

Constructing the Middle Ground: Cultural Competence in Medicaid Managed Care

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February 2000

Summary Notes

Health care organizations serving Medicaid managed care patients are heavily shaped by the real economic and regulatory marketplace of the American health care system. Their ability to serve patients appropriately requires that they successfully negotiate the strengths and weaknesses of the Medicaid system in their state(s). They do this alongside their other “product lines” and service populations.

In organizational terms, Medicaid managed care is a set of related economic and regulatory forces that define the conditions that direct and limit the actions and interactions of many institutions and people in many different ways. For many clinics, that economic and regulatory environment produces a pressure cooker, the result of an continuing mismatch of rising expectations, rising demands, rising costs, capped, unstable, or declining resources, and business decisions.

Generally, Medicaid managed care goals include:

- Constraining medical rising costs
- Privatizing public services
- Expanding coverage
- Improving access
- Improving management and accountability
- Redressing historical under-funding of care
- Protecting special, vulnerable populations
- Resolving conflicting or overlapping care responsibilities
- Making participation mandatory rather than voluntary

These goals suggest an integration of services to the poor with mainstream managed care systems, resulting, for example, in having mainstream managed care health care plans and provider organizations participate heavily in these services.

Managed-care is premised on numbers. Its workability is based on balancing the relationships among funding levels, reimbursement rates, population size, enrollment, recruitment, retention, eligibility criteria, health status, cost/benefit, cost effectiveness, efficiency, profitability, utilization, practice norms, clinical guidelines, speed of payment, and size of network; measurement, if not analysis, is everywhere.

Numbers depict not just the very large scale but a great deal of the change in Medicaid managed care, changes which may support or erode cultural competence as a basic ingredient of access and service. Medicaid contract-responsive economic realities,

structural forces, and organizational arrangements are likely to be far more determinative of the ability to be culturally competent than are federal or state quality requirements. The requirements can have force only once there is a sound economic base, including incentives, underneath these plan and provider organizations. To the degree that plans and provider organizations can conceptualize no longer doing this work, in the face of declining economic attractiveness and increasing reporting and regulatory requirements, these quality requirements do not appear to be or become a driving force for cultural competence in program design or implementation.

The factors noted above –the concentration of Medicaid patients in large plans, the larger role of commercial plans in enrolling large numbers of Medicaid patients, the very newness of many plans, the departure of many plans from Medicaid managed care in many locales, significant quality assurance and resource questions, and the growth of Medicaid-only and Medicaid-dominated plans all have a critical bearing on the desire and ability of Medicaid managed care organizations to be or become culturally competent.

What participating organizations must do is engage in solutions which cover these costs and demands – find additional non-Medicaid funding bases, contain costs, divert savings, devise alternatives modes of service delivery, and so on. These solutions are patched together to underwrite other needed services to Medicaid clients, the employed insured, and the uninsured, and those who go back and forth among the three. The Medicaid-aligned organizations we have interviewed have either 1) a parent organization that acts as an angel on finance, or 2) commercial products some of whose profits are diverted to Medicaid service, or 3) are academic institutions or programs that bring in ancillary dollars, or 4) are community health centers receiving varied public program and grant dollars. In effect, they turn a closed system into a more open system by infusing it with more resources garnered elsewhere.

Funding access and services to the poor, as an aspect of organizational practice, is necessary to organizational cultural competence. The desire and ability to seek, find, and expend funds on behalf of the poor is a direct reflection of the mission and culture of the plan or provider organization. Relative success in capturing those funds is an indicator of the ability to actually serve the poor.

State Medicaid contracts determine much of the organizational cultural competence provided to Medicaid managed care populations. Many state Medicaid offices are experiencing tremendous and expectable tensions as they move, to various degrees, from fee-for-service to managed care. State procurement processes and subsequent contracts determine which plans and provider organizations in which locales may serve the poor minority populations, the reimbursement rates which encourage and discourage different provider organizations, the benefits package which may or may not reimburse for language interpretation and patient transportation, and the performance reporting which may or may not include substantive measures of appropriate services for ethnic and linguistic minorities.

Unstable economics and changing regulatory environments makes it unlikely for health care plans and provider organizations to devise and implement culturally competent advances. It falls to state Medicaid agencies to constrain these many uncertainties. It is these changing conditions that, ultimately, encourage or discourage, support or erode organizational cultural competence.

When a state changes its procurement procedures and standards and resulting contract terms, the plans and provider organizations respond to the changes by taking avenues perceived appropriate to their mission, survival, and success. As with other major purchasers of health care, a state will want to maximize the use of its funds by maximizing the productivity and efficiency of contract plans and providers. As with the larger health care industry, it is becoming increasingly difficult to find new efficiencies in the current system; much of the “fat” (e.g., waste, fraud, excess profit) has largely disappeared. Further “efficiencies” may come at the cost of access to care and existing or improving quality and quantity of service. Fewer dollars will be available to invest in long-term advances in customer services, cultural competence, clinical services, performance monitoring, and responding to complaints and grievances.

Some HMOs integrate their Medicaid managed care patients into the full range of services available to all other enrolled members, even though the Medicaid rate is far less than for other insured members. They intend, through economies of scale, to blend the resulting cost, income, and practice differences.

The business solution of mainstreaming Medicaid managed care patients into an HMO’s entire membership leaves unanswered the question whether such HMOs have the vision, incentive, will, resources, time, and tools to become more culturally competent. The alternative solution, creating special administrative and service structures and practices for the Medicaid managed care population only, poses costs which may be perceived by many to be even more prohibitive.

Some large mainstream for-profit plans and not-for-profit plans and provider organizations have reported that they lost a great deal of money on their Medicaid and other public contracts. Many plans were not organized and financed sufficiently to overcome these problems. Some also simply made poor business and bidding decisions. Some plans are in trouble now, not because of the economics of Medicaid managed-care alone, but because of associated business decisions, such as mergers, conversions of information systems, co-locations of staff, inappropriate allocation of corporate costs to the Medicaid product line, corporate restructuring, workforce reductions, stockholder and stock analyst opinions, and marketing decisions, all of which result in costs, delays, disturbances, and inefficiencies.

In many instances, it is the charitable, community-based, education-based, or not-for-profit part of the plan or provider organization that serves the Medicaid managed-care population. This part is subsidized, often unwillingly, by other profit centers in the organization. In each case we had access to, regardless of the mission, purpose, or tax status of the larger organization, the corporate decision to subsidize the Medicaid product

line is limited in terms of timing and scale. In every case these financial matters are significant, contrasting sharply the competition between organizational mission and organizational finance. The dollar amounts are large and pose a hazard to the relative competitiveness and success of the overall organization.

As a product, Medicaid managed care may be detrimental to the organization's short-term financial position, but critical to its long-term financial position, particularly its marketshare in an environment of changing demographics. Some HMOs and plans, based on their own mission, organization, size, finances, internal politics, culture, and role in the community simply cannot walk away from their growing minority populations. Minority populations, over time, contain a range of social strata, from the homeless to the homeowners, the unemployed to the well-employed, the poor to the rich. In the long run, it may make more sense for an HMO to market a product to each and every stratum within that population, to cement members' attachment to the HMO as they move through these strata over decades, even lifetimes. It can do so by participating in publicly funded programs based on each level of poverty/income and by marketing other plans to small and large employers and insurers. That is one way to ensure marketshare in increasingly competitive and stratified markets.

it may very well be that only unique HMOs, smaller plans, and smaller provider networks with access to alternative funding sources, with the ability to become increasingly cost-effective in administration and to limit their capital intensive aspects will be able to continue to serve this population appropriately over time. This, in turn, is dependent on their ability to capture and manage capital sufficiently to be technologically proficient and lean; as well, it is dependent on their ability to capture and retain loyalty from the Medicaid managed care patient population over the long haul.

