Overview

• ACA’s Vision, Promise, and Background
• Impetus & Background on our ACA Initiatives
• Implementation Progress of Equity Provisions
  – Health Insurance Exchanges
  – Health Care Safety Net
  – Workforce Support and Diversity
  – Data, Research, and Quality
  – Public Health and Prevention
• Overall Priorities for Advancing Equity through ACA
• Next Steps for our Current ACA Initiative
ACA’s Vision and Promise

• Working to eliminate health disparities and advance health equity is central to the Affordable Care Act (ACA) of 2010.

• Over three dozen provisions directly advance racial and ethnic health equity, diversity, and cultural and linguistic competence.

• Dozens of other general provisions with major implications for racially and ethnically diverse populations.
History & Scope of Work

2008
- Obama vs. McCain Health Care Proposal Analysis
- House & Senate Health Reform Bills Analysis

2010
- Joint Center Report: Advancing Health Equity for Racially and Ethnically Diverse Populations

2011
- Federal agency progress on ACA & Equity
- *Health Affairs* article on ACA & Safety Net

2012-2014
- ACA & Racial and Ethnic Health Equity Series: Comprehensive Tracking of implementation progress, emerging guidance & programs
A Recognition of:

- Rapidly growing racial, ethnic, and linguistic diversity across the nation.
- Continued disparities in access, quality, and health indicators by race and ethnicity.
- Opportunities in the ACA focused explicitly on diversity & disparities.
- Need to monitor progress and identify best practices and resources to facilitate and take ACA’s vision to reality.
Disparities in Access to Care in U.S., 2011

- Hispanics had worse access to care than non-Hispanic Whites for 63% of measures.

- AI/ANs had worse access to care than Whites for 62% of access measures.

- Blacks had worse access to care than Whites for 32% of access measures.

- Asians had worse access to care than Whites for 17% of access measures.

Disparities in Quality of Care in U.S., 2011

- Blacks received worse care than Whites for 41% of quality measures.

- Hispanics received worse care than non-Hispanic Whites for 39% of measures.

- Asians and American Indians and Alaska Natives (AI/ANs) received worse care than Whites for about 30% of quality measures.

Our Current ACA Work

- We are utilizing a “health equity lens” to monitor implementation of 60+ provisions in the ACA with mention of or implications for racially and ethnically diverse communities across five areas:
  - Health Insurance Exchanges
  - Health Care Safety Net
  - Workforce Support and Diversity
  - Data, Research, and Quality
  - Public Health and Prevention
## Health Insurance Exchanges

<table>
<thead>
<tr>
<th>Provisions</th>
<th>Good</th>
<th>Moderate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plain Language Requirement for Health Plans</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove Cost Sharing For Indians</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Discrimination in Federal Programs and Exchanges</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment of the Exchanges</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally/Linguistically Appropriate Benefits Summary/Glossary</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally/Linguistically Appropriate Claims Appeals Process</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally/Linguistically Appropriate Information in Exchanges</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentive Payments in Health Plans for Reducing Disparities</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
State Exchange Decisions

Declared State-based Exchange (17 + DC)  Planning for Partnership Exchange (7)

Default to Federal Exchange (26)

About 42% (or over 12 million) of people enrolling through the Exchanges will belong to a Non-White racial and ethnic group.

Nearly one in four will speak a language other than English at home.

How are Exchanges Integrating Diversity & Equity into their Planning?

- Requiring racial and ethnic representation on the Board of Directors.
- Ensuring diversity and equity objectives are explicitly a part of the exchange vision and mission.
- Requiring stakeholder advisory groups to include racial and ethnic representation.
- Engaging racial and ethnic community members, advocates, and other representatives to provide input on various aspects of planning.
- Adopting a tribal consultation policy and consulting federally recognized tribes.

Note: Findings are Based on Case Studies of 7 State-Based Exchanges (California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington).
How are Exchanges Targeting Outreach & Education to Diverse Communities?

- Developing culturally and linguistically tailored outreach through multiple mediums (e.g., translated print & online information, multilingual hotlines, in-person programs).

- Ensuring the Navigator and Assister Programs are reflective of diverse communities and have the capacity to inform and enroll diverse individuals (e.g., bilingual, trusted, community-based).

