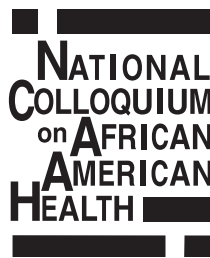


CULTURAL COMPETENCY



National Medical Association



CULTURAL COMPETENCY

"The application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhances a provider's effectiveness in managing patient care." -The National Medical Association

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Lillian Tom-Orme, RN, MPH, PhD, FAAN

Rudolph M. Williams, Executive Director, NMA

Augmenting the expertise of the Medical and Health & Human Service Faculty were NMA Specialty Section Chairs, who provided leadership in the review and evaluation of clinical guidelines during the work group session. Specialty Section Chairs who participated in the cultural competency training design conducted in Hawaii included the following:

NMA SPECIALTY SECTION CHAIRS

Atoinne Able, MD

Gideon Adegbile, MD

Billy Ballard, MD

Carolyn Britton, MD

Valerie Callendar, MD

Robert Collins, MD

Fernando Daniels, MD

Earl Harley, MD

William McDade, MD

Albert Morris, MD

Averette Mhoon Parker, MD

Gilbert R. Parks, MD

Stephan Parnell, MD

Lawrence Saunders, Jr., MD

Wilma Wooten, MD

I. INTRODUCTION

The National Medical Association (NMA) is the oldest and largest national organization representing African American physicians and health professionals in the United States. Established in 1895, the NMA is the collective voice of more than 25,000 African American physicians and the patients they serve. Since its inception the NMA has been committed to improving the health status and outcomes of minority and disadvantaged people. While throughout its history the National Medical Association has focused primarily on health issues related to African Americans and medically underserved populations, its principles, goals, initiatives and philosophy encompass all sectors of the population.

At its inception, the National Medical Association's objective was:

"Conceived in no spirit of racial animosity, fostering no ethnic antagonisms, but born of the exigencies of the American environment, the National Medical Association has for its purpose, the bonding together of men and women of African descent, for the mutual cooperation and helpfulness, who are legally and honorably engaged in the cognate practice of medicine and surgery."

More than 100 years later, the National Medical Association has become firmly established in a leadership role in medicine. The NMA serves as a catalyst for the elimination of disparities in health and the leading force for parity in medicine.

In accordance with its purpose, the National Medical Association has upheld its priority of developing strategies to facilitate improvements in health care for African Americans through policy initiatives, special programming, training opportunities, and collaborative partnerships. The NMA's focus on cultural competency reflects its mission, historical commitment to improve health outcomes for people of color, and its on-going programmatic thrusts to achieve parity in health care.

Membership on the former US Surgeon General David Satcher's Steering Committee on Racial and Ethnic Disparities, the formation of the NMA Commission on Health Disparities and the Impact of Racism on African American Health Status (*aka* Commission on Health Disparities), and publication of the Consensus Paper on Racism in Medicine and Health Parity for African Americans: "The Slave Health Deficit" are examples of national efforts undertaken by the NMA to strengthen its agenda and platform for improving minority health, nationally. Recognizing the need to augment policy initiatives and public awareness strategies with tangible provider-oriented activities served as the impetus for the NMA's governing body to launch the development of a training design in cultural competency for physicians and other health care providers.

Consensus building around the cultural competency training initiative was spearheaded by Randall W. Maxey, MD, PhD, Chairman, NMA Board of Trustees. The 2001 NMA Conference in Nashville, TN was the site where the initial synergy evolved for developing a comprehensive training design. Several members of the NMA governing body and staff engaged in pre-

