

Caring

HEADLINES

Inside:

Special Diversity Issue

- Disparities in Health Care 1
- Jeanette Ives Erickson 2
 - The Changing Face of America
- New Bostonians Community Day 3
- Health Disparities from a Social Work Perspective 4
- Health Disparities from a Rehabilitation Perspective .. 5
- Cuba Revisited 6
- Foreign-Born Nurses 7
- Disabilities and False Perceptions 8
- Health Care as a Civil Right ... 9
- Interpreter Services 10
- Fielding the Issues 14
 - Health Literacy
- Educational Offerings 15
- Resources 16

Disparities in health care: the challenge for the new millennium

Why do minority populations have shorter lifespans than the majority population? Why do minorities experience more chronic illness than the majority population? These are the core issues behind many new initiatives striving to reduce and eliminate healthcare disparities in this country. Disproportionate access to care reminds many of us of a social history we hoped we had moved beyond. Now we see evidence of racial and ethnic disparities in the one arena that should be a safe haven for all people. Phrases like 'disproportionate burden,' 'prevalence rates,' and 'access to quality care' are becoming increasingly familiar as we seek to understand the relationship between being a

—by Deborah Washington, RN, director of PCS Diversity

minority, suffering from chronic illness, and dying young. Evidence suggests there is a correlation.

What are health disparities? The National Institutes of Health (NIH) describe health disparities as, "differences in the incidence,

prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations in the United States."

Health Resources and Services Administration (HRSA) says, "Health disparity is a population-specific difference in the *continued on page 11*



Work forum examines health care disparities

Weekly Journal

Senior vice president for patient care and chief nursing officer, Jeanette Ives Erickson, RN, presented her keynote address at the "Work Forum Examines Health Care Disparities" held at the Massachusetts Convention Center in Boston on October 14, 2003.

The report also focuses on the need for a patient-centered approach to care, one that recognizes the role of the patient in their own care. Erickson emphasized the importance of cultural competence and the need for healthcare providers to understand and respect the differences in their patients.

Other speakers at the forum included Dr. [Name], who discussed the impact of social determinants of health, and Dr. [Name], who highlighted the role of the community in addressing health disparities.

The forum was a significant event, bringing together healthcare professionals, community leaders, and policymakers to discuss the challenges of health care disparities and to explore strategies for improvement.

The face of America is changing: is health care keeping pace?

At the turn of the 20th century, only one in eight Americans was non-white. By 2001, Latinos accounted for 12.5% of the population surpassing African-Americans as the largest minority in the United States. By 2050, an estimated one in three Americans will be African-American, Latino, Native American or Asian/Pacific Islander.

Over the past several decades there have been enormous advances and improvements in health care. No one has benefited more from those advances than Americans. But all Americans have not benefited equally. According to recent national health studies, ethnic and racial minorities have not shared the same positive health outcomes as the majority population. The fact that

disparities exist along racial and ethnic lines is disturbing and should be a call to action for all caregivers.

One way to approach the problem is to look at the factors contributing to disparities. The American Hospital Association (AHA) recently published a report entitled, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care."

The report suggests that racial and ethnic disparities are caused by both patient-related and system-related factors. Patient-related factors include:

- socioeconomic differences
- health-education differences
- health-behavior differences

System-related factors:

- discrimination
- language differences

- workforce diversity differences
- cultural competence differences
- payment/reimbursement differences for treating Medicare, Medicaid and uninsured patients
- insurance coverage differences
- data deficiencies

The AHA has announced its commitment to identify and eliminate healthcare disparities in the United States. The PCS Diversity Steering Committee has made health disparities its new priority. And I ask each of you to participate in this important work. As with all challenges, solutions begin with ideas. We need to be creative and emphatic in our effort to ensure that patients of every racial, ethnic, and cultural origin receive the same



Jeanette Ives Erickson, RN, MS
senior vice president for Patient
Care and chief nurse

access to, and quality of, care.

The face of America is changing. It's up to us to see that health care responds to that change in a way that is fair, proactive, and timely. Please summon your creativity and contact a member of the Diversity Steering Committee with your ideas.

Updates

I would like to take a moment to thank you all for your hard work, preparation, and performance during our recent JCAHO visit. In every interview and exchange I witnessed, I saw MGH clinicians at their best. I saw the

skill and spirit that make this hospital the world-class institution it is. Thank-you.

I am pleased to announce that Susan Finn, RN, has accepted the position of clinical nurse specialist for the Blake2 and Bigelow 12 Cancer Infusion Units.

Kristen Jagodynski, BS, has accepted the position of health educator for the Patient & Family Learning Center. Kristen will develop health-promotion programs and patient-education materials and oversee the selection and maintenance of consumer-health pamphlets and Internet links.

The Nursing Career Coaching Program

MGH is introducing the Nursing Career Coaching Program with a special information session

Monday, October 27, 2003

11:30am-12:30pm

Walcott Conference Room

The coaching program will provide information about careers in nursing, scholarships, nursing schools, financial aid, and other resources available to individuals considering a career in nursing.

The Nursing Career Coaching Program is a collaboration between the department of Nursing and the Training and Workforce Development Office within Human Resources. It is a pilot program funded by the statewide Nursing Career Ladder Initiative to help address the nursing shortage.

NOTE: Training and Workforce Development has moved to 100 Charles River Plaza, Suite 200

For more information, call: 6-6386

REMINDER!

The Staff Perceptions of the Professional Practice Environment Surveys must be returned by October 24, 2003.

If you have not received a survey, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are confidential. Please complete and return your survey by October 24th.

Your voice is important!

New Bostonians Community Day 2003

—by Khalil El-Rayah,
Arabic medical interpreter

On Wednesday, September 17, 2003, New Bostonians Community Day was celebrated at City Hall Plaza in Boston. It was the first time I'd ever participated in such an event, and I was impressed to see the number of people who attended. It was a group unlike any other I'd ever seen—so many different nationalities and backgrounds. People stopped at the many tables set up by various organizations.

The purpose of the day was to provide information about how local government works and facilitate access to community resources for immigrants new to Boston's rich multi-cultural landscape. In a collaboration between the PCS Diversity Committee and the Partners International Program, MGH staffed a booth that provided free blood-pressure screening and MGH ID cards that

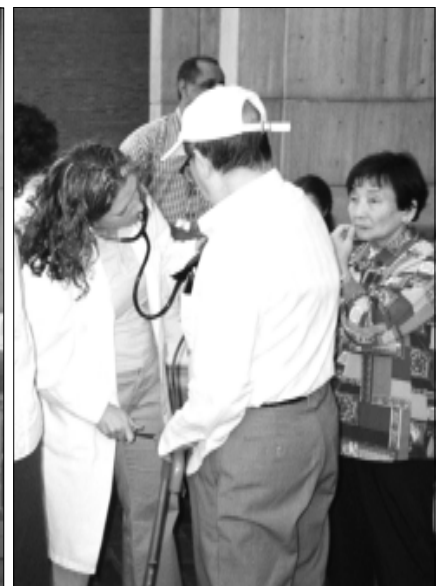
displayed each person's name, preferred language, blood pressure, known allergies, and emergency contact information. It was great to see so many people interested in having their blood pressure taken. I think a lot

of people weren't aware of the health services available in the city. Hopefully, word of mouth will carry this information to others who may need it.

