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Encouraging More Culturally & Linguistically Competent Practices in Mainstream Health Care Organizations:

A Survival Guide for Change Agents

Thomas D. Lonner, PhD
tlonner@qualityhealth.org

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www.thomaslonner.com

access

Organizational Development & Capacity in Cultural Competence:
Building Knowledge and Practice

engagement

opportunity

inclusivity

accountability

diversity

openness

Organizational Development & Capacity in Cultural Competence:
Building Knowledge and Practice

Ask anyone who has been working for a sustained period of time to promote cultural competency, build multicultural capacity, or develop culturally responsive systems of health care and they can tell you that there have been decades of effort devoted to increasing recognition of the need for action to address the health needs of diverse communities. They may sound a bit weary, for systems and institutions are slow to take action, and even when plans are in place, progress often proceeds at a snail's pace...or so it seems. Champions and change agents inside organizations soon recognize that working toward tangible changes felt by patients, clients, and communities affect organizational systems, structures, and practices, along with individual level skills and behavioral change. We believe this kind of leadership, awareness, and investment in organizational development and capacity building, beyond episodic training and policy development, are what determine the pace of change. This monograph series articulates several approaches to organizational development and capacity building in cultural competence.

A Critical Juncture – Development of the cultural competence field has been from the margins of a system that has not fully embraced it, but recognition of the systemic changes required to work effectively with culturally diverse communities are more than a notion. Now is a critical stage in the journey. Can cultural competency become integral to the way that health services are delivered? Will it remain on the margins, trying to push its way in? Or, will it simply fade away as a well meaning, but failed experiment? A lot is at stake – the health of our nation and, particularly, populations with the least access to care which suffer the greatest impact of disparities in health and health care.

Momentum Built – Looking back over the past two decades, the momentum built has been noticeable. Many large health systems – both public and private – have taken action. The players who are engaged in this work are broader than ever before and are lending more teeth to the effort. For example, the Commission (formerly the Joint Commission on Accreditation of Health Care Organizations) has begun to highlight issues of linguistic and culturally appropriate care in its accreditation processes. In the nonprofit capacity

building field you hear more and more people say that such competency is an essential component of organizational effectiveness. Now the movement for cultural competency has accumulated a wealth of experience and knowledge that can serve as a foundation for future action.

A Field in its Infancy – From another perspective, these efforts are still in their infancy. Several decades in the history of humankind are but a speck in time when compared to the years of human experience and knowledge accumulated for many cultural health practices, the science of western biomedicine, and even the development of modern health care systems. The field of cultural competency is relatively new, and from this perspective, is just beginning to develop knowledge and wisdom. There is a relatively short history to learn from with little or no evidence base or consensus about what works and what doesn't work. Given this, cultural competency practice provides us with an amazing laboratory for learning.

Need for Good Theory and Practice – Ask anyone who has been in the field of cultural competency for years and they will tell you that many cultural competency efforts are ill conceived. They can cite examples of organizations seeking "quick fixes" through two-hour workshops, which, by the way, managers will not be attending. They can also tell you about concerted efforts that "fail" or that are not sustained over time. One reason these efforts do not succeed is that there is no shared understanding of what success looks like, let alone a clear path for how to get there. Even the term "culturally competent" may suggest a static state that may sometimes direct much effort and energy toward a finite point rather than generative capacities of learning and adaptation. We need both good theory to inform our practice and practice to inform our theory. We need *praxis*, which occurs in the dance between theory and practice, resulting in greater knowledge and, ultimately, more effective practice.

Purpose of this Series – This monograph series came about as a result of the desire to dance the dance of theory and practice in looking at how to make cultural competency come alive in organizations. Its purpose is to promote learning and strengthen the effectiveness of both theorists and practitioners in the field. It explores a variety of frameworks for organizational development or capacity building

and their implications for practice, taking on a number of issues that arise in real world practice. At essence, the basic questions explored are "Where are we going?" "How do we get there?" and "How do we know when we've made progress?" Its audience is not the unconvinced; rather it is aimed at those people who are working as change agents within health organizations. It is assumed that the reader acknowledges the importance of this work and wants to look deeper into the complex issues that arise in practice. This monograph series will serve as a jumping off point for a convening of change agents in health organizations who will add their experience and perspectives to the dialogue.

Monograph Series Partnership – This monograph series is produced through a partnership between CompassPoint Nonprofit Services and The California Endowment. After commissioning several cultural competence change agents and researchers to draft papers on organizational development and capacity building practices, The California Endowment asked CompassPoint to organize a day-long dialogue about the papers with cultural competence change agents within health organizations and capacity builders who have worked with health organizations in this area. Ignatius Bau, Beatriz Solis, and Dianne Yamashiro-Omi have all been integral to the planning of this dialogue. For The California Endowment, it is an opportunity to contribute to their vision for culturally competent health systems, which involves partnering with multiple players in health systems, educational institutions, businesses, and communities to develop research, policy, practice, education, and workforce development.

As a nonprofit capacity building firm based in the San Francisco Bay Area for the past 30 years, we have witnessed and helped to support the changing orientations of community-based and community-led nonprofits through work on strategic plans, board member composition, and staff recruitment that has only slightly lagged behind the sweeping demographic changes in our communities. This monograph series has been a wonderful opportunity to summarize our capacity building work in cultural competence, work that has developed over time through the lens of organizational effectiveness frameworks.

Description of Papers – The authors in this series share a common set of values as well as their own unique perspective.

- Mayeno's papers discuss the applicability of multicultural organizational development (MCOD) for building the multicultural capacity of health organizations, positing that multicultural capacity and equity are interconnected. The papers look at theories from the behavioral sciences, which have been applied in organizations, including Lewin's field theory and Prochaska's transtheoretical model, more widely known as the "stages of change."

- Lonner's paper, which had many sections co-authored by Beatriz Solís, is written as a survival guide for change agents and systems who intend to advance the cultural and linguistic (C&L) practices of mainstream health organizations. This paper discusses the key challenge of introducing C&L advances into the cultures, interests, and features of large mainstream health care organizations. Its perspective is that the organizations, not the patients, pose the cultural challenge.

- The National Community Development Institute's (NCDI) paper delves into the definition of culturally-based capacity building, presenting three field experiences in which this framework was applied. For NCDI, community is central to culturally-based capacity building. In the case studies presented, capacity building is informed by community voices, conducted in partnership with community, and works for community transformation. Organizational players are co-learners and resources for community.

- CompassPoint's paper discusses the relationship between improving cultural competency and improving organizational effectiveness. It also describes a capacity building approach to improving cultural competency in an organization where systems issues are dealt with through the lens of multicultural organizational development.

Invitation to Readers – In closing, we invite you, the reader, to see yourself as a contributor to the learning laboratory. We hope that these papers stimulate new thinking, provide new ideas for practice, and raise new questions. We hope that these papers remind you that you are not alone in the challenges you face. We invite you to read with both a critical eye and with an open and generous mind. We recognize that that we are on a collective quest and that none of the authors has "the answers." Each has taken the risk of committing their ideas to paper. We invite you to engage with these papers as part of an ongoing process of learning from theory and practice, taking what we learn and exploring ways to apply it. It is in this spirit of building knowledge that we will widen the practices of creating culturally competent health organizations, and speed the pace of change that is needed to serve and engage people and communities.

Many Thanks – This series and the convening held on July 30, 2007 to discuss the papers would not have been realized without the steady stream of projects, meetings, and networking and grantmaking conducted by Ignatius Bau at The California Endowment. Ignatius is all about widening the field, and we hope that this monograph series contributes to that effort.

Along with graciously agreeing to rounds of review and editing of their papers, each of the monograph authors also reviewed each others' papers and participated in discussions and planning meetings to shape the day-long dialogue on July 30, 2007, that we organized in conjunction with the release of the monograph series. Anushka Fernandopulle, Beatriz Solís, Laurin Mayeno, Omowale Satterwhite, Shiree Teng, and Tom Lonner, along with the many organizations they have worked with, have seen lots of pages recycled as they put their ideas to keyboard. Each of the authors has many thanks and appreciations for comments they received earlier on their papers, and they are acknowledged with those papers.

