectives from a range of sectors and players in the field, the goal of this *Series* is to offer a unique resource and reference guide on the implementation status of the ACA's diversity and equity provisions along with emerging opportunities and actions to reduce disparities. However, given the health care arena is rapidly evolving and expanding, with new guidance, policies, and actions emerging almost daily at all levels, this *Series* offers a point-in-time snapshot of information, perspectives, and resources that were readily available and accessible during the time this project was undertaken.

Reports issued as part of this *Series* are intended for broad audiences and use. For example, federal government agencies may utilize information on best practices, resources, and concerns in the field to inform the development of ACA-related rules and regulations addressing equity, diversity, language, and culture. Nonprofit and community organizations may look to the reports for concrete opportunities for involvement, collaboration, or funding. Health care providers, public health agencies, state exchanges, and health plans may draw on models, best practices, and resources to implement or enhance their own efforts to tailor and ensure racial and ethnic equity and diversity are core to their plans and actions. Advocacy organizations may use data or findings to advocate for appropriations, funding, or support for a variety of equity priorities supported by the ACA, but left unfunded or underfunded.

II. Methodology

We utilized a multi-pronged, qualitative design to monitor and assess the implementation progress, opportunities, and challenges of the Affordable Care Act's (ACA) public health and prevention provisions with major implications for racially and ethnically diverse communities. In this section, we provide a brief overview of our methodology.

Literature and Policy Review. We conducted a comprehensive review of literature on public health and prevention programs, generally and in context of both racial and ethnic health disparities and the ACA. This was complemented by a review of federal regulations, policies, and guidance that have been published to date for implementing each of the eleven public health and prevention related provisions. Given the constantly evolving nature of the field, information and research included in this report is current as of September 30, 2013. In addition, we conducted an extensive review of research and articles on state activities along with programs and models emerging among public health and prevention programs, with the intent of identifying information and guidance that can inform what is required to effectively implement the eleven provisions.

Key Informant Interviews. To obtain the most recent information and the perspectives from individuals currently working on these issues, we interviewed state and county health officials, public health researchers, and representatives from community and advocacy organizations. Appendix A contains a list of individuals interviewed as key informants, and others who contributed information and feedback for our project. We identified interviewee names and contact information from reports, recommendations from those knowledgeable on the ACA's implementation issues, national organizations, and other sources. Questions sought information on the following:

- Specific examples of programs that explicitly express disparities as recommended by the five recommendations in the National Prevention Strategy as well as foreseeable challenges to achieving these objectives;

- State-level actions and participation in the ACA's public health initiatives around prevention and wellness, such as the National Diabetes Prevention Program, including goals specified to target racially and ethnically diverse populations;

- Indicators of early successes in advancing the health of diverse communities through programs funded through the National Prevention and Public Health Fund; and

- Addressing the health of racially and ethnically diverse communities through Community Transformation Grants.

These questions were tailored to different respondents to capture a range of perspectives from national-level experts in public health, state and county health departments, and community and advocacy organizations. We also asked situational and follow-up questions in some interviews, and interviewees often provided further information as well as references to reports on their priority areas.

Synthesis and Analysis. Based on common themes and issues that affect constituents and populations in public health, the 11 provisions were categorized into three priority areas and organized as follows:

4. **Public Health Initiatives for Children and Adolescents**
   - Maternal, Infant, and Early Childhood Home Visiting Programs (§2951)
   - Personal Responsibility Education (§2953)
   - Funding for Childhood Obesity Demonstration Project (§4306)

5. **Community Health and Prevention**
   - National Prevention, Health Promotion and Public Health Council (§4001)
   - Prevention and Public Health Fund (§4002)
   - Clinical and Community Preventive Services (§4003)
   - Community Transformation Grants (§4201)

6. **Chronic Disease Programs Targeting Diverse Populations**
   - Oral Healthcare Prevention Activities (§4102)
   - Indian Health Care Improvement (§10221)
   - Young Women's Breast Health Awareness and Support (§10413)
   - National Diabetes Prevention Program (§10501)

For each provision, the Project Team compiled research, latest policy updates, regulations and guidance, along with synthesized key informant interview findings to address the following areas of inquiry:

1. **Legislative context** of each provision, both as authorized by the ACA and also by any prior legislation.

2. **Implementation status and progress** as documented in the *Federal Register* as regulations, guidance, or taskforces; peer-reviewed literature and national reports; government or foundation-based funding opportunity announcements; and other actions.

3. **Emerging models and programs**, including those established prior to ACA that can inform current implementation, as well as those that have emerged from ACA funding and support.

4. **Challenges and next steps** to realizing the objectives of the provision in the near and longer terms.

Information from the interviews can be found throughout the sections of the report, and respondents were told that their responses would not be attributed or quoted without their permission. Responses were not statistically analyzed and are not intended to be a representative sample of states, hospitals, health centers, or other providers. Rather, this information is qualitative in nature and serves to fill gaps in information on the implementation of specific ACA provisions.

III. Implementation Progress of the ACA's Provisions for Public Health and Diverse Populations

Health disparities are deeply entrenched by race and ethnicity. Individuals of diverse racial and ethnic heritage disproportionately experience both higher rates and a greater severity of diseases such as cancer, diabetes, and injury. While these conclusions have been generally consistent for decades, much less clear are the strategies, practices, and policies necessary for eliminating health inequities, though there is a growing recognition that building healthy communities and assuring cultural competence in all facets of health care are core to reducing disparities. As such many recent public health efforts to address disparities have stressed the importance of broader strategies that include but extend beyond a focus on disease to improving access to preventive care and ameliorating inequities in underlying physical and social determinants of health.[10] In this context, a growing body of research suggests that investments in public health are tied to improved health outcomes, particularly for low-income communities and neighborhoods. One recent study found that for every 10% increase in local public health spending, mortality rates from preventable conditions were reduced between 1.1% to 6.9%. These findings emphasized that local public health investments can improve community health status and outcomes, especially among low-resource communities.[11]

Public health initiatives that include community-based participatory efforts[12,13] and interdisciplinary collaborations[14] have shown promising results in promoting health equity for diverse populations. And more recently successful strategies to achieve health equity have underscored modifying social determinants of health and environmental factors that are inequitably distributed across society[15] –in essence concluding that good health stems from a healthy community that has re-focused public health interventions to where people live, work, and play. To this end, national health policy priorities have shifted to incorporate multiple sectors beyond those directly related to health and human services, such as housing, transportation, and environmental divisions. Many of these policies require local level collaboration, manpower, and resources giving way to a rising recognition of the importance of community partnerships to achieve successful implementation.

The ACA contains a number of opportunities for developing, supporting, elevating, and enhancing initiatives and priorities intended to advance health equity in public health and prevention. Central to this objective is a focus on prevention of chronic diseases. A significant number of new programs and funding proposed under the law aim to enhance population health and build upon public health programs and infrastructure, most of which are funded through the Prevention and Public Health Fund. Many of these initiatives contain interwoven objectives or language explicitly incorporating the goal of reducing health disparities. In addition, the ACA offers a unique opportunity for community and local partners to take center stage for healthy living and prevention programs. Community Transformation Grants, for example, represent a distinct opportunity to improve the health of communities, including racially and ethnically diverse populations, by building and improving on the local, built environment, enhancing access to healthy foods, and promoting healthy behaviors. The National Prevention, Health Promotion and Public Health Council is a newly established body under the ACA designed to shift federal priorities to health prevention by underscoring a "health in all policies" approach. A central

tenant of the Council's National Prevention and Health Promotion Strategy includes the elimination of health disparities.

This section describes the implementation progress, challenges, and road ahead for 11 provisions in the law which are expected to have major implications for prevention and overall health of racially and ethnically diverse patients and communities. These provisions are organized into the following three priorities based on common themes and issues that comprise public health and prevention policy:

- Public Health Initiatives for Children and Adolescents;
- Community Health and Prevention Initiatives; and
- Chronic Disease Programs Targeting Diverse Populations.

Research and evidence is first presented on the importance for addressing each of these themes—and the provisions that fall under them—in context of advancing racial and ethnic equity in prevention and public health. Essentially, why are these actions in the ACA so critical for the health of underserved and diverse patients? What is at stake if these reforms are not put into action appropriately and in a timely manner?

This summary is followed by an overview of the legislative context for each provision, including appropriations, timeline, and other requirements authorized by the Act, along with details on implementation progress such as a summary of interim and/or final federal rules, establishment of working groups, and new funding opportunities and programs that have emerged. Essentially, to what extent has the original intent envisioned by the new law to support and enhance public health and prevention been advanced? Which areas of the law are leading in action and which are lagging?

A final section discusses challenges ahead and important next steps for assuring the full realization of what was originally authorized and intended by the health care reform law. Appendix B provides an "At-A-Glance" summary of these provisions, along with their funding allocations, implementation status, and progress.

A. Public Health Initiatives for Children and Adolescents

Children from diverse racial and ethnic heritage experience persistent and pervasive disparities across multiple health and health care measures when compared to Whites of similar ages.[16] In a nationwide household survey on health, health care, and provider interactions, Hispanic and African American families were significantly less likely to report their children being in good or excellent health. These populations were also more likely to report being uninsured and that their provider did not understand their child-rearing practices.[17] Children from diverse communities and low-income households are also more likely to be overweight and obese.[18] Recent research shows that Hispanic and African American high school children have significantly higher obesity rates than their White counterparts (16.6% and 18.3%, respectively versus 10.8%).[19] Non-White children are also more likely to live in low-income neighborhoods, which often have limited access to healthy food options, fewer parks and recreations areas, and generally are less safe. Sociocultural factors, such as cultural beliefs about diet and the prevalence of breast feeding, may also contribute to the heightened risk of obesity among racially and ethnically diverse children.

These disparities extend well beyond obesity to include critical if not life-threatening health and health related circumstances. Infant mortality rates are 2.5 times higher among African Americans than Whites,[20] and African American mothers are less likely to receive prenatal care.[21] African American children have a 20% higher chance of being diagnosed with asthma and having an asthma attack in the past year.[22] Hispanic, African American, and Native American teens experience disproportionately higher rates of teen pregnancies and births as compared to White teens.[23]

Comprehensive policy reforms proposed to ameliorate the excess burden of poor health among diverse children have gone beyond ensuring health insurance coverage to advocating for services such as: health and nutrition counseling for pregnant women and infants; home visiting for at-risk families;[24] and multi-sector strategies that promote behavior change at the individual, institutional, and community levels. At least three key provisions in the ACA build on this foundation and enhance the ability to bridge gaps in access, care, and outcomes for racially and ethnically diverse children. This section provides an in-depth review and update on implementation progress of these three provisions:

- Maternal, Infant, and Early Childhood Home Visiting Programs (§2951);
- Personal Responsibility Education (§2953); and
- Funding for Childhood Obesity Demonstration Project (§4306).

The ACA enhances the previously established maternal and child home visiting programs designed to link at-risk families to a variety of services beyond health care such as early childhood education, programs to prevent child abuse, as well as educational programs related to parenting skills and healthy nutrition. A growing body of research documents that these programs improve behavioral, academic, and economic outcomes for children and families.[25,26] Some state health departments have been providing such services to vulnerable families for as many as 30 years.

Also enhanced under the ACA are Personal Responsibility Education Programs (PREP)—intended to be culturally tailored to teens and young adults to prevent unplanned births and sexually-transmitted infection (STI) in minority communities. PREP focuses on both abstinence and

contraception education among adolescent populations with high birth rates.[27] PREP is geared toward preventing pregnancy among minority groups that are particularly at-risk. In 2009, 30% of Latino and 30% of African-American teens did not use condoms or birth control pills as compared to 6% of White teens.[28] In addition to abstinence, PREP aims to teach contraception use given its strong link to preventing teen pregnancies. Data from 1990 to 2008 show that there was an 86% decline in teen pregnancy from contraception use.[29]

Finally, the ACA supports Childhood Obesity Demonstration Projects, first described in the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA). The ACA funds these demonstrations with the goal of providing successful evidence-based models to combat the rising obesity epidemic among low-income and underserved children.

Maternal, Infant, and Early Childhood Home Visiting Programs

Legislative Context

Section 2951 of the ACA intends to strengthen maternal, infant, and early childhood home visiting programs, improve service coordination for at-risk populations, and improve outcomes for families through the provision of comprehensive services. Prior to receiving funding, the law requires states to conduct a statewide needs assessment to identify communities with high rates of premature birth and infant mortality, poverty, and domestic violence among other indicators, as well as to evaluate the quality and capability of current home visiting programs in the state. Grants are authorized for states to deliver maternal, infant, and early childhood home visiting programs with the goals of reducing child abuse, neglect and injuries, and improving health outcomes such as infant health, child development as well as outcomes in parenting skills and school readiness. Eligible entities include states, U.S. territories, Indian Tribes or Tribal Organizations, or in cases where states do not apply or are not approved for funding, non-profit organizations.

Implementation Status and Progress

The Health Resources and Services Administration (HRSA) awarded funding in FY 2010 to FY 2013 for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. In FY 2010, $91 million were awarded to states to begin implementation planning to each of the 56 states and territories. Of these awarded funds, $500,000 was intended for states to complete their updated state plans with the remainder pending approval of that plan. In FY 2011, $124 million were awarded by formula to 55 states and territories and $100 million were awarded by competition to 22 states. In FY 2012, HRSA awarded $125 million by formula to 54 states and territories and awarded $174 million to 38 states by competition as well as $900,000 for research projects. Information on awarded grantees is not yet available for FY 2013. Figure 2 summarizes the mandatory appropriations for this provision which total $1.5 billion.

Figure 2. Mandatory Appropriations for Maternal, Infant, and Early Childhood Home Visiting, FY 2010 - 2014

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
MIECHV Program	$100 m	$250 m	$350 m	$400 m	$400 m

Source: Congressional Research Service. Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA). October 14, 2010

Emerging Models and Programs

All grantees have targeted maternal, infant, and early childhood home visiting programs to groups determined to be at-risk. As defined in the law, high priority populations include families who:

- Reside in communities of need as determined by the statewide needs assessment;
- Are pregnant women under the age of 21;
- Have had a history of child abuse, neglect, or prior interactions with child welfare services;
- Have a history of substance abuse;
- Use tobacco in the household;
- Have children with low student achievement;
- Have children with developmental disabilities; or
- Are serving or formerly served in the Armed Forces.

A review of program descriptions reveals that essentially all plan to expand home visiting programs in specific at-risk communities through: increased program enrollment; infrastructure improvements that will better connect existing home visiting programs; other state-level capacity development activities such as improved technical assistance, data collection and analysis, and centralized intake processes; and an increased focused on implementing evidence-based models for home visiting. Common anticipated outcomes described by grantees include improved child health, improved school readiness, and enhanced parenting practices. All programs are targeted to vulnerable and at-risk families and in addition several programs plan to explicitly tailor services to improve outcomes among diverse racial and ethnic populations or individuals with cultural and/or linguistic differences. Following are examples of programs with an explicit focus on race, ethnicity, or diversity:

- ***California Department of Public Health*** is expanding its MIECHV programs to eight new local health jurisdictions comprised of communities facing cultural and linguistic barriers among other challenges. The aim of the program is to reach out to minority and other at-risk families experiencing adversities such as child maltreatment, substance abuse and domestic violence with particular focus on enrollment and retention of diverse, high-risk populations.

- ***Michigan Department of Community Health*** plans to create a more integrated system and improve infrastructure for their MIECHV program. Michigan describes a process for increasing capacity of its current home visiting program by expanding the evidence-based program, Nurse Family Partnership, to target African American first-time mothers in six at-risk communities.

- ***New Jersey Department of Health and Senior Services*** is using MIECHV funding to increase its program capacity by 50%, reaching out to all 21 counties and approximately 5,200 families across the state. High-risk communities were identified in the state's needs assessment process which involved both community input and consideration of risk factors such as single parent's or first-time parent's status, poverty, medical or child welfare risks, and cultural and linguistic barriers.
- ***Tennessee Department of Health*** is using MIECHV funding to expand its home visiting program to 10 at-risk counties, strengthen the state's home visiting workforce through a core competency curriculum, and to build a centralized intake system that will allow screening for all 95 counties. Among the state's overall goals is to ensure that these services will meet the needs of vulnerable children and families in a culturally competent manner.

