

March 4, 2009

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
511 Hart Senate Office Building  
Washington, DC 20510

The Honorable Chuck Grassley  
Ranking Member  
Committee on Finance  
United States Senate  
135 Hart Senate Office Building  
Washington, DC 20510

The Honorable Edward Kennedy  
Chairman  
Committee on Health, Education, Labor  
and Pensions  
United States Senate  
317 Russell Senate Office Building  
Washington, DC 20510

The Honorable Michael Enzi  
Ranking Member  
Committee on Health, Education, Labor  
and Pensions  
United States Senate  
379A Russell Senate Office Building  
Washington, DC 20510

Dear Senators Baucus, Grassley, Kennedy and Enzi:

**The undersigned organizations, which share a common interest in eliminating health inequities and disparities, urge you to make efforts to include provisions that improve health equity for all Americans in health reform legislation currently being developed by Congress.** Health and health care inequality exact a huge human and economic toll on the nation. Their persistence means that millions of Americans and their families suffer needlessly from a high burden of illness and mortality. Health inequality leaves these Americans less able to contribute to the nation's economy and productivity, and to participate fully in social, civic and political affairs in their communities. With projections indicating that nearly 1 in 2 people living in the U.S. by mid-century will be a person of color, our nation's health status clearly depends on our ability to improve the health of our fastest-growing communities. Health reform legislation currently being developed by Congress presents a unique opportunity to address the deficiencies in our nation's health system and work towards the elimination of health disparities. It is also an opportunity to ensure that government programs adhere to civil rights laws that address "unintentional" racial disparities (Title VI of the Civil Rights Act of 1964), including those that safeguard health and other economic needs, so that available resources are utilized in a manner that supports achievement of the highest attainable standard of health for every individual. In particular, we urge you to:

**Sustain and support the role of traditional safety-net providers.** Minority and health disparity populations are more likely to access health care in safety net institutions, such as community health centers and public hospitals, which provide primary care, women's health care, dental services, and other support services that facilitate health care (e.g., language interpretation, transportation and health outreach). These institutions often represent the only access point in otherwise under-resourced communities. In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals. The survival of safety net institutions depends on the manner in which health insurance expansion is carried out. These institutions will likely continue to face financial vulnerability until universal coverage is achieved and financial incentives are instituted to attract and retain health providers to practice in these medically underserved and provider shortage areas. Health reform legislation should assess the impact of health insurance expansion programs on these institutions and provide additional financial resources or other support where needed.

**Ensure access to a medical home.** Having a “medical home”—a health care setting that enhances access to providers and timely, well-organized care—is associated with better management of chronic conditions, regular preventive screenings, and improved primary care. Racial and ethnic minorities and other disparity populations are less likely to report having a medical home, but when they do their health care access gaps are significantly reduced. In a medical home setting, the patient plays an essential decision making role with his/her team of health professionals that provide care and health information to patients in a continuous, accessible, comprehensive, and coordinated manner. We urge you to expand and promote the development of medical homes in health care institutions that serve minority and health disparity populations.

**Expand community-based prevention and wellness.** We urge you to support and expand community-based prevention and wellness programs designed to reduce health disparities through improved access to health care, primary prevention activities, health promotion and disease prevention activities, health literacy education and services, and other education and outreach activities. Grants should be made available to facilitate partnerships between public and private institutions, particularly those that work in underserved areas and target minority and health disparity populations, such as safety net organizations, safety net hospitals, federally qualified health centers, community mental health centers, community-based organizations, Indian health service programs, Title X family planning clinics, and faith-based organizations. Grants also should be used to support coordination and integration of community-based strategies to improve the health of communities through improvements in education, housing, the environment, labor, and transportation. Finally, grants should be used to support community health workers (also known as lay health navigators or promotoras), who are trained members of medically underserved communities that teach healthy behaviors and disease prevention, conduct simple assessments of health problems prevalent in their communities, help their neighbors access and enroll in public and private health and human services, and teach community wellness and awareness. In health care contexts, community-based programs serve as a liaison between communities and health systems and will be instrumental in helping individuals, families and communities transition to and navigate a new, reformed health system.

**Increase diversity among the health professions and address shortage areas.** Underrepresented minorities make up about 25 percent of the population, but only represent about 10 percent of the health professions workforce. A greater representation of racial and ethnic minorities in the health care workforce can reduce health disparities by improving access to and quality of care among minority populations. Existing federal programs that support the education and training of primary care, public health, nursing, and behavioral health professionals are woefully underfunded and do not sufficiently target minority students. Additional funding and resources should be directed to the Public Health Service Act Title VII and VIII diversity programs that make medical schools more affordable for minority students, help medical schools establish a diverse faculty, better prepare primary and secondary minority students for college, and create incentives for minority medical school graduates to practice in underserved communities. These programs should be required to collect data and report on the number of minority students graduating from medical schools and their intended medical specialty and practice location.

