

STATE OF NEW MEXICO



Initial Report of the

**Task Force on Cultural Competence Education
in the Health Sciences**

Presented to:

Governor Bill Richardson
New Mexico State Senate
Council of University Presidents

By

The Task Force on Cultural Competence (SB 600)

Deputy Secretary of Higher Education William Flores, Chair

Mr. Lorenzo Garcia, Vice-Chair
Dr. Valerie Romero-Leggott, Vice-Chair
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December, 2007

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Former Surgeon General
David Satcher



UNM School of Medicine
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Occupational Therapy

NEW MEXICO HIGHER EDUCATION DEPARTMENT



Dear Colleagues,

December 3, 2007

The Initial Report of the Task Force on Cultural Competence Education in Health Sciences is a direct response to Senate Bill 600. On March 30, 2007, Governor Richardson signed SB 600 creating the Task Force on Cultural Competence Education. Introduced by Senator Bernadette Sanchez, this bill mandated that a Task Force on Cultural Competence undertake to study health-related educational fields and offer recommendations on specific curricula in New Mexico's public post secondary educational institutions.

This report summarizes the findings and recommendations of the Task Force, and represents the distillation of the Task Force's efforts to fulfill SB 600's legislative charge. The report is intended to facilitate a statewide conversation about the health services provided to New Mexico's multicultural citizenry. It addresses potential "best practices" for preparing healthcare practitioners to work with patients from varying backgrounds and unique cultural traditions. Finally, this report is the initial attempt to compile information that is pertinent to the ultimate creation of a culturally and linguistically competent curricula for health-related educational fields.

The Task Force created subcommittees, asked the state's higher educational institutions to appoint liaisons, and identified students to assist with the research and writing of this report. Therefore, the Task Force on Cultural Competence is deeply grateful for the combined efforts of these talented people from many different fields and multifaceted backgrounds. Their professional insight, expansive knowledge, and thoughtful attention ensured the integrity and quality of this Initial Report on Cultural Competence Education in the Health Sciences.

Sincerely,

A handwritten signature in black ink, appearing to read "William V. Flores".

William V. Flores, Ph.D.
Deputy Secretary
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New Mexico Higher Education Department

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AN ACT

RELATING TO HEALTH; ESTABLISHING A TASK FORCE TO DESIGN CULTURAL COMPETENCE EDUCATION REQUIREMENTS IN CERTAIN HEALTH EDUCATION PROGRAMS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. TEMPORARY PROVISION--HEALTH EDUCATION CULTURAL COMPETENCE TASK FORCE--HIGHER EDUCATION DEPARTMENT-- APPOINTMENT--DUTIES--REPORT.--

A. The secretary of higher education shall appoint a task force on cultural competence composed of health curricula specialists from two- and four-year public post-secondary educational institutions; health professionals; and representatives of the New Mexico health policy commission, the department of health, the Indian affairs department and the office on African American affairs. Members shall be appointed with due regard for geographic distribution and cultural and health-professional diversity.

B. The task force shall study and make recommendations on specific cultural competence curricula for each health-related education field offered in New Mexico's public post-secondary educational institutions. The curricula shall ensure that students are provided knowledge of cultural awareness and competence in their respective

1 health service field, including:

2 (1) cross-cultural communication;

3 (2) culturally and linguistically

4 appropriate health policy considerations;

5 (3) exploration of health beliefs and

6 explanatory models;

7 (4) culturally competent health care

8 delivery;

9 (5) health disparities, privilege and equity

10 factors in the health system; and

11 (6) culturally and linguistically competent

12 care supported by policy, administration and practice.

13 C. The curricula developed by the task force shall
14 be designed to be offered electronically and through various
15 distance-education models and media so as to minimize
16 duplication and expense for students and educational
17 institutions.

18 D. The task force shall review its findings and
19 recommendations with the legislative health and human services
20 committee by November 2007. The task force shall make its
21 final report to the governor, the legislature and the
22 presidents of the public post-secondary educational
23 institutions by December 15, 2007.

Initial Report

A Navajo family opposes the examination of the body of their deceased relative by hospital personnel. A paranoid patient asks a social worker not to keep notes. A transgendered person has a different gender than what is shown in the medical charts. A Vietnamese patient has her eight-year old daughter translate for her because the hospital has no Vietnamese interpreter.

Each day health providers face multiple issues involving the culturally complex environment in which New Mexicans seek health care services. It is essential that healthcare providers be aware of and sensitive to the diverse needs of their patients; it is essential that healthcare providers be culturally competent.