liminary discussions to assess 1) the need for physician training in cultural competency and 2) its relevance for eliminating health disparities. Citing various trends such as growth rates for minority populations, health status indicators, legislation and regulations, increased provider accountability requirements, as well as the proliferation of training activities in cultural competency was how the visioning process unfolded and began to take shape for an NMA cultural competency training program. In its embryonic stages, the vision encompassed a training design and curriculum for NMA members that offered continuing medical education credits as well as an opportunity for board certification in Ethno-Cultural Medicine. As this vision was shared with other governing body members, it was expanded to include plans for a board certification process for all physicians who treat persons of color. Understanding the significance of this vision, immediate steps were taken to formally present the concept to the entire leadership of the NMA. Meetings were scheduled and convened with the Board of Trustees, NMA Specialty Section Chairs, and House of Delegates. Presentations during regional conferences are now in progress. Concurrent activities are underway that are designed to: 1) develop a cultural competency curriculum that is grounded in evidence-based medicine; 2) review clinical standards and guidelines to assess their appropriateness for use among minority populations; and 3) develop an electronic study guide consisting of a bank of questions that have been field-tested for use in preparing for the certification examination. These action steps support the NMA's goal of proactively taking a leadership role in developing innovative approaches to cultural compe-

tency education in medicine that are both grounded in scientific evidence and reflect a responsiveness to the effective practice patterns of minority physicians.

II. OVERVIEW OF CULTURAL COMPETENCY

Cultural competency has increasingly become a central theme for discussion and investigation not only in medicine but also in other health and social service professions. Because cultural competency is still evolving, a number of definitions have been attached. For instance, the Van Cover Ministry for Children and Families says "...cultural competency refers to the ability of organizations and systems to function and perform effectively in cross-cultural situations." (*Vancouver Ministry for Children and Families, 2002*). The US Department of Health and Human Services, Office of Minority Health uses as its working definition, "...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." (*Meadows, M 2002*). The American Medical Student Association refers to cultural competency as "...a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups" (*AMSA website, September, 2001*). At the National Medical Association cultural competency is defined as "The application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhances a provider's effectiveness in managing patient care."

OTHER KEY CONCEPTS

CULTURE

- Everything we learn is through the process of socialization.
- Refers to:
 - Customs*
 - Beliefs*
 - Values* - general ideas about what is good or bad, right and wrong
 - Includes symbols and language
- Is a dynamic pattern of learned behaviors, values, and beliefs exhibited by a group that shares history and geographic proximity
- It is everything we are not born with
- The culture socializes the individual on how to think, act and feel toward illness. It determines the health attitudes and behaviors of providers and consumer, and the roles of the actors-the healer (the physician) and the patient.

INSTITUTIONS OF CULTURAL TRANSMISSION

- Family (nuclear and extended)
- Educational system
- Political & Economic systems
- Religious systems
- Reference group(s)
- Media

- Language
- Symbols

Despite considerable attention devoted to this topic, there are various schools of thought about the need for cultural competency training. For purposes of this paper, three dominant perspectives are identified. One perspective contends that understanding and accepting multiculturalism and its relevance in health care will lead to improvements in service delivery and health care outcomes if proper education and training is provided. This group tends to maintain liberal views about cultural competency and proactively seeks to develop services and programs using a multicultural contextual framework. This includes institutionalizing culturally competent approaches that are reflected in organizational policies, facility décor, integration of cultural competency concepts in treatment protocols and patient education activities, making available interpretation services, providing on-going cultural competency education for providers and staff, and hiring providers and staff that represent the populations served.

Another perspective fosters the status quo and asserts that generic protocols and guidelines are appropriate for and applicable to all populations. Supporters of this frame of reference assume that the differences, if any, in the effectiveness of various treatment/intervention regimens with various populations are minor or inconsequential to patient compliance and subsequent successful health care outcomes. Further, that other factors such as levels of patient education, income, race, and class may be con-

sidered more reliable predictors of successful patient care outcomes.

The third perspective contends that adopting multicultural perspectives will lead to further imbalances in service delivery and unnecessary provider competition. Generally predicated on fear and limited knowledge about the relevance of cultural influences on practice patterns and patient care outcomes, supporters of this contextual framework are generally resistant to change. Often, their view of cultural competency education for providers is seen as a systematic approach to impose additional barriers to care and spur further competition among providers for patients.