Visiting a new country can be very stressful. Moving to a

new country can be even more challenging. But being informed about the services and resources available can make a real difference in the immigration experience for individuals new to our city.

Photographs clockwise from upper left: Staffing the MGH table are (l-r) Reina Rico, Khalil El-Rayah, Beth Nolan, and Cassandra Earley; nursing student, Meghan McDonald checks blood pressure; June McMorrow, RN, checks blood pressure; El-Rayah provides health information to visitors.



Health disparities from a social work perspective

—by Ellen Forman, LICSW, coordinator of the Social Service Department's Community Resource Center

(The following article is a summary of Forman's presentation at the PCS Diversity Committee's Conference on Health Disparities)

Addressing health disparities is integral to the practice of social work. Having access to medical services is an obvious contributor to good health. But optimal health also requires a safe community, a safe home (lead-free, with heat and hot water, free of violence), adequate food and clothing, and access to quality mental health services. Unfortunately, the impact of our failure as a society to fully address these issues falls disproportionately on communities of color.

While the majority of poor people in the United States are white, people of color and recent immigrants are disproportionately represented (US Census) and are therefore more likely to rely on public benefit programs to meet their basic needs. When these programs originated, they categorized people as 'worthy' and 'unworthy,' and that system continues today. As a society, we distrust the poor and blame them for their poverty, ignoring factors such as race, language, disability, etc., which may be

significant contributing factors.

These facts about families receiving 'welfare,' or Temporary Assistance for Needy Families (TANF), may surprise you:

- There is no federal welfare program that provides income to able-bodied adults without children.
- Of the 14 million TANF recipients, only 4.9 million are adults, and of those 90% are women.
- Half the children in welfare families are under age 6
- Sixty percent (60%) of all children on welfare live with someone who works part- or full-time
- Where full child-care subsidies are available, there is a dramatic increase in labor force participation among the poor

It's worth looking at the federal Supplemental Security Income (SSI) Program. SSI is a cash-assistance program for "aged, blind, and disabled individuals who have little or no income." For individuals living alone, a blind person receives up to \$701 a month, an elderly person up to \$680 a month, and a disabled person up to \$666 a month. These discrepancies extend to all categories

of living arrangements. These 'worthy' poor people receive assistance that places them below the federal poverty level (which is currently \$749 a month, arguably an unrealistic estimate of what constitutes poverty).

Our treatment of immigrants is another example of how we as a society contribute to unfair access to assistance. The Welfare Reform Law of 1996 created two groups of legal immigrants: 'qualified' and 'unqualified' (also called, 'special status'). The current state budget eliminated MassHealth insurance for 'special status' aliens (who, by the way, pay taxes). This includes immigrants fleeing persecution with pending applications for asylum, immigrants with permission to live in the United States because conditions in their home countries are unsafe, and certain permanent legal residents who won't be eligible for federal benefits for five years from their date of entry.

Massachusetts, like many other states, has provided health coverage for immigrants no longer eligible for federal Medicaid since 1997. At that time, Speaker Finerman called the federal failure to cover legal

immigrants, "a shameful and cynical act."

How do we decide who's living in this country legally versus illegally? Historically, there have been caps placed on the number of entrants allowed from some countries and preferential treatment extended to others based, to some extent, on race. Currently, Cuban refugees are allowed freedom until their cases are heard, but under a policy instituted last year, Haitians are held in federal detention while awaiting the results of their asylum applications. *America's Schizophrenic Immigration Policy: Race, Class, And Reason*, by Charles J. Ogletree, Jr. says, "This oft-cited disparity in the treatment of Haitian as compared to Cuban refugees is not an isolated situation, but rather an apt illustration of the factors and considerations that inform American immigration policy as a whole."

Individuals who reside in this country illegally, or as 'undocumented' immigrants, are eligible for very little public assistance, such as emergency medical care. They are not eligible for cash assistance. The short-sightedness of this policy can be seen in a recent case right here at MGH. Prior to admission, a young male patient was healthy, employed, and self-sufficient. While hospitalized, he experienced a

catastrophic accident that left him vent-dependent, quadriplegic, and requiring 24-hour care. He couldn't go to a nursing facility because he wasn't eligible for coverage due to his immigration status. And there are patients like this at all of Boston's teaching hospitals at any given time. They're getting great medical care, but not the social stimulation and recreation they would receive in a nursing facility. Is this an appropriate use of resources for these patients? Is this in anyone's best interest?

Racial disparities also exist in the area of mental health. In August 2001, US Surgeon General, Davidatcher, released a report, "Mental Health: Culture, Race, and Ethnicity: a Supplement to Mental Health." It stated that mental health disparities represent, "a critical public health concern."

The report found "striking disparities in care," with minorities:

- having less access to, and availability of, mental health services
- often receiving a poorer quality of mental health care
- being underrepresented in mental health research

The barriers faced by minorities, according to the report, "are the same as the barriers for all Americans: cost, fragmentation of services, lack of availability of
continued on page 12

Health Disparities from a Rehabilitation Perspective

—by Carmen Vega-Barachowitz, SLP,
director, Speech-Language Pathology

(The following article is a summary of Vega-Barachowitz's presentation at the PCS Diversity Committee's Conference on Health Disparities)

In 1999, Congress requested a study of the disparities that exist in the quality of health services provided to racial and ethnic minorities; to explore factors that may contribute to inequities of care; and recommend policies and practices to eliminate these inequities. The study revealed evidence of unequal treatment and services for racial and ethnic minorities.

Though the study focused only on racial and ethnic disparities, a case can be made that there is also a connection between disabilities and health disparities. One illustration of this appears in an August 3, 2003, *Boston Globe Magazine* article. Neil Swidye published an interview with Lisa Iezzoni, a Harvard Medical School professor who has had multiple sclerosis for 26 years and uses a battery-powered scooter for mobility. Iezzoni is the author of the book, *When Walking Fails*, and during the interview she spoke about some of the issues faced by individuals with mobility prob-

lems. She was surprised to learn that women in wheelchairs are 40% less likely to get Pap smears and 30% less likely to get mammograms than the rest of the population. Her observation was that, "People with disabilities are not getting the kind of care that other people get."

As healthcare providers it is helpful for us to understand some of the barriers individuals with disabilities encounter when seeking care.

The World Health Organization (WHO) frames human functionality in two ways: the first has to do with functioning and disability. The second refers to contextual factors.