New Mexico ranked number 48 in the Health Index of States. The Health Index is a measurement of access to health care providers, affordability of healthcare, and a generally healthy population. Recent demographic statistics, which reflect an increase in the number of diverse populations residing within the state, magnify the complexity of the task of creating a culturally competent and responsive healthcare system. These combined factors underscore both the timeliness and importance of a study of the educational programs that produce New Mexico's healthcare providers. SB 600 and the work of the Task Force on Cultural Competence represent an essential step toward remedying the chronic disparities in access to and quality of health services between New Mexico's diverse communities.

New Mexico's population of 1,954,599 persons is culturally and ethnically diverse. 43.1% of residents classify themselves as White, 2.4% African American, 10.2% Native

According to the New Mexico Medical Review Association, *cultural competence* is “the ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social cultural and linguistic needs.”

American, and 43.4% Hispanic.¹ Racial and ethnic minorities – even those who possess equivalent socioeconomic status, education, and healthcare access – receive lower-quality care than white patients for many medical conditions. These differences in health outcomes between majority and minority populations are commonly referred to as *racial or ethnic disparities in health*. The primary ethnic subgroups in which health disparities are consistently overrepresented include Native American, Hispanic, and African American communities. People with disabilities, Medicaid eligible subpopulations such as the poor and working poor, subpopulations of immigrants including refugees and undocumented individuals, and rural and frontier communities also suffer endemic healthcare disparities. Mistrust, subconscious bias, and stereotyping – which practitioners and patients both may bring to clinical encounters – all influence an individual’s decision to seek healthcare as well as a practitioner’s ability to provide it. Thus, New Mexico is faced with a difficult but crucial challenge: build a more responsive healthcare delivery system by addressing the educational programs that produce the state’s healthcare providers.

Between 1992 and 2000, the health arena underwent dramatic changes. Silence about medically unethical practices and institutionalized disparities was replaced by open discussions about the underlying causes of disparities.² In response to Senate Joint Memorial 13, a Health Care Profession Survey was conducted in 2004 by the New Mexico Department of Health. The survey investigated whether schools that provide healthcare educational programs have curricula that support the acquisition of knowledge and skills in seven specific areas: cultural awareness;

¹ 2005, U.S. Census Bureau Statistics
<http://quickfacts.census.gov/qfd/states/35000.html>

² Report of Senate Joint Memorial 13. “The Study of Cultural and Linguistic Issues in Health Care in New Mexico.” Oct. 1, 2004.
<http://doh.state.nm.us>

cultural diversity; culturally-defined health beliefs and practices; perspectives of illness and disability; implications in assessment, diagnosis, and treatment; cross-cultural communication; and working effectively with interpreters. 54% of the schools reported that their curricula include working effectively with interpreters. 81% reported inclusion of all other areas of knowledge and skills.³ Further, 17 licensing boards for health professionals were queried to determine whether the boards required applicants to demonstrate knowledge or skills in providing health services in a culturally competent manner a) when they applied for an initial license or b) when they applied for license renewal. Only the Board of Social Work Examiners reported maintaining licensing requirements for Cultural Competence.

Measures have been developed, throughout the state and nation, to disseminate Cultural Competence more thoroughly throughout the healthcare fields. The New Mexico Review Association defines Cultural Competence as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social cultural and linguist needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.” The New Mexico Review Association has taken its commitment to increased Cultural Competence in the health sciences beyond the theoretical and into the actual. It has launched the Culturally and Linguistically Appropriate Services (CLAS) Project, an online course in Cultural Competency, which is free to New Mexico’s practitioners. Some of the aims of the CLAS Project include improving communication with patients, providing access to online training tools, videos, and workbooks on culturally responsive care, and developing a management plan that treats patients from all cultures as partners. Further, the US Department of Health and Human Service’s Office of Minority Health provides an online

³ Report of Senate Joint Memorial 13, pg. 32

training course entitled “A Physicians Practical Guide to Culturally Competent Care” which is offered to healthcare providers at no cost. These courses represent tremendous strides forward in the attempt to address and reduce the healthcare disparities that result from cultural barriers.⁴ Certainly, much more must be done.

On March 30, 2007, Governor Richardson signed SB 600 creating the Task Force on Cultural Competence Education. Introduced by Senator Bernadette Sanchez, this bill decreed that a Task Force on Cultural Competence undertake to study health-related educational fields and offer recommendations on specific curricula in New Mexico’s public post secondary educational institutions.

