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**Partnerships to Achieve Health Equity
Plenary Session III: Breaking New Ground in Cultural
Competency
Society for Public Health Education
November 2, 2007**

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ELAINE: Good morning. I hope you had a great evening last night. Was a fantastic social. I saw many people networking around and viewing the posters. And just want to take a moment to thank again the National Capital Area SOPHE chapter for coordinating that event last night. Let's give them a round of applause. [Applause]

Here we are day two of our very busy conference. Couple things I want to just to note for you. First of all our SOPHE banquet which will take place tomorrow evening, November 3, at the Ronald Reagan Trade and International Center, a very, very nice evening to celebrate the highlights and the accomplishments of our distinguished fellow, honorary fellow and many, many SOPHE members and students who have done exemplary work. And if you haven't already purchased a ticket to that, we still have a few left. See the onsite registration desk. We will be providing transportation from the hotel to the banquet site and then you'll be responsible for getting back here on your own with cabs or metro. But I do want to put a strong recommendation for that for your social agenda. We also have tickets for Mt. Vernon, if you are interested in taking a Saturday afternoon tour to Mt. Vernon, delightful place to visit. Please purchase your ticket by 10:30 this morning, because we can only accommodate a certain number of folks for that.

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At 12:15 today we invite everyone, SOPHE members and non SOPHE members to our all member business meeting which will be here in the Plaza Ballroom to hear about the accomplishments of this past year, to meet your new SOPHE officers for 2008 and for you to give an opportunity to give us some feedback in future directions. 4:45 today after this morning's session is when we'll all be rejoined for our Plenary IV session on policy. This afternoon we have an outstanding panel of both federal and local policy makers, state policy makers, philanthropy and I really hope that you'll all turn out for that session this afternoon.

You've been very cooperative. You notice we have to do a lot of logistics with the air wall. So I really do appreciate leaving those of you who have been able to vacate the session so that we can get those air walls and ensure your safety. Today we'll have a couple of those logistical turns and so your cooperation is greatly appreciated and thank you for that.

And now without further ado, I'd like to introduce this morning's moderator for this session. We're delighted to have Dr. Leandris Libard from the Centers for Disease Control and Preventions National Center for Chronic Prevention and Health Promotion. I'm sorry, always a mouthful at 8:30. Leandris is the Director of the Program Services Branch for that division, a very large and challenging role and among many of the

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programs that she supervisors is the Reach program. So please help me in welcoming her this morning to the desk. [Applause]

DR. LEANDRIS LIBARD: Thank you, Elaine and good morning everybody. It is my great privilege to be able to moderate this first plenary session for the second day of this very exciting meeting. I think, but I can't say that there was a single session that I sat through yesterday that I wasn't absolutely stimulated by and excited about and so we are going to start today with that same fervor, that same excitement, that same passion and commitment to the work of achieving health equity.

Our session this morning is titled Building New Ground in Cultural Competency. As our nation and communities become increasingly diverse, both how we understand and respect difference as well as how we incorporate that into our health education programs, community interventions, research, policy and so forth continues to command the attention of health education scholars and practitioners. This morning I am pleased to welcome to our panel Dr. Ruth Zambrana and Tawara Goode to share their expertise in this important work.

I'll begin with Dr. Zambrana who is Professor and Graduate Director in the Women's Studies Department and Program Director of Research of the Consortium on Race, Gender and Ethnicity at the University of Maryland College Park and she is also adjunct Professor of Family Medicine at the University of

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Maryland in Baltimore School of Medicine and the Department of Family Medicine. Her work focuses on the inner sections of gender, race, ethnicity and socioeconomic status and institutional factors and health disparities with an emphasis on Latino women and children. She has published two books, Health Issues in the Latino Community and Drawing From the Data - Working Effectively With Latino Families and most recently her work focuses on domains of patient centered care and chronic conditions among women of color. I could go on and continue to share many of her accomplishments, but I will leave that time for her to give her presentation. So Dr. Zambrana. [Applause]

Alright we're going to make a slight shift. We're going to start with Tawara Goode. So I will share her introduction with you. Ms. Goode is an instructor in the Department of Pediatrics at Georgetown University Medical Center right here in Washington D.C. She has been on the faculty of the Georgetown University Center for Child and Human Development for the past 27 years and has served in many capacities. She has degrees in Early Childhood, Special Education and Human Development and over 26 years of experience in the field. She is also the Director of the National Center for Cultural Competence at GUCCHD. Ms. Goode. [Applause]

TAWARA GOODE, M.A.: Good morning. I'm absolutely very thrilled to be here and have a chance to share the panel with

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Ruth. It's very, very exciting. Also thank the committee for extending this invitation for us to share the work in which we've been engaged at the National Center for Cultural Competence. In discussing this particular panel presentation, we are sharing a couple of perspectives. I'm going to share with you framework for achieving cultural linguistic competence and actually some insight from one of the papers that we did for the Commonwealth Fund, evidence base for Cultural and Linguistic Competence and then looking at the relationship with all of that work in health equity.

Well, many of us talk about cultural linguistic competence. I can't assume that we all share the same framework and definition. I'd like to offer you an understanding of our definition for cultural and linguistic competence that we use to underpin all of our work at the National Center. We really define cultural competence based on framework that was set in 1989 by Terry Cross, Barbara Baseron, Carl Dennis and Marissa Isaac and it was actually for children's mental health. In doing our research for the Commonwealth Fund Paper, however, as we looked at the myriad of definitions that are there for cultural competence, we frequently saw reference to this framework. Oftentimes people claim it as their own, perhaps change one or two words, but I would say that it's probably not by coincidence. We really feel that this framework is pretty much universally applicable across multiple systems of care.

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And so for the purposes of our presentation this morning, we're defining cultural competence as really requiring organizations and systems to have a congruent and defined set and values and principles. And those systems and organizations must be able to demonstrate policies, practices, behaviors, attitudes in order for them to work effectively in cross cultural situations.

We feel that there are five elements of cultural competence, particularly when we're looking at the organizational level. Must be able to value diversity. Many organizations and systems say they do, it's in their brochures, it may be on posters, but it's not reflected in the makeup and the organization, particularly as we look at the staffing patterns and especially when we look at it in terms of hierarchy. So it's really looking at value and diversity in every sense of the word.

Being able to conduct self-assessment. We've done a lot in the area of self-assessment much of which is on our website developing to and processes but this is a way in which we can look at an organization and a system to assess strength. And then to look at areas for growth as related to serving diverse populations.

