

AN ANALYSIS OF TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Summaries of key provisions in the “Patient Protection and Affordable Care Act” (HR 3590) as amended by the “Health Care and Education Reconciliation Act of 2010” (HR 4872) as of August 3, 2010

Initiative	Summary	Important Dates	Participants
INNOVATION			
<p><i>National Prevention, Health Promotion and Public Health Council</i></p> <p>(HR 3590, Sec. 4001)</p>	<p>The President will establish the council within HHS and appoint the Surgeon General to chair the council. The Council will provide federal coordination and leadership with respect to prevention, wellness and health, the public health system, and integrative health care. In so doing, the council will gather input from stakeholders, provide recommendations to the President and Congress, and develop a national prevention and wellness strategy.</p>	<p><u>March 23, 2011</u> - Within one year of enactment, the Council, in consultation with the Chairperson, will develop and make public a national prevention, health promotion and public health strategy, and will revise the strategy periodically.</p> <p><u>June 10, 2010</u> – The President issued an Executive Order establishing the Council.</p>	<p>The council members will be The Secretaries of: Agriculture; Labor; Health and Human Services; Transportation; Education; Homeland Security; as well as the Administrator of the Environmental Protection Agency; the Chair of the Federal Trade Commission; the Director of National Drug Control Policy; the Assistant to the President and Director of the Domestic Policy Council; the Assistant Secretary of the Interior for Indian Affairs; the Chairman of the Corporation for National and Community Service; and the head of any other executive department or agency that the Chair may determine is appropriate.</p>
<p><i>Advisory Group on Prevention, Health Promotion and</i></p>	<p>The President will establish this Advisory Group within HHS, and the Group will be housed within HHS and report to the Surgeon General. The group will help develop the new national</p>	<p><u>June 10, 2010</u> – The President issued an Executive Order establishing the Advisory Group.</p>	<p>The President will appoint no more than 25 non-federal members to the Group, and in so doing will ensure that the Group consists of a diverse group of licensed health professionals. The Advisory Group will include integrative</p>



<p><i>Integrative and Public Health</i></p> <p>(HR 3590, Sec. 4001)</p>	<p>prevention and wellness strategy, and will also develop policy and program recommendations, advise the Council on lifestyle based chronic disease prevention and management, integrative health care practices and health promotion.</p>		<p>health practitioners who are representative of, or have expertise in, worksite health promotion, community services, preventive medicine, health coaching, public health education, geriatrics and rehabilitation medicine.</p>						
<p><i>National Prevention and Health Promotion Strategy</i></p> <p>(HR 3590, Sec. 4001)</p>	<p>After obtaining ideas from relevant stakeholders and working closely with the Advisory Group, the Council will develop a national prevention and health promotion strategy. The strategy will, in part, make recommendations, set specific goals, create measurable actions, and corresponding timelines for improving the health of Americans through federally-supported prevention, health promotion and public health programs.</p>	<p><u>June 10, 2010</u> – The President issued an Executive Order authorizing the formulation of this strategy.</p> <p><u>March 23, 2011</u> - Within one year of enactment, the Council, in consultation with the Chairperson, will develop and make public a national prevention, health promotion and public health strategy, and will revise the strategy periodically.</p>	<p>The Advisory Group on Prevention, Health Promotion and Integrative Public Health will inform the National Prevention, Health Promotion and Public Health Council in formulating this strategy. The Chair of the Council, the U.S. Surgeon General, will be responsible for developing and making public the strategy, and for reviewing and revising it periodically.</p>						
<p><i>Prevention and Public Health Fund</i></p> <p>(HR 3590, Sec. 4002)</p>	<p>The new law designates the Secretary to administer a newly created Prevention and Public Health Fund, for the purpose of expanding and sustaining a national investment in prevention and public health programs. Specifically, these funds will be used within HHS to increase funding, over the FY 2008 level, for programs authorized by the Public Health Service Act that focus on prevention, wellness and public health activities.</p>	<p><u>FY 2008</u> –This is the base level funding by which increases to qualifying programs will be measured.</p> <p><u>FY 2010</u> –Funds are appropriated for FY 2010 and beyond.</p> <table border="1" data-bbox="978 1317 1289 1416"> <thead> <tr> <th>FY</th> <th>Appropriated</th> </tr> </thead> <tbody> <tr> <td>2010</td> <td>\$500 Million</td> </tr> <tr> <td>2011</td> <td>\$750 Million</td> </tr> </tbody> </table>	FY	Appropriated	2010	\$500 Million	2011	\$750 Million	<p>Programs authorized by the Public Health Service Act that focus on prevention, wellness and public health activities, including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach campaign for Preventive Benefits, and immunization programs will receive funds under this new initiative.</p>
FY	Appropriated								
2010	\$500 Million								
2011	\$750 Million								