I want to thank Laurin Mayeno and Ignatius Bau for helping me navigate through additional conferences, documents, health parlance, and organizational acronyms so that the planning and production process was even more thoughtful and inclusive. In addition to the authors, Ellen Wu, Ignatius Bau, Dianne Yamashiro-Omi, and Melissa Welsh have all contributed their thoughts to this series. Jeanne Bell provided editorial guidance and Cristina Chan combed through and made additional suggestions on each of the papers as copy editor of the series. On behalf of these individuals, we thank the many organizations that we have worked with and that informed each of the papers. Within this large group are the champions and change agents that generated the successes and lessons that we see happening throughout California.

Steve Lew
Director of Organizational Impact
CompassPoint Nonprofit Services

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tlonner@qualityhealth.org   www.thomaslonner.com

I. Executive Summary

The purpose of this paper is to encourage and guide a very narrow potential audience – those change agents internal and external to mainstream health care organizations and systems who intend to advance the cultural and linguistic (C&L) practices of those organizations. The conclusions are based on years of research conducted on the cultural and linguistic advances in public and private hospitals, clinics, and provider offices.

The central conclusion is that the key challenge is how to introduce C&L advances into the cultures, interests, and features of large mainstream health care organizations, not how to define or implement these advances or how to serve the various patient cultures presenting themselves for health care services. From a cultural perspective, it is the organizations not the patients who pose the cultural challenge.

Contemporary health care provider organizations are far more complex than outsiders (and most insiders) can readily understand. Their core purposes and constantly changing procedures, power relationships, and bureaucratic procedures are invisible to most and pose a minefield to both internal and external change agents. To the degree that power is distributed widely within such organizations, this minefield can be quite great to member hospitals and to major departments. Change agents require reliable maps to the organizations in which they intend to create C&L advances. They require just as accurate understanding of their organization's culture(s) as the organization does of the community culture(s) it serves.

It is possible to create and measure C&L advances expressed as new and enhanced practices in medical encounters, treatment team encounters, non-clinical support services, and specific units, departments, and facilities. These practices become manifest where cultural and linguistic competencies are significant, that is, the *intersections* between provider and patient and between provider organization and community. It is far more difficult to create and measure C&L advances in multihospital corporations which have no such intersection and whose concerns and business products are financial,

technological, and policy. Until such policy is implemented through observable practice, its meaningfulness is unknown.

C&L services are a low priority in most mainstream health care organizations. As a result, change agents require evidence to support the "cases" required by each critical organizational decision maker to even consider supporting or allowing C&L advances. As many mainstream organizations are generally indifferent to or unaware of the importance of C&L concerns, they tend to keep their investments in these efforts very small and to delegate them downward and away from the center to the organizational periphery (i.e., facilities, departments, offices) as rapidly as possible. This "non-approach" to culture and language is typified by minimalism, formalism, deferral, and voluntarism (described in detail in the text).

At these lower, operational levels, resistance to C&L is couched less in the political terms that tend to accompany "special" services to minorities, and more in the new and additional techno-bureaucratic challenges that external forces constantly pose to provider organizations. In this sense, C&L advances and the immediate practical response to them is typical of all quality advances in health care. The techniques used in other quality advances can serve as reliable guides to the course and prospect of success in C&L services.

Quality advances have often been associated with the perceived need to 1) make enterprisewide transformational cultural changes and 2) follow extensive strategic and implementation plans. Both are frequently experienced as methods to defer taking practical, effective, meaningful, and immediate action. It is suggested that the necessary internal cultural transformations will occur as the result of altering practices and behaviors and reaping the rewards from doing so, in other words setting the path for a continuous stream of changes through *pervasive incrementalism*.

Experience suggests limiting initial planning to the first two to three steps. Future actions should be determined by events on the ground where the organization and the community, the provider, and the patient engage one another. These events will determine the degree and manner in which mechanical or organic, technological, and interpersonal advances should be pursued. Unlike large centralized technology advances, the history of C&L "centers of excellence" suggests that C&L advances are best pursued in an emergent evolutionary fashion, specific to each relevant organization, its functions, and its service community.

C&L concerns are far more germane organizationally at the direct service level where access to and control over resources are most limited. Yet, within large systems, C&L advances are most likely to start at peripheral locations with minimal resources, rather than in corporate or executive headquarters. Equally, while executive mandate, license, or sponsorship can be quite helpful, it is far more common for C&L advances to begin in peripheral locations and be led by second, third, or fourth tier managers. C&L advances are directly dependent on these issue leaders and their ability to manage complex matters and relationships above, around, and beneath them. Advances licensed from the top of an organization or system run the risk of never

producing improved practices on the ground. Conversely, advances made at the organizational periphery run the risk of never altering the practices of sister departments or the larger system. Both risks result from the failure of internal organizational communications capacities and practices.

My examination of C&L projects concludes that, in every organizational setting, it is not the organization that acts but only key individuals. Successful advances are directly dependent on key individuals willing to engage in risky but rewarding change on behalf of broad organizational purposes. These key individuals function as issue leaders, local champions, local experts, and energetic project sparkplugs, and their sidekicks as coconspirators.

As a guide to change agents, this paper suggests the need for every change agent to become more expert in the organizational context in which they work: the core interests of key executives, the power relationships between the center and the periphery, the likelihood of engaging second and third tier executive champions, the value and personal relationships among mid-level managers and regional authorities, the levers and procedures most likely to create near-term and sustainable operational advances, and so on. Since any of these organizational attributes can cripple an advance or increase its likelihood of success, acquiring such expertise may require change agents to conduct extensive but informal individual inquiries among executives, managers, and other influential persons.

In sum, *the brightest prospects for successful C&L advances emerge from multiple, overlapping, self-sustaining, and mutually supportive advances in practices initiated in a significant peripheral location (e.g., site, department, or function) led by an issue leader or change agent with strong professional and interpersonal attachments to influential executive champions – and their interests – in the organization's high to middle (e.g., regional or operations) functions*. In these peripheral settings, the "organizational culture" is the sum of the values and real operations of provider organizations at the points closest to the direct delivery of service, that is, *the periphery of the organization, but the center of the service*. In proceeding with a pragmatic, facility-based, staff-based, or unit-based C&L advance, the most important elements include clear expectation setting, the empowerment and coaching of mid-level operational leaders, a focus on exact operations, the provision of effective tools and approaches from experts, and the provision of streamlined rules and measures. These combine to create "sticky habits," perhaps itself the best definition of practical organizational culture.

II. Purpose of this Paper

The purpose of this paper is to encourage and guide a very narrow potential audience – those change agents internal and external to mainstream health care organizations who intend to advance the cultural and linguistic practices of those organizations. It is my belief, based on spending much time with and posing many questions to similarly situated change agents, that new change agents would benefit from better guideposts and warning signs to increase their chances for personal, professional, organizational, and project success/survival and to reduce the great inherent, but often invisible, risks related to being a change agent in a modern American health care organization. This approach is complementary to the assessment tools, implementation checklists, and experienced consultants already available to them.

As with other survival guides we find on the shelves of outdoor recreation stores, this will not always be a happy narrative because not everyone survives or succeeds. I have sacrificed happy talk for what I hope is clarity in service of change agents' survival and success, by addressing what I would want to know if I were a C&L change agent. Readers will find numerous lists of key concerns unaccompanied by extensive text, to keep the guide from becoming a book. Change agents can use these as checklists, asking how the concerns are addressed in their own organizations and work.

What I intend to convey to change agents is that 1) the cultural challenges are real, 2) the difficult conceptual and practical issues can be managed, 3) local solutions for local communities and local facilities are required, 4) organizational cultures and practical contexts must be understood and accommodated, 5) the results of initial steps can be measured and found rewarding, 6) organizational measures and measurements must focus on tangible local advances and their beneficiaries, and 7) organizational advances require sound management structures, practices, focus, and tools.

