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Organizational Factors Impacting Implementation of Culturally Competent Care Modules in a Large Health Maintenance Organization

By

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in a Large Health Maintenance Organization

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By

Karen Leanne Koh

ABSTRACT

This dissertation study describes the process of organizational innovation which four Kaiser Permanente medical facilities underwent to launch six culturally competent care (CCC) modules: multidisciplinary and multi-specialty primary care clinic modules staffed from the front desk to the exam room with bilingual, bicultural health care providers and support staff. The CCC modules selected for this dissertation study are open to all patients, but tailored to non-English speaking and limited English-proficient patients of Hispanic or Asian racial/ethnic backgrounds.

The aims of this study are to 1) describe the organizational innovation process of select Kaiser Permanente medical facilities which developed and implemented culturally competent care (CCC) modules for their large non-English speaking and limited English-speaking Hispanic and Asian patient populations experiencing language and cultural barriers in accessing care; and 2) ascertain how physician leaders and administrative leaders who led the CCC module implementation overcame barriers and leveraged facilitators in order to successfully operationalize and institutionalize these modules.

I utilized a multi-site case study design in which a "case" was defined as a CCC module and selected my study sites utilizing a purposeful, criterion-based sampling approach. 22 physician leaders and administrative leaders were interviewed and their responses were qualitatively analyzed utilizing Atlas.ti software. I supplemented the interview data with archival materials collected from each CCC module and conducted site visits to each of the six modules.

The findings from this study illustrate that organizations do indeed follow a staged model for the process of organizational innovation, progressing through the following five stages: readiness to change, awareness of the need to change, identification and selection of changes, implementation of changes, and institutionalization of changes.

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CHAPTER 1: INTRODUCTION

Over the past two decades, the health care field has experienced a large increase in the number of organizations articulating a commitment to culturally and linguistically competent health care delivery in their mission statements, goals and objectives. The primary reason for this increase is the evidence of disparities in access to care and quality of care experienced by patients of racial and ethnic minority backgrounds in the U.S., in particular those who are non-English speaking or limited English proficient.

To this end, many health care organizations across the nation have developed and implemented culturally competent health care innovations which reduce or eliminate language and cultural barriers for racial and ethnic minority patients who are non-English speaking or limited English proficient. The most popular types of culturally competent care innovations which have been developed and implemented include (Brach & Fraser, 2000):

- provision of medical interpreter services.
- recruitment and retention of racial and ethnic minority group members in health systems.
- cultural competency training programs aimed at increasing cultural awareness, knowledge, and skills which lead to changes in staff behavior and patient-staff interactions.
- coordination of care with traditional healers (i.e. complementary and alternative medicine).
- use of bilingual and bicultural community health workers who can serve as liaisons between communities of color and the health system.
- conducting culturally competent health promotion by incorporating culture-specific attitudes and values into messages and materials.
- inclusion of family and/or community members in health care decision making processes such as obtaining consent for and adherence to treatment.
- immersion into another culture.
- administrative and organizational accommodations affecting access to and utilization of health care.

As culturally competent health care delivery has garnered significant attention from health care providers, administrators, policymakers, insurers, and educators as a key strategy in reducing and eliminating racial and ethnic health care disparities, it is extremely important for organizations to implement and institutionalize culturally competent care innovations which have proven to be successful at positively impacting health care access, quality of care, and outcomes for racial and ethnic minority patients. However, in managed care, there has been the legitimate concern that cost-containment efforts will marginalize the demand for culturally competent care as something nice to do, but too expensive or not cost-effective to implement/institutionalize (Chin, 2000).

Successful implementation and institutionalization of innovations which ensure culturally competent care delivery is important for several reasons, as outlined by the National Business Group on Health (2003):

1) <u>response to demographic changes</u>: the composition of the U.S. population continues to change due to immigration patterns and significant increases among racially, ethnically, culturally, and linguistically diverse populations already residing in the U.S.

2) <u>elimination of health disparities</u>: there are continuing disparities in the morbidity and mortality rates of racial and ethnic minorities as compared to Whites.

3) <u>quality improvement</u>: communities of color experience decreased access to health care and lower quality of health care than their White counterparts.

4) <u>business case</u>: As studies have shown that culturally and linguistically appropriate care leads to increased patient satisfaction, improved health outcomes, and higher levels of preventive care service utilization, health care organizations implementing and institutionalizing culturally and linguistically competent health care will positively impact health care provider recruitment and retention as well as increase their market share, all of which are important "bottom line" business issues for today's health care organizations.

5) <u>advancement of social justice</u>: tackling inequities through implementing cultural competency is important, as communities of color bear a disproportionate burden of illnesses and diseases.

Last but not least, cultural competency in health care has garnered the attention of influential bodies and policy organizations. Examples of professional associations and accrediting bodies that have developed or formally stated their support of standards for cultural competent health care delivery include:

- Joint Commission on the Accreditation of Healthcare Organizations
- National Committee for Quality Assurance (accredits managed care organizations and behavioral health managed care organizations)
- Association of American Medical Colleges (developed cultural competence curricula guidelines for medical schools)

Study Significance

The aims of this dissertation study were to 1) document the organizational innovation process of select Kaiser Permanente medical centers and outpatient medical office buildings which implemented culturally competent care (CCC) modules for their large non-English speaking and limited English-speaking Hispanic and Asian patient populations experiencing language and cultural barriers in accessing care; 2) identify challenges and facilitators experienced by physician leaders and administrative leaders who led the CCC module implementation; and 3) understand how physician leaders and administrative leaders overcame these challenges and leveraged facilitators in order to successfully operationalize and institutionalize these modules.

Established in 1945, Kaiser Permanente (KP) is the nation's largest nonprofit health plan and nongovernmental integrated health care delivery system, providing care to approximately 8.6 million members across eight geographic regions (Northern California, Southern California, and parts of Colorado, Georgia, Hawaii, the Northwest region and the mid-Atlantic States). California possesses the largest membership, as KP provides care to over six million members in this state.

As the mission of KP is "to provide affordable, high quality health care services to improve the health of our members and the communities we serve", KP provides a continuum of health care services through its <u>medical centers</u> (hospitals which provide multispecialty outpatient and ancillary services) and <u>medical office buildings</u> (ambulatory centers which typically offer outpatient services such as primary care, laboratory, radiology, and pharmacy services. KP's workforce is comprised of approximately 14,600 physicians and 167,000 non-physician employees. Regarding the physician workforce, approximately 38% are women and 43% are people of racial and ethnic minority backgrounds. For the non-physician workforce, approximately 74% are women and 56% are people of racial and ethnic minority backgrounds.

This research study is important for the following reasons:

- There is a dearth of descriptive studies in managed care documenting the process of organizational innovation, especially in the area of implementing culturally and linguistically competent health care service delivery for racially and ethnically diverse patient populations who are non-English speaking and limited English proficient.

- The four Kaiser Permanente medical centers and medical office buildings described in this dissertation study implemented these culturally competent care (CCC) modules not because of an organizational mandate, but because it was "the right thing to do" both from the organizational perspective and the patient care perspective. The CCC modules were launched from "grassroots" efforts spearheaded by a handful of physician leaders and administrative leaders, who took the initiative to do this because "it made sense."

- Most organizations suffer from lack of permanent space and/or inadequate financial and human resources when implementing and institutionalizing innovations. However, the Kaiser Permanente medical centers and medical office buildings which were studied had access to all these important assets plus administrative and physician leaders who led the innovation process of developing, implementing, and institutionalizing the CCC modules.

The findings from this dissertation study will make the following contributions to the field:

1) This study aims to shed light on the process of organizational innovation specific to a managed care organization's efforts to deliver culturally and linguistically competent health care to patients experiencing language and cultural barriers in accessing care.

2) The study findings will lead to better understanding of challenges experienced and how they were addressed during the process of organizational innovation, which will lead to improved planning and implementation activities.

CHAPTER 2: LITERATURE REVIEW

This dissertation study draws upon two organizational bodies of literature: the cultural competency field and the organizational innovation field. The cultural competency field is relatively new spanning the last few decades, while the organizational innovation field spans many decades of research. The first part of this chapter reviews the relevant literature on cultural competency, focusing on the need for cultural competence in health care, the importance of addressing language and culture in health care delivery, and the conceptual framework developed by Anderson et al. (2003) which shows how culturally competent innovations have the power of impacting health outcomes. The latter part of this chapter reviews the relevant literature on organizational innovation (OI) as it relates to this dissertation study, focusing on the historical background of studying OI, definition of OI, main approaches to studying OI, facilitators and challenges to successful OI, and lastly the framework developed by Rundall et al. (1998) for OI which this dissertation will utilize as the analytic framework guiding each case study.

CULTURALLY COMPETENT HEALTH CARE

Ensuring that health care delivery to racially and ethnically diverse populations takes into account language and cultural needs constitutes a major challenge for the U.S. health care system. According to a projection by the U.S. Census Bureau's Population Division, Whites will comprise up 49.9 percent of the population by 2050 and the non-White U.S. population will reach 47.2% by 2050 with the following population growth projections: Blacks will make up 12.2 percent (virtually unchanged from today), Hispanics (currently 15 percent of the population) will rise to 28 percent, and Asians are expected to increase from 4.4 percent of the population to 6 percent.

Importance of Addressing Patients' Language Needs in Health Care

Because the primary language patients speak impacts their healthcare access, healthcare utilization, quality of care received, satisfaction with care received, and health outcomes, the need for linguistically appropriate health care services is great. Approximately 47 million people (18% of the U.S. population) speak a language other than English at home *(*U.S. Bureau of the Census, 2000*)*. The number of people with limited English proficiency (LEP), identified as those that speak English "not well" or "not at all" range from almost 11 million people to over 21 million (U.S. Bureau of the Census, 2000).

It is vital that LEP patients be able to communicate effectively with and be understood by their health care providers. Research findings show that LEP patients are less likely to have a usual source of medical care (Kirkman-Liff and Mondragon, 1991); lower utilization of preventive services (Marks et al., 1987; Woloshin et al., 1997); higher utilization of unnecessary diagnostic testing (Hampers et al., 1999); and worse adherence with medical advice (Manson, 1988) and follow-up care (Kline et al., 1980). Additionally, studies show that patients experiencing language barriers wind up having longer hospital stays (John-Baptiste et al., 2004), experience more medical errors (Divi et al., 2007), report lower satisfaction with care received (Weech-

Maldonado et al., 2004; Woloshin et al., 1995); and are less likely to receive health education as well as report worse interpersonal care (Ngo-Metzger et al., 2007).

In the literature, research findings have shown that communication to patients in their own language (i.e. language concordance) improves patient compliance and understanding of their disease/condition, access to primary care and preventive services, and patient-reported well-being and function. For instance, patients with diabetes and hypertension reported better health outcomes when their physicians spoke their native language (Perez-Stable et al., 1997); patients who saw language-concordant physicians asked more questions and had better understanding than those who saw language-discordant physicians (Seijo et al., 1991); and patients who had health care providers who spoke their native language reported the highest levels of understanding their diagnoses and treatment plans when receiving hospital care (Baker et al., 1996). Furthermore, the benefits of language concordance have a positive impact on health care providers as well, since there is increased ability to understand and improve accuracy of diagnoses and selection of appropriate treatment (Ngo-Metzger et al., 2007).

Importance of Addressing Patients' Racial/Ethnic Cultural Backgrounds in Health Care

While the primary language patients speak impacts their health care and health outcomes, race/ethnicity is also a major influence as it impacts their health beliefs, help-seeking behaviors, and treatment choices in health care. A patient's racial/ethnic culture influences how he/she defines "health" as well as "illness." According to the Surgeon General (U.S. DHHS, 2001), numerous researchers have shown that although we all share universal health concerns such as anxiety, pain, and fear, it is our culture that impacts: 1) our experience of illness, 2) response to illness, 3) access to health care services, 4) utilization of health care services, 5) interactions with health care providers, and 6) communication with health care providers.

More importantly, the race/ethnicity of patients impacts their health status and the health care they receive. As it has been well documented in the 2002 Institute of Medicine Report *Unequal Treatment* (Smedley, 2002), race, ethnicity and culture greatly affect the health status of racial and ethnic groups as well as their health care access, diagnosis, treatment, and recovery. Shocking examples of differences in the health status of racial/ethnic minorities compared to Whites include:

- African Americans, Hispanics, and Native Americans experience a 50%-100% higher burden of illness and mortality from diabetes than White Americans (Smedley et al., 2002).

- Hispanics who were hospitalized as a result of HIV-related illness experience twice the risk of dying as Whites (Cunningham et al., 2000).

- African-American women with breast cancer were more likely to die than White women with breast cancer (30% vs. 18%, respectively) and experienced shorter average survival (Howard et al., 1998).

- Vietnamese women have the highest incidence of cervical cancer (43 per 100,000 females), greater than 5 times the rate in non-Hispanic white females (Miller et al., 1996).

This seminal IOM Report reviewed and analyzed a large body of studies which documented and found differences in health care received by Whites and racial/ethnic minorities in areas of which evidence of racial/ethnic disparities was consistent across a range of illnesses and health care services: cardiovascular care, asthma, cancer, cerebrovascular disease, renal transplantation, HIV/AIDS, asthma, analgesia, diabetes, rehabilitative services, maternal and child health, children's health services, and mental health services. Of the majority of studies reviewed in the aforementioned areas, racial/ethnic disparities remain even after controlling for insurance status, income, age, and severity of medical condition for racial/ethnic minorities.

With regard to disparities in health care received, racial/ethnic minorities are less likely than Whites to receive routine medical procedures, clinically necessary procedures, and experience decreased quality of health care services, some examples of which include:

- African-American men and women were significantly less likely to undergo coronary artery bypass graft surgery (CABG) or angiography than Whites (Ford et al., 1989); Whites were nearly four times more likely than African Americans to receive CABG (Goldberg et al., 1992).

- Hispanic patients were twice as likely as White patients to receive no pain medication (Todd et al., 1993).

- African American patients with diabetes were less likely to undergo a measurement of glycosylated hemoglobin, lipid testing, ophthalmologic visits, and influenza vaccinations than White patients with diabetes (Chin et al., 1998).

- African American patients with HIV infection are less likely to receive antiretroviral therapy, less likely to receive prophylaxis for pneumocystic pneumonia, and less likely to receive protease inhibitors than non-minorities with HIV (Shapiro et al., 1999).

According to the IOM Report, "*The sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and clients*" (Smedley et al., 2002).

A Solution: Culturally & Linguistically Competent Health Care Provision

Since the 1980s, cultural competency, or the ability of health care systems to deliver culturally and linguistically competent healthcare services, has emerged as a key strategy to reduce and eliminate disparities in access to and quality of health care for patient populations who experience language and cultural barriers. Please note that while the word "culture" refers to the "integrated *patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups*"

(Cross et al., 1989) for the purposes of my dissertation study, I will use the word "culture" in the context of racial/ethnic culture.

While there has been the development of many similar definitions of cultural competency, here are two which are the most relevant and comprehensive in their scope for this dissertation study:

> "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." -Cross et al., 1989

> "Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." -Betancourt et al., 2005

Over the past three decades, the most popular types of culturally competent care innovations which have been developed and implemented have included (Brach & Fraser, 2000):

- provision of medical interpreter services.
- recruitment and retention of racial and ethnic minority group members in health systems.
- cultural competency training programs aimed at increasing cultural awareness, knowledge, and skills which lead to changes in staff behavior and patient-staff interactions.
- coordination of care with traditional healers (i.e. complementary and alternative medicine).
- use of bilingual and bicultural community health workers who can serve as liaisons between communities of color and the health system.
- conducting culturally competent health promotion by incorporating culture-specific attitudes and values into messages and materials.
- inclusion of family and/or community members in health care decision making processes such as obtaining consent for and adherence to treatment.
- immersion into another culture.
- administrative and organizational accommodations affecting access to and utilization of health care.

There have been many different analytic frameworks developed to demonstrate how culturally and linguistically competent health care delivery impacts health outcomes, of which the most relevant conceptual framework for this dissertation study is the one developed by Anderson et al. (2003):
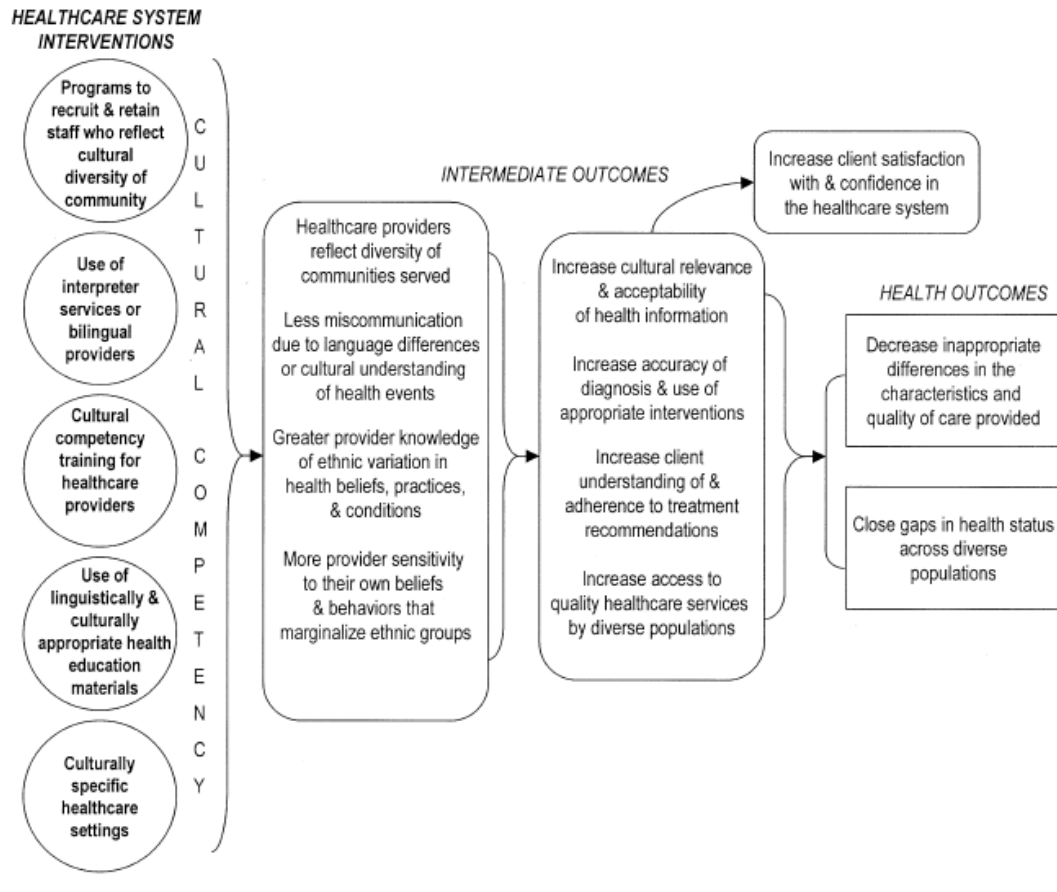
Figure 1: Conceptual Framework Describing the Potential of Culturally Competent Health Care Interventions Impacting Health Outcomes (reproduced with permission)

According to Anderson et al. (2003), through this conceptual model, the culturally competent health care system develops and implements interventions which address patients' languages and racial/ethnic cultures. Patients gain trust and confidence in accessing health care which then reduces differentials in contact or follow-up that may result from a variety of causes (e.g. communication difficulties, differences in understanding of health issues, or perceived or actual discrimination). Health care providers increase their ability to understand and treat a culturally diverse patient population with varied health beliefs and practices, thereby improving accuracy of diagnoses and selection of appropriate treatment.

ORGANIZATIONAL INNOVATION

Introduction

In a review by Rogers and Eveland (1978), innovation studies conducted before the 1980s mainly focused on *individuals* adopting innovations and only a small amount of studies focused on *organizations* adopting innovations. It wasn't until later on in the 20th century (late 1970s

onward) when researchers began focusing on *organizations* being the adopters of innovations with the unit of analysis being organizations rather than individuals (Rogers, 1983). In the health care arena, there have been many innovations developed and implemented which aim to enhance life expectancy, quality of life, diagnostic and treatment options, as well as the efficiency and cost effectiveness of the health care system (Omachonu & Einspruch, 2010).