A third element is looking at managing the dynamics of difference and this is really looking at this audience and probably the setting at which you work are very, very, very diverse and we have to have the skills and capacity to manage

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that diversity. Even when two people from the same cultural group come together in any encounter, it is a cross cultural situation and we need to be able to understand the dynamics of that, plan for that and address that in the things that we do daily.

The fourth is being able to institutionalize cultural knowledge. And this is really looking at the capacity of a system and an organization to acquire cultural knowledge about the communities and individuals that they're serving and to be able to integrate that through the fabric of that organization. An example would be that oftentimes there are people who are hired. They may be a cultural competence specialist and maybe someone who is a specialist in working with a particular population group. And people within the organization are quite, I don't know I could say content, to have that individual really share and take care of those issues. That's happened in our own organization. If that individual leaves the organization for whatever reason, that organization and system is right back where it started from because they've not instituted anything, anything to really ensure that that knowledge is shared across the board. So it's very important for us to look at institutionalizing cultural knowledge.

And lastly systems and organizations must have the capacity to adapt to diversity in the areas that you see listed, including the policies, services and practices. At the

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individual level, again focusing on cultural competence, individuals must be able to acquire acknowledged cultural differences and sometimes that's very difficult in an environment in which we practice political correctness. But being truly able to acknowledge those differences would be key. Also, understanding their own culture because that's the lens by which we view the world. And that's looking at your culture of origin, the culture as influenced by the disciplines in which you studied and have been trained, looking at the cultural lens by which you view the world based on your own organization. All of these are really very key in understanding how that impacts your work. Engaging in self-assessment and again we've developed tools to look at self-assessment at the individual level, acquiring cultural knowledge and skills which we should look at that on an ongoing basis, and being able to view behavior within a cultural context. These are all elements of cultural competence.

So as we think about that and especially looking at this at a systems level, systems and organizational level, each of those elements must be in place within a system, at the policy making level, the administrative level, practice and service delivery level, at the consumer/patient/family level and at the community level. And I typically say it's very difficult to be a culturally competent, you fill in a blank, researcher, health educator, instructor in an organization and

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system that does not support you with policies to procedures and resources. So we're looking at all of these things being in place as it relates to cultural competence.

We believe that cultural competence occurs along a continuum, time precludes going through each one of those levels from cultural destructiveness to cultural proficiency. And there are characteristics of organizations along this continuum and also systems. I think what's important is not to label an organization that they're culturally competent or they're not. I don't think that's particularly helpful. What's important is that you start where you are and you continue along the continuum moving in different directions. For instance, it may be very excellent in terms of supporting individuals who are teenagers and providing health education and information to them, not so good in working with elderly population; really excellent when conducting research within certain communities but not so much in being able to partner and understand the dynamics within other communities. So what's important is that you're going to be at different places at different times along this continuum and that's okay. But as long as your continuing to progress toward the positive end is what's important.

I'd like to now offer a definition of linguistic competence and again and the work and the research for our Commonwealth Fund paper and looking at the literature we saw a

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linguistic competence emerge particularly after the enactment of the Class Standard. However, we saw very few definitions and frameworks to think about linguistic competence and I'd like to offer to this to the audience this morning. We view linguistic competence as really the capacity of an organization, system and the personnel within those systems and organizations to be able to convey information in a manner that is easily understood. I can underline and highlight easily understood and that would be by diverse audiences. And we think about our healthcare delivery systems in particular. There are many, many people who have an array of communication needs. We've typically thought about it in terms of individuals who may have limited English proficiency. We wanted our framework to really extend to this truckload of people who indeed need to receive information that would be reflective of their own cultural understanding. So that may include individuals who speak a language other than English. It may include people who may or may not be literate either in English or their language of origin and it also includes people with low literacy skills and individuals who have disabilities. And that's at a minimum in terms of how we communicate that information.

A linguistically competent organization also has the capacity to address the health literacy needs of populations served and again that would be across the board no matter what language that may be. And lastly, you have to ensure that the

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organization and system has this embedded in terms of its policies, its structures, its procedures and dedicated resources. We found oftentimes that an organization may indeed or a system may indeed have this capacity but they really haven't dedicated adequate resources in order to do it. And so again looking at linguistic competence from this perspective. Your handouts give a more full definition from which to reference.

So as we think about cultural competence and linguistic competence and especially looking at the whole area of health equity, we believe that you can't make a dent, not one dent, in the racial and ethnic disparity that we see across the country unless you're looking at cultural competence, linguistic competence, community engagement, patient centered and family centered care, health literacy and partnerships between patients and professionals. And we feel that they're all intricately linked and if any one piece of the puzzle was missing, you're going to get a very different outcome. So at a minimum, again and thinking about health equity and addressing disparities, these are very key, key components and to think about those within the context of the work that you do each and every day.

I'd also like for us to think about cultural and linguistic competence within the context of organizational change. Again, in the literature we found a lot that really

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focused on cultural competence at the provider or practitioner level, not really looking at it systematically again within our healthcare delivery systems, our health education systems, our educational systems.

And I'd like to really draw upon the leadership literature on this. This is Leadership Without Easy Answers with Heifetz out of Harvard University. And oftentimes our experience has been in supporting, particularly public health programs across the country, to implement policies and procedures and really support its capacity around cultural and linguistic competence, that many times those programs approach it as a technical challenge. And that is really looking at training and that's been the major vehicle by which they approach cultural competence, that here's a workshop, here's a symposium, here's a training session, here's a curriculum. And while that might indeed get to change, it doesn't get to substantial change within systems and organizations. I suggest to you when we think about cultural competence and linguistic competence that it may indeed not just be a technical challenge, but an adaptive challenge and how do we tell the difference between those two things. And it's simply by asking the question that's posed in this slide, does making progress require changes in peoples values, their attitudes and habits or behaviors? And I would say for cultural competence and linguistic competence the answer to that question would be yes,

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yes, yes, yes because it really makes us do something different in our behavior.

And again in our work we found a great degree of resistance for cultural and linguistic competence and again we looked at this within the context of organizational change. We know that change in any way is very difficult and that people resist it because people do. But when we think about the nature of cultural linguistic competence, at some of the issues that are raised by this including at looking at issues of health equity, that resistance may be very, very different and that because it brings up issues of culture, race, it brings up issues of the isms and that's a broad range of isms that we see within our society that that resistance tends to have a very different nature. And so it's very important for efforts around systemic cultural and linguistic competence that people who are planning for it, anticipate that there will be resistance. And what we have found is that people typically do not do that. They don't anticipate that resistance. Nor do they understand the nature of the resistance. So if part of the resistance from this is basically that I don't understand this, I've never worked with these populations before, that is a very different approach that we would than if the resistance came from a place of bias discrimination and or prejudice.