III. Background of this Paper

This paper flows from a question posed to me in 2005 by a program director of The California Endowment: "Is it possible to measure progress in culturally competent performance in health care organizations?" I was just in the process of completing a meta-evaluation of The California Endowment's Strategic Language Access Initiative from 2003 to 2006. My associate, Beatriz Solís, and I had conducted this research of over three-dozen large and small projects conducted in public and private health care institutions and systems in California and elsewhere. Based on continuous participant observation and open-ended interview methods and continuous case comparisons, we discovered many probabilistic aspects of directed cultural and language (C&L) change intended to inform future Endowment investments.

Our evaluation work was largely descriptive and focused on the *flow of new action* within these institutions. However, since we had to account for the forces that were constraining and shaping the relative success of these actions, our evaluation produced some larger research findings as a byproduct; as researchers, we just could not stop ourselves from making these findings. Our investigations resulted in several serialized highly detailed book-length reports of emerging discoveries.

The new "measurement question" led to the necessary consideration of several preceding questions of vital practical importance to change agents:

- At an action level, what is culturally competent performance?
- What arguments can sell the desire to be more culturally competent to mainstream health care organizations and who needs to be sold that desire?
- How can or do organizations or systems become more culturally competent?
- What are the forms and content of organizational resistance to this particular change?
- How is such resistance bypassed, finessed, or overcome?
- What knowledge, skills, and personal attributes do change agents, at any organizational level or location, require to survive and succeed in these organizations?
- Are the most likely C&L advances transformational or incremental, practical or conceptual, mechanical or organic, technical or attitudinal, centralized or peripheral, person-based or process-based, externally driven or internally sustained, executive-led or follower-led?

Logically, matters of measurement would be the last consideration of these preceding matters.

To begin to address these questions in this paper, I have borrowed from some of The California Endowment findings (including italicized quotes from respondents), from other studies I have performed (Lonner 2000a,b), and from my own experience as a program administrator and change agent. Within the last nine years, I completed a major field inquiry for The Robert Wood Johnson Foundation on cultural

competency in Medicaid managed care, focusing largely on a representative set of community health centers, family practice practitioners, and Medicaid dominated plans. This experience has formed much of my understanding of what cultural competency is at the level of direct action and thinking. During the same period, I also completed studies of community development within refugee communities and community engagement in diabetes care, tobacco cessation, and substance abuse prevention. All of these added to my understanding of the intersection of community and organization, a topic that has dominated my professional career since 1979. And, of course, I have benefited greatly from the published work and unpublished contributions of insightful colleagues.

A number of inferences and conclusions to consider have emerged from this excess of research findings. The conclusions are intended to spur debate and the consideration of contrary evidence. I cannot estimate the degree to which these inferences and conclusions can be generalized to other organizations in other locations or specific enough for some organization to construct practical C&L actions. I do suggest, however, that it would be risky to dismiss them in pursuing practical advances or actionable theories.

Some readers may object that some elements common throughout organizational change theory routinely appear, but are just recast a bit; the way consultants often do when repackaging old information in new paper. They may object that these common elements are presented 30 degrees "off-bubble" merely to make them appear more interesting. Without apology, I suggest that the paper highlights contextual, internal, and relational features that some others ignore but that I could not, namely that 1) the elements appear as I found them in research observations, interviews, and grounded comparative case analysis, 2) they lead to somewhat different conclusions for policy and action, 3) they are less politic than practical, and 4) they will actually reduce the risk to change agents and investors in change.

IV. Personal Note and Methods

Based on objective inquiries, this paper does not pretend to be either dispassionate or politically correct to either the cultural competency advocacy or health care organizational establishments. It is my personal view based on my entire career of objective applied policy and action research focused almost exclusively on organizational actions on behalf of certain societal values related to ethnic and racial minorities in United States. It is the product of over thirty years of moderately successful applied policy research on behalf of different specific minority communities and their issues in the United States, combined with my own roots as the son of impoverished limited English proficient (LEP) refugees to this country. I continue to recognize my own parents in the impoverished LEP patients in the waiting rooms of primary care facilities and in the wards of our hospitals.

It was never my intention, at the outset of my career as an applied medical sociologist, to focus my career on these matters and populations. It just happened that way, for which I am forever grateful; it gave focus and purpose to my career. It also has created a contentious career, in that I seem to be locked in perpetual combat with public agencies, legislative bodies, and large organizations that do not always welcome a dose of cold reality from the very communities they suggest they wish to assist. Too often, as the legitimated academic intermediary between community and agency, my reports have to be couched in too-diplomatic terms for my taste.

Most of my research is commissioned by large organizations and is not addressed to academic audiences or the general public. Because these reports need to be heavily defended to these very critical audiences, they tend to result in book-length products. Without exception, my work intends to answer their applied policy questions and future action concerns rather than to test or produce theories. It is, more often than not, treated as proprietary material, even in the public sector. Many have to access my reports by filing Freedom of Information claims.

At a personal level, I have become increasingly impatient with the exceedingly slow processes of health care organizations that, so far, seem unable or unwilling to even start to put their toe into the C&L waters. If progress is produced by nothing more than putting one foot carefully in front of the other, I wonder at their inability or unwillingness to do even that. I am frustrated by their stated need for considerable planning to precede taking any action, because such extensive planning often results in long-deferring action or taking no action at all. That form of organizational thinking started being abandoned decades ago in favor of more emergent and evolutionary approaches to change in other service sectors. Too often, this approach is a smokescreen, a way of fending off taking that first step, like those writers who fail to write their great novel because they never have enough pencils sharpened.

Many working to change C&L realities in health care delivery feel that the frictions over culture and language in human services are relatively new, beginning with, say, Terry Cross, et al. in 1989. But the flowering of C&L awareness appeared

in the 1950s through the 1980s in major books on culture and medicine by such authors as Alan Harwood (1981) and Margaret Clark (1959), in culture and nursing by Madeleine Leininger (1970-1994), culture and social work by Elaine Pinderhughes (1989), and culture and mental health by many authors. These beginnings were coincident with the development of community health centers whose successful efforts and practices in cultural, linguistic, and community bridging remained unpublished and unheralded in the wider health care community. The persistence of inadequate responses to the C&L challenge over these decades is astounding and dismaying.

Many are impatient with the "slows," the amount of time it takes for cultural and linguistic messages to be refined, disseminated, and heard, and for health care organizations to get past the "We don't have the data" approaches to understanding the problem and the training approaches to solutions. The organizational "slows" take many common forms: revising the mission statement, conducting strategic planning, conducting executive and staff trainings and orientations, performing assessments and other studies, mounting pilot projects, reprioritizing budgets, developing technologies, changing workforce recruitment policies, and on and on. Yet from everything that I know about contemporary health care organizations and from the literature on organizational change, I recognize that such change must be incremental and takes time; it is simply the way large organizations conduct their normal business.

On the other hand, every month and every year that passes produces literally hundreds of thousands of provider-patient encounters in hospitals, clinics, and physician offices where critical communications are severely compromised by 1) the lack of language supports and mutual cultural understanding and 2) broad financial policies and operational procedures do not reflect the needs of the communities that are to be served. While lacking definitive and unassailable scientific evidence concerning the avoidable negative health care and health status outcomes associated with these compromises, there is no argument that the actual risks to health status (e.g., misdiagnosis or noncompliance) are unacceptable (Goode, 2006; Divi, 2007).