Innovation has been defined and conceptualized by researchers, practitioners, and scholars as both a product as well as a process. While there have been many scholars and researchers who have drafted their own definitions for innovation, Hage observed that organizational innovation has been consistently defined over several decades as the "adoption of an idea or behavior that is new to the organization" (Damanpour 1988, 1991, Daft & Becker 1978, Hage 1980, Hage & Aiken 1970, Zaltman, Duncan & Holbek 1973, Oerlemans et al. 1998, Wood 1998, Zummato & O.Connor 1992). For the purposes of this dissertation study which focuses on implementation of culturally competent health care innovations, I will utilize a definition developed by Varkey et al. (2008) that "healthcare innovation can be defined as the introduction of a new concept, idea, service, process, or product aimed at improving treatment, diagnosis, education, outreach, prevention and research, and with the long term goals of improving quality, safety, outcomes, efficiency and costs."

When developing and implementing organizational innovations, understanding what the facilitators and barriers are to successful implementation and institutionalizing of the innovations is crucial. Research studies have looked at what facilitates or inhibits organizational innovation. For instance, Ely (1990, 1999) concluded, through a series of studies which looked at implementation of innovations, that there were eight facilitative conditions:

1. leadership of the executive officer or board as well as leadership within the organization or project that was related to the day-to-day activities of the innovation being implemented.
2. dissatisfaction with the status quo.
3. existing knowledge and skills possessed by users of the innovation that relate to the innovation.
4. availability of financial, human, and equipment resources that are required for the implementation of the innovation.
5. allocation of time for users of the innovation to acquire and practice the knowledge and skills needed for the innovation.
6. rewards or incentives related to innovation implementation.
7. participation as evidenced by shared decision-making and communication amongst all parties involved with innovation implementation.
8. endorsement and continuing support for the innovation.

Similarly, Bisaillon et al. (2004) found that commitment to the innovation by formal leaders, informal leaders, and front-line staff as well as a supportive organizational structure were found to be organizational facilitators contributing to successful implementation of innovations. Last but not least, Fleuren et al. (2004) found the following determinants to be needed for successful implementation of an innovation in the organizational setting:

- Financial resources made available for implementing the innovation.
- Reimbursement for health professionals/organizations to facilitate extra efforts in applying the innovation.
- Other resources made available for implementing the innovation (e.g. equipment, manuals).
- Administrative support available to the users (health professionals) of the implementation.
- Time available to implement the innovation.
- Availability of staff responsible for coordinating implementation in the organization/department.
- Health professionals are involved in the development of the innovation
- Opinion leader who influences opinions of others in the organization or department (not the coordinator)

Main Approaches to Studying Organizational Innovation

There have been numerous research studies and theoretical papers devoted to organizational innovation and Wolfe's (1994) seminal article on organizational innovation organized them into three main research approaches: 1) **diffusion of innovation (DI)** - where the unit of analysis is the innovation and the research question is "what is the pattern of diffusion of an innovation through a population of potential adopter organizations?; 2) **organizational innovativeness (OI)-** where the unit of analysis is the organization and the research question is "what determines organizational innovativeness"; and 3**) process theory (PT)** - where the unit of analysis is the innovation process and the research question is "what are the processes organizations go through in implementing innovations?"

It is process theory research which is most applicable to my dissertation study, as this research approach focuses on studying the temporal sequence of activities in innovation development and implementation and looks at the nature of the innovation process, as well as inquiring how and why innovations emerge, develop, grow, and terminate (Wolfe, 1994). Wolfe categorizes PT research into two streams- first generation process theory research, commonly referred to as stage model research and second generation process theory research, commonly referred to as process theory research.

Stage models of organizational innovation capture and conceptualize innovation as a series of stages that progress over time, emphasizing the sequence of precursor events and their determinants (Wolfe, 1994). While many researchers and scholars have developed their own stage models for organizational innovation (Zaltman, Duncan, & Holbek, 1973; Daft, 1978; Ettlie, 1980; Tornatsky et al., 1983; Rogers, 1983; Meyer and Goes, 1988; Cooper and Zmud; 1990), Wolfe generalizes that these models tended to vary on the following general pattern, which he succinctly describes as this: "a decision-making unit becomes *aware* of an innovation's existence, a problem or opportunity is *matched* to the innovation, the innovation's costs and benefits are *appraised,* sources of support and/or opposition attempt to *influence* the process, a decision is made to *adopt(reject)* the innovation, the innovation is *implemented ,* the

innovation decision is reviewed and *confirmed (reversed),* the innovation becomes accepted as *routine,* and the innovation is *infused (*i.e. is applied to its fullest potential)."

Conceptual Framework for Studying Process of Organizational Innovation Utilized in this Dissertation Study

Building on the work of influential organizational innovation researchers and scholars such as Rogers (1983), Van de Ven (1993), and Van de Ven and Poole (1995), Rundall et al.'s (1998) staged model of the process of organizational innovation will serve as the organizing framework for this dissertation study. Illustrated and described below are the five stages in the process of organizational innovation:
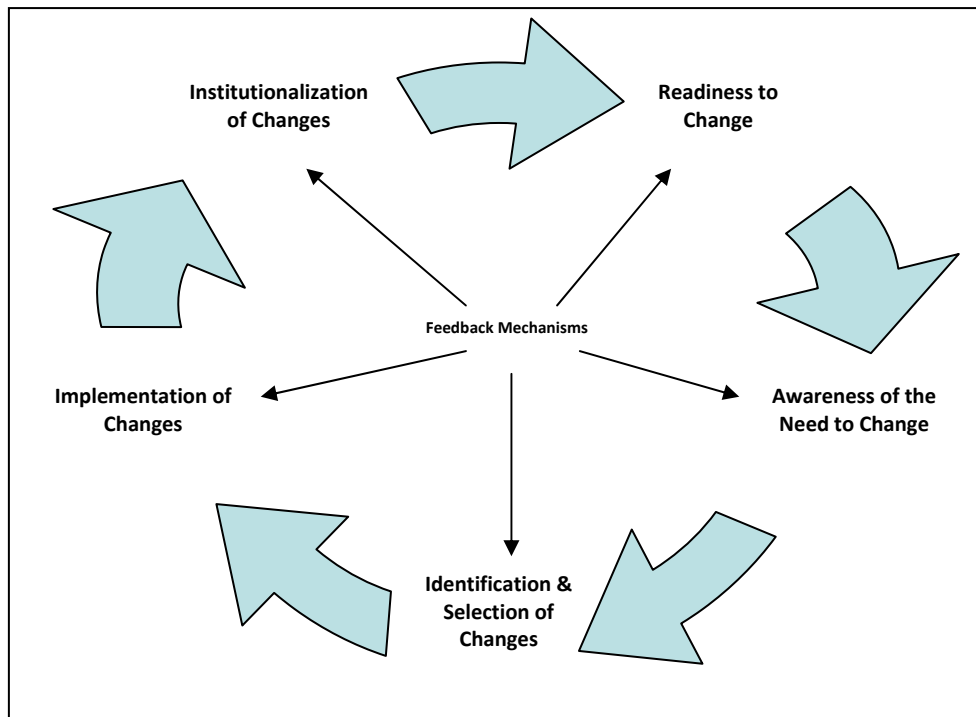
Figure 2: Five-Stage Model of the Process for Organizational Innovation (Rundall et al., 1998)

a) <u>Readiness to change:</u> Readiness to change encompasses two dimensions of which the first is defined as how accepting of change the organization is (e.g. organizational members' receptivity to change or belief in change) and the second is defined as the organization's capacity to innovate (opportunistic leadership, availability of human and/or financial resources to support change, etc.).

b) <u>Awareness of the need to change:</u> This stage is conceptualized as the growing realization among organizational members that the organization's performance in some area is inadequate and there is pressure for change building internally or external to the organization.

c) <u>Identification and selection of changes:</u> This stage involves identifying alternatives to address the performance gaps and the selection of one or more of those alternatives for implementation.
d) <u>Implementation of changes:</u> This stage involves the actions taken to put in place the selected change(s) within the organization or relevant work unit within the organization.
e) <u>Institutionalization of changes:</u> This stage refers to the integration of the change into the ongoing activities of the organization such that it is no longer perceived as the "new way" but as the standard way of operating.

This conceptual model was chosen because it allows the researcher to capture the various dynamics involved, the landmark decisions, the planning and implementation activities, and the milestone events of how several medical centers and medical office buildings successfully implemented culturally competent care clinic modules for their Spanish-speaking and Asian-language speaking patients. To reiterate, the aims of this dissertation study are to 1) describe the organizational innovation process select Kaiser Permanente medical centers and medical office buildings underwent to develop and implement culturally competent care (CCC) clinic modules for their large non-English speaking and limited English-speaking Hispanic and Asian patient populations; and 2) ascertain how physician leaders and administrative leaders who led the CCC module implementation overcame barriers and leveraged facilitators in order to successfully institutionalize these modules.

Having previously been utilized to capture the organizational innovation processes of nine U.S. hospitals implementing innovations in the areas of patient care process, service, administrative, and human resources, Rundall et al.'s staged model of the process of organizational innovation is applicable to this dissertation's study research questions, which are:

1. What culturally competent care delivery strategies were implemented by select Kaiser Permanente (KP) medical centers and medical office buildings to improve health care delivery to limited English-proficient/non-English speaking Latino and Asian patient populations?
2. Why did these KP medical facilities decide to implement Culturally Competent Care (CCC) modules?
3. To what extent were the Kaiser Permanente medical facilities ready to implement CCC modules?
4. How did the medical facilities decide on the specific strategies for implementation in the CCC modules?
5. How were the CCC modules implemented?
6. What were key challenges experienced during the CCC modules implementation process at each study site? By all sites? By most sites?
7. What were key facilitators contributing to successful CCC module implementation at each study site? By all sites? By most sites?

CHAPTER 3: STUDY DESIGN & METHODS

Study Purpose

The aims of this study are to 1) describe the organizational innovation process select Kaiser Permanente (KP) medical centers and medical office buildings underwent to develop and implement their culturally competent care (CCC) clinic modules for their large non-English speaking and limited English-speaking Hispanic and Asian patient populations who were experiencing language and cultural barriers in accessing care; and 2) ascertain how physician leaders and administrative leaders who led the CCC module implementation overcame barriers and leveraged facilitators in order to successfully institutionalize these modules.

The research questions I developed to guide my data collection were:

1. What culturally competent care delivery strategies were implemented by select KP medical centers and medical office buildings to improve healthcare delivery to limited English-proficient/non-English speaking Latino and Asian patient populations?
2. Why did these KP medical facilities decide to implement Culturally Competent Care (CCC) modules?
3. To what extent were these KP medical facilities ready to implement CCC modules?
4. How did these KP medical facilities decide on the specific strategies for implementation in the CCC modules?
5. How were the CCC modules implemented?
6. What were key challenges experienced during the CCC module implementation process at each study site? By all sites? By most sites?
7. What were key facilitators contributing to successful CCC module implementation at each study site? By all sites? By most sites?

Study Design

To answer my research questions, I utilized a multi-site case study design. For the purpose of this study, a "case" was defined as a CCC module. The case study method was chosen because of my desire to understand the various stages of innovation the KP medical facilities underwent to successfully implement their culturally competent care modules. Additionally, I chose the case study method because of the relatively small number of study sites (N=6) that were going to be studied (Patton, 1990). To quote Merriam (1998, page 19): "A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved. The interest is in process rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation."

Selection of Study Sites

Because of limited resources, I selected my cases (i.e. the culturally competent care clinic modules) utilizing a purposeful, criterion-based sampling approach (Patton, 2002) as well as Yin's replication logic of selecting "exemplary cases" (Yin, 2003). I searched the internal Kaiser Permanente intranet using the keywords "culturally competent care" and "module" to locate

where the culturally competent care (CCC) modules were and who the physician leader in charge of the module was. Of the seven CCC Modules I located using the Kaiser intranet and invited to be in my study, six agreed to participate.

Please note that each CCC module constitutes one clinic module out of the overall medical center/medical office building it is based in; thus the unit of analysis is the CCC module, and not the medical center/medical office building. General characteristics of each CCC module are summarized in the table below.

Module Name	Year Launched	Target Racial/Ethnic Population	Number of Bilingual, Bicultural Physicians Serving Target Population Staffing each CCC Module
For Spanish-Speaking Patients			
Hispanic Module, based at the KP Northern California (NCAL) #1 Medical Center	1998	Spanish-speaking adult patients who are limited English proficient and non-English speaking	2 Hispanic bilingual Spanish-speaking physicians and 1 Chinese trilingual Spanish-speaking physician
Hispanic Module, based at the KP Southern California (SCAL) #1 Medical Office Building	2000	Spanish-speaking adult patients who are limited English proficient and non-English speaking	4 Hispanic bilingual Spanish-speaking physicians
Latino Health Center, based at the KP NCAL #2 Medical Center	2006	Spanish-speaking adult patients who are limited English proficient and non-English speaking	4 Hispanic bilingual Spanish-speaking physicians
For Asian-Language Speaking Patients			
Chinese Module, based at the KP Southern California (SCAL) #2 Medical Center's Satellite Medical Office Building	1998	Chinese-speaking adult patients who are limited English proficient and non-English speaking	8 bilingual Chinese-speaking physicians
Vietnamese Module, based at the KP Southern California (SCAL) #1 Medical Office Building	2003	Vietnamese-speaking adult patients who are limited English proficient and non-English speaking	8 bilingual Vietnamese-speaking physicians
Vietnamese Module, based at the KP Northern California (NCAL) #1 Medical Center's Satellite Clinic #1	2003	Vietnamese-speaking adult patients who are limited English proficient and non-English speaking	6 bilingual Vietnamese-speaking physicians who are not localized in the module but spread throughout the medical facility

Table 1. General characteristics of each culturally competent care (CCC) module

In order to obtain approval of the CCC modules to be in my study, I contacted the physician leaders overseeing each CCC module via the secure, encrypted Kaiser Permanente email communication system as well as by telephone and introduced myself, described my dissertation study, and inquired whether I could include the module in my dissertation study. These conversations were my initial contacts with the CCC modules to which I learned about the history, rationale, target population, and culturally competent care strategies implemented. The physician leaders learned about my study and what participation would entail. While all of the physician leaders were interested and enthusiastic about participating, they informed me that I would need to obtain formal approval from the following key individuals at each medical center/medical office building: the Physician-in-Chief/Physician-in-Charge, the Chief of the Department of Medicine, and the physician lead for research.

After obtaining formal approvals from the aforementioned individuals from all study sites, I then sought institutional review board (IRB) approval from both Kaiser Permanente and the University of California at Berkeley. Once IRB approval was secured from Kaiser Permanente and UC Berkeley, I contacted each culturally competent care module for permission to conduct a site visit and in-person interviews with physician leaders and administrative leaders who led the CCC module planning and implementation. I conducted site visits at each culturally competent care module during the period of August 2007- August 2008 to observe the physical environment of the modules as well as to conduct the in-person interviews. For those individuals I wasn't able to interview in-person, I conducted phone interviews and, with their permission, recorded them for the purpose of transcribing the interviews for qualitative data analysis. All of my interviews were conducted during the period of May 2007-December 2008.

For each study site, the following procedures were undertaken by me: site visit, document collection, and in-person or phone interviews with physicians and administrators who led the change efforts to implement the CCC Modules.

Site Visit

I conducted site visits at each CCC module to meet the clinical staff, observe the physical environment, and learn more about the history, development, and implementation of the Module.

Document Collection

During the site visits, I collected information about the CCC module (e.g. fact sheets, brochures, written reports, published materials, administrative documents such as meeting minutes, agendas, progress reports, etc.) whenever it was available.

Semi-Structured Interviews

Primary data collection consisted of the in-person and telephone interviews I conducted which occurred during the period of May 2007-December 2008. Each interview was recorded using a digital tape recorder for the purpose of ensuring accurate data collection and analysis. Interviews ranged from 30 minutes to 1 hour 30 minutes, with a majority of interviews lasting 45 minutes.

Key respondents for the semi-structured interviews I conducted in-person as well as over the telephone consisted of the following individuals for each study site: the physician leader (past and current) of the CCC modules, the Chief of the Department of Medicine, the Physician-in-Chief/Physician-in-Charge of the overall medical facility, physician champions for the CCC modules, and executives who led the planning/implementation of the CCC modules. In my process of identifying key respondents to conduct interviews with, I utilized a snowball sampling strategy and always asked interviewees who they thought I should invite to participate in the study, so as to reach saturation by interviewing everyone who played an integral role in launching the CCC module. After the interviews, I re-contacted some respondents via email and phone for follow-up questions and fact-checking. Please see Table 2 below for a summary of individuals interviewed.

CCC Module	Physician Leaders Interviewed	Administrative Leaders Interviewed
Latino Health Center, based at the KP Northern California (NCAL) #2 Medical Center	3	2
Hispanic Module, based at the KP Northern California (NCAL) #1 Medical Center	4	
Hispanic Module, based at the KP Southern California (SCAL) #1 Medical Office Building	2	1
Chinese Module, based at the KP Southern California (SCAL) #2 Medical Center's Satellite Medical Office Building	3	1
Vietnamese Module, based at the KP Northern California (NCAL) #1 Medical Center's Satellite Clinic #1	2	1
Vietnamese Module, based at the KP Southern California (SCAL) #1 Medical Office Building	2	1
TOTAL	**16**	**6**

Table 2. Number of administrative and physician leaders interviewed at each CCC module

Interview Protocol for Semi-Structured In-Depth Interviews with Administrative and Physician Leaders

Described below are the semi-structured interview questions, with probes, utilized in the dissertation study:

1. Can you briefly describe the culturally competent care (CCC) module and who it serves?
    Probe: How long has it been operating?
            What were the reasons for creating the culturally competent care module?
2. Who has been involved with developing and implementing the culturally competent care module and what has been their roles?
3. Who did you need to obtain support/commitment from in order to launch the CCC module?
    Probe: How did you obtain support/commitment for this?
4. What kinds of resistance did you encounter, if any?
    Probe: Who (groups, individuals, etc.) did you face resistance from, if any?
5. How is this CCC module different from the past way of delivering services?

Probe: Do you feel this program is an incrementally different or radically different way of doing things here? Please elaborate on your answer.

6. Can you describe for me what kinds of challenges/barriers you faced in implementing this CCC module?

Probe: How were these challenges overcome?

7. Can you tell me what facilitators helped launch the CCC module?

Probe: How did you leverage these facilitators?

8. What have been the outcomes in terms of patient health status as well as other outcomes achieved thus far?

9. What have been some lessons learned with regard to planning, implementing, and institutionalizing the CCC module?

10. Is there anything else you would like to share about the planning, implementation and institutionalization experiences?

Data Analysis

The main approach I utilized for data analysis was a detailed analysis of the interview transcripts. After conducting each interview, I transcribed the interview and coded the interview utilizing Atlas.ti qualitative data analysis software. Preliminary codes describing the various stages of organizational innovation, organizational factors that facilitated innovation implementation, and organizational factors which impeded innovation implementation were developed based on concepts identified during the literature review.

All the interview transcripts were then content-analyzed for recurring themes, categories, and patterns within each case as well as across cases. Analytic memos and contact summary sheets were written up for each interview. I utilized methodological triangulation to strengthen this research study, with the interview data and document review comprising the bulk of qualitative data collected to ascertain what the facilitators and barriers were to successful implementation and institutionalization of the culturally competent care modules.

Within-case analysis was utilized to examine the data for within-case similarities and differences. Thus, data tables were constructed to summarize information related to the various stages of organizational innovation, as well as facilitators and challenges. Then multi-case analysis followed, by which I examined all the cases and categorized similarities and differences across all the cases, across the majority of the cases, and those unique to individual sites.

CHAPTER 4: CASE STUDY OF THE HISPANIC MODULE, BASED AT THE KAISER PERMANENTE NORTHERN CALIFORNIA (NCAL) #1 MEDICAL CENTER

BACKGROUND

Serving California's Silicon Valley, the Kaiser Permanente (KP) Northern California (NCAL) #1 Medical Center provides ambulatory and inpatient health care services for 289,000 patients through its main medical center campus and its satellite clinics in three neighboring cities. It is a large health care organization with approximately 485 physicians and 4300 clinical and administrative staff providing care to patients residing in the KP NCAL #1 Medical Center's service area, which extends as far north as Palo Alto, as far south as San Jose, to Milpitas in the east and to the Santa Cruz Mountains in the west.

Prior to the late 1990s, the KP NCAL #1 Medical Center did not have any bilingual Spanish-speaking physicians. It wasn't until the late 1990s that a Hispanic bilingual Spanish-speaking physician was hired and worked there for a few years before leaving the organization. In 2001, a Chinese trilingual Spanish-speaking physician was hired, constituting the only Spanish-speaking physician at the medical center until two years later when a Hispanic bilingual Spanish-speaking physician was hired, bringing the number up to 2.0 full-time equivalent Spanish-speaking physicians in the Department of Medicine. Physician leaders at the medical center were aware of the large number of non-English speaking and limited English-proficient Hispanic patients who were experiencing challenges navigating the Kaiser Permanente health care system because of language and cultural barriers.

