

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES AND RESOURCES ADMINISTRATION
Asian American and Pacific Islander Initiative
IMPLEMENTATION PLAN**

1) INTRODUCTION

Overview of HRSA:

The mission of the Health Resources and Services Administration (HRSA) is to improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. It is committed to forging a healthier tomorrow, in particular for special needs, underserved, and vulnerable populations. As such, HRSA serves as the Nation's safety-net provider.

HRSA strives to accomplish its mission by focusing its bureaus, offices, programs, staff, and partners on three strategic goals. They are to: 1) **Eliminate barriers to care**, thereby assuring access to comprehensive, timely, culturally competent and appropriate health care services; 2) **Eliminate disparities in health status** and health outcomes; and 3) **Assure quality of care** to the underserved by fostering a diverse, quality work force and through the utilization of emerging technologies. To achieve these goals over the next six fiscal years, HRSA will utilize seven core strategies. They are: integrated systems, capacity building, partnerships, service delivery, information systems, performance measurement, and organizational re-invention.

HRSA delivers a wide range of programs, including the Community Health Centers and the Maternal and Child Health Block Grants to States, through its primary operating units. They are:

- The Bureau of Health Professions;
- The Bureau of Primary Health Care;
- The HIV/AIDS Bureau;
- The Maternal and Child Health Bureau;
- The Office of Rural Health Policy; and
- The Office of Special Programs.

The Needs of AAPI Communities and HRSA's Mission:

With a statutory emphasis on the unique needs of underserved, vulnerable, and special needs populations, the issues being addressed by the Asian American and Pacific Islander (AAPI) Departmental Initiative resonate with HRSA's commitment to assure health care access for these target populations.

The Departmental Working Group's Framework identifies the AAPI population as the fastest-growing racial/ethnic group in the United States, characterized by its great ethnic diversity. This population includes a high proportion of immigrants and refugees, with 40% of AAPIs having limited English proficiency. A chief concern for AAPI communities, therefore, is the need for culturally competent and linguistically appropriate services. HRSA's goals correspond with the community's desire for such services. Fittingly, the Departmental Working Group charged HRSA with the lead to

broaden AAPI access to and utilization of health and human services. Their recommendations emphasized the development of guidelines and materials to foster cultural competency in health services delivery.

Another concern of the community is the lack of adequate data about AAPI health needs. Aggregated data for this population present a generally positive profile, obscuring significant disparities in health status among AAPI subpopulations. AAPI health leaders have identified the need to collect disaggregated data and to conduct research that focuses specifically on AAPI health. HRSA is strongly committed to eliminating disparities in health status for underserved populations; bridging the health gaps in the AAPI community is integral to HRSA fulfilling its mission. Monitoring and surveillance systems to assess health status and unmet needs will be put in place to assist the Agency in achieving this goal.

Finally, there are approximately 2 million AAPIs with no form of health insurance. This significant problem is compounded by recent changes in welfare and immigration laws that further restrict access to health services. HRSA's programs provide primary care services to individuals and families regardless of their ability to pay. In its principal role to fill the gaps in the Nation's health care system, HRSA is poised to assist uninsured and other AAPIs in need.

HRSA's Investments in AAPI Health:

The majority of HRSA's client population are members of racial/ethnic minorities, including AAPIs. HRSA supports a significant number of programs for AAPIs that are tailored to their specific cultural health needs. These projects include:

- Native Hawaiian Health Care Program, which is designed to improve the health status of Native Hawaiians through supporting planning and advocacy activities conducted by Papa Ola Lokahi; the provision of health care services; and the provision of scholarships for Native Hawaiian students pursuing careers in the health professions.
- Project Healthy Asian Teens, which decreases the barriers that Chinese, Cambodian and Vietnamese immigrant and refugee youth face in accessing primary health care services.
- New York State Program to Overcome Linguistic and Cultural Barriers to Genetic Services, which works with local health centers and hospitals to enhance genetic screening and counseling, and maternal and child health care among Chinese and Southeast Asian immigrants.
- Asian and Pacific Islander Wellness Center of San Francisco, which is developing a manual that will describe culturally competent methods to improve HIV services for Asian and Pacific Islanders who are living with HIV disease.

HRSA also supports programs to increase the number of AAPIs in the health professions, or to increase the ability of current providers to serve AAPI populations within their cultural context. These include:

- Health Careers Opportunity Program at the University of Hawaii, which aims to increase the number of Native Hawaiians, Filipinos, Micronesians, Chamorros, Southeast Asians, and Koreans in the Department of Psychology and the School of Medicine.
- Primary Care Nurse Practitioner Program at the University of Hawaii, which targets Native Hawaiians, Pacific Islanders, and Filipinos.
- Maternal and Child Health National Center for Cultural Competence, which seeks to increase the capacity of grantees under the Maternal and Child Block Grant to States to deliver culturally-competent services for children with special health needs and their families.
- Pacific AIDS Education and Training Center, which strives to increase the competence and willingness of health care professionals to diagnose, treat, and manage HIV infection, and to disseminate state-of-the-art HIV information.
- *Developing Cultural Competence in Asian American and Pacific Islander Communities: Opportunities in Primary Health Care and Substance Abuse Prevention*, a monograph being produced in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA).

With regard to data collection and research, there have been several studies that examine general race/ethnicity and language patterns at HRSA grantee sites, such as the *Study on Ethnicity/Race of Subpopulations: User/Clients and Providers in Bureau of Primary Health Care Supported Programs*, and *Assessment of Bi/Multilingual Services Offered at Selected Community and Migrant Health Centers*. There is the need, however, to focus more of the Agency's research efforts on AAPI health issues, and to institute the collection of disaggregated data for this community.

Development of HRSA's AAPI Initiative:

The following Implementation Plan summarizes preliminary commitments from the Agency's four bureaus to the activities suggested for HRSA by the Departmental Working Group. It constitutes the first step, rather than the end point in the development of HRSA's AAPI Initiative. HRSA is strongly committed to engaging the community in the development of its Implementation Plan, that will serve as the Agency's strategy for improving the health of AAPIs over the next decade. Community input will be gathered during two Invitational Meetings which HRSA will convene with AAPI health leaders: the Pacific Basin Summit, from March 16-17, 1998, and the AAPI Invitational Meeting, from March 17-18.

At the AAPI Invitational Meeting, HRSA will work with the AAPI health leadership to define the direction and determine the strategies to accomplish the goals identified by the Departmental Working Group. The Agency will also finalize its response to the recommendations for HRSA that emerged from the National Summit of Asian and Pacific Islander American Health Organizational Leaders, held in 1995. The enclosed first draft of HRSA's Implementation Plan will serve as a platform for discussion at the meeting, where with the community, it will be refined and fully developed, and ultimately submitted in April in final draft. This unprecedented meeting will afford opportunities for HRSA and AAPI communities to build stronger links.

A separate, simultaneous meeting will focus on the health issues of the six U.S. associated Pacific Basin jurisdictions. Key health officials from the Pacific Basin will work with HRSA staff to forge a health policy framework that will guide primary health care delivery and infrastructure development in the region. Strategic planning will be conducted around the recently-released *Institute of Medicine Pacific Basin Health Report*. Issues and decisions arising from the Pacific Basin Summit will be integrated into the development of HRSA's Implementation Plan. Holding two concurrent meetings will allow for the level of specificity that Pacific Basin health issues require, yet preserve an integrated approach to HRSA's AAPI Initiative.

HRSA's AAPI Implementation Plan will be formulated around HRSA's Strategic Plan for FY 1998-2003. Developing the activities of the AAPI Initiative in line with HRSA's goals will facilitate their implementation, by embedding AAPI health issues into the business of this Agency.

Planning Process:

An internal planning committee, composed of representatives from HRSA's bureaus, meets monthly to coordinate the activities of HRSA's AAPI Initiative. Community representatives were active in formulating the invitation list for the AAPI Invitational Meeting, and were consulted in the development of the meeting agenda. HRSA will continue to engage the community in the planning process. Moreover, community involvement will remain central to HRSA's AAPI Initiative during the implementation phase. The extent and manner of the community's involvement during this next stage will be determined by the participants during the invitational meetings.

A separate planning body has been struck for the Pacific Basin Summit. Its membership is comprised of HRSA staff representing all four Bureaus, as well as staff from other HHS agencies and government departments, and community representatives. The two planning bodies coordinate their efforts, as appropriate.

HRSA staff from the regional offices with the highest concentrations of AAPIs will attend the Invitational Meetings. Shortly, a conference call will be held to apprise HRSA regional staff and Office of Minority Health field contacts of this Initiative, and to mobilize their involvement.

2) IMPLEMENTATION INFRASTRUCTURE

A two-pronged committee structure is being instituted in the Agency to coordinate the implementation of minority health initiatives, including the AAPI Initiative. At one level, Deputy Associate Administrators from the bureaus and other senior staff will meet with the Acting Deputy Administrator and the Acting Director of the Office of Minority Health. This group has oversight responsibility for minority health initiatives. At another level, OMH staff will also meet monthly with liaisons from the bureaus and offices to provide ongoing monitoring of these initiatives.

