

CULTURAL COMPETENCE WORKS

*Using Cultural Competence
To Improve the Quality of Health Care for Diverse Populations
and Add Value to Managed Care Arrangements*

Health Resources and Services Administration
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2001



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CULTURAL COMPETENCE WORKS

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EXECUTIVE SUMMARY

As the United States grows in diversity, health care providers are increasingly challenged to understand and address the linguistic and cultural needs of a diverse clientele. The Health Resources and Services Administration [HRSA] has had a long-standing and particular interest in cultural competence because so many of its grantees provide care to traditionally underserved populations that include culturally and linguistically diverse communities.

The following is a useful definition of cultural and linguistic competence:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Many health care providers, and especially HRSA grantees, have developed creative and successful programs to address the needs of underserved, culturally diverse communities, including interpreter services, cultural competence training for staff, targeted outreach programs, and other culturally appropriate interventions. As more underserved populations are incorporated into managed care arrangements, these culturally competent practices may make HRSA grantees attractive partners to managed care organizations.

HRSA's Center for Health Services Financing and Managed Care sponsored the Cultural Competence Works competition, a nationwide search beginning in the Fall of 1998, to recognize and honor outstanding HRSA-funded programs and to highlight the practices they employ to provide culturally competent care for diverse populations.

Successful Practices in Delivering Culturally Competent Care

Overall, the nominated programs that most successfully provide culturally competent services tend to: 1) define culture broadly; 2) value clients' cultural beliefs; 3) recognize complexity in language interpretation; 4) facilitate learning between providers and communities; 5) involve the community in defining and addressing service needs; 6) collaborate with other agencies; 7) professionalize staff hiring and training; and 8) institutionalize cultural competence.

◆ Define Culture Broadly

Most people understand culture in its broadest sense, and usually interpret it as something that groups possess. But health care is generally dispensed to individuals, and there are other things in addition to race, language, and ethnicity that contribute to a person's sense of self in relation to others. These may be

more specific or more general cultural subcategories based on shared attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, occupation, or homelessness).

It is the convergence of multiple memberships in various cultural and subcultural groups that contribute to an individual's personal identity and sense of their own 'culture.' Understanding how these factors affect how a person seeks and uses medical care, as well as their culture group's historical relationship to the medical establishment, is an integral part of providing culturally competent care. For many of the nominated programs, employing this broad understanding of culture has enhanced program success.

◆ **Value Clients' Cultural Beliefs**

Another way in which cultural competence is demonstrated is the extent to which a program is able to learn about and value its target community's knowledge, attitudes, and beliefs about health care. Competence is also reflected in the extent to which that information is applied to program areas to improve access to and quality of care while respecting cultural health beliefs and practices.

In order to communicate effectively with clients, providers need to understand how to talk about sensitive issues such as sexuality, drug use, and personal violence, among others. In many cases, the provider must be willing to explore the individual life experiences of a client to find the underlying causes of their behaviors, which may not be readily apparent.

◆ **Recognize Complexity in Language Interpretation**

In the experiences of the nominated programs, being able to speak a client's language is essential, but it does not always guarantee effective communication between the client and the provider. Communication is more than simply shared language; it must also include a shared understanding and a shared context as well.

As explained by several nominated programs, there are three overarching concepts to consider when providing culturally and linguistically appropriate health care:

- ◆ Recognizing the linguistic variation within a cultural group;
- ◆ Recognizing the cultural variation within a language group; and
- ◆ Recognizing the variation in literacy levels in all language groups.

Because not all programs can afford to hire full-time staff, most need to use multiple strategies to meet their language needs. Contracting with commercial telephone interpreter services, though somewhat costly, has been very useful to smaller programs, especially those who have seen a rapid increase in the

number of languages spoken by new clients. Other programs, recognizing a larger need, were proactive in creating services where none existed before. Many programs, particularly those providing health care and services to migrant and seasonal farmworker communities, address not only language and race/ethnicity, but also literacy, since some individuals may not be literate in their native language.

◆ **Facilitate Learning Between Providers and Communities**

Creating environments where learning can occur is crucial to improving the health of both individuals and communities. Health care providers need to learn more about the cultural context, knowledge, beliefs and attitudes of the communities they serve. Communities need to learn more about how the health care delivery system works. Both need to learn how collaboration between providers and communities will improve access and quality of care through improved cultural competence.

Several nominated programs have made concerted efforts to create and sustain a “learning loop” between their providers and their client community. In some cases, cultural competence is also a matter of understanding that one’s collaborating agencies and organizations are groups that have their own organizational cultures.

◆ **Involve the Community in Defining and Addressing Service Needs**

Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. Programs that are truly culturally competent involve clients and community members in identifying community needs, assets, and barriers, and in creating appropriate program responses. In this approach, clients and community members play an active role in needs assessment, program development, implementation, and evaluation. Some organizations institutionalize this relationship by making individuals from the community voting members of their governing boards. Others ensure input and recommendations by using community advisory boards, client panels, task forces, or town meetings. Still others sponsor locally based community research (interviews, focus groups, etc), and integrate the results into program design.

Some programs integrate clients and community members into programs by using volunteers from the target community in a variety of program areas, serving as peer advocates who help new clients negotiate the system. Most of the nominated programs also try to hire individuals from the community, or from cultural, economic, and linguistic backgrounds that complement those of community members.

◆ **Collaborate with Other Agencies**

A number of the program nominees have been proactive in their communities to expand culturally competent services by combining forces with other local agencies and organizations. Some programs, for example, have built strong collaborative relationships with medical school residency programs, and described the benefits of these staffing arrangements to the provision of culturally competent care.

◆ **Professionalize Staff Hiring and Training**

Many of the nominated programs suggested ways to professionalize hiring and training practices. Among these are:

- ◆ Establishing specific hiring qualifications and mandated training requirements for all staff in language, medical interpretation, and cultural competence as their positions necessitate;
- ◆ Producing a comprehensive and replicable training curriculum and qualifying factors; and
- ◆ Allocating the budget and time for staff training including training for new staff, annual updates and review, as well as testing and job application criteria.

Many of these programs approach training in cultural competence and medical interpretation with the same seriousness as training in other essential clinical skills.

◆ **Institutionalize Cultural Competence**

Nominated programs made several suggestions for institutionalizing cultural competence in a health delivery system. These include: 1) making it an integral part of strategic planning at all levels; 2) making staffing and activities for cultural competence an integral piece of a sustainable funding stream; and 3) designing cultural competence activities with replicability in mind (both for other cultural groups and for other health care programs).

Critical to the long-term survival of culturally competent service delivery is sustainable funding for staff, training and other essential activities. Of all of the goals, this may be the most difficult to achieve. Some of the nominated programs demonstrated how they have moved toward more sustainable funding for culturally competent services.

Cultural Competence and Managed Care

The potential for collaboration between managed care organizations (MCOs) and HRSA grantees, especially around issues of cultural competence, is great. Many MCOs are now serving culturally diverse, underserved populations since Medicaid beneficiaries are being enrolled in MCOs. Many HRSA service delivery grantees have traditionally served culturally diverse, underserved populations; and thus, have a range of creative and successful practices for serving those populations. Therefore, it is a natural fit for HRSA grantees to develop relationships with MCOs to continue to serve these populations. Two-thirds of the grantees who submitted nominations described a relationship between managed care and their culturally competent activities.

HRSA grantees are attractive to many MCOs because of their long-standing and well-developed expertise with services that enable culturally and linguistically diverse populations to better utilize medical care or social services. These services frequently include interpretation, translated written materials, transportation, and child care assistance for clients.

Another successful point of interface between HRSA grantees and MCOs is where grantee organizations with long-standing links to the community and culturally competent programs are able to use those strengths as a bridge to managed care providers or systems

Some HRSA grantee nominees reported success in their efforts to collect the kind of data necessary to show that culturally competent care is worth the investment. However, proving the value of programs is often not enough to secure long-term financial support. Third party reimbursement is an important future key, although reimbursement rates provided by commercial insurers are not always adequate to meet costs of their specialized services.

One of the greatest challenges for HRSA grantee programs that provide culturally competent services is finding the means to sustain those cultural services. Recent trends have led to shifting funding streams or diversifying the funding base in an effort to become part of Medicaid managed care systems. Seeking opportunities to collaborate with others or to participate in managed care arrangements may be viable options for many programs.

INTRODUCTION

Cultural Diversity and Cultural Competence

As the United States grows in diversity, both in rural and urban areas, health care providers are increasingly challenged to understand and address the linguistic and cultural needs of a diverse clientele. The Health Resources and Services Administration [HRSA] has had a long-standing and particular interest in cultural competence because so many of its grantees provide care to traditionally underserved populations that include culturally and linguistically diverse communities.

Currently, there are as many definitions of cultural competence being used as there are programs exemplifying the practice. The following is a useful comprehensive definition.¹

Cultural and linguistic competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”

Cultural competence within the ... health system requires:²

- **Care** that is given with an understanding of and respect for the patient’s health-related beliefs and cultural values; [that] takes into account disease prevalence and treatment outcomes specific to different populations; and [that incorporates] the active participation of community members and consumers.
- **Staff** who respect [the] health-related beliefs, interpersonal styles, and attitudes and behaviors of the individuals, families, and communities they serve.
- **Administrative, management, clinical, and organizational** assessment and processes that ensure a uniform and consistent response by all staff in every policy, procedure, and interaction.
- **Recruitment, retention, and training** of staff who reflect and respond to the values and demographics of the communities served.

¹ Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda (1999), www.omhrc.gov/clas, p. 14.

² "Health Care Rx: Access for All", The President's Initiative on Race, U.S. Department of Health and Human Services, Health Resources and Service Administration, 1999, p. 17.

Culturally competent health care not only can contribute to better health outcomes and more satisfied patients, it can also be cost efficient. The following features underlie its effectiveness³:

- It allows the provider to obtain more specific and complete information to make a more appropriate diagnosis.
- It facilitates the development of treatment plans that are followed by the patient and supported by the family.
- It reduces delays in seeking care and allows for more use of health services.
- It enhances overall communication and the clinical interaction between provider and patient.
- It enhances the compatibility between Western health practices and traditional cultural health practices.

Many health care providers, and especially HRSA grantees, have developed creative and successful programs to address the needs of underserved, culturally diverse communities, including interpreter services, cultural competence training for staff, targeted outreach programs, and other culturally appropriate interventions. As more underserved populations are incorporated into managed care arrangements, these culturally competent practices may make HRSA grantees attractive partners to managed care organizations.

Cultural Competence Works

HRSA's Center for Health Services Financing and Managed Care sponsored the Cultural Competence Works competition, a nationwide search to recognize and honor outstanding HRSA-funded programs and to highlight the practices they employ to provide culturally competent care for diverse populations.

In the fall of 1998, all HRSA service delivery grantees (approximately 5,000 total) were sent a Call for Nominations. Grantees were invited to nominate their programs in one of the following three categories:

Category 1: An organization serving a diverse multicultural clientele that integrates cultural competence into all aspects of its program.

Category 2: An organization primarily serving a specific ethnic group (i.e., Latino, Asian Pacific/Islander) that integrates cultural competence

³ "Health Care Rx: Access for All", The President's Initiative on Race, U.S. Department of Health and Human Services, Health Resources and Services Administration, 1999, p.18.

into all aspects of its program.

Category 3: An organization with a specific program or intervention that enhances the ability of culturally diverse clientele to access or benefit from health-care and related supportive services.

Nominees were asked to describe culturally competent project or program activities as they related to four broad areas:

- ◆ Consumer and Community Responsiveness
- ◆ Quality of Culturally Competent Methods
- ◆ Collaborative Relationships
- ◆ Sustainability/Replicability

Nominees were also asked to describe in detail specific aspects of their programs from a list of possibilities provided. (The complete list is provided in Appendix C: Call for Nominations). Overall, programs were sought that could demonstrate:

- ◆ Quality in the design, implementation, and maintenance of culturally competent practices; and
- ◆ Responsiveness to community needs and community/client participation in program planning and implementation.

There was particular interest in applicants that had used culturally competent programs to enhance or attract collaborative relationships or participation in a managed care system.

Summary of the Nominations Review Process

In the process of reviewing the nomination packages, it was discovered that the suggested criteria themselves, while perhaps representing a comprehensive description of a range of “culturally competent practices,” did not realistically represent how grantees characterized their efforts to serve diverse populations. The criteria suggest a systematic, linear, analytical approach to cultural competence when, in reality, many activities grew organically out of the expressed needs of the community served.

A truly culturally competent organization doesn’t “pass the test” when it can check off a list of specific criteria. Cultural competence implies the ability to choose what is appropriate for each community from a universe of possibilities. It is always adapting and reinventing itself according to the changing environment

(including demographics, socio-economics, literacy levels, and acculturation), and the expressed needs of its surrounding community.

The purpose of the Cultural Competence Works competition was not to identify “best” or “model” practices. “Best” practice implies a consensus about what is best, as well as an accepted body of competitive criteria with which to judge these practices. So rather than depend upon a numeric scale based on quantified indicators to compare candidates, the Cultural Competence Works team created an assessment tool that reflected a qualitative analysis of a wide variety of cultural competence practices as described by the nominated programs.

It should be noted, therefore, that neither the analysis nor the criteria have been formally vetted or approved by any national consensus body, although they were reviewed by the project Technical Advisory Committee (TAC), composed of HRSA officials. Also, the sample size that responded to the call was relatively small (37 self-nominations were received), and did not include a number of organizations or programs that are widely known for their culturally competent practices. However, these 37 nominations did represent significant geographic diversity, as well as diversity of program types. While a brief description of the Nominations Review Process is provided below, a complete description of this process is provided in Appendix D.

Upon receipt of nominations, any identifying information was deleted or obscured so that two reviewers could judge nominations anonymously. After both reviewed all nominations, scoring was compared and cross-checked, and 20 of the 37 nominees were chosen as semi-finalists. Telephone discussions of approximately one hour each were then held with program representatives of each semi-finalist to clarify or provide any details not covered in the nomination. The reviewers reconvened to consider which nominees would be recommended for consideration to the TAC. A brief summary of each program was presented to the TAC, which then gave the final recommendations for three types of recognition:

- ◆ Awards of Excellence
- ◆ Certificates of Recognition
- ◆ Programs of Note

On January 10, 2000, the Cultural Competence Works Awards Ceremony was held in Rockville, Maryland, to honor the nine winners of Awards of Excellence.

About this Publication

Rather than document each nominee’s individual practices, this publication provides a summary of culturally competent practices as reported in the program nominations and follow-up discussions with program personnel. (Unless otherwise noted, quotations are from the program’s nomination.) The examples

included are meant to illustrate the range of culturally competent methods and practices that nominees have implemented in order to enhance their ability to serve linguistically and culturally diverse populations. Where appropriate, nominees also describe the impact that these services have had on their relationships with managed care organizations. Again, the cultural competence practices described here are seen as “exemplary practices,” rather than “best” or “model” practices.