The strength of CHCs is in their own histories and their singular focus on their mission to serve the under-served. Starting as very small community-based organizations or programs, they have managed their way by relying on multiple sources of support. While some are very concerned about increasing financial dependence on Medicaid managed care, the CHCs have always been dependent on federal and state funds; it is the programs and program rules that have changed, not the ultimate source of funds.

Federal programs have constituted the backbone of much of CHC development. The CHC organizational style and mode of practice were designed around these funding sources. Now, even though FQHC funds continue, Medicaid managed care contracts have impacted CHCs greatly. As a recent report (Lewin, 1999) and our field interviews disclosed, the combined effects of federal and state action include:

- elimination or shift in cost-based reimbursement
- instability in the number of uninsured using FQHCs
- restricted beneficiary freedom of choice of plan and provider
- increased competition among providers for Medicaid patients
- an increased emphasis on primary care and primary care-providers
- changes in the roles of those providers (e.g., referrer, care coordinator, advocate)

- development of team approaches to providing care
- emphasis on the health status of panels rather than individuals
- a shift away from episodic walk-in encounters
- reduced emergency room visits
- improved provider productivity
- cuts in enabling services
- aggressive efforts to find sources of funds for these enabling services
- increased need for patient education about access and benefits
- increased consumer confusion about the need to enroll
- increased demands on paperwork and management information systems
- problems in managing and obtaining specialty referrals.

Perhaps the most profound changes are two – the net reduction in funding and the FQHC mirroring of Medicaid managed care policies. In our research project, we heard about all of these impacts and the consequent changes in mission, finance, administration, staffing, productivity, clinical practice, and customer service. We suggest that each of these has an impact, some good, some not, on the ability of the organization to be culturally competent. In this sense, Medicaid managed care itself is another culture affecting the health care industry and shaping the relationship of poor and minority patients to that industry.

Given the complexity and uncertainty of their funding sources, CHCs lack a confident version of the future. It is not surprising, then, that many CHCs constantly confront major management decisions without a firm basis on which to commit direction and resources. What they should construct and how is based on very different competing versions of the future. This is not new to them, but the risks and levels of commitment may be far higher. Finally, it is clear that it is not only the volume of funds which is significant, but their ability to innovate, decategorize, and braid funds to underwrite more services to Medicaid patients and services to uninsured populations.

Other issues make CHCs' survival in this marketplace, while necessary, also uncertain -- economic recession, employment recession, declining dollars in Medicaid, increased costs within the industry, managed-care responsibilities and regulations, uncertain controls over who is coming to their doors for service, and changes in reputation if the CHCs start turning some people away based on reimbursement issues.

Clearly, the risks are not solely financial survival; they include the actions that CHCs use to ensure that survival. One of the ominous demands is that CHCs begin to operate in a more businesslike fashion, like their commercial counterparts, but not so businesslike as to lose their mission. Finding a balance in this convergence is going to be very difficult. Some are beginning to look at commercial plans and other commercial enterprises as a source of stability against governmental funding changes and as a source of excess proceeds to be applied to their services for low income people. Can they do commercial work without becoming commercial? Can they become commercial and retain their intention to be culturally competent?

It is quite clear how significant financial arrangements and financial health are to every aspect of organizational performance. One cannot divorce cultural competence from the answers to preceding questions about mission, finance, subsidy, drivers, markets, reporting, growth, access, location, and so on. These economic realities, structural forces, and community and organizational arrangements are likely to be far more determinative of any organization's to be culturally competent than are Medicaid or other federal quality assurance requirements. Quality assurance requirements can have force only once there is a more predictable long-term economic base underneath these organizations.

Some CHCs have allied themselves to Medicaid-only or Medicaid-dominated plans. In this early period of managed care in public programs, Medicaid-dominated plans may thrive in an area of business that is perceived as too small, profitless, risky, or unknown by much larger plans competing with each other for commercial marketshare and saddled with large liabilities and infrastructure. The more these large players abandon the Medicaid environment, the greater the opportunity for those CHCs that have survived the recent changes in health care funding and regulatory environment.

These new Medicaid managed care plans share the basic managed care theories of risk, capital formation, quality improvement, and accountability. They require a clear mission, community loyalty, a well-organized and integrated provider network, and appropriate scale within their community and their particular niche; appropriate scale is based on such considerations as aggregation of risk and the ability to manage and report information. These plans, like all other health care plans, have basic business requirements dictated by insurance principles, general business practices, and state contracts. These tend to make Medicaid-dominated plans look very much like their commercial counterparts. Because these principles and contract requirements may be quite different than and even alien to what CHCs have previously experienced, tensions will arise between CHCs and their plans and be resolved in changing power relationships between them.

Medicaid-dominated plans, confronting the same financial and regulatory uncertainties but having shorter histories, emulate many of the business strategies of their commercial counterparts -- cost containment, closed networks, close relationships with their provider groups, growth of Medicaid enrollment, development of commercial product lines, and the development of other public product lines to remain financially healthy. None has a long enough history to know what the long-term commitment to Medicaid managed care will mean financially.

Clearly, there are potential conflicts between CHCs and Medicaid-only or Medicaid-dominated plans; these have to do with their organizational bases. CHCs are community-based, highly independent, survivalist organizations, attached to their direct service customers, and reliant on their own internal cultures and management practices.

Medicaid-dominated plans, by contrast, are new, non-community based insurance companies, driven by a more actuarial attachment to members, and highly responsive to their state government customers. While they may be dedicated entirely to providing

services to the under-served, how they calculate and pursue that dedication may cause conflict with their CHC partners. This may occur whether the CHCs are contractors to, owners of, or partners in the plan. Regardless of the business arrangement between plan and CHC, each organization must assist the other to succeed.

In order to succeed, the CHCs must continue to operate as they have traditionally -- relatively slim and conservative organizations, marked by informality, consensus, and the easy and rapid exchange of information; not particularly resource-rich or capital-intensive in terms of professional staff, administration, facilities, space, or equipment; supplemented with local and federal public funds; and staff motivated by mission and philosophy, and comfortable in serving the poor, the underserved, the underinsured, the uninsured, and ethnic and cultural minorities. This is not difficult for them to do, given their histories of self-reliance. In any event, many CHCs will be unwilling to surrender to a centralized insurance company those aspects of control that have enabled the CHCs to withstand preceding changes in the funding environment. That is, many will hesitate to place all of their important eggs in the Medicaid -dominated plan or even Medicaid managed care basket.

Ultimately, CHCs and the plans that contract with them must resolve numerous contradictions and tensions -- constraining administrative costs and meeting reporting requirements, meeting provider and plan purposes and values, retaining the niche market and expanding in response to a changing market, achieving greater scale and serving the target community, serving the under-served and diversifying funding bases, increasing numbers of Medicaid members and remaining non-dependent on Medicaid, experiencing corporate growth and avoiding bureaucratic inertia, being community responsive and contract compliant, and increasing both professionalization and cultural competence. Every resolution has an implication on cultural competence as it is experienced by the patients and communities served by these organizations.