This report summarizes the findings and recommendations of the Task Force. The report is intended to facilitate a statewide conversation about the rewards and challenges of providing health services to New Mexico’s multicultural citizenry. It addresses potential “best practices” for preparing doctors, nurses, pharmacists, social workers, and therapists to work with patients from varying backgrounds and unique cultural traditions. Finally, this report is the initial attempt to compile information that is pertinent to the ultimate creation of a culturally and linguistically competent curricula for health-related educational fields.

The Task Force created subcommittees, asked the educational institutions to name liaisons, and identified students to assist with the research and writing of this report. Dr. William Flores, Chair of the Task Force and Under Secretary of Higher Education, sent a letter to twenty-eight institutions of higher education requesting: 1) a campus contact for the Task Force that would be responsible for providing a list of all health-care related programs at the school; 2) a list of any current courses or programs in Cultural Competence taught at the school;

⁴ New Mexico Medical Review Association: Underserved and Rural Beneficiaries.
http://www.nmmra.org/providers/physicians_underserved.php

and 3) any requirements in the area of Cultural Competence that must be met for licensing or graduation from the school.

Summary of Findings and Conclusions

1. Nationally, the medical professions have not yet developed model curricula on Cultural Competence. The Association of American Medical College's response to the received inquiry clearly summarizes the current situation in New Mexico: "we do not have a resource documenting national models or best practices. It is a challenge from a national perspective to disaggregate and characterize the full spectrum of training available."
2. Efforts to create Cultural Competent curricula must be profession-specific and aimed at creating a knowledge and skill set based on the discipline. Several national organizations have decided that it is not feasible to develop one model for Cultural Competence, nor is it appropriate to impose that model on the disparate health service areas. Instead, individual professional entities, such as *the National Heart, Lung and Blood Institute*, *the Cultural Competence and Health Disparities Education Collaborative*, and four California schools funded by the *California Endowment*, are developing mnemonic, assessment, and learning tools. Their purpose is to address ethnic, cultural, religious, socioeconomic, and linguistic factors that contribute to health disparities by crafting medical educational programs. These programs aim to build the Cultural Competent knowledge base and skill set of medical students, house staff, and other professionals, including practicing physicians.
3. For these reasons, and after broad consultation with representatives from the various health fields, the Task Force feels it would be best to develop profession-specific

approaches rather than one single curriculum. The formation of working groups within the Task Force will allow focus to be placed upon the providers' unique experiences in an effort to identify best practices. Consequently, working groups from Medicine, Registered Nursing, Pharmacy, Social Work, and Occupational Therapy will explore how to teach Cultural Competence and make recommendations to the Task Force.

4. Certain professions in New Mexico, such as Social Work, have tied Cultural Competence standards to accreditation criteria for academic programs and require testing of that competence for licensure.

Federally Mandated CLAS

Standards

5. Twenty-seven programs in New Mexico's institutions of higher education responded to the letter sent out by the Task Force chair. Sixteen addressed four of the five targeted professions: Medicine, Registered Nursing, Social Work, Occupational Therapy, and Pharmacy. Only one institution has a medical program leading to a M.D. Eleven have registered nursing programs ranging from two to four years and leading to an Associate or Baccalaureate degree. Two institutions report accreditation through the Commission on Collegiate Nursing Education, whilst nine report accreditation through the National League of Nursing Accrediting Commission. Two institutions offering Social Work degrees or training responded. Only one of these institutions is working towards accreditation with the Council of Social Work Education; as such, it is extending efforts to comply with the

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumers with limited English proficiency at all points of contact, in a timely manner .

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/ consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation during all hours of operation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Council's standards. Two Pharmacy education programs submitted responses, but both failed to supply accreditation and licensing information. Finally, one institution addressed Occupational Therapy by reporting that the accreditation process is carried out by the Accreditation Council in

Occupational Therapy Education (ACOTE), which dictates that the curriculum must include certain Cultural Competence elements.

6. Information on relevant courses in Cultural Competence ranges from stand-alone courses to independent competence units within the larger curriculum. The compiled information spans from exceedingly vague to thoroughly detailed; thus, it is difficult to ascertain the part that the Cultural Competence sections play within the broader educational context. More investigation is required to gain a clear picture of the current status of Cultural Competence in New Mexico's health-related educational curricula.