The appendices include program abstracts and contact information for the nominations selected for recognition (Appendix A), and a brief list of resources on both cultural competence and managed care (Appendix B).

SUCCESSFUL PRACTICES IN DELIVERING CULTURALLY COMPETENT CARE

The nominated programs honored by HRSA, and summarized in Appendix A, offer numerous examples of policies and practices used to ensure that services reach and are used by diverse clientele. Many of the practices are common to a number of programs, a few are unique, but all are instructive in presenting strategies that increase the likelihood of clients' receiving culturally competent care and services.

Overall, the nominated programs that most successfully provide culturally competent services tend to: 1) define culture broadly; 2) value clients' cultural beliefs; 3) recognize complexity in language interpretation; 4) facilitate learning between providers and communities; 5) involve the community in defining and addressing service needs; 6) collaborate with other agencies; 7) professionalize staff hiring and training; and 8) institutionalize cultural competence. Each of these practices will be discussed in turn in this chapter.

◆ Define Culture Broadly

Most people understand culture in its broadest sense, and usually interpret it as something that characterizes distinct groups. This interpretation uses race and language as the primary recognizable markers of group membership, and results in the use of categories such as those used by the Census Bureau (e.g., Hispanic, African American, Asian American and Pacific Islanders, American Indian and Alaskan Native). People have also come to recognize the diversity of ethnicity within these broad definitions (hence such national/political designations as Chinese Americans, Cuban Americans, or Lakota).

But health care is generally dispensed to individuals, and there are other characteristics in addition to race, language, and ethnicity that contribute to a person's sense of self in relation to others. These may be more specific or more general cultural subcategories based on shared attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, occupation, or homelessness).

Cultural competence is believed to include not only patients who are members of racial/ethnic minority groups; but also patients who are poor, and are disenfranchised from mainstream society in a "culture of poverty". This includes patients who may be mentally ill, homeless, dependent on alcohol or other drugs, jail inmates, veterans, and victims of domestic violence.

**-Family Healthcare Center
Fargo, ND**

It is the convergence of multiple memberships in various cultural and subcultural groups that contribute to an individual's personal identity and sense of their own 'culture.' Understanding how these factors affect how a person seeks and uses medical care, as well as their culture group's historical relationship to the medical establishment, is an integral part of providing culturally competent care.

For many of the nominated programs, employing this broad understanding of culture has enhanced program success. **Project Street Beat**, an HIV outreach program of **Planned Parenthood of New York City, Inc.**, works with homeless

Knowing that sexual subcultures exist within racial and ethnic cultures is essential to HIV preventive case management on the street.

**-Project Street Beat
New York, NY**

individuals or individuals primarily living on the streets. Although language and race/ethnicity are essential considerations when designing and staffing a program to reach a multiethnic and multilingual population, understanding the behaviors, vocabulary, and environment of New York City's 'street culture' are important as well. One element this project finds important in the design and delivery of services is the degree to which a cash economy is absent among these highly impoverished individuals. "Sex is the currency in the drug economy of the street. Therefore, understanding the culture of substance abuse combined with the culture of transsexual/transgender commercial sex workers gives **Project Street Beat** providers a

context, as well as a perspective, from which to understand the needs and barriers of clients to prevent HIV transmission."

Migrant Health Services of Community Health of South Dade, Inc., used an understanding of gender relationships in their target community of migrant farmworkers to develop a program, funded by the Robert Wood Johnson Foundation, to decrease the social and cultural barriers to maternal and child health and increase male health care access. As they explained in their nomination, "[t]his program hired and trained six male farmworkers to do outreach and teach male farmworkers about family planning and reproductive health...the program had three components: outreach, education, and evening clinics. Those components worked well, and the program made significant progress in the area of family planning and male access to health services." They saw a 54% increase in one year in women who reported "feeling more freedom to seek those services..." and a 110% increase in "the number of males seeking health care from 1995 to 1997. ...[P]erhaps the most indicative sign of the success of this program was the fathers' involvement in the children's health care. While before the program, farmworker males used to bring their wives and children to the health center and wait in their car at the parking lot, now some male farmworkers are bringing their children alone to the center for health care."

One nominated program, **Betances Health Unit, Inc.**, identifies two types of cultural competence. One type is called “indigenous cultural competence,” which means one’s cultural knowledge is possessed as a result of “birth and life experience,” while the other type, “acquired competence,” is learned, with “varying levels of language and socio-cultural proficiency.” As explained in their nomination, **Betances** values both varieties of competence, and draws on a combination of these competencies within their staff to “enhance...peer-to-peer dialogue on culture within the context of in-service training sessions...and in departmental service pods that provide forums for problem-solving regarding clinic operations. The cultural context of patient needs and service barriers are inherent features of the dialogue.”

Cultural competence is demonstrated not only by a broad knowledge of cultural groups represented, but also through a wealth of practical, experience-based knowledge about the community being served. Sometimes what may appear to be insignificant details about a community can actually be life-saving information (see box).

When South Cove providers advise parents to give cough syrup to their children, they must remember that Chinese ‘teaspoons’ are generally much larger than American ones. Without this information, many children would be dangerously over-medicated.

**-South Cove Community Health Center
Boston, MA**

◆ Value Clients’ Cultural Beliefs

Another way in which cultural competence is demonstrated is the extent to which a program is able to learn about and value its target community’s knowledge, attitudes and beliefs about health care. Competence is also reflected in the extent to which that information is applied to program areas to improve access to and quality of care while respecting cultural health beliefs and practices.

In order to effectively communicate with clients, providers need to understand how to talk about sensitive issues such as sexuality, drug use, and personal violence, among others. Just as importantly, the provider must learn how not to react negatively when client responses differ from one’s own belief system. One excellent example came from **The Perinatal Program: A Community Health Worker Model of La Clinica del Cariño Family Health Center, Inc.** Margie Dogotch, Perinatal Nurse Case Manager, explains, “...in Hispanic culture..., there’s a strong belief about a fallen fontanel, the soft spot, when a baby’s soft spot is sunken, or low around the hole in the skull, that’s a bad thing, so they will hold the baby upside down by the feet and shake it a little so the hole fills back up. Medically, the Western belief is that it is sunken from dehydration. Mind you, it’s not a strong shake, you just turn the baby upside down, then turn it back up again. So we don’t blow that tradition off, we say, ‘what have you done so far,

ok, you held the baby upside down, good, you need to do that, but you also need to give the baby lots of water, or breast milk, or formula. So every time you see this, do the holding upside down, but also make sure the baby gets lots of liquids.’ That’s the value of the information from the community being integrated into medical care. We honor and respect their beliefs and traditions, and the children are also being attended to medically.”

In another example, an attending nurse may request that a women take a post-partum shower, whereas taking a shower is not acceptable for those following Chinese traditions. Staff at **South Cove Community Health Center** are often called upon in just such a situation to work with the nurse and patient to find a compromise. Similarly, for their **BRIDGES Project**, the **Asian/Pacific Islander Coalition on HIV/AIDS (APICHA)** hired a consultant trained in both Chinese and Western medicine to help close this cultural gap. Many nominated programs indicated they are now making traditional healers and services available to clients on request.

Each year, or when new or remodeled facilities are opened, a traditional blessing ceremony conducted by Native American healers is included in the dedication. A staff position is dedicated to the needs of Native American clients, and assists in all aspects of care planning, as well as providing training to staff and outside agencies about specific cultural needs of Native Americans.

**-Maricopa Multicultural Program
Phoenix, AZ**

Understanding that some very basic concepts differ from one group to another is an integral part of the process of providing culturally competent care. In 1994, for example, the **Community Health Education Center (CHEC)** of the **Massachusetts Department of Public Health** produced an award-winning brochure on domestic violence created by a group of clients. Lisette Blondet, **CHEC**’s Director, describes the process as “one of the most invigorating, rewarding professional experiences I ever had. It was a very mixed group, I think we had two Latinas, two Haitians, three African American women and one Puerto Rican woman...the beautiful part was that we spent one whole session discussing

domestic violence in cultural terms. They decided that domestic violence is usually seen as an absolute term, but in some cultures what may be domestic violence is not domestic violence in another culture. So we had to go back to, ‘what are the essential ingredients of domestic violence, what has to occur across cultures for a situation to be violence?’ The group concluded if you are afraid of your man, you are being abused. So fear, at the core, is the element of domestic violence that transcends culture. There was resistance to a homogenous definition of domestic violence, but we were able to come up with a core ingredient that’s applied differently in different cultures. Once we were able to identify the root itself, we were also able to pick the different trees that can come out from that root. The brochure shows three vignettes of domestic

violence (physical/sexual, mental, and emotional abuse), while incorporating issues relevant to immigration, family dynamics, and internalization of abuse.”

But understanding the target community’s health beliefs and delivering culturally appropriate services does not always mean there is a direct relationship between those belief systems and the services provided. ***The Church Avenue Merchants Block Association (CAMBA)***, for example, offers acupuncture treatment to their clients with HIV and AIDS. As their nomination explains, “Many individuals we work with are accustomed to traditional folk medicine as an adjunct or substitute for Western-style treatments--many families in these Caribbean island nations rely upon herbs for a wide variety of ailments--the enthusiastic reaction to acupuncture seems to resonate with clients yearning for something old fashioned and a reminder of home. Ironically, acupuncture is not something they grew up with, however, it is a non-western philosophy and therefore consistent with their indigenous, holistic approaches to health care. Moreover, acupuncture seems to help people heal from the ‘inside out,’ in a way that is similar to herbal medicine.”

In many cases, however, it is not only cultural competence, but also the provider’s willingness to explore the individual life experiences of a client to find the underlying causes of their behaviors, which may not be readily apparent. For example, Laura Trejo of the ***Latino Alzheimer’s Project*** described a client who consistently failed to register for Social Security benefits. After eliminating the possibility of language or transportation problems, program staff finally determined through further discussions with the woman that there was an armed guard at the Social Security office, and “he’s asking for papers at the door, and they might take them.” In her experience in Latin America, relatives had entered government buildings with armed guards, never to return. A care advocate with the program spoke with her and accompanied her to the Social Security Office where the client entered the building “under the condition that [the guard] wouldn’t ask to see anything and...wouldn’t lock the door behind her.”

◆ **Recognize Complexity in Language Interpretation**

In the experiences of the nominated programs, being able to speak a client’s language is essential, but it does not always guarantee effective communication between the client and the provider. That is, communication is more than simply shared language; it must also include a shared understanding, and a shared context, as well.

As explained by several nominated programs, there are three overarching concepts to consider when providing culturally and linguistically appropriate health care:

- ◆ Recognizing the linguistic variation within a cultural group;
- ◆ Recognizing the cultural variation within a language group; and
- ◆ Recognizing the variation in literacy levels in all language groups.

Similarly, when contracting for needed language services, providers must understand the difference among services. To illustrate:

- ◆ **TRANSLATION** refers to the written word, indicating materials written in one language are translated into another. When casually or improperly performed, this strategy can result in misuse of some terms or misunderstanding of contextual information in the new language. Some projects therefore had their materials developed and written in the client language so that all of the context and nuances of the message are retained.
- ◆ **INTERPRETATION** refers to the spoken word, indicating a conversation between two speakers is interpreted from one language into another by a third party (this includes sign language). Several programs described the difficulties encountered using a client's family members to interpret. For example, family members were frequently unwilling to give bad medical news to a relative, or to ask personal questions, or to relay embarrassing responses back to the provider. Some providers discussed difficulties encountered in relying upon bilingual staff for ongoing interpretation: they were not always available; there were not enough bilingual staff to fill this need; or time spent on interpretation took them away from their own duties.
- ◆ **MEDICAL INTERPRETATION** is the ability to interpret the spoken conversation between provider and client within the medical context, with a specific emphasis on the ability to use and explain medical terms in both languages. Several nominated programs utilized trained medical interpreters; some had full-time trained medical interpreters on site; a few actually had training in medical interpretation.

For programs that are dependent on using bilingual staff to serve interpretation needs due to budgetary and/or staffing constraints, **Vista Community Clinic's Medical Interpretation and Cultural Competence (MICC)** program trains community clinic support staff on how to improve their linguistic capabilities, become capable interpreters, and increase their knowledge of cultural practices in order to enhance the overall quality of health care. Training is also provided for medical providers and for health care agencies, such as home health and hospice organizations, hospitals, nursing homes, and mental health and social

service agencies. Continuing education credits are offered to licensed medical staff who complete the training program.

Because not all programs can afford to hire full-time staff, most need to use multiple strategies to meet their needs. Contracting with the commercial telephone interpreter services, though somewhat costly, has been very useful to smaller programs, especially those who have seen a rapid increase in the number of languages spoken by new clients. Other programs, recognizing a larger need, were proactive in creating interpreting services where none existed before.

Many programs, particularly those providing health care and services to migrant and seasonal farmworker communities, address not only language and race/ethnicity, but also literacy, since some individuals may not be literate in their native language. The nomination for *La Clinica's Perinatal Program* described how, "[a]s a result of a community survey we conducted to assess the literacy level of our immigrant patients, all program materials are designed or revised accordingly. Our Health Promotion Director, a Washington [state]-certified medical interpreter as well as a respected presenter on health education for adults with limited literacy, now screens and modifies whatever is given in writing to patients and helps train every new staff member in appropriate oral communications. Periodic inservices on cultural norms relating to patient education and communications are [also] shared with staff members."

◆ Facilitate Learning Between Providers and Communities

Creating environments where learning can occur is crucial to improving the health of both individuals and communities. Health care providers need to learn more about the cultural context, the knowledge, beliefs, and attitudes of the communities they serve, and communities need to learn more about how the health care delivery system works. Both need to learn how the collaboration of providers and communities will improve access to and quality of care through improved cultural competence.

Several nominated programs have made concerted efforts to create and sustain a "learning loop" between their providers and their client community. Perhaps the best example is *Parents Helping Parents'* program, *Managed Care Health Plans: Introducing Family-Centered Care*, which itself arose out of the need for the parents of special needs children to educate providers. The culmination of this effort has been the institutionalization of the learning loop by the sponsoring health maintenance organization (HMO). The program requires providers to attend a professional training taught by both parents and professionals that focuses on the principles of family-centered care, family/professional collaboration, and cultural competence.

APICHA's BRIDGES Project conducted focus groups with their own staff of bilingual peer advocates to learn from their expertise about the local community. In the process, they also learned that these staff members needed better support for their work from within the system, such as more mentoring by their supervisors, more opportunities to discuss their experiences or get advice on particularly difficult cases, and the chance to receive ongoing encouragement and support from the program.