Many CHCs are at least a partial refutation of the paradigm of conflict among cost, access, and quality. CHCs have the ability to engage in primary preventive care, incorporate language skills into their professional and support staffing, pursue homogeneous service populations, retain their members, access other funding sources for the under-served, access dedicated providers, seek and receive some forgiveness from their patients on customer service issues, and contain their costs.

Most respondents suggested that CHCs are, in fact, specialty providers but that their specialty is primary preventive care and social support to the underserved. "For CHCs, providing health-care for the underserved is not a product line, but their basis of existence." (clinic manager) They suggest that providers try to hold on to their clients for as long as they can to insure the efficacy of prevention. They also tend to believe that their primary care physicians are far more competent to meet a range of patient needs than is normally attributed to them in the industry or in urban areas that are replete with specialists.

CHCs organize their work somewhat differently because the minority (in society at-large) is the majority of their service population. Being local, of optimal size, culturally similar to or attached to the service population, and federally-supported, CHCs may enjoy a marginal economic advantage compared to their commercial counterparts. Some of the advantage depends on whether they are defined as “dense pack” or “loose pack” (the authors’ terms). CHCs that are dense-pack serve a narrowly defined and geographically compact service population, have a narrow mission, and cultural affinity in staff and staff language to the service population. Dense-pack CHCs result from local demographics and history, board or management preferences, or political or community agendas, such as, “we are the Latino clinic.” CHCs that are loose-pack serve a more broadly defined and scattered service population, multiple ethnic groups, and small ethnic concentrations; they may have far less cultural affinity with each of their service sub-populations.

It may be the case that a culturally competent organization is already an alternative organization, no matter how consistent it is with general operating finances, structures, practices, and procedures. There may be principles at the core of this organization that pervade the organization and make it different from its colleagues. It may use different attributes, a different set of operating ideas and procedures, a different world view, and a different set of relationships with the service population and the community, with no obvious barrier between the organization and the community it serves. Its practices may not be in addition to what everyone else does, but a substitution for what everybody else does. Thus, in a zero-sum game of organizational resources, it may cost no more to be culturally competent than to be incompetent. As one respondent noted, "you can graft on the signage, but you can't graft on the soul." (medical faculty)

The literature emphasizes two different perspectives on developing cultural competence. The mechanical perspective suggests that cultural competence can be measured as a number of distinct attributes or elements, as if practitioners or organizations could select some and not others from an available menu or checklist and graft them into daily practice. By mechanically adding these elements, the practitioner or organization is likely to become (or appear) measurably more competent by definition. This approach is one way to measure and advance competence; it can be designed, benchmarked, and implemented in a fairly mechanical and often costly fashion.

Grafting new elements, practices, or processes to the existing structure does not necessarily alter organizational core structure. Grafted improvements may, indeed, enhance some aspects of the organization, but may not impact its cultural competence. Some suggest that grafting some elements, practices, or processes are 1) required for any progress to be made and 2) make it more likely that progress will continue, as administrators and practitioners see the value of initial advances and demand more. While grafting elements is not sufficient, they suggest this process may be necessary to precede and thus develop more organic changes.

An alternative view is that cultural competence is not a set of discrete elements but a pervasive way of thinking and acting that pervades the entirety of a practitioner's or organization's work. An organization that is organically culturally competent will 1)

incorporate a wide array of elements, actions, practices, behaviors, and processes, and 2) integrate them with one another to create a new organizational culture.

The polar opposites, then, are mechanical organizations, created by the investment of money, personnel, and facilities into some standard organizational form available from a menu within the health care industry. Mechanical organizations are generally hierarchical, formal, constructed rather than emergent, related to means rather than ends, self-interested, compartmentalized, technical, and extrinsically rewarding (i.e., profits, pay, promotion).

In choosing to look at CHCs and similar organizations as the organizations of analysis, we did so on a presumption, based on experience and reputation, that these organizations, community-based and dedicated to serving underserved, uninsured, and ethnic minority patients, would develop in organic forms particular to these purposes. We expected CHCs to be strongly interpersonal, collective, egalitarian, voluntaristic, vision-driven, inclusive, related to ends, and intrinsically rewarding. We expected that the need to be culturally competent for their service population would result in an organic approach to organizational form and practices.

By organic, we mean that each would develop as it responded with its own local, homegrown, and internal solutions to its work challenges, rather than importing and applying forms developed elsewhere; it would be alien to bureaucratic structures and professional cultures, be driven by ideology and mission, follow a paradigm of care, and have many external attachments to its community and cultural environments. Money would be only one of the resources, among a myriad of actions and relationships, which keep it alive. Money would be the means, not the ends, of organizational action. Such organizations produce would more than expectable, given limited financial resources. For these organizations, character, traits, and practices emerge from within, flowing naturally in response to challenges and opportunities. Their creativity, novelty, variety, number, and apparent reasonableness attest to the intimate relationship between organization and community and the depth of attachment of these health organizations to their patients' well-being.

Organizational mission is the stated and often unstated purpose of the organization. An organization that is constructed, over time, specifically to serve the poor and ethnic minorities seems far more able to move directly to business, financial, and practical solutions to provide that service. It will also find economies of scale in pursuing this mission, maximizing and balancing resources and deliverables. An organization that is constructed for another purpose has significant difficulty and cost in adding service to the poor or cultural competence to its mission list. These new missions will always be viewed as competitive for resources and rewards within the organization with already established structures and missions. Larger organizations will require more time to develop leadership attachment and change agents, a strategic plan, resources to pursue mission, and so on.

Managed care plans and provider organizations make decisions and take actions often without the benefit of self-reflection on the relationship between the decision and the purpose, the action and the mission. The ability to be self-reflection is a competence in itself and is difficult in organizations, regardless of size and resources.

We found that the organizations most likely to admit to failure to perform in a culturally competent fashion are those programs closest to the client population. They are more self-reflective and self-critical, although privately. This admission is the first step to a solution. Those who deny they have a problem or deny that a need or a value exists are least likely to move towards cross-cultural competency.

Medicaid managed care has resulted in the creation of new managed plans (or products) and the rapid growth of many community health centers and similar organizations. Rapid growth of new and small organizations constructed to serve the poor poses major challenges to the organizations themselves, taxing their ability to maintain their focus, develop needed management competencies, recruit and train their staff, respond to external and internal demands, and so on.

These organizations require scale, facilities, economies of scale, professionalism, strategic plans, technologies, and other attributes which are more common among larger organizations. At some point, attempts to maximize their ability to serve the poor may actually cripple their existing abilities and competencies. It is the classic case of expanding a boutique into a department-store or franchising a local restaurant into a chain. The qualities that made the original successful may be lost as the mission, culture, staff, and practices are replicated and diffused through much longer chains of relationships and accountability. The span of control, oversight, leadership, and vision become attenuated, through layers of management, formal training programs, recruitment and replacement, loss of direct contact with customers, bureaucratization and mechanization of quality assurance, and so on.

Plans and CHCs generally believe that they must grow in order to survive in the rapidly changing funding environment in which they live. They have done so by increasing their membership, aligning themselves with plans that are aggressively seeking Medicaid managed-care contracts, applying for and receiving special outreach and service project funds, adding new facilities, hiring additional staff, and building increased capacity in financial management and management information systems.