RECOMMENDATIONS

1. **CLAS Service Standards.** The Task Force recommends that the state legislature adopt the national standards on Culturally and Linguistically Appropriate Services ("CLAS standards") promulgated by the U.S. Department of Health and Human Services, Office of Minority Health. The CLAS standards are the result of a thorough analysis of Federal and State laws, regulations, and standards combined with extensive input from healthcare professionals and the general public. As such, the Task Force feels that the legislature's adoption of these standards represents

a significant stride forward in the eradication of health care disparities and associated prejudices within New Mexico.

2. **Education and Training Programs in the Health Fields.** The Task Force recommends that all training programs for healthcare providers require culturally and linguistically appropriate competencies. In addition, public institutions of higher education should be required to provide training of CLAS mandates, guidelines, and recommendations in their healthcare programs. Program funding should be contingent upon the incorporation of CLAS standards into the program curriculum. The New Mexico Higher Education Department or other appropriate agencies should be assigned oversight to ensure full implementation of CLAS standards within these programs.

3. **Licensing and Continuing Education.** The Task Force recommends that licensing and continuing education requirements include cultural and linguistic competence. Board and Licensure examinations should include sections that measure a healthcare provider's understanding of cultural competence.

4. **Continuation of Task force.** The Task Force recommends that more time be allowed to complete the full charge of SB 600. Specifically, the Task Force recommends that the time for the study and development of curricular modules be extended until November 1, 2008.

- a. The Task Force further recommends that time be allotted to inventory all health-related education fields in New Mexico. No inventory is currently extant. The lack of such an inventory stymies attempts to satisfy the SB 600 mandate that the Task Force “study and make recommendations for each health-related education field offered in New Mexico’s public post secondary educational institution.”

- b. The Task Force recommends that a definition be established for the term “health related field.” To date, the Task Force focused on five professional health fields: Medicine, Pharmacy, Registered Nursing, Social Work and Occupational Therapy. However, this was only an initial step towards satisfying the legislative intent.
- c. The Task Forces recommends that its work be divided into the following phases:
- i. **Phase I: Identification of Priority Disciplines.** During Phase I, the Task Force will focus on Medicine, Registered Nursing, Pharmacy, Social Work and Occupational Therapy. The institutional liaisons will compile campus-specific information and, with the Task Force members, will identify national curricular and/or continuing education models, core competencies as noted in SB 600, and gather best local practices. The Task Force will expand its geographic purview by holding regional, public meetings with stakeholders in communities outside of Santa Fe and Albuquerque.
 - ii. **Phase II : Expansion to Other Health Science Disciplines.** Phase II will focus on the health science areas and disciplines that were omitted from the first phase of investigation including, but not limited to: Mental Health Counseling, Psychology, Dentistry, and undergraduate and community college programs. Licensing Boards will also be evaluated for adherence to CLAS standards and other implemented Cultural Competence paradigms.
 - iii. **Phase III: Accreditation, Licensing, and Curricula.** Phase III will focus on accreditation procedures, licensing standards, and the creation of a Cultural Competence core curricular model for New Mexico.

The process by which the Task Force reviews national standards, researches licensing requirements, and achieves consensus and “buy in” from the various institutions is a crucial, albeit protracted, element of the Task Force’s work plan. There are manifold complications to the Task Force’s continuing work into the fundamentally important issue of Cultural Competence, the most glaring of which include: 1) the disparity between health science disciplines and their respective sets of standards for Cultural Competence, and 2) the vastness of a comprehensive review of standards’ scope. The integrity and thoroughness of the investigation perforce requires the unalloyed time and attention of a cadre of dedicated individuals from the various professions involved as well as specifically designated funding for the continuation of the Task Force’s work toward satisfying the intent of SB 600. The Task Force emphatically believes that a core curriculum for Cultural Competence will function as a mechanism by which New Mexico’s healthcare system is purged of the variegated biases that impede our great State’s multi-cultural citizenry from accessing quality healthcare.

UNM HOSPITALS | **Información en Español**

- ▶ Acerca del Hospital
- ▶ Lo Que Usted Necesita Saber Sobre Su Estadía en el Hospital
- ▶ Manual del Paciente
- ▶ Directorio Telefónico



Hospital Operators: (505)272-2111

SB 600 required the Secretary of Higher Education to appoint a task force on Cultural Competence composed of health education specialists from both two and four year post-secondary schools, health professionals, and representatives from the New Mexico Health Policy Commission, the New Mexico Department of Health, the Indian Affairs Department, and the Office of African American Affairs.

Members of Task Force

William V. Flores, Deputy Secretary	NM Higher Education Department
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Bibliography & Resources

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U.S. Department of Health & Human Services, The Office of Minority Health
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

Appendix:

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both

verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information

about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information