



HEALTH EQUITY *and the* AFFORDABLE CARE ACT

How the ACA Can Help to Advance Racial and Ethnic Health Equity in Colorado

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» **ABSTRACT**

National health reform has the potential to advance the health of Coloradans and to move the state toward health equity. A number of policies within the 2010 Patient Protection and Affordable Care Act (ACA) focus on reducing health disparities, particularly those experienced by racial/ethnic minorities.

The laws' broadest provisions expand access to care through Medicaid expansion, health insurance exchanges and new requirements for employer insurance. Racial/ethnic minorities make up more than 346,000 of Colorado's 829,000¹ uninsured, and expanded access will help to close the coverage gap. The law also bolsters public health and prevention programs and the health care safety net.

Targeted provisions in the ACA focus specifically on improving quality of care for racial/ethnic minorities. These provisions include increased data collection efforts, resources to improve culturally competent care, workforce development strategies, increased funding and priority for research into health disparities, and support for innovative solutions to address social determinants of health – the economic and social conditions in which people are born, grow, work and live. These conditions influence both individual and population health² and include such factors as quality of housing, neighborhood safety, transportation options, education and food access, and the distribution of income, wealth and power.

This paper examines the ACA policies that relate to racial/ethnic health disparities and discusses what Colorado is already doing to reduce disparities. It also looks at what Colorado policymakers can learn from other states' experiences and how they could use those lessons and the ACA to move forward in eliminating racial/ethnic health disparities.

» INTRODUCTION

The ACA, which was signed into law by President Obama on March 23, 2010, aims to expand access to health care, improve the quality of care and contain health care costs. The law also has the potential to advance health equity. In this report, health equity is defined as the elimination of inequalities affecting racial/ethnic populations so all Coloradans can achieve optimal health.

Racial and ethnic minority populations are defined as:

- Asian American
- Black or African American
- Hispanic or Latino
- Native Hawaiian and Other Pacific Islander
- American Indian and Alaska Native.

The greatest health disparities¹ exist along socioeconomic lines. High socioeconomic status (SES) is linked to better health, while low SES is closely correlated with poor health. Because racial/ethnic minorities are disproportionately represented among low-income populations, they experience disparities based on SES.³

Colorado policy leaders can use relevant components of the ACA to address the social and economic costs of racial/ethnic health disparities.

Racial/ethnic disparities go beyond those correlated with income, however. Controlling for SES, racial/ethnic minorities are less likely than the general population to have insurance and access to health care. They also suffer worse health outcomes across a spectrum of health indicators, including life expectancy, infant mortality, rates of chronic disease and self-reported health status.⁴

¹ Other populations, such as individuals with disabilities and the gay, lesbian, transgender community, also suffer from disparities in health. This paper focuses solely on racial/ethnic health disparities.

Studies show that lack of health insurance negatively affects the quality of health care services received by racial/ethnic minorities and that expanding access to care helps reduce racial/ethnic health disparities.⁵ When coupled with state health reform efforts, such as the Colorado Health Care Affordability Act of 2009, the ACA can provide health care coverage for up to 500,000 additional Coloradans. It is also estimated that up to 90,000 small businesses may be eligible for tax credits that will help them affordably insure their employees.⁶

Health coverage alone is not sufficient to eliminate racial/ethnic health disparities, however. Even when insurance status is equal across populations, disparities in both quality and access to care persist along racial/ethnic lines.³ Access often is limited by other factors such as cultural and linguistic barriers, lack of transportation or lack of providers in a particular geographic area.

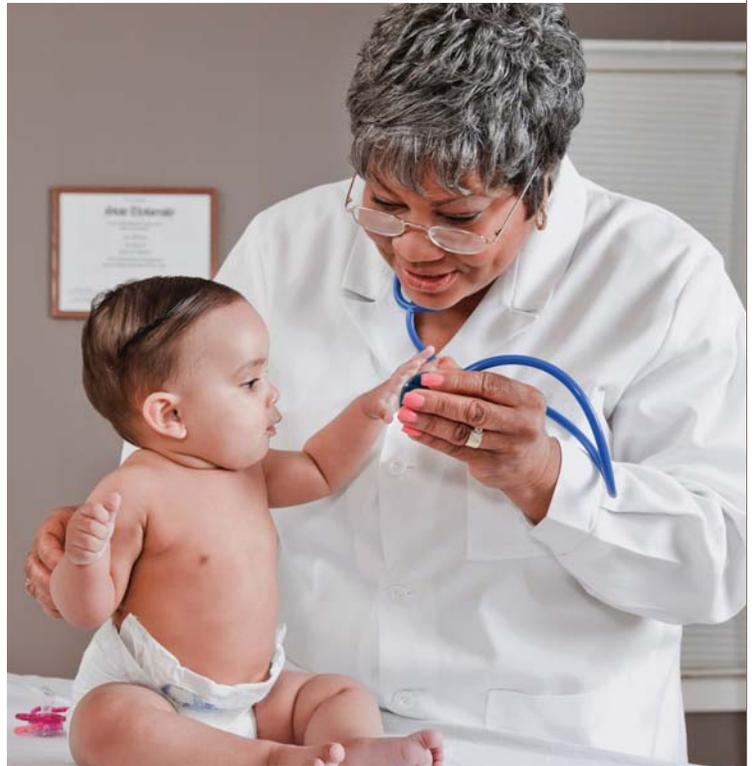
Colorado policy leaders can use relevant components of the ACA to address the social and economic costs of racial/ethnic health disparities and improve quality of care by making health equity a priority. Such actions would add to Colorado's history of pursuing innovative solutions to problems of access, system inefficiencies and high costs through legislation ranging from the 2008 Blue Ribbon Commission for Healthcare Reform to the passage of the Colorado Health Care Affordability Act.