		2012	\$1 Billion		
		2013	\$1.25 Billion		
		2014	\$1.5 Billion		
		2015 and beyond	\$2 Billion		
<p><i>Clinical Preventive Services Task Force</i> (HR 3590, Sec. 4003)</p>	<p>The new law amends the Public Health Service Act to increase the authority of the Preventive Services Task Force (USPSTF). Under The Affordable Care Act, the Task Force’s development of recommendations for clinical preventive services will be expanded, with enhanced transparency and public involvement in the processes of the Task Force. The Task Force members will continue to review the scientific evidence related to clinical preventive services in order to update and develop recommendations on clinical preventive services for the health care community. The Task Force’s recommendations will consider best practices from stakeholders, including the AHRQ, NIH, CDC, Institute of Medicine, specialty medical associations, patient groups, and scientific societies. Significantly, insurers will be required to pay fully for services that receive an “A” or “B” recommendation from the Task Force.</p>	<p><u>March 23, 2010</u>- Funds are authorized to be appropriated in such sums as necessary for each FY to carry out the activities of the Task Force.</p>	<p>Founded in 1984, the Task Force currently has 16 members, many of whom are doctors. The group meets three times a year, and is staffed by officials at the Agency for Healthcare Research and Quality (AHRQ). The Task Force is an independent panel of experts in prevention and evidence-based medicine, and is composed of primary care providers, such as internists, pediatricians, family physicians, gynecologists, obstetricians, nurses and health behavior specialists. The USPSTF conducts scientific reviews of a broad range of clinical preventive health care services, such as screening, counseling and preventive medications, and develops recommendations for primary care clinicians and health systems.</p>		
<p><i>Community Preventive Services Task Force</i></p>	<p>The Public Health Service Act is amended to enhance the role of the Community Preventive Services Task Force’s efforts in identifying and distributing evidence-based recommendations on important public health decisions to inform</p>	<p><u>March 23, 2010</u> - Funds are authorized to be appropriated in such sums as necessary for each FY to carry out the activities of the</p>	<p>The Task Force is a 15-member non-Federal Task force supported by the Centers for Disease Control and Prevention (CDC). It is an independent, volunteer body of public health and prevention experts, who are appointed by the Director of the CDC. The role of the Task Force is to</p>		



(HR 3590, Sec. 4003)	policymakers, practitioners and other decision makers. CDC scientists review the effectiveness of health care interventions, and the Task Force then makes recommendations to the public health community and health care delivery organizations in the <i>Guide to Community Preventive Services</i> . Community preventive services are defined as any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.	Task Force.	oversee systematic reviews led by CDC scientists, carefully consider and summarize review results, make recommendations for interventions that promote population health, and identify areas within the reviewed topics that need more research.
ACCESS TO PREVENTIVE CARE			
<i>National Prevention and Health Promotion Outreach and Education Campaign</i> (HR 3590, Sec. 4004)	The Secretary, acting through the CDC, will oversee a national campaign to raise public awareness about health improvement across the lifespan. The campaign will distribute information detailing access to, and the importance of, preventive services through a media strategy, public-private partnerships, and a federal internet website, which will host several personalized prevention tools.	<u>March 23, 2011</u> - Not later than one year after enactment the national, science-based media campaign on health promotion and disease prevention will be established. Funding for these activities is authorized, but not appropriated, and it shall take priority over funding provided by CDC for grants with similar purposes. Funding for this section shall not exceed \$500 million.	The Secretary, acting through the CDC, will establish and implement the national campaign.
<i>Medicaid Awareness Campaign</i>	Directs the Secretary to provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid	<u>January 1, 2011</u> - By this date, and every three years thereafter, the Secretary shall report on the status	In coordination with the guidance provided by the Secretary, each state will design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of obesity-related services that

