

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services



Office of Minority Health Publishes Final Standards for Cultural and Linguistic Competence

By Houkje Ross

In late December 2000, the Office of Minority Health (OMH), U.S. Department of Health and Human Services, published the final recommendations on national standards for culturally and linguistically appropriate services (CLAS) in health care. Federal and state health agencies, policy makers, and national organizations now have a blueprint to follow for building culturally competent health care organizations and workers.

The 14 standards are based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations. The standards were developed with input from a national project advisory committee composed of individuals representing State and Federal agencies, health care organizations and professionals, consumers, unions, and health care accrediting agencies. OMH conducted a four-month public comment period and held three regional meetings in early 2000 to solicit testimony and advice for the first draft of the standards.

Although many excellent standards do exist, many are limited in their scope—they address only a specific issue, geographic area, or subfield of health care such as mental health, according to OMH's final report.

Four of the standards (4-7) reflect existing federal guidance that address language assistance services for people with limited-English proficiency (LEP). Language barriers are a problem for many Hispanic and Asian Americans with limited English proficiencies. Take for example, a recent Asian American or Hispanic immigrant who speaks little or no English. The person may live a block from the local hospital, but be unable to receive adequate medical care if there are no interpreters available. Accessing health

care is an issue that appears over and over in literature, research, and studies that examine the lowered health status of our nation's minority populations.

The CLAS standards that deal with language assistance services are consistent with HHS' Office of Civil Rights (OCR) written policy guidance to help ensure that



LEPs can effectively access critical health and social services. The OCR standards were introduced in August 2000 (See story, page 4). The remaining CLAS Standards are recommendations suggested by OMH for voluntary adoption by health care organizations (Standard 14) and guidelines or activities recommended by OMH for adoption by federal, state, and

national accrediting agencies (Standards 1-3; 8-13).

Leveling the Playing Field

"At a very basic level these standards are about ensuring that all persons entering the health care system, regardless of race or ethnicity, receive equal, fair, and quality treatment," said Guadalupe Pacheco, project officer at OMH. According to OMH's final report, the CLAS standards are a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients and consumers. "The standards are also a way for providers, policymakers, and others in the health care community, to create accountability within their organizations for providing equitable, quality services," he said.

When it comes to treating minority patients and consumers, what is fair and equal treatment needs to be looked at closely. Current research and literature point to overwhelming disparities in health status of minorities when

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OFFICE OF PUBLIC HEALTH
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compared to whites. Minorities have higher prevalence and mortality rates of diseases like cancer, diabetes, and cardiovascular diseases. For example, African American men have some of the highest incidences and mortality rates of cancer. And in many American Indian and Alaska Native communities, diabetes is rampant.

Wilbur Woodis, management analyst and a behavioral health specialist for the Indian Health Service, noted that acknowledging the problems of minority populations is only the first step to eliminating health disparities. It has long been known that American Indians and Alaska Natives (AI/ANs) have high incidences of behavioral health issues such as suicide, substance abuse, and mental health problems. "It is easy to acknowledge the problems and the government programs that work to address these problems. What is harder, however, is acknowledging how culture influences the health of AI/AN and other minority populations," said Woodis.

"Culture and language are an integral part of how we define who we are. The CLAS standards bring attention to the need and importance of culture and language for people of color," said Woodis, who also served on the CLAS advisory committee that helped review draft standards.

Under the CLAS standards (see page 3 for full list), health care organizations are encouraged to ensure that patients receive understandable and respectful care that is compatible with their cultural health beliefs, practices, and preferred language. This may mean providing an environment in which patients from diverse cultural backgrounds feel comfortable discussing cultural health beliefs or practices; using community workers as a check on the effectiveness of communication and care; or encouraging patients to express their spiritual beliefs and cultural practices, according to OMH.

Data Issues And Discrimination Also Addressed

Ensuring that our minority populations receive culturally appropriate care is only one of a handful of problems addressed by the CLAS standards. For some minority groups like Asian Americans and Pacific Islanders and American Indians and Alaska Natives, statistical data on disease mortality and prevalence are either not available or limited. Limited data on racial and ethnic minority health can make it difficult for agencies to identify health disparities, justify the

need for special initiatives, or measure progress made by state initiatives.

To gain a better understanding of the health problems that exist in minority populations, CLAS Standard 10 recommends that health care organizations collect data on an individual patient's race, ethnicity, and spoken and written language. CLAS guidelines also recommend that organizations maintain a current demographic, cultural, and epidemiological profile of the community, as well as a needs assessment, to accurately plan for and implement services that respond to the cultural and linguistic characteristics of a service area.

Unfortunately, discrimination is still a factor in the quality of health care services some minorities receive. A recent study from the Kaiser Family Foundation, *Perceptions of How Race & Ethnic Background Affect Medical Care*, found that minority patients are often distrustful of the U.S. health care system. Reasons cited for the lack of trust included lack of time and attention given to patients by health care professionals and the perception that health care professionals hold negative stereotypes of minority patients.

To help curb discrimination, the CLAS standards recommend that health care organizations develop participatory, collaborative partnerships with minority and ethnically diverse communities. There are many formal and informal mechanisms available for this, including participation in governing boards, developing community advisory committees and ad hoc advisory groups, or conducting interviews or focus groups, according to OMH. Health care organizations are also encouraged to develop culturally and linguistically sensitive grievance resolution processes for resolving cross-cultural conflicts or complaints by patients and consumers.

A 1999 study conducted by the Oregon Office of Multicultural Health, *Strategies in Collaboration*, supports the CLAS recommendation for including minorities in health care organizations. The study notes that central to beginning the process of gaining trust from ethnic minorities is finding 'natural leaders' from within the minority communities. "Mainstream agencies need to foster opportunities for ethnic community leaders to meet within and across communities. This will help clarify needs, including how services need to be adapted to fit each community," said the study.

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Revised CLAS Standards

From the Office of Minority Health

1. Health care organizations should ensure that patients/consumers receive from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.
- *Note: The standards are organized by three themes.*
1. *Culturally Competent Care (Standards 1-3)*
 2. *Language Access Services (Standards 4-7)*
 3. *Organizational Supports for Cultural Competence (Standards 8-14).*

HHS' Office of Civil Rights Focuses on Title VI Policy Provides Guidance for Ensuring Linguistic Access

By Houkje Ross

In August 2000, the U.S. Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) released a written policy guidance to help ensure that persons with limited English skills can effectively access critical health and social services.