» RACIAL/ETHNIC HEALTH DISPARITIES

Racial/ethnic minorities are more likely to be uninsured or underinsured than their white counterparts. Despite accounting for 30 percent of the general population, racial/ethnic minorities make up nearly 42 percent of the 829,000 uninsured Coloradans. Twenty-six percent of Colorado's Hispanic population and 14 percent of the non-Hispanic black population are uninsured compared with 13 percent of the non-Hispanic white population.¹ Individuals who lack health care insurance are less likely to have a usual source of care or visit a primary care provider, and are more likely to utilize the emergency room, resulting in greater costs to the individual's health and to the health care system.⁸

Hispanics make up the largest minority group in Colorado and are most at risk of being uninsured. This rapidly growing population also suffers from a number of poor health outcomes, including higher rates of obesity and chronic liver disease as well as higher diabetes mortality than the white population. African Americans experience the greatest magnitude of racial/ethnic health disparities in the state, including increased incidence of infant and perinatal mortality, low birth weight, obesity, hypertension and higher mortality related to heart disease, diabetes, HIV and cancer.⁹

A number of national and state public health campaigns, such as the Colorado Turning Point Initiative of 2001, Healthy People 2010 and Healthy People 2020, have put forth plans to help eliminate health disparities. Other strategies in the state have focused on programmatic and community-level interventions. A web of safety-net providers, community-based organizations and policy advocates has striven to provide culturally and linguistically appropriate access to care for racial/ethnic minorities, working to improve the quality of health care and address other socioeconomic barriers to health and health care.



Confronting Racial and Ethnic Disparities in Health Care, has served as a catalyst to address health equity. The report synthesized a large body of research

Disparities in quality of care exist even when health care coverage is equal. In a study of diabetes outcomes, disparities existed between black and white patients treated by the same physician, even when controlling for patient characteristics, insurance coverage and socioeconomic status.¹¹

Governmental agencies help to integrate health equity work in Colorado. The Office of Health Disparities in the Colorado Department of Public Health and Environment (CDPHE) builds capacity and knowledge about health disparities by serving as a coordinator and educator for public health programs and community-based organizations. The federal Health and Human Services Region VIII Minority Health Office also builds capacity and provides technical support on health equity issues in Colorado and surrounding states. Colorado's Minority Health Advisory Commission allows community members and advocacy leaders to provide input on addressing health disparities within health programming for CDPHE.¹⁰

For the past decade, the landmark 2002 Institute of Medicine (IOM) report, *Unequal Treatment*:

that demonstrated the severity of health disparities and gave suggestions on how to address these disparities. The broad policy agenda that has emerged since the report's release includes expansion of health insurance, delivery and payment reform to elevate the *value* of health care services provided over the *number* of services, and expansion of public health programs and preventive health care. The agenda also seeks to address health disparities through increased data collection, a focus on cultural competence

Despite accounting for 30 percent of the general population, racial/ethnic minorities make up nearly 42 percent of the 829,000 uninsured Coloradans.

of providers (i.e., the ability to interact effectively with people of other cultures), increased resources for research and development of evidence-based practice, and support for safety-net providers. Also called for is workforce development, including use of community health workers and patient navigators (see box on page 9), and recruitment of providers from racial/ethnic minority communities to increase diversity of the health care workforce.

Hispanics make up the largest minority group in Colorado and are most at risk of being uninsured.

Unequal Treatment also called for a multi-disciplinary approach to the social determinants of health. This requires collaboration between leaders and policymakers from various fields (not just health care) that can address all the issues that contribute to health. The idea behind such an approach is that health care reform alone cannot address all of the factors that contribute to racial/ethnic health disparities.



The ACA adds to the advocacy and policy changes that were building even before *Unequal Treatment*, such as the 1986 creation of the national Office of Minority Health. It provides a roadmap of strategies that target the complex social, economic and environmental factors that contribute to disparities and, in many cases, the act provides funding streams.

» POLICY SOLUTIONS TO ACHIEVE HEALTH EQUITY

Although a number of ACA provisions mirror policies put forth by health equity advocates,^{9,12,13} health equity must be a priority during implementation of the ACA or widespread disparities are likely to persist.³ Health equity is not dependent upon the ACA, but implementation of the law provides a unique means for addressing the issue.

The next two sections of this paper describe the ACA provisions that advance health equity, including those related to health care coverage, delivery and payment reform, and areas specific to health disparities, such as data collection and cultural competence. It also provides related information specific to Colorado.

Health Equity: ACA Provisions and Related Colorado Efforts

The ACA increases access to coverage through expansion of public programs and subsidies to help people and businesses obtain private health insurance. Insurance will be available to more people in racial/ethnic minority communities through the state health exchange and subsidies to employers, and possibly through a future Medicaid expansion.

Medicaid

ACA Provisions. Health reform provides states with an opportunity to extend Medicaid coverage to individuals earning up to 133 percent of the Federal Poverty Level (FPL) – \$14,856 per year based on 2012 standards. Funding for an expanded Medicaid program would be provided by federal dollars from 2014-2016; individual states, however, would be required to increase Medicaid spending to 5 percent of the expansion cost in 2017 and 10 percent by 2020 and beyond.⁶ While the Supreme Court in June

Colorado Health Care Affordability Act

This 2009 act expanded:

- CHP+ and Medicaid to pregnant women and children up to 250 percent of the federal poverty level (FPL)
- Medicaid for parents up to 100 percent of 100 percent of FPL
- Medicaid buy-in for people with disabilities up to 450 percent of FPL
- 12-month continuous eligibility for children on Medicaid (which already existed for CHP+).

2012 upheld the validity of the ACA, it effectively made the previously mandated Medicaid expansion an option to be considered by each state.

In Colorado. The Colorado Health Care Affordability Act, passed prior to the ACA in 2009, allowed Colorado to expand coverage to some childless adults in 2012. The expansion extended coverage to nondisabled, childless adults earning up to 10 percent of FPL – just over \$90 per month. Approximately 50,000 Coloradans are eligible for this expansion, although restricted funding has limited coverage to 10,000 individuals selected by a lottery system.¹⁴

Beyond the childless adult population, Colorado offers Medicaid/ Children's Health Insurance Program (known nationally as CHIP and as Child Health Plan *Plus* [CHP+] in Colorado) coverage up to 250 percent of FPL for children and pregnant women, and Medicaid coverage up to 106 percent of FPL for parents.¹⁵ These levels were increased through the Colorado Health Care Affordability Act, which expanded public insurance coverage to 130,000 previously uninsured low-income children and adults.⁶

Medicaid expansion has the potential to increase access to care for racial/ethnic minorities. In Colorado, Hispanics, American Indians and non-Hispanic black populations are more likely to live at or below the poverty level and have lower median incomes than white and Asian populations. Twenty-

seven percent of non-Hispanic blacks live below FPL, versus 9 percent of non-Hispanic whites.¹⁶ Approximately 39 percent of those who would be newly eligible under an expanded Medicaid program would be a racial/ethnic minority.¹⁷

Among children eligible for public insurance programs, racial/ethnic minorities are less likely to be enrolled.¹⁸ Should Colorado move forward with Medicaid expansion, targeted outreach and enrollment efforts in racial/ethnic communities could help increase awareness of the public program and promote access to care.