Center staff recently participated in a mock drug study during which they took candy placebos on a typical drug schedule [in imitation of complex antiretroviral and protease inhibitor regimens]. The difficulties staff encountered in adhering to these difficult regimes enlightened staff on client barriers to medication compliance.

**-Comprehensive Family AIDS Project
Ft. Lauderdale, FL**

In some cases, cultural competence is also a matter of understanding that a program's collaborating agencies and organizations are groups that have culture, too - organizational culture. Laura Trejo, of the ***El Portal: Latino Alzheimer's Project***, explained that some of the agencies they work with "found it difficult to accept our feedback because it was critical in nature...you see, their culture said, 'if I treat you wrong, you'll take my money away.' So...our lead agency explained they try not to punish people for learning. They

need to feel safe in the learning, but they wanted it in writing on letterhead that we weren't going to disallow their money. We don't know where it came from, but it's part of how they do business, if something looks, not perfect, it's an affront to the contract. So we had to teach them it's OK to say 'I don't know,' to take risks in trying things, to allow staff to try things beyond what other staff might be doing."

One way that many of the programs incorporate "indigenous cultural competence" is through the employment of community members as providers, support staff, community outreach workers, and community health workers. Using peer advocates as outreach and education staff can be an advantage when these staff have life experiences or conditions similar to those of the targeted community. Examples include peer advocates living with HIV, managing diabetes, recovering from substance or alcohol dependence, or experiencing teenage parenthood. The Outreach Director of ***Project Street Beat*** describes the benefits provided by intensive training of former clients of the program as peer advocates as follows: "Based on the fact that they have similar experiences [as potential clients] and can talk about them, those connections inspire and motivate...." The Associate Vice President for Clinical Services of the same program explains: "Our staff includes peer educators who were actually clients of ***Project Street Beat***; we trained them, we gave them outreach training and HIV training, pre/post test training. Our outreach workers are more outreach assistants; they provide street case management services, like crisis intervention

services to clients...[T]hey were recruited from clients to staff...now they're on our Consumer Advisory Board, and are actively participating in groups.”

◆ **Involve the Community in Defining and Addressing Service Needs**

Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. Programs that are truly culturally competent involve clients and community members in identifying community needs, assets, and barriers, and in creating appropriate program responses. In this approach, clients and community members play an active role in needs assessment, program development, implementation, and evaluation. Some organizations institutionalize this relationship by making individuals from the community voting members of their governing boards. Others facilitate input and recommendations by using community advisory boards, client panels, task forces, or town meetings. Still others sponsor locally based community research (interviews, focus groups, etc), and integrate the results into program design.

Some programs integrate clients and community members into programs by using volunteers from the target community in a variety of program areas, serving as peer advocates who help new clients negotiate the system. The extent to which clients and the community are involved is particularly evident in the level of leadership shown by clients and community members. ***The Comprehensive Family AIDS Project***, for example, has many active clients participating as peer educators or consumer advocates. There is a high participation rate by clients, who often take charge of project events as well. “There is no staff involved except for the fact that we give them money.” said Marie Brown, Project Manager. She also explained when the yearly “Back to School Bucks” event (in which client families receive vouchers for donated school clothes) was almost cancelled, the clients took over organizing and operating the entire event. “They called organizations to get donations, they picked them up, washed and ironed, sent invitations, they ran the event, and it was the best event... it was the most committed I had ever seen them... everybody stayed late, there was a great sense of community, like we were a big family working together and this was an event they had done completely by themselves.” The job referral network that the project currently operates also grew out of a need which was both recognized and addressed by clients on their own.

In addition to having community members on boards of directors, community advisory boards, and participating in focus groups, most of the nominated programs make efforts to hire individuals from the community or from similar cultural, economic, and linguistic backgrounds as community members. Programs hire office staff, community health workers, outreach workers, and all levels of nursing and provider staff, as well as providing residency and training

opportunities for minority providers. Community members serving in any of the above capacities may provide direct services, act as cultural brokers, facilitators, and interpreters between staff and clients, and serve as resources for training other staff.

Many programs also find it advantageous to employ bilingual/bicultural people from the local community in project positions (as office staff, for example), both to facilitate communication and to help make clients comfortable by being able to interact with another member of their own community. Still others are able to

[W]e offer extensive training to bring talented, capable, eager women [from the community] into the workforce where they receive competitive wages and fringe benefits, such as health and life insurance, paid vacations and retirement funds. A number of staff members have confided that they had never worked at jobs that offer these benefits.

**-Buffalo Prenatal Perinatal Task Force
Buffalo, NY**

incorporate community members into the health care delivery system by using a community health worker model. This is a particularly effective way of bridging the gap between the service delivery system and the community, because community health workers can serve as intermediaries, relaying the community's concerns to the program, and educating the community on health concerns through their own value system (see *The Liaison Role*, next section).

When planning to meet the health needs of a community, most nominated programs examine morbidity and mortality data available for their population or for similar populations. Several programs are also active in establishing their own baseline data for the specific local populations that they serve to be compared with similar populations elsewhere or, in some cases, to collect baseline and intervention data for populations for which the data are scarce or nonexistent. For example, “[g]iven the prevalence of diabetes mellitus among Asian immigrants...**South Cove Community Health Center** and Joslin Diabetes Center established the Diabetes Service and Research Project, which has identified diabetic patients, helped control their diabetes, and provided original data about the diabetes within this population.”

A number of programs use intake databases to ensure that client cultural, linguistic, and personal background information is documented and considered in designing care. For example, the **Multicultural Program** of the **Maricopa Integrated Health System** uses “a computerized intake program...which captures language, ethnicity, nationality data used for program management. Treatment plans, including discharge planning and follow-up include cultural needs and involve the patient and family. The Indian Health Liaison uses specifically developed forms for discharge which includes family, tribe, language, spiritual practitioner, native medicines, [and] transportation needs.”

◆ Collaborate with Other Agencies

A number of the program nominees have been proactive in their communities to expand culturally competent services by combining forces with other local agencies and organizations. When the **Family Healthcare Center (FHC)** in Fargo, North Dakota, began to serve a large new and diverse refugee community, **FHC** was a catalyst in the development of a medical interpretation training and provision program. The interpretation program is now operated independently, with many agencies and organizations using its services. Developing such a service in an area whose population previously consisted of a large Scandinavian American population and smaller American Indian and Spanish-speaking migrant farmworker populations has allowed local agencies to build an infrastructure that can adapt to and serve the many new refugees resettling in the area.

Similarly, when **Migrant Health Services of Community Health of South Dade, Inc.** saw an increasing number of Mixteca (a native Indian tribe of Mexico) clients, they worked with the Mexican Consulate to create an educational program to help providers understand this newly arrived ethnic group. A Mexican teacher provided three weeks of language training and a full day workshop about the Mixteca culture to the program staff and 18 partner agencies, including law enforcement, churches, education, and social services providers. In North Carolina, in order to meet the need for Spanish-speaking interpreters across a large geographic area, **Tri-County Community Health Center** initiated a statewide telephone interpreter program, thereby creating a resource and infrastructure support mechanism not previously available. As they explained in their nomination, “[i]n some areas of the State the low number of Spanish-only speaking clients some clinics see make it not feasible to hire a translator and/or the availability of a qualified translator is extremely limited. Our interpretation service provides medical translation via an 800 number for approximately 300 medical providers each month who have someone in their office that is in need of translation to complete the provision of medical care. This service is funded through a grant and is provided free of charge to the medical provider and the client. Translation is provided by a native speaker who has also undergone a professional interpreter training.”

Two of the programs have built strong collaborative relationships with medical school residency programs, and described the benefits of these arrangements in staffing to the provision of culturally competent care. The **Family Healthcare Center (FHC)** in Fargo, North Dakota (a program serving migrant and seasonal farmworkers, American Indians, local low-income descendants of Scandinavian immigrants and a large number of recent refugees from all over the world), notes, “[Our] strongest collaborative relationship... is with the family practice residency program. The **FHC** contracts with an area medical school to serve as the ambulatory care clinic for family practice residents during their three years of residency training...The residency actively recruits minority residents, including Native American, East Indian, Russian, South American, and Asian residents. This [FHC] residency collaboration enables family practice residents to train in a culturally diverse environment, which will better prepare them for a culturally competent practice in family medicine.”

The **South East Asian Community Clinic (SEACC)** in Chelsea, Massachusetts, provides psychiatric, psychological and support services to “severely traumatized, seriously ill Southeast Asian refugees who are survivors of war trauma, genocide, or political terrorism.” Their nomination describes how **SEACC** “maximizes limited funding by integrating a subsidized residency training program into clinic services and community agencies providing training and consultation to both. This model enhances the competence of all components...psychiatry residents get excellent training, clinic and community agency staffs receive additional training lifting them to a higher level of functioning, and the clients receive superior care. An additional advantage is that the model is a powerful recruitment tool; a major benefit since recruiting culturally competent staff is particularly difficult.”

Our relationship with the key provider of [HIV] case management services in the city...provides our clients with access to a broad range of...services...[that are provided] on site at the HIV clinic at...[a] health center which we manage...

Additionally, the HIV case management agency contracts with us to conduct a primary health clinic at their site 5 days a week, as well as provide their clients with...dental services... This relationship provides the two agencies’ clients with timely access to needed clinical and support services and avoid lengthy waits at the city’s only public hospital.

**-Mercy Mobile Health Care
Atlanta, GA**

◆ Professionalize Staff Hiring and Training

Many of the nominated programs suggested ways to professionalize hiring and training practices. Among these are:

- ◆ Establishing specific hiring qualifications and mandated training requirements for all staff in language, medical interpretation, and cultural competence as their positions necessitate;
- ◆ Producing a comprehensive and replicable training curriculum and qualifying factors; and
- ◆ Allocating the budget and time for staff training including training for new staff, annual updates and review, as well as testing and job application criteria.

In other words, many of these programs approach training in cultural competence and medical interpretation with the same seriousness as training in other essential clinical skills.

While a number of programs provide needed training for themselves, some, such as **Family Healthcare Center**, have been instrumental in setting up training facilities in their area and make use of them for their own staff, as well as for training of other organizations. Two of the nominated programs are themselves training facilities: **Community Health Education Center (CHEC)** in Boston and **Vista Community Clinic's Medical Interpreter and Cultural Competence Program** in San Diego.

The **Community Health Education Center (CHEC)** of the **Massachusetts Department of Public Health** in Boston, provides ongoing training and professional development opportunities to outreach educators through a Comprehensive Outreach Education Certificate Program (COER). Sessions include leadership development, assessment techniques, cultural competence, public health, outreach methods, cross-cultural communication, and design of educational materials. Their model, which is slated to be replicated statewide, utilizes regional training centers, to which they add localized knowledge and training.

Many programs have included cultural competence (and in some instances interpretation) as part of job descriptions and employee performance measures. For example, **The Rainbow Center for Women, Adolescents, Children and Families**, in Jacksonville, Florida, has an annual cultural competence training session for all staff members and participation is part of routine employee review plans. Staff (and community representatives) also participate in an annual strategic planning session where the organization's operational plan is reviewed and revised to meet the needs of the community served.

A number of nominated programs emphasize the importance of using training curricula that can be customized to the issues of specific cultures and communities, as well as including more generally applicable cultural competence and medical interpretation models. Models that stress the importance of learning about individuals and communities can guide staff in appropriate ways to approach cultural and linguistic differences in multiple communities. These learning-based models of cultural competence can easily be enhanced to include community- and culture-specific knowledge and can also be adapted to new populations. This is particularly important because none of the nominated programs serves a single cultural or language group. Programs are constantly working to find strategies to understand the needs of and ensure quality service to new cultural groups or emerging populations. According to a number of nominees, the most culturally appropriate programs are community-specific rather than ethnic group general; that is, what is appropriate for an Hispanic population in New York City may not be for an Hispanic population in Dallas.

Several nominated programs, like the **Sunset Park Family Health Center Network** (see box), have realized that they need to make more professional training available for their interpretive staff. Jim Stiles, Executive Director of the Sunset Park Family Health Center Network, further described their experience: "We started with a training program that was similar to others where health organizations take seriously the need to use trained interpreters, not just any

bilingual person. We're slowly working through our bilingual staff and putting them through a 48-hour training, which is a serious time commitment. We trained 22 staff the first time, staff who spoke Spanish or Cantonese. We're now in our second training, which is mostly those who speak Arabic and Spanish. This summer, we'll have a class with Spanish and Russian-speaking staff. So they're really getting skills, even though they were getting the job done all along, but it's very different, they have duties both as a medical assistant and as an interpreter and no one ever recognized how difficult that is for them before. So we help them

Before, we just hired Spanish- or Cantonese-speaking people on staff, and thought, well, they'll do the translation. Most health professionals make that assumption...we soon realized how incredibly wrong we were...[B]ut at that time, there was no such thing as a certified medical interpreter, only a few available locally, and they were not recognized as needed in the health profession.

**-Jim Stiles
Sunset Park Family Health Center Network
Brooklyn, NY**

improve their medical terminology, and how to understand the dynamics of the triadic relationship."

◆ Institutionalize Cultural Competence

Nominated programs made several suggestions for institutionalizing cultural competence in a health delivery system: 1) make it an integral part of strategic planning at all levels; 2) make staffing and activities for cultural competence an integral piece of a sustainable funding stream; and 3) design cultural competence activities with replicability in mind (both for other cultural groups and for other health care programs).

Several nominated programs have managed to vertically integrate cultural competence by incorporating it in all planning, goals, and protocols at all levels of the agency. Using this approach, management is not only aware of, but committed to and responsible for this integration. Joseph Wahl, of the **Multnomah County Health Department**, described their process: “We wanted to really talk about making quality and diversity and cultural competence part of the way we do business. Our strategy was to incorporate everything in the strategic plan, to weave it into the fabric of our operations, so we didn’t have all these separate efforts going on, but employees would see it all in one document, representing our mission, vision, values, something that says, this is about who we are and how we operate. One of the things that was the greatest step for us as an agency, was the strategic planning process. We incorporated values on diversity, cultural competence, and quality into the strategic plan...all staff can see the department is committed to achieving certain levels of quality improvement and cultural competence for everyone. We have cultural performance objective plans...for managers to help increase [their] own cultural competence, then they’re able to work on that with their teams. The strategic plan states all managers will go through an orientation...and will select objectives for their annual performance evaluation having to do with diversity and cultural competence that they will be evaluated on, so it becomes part of their performance evaluation. That’s a way of building accountability into it, and because managers are now focused on that, it’s made part of the team’s focus.”