The guidance outlines the legal responsibilities of providers who receive federal financial assistance from HHS. Providers such as hospitals, HMOs, and human service agencies now have an outline for complying with the "Policy Guidance on the Prohibition Against National Origin Discrimination As it Affects Persons with Limited English Proficiency." The guidance applies to part of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin.

Publication of the OCR guidance makes HHS the first federal agency to publish guidance since the issuance of Executive Order 13166 on serving persons with limited English skills. Signed in August 2000, the executive order requires each federal agency to have written policies on providing effective service to those with limited English proficiency who are served by federally funded programs.

The OCR policy guidance recommends that health care agencies and providers develop a plan for providing written materials in languages other than English. This should be done in areas where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively. To ensure satisfactory services to limited-English-proficient (LEP) clients, providers also should:

- Have policies and procedures in place for identifying and assessing the language needs of the individual provider and its client population;
- Provide a range of oral language assistance options, appropriate to each facility's circumstances;
- Provide notice to LEP persons of the right to free language assistance;
- Provide staff training and program monitoring, and
- Establish a plan for providing written materials in languages other than English.

Meaningful Access Must be Provided

According to OCR, agencies and providers must ensure meaningful access to LEPs. Office of Civil Rights (OCR) Director Thomas Perez commented in a press release that, "Effective communication is

the key to meaningful access, whether it is a hospital, a clinic or a benefits program. Failure to communicate effectively can have serious consequences for millions of Americans."

According to the Cross Cultural Health Care Program (CCHCP), a non-profit organization in Seattle, many institutions are now depending upon family members, friends, or support staff such as receptionists and technicians, to provide language assistance. But family members are notoriously bad interpreters because they routinely edit, add, or change messages from patient to doctor, according to CCHCP.

Providing health care across language barriers without the use of an interpreter can be like walking blindfolded across a minefield. The practice can be dangerous, and in some cases, life-threatening.

"A doctor in our hospital was treating a diabetic patient who only spoke Spanish," said Estela McDonough, coordinator of training and education at the Interpreter Services Program at the University of Massachusetts Memorial Medical Center.

According to McDonough, the doctor said he did not need an interpreter because he said he knew Spanish. But the physician failed to pick up that the patient had been fasting due to religious beliefs. The patient was in a much more serious sugar crisis than the physician was aware of. Luckily, the interpreter had stayed in the room as a precaution. "Later on, the doctor told me that for many years he thought he had been communicating accurately with his patients. He had no idea he was putting his patients at risk," said McDonough.

Interpreting - More than Words

Interpreting is more than just translating the words, according to McDonough. "The interpreter acts as the conduit between the patient and the health care provider. A trained and qualified interpreter has to have certain skills, including memory, concentration, knowledge of medical terminology, anatomy, physiology, and an understanding of how to deliver a message in the target language," she added.

Using professional on-site interpreters is a more reliable approach for providers because these persons have been screened for their language skills, trained in interpretation ethics and techniques—which includes learning to be accurate, complete, and to consider cultural frameworks—and contracted only to interpret, according to CCHCP.

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"No person in the U.S. shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." –Title VI

Professional interpreters should also have a good grasp of the nuances of culture and language, according to McDonough. “I had an interpreter who came to our program from Europe. She had a full year of training in Spain, but she still misunderstood what the patients from Puerto Rico were saying when describing “fatiga,” which in her native Spain means “tired.” For the patients from Puerto Rico, “fatiga” is a word used to describe wheezing from asthma,” said McDonough.

Massachusetts is one of a handful of states that has standards for the use of medical interpreters. The Massachusetts Medical Interpreter Association’s (MMIA) standards address issues of interpreter skill, behavior, linguistic and cultural knowledge, and ethics. In April 2000, the Massachusetts Emergency Room Interpreter Bill was signed into law. The law requires that all hospitals, public or private, which provide acute care, either in emergency rooms or in acute psychiatric facilities, when treating non-English speakers, must use competent interpreter services. The law goes into effect in July 2001.

Getting Everyone on the Same Page

Some medical associations and other critics of the OCR guidance strongly oppose

requirements that doctors who accept Medicaid funds provide and pay for interpreter services for patients with limited English speaking abilities. The high cost of the requirements will place an “unreasonable burden” on physician practices, critics say. OCR officials maintain that the guidelines do not represent a new initiative but are intended to more fully explain existing policies in place to enforce Title VI of the Civil Rights Act of 1964.

Although some physicians and other organizations may feel the OCR guidance is burdensome, there are ways to get everyone on the same page. A 1995 study conducted by the New York Task Force on Immigrant Health, *Access through Medical Interpreter and Language Services*, found that motivation to develop an interpreter program is often shaped by several factors. These include: pressure from physicians; a desire to gain a larger share of the market through increased patient volume; the threat of malpractice law suits; a response to the influx of refugees and immigrants; and the fact that providing in-person interpreter services is more cost-effective than telephone interpreter services.

Federal funds are available for States’ expenditures related to the provision of oral and written translation administrative activities and services provided for the Health Care

Financing Administration’s State Children’s Health Insurance (SCHIP) and Medicaid programs.

Some of the most common complaints OCR works to resolve include: failing to inform LEP persons of the right to receive free interpreter services or requiring them to provide their own interpreter; or providing services to LEP persons that are not as effective as those provided to persons with proficiency in English.

In cases where OCR has found health care organizations to provide inadequate access for LEP patients, the agency has required these agencies to establish a system for tracking LEP clients and client needs. It has also required organizations to publicize the availability of no cost programs and services in non-English community media outlets and to provide cultural sensitivity training for staff.

For information on the OCR guidance, go to <http://www.hhs.gov/ocr/lep/> or call OCR at (800) 368-1019. To contact the Interpreter Services Program at University of Massachusetts Memorial Medical Center, call (508) 856-5793. MMIA can be reached at (617) 636-5479. ❖

Good Communication is Good Medicine

In a recent study conducted by the Office of Ethics and Health Policy Initiatives at the Albert Einstein Healthcare Network in Philadelphia, focus group participants who were limited-English-proficient felt that their ability to communicate with providers was restricted. One focus group participant in the 1999 study, *Approaches to End-of-Life Care in Culturally Diverse Communities*, commented, “If you don’t speak English, you’re a handicap. You’re going to take a long time to deal with. I’m going to leave you for last, and I’m going to help that person who speaks English.” Richard Lerner, MD, a general practitioner at the University of Massachusetts Medical Center in Worcester, admits that it does take more time to use an interpreter. “But without them, the interaction between provider and patient would be limited,” he said.