Challenges and Next Steps

Political challenges have confronted states as they seek to implement MIECHV programs under the ACA. The prominent example occurred in Florida where the state stood to receive $31.3 million over five years in total grant funding for MIECHV. The state performed the needs assessment as required by the law and awarded five local organizations funding to implement program activities. However, progress was thwarted by the state's legislature, which rejected subsequent years of funding due to general opposition to the ACA.[30] These actions have left the state's program directors challenged in finding appropriate resources for their planned MIECHV programs. It is estimated that terminating programs due to the cuts would result in 84 jobs lost and a restriction in services to 500 families.[31] In response, the federal government has opened funding opportunities for non-profit organizations in states that have relinquished their funding for the MIECHV program.[32] Next steps for advancing racial and ethnic health equity in MIECHV programs are to ensure that approved evidence-based home visiting programs include cultural competency components. It is also important to ensure that race and ethnicity data are collected whenever possible so that outcomes for diverse populations can be reported appropriately.

> *"Our state has received huge investments in maternal and child home visiting programs and we are happy this is something the federal government has continued to fund. It makes sense in terms of how much is averted in social cost."*
>
> *-Key Informant*

Personal Responsibility Education

Legislative Context

Section 2953 of the ACA authorizes a Personal Responsibility Education Program (PREP) for adolescents providing education in abstinence and contraception in order to prevent pregnancy and sexually-transmitted diseases. The program is required to:

- Be based upon rigorous research and evidence-based models for delaying sexual activity, increasing contraceptive use or reducing pregnancy;
- Be medically accurate;
- Incorporate principles on both abstinence and contraception into education on responsible sexual behavior for youth who are sexually active;
- Target pregnancy and sexually-transmitted disease prevention by placing "substantial emphasis" on abstinence and contraceptive use;
- Ensure program activities are age-appropriate; and
- Incorporate culturally-appropriate information into program activities.

The provision authorizes $75 million in mandatory funding per year for FY 2010 to FY 2014 for grants to states. The Administration for Children and Families at the U.S. Department of Health and Human Services is authorized to administer these grants. Funding is also available for Indian tribes and tribal organizations as well as for research and evaluation, training, and technical assistance. The law also specifies that if states do not apply for funding, beginning in 2012, funds may be distributed to community-based organizations in those states.

Implementation Status and Progress

As of October 16, 2011, 46 states had received funding under this provision.[33] In each fiscal year, $55.25 million of appropriated funds is available to states by formula to implement evidence-based programs, $10 million is available for testing innovative approaches in personal responsibility education, $3.25 million is allotted for tribes and tribal organizations, and $6.5 million is designated for supporting and evaluating the program.[34] Figure 3 summarizes the mandatory appropriations for FY 2010 to FY 2014, which total $375 million.

Figure 3. Mandatory Funding for Personal Responsibility Education, FY 2010 – FY 2014[35]

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Personal Responsibility Education	$75 m	$75 m	$75 m	$75 m	$75 m

Source: Congressional Research Service. (2010). Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA).

Emerging Models and Programs

Based on a review of brief program descriptions, all grantees describe goals around reducing rates of teen pregnancy, HIV, and STIs among at-risk groups. These goals will be targeted by implementing educational programs that teach decision-making skills for establishing personal behavioral limits, recognizing threats and refusal skills, making safe choices, especially around sexual practices and contraception use, imagining a positive future and identifying how risky behaviors can be barriers to success later in life. Other programs describe approaches such as teen health hotlines and social media campaigns. The vast majority of program descriptions mention their intent to target racially and ethnically diverse teens. In fact, programs from at least 29 states focus on diverse populations.[36] Following are examples of select programs:

- ***George Washington University***, in partnership with Identity, Inc. and other community organizations, is enrolling students into *Be Yourself/Se Tu Mismo*, a tier 2 research and demonstration project funded under the ACA. The program aims to reduce risky behaviors and teen pregnancy rates among 9th and 10th grade Hispanic students. The program consists of after school group sessions, a weekend retreat for intensive education, social media components, and case management services. Current progress has involved the strengthening of the program's curriculum and manuals as well as piloting the after school and weekend programs. The new funding is also expected to increase enrollment and improve training among staff. In order to measure outcomes in delayed sexual onset, prevalence of pregnancy, and utilization of contraception and family planning services the grantee has developed evaluation surveys and instruments.[37]

- ***Maricopa County Department of Health*** is implementing a teen pregnancy prevention program in the Phoenix area under the Teen Outreach Program model at 12 community sites. The project is reaching approximately 300 youth between the ages of 14-18 years, annually. The grantee aims to reduce teen births by establishing a comprehensive, culturally competent youth development program. Other goals target improving community capacity to implement evidence-based curriculum and providing enhanced support services.

- ***The Center for Health Disparities*** at the University of Nevada Las Vegas is implementing Becoming a Responsible Teen (BART) curriculum in local churches. The grantee is serving approximately 100 African American teenagers between the ages of 14-18 years, annually. Education is provided on the following: HIV/AIDS prevention; negotiation skills regarding sex; and contraception and abstinence. Goals identified include delaying sexual initiation among youth, reducing sexual activity, and increasing condom use among sexually active participants.

Challenges and Next Steps

While the vast majority of states received funding for personal responsibility education and most funded programs placed special emphasis on racially and ethnically diverse adolescents, five states did not apply for funding in FY 2010 and FY 2011. Among them were Florida, Indiana, North Dakota, Texas and Virginia. As a result, as stipulated in the ACA, other nonprofit and community-based organizations in those states became eligible for and received the remaining funds.[38]

The ACA also restored funding for abstinence-only education, as outlined in Section 2954, although research suggests that these less comprehensive programs are not as effective for the prevention of pregnancy and STIs.[39,40] State health departments in 30 states including Texas, Florida, North Dakota and Virginia received funding for these abstinence-only programs.[41] The abstinence-only programs, as described in the law, do not require specific tailoring for diverse youth which may further limit their effectiveness among populations who differ by culture, language, race, and socioeconomic status.

Childhood Obesity Demonstration Projects

Legislative Context

Section 4306 of the ACA amends the Social Security Act by appropriating funding for grants to conduct childhood obesity demonstration projects for FY 2010 through FY 2014. According to the Social Security Act, these projects should identify obesity risk factors and screening benefits for those children at risk. They should also assure continued support to participating at-risk children and their families for both risk reduction and use of appropriate preventive and screening techniques. Awardees should use funds for age-appropriate and community-based programs as well as to develop partnerships with schools and daycares to promote active living and healthy eating among other activities and to provide education, guidance, and counseling to children's families regarding these behaviors.

Implementation Status and Progress

On September 29, 2011, CDC announced the three grantees that received funding to establish a Childhood Obesity Demonstration Project:[42]

- The University of Texas Health Science Center at Houston;
- San Diego State University; and
- Massachusetts State Department of Health.

A fourth grantee, The University of Houston Texas Obesity Research Center, received funds to evaluate the interventions, and share best practices and successes. Mandatory appropriations were authorized in the law in the amount of $25 million for the period of FY 2010 to FY 2014.[43]

Emerging Models and Programs

All three of the funded entities with demonstration projects to reduce childhood obesity describe objectives specific to targeting racially and ethnically diverse and/or low income children:

- ***The University of Texas Health Science Center at Houston*** aims to implement obesity prevention and control programs in two communities in Austin and Houston. Both the Michael and Susan Dell Center for Healthy Living and the USDA/ARS Children's Nutrition Research Center at Baylor College of Medicine will implement programs with these funds. The University of Texas Health Science Center at Houston is building on evidence-based programs Mind Exercise Nutrition Do it! (MEND) and Coordinated Approach To Child Health (CATCH) to target obesity prevention in underserved, ethnically diverse children. CATCH engages families and community members to change both individual and environmental behaviors to promote better health through school physical activity programs. Successful results have been found in El Paso where the number of obese fifth graders decreased significantly (11% for girls and 8% for boys). Expansion of the program into Travis County schools, 58 of which are low-income, has shown positive results after one year of implementation: a 7% net difference in CATCH schools.[44] Building on these results, Texas Childhood Research Demonstration (Texas CORD) launched in the summer of 2012 with goals to both implement and evaluate CATCH and MEND in low-income, ethnically diverse areas in Austin and Houston.

- ***San Diego State University*** is partnering with Imperial County Public Health Department and Clinicas de Salud del Pueblo to target childhood obesity in Imperial County, California (and particularly in the communities of Brawley, Calexico, and El Centro), the county with the highest obesity rate in the state. The three phase intervention will promote behavior change at multiple levels such as policy-level, community-level as well as homes, federally qualified health centers, daycares and schools. Clinicas de Salud del Pueblo will use their *promotor* program to work with families in their home environment.

- ***Massachusetts State Department of Public Health*** announced its effort in October 2011 to implement Mass in Motion in the areas of Fitchburg and New Bedford to target obesity prevention among underserved children. Interventions will occur in a multitude of settings such as daycare, primary care, and after-school programs and will incorporate policy change and community-level marketing efforts. Overall program goals center around reducing the rate of childhood obesity as well as the prevalence of chronic disease associated with sedentary behavior and poor eating habits, especially among minority and low-income children. The program is engaging champions from various sectors as well as including a special role for community health workers.

The evaluation component of the grant is being undertaken by researchers from the University of Houston's Texas Obesity Research Center (TORC) and Texas Institute for Measurement, Evaluation and Statistics (TIMES). TORC specializes in researching obesity and its health consequences by conducting interdisciplinary and longitudinal studies; promoting education and training; and collaborating with local community organizations. TIMES brings expertise in statistical methods for measurement and evaluations. After collecting data from the three grantees, the evaluation team intends to provide a thorough assessment of several program areas including effectiveness, delivery of services, feasibility, and sustainability.

Challenges and Next Steps

Results from the childhood obesity demonstration projects have immense potential to fill the current evidence gap in the effectiveness of obesity reduction among diverse and low-income populations. Research in child health disparities has not made the same progress as in adult health, creating a so called "disparity in disparities.[45]" Results of the demonstration projects to be released in 2015 will inform federal, state, and local policy, and provide important next steps to curbing the childhood obesity epidemic among underserved children. However, future legislation will be required to continue and expand upon this initiative, thus making potential widespread intervention spanning the U.S. unclear.

B. Community Health and Prevention Initiatives

The ACA aims to improve health outcomes and create healthier communities by building upon foundations in community health and prevention as well as efforts targeting determinants of health. Related research has confirmed the promise of community-based approaches designed to alleviate the burden of chronic disease. The New York Academy of Medicine created a compendium of 84 articles identifying effective community-based disease prevention programs. Such programs were created to promote physical activity, improve nutrition, and reduce tobacco use; and it was found that evidence-based initiatives can create behavior changes that lessen the incidence and severity of chronic disease.[46] For example, in an effort to target heart disease among a population of 122,800 people, the Stanford Five-City Project implemented comprehensive community education programs drawing from social marketing methods, social learning theory, and community organization strategies and experienced positive outcomes. Researchers found that after five years, risks for coronary heart disease and cardiovascular disease mortality had declined as had measures such as smoking prevalence, blood pressure, resting pulse, and cholesterol.[47]

Examining the underlying determinants of health can help to explain our nation's unequal distribution of good health and wellness. In doing so, we can understand that health is not only influenced by quality and availability of medical services, but is also determined by the overall conditions in which we live, work, and play. Examples of the social and physical factors that affect our nation's wellness include: clean and safe housing, workplaces, and neighborhoods; access to healthy foods; and a built environment that promotes safe transportation and active living. Addressing the current disparities in such determinants is an important step to achieving true health equity, and the ACA has woven this concept into several of its provisions.

This section describes the implementation progress of the ACA's provisions that advance health equity explicitly, or by implication, through community health and prevention. These provisions include:

- National Prevention, Health Promotion and Public Health Council (§4001);
- Prevention and Public Health Fund (§4002);
- Clinical and Community Preventive Services (§4003); and
- Community Transformation Grants (§4201).

The National Prevention and Health Promotion Strategy, developed by the National Prevention and Public Health Council, supports health equity through addressing the underlying determinants of health. The strategy's "health in all policies" approach emphasizes that participation from multiple federal departments, such as transportation, agriculture and education is crucial to achieving improved health for all populations.[48] A call for a national strategy to achieve overarching goals in health and wellness pre-dates the passage of the ACA. *New Horizons for a Healthy America: Recommendations to the New Administration* was released in 2009 and emphasized that both presidential backing and adequate funding are necessary to realize such objectives. The report also provided a roadmap for the "health in all policies" concept, acknowledging that health-related policies span the scope of over 40 different federal agencies. A unified effort is outlined in which leaders from various federal agencies establish goals and implement innovative models to improving health within their agencies.[49]

The ACA also establishes the Prevention and Public Health Fund and Community Transformation Grants (CTGs) that aim to alleviate our nation's most pressing health problems in part through modifying the underlying health determinants as well as through community-based approaches in chronic disease prevention. Local efforts targeting health and wellness goals such as healthy eating, active living, and tobacco-free environments were funded as part of the American Recovery and Reinvestment Act's Communities Putting Prevention to Work (CPPW) initiative in 2009. CPPW funded 50 communities to reduce the burden of disease caused by obesity and tobacco use through changes in the environment that improve active transportation, facilitate healthy nutrition as well as promote tobacco cessation and tobacco control activities. The intent was to widely affect these communities in a variety of ways, creating healthier lifestyles and modifying risk factors for obesity and tobacco-related diseases such as diabetes, heart disease and cancer. One example of success under this program is the city of San Diego's effort to improve nutritious food options for its low-income residents by increasing the number of farmers' markets that accept food stamps. Sales through these means totaled more than $29,600 at two farmers' markets within a five-month period, a number that is expected to increase as more markets begin accepting this type of payment.[50] Both the Fund and the CTGs were built on this strategy for improving population health.[51]

The ACA also enhances the Clinical and Community Preventive Services Task Force, created as a complement to the U.S. Preventive Services Task Force established in 1984 and tasked with providing recommendations on clinical preventive services. The Community Preventive Services Task Force has been enhanced under the law to investigate new topics involving community preventive programs and policies. The Task Force has previously provided recommendations related to health topics such as preventing excess alcohol consumption, asthma control, preventing birth defects, cancer and cardiovascular disease control, and improving mental health. However, previous work of the Task Force did not explicitly consider the application of recommendations to diverse communities, whereas the ACA creates opportunity to ensure that racial and ethnic minorities are incorporated into future policy recommendations.

Racially and ethnically diverse populations potentially have much to gain from these newly established priorities put forth by health care reform which intend to address the underlying social and physical determinants of health within communities. Social determinants of health such as education level, socioeconomic status, and neighborhood often differ by race and ethnicity – for example, African Americans, Hispanics and American Indians are more likely to be poor than White populations. There is an established link between socioeconomic status and racial and ethnic disparities in health,[52] and in fact, racially and ethnically diverse individuals are more highly affected by chronic diseases such as obesity[53] and diabetes[54] and some diverse groups have a higher prevalence of tobacco use.[55] As such, both novel national-level policies and an expanded scope of existing entities present a substantial opportunity to improve the health status of these populations who suffer disproportionately from social and physical disparities in health determinants and are more at-risk for numerous chronic conditions.

National Prevention and Public Health Council

Legislative Context

Section 4001 authorizes the establishment of the National Prevention, Health Promotion and Public Health Council, a federal interagency group established by the President. The Council is

required to develop its first annual report by July 1, 2010 and will continue to do so through January 2015. The Council will be supported by a 25-member Advisory Group on Prevention, Health Promotion, and Integrative Public Health appointed by the President. The Council's charge is to coordinate federal efforts in health promotion, prevention, and wellness, develop a national prevention strategy as well as make recommendations to the President and Congress regarding federal health priorities.

Implementation Status and Progress

In June 2011, the National Prevention Council, comprised of 17 federal agencies and directed by the U.S. Surgeon General, released the National Prevention Strategy. The Strategy emphasizes that optimal health should come not only from the medical care received in hospitals and clinics, but should be woven into where Americans live, work, learn, and play through improvements in clean air and water, nutritious foods, and safe recreation areas, homes, and work places.