Functioning and disability includes:

- body function and structure: physiological or psychological functions of the body, and the anatomical parts of the body and their components (such as the pharynx and larynx, which have a key role in swallowing).
- activity and participation: the performance of a task by an individual, and the individual's ability to participate in a life situation. (such as eating out in a restaurant).

Contextual factors include:

- environmental factors: the physical, social, and attitudinal environment.
- personal factors: such as age, race, gender, education, background, and lifestyle.

All of these factors intertwine to facilitate or block normal functioning. An individual may have a moderate degree of hearing loss (body function and structure). She has a hearing aid that allows her to hear well in most situations (activity and participation), but environmental factors impact the success of the amplification. If this individual visits the MGH cafeteria at 10:00 in the morning, she is able to sit and have a quiet conversation with her husband. If she goes to the cafeteria at noon, she won't be able to hear her husband because of the significantly increased level of environmental noise. Her disability impacts her activity and participation at certain times of the day, under certain conditions.

What about a person who is only able to ambulate a short distance? This person may have no difficulty if his physician's office is close to where he's dropped off

at the hospital. But what if he has to go from one end of the hospital to the other? Surely he will encounter difficulties and delays, and may need a wheelchair to complete his trek.

The role of rehabilitation healthcare providers is to improve the quality of life for our patients by reducing impairments of body function and structures, activity limitations, participation restrictions, and environmental barriers. To do so, we need to identify contextual factors that serve as barriers to function. For instance:

- Telephones: Most offices, including medical practices, rely on voice-mail systems to schedule or cancel appointments, refill prescriptions, obtain referrals, and reach specific providers. Voice mail can be difficult to use for elderly patients and patients with cognitive and memory disorders. Information on voice-mail recordings may be too long and complex for someone who has difficulty processing auditory information.
- Physical structure and building environment: —Some buildings have ramps for easier access for those with mobility problems but other impairments may still impede their access. —Patients with visual-perception difficulties may be

unable to read a hospital map to find their way around.

—A patient with a degenerative disease who fatigues easily may be unable to travel from one department to another without frequent pauses to rest and recover.

—Individuals in wheelchairs, elders, and individuals with disability of the hand or arm may not be able to open heavy doors.

- Navigating the referral system: Medical and insurance systems in this country are complex. Most insurance companies require referrals and approvals for patients to see a specialist or receive a specialized intervention. Individuals with language, cultural, educational, or cognitive issues may be unable to understand the steps necessary to navigate the system to receive appropriate care (An individual with dyslexia may not be able to read information regarding his insurance).
 - Community agencies and resources: Ambulatory patients may require services outside the hospital setting. A shortage of resources in their community may be a barrier to achieving maximum function. Services vary by community and patients
- continued on page 12*

Cuba revisited: building bridges to a broader community

—by Donna Perry, RN,
professional development coordinator

On Wednesday, September 24, 2003, Donna Perry, RN, professional development coordinator; Carmen Vega-Barachowitz, SLP, director of Speech-Language Pathology; Oswald Mondejar, Human Resources manager; and special guest, Senator Jarrett Barrios, presented, “Cuba revisited: building bridges to a

broader community,” in O’Keeffe Auditorium. The presentation focused on a recent visit to Cuba that was part of a humanitarian outreach program sponsored by ACCESO (Americans and Cubans building Community through Exchange, Support, and Outreach). ACCESO was created to provide humanitarian support to

the people of Cuba through the donation of medicine, medical supplies and equipment, and reading materials. ACCESO sponsors an annual humanitarian mission that not only delivers material goods but helps build relationships between Americans and Cubans.

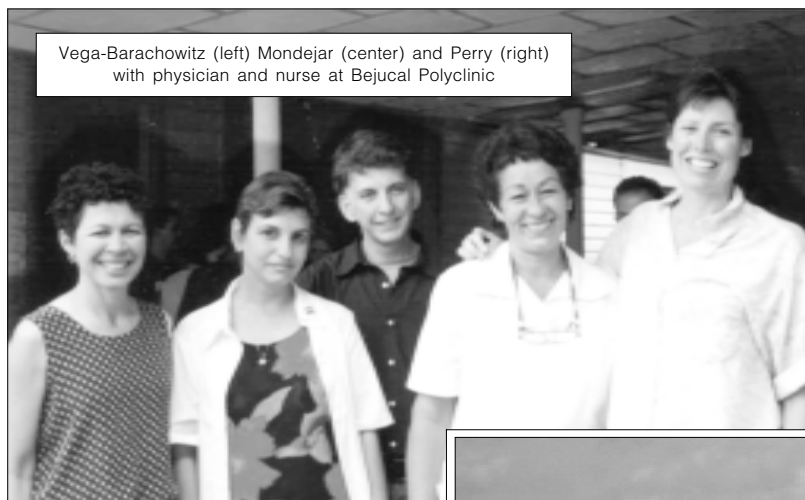
Mondejar and Barrios both have family in

Cuba. Barrios organized a book drive several years ago after visiting Cuba for the first time. He learned that despite a 95% literacy rate, books were in very short supply. He returned to Cuba the following year with several thousand books donated by individuals and organizations for use in Cuban schools and libraries.

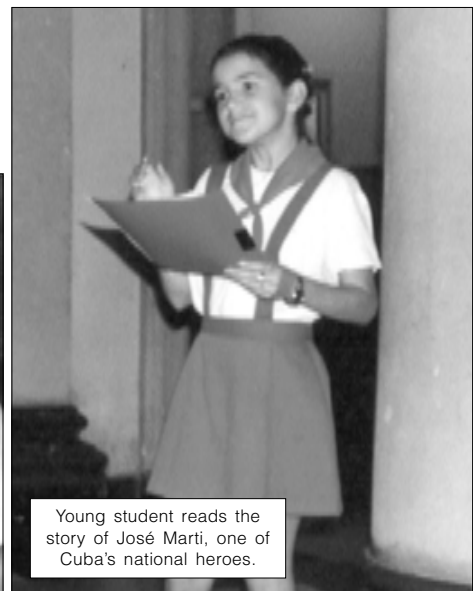
Mondejar, who is co-chair of the Governor’s Commission on Employment of People with Disabilities, joined Barrios the following year adding equipment for children with disabilities. And that’s how ACCESO was born.

This past year, a medical component was added to the mission

continued on page 13



Vega-Barachowitz (left) Mondejar (center) and Perry (right) with physician and nurse at Bejucal Polyclinic



Young student reads the story of José Martí, one of Cuba’s national heroes.