In 1999, the Agency for Healthcare Research and Quality sponsored a workshop on cultural competency in health systems, entitled *Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems*. Workshop presenters indicated that research and anecdotal evidence suggest that the improved communication between doctors and patients leads to greater patient satisfaction.

Looking for more information on communicating in health care? Check out the third edition of *Health Communication: Strategies for Health Professionals*, by Peter G. Northouse, Ph.D., and Laurel L. Northouse. The 1998 book, which provides health care professionals with theory-based strategies they can use to improve communication with patients, families, and other health care professionals, includes a chapter on intercultural communication. ❖

On The Road to the National Leadership Summit

By John West

First in a series of articles on the upcoming National Leadership Summit, to be held in Washington, DC, September 4-6, 2001.

Since its inception in 1985, The Office of Minority Health (OMH), U.S. Department of Health and Human Services has been committed to improving the health of all Americans by helping to eliminate disparities in health. To further this goal, OMH and its federal and non-federal partners will convene a National Leadership Summit for the Elimination of Racial and Ethnic Disparities in Health Sept. 4-6, 2001, in Washington, D.C.

The Summit is slated to bring together nearly 1,000 participants who work at the community and policy-making levels to set up partnerships and engage in a dialogue on strategies and activities that promote healthy communities.

According to Capt. Howard L. Kelley, DDS, MPH, OMH project director, the Summit is designed to be a cohesive and an on-going partnership. "This summit represents a federal effort to foster public and private sector collaboration with community organizations and generate community participation in policies and strategies for improving health for all of us," Kelley said.

Kelley, who has been involved in the event's planning from the start, also said that the Summit will strive to establish meaningful and lasting partnerships. "We want to create an atmosphere of developing relationships with traditional and non-traditional, community-based, faith-based, and tribal organizations working at the community level," he said. "There are a lot of good things being done out there that should be shared," Kelley added.

In addition to the Summit, Kelley said that OMH will put together a compendium of recommendations and best practices that will be known as the "Community Toolkit." "This Toolkit will contain many useful things such as ideas and workable models that people can utilize to tailor programs for their own communities," Kelley said. "Their advice and recommendations for this "Toolkit" will focus on activities, projects, policies, and evaluation methods that would be effective in programs intended to eliminate racial and ethnic health disparities in communities around the country," he added.

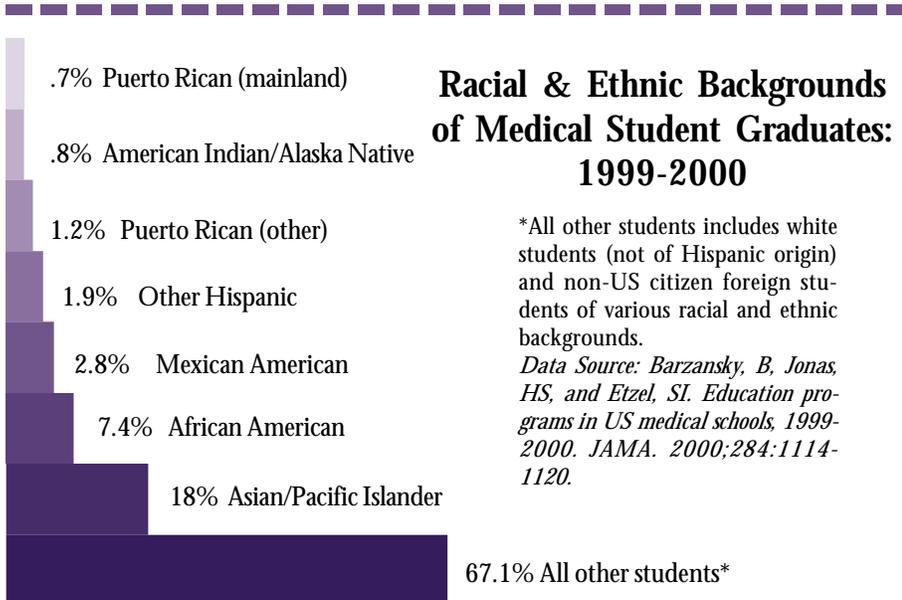


OMH's working partner for Summit planning is Betah Associates, Inc., of Bethesda, MD, which will handle all seminar scheduling and logistics to include registration and exhibition planning.

In addition to the Summit program currently being developed, Kelley said that there will be many opportunities for exhibitors and sponsors. "We welcome all organizations or individuals who are interested in exhibiting or sponsoring to contact us for more information," he said. "We want to make this Summit a viable and interesting event for all attendees," he added.

The official program for the National Leadership Summit will contain advertising pages to complement participation. Ads can be camera-ready color art or film. However, program officials said that no tobacco or alcohol advertisements would be accepted.

Information on the National Leadership Summit can be obtained by calling toll-free 1-888-516-5599. *(This is the first in a series of articles designed to keep our readership informed about the upcoming National Leadership Summit to be held in Washington, D.C. in September 2001. Mr. West is a member of the OMH Closing The Gap Staff and assists in Summit event planning.)*



Diversity Training in Medical School: AMSA Tests Pilot Curriculum

Guest Editorial by Meredith Burke Lawler, American Medical Student Association

Our Nation is growing more diverse. By 2010, minority populations will constitute 32 percent of the U.S. population. By 2050, nearly half of the U.S. population will be composed of members of ethnic and racial minorities. In order to become effective and responsible physicians, medical students need to learn to respond to the unique needs of patients from varying ethnicities, races, sexual orientations, and cultural backgrounds. Medical schools have a responsibility to prepare their students for cross-cultural relationships with their patients.

In an effort to foster cultural competency curricula in medical schools, the American Medical Student Association (AMSA), in conjunction with the Promoting, Reinforcing and Improving Medical Education (PRIME) project, funded by the U.S. Department of Health and Human Services, has developed a one-year pilot curriculum for addressing issues of diversity in medicine.

Culture and Diversity Pilot Curriculum

The educational goal of the Culture and Diversity curriculum is to provide a curriculum on cultural competency that will help physicians-in-training develop the attitudes, skills, and knowledge base to serve diverse populations effectively, especially underserved and vulnerable populations.

The curriculum is based on specific core competencies that each school must address. Some of the core competencies include: cultural models of health, disease and illness, cultural/traditional health care practices, negotiating cultural conflicts in the doctor-patient relationship, effective communicating and interviewing, and using interpreters. Medical schools participating in PRIME

adapt the curriculum to reflect the characteristics of their institution and surrounding community and resources.