Lastly, again thinking about cultural competence and linguistic competence within the context of organizational

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change, we have found in working with systems and organizations that often people talk about it a lot but there's no collective vision for what cultural linguistic competence means. And what we're seeing typically within organizations and systems is that there's not been any time in which people came together, reached consistence on what does it mean for this system, what does it mean for this organization, what difference would it make and what does it look like. And again this is from the Leadership literature and it's looking at managing complex change and it gives different outcomes that you would have if you had not gone through this process. So without a vision for cultural and linguistic competence you get confusion. Without skills, because you do need people skilled to lead this, you have anxiety. Without incentives you look at change but it may be very gradual change. You also need resources. And we found that people don't tend to put their resources or put minimal resources so you get a lot of frustration. And lastly you need an action plan. You need to know how to get from A to B and without an action plan you get multiple false starts. So this is a very interesting framework to think about cultural and linguistic competence.

I'd like to share with you very quickly Just Word About the Evidence and again this is a paper that we researched for the Commonwealth Fund, it was published in 2006. This is a model that we put forth seeing that cultural linguistic

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competence as we defined it would, if it was in place, that it would have benefits to patients and their families, communities, health and mental healthcare providers and systems and that we would see improvements in the areas that are noted there in the ovals. Quality and effectiveness of care, mutual respect of shared decision making, then we would also see corresponding decrease in health and mental health disparities, disproportionate burden of disease and mortality, systems cost, bias and discrimination.

And looking at the research and really thinking about the challenges that we have ahead of us in terms of really examining these areas in greater detail, is thinking about isolating, defining and measuring specific aspects of cultural competence. What we found is that few studies described what they meant by cultural competence nor were the elements of cultural competence measured. So that there were studies that said yes, we use culturally competent approaches, but we didn't know what that meant. And it was all indeed grouped together. Studies failed to really again recognize within group differences as we look at population definitions that include variables other than race and ethnicity. They failed to recognize that within group differences among racial, ethnic and cultural populations, just checking the box Latino, Native American, Asian does not give us much information about who an individual is nor what consists that particular population

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group. We found that there is very little in extant literature that really looked a measurement for cultural and linguistic competence. Very, very little that was indeed there. And lastly, most of the studies focused on short term and intermediate outcomes and they were not funded at any significant length of time.

One study, though, that we saw was very promising when we look at this, was the first to link cultural competence to organizational policy practice and quality of care. And this was a study done by Lew et al in 2004 that was published in pediatrics. This study showed a significant positive relationship between cultural competence, policies at sites that were caring for children with asthma who were Medicaid recipients and improved quality of care. And that was very closely associated with the use of preventive medicine, appropriate use of preventative medicine for asthma and for parent satisfaction of care. And I think what was very exciting about this particular one is that it really looked at cultural competence at a policy level. They were able to define the policies and see differences between sites when these policies and procedures were indeed in place.

Again really thinking about the evidence is that we know that with this current pool of evidence that is in an early developmental phase, that the preponderance of evidence that we saw really was conceptual. It looked at advocacy and

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there were a number of reviews. There were few empirical studies that were emerging that looked very promising and as we looked at the evidence that was existing to really support our benefits model, really those results varied. We certainly saw within the evidence, within the literature quality and effectiveness of care related to health outcomes, so that we know that cultural and linguistic competence has a significant impact there. But it was really inconclusive about decreased systems costs because we could not indeed find that within the literature. And I say that because many of us including myself within this arena have really said well, if you just do things in a culturally and linguistically competent manner, then it's going to cost less. There's not conclusive evidence to show us that.

Our concluding comments around looking at the evidence base is that we really feel that it is definitely enough evidence to warrant continued investment of both intellectual and fiscal capital to support and sustain a robust research agenda on cultural and linguistic competency in healthcare. And while again these early studies are just that, they're very early they really do hold great promise. And I encourage those of you in the audience who are involved in research, who support research to continue to add to this base.

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My last remarks I'd like to really help us think about addressing cultural and linguistic competence in lessons of the journey. We just published a monograph, it's not yet on our website but will be available and if you e-mail us we'll be very pleased to send you a hard copy, to really look at what are the lessons learned in advancing and sustaining cultural and linguistic competence over the past 13 years. And a colleague of mine who's at University of California School of Public Health at Berkley asked me to do a presentation to really think about have you learned over the last 12, 13 years and I was quite intimidated because I don't tend to talk about what I've learned. I tend to talk about things that we've done together. So I was all stressed out over this presentation and it really made me focus and hone in on what have I learned and what could I honestly think that I could share with the field. And I think this monograph is a compendium of that.

I've come up with five lessons of the journey that I'd like to share with you today. The first one is looking at leadership. When we think about cultural and linguistic competence, the leadership needs to be cultivated at all levels of organization. Oftentimes, we see individual champions and mostly they are not people who are in a decision making capacity within their organization. And so really we need to look at those leadership roles and cultivate it at every level. We also need to look at the traditional role of the leader and

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it really must be revisited and adapted to address ongoing and emerging challenges such as organizational change processes, differences across and within cultural groups, resistance to change and differences in power. So those are things that the leader would need to focus on.

We also need to look at shared ownership and again this has very interesting. Our experience has been lots of time people will think about cultural competence only for people of color. And we've seen communities that will dismiss this whole notion because quote, they don't have a lot of folk like that within that community. As we look at definition of culture we know that we're all cultural beings and it impacts all of us and so we need to be able to articulate reasons for cultural competence that everyone can share. Staff, families, community partners, and key stakeholders need to be on the same page with a shared understanding of what cultural competence is and what the benefits are for health education, for health promotion and for healthy communities.

A third one is looking at the isms and confronting the undercurrents. And many things would fall under this umbrella of the isms. One of the first things I think that we really need to think about is being able to call it what it is. What we found when there's overt discrimination that may happen within our healthcare and mental healthcare systems, people are very reluctant to call it what it is. That really makes people

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who are experiencing this feel that their experiences are not legitimate and so really being able to call it what it is, is very, very important.

Another is being able to create an environment for intolerance. And when I first did this, my secretary said did you make a typo there. And I said no, I didn't make a typo there. It's intended to say create an environment of intolerance. And that means that in healthcare and mental healthcare and health education the environment that this is no place for hate, this is no place for isms, this is no place for bias and discrimination and sometimes that message needs to be quite overt and we've not taken the time to really do that. There have been a number of successful No Place For Hate campaigns that we've seen across the country.