The Strategy identifies four Strategic Directions:

- Healthy and Safe Community Environments;
- Clinical and Community Preventative Services;
- Empowered People; and
- Elimination of Health Disparities.

Emerging Models and Programs

The National Prevention Strategy outlines five recommendations to achieve the Strategic Direction of eliminating health disparities:

- Ensure a strategic focus on communities at greatest risk;
- Reduce disparities in access to quality health care;
- Increase capacity of the prevention workforce to identify and address health disparities;
- Support research to identify effective strategies to eliminate health disparities; and
- Standardize and collect data to better identify health disparities.

In June 2012, The National Prevention Council released its Action Plan enumerating goals around the outlined strategy. Each participating federal agency commits to activities performed in alignment with the National Prevention Strategy and outlines current or planned opportunities to implement goals under the Strategy, which total more than 200 specific actions.[56] Many of these initiatives include a focus on the elimination of health disparities. Following are examples of how certain federal agencies are explicitly addressing health disparities through this provision:

- ***Department of Transportation*** is implementing Parents Central, a program designed to improve child passenger safety and reduce death and injury related to car accidents, especially among high-risk populations such as low-income individuals and racial and ethnic minorities. The department further plans to partner with private sector organizations such as the American Medical Association and the American Occupational Therapy Association to address goals in counseling and assessing older drivers who face a

higher risk of injury and death from car accidents.

- ***Environmental Protection Agency*** plans to collaborate with Federal Interagency Working Group on Environmental Justice to work toward goals in environmental justice. These include reducing exposures to environmental risks and improving access to healthy environments for populations who are disproportionally impacted, such as racial and ethnic minorities, by potential environmental hazards. EPA is implementing activities that will incorporate children's environmental health into practices of health care providers.[57,58]

- ***Department of Housing and Urban Development*** is identifying high-need localities experiencing health disparities and is working to improve coordination and leverage resources to meet the needs of those areas. The department is collaborating with other agencies to improve access to housing and support services, such as mental health and substance abuse, for individuals with HIV/AIDS. The effort is part of the department's efforts to implement the National HIV/AIDS Strategy and build upon and strengthen local partnerships.

- ***Department of Labor*** is strengthening multi-sector community-focused programs to improve access to better jobs, educational and economic opportunities, and to support healthy living through access to recreation areas, safe neighborhoods, and grocery stores. In collaboration with the U.S. Department of Agriculture (USDA), the department is implementing the Jobs and Innovation Accelerator Challenge grants. These grants are concentrated in economically disadvantaged areas throughout the country and invest in manufacturing at the local level by awarding grants to businesses, non-profits, and stakeholders clustered in a specific area. Overall goals target enhanced economic security among disparate populations as well as better access to health insurance and prevention services.

Challenges and Next Steps

The Prevention Council faces considerable challenges in carrying out its outlined duties to the fullest capacity. The current economic crisis poses a threat to the sustainability of new policies across all sectors. The council receives funding from the Prevention and Public Health Fund and reducing or eliminating funding for the Council will make it more difficult to achieve its purpose. Collaboration between multiple federal agencies may become strained under financial pressures; little time is left for coordinating new efforts when each agency is expected to maintain broad roles and responsibilities with waning resources. It has even been suggested that agencies may be forced to compete for limited funding under the current fiscal scenario. Furthermore, cross-sector collaborations have historically demonstrated their own set of unique challenges ranging from unclear divisions of responsibility to uncertainty around accountability for proposed goals. [59]

Prevention and Public Health Fund

Legislative Context

Section 4002 of the ACA authorizes the Secretary of HHS to transfer funds, beginning in FY 2010, to HHS programs for prevention, wellness, and public health activities intended to both improve

health and control health care costs. These include numerous programs such as the Community Transformation Grants and the Education and Outreach Campaign for Preventive Benefits, among others. Starting in FY 2015, the provision states that funds are to increase to $2 billion each year.

Implementation Status and Progress

Allocations from the Prevention and Public Health Fund have been distributed to a range of ACA programs, such as Nurse Managed Health Centers, the Community Preventative Services Task Force, and the National Prevention Strategy. A summary of the funded programs and dollars allocated by agency and fiscal year is provided in Figure 4.

During the first year of ACA implementation, funding from the Prevention and Public Health Fund was targeted primarily to infrastructure and workforce support (approximately 69%), of which a majority was dedicated to primary care workforce development. In FY 2011 and FY 2012, the largest proportion of funds were administered for efforts involving community prevention (40%) which includes programs such as Community Transformation Grants, Racial and Ethnic Approaches to Community Health (REACH), and tobacco prevention. Other programs which received considerable support over these two years included (from greatest to least funding): clinical prevention (HIV screening and prevention and other efforts related to improving access to preventive services); workforce and infrastructure support (Epidemiology and Laboratory Capacity Grants, National Public Health Improvement Initiative, and Public Health Training Centers); and research and tracking(Environmental Public Health Tracking, Prevention Research Services, CDC and SAMHSA Healthcare Surveillance). In FY 2013 funding was reduced across all categories, representing "significant reductions to critical programs and services aimed at community prevention, immunization, substance abuse and mental health, and health equity."[60] Further details regarding these reductions are outlined in the *Challenges and Next Steps* section.

Emerging Models and Programs

The fund has been put to use to support a range of disease prevention and promotion initiatives from smoking cessation programs, disease screening, and immunizations to improved nutrition and physical activity promotion programs. Many of these include a specific focus on reaching out to and engaging communities of color and other underserved communities. As previously stated, most of the Prevention Fund's investment in FY 2010 was awarded to public health infrastructure, including primary care workforce support and public health preparedness programs. This support is beneficial to many underserved communities as these individuals are particularly vulnerable during emergencies and infectious disease outbreaks.[61] Workforce training programs, many of which have important implications for diverse communities, have also received substantial support through the Fund.[62] With Prevention Fund funding, for example, two counties in South Carolina implemented a REACH initiative to reduce health disparities among its diverse communities by partnering with a university for diabetes prevention and management programs. The initiative's successes include a 44% reduction in amputations among African Americans.[63] See Texas Health Institute's Report No. 3 entitled, *Enhancing and Diversifying the Nation's Health Care Workforce,* for additional information on workforce diversity initiatives and the ACA.

Figure 4. Summary of Prevention and Public Health Fund Allocations, FY 2010 - FY 2014

	FY 2010 Enacted	FY 2011 Final Allocation	FY 2012 Final Allocation	FY 2013 Final Allocation	FY 2014 President's Budget Request
Agency for Health Care Research and Quality (AHRQ)					
Clinical Preventative Services Research	--	5 mil	5 mil	--	--
Clinical Preventative Services Task Force	5 mil	7 mil	7 mil	6.465 mil	--
Healthy Weight Practice-based Research Networks	.5 mil	--	--	--	--
Subtotal	**5.5 mil**	**12 mil**	**12 mil**	**6.465 mil**	**0 mil**
Centers for Disease Control and Prevention (CDC)					
Community Guide/Community Preventative Services Task Force	5 mil	7 mil	10 mil	7.378 mil	10 mil
Prevention Research Centers	--	10 mil	10 mil	6.456 mil	--
Public Health Research	--	20 mil	--	--	5 mil
Education and Outreach Campaign Regarding Preventive Benefits	--	2 mil	--	--	--
Nutrition, Physical Activity, Obesity State Grants	--	10 mil	10 mil	8.823 mil	--
Coordinated Chronic Disease Prevention State Grants	--	42.2 mil	--	--	--
HIV Screening	30.367 mil	--	--	--	--
Public Health Workforce	7.5 mil	25 mil	25 mil	15.609 mil	25 mil
Public Health Infrastructure	50 mil	40.2 mil	40.2 mil	21.663 mil	40.2 mil
Healthcare-Associated Infections	--	11.750 mil	11.750 mil	11.750 mil	11.750 mil
Epidemiology and Laboratory Capacity Grants	20 mil	40 mil	40 mil	32.424 mil	40 mil
ARRA: Communities Putting Prevention to Work	36.433 mil	--	--	--	--
ARRA: Evaluation	4 mil	--	--	--	--
ARRA: Media	4mil	--	--	--	--
Community Transformation Grant Program	--	145 mil	226 mil	146.34 mil	136.34 mil
Section 317 Immunization Program	--	100 mil	190 mil	90.883 mil	72.46 mil
Racial & Ethnic Approaches to Community Health (REACH)	--	25 mil	40 mil	--	--
Tobacco Prevention	--	50 mil	83 mil	60.302 mil	95 mil
National Media Campaign on Tobacco Use	9.5 mil	--	--	--	--
Tobacco Quitlines	5 mil	--	--	--	--
CDC Healthcare Surveillance	19.858 mil	30 mil	35 mil	28.514 mil	30 mil
Environmental Public Health Tracking	--	35 mil	35 mil	20.740 mil	29 mil
National Prevention Strategy	.142 mil	1 mil	1 mil	.992 mil	1 mil

Promoting Obesity Prevention in Early Childhood Programs	--	.750 mil	--	--	--
National Youth Fitness Survey	--	6 mil	--	--	--
Workplace Wellness	--	10 mil	10 mil	--	--
Unintentional Injury	--	--	--	--	--
Baby Friendly Hospitals/Breastfeeding	--	--	7.05 mil	2.5 mil	2.5 mil
Viral Hepatitis Surveillance	--	--	10 mil	--	--
Elderly Fall Prevention	--	--	--	--	--
Diabetes Prevention Program	--	--	10 mil	--	--
Cancer	--	--	10 mil	--	173.064 mil
Million Hearts	--	--	--	4.612 mil	5 mil
Healthy Weight Taskforce	--	--	5 mil	4 mil	4 mil
Child Health and Development	--	--	--	--	--
Health and Development with Disabilities	--	--	--	--	74.796 mil
Public Health Approach to Blood Disorders	--	--	--	--	--
State and Local Lab Efficiency and Sustainability	--	--	--	--	--
Subtotal	**191.8 mil**	**610.9 mil**	**809 mil**	**462.916 mil**	**755.110 mil**
Center for Medicare and Medicaid Services (CMS)					
Health Insurance Enrollment and Support	--	--	--	453.803 mil	--
Subtotal	**0 mil**	**0 mil**	**0 mil**	**453.803 mil**	**0 mil**
Health Resources and Services Administration (HRSA)					
Primary Care Residencies and Physician Assistant Training	198.122 mil	--	--	--	--
Traineeship for Nurse Practitioner Students	31.431 mil	--	--	--	--
State Health Workforce Development Grants for Primary Care	5.750 mil	--	--	--	--
Nurse Managed Health Centers	15.268 mil	--	--	--	--
Public Health Workforce Development	--	20 mil	23.864 mil	--	4.776 mil
Public Health Training Centers	14.829 mil	--	--	--	--
Standards for Child Care Obesity Prevention	.255 mil	--	--	--	--
Healthy Weight Collaborative	5 mil	--	--	--	--
Alzheimer's Prevention Education and Outreach	--	--	2 mil	1.847 mil	5.3 mil
Newborn Hearing Screening	--	--	--	--	18.66 mil
Heritable Disorders Program	--	--	--	--	9.834 mil
Mental and Behavioral Health – health professions	--	--	10 mil	--	--
Poison Control Centers	--	--	--	--	18.83 mil
Subtotal	**270.655 mil**	**20 mil**	**37 mil**	**1.847 mil**	**57.4 mil**

Substance Abuse & Mental Health Services Admin. (SAMHSA)					
Primary & Behavioral Health Integration	20 mil	35 mil	35 mil	--	28 mil
Suicide Prevention – Garrett Lee Smith	--	10 mil	10 mil	--	--
Screening, Brief Intervention and Referral to Treatment	--	25 mil	25 mil	--	30 mil
SAMHSA Healthcare Surveillance	--	18 mil	18 mil	14.733 mil	--
STOP Act	--	--	--	--	--
SAMHSA Agency-Wide Initiative: Tribal Prevention Grants	--	--	--	--	40 mil
Prescription Drug Monitoring	--	--	4 mil	--	--
Subtotal	**20 mil**	**88 mil**	**92 mil**	**14.733 mil**	**58 mil**
Administration on Aging (AoA)					
Chronic Disease Self Management	--	--	10 mil	7.086 mil	10 mil
Alzheimer's Prevention and Outreach	--	--	4 mil	0.15 mil	4.2 mil
Alzheimer's Disease Services	--	--	--	--	10.5 mil
Elder Justice Research	--	--	6 mil	2 mil	--
Elder Falls Prevention	--	--	--	--	--
Subtotal	**0 mil**	**0 mil**	**20 mil**	**9.236 mil**	**24.7 mil**
Office of Secretary (OS)					
Media: Tobacco Prevention	--	10 mil	10 mil	--	--
Obesity Media Activities	9.12 mil	9.1 mil	--	--	--
Prevention Outreach and Education	--	--	20 mil	--	--
ASPA Subtotal	*9.12 mil*	*19.1 mil*	*30 mil*	*0 mil*	0 *mil*
Healthy Living Innovation Awards/Evaluation	.1 mil	--	--	--	--
ASPE Subtotal	*.1 mil*	*0 mil*	*0 mil*	*0 mil*	*0 mil*
Tobacco Cessation	.9 mil	--	--	--	--
President's Council on Fitness, Sports, and Nutrition	.925 mil	--	--	--	--
Teen Pregnancy Prevention	--	--	--	--	104.79 mil
Strategic Planning	1 mil	--	--	--	--
OASH Subtotal	*2.825 mil*	*0 mil*	*0 mil*	*0 mil*	*104.79 mil*
Emerging Public Health Issues	--	--	--	--	--
Alzheimer's Disease Activities	--	--	--	--	--
Subtotal – All GDM	12.045 mil	19.1 mil	30 mil	0 mil	104.79 mil
TOTAL	**500 mil**	**750 mil**	**1,000 mil**	**949.0 mil**	**1,000 mil**

Note: ASPA = Assistant Secretary for Public Affairs; ASPE = Office of the Assistant Secretary for Planning and Evaluation; OASH = Office of the Assistant Secretary for Health; GDM = General Departmental Management

Source: American Public Health Association. Prevention and Public Health Fund. Detailed Activities by Agency. Available at: http://www.apha.org/NR/rdonlyres/A448A5CD-6BFE-4AA5-B25D-DF59C195484E/0/PPH2010201441613.pdf.

Challenges and Next Steps

Prevention and Public Health Fund challenges have stemmed from political disagreement regarding the amount allocated, diversion of funding for other priorities as well as sequestration. The amount outlined in the law—originally $15 billion—was set aside as mandatory funding to add to and support additional public health programs, but many Congressional representatives viewed this amount as too high. The law also includes an exception allowing Congress to draw from the Fund in order to support already established public health programs,[64] representing a challenge for launching new public health programs described in the law. In 2010 and 2011, the Fund became a potential target for substantial reductions by both political parties to pay for other priorities, while the President also advocated for decreased support, by $3.5 billion in FY 2011 and $4 billion in his FY 2013 budget request. Eventually, the Middle Class Tax Relief and Job Creation Act, passed in February 2012, reduced the Fund by $6.25 billion from the original amount over 9 years beginning in FY 2013 to fund the extension of Medicare physician payments.

Additional loss of dollars also occurred during FY 2013. Sequestration—or automatic, across the board federal spending cuts—which began in March 2013, eliminated $51 million from the Fund. And in April 2013, $453.8 million was used to supplement insurance enrollment activities for the ACA's Health Insurance Marketplaces.[65] Moreover, in some states and localities funds distributed may have been used to fill gaps in currently under-funded programs rather than to create new initiatives.[66] In sum, these challenges call into question whether the Prevention and Public Health Fund will be able to achieve its goal of significantly reducing rates of chronic disease and controlling health care costs.