Designing a model program that can be successfully replicated is another way of institutionalizing cultural competence in the delivery of services. **The Los Angeles Alzheimer’s Association**, for example, used funds from an Alzheimer’s Demonstration Grant to States to develop and implement **El Portal: Latino Alzheimer’s Project**. They created a model, documented the process of implementing that model, evaluated its effectiveness for the target community, and created a project protocol and replication manual. These efforts were critical if they wanted to replicate the model elsewhere with other Latino communities. But even more importantly, by viewing it as a model for culturally appropriate services, rather than a simply a model for Latino services, they were able to use their experience to create a parallel program for African-American communities.

Critical to the long-term survival of culturally competent service delivery is sustainable funding for staff, training and other essential activities. Of all of the goals, this may be the most difficult to achieve. To develop the activities and staff positions necessary to provide culturally competent care, some programs depend on funds, or a portion of funds, from specific, time-limited funding sources. In many cases, the funding can be used only for a certain initiative, such as diabetes screening, and not applied across the entire range of services their program provides. Continued funding may be dependent upon grant renewal or on constantly applying for short-term funding.

Diversity and cultural competence are historically considered the soft side of the business. We looked at combining the notion of diversity and cultural competence as part of quality, the best quality of services to clients.

-Joseph Wahl
Multnomah County Health Department
Portland, OR

Some of the nominated programs demonstrated how they have moved toward more sustainable funding for culturally competent services. For example, **Parents Helping Parents** now has their **Managed Care Health Plans: Introducing Family-Centered Care** program under contract to the large health maintenance organization with which they originally cooperated under a grant. Both **Maricopa** and **Multnomah** counties have multicultural health programs that

have successfully established permanent staff positions and include a permanent budget for activities such as planning, cultural competence training, and evaluation. Other programs providing outreach services are being contracted by States and managed care plans to conduct outreach to enroll eligible clients or explain new Medicaid managed care plans and choices to their communities.

Sunset Park Family Health Care Network noted the following in their nomination: "[M]any of the principles required to incorporate cultural competence into the organization do not require financial resources, such as customer service and on-time completion of services...Models of successful cultural competence [begin with]...the principles of patient-focused care...[which include] quality, cultural competence, patient and staff satisfaction as critical components in the overall mission and goals of the organization, which is fully supported by the governing board."

CULTURAL COMPETENCE AND MANAGED CARE

The potential for collaboration between managed care organizations (MCOs) and HRSA grantees, especially around issues of cultural competence, is great. Many MCOs are now serving culturally diverse, underserved populations since Medicaid beneficiaries are being enrolled in MCOs. Many HRSA service delivery grantees have traditionally served culturally diverse, underserved populations; and thus, have a range of creative and successful practices for serving those populations. Therefore, it is a natural fit for HRSA grantees to develop relationships with MCOs to continue to serve these populations. Two-thirds of the grantees who submitted nominations described a relationship between managed care and their culturally competent activities.

Some grantees are already actively participating in managed care networks, while others are not yet because of the lack of managed care penetration in their communities or the challenges of operating in a managed care environment, such as determining the cost of services. A few programs have seen their clientele enrolled in Medicaid managed care plans, while others have contracted with MCOs to enroll eligible clients from specific ethnic communities (***Project Street Beat of Planned Parenthood of NYC, Betances Health Unit, The Buffalo Prenatal-Perinatal Task Force, and Maricopa Integrated Health System's Multicultural Program***). Several nominated programs have recently initiated (and institutionalized) collaborative ventures with MCOs, such as ***Parents Helping Parents' Managed Care Health Plans: Introducing Family Centered Care***. Another, the ***Sunset Park Family Health Care Center Network***, co-founded a managed care organization with other community partners almost fifteen years ago.

When it comes to the intersection of cultural competence and managed care, three main issues arise: 1) developing and implementing needed programs, 2) proving the worth of those programs, and 3) securing adequate funding to sustain them.

Culturally Competent Programs that Benefit Managed Care

Providing direct care or enabling services

HRSA grantees are attractive to many MCOs because of their long-standing and well-developed expertise with services that enable culturally and linguistically diverse populations to better utilize medical care or social services. These are frequently referred to as enabling services. There are many definitions of enabling services for the area of cultural competence; they most frequently include interpretation services, translated written materials, transportation and child care assistance for clients. MCOs and State agencies contract with HRSA grantees to provide primary or specialty care services, usually because they have well-located clinical capacity in underserved areas and provide services in a

culturally competent manner, or because they have developed specific targeted interventions that have culturally competent approaches as an intrinsic part of the program design. Several examples follow.

The **BRIDGES Project** of the Asian and Pacific Islander Coalition on HIV/AIDS (APICHA) of New York City supports a Bilingual Peer Advocate program and sponsors cultural competence training at service sites. Focus groups for the project indicate that the program and its cultural competence training have improved the interaction of outside service providers with Asian and Pacific Islander immigrants with HIV disease. According to the project, “Benefits to service sites include client referrals, reliable interpretation and hence better communication with patients, and greater knowledge of [Asian and Pacific Islander] issues, and greater sensitivity to HIV-related issues such as gender roles and identity and sexual orientation. Benefits to the grantee include greater awareness of its services and, in some cases, client referrals. A major benefit is the development of stronger bonds with service providers, which will facilitate collaboration in other areas, in particular around Medicaid managed care for clients.” The Bridges Project, in collaboration with another Asian community provider, is specifically marketing a package of services to the Special Need plans that provide HIV services under New York’s Medicaid managed care program.

The **Comprehensive Family AIDS Project** of the Children’s Diagnostic and Treatment Center in Fort Lauderdale, Florida works with several managed care organizations, and is part of the Children’s Medical Services (CMS) Network. The project provides primary care to children with special health care needs, and as part of the CMS HIV Network, provides primary care to children with HIV/AIDS. “Our reputation of providing quality health care and case management has attracted the interest of [another MCO], which has requested that we provide our services to their Medicaid HIV clients. The aspects of culturally competent service delivery or expertise that were incentives for developing these partnerships are fundamentally rooted in respect for those we serve which empowers our families to become active participants in their own care.” And **South Cove Community Health Center** of Boston, is working with an MCO and a medical center with funding from the U.S. Department of Health and Human Services (HHS) Office of Minority Health, to develop “A Culturally Competent Practice within a Managed Care System,” as a model to improve access to managed care for the Asian immigrant and refugee population.

Parents Helping Parents, Inc., a consumer group of parents of children with special health care needs, collaborating with Kaiser Permanente in California, has established two hospital-based Parent-Directed Family Resource Centers (PDFRCs) as a model for introducing family-centered, culturally competent services for CSHCN in managed care facilities. The specific contributions of each partner in this collaboration are described below:

“The consumer agency is responsible for setting up the PDFRC at the managed care facility for the hiring, training, and supervision of the parent liaisons staffing this center, for planning and conducting the trainings of parents and professionals, for creating the evaluation instruments and coordinating the collection of data, and for keeping records of contacts with families and services provided. The managed care organization is responsible for providing a suitable location at the hospital site for the PDFRC, for providing appropriate signage, for providing office furniture, phone and fax lines, for allowing the use of conference rooms for trainings and the use of staff for co-training. The educational institution is available for consultation in the development of evaluation instruments and appropriate methodology for conducting the evaluations and for co-training with the consumer agency.”

This collaboration proved so successful that Kaiser Permanente decided to institutionalize the program after the grant ended. HRSA has also funded the replication of this model in two new settings.

Serving a liaison role between diverse communities and mainstream health providers

Another successful point of interface between HRSA grantees and MCOs is where grantee organizations with long-standing links to the community and culturally competent programs are able to use those strengths as a bridge to managed care providers or systems. A variety of approaches are used, including service outreach and client education using community health workers, and case management. These approaches are obviously not exclusive to cultural competence, but it appears that a combination of community trust and culturally aware materials and outreach strategies is particularly attractive to those seeking to enroll and adequately service clients in managed care systems.

The ***Church Avenue Merchants Block Association's (CAMBA)*** of Brooklyn, NY, has worked intensively with clients transitioning into Medicaid managed care through a Community Health Worker Training Program. This program trained teams of immigrant women to be peer educators on primary health care needs and on how to enroll in Medicaid managed care.

In a project funded through the HHS Office of Minority Health, the ***Sunset Park Family Health Center Network*** of Brooklyn, NY, provides technical assistance to a local Chinese community organization and community residents regarding seeking and using health care services under managed care. This includes information on choosing a plan, knowing and exercising patient rights, seeking services under managed care, and accessing preventive health care services. The Chinese-language media is utilized, as well as community events.

The **Perinatal Program of La Clinica del Cariño** in Hood River, Oregon, works directly with the Oregon Health Plan (Oregon's Medicaid managed care program), which has placed one full-time and one part-time outstationed eligibility worker at the **La Clinica del Cariño** program center. These outstationed workers work very closely with the program to ensure all patients eligible for the Oregon Health Plan are signed onto the Plan. In addition, eligibility workers work closely with the *La Clinica* program to identify patients who are ineligible for the Oregon Health Plan, but need emergency medical care which qualifies under the emergency Medicaid program. This eliminates cost as an access barrier to care.

Similarly, by utilizing Community Health Advisors, *the Maricopa Integrated Health System's Multicultural Program* has seen a growth in the number of new Hispanic clients enrolling in the health maintenance organization. **Project Street Beat**, which has managed care contracts with 15 companies, has developed materials to inform consumers about their State program, allowing women under managed care to go directly to gynecological and family planning services without first going to their primary physician.

Demonstrating the Value of Cultural Competence

On occasion, grantees are able to secure MCO partner or State funding for these educational or bridge services. For example, **La Clinica** is working with Central Oregon Independent Health Services, the region's principal Medicaid managed care plan, to demonstrate the cost-effectiveness of lay health education and case management for patients with diabetes, hypertension, and heart failure. They hope to gather cost data so that they may obtain reimbursement for such services.

“This year we were involved in a national pilot project to determine the cost/value of our enabling services -- translation, interpretation, outreach, culturally competent education, etc... We just received the preliminary results which indicate that 30 - 60% of our cost per visit is for enabling services. The perinatal program enabling costs are on the high side because of the almost universal need for interpretation, the literacy and cultural adjustment of educational programs and material, and the need for outreach and intervention. Armed with this information, we are advocating for additional funding for enabling services for Oregon Health Plan patients. The proposed State budget currently includes funding for at least some enabling services. “

Other HRSA grantee nominees reported success in their efforts to collect the kind of data necessary to show that culturally competent care is worth the investment. The Massachusetts Department of Health's **Community Health Education Center (CHEC)** demonstrated in their MOMS (Mothers, or Moms in

Recovery) Project that recruiting women to go to perinatal health services before the 3rd and 6th months of pregnancy resulted in savings on emergencies and long-term costs. This information represents a link between prevention and cost savings. “It’s a good model which shows that prevention translates long term into incredible numbers due to outreach.” **South Cove Community Health Center** in Boston has a collaborative Diabetes Service and Research Project, which has helped to identify and provide original data on diabetic patients within the Asian immigrant and refugee community for long-term tracking on health outcomes.

However, proving the value of programs is often not enough to secure long-term financial support. **La Clinica del Cariño** of Oregon notes that third party reimbursement is an important future key, although reimbursement rates provided by commercial insurers are not always adequate to meet costs of their specialized services.

Securing Adequate and Sustainable Funding

As described above, one of the greatest challenges for HRSA grantee programs that provide culturally competent services is finding the means to sustain those cultural services. Recent trends have led to shifting funding streams or diversifying the funding base in an effort to become part of Medicaid managed care systems. Seeking opportunities to collaborate with others or to participate in managed care arrangements may be viable options for many programs.

The HRSA grantees responding to the “Call for Nominations” expressed a number of concerns about the impact of shifting their traditional clients into managed care plans, clients around whom they have developed an entire approach of culturally competent service delivery. Under cost-based reimbursement, grantees that are Federally Qualified Health Centers (FQHCs) built a rich array of special services around meeting the more demanding needs of diverse and vulnerable populations. Under Medicaid managed care, grantees are attractive to MCOs precisely because of this cultural competence, and they need to participate in the managed care networks to retain their clients. Some States and MCOs do not fully recognize the cost and complexity of providing cultural competence services. Most grantees do not have other sources of funding for innovative service delivery models after demonstration grant dollars are over. Interpreter services, ongoing staff training, and document translation may be integral to the way an agency conducts business, but a stable source of funding for them is essential.

We know we’re providing valuable services; now how can we get them reimbursed?
**-La Clinica del Cariño
Hood River, OR**

Another problem faced by the grantee respondents is that their programs are key health care providers to uninsured patients who have nowhere else to go, but

can not afford to pay for their care at a level that would cover the actual costs of culturally competence services. These grantees may be able to pick up some revenue-generating insured patients from new programs like the State Children's Health Insurance Program, but the increase in numbers of uninsured clients places additional financial strain on available resources.

SouthEast Asian Community Clinic (SEACC) receives a reimbursement differential for psychiatric visits for patients requiring interpretation (\$14.50 per 30 minute session), but this does not cover the cost of bilingual/bicultural workers. **Vista Community Clinic** indicated that only FQHC reimbursement adequately covers their costs of delivering cultural competence services. A combination of Federal U.S. Department of Health and Human Services, Office of Minority Health grants, local foundations, State grants, in-kind support, and general overhead allows the organizations to provide culturally competent and interpretation services. **Maricopa Integrated Health System**, by virtue of being an MCO, "has long recognized the importance of [culturally competent] health services...and the costs are part of the overall costs of doing business." Another respondent, the **Family Health Care Center** (in Fargo, North Dakota), noted that they are considering whether they will be able to continue such services at present levels. Most of the organizations have attempted marketing to MCOs, and while MCOs are "supportive and appreciative," and "[they] like the [HRSA grantee's] training program," financial support has not been forthcoming.

La Clinica del Cariño sees hope in marketing its special approach to care delivery. "As far as the perinatal program cost center [is concerned], in the last year we pursued [maternity case management reimbursement] aggressively, whereas in the past, the perinatal program was strictly funded by grants. We're committed to maintaining services and outcomes that the program offers to patients, so as a result, we're looking at how can this program bring in money? In the past, we thought, well, we're never gonna get funding, we have to look at grants to keep the program going. Now, our whole mindframe has changed, we think, how can we generate income from this program, how can we get reimbursed ...from Medicaid... We did a cost analysis of what it costs to provide these services, and how much time, and which services we were providing, and now we're using it to try to drum up reimbursement. We know we're providing valuable services, now how can we get them reimbursed?"