Health Insurance Exchange

ACA Provisions. The ACA requires that by 2014 states have an operational health benefits exchange that allows individuals, families and employers to buy health coverage. The exchanges are meant to simplify the process of shopping for health coverage and to help those purchasing insurance to select and enroll in high-quality, affordable health plans.¹⁹ Individuals and families must have incomes between 133 percent and 400 percent of FPL to receive subsidies and tax credits through federal or state health care programs. Nationally, nearly half of the uninsured adults who will be eligible for subsidies to purchase through the exchange are racial/ethnic minorities.⁴

In Colorado. The development of Colorado's state-run exchange, the Colorado Health Benefit Exchange (COHBE), is well underway and scheduled to be operational in Fall 2013. COHBE could expand private health coverage access to many individuals who do not have access to employer-based coverage and whose income is too high for public programs.

Initial estimates predict that COHBE will have insurance plans available to nearly a million Coloradans, including:²⁰

- Individual insurance plans for 460,000 Coloradans who will receive financial assistance to reduce their premium cost, and for 160,000 other Coloradans who will purchase unsubsidized individual plans through the exchange
- Insurance plans for employers that will cover 80,000 employees and dependents who will receive tax credits to reduce premium costs, and another 260,000 people who will purchase employer-offered insurance without subsidies.

Massachusetts advocates found that success hinged largely on outreach and enrollment efforts that included education and culturally and linguistically competent navigators who could explain the complexities of the process of acquiring insurance and care.

Included in the ACA is a requirement that exchanges provide culturally and linguistically sensitive information and materials.²¹ COHBE has begun to develop relationships with community-based organizations, health navigators (who help patients understand and maneuver through the health system) and nonprofits to facilitate communication and outreach in racial/ethnic minority communities. Its outreach and marketing campaign will include a range of materials in Spanish, including brochures and television and radio advertisements. The exchange website will be available in both English and Spanish, and customer service representatives

and exchange navigators will be available in Spanish and other languages, depending on need.

Colorado can also learn from the efforts of other states. For example, in implementing the individual mandate component of its 2006 health reform legislation, Massachusetts learned the importance of specific strategies in reaching racial/ethnic minority communities. Massachusetts advocates found that success hinged largely on outreach and enrollment efforts that included education and culturally and linguistically competent navigators who could explain the complexities of the process of acquiring insurance and care.¹⁵

As well, the exchange boards in Connecticut and Minnesota are undergoing health equity training, and staff is attending education sessions. Minnesota included leaders from racial/ethnic minority communities on its exchange task force to provide input on the best strategies to engage diverse communities. Minnesota also created data collection standards for the exchange based on race, ethnicity and language.

In Arkansas, community health navigators and *promotores* (laypersons who receive specialized training to provide basic health care in the community) educate consumers about the exchange. Arkansas also has developed a train-the-trainer cultural competency curriculum for exchange staff.²¹

Employer Requirements

ACA Provisions. By 2014, large employers with 200 or more employees must provide insurance and automatically enroll full-time workers in their employer-sponsored health coverage plans. Employers with at least 50 employees must offer health insurance to full-time employees or pay a penalty of \$2,000 per employee. Employers with fewer than 25 employees and an average wage of \$50,000 or less are eligible to receive a tax credit to help provide insurance to their employees beginning in 2010.

In Colorado. It is often more difficult for small businesses to afford insurance than it is for larger companies.²² One-third of Colorado businesses with fewer than 25 employees offered insurance in 2008, versus 56 percent with 25-50 employees and 98 percent with 50 or more employees.¹⁷ Approximately 46,400 small businesses in Colorado are minority owned,²³ and of the state's approximate 534,500



small business employees, approximately 20 percent are Hispanic or non-Hispanic black.²⁴ Tax credits to help small businesses provide health insurance have the potential to increase access to care and advance the opportunity for better health among minorities.

A recent evaluation of data found that approximately 69 percent of Colorado small businesses are eligible for the tax credit²⁴ under the ACA to provide health coverage to employees; yet only 5 percent²⁵ have claimed it. The Government Accountability Office reported that a major factor limiting the credit's use is that most small employers do not offer health insurance, and the credit is not large enough to encourage them to do so.²⁶ In Colorado, nearly three-fourths of small companies eligible for the credit do not offer insurance to employees.²⁵

In addition, the complexities of calculating the credits have deterred claims, and at least some of the low participation rates can be attributed to small employers being unaware of the provision. In a 2011 survey by the advocacy group Small Business Majority, only 43 percent of small business respondents were familiar with the tax credits.²⁷ It remains to be seen what effects the provisions will have on employer-based insurance when penalties for larger employers go into effect in 2014.

Delivery and Payment System Reform

ACA Provisions. The ACA promotes delivery and payment reform primarily through provisions that affect Medicaid and Medicare. The newly established federal Center for Medicare and Medicaid Innovation allows for testing of innovative quality-improvement, cost-containment strategies for Medicare, Medicaid and the State Children's Health Insurance Program.

The reforms within ACA provide incentives to health care providers to practice evidence-based care, monitor quality and implement strategies that will target patients who consistently struggle with poor health outcomes.⁴ Because racial/ethnic minorities make up a disproportionate number of individuals enrolled in public health programs, delivery reform in this area could have a significant impact on access and quality of care in minority communities.³

The law encourages reform of the health care delivery system through the development and utilization of patient-centered medical homes (also known as health homes). Medical homes

provide coordinated care across the spectrum of health needs with a team of primary health care professionals working in partnership with their patients, optimally leading to more accessible and higher-quality care.