Community Transformation Grants

Legislative Context

Section 4201 of the ACA authorizes the HHS Secretary to award grants to a variety of entities—including state and local government agencies and community-based organizations—to reduce rates of chronic disease and address health disparities through community-level prevention programs. The Act further specifies that no less than 20% of the grants be awarded to recipients in rural areas. Activities under the grants are to focus on ensuring healthier school environments, building infrastructure to promote active living and improved safe food access, highlighting healthy food options at restaurants, and implementing strategies to improve the varied determinants of health underlying racial and ethnic disparities, among other priorities. The law authorizes such sums as necessary for this provision for FY 2010 to FY 2014. The list of possible activities as outlined in the law include: "prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health," and "addressing special populations needs, including all age groups."

Implementation Status and Progress

In FY 2011, CDC awarded 61 Community Transformation Grants in the amount of $103 million, 35 of which were implementation grants and 26 were capacity building awards. The CDC estimates that one in three Americans (120 million residents) will be reached by these grants which span across 36 states. Grant recipients are charged with engaging community-based organizations to facilitate participation from a wide array of community members. In addition, $4 million were

awarded to six networks of community-based organizations. These groups received awards for two main purposes—either to disseminate the Community Transformation Grants' evidence-based interventions to their networks or to accelerate proven strategies broadly across the country. Both dissemination and acceleration awardees aim to reach rural areas and areas experiencing health disparities. Figure 5 summarizes these 61 grantees by type of organization and Figure 6 displays the six national network grantees.

Figure 5. Summary of 2011 Community Transformation Grants

Type of Grantee	Type of Award	No. of Awards
State Health Departments	Implementation	17
	Capacity-building	4
	Subtotal	*21*
City/County Health Departments	Implementation	10
	Capacity-building	9
	Subtotal	19
Nonprofit/Not-for-profit/501(c)(3)	Implementation	4
	Capacity-building	3
	Subtotal	7
University	Implementation	2
	Subtotal	2
Tribes and Territories	Implementation	2
	Capacity-building	6
	Subtotal	8
Private foundation	Capacity-building	1
	Subtotal	1
Hospital System or Collaboration	Capacity-building	3
	Subtotal	3
Total		**61**

Figure 6. National Network 2011 Community Transformation Grants

Grantee	Type of Award
American Public Health Association	Dissemination
Asian Pacific Partners for Empowerment, Advocacy and Leadership	Dissemination
Community Anti-Drug Coalitions of America	Dissemination
American Lung Association	Acceleration
National REACH Coalition	Acceleration
YMCA of the USA	Acceleration

Community Transformation Grants were again awarded in 2012 in the amount of $70 million to 40 communities with fewer than 500,000 people. Awardees included towns, counties, tribes, cities, neighborhoods and school districts, with 9.2 million individuals estimated to be impacted. Goals of this small communities program are aligned with the overall scope of the Community

Transformation Grants which is to provide support for tobacco-free programs; physical activity and healthy eating initiatives; preventative services; and a safe built environment. Figure 7 displays the authorized and actual funding amounts for the Community Transformation Grants for FY 2010 to FY 2014.

Figure 7. Authorized Funding in ACA and Actual Funding for Community Transformation Grants (CTGs), FY 2010-2014

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
CTGs	SSAN	$0 m	SSAN	$145 m	SSAN	$226 m	SSAN	$146 m	SSAN	$146 m

SSAN = Such sums as necessary
Auth. = Authorized amount

Emerging Models and Programs

All grantees are implementing community interventions to promote healthy living through initiatives in: tobacco-free living; physical activity and healthier eating; and clinical and community preventive services. Grantees describe partnerships between various entities such as state and county public health departments; state, local and community-based organizations; health providers; schools; and businesses. Examples of activities proposed under the grant include working with community health workers to assist with control and management of blood pressure and cholesterol; establishing farmer's markets or farm stands in underserved areas; and working with schools to provide healthier lunch options. Twenty percent of the funding was awarded to interventions targeted in rural areas. Several awarded programs stand out as their work includes a significant component or innovative model to address health disparities. Approximately two-thirds of current grantees address populations experiencing health disparities.[67] We highlight a sample of those initiatives below and describe their early successes.

- ***Massachusetts Department of Health*** initiated Mass in Motion, a public health campaign in 2009. The initiative's core structure centers on a community-driven approach to promote physical activity and healthy eating in order to reduce overweight and obesity while engaging a variety of partners from multiple sectors. Through the ACA's Community Transformation Grant, Mass in Motion was expanded to additional counties and municipalities. Massachusetts Department of Health received two grants, both approximately $1.5 million.

  The Massachusetts Department of Health has incorporated several strategies into its project proposal that will increase their capacity to reach out to and engage diverse communities. For example, the Department describes partnering with the Massachusetts League of Community Health Centers, an entity that strives to provide culturally and linguistically competent care, to facilitate access for their clients, many of whom experience higher rates of chronic disease, to the initiatives revolving around physical activity and healthy eating. By partnering with community health centers, the health department plans to reduce disparities in disease rates by identifying resources the community needs, creating sustainable communication channels for patients, clinicians

and agencies in the community, and engaging a clinician champion to achieve broad program support. Mass in Motion encourages community health centers to leverage team members such as community health workers to identify and target hard-to-reach and underserved populations. Their plan further includes integral participation from the Community Transformation Health Equity Staff to provide trainings in Culturally and Linguistically Appropriate Services (CLAS) and to educate clinicians participating in the grant's activities on the use of medical interpreters. Each participating site is to implement training procedures for CLAS standards and medical interpretation. Ensuring equity in delivering Mass in Motion will also be facilitated by senior members of the department of health, some of whom serve on the Massachusetts Health Disparities Council, an entity that formed from the 2006 health reform law that makes policy recommendations to eliminate racial and ethnic disparities.[68]

- ***Tacoma-Pierce County Health Department*** in Washington has received a Community Transformation Grant to improve the health of the county's residents. With up to five years of funding for $800,000 per year, the Department has outlined plans to achieve specific goals in health and wellness. The Department has developed content-driven coalitions to implement community programs based upon the CTG's mission. The Coalition for Active Transportation works to build safe streets facilitating comfortable walking and biking use. Healthy Communities of Pierce County aims to implement nutritious options at food banks, works with large employers to achieve healthier meals in cafeterias and vending machines, and promotes increased physical activity in schools. The Community and Clinical Preventative Services Coalition is working closely with local health care systems on best practices in surveillance and treatment of chronic diseases as well as to improve information sharing between county health care entities. The Tobacco-Free Alliance of Pierce County leads the coalition to implement smoke-free policies among public housing units, colleges and universities, and area parks.

The fifth coalition, the Cross-Cultural Collaborative of Pierce County, collaborates with the four previously described groups to assure that programs are inclusive of diverse populations and by providing a "health equity lens" for program goals. The Collaborative is made up of 20 multicultural community-based organizations and seeks effective and innovative approaches to eliminating health disparities by making sure that low-income and underserved communities have a voice. This group has been crucial in initiating a cultural shift as they work with other participating coalitions.

In developing program goals, for example, in active transportation, the leadership team focused on areas with a highly diverse population and in targeting active living goals, the focus started with schools with a high number of reduced lunches. The transformation grant leadership will also encourage partnership with community health workers, with the aim of improving access to care. These trusted navigators are seen as essential to achieving community support especially from members who may be diverse in race, language and culture.

> *"The Cross-Cultural Collaborative helps us earnestly serve folks who have traditionally been left out. Community members give feedback and bring it back to the CTG staff."*
>
> *-Key informant*

- ***National REACH Coalition*** has received a CTG which focuses on core components of active living and healthy eating, tobacco-free policies, safe physical environments as well as other preventive services with a clear aim of improving the health and well-being of Black or African American, Hispanic or Latino, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaskan Native communities. The National REACH Coalition was built from several CDC-funded organizations, beginning in 1999. As an acceleration grantee, the National REACH Coalition is providing funding to its sub-recipients for up to $90,000 each year. Trainings and technical assistance will be provided to such recipients using the proven Racial and Ethnic Approaches to Community Health (REACH) model. Topics for these trainings span several areas, including:

    - Racial justice;
    - Health equity;
    - Creating sustainable partnerships with communities of color and other underserved populations;
    - Using impact assessments for planning in rural areas and in communities of color; and
    - Identifying and addressing structural racism.

    The model employs several evidence-based concepts in reducing health disparities such as community-based participatory research to analyze community risk factors for intervention planning as well as the provision of culturally and linguistically appropriate programs in disease management. In a survey of CDC's REACH programs, data showed promising improvements: cigarette smoking among African American men in participating REACH communities decreased from 42% to 20% in 4 years while the rate of mammography screening increased from 29% to 61% among African American women in 8 years. The Northern Manhattan Start Right Coalition, a REACH program, has narrowed the gap in immunization rates among Latino and African American children who are no longer below city and national rates of immunization.[69] In fact, A 2003 Government Accountability Office report showed REACH as one of the nation's most effective programs in addressing health disparities.[70]

Challenges and Next Steps

Community Transformation Grants have not been without controversies and challenges throughout the early stages of implementation. As with other public health programs, funding for these grants have been threatened by the nation's ongoing fiscal challenges. For example, the FY 2013 budget allocated $80 million less than the President requested in 2012 for community programs set up and currently being implemented by the CTGs,[71] meaning less support for advancing the goals outlined. According to key informant interviewees, it is challenging for county or state health departments to try not to remedy existing budget cuts by applying grant funds to fill current gaps.

Funding cuts are particularly concerning for REACH initiatives funded under the ACA. As described previously, the National REACH Coalition is a funded CTG grantee. Other REACH programs such as REACH U.S. and REACH CORE, though not funded as a CTG, were previously funded by the ACA in FY 2011 and FY 2012; funding for these programs was eliminated in

subsequent years. Reasons cited were that the programs' goals could be achieved by the CTGs.[72] Diminishing support for REACH programs and other similar initiatives for reducing disparities poses a significant barrier to achieving objectives for advancing equity—generally in the health care system, but also importantly within prevention and health promotion initiatives.

Other sources of controversy have grown from doubts around whether the novel programs the fund supports are truly worth the investment. For example, by promoting active living and healthy and safe environments, many programs propose community enhancements such as sidewalks and walking trails. However, critics and political opponents have cited uncertainties of the effectiveness of such changes to the built environment in reducing obesity and other chronic diseases and criticize the spending amount allocated as simply too high. Criticism has also surfaced around the effectiveness of the Community Transformation Grants. Opponents of the grants have labeled them "extremely expensive experiments."[73]

Clinical and Community Preventive Services Task Force

Legislative Context

Section 4003 of the ACA amends the Public Health Service Act to clarify the role of two previously established prevention task forces. AHRQ's Preventive Services Task Force is authorized to review research and evidence of effectiveness, appropriateness, and cost-efficiency for clinical preventive services. To this end, the Task Force is charged with: developing new recommendations based on this review; updating previous preventive recommendations for various entities in the health care community; and publishing their findings in the Guide to Clinical Preventive Services. Among other duties, the Task Force will develop new recommendations for "specific sub-populations and age groups."

The Act further specifies that the CDC's Community Preventive Services Task Force publish its recommendations around effectiveness, appropriateness, and cost-efficiency of population-based prevention programs in the Guide to Community Preventive Services. The duties outlined for this independent Task Force include "the development of additional topic areas for new recommendations and interventions, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups." The law further specifies that the Task force "review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling." The CDC Task Force is also required to report gaps in research and future priority areas to Congress on an annual basis.

Implementation Status and Progress

In 2011, The Community Preventive Services Task Force, a 15-member body of experts in the field of public health and prevention, released the *Community Preventive Services Task Force First Annual Report to Congress and to Agencies Related to the Work of the Task Force* in response to the ACA. This report provides recommendations on effective "real-world" programs and policies— for example, those that are implemented in schools, communities, workplaces and health plans. Recommendations are intended for a diverse group of decision-makers and

stakeholders who are able to leverage resources to improve population health.[74] The Task Force's *2012 Annual Report to Congress* provides updates on recommendations and activities since the previous year's report. These included new findings related to preventing infectious and chronic disease, improving mental health and reducing health disparities.[75]

To date, the Task Force has released over 200 recommendations based on their review of current evidence related to pressing public health topics affecting all ages and population groups. Recommendations are based on thorough systematic review methods that analyze strengths and weaknesses of programs, services and policies related to health promotion and disease prevention among topics deemed "high priority." The Task Force also evaluates such programs for how well they apply to diverse populations including varying racial and ethnic, socioeconomic, and geographic groups.[76] In prioritizing areas for future review several criteria are used including the "potential to reduce health disparities across varied populations based on age, gender, race/ethnicity, income, disability, setting, context, and other factors."[77]

Emerging Models and Programs

The Task Force's first and second reports to Congress highlight ways in which communities are implementing its recommendations, provide updated recommendations and findings, and reveal current research gaps and future priorities including those related to health equity. Following are relevant highlights from these reports.

The Community Guide in Action

The Task Force developed "The Community Guide in Action" to demonstrate how communities are successfully implementing its recommendations. The following sites have incorporated recommendations put forth by the task force into local policies and programs which have shown positive outcomes toward reducing disparities among racially and ethnically diverse populations:

- ***San Carlos Apache Tribal Police Department*** in Arizona was funded by CDC in 2004 to implement media campaigns, sobriety checkpoints, improved police enforcement, and events in the local community targeting reduced alcohol-impaired driving and increased seat belt use. In 2007, the San Carlos Tribal council passed local policies related to seat belt and blood alcohol concentration levels to also target this Task Force recommendation. Between 2004 and 2005, among the positive results stemming from these community-based approaches were: a 52% increase in arrests for driving under the influence; seat belt use improved 46%; and the rate of motor vehicle accidents dropped 29%.

- ***St. James-Santee Family Health Center*** in South Carolina focused on the Task Force's recommendations to increase breast and cervical cancer screening among African American communities in three medically underserved counties. Implemented strategies included: client reminders; one-on-one education; group education; reducing out-of-pocket expenses; and creating reminder and feedback systems for clinical providers. Two years after initiating the intervention, breast and cervical cancer screening rates increased by 10%. The Center also targeted missed appointments at four of its locations and succeeded in reducing the missed appointment rate by 30% in six months.

- ***Hoonah Fun and Fit Partnership*** in rural Alaska implemented community-based campaigns to address physical activity among its predominately Alaska Native community. The community partnership collaborated with school districts to improve nutrition and increase gym hours in local schools as well as identified several other opportunities to improve health in the community such as promoting access to hike and bike trails and reopening a local pool.

- ***Los Angeles County Department of Public Health*** has supported policies to curb obesity and improve physical activity in El Monte, a city with a large Hispanic population, through improvements in the city's facilities. A 1-mile walking circuit was developed with access to neighborhood schools, public transit, and community centers. The department has also implemented community guide findings around tobacco control and enacted approximately 100 new policies which have contributed to the county having one of the lowest smoking rates among the nation's counties.

Updates to Systematic Reviews and Future Priorities

In the 2011 report to Congress, the Task Force listed topic areas of its systematic reviews, among which health disparities was not included. However, since the publication of that report, the Task Force has released one new systematic review under the topic area of "Addressing Disparities in Health Status (Health Equity)" which evaluates the effect of full-day and half-day kindergarten for low-income and diverse students on health-related educational outcomes. The task force has outlined its highest priorities for 2012 to 2013, which include addressing health disparities.[78]

Research Gaps

In general, the Task Force has found that actions addressing racial and ethnic disparities warrant additional research. In particular, the Task Force determined that the effectiveness of interventions for racially and ethnically diverse communities required more evidence for evaluation. Studies reviewed frequently did not report racial/ethnic status or only had a small number of minority participants. The implementation of electronic health records was identified as a potentially promising health care delivery strategy, especially in assisting both socio-demographically diverse and/or hard-to-reach populations in inner city or rural areas. However, the Task Force found insufficient evidence to evaluate the efficacy of this approach for improving health for such vulnerable groups. According to the first annual report, the Task Force is also enhancing the process of providing technical assistance to local communities that wish to implement its recommendations. Its liaisons and partners are assisting local representatives with hands-on help and consultation to further advance effective dissemination of findings and improve health in schools, communities, and workplaces.