This case study describes the proactive efforts undertaken by three physician leaders (the Physician-in-Chief of the medical center, the Chief of the Department of Medicine, and the Chinese trilingual Spanish-speaking physician leader) during the late1990s/early 2000s in creating the Hispanic Module, an adult primary care clinic module open to all patients but tailored to non-English speaking and limited English proficient Hispanic patients.

READINESS TO CHANGE

Acceptance of Change

Medical center leadership recognized the importance of providing culturally and linguistically competent health care services to a large and rapidly growing Hispanic Spanish-speaking patient population. As expressed by one physician leader, "*The medical center wanted to try and bring the same level of access and care to this underserved segment of the patient population in which there have been obstacles due to language and culture.*" To this end, medical center leadership discussed the innovative idea to develop a culturally competent adult primary care module in which every point of the patient care experience, from the front desk to the exam room, was going to be staffed by bilingual Spanish-speaking receptionists, medical assistants, and physicians. Another physician leader explained, "*The Department of Medicine has 70 primary care physicians- we're divided into 4 big modules and each module has 15-18*

physicians...We're trying to better serve the Hispanic population here in the South Bay. Santa Clara and San Jose have large Hispanic populations and our service population has a lot of Spanish-speaking patients so the idea was that we wanted to have a clinic module within the Department of Medicine where they feel more comfortable to go to, in terms of knowing that their provider speaks their language, the medical assistant speaks their language, and where we have health education handouts for them in Spanish."

The Chief of the Department of Medicine added, *"[The idea we have is] to launch the Hispanic Module, where we group all the Spanish-speaking physicians together in order for them to then have exam rooms that they could either use as their own or share, to have Spanish-language educational material in the exam rooms, and then to also try to as much as we can to get them, Spanish-speaking medical assistants who can help them with their patients."*

Capacity of the Organization to Change

According to the Chief of the Department of Medicine, since the Department of Medicine controlled its own facility space, there was existing space for creating the new Hispanic Module and re-locating the medical center's existing bilingual Spanish-speaking physicians, medical assistants and front desk staff to work in the Module. Financial resources were readily available, with the budget not being an issue or challenge. As the Chief of the Department of Medicine explained: *"I would have the same budget anyways for the physicians and the medical assistants. It's just more of an organizational issue [regarding moving medical and support staff into one physical area] and then making sure you've hired the medical assistants with the right language capability."*

AWARENESS OF THE NEED FOR CHANGE

In an attempt to provide Spanish language interpretation services to compensate for the shortage of bilingual Spanish-speaking physicians and frontline support staff (i.e. medical assistants and front desk staff), the organization had made available to their providers the AT&T Language Line (a telephone-based interpretation service accessible via the phones placed in each patient exam room). However, this telephone-based interpretation service was not optimal, as one physician leader who had a large number of non-English speaking and limited English proficient Hispanic patients on her panel explained: *"Even though the AT&T language line is available, think of how you're interacting with the AT&T service. The provider speaks to the interpreter in English, the interpreter speaks in Spanish to the patient, the patient responds to the interpreter in Spanish, and then interpreter switches back to English to tell the provider what the patient has said. So whatever the provider says takes twice as long [to reach the patient]. And in a busy practice, I think it's understandable that a lot of providers don't like to utilize the AT&T service unless they have to."*

The AT&T language line was an inefficient and inadequate tool that negatively impacted the ability of physicians to provide quality patient care. The Chief of the Department of Medicine further stated, *"Quite frankly when physicians use the AT&T language line, it doubles the time, thereby increasing the time it takes to get a patient history or figure out what the problem is and*

what we need to do about it. If you don't have a high percent of patients needing the AT&T interpretation service, you can do that. But when you have over 25%-30% of your patients needing it, you need to have a medical assistant who has that specific language capability helping the physician." The Chief knew that the physicians relied on their medical assistants to conduct certain pre-exam room processes and collect information from the patient before they saw the patient in the exam room.

While language constituted a major access barrier for non-English speaking and limited English proficient Hispanic patients, the leadership realized that it wasn't enough to just address language barriers- cultural barriers to care had to be also be addressed. For example, one bilingual Spanish-speaking physician described the cultural belief communicated to her by her Hispanic Spanish-speaking patients: *"When my Hispanic patients come in to see me and have back pain, they never allude to back pain. They always tell you that they have kidney pain. It's not a language barrier, it's a cultural barrier. You have to be in tune with their culture, because if you are, then you will know that…it's not because they use kidney to describe their back- it's not a vocabulary issue, it's more of a cultural issue…It's important to be able to see things from their perspective. Once you see things from their perspective, you explain to them 'this is not kidney pain, this is a muscle strain', then they will comply with treatment better, and they won't keep coming back to see a different provider because they're concerned about kidney pain."*

IDENTIFICATION AND SELECTION OF CHANGES

To respond to the language and cultural needs and issues outlined above, the medical center leadership decided to implement a Hispanic Module within the Department of Medicine for the large number of non-English speaking and limited English proficient Hispanic patients who were experiencing language and cultural barriers in accessing care at the medical center.

In order to operationalize the Module, the following changes were identified and selected for implementation through an informal but fairly systematic planning process undertaken by the Physician-in-Chief who was the head of the medical center and the Chief of the Department of Medicine of the medical center:

- Hiring additional bilingual/bicultural Spanish-speaking physicians
- Grouping bilingual Spanish-speaking physicians and medical assistants in the same geographic area of the medical center (versus having them spread out all over the medical center)
- Pairing Spanish-speaking physicians with Spanish-speaking medical assistants (versus continuing the existing strategy of rotating medical assistants around to different departments regardless of language spoken by the MA)
- Improve continuity of care and coordination of care for patients by ensuring Spanish-speaking patients were referred to bilingual Spanish-speaking diabetes care managers and health educators at the medical center

IMPLEMENTATION

The implementation process for the Hispanic Module was relatively simple and quick. Stakeholder buy-in did not occur. The Physician-in-Chief, who was head of the medical center, was one of two senior leaders who developed the idea for the Hispanic Module. She stated, "*I'm at the top. One of the nice things about my job is that I can say 'that's a good idea, we're gonna do it.'*"

The leadership made the decision to only refer to the Hispanic Module as such for internal management purposes, and not publicly promote it to patients or the external community as a separate module. Rather, the Module would be promoted to patients as the medical center having Spanish-language services to better care for Hispanic Spanish-speaking patients. Information about the new Spanish language services was posted on the medical center's website and in quarterly member newsletters.

CHALLENGES FACED DURING THE IMPLEMENTATION PROCESS

Aligning Spanish-Speaking Medical Assistants With Spanish-Speaking Physicians

The Chinese trilingual Spanish-speaking physician leader for the Hispanic Module and the Chief of the Department of Medicine had to fight battles with the administrative side of the medical center for getting Spanish-speaking medical assistants paired up with bilingual Spanish-speaking physicians on a consistent schedule. The Hispanic Module physician leader explained why it was so challenging: "*Let me tell you how things work here. The physician leaders hire the physicians and the administrative managers hire the medical assistants. Since the medical assistants are unionized, the administrative manager thinks that things should be standardized and that all the MAs should rotate around and work with different physicians every day. So say for instance if you have 18 doctors and you only have 10 medical assistants, the MAs need to rotate around. The reason why there's not one specific MA assigned to one specific doctor is because the budget doesn't allow it.*"

Hiring Additional Bilingual Spanish-Speaking Physicians

Despite great efforts undertaken to find additional Spanish-speaking physicians and having financial resources readily available for hiring additional bilingual Spanish-speaking physicians, medical center leaders were only able to hire one more Spanish-speaking physician, thereby increasing the Hispanic Module's physician staffing to three full-time equivalents (3.0 FTE). The Physician-in-Chief of the medical center stated, "*To the extent that we can hire physicians who speak Spanish, we will continue to cohort them in the Hispanic Module- but it's really recruitment-limited more than anything, not intention or willpower-limited.*" She describes the efforts to hire additional bilingual Spanish-speaking physicians as "*finding a pearl in an oyster.*"

Hiring Additional Bilingual Spanish-Speaking Medical Assistants

In the past, there weren't any rules prohibiting the medical center from posting job announcements for language-specific medical assistants. Thus, the medical center was able to hire bilingual Spanish-speaking medical assistants for the physicians who had large volumes of Spanish-speaking patients. In recent times though, a new union policy dictated that there couldn't be anymore posting for language-specific medical assistants since the AT&T language line service was made available to providers in every patient exam room.

This new union policy was challenged by the medical center physician leadership because out of the three bilingual Spanish-speaking physicians, one physician had 70% of her patient panel comprised of Spanish-speaking patients and she didn't have a Spanish-speaking medical assistant to help her. The Chief of the Department of Medicine had advocated the following points in order to champion this physician getting a Spanish-speaking medical assistant assigned to her on a consistent basis: *"There's no way that this physician is going to be able to function if her medical assistant doesn't speak Spanish. She cannot use the AT & T language line for 70% of the patients she sees. Because this physician doesn't have a Spanish-speaking medical assistant, she has to take care of all the non-physician, clerical responsibilities [that typically would be the responsibility of her medical assistant]. So I and the Physician-in-Chief basically pushed this issue up to the top levels of leadership in the Northern California region and then got the special circumstance exception and permission to hire a Spanish-speaking medical assistant to support this physician."*

INSTITUTIONALIZATION OF THE HISPANIC MODULE

The Hispanic Module has been operating for over 10 years now and has been successfully institutionalized at the KP NCAL #1 Medical Center. There is permanent alignment of Spanish-speaking medical assistants for the three bilingual Spanish-speaking physicians working in the Hispanic Module. Senior leaders of the medical center monitor on an ongoing basis the recruitment of bilingual Spanish-speaking physicians and medical assistants. The Physician-in-Chief for the medical center stated, *"It's one of those things where you have to be a guardian and watch over the staffing and have a little due diligence to make sure that what you set up and how you set it up keeps running that way."*

Another physician leader attributed the successful institutionalization of the Module to the following: *"In this case, there's a need, and then I think what happened is that you have a few physicians who realize the importance of having a service like that for a group of patients and are committed to sustaining it. If there's physician leadership, then many other things fall in line."*

With regard to the impact of the Hispanic Module, the following anecdotal evidence has been reported by physician leaders for the following areas:

Improvements in Medication Adherence

There are anecdotal reports of Hispanic Spanish-speaking patients' medication adherence improving because of the language concordance between physician and patient resulting in

improved communication. Patients are better able to follow instructions regarding taking medications and they feel better knowing and understanding why they're on certain medications. The Chinese trilingual Spanish-speaking physician for the Module explained, *"Hispanic populations are a little bit more resistant to taking medications to begin with, and sometimes also because of socio-economic background, they don't have the money to spend on medications. But once you are able to have Spanish-speaking medical staff who takes some extra steps to call patients and say 'we're checking on you to see how the medication is working' or have the Spanish-speaking provider explain why we are prescribing this medication and what needs to be monitored, compliance goes up. And when compliance goes up, treatment is better. You end up doing a lot more preventive health care, which is not possible if you don't speak the right language."*

Provider Satisfaction

In terms of provider satisfaction, the physicians and support staff who work in the Module know upfront that they are going to be working with mainly a Hispanic Spanish-speaking patient population; since they're familiar with that culture they get personal as well as professional satisfaction for taking care of these patients. One physician leader, *"I think it's also important to realize what drives personal satisfaction for the providers, that it's not just scores or other things. It's really being able to deliver care to this population…to see that they're complying better with medications."*

Patient Satisfaction

There are anecdotal reports from physicians that patient satisfaction has improved since implementing the Hispanic Module, as patients feel that they are heard and understood. Patients feel that the doctors are able to explain better to them what's going on with their health care when it's in the same language as their native tongue and they feel better about navigating the "Kaiser system" without getting lost. Patients especially like the fact that the Spanish-speaking medical assistants will give them their phone number, as patients can call them and speak to them in Spanish about any questions and concerns they have post-visit.

CHAPTER 5: CASE STUDY OF THE VIETNAMESE MODULE, BASED AT THE KAISER PERMANENTE NORTHERN CALIFORNIA (NCAL) #1 MEDICAL CENTER'S SATELLITE CLINIC #1

BACKGROUND

Serving California's Silicon Valley, the Kaiser Permanente (KP) Northern California (NCAL) #1 Medical Center provides ambulatory and inpatient health care services to 289,000 patients through its main medical center campus and its three satellite clinics located in three surrounding cities. Approximately 485 physicians and 4300 clinical and administrative staff care for patients residing in the Kaiser Permanente NCAL #1 Medical Center's service area which extends as far north as Palo Alto, as far south as San Jose, to Milpitas in the east and to the Santa Cruz Mountains in the west.

The medical center has three satellite clinics in neighboring cities which provide convenient access to KP physicians and medical services for patients who live nearby. The KP NCAL #1 Medical Center's Satellite Clinic #1 serves 80,000 members and provides ambulatory health care services.

This case describes the efforts of physician leaders and administrative leaders during the early 2000s in launching the Vietnamese Module, an adult primary care clinic module open to all patients but tailored to non-English speaking and limited English proficient Vietnamese patients.

READINESS TO CHANGE

Acceptance of Change

Clinical and administrative leaders at the KP NCAL #1 Medical Center and its Satellite Clinic #1 recognized the importance of providing culturally competent care to the ethnically diverse patient populations they served. One administrator stated, "*We had been identified as one of the facilities with the largest non-English speaking Vietnamese population within Northern CA for KP. The physicians identified some of the needs of that particular group of members and we wanted to sit down and talk about how we could address some of their concerns*." One senior physician leader summarized the leadership's rationale for wanting to create a Vietnamese Adult Primary Care Module at the KP NCAL #1 Medical Center's Satellite Clinic #1, "*We took a look at the Vietnamese patient population because amongst our various ethnicities, this seemed to be the largest patient population, and one in which we felt that we could make the greatest impact.*" She continued, "*[Launching a Vietnamese Module] was certainly something that we wanted to take a look and see about doing. We had general support from the Physician-in-Chief, including the Chief of Medicine. This was something that was a common goal for all of us in the leadership group.*"

Capacity of the Organization to Change

There was organizational capacity to implement a Vietnamese Adult Primary Care Module at the satellite clinic, in terms of physical space and the budgetary resources needed to recruit and hire additional bilingual Vietnamese-speaking physicians and medical assistants needed to operationalize such a module.

Furthermore, the KP NCAL #1 Medical Center had already developed and institutionalized several language-specific adult primary care modules (namely the Hispanic, Korean, Russian, and Japanese Modules); thus the medical center leadership gave their support as well as the financial and human resources needed for the development and implementation of a new language-specific Module tailored to the Vietnamese patient population to be based at the KP NCAL Medical Center #1's Satellite Clinic #1.

AWARENESS OF THE NEED TO CHANGE

There were several important reasons why the clinical and administrative leaders at KP NCAL #1 Medical Center and its Satellite Clinic #1 wanted to improve provision of culturally and linguistically competent health care services to their Vietnamese-speaking patients, many of whom were non English-speaking or limited English proficient, via implementation of a Vietnamese Module.

Firstly, the few bilingual Vietnamese-speaking physicians working at the clinic during the early 2000s were hearing on a weekly basis from non-English speaking and limited English proficient Vietnamese patients that they wanted to have more Vietnamese-speaking physicians and medical support staff to help them. In the early 2000s, the census count of Vietnamese patients seeking care at the KP NCAL #1 Medical Center's Satellite Clinic #1 was over 1600. Of those 1600 patients, more than 800 needed an interpreter during office visits because they were non-English speaking or limited English proficient.

Secondly, the bilingual Vietnamese physicians' workflow was at stake, as there was extra work they had to do and extra roles they had to assume due to lack of bilingual Vietnamese-speaking medical assistants and nurses to help them follow-up with Vietnamese-speaking patients.

The impetus to create the Vietnamese Module did not only stem from an internally expressed need by the physicians but also an externally expressed need from patients, which was documented through the leadership convening a voluntary focus group of Vietnamese-speaking patients to hear their recommendations on how KP could better address their health care needs and better provide service to them. As one bilingual Vietnamese-speaking physician leader recalled, "*The Vietnamese patients were very willing to come to the focus group, and they were very enthusiastic about being asked to participate, as they really wanted us to hear their voice.*"

The Vietnamese patient focus group feedback centered on several key access issues:

1) Patients were frustrated with having to use the centralized call center to make appointments and leave messages for their physicians, as the call center didn't have telephone service staff who spoke Vietnamese, and the automated phone tree options

were only available in English and Spanish- which thus resulted in them not wanting to utilize the call center.

2) When Vietnamese patients had an acute concern or minor problem (e.g. a severe headache, bad cough or bad knee pain, which was not life-threatening, but acute enough for them) they wanted to be able to have same-day access to their physician versus being scheduled for an appointment at a later date.

3) Since patient information/health education resources and the biographies of physicians were only available in English on the organization's website, Vietnamese patient wanted to have the website translated into Vietnamese so that they could access the information.

4) Signage in the clinic was difficult for Vietnamese patients, since all signs were in English, some in Spanish, and some in Chinese- but nothing was in Vietnamese.

IDENTIFICATION AND SELECTION OF CHANGES

Based on the input from the Vietnamese physicians and the feedback from the Vietnamese-patient focus group, the leadership at Satellite Clinic #1, with the support of the overarching leadership at the KP NCAL #1 Medical Center, decided to create a Vietnamese Module so that they could better serve their Vietnamese patient population. In order to operationalize the Module, the following changes were identified and selected for implementation:

- Hiring additional bilingual Vietnamese-speaking physicians
- Hiring bilingual Vietnamese-speaking medical assistants to support the physicians
- Aligning the pairing of physicians and medical assistants to be language-based by aligning Vietnamese-speaking physicians with Vietnamese-speaking medical assistants (versus continuing the existing strategy of rotating medical assistants around to different departments)
- Creating a Vietnamese language phone line voicemail for Vietnamese-speaking patients to call and make appointments as well as leave messages for their physicians
- Providing patient handouts/health education materials in Vietnamese

IMPLEMENTATION OF THE VIETNAMESE MODULE

The implementation of the Vietnamese Module was relatively straightforward and consisted of the following activities:

Hiring Additional Bilingual Vietnamese-Speaking Physicians

Through its diligent efforts, the leadership of the satellite clinic was successful in hiring additional bilingual Vietnamese-speaking physicians such that improved access to a continuum of care could now be ensured for Vietnamese patients. The following Vietnamese bilingual/bicultural physicians were hired: a dermatologist, a pediatrician, and additional adult medicine physicians.

Hiring Additional Bilingual Vietnamese-Speaking Medical Assistants

Despite spending a lot of time searching for bilingual Vietnamese medical assistants, the satellite clinic leadership was only able to hire three individuals, which unfortunately still left the clinic with a shortage. One of the ways the leadership of the satellite clinic overcame this shortage problem was to create a Vietnamese Language Voicemail in which one bilingual Vietnamese-speaking medical assistant would devote part of his/her time listening to messages left by Vietnamese-speaking patients on the backlines (i.e. direct phone lines) of Vietnamese-speaking physicians to see if there were requests/processes that could be taken care of that didn't require physicians to handle (e.g. medication refill processes, informing patients of lab hours, etc.)

Communicating Changes to Patients and the Broader Community

The leadership decided that the Vietnamese Module was only going to be internally designated; they were not going to market the Vietnamese Module to Vietnamese patients as a new module, since they felt that it wasn't truly following the "module" format. One physician leader explained, "*We have bilingual Vietnamese-speaking physicians that are scattered throughout the Department of Medicine rather than grouping them all together in one area like some of the other language-specific modules that I've heard of in the past.*" Regarding promotion of the Vietnamese Module to patients and the community, the leadership framed the new module as the clinic having Vietnamese language capacity to serve Vietnamese-speaking patients.

KEY CHALLENGES ENCOUNTERED

Recruiting and Hiring Bilingual Vietnamese-Speaking Medical Assistants

The leadership, in their search efforts, had found out that there was a local (as well as national) supply shortage of Vietnamese-speaking medical assistants. The three bilingual Vietnamese-speaking medical assistants who were hired were simply not enough to fulfill physician and patient needs at the clinic. One physician leader expressed, "*We still have yet to hire more Vietnamese-speaking medical assistants- I think that's still the main focus for our medical center at this point. We are still getting more and more Vietnamese-speaking patients requesting for services. Also, we have hired more Vietnamese physicians who need Vietnamese MAs to assist them.*"

Another surprising turn of events in hiring additional Vietnamese medical assistants was that at first the leadership had thought they should align them with the bilingual Vietnamese-speaking physicians, but then it turned out that they were needed to support non-Vietnamese speaking physicians more than the Vietnamese-speaking physicians.