An optional provision of the health reform law allows states to establish Medicaid health homes. These health homes can serve individuals who have either two or more chronic conditions, one chronic condition with the risk of developing another or one persistent mental health condition. Under the ACA, federal funding to serve Medicaid patients in health homes is available at an enhanced 90 percent matching rate for two years.²⁸ The law also establishes the Medicare Shared Saving Program that allows networks of providers to serve as Accountable Care Organizations (ACO) for Medicare recipients with the aim of enhancing care quality and curbing costs.²⁹ ACOs are groups of health care providers who provide coordinated care and chronic disease management to improve the quality of care Medicare patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Finally, grant funding is available for new community health teams to work in concert with primary care providers to further promote the success of medical homes. These community-based interdisciplinary, interprofessional health teams will support primary care practices, including obstetrics and gynecology, within the hospital areas served by the grant recipients.

In Colorado. Independent of the ACA, Colorado began delivery reform in Medicaid with a program testing ACO-like strategies. The Accountable Care Collaborative, a new Medicaid program aimed at improving patients' health and reducing costs, shifts payment from the traditional fee-for-service model to a regional outcomes-based model of care that pays providers a pre-established fee for each patient in a specified time (such as a year or month) rather than paying for each procedure. Thus far the project has demonstrated modest improvement in cost containment and promising reductions in expensive services.³⁰

The Colorado Multi-Payer Patient-Centered Medical Home Pilot, which ran from 2009-2012, was created to show that the medical home can make care more

focused on the patient, improve health outcomes and decrease costs. Results included decreases in emergency department visits and some payer returns on investment, although payers also ran into obstacles, including employer-sponsored plans refusing to pay the enhanced fees necessary to cover the cost of the patient-centered medical home expansion.³¹ The pilot demonstrated that strong commitment from a variety of stakeholders is needed to make medical homes successful.

Any efforts to leverage ACA dollars to enact delivery reform will benefit from the lessons learned in Colorado's efforts to implement medical homes. Other states also are taking initiative to reform delivery systems and leverage ACA provisions. Ohio is providing funding for patient-centered medical home pilot programs that target racial/ethnic minority communities. Hawaii is educating communities about medical homes and the ACA and soliciting feedback on implementation.²¹ Because the efforts are early in the implementation process, information on their effectiveness is not yet available. Colorado policymakers and health care leaders will want to keep an eye on these efforts to determine if successful models could benefit the state.

Safety Net

ACA Provisions. Community health centers (CHCs), public hospitals and public health programs make up a critical safety net of care in medically underserved communities. Approximately two-thirds of the 20

million individuals who receive care at a CHC are racial/ethnic minorities. Other safety-net providers also provide a large portion of care to racial/ethnic minority communities. These providers promote health equity by serving individuals and families who might not otherwise have a medical provider.

The ACA allocates funding to bolster the safety-net system by expanding capacity and improving the facilities of existing community health centers. Nationally, the ACA will invest \$11 billion in community health centers for operational support, capital projects and health care services.

Beyond financial support, the ACA offers solutions to help improve the quality and continuity of care provided by myriad safety-net providers. The Community-based Collaborative Care Network promotes the ability of a consortium of providers – such as federally qualified health centers, safety net hospitals and health systems – to organize as a network and coordinate care for vulnerable populations. This could be an important step toward health equity because, while CHCs are able to provide quality primary care services, they face challenges in connecting their patients to diagnostic testing and specialty care.³²

Other ACA provisions that can improve the safety net are grants for the interdisciplinary community-based health teams described above and the establishment of an office to help improve care for patients eligible for both Medicare and Medicaid.

Undocumented Immigrants

In 2010, the estimated undocumented immigrant population in Colorado was approximately 180,000. The ACA excludes undocumented immigrants from purchasing coverage through the health exchange and from gaining coverage through any public program. It does not apply exclusions on funding for the safety net, where most undocumented immigrants seek care.

Data regarding undocumented immigrants are difficult to obtain because many common data sources do not ask for immigration status. Language differences and fear of deportation also create barriers to data collection. Despite limited data, studies have shown that immigrants are less likely to have health coverage and experience greater barriers to care. Over time, these factors can lead to diminished health status, even in young and healthy populations.⁹

Efforts to pursue health equity will need to take into account the large number of undocumented immigrants in the state and the effect that lack of access to health care has on them individually as well as the state's health system.

As implementation of the ACA continues to unfold, an influx of newly insured individuals joining the health care system will likely lead to greater demand for safety net providers and increase the need for a strong safety net.

Despite substantial investment in the safety net, the strain of caring for the newly insured means these providers and organizations will still be reliant on their current sources of funding from state funds, private payers and foundations. The new provisions will strengthen the safety net, but only if the funding they currently receive is maintained and stakeholders collaborate to take full advantage of the opportunities within ACA.

In Colorado. Three Colorado federally qualified health centers received more than \$60.5 million in capital development grants through the ACA in 2010. The grants funded Clinica Family Health Services to expand the Thornton facility, Metro Community Provider Network to build a new facility in Jefferson County, and Valley-Wide Health System to build a new facility in La Junta and renovate the Monte Vista building to replace the Rio Grande Medical Center.⁶

Colorado CHCs also received more than \$7.5 million in funding through the Increased Demand for Community Health Care Services Grants, originally funded through the American Recovery and Reinvestment Act and continued through the ACA.³³ These grants were provided to expand services offered by CHCs and to help them meet the increased need for affordable health care during the economic downturn.

Public Health and Prevention

ACA Provisions. The ACA allocates several funding streams to improve public health and prevention services. The newly established National Prevention, Health Promotion and Public Health Council coordinates public health policies across multiple federal agencies and disciplines. The Prevention and Public Health Fund is a new funding stream to address public health concerns. Within this fund,

money is earmarked for Community Transformation Grants (CTG), aimed at helping local providers and community-based organizations provide innovative treatment of chronic disease. Monies are also available for school-based health centers and nurse-managed clinics.