Young girl at the Panama School for Children with Physical Limitations



School children in Havana

Empowering foreign-born nurses: preparing for the future

—by Kathleen M. Myers, RN,
nurse manager

In reflecting on what I wanted to write about for this special issue of *Caring*, I looked back through a number of articles in my portfolio. One particular article caught my eye. It began, “I have been doing this for 20 years.” (That meant it was seven years old.) It described a seminal time in my career. That year, there had been a number of issues involving cries of racism, treating people differently, and staff with chronic medical problems. It was a difficult year that led me to put my thoughts and feelings down in writing. It was also an important year, because it moved me forward on a path I’m still traveling today. It made me realize I wanted to be part of a change; I wanted to make a difference in promoting diversity at MGH.

As I re-read the article, my words instructed me to be proactive, not reactive, in looking at ways I could be a leader who supported a diverse staff caring for a diverse patient population. I didn’t want to wallow in the tribulations of a difficult year. It wasn’t a conscious decision that led me to this path, but it was a good decision, and one I

have never regretted.

Two staff nurses on my unit, Claribell Amaya, RN, and Ivonny Niles, RN, have joined in this endeavor. I have mentored them over the past two years and seen them grow into nurses of exceptional wisdom and compassion. They are both seen as leaders in diversity initiatives by other staff on the unit and throughout the hospital.

This summer I had the pleasure of presenting a poster with Claribell and Ivonny in Puerto Rico at the National Hispanic Nurses Association Conference. I was so proud of the way they represented the hospital. People came up to me just to tell me how clear, concise, and professional they were. Leadership of the association must have shared those views because we have been asked to come back again next year.

If it’s true that our popu-

lation is going to continue to become more and more diverse, then we must be prepared. As I look back over all my documents, so many of them have to do with commitment to diversity. Is it too much. Or is it not enough?

The answer remains to be seen, but this year I’ve been asked to chair

the Foreign Born Nurses Group, a committee that seeks to make it easier for nurses trained in other countries to resume their nursing careers here in America. I plan to involve Claribell and Ivonny in this work—who better to precept one foreign-born nurse than another foreign-born nurse?

One of our first efforts will be teaming up with Bunker Hill Community College to develop a program to assist nurses in preparing

for the licensing exam. We have heard from other nurses that this is a difficult and confusing process. The two primary concerns for international nurse are competency-development and competency-evaluation (which differ according to program and country of origin).

Our first priority will be to establish a relationship with an academic liaison to determine a list of prerequisites starting with English proficiency, followed by the NCLEX licensing exam or entry into an accredited nursing program. Mentors will play a big part in the process. Our hope is to have something in place by the end of the year.

A recent article in *Advance Nurse*, spoke about foreign-born nurses as the potential solution to the nursing shortage. If this is true, we need to be active and vigilant in our efforts to assist foreign-born nurses. As we move forward with this initiative, we will evaluate the program in hopes of refining the process.

I’m very excited at the prospects for the future, and I have the luxury of being supported by two nurses who value this work as much as I do.



Myers (seated) with Claribell Amaya, RN (left), and Ivonny Niles, RN.

False perceptions can be more disabling than disability

—by Oswald Mondejar,
Human Resources manager

I vividly recall as a young boy being told by caregivers that I wouldn't be able to do certain things because of my disability. This went on until I was in my early teens. "You won't be able to tie your shoes, ride a bike, drive a car or button your shirt without a special device or procedure." This was a difficult message to hear because as a child, you always think professionals know best. It was particularly distressing because they had no way of understanding my limitations. They were judging my ability through their own experience of having two perfect hands.

As a young boy, I didn't question my elders out of respect. But there came a time when I realized I could assert myself, and I was no longer made to feel inferior to, or 'less' than, others.

I am not chastising. From my own experience, I know how important it is for caregivers to make sure that individuals with physical or mental disabilities feel valued as whole. It's helpful for all of us to examine our own experiences and assumptions about those who are physically different because those assump-

tions can be more disabling than an actual disability.

People think that environmental obstacles such as stairways, revolving doors, curbs, and inadequate signage are the biggest barriers to accessibility. I personally think that attitudinal barriers present the greatest challenge. We can alter or adapt our physical environment relatively quickly; how long does it take to change someone's way of thinking? Certainly, raising awareness is the first step.

The Americans with Disabilities Act (ADA) has helped considerably in raising our awareness about many issues related to individuals with disabilities. The ADA is a federal civil rights law designed to prevent discrimination and enable individuals with disabilities to participate fully in all aspects of society.

Requirements of the ADA address:

- Title I: Employment
- Title II: Public Services
- Title III: Public Accommodations
- Title IV: Telecommunications
- Title V: Miscellaneous Provisions

The ADA does not allow an employer to ask questions about a

disability or require medical examinations until after a conditional job offer is made.

The ADA requires public buildings to have reasonable accommodations for individuals with disabilities. Reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. Accommodations vary depending upon the needs of the individual. Not all people with disabilities (or all people with the *same* disability) require the same accommodations. For example:

- A deaf person may need a sign-language interpreter during a job interview.
- An employee with diabetes may need regularly scheduled breaks during the work day to eat properly and monitor blood-sugar and insulin levels.
- A blind person may need someone to read information posted on a bulletin board.
- An employee with cancer may need special leave to have radiation or chemotherapy treatments.

As the population ages, we will see an increase in the number of

individuals with disabilities, which will challenge us to think of new ways to accommodate our patients. Consider these facts:

- There are 54 million Americans with disabilities.
- 1 out of every 5 Americans has a disability
- by 2020, 75 million people will be over the age of 55

It has been my experience that most people are not trying to be insensitive. However, some of us are uninformed. We all have fears about people who are 'different' from us. The trick is not letting those fears distort how we perceive or interact with others, especially individuals with physical differences.

I have found that the following tips can be useful:

- Use first-person language whenever possible (for example: 'people with disabilities' not, 'the disabled')
- When offering assistance, always ask *before* providing assistance
- Direct your communication to the individual
- Relax. Don't be embarrassed or afraid to use common phrases like, "Can I walk you to the door," (if the person is in a wheelchair) or "Did you see the new Denzel Washington movie?" (if the person is blind.)

As in most cases, if you let common sense and consideration be your guide, you and the disabled individuals you care for will do just fine.

For more information, please contact Oz Mondejar at 6-5741.

The Employee Assistance Program Work-Life Lunchtime Seminar Series presents

"Successful Singlehood: Expanding your Social Network"

Presented by Henri Menco, LICSW

Being single and meeting new people can be challenging. This is especially true when moving to a new city. Henri Menco believes the number one thing preventing people from meeting new people is fear of rejection. Menco will discuss ways of making yourself visible, social networking, places to meet people, positive self-talk, and just how to have more fun in life

**Thursday, November 13, 2003
12:00-1:00pm
Wellman Conference Room**

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

Advocating for health care as a civil right

—by Donna Perry, RN,
professional development coordinator

At the recent Health Disparities Conference sponsored by Patient Care Services, Senator Jarrett Barrios spoke about the societal issues that lead to poorer health outcomes for low-income and minority families. He stressed the need to address these issues at the local, state, and national level, and to seek understanding about why these disparities exist. While institutional changes are important, there is also a broader social context.