Another is offering a refuge for authentic discussions. We've convened these in many settings that oftentimes people don't have a chance to talk about race, issues of isms and class and sexual orientation in a safe environment. We've been able to help structure those because if we don't structure those and have forums for that to convene, the kinds of stereotypes and other issues continued to be there that really undercut the work that we want to do.

And then lastly, sometimes we have to invoke legal interventions because they're necessary because some forms of

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behavior are indeed illegal and we need to be able to address those.

Keeping It Real. Well, I chose this title because I was trying to impress my son and he was not impressed. He still said it was old language. Okay. Oh, well. What to do with teenagers. But looking at Keeping It Real really does think about unless people understand what cultural and linguistic competence means in their day-to-day responsibilities and lives, they're not going to pay much attention to it. And so they may undermine it, they may ignore it, they may make half-hearted efforts. But it certainly has to be linked to job functions, to position descriptions and many instances to performance evaluation and measures. And so it has to be real and concrete to what it is that they do.

As I think about this audience in particular looking at the research, designs and methodologies and I know that Ruth is going to talk about that in great detail, and teaching and curriculum development, so it's not just the one lecture on cultural competence or cultural sensitivity or any of those culturally hyphenated words, but it really is looking at how does cultural and linguistic competence relate to what I do in my position and research and instruction and just across the board.

Lastly when we look at cultural and linguistic competence and to really thinking about weaving it into the

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fabric of the organization, we often see that people think about cultural and linguistic competence as an add-on. We actually were asked to do an organizational self-assessment process for an entity, I'm not going to name that, but they wanted to embark on a couple of efforts that there was an organizational self-assessment process here but then we would deal with the issues of cultural and linguistic competence over here so that they would never see this integrated. And since we think about cultural and linguistic competence we can eliminate the perception that it is an add-on. It is intrical to everything it is that we do. I'm going to date myself yet again. I kind of think about Tina Turner and her song What's Love Got to Do With It? where I frequently ask people what does culture have to do with it, what does language have to do with it so that we can think about it in a way in which it is not separate and not an add-on. So it has to be intrical to the system as a whole. And so as we look at these things and thing about these frameworks and concepts and apply them to health education and health promotion and research and particularly looking at health equity, well I really feel that while cultural and linguistic competence both have a very essential role, they simply are not sufficient because we know that the isms are deeply rooted within our society and that we're needing to address this is in multiple ways.

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Lastly as we think about this theme of health equity and many of the communities that we serve are experiencing other forms of inequities and unless we're really looking at those other forms of inequity whether it's income, whether it's employment, whether it's school, whether it's other things within an environment, we can't get to health equity because again they're all intricately linked. So I'm going to conclude my remarks right now and turn things over to my colleague Ruth. Thank you. [Applause]

RUTH ZAMBRANA, PH.D.: Good morning. Buenos dias. I want to thank Ellen Alt, Henry Montez and Sophie for the invitation to speak at this annual meeting. I also want to thank Dr. Goode for an eloquent presentation on where we are with cultural competence.

I'm very honored to have this opportunity to share my thinking with you about a topic that I've been struggling with and reflecting on for the last couple of years. The goal of my remarks is to provoke, reflect, challenge and generate a larger vision on the topic of culture, cultural competency and health disparities. My goal is to interrogate how we got to cultural competency from a theoretical and methodological perspective.

In thinking about this, the questions for me have been what is the role of culture and measures of acculturation and understanding and reducing health disparities? What is there useful to date both conceptually and methodologically

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understanding health disparities? And is cultural competency the most effective intervention in reducing health disparities? Let me see if I can work this and talk at the same time.

So for this presentation I looked back at the research and asked what do we know about culture and acculturation as factors in health disparities and what do we know about cultural competence and it's translational ability to increase quality of care and decrease disparities among the Latino population. Since most of the research has been done on the Latino population, I want to give you a few sociodemographics before we proceed. 2005 Latinos represented about 14.5-percent of the United States population, 64-percent of the Latinos were Mexican, 9-percent Puerto Rican, 3.5-percent Cuban, 2.7-percent Dominican, about 15-percent South American. In March 2000 10-percent of the U.S. population was foreign born. The proportion of the foreign born population was much higher among Asian Pacific Islanders at 61-percent than other minorities, Latinos 39-percent, Blacks 6.3 and Whites 3.6. The majority of the Mexican origin persons living in the United States are U.S. citizens. Two out of five Mexican origin persons living in the United States were born in Mexico although approximately half of them migrated more than 10 years ago.

Within the Latino foreign born population about one-half, and this was surprising statistic to me, of the Salvadorians are foreign born which means that close to half

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are U.S. born followed by Dominicans and Cubans. For all other Central and South Americans who are the most recent immigrants 65 to 85-percent are foreign born. Clearly foreign born Hispanics are much more likely to be uninsured than U.S. born. In 2005 the poverty rate for Latino adults was 18-percent, for Blacks 20-percent and Whites 9.5-percent. Clearly these data vary by ethnic origins for Latinos with Mexicans having the highest rate for uninsurance, Puerto Ricans having very high rates of poverty. In terms of language, 75-percent of all Hispanic immigrants are speaking English regularly and the new report from the Child and Family Forum shows that 80-percent of all Latino children speak English.

The next question I had were well, what are the definitions of culture since that seems to be the focus of our research? I found three definitions. I will not read all these slides to you but we'll look at the public health definition. Integrated patterns of behavior that include the language, thoughts, communication, action, customs, beliefs, values and institutions of racial, ethnic, religious or social group.

Let's examine what we know about culture to determinant of health. There are many, many views on the role of culture in explaining disparities. Very different views. Some view it as central or significant predictor of health, while some view it as not important at all. Some view it as having some role which is not yet clear. And others view it as a contextual variable

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that may promote or enhance use of health services, which is directly related to health disparities. And look at these definitions, the questions that are raised from this, do we want to change the culture or do we want to help these groups negotiate another culture, the host culture? How does socioeconomic status influence negotiation and influence the fluidity of culture? How did we get to the notion that culture is a predictor of health disparities?

To answer this question we need to interrogate the role of public health and the science of knowledge production. Public health focuses on population and the common good and recognizes the social determinates of health. That is the acknowledgement that the health of populations is a function more of good public health measures and socioeconomic conditions and biomedical advances. Although public health focus since the 19th century has been on the health of populations, it has not had a steady history in addressing issues of social and economic inequality and inequity.