Many of the prevention and public health programs that received funding and support through the ACA are evidence-based and have already demonstrated efficacy. For instance, Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV)

Community Health Workers and Patient Navigators

ACA Provisions. The ACA makes grants available for public or nonprofit private entities to hire Community Health Workers (CHWs) to provide culturally and linguistically appropriate services. Many Colorado health care providers and organizations already utilize CHWs – laypeople or paraprofessionals who are often from the community they serve and therefore share similar racial, ethnic, language and cultural backgrounds. A growing body of evidence demonstrates that CHWs help to improve health outcomes in underserved communities and to decrease racial/ethnic health care disparities. CHWs can be a valuable resource on the health care team by helping patients navigate the complexities of the system and educating them on self-care and healthy behaviors. Similarly, patient navigators are non-medical workers who help patients learn about their disease, get screenings and treatment, and find services to help them stay healthy. The ACA reauthorized the Patient Navigator and Chronic Disease Prevention grants to help health care centers develop navigator programs.

Approximately two-thirds of the 20 million individuals who receive care at community health centers are racial/ethnic minorities.

funding is only available to certain programs that have consistently demonstrated a positive effect on health and social indicators.

The National Prevention Health Promotion and Public Health Council released an action plan in June 2012.

outcomes among populations with high rates of preventable diseases. Finally, health reform eliminates cost-sharing for a variety of preventive services under qualified health plans.

The ACA permanently reauthorized the Indian Health Care Improvement Act (IHCIA) which originally passed in 1976. The law is intended to maintain and improve the health of American Indians and Alaska Natives and to establish a statute that provides for health care delivery to them through the Indian Health Service. The Colorado Office of Health Disparities reports that nearly 34 percent of American Indian and Alaska Native adults in the state are uninsured. The permanent reauthorization of the IHCIA could help improve health access and health care for both populations by increasing the health care capacity needed to serve these groups both nationally and in Colorado.

The plan includes directives to create and sustain communities that promote health and wellness, and emphasizes prevention-focused health care and community prevention, supporting individual healthy choices, and eliminating health disparities.³⁵ The plan also puts forth strategies to accomplish 2020 Healthy People goals and highlights promising public health and prevention strategies to help achieve newly defined public health goals. Additionally, it discusses ways in which the U.S. Health and Human Services department is implementing these strategies and details cross-agency projects the council is undertaking or planning.

In Colorado. In Colorado, the Denver Health and Hospital Authority received a CTG to work on cardiovascular disease prevention efforts in targeted Denver communities. The project employs CHWs to screen for disease, address social determinants of obesity, work with housing developments to reduce children's tobacco exposure and collaborate with the Denver Public Schools to make more places safe for physical activity.

The Colorado Office of Health Disparities reports that nearly 34 percent of American Indian and Alaska Native adults in the state are uninsured.

As well, the ACA contains provisions for education campaigns about breast and oral health, and grants to employ community health workers (CHW) (see box on page 9) to promote positive health behaviors at health clinics, hospitals, health centers and public health departments. Public health and prevention strategies such as patient education, disease and chronic care management, and patient navigators are designed to reduce costs and improve health



Racial/ethnic minorities, particularly African American populations in Colorado, also suffer a number of disparities in reproductive health, including poor birth outcomes and higher rates of sexually transmitted diseases. The ACA provides funding for public health programs to educate and assist patients in improving their reproductive health, with a focus on sexually transmitted disease and maternal/child health programs.

Colorado received a five-year funding stream beginning in 2011 for MIECHV, which have expanded access to three important prevention programs: Nurse Family Partnership, Home Instruction for Parents of Preschool Youngsters and Parents as Teachers. Through this funding, the programs have expanded services to some of the highest-need counties in the state.

» DISPARITIES SPECIFIC POLICIES

Data Collection

ACA Provisions. The Affordable Care Act requires that all federally funded health programs and population surveys collect data on race, ethnicity and language (REL).³⁷ As a federally funded program, Medicaid is subject to data-collection standards, and useful data on disparities may result from this, particularly since racial/ethnic minorities are highly represented in the Medicaid ranks. Yet, because the provision applies only to federally funded programs, wide gaps remain in data collection at the state level. Private insurers and providers are not required to collect data, which could be key to developing interventions targeting specific racial/ethnic populations. More data are needed to reveal patterns in disparities and to assess and improve the quality of care received by racial/ethnic minority communities.

Education efforts about the potential cost savings and improved quality of care that can result from robust data analysis could gain the support of payers and providers. One national survey found that about 30 percent of physicians sampled believed that health disparities in cardiac care existed, yet only 5 percent believed that the disparities existed within their own practice.³⁸

Coordinated, standardized data collection, which can be disaggregated for analysis, provides a means by which to measure health care quality, performance and outcomes, and which can be used to develop evidence-based, targeted interventions to promote health equity.

More data are needed to reveal patterns in disparities and to assess and improve the quality of care received by racial/ethnic minority communities.

In Colorado. Colorado has several large-scale data collection efforts. The Colorado Health Access Survey (CHAS) tracks Coloradans' health care coverage, access and utilization every two years, including specific data on racial and ethnic minority populations. The Office of Health Disparities in the Colorado Department of Public Health and Environment issues periodic reports detailing indicators of health among communities of color in Colorado. And the Center for Improving Value in Health Care's All-Payer Claims Database (APCD) shows what public and private payers – commercial health plans, Medicaid and Medicare – actually pay for health care services.

Colorado can look to other states for innovative implementation strategies. A work group in Minnesota has begun to lay the framework for more robust opportunities for data collection. Believing that data collection is an important step in understanding and eliminating racial/ethnic disparities in health care, the workgroup³⁹ created recommendations for the Governor's Task Force on Health Reform as well as the Health Insurance Exchange Task force, including:

- Collection of REL data based on statewide data collection standards to ensure consistent collection by all health care organizations
- Creation of a uniform coding structure that allows for data to be exchanged between health care organizations
- Collection of additional data points related to social determinants of health.

Each of these strategies could serve to improve data collection efforts in Colorado, providing information that might be helpful in developing targeted interventions to reduce or eliminate health care disparities.

Connecticut has used its APCD as the primary tool to collect and analyze REL data. Colorado's APCD data submission requirements are based on similar efforts across the country. Payers do not generally collect ethnicity and language demographic information, so these are not included in Colorado's APCD. While the Colorado APCD does have fields for race data, payers only provide the information approximately 40 percent of the time. Feedback from payers in other states indicates they are reluctant to require this information from enrollees because of privacy/discrimination concerns.