Termination of the Vietnamese Language Voicemail

Due to budgetary resource shifts and the reality that there came to be redundancy of efforts, the Vietnamese Language Voicemail had to be terminated after almost one year of operation. One Vietnamese physician explained, "*There's redundant work that goes back and forth between us physicians and our medical assistant. Our medical assistants and patients ask us for the same*

thing, and we have to get back to all of them, so a lot of physicians felt it wasn't worth that effort."

Consequently, due to the Vietnamese Language Voicemail shutting down, Vietnamese-speaking patients resorted to other strategies to schedule appointments since they didn't want to utilize the centralized call center due to there being no Vietnamese telephone service representatives at the call center to help them. These strategies consisted of Vietnamese patients walking into the clinic without an appointment, contacting their physician by their specific physician's backline (i.e. direct phone line), or mailing a letter to their physician which was written in Vietnamese to request an appointment. Despite the opportunity Kaiser Permanente provided patients to email their physician, this particular patient population wasn't able to take advantage of that opportunity- Vietnamese language characters had to be typed out using a special keyboard or displayed using special computer software which the organization currently did not have the hardware or software to support.

INSTITUTIONALIZATION OF THE VIETNAMESE MODULE

The Vietnamese Module at KP NCAL #1 Medical Center's Satellite Clinic #1 consists of bilingual Vietnamese-speaking physicians with specialties in internal medicine (7 physicians), pediatrics (1 physician), dermatology (1 physician), OB-GYN (1 physician), allergy (1 physician), optometry (1 physician), and mental health (1 physician). These physicians are not physically grouped in one clinic module but spread out over three buildings at the satellite clinic. Senior leaders do monitor the Module operations and physician leaders do report to senior leaders about the Module's progress, albeit not as actively as during the early days of the Module's launch.

While the Vietnamese Module has been successfully institutionalized at the satellite clinic with regard to being incorporated into the operating budget and integrated into the standard of care, there are still things which need to be improved. A Vietnamese bilingual physician leader stated, *"The Module is in "status quo but there are still things we need to do to improve service. We still have yet to hire more Vietnamese-speaking MAs, I think that's still the main focus for our medical center at this point. We are still getting more and more Vietnamese-speaking patients requesting for services and it is important to hire bilingual Vietnamese-speaking MAs."*

The Vietnamese Module has received positive patient feedback and utilization of the Module is high. A bilingual Vietnamese-speaking physician leader reported the following anecdotal patient feedback, *"Vietnamese patients like that they can get access to health care more quickly. They give me this feedback that I will always remember, in that they judge the health plan or medical group's ability to take care of them based on the mundane, common stuff. So if they call for a common cold and they can't get in for an appointment, how can they trust that if they were to get really sick, they can get in to see the doctor? That's a very important point to remember-, that no matter how mundane a patient's concern may be, it's quite important for us to get back to them as quickly as possible."*

The Vietnamese physician workforce has also responded favorably to the Module. One senior physician leader reported, *"For the Vietnamese physicians, especially since they tended to have the largest panels in primary care of Vietnamese-speaking patients, they were hugely happy to see that we were doing something to help them manage their practices and increasing their patients' access to services."*

CHAPTER 6: CASE STUDY OF THE HISPANIC MODULE, BASED AT THE KAISER PERMANENTE SOUTHERN CALIFORNIA (SCAL) #1 MEDICAL OFFICE BUILDING

BACKGROUND

The Kaiser Permanente (KP) Southern California (SCAL) #1 outpatient Medical Office Building (MOB) is centrally located in southern California's Orange County, serving 331,116 patients annually. The MOB provides primary and specialty health care services for patients residing in Garden Grove, Bolsa (a.k.a Little Saigon), Tustin, and Santa Ana. One of the organization's largest patient populations served are Hispanic patients, many of whom are non-English speaking and limited English proficient.

The MOB leadership was well-aware of the large Spanish-speaking population in their geographic service area and neighboring cities. Over the past decade, the MOB's Spanish-speaking patient population had been growing steadily, and the MOB leadership knew that did not have enough Spanish-speaking health care providers (doctors, nurses, medical assistants) and front desk staff to address the health care needs, issues and concerns of their Spanish-speaking patients. Additionally, the efficiency of the workflow was at stake due to bilingual Spanish-speaking physicians not being able to be consistently paired up with Spanish-speaking bilingual nurses and medical assistants due to these medical support staff having rotating schedules and being pulled away to provide interpretation services for the majority of physicians working at the MOB who did not speak Spanish.

To remedy the aforementioned problems, three change agents – the senior administrator of the MOB, the MOB's senior physician leader, and an executive physician leader for the geographic service area- engaged in the development and implementation of an innovative Hispanic Module, a primary care clinic module within the MOB which would be open to all patients but would specifically be targeted to Spanish-speaking patients. This new Hispanic Module would be staffed with Hispanic bilingual Spanish-speaking physicians, nurses, medical assistants, and front desk staff such that there would be patient communication at every point of the care experience from the front desk to the exam room. This case study describes the organization's innovation process of developing and implementing the Hispanic Module during the late 1990s.

READINESS TO CHANGE

Acceptance of Change

The MOB's organizational readiness to change was quite evident, as senior leadership recognized the need for and importance of providing culturally and linguistically competent care. The senior administrator of the MOB described the leadership's readiness in the following way: "*We identified the need for culturally competent care, we talked about it in our leadership team meetings, and we said as we hire on, this is what we're going to do- hire bilingual/bicultural Spanish-speaking physicians, nurses, medical assistants, and receptionists.*"

The MOB's senior physician leader stated, *"We do have data that shows if you can talk to your patients in the language they prefer, you get more effective treatment and compliance with regard to clinical goals, clinical benchmarks, diabetes control, etc."*

An executive physician leader of the geographic service area of which the MOB fell under had expressed the following perspective: "*Bilingual and bicultural support staff are #1, and the doctors are #2. The support staff is #1 because the patient is going to spend the bulk of their time with them and only 10-15 minutes with the doctor. If patients go out or come into reception, or go out to nursing and don't have a good experience [because of communication barriers], I don't think it's going to help their [patient experience]."*

In order to move forward with launching the Hispanic Module, the primary care chiefs, the geographic service area medical director and head medical group administrator needed to weigh-in and endorse the implementation. Once the Hispanic Module idea was pitched to them, it turned out to be "*a pretty easy sell*" since they have always recognized the cultural diversity and growing Hispanic population in nearby cities surrounding the MOB. Furthermore, these top leaders were "*always pleased for new and innovative ideas that would provide better medical care for patients.*"

Capacity of the Organization to Change

There was organizational capacity to implement the Hispanic Module at the KP SCAL #1 MOB in terms of existing physical space within the MOB that the Hispanic Module could be based out of and budgetary resources to hire additional bilingual Hispanic bilingual Spanish-speaking physicians, nurses, medical assistants and front desk staff needed to operationalize the Hispanic Module. Prior to launching the Hispanic Module, there were already two Hispanic bilingual Spanish-speaking physicians, as well as several Hispanic bilingual Spanish-speaking nurses and medical assistants on staff at the MOB; however, they were spread out all over the MOB versus being grouped into one clinic module prior to launching the Hispanic Module.

AWARENESS OF THE NEED FOR CHANGE

Leadership at the local MOB and senior leadership at the geographic service area level recognized the importance of providing culturally and linguistically competent health care services to a rapidly growing Spanish-speaking patient population. They wanted to try and bring the same level of access and care to this underserved segment of their patient population in which there were obstacles due to language and culture. When the MOB's senior physician leader walked the halls of the MOB to find out what the physician workforce needed to be better able to do their job, the Hispanic bilingual Spanish-speaking doctors would tell him they needed a Spanish-speaking medical assistant "*because the Spanish-speaking MA was going to be able to ask patients what medicines they're on, what allergies they have, tell them what to do, etc."* The senior physician leader for the MOB explained, "*There's a lot of things that get done in the initial patient encounter by the MA when processing the patient that makes the patient ready to be seen by a physician. And if a physician has to go and ask the patient these basic questions himself, it becomes a [big workflow efficiency] issue.*"

He continued, "*For English-speaking patients who have questions about navigating the Kaiser system - for instance, how to get a consult or how to get a lab drawn, or needing letters written by doctors explaining the need for medical treatment, etc.- those can easily be handled by MOB staff throughout the organization. But if I am a Spanish-speaking doctor and I don't have enough Spanish-speaking support staff to address these basic questions, those questions will make it into my exam room and I may spend 25% of my visit with the patient dealing with those questions. If I add 2 or 3 minutes per Spanish-speaking patient to address such concerns and I see 20 patients like that in a day, that's an extra hour added to my day. Getting the right support in place makes sense from a business aspect, from a time aspect, a patient safety aspect, and patient compliance.*"

However, it wasn't only language barriers that the Hispanic Module would be eliminating. Cultural barriers to care also needed to be addressed- hence the strategy of staffing the Module with Hispanic bilingual, bicultural medical staff. The MOB's senior physician leader (who is not Hispanic) explained, "*There are certain things that are very cultural about illness that I may not understand, whereas a physician from that culture would understand. For instance, I've been told by my [Hispanic bilingual Spanish-speaking] physicians that the concept of diabetes or some of these other chronic illnesses is perceived in this manner - there are some beliefs in some of the Latino cultures that some of these conditions come about because of a stressful encounter--a motor vehicle accident, death of a loved one, that kind of thing. So, the view on illness, on how you get an illness is a little bit different ...The doctor has to go in and understand where the patient is coming from and then work with them to bring them around to the scientific reasons for why they may have diabetes, that it wasn't a car accident that started it or a death of a loved one, etc.*" He continued, "*Furthermore, Hispanic patients may not want to spend money on medications that we're asking them to pay for until they've tried some cultural type of remedy. And having someone of your same language and same culture telling you to take a medicine is a far more compelling argument than someone outside the culture who doesn't understand where that's coming from.*"

IDENTIFICATION & SELECTION OF CHANGES

Based on the issues outlined in the above section, the MOB's leadership team and the overall geographic service area's leadership team approved the decision to implement a Hispanic Module, an adult primary care clinic module open to all patients but tailored to Hispanic Spanish-speaking patients who were experiencing language and cultural barriers when accessing care. The following strategies were identified by the MOB's senior physician leader and senior administrator to be implemented in order to operationalize the Hispanic Module:

- Grouping existing Hispanic bilingual Spanish-speaking physicians, nurses, medical assistants, and front desk staff in one section of the MOB that was going to be designated as the Hispanic Module so that Spanish-speaking patients would have their language and cultural needs addressed at every point in the care experience from the front desk to the exam room. Additionally, by grouping all the Hispanic bilingual Spanish-speaking health care providers and medical support staff in one section of the MOB designated as the Hispanic Module (versus having everyone spread out all over the MOB), workflow

efficiency would be improved. The MOB's senior administrator explained, *"Our Spanish-speaking physicians and their Spanish-speaking support staff (meaning nurses and medical assistants) are about 35% more effective when their support staff don't have to leave them to go [interpret for another doctor's Spanish-speaking patient because that doctor doesn't speak Spanish] … sometimes these interpretations can take long -they can take up to a half hour- which puts the physician behind in seeing patients."*

- Hiring additional Hispanic bilingual Spanish-speaking physicians, nurses, medical assistants, and front desk staff to improve workflow efficiency, as the MOB's senior physician leader stated, *"If you have a Spanish-speaking physician, a Spanish-speaking nurse and a Spanish-speaking medical assistant, it becomes much easier to address the questions that might come in from patients…It also is easier to book the patient and get them into the exam room. You don't have to pull in an interpreter. It was a much faster process."*

- Once additional Hispanic bilingual Spanish-speaking nurses were hired, they could assume the responsibility of addressing Spanish-speaking patients' psycho-social and non-medical related concerns, which historically had been taking up too much of existing Hispanic bilingual Spanish-speaking physicians' time to address. The MOB's senior physician leader explained, *"Hispanic Spanish-speaking patients may come to their physicians with immigration questions, and they may have special forms that need to be filled out…So, [we will try] to make sure that the nurse team leader can buffer as many of these things as possible…The nurse team leader will try to address the issue first, and if they can't, they will forward the issue to the physician to be resolved."*

- Ensuring that the Hispanic bilingual Spanish-speaking physicians working in the Hispanic Module would always have the same Hispanic bilingual Spanish-speaking medical assistants working with them 70%-80% of the time: this new strategy would allow for medical support staff to be consistently paired up physicians based on language needs versus having the medical assistants rotate around the MOB based on functional areas (pediatrics, adult medicine, etc.). The MOB's senior administrative leader explained, *"It used to be that you know, we only had 2 or 3 Spanish-speaking medical assistants and they didn't have permanent assignments with our Spanish -speaking physicians so these Spanish-speaking medical assistants were always being pulled hither and beyond…and it really became a challenge to make sure we had some continuity of care not only for the patients but for our Spanish-speaking physicians in that they would always have their medical assistant there to support them."*

IMPLEMENTATION OF THE HISPANIC MODULE

Obtaining Stakeholder Buy-In

The Hispanic Module concept was presented to the existing bilingual Hispanic Spanish-speaking physicians who were invited to work in the Module by the MOB's senior physician leader. The senior physician leader relayed the following strategies to them: *"We're going to give you a*

bilingual Spanish-speaking medical assistant and a nurse team leader who speaks Spanish. We're going to try and make sure you have all the patient handouts you need in Spanish. We'll give you support in your care of Spanish-speaking patients." The feedback from these physicians was positive, as they were eager to work with this patient population. The only concern they had was around the extra work/extra roles they would have to assume which revolved around cultural and psycho-social needs/issues usually brought forth by Hispanic patients who were limited English proficient/non-English speaking. The MOB's senior administrator explained, *"Things have gotten so complex that when our Hispanic bilingual Spanish-speaking physician has a Spanish-speaking patient, they have to be the physician, the educator, the social worker, all of those things other than just coming in and saying this is your diagnosis and take your medication. The physicians have to do all these other jobs because there isn't really anybody there to help these Spanish-speaking patients."* To address the physicians' concerns, the MOB's senior physician leader informed them of the strategy to hire additional Spanish-speaking nurses who would be the first ones on the health care team to address these types of cultural and psycho-social patient needs/issues.

After obtaining physician buy-in from the Hispanic bilingual Spanish-speaking physicians who would be working in the new Hispanic Module, the leadership began posting job announcements for bilingual Spanish-speaking nurses and medical assistants. Since the leadership team had conducted meetings with the nurses and support staff unions (which represented the medical assistants and receptionists) right from the beginning when planning for the Hispanic Module, the unions were supportive of the Hispanic Module; therefore they did not pose any objections to recruiting for nurses, medical assistants, and administrative support staff based on language versus other criteria (e.g. seniority).

Hiring Additional Hispanic Bilingual Spanish-Speaking Physicians and Nurses

The MOB recruited for additional Hispanic bilingual Spanish-speaking nurses and medical assistants, and were able to hire two bilingual Spanish-speaking nurses (a licensed vocational nurse and a registered nurse). Furthermore, additional Hispanic bilingual Spanish-speaking physicians were hired bringing the level up from 2.0 FTE to 4.0 FTE and a bilingual Spanish-speaking receptionist was hired, thereby turning the vision of patient communication at every step of the care experience into reality. Thus, when Spanish-speaking patients came in to receive care at the MOB, there was a Hispanic bilingual Spanish-speaking receptionist to help them check in, a Hispanic bilingual Spanish-speaking medical assistant to process the patients so that they would be ready to be seen by the physician, a Hispanic bilingual Spanish-speaking licensed vocational nurse who would give them their medications and explain medical procedures to them, a Hispanic bilingual Spanish-speaking nurse team leader who would be their primary telephone contact for any questions/concerns post-visit, and a Hispanic bilingual Spanish-speaking physician who would examine the patient.

Communicating about the Hispanic Module to Patients and the Community

The Hispanic Module is not publicized to patients or marketed externally to the community as a Hispanic Module, as the name is more for internal management purposes, according to the MOB leadership's team. The MOB's physician leader stated the rationale for this: *"We will market the*

fact that we have Spanish-speaking doctors with Spanish-speaking staff, but we will not actually say, 'This is the Hispanic Module', to our patients because there is a certain number of people who may misunderstand what we're trying to say and think that that Module is only set up to deal with the Spanish-speaking community. That's not the case- the Module is open to all of our patients for care."

Medical staff refer to the Hispanic Module as such internally, but patients booking appointments are told that the MOB has Spanish-speaking physicians should they need one. Spanish-speaking patients tended to identify more with their primary care physician than the fact that they were receiving care in the Hispanic Module.

KEY CHALLENGES ENCOUNTERED POST-IMPLEMENTATION

Despite the strategy of having the Hispanic bilingual Spanish-speaking nurse team leader being the first responder to Spanish-speaking patients' concerns/needs, there was still extra work that Hispanic Module physicians had to take on that went beyond language needs, as they were finding that they still needed to address psycho-social/cultural issues raised by their Spanish-speaking patients. The MOB's senior administrator said, *"[The extra work/roles issue the physicians are taking on] actually has been brought to executive management's attention... Everyone's recognizing it as a problem, and I think it's finally come to the forefront where it is identified as a problem but they have to work on a solution."*

INSTITUTIONALIZATION OF THE HISPANIC MODULE

The Hispanic Module has been successfully integrated into the daily operations of the MOB. Senior leaders monitor on an ongoing basis the recruitment and hiring of additional bilingual health care providers as needed. There is ongoing physician commitment to working in the Module and serving the Spanish-speaking patient population. Because of the leveraging of existing human/financial resources and the Module incurring few new costs (e.g. the hiring additional physicians which actually had already been factored into existing budgets), the Module has been successfully institutionalized at the KP SCAL #1 MOB as part of the Department of Medicine's standard clinical operations.

With regard to patients' perspective of the Module, the MOB's physician leader expressed, *"It's been responded to very favorably by our Hispanic Spanish-speaking patients. The Hispanic Module is very much a place where people feel very safe and comfortable in getting their care. I can give you anecdotal evidence that patient satisfaction seems to go up when patients feel more comfortable in the environment...I have patients come up to me and say I love Dr. So-and-So and I love his medical assistant and that's why my family is here. That's why I enrolled them all in Kaiser."*

CHAPTER 7: CASE STUDY OF THE VIETNAMESE MODULE, BASED AT THE KAISER PERMANENTE SOUTHERN CALIFORNIA (SCAL) #1 MEDICAL OFFICE BUILDING

BACKGROUND

The Kaiser Permanente (KP) Southern California (SCAL) #1 outpatient Medical Office Building (MOB) is centrally located in southern California's Orange County, serving 331,116 patients annually. The MOB provides primary and specialty health care services for patients residing in Garden Grove, Bolsa (a.k.a Little Saigon), Tustin, and Santa Ana. Two of the organization's largest racial/ethnic patient populations are Hispanic/Latino patients and Vietnamese patients, many of whom are non-English speaking and limited English proficient. It is demographically well-known that KP SCAL #1 MOB is located in a community with the largest Vietnamese population in the world, outside the country of Vietnam.

The KP SCAL #1 MOB had on staff bilingual Vietnamese-speaking physicians to serve their large Vietnamese patient population since the 1990s and has been serving the Vietnamese patient population for even longer than that. Over the past decade however, the MOB's Vietnamese-speaking patient population had grown, and the number of bilingual Vietnamese-speaking physicians, nurses and medical assistants on staff at the MOB were not enough to support this population growth.

To remedy this problem, three change agents – the senior administrator of the MOB, a senior physician leader of the MOB, and a higher-level executive physician leader for the overall geographic service area of which the MOB was a part of- lead the way for implementing an innovative Vietnamese Module, a culturally and linguistically competent adult primary care clinic module which would be open to all patients but would specifically be targeted to Vietnamese-speaking patients who were limited English proficient and non-English speaking. The Module would be staffed with bilingual/bicultural Vietnamese-speaking physicians, nurses, medical assistants, and front desk staff such that there would be patient communication at every point of the care experience from front desk to the exam room. This case study describes the organization's innovation process of creating the Vietnamese Module.

READINESS TO CHANGE

Acceptance of Change

Top leaders overseeing the KP SCAL #1 Medical Office Building were "*always pleased to explore new and innovative ideas that would provide better medical care for patients.*" Since the organization had experienced success with implementing and institutionalizing their Hispanic Primary Care Module, they wanted to develop a Module to better serve their Vietnamese patient population, in particular their non-English speaking/limited English proficient Vietnamese patients who faced significant language and cultural barriers in accessing care. The senior administrator for the MOB said, *"[The Hispanic Module] was so successful…So, we wanted to*

replicate the design of the Hispanic Module… to support our [Vietnamese-speaking] population."