SouthEast Asian Community Clinic (SEACC) had a similar experience whereby to its MCO, providing culturally competent services was "using two professionals instead of one at twice the expense." But working with the Massachusetts Behavioral Health Partnership (MBHP), an HMO Medicaid provider with which **SEACC** has a contract, SEACC bills for the services of their bilingual/bicultural workers who assist the psychiatrists in delivering mental health and substance abuse work despite the fact that these workers have no postgraduate degrees. As noted earlier, MBHP reimburses SEACC for visits

requiring the use of interpreters using a billing category for a 'complex visit.' The majority of SEACC's clients are covered under Medicaid.

Ongoing staff training in cultural competence, and the creation of translated documents may be integral to the way a culturally competent organization conducts business, but these items may constitute additional costs not covered by current reimbursement structures. Collaborating with other organizations may provide an opportunity to share resources among multiple providers.

Many of the nominated programs use community health outreach workers to bridge the cultural gap between providers and community. Because community health workers are members of the communities served, they are indigenous experts who understand and can communicate the needs of individuals and communities to mainstream health organizations.

Again, the primary challenge is funding. Some have negotiated with MCOs to cover the cost of training and other essential organizational development. The **Community Health Education Center (CHEC)** of the Massachusetts Department of Public Health, works with one of the largest managed care systems in the State, the Partners Health Care System. **CHEC** trains all the community health outreach workers for the system's six community health centers, and the MCO reimburses for the training, as well as networking lunches, a certificate program, and additional specialized training sessions.

Community Health Outreach Workers:

- ◆ Link community residents to culturally and linguistically appropriate health care and social services.
- ◆ Teach individuals and communities about health and health care.
- ◆ Educate providers about the community's health needs and priorities, cultural norms and needs for culturally competent care.

Some grantees are beginning to work out innovative payment relationships with State agencies and MCOs, or on their own as managed care plans. **Sunset Park Family Health Center Network** of Brooklyn, NY, offers an example of how one Federally Qualified Health Center has aggressively served its culturally diverse clientele and used its cultural competence services to pursue and create managed care opportunities. For the past 30 years, it has served the ethnically diverse, medically-underserved neighborhoods of Southwest Brooklyn: Latino, Chinese, Arabic, Russian, and a growing Caribbean community with 80,000 users. Executive Director Jim Stiles explains:

“Operating as a managed care network, this Network has driven cultural competence into its mission, ongoing community needs assessments, staffing, staff training and development, program

planning and analysis, quality improvement activities through the use of Report Cards which measure quality of service (access and patient satisfaction), quality of work life (staff satisfaction), quality of care (clinical indicators), and cost/efficiency. In each of these measures, we target how we can improve our patient focused care efforts using cultural competence techniques to encourage new immigrant groups to utilize primary care and community-based services to improve their quality of life.

Funding had a lot to do with our success. **Sunset Park** has been on the cutting edge of everything that came out over the years. We were one of first in the country in Medicaid managed care, Children's Health Plus, ambulatory HIV/AIDS case management, substance abuse and mental health, etc. We've always been involved in innovative programmatic or financial arrangements, which then became natural for us to do, and we were not nervous about taking risks. We go in and say even though we're doing pretty good in primary care and community-based programs for our Latino and white population, the neighborhood is radically changing, And if we can't do it ourselves, who can? So we were aggressive about forming partnerships with community-based organizations who are already working with those populations.”

And the **Multnomah County Health Department** in Portland, Oregon is negotiating with the State for a wrap-around reimbursement contract for themselves and other community and migrant health centers in Oregon that would cover more of the cost of enabling services like cultural competence. In the meantime, they praise their relationship with one of their partner MCOs. “CareOregon highly values our cultural and linguistic competence. It adds great value to their MCO operation. They have championed with us and for us the value of these services to clients, interest groups, and the State.”

CONCLUSIONS

The nominated programs are of varying sizes, serve many different populations and work with very different access to resources and staff. Their range of activities, however, illustrate practices that serve to advance them on a path towards three important goals of culturally competent delivery of health services:

- ◆ First, to permanently engage with communities being served to identify needs, to mobilize or create community resources to address those needs, and to continually reassess and redesign service delivery based on expressed needs;
- ◆ Second, to insure professional and ongoing methods of training staff and community members in both the knowledge and practices needed to develop and carry out activities, protocols, and service delivery in culturally sensitive and appropriate ways; and,
- ◆ Third, to establish cultural competence as an integral, replicable and sustainable component of the community's health care delivery system.

For many programs, collaboration with a variety of agencies and organizations, including MCOs, is increasingly important to achieving these goals. There are many challenges to collaboration, however. Concern about the sustainability of innovative programs is not exclusive to cultural competence, but it may be more difficult to resolve given the lack of widely-recognized outcome data on culturally

appropriate interventions. Collaborations with MCOs can help, but programs need to establish outcomes and prove that their culturally competent services are cost effective.

The greatest obstacle we had to overcome was the time required for the development of sufficient trust in each other...It is a process that cannot be rushed and is facilitated by open, honest communication and mutual respect for the expertise brought to the table by the other partner.

**-Managed Care Health Plans:
Introducing Family-Centered Care
Parents Helping Parents, Inc.
Santa Clara, CA**

Getting innovative and culturally appropriate interventions recognized and properly reimbursed by State payors and MCOs is especially important given the attractiveness of culturally competent programs to "non-revenue generating patients," such as those who are uninsured or ineligible (non-citizens and recent immigrants). Similarly, reimbursement for enabling services is crucial, but difficult at best, and rarely available for ineligible populations.

There is no one single formula to providing culturally competent care. In most instances, it grows out of a commitment to provide appropriate care to traditionally underserved communities. It means listening to their needs, involving them in creating solutions, and continually adapting to change. To accomplish this, nominated programs:

- ◆ Define culture broadly;
- ◆ Value clients' cultural beliefs;
- ◆ Recognize complexity in language interpretation;
- ◆ Facilitate learning between providers and communities;
- ◆ Involve the community in defining and addressing service needs;
- ◆ Collaborate with other agencies;
- ◆ Professionalize staff hiring and training; and
- ◆ Institutionalize cultural competence.

Because managed care is an increasingly prominent part of the health care environment, programs need to consider the advantages of collaborating with MCOs to provide the kind of care communities need. The benefit for HRSA grantee programs is the possibility of securing sustainable funding mechanisms for culturally competent programs. MCOs benefit by being able to provide experienced, trusted, culturally competent care for their clients.

As one of the program staff interviewed during the competition noted, "it's all about the journey." The process of integrating cultural competence into health care happens in different ways, at different levels and in different settings. It is a process that is deliberate, challenging, and full of opportunities to learn. One thing is certain, however: **cultural competence does indeed work.**

APPENDIX A

Description of Programs Included in this Publication

Awards of Excellence
Certificates of Recognition
Nominated Programs of Note

CULTURAL COMPETENCE WORKS

Award of Excellence

Community Health Education Center (CHEC)

Massachusetts Department of Public Health
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- ◆ Community health worker training provided in outreach and education.
- ◆ Locally-based knowledge and cultural competence emphasized in all training and health education materials.
- ◆ Program scheduled to be replicated statewide.
- ◆ Training costs reimbursed by managed care system.

CHEC provides training and support to 1400 outreach educators in Boston, and growing numbers throughout the state. Outreach educators, employed by community health centers, local organizations, hospitals, and government agencies, effectively deliver health education information to racially and ethnically diverse communities and make appropriate referrals. CHEC's Comprehensive Outreach Education Certificate Program (COEC), seeks to standardize the field of outreach education by providing training in core outreach education skills and competencies, as it prepares participants to deliver accurate and relevant health information to their communities. In addition to dedicating a core session of the Certificate program to raising cultural awareness, issues relative to cultural competence are addressed in every training. CHEC training is designed within the context of leadership and community development. Through partnerships with several local colleges, college credit is awarded for completion of the Certificate program. CHEC has been asked to replicate their local, community-based program with regional training centers and local advisory boards statewide.

Ongoing participatory planning with outreach educators working with culturally diverse groups inform every aspect of program design, from identifying public health issues to incorporating program components which speak to the cultural and linguistic needs of community residents. As community members, their input speaks specifically to community needs. CHEC serves as a contact point for community health workers in the area and encourages them to become resources for each other. Input from community residents through interviews and field-testing dictate the content and design, development, and production of all health education publications and materials. Multiple-funded by the City of Boston and a state initiative, CHEC serves as a partner in a large managed care system, Partners Health Care System. CHEC bills Partners for the training needs of the community health workers in the six city-owned community health centers, as well as every community health center in the Region. CHEC is involved with shaping the future of culturally competent outreach education practice within the managed care health system.

El Portal: Latino Alzheimer's Project

Los Angeles Alzheimer's Association
5900 Wilshire Boulevard, Suite 1710
Los Angeles, CA 90036

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- ◆ Project uses adaptations of existing ethnic-sensitive practice models, together with community participation, to provide culturally appropriate services.
- ◆ Successful outreach efforts resulted in high service utilization, with over 1,000 caregiving families identified since 1992.
- ◆ A project protocol and replication manual are in development, and parts of the project model are already being replicated in other communities.

The Los Angeles Alzheimer's Association serves as the local lead agency of a coalition of public, private and voluntary agencies in Los Angeles County, including the California State Departments of Health Services, Aging, Mental Health, and Social Services. This coalition, with funding from the Alzheimer's Demonstration Grants to States, developed and implemented El Portal: Latino Alzheimer's Project, to provide culturally and linguistically competent educational, medical, social, and supportive services for Latinos affected by Alzheimer's Disease and other Dementias and their caregiving families.

El Portal offers a range of direct services, including: a Spanish language telephone help-line, public awareness and outreach, education and respite subsidies. Through a network of subcontracting agencies, El Portal delivers culturally appropriate dementia-specific services including dementia day services, in-home respite, diagnostic services, legal assistance, case management, counseling, transportation, and support groups. Program publications include an "Annotated Bibliography of Spanish Language Literature on Alzheimer's Disease" and "The El Portal Latino Alzheimer's Project: A Model Program for Latino Caregivers of Alzheimer's-Affected Persons." An extensive project protocol and replication manual, "Meeting the Needs of Dementia Affected Latinos and Their Family Caregivers," is currently in draft form.

Two training programs in cultural competence and dementia were developed with the coalition agencies and offered to other providers in the target area: one for line staff and one for management. To support community members' participation, El Portal uses principles of community organizing and grassroots development.

Project components have been replicated in Guatemala and a parallel project has now been developed by the local lead agency to reach African-American dementia-affected caregiving families.

CULTURAL COMPETENCE WORKS

Award of Excellence

Family Healthcare Center (FHC)

306 Fourth Street North
Fargo, ND 58102

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- ◆ Funding of services is institutionalized.
- ◆ FHC was proactive in establishing a community interpreter center.
- ◆ Interpretation is part of job descriptions.
- ◆ Interpretive training and competence assessed through the community interpreter program.

The Family Healthcare Center (FHC) is a community health center and residency program providing primary care to underserved populations in Cass County, North Dakota, and Clay County, Minnesota, where 45,000 people live below 200% of poverty. Thirty-five percent of clinic patients are members of a racial/ethnic minority group. Clinical services and programs, including dental care, are targeted to special populations including homeless, refugee, migrant, and Native American clients. FHC is the primary care provider for refugees resettled in the community each year from Europe, Asia, and Africa by the Office of Refugee Resettlement, U.S. Department of Health and Human Services, and local agencies.

In collaboration with the University of North Dakota School of Medicine, WIC, Migrant Health Services, Head Start, public health, Lutheran Social Services Refugee Programs, and area mental health agencies, the FHC successfully recruits minority providers and clinic staff, and maintains cultural diversity with attention to the unique needs of its patient population. The FHC/University of North Dakota Medical School family practice residency collaboration enables family practice residents to train in a culturally diverse environment. The residency actively and successfully recruits minority residents, including Native Americans.

FHC was the first health/human service agency in this largely Anglo, Scandinavian American region to utilize paid interpreters for all appointments with patients who speak languages other than English. Clinic staff participated on a task force to establish a community interpreter center, which has a formal training program for all interpreters. The clinic is the largest user of interpreter services in the community and has encouraged the use by most other social service providers. Interpretation is built into the job descriptions of bilingual staff and training and competence assessed through the community interpreter program. The cost of interpreters and a Refugee Coordinator position, covered initially from local grants, is now built into the clinic budget. Clinic staff participate in planning an annual conference on meeting the health care needs of refugees, provide health education/orientation to new refugees, and consult to the local cultural diversity program. Staff organize and conduct focus groups with minority populations, and share health assessment materials and experiences with other clinics serving minority populations.

Managed Care Health Plans: Introducing Family-Centered Care

Parents Helping Parents, Inc.
3041 Olcott Street
Santa Clara, CA 95054

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- ◆ Successfully institutionalized in managed care facilities.
- ◆ Recognizes and provides for the special cultures of parents of children with special health care needs (CSHCN) and health care institutions.
- ◆ Publications and technical assistance are available to other programs.

A consumer/provider partnership between two hospital-based Parent-Directed Family Resource Centers (PDFRC's) the program was set up by a consumer group, Parents Helping Parents, and a managed care organization, Kaiser Permanente, with the technical assistance of the University of Santa Clara and San Jose State University. Parents Helping Parents is responsible for setting up the PDFRC's at Kaiser hospitals in Santa Clara and Santa Teresa, California. HRSA is funding replications of the program at a County Hospital and at a for-profit hospital. Before setting up centers, the program conducts a needs assessment at each hospital site to determine not only language and cultural needs, but also the type of health problems presented by children at that site.

The PDFRC's offer parents and professionals information about community resources, books, newsletters, and videos focusing on children with special health care needs (CSHCN). Centers are staffed by bilingual Parent Liaisons who conduct primary outreach, help families to become more effective participants in the health care of their child, and help professionals to understand parents' perspectives. The PDFRC's serve as satellites and connect parents with staff representing a wide variety of races and cultures, and speaking a variety of languages. Most staff and mentors are hired not only for language and cultural skills, but also for being parents of CSHCN. Whenever possible, parents needing help with issues related to CSHCN or school problems are matched with experienced parents dealing with similar issues who speak their language either as mentors or in support groups. Parent support groups are available for parents of Asian Indian, Spanish, Vietnamese, Japanese and Filipino descent. At least two hundred (200) families are served by the Spanish and Vietnamese-speaking support groups.

Family-centered care, family/professional collaboration and cultural competence principles are discussed in each major training for physicians, nurses and other health care providers. Training is ongoing and is available in Bilingual English/Spanish. Trainings are co-taught by both parents and professionals and the program is responsive to input from both groups. Salaries are funded by the managed care organization through a contract with the consumer agency. A replication manual, a training manual and technical assistance are available from the program.