The actual implementation of the activities within the Agency will follow two channels:

1. Along bureau/office lines - Each bureau has made preliminary commitments to actualize the DWG's suggested activities. Additional or revised activities resulting from the Invitational Meetings

will be implemented through the bureaus, as appropriate. Bureaus are encouraged to form their own AAPI working groups to aid in the implementation of this Initiative. The groups will include senior-level staff and program directors to ensure that this Initiative receives the appropriate priority and support within their bureaus. Additionally, the bureaus will capitalize on the cultural/ethnic diversity that already exists within their staff by recruiting AAPI staff to their committees with an interest in, and commitment to, AAPI health issues. Their personal knowledge of these issues, as well as their linkages to AAPI community partners, will offer a tremendous resource to this Initiative.

2. Within the working groups that are charged with implementing the goals of HRSA's strategic plan - These groups are composed of representatives from HRSA's bureaus and offices. The AAPI planning committee will collaborate closely with the working groups to ensure that AAPI issues are considered during their deliberations. They also serve as a conduit through which the activities in HRSA's Plan will be implemented. Working through this channel ensures that efforts to address the recommendations are integrated into HRSA's Strategic Plan, and that HRSA managers are accountable to the Acting Administrator for their accomplishment.

3) FRAMEWORK SECTIONS / IMPLEMENTATION PLAN

I. ACCESS TO AND UTILIZATION OF HEALTH AND HUMAN SERVICES

GOAL 1: Improve health and well being of AAPIs by increasing their access and utilization of health and human services.

Objective 1.1: Develop strategies to eliminate the disparities and increase AAPI participation in major preventive health activities.

3. Ensure AAPI youth are being served by comprehensive school health programs to prevent important health problems, and to improve health and well being through increased rates of retention and completion of secondary school, particularly in the U.S. associated Pacific Island jurisdictions. In addition, efforts need to be made to reach out of school AAPI youth through other community-based, non-school sites. (HRSA) (short term)

Key Agency Activity:

BPHC:

a. Use BPHC technical assistance contracts, as well as BPHC school health staff, to complete a **needs assessment** determining the demand for school-affiliated health services, as well as general unmet need in the AAPI community.

b. Make specific efforts to **target AAPI youth living in Pacific Island jurisdictions**.

c. The Healthy Schools, Healthy Communities (HSHC) model of school health services and health education can be used to **design health and education services for the AAPI population**; only if it is determined that HSHC are needed and wanted by the AAPI community.

d. Currently the BPHC school health program is adapting a **clinical and administrative manual for use in all school-based health centers (SBHCs)**. These manuals can be tailored specifically to sites serving the AAPI community.

e. Members of the **AAPI** community who are conversant with health education needs of this population will be included in all groups convened by BPHC to determine **standards and parameters for SBHC services** (above).

MCHB:

f. **Project Healthy Asian Teens**—The project seeks to decrease barriers faced by Chinese, Cambodian, and Vietnamese immigrant and refugee youth in accessing primary health care services.

Lead Entity:

a-e. BPHC / DPSP, Jane Martin

f. MCHB

Time Frame:

a-e. FY 1998

f. 10/1/96-9/30/2001

Measurable Outcome:

a. AAPI needs assessment which will determine the demand for school-affiliated health services.

b. Increased efforts to serve Pacific Islander youth.

c. Design of health and education services for AAPI populations in schools.

d. Adaptation of clinical and administrative manuals tailored to school sites serving AAPIs.

e. Greater inclusion of AAPIs in BPHC-convened groups to determine standards and parameters for school-based health centers.

f. Project Healthy Asian Teens. Increase in the number of youth using primary health care over a 5-year period. Cost: \$49,067.

6. Increase attention to AAPI domestic violence issues in health professions training, violence prevention activities and among health care service providers. [See also Domestic Violence Initiative in the attachment.]

Key Agency Activity:

a. BPHC plans to convene a **working group** of community health professionals and experts in the field that are representative of BPHC program populations including Asian Americans and Pacific Islanders. The working group will produce recommendations regarding best practices, and identify key issues and barriers to preventing, identifying and treating victims of **family and intimate partner violence**. BPHC participates in the HHS Violence Against Women Steering Committee and assists HRSA in the implementation of the HRSA National Family and Intimate Partner Violence Prevention Initiative.

Lead Entity:

a. BPHC / OMWH, Kathleen Shannon

Time Frame:

a. FY 1998

Measurable Outcome:

a. Working group on family and intimate partner violence to be representative of BPHC program populations, including AAPIs. Identification of issues, barriers, and best practices in addressing family and intimate partner violence.

7. Provide continuing support for HIV/STD/TB surveillance, prevention and treatment activities targeting AAPIs in the U.S. associated Pacific Island jurisdictions and the continental U.S. (CDC, HRSA) (short term)

Key Agency Activity:

a. **Pacific AIDS Education and Training Center (PAETC)** - The PAETC provides HIV/AIDS training at 16 sites in the four states of California, Arizona, Nevada and Hawaii. The Hawaii ETC activities are subcontracted through the University of Hawaii at Manoa, John A. Burns School of Medicine.

Lead Entity:

a. H/AB / Division of Training and Technical Assistance & AIDS Education and Training Center Program, and BHP, Alice M. Litwinowicz.

Time Frame:

a. 1993-1998; Ongoing

Measurable Outcome:

a. Training to increase the competence and willingness of health care professionals to diagnose, treat, and manage HIV infection and to offer interventions that prevent HIV, to disseminate state of the art HIV information to providers and to develop HIV provider materials. HRSA's National ETC Program establishes short-term priorities each budget period. \$98,412 for PAETC.

Objective 1.2: Designate a lead agency for ongoing assessment of AAPI access to health services and dissemination of information on effective methods to assure access to services.

Suggested Activities:

1. HRSA will work in collaboration with other HHS components and community partners to assure that there is in place an assessment process that on a subpopulation basis will: (long term)

Key Agency Activity:

A. Systematically assess health status and unmet need of AAPI subpopulations (long term)

BPHC:

a. BPHC/Office of Evaluation, Analysis and Research (OEAR) has developed new **shortage designation methodology that relates to AAPIs**. A geographical area or community may be designated as a "primary care shortage area" (or primary care health professional shortage

area) when “the proportion of the population in the area is either a racial minority or Hispanic, and the proportion of the population in the area is “linguistically isolated” (where neither speak English well nor have a household member who can translate)”. Designation as a primary care shortage area is a prerequisite towards the placement of National Health Service Corps scholars and loan repayers and in general, it is indicative of possible unmet health needs.

b. BPHC/Division of Community and Migrant Health will conduct an **“Evaluation of the Effectiveness and Impact of Community Health Centers”** on access of BPHC program clients; including AAPIs, to BPHC program services.

H/AB:

c. Community-based needs assessments and Ryan White CARE Act, Title I Planning Councils:

Title I and Title II programs emphasize State and community roles in program development and operation. Flexibility is encouraged to enable programs to identify and reach all segments of the populations in need. A Community-based needs assessment process is used to ensure that correct questions are asked, the answers are properly interpreted, and that community input and participation are maximized.

H/AB guidance, directives and technical assistance activities are targeted to support collaborative Federal, State and community (local) level sensitivity and cultural competence and to ensure that all HIV impacted segments of the community have access to existing health care resources and services.

Lead Entity:

- a. BPHC / OEAR Bonnie Lefkowitz.
- b. BPHC / DCMH Judy Rodgers.
- c. H/AB / Division of Service Systems, Anita Eichler, Director

Time Frame:

- a. FY 1998
- b. Study will be completed in FY 1998.
- c. Current and on-going activities.

Measurable Outcome:

- a. New shortage designation methodology that relates to AAPIs. Process establishes primary care shortage areas.
- b. “Evaluation of the Effectiveness and Impact of Community Health Centers” will be completed. Study includes AAPIs.
- c. Review and analysis of formula and supplemental grant applications, progress reports and products. Exchange of information and data with other HHS and/or State programs operating initiatives or activities either targeted to AAPI populations or serving AAPI’s within the larger community.

Key Agency Activity:

B. Study the health care delivery systems currently in place and identify barriers to care. This will include determining the extent to which cultural competency, especially the use of language, hinders access to care and compliance with prevention and treatment plans (long term)

BPHC:

a. The **BPHC/Division of Community and Migrant Health** in identifying barriers to care for community and migrant health center (C/MHC) patients, including AAPIs, plans to increase the number of patients served by offering a full range of **culturally appropriate primary and preventive care**, including mental health services, substance abuse services, and outreach services. This will be accomplished by increasing the number of sites that fully utilize primary care teams which are culturally and linguistically competent, inter-disciplinary, and patient focused.

MCHB:

b. **Emergency Medical Services for Children Planning Grant**—Extension of emergency medical services and trauma systems in the Northern Mariana Islands linking prehospital, hospital, and rehabilitation services to prevent death and long-term disability.

Lead Entity:

- a. BPHC / DCMH, Richard Bohrer.
- b. MCHB

Time Frame:

- a. FY 1998
- b. 10/1/95-9/30/98

Measurable Outcome:

- a. Identifying barriers to care for community and migrant health center (C/MHC) patients, including AAPIs. Increasing the number of sites that fully utilize primary care teams which are culturally and linguistically competent, inter-disciplinary, and patient focused.
- b. Emergency Medical Services for Children Planning Grant for the Northern Mariana Islands. Measures to reduce language barriers, better access of health care system.

