



*Advancing community health
through California's open door providers*



Beyond Translation

Promoting Cultural Competence
at California's Open Door Providers

INTRODUCTION AND PURPOSE

The California Health Care Safety Net Institute is a 501(c)(3) research and education affiliate of the California Association of Public Hospitals and Health Systems dedicated to enhancing the capacity of open door providers* and their strategic partners to advance community health.

The institute has identified the problem of racial/ethnic disparities in health as a primary focus of its community health agenda. Research shows that racial minorities tend to have poorer health status, poorer access to health services, and poorer health outcomes. While research reveals stark differences, relatively little is understood about the underlying social, economic and medical factors contributing to these disparities. With the Census Bureau's recent announcement that California's minorities are now the majority, the importance of this issue takes on new urgency.

The Office of Women and Minority Health in the Bureau of Primary Health Care, Health Resources and Services Administration defines cultural and linguistic competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations." Although society has a long way to go in better understanding and eliminating racial health disparities, one obvious step that health care systems can take now involves improving the cultural competence of their providers and staff system-wide.

Open door providers throughout California serve a patient population that is over 80 percent Black, Asian, Latino and Native American. As such, these providers are making a special effort to improve cultural competence in their systems. Here are a few examples of the innovative approaches they are taking to address this issue:

- Viewing the health care system through the eyes of non-English speakers and making changes in the way the system communicates with patients
- Reducing health risks for specific ethnic groups through community-based health promotion programs
- Instituting cultural competence training for employees
- Highlighting and celebrating the cultural diversity of our communities through special events and other activities

In the spring of 2001, the institute updated an earlier survey of the efforts of California's open door providers to promote culturally competent health care. This document briefly summarizes the results of that survey. The report only touches on the breadth of these programs; not all open door providers responded to the survey, and those that did may not have described every effort underway to improve cultural competence. For example, it is assumed that all open door providers have translation services; only those programs that go beyond basic translation are mentioned here.

* Open door providers are the hospitals, health systems and academic medical centers that share a mission and mandate to serve the health care needs of all Californians, regardless of insurance status or ability to pay.

The document is intended to give the reader a sense of the commitment open door providers share to achieve cultural competence and reduce racial health disparities. The report also provides information about a range of very unique approaches for those who may wish to contact the programs for more information. Finally, the survey results have triggered a number of research questions that bear further investigation in order to better understand the challenges of addressing cultural diversity in the health care setting.

The enclosed *QuickGuide to Cultural Competence Programs at Open Door Providers* that accompanies this booklet is organized by category of program. The color orange indicates programs focused on creating change at the institutional level. Programs listed in blue are aimed at addressing the needs of a particular population or populations and may also focus on a certain service, such as psychiatric services, or a particular health problem, such as diabetes. Purple signifies training programs. Some programs have more than one focus, and this is noted by two colors.

OBSERVATIONS AND AREAS FOR FURTHER INQUIRY

The Impetus for Change: Contrasting the origins of these programs provides a glimpse of what drives change. Clear data and a growing recognition of the problem of Black infant mortality and morbidity drove the establishment of the state-run Black Infant Health Program and the application by counties like Los Angeles and Riverside to apply for those funds. Other efforts, such as Su Salud, a community-based organization that established a clinic at San Joaquin General Hospital, grew out of grass-roots, local recognition of emerging Latino health needs and a unique and innovate partnership between a community-based organization and a public hospital. The Refugee and Child Health Program within the Santa Clara Valley Health and Hospital System, like most refugee health programs, emerged as a unique role of public health systems because of their status as an arm of local government with a mandated responsibility to ensure access to health care for refugees.