Cultural Competence

ACA Provisions. Under the ACA, five years of support will be available for research and demonstration and to educate health care professionals how to provide care in a manner that is mindful of a patient's background and cultural beliefs and practices. These evidence-based educational materials will be disseminated via a web-based clearinghouse that will be available to clinicians

across the country. The ACA also makes loan repayment available for some health care providers, giving preference to those with cultural competence training.⁴

Cultural competence – the behaviors, attitudes and policies needed to enable health care professionals to work effectively in cross-cultural situations – is particularly important in these populations where culture and language can present barriers to care.

Cultural competence – the behaviors, attitudes and policies needed to enable health care professionals to work effectively in cross-cultural situations – is particularly important in these populations where culture and language can present barriers to care. Cultural competence allows providers to have meaningful interactions with patients and to offer high-quality care to a diverse population. It extends beyond language to include issues of literacy, health literacy and ability to bridge the “digital divide” that some technologies can create between patients and providers. The U.S. Department of Health and Human Services (HHS) considers cultural competence to be “one of the main ingredients in closing the disparities gap in health care.”⁴⁰

In Colorado. Approximately 17 percent of Coloradans speak a language other than English at home.⁴¹ Immigrants make up nearly 10 percent of the state's population, including a large portion of the Hispanic and Asian populations.⁹

Past attempts to legislate cultural competence measures in Colorado have met resistance. A 2006 bill that would have required cultural competency training at education institutions that provide health care degrees was vetoed by Governor Bill Owens, who feared the bill would infringe on the rights of institutions to set their own curricula and create a “complex new bureaucracy.”⁴² Increasing demands on the education of health care professionals have made cultural competence training unpopular among many stakeholders. The IOM report, however, notes that cultural competence can help providers determine



effective ways to communicate with patients to ensure quality care.

Colorado policymakers and health agencies can leverage the new web clearinghouse by creating a formal strategy with mechanisms to disseminate and promote use of evidence-based practice to Colorado providers. While a great many providers are dedicated to culturally competent practice, those new to practices with patients from different cultures and with different languages could benefit from training opportunities. Health agencies working to raise their staff's level of cultural competence may want to determine staff needs and investigate methods of training as a step toward health equity. According to *Unequal Treatment*, as well as health care workers interviewed for this report, "education may be one of the most important tools as part of an overall strategy to eliminate health care disparities."

To promote cultural competence in the future, Colorado also could consider steps advocated in *Unequal Treatment*, including promoting the role of CHWs in care; incorporating cultural competence training as a component of health care providers' accreditation and licensing; mandating evidence-based cultural competence training at educational institutions that provide health care degrees; and funding government agencies to perform technical assistance and training for health care providers.

Workforce Development

ACA Provisions. ACA components focused on workforce development include funding to train low-income individuals as home health aides and other health care paraprofessionals, investments in historically minority colleges, and scholarships and loan forgiveness for primary care providers. Workforce development strategies also include funding for increased implementation of the community health worker model.

Workforce development goes hand in hand with cultural competence as a tool to advance health equity. A major concern as the ACA is implemented is the shortage of primary care providers available to absorb a large group of newly insured individuals. This concern will be particularly relevant for racial/ethnic minorities, many of whom already live in medically underserved areas.

Strategies to diversify and build a workforce prepared to serve racial/ethnic minority communities



include making health care education affordable and developing programs to recruit people from racial/ethnic minority communities into provider and leadership roles. Minorities who become health care professionals are more likely than their white counterparts to serve in minority and underserved communities.⁴ Furthermore, concordance of race and ethnicity between patient and provider can improve cultural understanding as well as trust and patient satisfaction.⁴³

Workforce development goes hand in hand with cultural competence as a tool to advance health equity.

In Colorado. Colorado's Recruiting and Retaining Youth of Color task force is a program of the Office of Health Disparities. The task force is charged with leading a statewide coalition to recruit minority youth interested in health professions through advocacy and technical assistance.⁴⁴ The Colorado Interagency Health Disparities Leadership Council also included strategies to increase workforce diversity in its 2008 strategic plan.⁴⁵

Efforts to integrate Colorado's existing workforce diversity development strategies with the ACA provisions may help to increase diversity in the state. Gauging the successfulness of these efforts could provide guidance for future programs and policies.

Research

ACA Provisions. The ACA promotes the National Center on Minority Health and Health Disparities to institute status, which gives it the planning and coordinating power to conduct more intensive health disparities research. The new Patient-Centered Outcomes Research Institute will carry out comparative effectiveness research – research that directly compares health care interventions to determine effectiveness – which can inform disparities interventions.⁴ This action will allow researchers to examine the differences in health outcomes based on race/ethnicity and help them determine the factors that contribute to differences and what can be done to address them.

Along with data collection, increased research into health disparities will help build an evidence base to inform health equity initiatives. Many researchers in the field of health disparities are interested in community-based participatory research – a model of research in which communities and research experts work in partnership to conduct research.

This collaboration allows health disparities to be studied in the specific context of the communities affected.

In Colorado. Although provisions focused on research are primarily relevant to federal agencies, Colorado policymakers, advocates and providers could benefit from increased knowledge, information and evidence-based practice that can help improve quality in serving racial/ethnic minorities. Because the institutes have only just been established, no immediate impact can be expected.

Social Determinants of Health

ACA Provisions. Although not extensive in scope, the ACA has provisions to help health care policy and decisionmakers better understand and begin to address the social determinants of health. The law tasks the Community Preventive Services Task Force with developing new topic areas for health interventions that take into consideration the social, economic and physical environments that affect health. The task force is also charged with annually reporting gaps in research and future priority areas to Congress. The task force then can evaluate interventions using tools such as Health Impact Assessments – a combination of evaluation methods to determine the effects of interventions on population health – to determine efficacy and reproducibility.⁴

The National Prevention, Health Promotion and Public Health Council oversees cross-agency collaboration, providing another opportunity to address the multi-disciplinary contributors to racial/ethnic disparities.