<p>(HR 3590, Sec. 4004)</p>	<p>enrollees, including obesity screening and counseling for children and adults.</p>	<p>and effectiveness of these efforts, including summaries of states' efforts to increase awareness and coverage.</p>	<p>are covered by Medicaid.</p>
<p><i>Oral Healthcare Prevention Education Campaign</i> (HR 3590, Sec. 4102)</p>	<p>The Secretary and the CDC will establish a five year national, public education campaign focusing on oral healthcare prevention and education. The campaign's activities are to be targeted to specific populations, including older adults and individuals with disabilities, in a culturally appropriate manner.</p>	<p><u>March 23, 2012</u> - Subject to the availability of funding, within two years after enactment, the Secretary will begin implementing the campaign.</p> <p><u>March 23, 2010 – March 22, 2012</u>- During the two year period prior to implementation, the Secretary will conduct planning activities with respect to the campaign.</p>	<p>The Secretary, the CDC, and professional oral health organizations will establish the campaign, and the Secretary will conduct planning activities before the campaign is established.</p>
<p><i>Medicare Annual Wellness Visit</i> (HR 3590, Sec. 4103)</p>	<p>The Social Security Act is amended to include Medicare coverage for an annual wellness visit, and accompanying personalized prevention plan for all beneficiaries. Medicare will continue to cover a Welcome to Medicare physical exam for new beneficiaries within their first year of enrollment in Part B. This exam will remain free, with no cost sharing, and new enrollees may not receive both the annual wellness exam and the Welcome to Medicare exam in their first 12 months of enrollment. Instead, the Welcome to Medicare exam will be available during this introductory period, with the annual exam available each year after that.</p>	<p><u>January 1, 2011</u> – Medicare beneficiaries will be eligible for the new benefit, an annual wellness visit with their primary care physician.</p> <p><u>March 23, 2011</u> – Guidelines for the annual health risk assessment will be developed by the Secretary.</p>	<p>Currently, Medicare covers some preventive services, with varying levels of cost sharing. For some beneficiaries, the annual Part B deductible may apply, requiring the enrollee to pay the full cost of the service up to an annual deductible amount (\$155 in 2010). Additionally, some beneficiaries are also required to pay the standard 20 percent coinsurance for Part B services once the deductible is met.</p>

<p><i>Medicare Personalized Prevention Plan</i></p> <p>(HR 3590, Sec. 4103)</p>	<p>As part of the annual wellness visit, Medicare beneficiaries will be eligible to receive a personalized prevention plan, for which cost-sharing will be prohibited. The prevention plan includes the creation and consideration of comprehensive health risk assessment. The risk assessment may include compiling an individual's family medical history and a list of current providers, a routine physical examination, the screening for cognitive impairments, developing a preventive services screening schedule and a list of risk factors and recommended interventions, personalized health advice and appropriate referrals, and any other element the Secretary determines is appropriate.</p>	<p><u>March 23, 2011</u> – Guidelines for the annual health risk assessment will be developed by the Secretary.</p>	<p>Currently, Medicare covers some preventive services, with varying levels of cost sharing. For some beneficiaries, the annual Part B deductible may apply, requiring the enrollee to pay the full cost of the service up to an annual deductible amount (\$155 in 2010). Additionally, some beneficiaries are also required to pay the standard 20 percent coinsurance for Part B services once the deductible is met. Under the new law, beneficiaries will have access to the same preventive services under Medicare, but with no cost sharing for Medicare-covered services that receive a grade of A or B from the United States Preventive Services Task Force, or for the personalized prevention plan.</p>
<p><i>Removal of Barriers to Preventive Services in Medicare</i></p> <p>(HR 3590, Sec. 4104)</p>	<p>The Affordable Care Act waives the Part B deductible and the 20 percent coinsurance requirements for most preventive services under Medicare, eliminating all out-of-pocket costs to beneficiaries and requiring Medicare to cover 100 percent of the costs. Services that will be free include the annual wellness visit, the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but become diagnostic or therapeutic interventions based on findings during the test.</p>	<p><u>January 1, 2011</u> - Also starting next year, Medicare beneficiaries will no longer have to pay any out-of-pocket costs for most preventive services. Beginning in 2011, no coinsurance or deductibles will be charged in traditional Medicare for preventive services that are rated A or B by the U.S. Preventive Services Task Force.</p>	<p>Currently, Medicare covers some preventive services, with varying levels of cost sharing. For some beneficiaries, the annual Part B deductible may apply, requiring the enrollee to pay the full cost of the service up to an annual deductible amount (\$155 in 2010). Additionally, some beneficiaries are also required to pay the standard 20 percent coinsurance for Part B services once the deductible is met. Under the new law, beneficiaries will have access to the same preventive services under Medicare, but with no cost sharing for Medicare-covered services that receive a grade of A or B from the United States Preventive Services Task Force. These services include: an annual mammogram; screenings for colorectal, cervical and prostate cancer, aortic aneurism, diabetes, cholesterol and cardiovascular problems; nutrition therapy for diabetes or kidney disease; bone mass measurement and annual flu vaccination.</p>