The MOB's readiness to change was quite evident, as senior leaders of the MOB recognized the importance of providing culturally competent care. An executive physician leader of the overall service area who championed the change stated: *"Bilingual and bicultural support staff are #1, the doctors are #2. The support staff is #1 because the patient is going to spend the bulk of their time with them and only 10-15 minutes with the doctor. If patients go out or come into reception, or go out to nursing and don't have a good experience [because of communication challenges], I don't think it's going to help their [patient experience]."*

Capacity of the Organization to Change

There was organizational capacity to implement a Vietnamese Module at the KP SCAL #1 Medical Office, in terms of physical space to house the Module and financial resources to hire additional bilingual Vietnamese-speaking physicians, nurses, medical assistants and administrative support staff needed to operationalize such a module.

AWARENESS OF THE NEED FOR CHANGE

The MOB leadership felt that this new Vietnamese Module, like the Hispanic Module, by having language concordance between patients and healthcare providers would make sense from a business perspective, workflow efficiency perspective, patient safety perspective, and treatment compliance perspective. Through a long history of caring for the MOB's Spanish-speaking and Vietnamese-speaking patient populations, the organization's leadership had found out that when there was permanent alignment of bilingual language-appropriate nurses and support staff (i.e. medical assistants and receptionists) with bilingual physicians, the care team was more effective when serving non-English speaking/limited English proficient patients. As the administrator overseeing the MOB explained, *"It wasn't a great statistical survey, but we found out, in having the physician and their medical staff are about 35% more effective…Prior to implementing the Hispanic and Vietnamese Modules, it used to be that our [bilingual Spanish-speaking and Vietnamese-speaking physicians weren't permanently assigned to bilingual medical assistants], so the bilingual medical assistants were always being pulled hither and beyond in the facility to provide interpretation, and then no one would cover for them, and it really became a challenge to make sure we had some continuity of care not only for our Spanish-speaking and Vietnamese-speaking patients but also continuity for our Spanish-speaking and Vietnamese-speaking physicians in that they would always have their bilingual medical assistant there to support them.*

The MOB leadership was also well aware that bilingual Vietnamese-speaking physicians who had large segments of non-English speaking and limited English proficient Vietnamese patients in their panels had extra work to do than those physicians who didn't have these patients. In many cases, this extra work should have been addressed by medical support staff (i.e. nurses and medical assistants), but the organization didn't always have language-appropriate support staff on hand who could address those issues. For instance, one senior-level physician leader

explained, "*Let's say an English-speaking patient who's new to Kaiser comes in and has a question about how to get a consult or how to get a lab drawn or where are our acute care services. Usually my support staff is able to explain that to them. But if I am a doctor who speaks a specific language and no support staff speaking that language are around to address these questions, those questions will make it into my exam room and I may spend up to 25% of my patient visit dealing with those questions. If you add 2 or 3 minutes per patient to address those types of questions, and you see 20 patients like that in a day, that's an extra hour added to your day.*"

Other times, this extra work would be focused on addressing Vietnamese patients' psychosocial concerns, especially if the patients were immigrants or refugees. As the MOB's senior administrator puts it, "*When the bilingual Vietnamese physician comes in and has a Vietnamese-speaking patient, they have to be the physician, the educator, the social worker…they have to be all of those things rather than just saying this is your diagnosis and take your medication- they have to do all these other jobs because there isn't really anybody there to help them.*"

Clinical and administrative leaders were also well aware of Vietnamese norms affecting patients' healthcare as well. Through the MOB's senior-level administrator's working closely with bilingual Vietnamese-speaking physicians, nurses, medical assistants, and other support staff, she describes Vietnamese patients' cultural norms around the doctor visit as told to her by her staff: "*In the Vietnamese population, the physician is a revered individual and so there's a social etiquette that you have to go through and there's certain words you can't discuss or talk about. Thus, as a healthcare provider, you have to become a detective then because you have to know the right questions to ask and understand what patients are trying to tell you because a lot of times, all of the sexual-related issues they can't tell you about. You can't ever use the word cancer in a Vietnamese family- you can say tumor, you can say growth, but you just can't ever use the C-word because culturally that's their death certificate. You can say we're going to treat your tumor, we're going to treat this growth but you can't ever say cancer.*"

IDENTIFICATION AND SELECTION OF CHANGES

Based on the important issues outlined above, the leadership identified the need for implementing a Vietnamese Module in which bilingual Vietnamese-speaking physicians would permanently be aligned with bilingual Vietnamese-speaking nurses and medical assistants. These healthcare providers would be physically grouped in one designated area of the MOB. Prior to implementing the Vietnamese Module, bilingual Vietnamese-speaking physicians, nurses, and medical assistants had been spread out over the whole building and medical assistants had not been permanently aligned with physicians based on language capabilities.

The rationale for developing the Vietnamese Module stemmed from the leadership wanting to reduce access barriers based on language, thereby ensuring patient communication at every point in the care delivery system. One bilingual Vietnamese-speaking physician leader who was part of the planning process pointed out, "*Ideally what we want in terms of providing care to an ethnic group of patients in general who don't speak English is to make sure that language is not a barrier at any level of the care- whether it be when the patient calls to make an appointment,*

when the patient checks in, when the patient is being evaluated by the physician, when the patient is being discharged, and when the patient follows up- all that should take place in a way such that language barriers do not affect the patient's care and outcomes."

Last but not least, improving follow-up and coordination of care served as another major driver for creating the Vietnamese Module. As one bilingual Vietnamese physician explained, *"When we order special procedures or make appropriate referrals for non-English speaking or limited English proficient Vietnamese patients, a lot of time is required and additional work as well from our standpoint and our support staff assisting these patients to follow through. There's additional work for our medical assistants, nursing staff, and doctors. For example, say the patient has a problem and they need a colonoscopy to further evaluate the blood in their stool. Now if we put in the referral and the person speaks English, we just give the patient a phone number to call and schedule the appointment and that would be it. But for a patient who doesn't speak English well or at all, that could be a problem, so we have to handle it in a way where they don't fall through the cracks because they can't call due to language being a barrier."*

In order to operationalize the Vietnamese Module, the leadership team identified the following changes to be implemented:

- Grouping existing bilingual Vietnamese-speaking physicians, nurses, and support staff into one clinic module at the KP SCAL #1 MOB
- Hiring additional bilingual Vietnamese-speaking physicians and nurses
- Hiring additional bilingual Vietnamese-speaking support staff, namely medical assistants and front desk receptionists

IMPLEMENTATION OF THE VIETNAMESE MODULE

In order to implement the changes necessary to operationalize the Vietnamese Module, the leadership of KP SCAL #1 MOB and leadership overseeing the overall geographic service area of Orange County instituted a simple process, as the MOB senior administrator recalled: *We identified [the changes to be made], we talked about [them] in our leadership team, and we said as we hire on medical and administrative staff, this is what we're going to do…and we would always make sure when staffing the module, there's medical and administrative staff] who speak Vietnamese."*

By the time the new Vietnamese Module was all set to be rolled out, the leadership had recruited and hired six bilingual Vietnamese-speaking physicians and nine ancillary support staff members to work in the Module. As a higher-level executive physician leader for the overall service area expressed, *"Honestly I think having a module is helpful versus [having the physicians and support staff spread out] throughout the building. [Having bilingual physicians and support staff grouped in one module] would be language and culturally appropriate*."

The leadership realized that since they had increased the number of bilingual Vietnamese-speaking physicians and ancillary support staff, which in turn would naturally lead to more Vietnamese patients accessing care, they needed to have Vietnamese language capacity at the centralized call center for patients to make appointments and leave messages for their physicians.

However, the call center did not have telephone service representatives who could speak Vietnamese.

To remedy this language gap, the KP SCAL #1 MOB leadership, with the help of several bilingual Vietnamese-speaking medical staff, created the Vietnamese Language Line through which they were able to program the telephone system at the call center to add a phone tree option where Vietnamese-speaking patients could press the number 3 option to hear information in Vietnamese. When patients chose the number 3 option, they would hear a pre-recorded message that said "*If this is an emergency, you need to call 911. If you want to leave a message for your physician or have any questions, please do so at the beep*." Vietnamese-speaking patients would then be able to leave their message on this voicemail which would then trigger a pager that one of the bilingual Vietnamese-speaking support staff at the KP SCAL #1 MOB carried. The staff member would then call the voicemail, retrieve the patient's message and call the patient back.

As the MOB's senior administrator recalled, "*In the beginning when the Vietnamese Language Line was rolled out, it took some time for patients to know about it and there were some messages but not as many as we expected. However, now we're up to 700 messages a month from Vietnamese-speaking patients not only receiving care from this medical office, but from Vietnamese patients in the broader geographic service area of Orange County because a lot of times they'll call the Language Line and our staff will facilitate getting them to their specialist appointment and going through the process with them.*"

Communicating to Patients and the Community about the Vietnamese Module

The organization's leaders decided to only refer to the Vietnamese Module as such for internal management purposes, and not to publicly market the Vietnamese Module as a separate module. The leadership did work with the marketing department to get the word out to the community about the medical office's increased staffing of bilingual Vietnamese physicians and medical staff who would be able to better serve the Vietnamese community.

KEY CHALLENGES ADDRESSED

Patient Appointment Scheduling

There are ongoing challenges around patient appointment scheduling even with the creation of the innovative Vietnamese Language Line service. One Vietnamese physician leader explained why: "*The patient dials the call center, hears the phone tree options, then pushes option 3 for Vietnamese, hears the recorded message and leaves his/her message, which sets off the pager that's connected to the voicemail system. Then the pager goes off and any one of the Vietnamese support staff here will call back the patient to gather more information. There's a wait time between the pager going off and the staff person being able to call back the patient such that the turnaround time could be up to several hours. The volume of messages on the voicemail varies day to day so it's difficult to respond the patient in a timely manner. Lastly, we're basically assigning our MA, LVN, or RN to do patient appointment scheduling which is really call center*

work, so that's not really an ideal way to utilize their time, since their time is being used here for direct patient care. From the patient perspective, yes somebody will call them back and talk to them, but it may not be in real time and the patient might not be sitting around the phone waiting around for a couple of hours for the medical staff to call back. The work that the MA, LVN, or RN does with the language line is in addition to their direct patient care, so when it's in addition, a lot of time it's not the priority. When my MA is working with me, and she has her work to do, and then in addition to that she has to periodically watch the pager, her priority is getting the patient in and out in a timely manner, and to assist me with my patient that's already here."

The MOB leadership looked into trying to get the call center to hire telephone service representatives who could speak Vietnamese but it was unsuccessful, as the job required the ability to speak fluently in both English and Vietnamese, as well as have basic computer skills. The Vietnamese physician leader for the Module described the challenges they faced in hiring for such staff: "*The appointment center is entry level work, so you're not going to be able to find qualified candidates who would stay long for that kind of position. The call center has a very high turnover rate for entry level positions. Once people work there for a little bit, they tend to move up the ladder, so it's not something they would stay for. So in recruiting for that particular position, you won't find a lot of Vietnamese individuals who speak fluently in both English and Vietnamese languages and have computer work skills who would want an entry level position. So there's been talks about creating a position with these three requirements but paying people more. However, then there's union issues. So there's not a simple solution.*"

<u>High Turnover of Bilingual Vietnamese-Speaking Support Staff</u>

Hiring and retaining bilingual Vietnamese support staff poses an ongoing challenge. The MOB's senior administrator worked closely with bilingual Vietnamese medical staff and shared the following information: "*In the Vietnamese culture, most people were in business, manufacturing, or working as physicians or pharmacists. There were very few people who were available for entry level positions such as receptionists and medical assistants, and those that were in those entry-level jobs engaged in furthering their education to move up the career ladder. The couple of bilingual Vietnamese-speaking receptionists we hired for the Vietnamese Module were mostly working our evening schedules because they were going to school- they were in the process of furthering their education, but at least we are able to get them for a little while before they quit to move on with their careers.*"

INSTITUTIONALIZATION OF THE VIETNAMESE MODULE

The Vietnamese Module is in a steady state, according to the bilingual Vietnamese-speaking physician leader for the Module. The staffing structure for the Module consists of 8 bilingual Vietnamese-speaking physicians, 2 bilingual Vietnamese-speaking registered nurses, 3 bilingual Vietnamese-speaking licensed vocational nurses, and 10 bilingual Vietnamese-speaking medical assistants. Senior leaders monitor on an ongoing basis the recruitment and hiring of additional bilingual providers as needed and there has been ongoing physician commitment to the Module. Because of the leveraging of existing human and financial resources which led to incurring few new costs (e.g. hiring additional physicians had already been factored into existing budgets), the

Module has been successfully institutionalized at the KP SCAL #1 MOB as part of the Department of Medicine's standard clinical operations.

For almost a decade now, the Vietnamese Module at the KP SCAL #1 MOB has provided care to a community that possesses the largest Vietnamese population outside of Saigon, Vietnam. Bilingual Vietnamese-speaking physicians, nurses, medical assistants, licensed vocational nurses, pharmacists and specialists care for more than 2,000 Vietnamese patients, which represent about one-third of the local Vietnamese community.

The bilingual Vietnamese-speaking physicians have reported to the MOB leadership that patient satisfaction has gone up since their patients feel more comfortable in the care environment knowing that they can communication freely and clearly to providers and medical staff at every point of their care. There are also anecdotal reports that Vietnamese patient retention in Kaiser has gone up. The Module also has attracted additional Vietnamese patients from outside the local service area as well.

Patient feedback about the Vietnamese Module has been positive because many Vietnamese patients have had specific medical issues and concerns which have been going on for years that they weren't able to have evaluated or weren't able to bring up due to not being able to communicate with physicians and ancillary support staff who spoke their language. The physician leader of the Vietnamese Module stated, *"We're doing better now than 6 years ago, as right now we have more Vietnamese female physicians. In the past, there were more male providers, and for females, there's some issue about wanting to be examined by only a female provider and there's that certain apprehension when especially doing Pap and women's health."*

Provider satisfaction has also improved, as many bilingual Vietnamese-speaking physicians, nurses, and support staff who were re-located to the Module or hired for the Module have found their work personally satisfying and rewarding because they do speak the patient's language and they do know the extra work they put in really helps the patients. As one physician leader puts it, *"It's more of a personal reward than any additional monetary reward, and more personal satisfaction [that comes from working in the Module]."*

CHAPTER 8: CASE STUDY OF THE CHINESE MODULE, BASED AT THE KAISER PERMANENTE SOUTHERN CALIFORNIA (SCAL) #2 MEDICAL OFFICE BUILDING

BACKGROUND

In the late 1990s, the Kaiser Permanente (KP) Southern California (SCAL) #2 Medical Center's senior leaders had observed that the Chinese-speaking community was growing within their medical center's geographic service area of the San Gabriel Valley in southern California. Thus, senior leaders hired the first two bilingual Chinese-speaking physicians to work at the medical center's satellite ambulatory clinic located in the San Gabriel Valley, where there was already a large Chinese-speaking patient population.   The hiring of two bilingual Chinese-speaking physicians constituted the early efforts made by the medical center leadership to better serve the rapidly growing Chinese patient population, many of whom were non-English speaking and limited English proficient (LEP). These non-English speaking and LEP Chinese patients faced challenges in accessing care and navigating the KP health care system because of language and cultural barriers.

The KP SCAL #2 Medical Center was not alone in its challenging situation to find ways to better serve the Chinese-speaking patient population. Nearby, the KP SCAL #3 Medical Center also faced similar challenges and wanted to improve care delivery to its Chinese-speaking patient population, many of whom were also non-English speaking and limited English-proficient. The KP SCAL #3 Medical Center leadership knew that they had a large Chinese-speaking patient population in their geographic service areas represented by the cities of Monterey Park, Rosemead, El Monte, Alhambra, and South Pasadena. Therefore, they were in the process of looking for a geographically accessible location to build an ambulatory clinic that would be staffed with bilingual Chinese-speaking physicians, nurses, medical assistants, and front desk staff. Unfortunately there wasn't a whole lot of available real estate which fit their needs and budget.

The KP SCAL #2 and KP SCAL #3 Medical Centers had individually attempted to meet the needs of their rapidly growing Chinese-speaking patient populations with varying degrees of success. With all these issues in mind, the leadership teams of both medical centers met and collaboratively discussed launching a new culturally competent care module that would be open to all patients, but be tailored to their large Chinese-speaking patient populations and staffed with bilingual Chinese-speaking physicians, nurses, medical assistants, pharmacists and front desk staff. Thus, the impetus to create the Chinese Module was born out of the two medical centers' discussions on how to better meet the cultural and language needs of their rapidly growing Chinese-speaking patient populations residing in their geographic service areas, improve the continuum of care for these patients, and improve coordination of care for these patients.

This case study describes the organizational process of innovation which was undertaken by two Kaiser Permanente Medical Centers (SCAL #2 and SCAL #3) which collaboratively combined their human resources, information technology and financial resources to develop, implement, and institutionalize the Chinese Module, a culturally and linguistically competent adult primary

care clinic module open to all patients but tailored to Chinese-speaking patients that is based at the KP SCAL #2 Medical Center's satellite outpatient Medical Office Building (MOB).

READINESS TO CHANGE

<u>Acceptance of Change</u>

The KP SCAL #2 & KP SCAL #3 Medical Centers' leadership recognized the importance of providing culturally competent care to their large Chinese-speaking patient populations, as they knew that language and cultural barriers in health care impacted access to care. One administrator representing the KP SCAL #2 Medical Center recounted, *"The Chinese Module was essentially an idea that was brought forth by the senior leadership of both the KP SCAL #2 and KP SCAL #3 Medical Centers, and then was brought to us at the local leadership level. And myself and the group of people to be involved at the time in collaborating on how this was going to be done got together in an initial meeting and had planning meetings throughout."*

One senior level physician leader explained the rationale behind launching the Chinese Module, *"We wanted to tailor services to a specific ethnic group with certain cultural and linguistic needs by bringing together a group of providers and ancillary support staff in one physical space and trying to hire across the continuum -from the receptionist, medical assistant, nurse, physician, and to the level of the pharmacist, thereby creating a group of caregivers and a health care team who all had similar linguistic capabilities and cultural capabilities so they could address that particular population's needs."*

Several years ago, the KP SCAL #2 Medical Center developed and launched a similar clinic module for their Hispanic Spanish-speaking patient population- the Hispanic Module- which was housed at the KP SCAL #2 Medical Center's satellite outpatient Medical Office Building (MOB). By virtue of the MOB being located where there was a large Spanish-speaking patient population and a rapidly growing Spanish-speaking community, the leadership had, for quite a number of years already, implemented and successfully institutionalized the Hispanic Module for their Spanish-speaking patients, many of whom were non-English speaking and limited English proficient. To bridge the language gaps, the leadership had hired bilingual Spanish-speaking physicians, nurses and ancillary support staff (medical assistants and front desk receptionists) in order to eliminate language barriers at every point of the patient visit.

<u>Capacity to Change</u>

The KP SCAL #2 Medical Center already had its satellite outpatient Medical Office Building (MOB) which had ample space to house the new Chinese Module. Furthermore, there was organizational capacity in terms of both medical centers possessing the necessary human and financial resources to develop and implement the new Chinese Module. Both KP Medical Centers had existing bilingual Chinese-speaking physicians who could re-locate to the new Chinese Module that was to be housed at the KP SCAL #2's satellite Medical Office Building (MOB) and had the budgetary resources to hire additional Chinese-speaking physicians, medical

assistants, nurses, and receptionists to meet the health care needs of the large, and steadily growing Chinese-speaking patient population.

AWARENESS OF THE NEED TO CHANGE

Prior to implementing the Chinese Module, both Medical Centers did not have enough bilingual Chinese-speaking physicians, nurses, and ancillary support staff (i.e. medical assistants and front desk staff) to adequately serve their Chinese-speaking patient populations who faced both language and cultural barriers in accessing care. Bilingual Chinese-speaking health care providers felt that they were doing additional work to book appointments, educate patients and provide interpretation during routine procedures for this large patient population who were largely limited English proficient and non-English speaking.