Such varying perspectives clearly substantiate a need for further awareness and educational efforts in this area. Likewise, more information is needed to show the linkages between cultural competency and the health care of minorities. According to the Institute on Race, Health Care and the Law, "...The widening gap in healthcare between people of color and white America is not due solely to economics, but to the lack of culturally relevant healthcare treatment and medical information designed to reach the nation's fastest growing populations effectively" (*Vernellia R. Randall, 2002; New America Wellness Group, 1999*).

Increasingly, cultural competency is being addressed with varying degrees across sectors, disciplines, and arenas. Through awareness building efforts cultural competency is finding its way on the agendas of policy-makers, accrediting bodies, professional organizations, and in university curricula.

For instance, President Clinton's Race Initiative highlighted six health disparities that were targeted for elimination, they included the following:

- Infant Mortality
- Cancer Screening and Management
- Cardiovascular Disease
- Diabetes
- HIV infection
- Immunizations
 - Child and adult

President Clinton's Race Initiative grew out of the need to address these health concerns that were disproportionately impacting the health status of minority populations. Health status indicators such as morbidity, mortality, and service utilization rates validated the need for a more aggressive action plan to address these six health targets. Linkages among socioeconomic, biological conditions, and health disparities have been documented throughout the literature. A summary of such contributing factors include the following.

- Genetics
- Culture
- Socioeconomic
- Differential access to health care
- Poverty
- Lifestyles

**NATIONAL
COLLOQUIUM
on AFRICAN
AMERICAN
HEALTH**

In a workshop for senior state health officials entitled, *Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems*, US Census Bureau projections provided the contextual framework for developing strategies to more effectively address the health care needs of minority populations. Framing the dialogue was Census data, which indicated that the "...proportion of the overall population considered to be "minority" (those persons who are not white and of non-Hispanic origin) will increase from 26.4 percent in 1995 to 47.2 percent in 2050. By the year 2030, minority children will account for more than one-half of the Nation's population under age 18. Health status indicators such as morbidity and mortality rates, infant mortality rates, and service utilization rates across racial and ethnic groups were used to support the growing views that the health care system is not culturally competent. Among the conclusions reached during the session was-"To promote the delivery of health care services that better address the needs of racial and ethnic minorities, it is increasingly important to improve the cultural competence of health care delivery systems and providers." (*Agency for Health Care Policy and Research, 1999*).

According to a communications representative, The Joint Commission for the Accreditation of Health Care Organizations (JCAHO), which has more than 500 compliance standards that organizations must meet in order to achieve accreditation., has taken a step towards assessing cultural competency by inquiring about the treatment of patients as individuals with unique needs. Such inquiries are part of JCAHO's review process concerned with patients rights. (*Office of Minority Health Resource Center, 1997*).

The National Mental Health Association also promotes access to services and the effectiveness of care for mental health consumers. According to the National Mental Health Association, "...a culturally competent mental health system incorporates skills, attitudes, and policies to ensure that it is effectively addressing the treatment and psychosocial needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and/or language..." The Association further advocates for cultural competency by urging mental health providers follow a set of recommended action steps that include formal planning, materials development, representative staff, treatment plans that are compatible with consumers environments, and use of specialized assessment and treatment techniques. (*NMHA website- Cultural Competency in Mental Health Systems, 1998*).

Promoting a culturally competent health care system is best accomplished when there is better understanding about how perceptions and assumptions are shaped. "Patients and physicians live and function in a multiplicity of cultural domains shaped by profession, socioeconomic class, ethnicity, race and community affiliation. When physicians and patients interact, their cultural domains influence their assumptions and perceptions." (*Flores, G.R. 2002; Mattingly, 1997*). Medical professionals need to examine their own cultural and health assumptions as they attempt to incorporate patients' beliefs and customs into medical encounters of all types. To provide good family health care rather than context-free "interventions," physicians must acknowledge the link

between illness and social marginality. (Flores, G.R., 2002; L. and A. Marcus, 1988).