So how did public health link culture and health disparity? Acculturation has been the measurement tool in public health to measure culture. What is acculturation research? What does it measure? What does it reveal about group health and how to effectively intervene? In my view definitions of acculturation and what was actually measured seem inconsistent with the meaning of acculturation.

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Let's look at some of these definitions. One of the common themes in these definitions is about the influence of one society or ethnic group on another as a result of continuous face-to-face contact. The dual process of cultural and psychological change that takes place as a result of this interaction. In public health they talk about acquiring a hearing to a new dominant culture independent of maintaining the original culture. We observed from these definitions that the acculturation measure that we have used for the last 15, 20 years did not measure culture, nor the process of acculturation. For example, cultural and psychological change was not measured or cultural modifications such as changes in religious, social and artistic institutions or the affects of interaction with another culture. We are more recently measuring those through measures of mistrust and perceived racism when in the past we have not. In fact, the overwhelming majority of studies, as many of you already know, have used indicators such as English language proficiency, self-reported ethnic identity, place of birth, educational level.

Interestingly, although Cubans are more likely to foreign born than Mexicans and most are more likely to speak Spanish, few studies on acculturation and health disparities have been conducted on this group. In particular, we must question how does the finding that higher levels of acculturation to mainstream U.S. society, that is speaking

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English only and being born in the United States, is associated with poor physical and mental health among Mexican Americans? How does this inform us on factors that contribute to disparity? How does this relate to socioeconomic position in the United States for U.S. born Latinos or actually for Mexican origin or Puerto Ricans on whom the overwhelming majority of studies have been conducted?

In recent years we have had a number of critiques of does acculturation matter in health disparities? This is summary of findings. Multiple researchers have provided some critical observations. First one looks at models of acculturation have remained implicit or poorly specified. The lack of model specificity oftentimes leads to inadequate generalizations on Latino U.S. born immigrant populations. Acculturation based explanations for immigrant health outcomes are problematic in part because they place the onus of culture on the individual. As such they are likely to lead to individuals centered interventions at the expense of addressing the structural context that reproduce social and economic inequities.

Lastly, acculturation as a variable in health research when you base more on ethnic stereotyping than on objective representations of a real cultural difference. In a recent article Hunt reviewed about 100 studies on acculturation and this was her conclusion. In the absence of a clear definition

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and an appropriate historical and socioeconomic context, the concept of acculturation has come to function as an ideological convenient black wherein problems of unequal access to health posed by more material barriers such as insurance, transportation, education and language are pushed from the foreground and ethnic culture is made culpable for health inequalities. Like race, like culture they become predictors of an outcome that is larger than either race or culture.

I think there is a general agreement in the literature and we reviewed the literature on Mexican and other Latinos for the last 30 years and I think the literature clearly shows that lack of health insurance for some limited English language proficiency, although a significant number of Latinos speak English. The combination, though, of English language proficiency with poverty and a racialized ethnic group are the major barriers to quality of care in that culture.

Now cultural competency emerged from the focus on Latinos as merely a cultural group, a backward cultural group perhaps, with limited attention to their social position in society and the historic patterns of mistreatment. I think some of this was reviewed by Dr. Goode but I went back to the three dimensions of cultural competency, which when you look at the literature the one piece is in it, the other piece is in it, but this is the full picture. And what does this say to us? We need knowledge; we need knowledge of the group that we are

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serving. We need skills. Now for years we've been talking about since the 60s, you need to have a profile of whom you serve. You need to have a profile of your community. You need to know what their socioeconomic needs are. What their barriers are.

So skills, we need skills. We cannot intervene without skills yet few providers really look at who is their community, what do they need. We need a lifelong commitment to know about difference. We need a personal commitment. We need a professional commitment. The professional commitment perhaps as Dr. Goode commented, it needs to be at the institutional level, at the system level. So in what ways have we implemented all these dimensions? I think we have implemented them in varied ways throughout the system.

Then we looked at definitions of cultural competency. I think it's important to observe that we do start some of these definitions. There are two themes throughout these definitions. One are the needs of the population. The other one is system change. Interestingly I found the Office of Women Health definition to be the most vague after all these years of cultural competency we really moved away. Being aware of cultural difference among diverse racial, ethnic and other minority groups respecting these differences and taking steps to apply the knowledge to professional practice. So we have gone from a more specific framework to a very vague framework in 2007, which should be of concern to us.

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I looked at several reports that have been produced on cultural competency. I thought, again, the most interesting in mental health is that racial and ethnic minorities collectively experience a greater disability burden from mental illness than do whites. However, the higher level of burden stems from minorities receiving less care and poorer quality of care rather than from their illnesses being inheritantly more severe or prevalent in the community. I thought that was important. The other part of this is that mental healthcare disparities decrease minority groups and we are talking predominantly about the historically being represented as we looked at the data African Americans, Mexican Americans and Puerto Ricans.

The IOM on Unequal Treatment as many of you know documented disparities, fragmentation of healthcare along socioeconomic lines. Even though each and every report talks about socioeconomic status, in cultural competency we tend to downplay that which is downplaying issues of inequality and inequity. The Physicians for Human Rights clearly stated that this was a political issue of our country. The Hispanic Federation, which was the one Latino report we found the forgotten ones in 2005, again clearly talks about those issues of poverty, lack of health insurance, discrimination as major issues in looking at Latino health disparities. Commonwealth Fund, which Dr. Goode has already referred to, had some findings and looked at some issues, a lack of competence to

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address disparities and looking at the importance of documenting disparities.

So what are some of the challenges to cultural competency practice? I think again Dr. Goode mentioned these. There is absolutely a wide range of what people understand by diversity, by Latino, by cultural competency. So every word by accepting differences, respecting differences, what does that mean? So there's a lack of agreement on the terms, definitions and core approaches. There is limited research on impact and effectiveness. I think it's very hard to examine impact and effectiveness if we don't agree on any of the terminology. And misperception that the activities are focused exclusively on people of color rather than on diverse populations. And the absence of a financing funding source.

Now we have the issue of quality of care and have we reduced disparities after all these years of cultural competency, etcetera? And these two reports raised these issues. One key finding is that quality of care represents one of the major factors in health disparities. It's interesting that the Latino health paradox, which is the observation that despite having many forms of social disadvantage, Latinos on average have many positive outcomes on multiple domains was challenged seriously by the 2005 Healthcare Disparities Report. And these are some of the indicators that reflect poor quality of care. And almost every indicator, Hispanics received worse

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quality of care, and disparities were increasing for most measures. In the last bullet you see 80-percent and 60-percent for poor people.