System-wide Changes: Beyond making improvements in individual staff/physician knowledge of and attitudes and sensitivity towards ethnic/cultural/language differences, what system changes are important for increasing cultural competence in health care? Open door providers in several counties have undertaken system-wide approaches to assess and enhance cultural competence. For example, the Los Angeles County Department of Health Services (DHS) created the Office of Diversity Programs to establish systems that promote cultural competence throughout DHS. Cultural diversity is addressed using an approach that ensures consistency in staff training yet allows for unique local approaches. To ensure that all 23,000 employees are exposed to the concepts of cultural competence, Los Angeles County DHS has mandated four hours of training on “unlearning prejudice” for all employees and developed a Cultural Competency Certificate Program for senior managers. In addition, its Diversity Operations Council collaborates with the Office of Diversity Programs and local councils in eight regions throughout the county, often based at public hospitals, to implement the diversity strategic plan.

Santa Clara Valley Health and Hospital System’s Public Health Department took a different approach to improve the cultural competence of its workforce. Administration felt that before implementing system-wide changes as part of its overall redesign effort,

the department needed to assess its own level of cultural competence as an organization and identify what was needed in order for the system to be more culturally competent and accessible to diverse populations. In 1999 it created aDAPT (a Diversity Action Planning Team) comprised of representatives from various department divisions that assesses the cultural competence of the department and makes recommendations for improvement. San Joaquin County Health Services took a similar approach in developing its Mental Health Cultural Competency Plan, which involves a comprehensive review of the problems of access to mental health services for various ethnic/language minorities.

Getting Down to Basics: One of the most basic and effective strategies for increasing organizational cultural competence is to build a staff that closely reflects the racial, ethnic, and linguistic composition of the populations served. Some public health care systems have made a serious commitment to hire more staff who are bilingual and from diverse racial/ethnic backgrounds. For example, Riverside County Health Services has set targets to increase its bilingual staff (primarily Spanish/English) to 35 percent of its Medically Indigent Adult Services program staff and 45 percent of its Provider Relations Office staff. It bears further investigation to determine what strategies have been used to increase the diversity of the public health care workforce and how successful they have been, especially given the current health care workforce shortages. A particular challenge for providers in some geographic areas, such as Riverside County, where Spanish is the primary spoken language for a large proportion of patients, is recruiting Spanish-speaking nurses. Data indicate that Latinos represent 28 percent of the working age population in California but only five percent of the active California registered nurses.¹

When matching patients and providers by language is not possible, effective interpretation is essential. While most health care systems in California provide some interpretation services, many open door providers have such widely diverse patient populations that they have developed very extensive services to ensure language access. For example, interpretation in 14 languages is available on-site at San Francisco General Hospital. Santa Clara Valley Health and Hospital System has created a separate service called Valley Connections that provides interpretation services and translation of written materials for patients. Contra Costa Health Services has a Cultural and Linguistic Team that addresses various issues related to linguistic access for patients, including development of a training curriculum for interpreters in eight languages. Working in partnership with the organization Health Access, Alameda County Medical Center and the Community Health Network of San Francisco are pilot-testing a state-of-the-art videoconferencing technology that provides patients and clinicians with face-to-face support in multiple languages from medical interpreters who may be located on or off-site.

Given the vast experience of open door providers in addressing language access needs, much could be gained by taking a closer look at what has been learned in the public sector regarding how to build effective interpretation and translation services in the health care system. Included in this inquiry could be an assessment of emerging models for effective medical interpretation, including innovative partnerships with ethnic-oriented community-based organizations, and an analysis of how these services are financed. The answers to these questions are especially relevant given the recent issuance by the U.S. Department of Health and Human Services of written policy guidance for federally

funded health care providers to ensure language assistance for persons with limited English skills.

The Public Health Care Systems' Role in Medical Training: California's open door provider hospitals train 45 percent of the state's graduate medical residents as well as a significant number of nurses and other health professionals. Open door providers play a particularly important role in training underrepresented minority health professionals. Studies have shown that minority physicians are more likely than white physicians to enter primary care specialties, practice in underserved areas, and care for minority patients.² Results from a 1990 survey conducted by the National Association of Public Hospitals and Health Systems showed that 19 percent of residents trained in public hospitals nationwide were African American, Latino, or a minority other than Asian/Pacific Islander, compared to 11.4 percent underrepresented minorities among all residents. It is likely that these statistics have become even more pronounced given the effect that anti-affirmative action policies have had on the number of minorities entering medical school.