**Incorporate universal adoption of cultural and linguistic competence in health care settings.** Health care providers and systems must be culturally and linguistically competent to improve health care access and quality for an increasingly diverse U.S. population. The federal Culturally and Linguistically Appropriate Services (CLAS) standards identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health

systems and providers. Federally-funded health care organizations are mandated to meet four of the standards, but the federal government can take steps to require more widespread adoption of the guidelines and recommended standards by all health care providers, not just those receiving federal funds. These include providing incentives that encourage and reward health care organizations that implement the CLAS standards, such as federal reimbursement for culturally and linguistically appropriate services for uninsured and underinsured patients.

**Develop a strategy and standardized measures for collecting, monitoring and reporting data on health disparities.** The federal government should devise a strategy for developing appropriate standardized measures, indicators and methods for collecting and reporting data to learn more about health care access, quality and outcomes by patient demographic factors, including race and ethnicity, age, gender, primary language, socio-economic position, geographic location, and health literacy. In developing these standards, it is important to ensure appropriate privacy and security protections for the data, as well as that under-resourced health care facilities have the capacity and resources to collect and accurately report data. Data should be analyzed for trends in disparities and interactions between various disparity indicators, including how social and community environments affect health by using social and community research and community-based participatory research, which builds upon the culturally-based norms and practices that exist in communities. Data and findings should be disseminated to government agencies to inform policy decisions and assist in efforts to eliminate health disparities. When appropriate, data should be made accessible to nongovernmental entities and the public to promote greater public accountability.

**Improve interagency collaboration and implement health impact assessments.** Health among populations is intricately tied to community design and directly affected by policies and programs across various sectors, including housing, transportation, environment, land use, labor, and education. The federal government should take steps to coordinate the work of agencies that impact the health of minority populations to reduce duplication of effort, increase efficiency and more effectively address health disparities. In addition, government agencies from a variety of sectors should assess the impact of their policies and programs on the health of communities and health disparities. The Centers for Disease Control and Prevention should develop a portfolio of best practices based on scientific evidence, and standardized tools and measures to assess the impact of policies and programs on the health of the community.

**Encourage the adoption of quality improvement programs that address the health care challenges and needs of underserved communities.** Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But because underserved communities and populations are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income and minority communities and populations. Quality improvement efforts should be expanded and take into account the challenges and needs of underserved communities and populations and reward efforts that reduce disparities and improve patient outcomes. In addition, quality improvement incentives can be targeted to safety net institutions and other providers that disproportionately serve minority and health disparity populations.

**Support efforts to improve the health of minorities and disparity populations living in rural and frontier communities.** Research indicates that individuals living in rural areas are poorer than their urban counterparts, yet people of color in rural and frontier communities have even less income than their white rural neighbors. Moreover, rural

dwellers are least likely to have employer-based health insurance, prescription drug coverage or public health insurance. Factors such as geographic isolation, few community economic resources, the lack of transportation, and a shortage of primary care providers, dentists and health specialists in rural and frontier areas contribute to significant chronic health problems for these inhabitants. In addition to providing adequate financial support for the Health Resources and Services Administration's (HRSA) Office of Rural Health Policy, further initiatives should be established to address the disparities impacting individuals in rural and frontier communities.

**Establish an Office of Urban Health.** According to the Census Bureau's latest American Community Survey, racial and ethnic minorities make up half of the population of the nation's largest cities. Minority and low-income urban communities suffer disproportionately from health disparities that result from lack of access to quality health services, healthy housing, healthy foods, safe places to play and exercise, clean air and water, and good jobs and economic opportunities. The Department of Health and Human Services should establish an Office of Urban Health within HRSA to administer grant programs and provide technical assistance and counseling to improve urban health and conduct urban health research.

**Reduce barriers to enrollment in public health insurance programs.** We urge you to establish clear and easy-to-understand processes and procedures for enrolling children and families into public health insurance programs—processes that do not discriminate on the basis of race or ethnicity, and that reflect culturally competent and linguistically appropriate practices. As a critical first step in this, the Department of Health and Human Services should eliminate, or at least ameliorate, citizenship documentation requirements in public programs. Studies have indicated that this requirement disproportionately impacts eligible low-income U.S. citizens who may not have access to required documents to establish proof of identity and citizenship.

The recent Children's Health Insurance Program (CHIP) reauthorization provides states with the option to match the social security numbers of applicants for public health programs to a central database, instead of requiring actual documentation to establish citizenship. Additionally, it gives states the option to cover eligible legal immigrant children without a five year waiting period. Unfortunately, some states may not do either. Federal demonstration projects and funding should be made available to allow states to incorporate these options and to further improve, streamline and simplify enrollment procedures for public health insurance programs.