So we ask ourselves does culture matter? I think culture matters when you're poor, when you have low levels of education and limited literacy because you have less opportunity to learn to negotiate the system, when you have limited access to quality healthcare and experience bias and stereotyping. Culture is a social construction, which is associated by perception by host society of economic and social capital and historical and political context.

Future research in the Institute of Medicine, I think has recommended this, should include a culture examination of the sources of cultural bias in the U.S. medical system. I think the important point is that an entire field of cultural competency emerged based on concepts of acculturation that measured SES and individual attributes which as yielded an inference to group attribution rather than to structural processes.

So after reflecting on what we know, central questions remained. What can we do to assure that disparities will not be an inevitable byproduct of culture or of a cultural group? Drawing from a wide spectrum of disciplines that addresses social and economic and disease of disparities, I've compiled two sets of recommendations. This model is an adaptation of a

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model from the Institute of Medicine Report where culture was on the outside. I think that culture is at the intersection of social, political and economic. It is shaped by economics. It is shaped by social perceptions. It is shaped by political ideology. It is shaped by historic patterns. It is shaped by how the society and all its domains perceive that cultural group. Negative perception of that cultural group by the main society leads to disproportionality by socioeconomic status, race and ethnicity in every single area. And I thought this really captured Latinos and African Americans are less likely to get preventive services, are less likely to have early detection, are less likely to be diagnosed or less likely to get good quality treatment and are more likely to die. So this captured, I think, how culture is at the intersections of all these issues.

So the question, which of these solutions that have been proposed in the United States will assure that disparities will not be an inevitable byproduct of culture? So here are some economic, social and community based recommendations, which we pulled from a wide spectrum of disciplines. Living wage, I think that would reduce disparities a lot. So we are currently at \$5.85, the U.S. Department of Labor suggested that \$12 a hour is living wage. Universal Healthcare and Focus on Prevention. We know that mobile vans work. We know that community based clinics work. Some coordination in this country

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for equitable public health services. Increase the proportion of ones represented of U.S. racial and ethnic minorities. The Sullivan Commission made that point very clear. The Sullivan Commission said that quality of care would improve when infusion among the represented of health professionals into those communities because of their personal and professional commitment. Community health workers. As far back as I can remember we've been saying that they work. Remotores, navigators, whatever you want to call them, they work. They know the community. Increased reporting. Use community based participatory approaches. Ask the community what they need. Don't come in and tell them what they need based on what you think.

Then we have current recommendations, which we pulled from a bunch of different reports, the Commonwealth, Kaiser, the government. Develop a consensus on cultural competency for clinicians, providers and other staff. Conduct and disseminate research to connect cultural competency behavior to specific health outcomes. Create multi lingual low literacy written material. I think that's important. Hire interpreters. Improve the capacity of healthcare providers to make accurate diagnosis. I think all of us need to reflect on this set of recommendations and decide for yourselves, which will decrease disparities for different low income cultural groups.

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I just want to conclude by saying that we have focused on culture in public health as a group deficiency, almost, when the cause of poor health is access to healthcare, barriers to healthcare and exclusion or institutional discrimination. This persistent use of implicit individual or cultural attribution deficit models in much epidemiologic and medical research has really ignored the impact of low SES, residents and low resource communities. And institutional patterns of both unconscious and conscious mistreatment, all of which contribute to disparities.

Cultural competency practice is an effective intervention when the providers know the population they are serving, understand and respond to both their medical and non-medical needs and how these influence the health status and outcome. And they have a personal and professional commitment to provide high quality care. A lot of the recommendations talked about compassion and caring and helping doctors to make a good diagnosis. That's kind of scary to me if they don't know how to make a good diagnosis. But it may be related to the fact that they don't have a commitment to these groups. We know that effective cultural competency practices exist in many community-based organizations. I have visited many professionals who are committed who speak the language, who are from that community. They oftentimes do not have the resources nor the skills to evaluate those programs but they exist.

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We also know, because I've also been there, that cultural competency at all levels exist in many high-end, for the wealthy, healthcare facilities. We know that there are translators there, that there are people to respond to these needs. However, these competencies are least likely to exist in public service systems that serve low income Latinos due to lack of resources. Does a larger vision entail asking ourselves if we had equity in our political, economic and healthcare system, how would culture matter? If we had equity, cultural competent care would probably be inherent in healthcare practice. Knowing your patients needs, having the skills to address these needs and a personal commitment to continue to learn about these diverse populations that visit your clinic or office. Thus I encourage all of us to broaden our vision because until we have a broader vision, we cannot challenge what currently exists. We need to push for equity in our system to ensure cultural competency for all. Thank you. [Applause]

DR. LEANDRIS LIBARD: Thank you Dr. Zambrana and Ms. Goode. We'd like to open the floor up for questions. We have some time, I know you have some questions.

JOHN CYPRUS: My name is John Cyprus and I'm in Kensey, Missouri and I have three points to make, not so much just questions because we haven't discussed that I heard so far the subcultural element. That just because you look at a person who looks African American, they may respond to you in Spanish,

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they may be from Ethiopia or Sudanese that it's a subculture. And what helped me learn was Justine Orr back home who's Native American who said if you look at the diversity of Europe from Scandinavia to the Iberian Peninsula, Eastern Europe to Greece, compare that to the diversity of Native Americans. But also Hispanic Latino, African America and Africans.

The second point is if you look at your community, a great resource is the medical team provides culture, companies who do services or translation services. They can give you insights to their community. It's just wonderful.

The third point is emotional. We are one of the Reach projects not funded and this caused me to say thank you for this wonderful six year opportunity to learn culture in my community. Thanks to all the Reach people who have linked us together. We complain, we need to say thank you. [Applause]

DR. LEANDRIS LIBARD: Other questions? Please come to the microphone right here.

LINDA: Hi, my name is Linda. My question is yesterday we had a speaker that spoke about how the Hispanic's lifestyle, they live longer because of whatever. We don't know what they were doing but we had a professor that said that whatever they were eating, whatever they were doing they live longer and that everything that takes us out as far as from cancer, diabetes, obesity and everything. And then I hear, I feel like I'm walking dead because I hear that Blacks, we're at the top of

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everything. And then today I hear from you is that it's the opposite. So I'm kind of confused because yesterday I heard something different about Latinos and then today I hear something else. So can you explain that to me?