CULTURAL COMPETENCE WORKS

Award of Excellence

Multnomah County Health Department

426 Southwest Stark, 8th Floor
Portland, OR 97204

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- ◆ Serves a large, ethnically diverse community, including refugees.
- ◆ Cultural competence is institutionalized in strategic plans and operations.
- ◆ Permanent staff are used to implement cultural competence objectives.
- ◆ Staff-wide cultural diversity training is required.
- ◆ Trained and tested interpreters are used.

Multnomah County Health Department (MCHD) in Portland, Oregon provides direct services at seven primary care and speciality (HIV, TB, STD) clinics and several hospitals. Additionally, they have an extensive referral system for specialty care and social and support services. MCHD serves an ethnically diverse community, including a number of refugee groups, of more than 41,000 individuals, including Afghans, Bosnians, Cubans, Czechs, Ethiopians, Haitians, Hungarians, Iranians, Iraqis, Polish, Romanians, Sudanese, Somalis, Chinese, Ghanis, Hmong, Lao, Mien, Polish, Russian, Cambodians, Vietnamese and Latin Americans. MCHD has an internal Language Service Program providing comprehensive language proficiency testing (for interpreters) and client needs assessment, about seventy on-call interpreters, and special language contracts with AT&T's telephone translation service. They employ a pool of translators for the documents, brochures, forms, signage and flyers needed by different programs. Waiting time for appointments by clients needing translation services has been reduced by utilizing a central appointment scheduling bank and referring clients directly to provider sites where the appropriate language interpreters are available on a specific schedule.

MCHD's Cultural Competence Committee developed a Manager's Strategic Plan for Developing Cultural Competence, a guiding document that includes statements on mission, vision, and values, quality improvement, and strategic planning. It also includes a system of accountability requiring each management team to design and implement project-based cultural performance objective plans. All new employees go through a basic diversity and cultural competence curriculum. Managers get similar training, including an orientation to the Manager's Strategic Plan for Developing Cultural Competence. MCHD employs a staff of three consultants and two trainers who provide all cultural competence training, as well as meeting facilitation, team building, and strategic planning.

MCHD plays an active role in shaping statewide policy in the emerging managed care system in Oregon, and is working with organizations in the private sector through Oregon Health Systems in Collaboration, an organization made up of the CEOs of all the major private sector providers and MCHD'S director.

The Perinatal Program: A Community Health Worker Model

La Clinica del Cariño Family Health Center, Inc.
849 Pacific Avenue
Hood River, Oregon 97031

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- ◆ Train and apprentice health promoters from the communities served.
- ◆ Use popular education model for training.
- ◆ Plans to proactively establish mechanisms for reimbursement for enabling services.

The Perinatal Program provides comprehensive, multidisciplinary prenatal case management, education and outreach services for pregnant women, with specific emphasis on culturally competent care for the Hispanic/Latina population, teen and single mothers, farmworking families, the uninsured, and all high-risk pregnancies. They serve 280 pregnant women a year, with 150 births a year. Available to all pregnant and post-partum patients, the program's case management model includes: comprehensive health; dental; social assessments; medical care; multidisciplinary care planning; home visitation; coordination and referral to needed social services and social service agencies; coordination with delivery and hospital care; and extensive patient education. Special education offerings include labor and delivery classes, preconception counseling and family planning assistance.

The Perinatal Program trains culturally competent community health promoters to provide education, outreach, and eventually some case management responsibilities. Health promoters receive a full one-year orientation, then gain further experience and responsibility until they become perinatal case managers with full access to physicians. The outreach and educational methods employed in the program conform to principles of popular education including: 1) capacitating the learner by building on what he or she already knows; 2) utilizing small group and one-to-one sessions; 3) taking adequate time for review and reinforcement; 4) speaking with the learner as a peer and advocate; 5) using only culturally-, linguistically-, and educationally-appropriate materials; 6) working in the settings most accessible and comfortable to the learner; and 7) ensuring that learning is highly interactive.

The Program partners with other agencies and programs that also provide good bilingual, bicultural services. They are seeking to make services self-supporting through exploring third-party billing for case management; lobbying the state legislature for Medicaid reimbursement rates; participating in a national pilot project to determine the cost/value of enabling services; and through the Oregon Primary Care Association by participating in a national trial to develop a reimbursement system for enabling services.

CULTURAL COMPETENCE WORKS

Award of Excellence

SouthEast Asian Community Clinic (SEACC)

North Suffolk Mental Health Association

301 Broadway

Chelsea MA, 02150

Contact: Nancy J. McDonnell, M.D.

Title: Medical Director

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- ◆ Trains Bicultural Workers to work in triadic treatment model.
- ◆ Utilizes a Cross-cultural community psychiatric residency program to provide services.
- ◆ Has successful HMO reimbursement waivers for unique treatment modalities.

The SouthEast Asian Community Clinic (SEACC), operated by North Suffolk Mental Health Association (NSMHA) in Boston, Massachusetts, is an outpatient psychiatric facility that treats severely traumatized, seriously ill Southeast Asian refugees who are survivors of war trauma, genocide, or political terrorism. Modalities of treatment include individual, group, and family therapy; medication management; outreach; day treatment; emergency intervention; "Living in the USA" groups; English as a second language; social skills groups; rehabilitation training; field trips to acclimate clients to their new surroundings; and traditional, religious and medical treatment options.

SEACC has attracted and promoted culturally competent clinicians and staff from the Southeast Asian community. Cambodian and Vietnamese nonprofessionals are hired and trained by NSMHA. Training is accomplished through didactic methods and through teaming the individual with an experienced, culturally competent clinician, who provides direct supervision on the job. A triadic treatment model consisting of a therapist or psychopharmacologist, a bilingual, bicultural worker and the client is used. The English-speaking clinician relies upon the bilingual, bicultural co-therapist to provide culturally relevant interpretation, information, education, and guidance.

SEACC integrates a subsidized psychiatric residency training program at Massachusetts General Hospital into clinic services and into other community agencies serving the refugee community, providing training and consultation to both. The residents are prepared prior to their community rotations by attending seminars on cross-cultural psychiatry. Residents conduct educational seminars for the agency staff, perform case consultations on individual clients, and are available to the staff as consultants on psychiatric issues that arise. The psychiatric residents are receiving intensive training in cross-cultural psychiatry while the staff members at SEACC and in the community agencies are raised to a higher level of competence and functioning.

With Massachusetts Behavioral Health Partnership, an HMO Medicaid provider, SEACC has been able to obtain waivers for billing the services of their bilingual/bicultural workers who assist the psychiatrists in mental health and substance abuse services. The HMO has responded to the need for the longer visits required by SEACC clients by initiating a billing category for a "complex visit." SEACC is currently involved with a cultural competence initiative for quality management with an expert in quality and mental health statistics and the HMO.

South Cove Community Health Center

145 South Street
Boston, Massachusetts 02111

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- ◆ Services are provided in many Asian languages using bi-lingual providers or trained and tested interpreters.
- ◆ Client assessments and care planning are performed in client's primary language.
- ◆ Collaboration on diabetes research provided positive outcome/cost data and original data on diabetes in Asian immigrant populations.
- ◆ Collaboration to develop culturally competent model to improve access to managed care for the Asian immigrant and refugee population.

South Cove Community Health Center (SCCHC) provides primary health care, specialty health and social services to a diverse Asian community in more than 30 towns and neighborhoods in greater Boston. Founded to deliver primary health care to the Chinese community in Boston, South Cove has evolved its services to meet the changing needs of the community. Today, South Cove offers an array of services, including the Metropolitan Indochinese Children and Adolescent Services and Brighton/Allston Afterschool Enrichment Program. SCCHC works in collaboration with a wide range of agencies, including providing mental health services for clients of the only shelter for domestic violence for Asian women in New England, and with local churches provides screening services to Asian elderly persons. South Cove offers services in the following Asian languages: Cantonese, Japanese, Khmer, Mandarin, Swatow, Toisanese, and Vietnamese. Some of these services are provided via interpreter; most are provided by bilingual providers.

All client assessment and care planning is done in the patient's primary language. The majority of the staff of 150 are bilingual Asian immigrants. All interpreters at South Cove undergo interpreter training for medical staff at New England Medical Center. In addition, South Cove has begun to offer on-site English-as-a-second-language courses for staff to increase their ability to interface between patients and mainstream providers. Providers and staff are often the liaisons between hospitalized patients and hospital staff. South Cove through its Department of Community Health Services provides intensive, bilingual/bicultural outreach and community health education to bring Asian adults into care and to teach them to use preventive care services.

A collaborative Diabetes Service and Research Project, undertaken with Joslin Diabetes Center, has been successful in identifying and controlling diabetes within the Asian immigrant and refugee community. The project has identified diabetic patients, helped control their diabetes, and provided original data about the diabetes within this population, including positive outcome/cost data. In collaboration with Harvard Pilgrim Health Care and Beth Israel Deaconess Medical Center, South Cove is developing a culturally competent model to improve access to managed care for the Asian immigrant and refugee population. This project, funded by the Office of Minority Health, U. S. Department of Health and Human Services, is entitled, "A Culturally Competent Practice within a Managed Care System".

CULTURAL COMPETENCE WORKS

Award of Excellence

Sunset Park Family Health Center Network

150 55th Street, Station 20
Brooklyn, New York 11220

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- ◆ Operates as a managed care network.
- ◆ Conducts yearly community needs assessment by network site to analyze changing demographics and identify new/changing needs.
- ◆ Cultural competence institutionalized, including a Cultural Access Task Force.

The Sunset Park Family Health Center Network (SPFHNC) is a multi-site primary care system and a Federally Qualified Health Center that operates seven full-time primary care centers, eleven school-based health centers, several part-time medical sites, and a comprehensive behavioral health program. SPFHNC also operates numerous community-based programs including day care centers, educational opportunity programs (family literacy, high school equivalency, English as a Second Language classes), Americorps, programs for seniors, Meals on Wheels, and multiple WIC sites which help bridge cultural needs across health and community services. The program serves “the ethnically diverse, medically-underserved neighborhoods of Southwest Brooklyn [including] Latino, Chinese, Arabic, Russian and Caribbean communities with 80,000 users.”

All new network staff participate in a full-day orientation, including cultural diversity and competence principles, and interpretation issues. Training on customer service, cultural diversity and cross-cultural health care issues are also available, and bilingual staff participate in an intensive, 12-week course (48 hours) on medical interpretation, which includes interpreter standards of practice and medical terminology; cycles in Arabic, Spanish, and Chinese medical interpretation training have been held. Americorps members trained in cultural competence and translation skills are used to help conduct Network outreach and educational activities. They also assist in patient surveys, home visits and assisting patients to negotiate the system in their primary languages.

The Cultural Access Task Force, whose members include key administrative staff, clinical leadership and experts on cultural issues from the Network and hospital staff, evaluates institutional needs, develops policy and directs the development of new activities in the areas of cultural and linguistic competence. A full-time Cultural Initiatives Coordinator coordinates activities of the Task Force, and provide expertise and leadership in implementing its directives.

About 15 years ago, Sunset Park, in partnership with Lutheran Medical Center, formed a Medicaid managed care HMO, Health Plus. Child Health Plus, their plan for uninsured children, is the fastest growing HMO in New York state, with over 100,000 enrollees expected by 2000.

Multicultural Program

Maricopa Integrated Health System

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Phoenix, AZ 85034

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- ◆ Integrate services and costs.
- ◆ Institutionalize program.
- ◆ Publications are available to other programs.

The Maricopa Integrated Health System (MIHS) provides healthcare to Phoenix and surrounding Maricopa County, Arizona, a geographically large county with an estimated population of 2.7 million. MIHS is the primary source for low-income health care in Phoenix region, and provides care for a large number of minority clients, especially Hispanic Americans, African Americans and Native Americans. The Multicultural Program operates throughout the county-wide health and hospital system to provide staff with the training and tools to offer culturally and linguistically competent health service to clients and their families. The Program includes mandatory cultural competence training for all new staff; the use of bilingual/bicultural staff or of language interpreters when bilingual staff are not available; culturally appropriate internal publications; outreach to ethnic communities; and collaborative relationships with organizations serving ethnically diverse communities. Traditional healers and practices are included as part of an individual's health care, when possible and if desired, by the client and the family.

The cultural competence program is an integral part of MIHS operations and crosses functional boundaries, such as education, clinical departments, marketing, and personnel. Each functional area includes resources in its operating budget for issues related to cultural competence. Policy and administrative issues are handled by a Culturally Sensitive Care Committee comprised of representatives from all areas of the system including physicians, nurses, managers and administrators. Permanent staff are retained to operate the program including a Community Relations Manager and three Community Health Advisors. A 60-hour Spanish Bilingual Assistance Program is available to bilingual staff to improve their medical interpreting skills.

MIHS has publications which are available to other programs including a Health Communication Guide (Spanish and English phrases, terms and vocabulary); and a publication on Providing Health Care to the Hispanic Community. Information on publications can be accessed on the White House's *Promising Practices* webpage. MIHS's Spanish-language webpage provides information on services and provides bilingual e-mail access.

MIHS covers many of their low-income clients in their Medicaid AHCCCS Plan, which is a contractual HMO plan. Since employing Community Health Advisors to perform community outreach they have seen a growth in the number of new Hispanic clients enrolling in the HMO.

CULTURAL COMPETENCE WORKS

Certificate of Recognition

Project Street Beat

Planned Parenthood of New York City, Inc.
26 Bleecker Street
New York, NY 10012

Contact: Vicki Breitbart
Title: Associate Vice President for Clinical Services
Telephone: (212) 274-7283
Fax: (212) 274-7219
Website: <http://www.ppnyc.org>

- ◆ Provides HIV and medical outreach, education and crises intervention to vulnerable populations living on the streets.
- ◆ Program uses broad definition of culture including an understanding of the cultural aspects of poverty, addiction, and street life.
- ◆ Program utilizes former clients as Peer Outreach Workers.

Project Street Beat (PSB) is a street-based outreach program created in response to escalating rates of HIV/AIDS and a dearth of related services for the women, men and teens living and working on the streets of four boroughs of New York City (The Bronx, Manhattan, Brooklyn, and Queens). Project Street Beat clients represent hard to reach and highly vulnerable communities. An estimated 40 percent of clients are HIV-infected and nearly 4 out of 5 are homeless. Almost one quarter of their clients are immigrants, and about one-quarter are adolescents. A majority of clients are substance users who are living and working on the streets as commercial sex workers. The majority of the clients are African American, African Caribbean and Latino individuals.