All are concerned about the implications of size, rapid growth, and an increased focus on financial survival and success on their ability to assure themselves, their patients, and their purchasers that they can continue to deliver and improve upon their quality of service and, more precisely, access to care. Many suggest that rapid growth has outstripped the capacity of the organizations, at least temporarily, to be sufficiently self-reflective about where they are going and how. Most of them express the difficulty of constantly having to juggle and balance the competing interests of growth, economic stability, risk, customer satisfaction, contract compliance, measured performance, community responsiveness, and quality. Some view financial success as 1) a potential

threat to their ability to focus clearly on their primary mission to serve the underserved and 2) as increased dependency on a single source of funding.

Health care plans and Medicaid provider organizations rely extensively on specialty providers and hospitals to carry out work on behalf of their patients. Many providers and provider organizations have to be sold on the notion of accepting Medicaid managed care patients. Medicaid-dominated plans and CHCs have to get these specialty providers both to accept their patients and provide them with quality services, including cultural and linguistic competence.

In the quest to build sufficient provider networks to be competitive in each geographic area that they serve, Medicaid plans must engage in a “hard sell” to convince providers to accept a lower reimbursement rate and, in some ways, more complex patients. When asked about also demanding culturally competent services from these providers, most provider relations staff suggest that they have a hard enough time just getting enough provider bodies as it is and that making additional demands will simply limit their ability to recruit a sufficient number of providers.

Non-network specialists want fewer Medicaid patients or devise office caps to limit their number, due to declining reimbursement rates, increased administrative and practice (e.g., no-shows) costs, increased risk, and a desire/need for a larger patient population that pays closer to true market rates. The selling relies heavily on these providers' being willing, for a variety of reasons, to accept the mission of the plan and provider organizations.

Respondents agreed that cultural competence, however defined, was integral to their mission. Most mission statements did not mention cultural competence in any form, but respondents assumed that providing the poor with quality care implied such competence.

Given the common silence of mission statements on cultural competence and the common gap between mission and practice, the best place to look for cultural competence is its real-life measures and procedures for assuring cultural competence performance. If these exist and are applied on a routine basis, then the organizational mission can be inferred from these practices.

In effect, customer satisfaction surveys, customer complaint data, and disenrollment rates remain the only measures of performance. Essentially, the entire burden of cultural competence performance is borne by the customers and their willingness to report or act in response to that performance. Plans and provider organizations do not direct, establish, measure, or reward such performance. In this context, it is difficult to conclude that an organization's true mission includes cultural competence.

In the absence of formal or self-conscious performance measurement tied to mission, plans and CHCs may still support staff to be culturally competent. This becomes very difficult under conditions of a high growth rate and heavy demand.

The “mission drift” we have noted appears far more profound in some organizations than others. In particular, the smaller CHCs appear to experience less drift or uncertainty than do their much larger counterparts. While meeting the same major challenges, they tend to communicate more rapidly across staff levels and quickly raise and resolve mission and value issues. However, they too do not remain static. For example, one clinic, in maximizing their efforts to have all of their eligible patients covered by health care insurance, still carried on an internal discussion of how that might appear to change their mission and the attractiveness of their clinic to the uninsured.

One problem for successful (from an objective business perspective) CHCs is that they have to look, more and more, like their mainstream counterparts - bureaucratization, professionalization of management, corporate practices, electronic information systems, management decentralization and/or centralization, accountability and authority systems, communications systems, decisionmaking processes, tracking the fiduciary bottom-line, establishing procedures and standards, conflict resolution, and solving unresolved tensions within parts of the organization. These attributes and the mainstream cultural baggage attached to them all come with a cost in time, attention, money, reorganization, staffing, and abandoned alternatives. Concurrently, the CHCs have to keep their eye on their mission, values, and constituents. How they do that, particularly in rapidly growing organizations, is becoming more problematic.

Respondents spoke volumes about these matters. What was noteworthy was their near-total lack of a perceived relationship between these attributes and organizational cultural competence in:

1. Organization/Disorganization
2. Leadership
3. Management Teams and Decisionmaking
4. Bottom-Up Decisionmaking
5. Planning versus Firefighting
6. The Challenges of Organizational Professionalization
7. Centralization and Decentralization
8. Quality Assurance
9. Management Information and Self-Reflection
10. Computers and Performance

Community-based organizations, such as community health centers, have their leadership and staff roots in their community. Focused on a vision of service, community persons have sought and discovered local solutions to creating that service over the last 20-30 years. Leaders and boards have hired professionals, such as physicians, nurses, and accountants as employees, while retaining for themselves the ownership of the vision.

As noted throughout this report, there is a new convergence of forces in the marketplace that require higher and higher degrees of CHC organizational performance in administration, finance and billing, human resources, facilities, customer service, information systems, clinical management, and so on. Such demands can either paralyze a CHC or motivate it to action. To meet these performance requirements, CHCs are

demanding more and more of their management and staff, sometimes exceeding their capacity.

CHCs that, in the past, had willingly promoted for higher positions from within their own staff now demand more professional attributes from these internal applicants; some invest in their training and experience to construct these attributes.

Increased professionalization is seen as a good thing by many. Some note that, with financial success, there is now the opportunity to purchase rather than construct the desired skills. As these professional prerequisites are raised, fewer staff positions can be filled from within the recipient communities. In reality, the pool of persons with these educational and experiential backgrounds in the community is limited. This smaller pool, in turn, is often subject to intense recruitment competition from other businesses and agencies that also want these skills from the community. Ethnic minority and immigrant professionals and sub-professionals often quickly acquire career, geographic, economic, and social mobility and are unavailable to community-based organizations. For these reasons, culturally competent organizations will invest in training as an essential component of their own survival in their service niche.

The world-views, values, and experiences of these new professionals and sub-professionals are far more likely to reflect the larger society. As these professionals begin to populate the managerial and service ranks of the organization, they are more likely to perform in ways consistent with mainstream values; their presence is predictive of business success. Unfortunately, their collective decisions and actions are also predictive of organizational failure to pursue the value-based mission and to be culturally competent.

Organizations struggle with this predicament. Some solve the problem by fiat, by requiring that certain or most positions of influence be filled by professionals who have cultural affinity with the recipient population. Their recruitment efforts are intensive within the local and non-local ethnic minority populations, as they search for that one person out there who can fill the bill. They simply do not fill that position until they are satisfied they have found the right one. Other organizations settle for a mixed solution, mingling minority and non-minority managers or staff, intending that the processes of socialization will result in the proper value set for the entire group.

Containing costs and capturing resources at the organizational level is an important, but often unseen, organizational tool which can be applied to increased access by and services to minority populations. Re-allocating captured resources can increase the number of insured persons, increase the services available to the uninsured, recover and retain more funds at the clinic level, increase the number of supportive services to the Medicaid managed care population, increase the utilization of routine preventive care, increase the availability of unrestricted funds, underwrite more effective practices, encourage continuity of care and staff-patient relationships, and support values, services, and personnel that are clearly part of organizational cultural competence. On the other

hand, if done poorly, cost containment will threaten the quality of clinical care, customer service, and cultural competence.

Federal funding of care to the poor mandates both cultural competence (e.g., equitable access, language interpretation) and cost containment. As federal and state quality measures become more detailed and comprehensive and state contracts become both more explicit in their requirements and financially constrained, being able to succeed in both ambitions becomes a major management challenge. Melding these ambitions requires detailed data and measurement, close planning and coordination, local innovation, some compromise, and overcoming institutional and professional resistance. States are unlikely to fund the full range of required organizational advances, so it will fall to insurance plans and provider organizations to find necessary resources within their contracts and other sources.