A critical first step calls for analyzing population trends. Demographic shifts accompanied by increased awareness and political savvy of minority groups, legal consequences and policy changes, persistent health and social disparities, as well as increased pressures for provider accountability all combined have provided an impetus for greater attention and focus on multiculturalism and the delivery of culturally competent care.

According to Dr. Aida Giachello, member of the NMA Advisory Committee on Cultural Competency, a review of the literature reveals that during the past two decades, minority populations have shown significant growth rates. According to US Census data, between 1980 and 1990, African Americans represented 13 percent of the US population, increasing from 26.5 million persons in 1980 to approximately 30 million persons in 1990. Similar growth patterns occurred among other segments of the population during this time period as well. Asian Americans and Pacific Islanders grew 95%, from 3.7 million to 7.2 million persons and Native Americans and Alaskan Natives increased 28 percent-increasing from 1.5 million to 2 million persons. The fastest growing segment of the population, however, has been among the Hispanics/Latinos. This segment of the population experienced a 53 percent growth rate-increasing from 15.7 million to 22.3 million persons. In comparison, the European American population increased only by 5.6 percent during the same period.

The racial and ethnic composition of the US population has continued to diversify over the past decade. Between 1990 and 2000, minorities represented 29 percent of the total US population and racial minorities and Hispanics grew at a rate that was six times that for non-Hispanic whites. Within the US four states-California, Texas, Florida, and New York-accounted for well over half the minority growth rates between 1990-1998. Contributing to domestic population shifts are immigrants, of whom approximately 1 million come to the US each year.

Within these racial and ethnic groups are sub-segments of the population that have special needs. Often these sub-segments of the population are grouped according to age (i.e., seniors, young and middle aged adults, adolescents, and children-one third of whom are minorities); gender (males, females); sexual preferences (gays, lesbians); functional status (i.e., the physically and mentally challenged), and health status (e.g., the chronically ill). Caring for individuals within each group requires a holistic approach that encompasses understanding not only their physical and mental health needs, but also influences on attitudes, behaviors and lifestyles within a cultural context. Knowing what is perceived to be culturally acceptable and unacceptable is a major step towards better understanding risk behaviors, achieving compliance with treatment regimens and, subsequently, more desirable health status outcomes.

The question then becomes what steps must be taken to systematically change the current land-

scape of the health care system so that it reflects a more culturally competent system of care. The NMA Advisory Committee purports that awareness, sensitivity, education, and training are pivotal to the transition process for achieving a more culturally competent system of care.

As with the schools of thought, cultural competency training programs run the gamut of structures, intensity, and settings. Some training programs are offered through workshops, seminars, integrated into school curriculum, or offered as continuing medical education. A few examples are presented as follows. The Milwaukee AHEC: Breaching Cultural Barriers to Health Care Delivery is a training program for health professions students, residents, and faculty. The curriculum focuses on such conditions as childbirth, chronic illnesses, or death of an elderly family member and the effect that cultural traditions, values, and beliefs have on the delivery of health care for these conditions. Developed in conjunction with the Medical College of Wisconsin and the University of Wisconsin's health professions schools, the initiative includes three programs-Community cultural rounds (a seminar series for medical students and health providers), Cultural Competency Training (for medical clerkship students), and the Wisconsin Partnership for Training Program (for nurse practitioners, certified nurse midwives, and physician assistants).

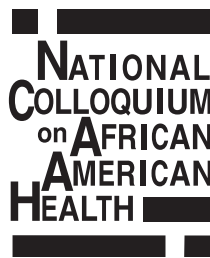
The **Massachusetts** League offers a web-site for primary care providers who work in community centers reference critical elements of culturally competent services. The League promotes culturally competent services that "... focus on population-specific issues that include health-related beliefs and cultural values (the socioeco-

nomics perspective), disease prevalence (the epidemiologic perspective), and treatment efficacy (the outcome perspective)..." (http://www.massleague.org/clinicians/cultural_competency.htm).

In *What It Really Takes to Improve Cultural Competency* in an interview by the Office of Minority Health Research Center with Juan Ramos, PhD, Associate Director for Prevention, National Institute of Mental Health, "...It is vital that mental health facilities, educational institutions, and accrediting and licensing bodies incorporate cultural competency in their standards, criteria, and requirements..." (Closing the Gap, 1997).