- Developing training materials on cultural and linguistic competency for Navigators and Assisters.

- Monitoring outcomes of culturally and linguistically tailored outreach and education on enrollment, satisfaction, and other measures.

Note: Findings are Based on Case Studies of 7 State-Based Exchanges (California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington).
Questions Ahead for Exchanges

• How to address diverse community outreach, when the focus remains on start-up, building IT, and meeting short deadlines?

• How to fund outreach and education when critical programs, such as Navigators, are prohibited from being funded by Exchange establishment grants?

• How to reach communities which:
  – Are not familiar with the concept of health insurance?
  – Are linguistically isolated, particularly smaller groups of non-English speaking populations that do not meet federal threshold requirements?
  – Have low literacy?
  – Belong to mixed-citizenship families?
  – Do not trust Government and federal programs?
  – Face a combination of the above factors?
Guidance on Promising Practices

• Integrate diversity and equity objectives from the get-go in exchange planning and operation.

• Work with trusted representatives who are reflective of diverse communities and are culturally and linguistically competent to provide targeted outreach and education.

• Ensure culturally and linguistically appropriate information is provided by the exchange through various mediums & channels.

• Actively share and disseminate information on experiences, promising practices, and lessons learned across states.
<table>
<thead>
<tr>
<th>Provisions</th>
<th>Good</th>
<th>Moderate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP Reauthorization</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Needs Assessment</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School-Based Health Centers</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Health Centers</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nurse-Managed Health Clinics</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicaid Disproportionate Share Hospital Payments*</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Disproportionate Share Hospital Payments*</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Scheduled to take effect in 2014.
State Decisions on Medicaid

Where the States Stand: February 27, 2013
24 Governors Support Medicaid Expansion

- 24 states + DC will expand
- 14 states will not expand
- 12 states undecided
Medicaid Eligibility by Race & Ethnicity

6.8 million or 45% of Newly Eligible are Non-White*

Percent of Population with Income below 138% FPL who will be Eligible for Medicaid in 2014, by Race and Ethnicity

- **White**: 54.9%
- **Hispanic or Latino**: 19.4%
- **African American**: 18.7%
- **Other**: 7.0%

Who will be left out of Medicaid?

Number of Racially & Ethnically Diverse Individuals with Incomes Below 138% FPL & 100% FPL by State Decision Regarding Medicaid

<table>
<thead>
<tr>
<th></th>
<th>24 States + DC Opting for Medicaid</th>
<th>14 States Opting Out</th>
<th>12 States Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 138% FPL</td>
<td>3.4 mil</td>
<td>2.7 mil</td>
<td>0.7 mil</td>
</tr>
<tr>
<td>&lt; 100% FPL</td>
<td>n/a</td>
<td>2.1 mil</td>
<td>0.6 mil</td>
</tr>
</tbody>
</table>

2.1 million Non-White diverse individuals with incomes below 100% FPL will have no source of new coverage under the ACA, in opt-out states. This represents roughly half of all those left uninsured from Medicaid opt-out.

Community Health Centers

• Considerable new support and funding for health centers through the ACA.

• But cuts to discretionary funding for health centers which started in FY 2011, represent the first federal funding setback in almost 30 years.

• While ACA intended to increase capacity of health centers to serve 20 million new patients, funding cuts will only allow for 10 million new patients by 2015.

• Given two-thirds of health center patients are racially and ethnically diverse, they are likely to feel the brunt.
Other Health Centers & Clinics

- **Nurse-Managed Health Clinics**
  - Authorized $50 mil in FY 2010 & SSAN for FY 2011-14
  - Only received $14.8 mil in FY 2010

- **Teaching Health Centers**
  - Authorized $100 mil for FY 2010-2012; no funding to date
  - THC Graduate Medical Education Payment program has received $20 mil of the $230 mil authorized

- **School-Based Health Centers**
  - Appropriated $200 mil in FY 2010-2013
  - Received $175 mil
• ACA reduces Medicaid Disproportionate Share Hospital (DSH) payments by $18 billion between 2014–2020.

• Medicare DSH spending is reduced by $22 billion over 10 years.