PSB provides outreach, prevention and education services, as well as crisis case management, and clinical/medical services, using medical and outreach vans. PSB is also connected to a network of comprehensive HIV prevention services including: basic survival services; drug treatment programs; harm reduction programs; HIV counseling and testing; STD screening and treatment; Ryan White CARE Act service providers; mental health providers; social service providers, and housing providers. Using an agency-wide, on-line computer system, staff can track all referrals and evaluate their success.

PSB uses a broad understanding of culture that is not limited to ethnicity or language, but includes age, gender, and sexuality, as well as an understanding of the cultural aspects of poverty, addiction, and street life. Former clients serve as Peer Educators in the Peer Outreach Program. PSB designates a case manager or other staff member for each peer educator; these staff members are responsible for helping the peer educators stay drug-free and provide guidance for problems and challenges they encounter on the job. More intensive support -- including mental health counseling -- is provided for those peer educators who are HIV-infected.

Project Street Beat has developed managed care contracts with 15 companies. They also developed materials to inform consumers about the New York State program allowing women under managed care to go directly to gynecological and family planning services without first going to their primary physician.

Tri-County Community Health Center

P.O. Box 227

Newton Grove, NC 28366

Contact: J. Michael Baker
Title: Executive Director
Tel: 910-567-6194 ext. 5000
Fax: 910-567-5342
E-mail: ncmigrant@aol.com

- ◆ Single year-round health center dedicated to serving migrant and seasonal farmworkers in North Carolina.
- ◆ Operates only bilingual substance abuse treatment program in North Carolina.
- ◆ Provides a statewide Spanish telephone medical interpretation service.

Tri-County Community Health Center (Tri-County) is located near a town of 800 persons, and serves individuals in three rural counties in eastern North Carolina. The clinic provides: full primary medical, dental care, hospitalization and delivery; lab; x-ray; pharmacy; WIC; nutrition; HIV testing and counseling; parenting education; and, substance abuse counseling. Eighty-five percent of the population served are migrant or seasonal farmworkers, and the client base is 75% Hispanic American, and 15-20% African American. The Center has a team which consists of at least one medical provider and several other outreach staff that go to many of the 150 migrant labor camps several nights a week to perform health screenings and provide health education.

All care instructions and discharge information is provided in both English and Spanish. The medical staff is currently advocating with the local hospital for the availability of Living Will and Advanced Directive forms in Spanish from the North Carolina Medical Society. The personnel include staff representative of clients in terms of language and ethnicity including those who have a background in or are still actively engaged in farmwork. Many staff are recruited from the population served and are trained on the job. Ongoing collaborative relationships include those with Student Action with Farmworkers (SAF), providing a student experience working at the clinic and in migrant camps, and with North Carolina Central University, an historically black university, providing jointly with the Center extensive pesticide education, research, outreach services, and social work case management.

Tri-County operates the only bilingual substance abuse treatment program in North Carolina. The program is specifically designed for farmworkers dealing with substance abuse issues, but accepts clients from the community at large. The program has relationships with other local agencies to collaboratively serve and provide case management for African American and Hispanic American clients at high risk for substance abuse, HIV and other related health issues.

Tri-County provides a Spanish Telephone Interpretation Service available throughout the state. The service provides medical translation via an 800 number for approximately 300 medical providers each month. A native Spanish speaker who is a professionally trained medical interpreter provides translation. This service has on-going, reliable funding.

CULTURAL COMPETENCE WORKS

Nominated Programs of Note

Betances Health Unit, Inc

280 Henry Street
New York, NY 10002

Contact: Susanna Miller
Title: Program Developer
Telephone: (212) 227-8401
Fax: (212) 227-8842
E-mail: smiller@betances.org

Betances Health Unit is the only community-based, Latino medical provider in Lower Manhattan. Betances offers multi-lingual, family-based care tailored to the health beliefs and practices of a mostly Latino constituency of over 11,000 patients. Their strategy integrates Western medicine with mental health and substance abuse counseling, and a full range of holistic treatments consonant with diverse, culture-specific orientations. Betances' distinctive strategy of integrated care, which incorporates treatments from Western medicine with a host of holistic treatments, from acupuncture to nutrition intervention, was initially developed in direct response to consumer preferences. Betances' delivery of culturally competent medical care is shaped by the indigenous cultural competence of its providers by birth and life experience. Betances also trains non-Latino providers to acquire cultural-competence through systemic practices in areas of treatment, assessment and quality assurance. Betances' Spanish-speaking community health workers conduct outreach to client populations to explain the mandatory Managed Care Medicaid system using language and culture appropriate materials developed on site.

The BRIDGES Project

Asian and Pacific Islander Coalition
on HIV/AIDS, Inc. (APICHA)
275 Seventh Avenue, Suite 1204
New York, NY 10001-6708

Contact: Teresita R. Rodriguez
Title: Executive Director
Telephone: (212) 620-7287
Fax: (212) 620-7323
E-mail: apicha@aidsinfonyc.org
Website: <http://www.APICHA.org>

The BRIDGES Project is designed to improve access to services for HIV-infected, immigrant Asians and Pacific Islanders who speak limited English in New York City's complex service delivery system. Resources are allocated half in prevention/education and half in direct services, including case management, free acupuncture services, a free ethnic food pantry, emergency financial assistance, support groups, a legal clinic, and Bilingual Peer Advocates (who do both interpretation and advocacy). Through their Referral Services Network, clients can access medical, mental health, financial and legal services, including primary health care, HIV specialty care, social services, and other community-based assistance. Formal linkage agreements exist with 8 comprehensive service sites, and there are informal linkages with numerous other service providers. Trainings in cultural competence and HIV sensitivity are conducted at service sites.

CULTURAL COMPETENCE WORKS

Nominated Programs of Note

Buffalo Prenatal-Perinatal Task Force

625 Delaware Avenue, Suite 410
Buffalo, New York 14202

Contact: Mildred Hall
Title: Network Program Manager
Telephone: (716) 884-6711
Fax: (716) 884-0513
E-mail: bufprntl@localnet.com

The Buffalo Prenatal-Perinatal Task Force includes six programs that work cooperatively to reduce infant mortality and to improve the health of women and children in the Buffalo regional area. The Task Force uses a variety of approaches, including individual intensive case management and education with women at high risk for having problem pregnancies, many of whom are African-American and Latina. The staff of the Task Force reflects the ethnicity of the target population, and is over 90% female. The outreach approaches, case management and education are all developed to be culturally appropriate to the lives and needs of the women at risk. The success of the program is documented by a decrease in infant mortality for the program participants. The Task Force is working with New York State to provide culturally congruent information on managed care to their clients.

Church Avenue Merchants Block Association (CAMBA)

1720 Church Avenue
Brooklyn, NY 11226

Contact: Joanne M. Oplustil
Title: Executive Director
Telephone: (718) 287-2600
Fax: (718) 287-0857
E-mail: oplustil@worldnet.att.net

CAMBA, the Church Avenue Merchants Block Association, Inc., is a multicultural HIV/AIDS, health, social service, education, and job training organization located in the ethnically diverse communities of Flatbush and East Flatbush, Brooklyn. CAMBA is well-recognized throughout the area for the provision of numerous culturally sensitive health care and education programs such as: 1) acupuncture and other holistic healing for substance abuse and HIV/AIDS, 2) holistic health training, personal empowerment, and support; 3) case management, social services, job training, and personal/cultural empowerment activities; and 4) a broad array of other culturally competent initiatives. These programs serve over 15,000 participants annually from Caribbean, Central American, Asian, and other Nations as well as low-income, high-risk American-born individuals and families. CAMBA staff work with clients in their native languages and with respect for their culture, empowering them and bolstering their education and skills so they can move from poverty to self-sufficiency.

CULTURAL COMPETENCE WORKS

Nominated Programs of Note

Comprehensive Family AIDS Project

Children's Diagnostic &
Treatment Center
417 St. Andrews Avenue
Fort Lauderdale, FL 33309

Contact: Susan M. Widmayer, PhD
Title: Administrator
Telephone: (954) 728-8080
Fax: (954) 779-1957

The Comprehensive Family AIDS Project (CFAP), of the Children's Diagnostic & Treatment Center, is a coordinated system of primary and specialty medicine, clinical research, financial assistance, support groups, peer education programs, and linkages to community providers for children and families infected with and affected by HIV/AIDS in Broward County, Florida. CFAP's goal is to provide quality services to underserved children and families living with HIV/AIDS. Broward County has the third highest incidence of HIV among minorities in the U.S. Most families are supported by single, minority, unemployed, HIV-infected women with two or more dependent children. The majority of clients are members of ethnic and minority populations, and the program provides documents in English, Spanish, and Creole. CFAP uses Family Resource Assistants who are full-time staff who are infected with or affected by HIV/AIDS and represent ethnic groups served by the Center. They work closely with social work staff assisting with case management, delivering medicines and food, and co-facilitating support groups.

Medical Interpretation and Cultural Competence Program

Vista Community Clinic
1000 Vale Terrace Clinic
Vista, CA 92084

Contact: Barbara Mannino
Title: Executive Director
Telephone: (760) 631-5000 ext. 1131
Fax: (760) 726-2730

Vista Community Clinic's Medical Interpretation and Cultural Competence (MICC) Program, trains community clinic support staff to improve their linguistic capabilities, become capable interpreters, and increase their knowledge of cultural practices in order to enhance the overall quality of health care. The MICC curriculum was developed based on a needs assessment questionnaire distributed to nurses, medical assistants, nurse practitioners, physicians, and other medical support staff throughout San Diego, Imperial, and Orange counties. Designed by a cultural anthropologist and a medical interpreter, the MICC curriculum addresses both linguistic issues and cultural norms, and contains components such as theoretical information on consecutive interpretation, note taking practice sessions, ethics and standards, challenges of interpretation, vocabulary development, cultural concepts, provider roles, dialogue role plays, personal reactions and discussions about the activities, and additional resources for independent learning. Fourteen organizations in California and other States have replicated MICC program elements.

CULTURAL COMPETENCE WORKS

Nominated Programs of Note

Mercy Mobile Health Care

St. Joseph's Mercy Care Services
60 11th Street
Atlanta, GA 30309

Contact: Sister Angela Ebberwein
Title: Vice President
Telephone: (404) 249-8108
Fax: (404) 249-8940
E-mail: Aebberwein@sjha.or

Mercy Mobile Health Care's (Mercy) mission is to provide primary health care services to the underserved in metropolitan Atlanta, Georgia. The staff travels to those in greatest need and links them into a culturally appropriate and cost effective system of care. Individuals targeted include those who are homeless, poor, infected with HIV, or are recent immigrants and refugees. In addition to three fixed clinic sites, the agency uses five mobile vans and two fully equipped medical units to bring primary care, social services, and education to almost 18,000 persons. Culturally appropriate services include an information and referral line using trained bilingual Hispanic and Vietnamese staff who answer more than 26,000 calls annually; bilingual staff from the targeted communities trained to be medical interpreters and educators; and perinatal, as well as HIV prevention programs with specific curricula addressing the clients' unique needs.

Migrant Health Services

Community Health of South Dade, Inc.
10300 S. W. 216th Street
Miami FL 33190

Contact: Hilda Ochoa Bogue
Title: Coordinator, Migrant Health
Telephone: (305) 252-4853
Fax: (305) 254 2011
E-mail: hbogue@hcnetwork.org

The Community Health of South Dade, Inc. (CHI) Migrant Health Program provides primary health care services, outreach, health promotion and disease prevention activities to about 9,000 migrant and seasonal farmworkers (MSFW) in south Miami-Dade County, Florida. CHI delivers primary health care services at two health centers located near farmworker living facilities. The farmworkers are from Mexico, Central America (Guatemala, Salvador and Honduras) and Haiti. The centers have bilingual physicians and staff, many from farmworker backgrounds. They have accessible hours of operation, including evenings and Saturdays, and have a multilingual phone system for after-hours. CHI has carried out a Comprehensive Prenatal Health Program, which increased the percentage of pregnant women entering prenatal care in the first trimester of pregnancy from 5% in 1995 to 48% in 1997. To address a growing number of monolingual Mixteca speakers in the farmworker community, the program worked with the Mexican Consulate to establish a Mixteca Program, in which a Mexican teacher provided three weeks of language training and a full day workshop about the Mixteca culture to the CHI staff, as well as to some partner agencies.

CULTURAL COMPETENCE WORKS

Nominated Programs of Note

Rainbow Center for Women, Adolescents, Children and Families

University of Florida
653-1 West Eighth Street
Jacksonville, FL 32209

Contact: Mobeen H. Rathore, M.D.
Title: Associate Professor & Chief
Div. of Pediatric Infectious Diseases
Telephone: (904) 549-3051
Fax: (904) 549-5431
E-mail: mobeen.rathore@jax.ufl.edu
Website: <http://www.ufhscj.edu/nefpap>

The Northeast Florida Pediatric AIDS Program's Rainbow Center is a multi-disciplinary, comprehensive program for HIV-affected children and their families and is a nationally recognized regional service and research center serving northeast Florida and southern Georgia. The center provides single entry access to a full range of family centered, consumer driven health and social services. The program serves 175 families of which 95% are African-American. An annual cultural competence training session is scheduled for all staff members and participation is part of routine employee performance plans. All staff also participate in an annual strategic planning process where a written operational plan is reviewed and revised to meet the current needs of the population. The consumer advisory representative also attends this planning session and in turn shares policies and plans with the larger group. Interpreters are available if needed through the academic/medical center or Lutheran Social Services. Staff review all educational information for cultural/ethnic appropriateness and reading level.