Cost containment measures at the system, plan, and clinic level serve somewhat different purposes. At the system level, they act as a legislated budget cap not necessarily related to measured need. At the plan level, such measures can generate profits, excess proceeds, reduced deficits, or improved competitive position. At the provider level, such measures generate either profits or excess proceeds to apply to services for the uninsured, better services, or new services not included in the Medicaid contract.

Provider organizations are often hesitant about investing in advances in cultural competence. They are often unsure about what it is and produces for them or their patients. They also think that it is expensive. However, it remains an untested assumption that cultural competence costs more money than cultural incompetence.

Clearly, some Medicaid managed care (and uninsured) populations bring concomitant higher costs -- lower health status and increased severity of problems for many, longer office visits due to severity and language issues, a high rate of "no shows," the actual cost of language interpretation, noncompliance with medical treatment plans, and so on. These costs are understood by and built into the operations of community and migrant clinics that have traditionally served the Medicaid population. While some have characterized CHCs as providing a lower quality of care, customer service, and facilities due their financial constraints, there is no evidence of these characterizations under Medicaid managed care; many such clinics appear to be paragons of quality care. Where the CHCs appear to be threatened is by the combination of increasing administrative costs, decreasing reimbursement rates, and the initial loss of many Medicaid patients to commercial plans and HMOs.

Smaller organizations, like CHCs, appear to have some advantages in serving the Medicaid managed care population. By design and history, they tend to have a more intimate relationship with their service population, a preponderance of whom are the poor and ethnic and linguistic minorities. CHCs have advantages such as bilingual staff, more affinity with the patient population, centralized interpretation, a smaller product line, and a singular focus on primary preventive care. It is these features, rather than scale alone, which distinguishes these organizations. However, while in the past they may

considerably less administrative overhead, less commitment to a large professional workforce, and smaller fixed costs for facilities and infrastructure, Medicaid contract requirements may be removing these advantages.

In larger organizations, the Medicaid population is viewed as special and therefore require or incur special costs. The costs associated with making changes in these organizations to accommodate the Medicaid population may be quite high and may require a long amortization period. Cultural competence may cost more initially for those organizations that have had no history of serving the local Medicaid population and must modify their organizations to meet the needs through alternative structures and practices. It will certainly cost more if these organizations only graft on new features, rather than substituting culturally competent practices and staff for their current staff and practices. It is like any other industry that would like to move from producing radios to producing computers, but avoid the cost of changing the production line, retraining staff, and rethinking entirely what is needed to be successful in a new product line.

Cost containment measures include the following:

1. Primary Preventive Care
2. Fiscal Monitoring and Management
3. Maximize Information Availability
4. Capturing All Legitimate Funds
5. Case Management
6. Co-locating Services
7. Ensuring Coverage
8. Integrating Language Interpretation
9. Layered Care and Team Approaches
10. A Rational, Reality-Based Productivity Model
11. Recovery of Savings
12. Loan Repayment Staffing: A Shrinking Federal Subsidy
13. Substituting Intrinsic for Extrinsic Rewards
14. Diffusing the Costs of Facilities Development

We cannot assume that every mature ethnically-driven community-based organization remains attached to its roots. Serving the poor can form a basis of lucrative personal and organizational careers. Lack of external oversight by larger political bodies or effective local communities can lead to granting special status to these organizations which is unwarranted by their actual attachments and performance.

Access to health care is a cultural competence question for ethnic minority and immigrant populations. American health care, particularly the Medicaid program which many providers depict as "the Cadillac" of public coverage, is like a treasure chest. All of the cultural competence issues that surfaced in field interviews are, in one sense, about problems and solutions to accessing some aspect of that treasure chest. Failure to provide access is denial of an entitlement and a contravention of important social and public health purposes.

The literature on cultural competence focuses generally on processes that occur after a patient has already substantially accessed the health care system. Culturally competent practices are too often presumed to start at that point. However, by access, we mean access to the strengths of Western health care concepts, practices, systems, and benefits. It requires highly pro-active public agency, health care plan, and provider cultural competence.

Barriers to Medicaid managed care are based in significant socioeconomic, cultural, experiential, and linguistic differences between the health care industry and the patient populations. The costs of denied or delayed access include delay and/or error in appropriate diagnosis, denial of services, slow recovery, delayed intervention, increased severity of health problems, and increased utilization of high-cost technology and services. Solutions to overcome these require concerted organizational and personal activity. Barriers include

1. lack of information and understanding
2. lack of care seeking behavior
3. eligibility and enrollment problems
4. language differences
5. discontinuity of care
6. lack of experience
7. time/transportation/distance
8. discrimination
9. loss of minority providers
10. individual and family conditions
11. lack of agency welcome

Health care organizations that have embedded “serving the underserved” in their mission pursue numerous integrated strategies to assure access. These efforts are consistent with their own survival in that ensuring financial coverage and customer satisfaction with their services provides them with a reliable patient and financial base. These efforts are consistent with Medicaid purposes as well.

A culturally competent organization will apply a full range of services to promote access. It will engage in community outreach in order to get people to sign up with Medicaid, it will provide whatever assistance is required in completing and filing the paperwork and other activities to insure their eligibility and membership, and then it will provide these patients with uncompensated services, often in advance of the establishment of eligibility and assignment to a plan/provider.

By investing their limited resources in outreach and eligibility work, such organizations are doing the work of public social agencies. Since they themselves cannot, by law, advertise either their own services or their plan partners to these potential patients, they are certainly not assured of any return on investment by successfully making these persons eligible for Medicaid services. Their purpose is creating access to Medicaid services with 1) a hope that they will be the providers of service and 2) an intention that these persons will not remain in the ranks of the uninsured.

The ability to bridge the language gap between providers and patients is one critical element for culturally competent care is. This ability produces access to everything that follows. Language and cultural interpretation is a competence issue for all health care organizations, regardless of size, staff composition, and history. For ethnic minority, linguistic minority, and immigrant populations to access all aspects of the care available to them under Medicaid managed care, they require the ability to communicate clearly with state agencies, managed care plans, and provider staff. This often requires the agencies, plans, and providers to bridge major language differences through the use of bilingual staff, bilingual medical interpreters, and translated materials.

Providers need significant communication skills in English and then competence either in the first language of their patients or in the use of competent interpreters. Patients, too, need sound communications to be able to hear and be heard completely, so that they can be knowledgeable about and participant in their own care.

For both providers and patients, there is an additional need, the ability to incorporate cultural context in the communications between them. That is, while the accuracy of the interpreted language is key to communications, both parties may require the addition of cultural context, particularly where there are no equivalencies or one-to-one correspondences between concepts spoken in one language and heard in another. Such concepts may cover a broad range of social, historical, religious, medical, and folk meanings.

To be effective, competent language and cultural interpretation must be incorporated self-consciously and routinely into the practices of managed care plans, provider organizations, and providers. Haphazard and ad hoc solutions will guarantee neither access nor the continuity of communications required by providers, their patients, and the patients' families. Bilingualism and/or skilled interpretation are a competence like any other routine and required competence to achieve desired health service and health status outcomes. It requires policy, budget, staffing, planning, assessment, supervision, and pervasive routinization.

Since language interpretation is a legal and contractual obligation, state Medicaid agencies have an obligation to create the workforce conditions in which this can be accomplished. These include state standards, state support for medical interpreter accreditation, state reimbursement for interpretation, and the development of qualified interpreters in all relevant languages. It is not demonstrated that free market dynamics can or will create the conditions for this competence to be accomplished.