Arguments based on social justice and national health care disparities statistics may lead one to continue to accept the need for long timelines to accomplish large social equity objectives, but concern for the care of current patients and the efficacy of the work of current providers suggests that there is a need for persistent impatience – 1) a demand that organizations take some immediate, concrete, and important first step and then 2) patience as long as each continues to pursue systematic and sustained progress after that step. My personal impatience is spurred by frustration with the limited means we have to persuade organizational actors to open their minds to sources of change – reason (theory, argument, and evidence), chance (opportunities, situations, and experiences), or passion (empathy, intensity, dedication, and commitment). Our difficulty in expressing the need for cultural and linguistic competency in words is like describing dance, music, art, or nature in words. We know it best when we see it. We can only approximate it in words, which is one reason why our discussions are so complicated

and our choice of words so careful and hedged or over-the-top hyperbolic.

I am also impatient with the too-facile bromides sold to health care organizations in cultural competency and linguistic services, many of which have been oversold as total solutions to organizational obligations (e.g., "This turnkey product will solve your problem") or, conversely, undersold in their significance (e.g., "This is a nice charitable benefit to our patients"). I have been troubled by the spate of overly simple solutions that bear no proven relationship to the desired outcomes for today's or even tomorrow's minority patients and communities. I have been troubled by "perfect" solutions, in which "the perfect becomes the enemy of the good"; that is, the perfect appears so complicated, expensive, and formidable that organizations fear the inevitable costs of taking even the first practical step. And, finally, I have been troubled by "the curse of the good enough," in which organizations, having taken their first minimal and formal step, view that step as sufficient and therefore it is their last step.

But I am most impatient because I carry around numerous images from my field experiences in real life health care settings. In one, I am present in a Filipino community hall in which a nutritionist is presenting information on daily diet to a number of diabetics and their families who are puzzling through her presentation. Only in the third hour does it emerge what she means by "portion," described by one Filipina as the size of a deck of playing cards, a staple of Filipino community life. The community knows far more than it is credited with.

In another, an African-American high-risk obstetrician, who for many years has used the assistance of interpreters in his work with his teenage Latina patients, describes to me his great frustration at learning that when counseling these patients on the problems of gestational diabetes and the need to maintain proper blood sugar levels, for years they have left his office thinking that they have too little sugar below their waists.

And, finally, there sticks with me the scene of a monolingual elderly Chinese woman arguing about a small co-pay with a Euro-American pharmacist through the holes in the Lexan barrier in the pharmacy. Frustrated, she is screaming at him in Cantonese and he, increasingly red-faced and half out of his chair, is screaming back at her in English and no one is there to solve this simple problem of mutual incomprehensibility.

From time to time, I have provided training to C&L organizational change agents. I spoke very little about cultural competency and far more about how they needed to understand the organizations in which they work. Few understood the organizational building blocks as their executives and managers do. Those who work in organizations tend to work in their own silos and fail to see the whole. It is dangerous to assume that, from these silo vantage points, we understand our organizations, without actually speaking with other internal experts. I pointed out the dangers of returning from training full of the zeal of the convert, pursuing the true and the good, and then tripping through

the hidden minefields of their home organizations. I was concerned that, without knowledge of their own minefield, they would do immediate harm to their career and employment.

There is no one right way to tell my story of organizational C&L advance. It is hard to choose which thread to pull to unravel that mystery. So, I will start at the end, the most positive part, in chapter V which addresses the question "Is it possible to measure progress in organizational cultural competency in health care?" The answer to this question 1) establishes what I mean by organizational cultural competency and 2) supports my key contention that health care organizations can develop and sustain observably more culturally and linguistically competent practices.

I follow chapter V with an equally important chapter on the cultures of health care organizations and how they can be usefully addressed. The ensuing chapters provide more detail and complexity (sorry!) on critical aspects of health care organizations and change agency.

V. If You Can Measure Advances, You Can Make Them (and Vice Versa)

1 Since You Can't Measure Cultural Competence, It Doesn't Exist?

Given that cultural competency is perceived by many in health care delivery as an invisible, ineffable, and unwelcome challenge, they often raise the following objection: "You can't exactly define or measure cultural competency, therefore you don't really know what it is, therefore we don't have to do it." This is a canard (the absurdly false argument, not the duck), similar to those attacking theories based on hard-to-measure elementary particles in the physical sciences. As a researcher, I am compelled to reject this perspective.

The best way to conceive of organizational cultural competency in health care is as a continuum with no absolute fixed endpoints; that is, there is neither an exact bottom for total cultural incompetence nor an exact top measure, because no person or organization can pretend to total cultural competence. Similarly, there are no absolute measures to directly compare the cultural competency of different persons or organizations.

While cultural competency does not appear on an absolute scale, it readily appears on a relative scale, in which a per-

son or organization may perform in a more or less culturally competent manner compared to themselves at earlier points in time. Every person or organization can perform in a more culturally competent way by engaging in new practices, better practices, more practices, and different practices, all of which are themselves measurable. When we talk about health care providers and provider organizations implementing C&L advances and becoming more culturally competent, we are talking about their performance in moving on their own continuum from one point in time to another.

For researchers, the very concepts of performance and "movement toward more" provide us with the logical basis for systematic and valid measurement; indeed, the practical specification of the content of "movement toward more" is the basis for all quality advances. In cultural competency, "more" is defined as actions and movement from one observable and measurable set of practices, behaviors, relationships, and investments to others. Once we have found these truly observable phenomena, measurement becomes easier (but never easy) because then we have even more good measures, such as location, persons, content, direction, scale, pace, timing, effort, and outcome. To the degree that we are also committed to the quality of these advances, we can also specify and measure aspects of them, such as their adequacy, appropriateness, accessibility, affordability, cost/benefit, universality, utility, and utilization. So, regarding the existence, definition, and measurement of culturally competent performance, "If it looks like a duck, quacks like a duck, and swims like a duck, it is a duck," and the canard is refuted.

Having postulated that we can measure cultural competency advances, the remainder of this chapter discusses the relationships between actions and measures at different locations within health care provider organizations.

2 Relationships as the Measure of Performance

Cultural competency occurs 1) at an interpersonal level, between a health care provider (e.g., physician, nurse, pharmacist, health educator, dentist, medical assistant, etc.) and a patient or family member, 2) when system decision makers make decisions informed by their potential impacts on real patients, and 3) at the intersection between health care organizations and the communities they serve (see Chapter VI).

Ultimately, provider cultural competency is experienced and best measured by patients who feel that they understand and are understood, respected, served, and so on. The intermediate results of cultural competency are measured by the behavioral responsiveness of patients to their encounters, such as posing their own questions, complying with treatment regimes, and returning for follow up visits. Cultural competency can be measured only by direct experiences, not by tests of cultural information.

This raises the issue of what, in practical terms, people mean by culture. In conducting research about the desired, achieved, and unachieved relationships among organiza-

tions, providers, and patients, I have not found much that was exclusively cultural, in the scholarly, particularistic, anthropological use of that term. Practical care issues were infrequently couched in terms of bridging different cultural explanations of and beliefs about disorders, their causes, and their treatment. While these were surely present, they were a small subset of far greater and more profound issues dividing the providers from their patients. While social investigators quite reasonably attempt to distinguish cultural issues from socioeconomic, sociological, psychological, historical, and community issues, and deep and abiding phenomena from more situational and time-specific factors, this is not, in fact, what health care organizations and practitioners tend to do. These many issues are intermingled and experienced collectively.

Among many providers, cultural competence appears a personal, individual journey toward insights and techniques for more effective care of individual patients. Among administrators and staff, it is an attempt to treat low-income and immigrant patients with appropriate respect and concern. For Medicaid plans and provider organizations, cultural competence is seen as contributive to recruit and retain people in primary preventive care and obtain the benefits of that care. For patients, it is expressed as a need to be seen and heard in an effective and respectful fashion. *In all cases, cultural competence has to do with relationships* – how relationships are conceived, built, maintained, and used to solicit and transmit information and improve personal and family health.