Barrios sited environmental issues as one key factor impacting health disparities. Poorer populations tend to live in urban, industrial

communities where the air, soil, and water contain contaminants not found in wealthy communities.

A study by Faber and Krieg of Northeastern University looked at environmentally hazardous sites in Massachusetts and concluded that hazardous sites are disproportionately located in low-income and minority communities. The study found that communities in which people of color make up 15% or more of the population have four times the number of hazardous waste sites and five times the amount of chemical pollutants as communities where peo-

ple of color make up less than 5% of the population. Communities with household incomes on average less than \$30,000 per year have more than four times the hazardous waste sites and seven times the chemical pollutants as communities with incomes of more than \$40,000.

When talking about health disparities, said Barrios, environmental problems *must* be part of the conversation.

One community that deals with a number of environmental issues is Chelsea. The Northeastern report identified Chelsea as the third most environmentally

overburdened city in Massachusetts. Recently, citizens of Chelsea formed The Chelsea Green Space and Recreation Committee to address environmental issues and help protect and expand Chelsea's parks and recreational areas. In one urban area, residents have transformed a vacant lot into a beautiful community garden. The Chelsea Green Space and Recreation Committee has a youth component called The Youth Environmental Crew, a group of teens who work on local environmental projects.

Barrios has introduced a number of bills to help alleviate some of the burden caused by environmental factors, such as The Clean and Healthy Communities Act, (to empower neighborhood communities to

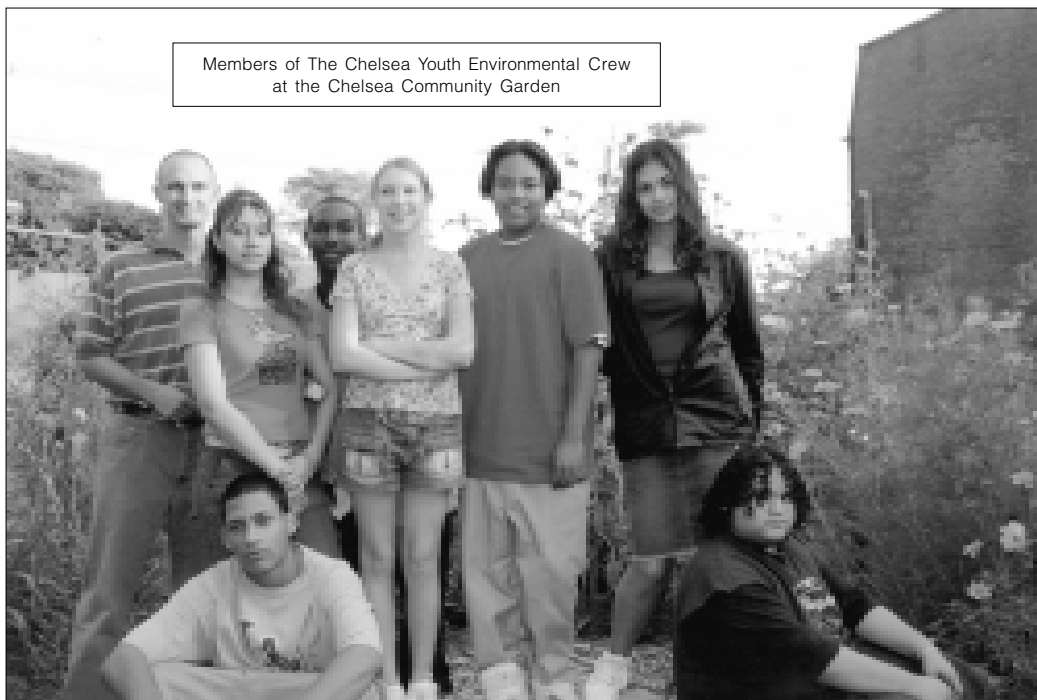
promote environmental safety by providing greater protection from pollution and hazardous waste); An Act to Reduce Disparities in Disease Outcomes through Improved Prevention, Detection and Treatment for Uninsured Massachusetts Residents (to improve early diagnosis and treatment for all residents).

Barrios advocates for changes in policy and practice that will ensure preventative health care and effective diagnostic systems for everyone. He points to the Massachusetts Interpreter Law as a model for change.

Barrios recounted a story about a child in the Boston area who was put on the wrong school bus because his skin color led staff to assume he was from a low-income neighborhood. Environmental equality and health disparities are part of the same problem.

During a recent visit to Australia, Barrios was struck by the fact that Australia emulates the United States in almost every area... except health care. American healthcare practices are not emulated because so many of our citizens don't have access to care.

Access to quality care is a civil rights issue. America was founded on the promise of liberty and justice for all. Changes need to be made in our healthcare system in order to fulfill that promise.



Members of The Chelsea Youth Environmental Crew at the Chelsea Community Garden

Delivering effective interpreter services: a worldwide challenge

—by Lourdes Sanchez, manager,
MGH Interpreter Services

Language barriers are one of the primary factors contributing to health disparities. When patients enter the healthcare system, if they can't communicate, or locate appropriate resources to help them communicate, the chances that they will receive adequate care and treatment are greatly diminished.

History shows an ongoing influx of immigrants from many countries seeking residence in the United States. The growing immigrant population presents challenges to healthcare institutions struggling to keep up with the need for interpreter services.

Despite our relatively new understanding that interpreter services is an integral part of quality care, many states and countries have been unable to develop effective programs to adequately meet the need.

The Ludwig Boltzmann Institute for the Sociology of Health and Medicine in Vienna, in conjunction with the WHO Collaborating Center for Health Promotions in Hospitals and Health Care, initiated a European effort to promote health and health literacy for migrants and ethnic minorities. The pilot program targets three areas: lang-

uage services, patient-education, and culturally competent care. In searching for benchmark practices in these areas, they identified MGH Medical Interpreter Services as a model for the effective delivery of language services.

I was invited by the Boltzmann Institute to go to Reggio Emilia, Italy, to present our model of language services to hospital representatives from 11 European countries. I heard about the challenges these countries are facing. They are all at different stages of implementing and improving their interpreter services, but the challenge they're facing is the same: How do you deliver effective interpret-

er services when there are more than 5,000 languages in the world?

We discussed many different options. The most common methods for delivering language services are face-to-face and by telephone. One innovative new option is video-conferencing. But the preferred mode is face-to-face.

Obviously, it's very difficult to provide face-to-face interpreter services at all times, for all language groups due to the growing number of requests for service, the changing demand for languages, and the difficulty in finding competent medical interpreters.

Interpreting over the phone is one way to provide competent inter-

preter services across a large geographic area. Many clinicians at MGH use telephone interpreters and they report that it is more convenient and effective than they thought it would be. Patients felt comfortable and appreciated the added level of privacy they got from using a telephone.