A significant number of community health centers, migrant clinics, and other provider organizations are, essentially, bilingual organizations; there are also bilingual clinics in some major HMOs. In all departments or units and at all levels, a significant number of staff persons, even a majority, are bilingual in one of the languages spoken by their client population. How this has been accomplished is the result of a number of practices detailed in the appendix Constructing a Culturally Competent Workforce.

The bilingualism of the staff appears to attract patients to and retain them for these clinics. Equally, many bilingual staff members join these organizations specifically to serve patients from these cultures and find themselves more accepted and supported by these organizations than by others.

The strengths of a bilingual organization include immediate access for patients whose language is spoken by front-desk, triage, eligibility, billing, social service, and front-line staff. There are far fewer delays caused by the search for an interpreter of whatever kind. There is no reliance on the more impersonal telephonic system. Costs are reduced because bridging language is part of the normal overhead of the organization. Lack of language issues provides continuity as the patient moves from service to service. Cultural matters outside of language alone are more likely to be recognized by staff, even if not dealt with successfully. Inter-staff communications and scheduling are less troubled by language issues.

It is rare to find a large provider organization where every staff person is bilingual. In most clinics there is a considerable mix of language competence. We found programs where the clinicians were bilingual, but the administrators, office staff, front-desk staff, nurses, and medical assistants were, generally, not. Conversely, we found programs where the doctors, dentists, and nurses were generally not bilingual, but many of the rest of the staff members were.

These patterns were the result of human resources planning, recruitment, hiring, and retention activities as well as health care workforce market conditions. As important, however, is the degree to which the provider organization has control over human resources management. Clinics that have direct control over human resources can shape their staff; organizations, such as family practice residency programs, that are part of much larger health care organizations, often lack such control.

To the degree that language is an important skill area, the organization may have to reduce its demand for other skills in order to get language first; it then may have to invest more in skill training and supervision. Often, language skills must be demonstrated at some base level at the time of employment, but whether this level is appropriate to the patients or providers is untested.

In building a multilingual provider organization, great emphasis should be placed on high quality current information on the served populations as the guide to planning both the strategy of language services and a comprehensive and routine system for assuring the ready availability and quality of interpretation. To reduce the costly duplication of effort and the demand on limited interpreter availability, clinics should continue to specialize in the populations and communities where they have immediate language and cultural affinity and collectively encourage new patients to select provider organizations and providers where more affinity exists. Provider organizations should demonstrate to themselves that they have a seamless system in place to identify language needs as early as possible and a reliable system to ensure that quality interpretation occurs on time.

Standards include:

- Providing Continuity in Interpretation
- Managing the Costs of Language Services
- Assuring the Quality of Language Solutions
- Ensuring the Sufficiency of Communication

Organizational cultural competence is most often expressed and implemented through its customer services, that is, the way that organizational staff communicate with and manage the experiences of their patients. In this sense, customer services are principal tools in accomplishing cultural competence. Conversely, failures in customer service often perceived by patients and others as hostility or indifference to the patients based on their race, ethnicity, gender, language, or social class. As a result, it is often difficult for them and others to distinguish between cultural incompetence and bad customer service. Similarly, patients' frustrations with routine customer services practices are also interpreted by patients as indifference to them as a class.

Patients' complaints about the lack of cultural competence are most often couched in the form of some failure in customer service. Patients feel that they have to wait too long to get a scheduled appointment, have to wait too long once they arrive, are treated rudely or are ignored by front-line staff, are not listened to by their provider, do not understand their provider, and their complaints go unheeded. These concerns become apparent only when patients complain or when the organization or an outside body conducts customer satisfaction surveys, which are often used to measure and advertise the comparative performance of plans and provider organizations under Medicaid managed care. Plans and provider organizations seldom try to measure cultural competence directly; for them, its surrogates are customer service and customer satisfaction.

Health care purchasers and provider organizations assess patient experiences of and feelings towards the health care they receive and the practitioners who provide it. Given major methodological issues underlying these surveys, their audiences are often unconvinced that they actually know what these experiences and feelings are. Some reviewers find comfort in surrogate measures, that is, patients' actions, such as disenrollment or complaints filed, presumably taken as a result of their experiences and feelings.

Thus, an organization that provides poor customer service will be experienced as also culturally incompetent. If a patient has to wait for two or three hours past the appointment time or is treated rudely by a health worker, he or she will not feel mollified by the most culturally correct apology. If, on the other hand, the patient experiences smooth handling and good communications, he or she will often perceive this as a respectful approach to care. If an organization sets out to improve its customer service or its cultural competence, it will focus on many of the same concerns and practices, because they braid together to create the patients' experience of the organization.

We will not be the last to point out that the corporate industrial model of health care may conflict significantly with humanist goals. This model has not proved satisfactory in

many other industries -- publishing, media, hotel, restaurants, supermarkets. Businesses have grown larger and then failed. Good products have become franchised and diminished in quality and service. Front-line workers have damaged the corporate image and client satisfaction. Attention to the individual has disappeared. This can occur as quickly among non-profits as among profits.

Serving the underserved is no defense for committing the same corporate mistakes made by for-profit organizations who forget who their customer is and who neglect quality management for cost containment. Expressions of discrimination and poor service against health care organizations by Medicaid managed care patients are not limited to mainstream plans and provider organizations; they are also directed at CHCs and similar organizations. These are the organizations where many poor people seek or are required to seek their health care; it is also where they expect to be treated better than in larger, more mainstream health care institutions. Given the number of patients served by CHCs, the need to contain costs, their desire to also serve the uninsured, the problems posed by large number of “walk-ins” and “no shows”, problems with scheduling, and other factors, many CHCs have difficulty with many aspects of customer service. Providing greater access to care and quality of care may come at the cost of customer service. Some clinics appear to be more self-forgiving than they should be of their failure to meet a higher standard of service; for some, there is no clearly articulated standard of service. This may not be an intractable and inevitable problem, but it is a management challenge.

We suggested earlier that managed-care reflects an ethnocentric bias, an industrial mode of looking at health care and physician-patient relationships based on numbers. Success is measured by comparing all kinds of numbers -- funding levels, reimbursement rates, productivity, population size, enrollment, recruitment, retention, eligibility criteria, health status, cost/benefit, cost effectiveness, efficiency, profitability, utilization, practice norms, clinical guidelines, and speed of payment. Measurement is everywhere. There is considerably less measurement, however, of the real patient experience, expectations, or satisfaction.

In the performance and competitiveness of plans and provider organizations, governments, plans, and provider organizations use many approaches to measuring customer service and customer satisfaction. Many include a few cultural competence elements, such as staff bi-lingualism or interpreter services, but do not evaluate cultural competence directly. Cultural competence is examined through very distant surrogate measures, such as customer satisfaction changing health status, by race and ethnicity, on specific disorders.

Persons eligible for Medicaid and seeking health care services are independently functioning human beings, with limited power over health care institutions and, often, their own lives. While their path to health care services may be littered with multiple standard forms, income measures, eligibility standards, state computers, plan computers, benefits packets, performance reports, language barriers, and unknown choices of various kinds, they retain the ability to say “no”, to resist attempts to fit into managed care as

well as preventive care. In doing so, they may end up without care, the exact reverse of what Medicaid policy intends.

Who are these ethnic minority, linguistic minority, immigrant, and refugee patients?