For example, Wake Forest University in North Carolina adapted the PRIME curriculum to respond to the presence of Hispanic, Hmong, and American Indian populations that surround the school. Speakers during the fall 2000 semester have focused on common cultural and demographic misconceptions of the above populations, as well as their important values and health beliefs. Students have given excellent feedback on the small group sessions, which last from two to four hours each and are led by physicians, community leaders, and Wake Forest faculty.

The Medical University of South Carolina has adapted the PRIME curriculum to reflect the unique population of South Carolina, including migrant farm workers and the nearby Gullah community. Noon-time presentations have attracted a much greater audience than expected, with 146 students attending a recent "Religious Diversity" presentation.

The University of Kansas School of Medicine has also incorporated the PRIME goals into its medical school curricula. The school focused its curricula on eliminating biases. Small group class sessions included discussions of the Tuskegee Project, obtaining a relevant and complete cultural history, and the relationship between economics and health.

The PRIME project also developed the Community Responsive Curriculum Project, which focuses on teaching medical students the skills necessary to be a physician in underserved areas.

For more information on the PRIME curriculum projects, please go to <http://www.amsa.org/programs/prime.html> or contact Shadia Garrison, PRIME Project Manager, at shadia_g@www.amsa.org.

How Do Physicians-in-Training Become Culturally Competent?

Listen with sympathy and understanding to the patient's perception of the problem.

Explain your perceptions of the problem and your strategy for treatment.

Acknowledge and discuss the differences and similarities between these perceptions.

Recommend treatment while remembering the patient's cultural parameters.

Negotiate agreement. It is important to understand the patient's explanatory model so that medical treatment fits in their cultural framework.

Source: *A Teaching Framework for Cross-Cultural Health Care*. Berlin EA, Fowkes WC Jr, Western Journal of Medicine. 1983, 139:934-938.

National Medical Association Supports Culturally and Linguistically Appropriate Services

Guest Editorial by Rodney G. Hood, MD, President, National Medical Association

The National Medical Association (NMA) supports the HHS Office of Minority Health's (OMH) commitment and efforts to develop the Culturally and Linguistically Appropriate Services (CLAS) Standards. The final standards provide comprehensive direction to health care organizations and medical professionals on what they can do to ensure that patients/consumers are able to access health care that is sensitive to their cultural backgrounds and linguistic needs.

However, NMA believes there must be tools in place to ensure that the CLAS Standards are enforced. Without federal enforceability of each of these standards, there is no effective means of ensuring that our nation's proficiency in providing culturally and linguistically sensitive health care improves in any way.

In spite of the fact that this nation has experienced tremendous advances in biomedical research and the practice of medicine, the benefits of these developments have not fully translated into better health status or health care for African Americans and other racial and ethnic minorities. In fact, communities of color continue to be unduly plagued by disproportionate rates of death and disease. The CLAS Standards are extremely critical. If properly implemented and administered, these standards will help to elimi-

nate the racial biases and practices that unfortunately influence the manner in which care is delivered today.

CLAS Standards 1-3 address the critical need for health care organizations to ensure that their staffs reflect the communities they serve and that they are sensitive to their language needs and cultural differences. Standards 8-14 provide critical guidance on how health care organizations can institutionalize practices and procedures to strengthen their ability to fully serve and effectively address the health needs of all their patients. Racial and ethnic minority patients have historically been subjected to biases assumed by providers and entrenched throughout the nation's health care system in medical decision-making and treatment. OMH has provided critical guidance on how health care organizations and providers can correct the current inequities that exist in the nation's health care system and better serve all of their patients. These standards are important to improving the nation's effectiveness in addressing racial/cultural biases, improving clinical outcomes, and closing the racial and ethnic health gap.

Nationally recognized standards of cultural and linguistic competence in health care service delivery are essential and long overdue. NMA applauds this effort. ❖

HHS Briefs

- The Health Resources and Services Administration (HRSA) has a technical assistance center for use by faculty and staff of minority institutions of higher education. Those working at Historically Black Colleges and Universities, Hispanic Serving Institutions, and Tribal Colleges and Universities can receive hands-on assistance in preparing proposals for submission to the HRSA bureaus or offices. The technical assistance center can provide guidance on refining and specifying the objectives; conceptualizing the technical approach; or researching the background and rationale for a proposal. For more information, call (301) 585-7588 or e-mail hrsa@icrds.org
- The National Institute of Environmental Health Sciences, in collaboration with six other National Institutes of Health (NIH) components, announced the start of 12 five-year projects that will provide scientists with a better understanding of how social and environmental factors interact and affect the health of racial and ethnic minorities. For a list of principal investigators who are receiving NIH grants, go to <http://www.nih.gov/news/pr/jan2001/niehs-04.htm>
- A report from the HHS Office of the Inspector General says that federally funded health centers are one of the best ways to enroll eligible children into the State Children's Health Insurance Program (SCHIP). These health centers are often relied on to target hard-to-reach and minority populations in underserved rural and urban areas. According to the National Association of Community Health Centers, there are more than 1,029 community-based health centers in the U.S. today, serving over 11 million people through 3,200 delivery sites. Over four million of these patients are uninsured.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations

Health care organizations have been slow to develop and implement policies and structures to guide the provision of interpretation and translation services. In the absence of policies, structures and fiscal resources, the burden of such services remain at the practitioner and consumer level.

The following checklist is designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Does the primary health care organization or program have:

- A mission statement that articulates its principles, rationale, and values for providing linguistically and culturally competent health care services?
- Policies and procedures that support staff recruitment, hiring, and retention to achieve the goal of a diverse and linguistically competent staff?
- Position description and personnel/performance measures that include skill sets related to linguistic competence?
- Policies and resources to support ongoing professional development and inservice training (at all levels) related to linguistic competence?
- Policies, procedures and fiscal planning to insure the provision of translation and interpretation services?
- Policies and procedures regarding the translation of patient consent forms, educational materials, and other information in formats that meet the literacy needs of patients?
- Policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?
- Policies and resources that support community outreach initiatives to persons with limited English proficiency?
- Policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services?

Definitions: The terms interpretation and translation are often used interchangeably. The National Center for Cultural Competence makes a distinction between the two terms and has provided the following definitions. *Translation* typically refers to the written conversion of written materials from one language to another. *Interpretation* is the oral restating in one language of what has been said in another language.