• Nonprofit hospitals required to conduct a Community Health Needs Assessment every 3 years, including developing solutions for addressing identified needs.
The Safety Net at Crossroads

Rising Competitive Pressures
Declining Funding
Continuity of Care
Outreach & Education
Patient Insurance Volatility
Populations at the Margin

“How do [safety net providers] navigate this new system while keeping their souls intact?”

–Key Informant
• **Developing integrated systems of care**
  – Ensure continuity of care for patients expected to churn and hop month-to-month from uninsured to exchanges or Medicaid.
  – Important to ensure access to specialty care.

• **Expanding the scope of Community Health Needs Assessment to create healthier communities**
  – Opportunity to utilize these assessments for broadly creating healthy communities and addressing disparities

• **Engaging state and local philanthropy to complement the ACA in supporting the safety net**
  – Fill gaps in where the ACA falls short in supporting the safety net & also to assist providers to transition & adapt.
## Workforce Diversity & Support

<table>
<thead>
<tr>
<th>Provisions</th>
<th>Good</th>
<th>Moderate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for Primary Care Providers; Dentists; Mental and Behavioral Health Providers; and Nurses</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Healthcare Workforce Development Grants</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce Diversity Grants</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Health Service Corps</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area Health Education Centers</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redistribution of GME or Residency Positions</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrations for Health Workforce Needs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centers of Excellence</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBCUs and other Minority Serving Institutions</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>National Health Care Workforce Commission</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cultural Competency Model Curricula</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Community Health Workforce</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Why Focus on Workforce Diversity?

Total U.S. Dental Professionals by Race and Ethnicity, 2007

<table>
<thead>
<tr>
<th></th>
<th>Dentists</th>
<th></th>
<th>Dental Hygienists</th>
<th></th>
<th>Dental Assistants</th>
<th></th>
<th>% of U.S. Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>138,866</td>
<td>76.3%</td>
<td>137,795</td>
<td>88.9%</td>
<td>217,288</td>
<td>69.2%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Black</td>
<td>637</td>
<td>3.5%</td>
<td>3,410</td>
<td>2.2%</td>
<td>20,410</td>
<td>6.5%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>235</td>
<td>12.9%</td>
<td>4,340</td>
<td>2.8%</td>
<td>14,758</td>
<td>4.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>116</td>
<td>6.4%</td>
<td>7,440</td>
<td>4.8%</td>
<td>55,892</td>
<td>17.8%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>


Total U.S. Nurses, Physicians, & Physician Assistants by Race & Ethnicity, 2007-2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>2,549,302</td>
<td>83.2%</td>
<td>353,311</td>
<td>75%</td>
<td>75,408</td>
<td>77.2%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Black</td>
<td>165,352</td>
<td>5.4%</td>
<td>29,775</td>
<td>6.3%</td>
<td>7,606</td>
<td>7.8%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>169,454</td>
<td>5.5%</td>
<td>60,090</td>
<td>12.8%</td>
<td>5,382</td>
<td>5.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>109,387</td>
<td>3.6%</td>
<td>25,717</td>
<td>5.5%</td>
<td>8,053</td>
<td>8.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>AI/AN</td>
<td>18,099</td>
<td>0.6%</td>
<td>2,515</td>
<td>0.5%</td>
<td>470</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Supply & Diversity of Workforce

- **Titles VII & VIII of Public Health Services Act** mainly geared toward helping to increase supply & diversity in workforce.
  - Title VII: Targets Primary care providers
  - Title VIII: Targets Nurses

- ACA reauthorizes & strengthens many Title VII & VIII Programs, such as:
  - Primary Care Training & Enhancement Program was authorized $125 mil & such sums as necessary for FY 2010-2013, and by 2012, already received $315 mil from discretionary & other funds.
  - General, pediatric & public health dentists were appropriated $30 mil & such sums as necessary for FY 2010-2013, received $52 mil by 2012.
Workforce Support for Safety Net

• **National Health Service Corps (NHSC)** reauthorized by ACA & received an increase in funding to encourage medical residents to commit to serving in medically underserved areas.
  – ACA has grown the NHSC workforce three times
  – 46% of residents practice at community health centers
  – 13% African American, 10% Hispanic, 9% Asian/PI & American Indian

• **Unused Graduate Medical Education (GME)** residency positions were authorized to be redistributed to areas with provider shortages
  – Of 58 hospitals with increases in slots, half are located in cities or localities where more than 50% of population is Non-White
Cultural Competence (CC)

- **CC in Pain Care:** Authorizes HRSA to establish new grants program to train health care professionals in diagnosis, treatment, or management of acute or chronic pain. Explicit requirement to address cultural, linguistic, and literacy barriers. No funding to date.