Challenges and Next Steps

The Community Preventive Services Task Force has elevated priorities in targeting social determinants of health through supporting the growing understanding that public health interventions should be rooted in evidence-based efforts to build healthy, safe, and prosperous communities. This goal is especially important for racially and ethnically diverse populations, who suffer disproportionately from environmental risk factors, are more likely to suffer health related consequences due to socioeconomic status, and are more likely to live in areas with high rates of

crime or violence. The Community Preventive Services Task Force now includes the priority to address health disparities through evidence-based research. However, there still exists a large gap in this area which is apparent as the body's 2011 progress report did not include any systematic reviews related to health equity, and since the publication of that report, the group has only performed one systematic review addressing health equity. Moving forward, a greater focus on research and evidence related to reducing disparities and advancing equity is warranted.

C. Chronic Disease Programs for Diverse Populations

Today's most ubiquitous health problems stem from preventable chronic conditions; rates of chronic disease such as heart disease, cancer, and diabetes continue to rise and currently affect a substantial proportion of the nation's population. The prevention of chronic disease is a theme that permeates the ACA, and a number of national campaigns have been outlined to target costly and preventable health crises. Many of these chronic diseases affect racially and ethnically diverse populations disproportionately and the ACA recognizes this significant disparity by including explicit language to tailor programs and initiatives in diabetes, cancer, and oral health disease for these populations. In this section we describe implementation status and progress of provisions that address disparities for chronic disease programs, including:

- Oral healthcare prevention activities (§4102);
- Indian health care improvement (§10221);
- Young women's breast health awareness and support of young women diagnosed with breast cancer (§10413); and
- National Diabetes Prevention Program (§10501).

Among diseases that affect racially and ethnically diverse populations disproportionately are those that stem from poor oral health. The nation currently experiences alarming disparities in oral health status, which is frequently cited as the leading unmet health need among children and adults. Vulnerable populations include not only racial and ethnic minorities, but also the elderly, individuals residing in rural areas and immigrants. Non-Hispanic African Americans, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any of the racial and ethnic groups in the U.S. population.[79] African American children are nearly twice as likely to report having fair to poor oral health as Whites, while Hispanic children are nearly four times more likely.[80] In addition, a recent national survey suggested that a higher proportion of Mexican American children ages 12 to 23 months experience dental caries compared to other racial and ethnic groups.[81] The Institute of Medicine (IOM) Committee on Advancing Oral Health in America has recommended several approaches to improving the oral health of the nation.[82] This set of recommendations called the New Oral Health Initiative (NOHI) includes ten principles, with one focused explicitly on improving oral health literacy and cultural competence and another on reducing oral health disparities.

Across disease conditions, Native Americans and Alaska Natives experience a clear gap in health status as compared to their White counterparts,[83,84] and in fact, may suffer from health risk factors and chronic disease at higher rates than other racial/ethnic minority populations.[85] The Indian Health Service (IHS) provides health services to 1.9 million American Indians and Alaska Natives.[86] Approved by Congress in 1976, The Indian Health Care Improvement Act (IHCIA) authorizes health care services for this population through the Indian Health Service. Title V of the IHCIA health care is intended to improve access for American Indians by directing resources to 34 urban contracts in 19 states.[87] However, continuous implementation of the Act required returning to Congress for requests for reauthorization, and it was last reauthorized in 1992 which extended appropriations through fiscal year 2001.[88] The ACA contains a provision to permanently re-authorize the IHCIA.

In addition to advancing priorities for American Indian health and oral health, the ACA supports breast cancer awareness and education, generally, and targeting diverse communities. Disparities in screening, morbidity, and mortality of breast cancer are well documented with racial and ethnic minorities faring worse than White women. These disparities generally stem from differing rates of obesity, screening, and breast feeding as well as age at menarche, oral contraceptive use, and smoking prevalence.[89] Prior to the enactment of the ACA, the Education and Awareness Requires Learning Young (EARLY) Act was introduced in March 2009 with the intent of establishing a national education campaign to educate young women from diverse racial and ethnic heritage about risk factors for breast cancer. It was passed, however, as part of the ACA in March 2010.

Finally, the ACA also included support for a Diabetes Prevention Program—a comprehensive lifestyle program designed to reduce the prevalence of risk factors associated with type 2 diabetes. Studies have found that Native Americans and African Americans are both twice as likely and Hispanics are 1.7 times as likely to be diagnosed with diabetes as Whites in the United States.[90,91] In 2006, researchers from Indiana University conducted Translating the Diabetes Prevention Program into the Community: The DEPLOY Pilot Study in partnership with the YMCA in Indianapolis and found that diabetes lifestyle interventions could achieve similar results as found in the original clinical trial. They further found that costs could be significantly reduced by providing the intervention to groups of adults rather than through one-on-one intervention.[92] In 2009, CDC partnered with YMCA of greater Louisville to replicate the findings with positive results. In 2010 and 2011, CDC began wide-scale dissemination efforts to other YMCAs in order to reach a larger portion of adults at-risk for type 2 diabetes. The ACA authorizes additional opportunities to further expand upon these successful diabetes initiatives by creating the National Diabetes Prevention Program.

National Oral Health Campaign

Legislative Context

Section 4102 of the ACA authorizes a five-year public education campaign targeting prevention and education in oral health through the CDC. Priority populations, include children, pregnant women, the elderly, and racial and ethnic minorities. Additionally the campaign reinforces the importance of cultural and linguistic competence in delivery of related services. The law also specifies that activities be evidence-based and planning activities and implementation must begin within two years after enactment of the law. The funding for such a campaign is directed for community-based dental providers, federally-qualified health centers, local health departments, private dental service providers, and national organizations focused on improving children's oral health. This provision also authorizes several other oral health activities, including: extending grants for school-based dental sealant programs to 50 states; establishing cooperative agreements with states to enhance oral health infrastructure; and expanding oral health surveillance systems from 16 states to all 50 states.

Implementation Status and Progress

Grants to all 50 states for school-based dental sealant programs and improved data collection for oral health activities have been authorized by the ACA, but not funded. The CDC is using current

funding to implement these activities among 19 states (Kansas, Texas, and Vermont have been newly- funded). However, without new appropriations CDC has been unable to fund additional states. The five-year national oral health education campaign, with a focus on health disparities authorized under the law, has not received any appropriations to date.[93] Figure 8 displays authorized and actual funding for this provision for FY 2010 to FY 2014.

Figure 8. Authorized Funding in the ACA and Actual Funding for Oral Health Initiatives, FY 2010-2014[94,95]

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth	**Actual**	**Auth**	**Actual**	**Auth**	**Actual**	**Auth**	**Actual**	**Auth**	**Requested**
National Oral Health Campaign	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m
Oral Health Infrastructure	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$ 0 m
Oral Health Surveillance	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$0 m	SSAN	$ 0 m
School-based dental sealant programs	*	$15 m**	*	$15 m**	*	$15 m**	*	$14 m**	*	$16 m**

Auth = Authorized
SSAN = Such Sums as Necessary
*ACA does not authorize new funding;
**Represents funding for all of CDC's oral health programs under Section 317M of the Public Health Service Act (PHSA).

Emerging Models and Programs

While the ACA's oral health prevention activities have not received any funding through the law, many organizations and programs over the years have emerged to advance oral health for diverse communities. Following are examples of a few promising initiatives:

- ***Colgate-Palmolive Company/Hispanic Dental Association (HDA)*** groups have come together to form an education campaign around proper oral health care to reduce the gap in poor oral health among U.S. families. The campaign is focusing efforts on the Hispanic community and is ensuring its campaign is adequately tailored to this group by utilizing bilingual education materials. Mobile dental vans are implementing free dental screenings and education on oral health to underserved children.[96]

- ***Office of Minority Health*** launched the Cultural Competency E-learning Oral Health Continuing Education Program in 2010 to focus on disparities in oral health by providing cultural competency training for physicians and nurses. The web-based program is furthering goals around equitable treatment for racial and ethnic minorities by building on evidence from focus groups, literature review as well as guidance from national experts serving on the National Project Advisory Committee.[97]

- ***Maryland's Dental Action Coalition***, in partnership with state officials, has led the way in serving children's oral health priorities by meeting seven out of eight policy benchmarks defined by the Pew Center on the States. Both the share of Medicaid-enrolled

children receiving dental care and the share of high-risk schools with sealant programs exceed national averages.[98]

Challenges and Next Steps

Similar to many of the other ACA provisions under public health and prevention, the most prominent obstacle facing the oral health campaign for racially and ethnically diverse communities is funding. While the CDC Division of Oral Health continues to support infrastructure for oral health activities with its current budget, without funding for expansion of activities authorized under the ACA or complementary public education campaigns and disease management initiatives, it will be difficult to achieve the broad results in reducing the gap in oral health care experienced by vulnerable communities.

Support for American Indian/Alaska Native Prevention Programs

Legislative Context

Section 10221 of the ACA makes the reauthorization of the Indian Healthcare Improvement Act (IHCIA) permanent as well as authorizes new programs within the Indian Health Service (IHS) to increase the types of services available for American Indians and Alaska Natives. These efforts are intended to reduce preventable illnesses among this population, with an emphasis on diabetes, substance abuse, and suicide.

Implementation Status and Progress

The changes made by the ACA include improvements in the health care delivery system under IHS. For example, the law now authorizes hospice, long-term, and home-based care and authorizes the training of more American Indian and Alaska Native health care providers through the Community Health Representative program. Figure 9 displays a summary of sections of the Indian Healthcare Improvement Act permanently authorized under the ACA that are applicable to improving health among the American Indian/Alaska Native populations through preventive services.

The progress of these authorized changes has been slow for several initiatives. For example, while authority is expanded for diabetes and long-term care programs, implementation would require additional appropriations. The demonstration programs authorized for Indian health programs to address health professional shortages as well as the demonstration projects for mobile health stations will also require additional appropriations. The provision authorizing the increase in grant opportunities to Urban Indian Organizations requires additional funding to be implemented. The behavioral health prevention and treatment programs authorized have made partial progress. The assessment to evaluate need and cost of inpatient mental health care, required 1 year after the enactment of the law, has been completed. However, implementation of such services requires additional appropriations.[99] The Indian Health Service is further threatened by the recent automatic sequester budget cuts. According to one source, in 2013, the Indian Health Service will lose $228 million of its $4 billion budget which translates to 3,000 fewer inpatient admissions and 800,000 fewer outpatient admissions each year.[100]

One initiative currently being underway is The American Indians into Psychology Program. The law authorizes the increase of the award amount and number of universities in order to encourage American Indian/Alaska Native students to enter the behavioral health field. Three programs are currently funded, but increasing the number of universities would require additional funds.[101] On December 7, 2010 grants were awarded to Oklahoma State University, University of North Dakota, and The University of Montana.[102]

Figure 9. Indian Healthcare Improvement Act Reauthorization, Sections related to Preventive Health[103]

Section and Aim	Examples of changes under ACA
Title I *Indian Health Manpower*: increases provider supply at IHS facilities	Provides more community health aid workers at IHS facilities; demonstration project for workforce shortage in IHS facilities.
Title II *Health Services*: provides authorization for IHS health services, research, and payments	Increases authority for programs in diabetes, cancer, and long-term care.
Title III *Health Facilities*: construction and renovation of IHS facilities	Authorizes grants to build mobile facilities.
Title IV *Access to Health Services*: allows IHS programs to bill Medicare, Medicaid and private insurance	Allows IHS to bill State Children Health Insurance Program.
Title V *Health Services for Urban Indians*: authorizes urban Indian-serving health projects funded by grants	Increases grant opportunities available to Urban Indian Organizations.
Title VII *Behavioral Health Programs*: behavioral health and treatment programs authorized	Includes new programs related to youth suicide prevention.

Source: adapted from Heisler, E.J. (December 14, 2011). The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline. Congressional Research Service. Available at: http://www.ncsl.org/documents/health/IndHlthCareReauth.pdf

Emerging Models and Programs

Outside of the ACA, other organizations are working to advance the health status of American Indians. Models and promising programs targeting goals similar to those outlined in the ACA include:

- ***Center for American Indian Health, Johns Hopkins School of Public Health*** is providing services in infectious disease research, mental health, family services, youth fitness and nutrition to this population through 12 satellite health clinics. The Center also

consults with American Indian communities across the country. One program being implemented through the Center is "Together on Diabetes" which targets the prevention of type 2 diabetes in four tribal communities. The Center is collaborating with Indian Health Services personnel to identify gaps in diabetes prevention care in order to launch an evidence-based and culturally appropriate intervention.[104]

- ***Urban Indian Health Institute*** is implementing a campaign titled Native Generations, which targets high rates of infant mortality among American Indians and Alaska Natives with funding from the Office of Minority Health. The campaign is developing a consortium of Urban Indian Health Organizations to provide healthcare services, promote cultural activities as well as ensure connections to local communities to address infant mortality rates. The program builds on cultural awareness and the promotion of health goals by sharing stories of young American Indian and Alaska Native parents.

- ***Indian Health Board*** is working to improve the health and health care access of American Indians in Minneapolis. This initiative focuses on the provision of medical services for family planning, diabetes prevention and management, and health education. Mental health, including counseling and psychological assessment, and dental services for adults and children are also provided. The organization serves 7,000 patients each year.

Challenges and Next Steps

The reauthorization of the Indian Healthcare Improvement Act is a promising first step to reinforcing a commitment to and improving the health and health care of American Indian and Alaska Native populations. However, it remains unclear how much progress will be made with limited resources. Authorized programs under the law are still subject to annual appropriations and our review reveals that many have stagnated due to this. Next steps include working to gain adequate funding for these authorized, but currently unfunded programs, to ensure the law is successfully carried out to improve the health of American Indian and Alaska Native populations.

Breast Cancer Education Campaign

Legislative Context

The Education and Awareness Requires Learning Young (EARLY) Act was passed as part of the ACA as section 10413. It provides funding through the CDC for a breast cancer education campaign for young women, particularly those under age 40, to improve knowledge of the following:

- Breast health among women of all racial, ethnic, and cultural backgrounds;
- Breast awareness and good habits in breast health;
- Risk factors for breast cancer such as familial, racial, ethnic and cultural background;
- Evidence-based early detection strategies; and
- Availability of health resources for women with breast cancer.

The education campaign is intended to include national media campaigns targeted at young women through the use of billboards, television, radio, print ads, among other mediums. In

conjunction with the CDC, the Secretary is undertaking an education campaign targeting physicians and health professionals on breast health, especially early diagnosis and treatment for high-risk populations. This campaign will educate clinicians on: providing breast cancer counseling especially for those with family history; discussing healthy behaviors; improving awareness of available resources for promoting healthy behaviors; referring patients to genetic experts when appropriate; and providing counseling on long-term survivorship.
This section also describes the authorization of prevention research activities led by the CDC on survivorship, creating educational messages, developing social media strategies as well as surveys of knowledge, attitudes, and practices in breast cancer prevention.

Implementation Status and Progress

Figure 10 displays the authorized funding amount and appropriations for the ACA's Section 10413. For each year FY 2010 to FY2014, $9 million were authorized. However, for FY 2011 to FY 2013, $5 million were actually approved for each year.[105]

Figure 10. Authorized Funding in the ACA and Actual Funding for Young Women's Breast Health Awareness, FY 2010-2014

FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
$9 m	$0 m	$9 m	$5 m	$9 m	$5 m	$9 m	$5 m	$9 m	Not specified

Auth. = Authorized

As part of this provision, the CDC established the Advisory Committee on Breast Cancer in Young Women (ACBCYW). This committee is guiding the CDC in its development of policies and programs related to breast cancer awareness among young women. It will draw from evidence-based research to implement programs based on prevention research, education for health professionals, and new prevention strategies.[106]

Also as part of this provision, the CDC has approved funding for seven organizations for a three-year cooperative agreement to support programs for young women diagnosed with breast cancer. These organizations are building on existing programs or developing new initiatives to support women under the age of 45 who are breast cancer survivors. These entities participating in the cooperative agreement are also creating and disseminating strategies to improve patient and provider understanding of breast cancer risk as well as to increase general health and quality of life. These grantees are:

- John C. Lincoln Health Foundation;
- Living Beyond Breast Cancer;
- Louisiana State University and Health Sciences Center;
- Sharsheret;
- University of California at Los Angeles;
- University of North Carolina at Chapel Hill; and

- Washington University at St. Louis.