Source: "Linguistic Competence In Primary Health Care Delivery Systems: Implications for Policy Makers," January 2001: Policy Brief 2. National Center for Cultural Competence.

Looking for Cultural Competency Assessment Tools?

Campinha-Bacote, J. (1998). *Inventory for Assessing the Process of Cultural Competence (IAPCC) Among Health Care Professionals*.

Write to: Transcultural C.A.R.E. Associates, 11108 Huntwicke Place, Cincinnati, OH 45241.

Mason, James L. (1995). *Cultural Competence Self-Assessment Questionnaire: A Manual for Users*.

Write to: Portland State University, Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute for Human Services, Graduate School of Social Work, P.O.Box 751, Portland, OR 97207-0751.

National Public Health and Hospital Institute (1997). *Self-Assessment of Cultural Competence*.

Write to: NPHHI, 1212 New York Avenue, NW, Suite 800, Washington, DC 20005.

Roizer, M (1996). *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*.

Write to: Technical Assistance Center for the Evaluation of Children's Mental Health Systems, Judge Baker Children's Center, 295 Longwood Ave., Boston, MA 02115.

Success by 6/United Way of Minneapolis and Hennepin Medical Society (1996). *Cultural Competence Clinic Assessment Tool*.

Write to: Center for Cross Cultural Health, W-227, 410 Church St., Minneapolis, MN 55455.

Tirado, Miguel D. (1996). *Tools for Monitoring Cultural Competence in Health Care*.

Write to: Latino Coalition for a Healthy California, 1535 Mission Street, San Francisco, CA 94103.

Minority Enrollment

Total enrollment in schools for selected health professions by race and ethnicity 1996-97

Dentistry	Percent of Students
American Indian	.5
Non-Hispanic Black	5.4
Hispanic	4.0

Nursing (RN)	Percent of Students
American Indian	.8
Non-Hispanic Black	9.9
Hispanic	3.9

Optometry	Percent of Students
American Indian	.5
Non-Hispanic Black	2.4
Hispanic	3.9

Pharmacy	Percent of Students
American Indian	.4
Non-Hispanic Black	2.8
Hispanic	7.7

Podiatry	Percent of Students
American Indian	.6
Non-Hispanic Black	3.7
Hispanic	3.4

Minority groups listed are underrepresented in health care professions. Information can be found in United States Health Workforce Personnel Factbook 2000. This fact book is a compilation of data from secondary sources, such as the American Medical Association, and the Federal Bureau of Labor Statistics. To order, call the Health Resources and Services Administration (HRSA) at 1-888-Ask-HRSA or visit <http://www.ask.hrsa.gov>

CLAS...from page 2

The CLAS standards and the final report documenting all phases of the project issues related to the standards are available online at <http://www.omhrc.gov/CLAS>. A hard copy can also be requested by writing: Attn: CLAS/Guadalupe Pacheco, Office of Minority Health, 5515 Security Lane, Suite 1000, Rockville, MD, 20852. Or e-mail gpacheco@osophs.dhhs.gov. ❖

Recruitment and Retention Critical to Minority Health Professionals

By John West

Many observers believe that the cultural competency displayed by health care workers in all levels of an organization—or lack of it—has critically important effects on the quality of care received by that organization’s patients and customers.

Better education and training of staff currently providing services in health care systems and facilities could go a long way toward improving patient-provider interactions. Equally critical is improved recruitment and retention of minority students into health and allied health professions.

US Census projections indicate that by the year 2010, the U.S. minority population will increase by 60 percent.

Jordan J. Cohen, M.D., president of AAMC said, “this raises the question of whether or not enough medical students are developing the necessary cultural awareness and competence skills.”

According to Nycal Anthony, president of Alliances for Quality Education, Inc., a Washington-based, health and education resource development firm, there is not an automatic fix to building a more culturally competent health care workforce. “Balancing the supply and demand needs is essential,” she said. “To impact the education, recruitment, practice, and retention of physicians, pharmacists, advanced practice nurses, dentists, registered nurses, physician assistants, and other allied health professionals will require a ‘back to basics’ approach. We need to strengthen the pipeline connecting people, education systems, legislatures, and many others to identify and implement strategies to succeed,” she added.

Cohen further stated that despite the hard work of medical schools across the country, no more than 1,700 individuals from racial/ethnic groups, underrepresented in the

physician workforce, will be among the some 16,100 receiving their symbolic “white coats” this month. “At a time when underrepresented minorities make up more than 21% of our country’s increasingly diverse population, having barely 10.5% of our classes drawn from these communities is downright alarming,” he said (Reporter, Volume 9, Number 12; September 2000). Increased efforts must be made

to enact public policy that values and endorses cultural competence in the health care workforce.

Associate Director of the Institute of Public Health at Florida A & M University, and Publisher of the National Black Health Leadership Directory, Nathaniel

Wesley, Jr. said that increasing the number of individuals entering and exiting the pipeline as health care professionals is the key. “The basics of creating a culturally competent and diverse workforce requires access and opportunity,” Wesley said. “Equal opportunity is still as critical today as during the civil rights movement,” he added.

Wesley also said that without additional incentives, it is difficult for an undergraduate student to rationalize choosing a health care career with a starting salary of \$30,000 in comparison to an engineering career with a starting salary of \$45,000.

“In the future, we must return to pipeline programs that foster students through summer work study programs, encourage mentoring of new entrants into health care fields, and provide career counseling to mid-level health professions,” Wesley said.

According to Wesley, mentoring should not be monolithic in nature. “There has to be more open and meaningful communication and development across all levels,” he said. There must be a diverse cooperative pathway for success. ❖

“To impact the education, recruitment, practice, and retention of physicians, pharmacists, advanced practice nurses, dentists, registered nurses, physician assistants, and other allied health professionals will require a ‘back to basics’ approach....”

Linking Minorities to Health Services: Successful Strategies for Outreach Workers

By Houkje Ross

Accessing health care is a major challenge for minority and ethnic groups who may be unknowledgeable, fearful, or distrustful of 'mainstream' medical services. Community health workers, sometimes known as 'lay' health workers, are often the key to linking minority and other underserved communities to health care services.

Part of being a successful community health worker is being knowledgeable about the community you serve. "When you conduct outreach, you have to know the 'flavor' of the community—you have to be able to fit into and function within it," said Delores Burgess, coordinator for minority/community outreach and education program at the Mental Health Association of Allegheny County Pennsylvania (MHAACP). Burgess conducts outreach to unserved and underserved minority populations.