Bilingual Chinese-speaking physicians reported that their patients were dissatisfied because there weren't enough Chinese-speaking health care providers to address their health concerns and problems. One bilingual Chinese-speaking physician stated, "*Patients do not just have common colds and basic care, you know. People do have complicated medical problems and conditions…10% of Chinese patients tend to carry Hepatitis B and many of them may end up needing treatment…And you need to address their concerns or reluctance to have further treatment.*" One senior physician leader described how challenging it was for Chinese-speaking patients in navigating the Kaiser system to find Chinese-speaking healthcare providers: "*It was left up to the individual patient to try to find these providers (who were spread out all over the medical center) to get the care from these providers.*"

To help understand the needs of the Chinese-speaking patient population, several clinical and administrative leaders conducted a site visit of the long-time operating Chinese Module based at the KP San Francisco Medical Center to capture best practices and discover what types of issues were likely to arise during the planning and implementation of the new Chinese Module. In addition to the site visit, one senior administrator consulted with the Kaiser Permanente Asian Pacific Staff Association to gather some initial information about cultural aspects that should be incorporated into the development of the new Chinese Module. This administrator recounted an important cultural norm which was important to take into account, gleaned from consultation with the Chinese Staff Association President at that time, "*I was told by the president that if we wanted the physicians in this new module to be successful, we would have to get the organization to accept upfront lower patient satisfaction scores or the bilingual Chinese-speaking doctors wouldn't want to work in the new module. It's the cultural norm that Asians rate things lower. So when Asians are rating things on a scale of 1 to 10, they see 8 as essentially perfect. Then they go down from 8. They don't go down from 10. And he said that's just cultural with us, so if you have a medical director who's just looking at scores, and the bilingual Chinese-speaking doctors working in the Chinese Module are 2 points below all the other doctors in the area, there's ramifications and loss of incentive and things like that, and they won't want to work there.*"

IDENTIFICATION & SELECTION OF CHANGES

The leadership of both medical centers conceptualized the Chinese Module to be a one-stop shop that would provide primary and specialty care to all patients but have specific cultural and linguistic capacity to care for Chinese-speaking patients who were non-English speaking and limited English-proficient. It was also decided that the Module would be multi-specialty and multi-disciplinary, and enhance access to and coordination of secondary and tertiary care for patients. Thus, Chinese patients would access primary and secondary (specialty) health care services at the KP SCAL #2 satellite MOB and if they needed tertiary care, they would be referred to bilingual Chinese-speaking specialists at the KP SCAL #3 Medical Center. Armed with the knowledge and awareness of the multiple barriers and complexities facing Chinese-speaking patients, the leadership teams identified the following changes in order to operationalize the new Chinese Module:

- Grouping existing bilingual Chinese-speaking physicians, nurses, and support staff currently working at the KP SCAL #2 Medical Center and its satellite MOB into the new Chinese Module
- Re-locating bilingual Chinese-speaking physicians based at KP SCAL #3 Medical Center to the KP SCAL #2 satellite Medical Office Building
- Hiring additional bilingual Chinese-speaking physicians and nurses to staff the new Chinese Module
- Hiring additional Chinese-speaking support staff, namely medical assistants and front desk receptionists to staff the new Chinese Module

Since the Chinese Module was going to be operating as a joint venture between the SCAL #2 & #3 Medical Centers which traditionally did not combine human, financial, and information technology resources, there had to be systems redesign to ensure that productivity credit, revenue credit, and things of that nature would go to the appropriate medical center based. There also had to be systems redesign such that patient tracking (i.e. who belonged to the SCAL #2 Medical Center versus who belonged to the KP SCAL #3 Medical Center) could occur as well as how services were going to be billed and payroll would be conducted. One physician leader explained, "*Normally, how the Kaiser system works is that when a patient gets taken care of, the return on investment from revenues will be credited to the local medical center the particular patient belongs to. Furthermore, with the creation of this new Chinese Module, the primary care physicians who are staffing the Module will be coming from two different medical centers. So in addition to the specifics having to be ironed out around tracking which patients are from which medical center, there needed to be tracking of the individual physicians in terms of which medical center they belonged to so that they would be getting credited for the patient visit.*"

IMPLEMENTATION OF THE CHINESE MODULE

Outlined below were the main components addressed during the implementation process.

<u>Reconciling the Different Organizational Cultures of the Collaborating Medical Centers</u>

Before rolling out the Chinese Module, the different organizational cultures of the collaborating medical centers had to be mutually understood so that a middle ground could be developed that would be appropriate for the new Chinese Module. KP SCAL #3 Medical Center's focus was more about providing secondary (specialty) and tertiary care, whereas KP SCAL #2 Medical Center's focus was more about providing primary and secondary (specialty) care. While the intention behind the new Chinese Module was to improve access to primary care by having the Module based at the KP SCAL #2 satellite Medical Office Building, it also had the aim to improve access and enhance coordination of secondary care at the KP SCAL #2 Medical Center and tertiary care at the KP SCAL #3 Medical Center. Consequently, KP SCAL #2 Medical Center had to beef up their secondary care support because of certain conditions which disproportionately impacted the Chinese population. For example, approximately 10% of Chinese patients tended to carry Hepatitis B, with many of them possibly ending up needing treatment. However, there was a dearth of bilingual Chinese-speaking gastroenterologists at the KP SCAL #2 Medical Center. Thus, the leadership hired additional Chinese-speaking gastrointestinal specialists.

Obtaining Buy-in from Stakeholders

A senior physician leader described the process the leadership team utilized to obtain support and buy-in for the new Chinese Module: "*The most important thing is to get the actual group of people who are going to be staffing the Module involved in the planning process- the physicians, the receptionist, the nursing staff. If you have those people on board first, because they understand what the problems are- their patients are trying to get access to the system- they're in the much better position to help explain what resources are needed in order to make this happen. So once we got that first group together, it launched the whole discussion of if we're going to do this, we need educational materials in this language, prescription labels in this language, so all these other things came out of that group once it got together to plan what the Module was going to look like.*

The leadership, during the process of obtaining stakeholder buy-in, did experience some resistance regarding the Chinese Module being a separate module. Their response was to emphasize that the Chinese Module was not a separate entity but an integrated service which was part of primary care, publicly stating that creation of the Module was about having the language capacity rather than special treatment. The leadership team then invited representatives of the organization's culturally responsive care committee to do in-service trainings on cultural diversity issues, cultural beliefs impacting health care, and the language needs of patients who were non-English speaking and limited English proficient. Through these in-service trainings, the initial concerns of preferential treatment/reverse discrimination were either diminished or eliminated as a result of the cultural diversity training.

Additionally, the union was brought in right from the beginning as well, since discussions needed to take place around getting medical support staff (i.e. licensed vocational nurses, medical assistants and receptionists) transferred to/hired into the Module and to ensure that there was no "disadvantaging" of other employees who might want to work in that Module. Usually staff were transferred/moved based on seniority, but the organization was able to get an

exception to the seniority issue since there were specific language needs for support staff who could speak Chinese (Cantonese or Mandarin).

Communicating to Patients and the Community about the Chinese Module

The leadership promoted the new Chinese Module to patients and the broader community as an organizational service that allowed patients to not have to worry about bringing in family members or friends to serve as interpreters, since the new service aimed to meet the language needs of a large patient population which faced language barriers in accessing care. It was marketed from the perspective that there were physicians, nurses, and ancillary support staff (medical assistants and receptionists) who spoke Chinese. The Module was not publicized as a Chinese Module despite being tailored to the Chinese-speaking population, since it was open to all patients, regardless of their racial/ethnic backgrounds.

KEY CHALLENGES EXPERIENCED POST-IMPLEMENTATION

High Turnover of Chinese-Speaking Support Staff

An ongoing major challenge faced by the new Chinese Module was the high turnover rates of bilingual Chinese-speaking ancillary support staff: medical assistants, receptionists, and licensed vocational nurses. One senior administrator explained, "*One of the nice things about the KP system is that medical assistants and licensed vocational nurses are offered opportunities to further their education. LVNs can participate in an RN program and then they become RNs and move on, and MAs can participate in educational opportunities and training to become LVNs, so there's a fairly high turnover rate initially in those groups. What we found when we were looking for qualified bilingual Chinese-speaking LVNs, MAs, and receptionists is that there are people who were fluent in speaking the Chinese dialects, but they were not fluent in English. So there were times that it was a real struggle to keep the appropriate staffing in the Module, due to Kaiser's standards of English language fluency for those positions.*" The Chinese Module physician leader reported, "*It's still currently very difficult to find bilingual MAs. We had two interviews; however, their English is not at par with the Kaiser standards. They were very fluent in Cantonese and Mandarin, however, their English is sub-par, and so that prevented them for being hired …For years now, we are experiencing a shortage of bilingual Chinese-speaking MAs and LVNs.*"

Problems Experienced With Patient Appointment Scheduling

Once the Chinese Module was launched, the question of how Chinese-speaking patients were going to be able to make appointments and leave messages for their physicians posed a major challenge, since there were no telephone service representatives staffing the call center who spoke Chinese languages and there was no phone tree option to hear recorded information in Chinese languages-- only English and Spanish languages were available on the phone tree.

In order to rectify this, administrative and physician leaders obtained approval from the Southern California Regional Executive Medical Director and then worked with the Southern California

Regional Call Center manager on creating the very first Chinese language line for patients to call directly for making appointments or leaving messages for their physicians.

One physician leader explained, "*It took about 5-6 years to get the Chinese Mandarin Language Line developed and implemented. Because this is still a pilot project, data is still being collected, so this language line is only available for Chinese-speaking patients in the San Gabriel Valley geographic service area to use. It hasn't been expanded to the whole southern California region yet.*"

INSTITUTIONALIZATION OF THE CHINESE MODULE

The Chinese Module at the KP SCAL #2 satellite Medical Office Building has been successfully operating for the past decade and has been institutionalized in the Department of Family Medicine. One bilingual Chinese-speaking physician staffing the Module proudly stated, "*We managed to establish a pretty flawless comprehensive primary, secondary, and some to an extent, tertiary care service, tailored to the Chinese patient population.*"

Currently there are 8 Chinese-speaking physicians (4 from KP SCAL #2 Medical Center and 4 from the KP SCAL #3 Medical Center), 1 bilingual Chinese-speaking medical assistant, 1 bilingual Chinese-speaking licensed vocational nurse, and 1 Chinese-speaking registered nurse working in the Module. Collectively, the Chinese dialects spoken by the physicians, nurses, medical assistants, and front desk staff include Cantonese, Mandarin and Taiwanese.

Senior leaders monitor the Module's operations on an ongoing basis as well as the recruitment of bilingual Chinese-speaking physicians, nurses, and medical assistants as needed. One senior physician leader described how important monitoring and feedback is for continued success with operations: "*It's not just you build it and that's the end of it. You have to have the ongoing feedback of what's working, what else do you need, what's not working, what needs to be modified- you need to have some flexibility to change it down the line.*"

A senior physician leader reported, "*We've been tracking outcomes mainly from a business standpoint, and there has been more market share and penetration into certain areas which would utilize the service and increased patient satisfaction as well with the Module. We have received positive patient feedback about the Module.*" Patient satisfaction and market share has increased in the Chinese-speaking patient population as a result of launching the Chinese Module.

Since implementation of the Chinese Module, Chinese-speaking patients have become more satisfied with the care they receive. Physicians reported that their patients were extremely happy because they were able to arrive in the facility and then immediately be able to speak to somebody who spoke their language at every point of the care process, as opposed to in the past not having that ability- the Chinese Module has opened the doors for patients to be able to freely communicate and know that their physician, nurse, medical assistant, and front desk staff understands them and their needs.

CHAPTER 9: THE LATINO HEALTH CENTER, BASED AT THE KAISER PERMANENTE NORTHERN CALIFORNIA (NCAL) #2 MEDICAL CENTER

BACKGROUND

The Kaiser Permanente (KP) Northern California (NCAL) #2 Medical Center provides inpatient services as well as outpatient primary and specialty care to over 100,000 patients. Built in 1984, this large medical center provides healthcare services to a large geographic service area covering the Sacramento Valley. It is a long-standing institution in the Sacramento Valley, having provided 25 plus years of health care services to the community.

According to demographic population reports, Sacramento County is the most culturally diverse county in the state of California, and the Latino population is the most rapidly growing demographic, such that within 10 years, experts have predicted they will be the majority in California. As of the early part of the decade, Census Bureau data showed that there was greater than 20% prevalence of the Latino population in the Sacramento area.

During the early 2000s, the Medical Center had been receiving employee and patient feedback that they were not fulfilling the language and cultural needs of their large Latino patient population, of which many were limited English proficient and non-English speaking. One senior executive shared the message he kept on hearing from the Latino community residing in the geographic service area of the Medical Center. He stated, *"I've been very involved for the last 10 years in the Latino community within Sacramento, and one of the things I heard most often said about Kaiser Permanente by the Latino community was 'We have a large population in the Sacramento area. You are a large provider of services in the area...but you're not meeting our needs.' "*

The Medical Center did have on staff several Spanish-speaking healthcare providers and support staff, but they were spread out all over the organization in different departments and some of these individuals were not of Latino/Hispanic cultural background. Knowing that cultural beliefs and norms influence healthcare decision making and treatment compliance, one Latino Spanish-speaking physician expressed, *"My Latino patients want a healthcare provider who can understand them in their native language and who shares similar cultural beliefs, traditions, superstitions, etc."* Another bilingual Latino physician professed: *"I truly believe that Kaiser's integrated healthcare delivery system is the best for providing healthcare services and resources. When English-speaking patients come in for care, I'm very confident we'll be able to provide a service for them, whether they need a referral to see a specialist like a psychologist, a physical therapist, a dietician, or a clinical health educator. The challenge is to be able to provide these services for our Spanish-speaking patients. We do have a Spanish-speaking psychiatrist, a Spanish-speaking physical therapist, and a Spanish-speaking clinical health educator, but it's a hit or miss whether our Spanish-speaking patients were going to be able to access a Spanish-speaking provider."*

As a response to improving care delivery to the Medical Center's large Spanish-speaking patient population, one Latino bilingual Spanish-speaking physician, Dr. Visionary (*names have been*

changed to protect confidentiality), came up with the innovative idea back in 2002 to implement a culturally competent adult primary care clinic module that would focus on the Latino population. This clinic module, to be named the Latino Health Center (LHC) would be housed within the Department of Medicine and be staffed by a multidisciplinary team of bilingual, bicultural Spanish-speaking Latino healthcare providers and support staff who could provide a continuum of primary, preventive, and specialty health care services accessible to all patients, but would focus on Latino patients who were limited English-proficient and non-English speaking that were experiencing challenges in accessing and navigating the Kaiser healthcare system due to language and cultural barriers. Dr. Visionary developed a project proposal that included a mission statement, demographic data in support of the LHC implementation, identification of staff membership for a steering committee to guide implementation, list of physician champions to assist with gathering support/buy-in for the LHC, and another list of key stakeholders to seek buy-in from as well as collaborate with on to implement the LHC. Also outlined in the project proposal was a list of existing bilingual Spanish-speaking Latino health care providers and support staff who were supportive of re-locating to work in the LHC as well future medical staff which needed to be hired in order to launch the LHC.

Last but not least, the LHC proposal included other benefits to be gained. For instance, the decision to use the term "center" versus calling the new module a "clinic" stemmed from Dr. Visionary promoting the idea that the LHC would function beyond a clinic. His rationale was that a clinic functions to see patients for their health- but the LHC was going to go beyond that as the proposal discussed increasing community linkages and ties through providing community education and outreach activities such as health fairs. Furthermore, he pointed out that the LHC could also tackle racial and ethnic health disparities. He stated, "*When we look at Latino populations and compare them with other ethnicities, there are still gaps in health care outcomes whether it's for diabetes management, complications of diabetes, or the rates of prevention screening for colorectal cancer.*"

This case study describes the organizational innovation process spearheaded by administrative and physician leaders during the late 2000s which enabled the Latino Health Center to move from concept to reality.

READINESS TO CHANGE

Acceptance of Change

One of the driving forces behind moving the LHC from concept to reality was that there was a leadership change at the top level of the medical center in 2005. While the concept of the Latino Health Center seemed to be the obvious solution from both the patient care perspective and the business case perspective to improve care delivery to the medical center's large Spanish-speaking patient population, Dr. Visionary had came up with the idea way back in 2002 and finally attained the green light to move forward in 2005. Dr. Visionary explained, "*The new leadership was very open and creative to new ideas like launching a culturally competent care module such as the Latino Health Center, and they were very enthusiastic when I went to them to discuss the LHC…The new leadership valued diversity, seeing diversity as a great thing, and*

recognized the importance of providing culturally competent care from the patient care perspective and the business case perspective." He continued, *"It's great to see our new leadership have the bigger vision of going beyond providing Spanish interpreter services- that is to focus on what we are trying to accomplish in the big picture by creating the Latino Health Center."*

Capacity of the Organization to Change

There were several factors contributing to the medical center's capacity to create the Latino Health Center which would be open to all patients, but specifically focused on serving Spanish-speaking patients who were experiencing access barriers due to language and culture. First, there was existing facility space that the Latino Health Center could be built and housed in. More importantly, the Latino bilingual Spanish-speaking physicians, nurses, medical assistants, receptionists, and other healthcare providers (clinical health educator, psychologist, and physical therapist) were either already working at the medical center (but were spread out all over the organization) or were already part of the budget to be hired on in the near future. Thus the costs to develop and implement the LHC were going to be "budget-neutral."

Also instrumental to the capacity of the organization to implement the Latino Health Center were three dynamic change agents who paved the way for implementation of the LHC: Dr. Visionary (the Latino bilingual Spanish-speaking physician who created the LHC concept), Dr. Transformational (Executive Physician Leader in charge of the Medical Center), and Mr. Charismatic (Executive Administrative Leader of the Medical Center).

Summarized below are comments by medical center physicians and administrators describing these three individuals:

Comments about Dr. Visionary:

"I believe that the greatest catalyst for implementation of the LHC was the energy and leadership of Dr. Visionary. Without his energy and passion, there's no way that the Latino Health Center would be as successful as it is. This program, like any other program, will succeed if you have a strong physician leader and the right people guiding the program. And I think Dr. Visionary is a model for not only this Latino Health Center, but for also any program that you'd like to start up. He has incredible passion for this which is contagious and he's been able to recruit staff and physicians who are aligned with his vision."

"Dr. Visionary is the lightening rod. He's great, both in the Latino community as well as the Anglo community. Talk about being able to navigate both sides, being able to promote the concept. He's fantastic."

Comments about Dr. Transformational:

"He really supported opening a Latino Health Center, and I think that's what was the key. I think that he helped us get the Center here because he really understands the importance of

culturally competent care. If he hadn't been, it wouldn't have happened. If he didn't support this, I don't know how it would have happened."

Comments about Mr. Charismatic:

"He has been extremely supportive of the LHC and any functions affiliated with the Center. He's always visible, he's always there to support us…"If I need to talk to Mr. Charismatic, I could go talk to him. It's not like I gotta jump through bureaucratic hoops to reach him…That's how he functions, he has an open door policy like that."

AWARENESS OF THE NEED TO CHANGE

The medical center leadership, through patient feedback and employee feedback, had been made increasingly aware of the need to change the way they were delivering care to their large Latino patient population, of which a majority were limited English-proficient and non-English speaking.

From Kaiser patient surveys conducted in the Sacramento County service area (of which KP NCAL #2 Medical Center is one of three KP healthcare organizations serving KP patients residing in this area)- there were close to 70,000 Latino members who, when surveyed directly about whether they would like to have culturally competent health care services, had responded that they would love to have cultural and language access challenges directly met, including the ability to have their primary care services delivered in Spanish.

Key physician and administrative leaders pointed out the following challenges that faced their Latino patients, as they knew that of the estimated 12,000-13,000 Latino adult patients the KP NCAL #2 Medical Center served, a great majority of patients were limited English-proficient or non-English speaking and were experiencing language and cultural barriers in accessing care. When a survey was conducted in which language preference was one of the questions, over 9000 patients identified Spanish as their spoken language preference. Obstacles faced by Latino patients who were limited English-proficient and non-English speaking included:

1) being unable to communicate effectively with health care providers and support staff, which made it difficult to establish relationships of mutual respect.
2) pharmacy prescription instructions were not provided in their preferred language of Spanish.
3) having to rely on family members to serve as interpreters.
4) lack of patient education materials in Spanish.
5) not being able to have physical therapy, behavioral medicine, pharmacy, and clinical health education services provided to them by bilingual Spanish-speaking providers.

The medical center had already been providing professional interpreter services in Spanish (as well as in other languages), but many Latino bilingual medical staff members felt interpreter services were inefficient and inadequate to fully meet Spanish-speaking patients' needs as well as physicians' needs. Dr. Visionary explained: *"The great majority of physicians are seeing*

Spanish-speaking patients they wish they could communicate with, but they can't, so what they have to do is arrange for an interpreter. It's more demanding on your day when you have to do the extra step of getting interpreters, and you're never sure if patients understood you completely or you understood patients completely with an interpreter helping you."