Key Agency Activity:

C. Develop guidelines and other material to assist service providers in delivering quality health services that meet the language and cultural needs of the target populations (long term)

BPHC:

- a. Final Report to be released on the study **Ethnicity/Race of Subpopulations: User/Clients and Providers**. Study examines the race and ethnicity subpopulation data on service providers and users of health care.
- b. Final Report to be released on the study **Assessment of Bi/Multilingual Services Offered at Selected Community and Migrant Health Centers**. Voluntary surveys to assess the composition and provision of bi/multilingual services at 150 Community and Migrant Health Centers.

c. **Cultural Competence Monograph 5: Developing Cultural Competence in Asian American and Pacific Islander Communities: Opportunities in Primary Health Care and Substance Abuse Prevention** will be released. BPHC/Office of Minority & Women's Health (OMWH) is coordinating the production of this volume in collaboration with Office of Minority Health (OMH)/DHHS and SAMHSA/ Center for Substance Abuse Prevention (CSAP).

d. **Cultural Competence Monograph 8. Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention** will be released. BPHC/OMWH is coordinating the production of this volume in collaboration with OMH/DHHS and SAMHSA/CSAP.

e. **BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in Primary Health Care.** The Center is a joint BPHC-MCHB effort which will provide information, materials, training opportunities and technical assistance concerning cultural and linguistic competence issues in primary health care.

H/AB:

f. Through a contract with the **Asian and Pacific Islander Wellness Center of San Francisco**, the HIV/AIDS Bureau supports the **development of a manual that will describe culturally competent methods to improve HIV services for Asian and Pacific Islanders who are living with HIV disease.** The modules will address issues pertaining to the provision of primary care and mental health services, the cultivation of help-seeking behaviors and culture-sensitive communications, and the dynamics of family-based systems. The manual will be available for distribution in spring 1998.

MCHB:

g. **Expanding and Extending Genetic and Other MCH Services to Chinese and Southeast Asian Refugees in Greater Boston**—Expansion of genetic screening and counseling services for Asian immigrants and Southeast Asian refugees served by South Cove Community Health Center, and provision of technical assistance and training.

h. **New York State Program to Overcome Linguistic and Cultural Barriers to Genetic Services**—This activity seeks to enhance both genetic screening and counseling and primary maternal and child health care among Chinese and Southeast Asian immigrants in New York State.

Lead Entity:

- a. BPHC/Office of Minority & Women's Health (OMWH) Marion Primas, PhD.
- b. BPHC / OMWH, Marion Primas, PhD.
- c. BPHC/OMWH, Len Epstein.
- d. BPHC / OMWH, Len Epstein.
- e. MCHB, Diana Denboba, BPHC, Len Epstein & Helen Kavanagh.
- f. H/AB / Office of the Division Director and AETC Branch, Joan Holloway
- g. MCHB
- h. MCHB

Time Frame:

- a. September 1998
- b. September 1998
- c. Mid-March 1998
- d. Mid-March 1998
- e. March 1998
- f. Fall 1997; Completion scheduled for Spring 1998.
- g. 10/1/94-9/30/97
- h. 10/1/91-9/30/97

Measurable Outcome:

- a. Final Report, Ethnicity/Race of Subpopulations: User/Clients and Providers.
- b. Final Report, Assessment of Bi/Multilingual Services Offered at Selected Community and Migrant Health Centers.
- c. Release of Cultural Competence Monograph 5: Developing Cultural Competence in Asian American and Pacific Islander Communities: Opportunities in Primary Health Care and Substance Abuse Prevention. Cost: \$50,000.
- d. Release of Cultural Competence Monograph 8: Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention. Cost: \$50,000.
- e. BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in Primary Health Care. Cost: \$563,000
- f. A manual that will describe culturally competent methods to improve HIV services for Asian Americans and Pacific Islanders.
- g. Increase in genetic screening and counseling for Asian and Southeast Asian clients, provision of technical assistance and training to community health centers.
- h. Increase in genetic screening and counseling, production of educational brochures, training of community health workers.

2. HRSA will work in collaboration with other HHS components and community partners to assure that there a process in place to identify, disseminate and promote information about effective health services delivery for AAPIs such as (ALL):

A Protocols and materials developed by community-based organizations, health departments, and other organizations on the delivery of comprehensive primary care services that includes preventive, HIV/AIDS, substance abuse, mental health, and enabling services. (short term)

Key Agency Activity:

BPHC:

- a. The BPHC/Division of Community and Migrant Health will be working on **a plan to reduce health disparities for vulnerable and underserved populations including AAPI communities**, by:
 1. Identifying performance improvement measures from Healthy People 2000 goals and HEDIS outcome measures; and then by
 2. Communicating health performance and the subsequent improvement plan and its purpose to health centers; including those that serve AAPIs, states, Field Offices, and other partners.

H/AB:

b. Through a contract with the **Asian and Pacific Islander Wellness Center of San Francisco**, the HIV/AIDS Bureau supports the **development of a manual that will describe culturally competent methods to improve HIV services for Asian and Pacific Islanders** who are living with HIV disease. The modules will address issues pertaining to the provision of primary care and mental health services, the cultivation of help-seeking behaviors and culture-sensitive communications, and the dynamics of family-based systems. The manual will be available for distribution in spring 1998.

Lead Entity:

- a. BPHC/DCMH David Stevens, M.D.
- b. H/AB / Office of the Division Director and AETC Branch, Joan Holloway.

Time Frame:

- a. FY 1998
- b. Fall 1997; Completion scheduled for Spring 1998.

Measurable Outcome:

- a. Plan to reduce health disparities for vulnerable and underserved populations including AAPI communities, by using performance improvement and HEDIS outcome measures.
- b. A manual that will describe culturally competent methods to improve HIV services for Asian Americans and Pacific Islanders.

B. Best practice models and organizations that have historically served AAPI communities. These organizations can serve as mentors to assist other organizations in delivering linguistically-appropriate quality health care to members of AAPI communities (long term).

Key Agency Activity:

BPHC:

- a. The BPHC/Division of Community and Migrant Health in creating new models of care for the future plans to **identify 1-2 primary care strategies that specifically highlight AAPI best practice models**. These 1-2 strategies can then serve as “mentors” to assist other organizations in delivering culturally and linguistically appropriate quality health care to members of the AAPI communities.

H/AB:

b. **Support studies which evaluate innovative health service models focused on improving AAPI access to and utilization of services** by bridging language barriers and assisting them to navigate through mainstream health services.

Lead Entity:

- a. BPHC / DCMH Regan Crump, PhD.
- b. H/AB / Office of Science and Epidemiology, Special Projects of National Significance Branch, Mirtha Beadle

Time Frame:

- a. FY 1998
- b. FY 1999/2000

Measurable Outcome:

- a. Identification of primary care strategies that specifically highlight AAPI best practice models.
 - b. Initiative will include a targeted focus on AAPI health care models developed.
- Grant(s) will be awarded to organization(s) focused on AAPI health care issues.

Objective 1.3: Improve the health status of Native Hawaiians and Pacific Islanders through strategic development of effective health service system infrastructure and capacity.

Suggested Activities:

1. Incorporate the findings and strategic plan, as appropriate, from the Institute of Medicine (IOM) study on the health service system infrastructure in the Pacific Basin when the IOM report is released.

Key Agency Activity:

A. Coordinate CDC Public Health Advisor and Epidemiologist implementation activities with HRSA funded IOM Study on the Pacific Basin. (CDC, HRSA) (short term). **To be determined.**

Lead Entity:

Time Frame:

Measurable Outcome:

2. Develop goals and strategies for reducing the disproportionately high rates of infant mortality among Native Hawaiians and Pacific Islanders (CDC, HRSA)

Key Agency Activity:

B. Develop culturally appropriate and community-based intervention strategies to reduce infant mortality disparities by county and ethnicity among AAPIs in Hawaii. (CDC, HRSA) (long term)

- a. **Postpartum Women and Infants in Hawaii**—The goal of this program is to preserve the positive mother-infant and mother-child bond and ameliorate the long-term effects of alcohol and other drug use and to increase the availability of drug treatment services for pregnant and postpartum women living on the Waianae coast of Oahu.

Lead Entity:

- a. MCHB

Time Frame:

- a. 9/30/92-11/30/97

Measurable Outcome:

- a. Increase in availability of drug treatment services, decrease in the prevalence of substance abuse, reduction in severity of impairment among children born to substance-abusing women.

Key Agency Activity:

C. Assess the role of maternal infectious diseases, including bacterial vaginosis, in perinatal complications among Native Hawaiians and other Pacific Islanders through the development of sentinel surveillance systems to define the burden of disease in pregnant women and incidence of complications due to infections, including maternal infections, and infant prematurity, sepsis, and low-birth-weight. (CDC, HRSA) (long term)

Lead Entity:

Time Frame:

Measurable Outcome:

Key Agency Activity:

D. Develop, evaluate and integrate methods to optimize the prevention and early detection and treatment of infections in pregnant women and their newborns; explore the use of rapid diagnostic tests, including those that can be implemented in developing and underserved settings, for the detection of bacterial vaginosis and other infections linked to prematurity, infant complications and mortality. (CDC, HRSA) (long term)

a. **Northern California Thalassemia Center**—Improvement of coordination and communication between subspecialists caring for thalassemia patients.