The ACA has provisions to help health care policy and decisionmakers better understand and begin to address the social determinants of health.

In Colorado. The Community Preventive Services Task Force report and other findings provide health care stakeholders and decisionmakers in Colorado with recommendations on programs, services and policies that have proved effective in improving public health in communities, worksites, schools and health plans.⁴⁶ In Illinois, implementation of recommended street improvement projects increased physical activity and saved the local



Massachusetts' Drive Toward Health Equity

Advocates in Massachusetts leveraged the momentum of the state's 2006 health reform efforts to move toward health equity. The Massachusetts health care reform law (Chapter 58) closely mirrors the ACA in many aspects, including the creation of an exchange-like program, expansion of the state Medicaid program and an individual mandate requiring all individuals to have health care coverage.¹² As with the ACA, the Massachusetts law also contained some disparities-specific provisions such as creating a Health Disparities Council and a Health Care Quality and Cost Council, linking hospital performance and rate increases to reductions of disparities, and funding a study on the effectiveness of community health workers in reducing racial and ethnic health disparities.

After Chapter 58 passed, an advocacy coalition known as the Disparities Action Network (DAN) was formed to introduce legislation to further address disparities. The legislation, titled, "An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth," had myriad provisions, including:

- Establishing a state Office of Health Equity (OHE)
- Creating a Community Agency grant program to be run by OHE
- Coordinating data collection efforts
- Establishing a competitive grant program to help health care organizations hire community health workers, community-based participatory research and partnerships between community-based organizations
- Improving health literacy through dissemination of best practices for development of culturally and linguistically relevant health literature
- Establishing a council to develop strategies to increase workforce diversity
- Creating a statewide community health index to monitor social and environmental determinants of health and engaging other state agencies in addressing these inequities
- Establishing a chronic disease management program within the Public Health Department.

The DAN's work demonstrated how health care reform can be implemented in ways that advance health equity.

school district money through decreased need for school buses. In New York City, implementation of task force recommendations helped to reduce smoking prevalence. The expanded focus of the task force mandated by the ACA, and implementation of recommendations in Colorado, could help further address social determinants of health and health equity.⁴⁶

The opportunities are abundant in this burgeoning policy area, but a major component of work related to the social determinants of health is educating

stakeholders within the health field as well as individuals working on interrelated public policy issues. The complexity of social determinants calls for an emphasis on innovation and systems integration. Since health is more complex than what occurs in the doctor's office, systems that acknowledge and develop solutions recognizing the social and economic circumstances that determine health could move health equity efforts forward.⁴⁷

» MOVING FORWARD

Though racial/ethnic health disparities are complex, the Affordable Care Act provides a policy roadmap to help move Colorado toward health equity.

Looking at what other states are doing and will do, and framing those efforts within Colorado's policy landscape, points to a number of considerations that could help implementation in the state:

Coverage does not assure access. Increased health coverage is critical to reducing health care disparities. But health coverage alone does not lead to health equity or even meaningful access to care. Language, health literacy, provider shortages and different cultural understandings of health, among other factors, can all be significant barriers to care even with insurance.

Equitable care does not mean treating every patient the same; meaningful access relies on interventions specific to disparities. Strategies to target racial/ethnic minority communities and offer culturally and linguistically appropriate enrollment and navigation support can strengthen the ACA component that provides expanded opportunity to enroll in health coverage.

Data is power. A robust data collection strategy can play a key role in creating evidence-based interventions that target racial/ethnic health disparities. Data highlight disparities and provide evidence as to how to achieve health equity. In-state data collection – beyond the scope of the ACA – will allow more data to be collected and analyzed at the granular level, leading to more precisely targeted interventions. A correlated issue is how to provide incentives and educate payers and providers on collecting race, ethnicity and language data through a standardized method.

Collaboration is key. Health is determined by more than health care. Social determinants of health are the cornerstone of addressing health disparities, yet they are a complex issue with roots in everything from housing to transportation to education policies and opportunities. Determining how to leverage the provisions that address social determinants in the ACA could lay the groundwork for meaningful policy reforms in the future.

Many efforts to eliminate disparities occur at the programmatic level or within individual agencies. Small efforts at the programmatic level can be

brought into a larger equity agenda. Multidisciplinary collaboration across organizations and involvement from the communities in question are crucial to dealing with the intricacies of achieving health equity.

Health equity is a priority. In a deliberate effort to highlight the gravity and importance of racial/ethnic health disparities, health equity has stood alone as an issue pertinent to but separate from other health policy issues. An inequitable health system, however, affects not just those experiencing disparities but also the strength of the system as a whole.

Experience from Massachusetts' implementation of health reform has demonstrated that momentum from health care reform can drive changes to eliminate disparities and leverage a health equity agenda. Achieving health equity in Colorado is possible, and the ACA can help Colorado achieve this.