A large part of Burgess' job as a community outreach worker is to be able to gain the trust of those she tries to reach. "You can't walk into a community with a superior attitude. You have to be able to take information to individuals in the community and relate your life to theirs," said Burgess.

Under a grant from the National Mental Health Association's (NMHA) National Consumer Supporter Technical Assistance Center, MHAACP is working to create a manual on minority outreach programs that can be replicated by other consumer-supporter organizations.

Some other things to consider when conducting outreach to minority communities:

- **Conduct a community needs assessment.** The *Health Link* program in Rowan County, North Carolina, identifies community needs by holding focus groups and community meetings where resident needs are identified. The program seeks to make African American families aware of existing services for babies and young children through age 5. Community volunteers and outreach workers 'link' infants and children to existing services. The program also offers free transportation to health and social services throughout the county.
- **Bring services to the community.** Discomfort with western medical practices can make some minority groups, like American Indians and Alaska Natives reluctant to use 'mainstream' medical services. Terrence Shea, director of community health nursing at Denver Health, a community health service provider in Colorado worked with the director of a local Native American non-profit group, Native American Cancer Initiatives, Inc., to learn how to best reach women in the area. To make cancer screening more culturally appropriate, Shea set up screenings in

the American Indian Community Center. The women are encouraged to come together and stay all day, where they could eat food, drink coffee or tea, and socialize.

- **Structure your program.** The National Asian Women's Health Organization's program, *Communicating Across Boundaries*, was designed to increase the responsiveness of health care providers to Asian American women through cultural competency training. The program—a four-year cooperative agreement with the Centers for Disease Control—clearly lays out its goals, audience, design, process, and expected outcomes. Now in its final year, the program has been successful in opening a dialog with the community and establishing a platform of resources to offer the community.
- **Link existing community services.** To keep herself and her community aware of other public services, Burgess meets every other month with other community-based organizations like the Urban League, health care organizations, and even congressional representatives. Not only does it help Burgess stay abreast of the services available, but it keeps the organizations aware of each other's services.

For more information on Health Link, contact Dr. Jim Cowan, program director, (704) 638-2907. For more information on Communicating Across Boundaries, contact Cindy Moon, program coordinator, (415) 989-9758. For more information on Denver Health, call (303) 436-6000. To contact MHAACP, call (412) 391-3820. ❖

Looking for More Information on Lay Health Workers? Check out these stories, from past issues in *Closing the Gap*.

- ⇒ *Closing the Gap*. August 2000 Issue: Lifting the Unequal Burden of Cancer on Minorities and the Underserved. Page 4. *Vietnamese Women and Cervical Cancer: Lay Health Workers Can Help Change Behaviors*. (Publication # 422)
- ⇒ *Closing the Gap*. March 2000 Issue: State Children's Health Insurance Program. Page 9. *Reaching Rural Communities. Border Vision Fronteriza: Tapping Into Community Workers and Volunteers*. (Publication #412)

Call the Office of Minority Health Resource Center at (800) 444-6472 and ask to speak to an information specialist.

Dental Program Brings Latino Values To California Community

By Beatriz Roppe, Director of Health Promotion at Colaborativo Saber

Tuesday mornings you will find Imelda Perez in front of a group of 10 to 12 mothers waving tooth brushes, dental floss, and a large plastic model of perfect teeth. Imelda will talk to the group about the difference between cleaning teeth versus merely brushing.

Imelda is one of seven *promotoras de salud*, or health promoters, who teaches an eight-week dental health curriculum called *Sonrisitas*, or Little Smiles. The program is part of Colaborativo Saber, a school and community-based organization in San Diego, California. Spanish-speaking parents, mostly mothers, come to the Sherman Heights Community Center for the program. After the *pláticas*, or talks, the parents are better prepared to help their families and children develop good oral health practices.

As a local resident of the predominantly Latino community, Imelda and her fellow promotoras, Hilda, Berta, Angeles, Rosario, and Obdulia, are the best individuals to share health information with fellow Latinas. Many parents are monolingual, far from home, confused, frightened, or suspicious of the U.S. medical and dental systems. Imelda and the other dedicated promotoras understand and live the values of the community they serve. They are proud of their community and proud of the work they do. *Orgullo*, or pride, is an important motivator for Latinas and drives the development of the health promotion work that goes on in Sherman Heights.

Culturally Appropriate Care

Sonrisitas is a culturally appropriate program that relies on the traditional Latino promotoras model to change behavior and educate the community about dental health. The model uses the natural support system that exists within the Latino community. It is an informal system that helps people and families, utilizes existing resources as well as alternative sources of support, and is based on *confianza* (confidence) and *respeto* (respect). Latinos value interpersonal relationships and turn to individuals to confide in. To assure the success of our promotoras model, the community we serve has to respect and have confidence in our promotoras and our messages.

To help ensure success, our promotoras are recruited and educated through Colaborativo Saber's Instituto de Promotoras. Colaborativo Saber's dental health program—Sonrisitas—is one of four projects and was developed and designed with input from promotoras and parents. Working together in a collaborative effort is one attribute of the Latino culture. *Colectivismo* (working together), is associated with high levels of personal interdependence and facili-

tates working in unison to problem solve issues that affect the community. As members of the target community and its social network, promotoras are ideal individuals to promote health and reach their community.

The parents who attend the Sonrisitas program have *confianza* in the promotoras. Promotoras help change behavior through the Latino value of the extended family. *Familismo*, seeing the family as the primary social unit and support system, is an important Latino characteristic. The value works to keep parents open to education and information programs that will assist them in keeping the family healthy and well.

Curriculum is User-Friendly

The Sonrisitas curriculum is user friendly, has a pleasing and professional presentation. It is written in Spanish for the promotoras, who are not required to memorize the material. From the precision of the graphics and illustrations, to the quality of the paper and the binder, the curriculum values the sensibilities of the Latino culture by acknowledging the emphasis placed on appearance. The

effort taken to give the materials a professional look reflects the respect the Instituto de Promotoras holds for the promotoras who use the materials and the participants who take the materials home to share with family and friends.

The curriculum fosters lasting behavior change through role modeling, group activities, skill building, and goal setting. The Sonrisitas curriculum acknowledges the high degree of family formation, structure, and function of Latino households. The curriculum accentuates the positive and recognizes that Latinos have healthy habits, including good nutrition practices as well as moderate smoking and drinking habits.