Lead Entity:

a. MCHB

Time Frame:

a. 10/1/91-9/30/97

Measurable Outcome:

a. An increase in the number of AAPI patients who receive annual comprehensive visits.

3. Enhance access to primary care services in the U.S. associated Pacific jurisdictions in collaboration with other HHS components and organizations by targeting issues on a jurisdiction- by-jurisdiction basis:

Key Agency Activity:

A. Develop an action plan through the HRSA Pacific Basin Workgroup process (short term).
a. An **Action Plan will be developed** as an outgrowth of the Pacific Basin Health Summit to be sponsored by HRSA in March 1998.

Lead Entity:

a. BPHC / DPSP, Lu Ann Pengidore.

Time Frame:

a. 3rd Quarter 1998

Measurable Outcome:

- a. Development of an Action Plan for HRSA to respond to Pacific Basin health needs.

Key Agency Activity:

B. Develop the Pacific Basin Health Summit to review the Institute of Medicine Report on Health Services in the Pacific (short term).

- a. A **Pacific Basin Health Summit** is being planned for March 16 & 17, 1998 in Rockville, Maryland. The Summit will bring together key stakeholders in primary health care delivery and infrastructure development from the six U.S. associated Pacific Island jurisdictions for the purpose of building a health policy framework to guide health and health-related Federal support within each jurisdiction.

Lead Entity:

- a. HRSA

Time Frame:

- a. March 1998

Measurable Outcome:

- a. Health officials from HHS and Pacific Basin jurisdictions will review the IOM study findings at the Pacific Basin Summit.

Key Agency Activity:

C. Assist American Samoa in the redesign of its primary care system (short term)

- a. A **technical assistance** opportunity was planned and supported by the Division of Programs for Special Populations (DPSP) for a group of three **health planners from American Samoa** to visit community health centers in the State of Hawaii. Site visit was conducted in December 1997.

Lead Entity:

- a. BPHC / DPSP, Lu Ann Pengidore.

Time Frame:

- a. 1st Quarter 1998

Measurable Outcome:

- a. Technical assistance for health planners from American Samoa. Cost: \$4,000.

Key Agency Activity:

D. In conjunction with SAMHSA, assist Pacific Basin health authorities in establishing substance abuse certification programs and the delivery of mental health and substance abuse services to assure appropriate linkage with primary health care services. (long term).

a. **Discussions between HRSA and SAMHSA continue.** No specific activities are planned. Outcome will be the establishment of SAMHSA programs in the Pacific Basin. Cost: SAMHSA

Lead Entity:

a. BPHC / DPSP, Thomas Coughlin.

Time Frame:

a. On-going 1998

Measurable Outcome:

a. To be determined.

Key Agency Activity:

E. In conjunction with NIH, assist the Department of Energy in the selection of an organization to deliver specialized health care services and primary care in the Republic of the Marshall Islands. (short term)

Lead Entity:

a. NIH activity, BPHC / DPSP is assisting DOE.

Time Frame:

a. To be determined.

Measurable Outcome:

a. Collaboration with NIH and DoE in the selection of primary care delivery in the Marshall Islands.

4. Improve the health status of Native Hawaiians by strengthening the activities funded under the Native Hawaiian Health Care Act:

Key Agency Activity:

A. Provide technical assistance to Papa Ola Lokahi and the five Native Hawaiian Health Care Systems to improve planning, data systems, evaluation and services delivery (HRSA) (short term)

BPHC:

a. A contract was signed in September 1997. Training workshops have already been conducted and **technical assistance** has been arranged to be provided in FY 1998 in the following areas:

- 1) Accessing the Federal drug pricing program or coordination with health centers that access the drug pricing program.
- 2) A workshop on improving the uniform data system for the Native Hawaiian Health Care program.
- 3) Training on the elementary principles of managed care for the purpose of negotiating contracts for outreach services.

- 4) Training on case management reimbursement from managed care organizations.
- 5) Training related to the development and implementation of long-term outcome measures.

b. **The Native Hawaiian Health Care Program** is designed to improve the health status of Native Hawaiians living in Hawaii. The program has three components: 1) **Planning and advocacy** activities implemented by Papa Ola Lokahi; 2) **Health services** (i.e. outreach, health education, transportation, translation, hypertension screening) provided by five Native Hawaiian Health Care systems that serve all areas of Hawaii and make referrals to community health centers; and 3) **Scholarships** for Native Hawaiian health professions students.

Lead Entity:

- a. BPHC / DPSP, LuAnn Pengidore.
- b. BPHC / DPSP, LuAnn Pengidore.

Time Frame:

- a. FY 1998
- b. 1990-present

Measurable Outcome:

- a. Technical assistance will be provided to the Native Hawaiian Health Care program on health care management issues and data systems. Cost: \$50,000.
- b. Primary and preventive health care services for approximately 12,500 Native Hawaiians; outreach to 35,000 Native Hawaiians; and Scholarships for 5-7 Native Hawaiian students. \$3.1 million in FY 1997.

Key Agency Activity:

B. Strengthen relationships between the Native Hawaiian Health Care Systems and primary care providers to assure that Native Hawaiians' access to primary care is enhanced (long term).

a. **Discussions with the Native Hawaiian Health systems, community health centers and the Hawaii Primary Care Association continue.** A Native Hawaiian Health Summit will occur in March 1998 in Honolulu which will likely impact the development of the Native Hawaiian Master plan that will address this issue.

Lead Entity:

- a. BPHC / DPSP, Lu Ann Pengidore.

Time Frame:

- a. FY 1998

Measurable Outcome:

- a. Discussions continue; on-going.

Key Agency Activity:

C. Provide technical assistance to the Hawaii State Primary Care Association, Kamehameha Schools/Bishop Estates, and Papa Ola Lokahi to assure the most appropriate planning, train-

ing and placement of scholars under the Native Hawaiian Health Scholarship Program. (short term)

a. No specific T/A is identified or planned at this time. Discussions and improved communication among key players will take place. In FY 1998, it is **estimated that 5-7 Health Professions Scholarships will be awarded to Native Hawaiians**, and graduates will be placed in service sites in Hawaii.

Lead Entity:

a. BPHC / DPSP, Shirl Taylor

Time Frame:

a. FY 1998

Measurable Outcome:

a. Estimated that 5-7 Health Professions Scholarships will be awarded to Native Hawaiians. Placement in service sites. Cost: \$650,000.

Key Agency Activity:

D. Provide technical assistance to Papa Ola Lokahi and other organizations in the preparation and the conduct of the Native Hawaiian Health Summit. (short term)

a. **Technical assistance** will be provided following the Summit. Cost and lead to be determined later.

Lead Entity:

a. BPHC / DPSP, Tom Coughlin.

Time Frame:

a. FY1998

Measurable Outcome:

a. Technical assistance for Papa Ola Lokahi will be provided.

Objective 1.4 Develop strategies for increasing AAPI community participation in selected human service programs.

Suggested Activities:

None are indicated for HRSA.

II. ASIAN AMERICAN AND PACIFIC ISLANDER DATA

GOAL 2: Increase and improve collection, analyses, and dissemination of data about AAPI populations and subpopulations.

Objective 2.1: Increase and improve collection of data on AAPIs

Suggested Short-Term Actions:

None are indicated for HRSA, however the following are proposed.

4. Statistical and research Agencies should support local studies in States, regions and communities with higher proportions of AAPIs and, within these studies, separately identify the major subcategories of AAPIs. These HHS-supported targeted studies should be conducted in such a way that they are comparable to national surveys so that they can serve as community and regional benchmarks for AAPI populations. Funding should be made available through the Minority Grant program at NCHS for doing this. CDC should use their State and Local Area Integrated Telephone Survey (SLAITS) for such studies. The AAPI DWG should identify other potential opportunities. (CDC, ASPE, AHCPR)

Key Agency Activity:

H/AB:

a. **Study patterns of HIV-related care provided to Asian Americans and Pacific Islanders.** The HIV/AIDS Bureau's client level demonstration projects are designed to collect data about individuals who receive Ryan White eligible services. Four of the demonstration projects are on the West Coast, which include a relatively high concentrations of AAPIs. Plans for analyzing these data are currently being developed.

MCHB:

b. **Maternal and Child Health Services Federal Set-Aside Program**—Improvement, upgrade, and expansion of three major local maternal and child health (MCH) initiatives in the Mariana Islands.

Lead Entity:

- a. H/AB / Office of Science and Epidemiology / Epidemiology, Steven Niemcrylic
- b. MCHB

Time Frame:

- a. 1998/99
- b. 10/1/93-9/30/97

Measurable Outcome:

- a. One analysis that will be conducted will determine whether patterns of HIV-related care, which includes both medical and support services, differ by race/ethnicity. Because the client level demonstration projects are in their fourth year of funding, these patterns can be examined over time.
- b. Upgrade and expansion of information systems for MCH in the Mariana Islands.