**Foster greater equality through the enforcement of civil rights laws that impact health.** Institute of Medicine's Unequal Treatment report found that enforcement of civil rights laws is an important component of a comprehensive strategy to address healthcare disparities. Yet, the U.S. Supreme Court in the *Alexander v. Sandoval* decision made it impossible for private citizens to hold the government accountable for enforcing the key federal civil rights laws that address "unintentional" racial disparities in government programs (Title VI of the Civil Rights Act of 1964) and Congress has not yet responded to repair the damage. Authorizing individuals to hold the government accountable for violations of the law is necessary to address disparities in use of available resources. In addition, the Office for Civil Rights (OCR) at HHS, the agency charged with enforcement, has suffered from insufficient resources to investigate complaints of possible violations and to initiate compliance reviews of health care providers. Health care reform should ensure that all health care providers are aware of their obligations to comply with civil rights laws and that OCR is given sufficient resources dedicated to addressing both intentional and unintentional discrimination related to health disparities.

We appreciate efforts to reduce health disparities included in the recent CHIP reauthorization, including initial steps to reduce barriers to enrollment in public health insurance programs. We hope that you will continue to address the needs of minority and health disparity populations in health reform legislation. We look forward to working with you on these and other important minority health and health equity issues this year.

Sincerely,

AIDS Action Council  
AIDS Foundation of Chicago (Ill.)  
The AIDS Institute  
Alliance for Reproductive Justice  
American Academy of Nurse Practitioners  
American Academy of Nursing  
American Academy of Physician Assistants  
American Public Health Association  
Americans for Democratic Action  
The Archuleta County Victim Assistance Program (Colo.)  
Asian & Pacific Islander American Health Forum  
Association of Minority Health Professions Schools  
Association of State & Territorial Directors of Nursing  
B Free CEED: National Center of Excellence in the Elimination of Hepatitis B Disparities  
Black Women's Health Imperative  
Center of Excellence in Eliminating Disparities (CEED) (Ill.)  
Charles Drew University  
Charleston and Georgetown Diabetes Coalition (S.C.)  
CHASS/REACH Detroit Partnership (Mich.)  
Child Welfare League of America  
CommonHealth ACTION  
Community Health Councils (Calif.)  
The Disparities Solutions Center at Massachusetts General Hospital  
Equal Start Community Coalition (Wash.)  
Flint Odyssey House, Inc. Health Awareness Center (Mich.)  
Fort Greene Strategic Neighborhood Action Partnership (N.Y.)  
Genesee County Health Department (Mich.)  
Greater Brooklyn Health Organization (N.Y.)  
Healthy Lifestyle La Plata Coalition (Colo.)  
Hidalgo Medical Services- Family Support Services (N.M.)  
Institute of Social Medicine and Community Health  
Inter-Tribal Council of Michigan  
King County Board of Health (Wash.)  
Latino Center of Excellence for Eliminating Disparities--REACH US (Mass.)  
Lowell Community Health Center (Mass.)  
Meharry Medical College  
Mental Health America  
Morehouse School of Medicine  
National AHEC Organization  
National Association of Local Boards of Health  
National Association of Social Workers  
National Assembly on School-Based Health Care  
National Cambodian American Health Initiative  
National Center for Law and Economic Justice

National Council on Diversity in the Health Professions  
National Health Law Program  
National Hispanic Medical Association  
National Network of Abortion Funds  
Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED)  
Planned Parenthood of the Inland Northwest (Wash.)  
Promoviendo La Salud (Colo.)  
Public Health-Seattle & King County (Wash.)  
REACH Center of Excellence in the Elimination of Disparities at the Boston Public Health  
Commission (Mass.)  
REACH Detroit Partnership (Mich.)  
San Juan Basin Health Department (Colo.)  
Sea Mar Community Health Centers (Wash.)  
Seattle & King County REACH Coalition (Wash.)  
Society for Public Health Education  
Society of General Internal Medicine  
South Carolina Coalition Against Domestic Violence and Sexual Assault  
Southeastern US Collaborative Center of Excellence for the Elimination of Disparities  
(SUCCEED)  
St. John's Well Child and Family Centers (Calif.)  
Trust for America's Health  
University of Arizona National Center of Excellence in Women's Health  
William F. Ryan Community Health Network (N.Y.)  
Wisconsin Alliance for Women's Health  
YWCA of Greater Lawrence (Mass.)

Cc: Senate Committee on Health, Education, Labor and Pensions  
Senate Committee on Finance