IV. NMA BLUE PRINT FOR ACTION

With the assistance and support of the Advisory Committee, Phase I of the cultural competency training design has been completed. Phase I called for introducing the conceptual framework for cultural competency education and training to the organization's leadership and to encourage their embrace of the training design. Support of the vision for cultural competency training began with the Board of Trustees, Specialty Section Chairs, and House of Delegates. This encompassed introducing the governing body to the cultural competency training design and concepts, engaging them in the curriculum development process, and assessing what refinements to the training approach are needed in order to finalize the blue print for action. This has been accomplished through general meetings, work group sessions, and consensus building activities.



Four objectives support the overarching goal. They include the following.

• **OBJECTIVE ONE**

Convene work group sessions in each of the identified nine health priority areas to review selected national clinical guidelines and determine their appropriateness for use as standards of care in the treatment of African American patients.

• **OBJECTIVE TWO**

Reach consensus on the appropriateness of sample questions for inclusion in an electronic databank that would be made available via the NMA website to physicians and health providers preparing for certification in Ethno-Cultural Medicine.

• **OBJECTIVE THREE**

Apply information technology support to the curriculum development and consensus building process.

• **OBJECTIVE FOUR**

Validate the training design and curriculum development process for full-scale implementation among NMA's membership.

V. TRAINING DESIGN

The training design encompasses a five-year implementation process, which will begin with NMA's membership and then broaden to other ethnic groups as follows-Asian Americans, Native Americans, Hispanic Americans, and European Americans.

Phase One: Curriculum Development Work Group Sessions Board Of Trustees, Specialty Chairs, And Advisory Committee

- Review of Cultural Competency Concepts
- Discuss Relationship of Concepts to Research, Patient Care, and Public Health
- Review Selected Clinical Guidelines Published by the National Guidelines Clearinghouse for Cultural Relevance for Use With Persons of African Descent
- Recommend Modifications (As Appropriate)
- Draft Sample Questions for Study Guide Database (10 Questions Per Work Group)

Phase Two: Replicate Process At The Regional Meetings With State Chapter Presidents And Advisory Committee

Phase Three: Complete And Field Test Study Guide

Phase Four: Complete Curriculum Using A Workshop Series

Phase Five: Pilot Pre-Convention Workshops For Continuing Medical Education Credit At The 2002 Annual Convention and Scientific Assembly (Open to Registrants)

V. WHERE WE HAVE BEEN

Training Outcomes in Hawaii - Dr. Diane L. Adams, Director, Office of Health Policy, Research, and Professional Medical Affairs developed and implemented a 7-hour training activity in cultural competency for the NMA

Board of Trustees and Specialty Section Chairs on October 4th & 5th, 2001 in Honolulu, HI. Technical support for this activity was provided by the corporate staff of the National Consortium for African American Children Ms. Brenda A. Leath, President/CEO and Mr. Garland B. Hawkins, Chief Operating Officer. The training activity embraced a participatory model and included the Specialty Section Chairs as work group leaders during the small group sessions. A total of 94 NMA Trustees And Section Chairs were in attendance and received the training. The presentations included definitions of cultural competency, socio-demographic shifts and their implications for health care services, the relevance of genome research to cultural competency, implications for public health, and culturally competent patient care.

The Work Group Sessions - During the second half of the training activity work groups sessions were conducted that focused on assessing the appropriateness of selected clinical guidelines for use with African American patients. Four desired outcomes guided the work of the work groups, which included:

- ***Consensus on the best approach*** for developing the NMA's Cultural Competency Curriculum using an Evidence-Based Medicine Approach.
- ***Support of the proposed educational continuum in cultural competency*** that will lead to Board Certification in Ethno-Cultural Medicine by the year 2006.
- ***Development of an initial bank of multiple choice questions*** that can be field-tested, incorporated into a study guide, and used by medical students, physicians in training, and prac-

tioners to prepare for Board Certification in Ethno-Cultural Medicine.