5. The HHS statistical and research Agencies should support more analyses of the AAPI data that they already collect and development of improved ways to analyze AAPI data. More analysis should be done aggregating AAPI data and AAPI subgroup data over several years, for example. The statistical and research Agencies should consider using these analytic techniques routinely within their existing programs in order to do planning and programming that takes into consideration AAPI population characteristics and needs and making it possible to measure progress and effectiveness. (CDC, ASPE, AHCPR)

Key Agency Activity:

a. BPHC/Office of Evaluation, Analysis & Research (OEAR), developed and monitors the “Uniform Data System” (UDS) which identifies AAPI “Users” of BPHC funded services. It is estimated that in **Calendar Year 1999 or 2000, Asian Americans and Pacific Islanders will be made into two distinct reporting categories for BPHC funded programs.**

Lead Entity:

a. BPHC / OEAR, Bonnie Lefkowitz

Time Frame:

a. FY 1999 or 2000

Measurable Outcome:

a. AAPIs will be placed in two distinct reporting categories, providing more detail on their use of BPHC programs.

Objective 2.2: Increase and improve analyses and dissemination of data on AAPIs.

Suggested Activities:

None are indicated for HRSA.

III. RESEARCH ON ASIAN AMERICAN AND PACIFIC ISLANDER HEALTH

GOAL 3: Increase the number of funded research projects and programs targeted towards AAPIs.

Objective 3.1: Conduct analyses of the major health and mental health problems facing the AAPI communities.

Objective 3.2: Evaluate the impact of major health and human services changes, including welfare reform and coverage of uninsured children, on the access to care and services of the AAPI populations.

Objective 3.3: Develop a research agenda and solicit research proposals to increase clinical research and health care utilization information needed to reduce gaps in knowledge about AAPIs.

Objective 3.4: Include AAPIs in ongoing crosscutting research on health and human services issues, in developing new survey instruments, and by involving researchers familiar with AAPI issues in review groups and advisory panels.

Suggested Activities:

None are indicated for HRSA, however the following are proposed.

5. Ensure that AAPIs and specific subpopulations are included in clinical research and health surveys which track the impact of policy changes (e.g., restrictions on access to preventive services to new immigrants, cuts in the nutrition program - especially food stamps, welfare to work, job training and life time limits), particularly on immigrants and populations with limited English proficiency. (NIH, ASPE, AHCPR) (long term)

Key Agency Activity:

a. **Increase opportunities for children, youth and women living with HIV to participate in clinical research** and other research of potential clinical benefit, including children youth and women of Asian-American and Pacific Island heritage.

Lead Entity:

a. **H/AB**

Time Frame:

a. To be determined.

Measurable Outcome:

a. To be determined.

7. Identify (or create if necessary) and ensure implementation of strategies and mechanisms which ensure cultural sensitivity and community participation in all phases of research projects and identify lessons learned through existing academic community partnerships and research projects on AAPIs. (NIH, AHCPR, CDC) (long term)

Key Agency Activity:

a. **Support studies which evaluate innovative health service models focused on improving AAPI access to and utilization of services** by bridging language barriers and assisting them to navigate through mainstream health services. **Include AAPIs as a specific population in H/AB funding initiatives.**

Lead Entity:

a. H/AB/ Office of Science and Epidemiology, Special Projects of National Significance Branch, Mirtha Beadle.

Time Frame:

a. FY 1999/2000

Measurable Outcome:

a. Initiative will include a targeted focus on AAPI health care models is developed. Grant(s) will be awarded to organization(s) focused on AAPI health care issues.

IV. TRAINING

GOAL 4: Increase outreach to and participation of AAPIs in HHS or HHS sponsored training programs.

Objective 4.1: Expand participation of underrepresented AAPI sub-populations in HHS training programs.

Objective 4.2: Develop specific outreach strategies for AAPIs for training programs in health profession and research areas where AAPIs are underrepresented.

Objective 4.3: Increase availability of training opportunities that encourage researchers and health professionals to address health issues of AAPI communities.

Suggested Activities:

1. Review the health professions training programs in HRSA and minority researcher training programs for barriers to participation of underrepresented AAPI sub-populations (e.g. Pacific Islanders, Southeast Asians) and develop plans to remove identified barriers (HRSA, SAMHSA, NIH, AHCPR).

Key Agency Activity:

A. Assess impact of legislative requirements that limit participation in some scholarship/loan repayment programs to U.S. citizens

A.1 Assess barriers to increasing AAPI representation in training programs for physicians, clinical psychologists, nurse practitioners, physician assistants and nurse midwives.

BPHC:

a. In FY 1998, it is estimated that **5-7 Health Professions Scholarships will be awarded to Native Hawaiians, and graduates will be placed in service sites in Hawaii.**

b. BPHC/National Health Service Corps (NHSC) targets **recruiting efforts to those schools and programs who have a history of primary care and which have a high percentage of unrepresented minorities.**

BHPr:

c. **Health Careers Opportunity Program (HCOP) University of Hawaii @Manoa,** Department of Psychology; University of Hawaii, School of Medicine, Postbaccalaurate Program.

d. **Centers of Excellence Program (COE)** - The goals of the program are to strengthen the quality of the Native Hawaiian applicant pool, increase the number of Native Hawaiian students entering and graduating from the medical school, increase the number of Native Hawaiian faculty, enhance faculty and student research on health issues affecting minority groups, and expand medical curriculum to address Native Hawaiian health issues.

e. **Graduate Nursing Education/Nurse Practitioner/Nurse Midwifery Program/University of Hawaii** - The purpose of this project is to start a Primary Care Nurse Practitioner

(PCNP) program to prepare advanced practice nurses in pediatrics, women's health and family health. There is a special emphasis on recruitment of nurses who will serve ethnic minorities, especially Hawaiians, Samoans, Filipinos and other Pacific Islanders. Special content is offered to students in pediatrics and women's health in the care of drug exposed mothers and babies; special content in the care of the elderly is offered to family health practitioners.

f. Graduate Nursing Education/Advanced Nurse Education Program/University of Hawaii - The purpose of this project is to expand an existing nursing program by adding a newly merged nurse practitioner-clinical nursing specialist program (advanced practice nursing) in adult, family and mental health. Hawaiians have the shortest life expectancy and highest infant death rate of all ethnic and racial groups in Hawaii. Hawaii's population of multiethnic groups is unique in the US as there is no majority. The curriculum provides for delivery of health care services to these multicultural peoples.

Lead Entity:

- a. BPHC / DPSP, Shirl Taylor.
- b. BPHC / NHSC, Andy Jordan.
- c. BHPPr / Division of Disadvantaged Assistance, Mario Manecchi
- d. BHPPr / Division of Disadvantaged Assistance, Roland Garcia
- e. BHPPr / Division of Nursing, Madeleine Hess.
- f. BHPPr / Division of Nursing, Madeleine Hess.

Time Frame:

- a. FY 1998
- b. On-going
- c. 3 Years/1994-1997/Ongoing
- d. 3 Years/1996-1999/Ongoing
- e. 1993-1997/Ongoing
- f. BHPPr, Division of Nursing, Madeleine Hess

Measurable Outcome:

- a. Estimated that 5-7 Health Professions Scholarships will be awarded to Native Hawaiians. Graduates will be placed in service sites in Hawaii. Cost: \$650,000.
- b. NHSC recruitment from schools with high percentage of unrepresented minorities.
- c. Increase in the number of students from Hawaii and the Pacific Basin with training in clinical psychology and medicine. Cost: \$538,302.
- d. Aims to strengthen the quality and number of Native Hawaiian students and faculty in medicine, and to expand medical curriculum to address Native Hawaiian health issues. Cost: \$639,966.
- e. Establishment of a Primary Care Nurse Practitioner (PCNP) program, that emphasizes recruitment of nurses who will serve ethnic minorities, especially Hawaiians, Samoans, Filipinos and other Pacific Islanders. Cost: \$894,184.
- f. Expansion of an existing nursing program by adding a newly merged nurse practitioner-clinical nursing specialist program (advanced practice nursing) in adult, family and mental health. Cost: \$634,951.

- A.2 Assess cultural barriers that might limit utilization of clinicians who are not physicians.

BPHC:

a. BPHC/NHSC in conjunction with several Physician Assistant programs is looking into **expanding NHSC site development efforts for Physician Assistants and Nurse Practitioners.**

b. The NHSC is also undergoing a reorientation and increasing its **focus on improving the NHSCs ability to work closer with communities and to identify and address the communities needs for culturally and linguistically appropriate clinicians.**

c. **BPHC's Complementary Medicine & Alternative Health Practices (CMAHP) Initiative** sponsored a conference in Fall 1997 on complementary medicine as a tool for improving the health status for medically underserved populations. The importance of acupuncture, mind-body and herbal interventions as helpful treatment and prevention techniques for primary health clinicians was discussed over a two-day period. BPHC intends to **follow-up** on this successful conference through the following activities:

1. To survey community and migrant health centers (C/MHCs) concerning their use of acupuncture and other complementary therapies.
2. Based on the results of the above survey, BPHC plans to provide centers with information, resources and training materials concerning CMAHP.
3. BPHC will continue to sponsor education programs for C/MHCs concerning CMAHP and its potential for application in BPHC supported programs.

Lead Entity:

- a. BPHC / NHSC, Andy Jordan.
- b. BPHC / NHSC, Andy Jordan.
- c. BPHC / Office of the Director, Bob Viega, M.D.

Time Frame:

- a. FY 1998
- b. FY1998
- c. FY 1998

Measurable Outcome:

- a. Possible expansion of NHSC site development efforts for Physician Assistants and Nurse Practitioners.
 - b. Greater sensitivity of NHSC to community needs.
 - c. Exploration of the use of complementary and alternative health practices in community/migrant health centers. Education programs for C/MHCs in this area.
2. Identify areas and create opportunities for training and academic-community partnerships in community-based research on AAPI populations (NIH, AHCPR, HRSA).