Interpreting by video-conferencing is still in its infancy, but it will be available at MGH in the coming months. A recent study in Boston concluded that patients prefer video-conferencing because it gives them more privacy.

The European representatives I met with were impressed with the resources we have in place at MGH: a centralized interpreter system, a website to promote our services, a system to identify patients' preferred languages, a scheduling sys-

tem that integrates language services, and the guidelines we developed for clinicians on how best to work with interpreters.

I shared with them our practices of not allowing children under 18 to serve as medical interpreters, and discouraging caregivers from asking family members to interpret for their loved ones.

As the manager of MGH Medical Interpreter Services, attending the Migrant Friendly Hospital Forum in Italy was extremely satisfying. It was both rewarding and eye-opening.

I realized that the delivery of competent, effective interpreter services is a worldwide challenge. But despite the challenges, MGH, has been able to develop a multi-faceted system that other countries respect and emulate.



Manager of MGH Medical Interpreter Services, Lourdes Sanchez (second from left) addresses Migrant Friendly Hospital Forum in Reggio Emilia, Italy.

Healthcare Disparities

continued from front cover

presence of disease, health outcomes or access to care.”

The Center on Health Disparities Research at Johns Hopkins University School of Nursing defines health disparities as, “differences in access to care, processes of care, or health outcomes.” They describe underserved populations as those, “who have less access to care even though care may be available; those who receive less or different care than the majority of the general population; or those for whom traditional models of care are inappropriate for cultural or other reasons.”

Health disparities has become a major concern among healthcare

providers. The Department of Health and Human Services has identified six focus areas as part of the nation’s

new health agenda: Healthy People 2010. These areas are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations. These areas were selected because they affect minority populations at a disproportionately higher rate than white Americans.

Infant mortality rates are often used as an indicator of health status. In Massachusetts, four out of every 1,000 white babies die versus almost ten out of every 1,000 African American babies.

ed as ‘healthy.’ It has been reported that 30% of the 40 million beneficiaries of Medicare and Medicaid are blocked due to cultural and linguistic barriers.

The question that must be answered is,

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

**Dr. Francis Peabody
1926**

Medicare and Medicaid report that the average life expectancy in the United States is 76.8 years old. But not if you’re African American. The life expectancy of an African American is 70.3 years with only 56 years anticipat-

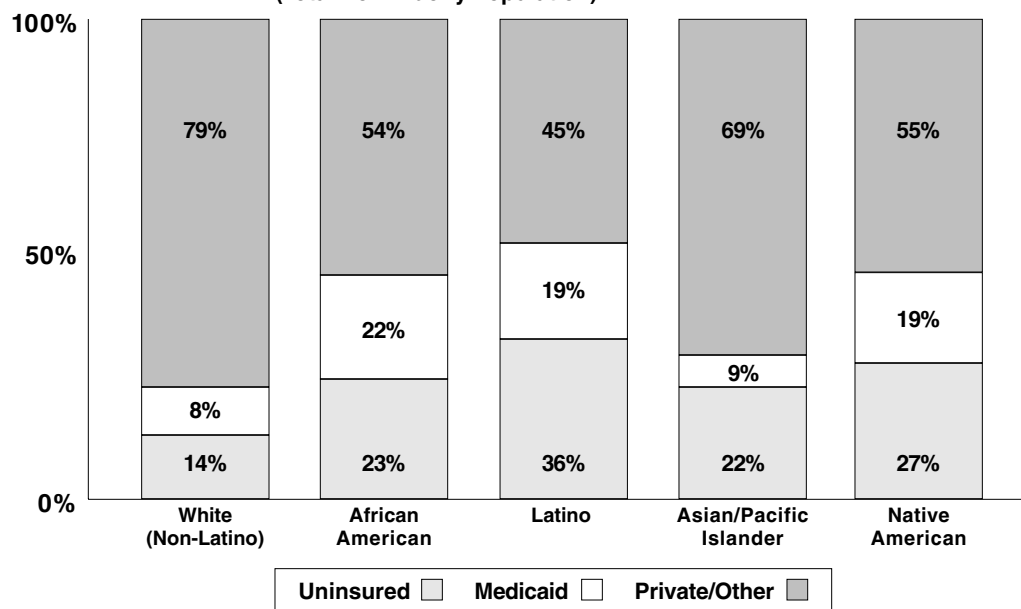
‘Why?’ Why do these disparities exist? The Office of Special Populations within the National Institute of Mental Health is looking at interpersonal, socio-cultural, and organizational factors as it researches this issue.

The National Institute of Nursing Research and the National Center on Minority Health and Health Disparities have funded a number of nursing partnership centers to focus on health disparities. These academic centers pair minority-serving institutions with majority-serving institutions to support nursing research into health disparities. These centers also help facilitate the development of minority researchers in the field. Working directly with affected communities and cultivating researchers from diverse backgrounds are important steps toward eliminating disparities in health care.

A great deal of attention is focused on this issue from many different venues. At the conference on Health Disparities sponsored by the PCS Diversity Committee recently, the complexities of the issue became abundantly clear. Health disparities is a legislative issue, a social issue, a care-delivery issue, a patient-driven issue, and a healthcare systems issue.

As we continue to grapple with the solutions to healthcare disparities, we must balance our search for answers with the immediate needs of minority patient who are coming through our doors *today*. Our attention and commitment to providing equal, high-quality care to all patients cannot be put on hold.

**Health Insurance Status by Race and Ethnicity
(Total Non-Elderly Population)**



(Source: KMCU, *Medicaid Today: Profile of a Program and the People it Covers*, 1999)

A Rehabilitation Perspective

continued from page 5

with similar disabilities may not have access to the same treatment (A child with significant language delays may require bi-weekly, one-on-one, speech-language therapy. The child attends a school that has been impacted by budget cuts and is placed in a therapy group with two other children. The therapist does the best she

can under the circumstances, but the child is at a significant disadvantage compared to a child attending a school where resources and staff are not an issue.

Through rehabilitation, physical therapists, occupational therapists, and speech-language pathologists treat patients who have disease processes that limit their activity and

participation in society. Our goal is to improve their quality of life by reducing impairments of body function and structure, activity limitations and participation restrictions. However, much can be done from a systems perspective to remove environmental factors that impede the process of rehabilitation and contribute to health disparities.

Addressing physical, social, and attitudinal factors is everyone's responsibility. Becoming aware of these bar-

The Employee Assistance Program
Work-Life Lunchtime Seminar Series
presents

“Working and Breast-feeding”

Presented by Germaine Lamberge, RN

This presentation will provide expectant and nursing parents basic information on breast-feeding, breast pumps, problem-solving, and much more.