Thus, many Spanish-speaking patients would have family members serve as their interpreters during the patient visit either because of personal preference or because the medical center wasn't able to obtain an interpreter for them at that particular time. Having family members serve as interpreters was not appropriate, and this belief was shared by many physicians and administrators, stated one Latino bilingual Spanish-speaking physician:

> *"Patients would bring in their family members to serve as their interpreters. So for example, the elderly would bring their nephews etc. and that was not a good way to do things in general, because a lot of the family members they brought in many times 1) were just too young and shouldn't be put in those predicaments; and 2) even if they were older, they didn't consistently know their family member well enough to answer all the necessary medical questions."*

Another bilingual Spanish-speaking Latino physician also elaborated on this issue:

> *"Many of us Latino health care providers who work here grew up with experiences where we came to the doctor with our mother, father, brother, sister, grandma, uncle, whoever it may be and at some point we had to translate what the doctor was saying to the people we came with. As children, it puts us in an awkward situation because we don't know all the medical terminology and we don't know how to explain things to the doctors since there might be sensitive issues and this and that, and then in translation, you lose a little bit as well."*

Latino patients also had difficulty accessing the complete range of primary care services, such as physical therapy, health education, behavioral health services, lab, and pharmacy, due to both language barriers and care coordination challenges. There were bilingual Spanish-speaking clinicians and staff working in those aforementioned service areas, but as Dr. Visionary explained, *"It was hit or miss whether that they were going to get that service in Spanish."*

IDENTIFICATION AND SELECTION OF CHANGES

As the LHC concept continued to evolve, as it now had the buy-in and endorsement of the medical center leadership to move forward with implementation, the LHC implementation team (headed by Dr. Visionary and comprised of key staff such as a bilingual Latino physician champion for the LHC and a frontline manager in the Department of Medicine) conducted a site visit at Kaiser Permanente's first Hispanic primary care clinic module, La Clinica de Salud, established at the KP San Francisco Medical Center back in 1997.

From this site visit, the LHC implementation team learned about the history of the culturally competent care module's development, details of the services it was able to provide patients, and

how patients and the community responded to the module. Additionally, the site visit enabled the LHC team to learn best practices for the delivery of culturally and linguistically competent care. Hence, the specific culturally competent healthcare delivery strategies to be implemented at the LHC consisted of the following:

- Grouping existing and to-be-hired bilingual/bicultural Latino Spanish-speaking physicians, nurses, clinicians, and support staff in one adult primary care clinic module within the Department of Medicine (versus having them spread out all over the medical center).
- Hiring additional bilingual Spanish-speaking physicians, nurses, and support staff (i.e. medical assistants and front desk staff) to staff the Latino Health Center, thereby providing Spanish language capacity at every step of the patient visit starting from the front desk to the exam room.
- Providing Spanish-language patient education materials (health education pamphlets, physician instructions, prescription directions, etc.).
- Establishing referral and patient tracking processes with bilingual Spanish-speaking clinicians in other departments to ensure coordination and continuity of care for Latino patients who needed clinical health education, physical therapy, behavioral health services, laboratory services, and pharmacy services in their primary language of Spanish.
- Establishing stronger community linkages and increasing community health education and outreach activities.
- Designing/decorating the LHC such that the culture of Latino patients would be reflected in the color themes, décor, and artwork.

IMPLEMENTATION OF THE LATINO HEALTH CENTER

The implementation process for the Latino Health Center was a transparent, inclusive, and formal one involving many stakeholders from different departments all over the medical center. There was a steering committee that met every two weeks with representatives from different departments within the medical center such as nursing, housekeeping, information technology, facilities, engineering, public affairs, and administration.

Securing the Support and Buy-in from the Medical Center's Physician Workforce

Once the medical center's leadership team gave their approval to implement the Latino Health Center, it was absolutely essential to obtain the support of the medical center's physician workforce, in terms of gaining their buy-in of the LHC as well as seeking patient referrals from them since there had been concerns raised by some in the organization about whether or not this new module could "pull its own weight" (i.e. see enough patients to support the cost of the LHC's daily operations).

When the idea of launching the LHC was presented to the physician workforce, Dr. Visionary recalled "*The great majority of the physicians loved it, because they also saw the benefits themselves. They were seeing Latino patients who they wish they could communicate with in*

Spanish, but they couldn't so what they had to do was arrange for an interpreter."   He continued, "*The majority of physicians were rather happy for those patients to be referred to the LHC not in the sense that they didn't like them, but in the sense that they did have a little bit of a problem, mostly with communication. And I'm sure, mixed in with that, were some cultural issues as well.*"

Once the buy-in was achieved, communication about the LHC went out to both physicians and patients. The communication to physicians consisted of the following: primary care physicians were sent a list of all their Latino patients, and were asked whether or not they wanted these patients to be seen at the Latino Health Center. If they didn't want certain patients or any of their patients seen by bilingual Spanish-speaking Latino physicians at the LHC, that was fine.

Letters were sent out to Latino patients informing them of the new Latino Health Center in addition to asking them if they were interested in being seen by bilingual Spanish-speaking Latino physicians working in the LHC. Patients were given the option to stay with their current physician- they were not mandated to switch doctors.

Working with the Labor Unions

Another important stakeholder to obtain buy-in from was the labor unions. Medical center administrators met with the unions representing the nurses and support staff (medical assistants and receptionists) regarding posting for Spanish language-specific positions. Since the labor unions were engaged and consulted early on during the LHC planning process, they were supportive of the new Latino Health Center and its staffing need of language-specific nurses and support staff. One frontline manager recalled, "*We met with them from the beginning to let them know that we wanted to implement the LHC, and described to them what it would look like and what we wanted to do. We explained that in order to meet the needs of our large Spanish-speaking patient population, we had to have providers and support staff there who could speak the language. Otherwise, it would be a disservice. So they understood that and they immediately agreed to let us post for those positions.*"

Coordinating Referral and Patient Tracking Processes With Key Departments

As mentioned by Dr. Visionary previously, "*Prior to implementing the Latino Health Center, when English-speaking patients came in for care, I'm very confident we'll be able to provide a service for them, whether they need a referral to see a specialist like a psychologist or a physical therapist or a dietician or a clinical health educator. The challenge was to be able to provide this for our Spanish-speaking patients.*"

Fortunately, the medical center already had Spanish-speaking health care providers in those aforementioned departments; thus it was more a matter of creating formal linkages with those departments and developing referral processes to ensure that Spanish-speaking patients could be matched with those bilingual health care providers. To accomplish this, the LHC implementation team spoke with those providers directly and the Chiefs of their Departments to obtain their buy-in and to develop linkages and referral processes.

Partnering with Public Affairs, Marketing, and Communications to Get the Word Out

Partnering with Public Affairs, Marketing, and Communications staff was essential as they helped with the development of collateral materials to promote and market the LHC, in addition to working with the implementation team very closely to secure media coverage of the LHC's opening dedication ceremony. There were advertisements printed in different Latino periodicals, announcements on Latino radio stations, and information sent to different community-based organizations primarily serving Latinos which described the new Latino Health Center and the services it would be providing.

Working with Facilities, Housekeeping, IT, & Engineering Departments to Build the LHC

Although there was existing space in the medical center to house the new Latino Health Center, the designated space needed a lot of repair and construction work done due to the following conditions: the space was dirty, cabinets had broken hinges, tiles on the ceiling were cracked, there were stacks of paper all over the place, equipment that was outdated or unused was sitting around taking up space, walls needed to be knocked down to create space for a medical assistants' workstation, new furniture was needed, the carpet needed to be replaced, the module walls needed new paint, and rooms needed to be re-configured to allow for a conference room, a family consult room, and computer workstations.

Several meetings occurred between the implementation team and staff representatives from Facilities, Housekeeping, Information Technology, and Engineering to negotiate terms to address and rectify the physical space issues outlined above.

KEY CHALLENGES ADDRESSED

There were several key challenges that arose during the implementation process which are described in further detail below.

Medical Staff Concerns about Reverse Discrimination/Preferential Treatment

A frontline manager relayed concerns some of the medical staff had around the launch of the LHC since they felt it was reverse discrimination and preferential treatment: *"There were lot of comments by medical staff such as 'You know, we understand what you're trying to do, but you're setting up something just for Latino or Hispanic patients...We don't have a module like this set up for Asians or African Americans."* There were comments made by medical staff such as *"Well, so what's the big deal? We have Spanish-speaking providers and they are spread throughout the medical center. So if we have a Spanish-speaking patient, no big deal. We can get them seen by someone who speaks Spanish."*

Mr. Charismatic had responded with honesty and practicality when confronted with such concerns. He stated, *"We need to start somewhere. We're implementing the LHC to meet a need and we have to start somewhere, and if you look at languages spoken by patients, the only language other than English spoken by our patient population that is greater than 5% here is*

Spanish."

To address these comments and concerns around reverse discrimination/preferential treatment, the medical center leadership viewed these staff concerns as an opportunity for education. "*The leadership kept reiterating to the medical staff that the point of implementing the new module was not to reverse discriminate*", the frontline manager explained. She continued, "*There's an obvious need for this because our doctors on the other primary care modules are seeing these patients, and they're seeing them with interpreters and that's not the best way to get somebody's health care needs met- having an interpreter there or a family member there to interpret sometimes if we couldn't get the patient one of our staff interpreters. Because of the growing Latino population in Sacramento Valley, we said to everyone that this is something that we needed to do."*

The LHC implementation team also educated the medical staff that there were other culturally competent care modules which had been launched within Kaiser Permanente for the similar goal of eliminating access barriers due to language for a significant segment of the patient population. For instance, the San Francisco Kaiser Permanente Medical Center had implemented a Chinese Module and a Spanish Module because of the large patient populations they served there who were facing language and cultural barriers in accessing care.

The frontline manager described the results of educating medical staff: "*Educating people, especially those who expressed dissension regarding why we were creating a Latino Health Center module, was key to helping people understand the rationale behind the module. Once we did this, most of those people understood- they may not have agreed, you know you don't have to agree with something but you can understand why we're doing this for our patients."*

Challenges Regarding Building & Designing the Latino Health Center

It turned out that building and designing the LHC to reflect the community they were serving by having Latino themes, colors, and artwork was another big hurdle to overcome because of the institutionalized architectural and interior design of clinic modules that was the standard in every Kaiser Permanente medical center.

The Latino artwork decorating the walls of the LHC were pieces lended by or donated by various local artists from the San Francisco and Sacramento areas. Collecting all these pieces in itself had proved to be a challenging task, albeit a positive one. Dr. Visionary developed relationships with local Latino artists and shared with them his vision for the Latino Health Center. He recalled, "*Before I started talking to them, I didn't know a single artist in the community. It wasn't like I had a gaggle of friends hanging out with me, and I could say Hey Hector, I need a picture. I knew nobody in that community, in the Latin artists' world."*

He continued, "*It turns out artists are cool people, you meet one of them, two of them, they introduce you to all their friends. Within a month, I had a list of names. And then I'm calling them. Artists are much easier to convince about vision. That's what they do. So we met with some of them in some coffee shops and I had to buy them lunch because some of them are on a budget but that's okay. So it turns out artists are very in tune to these global humanity, altruistic*

missions anyway, and they were really in tune with the idea that a big organization like Kaiser would [embark on launching something like the LHC]."

It turned out that some of the artists' paintings had religious icons and scenes in them which prompted some medical staff to question the appropriateness of displaying them. Dr. Visionary explained how he addressed this: *"Guess what happens in Latino artwork? It may be cultural. So the artists don't paint ice cream or stuff like that, they're going to paint crosses, burials, and things like that…So the artwork has cultural icons which are religious. But if you can get people to see the vision… we put it out there that you can't do a cultural service like the LHC without being cultural. So we're not here to preach to anybody or be religious, but at the same time we need to do reflect and acknowledge the Latino culture. It took a couple of emails here and there with the medical center leadership, a couple of discussions, and then everything turned out fine."*

INSTITUTIONALIZATION OF THE LATINO HEALTH CENTER

The Latino Health Center (also known as *Centro Latino*) has been operating since fall of 2006 and has been successfully integrated into the daily operations of the medical center, complete with its own budget. Contributing to its successful institutionalization is the ongoing support from senior leadership and the two-way communication flow between the LHC staff and medical center's senior leaders. The frontline manager who was part of the LHC implementation team stated, *"To sustain the LHC, you have to have support – administrative support meaning senior leadership here. We've had that and we just need to continue to have it. Most of the communication occurs with senior leadership through email, giving them updates as to what's going on at the LHC, in addition to Dr. Visionary (who is the Medical Director of the LHC) communicating with Dr. Transformational (the senior physician leader in charge of the overall medical center) on a consistent basis about what's going on with the LHC. Furthermore, having Mr. Charismatic (who is the senior administrator for the medical center) always involved and visible at LHC events in the community is a big deal."*

The LHC is staffed from the front desk to the exam room with bilingual, bicultural Spanish-speaking Latino physicians, medical assistants, a charge nurse, and a front desk receptionist. The Latino Health Center takes care of approximately 5000 patients who had close to 9000 visits during the first year of operation. During the first year of operations, the LHC had on staff three full-time Latino, bilingual Spanish-speaking physicians. Due to the large volume of patients seen at the LHC during their first year of operations, a fourth physician was hired the following year.

The following sections below describe the impact of the Latino Health Center.

Increased Community Linkages & Community Involvement

The Latino Health Center has established strong ties with the community. LHC clinicians and staff provide community health education via health fairs (of which the first-ever health fair sponsored by the medical center took place in 2008) and LHC physicians have been frequently approached by local ethnic media (e.g. Spanish television stations such as Univision and Azteca)

and mainstream media (e.g. Channel NBC) to serve as consultants for health segments and public health education.

Mr. Charismatic relayed how the Latino community has contributed to the success of the LHC's launch and ongoing operations. He stated, *"The word of mouth is happening. The calls I get now are all about people asking me to help get them on various physicians' panels within the LHC."*

Physician Workforce Satisfaction and Promotion

Mr. Charismatic expressed his observations of how previous dissenters got onboard once the LHC was successfully launched: **"*Once the LHC became successful, people really got behind it. And some of those individuals who had initially not been fully supportive of it, now they tout it and are proud of it.*"**

Soon after its launch, the LHC received increasingly large numbers of referrals from physicians throughout the medical center, as the overall physician workforce found it to be a module their Spanish-speaking patients could benefit from. One LHC physician explains the rationale behind this: *"Implementing the Latino Health Center turned out to be a great relief to many doctors, as it is more demanding on your day when you have to do that extra step of getting interpreters, and you're never sure if the patient understood you completely or you understood them completely even with an interpreter there helping you. Since the LHC opened, we would get frequent messages from other physicians in the medical center, saying 'Hey we forgot to give you this patient, you know there's Mr. So and So who I just saw- I forgot about him, and he would be a great patient to be seen by your Center so forth and so on.' "*

Patient Satisfaction & Promotion

Patients are very satisfied to receive care at the LHC, as quarterly patient satisfaction scores reflect this. With regard to patient satisfaction around care received by the Latino bilingual Spanish-speaking physicians staffing the LHC, Spanish-speaking patients have highly ranked these doctors with scores in the 80s (out of 100). One senior administrator stated, *"The LHC is one of our highest ranking clinic modules out of the entire medical center when it comes to patient satisfaction."*

Patients are seeing the benefits, and there's been tremendous positive feedback from all areas of service provided by the LHC. Dr. Visionary, the LHC Medical Director, proudly stated, *"Now we have a place where our Latino patient population can come and access a full range of service, whether it be primary care, physical therapy, behavioral medicine, or clinical health education- we're able to have our diabetic groups, our cholesterol groups, our high blood pressure groups, all conducted in Spanish and culturally tailored to our Latino patient population."* Additionally, Dr. Transformational remarked, *"It's widely known that you have much better patient compliance with therapy, compliance with medication, if you have health care delivered in a culturally competent manner."*

Interestingly, it's not just Spanish-speaking patients belonging to the medical center who

regularly seek care at the LHC. Dr. Visionary reported, *"Once people hear about us, they're willing to come from cities outside of our geographic service area to receive care here, as far as Roseville and Galt...they're more than happy to come and many do. It's far, but you know to them, it's worth it."*

Another LHC bilingual Latino Spanish-speaking physician explained why the LHC module is such a success: *"Anecdotally, I can say that patients are very happy in general. All of us who work here, we've all had experiences with our loved ones going to the physician and having to be the interpreter, which is similar to the experiences of our patients. So when they come here, I think in general the feeling is that <u>finally</u> there's going to be someone who can understand me in my own language and has my own culture, beliefs, traditions and superstitions whatever the case may be, and I think they feel that we can understand them a little bit better than maybe another physician who is not from their culture."*

In addition to patient satisfaction scores and anecdotal patient reports, there have been other metrics for success that the LHC has achieved. All clinic modules in the medical center are evaluated by different types of surveys and scores. On several of these parameters used to assess performance, the LHC has scored higher than a lot of the other clinic modules at the medical center.

Furthermore, with regard to the measurement of patient clinical outcomes by physician, one LHC physician's numbers for diabetic control for his patients have ranked one of the highest in the facility, and two other LHC physicians' numbers for that same parameter have been on the upper half of the scale as well.

For the LHC medical staff, it has been very personally rewarding to see just within the first month of operations a very positive culture change. Prior to the LHC opening, patients were used to bringing their family members to interpret for them. Dr. Visionary, the LHC Medical Director, explained, *"The elderly would bring their family members in to serve as interpreters, and that was not a good way to do things in general, because a lot of the family members they brought many times a) were just too young and you shouldn't put young people in those predicaments; and 2) even if they were older, they didn't consistently know their family member well enough to answer all the necessary medical questions. So now that we're able to remove that language barrier, from day one, it was very compelling to see that trend where people who used to bring their family members now come by themselves and have a big smile and walk up directly to the registration area receptionist and start speaking in Spanish."* He continued, *"Now patients feel like they're going to go see a family member- really that's what they say- they call the LHC home. This is like home they say, because they feel like the waiting area is like a living room area, the TV is in Spanish, and everyone's talking in Spanish, so they say this is great."*

CHAPTER 10: MULTI-CASE ANALYSIS & CONCLUSIONS

For the multi-case summary and analysis, I present similarities and differences across the five stages of the organizational innovation process experienced by the select Kaiser Permanente Medical Centers (which provide inpatient and ambulatory care) and Medical Office Buildings (which provide ambulatory care) in launching the following culturally competent care modules:

- the Hispanic Module based at the KP NCAL #1 Medical Center
- the Latino Health Center based at the KP NCAL #2 Medical Center
- the Hispanic Module based at the KP SCAL #1 Medical Office Building
- the Vietnamese Module based at the KP SCAL #1 Medical Office Building
- the Vietnamese Module based at the KP NCAL #1 Medical Center's Satellite Clinic #1
- the Chinese Module which is operated via a joint venture between the KP SCAL #2 and KP SCAL #3 Medical Centers but based at KP SCAL #2 Medical Center's Satellite Medical Office Building

For each of the five stages (Figure 3), I will begin by describing the findings shared across all six study sites, then present the findings shared by a majority/some of the sites, and lastly any findings unique to a site.
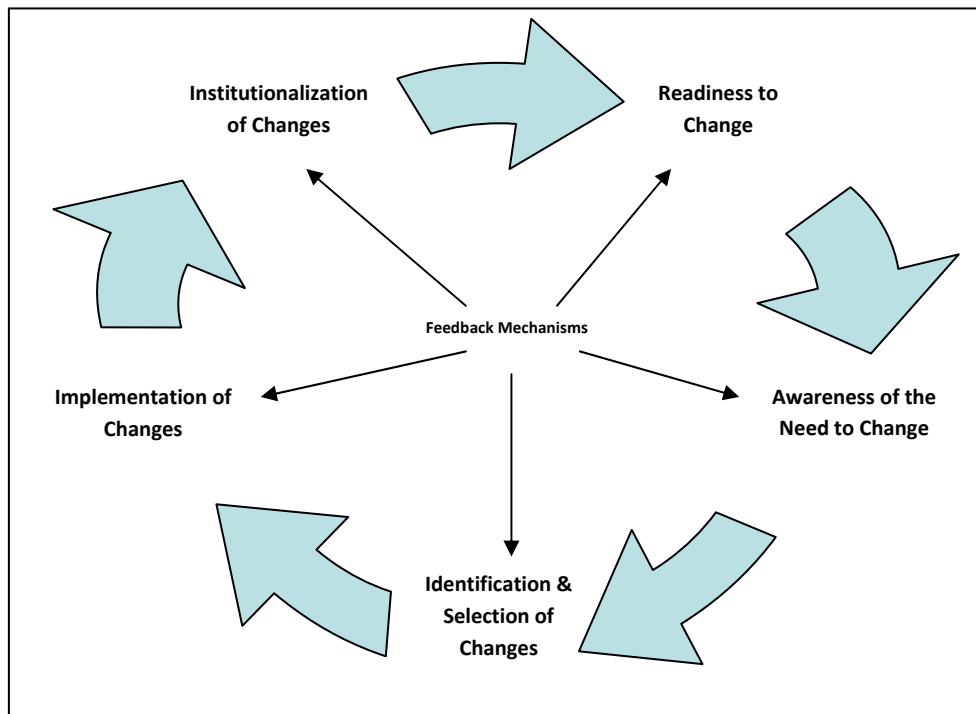

Figure 3: Five-Stage Model of the Process for Organizational Innovation (Rundall et al., 1998)

READINESS TO CHANGE

To reiterate, the "readiness to change" stage encompasses two dimensions of which the first is defined as how accepting of change the organization is (e.g. organizational members' receptivity to change or belief in change) and the second is defined as the organization's capacity to innovate (opportunistic leadership, availability of human and/or financial resources to support change, etc.).