DR. RUTH ZAMBRANA, PH.D.: Yes, that's a great point. Well, let me just say point in general about African Americans and Latinos. In general the data aggregate everyone. So there are differences in health status between professional, upper class, African Americans and low income African Americans. And that is a big problem from a research perspective where we take racial groups and generalize all the bad characteristics. For Latinos it is the same. I think you probably heard David Hayes-Bautista, my favorite scholar. I think the point he's making, when you look at immigrants who come here, in general they have a good diet, Mexican origin, Mexican immigrants. They eat less meat, they eat beans, they eat all the proteins. We should not be trying to change the culture, which is one of the points I am making. However, when you look at U.S. born Mexican origin in particular, over time probably economics, stress and living in poor communities, we have found has led to poorer health outcomes. There has been a myth, and it should be noted that up until 1980 Latinos were not part of the census, so that they were mixed in with Whites, so we have no baseline for knowing what was Latino health and I am sure when you are poor you tend to die young. You're a MD, right? You tend to die because you

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just don't have access to the nutritional, the healthcare, etcetera. One of the issues we see in research is that everyone is pushed together. So that it looks like all Mexican origin individuals were really doing well. That information is now being challenged.

From the other perspective, the culture is not what we want to change because there are many good things in the culture and I think that is what he is arguing, but that has little to do with the quality of healthcare received which is what we're talking about and overall disparities. When you look at people in Puerto Rico who live in the rural areas, they tend to eat much better; they tend to have a higher quality of life. Oftentimes in these conferences we don't have the opportunity to really look at or distinguish different Latino groups. One more example, the South Americans for example in this area, when you look at the Washington metropolitan area for Latinos, you see this bimodal distribution which is about 50-percent make over \$100,000, which is very different from any other place in the United States, and 50-percent make under \$100,000. When you know the history of the Salvadorian community, anyway I can't go into the history with the Latino groups but there are a lot of differences in terms of historic incorporation. In terms of color, the racialized groups, the Puerto Ricans who are Black, Dominicans who are Black, dark skin Mexican Americans have a very different experience in this country more

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similar to the African American than to the lighter skin Latinos who have a different experience. So all these factors matter. We can talk after.

FEMALE SPEAKER: Good morning. Thank you very much for two excellent presentations. I really appreciated the comment about organizational and systems change that needs to happen in regard to cultural competence. You both referenced the Sullivan Commission Report which very absently public health was not mentioned in there and the role of public health in terms of addressing health equity and how we can move the system toward health equity. Since many of us are change agents in our healthcare settings or community settings, I was wondering if you can refer us to some kind of an audit tool or some kind of an index where we can begin to making the organizational or identifying deficits and strengths in our organizational systems that support or inhibit cultural competence in our organizations.

TAWARA GOODE, M.A.: We've developed a number of such organizational self-assessment tools and have used them not just in public health settings, but as in state public health funded, county public health funded, but also for community health centers. And we have a whole section on our website that's devoted to looking at self-assessment tools, instruments and processes both at the organizational level and at the provider level.

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I will say this because I think this important, for about a five year period of our grant, which part of our funding is from Maternal and Child Health, we struggled to work with public health departments around just this, around organizational self-assessment. But they stepped up to the table that they said that they wanted to do and part of that is this whole notion of resistance to change. Once people realize it was doing something different, looking at their policies and procedures, looking at your staffing patterns, looking at position descriptions, doing things in settings and in ways they hadn't been used to, that became very challenging and that's when we got a lot of resistance as it relates to change. So we have noted, though, and some of this is documented on monograph, is that while some of these programs did undergo organizational self-assessment process, we weren't able to see the outcomes for three, four years out. And a lot of that had to do with willingness to change and then also leadership. So that one program in particular had a new leader that came in and said oh, we're definitely taking this direction. So I think that public health has a lot of self-assessment to do, not just in being able to check the list to say I have this policy procedure, but to really look at this whole notion that we have to do things very differently if we are to be effective.

DR. LEANDRIS LIBARD: Yes.

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VALERIE WELSH: Valerie Welsh from the office of Minor Health and HHS. You know I have some issues that I want to raise that are sort of just my own struggle in trying to understand these issues within my own office. But I was sort of struck by Dr. Zambrana's comments about how do we prevent health disparities from being attributed to culture and as defined by characteristics of particular communities and populations in this country and those characteristics tend to be color, race ethnicity, language, etcetera. And I would maintain that health disparities are in fact being attributed to those, at least in part, to those particular characteristics and then you also mentioned that the structural underpinnings are not being addressed because we're trying to frame the question in a way to put the issues on these particular communities of color and other types of minorities in this country.

So I would say that with health educators we're already taught to know our audiences, to know the populations that we're serving and to tailor our interventions accordingly. And I've been wondering as to how we frame these issues, the language we use to talk about these issues is very, very critical and I often question why we structure our language around cultural competency the way that we do. I mean if we are supposed to be tailoring our interventions to the needs of our audience, are we not talking about competent care. When we talk

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about culturally competent care, the framing device in this country suggests that some communities have culture and others do not, when we all have culture. And when we're talking about culturally competent care are we not suggesting that in order to provide culturally competent care we must provide competent care regardless of who those populations are that we're serving.

And I'll use another example and that is the issue of language where when we talk about linguistic competency know how these issues of English speaking, Spanish speaking, Chinese speaking whatever that the debate gets focused around whether someone speaks a particular language or not. And I have suggested in our office that isn't this about understanding and being understood. So that the question doesn't become one of whether or not someone speaks English or another language, but the fact that how can anybody communicate with each other if you speak a language, you can be speaking the same language, and a physician can be speaking at a level that's above the level of the patient and you're not having any understanding or being understood. But you frame it in a different way so that you're dealing with a common human need as opposed to reinforcing this need to speak around differences that pit groups against one another.

DR. RUTH ZAMBRANA, PH.D.: Well, thank you for your comments. They're excellent and I think public health educators

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need to develop a political voice to really express what you do, which is tailoring care to the needs of the people. In some of the new research competent care is a concept or culturally competent care is an equivalent to patient centered care. I think that's the ideal. The issue with cultural care, with culture as you're mentioning it, is that it targets one group as somehow in a deficit model approach, in a deficient way and that's what needs to be challenged. The issue of patient centered care would include a good doctor patient communication, which would need to be that they both speak the same language. I think, however, that we have taken this train, as I call it, of culturally competent care, which allows the system not to really address issues of equity and disparity and to resist system change. So I think that's why it needs to be challenged. So I agree with you.