- **CC Curricula:** Authorizes a grant program to develop, evaluate, and disseminate research, demonstration projects, and model curricula for cultural competency to reduce health disparities. No funding to date.

- **CC in Geriatric Care:** Creates new demonstration grants program to develop training competencies—including for cultural & linguistic competence and sensitivity—for geriatric & long term care. Of $15 mil authorized, $13 mil received in FY 2010-2012.
Investment in Academic Settings

- **Minority-serving institutions** received $255 mil in mandatory funding through 2019:
  - $100 mil for Hispanic Serving Institutions
  - $100 mil for HBCUs & Predominantly Black Institutions
  - $35 mil to Tribal Colleges & Universities & Native American colleges
  - $15 mil to Alaska & Hawaiian Native Institutions
  - $5 mil to Asian American & Pacific Islander Institutions

- **Centers of Excellence** also provided with increased funding to enhance diversity of health workforce. In FY 2010-2012, $150 mil was authorized, though only $72 mil was received.
Workforce Challenges and Priorities

• Continued shortage of health professionals, especially in highly underserved & diverse areas.

• Reluctance to pursue cultural competence as priority.

• Greater need to recognize importance of working with and supporting community-based settings & minority-serving institutions to address workforce needs.
Opportunities for Building a Diverse & Culturally Competent Health Workforce

- Expanding Scope of Practice—e.g., greater scope for Advance Practice Nurses & Physician Assistants
- Encouraging Interdisciplinary Team-Based Care—e.g., recognizing role of community health workers.
- Leveraging Opportunities in the ACA with Philanthropic and Foundation Support—e.g., for cultural competency efforts
- Identifying an organizational champion for diversity priorities
- Evaluating Health Care Workforce Diversity Needs, Capacity, and Outcomes
<table>
<thead>
<tr>
<th>Data, Research, &amp; Quality</th>
<th>Level of Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>Patient-Centered Outcomes Research Institute</td>
<td>✓</td>
</tr>
<tr>
<td>Center for Medicare and Medicaid Innovation</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>✓</td>
</tr>
<tr>
<td>Data by Race, Ethnicity and Language</td>
<td>✓</td>
</tr>
<tr>
<td>National Strategy for Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>Interagency Group on Health Care Quality</td>
<td></td>
</tr>
<tr>
<td>Minority Health in HHS Offices</td>
<td></td>
</tr>
<tr>
<td>Pediatric Accountable Care Organizations</td>
<td></td>
</tr>
<tr>
<td>Disparities Research in Post-Partum Depression</td>
<td></td>
</tr>
<tr>
<td>Develop, Improve &amp; Evaluate Quality Measures</td>
<td></td>
</tr>
<tr>
<td>Cultural Competency Research &amp; Curriculum</td>
<td></td>
</tr>
</tbody>
</table>
The ACA established a nonprofit corporation, unaffiliated with the Federal Government, known as PCORI, and created a Trust Fund within the Treasury Department to fund research commissioned by PCORI.

One of five research priorities of PCORI focused on “addressing disparities” with specific objectives on:

1. Ways to reduce disparities in health;
2. Benefits and risks of health care options across populations; and
3. Strategies to address health care barriers that can affect patient preferences and outcomes.

Series of funding announcements issued—e.g., in May 2012, PCORI issued funding announcements which included a focus on disparities, particularly in identifying “best options for eliminating disparities” as opposed to simply “describing disparities.”

In March 2013, PCORI announced its Disparities Advisory Panel.
The ACA created the Center for Medicare and Medicaid Innovation or “The Innovation Center” within CMS to test health care delivery and payment systems, support care coordination, and disseminate best practices across the health care delivery system.