Key Agency Activity:

A. Explore possibility of revising data collection instruments to obtain more thorough information on the needs of the subpopulations in the AAPI category.

a. BPHC/Office of Evaluation, Analysis & Research (OEAR), developed and monitors the “Uniform Data System” (UDS) which identifies AAPI “Users” of BPHC funded services. It is estimated that in **Calendar Year 1999 or 2000, Asian Americans and Pacific Islanders will be made into two distinct reporting categories for BPHC funded programs.**

Lead Entity:

a. BPHC / OEAR, Bonnie Lefkowitz.

Time Frame:

a. Projection: FY 1999 or 2000

Measurable Outcome:

a. AAPIs will be placed in two distinct reporting categories, providing more detail on their use of BPHC programs.

Key Agency Activity:

B. Work with community organizations to assess the distribution and needs of subpopulations and assess the distribution of clinicians.

BPHC:

a. BPHC/Office of Evaluation, Analysis and Research (OEAR) has designated **new shortage designation methodology that relates to AAPIs**. A geographical area or community may be designated as a “primary care shortage area” (or primary care health professional shortage area) when “the proportion of the population in the area is either a racial minority or Hispanic, and the proportion of the population in the area is “linguistically isolated” (where neither speak English well nor have a household member who can translate)”. Designation as a primary care shortage area assists towards the placement of National Health Service Corps scholars and loan repayers. Also see #3A. below.

BHPr:

b. **Partnerships for Health Professions Education (PHPE) - Ke Ola O Hawaii, Inc.** The major objective of the Ke Ola O Hawaii, Inc. project is to demonstrate that an integrated partnerships approach is more effective than a fragmented approach in increasing the number and quality of health professionals for underserved populations from minority and disadvantaged backgrounds and minority health professions faculty in Hawaii. Initial partners include: the University of Hawaii @ Manoa (UHM) School of Medicine, UHM School of Public Health, UHM School of Social Work, Kapiolani Community College, State Department of Health, Waianae Coast Comprehensive Health Center, Kalihi Palama Health Center, The Queen Emma Clinics, Kakua Kalihi Valley Health Center, UHM Department of Psychology, UHM HCOP and COE Programs, School-to-Work Program, and Farrington Health Academy.

c. **AHEC Cooperative Agreement** - The goals of the **KE OLA AHEC** are to: (1) establish a partnership for health between the Schools of Medicine, Nursing, Public Health, Community College System, community health center, and their communities; (2) to improve primary care to underserved and minority communities within the State; (3) improve community based health professional education and continuing education for primary care providers for underserved populations; (4) improve the supply and distribution of primary care providers to underserved areas; and (5) establish a telecommunications system and connecting all of the cooperating entities.

Lead Entity:

- a. BPHC / OEAR, Bonnie Lefkowitz and BPHC / NHSC, Andy Jordan.
- b. BHPPr / Division of Disadvantaged Assistance, Evelyn Rodriguez.
- c. BHPPr / Division of Medicine, Joseph West

Time Frame:

- a. On-going
- b. 3 Years/1996-1999/Ongoing
- c. 3 Years/1996-1999/Ongoing

Measurable Outcome:

- a. New shortage designation methodology that relates to AAPIs.
- b. New partnerships in Hawaii; an integrated approach to increase the number of health professions. Cost: \$425,200.
- c. The establishment of partnerships for health that will achieve the above-mentioned goals. Cost: \$997,750.

3. Identify ways to increase the number of AAPIs in primary care professions to address the increasing demand for primary health care services and providers that are appropriate for the cultural and linguistic needs of this population (HRSA). Examine how existing programs can:

A. Increase the number of culturally- and linguistically-competent clinicians for AAPI populations in community-based organizations such as community health centers, Native Hawaiian Health Systems and other access points. (For example, the Community Scholarship Program, the State Loan Repayment Programs, the Native Hawaiian Scholarship Program)

Key Agency Activity:

BPHC:

a. The **BPHC/National Health Service Corps'** mission is to assist underserved communities through the development, recruitment, and retention of community-responsive, culturally competent, primary care clinicians dedicated to practicing in health professional shortage areas. To reach its goals, the NHSC gives special emphasis to **increasing the number of culturally- and linguistically- competent clinicians for service to all underserved people, including AAPI populations.** In FY 1998, the NHSC is undergoing a reorientation and increasing its' focus on improving the NHSCs ability to work closer with communities and to identify and address the communities needs for culturally and linguistically appropriate clinicians.

- b. The **National Health Service Corps offers training in cultural competency** targeted at scholars in training and newly working scholars and loan repayers at its' annual conferences.
- c. The BPHC/DCMH will be working on a **plan to increase the number of culturally and linguistically competent clinicians**, including those that are AAPIs and serve C/MHC AAPI populations, through the following activities:
1. **65% of BPHC supported National Health Care health professionals will continue to serve underserved and vulnerable populations, including AAPIs**, after fulfilling their NHSC obligations;
 2. 80% of BPHC supported sites will improve provider satisfaction and reduce provider turnover to levels lower than industry average.

H/AB:

d. **Train HIV/AIDS service providers on delivering culturally competent care.** Support training programs/courses through established networks which address access, utilization, and delivery of culturally competent services to AAPIs. This new initiative has been proposed.

BHPr:

- e. **Establishment of Departments of Family Medicine in Hawaii** - The purpose of the project is to develop a Family Practice Residency program Behavioral Curriculum. As a part of this objective they have identified the multi-cultural psycho-social issues within the different groups in Hawaii. Faculty have been identified to teach the ethnic issues of the following groups: Filipinos & Marshallese, Somoan, Hawaiian.
- f. **Graduate Training in Family Medicine** - The purpose of the project is the establishment of rural and underserved training sites for medical students and residents. Establish a recruitment and Placement process for medical students and residents who will likely choose to practice in rural/underserved areas. Medical rotations will expose medical students to health care delivery to Asian/Pacific Islanders. This will increase their knowledge of disease prevalent among AAPIs such as growth retardation and smoking in rural areas.

MCHB:

- g. **Strengthening Genetics in Primary Care for Asians and Pacific Islanders**—Enhancement of genetic services in primary care for the Asians and Pacific Islander (API) population by increasing the understanding and knowledge of genetics among primary care providers serving APIs.
- h. **Comprehensive Care for Cooley's Anemia, Thalassemia**—A collaborative effort of five New England Hospital centers to provide optimal care for individuals and families affected by or at risk for Cooley's anemia/thalassemia.
- i. **Pacific Basin Maternal and Child Health Resource Center**—Enhancement of the well-being of families in the U.S.-related islands of the Pacific Basin by helping health care professionals gain access to the knowledge and resources necessary to overcome or reduce the health problems faced by each of the jurisdictions.
- j. **CISS Project to Enhance Services to Pregnant Women, Infants, and Children by Improvement on Health Information Systems**—An effort to computerize the health infor-

mation system to increase access and thereby enhance “one-stop” shopping of existing integrated services to the AAPI population.

k. **Maternal and Child Health Training Program**—This training program provides graduate-level instruction and continuing education opportunities in maternal and child health leadership.

l. **Maternal and Child Health Leadership Continuing Education for Pacific Islands**—Leadership training of MCH service providers and interagency staff with the emphasis being made on critical thinking and problem-solving processes.

Lead Entity:

- a. BPHC / NHSC, Andy Jordan.
- b. BPHC / NHSC, Andy Jordan.
- c. BPHC / DCMH, David Stevens, M.D.
- d. H/AB / Division of Training and Technical Assistance (DTTA), AETC Program

Note: Future training programs which specifically address the needs of AAPIs could be initiated by the Division of Training and Technical Assistance in collaboration with the Special Projects of National Significance Program. The collaboration could entail the development and evaluation of a program/course targeted toward mainstream health care providers which specifically addresses delivery of services to AAPI populations facing language and other barriers.

- e. BHPPr / Division of Medicine, Shelby Biedenkapp.
- f. BHPPr / Division of Medicine, Ellen C Grant.
- g-l. MCHB

Time Frame:

- a. FY 1998
- b. On-going
- c. FY 1998
- d. FY 1999/2000 (tentative)
- e. 3 Years/1997-2000/Ongoing
- f. 5 Years/1994-1999/Ongoing
- g. 10/1/95-9/30/98
- h. 10/1/88-9/30/97
- i. 10/1/92-3/31-99
- j. 10/1/96-9/30/2000
- k. 7/1/65-6/30/99
- l. 10/1/95-9/30/98

Measurable Outcome:

- a. Greater sensitivity in NHSC to AAPI community needs.
- b. Cultural competency training for NHSC scholars.
- c. Plan to increase the number of culturally and linguistically competent clinicians, including those who are AAPIs.