The CDC has also funded three health departments as part of the EARLY Act, section 10413 for a three-year cooperative agreement, "Enhancing Breast Cancer Genomic Practices through Education, Surveillance, and Policy." Under this agreement, the Michigan Department of Community Health and the Oregon Division of Public Health will continue their work with the CDC in breast cancer genomics, while the Georgia Department of Public Health is establishing a new breast cancer genomics program.

Emerging Models and Programs

During an April 18-19, 2012 Advisory Committee on Breast Cancer in Young Women meeting, convened by HHS, the CDC, and the Division of Cancer Prevention and Control (DCPC), the Committee advised federal agencies on research, implementation, and evaluation of activities described under the law, targeting the prevention of breast cancer among young, high-risk women. Funded entities under this provision provided a history and overview of their breast cancer program and progress toward objectives. Documentation included progress in implementing survivorship programs, education on family-based risk, resource assessment, and gap analysis. Two of the grantees describe incorporation of racially and ethnically diverse populations into their programs:

- ***Living Beyond Breast Cancer***, national education and support organization, is using funding to expand upon its Young Women's Initiative by enhancing online educational materials for young women, working with key liaisons in the community who are familiar with the needs of underserved populations to conduct a needs assessment, and building and planning future efforts on the findings from this assessment. As part of their needs assessment, the organization conducted key informant interviews with diverse stakeholders including cancer advocates who engage regularly with young Hispanic, African American, and Asian women diagnosed with breast cancer.

- ***Sharsheret,*** a national, not-for-profit organization, described its goal to create a breast cancer education program that offers culturally appropriate clinical and educational resources for young Jewish breast cancer survivors. In designing its program, the grantee investigated the needs of its target population through literature review and key informant interviews. The grantee intends its program to fill in the gaps in culturally-relevant research after they identified a paucity of such research in a literature review of 120 articles where only 3 articles addressed culturally and linguistically appropriate services for Jewish women.

During the April 2012 meeting, feedback from the Advisory Committee directed grantees to expand upon objectives in culturally appropriate breast cancer education by suggesting the following:

- Expand programs to reach out to and engage African American, Hispanic, and Asian women who currently have or have survived breast cancer.

- Convene focus groups of various age, risk, races/ethnicities, and income levels to inform the risk communication campaign and ensure effective messages reach different populations.

- Ensure that program activities developed are culturally and linguistically appropriate and can be understood by individuals at all reading levels (i.e., ensure use of pictures/drawings, plain language, monosyllabic words, white spaces).

- Add questions to assess breast cancer risk based on race/ethnicity such as: "Are you of Ashkenazi Jewish descent?" since the current NCI risk calculator does not include this ethnicity and would be difficult to modify.[107]

Challenges and Next Steps

While the activities under this provision appear to be making clear progress and have included specific focus in tailoring education to racially and ethnically diverse women who suffer from breast cancer, several challenges have surfaced around the efficacy and appropriateness of such a campaign. Concerns around prevention of breast cancer among young women have been raised. Leading cancer researchers have voiced concerns about the appropriateness of a widespread campaign, especially as breast cancer occurrence among women less than 40 years old is relatively rare. Some experts have suggested that risk factors for breast cancer among this age group are not widely accepted as modifiable and therefore should not be the focus of a federal campaign. Questions have also emerged around encouraging women to be screened based on ethnicity alone, when typically family history may be a more appropriate risk factor. The psychological impact of possible over-diagnosis that may occur resulting from mammography, a notably less specific screening tool among younger age groups, is also of concern. [108, 109]

National Diabetes Prevention Program

Legislative Context

Section 10501 of the ACA establishes a National Diabetes Prevention Program for high-risk adults with the goal of eliminating this disease. The provision is designed to disburse grants to model sites for community-based diabetes prevention and includes support for training and outreach for intervention instructors as well as a component for monitoring and evaluation conducted by the CDC. Entities that are eligible to apply for the funds, which are authorized for FY 2010 to FY 2014, include: state or local health departments, tribal organizations, national networks of community-based non-profits, and academic institutions. While the law does not include explicit language related to diverse populations, it does specify that the program be tailored to "adults at high risk for diabetes," and prior research demonstrates that this includes diverse populations such as African Americans, Hispanics, American Indians or Alaska Natives, and some Asian and Pacific Islander groups.

Implementation Status and Progress

Figure 11 summarizes the amount of authorized funding in the ACA and actual appropriations for the National Diabetes Prevention Program for each fiscal year 2010-2014.[110]

Figure 11. Authorized Funding in the ACA and Actual Funding for the National Diabetes Prevention Program, FY 2010-2014

FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
Auth	Actual	Auth	Actual	Auth	Actual	Auth	Actual	Auth	Requested
SSAN	$0 m	SSAN	$0 m	SSAN	$10 m	SSAN	$0 m	SSAN	$0 m

Auth = Authorized
SSAN = Such Sums as Necessary

In FY 2012 $10 million were distributed to the CDC for the National Diabetes Prevention Program. On June 22, 2012, the funding opportunity announcement, titled National Diabetes Prevention Program: Preventing Type 2 Diabetes among People at High Risk financed solely by 2012 Prevention and Public Health Funds, was released.[111] According to the funding opportunity announcement, measurable goals of the proposed programs should:

- Increase the proportion of persons at high risk for diabetes with prediabetes who report increasing their levels of physical activity;
- Increase the proportion of persons at high risk for diabetes with prediabetes who report trying to lose weight; and
- Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet.

The announcement does not specify that the program necessarily be tailored to racially and ethnically diverse populations or be culturally appropriate, however, given diabetes disproportionately affects diverse individuals, progress toward meeting objectives is critical to closing longstanding gaps in diabetes prevalence, care, and outcomes.

On October 9, 2012, the CDC awarded $6.75 million to six organizations listed below to expand upon the National Diabetes Prevention Program (NDPP). This funding is building a structured network of organizations that have engaged in this work previously in order to reach a higher number of people. Programs are to be implemented in alignment with the Diabetes Prevention Recognition Program Standards and Operating Procedures. Funded entities are to work with both employers and public and private health insurance companies to coordinate performance-based reimbursement to organizations implementing these programs. Grantees include:

- The American Association for Diabetes Educators;
- America's Health Insurance Plans;
- Black Women's Health Imperative;
- National Association of Chronic Disease Directors;
- OptumHealth Care Solutions; and
- YMCA of the USA.

Emerging Models and Programs

Each funded organization provides evidence-based programs designed to induce lifestyle changes in order to prevent type 2 diabetes among adults deemed at high risk. Common features of these programs include working in a group setting with a lifestyle coach for the duration of the 1-year

intervention. Sixteen core sessions occur once per week and six post-core sessions are given once per month. Of these six grantees at least five have incorporated strategies to target racially and ethnically diverse individuals at higher risk for diabetes through recruitment initiatives, culturally competent program goals, or as a part of the organization's vision:

- ***Black Women's Health Imperative*** is implementing its Diabetes Prevention Program in California, Indiana, Michigan, Missouri, and Virginia with particular emphasis on African American and Hispanic women through community-based strategies with culturally appropriate education materials tailored for these populations.

- ***YMCA of the USA*** is also funded through a Community Transformation Grant, focusing on African American and Hispanic populations. The program materials which focus on increased physical activity and healthy eating are translated into Spanish and life style coaches are piloting Spanish language delivery in a group setting which encourages participants to share successful strategies for overcoming barriers related to program goals.

- ***America's Health Insurance Plans (AHIP)*** is implementing the National Diabetes Prevention Program with four of its member plans in Florida, New Mexico, Texas, and New York. The health plans are charged with data collection and implementing the intervention while AHIP will aggregate and report data to CDC. One of the plans, EmblemHealth is targeting its program to two communities in New York—Cambria Heights and Harlem—which have high concentrations of African American and Hispanic residents.

- ***The American Association for Diabetes Educators*** is implementing the program in 12 target states: Alabama, Florida, Kentucky, Louisiana, Michigan, Mississippi, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, and West Virginia. Among the intervention sites identified, the grantee will target services in a Native American Tribe—the Choctaw Nation of Oklahoma.

- ***National Association of Chronic Disease Directors*** is partnering with several states (Kentucky, Colorado, Michigan, Minnesota, New Mexico, New York, Washington, and West Virginia) to expand the Diabetes Prevention Program by offering it to more communities. The organization's Diabetes Council's vision states: "Our active membership will include [Diabetes Prevention and Control Program] staff from every state/territory, as well as a broad range of other stakeholders, and it will reflect the geographic, racial/ethnic and professional diversity of the people we serve."[112]

Challenges and Next Steps

The most significant challenge facing the National Diabetes Prevention Program is funding. While authorized in FY 2010 and FY 2011, appropriations for this program did not occur until FY 2012, and this funding has not been sustained in subsequent years. No funding was provided in FY 2013 and no amount was requested for FY 2014. As with other public health programs, challenges facing the Diabetes Prevention Program include establishing meaningful and sustainable partnerships and building community capacity to assure that when grant funding may not be sustained, community organizations, advocates, and individuals are able to take charge. And

should future funding be made available, there remain questions around the extent that attention to race, culture, and language will be a part of related strategies.

IV. Public Health and Prevention: Emerging Opportunities and Challenges for Advancing Equity

Public health and prevention are key objectives of the ACA as reflected in the law's many new provisions addressing the underlying social, economic, and physical determinants of health. This focus is central to advancing health equity to ensure that all Americans have an equal opportunity to lead healthy lives. Our review of public health and prevention provisions with an explicit mention of or implications for health equity reveals a general focus on building evidence-based models and outcomes, fostering cross-sector collaboration, and advancing community-based initiatives. Support for such efforts has occurred through two primary funding streams.

First, the ACA has authorized dollars to extend programs already in existence to expand their reach to diverse and vulnerable populations. These include, for example, grants for maternal and child home visiting services and the Clinical and Community Preventive Services Task Force. Secondly, the ACA authorized and funded several novel programs focusing on priority services, diseases, and populations, such as grants for personal responsibility education, childhood obesity demonstrations, the National Prevention Council, the breast cancer education campaign and the Community Transformation Grants. Many of these new programs are financed through the Prevention and Public Health Fund. At the same time it is important to recognize that while the ACA authorized the expansion of other existing efforts, insufficient or no appropriations have severely limited implementation. For example, the expansions described under the Indian Healthcare Improvement Act as well as oral health prevention activities with a disparities focus have made little to no progress to date due to lack of adequate funds.

Figure 12 provides a summary of appropriated public health and prevention provisions and their intended role in advancing health equity through five important functions: (1) infrastructure support; (2) support for community-based organizations; (3) advancing culturally-appropriate care; (4) emphasis on evidence-based models; and (5) availability of preliminary findings or outcomes related to advancing equity. Of the ten funded public health and prevention provisions, at least four explicitly include infrastructure support to build the public health workforce, enhance organizational capacity at the state or local level, or develop more advanced information systems. For example, maternal and child home visiting programs are implementing infrastructure improvements that will better connect existing home visiting programs.

In addition, at least six of the ACA's provisions provide support for community-based organizations. The Community Transformation Grants, for example, support local community organizations as these entities are both eligible to receive direct funding under the law and may also be the recipients of funding from other grantees, such as local health departments. Four of the public health and prevention provisions of the law include, among their requirements, an explicit focus on culturally-appropriate care. For example, the Advisory Committee on Breast Cancer in Young Women is directing its grantees to provide culturally-appropriate breast cancer education and guides organizations on how to do so. Additionally, a large majority of provisions fund programs that draw from previous evidence-based research and models. For example, one requirement of the provision related to personal responsibility education is that they "be based upon rigorous research and evidence-based models for delaying sexual activity, increasing contraceptive use, or reducing pregnancy." Finally, as programs progress in implementation,

several are beginning to release preliminary findings or outcomes, generally, and in some cases related to racial and ethnic disparities and equity.

Figure 12: Summary of the ACA's Funded Public Health & Prevention Provisions and their Role in Advancing Health Equity

	Infrastructure Support	Support for community-based organizations	Advancing culturally-appropriate care	Evidence-based models	Availability of preliminary findings
Maternal, infant, and early childhood home visiting programs	+	+	-	+	?
Personal Responsibility Education	-	+	+	+	?
National Prevention, Health Promotion and Public Health Council	-	+	+	+	+
Prevention and Public Health Fund	+	+	+	+	+
Clinical and Community Preventive Services	-	+	-	+	+
Community Transformation Grants	-	+	-	-	+
Funding for Childhood Obesity Demonstration Project	-	-	-	+	?
Indian health care improvement	+	-	-	-	?
Young women's breast health awareness and support of young women diagnosed with breast cancer	+	-	+	?	?
National Diabetes Prevention Program	-	-	-	+	?

Note: Programs with evidence of each outcome are marked with "+" while those without evidence of that outcome are marked with "-." A "?" indicates that the evidence is uncertain at this time.

Prior to the passage of the ACA, conclusions from research and reports indicated that public health was generally struggling with a range of challenges to advancing population health, and particularly closing longstanding gaps in access, quality, and outcomes of care by race and ethnicity. These challenges ranged from major funding setbacks, including fragmented and declining funding streams, to poorly-developed mechanisms to measure health impacts and varied outcome measures, along with a culture of "working in silos." With the enactment of the ACA in 2010, public health professionals were energized by its promise in assisting to alleviate some of these barriers. With many provisions related to preventing chronic diseases and promoting healthier living, including those with emphasis on diverse communities, the new law affirmed prevention as an important concept in federal health policy and confirmed the elimination of health disparities as a priority. One key informant from a county health department voiced this affirmation:

> The ACA is confirmatory of our mission and gives us the resources to do what needs to be done. The [Community Transformation Grants] focus on tobacco and obesity which we've known are leading causes of death. Over time tobacco funding has dwindled. But the ACA allows us to continue the work we have begun with other grants. The ACA and the public health fund were put together with thoughtfulness from a public health standpoint. It turns out to align well with our priorities.

In addition, the law offered a renewed focus on social determinants of health. The Prevention and Public Health Fund and its funded activities, including the Community Transformation Grants, outlined clear goals in addressing the gaps in social and physical determinants of health, and a number of programs are underway to achieve related objectives. The National Prevention Strategy has released recommendations and recruited other federal agencies to address health disparities by focusing on employment, housing, economic and educational opportunities as well as improvements to the built environment. And the Community Preventive Services Task Force includes a more focused scope, with specific objectives for addressing disparities in evaluation of community-based programs.

Experts and public health professionals expressed appreciation of the comprehensiveness of the law, especially in incentivizing participation with public health. A key informant reinforced the importance and opportunity of such incentives in public health:

> The Act has sketched out some hammers that have brought people to the table. Part of the appeal to becoming involved in our Community Transformation Grant is that hospitals and providers have big costs associated with chronic disease. The CMS hammer penalized readmissions, so there are a lot of incentives to get on board and sign up with us to do community prevention.

While the ACA opened new doors for advancing public health and prevention, particularly to address the underlying social, economic, and physical factors which affect how diverse individuals and families access health care, the quality of care they obtain, and outcomes in terms of health status and healthy living, related opportunities have not been without barriers and challenges. In this context, at least three key dynamics with implications for public health, prevention, and health equity have emerged following the advent of health care reform:

- Continued challenges to funding public health and prevention;
- Need for more evidence-based outcomes related to public health interventions; and
- Enhanced emphasis on partnership development and community-based prevention.

In this section, we describe these dynamics for improving health equity through public health and prevention, while also discussing remaining challenges.

Continued Challenges to Funding Public Health and Prevention

The provisions under review present with varying levels of funding concerns and challenges. Some programs, such as the National Diabetes Prevention Program and the Indian Healthcare Improvement Act, were extensions of existing efforts and will continue with or without the additional support provided by the ACA, although they may not live up to their full potential due to the limited or partial funding appropriated. Whereas, other provisions have received mandatory funding, have not been subjected to funding cuts, and are well on their way to achieving stated goals. These initiatives include the maternal and child home visiting program and grants for personal responsibility education. One provision, the oral health prevention campaign, however, has made no progress to date as no funds have been appropriated.