What we have heard often from some provider organizations is that their goal is to establish a continuing relationship with their patients. Many see these relationships as far longer in duration than what the actuarial tables on enrollment and membership in Medicaid or with plans, managed care organizations, and primary care practitioners were telling them. Actuarially, many individuals go in and out of Medicaid based on seasonal changes in income-based eligibility, in and out of managed health care plans based on geographic moves, employment coverage, or changes in plans' "product lines," and switch primary care practitioners based on a variety of considerations. Many organizations obtain a large volume of demand through their emergency rooms, walk-in clinics, after-hours clinics, and similar "non-relationship" settings. Some large, but unknown proportion of relationships is crippled by transitory and time-constrained connections among provider organization, provider, and patient; conversely, it is enhanced by constructive and deepening relationships among provider organization, provider, and community.

Given the difficult time constraints posed by current institutional practice and financial considerations, some providers, using a variety of different terms, describe the desired relationship to their patients as a "middle ground" (Lonner, 2000b), or a space in which both parties can speak, hear, be listened to, check for understanding and concurrence, negotiate, educate, and so on. It contains elements of intimacy and respect, closeness and distance. This middle ground minimizes, to some degree, the inevitable power differences (e.g., to command or to resist) between the parties, the end result of which is some action or behavior on behalf of a shared health goal.

This middle ground is consciously constructed. It is built up, over time, using the personalized ways developed by individual providers to establish relationships with their patients and communities. These are based on practitioners' learned insights into the appropriate forms of address and discourse. The middle ground is also built up as patients have time and space, for instance, to shape their communications, to express their expectations, hopes, and fears, to pose questions, to verify their understanding of communications and what is going on around them, and to test their relationship with their providers over time. Inside this space, it is constructed as practitioners and patients alter or moderate, over time, their expectations of each other, themselves, their health care prospects, and their health status prospects, and try to avoid the anarchy described by Jecker (1995):

> ... *both the patient's and the physician's ideas about healing seem ordinary and "natural" within the context of their respective cultures. In attempting to communicate their respective orientations to each other, however, each will refer to practices and traditions, concepts and values, and systems and methods of knowledge that appear unusual from the other's perspective. Thus, cultural debates often seem to introduce moral anarchy because people lack shared cultural standards or vantage points from which to communicate and resolve value differences* (Jecker, 1995:6).

Health care provider organizations, providers, and treatment teams are dealing with the immediate present and the immediate presence of patients who are immersed in situations determined by the blending of cultural, socioeconomic, social, historical, and personal factors. Their purpose is to find acceptable solutions to the specific challenges posed by the clustering of these very real patients and do so within an industrial, still non-individualized (that is, not yet patient-centered) model of service (Berwick et al., 2006). The immediate issues are pragmatic, not philosophical – how much time do they have to individualize their care? How efficacious is spending how much time with each patient? How much more is gained by pursuing the details of the individual and his culture? How do I quickly elicit needed cultural information? How do I convey information in a culturally effective manner? What does this patient want or need? Or, as Ofri (2005) states, *I ask as few questions as possible for fear of eliciting new, unsolvable complaints.*

③ The Measures of Performance Vary by Setting

Cultural competency is a different phenomenon at each level within a provider system, organization, or setting, and needs to be understood and measured differently and separately at each level. To the degree that competency advances are integrated, comprehensive, organic, systematic, and effective for the patients, they also need to be measured in their totality. This is a far more difficult task.

I suggest that

- a provider's cultural competency is based on her ability to overcome misperceptions, misconceptions, and miscommunications at the one-to-one level with patients;
- an office's or team's cultural competency is based on its ability to demonstrate appropriate responsiveness to patients at every stage in a medical visit from every staff member who touches that patient. It is not measured by the amount of training that staff members get in diversity, sensitivity, or specific cultural others, but by actual individual and collective performance;
- an organization's cultural competency is demonstrated in the ability of the facility to account for cultural differences in all of its access and service policies, procedures, and methods of dealing with patients who are different for any reason, and in relationships created and sustained between the facility and the communities that it serves.

In measuring C&L performance, "misplaced" measurement is all too common, particularly in situations in which provider and organizational motives are sound but technical practices are limited. Rather than measuring the "thing to be changed" directly, perhaps because of issues of convenience, privacy, cost, or time, internal or external auditors rely on distant (possibly far too distant) surrogate measures, unreliable denominators, and dubious data sources such as patient charts, instead of actual experiences within clinical and non-clinical encounters.

Because cultural competence occurs in defined relationships and settings, I remain unsure that a multifacility health care system can be culturally competent, because the question must always be "culturally competent for whom?" There is not a single or generalizable "Cultural Other" or cultural community against which to measure system action, performance, and progress. Systemic cultural competence may, indeed, be simply the sum of the work of all subordinate persons, facilities, and microsystems, integrated and supported by specific and flexible policies, investments, and accountability systems, and producing and demonstrating its effects in access, quality assurance, and similar means.

4 The Key to Culture is Local

To the degree that anyone can learn about certain cultural and social attributes that appear in a served community, these attributes appear in the extended families and communities in which the individual patients live. People who settle or are resettled by circumstances in a particular area may share some common values, histories, experiences, beliefs, fears, and hopes. The only way to discover these presumably common attributes is to get to know the communities that are served by the practice or facility. This means that, at a social level, the facility or practice must reach into and actually engage the community, get to know it socially, form open-handed, long-term relationships, keep promises, demonstrate how the community changes the practices, and discover over time those current aspects of person, family, community, economy, history, politics, religion, beliefs, habits, and behaviors that may bear on health status and health concerns.

This is the least expensive and most effective form of 1) discovering who lives in the community and 2) having the community discover the facility or practice. It also means that as the community changes as different people settle into or leave the community, or as economics, employment and education change it, the practice or facility can sense these changes and respond appropriately. There are many examples of successful organization/community communications in health care and human services, including ministries, mutual assistance associations, community-based service organizations, and other often hidden forms of community life. Indeed, unless one is actively involved in such exploration and engagement, there is no way to determine and capitalize on great internal community capacities such as cultural and familial expertise, cultural authority, support systems, power arrangements, and decision-making.

Finally, consistent engagement (as distinct from "outreach") with the community produces avenues for the employment and education of health care workers from within the recipient community, the surest way of tracking ethnic minority populations into health care employment, bypassing formal education as the first point of entry. Having these employees from the community within the walls of the practice or facility creates permanent bridges to and reflections on what is actually going on in the community.

The history of more culturally and linguistically competent organizations, such as certain community health centers, demonstrates that most did not pursue a systematic design or plan of action to construct their "best cultural and linguistic practices." Rather, based on their service and employment relationship to the specific local communities and populations they served, they encountered challenges in providing equity, access, voice, and quality of service. They did not turn to theory to solve these problems but, in concert with their communities and service populations, devised local pragmatic solutions to meet their needs. Over time, usually decades, they improved incrementally upon these location-specific solutions, often by intuition, community insight, and trial and error, and integrated them with one another; these organizations have become, often unintentionally, the model programs that others now seek to emulate. In a few cases, new health care clinics have been designed and constructed based specifically on the key principles and practices derived from the analysis of these more competent organizations. The degree to which these advances occur can be measured.

5 Building Provider Cultural Competency

In terms of health care workers, I distinguish between the localized cultural competence of a facility or unit and the non-localized competence of highly mobile health care providers whose careers take them to different locales with different demographics and practice settings. I also distinguish between medical, nursing, dental, and pharmacy professionals with great career mobility and the subprofessional workers who tend to be more geographically, educationally, and occupationally fixed; many of the latter are drawn from the recipient community.

Cultural competence is not yet a scientific field in academic medicine. Rather, it tends to be viewed, variously, as an art, an aptitude, a skill, a process, a framework, a caution, a stance, a set of relationships, or a guide to action that occurs at the interaction, not technical, level. Like training physicians in communications or business models for private practice, academic courses in culture in medical school and medical professions tend to be optional, short in duration, and not very competitive or integrated with other curriculum alternatives. Those who seek these courses seem to be self-selected based on personal backgrounds and specialty, like family practice. I am unaware 1) how these educational objectives are currently measured and, more importantly, 2) if and how they actually alter ultimate provider practice in different settings and under different real world rules and constraints.