Many organizations have invested significant resources in preparing and distributing basic cultural and historical information about ethnic minority and immigrant populations to their providers. Books and guides are readily available which, in a succinct fashion, depict some of the common health care beliefs and behaviors of some of these populations. These documents often focus on the surface of culture – appropriate forms of greeting, discourse, and touch; some perspectives on the cause and cure of illness; and some common health practices. To the degree that these documents are accurate and used, they advance the probability of cultural competence.

The origins and effects of health promoting behaviors, manifestations and effects of biculturalism, and the processes associated with the migration experience itself are examples of issues that lend themselves to [ethnographic study], as does the study of notions about health and illness that immigrants bring and that shape their help seeking and service use in the United States. (National Research Council, pp. 172-3)

To the degree that books and other guides are not thorough and accurate or satisfy rather than stimulate curiosity, they may result in cultural stereotyping and oversimplification. The whole of any culture cannot be reduced to standard categories; the elements of culture cannot be reduced to the “thing-like” qualities that western scientific thought applies to many other phenomena. This in due, in part, to the great variety among and within cultures and the ineffable, unmeasurable aspects of culture, as a worldview, a moral universe, an explanatory framework, a way of seeing and relating.

Our purpose here is not to critique these works nor to create another short-hand guide to culture, but to introduce only some aspects of minority populations’ expectations of the American health care system and the learned roots for some of their health-care-seeking and health-care avoiding behaviors, much of which does not appear in the published literature. These expectations color their relationships to managed health care plans, provider organizations, and provider staff and result, in some ways, in their ultimate use of services offered and evaluation of services received.

We remind readers that we did not interview patients as part of this study. However, we were fortunate that many of the health care workers we interviewed were themselves poor, immigrant, and patients in the same institutions in which they worked. Their reflections on their own experiences and those shared by their patients are revealing.

There appears to be, in some respondents, some sense of irony and dissonance in their encouraging continued ethnic ideation and behavior among their patients while simultaneously encouraging their assimilation to American medicine. In order to succeed in American health care, these patients are seen as needing to accommodate to health care being a higher priority, to the need for insurance, to the demands of managed care, to

preventive care, and a host of other requirements. In other words, these patients must change the way they think and act. In this, ethnic minority patients are not alone; they are merely an extreme example of pervasive issues in managed care.

Many bilingual and bicultural health care workers do not seem to understand and incorporate the health and relationship beliefs of their clients into clinical practice. Quite often, these same staff talk about the need to acculturate their patients sufficiently to take advantage of primary preventive services and to learn how to use more effectively the mainstream American health-care industry. They see the need to alter the expectations and understandings of their clients so that they might take advantage of the services being offered, particularly primary preventive care with which many are unfamiliar.

Many provider staff note that health care is not a high priority for these otherwise resource-poor populations, except as they are concerned for their children. They have many life needs that precede health-care, such as food, housing, employment, transportation, safety, and so on. They have never had employer-provided health insurance. Many families have no experience with or expectations of continuous provision of health care services. It is just this aspect of their lives that these providers attempt to change.

In our interviews, we raised a number of questions with respondents, most of which proved unanswerable -- what aspects of patients need to be changed, how much they need to change, how fast they need to change, the incentives or penalties attached to change, who decides these matters, and who actually facilitates the change? We felt that these were fair questions to pose to CHC staff since many of them freely criticized mainstream providers for demanding that their ethnic minority patients speak English and keep their appointments. How was that different, we asked, from CHCs demanding that their patients engage in preventive health behaviors and use the CHCs' services as they have organized them?

When we inquired about where the dividing line was between legitimate and illegitimate demands on the patients, the general reply focused on "coercion", that is, the means rather than the ends. Some saw the implications of coercion as an exercise in power, the organization or the staff person exercising power over the relatively powerless.

Many individual opinions are not unsympathetic or hostile to the patients; in fact, they are often intended to be quite supportive. But they appear based in highly personal views of history, politics, and values, with a notable absence of investment in the patients' cultural integrity. It is as if patients could change their life priorities, the ways they think about health, and their health-seeking behaviors without affecting their culture. The result, however, is oppression by the organization or by individual staff, regardless of whether they derive from the same culture or community

Where patient education and voluntary acculturation or assimilation ends and coercion begins appears to be determined, in the main, by individual organizational staff and units, not by organizational policy. Health care organizations must discuss and debate these

matters internally and consult formally with the their communities to develop such policy and not leave direction to the personal philosophy and biases of individual staff. If it is the legitimate role of community-based health care organizations to bridge ethnic minority and immigrant patients into American culture, a thorough internal and external discussion of culturally appropriate means needs to take place, to reduce the dissonance and the temptation of patients to exercise their limited power over health care by the last and only means available ---simply saying “no.”

American medicine is an elite profession, with its new practitioners still drawn from the privileged classes. This accentuates class difference and experiential difference between the new practitioners and their Medicaid managed-care patients. It is difficult for some providers to see their patients as whole persons within a different class, different culture, and different history. Without extensive experience leading to a real commitment to serve the poor, it is hard to find the source of an impulse to become culturally competent with the ethnic minority and immigrant populations within the poor.

Clinicians in organizations serving the under-served are not there by accident. They were drawn to these organizations and populations by powerful motives which keeps them at their work even in the face of troublesome professional, organizational, and personal issues. The purpose in drawing attention to this fact is not merely to applaud the clinicians’ dedication to service, but to note its organizational implication: if an organization wants to provide more culturally competent clinical services, it must recruit, select, hire, support, reward, and retain these kinds of unusual clinicians. It must also continue to adhere to its mission.

It is clear that many of these physicians are meeting major personal life needs in this work -- political, ideological, religious, service, identity, and so on. Finding intrinsic life values in this work is what keeps them at this work; money, power, prestige, career, science, and other rewards are simply not available in these settings. One consequence, however, of the power of these life needs is that each physician develops his or her own solution to developing relationships with and expectations for these poor and minority patients and populations. It also means that each is on his or her own personal journey and applies his or her own personal standards to how culturally competent he or she needs to be and what is meant, in his or her practice, by cultural competence.

The actual road to caring for the under-served is direct, in terms of the intention, and circuitous in term of preparation. Most have unusual experiences in their backgrounds leading to this service, including considerable international health care work and work with migrant and peasant populations. Some learned about culture by working in the United States.

Many, returning to the United States, sought experiences here that approximated, as closely as possible, the populations and practice they were accustomed, even addicted, to. Upon their return to the United States, these clinicians reflected on what was transferable to their situations and patients here. For clinicians returning from overseas and other

experiences, among the key changes in their lives and practices was to be able to see into the real lives of their patients, an ability they can only vaguely approximate here.

It is one thing for a clinician to have a set of important service motives combined with expanded experiences with other languages and cultures. It is another to develop those skills and traits which make someone culturally competent. Cultural competence is treated of lightly in the medical school curriculum, if at all. One medical faculty hypothesized that

If treated as a learning unit, a two-week introduction like many others, much will be lost after the final exam, unless it is incorporated routinely into mentoring and practice.

The same problem exists, in large part, in family practice residency programs. New doctors are so involved in learning and becoming confident in medicine, most lack the time or focus to treat of cultural competence as an equivalent competence to other required elements.

