STRATEGIES FOR IMPROVING THE OFFICE OF MINORITY HEALTH

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The Office of Minority Health (OMH) was established in 1986 to improve and protect the health of racial and ethnic minority populations in the United States through the development of health policies and programs that will eliminate health disparities. Since its initial congressional mandate, it has produced multiple programs, campaigns, publications, and educational materials promoting the health of ethnic minorities. However, its continued existence is by no means assured. Recently, it faced harsh criticism regarding the success of its programs, and congressional leaders have introduced legislation designed to modify the office and its minority focus. In this report, we review 1) the accomplishments and inefficiencies of the current office and 2) provide recommendations to improve OMH's effectiveness in reducing health disparities and addressing health issues in minority populations. (*Ethn Dis*. 2008;18:373–377)

Key Words: Office of Minority Health, Health Disparities, Linguistic Competence, Cultural Competence, Health Education

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INTRODUCTION

The Report of the Secretary's Task Force on Black and Minority Health from 1985 revealed the existence of extensive and persistent disparities in the health of racial/ethnic minority Americans.[1] This report was the impetus for Congress to create an office focused on minority health issues as it attempted to find a solution to the unequal burden of illness shouldered by ethnic minorities. The Office of Minority Health (OMH) was created by the US Department of Health and Human Services (HHS) in 1986 (Public Law 105–392). OMH's current mission is to improve the health of racial and ethnic minority populations through the development of health policies and programs. It advises the Office of Public Health and Science and the Secretary of Health and Human Services on issues pertaining to racial and ethnic minority populations, including American Indians, Alaskan Natives, Asian Americans, Black/African Americans, Hispanic/Latino Americans, Native Hawaiians, and Pacific Islanders. It maintains regional offices, although six states do not have local OMH offices or satellite centers. Through these regional sites, OMH provides technical assistance and resource information through programs such as the OMH Resource Center (OMHRC) and the Center for Linguistic and Cultural Competence in Health Care (CLCCHC).[2]

Accomplishments and Initiatives

Notable accomplishments of OMH include its Closing the Health Gap initiatives and monitoring the *Healthy People 2010* goals.[3,4] Multiple summits and conferences organized by OMH increased awareness of health disparities among American minority populations nationwide. The first National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health gathered >2000 community representatives for strategy and skill-building sessions (2002). The First National Child Health and Child Welfare Conference (2004) addressed developing methods of bridging health and human services in order to improve outcomes in young racial/ethnic minorities.[5]

OMH also recognized the importance of making healthcare organizations and individual practices culturally and linguistically accessible, leading to the creation of the Center for Linguistic and Cultural Competence in Health Care and the development of the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Both the Center and the CLAS Standards have been instrumental in improving accessibility of services to Hispanics across the country, educating the healthcare system on the importance of cultural and linguistic competence, and establishing policies and programs across the United States to ensure the proper delivery of services.[6]

Through its grants and contracts OMH provides a multitude of services, which include assessing the healthcare needs of minorities, funding minority-targeted research, and coordinating/directing selected health services. Its OMH Resource Center (OMHRC) serves as a free information and referral service on minority health issues for community groups, consumers, professionals, and students. It publishes and distributes culturally competent health information, encourages public participation in HHS programs, and assists in conducting health campaigns. OMH also works with HHS operating divisions and other federal departments to improve collection and analysis of data on the health of minority populations.[7]

To address general health education of diverse minority groups, programs have been implemented such as the ''Know What to Do'' campaign, aimed at reducing infant mortality, low birthweight, and sudden infant death syndrome among African Americans. Programs targeted at Hispanic Americans include ''Celebra la Vida con Salud.'' This national education campaign promoted adopting healthier lifestyles and informing the public about preventive measures. Educational events, health fairs, and media outreach including radio shows, public service announcements, and online education were elements of this program.[8]

OVERVIEW OF OMH INEFFICIENCIES

Despite the development of numerous initiatives and campaigns, there is increasing nationwide criticism of the overall performance of OMH. The US Office of Management and Budget and other federal agencies responsible for assessment and evaluation of federally funded programs have identified inefficiencies in the OMH, and congressional reappropriation has proven increasingly difficult. The main areas of concern have been the lack of outcomes measures for its directly managed programs and the programs of its grantees and contractors, as well as potential duplication of services with other government agencies.[9]

With regard to grantees and contractors, the office requires demonstrable capacity of each to conduct the proposed programs and site visits during the funding period; however, it lacks objective performance measures to track progress over time. Current work plans, budgets, contracts, and other agreements do not reflect the individual role and contribution each provides in eliminating disparities. Reviewers of the OMH have noted that other agencies such as the Office for Women's Health and Office of Rural Health may be conducting similar programs and research and call for reduction of overlap to better use taxpayer dollars. Efforts are needed to demonstrate the differences and individual contributions of each of these offices.[9]

PROPOSAL TO IMPROVE THE PERFORMANCE OF OMH

Our group has drawn on site visits and interviews with OMH staff at both national and selected regional offices. All interviews were conducted with the mutual agreement of confidentiality. Document reviews were also conducted to identify areas in which we believe improvements could be made in OMH performance. We offer the following recommendations for a more effective OMH.