- ***Recommended modifications to selected clinical guidelines*** that may lead to improved health outcomes among African American patients who suffer from particular health conditions.

The guidelines reviewed were identified from the National Guidelines Clearinghouse in eight disease categories-cancer, cardiovascular disease, depression & mood disorders, diabetes, HIV/AIDS, injuries, kidney disease, obesity. The primary observation made from the work group participants was that the guidelines were outdated and some required alternative treatment approaches. This outcome led to various follow-up assignments to the Specialty Section Chairs and included the following:

- 1) Dr. William A. McDade agreed to take leadership in developing questions for the Board Certification test. He has agreed to provide us with an initial set of eighteen (19) questions for review and assessment of their appropriateness for testing.
- 2) Dr. Adams, Ms. Leath, and Mr. Hawkins requested a meeting with the Project Director of the National Guidelines Clearinghouse to share information about the NMA's cultural competency training design and to request copies of existing clinical guidelines for review during future work group sessions.

A ninth category, End-of-Life Care, was added and will be developed under the leadership of Michelle Grant Ervin, MD, MHPE, FACEP, Chairperson of Emergency Medicine at Howard University Hospital and Assistant Professor, Howard University College of Medicine. She

will be assisted by Joye M. Carter, MD, Chief Medical Examiner in Houston, Texas.

Continuing Medical Education Credit - An unanticipated outcome of the training was an opportunity to participate in a teleconference meeting arranged by Dr. William Matory, Director, Continuing Medical Education, NMA and physicians at Howard University College of Medicine. This meeting was the result of prior exploratory conversations about the use of web-based technology to expand the NMA's training capacity for granting CME-based courses over the internet. An outcome of the meeting was a commitment to augment the on-site cultural competency training workshop offered during the 2002 Annual Convention and Scientific Assembly with a web-cast of the session. Dr. Matory is following up on the logistics for this activity.

Since the training session in Hawaii, we have reviewed feedback about the training design conducted in Honolulu, which has been extremely positive and mostly verbal. While we received a low return rate on the evaluation forms, on those collected the overall training process was rated very positively. Areas in need of improvement as reflected by the participants included increasing the time allotted for the training activities and advance receipt of the training materials.

VI. WHERE WE ARE

Curriculum Development -We have analyzed qualitative information from summary reports of the workgroups conducted in Hawaii. Invaluable lessons were learned from these meetings,

some of which confirmed the need for heightened NMA involvement in assessing the appropriateness of existing clinical guidelines that are currently being promoted as national standards of care, treatment protocols, and universal guidelines. In several instances the review and assessment process yielded information that reflected out-dated clinical guidelines, inappropriate guidelines for use among African American patients, and/or the need for the development of alternative treatment protocols, clinical guidelines, and standards of care that are scientifically validated through such vehicles as clinical trials.

The process of reviewing existing clinical guidelines and protocols clearly is critical to the development of our strategy for evidence-based medicine approaches to cultural competency training, not only for NMA members but for any physician who manages the health care of persons of color. Achieving improvements in systems of care for people of color in general and African American patients in particular requires perpetual surveillance, monitoring, and adaptation of effective clinical practices. This is best accomplished through enhancement of provider knowledge and understanding of:

- 1) the cultural and ethnic influences on patients' health status and health seeking behaviors;
- 2) tools and approaches for making effective clinical decisions,
- 3) application of clinical decision-making support systems to assess appropriateness/efficacy of protocols, guidelines, and standards of care; and

4) relevant procedures for scientifically validating alternate treatment of diseases and disorders that disproportionately impact the African American community.