Open door providers' unwavering commitment to training minority residents is one clear contribution that public health care systems can make toward improving access to culturally competent health care for California's diverse population. All physicians and other medical professionals training in the ethnically diverse world of open door providers gain experience with a wide variety of sociocultural and socioeconomic factors that influence patient disease patterns, treatment regimens and the physician-patient relationship. This experience helps prepare them to practice medicine in our increasingly diverse society.

Some open door providers have found creative ways to incorporate cultural diversity training into traditional internship and residency experiences. For example, residents at Santa Clara Valley Health and Hospital System explore their personal perceptions of culture, health and ethnicity and learn about different cultures' understanding of health and illness. Similarly, Community Health Network of San Francisco has developed an extensive training curriculum on cultural diversity for medical students, faculty, residents and allied health professionals involved in medical training programs at San Francisco General Hospital.

Questions bearing further inquiry include: 1) How does cultural competence training get prioritized given the competing demands on medical interns' and residents' time? 2) Has each cultural competence training curriculum been developed in isolation, or do resources exist that can help in the design and implementation of effective diversity training programs for residents and other medical staff?

Celebrating Cultural Diversity: While all health care providers struggle with the daily challenge of meeting the cultural diversity needs of their patients, there are too few opportunities to celebrate the richness of our unique cultures and the incredible gifts that each has to offer. One example of an open door provider that has not forgotten the importance of embracing cultural diversity is the Quilt of Many Colors Project at the Richmond Health Center, part of Contra Costa Health Services. The project's mission is to increase peace, celebrate diversity and promote education through cultural contact. In the lobby of the health center where approximately 10,000 patients pass through monthly, a continuously changing display of stimulating art and history highlights the migration

and culture of various ethnic groups. Also included in the project are educational sessions on tolerance, cultural awareness and competence in the work place. Special evening events draw participants from local schools and other members of the community of all ages.

Need for Evaluation: The institute's survey raised a number of questions related to the evaluation of cultural competence programs. 1) Do employee diversity training programs work? 2) What are the variants that affect how well they work, e.g., duration, intensity, targeted to actual job specifications, repetition or tied to job promotion or compensation? 3) Do targeted programs serving specific populations and focused on particular diseases produce better health outcomes than would be obtained through a traditional health care setting? 4) How best can lessons learned within a population-specific, targeted program be disseminated to the larger provider network, staff, and system? 5) What are the benefits to the patient and the provider of these kinds of programs in terms of patient satisfaction, patient retention, improved communication, appointment keeping, etc? The answers to these and other questions are central to ensuring that the health care needs of our increasingly diverse population can be met.

CONCLUSION

This report provides a scan of the important efforts underway at open door providers to promote cultural competence in the health care setting. Admittedly, it asks more questions than it answers. With growing interest in learning more about the factors that improve the quality of health care for diverse populations, it is hoped that further research will illuminate many of the issues raised through this survey. The California Health Care Safety Net Institute and its affiliate, the California Association of Public Hospitals and Health Systems, look forward to continued involvement in efforts to ensure that California's "minority majority" has access to culturally and linguistically appropriate health care services.

NOTES

¹ Coffman, J., Rosenoff, E., Grumbach, K., Center for California Health Workforce Studies, University of California, San Francisco. Explaining the Underrepresentation of Minorities in Nursing: Disparity in Educational Attainment of Lack of Interest in Nursing Careers? Poster Presentation at the Association for Health Services Research Annual Meeting, Washington DC: June 2000

² Jameson, W., Pierce, K., Martin, D. California's county hospitals and the University of California graduate medical education system: current issues and future directions. Western Journal of Medicine, May 1998 – Vol 168, No. 5.



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