<p><i>Evidence-Based Coverage of Preventive Services in Medicare</i></p> <p>(HR 3590, Sec. 4105)</p>	<p>Authorizes the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent to which the modification is consistent with the U.S. Preventive Services Task Force’s recommendations.</p>	<p><u>January 1, 2010</u> – The Secretary may modify this coverage.</p>	<p>Currently, Medicare covers some preventive services, with varying levels of cost sharing. For some beneficiaries, the annual Part B deductible may apply, requiring the enrollee to pay the full cost of the service up to an annual deductible amount (\$155 in 2010). Additionally, some beneficiaries are also required to pay the standard 20 percent coinsurance for Part B services once the deductible is met. Under the new law, beneficiaries will have access to the same preventive services under Medicare, but with no cost sharing for Medicare-covered services that receive a grade of A or B from the United States Preventive Services Task Force. Further preventative treatments, test and screenings will be added to the list of free services offered to Medicare beneficiaries as they become available and are recommended by the U.S. Preventive Services Task Force.</p>
<p><i>Improving Access to Preventive Services for Eligible Adults in Medicaid</i></p> <p>(HR 3590, Sec. 4106)</p>	<p>The Social Security Act is amended to expand the current Medicaid state plan option to provide other diagnostic, screening, preventive, and rehabilitation services. States now have the option to cover all clinical preventive services that the United States Preventive Task Force assigns a grade of A or B and, for adults, all vaccines that have been recommended by the Advisory Committee on Immunization Practices. The legislation offers a one-percent FMAP increase for the provision of these services, and cost-sharing is prohibited.</p>	<p><u>January 1, 2013</u> – These changes will be effective, and states will receive a one percentage point increase in the FMAP for preventive services recommended by the US Preventive Task Force with a grade of A or B, and recommended immunizations for adults, if these services are offered with no cost sharing.</p>	<p>Currently, Medicare covers some preventive services, with varying levels of cost sharing. For some beneficiaries, the annual Part B deductible may apply, requiring the enrollee to pay the full cost of the service up to an annual deductible amount (\$155 in 2010). Additionally, some beneficiaries are also required to pay the standard 20 percent coinsurance for Part B services once the deductible is met. Under the new law, states may cover additional preventive services under their Medicaid state plans.</p>
<p><i>Incentives for Prevention of</i></p>	<p>The Secretary will award grants to states to provide incentives to Medicaid beneficiaries who</p>	<p><u>January 1, 2011</u> – For five years, beginning on this</p>	<p>States will have the flexibility to enter into agreements with Medicaid providers, community-based organizations,</p>