The medical residents we interviewed spoke at length about their development as interviewers, diagnosticians, negotiators, investigators, listeners, and the usefulness of those skills in drawing conclusions and taking individual actions, but not leaving a resulting body of knowledge for others. They talked about the great variability among cultures -- language, dialect, class, geography, history, generation's, etc.-- as confounding the ability to generalize about patients. They find written materials useful but misleading, because they lead to stereotypes. On the other hand, they apply stereotypes to their patients until their patients correct them. They find they have too little time with their patients to provide them with individualized care within the context of culture and history. The desired relationship is a foundation for care, having a thing-like quality like any other medical tool. Their approach generally continues to be biological at heart, with the only some real life, situational, familial, social, ideational, or spiritual accommodation which themselves become medical tools in the extension of the same medical model. These social and cultural factors are read as risk or protective factors. Culture is not seen or used to alter in the basic paradigm of care. Culture is simply one of a series of issues to be dealt with.

This pattern of development is not due to any failure on the part of the curriculum or the faculty, suggest most medical respondents. It is part of the individual personal development of a physician. Cultural components are built into most curricula along with their observation and mentoring opportunities with clinical faculty. In addition, some residency programs use the Balint process, a clinical self-reflection exercise used to develop the residents' understanding of their experiences.

This highlights a critical issue which we will discuss in greater detail later – the post-medical school development of a clinician is, essentially, a solo journey, not a program for a class or cohort. It is pursued through separate life and professional experiences, professional rather than school socialization, relative rather than absolute standards,

private rather than public practices, emergent rather than systematic lessons, and forms of mentoring and modeling.

Mentoring and socialization, rather than didactic classwork, are the tools most commonly used in family practice residency programs and community clinics to shape the practices of new clinicians.

It is often recommended that clinicians read in cultural anthropology to learn more about the cultures of the patients that they serve. The clinicians we interviewed recommended a course of self-education through reading, although few actually did so, in any organized or routine way. Reading about cultures is problematic for anyone. Anthropological writing, like all social science writing, is usually very difficult to read. Deriving simple formulations from this writing – “ten key things about Mexican Americans” -- suggests that people simply don't know what they are writing about. Furthermore, physicians tend to read in their own paradigm, which is pathophysiological, reductionist, and context-independent, none of which characteristics are true for culture. In the end, physicians tend to take the elements of culture, which constitutes a paradigm for its members, and incorporate them into another paradigm, applied medicine. Reducing culture to 20 pages of text enables physicians to treat culture as a thing, like the kidney. It is a small thing, rather than a very significant socially constructed universe of meaning different from physicians' own. Reading won't change this paradigm. If it did, clinicians would become far more flexible and less technical and formulaic. It would also place them at some jeopardy in their profession and institutions. (Chrisman, 1999, personal communication). This reductionist tendency is actually an example of extreme cultural incompetence, not taking culture on its own terms but on medical terms.

In order to create predictability in clinical cultural competence, at least three elements may be required: 1) professional attitudes which reduce ethnocentricity, 2) practice skills, such as interviewing and interacting, and 3) system status, that is, system supports to these attitudes and skills. Some feel that these attitudes and skills changes can be introduced and techniques learned in formal curriculum. Supporters of this approach suggest that both knowledge and approach needs to be professionalized, like any other intentional medical knowledge. Without routinization and professionalization of cultural competence, it cannot be demonstrated that actual practice is culturally competent and routinely produces desired effects.

Regardless of how it is defined – technique, knowledge, or attitude, culturally competent practitioners are unlikely to expand in numbers unless that competence is viewed as an acquired professional skill, not an art accessible to only by a narrow band of clinicians. This skill would include certain traits, ways of thinking, and ways of questioning, hearing, integrating, contextualizing, and joining with the patient, without a great body of anthropological knowledge, that will elicit and integrate the beliefs, traditions, responses, and fears of the cultural "other".

In our study, there was little clarity in what clinicians actually meant by clinical cultural competence, even though they all had dealt with the issue in their schooling, training, and

practice. Most of the physicians we interviewed focus on cultural competence as a set of techniques which can be both learned and repeated -- good interview techniques with patients, displaying empathy, seeking information from others of the same cultural community, team case conferencing, and reading in culture. However, the actual content of these techniques was fairly vague, even inarticulate, and high personalized.

Clinicians are quick to remind one that they live in the real, rather than some ideal, world. They stress the organizational, financial, and professional conditions that shape and limit their work. Throughout this history, the physician has become a corporate commodity, resource, or product line. In order to understand how managed care organizations influence the quality of health care and influence the behaviors of physicians, Landon, et al., suggest the need to understand:

- a) the degree to which physicians or their employer organizations assume financial risk and direct medical management functions
- b) the manner in which physicians are paid, e.g., fee for service, fee schedule with bonus, capitation, salary, and salary with incentives
- c) the manner in which organizational arrangements (plan, provider) filter incentives and controls (via fees, reports, contracts, QA, clinical guidelines)

They note that organizations can a) directly determine the nature and capabilities of their providers, including the amount of resources devoted to each type of provider (e.g., referral), b) influence care by direct contact with enrollees, c) adopt a broader population-focused mission characterized by public health and educational programs aimed at the larger community, and d) directly influence physician behavior.

The areas affected include

1. Organizational Power and Physician Autonomy
2. Physician Autonomy in Cultural Competence
3. The Limitation on Time with the Patient
4. Productivity Measures and Time with Patients
5. Managing the Quality of Medical Referrals

The published literature on cultural competence in health care is replete with references to the need for an organizational workforce that is described, variously, as diverse, culturally sensitive, bi-cultural, multi-cultural, reflective of the community, or staffed by the "recipient population." Affinity between organizational staff and organizational customers is often propounded as a key ingredient in attracting and retaining ethnic minority patients and providing them with more culturally competent services.

While staffing health care organizations for affinity increases somewhat the probability of these outcomes, we suggest that such staffing is far more complicated than simply increasing the numbers of ethnic minority persons on staff or matching staff demographics to community demographics. We suggest that organizations consciously pursuing this path are required to do far more than hiring based on diversity or affinity to produce the desired outcome of cultural competence.

Ethnicity-, racially-, and community-based organizations must guard against complacency in hiring. Hiring based purely on ethnicity, race, language, community politics, or family and friendship ties can mask inadequacy in cultural competence. Where there are gaps between the helpers and the helped, in terms of language, socioeconomic status, or generations, ethnic affinity alone will not overcome these gaps. Organizations intending to create a workforce capable of being culturally competent must be willing to deal consciously, strategically, and in a sequenced or integrated fashion complete with workforce goal-setting, establishing expectations, recruiting, screening, hiring, orienting, training, mentoring, supervising, performance measuring, rewarding, and retaining. Accomplishing only some of these tasks will not produce and assure a more culturally competent staff for patients.

Appendices

- A. Human Resources Goal-Setting and Planning
- B. Establishing Positions and Expectations
- C. Non-Professional Bi-Lingual, Bi-Cultural Staff Positions
- D. Recruitment for these Key Positions
- E. Expanding the Recruitment Pool
- F. Skills, Values, and Organizational Change
- G. Recruiting for Awareness of Patients' Lives
- H. Recruiting for Language
- I. Overcoming Social Status and Generational Differences
- J. Selecting and Hiring New Employees
- K. Orientation to the Organization's Mission
- L. Orientation to the Patients and Community
- M. Training, Mentoring, and Supervising
- N. Reducing Stress through Workload Management
- O. Measuring Performance
- P. Rewarding Performance
- Q. Retention, Turnover, and Replacement

[the above are selected notes from a 392 page volume available for sale or through the Center for Health Care Strategies, The Robert Wood Johnson Foundation]