Expand Cultural and Linguistic Competency Programs

A major accomplishment of OMH is the Cultural and Linguistic Competence initiative and the resulting CLAS Standards. The growing diversity of the nation calls for renewed and improved efforts to decrease language barriers. Increasing awareness of the importance of these standards has contributed to improvement in the quality of life and the accessibility to healthcare services among Hispanics.[10–12] However, linguistic barriers do not solely impede Spanish speakers but other ethnic groups as well. OMH could continue to effectively serve the minority communities in the future by maintaining its focus on cultural and linguistic competency. Proposing methods to enforce policy measures for improvement of language services across healthcare venues would be invaluable.

OMH should also take a more active role in the standardization of cultural competency training in health education programs. Although most medical education institutions have made cross-cultural education part of their curriculum, there is increasing concern of inadvertently reinforcing stereotypes and oversimplification of culture concepts. OMH could play a key role in the education of future physicians and other healthcare providers by assisting with a rigorous examination of programs and produce recommendations for an effective education model.[13,14]

OMH Should Be the Command Center for All Minority Healthcare Issues

OMH should remain the nucleus of all healthcare issues regarding minority health, and its primary focus should remain racial and ethnic health. Currently, minority health programs can be instituted and funded by any of a number of federal offices. This has led to the valid criticisms of unnecessary duplication of services, poor communication between federal offices, and wasted taxpayer funds.[9] OMH currently lacks the authority to coordinate minority health projects in other federal departments. OMH should be granted the power to unite and lead various components of the federal health system in regard to racial and ethnic minorities. Health funding assigned to other agencies currently covering health disparity populations should be reviewed and approved by a central office located in OMH to ensure equitable distribution of resources and elimination of duplicate services. OMH should also oversee and coordinate national public health programs during the duration of the project with other agencies to ensure the proper collection of healthcare data on minorities. These data should assist OMH's ability to influence the current and future strategies addressing disparities in healthcare outcomes among minorities.

Program Outcome Measures

Fear and limited understanding of disease and how to access health services often cause delays in minority popula-

tions obtaining appropriate and timely medical care.[15,16] OMH has sponsored many outreach programs in an attempt to reach Hispanics and improve health knowledge. We view continuation and development of new outreach programs as an essential service of OMH. In order to reduce congressional criticisms, OMH should develop pre- and post-intervention outcome measures to provide evidence of the effectiveness of their programs. Any program funded by OMH that sponsors patient outreach programs should be required to establish some type of measure for changes in attitudes, health behaviors, etc in its target population. OMH could provide a manual or guidelines to educate and provide technical assistance to program directors on valid techniques to obtain this data. These new requirements would allow OMH to critically review and modify or eliminate any poorly received or underperforming programs.

Stronger Partnerships with State and Local Offices of Minority Health

During our interviews at local and state OMH offices, office coordinators expressed a feeling of working in relative isolation from the federal office. Strong partnerships, communication, and support for these offices at the frontline of minority health are advisable. Many of the offices expressed frustration with being undermanned and underfunded. Some large and culturally diverse counties like Miami-Dade did not even have a designated OMH office. Instead, they incorporated minority health (Closing the Gaps) programs in the chronic illness or other department divisions, which potentially dilutes their effectiveness. In spite of this, local and state offices that we interviewed often accomplished much with minimal resources because they were passionate about the mission and learned to collaborate creatively with community partners. Nonetheless, OMH should regularly communicate with these offices, assess their needs, advocate for their financial and technical support, and more closely monitor their programs. This in turn would help provide OMH with current information on the changing needs of the community and allow it to track programs and outcome measures, the lack of which has drawn criticism as previously discussed.