The Prevention and Public Health Fund was intended to provide more continuous financial support to public health initiatives as, in the past, federal funding was provided by category, and this new fund was intended to move away from that approach. Many of the programs supported by the fund have considerable implications for racially and ethnically diverse communities, such as the REACH initiative, which established community-based, culturally and linguistically appropriate programs and interventions for diverse populations, and the Community Transformation Grants, about two-thirds of which address health disparities. However, questions remain as to whether the fund will fulfill its purpose. Public health was hit hard by the economic recession, and in fact according to one report:

> Health department directors were unanimous in declaring the economic recession to be the single biggest factor shaping their departments. Local health departments are seeing waves of reductions in state and local funding: county general funds, sales tax, property taxes, permit fees and medical care revenues have all declined.[113]

A report released by the National Association of County and City Health Officials (NACCHO) found that local health departments lost 16,000 jobs in 2009, resulting in a decline of about 15% of the local public health workforce over the previous two years due to a combination of budget-related cuts and other factors.[114] These difficult financial circumstances continued to play into the post-ACA era. A recent report issued by Trust for America's Health and the Robert Wood Johnson Foundation, entitled, *Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts*, examined public health funding across the nation, and attested to trends in declining public health budgets. The report generally stressed two major conclusions: (1) federal funding for public health is inadequate; and (2) state and local funding has declined drastically over the years, and in the post-ACA era. As for federal funding for public health, the report found that the budget for CDC "has decreased from a high of $7.31 billion in 2005 to $6.13 billion in 2012" and "federal funding spent to prevent disease and improve health in communities ranged significantly from state to state, with a per capita low of $13.72 in Indiana to a high of $53.07 in Alaska."[115]

In terms of state and local funding, the report found that 29 states decreased their public health budgets from FY 2010-11 to FY 2011-12. "Budgets in 23 states decreased for two or more years in a row, and budgets in 14 states decreased for three or more years in a row. In FY 2011-12, the median

state funding for public health was $27.40 per capita, ranging from a high of $154.99 in Hawaii to a low of $3.28 in Nevada. From FY 2008 to FY 2012, the median per capita state spending decreased from $33.71 to $27.40. This represents a cut of more than $1.15 billion, based on the total states' budgets from those years, which would be $1.9 billion adjusted for inflation."[116] Other research documented that during 2012, nearly half (48%) of all local health departments reduced or eliminated services in at least one program area, most frequently affecting: immunization; maternal and child health; and emergency preparedness services.[117]

Given these difficult financial circumstances, many state and local health departments have been tempted to use new funds from the Prevention and Public Health Fund to plug holes in previously underfunded programs, while reductions in personnel have encouraged supplantation of displaced staff, rather than expansion. Furthermore, the most commonly cited challenge among key informants from state and local public health departments was implementing programs with less funding than expected in addition to the uncertainty around future funding. A diminished capacity at baseline also proves to be challenging for executing large-scale projects. One key informant reported in regard to receiving a Community Transformation Grant:

> We are not supposed to use funds for process evaluations, but part of achieving success is having a good infrastructure in place. We had to find other funds to pay for that evaluation. We are using other funds, some funding is CTG and some is non-CTG.

Key informants also reported significant concerns around ACA-based program or initiative support once these funds are exhausted. Some respondents reported hesitancy to pursue the ACA's public health opportunities because of the temporary nature of such funding. Other grantees reported the necessity of creative planning for a program's sustainability when receiving one-time funding or funding for a limited number of years. For example, many Community Transformation Grants are funding infrastructure such as biking lanes, hiking trails and outdoor fitness equipment that, if needed, could be maintained by other local city departments. However, continued support for personnel and other program costs will need to come from other avenues.

Live Well, San Diego! is an example of an initiative that has developed a long-term funding strategy by garnering support from multiple sources to ensure its 10-year plan to improve health is successful. The initiative creates collaborative partnerships between 52 county departments and community groups to implement goals in healthy living. The program, which began in 2010, has drawn in funding from private foundations as well as federal support including CDC's "Communities Putting Prevention to Work" program and a Community Transformation Grant. *Live Well, San Diego!* reports promising results in its two-year progress report, such as a 3% obesity reduction rate among Chula Vista School District. In addition, the initiative supports residents' access to healthy foods, and the number of recipients of CalFresh, the state's nutritional assistance program, has increased by 8.5%.[118]

Some grantees that have not secured multiple funding sources to implement long-term public health initiatives have expressed frustration with the ACA's declining funding. Another Community Transformation Grant recipient voiced concern over the diversion of funds as well as politicization of the Prevention and Public Health Fund:

> The Prevention and Public Health fund is a 'slush fund,' but even before grants went out if you remember what was promised for the CTGs versus what was dispersed. We were awarded one-fifth of level requested and that was because of the cuts to public health and they had to divert funds for basic public health functions. The programs they did fund were

> under-funded. There are several times when the fund has been specifically targeted to offset Medicare physician reimbursement as well as offset the student loan expiration because the politicians don't understand difference between hatred for the [Affordable Care] Act and what's public health.

The sequestration authorized in FY 2013 further threatens these new funding streams. As a recent Congressional Research Service report cites:

> Generally, the annual appropriations in ACA are fully sequestrable at the rate applicable to nonexempt nondefense mandatory spending. That includes annual appropriations for [Prevention and Public Health Fund, Patient-Centered Outcomes Research Trust Fund], exchange grants, and the maternal and child health programs.[119]

While new funding streams are a promising start to improving population health and eliminating health disparities, it appears that budget deficits, cuts to the Prevention and Public Health Fund, and sequestration continue to challenge public health programs funded through the ACA. As local and state departments that have received ACA funding struggle to fulfill their general required duties and objectives, priorities in health disparities may remain on the sidelines. Additional provisions with clear implications for racially and ethnically diverse populations that have been slow to progress or have not progressed at all due to lack of appropriations are the National Diabetes Prevention Program, the national oral health campaign, and the American Indian prevention programs.

Need for More Evidence-Based Outcomes Related to Public Health Interventions

Data collection and evaluation have presented longstanding challenges in efforts to document effectiveness of population health programs, especially those related to health disparities. Frequently, public health departments and other organizations involved in public health interventions use different tools and measures to collect data and report progress. Many public health programs have had difficulty, for example, correlating investment with a decline in tobacco use. Instead, public health practitioners are more likely to track progress of process measures such as awareness of messaging and characteristics of persons reached. Furthermore, sharing and disseminating lessons learned and evidence-based practices resulting from state-based initiatives has historically been handicapped due to the lack of a centralized system or process to collate information, results, and data.[120] In addition, limited timeframes to demonstrate improvement for broad health outcomes for diabetes, obesity, or other conditions often prove challenging.

State and local public health departments have emerged as key settings to coordinate and implement initiatives targeting health disparities through health promotion and prevention. However, key informants report challenges such as limited financial and personnel resources, competition for those resources, and the need to quickly shift priorities when public health emergencies occur. These setbacks add to the chronic issues in addressing health disparities as state and local health departments may often have difficulty meeting basic requirements and responsibilities. Moreover, working within short time spans and dwindling resources and funding complicates measurement and reporting of effective public health interventions. Such challenges and limitations are likely to encumber efforts to demonstrate the value of public health investment. According to one report:

> Public health practitioners and advocates appear politically challenged to convince budgeters of its value. (That budget scoring of a provision's impact uses a short time horizon is also a challenge for promoting long-term investments in public health).
>
> Unfortunately, [seeing all interventions as interrelated] also exposes the weakness of existing tools for measuring actual impacts on health. In practice, many different performance metrics are in use, varying across programs. It is the work of a generation, not of an issue brief, to create reliable measures of this sort. The ACA will help. It contains numerous provisions meant to develop better information and standards for assessing effectiveness in clinical and population health.[121]

This theme of varying measures and outcomes also stood out in our analysis of the law's public health and prevention provisions. The evaluation and efficacy of such programs should be consistent across programs, including measuring improvement in health disparities. The ACA's enhancement of the Community Preventive Services Task Force presents a potential avenue to moving toward an enhanced and more standardized assessment of community health interventions, including those that will benefit diverse populations. Unfortunately, to date, the Task Force has released only one recommendation under the category of "health equity." (It has however identified the topic of eliminating health disparities as priority for the upcoming year). Other examples of potential areas for measure and monitoring improvement and developing a stronger evidence base may include breast cancer awareness among young women.

A key challenge to supporting initiatives to develop better metrics and monitor outcomes of prevention is a general political antipathy toward the very concept of prevention. As Senator Tom Harkin (D-IA) stated, prevention should be reframed in context of priorities that speak most to the public and politicians—i.e., rising health care cost.[122] To establish better support for prevention services likely to have significant benefit for diverse and other populations, emphasis should be placed upon investing in the short term for long term prevention goals (especially for rising chronic diseases) and cost saving. The urgency and significance of better health metrics including cost effectiveness data was highlighted in the following editorial:

> We are well past the point of simply responding with the slogan "prevention saves." Nor is it acceptable any longer to argue the benefits of population-based prevention are too multi-factored or too long-term to be effectively measured. In these extraordinarily tight fiscal times, where the notion of fiscal offsets is increasingly the key to program funding, we've done very little to demonstrate the value – in terms of economic or return on investment – of population-based public health.[123]

Enhanced Emphasis on Partnership Development and Community-Based Prevention

The fusion of a "health in all policies" approach and an increased focus on prevention at the community level holds much promise for significant progress toward health disparities. However, many key informants have reported that public health practitioners frequently "work in silos" hindering the scope and breadth of their work. Previously, federal funding for public health has not typically emphasized collaboration and was often provided through rigid categories. One report highlights the importance of partnering with communities as health disparities typically stem from social and physical health determinants:

> [Public health] can't just be about emergencies; we need to go further and see how we can insert ourselves in other areas where decisions are being made, and where we can improve

> community health, both short- and long-term. For example, chronic disease burden and health inequities have deep roots in venues such as land use, housing, transportation, and education, demanding our engagement. Tools and tactics include health impact assessments, introducing health into other policy approaches, and intervening in regulations addressing tobacco use or obesity. In these ways, public health can take charge, using its expertise to protect and improve the health of communities.[124]

Many provisions within the ACA aim to increase the importance of establishing partnerships across public health entities, communities, and other sectors as well as to promote flexibility in targeting goals for improved health. Community-based approaches have proven successful in targeting goals around disparities in health,[125] and these concepts are woven into the ACA's Community Transformation Grants as well as the National Prevention Council's action plan. According to the council's fact sheet:

> The National Prevention Council recognizes the importance of partners and their role as trusted members of the communities and populations they serve. The National Prevention Strategy encourages partnerships among federal, state, tribal, local, and territorial governments, the private sector, philanthropic organizations, community and faith-based organizations, and individual Americans to improve health through prevention. Improvements in health are amplified when those working both within and outside of government consider opportunities to address prevention and wellness.[126]

However, the challenges in developing sustainable partnerships were highlighted by one key informant, who stated: "In public health most of our work, including in health disparities, is centered on changing individual behaviors and environmental factors. Partnership development takes time especially around the often considerable effort to engage with other sectors (e.g., transportation and farmland preservation) and providing a valid rationale supporting collaboration with public health." This point is also true for partnerships between public health and community groups. Extensive research indicates that building sustainable partnerships with community organizations occurs over the course of years, not just the beginning months of a project. A four stage process ("forming, storming, norming and performing") that includes establishing roles and responsibilities as well as confronting and resolving conflict is common for such partnerships and becomes a continual process that starts again once a new partner enters the dynamic.[127]

Other challenges for building partnerships in public health include the difficulty in measuring and assessing the health impact of non-health policies. For non-health agencies, collecting baseline data and projecting impacts of a policy on health are both notably challenging tasks, especially in terms of training and supporting staff to conduct such activities.[128] One study quantifies the current status of a "health in all policies" concept among local governments across the U.S. Through a national survey, this study found that 27% of local government officials who responded reported that their comprehensive plan included goals related to public health which were addressed in areas such as land use, transportation, and recreation. Among these plans that included public health, however, the majority of respondents reported that they did not use a public health assessment or other type of data collection tool to identify community public health priorities. And yet the main reasons for including public health in municipalities and counties' comprehensive plans were community support and community awareness.[129] These findings highlight gaps in planning and evaluation, but confirm that community involvement is likely to be a critical component for leveraging public health priorities and implementing broad programs across different government sectors.

The successful implementation of a "health in all policies" will help to reduce the fragmentation of the funding for different programs and break down the "silo effect" among different agencies to promote health and equity. When results are integrated across sectors and partnerships are formed to acknowledge the connection between health and other non-health policies, it will minimize the perceived effect of separate programs churning out stand-alone results. Although our review has identified clear and important examples of progress, we have also found that many prominent challenges remain, and may threaten the full realization of the ACA's goals around health equity. As new policies promoting eliminating health disparities are being implemented, the expected challenges such as bureaucratic barriers and battles for territory have emerged, but it is perhaps the more unforeseen challenges that have gained attention and presented the most severe threat to the ACA's successful implementation. Overall resistance to the law and political threats including challenges to its constitutionality, sequestration, and other funding restrictions have altered timelines, appropriations, and potentially the development of important community partnerships. A mixture of financial pressures, political opposition and rising rates of chronic disease stand as road blocks to ensuring these policies and programs move forward quickly and effectively. Overcoming political opposition and barriers related to current funding cuts, as well as securing future funding will be essential to advancing these priorities.

V. Moving Forward: Strengthening Public Health & Prevention to Advance Health Equity

Investment in public health and prevention, particularly in the context of addressing the overarching determinants of health, are core to advancing and achieving health equity. As noted, despite the ACA's intent and support, the full realization of the law's public health and prevention objectives have generally been stalled by a combination of factors from political opposition to federal budget cuts including sequestration, and declining state and local budgets. The Prevention and Public Health Fund, in particular, has felt the brunt, serving more as a "safety-net" fund to support and sustain existing workforce and public health programs rather than being used to invest in new and novel public health and prevention initiatives. Still, the Fund did establish the Community Transformation Grant program, among others, which is intended to support community-level initiatives targeting the social, economic, and physical determinants of health. However, even this program has faced funding setbacks—with FY 2013 funding being $80 million less than requested by the President in 2012.

Strengthening public health and prevention to advance health equity will require involvement from multiple sectors, stakeholders, players, and funders. Opportunities should be sought not only within the ACA, but beyond. To this end, our review of the ACA's related provisions has identified at least four priorities that may assist in elevating its prominence and assuring that equity is core and central to any public health and prevention strategy:

- Leverage the ACA's health care delivery investments to support public health and prevention and reduce disparities;
- Encourage the explicit recognition and integration of health equity where absent in public health and prevention provisions of the ACA;
- Develop incentives to encourage cross-sector collaboration; and
- Align public health and prevention objectives with the National Standards on Culturally and Linguistically Appropriate Services (CLAS), where appropriate.

Leverage ACA's Health Care Delivery Investments to Support Public Health and Prevention and Reduce Disparities

Public health and prevention are integral to many dimensions of equity embedded in the ACA. As such, the Act includes numerous other equity opportunities that can feature, integrate and otherwise address public and prevention related priorities. Outcomes of integrating these goals and strategies may add both value to the provision intent and help expand recognition of their importance in addressing patient and population health. This section offers three examples among the many relevant provisions within the ACA where public health and prevention can both benefit from and enhance program objectives around equity: Community Health Needs Assessments (CHNAs); medical homes; and initiatives supported through the CMS Innovation Center.

Community Health Needs Assessments. The ACA requires all nonprofit, tax-exempt, or 501(c)(3) hospitals to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to address identified needs. A review of nonprofit CHNAs conducted recently in response to the ACA's requirements reveals that they contain numerous indicators to highlight community health issues. Advocates can leverage these opportunities to assure inclusion of public health and prevention data and priorities. CHNAs promote collaboration and a comprehensive, community-wide process which has typically involved a wide range of public and private partners, including educational institutions, health-related professionals, government agencies, human service agencies, and faith-based and other community organizations. These assessments are particularly important for public health as they involve a systematic approach to collect and evaluate data, and offer a new and unique opportunity to measure and monitor health disparities across various access and health outcome measures within communities. Moreover, these new requirements represent a significant opportunity for public health departments and other organizations to partner with hospitals to improve the health of racially and ethnically diverse and other communities.