» END NOTES

- ¹ Colorado Health Institute (CHI). *Uninsured on the Rise: What the 2011 Colorado Health Access Survey Tells us about Vulnerable Coloradans*. Denver, CO: CHI/Area Health Education Center Conversation Series; 2012.
- ² World Health Organization Page. http://www.who.int/social_determinants/en/.
- ³ Smedley B. *Health Reform at the Crossroads: Will the Affordable Care Act Help Eliminate Health Inequities?* Washington DC: Joint Center for Political and Economic Studies; 2012.
- ⁴ Andrulis D, Siddiqui N, Purtle J, Duchon L. *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Washington, DC: Joint Center for Political and Economic Studies; 2010.
- ⁵ United States Department of Health and Human Services (HHS). *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*. Washington, DC: HHS; 2011.
- ⁶ Meinhold L. *Implementing Health Care Reform: A Roadmap for Colorado*. Denver, CO: State of Colorado; 2010.
- ⁷ State of Colorado Page. <http://www.colorado.gov/cs/Satellite/HealthCareReform/CBON/1251593687826>.
- ⁸ Colorado Health Institute. *Colorado Health Access Survey Issue Brief: Overview of Coloradans' Health Care Coverage, Access and Utilization*. Denver, CO: The Colorado Trust; 2011.
- ⁹ Colorado Office of Health Disparities. *Racial and Ethnic Health Disparities in Colorado 2009*. Denver, CO: Colorado Department of Public Health and Environment; 2009.
- ¹⁰ Colorado Office of Health Disparities. *2008-2010 Strategic Plan*. Denver, CO: Colorado Department of Public Health and Environment; 2008.
- ¹¹ Sequist T, Fitzmaurice GM, Marshall R, Shaykevich A, Safran DG, Ayanian JZ. Physician performance and racial disparities in diabetes mellitus care. *Intern Med*. 2008;168(11):1145-51.
- ¹² Families USA: Minority Health Initiative. *Confronting Disparities while Reforming Health Care: A Look at Massachusetts*. Washington DC: Families USA; 2007.
- ¹³ Health and Human Services Advisory Committee on Minority Health. *Ensuring that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Eliminate Health Disparities: A Statement of Principles and Recommendations*. Washington, DC: HHS Office of Minority Health; 2009.
- ¹⁴ Kaiser Health News Page. <http://www.kaiserhealthnews.org/stories/2012/april/26/colorado-medicaid-expansion.aspx>.
- ¹⁵ The Kaiser Commission on Medicaid and the Uninsured. *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults*. Washington, DC: Kaiser Family Foundation; 2012.
- ¹⁶ Colorado Center on Law and Policy (CCLP). *New Poverty Estimates Paint Grim Picture for Many Communities Throughout Colorado*. Denver, CO: CCLP; 2012.
- ¹⁷ Families USA: Minority Health Initiative. *How Health Reform Helps Communities of Color in Colorado*. Washington DC: Families USA; 2010.
- ¹⁸ Colorado Health Institute Page. <http://www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/colorado-childrens-health-insurance-status-2012-update>.
- ¹⁹ HealthCare.gov Page. <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html>.
- ²⁰ Colorado Health Benefit Exchange (COHBE). *2011 Progress Report to the Colorado Governor and General Assembly*. Denver, CO: COHBE; 2011.
- ²¹ Hanlon C, Giles B. *State Policymakers' Guide for Advancing Health Equity Through Health Reform Implementation*. Washington, DC: National Academy for State Health Policy; 2012.
- ²² Cimmel B. *Premiums, Employer Costs and Employee Contributions for Private Sector Employer-Sponsored Health Insurance, Single Coverage by Firm Size, 1996-2006*. Washington, DC: Agency for Healthcare Research and Quality; 2009.
- ²³ United States Small Business Administration Page. <http://archive.sba.gov/advo/research/profiles/09co.pdf>.
- ²⁴ Families USA. *Good Business Sense: The Small Business Health Care Tax Credit in the Affordable Care Act*. Washington, DC: Families USA; 2012.
- ²⁵ The Bell Policy Center Page. <http://bellpolicy.org/node/4830>.
- ²⁶ Government Accountability Office (GAO). *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*. Washington, DC: GAO; 2012.

- ²⁷ Small Business Majority. *Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act*. Sausalito, CA: Small Business Majority; 2010.
- ²⁸ Medicaid.gov Page. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>.
- ²⁹ HealthCare.gov Page. <http://www.healthcare.gov/news/factsheets/2011/10/accountable-care10202011a.html>.
- ³⁰ Bontrager J. *Colorado's Medicaid toolbox: Approaches to Improving Quality and Controlling Costs*. Denver, CO: Colorado Health Institute; 2012.
- ³¹ Harbrecht M, Latts L. Colorado's patient-centered medical home pilot met numerous obstacles, yet saw results such as reduced hospital admissions. *Health Affairs*; 2012.
- ³² Doty M, Abrams M, Hernandez S, Stremikis K, Beal A. *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Finding from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers*. New York, NY: Commonwealth Fund; 2010.
- ³³ United States Department of Health and Human Services Page. <http://www.hhs.gov/recovery/programs/hrsa/ids.html>.
- ³⁴ Passel J, Cohn D. Unauthorized immigrant population: National and state trends, 2010. Washington, DC: Pew Research Center/Pew Hispanic Center. <http://www.pewhispanic.org/2011/02/01/unauthorized-immigrant-population-brnational-and-state-trends-2010/>.
- ³⁵ National Prevention Council. *National Prevention Council Action Plan: Implementing the National Prevention Strategy*. Washington, DC: National Prevention Council; 2012.
- ³⁶ American Public Health Association Page. <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393>.
- ³⁷ United States Department of Health and Human Services. Page. <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.pdf>.
- ³⁸ Lurie N, Fremont A, Jain A, et al. Racial and ethnic disparities in care: The perspectives of cardiologists. *Circulation*. 2005;111(10): 1264-69.
- ³⁹ Minnesota Health Reform Task Force. *Roadmap to a Healthier Minnesota: Recommendations of the Minnesota Health Care Reform Task Force*; 2012.
- ⁴⁰ The Office of Minority Health Page. <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>.
- ⁴¹ Migration Policy Institute Page. <http://www.migrationinformation.org/datahub/state.cfm?ID=CO>.
- ⁴² Goodland M. Governor vetoes cost study, signs PERA reform. *Silver & Gold Record*; 2006.
- ⁴³ Cooper L, Power N. *Disparities in Patient Experience, Health Care Processes and Outcomes: The Role of Patient-Provider Racial, Ethnic and Language Concordance*. New York, NY: The Commonwealth Fund; 2004.
- ⁴⁴ Colorado Department of Public Health and Environment Page. <http://www.colorado.gov/cs/Satellite/CDPHE-Main/CBON/1251588198480>.
- ⁴⁵ Interagency Health Disparities Leadership Council. *Colorado Health Disparities Strategic Plan 2008*. Denver, CO: Colorado Department of Public Health and Environment. Note: available in draft form only.
- ⁴⁶ Community Preventive Services Task Force. *Community Preventive Services Task Force First Annual Report to Congress and to Agencies Related to the Work of the Task Force*. Atlanta, GA: Centers for Disease Control and Prevention; 2011.
- ⁴⁷ Williams D, Costa M, Odunlami A, Mohammed S. Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *J Public Health Man*. 2008 November; 14(Suppl): S8-17.
- ⁴⁸ Center for Community Health Education Research and Service Page. <http://cchers.org/health-disparities-and-health-equity/disparities-action-network/>.



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