Expanding OMH into Centers for Medicare and Medicaid Services (CMS)

An important component of health disparities and poor healthcare access is poverty.[17,18] There is an expanding pool of minorities who do not have an employer-subsidized insurance program, making any visit to a healthcare provider a financial hardship. Current congressional proposals also include opening an OMH in CMS (HR 3459). Our group views this favorably since OMH can serve as an advocate for poor minorities in CMS. Many positive outcomes may result with the presence of OMH in CMS. Expanding the definitions of those who qualify for these programs may lead to more minorities being able to obtain affordable medical care. OMH can also spearhead the development of a simple, straightforward application for minorities to obtain benefits, especially those individuals with low literacy levels in Spanish, English, or other languages.

Minority Health Education and Research

Clinical Trials

Current congressional proposals include expanding the OMH office into the Food and Drug Administration (HR 3459). We again view this favorably since OMH can serve as an advocate for the development of new therapeutic options for diseases that preferentially affect minority populations and urge industry to increase testing of these medications in these groups, since they are underrepresented in clinical trials.[19,20] These steps may lead to the improvement of therapeutic options for our communities.

Research

OMH should develop nationwide research and grant programs that provide longitudinal, generational, observational data on health behaviors and health status of minority and health-disparate populations. This information would identify areas of need for health-risk intervention and risk reduction. OMH can play a larger role in the development of research projects that specifically target diseases and treatment for diseases that disproportionately affect ethnic minorities. Although OMH has had some grants, these have been primarily targeted at community outreach programs. OMH should develop recommendations and or research priorities for other agencies such as the National Institutes of Health and the private sector.

Workforce Diversity/Healthcare Provider Training

OMH should also become a louder voice in the efforts to improve workforce diversity in the healthcare professions. Underrepresentation continues in the areas of physicians, nurses, and technicians. Increasing representation in the health professions would greatly assist in diminishing the problems of language barriers and culturally sensitive health care. There is often a poor understanding of the requirements and education tracks needed to obtain advanced degrees in the United States among first-generation immigrants.[21,22] Providing opportunities for mentoring and increasing opportunities for exposure to possible careers in the health services may be invaluable. OMH should support measures to continue Title VII programs, which prohibit discrimination by an employer on the basis of race, color, religion, sex, or national origin (Pub. L. 88–352) and the continuation of pipeline programs

that focus on students in the sciences through funding and research opportunities.

Preventive Care Training

OMH needs to continue to emphasize the importance of preventive care and healthy behaviors. Poor understanding or complete lack of knowledge regarding cardiovascular disease and colorectal, prostate, and breast cancer screening may be in part responsible for minorities having a later stage of presentation at diagnosis accompanied by its attendant morbidity and mortality.[16,18,23] OMH programs such as Celebra la Vida con Salud are an excellent example of outreach programs that must be continued and new programs that must be developed for other emerging health issues.

Support Rebuilding Public Health Infrastructure

Because of budgetary cutbacks, many areas of the public health infrastructure are being neglected and/or closed. OMH should maintain oversight of changes in publicly funded health services such as community health clinics and hospitals. OMH should play a larger role in protecting these programs, many of which serve vulnerable and under-served minority communities.[24,25]

DISCUSSION

OMH has struggled with reauthorization and reappropriation these past years. In order to ensure swifter congressional action, reduce criticism, and quell discussion about the effectiveness of the office, a strategic plan needs to be developed with specific short- and long-term goals. Detailed objectives including timelines, methods, implementation of objectives, performance measures, and outcome achievement must be documented for its various endeavors. This is imperative for the continued success of the office and justification of its budget.

Proposed congressional changes (S 2091, HR 3459) include appending ''health disparity populations'' to OMH, resulting in numerous modifications in the duties of the office and its advisory committees. Grants, assistance programs, and health professions education programs all have ''health disparity populations'' appended to the initial target population, namely, racial and ethnic minorities. Although this may initially strike the casual reader as a minor change, it has major ramifications. Disparities exist in the population not only on the basis of racial differences but also gender, socioeconomic, and geographic differences.[26,27] The renamed OMH office would potentially be charged with addressing, improving, and funding research in any of these areas with disparities. The definition of a health disparity population is broad. Limited resources may be redirected away from ethnic minorities, and other segments of the population may benefit from this change based on current political inclinations and popular opinion.

Although we do not generally favor this change due to concerns regarding dilution of the office's minority focus, the proposed name change may provide larger congressional support for OMH. Budget increases included along with reauthorization may allow OMH to expand services and move beyond the role of policy advisor. Both legislative bodies should be encouraged to collaborate and propose a comprehensive minority health plan that places OMH and its resources in a pivotal role.

ACKNOWLEDGMENTS

Our group is deeply indebted to the National Hispanic Medical Association, Elena Rios, Jo Ivey Bufford, and Susana Morales. Their valuable input, support, and guidance made the completion of this project and submission of this manuscript possible. We extend our deepest thanks.

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