Considering medical education, we need to understand where certain "arts" (e.g., differential diagnosis, communicating with patients) are actually transferred. Cultural competency, in some more clearly "cultural" specialties like family practice and psychiatry, is taught in residency programs where newly minted physicians are working under the supervision and, more importantly, mentorship of senior physicians and faculty with extensive experience in serving minority patients. Generally, it is conveyed in workshops, modeling by more senior physicians, and particularly in case consultation.

In the latter form, residents share their cultural and other challenges posed by individual patients with a team of faculty and devise, test, and report back on practical solutions. In effect, it is conveyed one-on-one from one generation to the next, in fairly specialized training hospitals in particular medical specialties. Even then, it is not uniformly and successfully passed on. Performance is judged qualitatively and subjectively by the standards of these mentors, there being no objective measures. However, this is only one medical "art" of many that are judged this way.

Finally, cultural competency is not a universal part of all residency programs. It appears in only certain academic settings, locales, and specialties. These specialties draw only (and select for) certain kinds of medical students with very specific values, purposes, racial and ethnic origins and attachments, personal backgrounds, experiences in Third World international settings, and, often, foreign language skills.

In sum, it is not clear that cultural competency, however defined, can or will be effectively conveyed as a practical core skill to more broad segments of the medical student or

residency populations. At the individual level, its measurement remains a challenge although, at a collective level, such as in a primary care clinic, measurement seems more possible.

6 Organizations Can Attract a More Culturally Competent Clinical Workforce

American medicine is an elite profession with most new practitioners still drawn from privileged, educated, and scientific classes. This accentuates class difference and experiential difference between the new practitioners and their cultural minority patients. It is difficult for some providers to see their patients as whole persons within a different class, different culture, different society, and different history. Without a real commitment to serve these patients, it is hard to find the source of an impulse to become more culturally competent with them.

Conversely, clinical professionals in organizations serving large numbers of minority patients (e.g., public hospitals and clinics, charitable hospitals) are there seldom by accident. Many are drawn by powerful motives that keep 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 these 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, combine, reward, and retain these kinds of unusual clinicians. It must also define and adhere to its service mission.

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

The actual road to caring for cultural minority patients is direct in terms of the intention and circuitous in terms of preparation. Most of these professionals have unusual experiences in their backgrounds leading to this service, including considerable international health care work, village-level health care, inner city health care, and work with migrant populations. Many, returning to the United States, seek experiences here that approximate, as closely as possible, the populations and practice they were accustomed and, even, addicted to. They seek what is transferable to situations and patients here, to be able to "see" into the real lives of their current patients in the community rather than through a hospital setting; it is an ability many can only vaguely approximate here. Others, of course, learned about cultures by working in agricultural, rural, and inner city communities

in the United States. These factors are at play in all of the clinical professions. Organizations seeking such individuals to construct a culturally competent clinical staff can use Human Resources avenues to attract, recruit, and retain them. These staffing advances can easily be measured.

7 Measuring Performance at the Encounter Level

As suggested above, clinical cultural competency (as distinct from non-clinical but very important patient-support services) appears behind the door of the clinical encounter. In this setting, there is often a great gap between what people say and what they do. Evaluators, researchers, and auditors cannot rely solely on what providers self-report as cultural competency at the medical encounter level. We must 1) observe that care or 2) debrief providers and patients soon thereafter.

As a researcher, I tend not to survey patients about their satisfaction with their clinical care but ask them to tell me their version of what happened in the encounter. Many cultural minority patients do not answer direct questions, but prefer to tell their stories. In the story is embedded all of the issues, all of the variables, and all of the feelings and perceptions about those variables. As an analyst, I listen to the story, break it into its components, and then reconstruct it in light of medical or organizational cultural competency objectives or other standards. Over numerous stories (i.e., cases), I (or anyone, for that matter) can construct and apply overall measures of provider and provider organizational performance. Comparing patients' versions with providers' versions of the same encounter produces still more insights; reviewing recorded encounters provides the icing on the cake for field researchers, but is difficult and costly to accomplish.

Within facilities, it is often teams that provide the care, regardless of whether or not workers are organized into formal teams. For instance, physicians, receptionists, eligibility workers, medical assistants, nurses, interpreters, pharmacists and their assistants, laboratory technicians and their assistants, social workers, health educators, financial aid and eligibility workers, bill collectors, and others all communicate extensively and individually with patients, both conveying and receiving information (and, sometimes, advice). These interactions all moderate, modify, extend, support, or undercut the formal medical encounter as well as the individual, office, unit, or facility cultural competency.

The cultural competence of teams can be measured through stories, observations, interviews, and comparative case analysis. The structure and talents of the team as a whole and individually need to be accounted for in measuring the content, continuity, and impact of team cultural competency. However, measuring team performance by separately interviewing its members places the provider team at great risk on trust issues.

8 Measuring Performance at the Organizational Service Level

In American health care, it is the organizations or systems that dictate or shape the clinical, administrative, and support services. Using a variety of techniques (e.g., policies and procedures, clinical guidelines, productivity standards, scheduling, and reimbursement), they seriously constrain and direct the actions of their clinical and non-clinical employees and contractors. There are many misconceptions, based on distant history (say, the 1960s), about the power of professionals to be "free actors" and exercise overweening authority in these organizations. An individual soldier cannot win a war alone and an individual provider or support staff member, no matter how culturally or linguistically competent, cannot provide his patient with a culturally competent experience in an organization hostile or indifferent to patient cultures.

Organizational cultural competence is often expressed and implemented through its customer service, that is, the way that administrative services staff communicate with and manage the experiences of their patients. In this sense, customer service is a principal tool in accomplishing cultural competence. Conversely, failures in customer service are 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.

Generally an organization that provides poor customer service also will be experienced as 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 will not feel mollified by the most culturally-correct apology, signage, or colors on the walls. If, on the other hand, the patient experiences smooth handling and good communications, he 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 specific practices, because they braid together to create the patients' experience of the organization. These experiences can be measured.

Some organizations delegate cultural and linguistic competence downward in the organization to the lowest possible occupational levels, based on the surface similarity of class and background between workers and patients. Increasing diversity at the frontline level alone is seldom an answer, without concomitant improvements in recruitment, selection, hiring, training, mentoring, supervision, measuring, and rewarding of these frontline workers. It is frequently an example of the "curse of the good enough."

When trying to measure performance at the service level, I have discovered that workers often have divided loyalties. Whether physicians or receptionists, they tend to say, "I work for the organization, I see my organization failing in the following ways, and I don't know if I can tell you about this." As a consequence, when evaluating C&L performance, I tend not to rely on focus groups or group interviews. When interviewing patients about the story of their experi-

ence of the provider and the provider organization, I will go into a room with an individual staff member for an hour behind a closed door. I want to know who they were before they joined this organization, bringing them back to the point when they first joined the organization, discovered the organization, and had some visceral responses to it. I pull them back in time so that they can get rid of some of the guilt that they feel about telling me about bad things about the organization because, too commonly, what I am looking at is bad news. I will ask, "How do those patients feel when they've been waiting for two hours in the waiting room, how do you and the other staff feel about it, and what do you do about it?" If the reception staff treats the patients badly, "Why do they treat them badly?" "What is missing in the organization that they don't know how or are not supported to treat them better?"