TAWARA GOODE, M.A.: I think I probably respectfully agree with some things and respectfully disagree with other things because I think it has to do with how we understand culture and my frame workup were talking about culture, although time precluded us going through truly looking at culture and examining the manifestations of culture. We are all cultural beings. I think I did allude to that. So when I think about cultural competent care, I'm not saying that this care just for people of color. I'm looking that we need to be able to tailor what it is that we do to meet the cultural needs and

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preferences of whoever appears at the door, whoever that may be. And I think that it's basic lack of understanding of what culture is and the myriad factors that impact culture. We tend to think about culture around race ethnicity, sometimes gender, sexual orientation, etcetera, but that is not how we should think about culture. So I do think that all care should be culturally competent because we cannot separate ourselves from our culture, our culture of origin.

I also like to think about the convergence of cultural context. When we think about healthcare, healthcare has its own culture, it has its own language, it has its own norms and ways of doing things whether that's healthcare, mental healthcare, social service systems. People have to be able to navigate their systems, understand what people are talking about in a language that may be English but it may be foreign to them. And so I do think that we are indeed looking at understanding the nature of culture and how it plays out and that what is happened with the misunderstanding of cultural competence, I'm going to say that, is that some of the early work really looked around, this is what you have to do. I call it the four food group approach. This is what you do with African Americans. This is what you do with Latinos. This is what you do with Asians. This is what you do with Native Americans. And that is a very culturally blind way of approaching that because when

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you know me, you only know me. You can't look at the entire race and make some kind of a judgment as it relates to that.

I also think that we acknowledge within group differences so that there are significant within group differences that, I used that term today I think earlier but was looking at the differences that we see in and among and between racial ethnic cultural and indeed political groups. And so I think that people have to define what does cultural competence mean for them. What does it mean within a context of what it is that they indeed do and to truly understand the meaning of that. We always approach it from a systems change perspective and that culture is key to everything that we do because again, we are cultural beings.

Lastly, cultural competence and linguistic competence aren't going to cure disparities. It is one approach in addressing disparities in achieving health equity. Again there's clear discrimination, there's racism and bias. And cultural competence doesn't fix that. It does not fix that.

DR. RUTH ZAMBARA, PH.D.: I just have one point.

DR. LEANDRIS LIBARD: Sure. And then we have a question and then we need to wrap. See I told you this was going to be very stimulating and a good way to start the day.

DR. RUTH ZAMBARA, PH.D.: I just want to add to Dr. Goode. Culture is important when that culture is perceived as inferior. So the higher the racism, the higher the importance

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of the culture. However, the higher the SES, the lower the importance of the culture. So I think when people, culture doesn't matter to me, I mean I go to the doctor I hope for good quality care. So the higher the SES the lower the importance of the culture and I think it is that intersection that we are missing when we talk about cultural competence. That because of the society we live in, because of the racism and the way different groups are perceived that those perceptions influence how they are treated and the type of care they get.

DR. LEANDRIS LIBARD: Thank you.

LISA WEXLER: Hello, good morning. I loved the direction that this conversation is going because I think these are issues that really need to be brought up. My name is Lisa Wexler. I work at UMass Amherst and I work primarily with Alaskan natives. And what I'm curious about and there's been some allusion to it but there hasn't been any language around whiteness and the structures. If you want to look at whiteness as an ideology that permeates the healthcare systems that we work with and that is a huge part, I think, of perpetuating the disparities that we're seeing but also perpetuating the ways that certain culture groups are treated within those systems. So I think to name it, to name it and be better at understanding it a huge piece of culturally competent if that's the language you're comfortable with. But it's not just understanding them, it's understanding us and how we do things

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and the structures that we build our services on are very much Western and they very much buy into a very White ideology that sometimes does not serve the needs of the people that we're working with. So I think that sort of gets to a different level of self-examination and self-assessment that I think all providers should be really working with. So I guess where is that conversation about whiteness in this conversation and why isn't it more on the floor?

TAWARA GOODE, M.A.: Well, couple of things. Thanks for bringing that up and to be provocative. I probably may not call that whiteness in terms of the way our systems are indeed structured because that may be from the basis of the fact that all White people are alike and to me that substituting an old stereotype for a new one. When we look at White people, I would say that there's a great degree of diversity among White people and I think about the cultural influences on individuals who may be White, not just looking at race and not just looking at ethnicity, which would be important, looking at gender, but there are lots of other things that make people different whether they're White, whether they're African American, whether they're a Latino. I think that when we think about the way the system is and it may be historically structured by many people who have similar training, similar approaches, I wouldn't necessarily name it White, although people do need to look at in a great degree the extent to which culture, because

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again it's cultured medicine, it's cultured public health, they are inter-related and how all those things impact the way services and supports are delivered. With that said our self-assessment instruments do indeed probe looking at your cultural beliefs and practices that may be influenced by many things, not just race.

DR. RUTH ZAMBARA, PH.D.: You said that the whiteness ideology has to be interrogated by White people. It gives it more legitimacy. So I'm hoping that a group of more progressive public health people who are White will begin to interrogate that so that it would have some legitimacy and authority and our battle within that group rather across racial and ethnic groups, which of course is always a losing battle for us.

DR. LEANDRIS LIBARD: And I want to add just to really affirm the whiteness aspect and there is some literature around that that's coming out of the Humanities, not so much out of our arena, but the unspoken much of what we've been talking about are the one word that is also, it means it's as broad a construct as culture is the notion of power. And so the unspoken is about power and about the unwillingness of those in power to reconstruct their context to shift the power to the community, to the patients, to those so even in our kind of traditional understandings of cultural competency its unidirectional and we have to critique, interrogate the healthcare system and we have to, as Ms. Goode said, confront

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our own political correctness and how that's getting in our way and not dealing with the isms and I just want to reference one thing that you all get a chance to read it. Some years ago Cornell West wrote a book called The New Cultural Politics of Difference and I thought about that as Dr. Zambrana was talking about how higher SES lowers the importance of culture, the importance of culture because in some environments there's this attempt to do what I call an erasure of difference. So if I have a Ph.D., I'm in this room, we're all alike. Well, when I leave here and go to the airport, people don't assume I have a Ph.D., that I just left the SOPHE conference, that I work at CDC. It is something else.

So as the moderator I need to end. I knew I was going to get caught up in this. So thank you everybody for your attention and enjoy and continue to be inspired for the rest of the day. [Applause]

[END RECORDING]