<p><i>Chronic Diseases in Medicaid</i></p> <p>(HR 3590, Sec. 4108)</p>	<p>successfully participate in a healthy lifestyle program and demonstrate changes in health risk and outcomes by meeting specific targets. The programs must be comprehensive, evidence-based, widely available, easily accessible, and designed to address the needs of Medicaid beneficiaries. Additionally, the program must have demonstrated success in helping individuals lower cholesterol and/or blood pressure, lose weight, quit smoking and address co-morbidities which would include depression.</p>	<p>date, \$100 Million is appropriated to carry out this program.</p>	<p>faith-based organizations, public-private partnerships, Indian tribes, to carry out the program. Participation in this program will not affect a Medicaid beneficiary's eligibility for, or amount of, Medicaid benefits or, those received from any other program that is in whole or in part financed with federal funds. States receiving grants will carry out these initiatives for at least three years, within a five year window which begins on January 1, 2011, or when the Secretary develops the program criteria, whichever is sooner.</p>
<p><i>Removing Barriers and Improving access to wellness for individuals with disabilities</i></p> <p>(HR 3590, Sec. 4203)</p>	<p>Title V of the Rehabilitation Act of 1973 is amended to add a provision establishing standards regarding the accessibility of medical diagnostic equipment used in, or in conjunction with, medical settings. These standards will ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and that such individuals will have independent entry to, use of, and exit from, the equipment to the maximum extent possible.</p>	<p><u>March 23, 2012</u> - Within two years of enactment, the Architectural and Transportation Barriers Compliance Board, in consultation with the FDA, will promulgate these regulatory standards.</p>	<p>Medical diagnostic equipment used in, or in conjunction with, physician's offices, clinics, emergency rooms, hospitals and emergency settings will be subject to these new standards. Specifically, the covered equipment includes: examination tables, examination chairs, weight scales, mammography equipment, x-ray machines, and other commonly used radiological equipment.</p>
<p><i>Reauthorization of the Immunization Program</i></p> <p>(HR 3590, Sec. 4204)</p>	<p>The Public Health Service Act is amended to reauthorize the Immunization Program.</p>	<p><u>March 23, 2010</u> – The Immunization Program is authorized.</p>	<p>The new legislation reauthorizes the Immunization Program by authorizing appropriations for grants to be made for preventive health service programs to immunize, without charge, children, adolescents and adults against vaccine-preventable diseases.</p>

QUALITY AND SYSTEM IMPROVEMENTS

<p><i>Community Transformation Grants</i></p> <p>(HR 3590, Sec. 4201)</p>	<p>The Secretary, through the CDC, will award competitive grants to eligible entities to implement, evaluate and distribute evidence-based community preventive health activities. The goal of the programs is to improve health conditions and develop a stronger base of effective prevention programming. Grant recipients must develop community transformation plans that detail specific activities to promote healthy living, implement programs, policies and infrastructure improvements to promote healthier lifestyles, and measure changes in weight, nutrition, physical activity, tobacco use, overall mental health, emotional well-being, and other community-specific factors, or those factors to be determined by the Secretary.</p>	<p><u>March 23, 2010</u> – These provisions are effective. Funds are authorized to be appropriated from FY 2010 through FY 2014.</p>	<p>Eligible entities include state or local agencies, national networks of community based organizations, state or local nonprofit organizations, or Indian tribes. These groups may provide in-kind resources for carrying out these grants.</p>
<p><i>Medicare Healthy Aging, Living Well</i></p> <p>(HR 3590, Sec. 4202)</p>	<p>The Secretary, through the CDC, will award grants to eligible entities to carry out five year pilot programs that will provide public health community interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age. Grantees must design and carry out a strategy to provide these individuals with intervention activities designed to promote healthy lifestyles, such as through increased physical activity or improved nutrition. Additionally, grantees must conduct ongoing health screenings to identify risk factors for heart disease, cancer, stroke and diabetes among the target population in both urban and rural areas,</p>	<p><u>March 23, 2010</u> – This provision is effective. Funds are authorized from FY 2010 through FY 2014.</p>	<p>Eligible entities include state health departments, local health departments and Indian tribes. Grantees will provide more preventive health services to help reduce chronic diseases and address health disparities through collaboration with the CDC, AoA, and relevant local agencies and organizations.</p>