Unfortunately, I tend to interview in a deficits model, looking for the gaps in care and their underlying causes. Even in the best organizations, the deficits can be great. This approach, for example, revealed why, in one *campesino* clinic, the young, well-dressed Latina receptionists treated their farmworker patients as badly as they did. The receptionists came from the same population as the patients, being less than one generation removed from the adult immigrants. But while the receptionists had graduated from high school in the United States and spoke English (a mandatory skill to work in the clinic), most of the patients (and the receptionists' parents) had not. Most receptionists were in their first job after graduating from school, hired specifically for bilingualism and low cost. In reality there was a small class gap between them and the patients, but it was expressed as a huge cultural and class gap, in which respect was entirely missing. And they were not trained, supervised, mentored, monitored, or rewarded for doing otherwise. Indeed, one 20 year old bilingual Latina reception supervisor told her receptionists to greet the obviously monolingual middle-aged, elderly, migrant, and settled *campesino* patients in English, to reinforce their need to speak English and assimilate. Thus, her personal political/cultural beliefs became unofficial unseen policy and practice, creating immediate discomfort among the patients at their first point of contact with her clinic. (My unsolicited and ignored advice to the clinic was to hire empty nest mothers from the community to fill these gatekeeper and greeter roles.)

From a measurement perspective, these practices and dynamics are observable and quantifiable. They are also reportable by patients and other community members. Their resolution, of course, is entirely possible, based on different recruitment approaches in the recipient community, different hiring criteria, and continuous training, mentoring, and monitoring by skilled cultural agents.

9 Organizations Can Build a More Culturally Competent Non-Clinical Workforce

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, bicultural, multiethnic, multicultural, reflective of the community, or staffed by the recipient population. Affinity or concordance 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. To decrease the problem of mutual unintelligibility between providers and patients, more culturally competent organizations increase the number of persons recruited, hired, trained, and supervised who have cultural, linguistic, and community affinity with the patients. They also provide training and attempt to inculcate certain values and traits.

Affinity between the organization and the local community cultures may be a more important aspect of cultural competence than simply ethnic or linguistic affinity. Affinity comes in many different forms:

- being a member of the served community,
- being a member of a similar served community,
- being a member of similar minority population,
- speaking the language of the served community,
- extensive service experience in the home country of the served community,
- growing up in the served or a similar community,
- being an immediate descendent of the served or similar community,
- having a service calling or other value related to the served community, and/or
- having a history of serving the community.

While staffing health care organizations for affinity increases the probability of desired outcomes, I suggest that such staffing is far more complicated than simply increasing the numbers of cultural minority persons on staff or matching staff demographics to community demographics. Ethnically-, racially-, and community-based organizations must guard against complacency in hiring in this way. Affinity is not a surrogate measure for cultural competency, but its C&L effects must be measured. Too often, organizations are excessively self-congratulatory, assuming that achievement of one attribute has also produced the other attribute. Hiring based purely on ethnicity, race, language, community politics, or family and friendship ties can mask great inadequacy in cultural competence. Where there are significant gaps between the helpers and the helped, in terms of language, socioeconomic status, education, or generations, ethnic affinity alone will not overcome these gaps.

Organizations intending to create a workforce capable of being more culturally competent must be willing to deal consciously, strategically, and in a sequenced or integrated fashion with

- human resources goal-setting and planning,
- establishing positions and expectations for non-professional bilingual, bicultural staff roles,
- recruitment for these key positions from within the recipient community,
- expanding the recruitment pool as necessary,
- recruiting for awareness of patients' lives,
- recruiting for tested language skills,
- overcoming social status and generational differences,
- training, mentoring, and supervising,
- reducing stress through workload management,
- measuring performance,
- rewarding performance, and
- retention.

10 Measuring Performance at the Executive and Management Level

As noted above, cultural competence is not the same thing everywhere within a health care provider organization because each part of the organization deals with different kinds of matters and materials and has a different kind of relationship to its own internal and external customers. Therefore, organizations need to identify and establish expectations and practices that are appropriate and specific for each level within the organization and workforce.

At the top of the organizational ladder, away from direct contact with the patient-as-customer, it is hard to find people who think their practice area affects or is affected much by cultural competence. Higher-level personnel often see little relationship between what they do and some requisite level of personal cultural competence. As a perceptual matter, managers and staff in finance, information systems, provider management, human resources, and so on, generally see little link between themselves and the cultures of the patients-as-customers. These persons will generally aver that organizational cultural competence is important, but it has no relationship to their own job descriptions or responsibilities. Administrators and managers often see not their patients or their members as customers, but rather other managers, board members, shareholders, governments, insurance companies, the provider network, accrediting bodies, and agencies. Uniformly, they find a home somewhere else for that responsibility.

In their competitive workplace and marketplace, their key legitimate issues and terms of reference may be distant from issues of access and quality – for instance, maintaining the corporate status quo, protecting reward and power systems, increasing profitability and market share, and acquiring new technology and facilities. Embracing such change, in the absence of external incentives and disincentives, may conflict with their understandable desire for stability and predictability. Given competing motivations, demands, and incentives for attention to other issues, why would they choose language access or cultural competency? Yet, administrative policies, procedures, and operational and financial decisions certainly affect the organization's ability to produce culturally competent effects, that is, better provider, patient, family, and community outcomes.

There is a clear relationship between many administrative decisions and disparities of access, care, and health status outcomes. Disparities generally refer to societal and industrial policies and practices that produce population-evidenced differences in care and health status. Disparities are based in significant socioeconomic, cultural, experiential, linguistic, and geographic 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 and, in the best organizations, receive concerted organizational and personal activity.

Nothing could be more fundamental to care than that the patient actually has overcome access barriers and has access to a health care provider. Access, in this limited definition, is a necessary but insufficient step in receiving culturally competent services. However by true access I mean something larger, that is, access to language accord, useful information, successful referrals, diagnostic procedures, continuity of care, effective treatment, preventive care, and so on. True access requires highly proactive efforts by systems and organizations to overcome key organizational barriers to care, such as

- lack of information and understanding of and experience with the organization and delivery of health care in the United States,
- lack of care-seeking behavior,
- lack of active engagement of the patient, family, and community supports,
- eligibility and enrollment problems,
- language differences,
- discontinuity of care over time, caregivers, and hospital-community care management,
- time, transportation, and/or distance issues,
- loss of minority providers,
- individual and family conditions (e.g., immigration status, employment demands), and
- discrimination, racism, or classism at the point of service.

It is very difficult to measure cultural competency at the organizational or system executive management level even though its enterprisewide decisions shape, sustain, or erode cultural competency. Often unwittingly, executive actions are hidden in plain sight in budgetary, policy, marketing, merger and acquisition, human resources, operations, planning, facility development, organizational charts, and other formal documents in which the only measure is "presence/absence" of one or another desired element (e.g., "Do you collect demographic data on your served community?" or "Do you provide cultural competency training?" or "Do you have a language services policy?"). Executive actions that erode access and cultural competency as an intended or unintended by-product of other presumed advances cannot be easily identified in these materials.

Ultimately, the highest but most elusive measure of management performance is in the management functions of leadership, support, and assurance, and the willingness to make and sustain intelligent, informed, and demanding policy and operational changes, something that is done routinely at the higher and highest levels of the organization. The degrees to which such decisions consciously access, weigh, and respond to C&L concerns can be measured (or, at least, depicted). But, at a far more practical level, my preferred progress measure is "follow the money," not just the formal organizational financial investments, but changes in the direction and amount of the flow of organizational energy, commitment, attention, and action. This flow of real resources is far more revealing of organizational commitment than is organizational rhetoric. The absence of such change in flow is predictive of very minimal, if any, progress.

It is tricky to measure executive management cultural performance through interviews only because managers are generally quite adept in projecting positive images using rhetoric alone. Their issues, perceptions, and valuation of the provider-patient reality are often at odds with the reality of frontline workers. The chasm can be immense between them and is readily evidenced.

We do quality assurance and trainings for staff; we send out questionnaires to patients, although the results don't mean much to us anyway because we have a steady flow of patients and we're playing a numbers game. We're divorced from all of this, not because we don't care about these people, but because it's not in our job description or within our power to change it and we don't think or believe it affects the bottom line.
— hospital administrator

So, as with patients and providers, I tend to rely on stories and narratives to understand executive-level culturally competent performance. I witnessed one sad case within a very large, Medicaid-dominated managed health care plan. It staffed its customer service call center with mature and well-trained, fully-bilingual members drawn from other local community-based organizations. These workers were deeply drawn by and attached to the organization's mission to serve the community. While most of the members called to inquire about their benefits and assigned providers, some also asked referral and process questions about housing, employment, education, transportation, naturalization, and other issues common among immigrants. From my perspective and those of the call center personnel, assistance with these questions have a positive bearing on the health and well being of the members. But, of course, answering such questions extended the length of calls and reduced the overall call center productivity.