- d. Training courses/programs established.
Funding awarded to develop/refine/evaluate training course(s)/program(s).
Training courses/programs held.
 - e. The development of a Family Practice Residency program Behavioral Curriculum, focusing on the multi-cultural psycho-social issues of Filipinos, Marshallese, Samoans, and Hawaiians. Cost: \$90,000;
 - f. The establishment of a recruitment and placement process, and training sites for medical students and residents who will likely choose to practice in rural/underserved areas. Cost: \$626,000.
 - g. Development of a culturally sensitive training model for primary care providers serving AAPIs.
 - h. Coordination of services, including screenings, diagnosis, genetic counseling, comprehensive medical care, and psychosocial support, amongst New England network.
 - i. Expansion of Resource Center services to health professionals.
 - j. Improvement of existing health information system to increase access and to enhance one-stop shopping.
 - k. Provision of instruction in areas such as needs assessment, program administration, advocacy, interdisciplinary communication, and problem-solving.
 - l. Development of a training module for use in conducting island jurisdictions workshops.
4. Publicize HHS fellowship, internship and other training programs and actively recruit racial/ethnic minority candidates, including AAPIs (all).

Key Agency Activity:

BPHC:

- a. The BPHC/Division of National Health Service Corps (NHSC) markets and advertises materials routinely that **highlight photos and quotations from currently serving AAPI NHSC members as role models for future health care professionals**. In FY 1998, the NHSC has also arranged to **exhibit at the National Conference of the Asian Pacific American Medical Students Association**. NHSC targeted efforts will continue to recruit AAPI health professionals and students to participate in all NHSC programs, including scholarships, loan repayments programs, and student service/learning experiences.
- b. BPHC/Office of Minority and Women's Health in FY1997 and FY1998 has overseen the development, marketing and distribution of **"Black Bag" articles** on NHSC programs, minority women's health issues, models that work, minority organ donation etc. in the Journal for Minority Medical Students, Publisher SPECTRUM, Inc., New Orleans, Louisiana. The articles **routinely highlight photos, interviews and quotations from AAPI individuals and communities**.
- c. BHPr, To Be Determined.

Lead Entity:

- a. BPHC / NHSC, Andy Jordan.
- b. BPHC / OMWH, Helen Kavanagh.

Time Frame:

- a. On-going, and FY 1998
- b. FY 1997 and 1998

Measurable Outcome:

- a. NHSC targeted efforts to recruit AAPI health professionals and students to participate its programs.
- b. Inclusion of AAPIs in BPHC's literature on its programs. Cost: \$7,500/ issue.

V. WORKFORCE AND PARTICIPATION IN HHS OPERATIONS

GOAL 5: Ensure that issues affecting underserved AAPI populations are addressed through representation in the HHS work force and participation in HHS operations.

Objective 5.1: Increase the representation of AAPI employees on advisory boards, strategic planning committees, and task forces

Objective 5.2: Partner with AAPI national and local research and policy organizations to identify external AAPI community representatives to participate in HHS grant programs and other internal/external activities.

Objective 5.3: Provide technical assistance to AAPI community organizations on HHS programs and activities, to increase both these organizations' knowledge base and capacity to participate, and HHS program staff awareness of AAPI health and human services issues.

Objective 5.4: Develop strategies for increasing recruitment of senior level AAPIs to SES and other line positions in HHS agencies.

Suggested activities:

1. Involve AAPIs in ongoing program planning activities of HHS through AAPI representation in, for example, advisory boards, task forces, and strategic planning committees. A data base pool of appropriate individuals to show as such representatives would be useful in increasing involvement. Outreach procedures and activities designed to increase the pool of AAPI candidates for these positions will be developed.

Key Agency Activity:

H/AB:

- a. The Title I application process supports this HRSA suggested activity. The Ryan White CARE Act Amendments of 1996 require each **Title I planning council to "reflect in its composition the demographics of the epidemic in the eligible area involved**, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations." Direction is given regarding the appointment of provider and population categories.

The formula applications require grantees to complete charts on the composition of the planning council. The supplemental application includes an update to the planning council charts, accompanied by a more qualitative description of how the planning council ensures cultural competence and that the voices of affected and infected populations are heard.

The application processes are designed to ensure initial and ongoing review and correction of council composition on the basis of gender, ethnicity and HIV-sero status.

Lead Entity:

a. H/AB / Division of Service Systems, Anita Eichler, Director

Time Frame:

a. This is an established and on-going activity.

Measurable Outcome:

a. The measurable outcome is the actual composition of Title I Planning Councils within EMA's.

2. Involve AAPIs in ongoing policy development activities of HHS through AAPI representation in, for example, advisory boards, grant review panels, and peer review boards. Outreach procedures and activities designed to increase the pool of AAPI candidates for these positions will be developed. AAPI representation should include, where feasible, senior citizens and university/college students, and AAPIs with disabilities.

Key Agency Activity: **To be determined.**

Lead Entity:

Time Frame:

Measurable Outcome:

3. Improve capacity of AAPI community-based organizations to participate in HHS grant programs through partnerships with and increased involvement of AAPI national and local research and policy organizations.

Key Agency Activity: **To be determined.**

Lead Entity:

Time Frame:

Measurable Outcome:

4. Develop HHS-wide mechanisms to provide technical assistance to community-based organizations, evaluate effective strategies for serving AAPIs, identify best practices and disseminate information about HHS programs, services and funding opportunities.

Key Agency Activity:

BPHC:

a. **Goal 5 and its proposed activities #1-4 were sent to BPHC Divisions and Offices:** Division of National Health Service Corps'; Office of Evaluation, Research & Analysis; Office of Minority & Women's Health; Office of State and External Affairs; Division of Scholarships and Loan Repayment; Division of Programs for Special Populations; Division of Community & Migrant Health; Office of Program and Policy Development, for future consideration when writing policies, nominating Advisory Council members, completing technical assistance, forming committees, etc.

BPHC currently has two legislated **Advisory Boards:** The National Health Service Corps' Advisory Council (AAPI current member: **Dr. Larry Li**) and the National Advisory Council on Migrant Health (11/93-11/97 AAPI member: **Robert Sakata**).

b. The **BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in primary health care will be inclusive of AAPI individuals and communities** as important resources in the development of materials, provision of training and technical assistance, etc., to HRSA programs concerning cultural and linguistic competence issues in primary health care.

Lead Entity:

- a. BPHC / NHSC, Andy Jordan and BPHC / DCMH, Susan Hagler.
- b. MCHB, Diana Denboba and BPHC, Len Epstein and Helen Kavanagh.

Time Frame:

- a. On-going
- b. On-going

Measurable Outcome:

- a. Goal area on workforce and participation shared throughout BPHC's divisions. Asian Americans currently serve on two advisory boards.
- b. BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in primary health care will be inclusive of AAPI individuals and communities.

5. Consult with AAPI government professional organizations such as the Asian American Government Executives Network to do the following:

Key Agency Activity:

A. Identify barriers to AAPI outreach and recruitment to SES and front line positions, and political appointments in HHS.

To be determined.

Lead Entity:

Time Frame:

Measurable Outcome:

Key Agency Activity:

B. Develop outreach and recruitment activities to increase the pool of AAPIs considered for SES positions and political appointments in HHS.

To be determined.

Lead Entity:

Time Frame:

Measurable Outcome:

6. Determine if outreach and recruitment efforts are warranted to increase AAPI representation in key “front-line” positions such as regional office staff that work most directly with AAPI communities.

Key Agency Activity: **To be determined.**

Lead Entity:

Time Frame:

Measurable Outcome:

IV. CROSS CUTTING COLLABORATION TO ENHANCE HHS CUSTOMER SERVICE TO AAPIs

GOAL 6: Enhance HHS capacity to serve Asian American and Pacific Islander customers.

Objective 6.1: Improve collaboration within the Department to increase coordinated approaches to meeting AAPI customer needs.

Objective 6.2: Ensure that HHS programs and initiatives meet the needs of AAPIs by strengthening partnerships with AAPI community organizations.

Suggested Activities:

1. Identify all current Departmental Initiatives and request review and comments from each Initiative coordinator on the Work Plan. (Short term - **see attachment**) Ensure that all HHS Initiatives include and address issues specific to AAPI communities. (long term)

Key Agency Activity: **To be determined.**

Lead Entity:

Time Frame:

Measurable Outcome:

2. Each HHS division/program should seek to enact standards of competence for agencies and providers who deliver services to AAPI populations and to ensure that linguistically-isolated individuals can be identified and served effectively. Collaboration among OPDIVS and STAFFDIVS may be the most efficient means of developing a common set of principles or standards for service providers. Such standards for service delivery and community involvement should be incorporated where appropriate in published criteria for guidances to States, and other federally funded programs, as well as in published criteria for program announcements and/or requests for proposals. (ALL) (long term)

Key Agency Activity:

BPHC:

a. **BPHC/Office of State and External Affairs (OSEA) supports Primary Care Associations (PCAs) and Primary Care Organizations (PCOs) nationwide.** As part of their new program expectations, PCAs and PCOs funded by BPHC, are required to arrange for networking opportunities for BPHC-supported providers to share experiences/strategies for meeting industry standards around quality of care. In addition, these organizations have been asked to **identify resources that are available to assist in accomplishing quality focused activities, including the provision of culturally competent and linguistically appropriate care.**

b. **BPHC/Office of Evaluation, Analysis and Research (OEAR) has designated new shortage designation methodology that relates to AAPIs.** A geographical area or community may be designated as a “primary care shortage area” (or primary care health professional shortage area) when “the proportion of the population in the area is either a racial minority or Hispanic, and the proportion of the population in the area is “linguistically isolated” (where neither speak English well nor have a household member who can translate)”. Designation as a primary care shortage area assists towards the placement of National Health Service Corps scholars and loan repayers.