	and monitor these results. If, through the screening process, an individual is found to have chronic disease risk factors, grantees must ensure that such persons receive the appropriate clinical referral and treatment to reduce such risk.		
<p><i>Medicare Evaluation of Prevention and Wellness Programs</i></p> <p>(HR 3590, Sec. 4202)</p>	<p>The Secretary will evaluate qualifying community prevention and wellness programs. To evaluate these programs, the Secretary will review available evidence, literature, best practices and resources on relevant programs. Independent of the Secretary’s evidence review, CMS, in coordination with the Assistant Secretary of AoA, will evaluate existing AoA-sponsored community prevention and wellness programs, in order to assess the extent to which Medicare beneficiaries who participate in these programs experience improved health outcomes.</p>	<p><u>September 30, 2013</u> - The Secretary will submit a report on this evaluation by no later than this date. The evaluation will be funded up to \$50 million, from funds transferred from the Federal Hospital Insurance Trust Fund into the Federal Supplemental Medical Insurance Trust Fund, in accordance with the Social Security Act.</p>	<p>The Secretary will conduct an evidentiary review of community prevention and wellness programs, including those that are sponsored by AoA, are evidence based, and have demonstrated potential to reduce the risk of disease, disability, and injury among older Medicare beneficiaries. The Administrator of CMS, in consultation with the Assistant Secretary for Aging, will, independent from the Secretary, evaluate existing AoA community prevention and wellness programs.</p>
<p><i>Demonstration program to Improve Immunization Coverage</i></p> <p>(HR 3590, Sec. 4204)</p>	<p>The Secretary, through the CDC, will establish a demonstration program to award grants to states to utilize evidence and population based interventions for the purpose of improving immunization coverage for children, adolescents and adults. Possible interventions include those recommended by the Community Preventive Services Task Force, as well as other evidence-based interventions.</p>	<p><u>March 23, 2010</u> – This program is authorized. Sums are authorized to be appropriated from FY 2010 through FY 2014.</p>	<p>States wishing to participate in the program must submit a plan describing the proposed interventions, detailing how these actions will correlate with local needs and capabilities. In addition to the interventions recommended by the Community Preventive Services Task Force, other applicable evidence-based interventions may include: providing immunization reminders, educating targeted populations and providers, reducing out-of-pocket costs for vaccinations, and carrying out other immunization-promoting strategies.</p>



<p><i>State Authority to Purchase Recommended Vaccines for Adults</i></p> <p>(HR 3590, Sec. 4204)</p>	<p>This section authorizes the Secretary to negotiate and contract with vaccine manufacturers to purchase vaccines for adults. Additionally, states may obtain additional quantities of these vaccines by purchasing them directly from the manufacturers at the price negotiated by the Secretary.</p>	<p><u>March 23, 2010</u> – The Secretary and the states have this authority.</p>	<p>The Secretary may negotiate vaccine prices, and states may obtain these vaccines at the agreed upon price.</p>
<p><i>GAO Study and Report on Medicare Beneficiary Access to Vaccines</i></p> <p>(HR 3590, Sec. 4204)</p>	<p>The Comptroller General will conduct a study on the ability of Medicare beneficiaries, 65 or older, to access routinely recommended vaccines that are covered under Medicare Part D. The analysis will consider the number of beneficiaries who are eligible for the vaccines, the number of beneficiaries who actually received a covered vaccine, and any barriers to access these beneficiaries faced. The report will contain a summary of recommendations and findings regarding access to, and coverage of, vaccines under Medicare Part D.</p>	<p><u>June 1, 2011</u>: By this date, the report will be submitted.</p> <p><u>FY 2010</u>: \$1 million is appropriated for fiscal year 2010 to carry out this study.</p>	<p>GAO will conduct a study on the ability of Medicare beneficiaries who are 65 or older to access routinely recommended, Part D covered, vaccines.</p>
<p><i>Demonstration Program for Individualized Wellness Plans</i></p> <p>(HR 3590, Sec. 4206)</p>	<p>The Secretary will establish a pilot program to test the impact of providing at-risk populations who utilize community health centers with an individualized wellness plan designed to reduce risk factors for preventable conditions identified by a comprehensive risk factor assessment. No more than ten community health centers will be funded to participate in the pilot program. The wellness plan risk factors will include: weight, tobacco and alcohol use, exercise rates, nutritional status and blood pressure. The</p>	<p><u>March 23, 2010</u> – This provision is effective.</p>	<p>A maximum of ten community health centers will participate in the program. Individualized wellness plans will make comparisons between the individual involved and a control group.</p>