Thursday, November 4, 2003
12:00–1:00pm, VBK401

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

riers is the first step. Our goal *must be* to create a different kind of environment, an environment that will al-

low us to hear, “People with disabilities are getting the same kind of care that other people get.”

A Social Work Perspective

continued from page 4

services, and societal stigma toward mental illness. But additional barriers deter racial and ethnic minorities: mistrust and fear of treatment, racism and discrimination, and differences in language and communication.”

The report stated that a lack of adequate treatment leads to a greater disability burden on minorities, which grows as the minority population grows. “Racial and ethnic minorities in the US face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.”

Mental health practitioners need to be culturally competent in

caring for the communities they serve. But it may not be enough to understand someone's culture or speak their language; we may need to develop new, community-specific, interventions.

Bonnie Zimmer, director of HAVEN, the MGH domestic-violence intervention program, cites a useful example. The conventional model of empowering a survivor to break-off contact with his/her abuser isn't effective in communities of color where there is a high value on family and community. One community program provides cutting-edge services teaching abusive men how to renounce violence while staying connected as fathers. They work with men to

take responsibility for the violence, and help them talk with their children about how to help stop the cycle of violence.

What is the social work field doing to address disparities?

The NASW Code of Ethics includes principles and standards regarding social justice, dignity and worth of the person, competence, and diversity. Detailed Standards For Cultural Competence were adopted in June, 2001.

What is the MGH department of Social Services doing?

The Social Services' Cultural Competence Committee has been working to define issues and goals for the department. The committee has identified cultural competence and staff diversity as our two primary goals. We are working with an outside

consultant to analyze the results of a departmental-needs assessment and together we will identify and implement appropriate initiatives.

Another group is working with Interpreter Services to address issues unique to social work. Many in our department feel passionately about these issues and are finding creative ways to address them in their practice.

What can we do as individuals?

Empowering clients to get involved in community organizations and political actions can be an extremely useful clinical intervention. We all know of parents who have lost a child to violence and used their grief to impact legislation.

Patient advisory councils, such as the one initiated by the Cancer Center's HOPES pro-

gram, are another way to empower patients and families.

Don't underestimate the importance of voting and communicating with your legislators. Let your representatives know that you value safety-net programs. Learn more about groups like the Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA); Mass-Health Defense; and the Massachusetts Human Services Coalition.

The NASW Code of Ethics strongly encourages political advocacy as part of our responsibility to our clients and our profession. Health professionals are afforded a high level of trust and credibility by the public. We all have compelling stories to share. We are in a position to influence legislators and the public. I urge you to put that influence to good use.

Cuba Revisited

continued from page 6

when Mondejar was given the support of Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Jeff Davis, senior vice president for Human Resources. As a result of this partnership, ACCESO has received overwhelming support from the MGH community, including books donated by staff and the Treadwell Library, and donations of medical supplies and equipment. Trish Gibbons, RN, associate chief for The Center for Clinical & Professional Development; Dr. Jean Elrick, senior vice president for Administration; Brian Griffin and Ed Raeke of Materials Management; and the Chelsea and Everett health centers have all been strong supporters of this work.

Donna Perry, RN, coordinator of the International Nurse Consultant Program, visited Cuba for the first time this year as part of the ACCESO delegation. Perry joined the humanitarian delegation with the intent of giving but found instead that she, "was the recipient of the bountiful good will and love of the Cuban people." In her presentation, Perry spoke about the work of Clara Barton, a native of Oxford, Massachusetts, and founder of the American Red Cross. Barton led a group of nurses providing aid to Cubans during the Spanish-American war. The work of the Red Cross nurses earned them the respect of the US Congress and led to the formation of the Army Nurse Corps in 1901.

The Red Cross was founded on the principle that medical care transcends political boundaries. Perry stressed the

importance of focusing on human need. She quoted Barton, saying, "Think only of the need and the impossible is accomplished." MGH and ACCESO are focusing on the need.

Despite the limitations of the Cuban healthcare system, Cuba has made remarkable progress in medical care due to a comprehensive public health policy. Vega-Barachowitz described the system of medical care in Cuba and shared her impressions as a member of the ACCESO delegation. The Ministry of Public Health is the chief executive body of the national system of health care. The Cuban healthcare system is free to all citizens and available at three levels. At the primary level, the family doctor and nurse are the guardians of health for each community. At the secondary level, polyclinics are where patients go to be treated for minor emergen-

cies and receive obstetrical and surgical care. Polyclinics coordinate the activities of the community doctors and nurses. Patients who require more complex care are referred to one of three tertiary hospitals or one of the specialty hospitals in Havana. The Cuban healthcare system is seen as a model for public-health practice and has led to the eradication of several diseases including polio, measles, malaria, tetanus and diphtheria. The infant mortality rate, considered a reliable indicator of healthcare quality, is an impressive 7.1 per 1,000 births. The average life-expectancy in Cuba is 76 years.

Mondejar spoke about the important dialogues that occur during these annual visits and the progress that is being made to reacquaint Cubans and Americans after 40 years of estrangement.

In recognition...

Perry, Vega-Barachowitz, and Mondejar presented a special award to MGH president, Peter Slavin, MD; Jeanette Ives Erickson, RN, senior vice president for Patient Care; and Jeff Davis, senior vice president for Human Resources, in recognition of the tremendous support MGH has given to the people of Cuba through ACCESO. The award was accompanied by a potted rose bush to be planted somewhere on hospital grounds. Presenting the award, Perry read this poem by Jose Marti, a national hero in Cuba:

Rosa Blanca (The White Rose)

I cultivate a white rose.
In July as in January,
For the sincere friend
Who gives me his hand frankly.

As for the cruel person,
Who tears out the heart with which I live,
I cultivate neither nettles nor thorns:
I cultivate a white rose.

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Health literacy: an important factor in disparities of care

The following questions and answers were drawn from a presentation given by Lori Pugsley, RN, co-chair of The Patient Education Committee, and Taryn Pittman, RN, patient education specialist, at a recent Women's Health Coordinating Council meeting.

Question: What is health literacy?

Answer: Health literacy refers to a patient's ability to perform the basic reading and mathematical skills necessary to function in the health-care environment.

Question: Is health literacy really a factor in healthcare disparities?

Answer: Almost half of all adults in the United States have difficulty reading and understanding math. 21% of adult Americans are functionally illiterate (read below the 5th-grade level). Another 26% are only marginally literate (read at the 8th-grade level). That translates into a serious problem when trying to ensure that all patients have equal access to care.

Question: What can we do to ensure that literacy doesn't interfere with providing good care?

Answer: Being aware of the problem is the first step. Caregivers should assess a patient's literacy level as part of their initial assessment. If a literacy issue is identified, the caregiver can then tailor his/her communication to better meet the needs of the patient.

Question: Shame is often a factor in patients not revealing poor literacy skills. How can we get past those feelings to ensure that patients get the help they need?