Lead Entity:

a. BPHC / OSEA, Jim Macrae.

b. BPHC / OEAR, Bonnie Lefkowitz and BPHC / NHSC, Andy Jordan.

Time Frame:

a. On-going

b. On-going

Measurable Outcome:

a. PCAs and PCOs will identify resources on cultural and linguistic competence as part of their efforts to assure quality of care.

b. New shortage designation methodology that relates to AAPIs.

3. Each HHS division program should identify selected behavioral, educational, service, environmental or research issues that are critical to AAPI populations or have great potential to be miscommunicated or not communicated at all to AAPI populations, and organize appropriate outreach or educational efforts. Activities that support outreach on these sentinel

or target issues should include use of ethnic media; development of consumer publications, posters, videos or related items; including images of AAPI people in broad public outreach efforts to the general populace; or promotions organized by and with community-based organizations. Efforts should also ensure accessibility to information by AAPIs affected by disabilities that impact communications.

Key Agency Activity:

A. Sample activities proposed by HHS Operating Divisions include:

A.1 Translation of the Medicare Beneficiary Advisory Bulletin entitled “What Medicare Beneficiaries Need To Know About Health Maintenance Organization (HMO) Arrangements: Know Your Rights,” into AAPI languages. (OIG, HCFA) (long term)

This suggested activity is not indicated for HRSA, but see answers for Objective 4.3, # 4; Objective 1.2, #1.C; Objective 6.2, #6.

4. Each HHS division/program should review past and present collaborations with AAPI service organizations or facilities serving AAPI communities to identify “Best Practices,” in implementing linguistically-appropriate health education, prevention and treatment modalities and service delivery, and develop methods of disseminating this information broadly among other HHS agencies and HHS partners, such as the National Governor’s Association, the American Public Welfare Association, the Association of Maternal and Child Health Programs, the Association of State and Territorial Health Officers, and the National Association of City and County Health Officials. Among others, best practices include health centers that are community-wide, programs that have unique expertise delivering care to populations such as the homeless, people with mental illness, people living with HIV, and health departments. (OMH, HRSA, ASPE, SAMHSA, CDC) (long term)

Key Agency Activity:

a. See BPHC response to Objective 1.2, #2.B, re: creating new models of care.

Lead Entity:

BPHC / DCMH, Regan Crump

Time Frame:

Measurable Outcome:

6. Each HHS division/program should identify opportunities to research customer needs and customer satisfaction with services delivered to AAPI communities and clients. Divisions and programs should seek opportunities to (1) solicit advice from AAPI community groups, and (2) involve AAPI communities in materials development and decision making on customer service strategies and improvements. (ALL)

Key Agency Activity:

BPHC:

See response for #7.A below.

a. **BPHC 1994 User Survey** indicated that 93% of health center users believed they are treated with respect and note that the provider spoke their language. This survey was done with a representative sample of the Nation (per National Center for Health Statistics): 15 health centers and 2,000 respondents. **The survey was translated to Chinese.**

b. **BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in Primary Health Care will be soliciting advise from, and involving AAPI communities** in the identification, development and building of materials, service strategies and customer satisfaction.

Lead Entity:

- a. BPHC / OEAR, Bonnie Lefkowitz.
- b. MCHB, Diana Denboba and BPHC, Len Epstein & Helen Kavanagh.

Time Frame:

- a. Completed FY 1994
- b. Starting March 1998

Measurable Outcome:

- a. Survey found that 93% of health center users believed they were treated with respect and note that the provider spoke their language. Survey translated to Chinese.
- b. AAPI community input in activities of BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in Primary Health Care.

7. Strengthen partnerships with AAPI communities and service providers on HHS-related issues in the long term, through strategies such as:

Key Agency Activity:

A. Regional meetings to address differing needs and issues of AAPIs in urban and rural areas, and in States with high concentrations of AAPIs and with smaller, isolated clusters of AAPIs (OCR lead, all) (short term)

BPHC:

a. As part of their program expectations, **PCAs and PCOs** are required to conduct planning meetings with various groups to review the unmet needs for primary and preventive care services within their State, including an **assessment of the needs of special populations such as AAPIs.**

Lead Entity:

- a. BPHC / OSEA, Jim Macrae.

Time Frame:

- a. On-going

Measurable Outcome:

a. Planning meetings with AAPIs to assess unmet need, is a program expectation of PCAs and PCOs.

Key Agency Activity:

B. Sponsor invitational meetings to engage AAPI community health leaders, customers and researchers in dialogue about the AAPI Initiative, the work plan, and where applicable, implementation activities to respond to the recommendations that were a product of two national conferences. An invitational meeting is being planned by HRSA in December of 1997 involving issues such as access to safety net providers, HRSA grant programs, and health professions training. (short term)

- a. HRSA's **AAPI Invitational Meeting and Pacific Basin Summit** will be convened in the Washington, D.C. area.
- b. **Primary Care Associations and Primary Care Organizations can serve as conveners for forums** to respond to the AAPI Initiative, the work plan and where applicable, implementation activities to respond to the recommendations that were a product of two national conferences.

Lead Entity:

- a. HRSA-wide.
- b. BPHC / OSEA, Jim Macrae.

Time Frame:

- a. Pacific Basin Summit: March 16-17, 1998 AAPI Invitational Meeting: March 17-18.
- b. On-going.

Measurable Outcome:

a. The primary outcome of the AAPI Invitational Meeting will be the development of HRSA's Implementation Plan for the Departmental Initiative. It will also address, and put closure to, the 1995 Health Summit recommendations. HRSA's Implementation Plan will serve as the Agency's strategy for improving the health of AAPIs over the next decade. This meeting will afford opportunities for HRSA and AAPI communities to build stronger links.

The primary outcome of the Pacific Basin Summit will be a health policy framework to guide primary health care delivery and infrastructure development in the six U.S. associated Pacific Island jurisdictions. Strategic planning will be conducted around the soon-to-be-released *Institute of Medicine Pacific Basin Health Report*. Issues and decisions arising from the Pacific Basin Summit will be integrated into the development of HRSA's Implementation Plan.

b. PCAs and PCOs will be an additional avenues to implement the activities of HRSA's AAPI Initiative.

Key Agency Activity:

C. Include workshops or presentations on AAPI needs and on barriers within AAPI communities to accessing necessary and appropriate health care services during AAPI Heritage Month (May).

a. The **BPHC-MCHB National Resource Center on Cultural and Linguistic Competence in Primary Health Care** will be able to provide information, materials, training opportunities and technical assistance concerning cultural and linguistic competence issues in primary health care.

Lead Entity:

a. MCHB, Diana Denboba and BPHC, Len Epstein & Helen Kavanagh.

Time Frame:

a. Starting March 1998

Measurable Outcome:

a. Resources will be available in the system to develop cultural competence.

**NATIONAL HEALTH SUMMIT OF ASIAN AMERICAN AND PACIFIC ISLANDER
HEALTH ORGANIZATIONAL LEADERS - 1995**

RECOMMENDATIONS FOR HRSA

Below is the response from the Bureau of Primary Health Care. Responses from other bureaus and offices will be developed.

Recommendations:

3.1: *Acknowledge the ethnic diversity represented by aggregating Asian Americans and Pacific Islanders Wherever possible, specify the ethnicity....*

BPHC/Office of Evaluation, Analysis & Research (OEAR), developed and monitors the "Uniform Data System" (UDS) which identifies AAPI "Users" of BPHC funded services. It is estimated that in Calendar Year 1999 or 2000, Asian Americans and Pacific Islanders will be made into two distinct reporting categories for BPHC funded programs. Lead: BPHC/OEAR Bonnie Lefkowitz.

3.2: *When appropriate to generalize, use the aggregate term Asian Americans and Pacific Islanders to demonstrate the numerical strength and unprecedented growth rates of these populations.*

In 1996, there were 189,472 AAPI users out of a total of eight million users of BPHC's health centers. 115,389 (of the 189,472) AAPI Users were concentrated in 18 BPHC grantees serving over 2,000 AAPIs each. Another 30,549 AAPI Users are from 22 BPHC grantees serving over 1,000 AAPIs each.

Lead: BPHC/OEAR Bonnie Lefkowitz.

Approximately 20,000 are served annually in the Native Hawaiian program and 470 AAPIs in the Alzheimer's program. Lead: BPHC/DPSP Tom Coughlin.

3.3: *Determine the quality, availability and accessibility of culturally and linguistically competent health professionals who serve AAPIs and assure public accessibility to an on-line directory of such individuals..... Not available.*

3.4: *Develop curricula on linguistic and cultural competence that will be offered to health care providers serving AAPIs.*

By March 1998, BPHC will initiate a National Resource Center on Cultural and Linguistic Competence in Primary Health Care. This Center will be a joint BPHC-MCHB (Maternal Child Health Bureau) effort which will provide information, materials, training opportunities and technical assistance concerning cultural and linguistic competence issues in primary health care. Lead: MCHB Diana Denboba, BPHC Len Epstein and Helen Kavanagh.

Primary Care Associations and Primary Care Organizations can serve as distribution points for these materials, as well as a convener for forums on best-practices/experiences of BPHC-supported providers around culturally competent and linguistically appropriate care. Lead: BPHC/OSEA Jim Macrae.