Dr. Adams' idea to adopt information technology into the NMA's Cultural Competency program assisted in maximizing the effectiveness and efficiency of the curriculum development process. Accordingly, principals at the National Consortium for African American Children (NCAAC)-technical support consultants to the NMA-introduced the Director, Health Policy, Research, and Professional Medical Affairs, Executive Director, and Chairman of the Board to the Group Systems process. Group Systems is a nationally recognized information technology support tool that is used by various corporations and organizations to assist with information and data collection, processing, and refinement. It is an invaluable resource for regulating information in an efficient manner and facilitating group consensus building. Group Systems helps to create a repository of artificial intelligence that affords enhanced accessibility to myriad end-users. Through NCAAC's subcontractual arrangement with a local information technology company, members of the NMA Board of Trustees and House of Delegates became acquainted with this state-of-the-art technology during the February meeting.

The Office of Health Policy, Research, and Professional Medical Affairs is developing an expanded funding strategy that is designed to support refinements to the initial training design. The plan also is to include recommendations for the strategic involvement of selected NMA Board members to be engaged in fund development activities related to the cultural

competency training initiative. This will enhance efforts for garnering support for replicating the 5-year plan training design in other communities of color.

House of Delegates Meeting. Taking into consideration the lessons learned from the training activities in October with the Board of Trustees and Specialty Section Chairs, the training schedule and format was revised for the House of Delegates meeting in February. These adjustments were made to allow more time for members of the House of Delegates to review, in advance, the cultural competency notebooks that were prepared for the training in Honolulu. A summary of our adjustments made in preparation for this meeting includes the following.

1) Distributed an advance copy of the cultural competency notebook to House of Delegates members. Instructions included review of the document prior to the February meeting and bringing it to the meeting in Las Vegas, NV. Similar instructions were issued to the Board of Trustees as well.

2) Requested that Advisory Committee Members prepare an abbreviated version of the presentation that which was given in Honolulu. This is to be offered as a refresher for the Board and as a reinforcement of the readings to Members of the House of Delegates. In view of the importance and time requirements for the review of the clinical guidelines, we have expanded our emphasis on the work group component of the training.

3) Developed a strategy for assessing participants' understanding of cultural competency concepts through the use of multimedia resources (e.g., Group Systems).

4) Refined our process for assessing participant understanding of cultural competency concepts and have incorporated information technology support as part of our strategy to garner consensus on sample certification questions that are being developed for the NMA's cultural competency study guide and database.

5) Introduced the NMA's demo health web-site to the House of Delegates and Board of Trustees-A preview of the cultural competency web page.

VII. WHERE WE ARE GOING

Now that the House of Delegates training activities have been completed, we will embark upon the second phase of our training activities. This will involve further integration of feedback from the work group sessions into the curriculum development process. A curriculum development subcommittee was established during the February House of Delegates meeting. The committee has been charged with the development of a preliminary curriculum that will be pilot tested during the regional meetings. It is anticipated that the feedback from the workshop participants will be used to make further refinements to the process.

Regional Meetings - Adjustments to the original timetable for introducing curricular components at the regional level were made to allow adequate time for refining curricular elements. Two regions will receive the training during the remaining fiscal year. Special emphasis will be placed on definitions of health literacy and cultural competency; overview and update of

NMA's cultural competency training curriculum; and validation of the appropriateness of clinical guidelines as it relates to state policies and legislation.

Refining Curriculum for Implementation During the Annual Convention and Scientific Assembly -

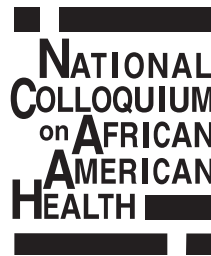
A pre-conference workshop is planned during the Annual Convention and Scientific Assembly. To ensure broad-based access to the information, a web cast of the workshop will be made available via the NMA Health web-site.

Exploring Production of a 30-Minute Training Video -

To assist in educating various health and human services professionals on cultural competency, the NMA is exploring the development of a 30-minute training video. Plans include development of a marketing and dissemination plan for the video.

Cultural Competency Web-site -

Consumers and providers will be able to access health information via the launching of the NMA Health web-site in April, 2002.