Answer: Many people with limited literacy skills do feel ashamed or embarrassed. In fact,

they may try to hide the problem from family, friends, and even caregivers. It's very important to establish a shame-free environment so patients of all literacy levels feel comfortable and supported. We suggest:

- reviewing all medication instructions, discharge information, and follow-up appointments before the patient leaves
- having a family member or friend present to hear relevant information
- using simple language when discussing procedures, medications, and treatment
- making it policy to assist patients with paperwork
- making follow-up phone calls to ensure patients understand and are complying with medical instructions.

Question: How can you ensure understanding?

Answer: To optimize a patient's understanding it's a good idea to:

- read and review all information with the patient
- use the 'teach back' method of having the patient repeat the instructions after you state them
- use the 'chunks and checks' technique of giving two or three concepts at a time, then checking for understanding
- always speak slowly and clearly
- avoid using highly technical medical jargon

Question: Is there anything else we can do to overcome literacy issues?

Answer: Much of our patient teaching is reinforced with written educational materials. We can apply the same principles to our written communication as our verbal communication. Keep it simple.

Here are some tips:

- Consider the age, gender, and culture of your target audience when preparing written information
- It's helpful to include people from your target audience in the planning of written materials
- Keep the literacy level of written materials to a 6th-grade level.
- Use common words (such as 'doctor' instead of 'physician,' 'use' instead of 'utilize,' etc.)
- Use short sentences, pictures, and diagrams to aid understanding
- Make sure your written materials are easy to read, consumer-friendly, and reader-focused.

For more information, visit these websites:

- www.plainlanguage.gov
- www.hsph.harvard.edu/healthliteracy
- www.nces.ed.gov/naal (for results of the 1992 National Adult Literacy Survey)

Infection Control Week Awareness Fair

Sponsored by the MGH Infection Control Unit

**October 21-23, 2003
11:30am-1:30pm.
East dining room**

The Infection Control Unit joins The Association for Professionals in Infection Control and Epidemiology (APIC) in recognizing National Infection Control Week.

Please stop by our table to pick up the latest information on disease prevention.

Women's Cancers Awareness Fair

Stop by the education booth in the Main Corridor to learn more about early detection, prevention, and treatment of the most common cancers affecting women today

**Friday, October 17, 2003
9:00am-2:00pm
in the Main Corridor**

The ProTech Program

The ProTech program is recruiting departments and staff to share their job experience with small groups of students from East Boston High School. Visits will take place on the morning of October 29, 2003.

Open your doors to a young person interested in learning about health careers.

For information, please e-mail gkagan@partners.org or call the ProTech office at 617-724-8326.

The ProTech Program is offered through the MGH Community Benefit Office.

Educational Offerings

October 16, 2003

When/Where	Description	Contact Hours
October 27 and 28 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: New England Baptist Hospital. Day 2: (VBK607)	14.4 for completing both days
October 27 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
October 30 1:30–2:30pm	Nursing Grand Rounds “An Overview of Case Management.” O’Keeffe Auditorium	1.2
October 31 8:00am–4:30pm	Wound Skin Care Update: 2003 Shriners Hospital	TBA
November 3 8:00–2:30pm	Pre-ACLS Course O’Keeffe Auditorium \$100. (to register e-mail: ccatt@partners.org)	---
November 4 8:00am–12:00pm	BLS Certification—Heartsaver VBK 601	---
November 5, 12, 13, 17, 18, 19 7:30am–4:00pm	Greater Boston ICU Consortium CORE Program VABHC	44.8 for completing all six days
November 5 4:00–6:00pm	Deb Wing Memorial Lecture Topic TBA. Wellman Conference Room	TBA
November 6 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
November 6 1:30–2:30pm	Nursing Grand Rounds “Communities of Color: Fact and Fiction.” O’Keeffe Auditorium	1.2
November 7 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
November 7 8:00–4:30pm	End-of-Life Nursing Education Program O’Keeffe Auditorium	1.2
November 12 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
November 12 1:30–2:30pm	OA/PCA/USA Connections “Radiology: We All Play a Role.” Bigelow 4 Amphitheater	---
November 12 5:00–6:30pm	Managing Pap Test Results in the Primary Care Setting O’Keeffe Auditorium	1.2
November 13 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
November 13 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
November 13 1:00–2:30pm	The Joint Commission Satellite Network presents: “Hospital-Wide Competency Assessment.” Haber Conference Room	---
November 18 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
November 18 8:00am–4:00pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
November 19 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Clinics 262	1.8

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111. For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

Health disparities: web-based resources

Office of Civil Rights: The HHS Office of Civil Rights drafted written policy guidelines to assist healthcare providers ensure that people with limited English can effectively access critical health and social services. For more information, visit <http://www.hhs.gov/ocr/lep/>.

Healthfinder en Español: This is a Spanish-language website that helps consumers find reliable information quickly and easily on the Internet. Healthfinder en Español presents health information on more than 300 topics, including issues of greatest concern to the Hispanic population. Visit: <http://www.healthfinder.gov/espanol/>.

MEDLINEplus: NIH's National Library of Medicine (NLM) launched MEDLINEplus, the Spanish-language counterpart to MEDLINE, which provides authoritative, full-text, medical resources. Go to: <http://www.medlineplus.gov/esp>.

Racial and Ethnic Adult Disparities in Immunization Initiative (READII): HHS launched READII, a new adult immunization initiative to reduce racial and ethnic disparities in influenza and pneumococcal vaccination coverage for adults 65 years of age and older, focusing on African-American and Hispanic communities. For information, go to <http://www.hhs.gov/news/press/2002pres/20020731a.html>.

The Office of Minority Health (OMHRC) established a Resource Center in 1987 to meet the public's need for reliable, accurate and timely health information. Some of OMHRC's services include referrals, publications, reference information, and access to minority health professionals across the country. For information, go to: <http://www.omhrc.gov>.

Healthy People 2010: Healthy People 2010 is a comprehensive set of health objectives for the nation, and includes two over-arching goals: increasing quality and length of life, and eliminating racial and ethnic disparities in health. Go to <http://www.health.gov/healthy-people> for more information.

Healthy People 2010 is the prevention agenda for the Nation. It is a statement of health objectives designed to identify

the most significant preventable threats to health and establish national goals to reduce these threats. For information, visit: www.healthypeople.gov.

Research by the Agency for Healthcare Research and Quality (AHRQ) has focused on identifying and understanding how inequities in health care contribute to disparities, and how disparities can be eliminated. For information, visit: www.ahrq.gov.

The Agency for Healthcare Research and Quality (AHRQ) has awarded grants to nine "Excellence Centers To Eliminate Ethnic/Racial Disparities" (EXCEED). Each center is investigating a different theme in an effort to identify and eliminate the causes of health disparities. For information, visit: <http://www.ahrq.gov/research/exceed.htm>.

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