	individualized wellness plan will respond to risk factors identified and may include activities such as nutritional counseling, physical activities, alcohol and smoking cessation counseling, stress management, dietary supplements, and compliance assistance.		
<i>Research on optimizing the delivery of public health services</i> (HR 3590, Sec. 4301)	The Secretary, acting through the CDC, will fund research in the area of public health services and systems. The research will be carried out with a particular focus on high priority areas within the National Prevention Strategy or Health People 2020, and will examine best practices, the translation of interventions into real world settings, and effective strategies for organizing, financing, or delivering public health services in real world community settings. This research will be coordinated with the Community Preventive services Task Force, by building on existing partnerships within the federal government, while also considering initiatives at the state and local levels, and in the private sector.	<u>March 23, 2010</u> – This provision is effective.	The Secretary and the CDC will fund the research, which will be coordinated with the Community Preventive Services Task Force and carried out by building on existing federal partnerships while considering state, local and private sector initiatives.
<i>Data Collection on Health Disparities</i> (HR 3590, Sec. 4302)	The Secretary will ensure that any federally supported health care or public health program, activity, or survey collects and reports data on race, ethnicity, gender, geographic location, socioeconomic status, language and disability status, at the smallest geographic level practicable.	<u>March 23, 2012</u> - The Secretary will ensure that no later than two years after enactment, any federally supported health care or public health activity will collect and report demographic data regarding health disparities.	Any federally supported health care or public health program, activity, or survey will collect and report demographic data regarding health disparities. The Secretary will analyze the data to detect and monitor trends in health disparities and provide relevant Federal agencies with this information.



<p><i>Laboratory Capacity Grants</i></p> <p>(HR 3590, Sec. 4304)</p>	<p>The Secretary, in coordination with the CDC, will establish an Epidemiology and Laboratory Capacity Grant Program to award grants to eligible entities to assist public health agencies in improving surveillance for, and response to, conditions of public health importance through enhancing information systems and developing and implementing prevention and control strategies.</p>	<p><u>FY 2010 – FY 2013</u> - Subject to funding availability, for each FY 2010 through 2013, \$190,000,000 is authorized to be appropriated.</p>	<p>Entities eligible to receive grants under this program include state and local health departments, tribal jurisdictions, and academic centers that assist such organizations.</p>
<p><i>Institute of Medicine Conference on Pain</i></p> <p>(HR 3590, Sec. 4305)</p>	<p>The Conference will increase the recognition of pain as a significant public health problem, evaluate the diagnostic and treatment of acute and chronic pain among the general population and various demographic groups, as well as identify and address barriers to appropriate pain care.</p>	<p><u>FY 2010 – FY 2011</u> - Such sums as necessary to carry out this provision are authorized for each of FY2010 and 2011. Not later than one year after funds are appropriated to carry out this subsection, the Secretary will seek to enter into an agreement with the Institute of Medicine to convene a Conference on Pain.</p>	<p>The Secretary will work with the Institute of Medicine of the National Academies to convene the Conference.</p>
<p><i>Interagency Pain Research Coordinating Committee</i></p> <p>(HR 3590, Sec. 4305)</p>	<p>The Committee will coordinate all efforts within HHS and other federal agencies that relate to pain research. It will be responsible for developing a summary of qualifying pain care research supported by the federal agencies, for identifying research gaps in the symptoms and causes of pain, will recommend how to best distribute information on pain care, as well as how to expand public-private partnerships to enhance</p>	<p><u>March 23, 2011</u> - Within one year of enactment, the Secretary will establish the Interagency Pain Research Coordinating Committee, and the Secretary will review the necessity of the Committee at least once every two years</p>	<p>The Committee will be composed of not more than seven federal representatives appointed by the Secretary from agencies that conduct pain care research and treatment, six non-federal members appointed by the Secretary from among scientists, physicians, and other health professionals, and an additional six members will be appointed by the Secretary from the general public; these members will represent leading research, advocacy, and service organizations for individuals with pain-related</p>



	collaborative research.		conditions. Other non-voting individuals will be included on the Committee at the Secretary’s discretion.
<p><i>Education and Training in Pain Care</i></p> <p>(HR 3590, Sec. 4305)</p>	<p>The Secretary may award grants to eligible entities for the purpose of developing and implementing programs to provide education and training to health care professionals in pain care. Successful applicants will agree to include in their program information about means testing, applicable laws that may impact patient access to pain care, interdisciplinary approaches to pain care delivery, demographic sensitivity, and recent developments in the provision of pain care.</p>	<p><u>March 23, 2010</u> – This provision is effective. Such sums as necessary are authorized, but not appropriated, for FY 2010 through FY 2012.</p>	<p>Eligible entities include health profession schools, hospices, and other public and private entities.</p>

Please note that NASUAD’s analysis of The Affordable Care Act will be updated as additional information becomes available.