**TABLE 1. A PROPOSED STRATEGY FOR DEVELOPING
THE AMERICAN BOARD OF ETHNO-CULTURAL MEDICINE**

(c) July 2001

ACTION ITEM	CONTENT ELEMENTS
1. Develop White Paper on the Need for Certification in Ethno-Cultural Medicine	<ul style="list-style-type: none"> • Summarize The Goals, Need, Significance, Implications, Proposed Approach, And Evaluation Measures.
2. Develop a Plan for Establishing Subspecialty Certification Designation in Ethno-Cultural Medicine	<ul style="list-style-type: none"> • Definition, Goals and Objectives • Resource Requirements (Technical Merit Providers) • Timeline • Primary Target Audience (Medical Students, Postgraduate Residents, and Physicians)
3. Conduct an Assessment of External Support for the Establishment of a New Board and Identify Potential Collaborators	<ul style="list-style-type: none"> • Determine Level of Support from Such Medical Organizations as the American College of Physicians, Hispanic Medical Association, the American Board of Medical Specialties, and the American Medical Association
4. Survey Level of Interest & Support Among NMA Members and Other Professional Medical Organizations	<ul style="list-style-type: none"> • Determine Level of Interest and Support from the NMA Membership and Other Professional Medical Organization Members
5. Review the American Board of Medical Specialties' Process for Approval of New Boards	<ul style="list-style-type: none"> • Guidelines and Essential Requirements
6. Draft Preliminary Standards and Guidelines	<ul style="list-style-type: none"> • New Board/Certification Essentials and/or Requirements
7. Develop Curriculum-Based Program with Self- Assessment Instrument	<ul style="list-style-type: none"> • Didactic & Practical Curriculum Elements • Self-Assessment Tool
8. Identify Mechanism/Vehicles to Conduct the Training	<ul style="list-style-type: none"> • Assessments Of In-Class, Publications, Case Studies, Role Playing, CD-ROM, On-line (future), and Conferences As Examples Of Training Methods

9. Identify Development Resources
 - Policy Advisory Board
 - Funding to Support Training, Materials Development, and Promotional Outreach Activities
10. Establish Evaluation Plan and Criteria
 - Effectiveness & Efficacy Indicators
 - Outcome Measures (on-going)

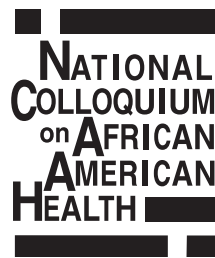
VIII. CONCLUSION

It is with the vision of Dr. Randall W. Maxey that the NMA is coming to the forefront of addressing critical health care concerns facing providers and patients. Evidence-based culturally competent medicine is what the NMA considers to be a must, if we are to make inroads into eliminating disparities among minority populations. To this end, the NMA recognizes that global changes are taking place and that the medical community must keep pace with these revelations. While there was once a time when we focused our attention on two dominant cultures—majority and minority, now we are faced with looking at the world through multiple lenses so that we can better appreciate the similarities and differences of multiple cultures and subcultures. With this mind, the NMA contends that only when we become culturally proficient will we begin to see modest improvements in the health of people of color. The NMA encourages physicians and other health care providers to embrace our national training initiative and view it as a means to remove obstacles that will bring about a healthier nation. In support of the training design, the NMA has identified the following recommenda-

tions that have implications for training, service delivery, and public policy.

RECOMMENDATIONS:

1. Integrate a universal cultural competency curriculum into the medical school curricula through a collaborative partnership with the Association of American Medical Colleges.
2. Develop a continuum of educational opportunities for medical school students, post-graduates, and physicians in practice.
3. Assess the level of support for the establishment of a Board or Subspecialty Board in Ethno-Cultural Medicine.
4. Provide training and technical assistance to senior level managers of health care corporations to assist them in preparing culturally competent programs both nationally and internationally.
5. Increase access to cultural competency information and materials through the use of information technology.
6. Develop a formal database on clinical guidelines that have been determined appropriate for use among minority populations.
7. Use telemedicine as a mechanism to facilitate provider access to clinical guidelines via hand-held PCs.
8. Promote civil discourse and public policy around the development and implementation of a national cultural competency health care agenda.



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