Patient-Centered Medical Homes. The ACA also provides support for Patient-Centered Medical Homes (PCMHs), with several provisions explicitly mentioning racially and ethnically diverse populations. PCMH is a model of care that emphasizes care coordination and communication between patients and families and their care providers. It is intended to transform primary care into "what patients want it to be." As such, many PCMH programs, including those funded through the ACA, integrate cultural and linguistic competence into care service and strategies, while at the same time affording an opportunity to address public health and/or prevention priorities. For example, section 2703 of the ACA creates a state option to provide health homes for Medicaid enrollees with chronic conditions to improve health outcomes. Ten states have approved plans, with equity integrated into their initiatives through the use of evidence-based, culturally sensitive wellness and prevention for smoking cessation, diabetes, and asthma. Both the Patient-Centered Outcomes Research Institute (PCORI) established by section 6301, and the CMS Innovation Center have provided awards to test the medical home model and, as such, offer new ways to develop integrated models of care that address the needs of culturally and linguistically diverse patients, especially those with chronic disease.

Other Initiatives Supported through the CMS Innovation Center. The CMS Innovation Center supports a range of programs which work to integrate public health and prevention with goals for advancing health equity. For example, Asian American for Community Involvement (AACI) received an award to improve access to care, disease screening and detection, and medication adherence among low-income Asian and Hispanic families in Santa Clara County. The grantee is working with patient navigators to provide services such as translation, appointment scheduling, referrals, among others to reach these goals. Other newly supported public health and prevention related efforts include the Delta Dental Plan of South Dakota, which is providing preventive oral health care to American Indians and will also work with diabetic program coordinators to better identify and treat diabetic patients. The plan covers more than 30,000 low-income, underserved American Indians on reservations throughout the state. The preventive care provided through the grant is anticipated to save over $6 million.[130]

As discussed, prevention and public health have historically been low among the federal government priorities. In fact, in 2005, diagnosis and treatment of disease received 93% of the federal government's health dollars, while only 7% was dedicating to research and prevention.[131]

However, as the aforementioned examples demonstrate, provisions within the ACA have the potential to elevate prevention and public health as a priority while at the same time adding depth and dimension to other program initiatives that are working to improve health equity. And for organizations that do not necessarily have a public health mission or currently work in the public health arena, this represents a new avenue to configure future funding.

Encourage the Explicit Recognition and Integration of Health Equity Where Absent in Public Health and Prevention Provisions of the ACA

Health equity, disparities reduction, and cultural and linguistic competence are clearly cited as priorities among a number of the ACA's public health and prevention related programs—a distinction common among many of the law's provisions. For example, the personal responsibility education grants identify the need for providing culturally appropriate education. However, the majority of provisions *have no explicit wording* citing or otherwise addressing these goals. For example, grants for the childhood obesity demonstration projects, diabetes prevention, and the maternal and child home visiting programs describe the need to target "at risk" communities and individuals but do not identify a distinct priority around the needs of diverse individuals or communities or for culturally appropriate services. As such, the importance of race, ethnicity, and language may become subsumed and lose focus under the broader scope and definition of "at risk"- which more often encompasses individuals vulnerable by income, age, sex, physical disability, or geography.

In fact, the definition of "at risk" under the ACA's maternal and child home visiting program includes a wide list of important vulnerable population groups—ranging from pregnant women, children with developmental disabilities, individuals with a history of tobacco use or substance abuse, or those formerly or currently in the Armed Forces, among others. However, race or ethnicity are not mentioned despite robust data which highlight the vulnerability of many racial and ethnic groups in infant, child, and maternal health. For example, the infant mortality rate among African Americans is more than double that of Whites, and African American women are less likely to receive prenatal care. For these and other provisions, specifically recognizing the role and importance of addressing health equity can elevate its importance and likely encourage initiatives that specifically address the needs of diverse patients and communities.

Should opportunity be available at the policy level, equity language should be included in federal rules, regulations, and guidance, funding announcements, or charter for related taskforces and committees. At the programmatic level, explicitly integrating racial and ethnic health equity priorities into public health and prevention may involve one or more of many concerted actions, such as:

- Strategically infusing health equity in program goals, objectives, and intervention targets;
- Working to assure diversity in staffing, particularly among public health practitioners in frontlines and working in communities;
- Developing culturally and linguistically appropriate outreach and education;
- Partnering with trusted community organizations reflective of at-risk and diverse populations;
- Engaging local racially, ethnically, and linguistically diverse communities to identify shared priorities and evaluate program appropriateness and effectiveness; and
- Evaluating program reach and outcomes by race, ethnicity, language, and related measures.

Recognizing that addressing health equity must not be an "afterthought" or a burdensome additional step is critical to addressing and combating disparities in many preventable areas of health and health care.

Develop Incentives to Encourage Cross-Sector Collaboration

Eliminating disparities requires comprehensive strategies that reach far into the daily lives of individuals and communities. As recently stated, "…racial and ethnic disparities in health status are primarily a reflection of inequality in U.S. society and it is this inequality—in housing, education, employment and in broader social, political and economic arrangements—that marginalizes and disenfranchises people of color".[132] Thus, addressing the social and economic dynamics that influence and determine health should be considered as a core aim in eliminating health inequalities. Multiple sectors, including public health, social service organizations, the community, and the health care delivery system should develop flexible roles and responsibilities and integrate services and goals for improved population health.[133] Comprehensively assessing health effects of non-health policies such as zoning regulations, housing permits, transportation and business initiatives is likely to be a central task. Public health expertise, experience, and roles can assist by providing, tracking, and analyzing data to demonstrate progress toward strategic goals.

Improving population health is not likely to occur without concerted support—if not specifically requiring—collaboration among multiple sectors. Related incentives, in the form of new payment models and structures and a shared financial target, will motivate different sectors "to engage in the difficult work of building effective partnerships based on shared goals, information systems, innovations in the use of human resources, and cross-sector leadership."[134] And while the shared goal of improved population health is surely important, successful cross-sector collaboration can also include opportunity for participating agencies to elevate their own status and influence.[135]

While more traditional categorical funding for public health has several advantages such as program-specific accountability and allowance for federal funding to be targeted for clearly-defined goals, chronic concerns persist around service fragmentation, difficulty in more fully addressing pressing community needs, and duplication of efforts.[136] In addition, low-resource communities and counties, with significant health and health related needs may not have adequate support—financial and otherwise—to compete for categorical grant funding. In these circumstances, more flexible funding streams can be used to target local needs identified in community health assessments.

Provisions within the ACA offer new chances to support and enhance both traditional and innovative partnerships in programs—including sharing services, reducing duplication of efforts, and improving program efficiencies in communities.[137] To this end, the National Public Health Improvement Initiative Grant, funded through Prevention and Public Health Fund, is intended to assist performance improvement among health departments through support for tracking program performance; fostering best practices; and elevating coordination and cohesion across states.[138] As an example of such innovation, the state of Massachusetts received one of these grants intended to improve public health infrastructure by ensuring that communities both share staff and work more efficiently in service provision.[139] It has been found that collaboration with the private sector can make the most of governmental investment in public health.[140] Million Hearts, which has also received funding from the Prevention and Public Health Fund, aligns multiple partners including communities, health systems, non-profit organizations, federal

agencies and private organizations to reduce heart disease and stroke.[141] Such models should continue to be monitored as promising practices to develop and expand upon incentives for cross-sector collaboration. In the current fiscal situation, assuring the greatest return on investment by encouraging collaborative models and partnerships and flexible funding sources can work to enhance public health benefit, especially for low-income and vulnerable populations.

Incorporate Enhanced CLAS Standards into Public Health and Prevention Initiatives

The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2013 comes at a pivotal point in efforts to redress longstanding disparities and advance health equity.[142] Demographic changes across the country, greater recognition of gaps in access to health services, and increased attention to the influence of race, culture, and language in quality of care have elevated equity in both prominence and importance, leading to efforts that span a spectrum of priorities from cultural competence training and use of interpreters to organizational adaptation and transformation. By its vision and objectives, these standards are a potentially rich resource to inform and guide public health and prevention. Building on the original standards issued in 2000, its expanded scope spans a broad range of activities central to enhancing prevention efforts and promoting public health, including: improving quality and safety; engaging communities; meeting standards and accreditation requirements; and justifying the business case through a set of identified actions ranging from governance, leadership, and workforce to communication, language assistance, and engagement as well as continuous improvement and accountability.

With the enactment of the ACA, CLAS also comes at a critical "moment in time" with the potential to greatly reduce the numbers of uninsured, create a more equitable health care, public health and prevention agenda, and improve the lives of diverse and vulnerable populations around the country. In particular, the ACA has clearly made reducing disparities and improving equity a centerpiece of its vision and goals—fundamental tenets that the enhanced CLAS standards share with the law and that should fit well within ACA related prevention and public health priorities. In fact, embedded in its intent is coordination and alignment with the ACA's race, culture, language and disparities reduction goals.

The CLAS standards—with their focus on eliminating health disparities, broadening cultural and linguistic competence, assisting in organizational transformation, increasing patient adherence and satisfaction as well as improving health outcomes— are intended to serve as a set of guiding principles for health care organizations in serving diverse populations. They are also designed to be adopted as a set of 15 equally important guidelines. At the same time, specific standards may have special relevance for public health and prevention. For example, the six standards included in Figure 13 highlight the importance of several dynamics and dimensions for these service settings such as: responsiveness to cultural and language needs; use of trained personnel in interpretation and employing a variety of strategies in communication; actively engaging communities; developing and using relevant, valid data; and conducting as well as acting on findings from health assessments.

Figure 13. Alignment of CLAS Standards with the ACA's Public Health Provisions

Standard	Description
1	Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
7	Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8	Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
11	Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12	Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Source: *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. (2013, April). HHS Office of Minority Health. Available at: https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf

The ACA has funded programs that are reinforcing and incorporating CLAS standards into public health and prevention programs. For example, the Massachusetts Department of Health's CTG is reaching out to and engaging diverse communities in their Mass in Motion campaign. The department is partnering with the Massachusetts League of Community Health Centers, an entity that aims to provide culturally and linguistically competent care in public health programs directed toward bettering health through healthy eating and physical activity. The health department's partnership with community health centers is targeting health disparities by improving communication channels for patients, clinicians and community agencies; engaging a clinician champion for program buy-in; and by identifying salient community needs. The department also plans to use their Community Transformation Health Equity Staff to provide trainings in CLAS standards and to educate clinicians participating in funded activities on the use of medical interpreters. Each participating site is expected to implement training procedures for CLAS standards and medical interpretation.

VI. Conclusion

The Affordable Care Act holds considerable promise for elevating the importance and, in turn, the contribution of public health and prevention to improving the nation's health. Moreover, many of the provisions discussed in this report directly or implicitly reflect the law's intent to advance health equity as part of the public health and prevention agenda. At the same time, given the goal of reaching and insuring new populations and supporting innovative programs aimed at addressing the needs of vulnerable individuals, this era of health care reform offers the chance to broaden knowledge and understanding around the role and value of public health and prevention in improving the nation's health. In particular, the intended initiatives offer new if not unique opportunities to improve the health of diverse and other vulnerable children and adults, including those with chronic conditions, while opening doors for engaging communities and forming partnerships with other service sectors.

Notwithstanding the intent of the law and its public health and prevention provisions, much remains uncertain. Shortfalls in appropriations, state budget restrictions, the lack of a stronger efficacy evidence base and historically low priority given to these programs threaten significant progress. Other current uncertainties around the rollout of the ACA's marketplaces and ultimate acceptance of the law's vision and principles may have a spillover effect that may inhibit fuller realization of public health and prevention goals. Nonetheless, the ACA has created the occasion for breaking new ground in advancing public health priorities. Time and intent will determine whether the hoped-for-goals are achievable.

Appendix A. Key Informants & Contributors

The Texas Health Institute would like to acknowledge and thank the many individuals who contributed valuable information, feedback, and perspective on various topics covered under the *Affordable Care Act & Racial and Ethnic Health Equity Series*. Nearly 70 individuals were interviewed or consulted. They represented a range of sectors—from federal, state, and local agencies to hospitals, health centers, health plans, professional associations, health policy experts, advocates, and community-based representatives. *Note: Opinions expressed in this report are of the authors only and are not to be attributed to the individuals or organizations listed below unless noted as such in the report.*

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Appendix B. ACA Public Health & Equity Progress At-A-Glance

Sec. No.	Provision	Summary	Funding Appropriated	Timeline
2951	Maternal and Child Home Visiting Program	Strengthens and improves upon existing Maternal and Child Home Visiting Programs as well as improves coordination of services and aims to improve outcomes in maternal, prenatal, infant and child health and development.	FY 2010 $100 million FY 2011 $250 million FY 2012 $350 million FY 2013 $400 million FY 2014 $400 million	2010-2014
2953	Culturally Appropriate Personal Responsibility Education	Funds grant programs for evidence-based personal responsibility education to educate adolescents on both abstinence and contraception to prevent pregnancy and sexual transmitted infections in an appropriate cultural context.	FY 2010 $75 million FY 2011 $75 million FY 2012 $75 million FY 2013 $75 million FY 2014 $75 million	2010-2014
4001	National Prevention and Public Health Council	Establishes the National Prevention and Public Health Council, a federal interagency group that serves as the coordinating body for prevention and health programs and makes recommendations to the President on health and wellness priorities.	FY2010 $.142 million FY2011 $1 million FY2012 $1 million FY 2013 $.992 million FY 2014: $1 million requested	2010-
4002	Prevention and Public Health Fund	Establishes the Prevention and Public Health Fund to support the investment in public health and prevention programs that aim to improve health outcomes and contain health care spending.	FY2010 $500 million FY2011 $750 million FY2012 $1 billion FY 2013 $949 million FY 2014 $1 billion requested	2010-2022
4003	Clinical and Community Preventive Services Task Force	AHRQ's Preventive Services Task Force is authorized to review research and evidence for clinical preventive services including in the areas of effectiveness, appropriateness and cost-efficiency. The task force is to 1) develop new recommendations based on this review; 2) update previous preventive recommendations for various entities in the health care community; and 3) publish their findings in the Guide to Clinical Preventive Services.	FY 2010 $5 million FY 2011 $7 million FY 2012 $10 million FY 2013 $7.4 million FY 2014 $10 million requested	N/A

Sec. No.	Provision	Summary	Funding Appropriated	Timeline
4102	National Oral health campaign	Develops a five-year oral health campaign for the prevention of oral disease targeting specific populations such as children, pregnant women and racial and ethnically diverse populations.	No funding appropriated	2010-2014
4201	Community Transformation Grants	Competitive grants are available to state and local agencies and community-based organizations for preventative health programs aimed at reducing rates of chronic disease, preventing the development of secondary conditions, addressing health disparities, and building stronger evidence for prevention initiatives.	FY 2010 $0 million FY 2011 $145 million FY 2012 $226 million FY 2013 $146 million FY 2014 $146 million requested	2010-2014
4306	Childhood Obesity Demonstration Projects	Amends the Social Security Act to provide funding for these demonstration projects to implement a model to reduce childhood obesity through community-based activities such as physical activity programs and healthy living curriculum.	$25 million	2010-2014
10221	Support for AI/IN Prevention Programs	Reauthorizes the Indian Health Care Improvement Act which authorizes the Indian Health Service to provide health care to American Indians/Alaska Natives as well as authorizes new programs for this population.	N/A	N/A
10413	Breast Cancer Education Campaign	Creates a national campaign to increase awareness of breast health, risks for breast cancer, early detection strategies among young women of all backgrounds.	FY2010 $0 million FY2011 $5 million FY2012 $5 million FY 2013 $5 million FY 2014 Request not specified	2010 -2014
10501	National Diabetes Prevention Program	Establishes a nationwide program for diabetes prevention by providing grants to community-based entities to implement lifestyle interventions for diabetes prevention.	FY 2010 $0 million FY 2011 $0 million FY 2012 $10 million FY2013 $0 million requested	2010-2014

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