The eight-week, hour-long sessions emphasize family dental health throughout the lifespan. Topics covered include: the primary teeth and the importance of preventing baby bottle tooth decay; proper teeth cleaning and the use of dental floss; the basics of nutrition and choosing healthy snacks for children; the importance of sealants and fluoride; and locating and accessing dental resources in the community. In true Latino fashion, the classes conclude with a graduation *fiesta* where the whole family is invited and the participants receive a diploma!

For more information on the Sonrisitas program and Colaborativo Saber's Instituto de Promotoras, on developing a promotora model, or on-site training for existing promotoras, contact: Beatriz Roppe, (619) 225-1032 or e-mail beatroppe@pacbell.net



End-of-Life Care Issues Need Culturally Sensitive Approaches

By Houkje Ross

For Carol and Carolyn Bloch, dying with dignity is a right that needs to be granted to every person facing the end of life—regardless of race, ethnicity, religion, or socioeconomic status. The Bloch twins are certified transcultural nurse specialists and transcultural/diversity consultants for the Los Angeles County Department of Health Services. They teach a class for the county called *Transcultural Perspective on Death and Dying*.

Respecting Cultural Beliefs

Not knowing about a patient's culture, religion, or ritual practices surrounding end-of-life can make already tense and emotional situations even more hurtful, according to Carol Bloch. "End of life issues are ingrained with cultural identity and affiliation," according to Carol Bloch. Learning what death means for a patient and a family is an essential part of becoming a culturally competent health care worker.

Carolyn Bloch recounted the story of an Asian boy who had died: Chinese culture dictates that the boy's body be dressed at the hospital, not at the funeral home. The beliefs of this particular family include life after death. The body usually is accompanied by jewelry, personal belongings, and money. A nurse manager came into the room and told the family they couldn't dress the boy at the hospital due to policy. The family was understandably upset.

There are ways to accommodate cultural beliefs, customs, and traditions, and still work within the boundaries of hospital policies, according to the Blochs. In the situation with the Chinese boy for example, the Bloch twins suggest that the nurse manager inform the family that the boy's body will have to be transported and handled by other health care workers and personnel. "Health care workers could have suggested to the family that it would be better to dress the body at the funeral home, so that the boy's money or valuables do not get lost or misplaced," said the Bloch sisters.



Resource Persons Network • *Connecting with Communities*

Both Bloch sisters are members of the OMHRC Resource Persons Network, a group of professionals who volunteer their services in support of the Resource Center's mission to improve the health status of racial and ethnic minority groups in the United States.

If you have experience working with culturally diverse populations, please contact OMHRC today to receive information on joining the Resource Persons Network. 1-800-444-6472 or e-mail info@omhrc.gov

Health Care Workers Face Moral, Ethical Struggles

Health care workers are often confronted with even tougher moral and ethical issues. "In some cultures, the family may not want their family member to know that he or she is dying," said Carol Bloch. "An Iranian family stayed by their mother's bedside 24 hours a day to prevent her from finding out she was dying. The family believed that if the mother knew she was dying she would lose hope and die sooner," said Bloch.

"In these instances, a physician or health care worker may feel a strong moral or ethical obligation to tell the patient," said Bloch. But Marjolein Ross, a home health care nurse who specializes in geriatric and end-of-life care says, "It is our job as health care workers to take care of the patient as best we can, not to judge the family's decisions." Complicating the issue is a lack of policy regarding these situations. The Bloch twins strongly recommend that hospitals and other health care organizations establish consent forms regarding end-of-life decision-making. The forms could be similar to living wills, which would allow a patient to legally give up his or her rights to a family member, said the Bloch sisters.

Often, end-of-life care can be improved for minority and culturally diverse patients by simply asking what is and is not acceptable for a family or individual, and finding ways to coordinate a patient's needs with hospital policy, said Carolyn Bloch. Other things health care professionals should consider when treating end-of-life patients from ethnically, religiously, or racially diverse backgrounds include:

- **Being aware of family dynamics when discussing medical care and choices.** Health care workers should be aware that in some cultures, the key decision-maker concerning medical treatment may not be the patient, so talking with a patient about end-of-life care medical choices may not be appropriate. "In some cultures, the patient isn't even aware of the disease they are suffering from. Family members make all the decisions regarding treatment," said Carol Bloch.
- **Building trust.** Some minority groups, such as African Americans and Hispanics are distrustful of the health care system due to historical events like the Tuskegee Syphilis study (conducted by the US Public Health Service between 1932 and 1972) or to fears surrounding immigration status. Taking the time to talk to and explain medical treatments and options is an important step in establishing trust.

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Resources

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000
<http://www.ama-assn.org>

American Medical Student Association
1902 Association Drive
Reston, VA 20191
(800) 767-2266
<http://www.amsa.org>

American Translators Association
225 Reinekers Lane, Suite 590
Alexandria, VA 22314
(703) 683-6100
<http://www.atanet.org>

Association for Multicultural Counseling and Development
5999 Stevenson Avenue
Alexandria, VA 22304
(800) 347-6647
(703) 823-9800
<http://www.counseling.org>

Association of American Medical Colleges
2450 N Street, NW
Washington, DC 20037-1127
(202) 828-0400
<http://www.aamc.org>

Association of Clinicians for the Underserved
501 Darby Creek Road, Suite 20
Lexington, KY 40509-1606
(606) 263-0046
<http://www.clinicians.org>

Bureau of Primary Health Care
Health Resources and Services Administration
4350 East-West Highway
Bethesda, MD 20814
(301) 594-4100
<http://www.bphc.hrsa.gov>

Cross Cultural Health Care Program
Pacific Medical Clinics
1200 Twelfth Avenue, South
Seattle, WA 98144
(206) 326-4161
<http://www.xculture.org>

Hispanic-Serving Health Professions Schools, Inc.
1411 K Street, NW
Suite 200
Washington, DC 20009
(202) 783-5262
<http://www.hshps.com>

Health Resources and Services Administration
Information Center
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
888-ASK-HRSA (888-275-4772)
<http://www.ask.hrsa.gov>

Indians Into Medicine (INMED) Program
University of North Dakota School of Medicine
P. O. Box 9037
Grand Forks, ND 58202-9037
(701) 777-3037
<http://www.med.und.nodak.edu/dept/inmed/home.htm>

Bereavement...from page 13

■ **Establishing effective communication.** If a patient is limited-English-proficient, this may make him or her less likely to ask questions about a medical diagnosis or treatment options, according to a 1999 study *Approaches to End-of-Life Care in Culturally Diverse Communities*. The study was conducted by the Office of Ethics and Health Policy Initiatives, at the Albert Einstein Healthcare Network in Philadelphia. Having an interpreter on hand is recommended.