APPENDIX B

Resources and Publications

Resources

Publications: Cultural Competence

Publications: HRSA Managed Care

RESOURCES

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)
4350 East-West Highway, 3rd Floor
Bethesda, MD 20814
<http://www.bphc.hrsa.dhhs.gov>

Center for Health Services Financing and Managed Care

Health Resources and Services Administration (HRSA)
5600 Fishers Lane, Room 10-29
Rockville, MD 20857
(301) 443-1550
<http://www.hrsa.gov/cmc>
<http://www.hrsa.gov/medicaidprimer>

Center for Multicultural and Multilingual Mental Health Services

4750 N. Sheridan Road, Suite 300
Chicago IL 60640
(773) 271-1073
<http://www.mc-mlmhs.org>

Cross Cultural Health Care Program

1200 12th Ave. S.
Seattle, WA 98144
(206) 621-4161
<http://www.xculture.org>

Diversity Rx

<http://www.DiversityRx.org>

Ethnomed

<http://www.hslib.washington.edu/clinical/ethnomed>

HRSA Information Center

P.O. Box 2910
Merrifield, VA 22116
1-888-ASK HRSA
<http://www.ask.hrsa.gov>

Initiative to Eliminate Racial and Ethnic Disparities in Health

U.S. Department of Health and Human Services
<http://www.raceandhealth.hhs.gov>

Medicare and Managed Care

Health Care Financing Administration
U.S. Department of Health and Human Services
Hotline 1-800-638-6833
<http://www.hcfa.gov/medicare/mgdcar1.htm>

Medicaid and Managed Care

Health Care Financing Administration
U.S. Department of Health and Human Services
<http://www.hcfa.gov/medicaid/mchmpg.htm>

Models That Work

Bureau of Primary Health Care
Health Resources and Services Administration
(301) 594-4334
e-mail: models@hrsa.dhhs.gov
<http://www.bphc.hrsa.dhhs.gov/mtw/mtw.htm>

National Center for Cultural Competence

3307 M Street NW, Suite 401
Washington, DC 20007-3935
1-800-788-2066
e-mail: cultural@gunet.georgetown.edu

National Clearinghouse for Primary Care Information

2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
(703) 821-8955, ext. 248
<http://www.bphc.hrsa.dhhs.gov>

**Office of Minority and Women's Health
Cultural Competence Program**

Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway, 3rd Floor
Bethesda, MD 20814
(301) 594-4490
http://www.bphc.hrsa.gov/omwh/omwh_20.htm

Office of Minority Health

Health Resources and Services Administration
5600 Fishers Lane, 10-49
Rockville, MD 20857
(301) 443-2964
<http://www.hrsa.dhhs.gov/dmh>

Office of Minority Health

Office of Public Health and Science
U.S. Department of Health and Human Services
5515 Security Lane, Suite 1000
Rockville, MD 20852
301-443-5084

Office of Minority Health Resource Center

P.O. Box 37337
Washington, DC 20013-7337
1-800-444-6472
e-mail: info@omhrc.gov
<http://www.omhrc.gov>

The Quality Center

Quality and Culture Program

Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway, 11th Floor
Bethesda, MD 20814
301-594-3808
www.bphc.hrsa.gov/quality

PUBLICATIONS

Cultural Competence

Building Bridges: Tools for Developing an Organization's Cultural Competence. La Frontera, Inc., 1995. Contact (520) 884-9920.

Building Linguistic and Cultural Competence: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born. Mid-America Institute on Poverty, Chicago: Heartland Alliance, 1999. Contact (312) 629-4500.

Communicating Effectively Through an Interpreter (video-1998). Cross Cultural Health Care Program. Contact (206) 621-4161.

Cultural Competence: A Journey. Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1999. Contact 1-800-400-BPHC or website <http://www.bphc.hrsa.gov/culturalcompetence/Default.htm>

Cultural Competence: Program Self-Assessment, Services to Children and Families. (Amherst H. Wilder Foundation, St. Paul, MN.) Contact (651) 642-4000.

Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. New York State Office of Mental Health, 1998. Contact (301) 443-6212

Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups, Center for Mental Health Services, SAMHSA, 1998. Contact (301) 443-6212

Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. Kaiser Family Foundation. (publication #1362) Contact (800) 656-4533,

Establishing Interpreter Services in Health Care Settings. Amherst Educational Publishing, Contact (800) 865-5549

Guidelines to Help Assess Cultural Competence in Program Design, Application, and Management, Bureau of Primary Health Care, Office of Minority & Women's Health website, <http://158.72.105.163.cc/guidelines.htm>

Medicaid Managed Care and Cultural Diversity in California, The Commonwealth Fund, March 1999. Contact (888) 777-2744.

Monitoring the Managed Care of Culturally and Linguistically Diverse Populations, Tirado, Miguel D., Ph.D. December 1998. Ordering Information – National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182, Telephone: 1-800-400-2742 or (703) 902-1248, Fax: (703) 821-2098, E-mail: primary_care@circsol.com).

Optional Purchasing Specifications: Cultural Competence in the Delivery of Services through Medicaid Managed Care. Developed by the Center for Health Services Research and Policy under contract to the U.S. Department of Health and Human Services, Health Resources and Services Administration, 2000. Contact : 1-888-ask-hrsa or visit website, <http://www.ask.hrsa.gov>

Tools for Monitoring Cultural Competence in Health Care, Tirado, Miguel D., Ph.D. January 1996.
Available from Latino Coalition for a Healthy California, 1535 Mission Street, San
Francisco, CA 94103, (408) 582-3967

What is Cultural Competence? Bureau of Primary Health Care, Office of Minority and Women's
Health website, <http://158.72.163/cc/7domains.htm>

Journal Articles:

Can Cultural Competence Reduce Racial and Ethnic Health Disparities? A Review and
Conceptual Model, Brach, Cindy and Irene Fraser, *Medical Care Research and Review*.
Vol. 57, Supplemental 1 (2000). 181-217.

Cross-Cultural Medicine Issue, *Western Journal of Medicine*, Dec. 1983 (vol. 139, no. 6).

Cultural Competence: Essential Measurements of Quality for Managed Care Organizations,
Editorial, *Annals of Internal Medicine*, 124:10 (1996) 919-20.

Language Barriers to Health Care, *Journal of Health Care for the Poor and Underserved*. Volume
9, Supplemental, 1998. 800-656-4533, publication #1396.

Promoting Cultural Competence in HIV/AIDS Care, *JANAC* 7, Supplement 1 (1996) 41.

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care,
Like, Robert C. R. Prasaad Steiner and Arthur Rubel, *Family Medicine*, Vol 8(4):291-
297, 1996.

PUBLICATIONS

HRSA Managed Care

HIV/AIDS BUREAU

Medicaid Managed Care & HIV/AIDS: A Guide for Community-Based Organizations. Produced
by AIDS Action Foundation with support from the U.S. Department of Health and Human
Services, Health Resources and Services Administration.. 2000 (Copies of this
publication may be obtained from the AIDS Action Foundation, 1906 Sunderland Place,
N.W., Washington, D.C., 20036, (202) 530-8030).

A Resource Guide for Ryan White CARE Act Grantees and Other HIV/AIDS Providers. U.S
Department of Health and Human Services, Health Resources and Services
Administration. Summer 1998. (Copies of this publication may be obtained from the
HRSA Information Center, P.O. Box 2910, Merrifield, VA 22116, 1-888-ASK HRSA,
<http://www.ask.hrsa.gov>).

HIV Capitation Risk Adjustment - the HRSA Conference Report. (Washington, D.C.: Henry J.
Kaiser Family Foundation). August 1997. (Copies of this publication may be obtained
from the Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington,
D.C. 20005, (202) 347-5270.)

Adequacy of Reimbursement for HIV Under Section 1115 Waivers. Richard Conviser, Ph.D., Deanna Kerrigan, M.P.H., and Stephen Thompson, M.A. (Rockville, Maryland: Bureau of Health Resources Development, Office of Science and Epidemiology). 1997. (Copies of this publication may be obtained by contacting the Office of Science and Epidemiology, HIV/AIDS Bureau, 5600 Fishers Lane, Room 7A-07, Rockville, Maryland, 20857, (301) 443-6560.)

BUREAU OF PRIMARY HEALTH CARE

Publications:

(These publications can be ordered from the HRSA Information Center, P.O. Box 2910, Merrifield, VA 22116, 1-888-ASK HRSA, <http://www.ask.hrsa.gov>.)

Medicaid Managed Care Education: A Workbook for Health Centers. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. Fall 1998.

Analysis of Managed Care Enrollment in Community and Migrant Health Centers, 1996. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. 1997.

Executive Summary: Evaluation of the Impact of Medicaid Waivers on Consumers and Services of Federally Qualified Health Centers. Prepared by the Lewin Group, Inc. For the Bureau of Primary Health Care, Health Resources and Services Administration. November 10, 1997.

Changes in Information Systems in a Managed Care Environment: Training Curriculum for Health Centers and Health Center Networks. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services and the National Association of Community Health Centers. May 1997.

Preparing for Managed Care: Strategies for Community-Based Organizations Serving People with HIV/AIDS. Videotape. Rockville, MD: Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. 1997.

Managed Care Internal Operations Self-Assessment Tool for Federally Qualified Health Centers. Rockville, MD: Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. October 1994.

Journal Articles:

Promoting Opportunities for Community Based Health Education in Managed Care, Gallivan, Leah P., Lundberg, Mary E., Fiedelholz, Jennifer B., Andringa, Kim, Stableford, Sue, and Visser, Laura, *Journal of Health Education* 1998; 29: S-28-33.

MATERNAL AND CHILD HEALTH BUREAU

(The following publications may be ordered from the National Maternal and Child Health Clearinghouse, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182-2536. Phone: (703) 356-1964. Fax: (703) 821-2098.)

Measuring Up: A Blueprint for Building Quality Assurance, (A National Instructional Video Conference for the Maternal and Child Health and Children with Special Health Care Needs Community), Chicago, IL: University of Illinois at Chicago, Measuring Up Website www.uic.edu/hsc/dscc/quality/ (funded by the Maternal and Child Health Bureau, Health Resources and Services Administration). September 1998.

Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts, Washington, D.C.: Association of Maternal and Child Health Programs. July 1998.

Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts, Executive Summary, Washington, D.C.: Association of Maternal and Child Health Programs. July 1998.

How to Negotiate and Contract for Services with Medicaid Managed Care Organizations, Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. February 1997.

Quality Community Managed Care: A Guide for Quality Assurance Measures for Children with Special Health Care Needs, Chicago, IL: University of Illinois at Chicago (funded by a grant from the Maternal and Child Health Bureau, Health Resources and Services Administration). January 1997.

Managed Care Contracting - The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction, Arlington, VA: National Center for Education in Maternal and Child Health. 1997.

(The following publications can be ordered from the Association of Maternal and Child Health Programs, 1350 Connecticut Avenue, NW, Suite 803, Washington, DC 20036, (202) 775-0436.)

Partnerships for Healthier Families: Roles for State Title V Programs in Assuring Quality Services for Women, Infants, Children and Youth in Managed Care, Washington, D.C.: Association of Maternal and Child Health Programs. June 1997.

Partnerships for Healthier Families: Roles for State Title V Programs in Assuring Quality Services for Women, Infants, Children and Youth in Managed Care, Executive Summary, Washington, D.C.: Association of Maternal and Child Health Programs. June 1997.

(The following publications can be ordered from the Maternal and Child Health Policy Research Center, 2 Wisconsin Circle, Suite 700, Chevy Chase, MD 20815, (202) 686-4797.)

1997 State Medicaid Managed Care Policies Affecting Children, Ruth A. Almeida, and Harriette B. Fox. March 1998.

A Compendium of Federally Funded Projects on Managed Care and Children with Special Health Care Needs, Maternal and Child Health Policy Research Center. February 1998.

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APPENDIX C

Call for Nominations

Call for nominations inserted here - PAGE 1

Call for nominations inserted here - PAGE 2

Call for nominations inserted here - PAGE 3

Call for nominations inserted here - PAGE 4

APPENDIX D

Nominations Review Process

CULTURAL COMPETENCE WORKS COMPETITION NOMINATION REVIEW PROCESS:

RECEIPT OF NOMINATIONS

ACTIVITIES

- ◆ Nomination date stamped on arrival.
- ◆ Nominations checked for parts A and B and for disk copy.
- ◆ Nominations logged-in by category and given tracking number.

SAFEGUARDS

- ◆ Logging procedure is responsibility of staff who will not be part of evaluation process.

INITIAL SCORING OF NOMINATIONS

ACTIVITIES

- ◆ Blinded disk copy of Part B of nominations distributed between two reviewers.
- ◆ Reviewers do an initial reading of assigned nominations.
- ◆ Reviewers reread and score assigned nominations.

SAFEGUARDS

- ◆ Part B text of each nomination checked for blinding by non-reviewer staff before distribution to reviewers.

INITIAL SCORING VERIFICATION

ACTIVITIES

- ◆ Nominations un-blinded and completed with part A.
- ◆ Reviewers exchange nominations and completed score sheets.
- ◆ Each reviewer verifies scoring, adding any changes and comments to the original scoring sheet.
- ◆ Reviewers discuss and concur on final scoring outcomes.

SAFEGUARDS

- ◆ Reviewer cross-checking, discussion and concurrence.
- ◆ Review of selected scoring by other project staff.

SELECTION OF SEMI-FINALIST NOMINATIONS

ACTIVITIES

- ◆ Each Reviewer assigns nominations to one of three categories:
 1. Strong nomination
 2. Nomination strong enough to qualify for a telephone interview
 3. Weaker nominations.
- ◆ Reviewers together verify this relative sorting.
- ◆ Nominations remaining in categories 1 and 2 after review become Semi-Finalists.

SAFEGUARDS

- ◆ Project staff review of methods and Semi-Finalist programs.

TELEPHONE DISCUSSIONS

ACTIVITIES

- ◆ Semifinalist programs notified of selection.
- ◆ Interviewers set appointment time for telephone discussion with nominees' designated contact.
- ◆ Interviewers reread nomination and scoring sheet to prepare for telephone conference.
- ◆ Interviewers hold telephone discussions of approximately one hour with each Semifinalist contact.
- ◆ Interviewers produce typed record of each telephone discussion.

SAFEGUARDS

- ◆ During telephone interviews permission was asked for Interview staff to contact the person interviewed or their designate if notes were not clear or if further questions arose.

EVALUATORS' SUMMARY, REVIEW, AND RECOMMENDATIONS

ACTIVITIES

- ◆ Evaluators reread nominations, scoring sheets and telephone discussions of each Semifinalist nominee.
- ◆ Based on review, evaluators prepare a short summary on each Semi-Finalist nominee.
- ◆ Evaluators cross-read summaries.
- ◆ Evaluators identify and concur on nominations deserving Awards of Excellence.
- ◆ Evaluators identify and concur on nominations deserving Certificates of Recognition.
- ◆ Evaluators identify and concur on nominations which, although containing interesting material for inclusion in publication, are not strong enough to receive a Certificate of Recognition.

SAFEGUARDS

- ◆ Evaluators' crossing-reading and consensus-producing process.

FULL STAFF REVIEW

ACTIVITIES

- ◆ Evaluators meet with the Project Monitor and Project Director to present current recommendations and review process of arriving at the nominees recommended for awards.

SAFEGUARDS

- ◆ Review of criteria, methodology and recommendations by staff uninvolved in scoring or telephone interviews.

MEETING OF TECHNICAL ADVISORY COMMITTEE

ACTIVITIES

- ◆ Meeting of the Government Project Officer, the Project Staff and the Members of the Technical Advisory Committee to review selection process and Project Staff recommendations.
- ◆ Consensus developed by Technical Advisory Committee for (1) Awards of Excellence; (2) Certificates of Recognition; and (3) Programs of Note.

SAFEGUARDS

- ◆ Review of selection process and recommendations by uninvolved health service provision experts.