Officially launched on November 16, 2010 and has supported a range of innovations projects, including:

- Bundled Payments for Care Improvement;
- Partnerships for Patients;
- ACO Development;
- Primary and Patient-Centered Care;
- Health Care Innovation Awards; and others.

Of 100+ Health Care Innovation Awards distributed in May/June 2012, roughly 15 percent explicitly cite racial/ethnic minorities, equity, health disparities, and related in their program descriptions. Although most have implications for low-income populations generally.
Challenges & Priorities for Data, Research & Quality

• Need for adequate support and funding to sustain programs in long-run – e.g., PCORI is only authorized until 2019; support for new OMHs

• Need to ensure that data, research, and quality initiatives explicitly link to disparities objectives.

• Given short term funding for several ACA initiatives, it is important for researchers to focus on measurable impact.

• Need to monitor the impact of these programs to ensure they do not have the adverse affect of exacerbating racial/ethnic disparities.
<table>
<thead>
<tr>
<th>Program</th>
<th>Good</th>
<th>Moderate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Transformation Grants</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal &amp; Child Home Visiting</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Responsibility Education</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical &amp; Community Prev. Services Taskforce</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Prevention Strategy &amp; Fund</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity, Diabetes, Cancer Programs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reauthorization of Indian Health Care Improv. Act</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>National Oral Health Campaign</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Prevention & Public Health Fund

- The ACA establishes the Fund to support investment in public health and prevention programs that aim to improve health outcomes and contain spending.

- In FY 2010, funds were primarily spent on infrastructure and workforce (69%), mainly for primary care workforce development.

- In FY 2011-2012 the largest portion of the funds was administered for efforts involving community prevention (40%).

- In 2012, Congress enacted legislation to cut $5 billion from fund over 10 years to offset costs of other priorities. Several other attempts made to cut or eliminate the fund.

- The Fund is critical for funding of public health priorities that directly impact communities of color—e.g., CTGs, emergency preparedness efforts, infectious disease programs, workforce diversity, and others.
Community Transformation Grants

- Grants available to state and local agencies & CBOs for preventive health programs aimed at reducing rates of chronic disease and addressing disparities.

- In 2011, 61 Awards to 36 States ($103 million). Of 35 Implementation Grantees:
  - All intend to address low-income populations
  - > 50% intend to target African Americans & Hispanics/Latinos
  - 1 in 3 will address health issues of American Indians/Alaska Natives
  - Nearly all target children & 1 in 5 will address older adults

- In 2012, CTGs were awarded to 40 communities with fewer than 500,000 people ($70 million).
All provisions funded have shown at least some emphasis on health equity or disparities.

Under some provisions, the majority of grant programs to states, communities, and non-profits have explicit focus on health disparities:

- All 3 Childhood Obesity Demonstration Project grantees; the majority of personal responsibility education grantees; at least 2/3 of CTGs

Funding

- Threats to Prevention and Public Health Fund – “slush fund”
- County or state health departments tempted to use funds to “plug holes” in existing programs
- Questions remain re: sustainability of funds and ACA supported programs
Priorities for Advancing Equity through ACA

Creating Healthy Communities
- Leveraging support for community initiatives.
- Promoting an integrated approach to health and social services.

Transitioning Health Care Organizations
- Supporting the safety net to enhance infrastructure and participate in systems innovation.
- Ensuring diversity and equity are organizational priorities.

Promoting Individual Health
- Ensuring adequate provider education on cultural competence to enhance patient adherence.
- Creating effective care & self-management programs for diverse patients.
For many health equity objectives in the ACA, the seeds have been sown. It is the opportunities that need to be seized.
Our Health Care Reform & Equity Team

Dennis P. Andrulis, PhD, MPH
Senior Research Scientist, Texas Health Institute
Associate Professor, University of Texas School of Public Health

Nadia J. Siddiqui, MPH
Senior Health Policy Analyst, Texas Health Institute

Maria Rascati Cooper, MA
Health Policy Analyst, Texas Health Institute

Lauren Jahnke, MPAff
Consultant, LRJ Research & Consulting

For questions, feedback, or to be added to our mailing list, please e-mail: nsiddiqui@texashealthinstitute.org.
Website: http://www.texashealthinstitute.org/health-care-reform.html