■ **Providing culturally appropriate publications and information.** According to Joan Lewis, project director for a Robert Wood Johnson Foundation grant on end-of-life care at the District of Columbia Hospital Association, many minorities underutilize hospice services, which generally thrive in suburban areas and with white patients. "We took a look at our publications and noticed that the information, including pictures and presentation, was geared for whites," said

Lewis. In order to better serve and reach minority communities about hospice services, Lewis recommends that health care organizations produce materials that take into account cultural views. *The Palliative Care Council of South Australia and Palliative Care Victoria recently published Multicultural Palliative Care Guidelines. They are available online at <http://www.pallcare.asn.au> To contact Carol or Carolyn Bloch, call (213) 240-7710. ❖*

Intercultural Cancer Council
 PMB - C
 1720 Dryden
 Houston, TX 77030
 (713) 798-4617
<http://icc.bcm.tmc.edu>

Minority Nurse
<http://www.minoritynurse.com>

National Alliance for Hispanic Health
 1501 16th Street, NW
 Washington, DC 20036
 (202) 387-5000
<http://www.hispanichealth.org>

National Center for Cultural Competence
 Georgetown University Child Development Center
 3307 M Street, NW, Suite 401
 Washington, DC 20007-3935
 (800) 788-2066
<http://gucdc.georgetown.edu>

National Dental Association
 3517 16th Street, NW
 Washington, DC 20010
 (202) 588-1697
<http://www.natdent.org>

National Hispanic Medical Association (NHMA)
 1411 K Street, N.W. Suite 200
 Washington, DC 20005
 (202) 783-6262
<http://home.earthlink.net/~nhma/>

National Indian Health Board
 1385 South Colorado Blvd., Suite A-707
 Denver, CO 80222
 (303) 759-3075
<http://www.nihb.org>

National Medical Association (NMA)
 1012 Tenth Street, NW
 Washington, DC 20001
 (202) 347-1895
<http://www.nmanet.org>

Office for Civil Rights
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F HHH Bldg.
 Washington, DC 20201
 (800) 368-1019
<http://www.hhs.gov/ocr>

Publications

- ***Cultural Competence: A Journey***, available from the Bureau of Primary Health Care (BPHC), profiles BPHC-supported programs designed to eliminate financial, geographic, or cultural barriers to health care. To order, call (800) 400-BPHC or go to <http://www.bphc.hrsa.gov/culturalcompetence/>. Ask for publication number PC546
- ***Cultural Competence Compendium***, available from the American Medical Association (AMA), is a 460-page guide designed to help physicians and other health professionals to communicate with patients and deliver individualized, respectful, patient-centered care. To place an order contact e-mail Enza Messineo at enza_messineo@ama-assn.org or call (312) 464-5333 or (800) 621-8335 or visit <http://www.ama-assn.org/ama/pub/category/3066.html>
- ***Eliminating Health Disparities in the United States***, describes the Health Resources and Services Administration's (HRSA) goal of 100% access to health care and zero health disparities. It outlines the Agency's new strategic direction for obtaining the goal. It contains detailed information about the Agency's current and future activities related to health disparities and to the Federal Department of Health and Human Services' 1998 Initiative to Eliminate Racial/Ethnic Disparities in Health. To order, call toll-free (888) ASK-HRSA or go to <http://www.hrsa.dhhs.gov/OMH/OMH/disparities/>. Ask for publication number HRS00167.
- ***A National Agenda for Nursing Workforce Racial / Ethnic Diversity*** presents issues related to racial/ ethnic diversity in nursing education and practice and recommends goals and actions that can serve as national agenda to be undertaken to address those issues. Report points out the need to have a culturally diverse workforce to meet the health care needs of our country's population. To order, call toll-free (888) ASK-HRSA or go to <http://www.ask.hrsa.gov/training.cfm?content=training>. Ask for publication number BHP00082.
- ***Policy Brief 3 Cultural Competence in Primary Health Care: Partnerships for a Research Agenda, Summer 2000*** and ***Policy Brief 2 Linguistic Competence In Primary Health Care Delivery Systems: Implications for Policy Makers, January 2001*** are just two of several cultural competence-specific publications available from the National Center for Cultural Competence at Georgetown University. To order, call (800) 788-2066 or go to <http://gucdc.georgetown.edu/nccc/ncccpubs.html>

For a list of journal articles on cultural competency, call the OMH Resource Center at 800-444-6472.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office of Minority Health Resource Center
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Closing the Gap

Conferences: 2001

April 19-21: *American Indian Nursing Education Conference.* Salish Kootenai College, Pablo, MT. For more information, contact Sandi Ovitt at 406-675-4800 ext.343 or e-mail sandi_ovitt@skc.edu

April 27-29: *Voices from the Community: Building Community Readiness to Improve Asian American and Pacific Islander Health.* Sponsored by the Asian & Pacific Islander American Health Forum. Hotel Sofitel San Francisco Bay. Redwood, CA. Contact: APIAHF (415) 954-9988.

May 5: *"HIV/AIDS In The African American Community!"* - the Brothers Fifth Annual Health Issue Series Conference. Decatur Holiday Inn Hotel and Conference Plaza, Decatur, GA. For more information, contact Don Speaks at (404) 778-5433 or visit <http://www.minority-health.org/>

May 5 - 8: *Health for All in 2010: Confirming Our Commitment - Taking Action.* Sponsored by the National Community-Campus Partnerships for Health (CCPH) at the Center for the Health Professions at the University of California, San Francisco. Westin Riverwalk Hotel, San Antonio, TX. For a registration brochure, call CCPH's fax-on-demand service at 1-888-267-9183 and select document #203. Or call Jane Stahl at 650-583-7249.

May 16-17: *"Mind Body and Spirit" - the 6th Annual Conference of The Center On Ethnic & Minority Aging, Inc.* Holiday Inn, City Line Avenue, Philadelphia, PA. For more information, contact Dr. Norma D. Thomas Widner at (610) 499-1133 or e-mail Norma.D.Thomas@widener.edu University Center for Social Work Education.

June 18-22: *7th Annual Summer Public Health Research Videoconference on Minority Health.* Sponsored by The Minority Health Project, University of North Carolina at Chapel Hill. For more information, go to <http://www.minority.unc.edu> or e-mail Minority_Health@unc.edu