Acceptance of Change

With regard to organizational members' receptivity to and acceptability of change, all six culturally competent care (CCC) modules were housed in organizations where top leadership recognized the value and importance of providing culturally and linguistically competent health care services. The following representative quotes echo similar beliefs and values expressed by administrative and physician leaders across all six study sites regarding the top organizational members' belief and receptivity to change:

- *"Our service population has a lot of Spanish-speaking patients so the idea was that we wanted to have a [clinic module where] they feel more comfortable to go to, in terms of knowing that their provider speaks their language, their medical assistant speaks their language, and where we have health education handouts for them in Spanish."*

- *"It was a natural progression of what was already going on- it was an evolution. It basically had to go in that direction, there was no other way that we could think of to take it where it needed to go."*

- *"There were a number of reasons that [the Module] just came into being…all of it was basically practical. If you have a Spanish-speaking [or Asian language-speaking] physician, Spanish-speaking [or Asian language-speaking] nurse and a Spanish-speaking [or Asian language-speaking] medical assistant, it's much easier to address the questions that might come in from the patient …it's easier to book the patient and get them into the room. You didn't have to pull in an interpreter. It's a much faster process."*

- *It just made sense to us that in order to be able to communicate with these patients better, we should have [our medical staff speaking their language] and having educational materials in that language in one location.*

- *[The decision to provide culturally competent care via creating an language and culture-specific Module] passed the common sense test.*

Capacity to Change

Another factor aiding organizational capacity to change present in all study sites was the availability of human and financial resources that could be directed towards the development and implementation of the CCC modules. All six CCC modules were housed in organizations which

had existing space for them to operate out of and existing bilingual/bicultural medical staff (physicians, nurses, medical assistants, and/or receptionists) who could be transferred into the new CCC module. For organizations which had to hire additional bilingual/bicultural physicians, nurses, medical assistants and receptionists, there were budgetary resources available for hiring new bilingual/bicultural staff to work in the CCC modules. Therefore, the six CCC modules were able to be easily implemented within existing budget allocations in each respective medical facility. Depicted below are representative quotes by administrative and physician leaders' regarding how budget-favorable/budget-neutral it was to launch the CCC module(s):

- *"These patients are already getting care here…you've got doctors that are here…you've got support staff supporting the doctors that are here. You just bring them all together…you're really not adding much in the way of resources. You're already providing the care."*

- *"I would have the same budget anyways for the physicians and the MAs and it's just sort of more of a re-organizing issue."*

- *"More or less we already have the pieces- in other words the physician that speaks Vietnamese, the RN…and we organized them and put them into a group that provided the service."*

- *"Before [the CCC module], you would have certain physicians or certain staff in different departments of the medical center who already have these language capabilities, but it was left up to the individual patient to try to find these providers and get the care from these providers. So, what is different about [having the CCC module] is the sole purpose of delivering care to a certain group of patients with certain cultural and linguistic needs by bringing a health care team who all have similar linguistic capabilities and cultural capabilities to serve this patient population."*

Furthermore, having a dedicated group of physician leaders/change agents who spearheaded the CCC modules' conceptualization and implementation processes contributed to each organization's capacity to change. All six study sites possessed a core of physician leaders who were committed to developing, implementing, and institutionalizing the CCC modules. A physician leader had stated, "*I think what happened is that you have a few physicians who realize the importance of having a service like that for a group of patients…If there's physician leadership, then many other things fall in line.*"

AWARENESS OF THE NEED TO CHANGE

To recap, the "awareness of the need to change" stage is conceptualized as the growing realization among organizational members that the organization's performance in some area is inadequate and there is pressure for change building internally or external to the organization. Analysis of the interviews conducted with administrative leaders and physician leaders indicated that all CCC modules were housed in medical facilities where the top leadership realized that the way they were delivering care to significantly large portions of their Asian and Hispanic patient

populations who were non-English speaking and limited English-proficient was not meeting these patients' health care needs due to language and cultural barriers. Quotes representative of organizational leaders' awareness of the vital need to eliminate language and cultural barriers to health care for Hispanic and Asian patient populations across all six study sites are depicted below:

- *"What we want in terms of providing care to an ethnic group of patients in general who don't speak English is to make sure that language is not a barrier at any level of the care... such that language barriers do not affect the patient's care and outcomes."*

- *"Many of us Latino health care providers who work here grew up with experiences where we came to the doctor with our mother, father, brother, sister, grandma, uncle, whoever it may be and at some point we had to translate what the doctor was saying to the people we came with. As children, it puts us in an awkward situation because we don't know all the medical terminology and we don't know how to explain to the doctors and there might be sensitive issues and this and that, and then in translation, you lose a little bit as well."*

- *"The great majority of physicians are seeing Spanish-speaking patients they wish they could communicate with, but they can't so what they have to do is arrange for an interpreter. It's more demanding on your day when you have to do the extra step of getting interpreters, and you're never sure if patients understood you completely or you understood patients completely even with an interpreter helping you."*

- *"In the Vietnamese population, the physician is a revered individual and so there's a social etiquette that you have to go through and there's certain words you can't discuss or talk about. As a health care provider, you have to become a detective then because you have to know the right questions to ask and understand what patients are trying to tell you because a lot of times, all of the sexual-related issues they can't tell you about. You can't ever use the word cancer in a Vietnamese family-you can say tumor, you can say growth, but you just can't ever use the C-word because culturally that's their death certificate. You can say we're going to treat your tumor, we're going to treat this growth but you can't ever say cancer."*

- *"There are certain things that are very cultural about illness that I may not understand, where a physician from that culture would understand it. For instance, I've been told by my Hispanic bilingual Spanish-speaking doctor colleagues, the concept of diabetes or some of these other chronic illnesses - there are some beliefs in some of the Latino cultures that some of this comes about because of a stressful encounter--a motor vehicle accident, death of a loved one, that kind of thing. So, the view on illness, on how you get an illness is a little bit different ...and the doctor has to go in and understand where's the patient is coming from and then work with them to bring them around to the scientific reasons for why they may have diabetes, that it wasn't a car accident that started it or a death of a loved one, etc."*

- *"When we order special procedures or make appropriate referrals for non-English speaking/ limited English proficient Vietnamese patients, a lot of time is required and additional work as well from our standpoint and our support staff assisting these patients to follow through... for a patient who doesn't speak English well or at all, that could be a problem, so we have to handle it in a way where they don't fall through the crack because they can't call due to language being a barrier."*

For two organizations, KP SCAL #1 Medical Office Building and KP NCAL #1 Medical Center, while eliminating language and cultural barriers to care was the top priority, improving workflow efficiency was identified as a secondary reason for change:

- *"When the bilingual Vietnamese physician comes in and has a Vietnamese-speaking patient, they have to be the physician, the educator, the social worker, all of those things rather than just saying this is your diagnosis and take your medication- they have to do all these other jobs because there isn't really anybody there to help them."*

- *"If I am a Spanish-speaking doctor and I don't have enough Spanish-speaking staff to address these questions, those questions will make it into my exam room and I may spend 25% of my visit with the patient dealing with those questions- if I add 2 or 3 minutes per Spanish-speaking patient to address such concerns and I see 20 patients like that in a day, that's an extra hour added to my day. Getting the right support in place makes sense from a business aspect, from a time aspect, a patient safety aspect, and patient compliance."*

- *"Quite frankly when physicians use the AT & T language line, it doubles the time, which increases the time it takes to get a patient history or figure out what the problem is and what we need to do about it. If you don't have a high percent of patients needing that interpretation service, you can do that. But when you have over 25%-30% of your patients needing it, you need to have a medical assistant who has that specific language capability helping the physician."*

- *"Even though the AT & T language line is available, think of how you're interacting with the AT & T service. The provider speaks to the interpreter in English, the interpreter speaks in Spanish to the patient, the patient responds to the interpreter in Spanish, and then interpreter switches back to English to tell the provider what the patient has said. So whatever the provider says takes twice as long [to reach the patient]. And in a busy practice, I think it's understandable that a lot of providers don't like to utilize the AT & T service unless they have to.*"

For one CCC module, the Latino Health Center based at the KP NCAL #2 Medical Center, establishing stronger community linkages via increasing community health education and outreach activities was another goal they accomplished. As one Latino bilingual Spanish-speaking physician leader explained, "*So part of the business case for the Latino Health Center which interested our leadership was getting more involved in the community, for example. So having a Center like this is a great link to the community because we'll go out there to the*

community and promote health fairs. As a matter of fact, this medical center has been around for over 25 years, and it has never had a health fair."

IDENTIFICATION & SELECTION OF CHANGES FOR IMPLEMENTATION

As stated previously, the "identification and selection of changes" stage involves identifying alternatives to address the performance gaps and the selection of one or more of those alternatives for implementation.   For all six CCC modules, the following care delivery strategies were identified by top leadership and selected for implementation in order to operationalize the CCC modules:

- Hiring additional bicultural/bilingual physicians, nurses, and/or medical assistants to ensure that language needs of Asian and/or Hispanic non-English speaking and limited English-proficient patients would be met.

- Developing formal linkages and referral processes with other departments that had health care providers who spoke the appropriate language(s) to ensure continuity of care for Asian and/or Hispanic non-English speaking and limited English-proficient patients.

For five CCC modules, the care delivery strategy of grouping bicultural/bilingual physicians, nurses, medical assistants and front desk support staff in one clinic module (versus having them spread out all over the medical facility) was selected for implementation. Only one CC Module, the Vietnamese Module based at the KP NCAL #1 Medical Center's Satellite Clinic, had their bilingual Vietnamese-speaking physicians scattered throughout the department of medicine rather than grouping them all together in one area.

Additionally, this particular Vietnamese Module was the only CCC module which chose not to align language-specific medical assistants with the appropriate language-specific physicians on a regular basis (i.e. not pairing up bilingual Vietnamese-speaking medical assistants with bilingual Vietnamese-speaking physicians on a regular basis). As the administrative leader put it, "*At first we thought we should put our Vietnamese speaking MAs with our Vietnamese-speaking physicians, but now it turns out that the Vietnamese-speaking MAs really need to support those non-Vietnamese speaking physicians more so than the Vietnamese speaking physicians."* However, the other five CCC Modules did identify and select the care delivery strategy of aligning the pairing of physicians and medical assistants to be language-based versus continuing the prior strategy of rotating medical assistants around to different departments.

IMPLEMENTATION PROCESS

The "implementation of changes" stage involves the actions taken to put in place the selected change(s) within the organization. The following types of implementation processes were found to have been conducted:

Formal & Complex Implementation Process: Two CCC modules – the Latino Health Center and the Chinese Module—underwent a more formal and complex implementation processes whereby top leadership convened planning and implementation committees to guide the change process, sought buy-in from many departments and multiple stakeholders across the organization, and coordinated formal referral processes and patient tracking processes.

Semi-formal & Moderately Complex Implementation Process: Three CCC modules- the Vietnamese Module based at the KP NCAL #1 Medical Center's Satellite Clinic #1, the Hispanic Module based at the KP SCAL #1 Medical Office Building and the Vietnamese Module based at the KP SCAL #1 Medical Office Building- underwent a semi-formal and moderately complex implementation process. Once top leadership made the decision to launch the new Module, these three Modules were launched with minimal stakeholder involvement beyond seeking buy-in from the labor unions and the bilingual physicians and other staff which would work in the new module.

Most Simple Implementation Process: The Hispanic Module based at the KP NCAL #1 Medical Center underwent the most simple implementation process. There wasn't really any stakeholder buy-in that occurred. The Physician-in-Chief for the medical center was one of the two senior leaders who developed the idea for the Hispanic Module, and she explained. "*I'm at the top. One of the nice things about my job is that I can say That's a good idea, we're gonna do it.*"

Unique Innovations Developed During the Implementation Process for the Asian CCC Modules

Once the three Hispanic Modules were launched, there were no other processes or innovations that had to be developed and implemented to support the increased volume of Hispanic Spanish-speaking patients who began utilizing the new modules. However, the Asian CCC modules- the Chinese Module and two Vietnamese Modules- had to innovate with regard to supporting the increased volume of patient appointment scheduling and patients wanting to leave messages for their physicians, since the KP centralized call centers (which usually handled patient appointment scheduling and forwarding patient messages to physicians) did not have telephone service representatives who spoke the Chinese and Vietnamese languages. These three Asian CCC modules had to add Chinese language and Vietnamese language capacity via addition of an automated line on the phone tree or an innovative voicemail-pager system. Due to budgetary resource shifts and the reality that there came to be redundancy of efforts, the Vietnamese Language Line for the Vietnamese Module based at the KP NCAL #1 Medical Center's Satellite Clinic #1 had to be terminated after almost one year in operation. One Vietnamese physician explained, "*Sometimes there's redundant work that goes back and forth- the MA and the patients asking us for the same thing, and us getting back to them, so a lot of physicians felt it wasn't worth that effort.*"

INSTITUTIONALIZATION OF THE CCC MODULES

All six CCC modules have been successfully institutionalized into the medical facilities they are based at as part of the Department of Medicine, largely in part because of their leveraging existing human and financial resources and incurring few new costs (e.g. hiring additional physicians which actually were already factored into existing budgets). Many of the bilingual physicians, nurses, and support staff were already employed at various medical facilities and could be re-located to work in the CCC Module. The presence of physician and administrative leaders who not only championed the implementation process but continued to oversee operations of the CCC modules were present across all study sites, contributing to successful institutionalization of the CCC modules. Depicted below are representative quotes from physician leaders and administrative leaders across the six CCC modules pertaining to elements required for successful institutionalization:

> *"It's not just you build it and that's the end of it. You have to have the ongoing feedback of what's working, what else do you need, what's not working, what needs to be modified- you need to have some flexibility to change it down the line."*

> *"It's one of those things where you have to be a guardian and watch over the staffing and have a little due diligence to make sure that what you set up and how you set it up keeps running that way."*

> *"In this case, there's a need, and then I think what happened is that you have a few physicians at least, who realize the importance of having a service like that for a group of patients and are committed to sustaining it. I think if there's physician leadership, then many other things fall in line."*

> *"To sustain the LHC, you have to have support – administrative support meaning senior leadership here. We've had that and we just need to continue to have it. Most of the communication occurs with senior leadership through email, giving them updates as to what's going on at the LHC, in addition to Dr. Visionary (who is the Medical Director of the LHC) communicating with Dr. Transformational (the senior physician leader in charge of the overall Medical Center) on a consistent basis about what's going on with the LHC. Furthermore, having Mr. Charismatic (who is the senior administrator for the Medical Center) always involved and visible at LHC events in the community is a big deal."*

CONCLUSIONS

This dissertation study has explored the organizational innovation process undertaken by several KP medical centers/medical office buildings to launch a total of six CCC modules. The findings from this study illustrate that organizations do indeed follow a staged model for the process of organizational innovation. In all cases that were studied, the organizations followed a fairly linear stage-by-stage process without "regressing" to a previous stage.

This descriptive multi-site embedded case study addresses the following research questions:

1. What culturally competent care delivery strategies were implemented by select KP medical centers/medical office buildings to improve healthcare delivery to limited English-proficient/non-English speaking Latino and Asian patient populations?
2. Why did the study sites decide to implement Culturally Competent Care (CCC) Modules?
3. To what extent were the KP medical centers/medical office buildings ready to implement CCC modules?
4. How did the medical centers/medical office buildings decide on the specific strategies for implementation in the CCC modules?
5. How were the CCC modules implemented?
6. What were key challenges experienced during the CCC modules implementation process at each study site? By most/some sites? By all sites?
7. What were key facilitators contributing to successful CCC module implementation at each study site? By most/some sites? By all sites?

Chapters 4-10 provide detailed answers to Questions 1-6 based on the within and and cross-case summaries and analyses, guided by the conceptual model Rundall et al. (1998) developed to describe a staged model for organizational innovation. With regard to answering Question 7, the findings from this study suggest the following facilitating factors contributed to successful implementation of the CCC Modules (please see table below). Of note, the only CCC Module which experienced severe challenges with the labor union was the Hispanic Module based at the KP NCAL #1 Medical Center. Many of these facilitators are consistent with the literature review findings discussed in Chapter 2.

	Latino Hlth Ctr- KP NCAL #2	Hispanic Module- KP SCAL #1	Hispanic Module- KP NCAL #1	Chinese Module- KP SCAL #2	Viet Module- KP SCAL #1	Viet Module- KP NCAL #1 Satellite Clinic #1
Leadership						
The organization's senior leadership values and supports culturally and linguistically competent health care delivery	X	X	X	X	X	X
There were physician leaders and senior administrators to lead the CCC Module development and implementation	X	X	X	X	X	X
Stakeholders						
Supportive labor unions (rep. medical assistants, receptionists)	X	X		X	X	X
Administration supported aligning bilingual medical assistants consistently with bilingual physicians	X	X		X	X	X
Strong physician leadership and support for implementation and institutionalization	X	X	X	X	X	X
Other primary care and specialty care departments supportive about and collaborating with CCC Module to improve coordination and continuity of care for target patient population	X	X	X	X	X	X
Partnering with other departments who assisted with marketing/promoting the CCC Module	X	X	X	X	X	X
Organizational Resources						
Existing space to house CCC Module	X	X	X	X	X	X
Cost to launch CCC Module was budget-neutral or budget-favorable	X	X	X	X	X	X
Some medical staff (physicians, nurses, medical assistants, etc.) could be re-located to staff CCC Module	X	X	X	X	X	X
Other Factors						
Other CCC Modules had been launched by the medical center/medical office building	n/a	n/a	n/a	X	X	X
CCC Module concept and the specific healthcare delivery strategies to be implemented in the module were incremental changes versus radical ones	X	X	X	X	X	X

Table 3: Facilitators for Successful CCC Module Implementation

Study Limitations

Describing the different stages of the organizational innovation process would ideally be studied longitudinally versus cross-sectionally, due to months and years spanning the different stages of development and implementation of the CCC modules. The newest CCC module I studied was almost two years old, while the oldest site was 10+ years old.

Because the CCC modules had already been launched and operating by the time I conducted my qualitative data collection, I had to rely on interview respondents' historical recollections and memories, which may become less accurate over longer periods of time.

Another study limitation was the number of interviews I conducted. The 22 interviewees were physician leaders and administrative leaders identified through snowball sampling strategy; the study would have been strengthened by increasing the number of interviewees per site. The study also would have been further strengthened by interviewing others involved with the CCC module implementation such as nurses, middle managers, ancillary support staff, and physicians who were not part of senior leadership or leading the change process.

With regard to selection of study sites, I had chosen only the successful implementation sites and did not include in my study KP medical centers and medical office buildings who failed to successfully implement CCC modules. Of note, when I searched for and asked around about such instances, I did not hear of any unsuccessful CCC Module launches. However, that doesn't mean there weren't any.

For Future Research

This dissertation study focused on describing the five stages of organizational innovation select Kaiser Permanente medical facilities, as well as the challenges and facilitators experienced by administrative and physician leaders during the innovation process. Leadership figures in top management impact the success as well as failure of innovation implementation and institutionalization as they are typically responsible for managing or overseeing change efforts because of their status within the organization, their decision-making power, their ability to influence, and their authority. Consequently then, the leadership style of individuals in top management play an important role in organizational innovation processes.

Future research that could build off this dissertation study could entail conducting a 360-degree leadership style assessment of the physician leaders and administrative leaders to investigate whether certain leadership styles are associated with successful implementation and institutionalization of culturally competent health care innovations that eliminate language and cultural barriers to health care. For instance, leadership researchers, over the past decade, have written about transformational leadership being the leadership style most suited to dealing with the dramatic and rapid changes occurring in the health care field due to environmental, regulatory, and financial pressures.

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