Based on these latter observations, the plan executives installed a "black box" call-monitoring device to measure the length of calls and to allow managers to listen to calls. The metrics involved in calculating call volume, response time, and productivity-by-worker were mechanical and produced results. If the member had multiple needs, the customer service representatives were instructed to "address" the priority plan issue and then go to the next call; they were instructed to avoid issues outside of plan- and provider-related issues. Further, they were notified that their jobs were

at risk. Disabled from their supportive role to really help the members, the call center personnel saw an increasingly obvious gap between the organizational mission statement and its true operational values. When they posed their distress directly to the CEO, he responded that he was not invested in keeping these or any other individual members in the plan because, every year, the state was assigning literally tens of thousands of new members to his plan and, in any event, this was just an insurance company like any other. Within four months, all of the skilled call center staff found work in other community organizations. I viewed this, then and now, as a detriment to these personnel, to the plan members, and to the C&L competence of the organization itself.

Finally, there is a too-common tendency among managers to use one-time events such as participating in health fairs as the one opportunity to make employees feel good about their work with patients and communities. On the surface, these activities seem appropriate, yet without the proper context and continuity, they tend to further stigmatize or reinforce perspectives on diverse communities without materially enhancing cultural competence or human relationships. They are pleasant aspects of civil society, but lack the commitment and structure to understand and address the obdurate complex needs of the community. Too often, employees are reinforced in their feeling that they are privileged and are better off than those they just served. One-time volunteer efforts are akin to non-sustained charity work. At the end of the day, change in organizational attitudes towards patients' multiple needs is still wanting.

11 Measuring Mechanical and Organic Forms of Cultural Competency

There are two perspectives on developing cultural competence at the system level. *The mechanical perspective suggests that cultural competence can be advanced as a number of distinct attributes or elements,* as if organizations could select some and not others from an available menu or checklist and purchase or graft them into daily practice. This approach can be designed, benchmarked, implemented, and measured in a fairly mechanical fashion. By mechanically adding these elements, the organization is likely to appear measurably more competent by definition. Mechanical changes result from hierarchical decisions and formal actions and investments, are constructed rather than emergent, are related to means rather than ends, and are self-interested, compartmentalized, technical, and extrinsically rewarding (i.e., through profits, pay, or promotion).

Mechanical solutions fit well into current health care organizational cultures. In order to address health care disparities, health status disparities, language interpretation services, and cultural competency, health care professions and organizations tend to operate according to Western models of change – break the problems down into reasonable sizes, put them into boxes with definitional and operational boundaries, apply scientific and other measurement techniques to each box, and build pilot projects and demonstration projects to test alternative solutions. In this, they reenact Western cultural norms – scientific, logical,

deductive, and mechanical – and apply them to solve multicultural and trans-cultural problems.

For certain challenges, such as language interpretation services, such a box-like approach can be productive. For example, language interpretation services do not require a wholesale reconsideration by an organization of its purpose, of whom it serves, and of how it serves them. While implementing a new and wholesale language interpretation service in an organization is complex, it is also essentially technical or mechanical in nature. Once the organization has decided to create such services, a decidedly political-financial-quality-cultural decision, implementation requires little more than an executive approving a budget, management adopting appropriate policies and procedures, and hiring or contracting, training, and delegation flowing from these actions. In this, it is like any other technical or procedural change.

There is a pattern in the medical professions and provider organizations to try to reduce the elements of work to formulae. As a biotechnical industry, medicine is based on statistical probabilities, regularities, and routines; it would quickly founder if every case were idiosyncratic. There is a similar impulse when medicine confronts other cultures, to reduce each culture to a set of evidence-supported "givens," for instance using handy-dandy guides from the nursing station or through intranet sites to describe how to deal with such matters as *cupping* or *fatalismo*. These become reductionist cultural stereotypes, no more useful or reflective of the individual patient's culture than would be a twenty page guide to American health care cultural beliefs and practices.

At the heart of cultural stereotyping is the unspoken and unexamined assumption that the generalizations that derive from and may apply to the group will also apply to each individual member of the group. Anyone who has been individually labeled by ascribed group characteristics can attest to the anger and frustration that this generates. Cultural stereotyping ignores that each individual has a personal history or story, a chronicle of real situations, events, experiences, observations, values, worries, relationships, capacities, wishes, tragedies, causes, and other personal knowledge which constitute the glue and meaning of daily personal, interpersonal, and community life. The stories of these individuals are often the means through which they organize and share their understanding of their current place and condition in life. The question is, can and do providers know the stories of their patients?

> *I'm very concerned about taking an anthropological approach to cultural competency, that is, a script with an inventory of cultural features that you can turn to and somehow capture enough to be culturally competent. I'm concerned that people reduce culture to a manual about the API community or about Samoans. You can read a travel guidebook, but it's not the same as traveling in the country. Until you inquire about the patient in front of you, you haven't advanced it. How do you know the person in front of you, not the culture which is from conveyed to us by European anthropologists that put things into boxes? We use Western ways of understanding other cultures. All of those are only partially cultural and may, in fact, be wrong.*
> — physician

It is misleading to expect that any patient perceives, thinks, believes, or behaves in a manner consistent with or derived from the culture attributed to her stereotypically by virtue of race, ethnicity, gender, nationality, education, occupation, language, religion, socialization, sexual orientation, disability, immigration experience, or participation in historical events. Each and every patient is an individual who needs to be understood as an individual rather than as a robotic reflection of a culture or society.

It is as inappropriate to generalize about an individual based on some knowledge of some version of her culture as it is to insist that the individual patient be seen in the health care setting as if she had no relevant culture or history. It is clear that patients need to be seen both in the contexts of their cultures and as individuals distinct from or within their cultures. Organizations need to provide services and approaches that reflect both the cultural context of patients' lives and the individuation of the patient in front of them. The more broad and inclusive the provider-patient cultural inquiry, the more likely it is that what will emerge is 1) complex and detailed cultural information and 2) comparably complex and detailed information about the individual, distinct from and even in opposition to the cultural generalization: "These things are often said about your culture, do any of them apply to you?" There is a small, but compelling literature on how to conduct such inquiry.

Thus, culturally competent performance is not a set of anthropological techniques, but part of the many unresolved issues of provider-patient communication and trans-cultural communications between medicine and all patients. No provider is completely culturally competent in dealing with patients. Cultural competency becomes a journey, not a destination. One can become more culturally competent over time and with disciplined self-reflective experience, humility, and patience. The concept that providers and provider organizations can perform in a more culturally competent manner is the keystone argument that providers, evaluators, and administrators can measure such progress over time.

True cultural competence solutions are very unlikely to fit into any tidy box-like mechanical solutions. Cultural competency requires a new way of seeing one's role and work in the community or marketplace and some significant change in the industry, and its facilities, professions, and practices. Since I argue below that the cultures that need to be dealt with are the cultures of medicine and health care organizations, cultural competency requires more than a new set of skills, knowledge, and techniques but a sea change in the way the organizations see themselves; however, I suggest that the sea change is more likely to result from the implementation of new practices rather than the reverse.

Grafting new elements, practices, or processes to the existing structure does not necessarily alter organizational paradigm, structure, culture, or culturally competent performance. Yet mechanically grafting some elements, practices, or processes 1) are 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, many suggest this process may be necessary to begin to develop more profound organic changes. More profound trans-formational change is thus directly dependent on having and pursuing an evolutionary course in which initial mechanical advances constitute initial and partial steps only.

The polar opposite perspective is that cultural competence is not a set or sum of discrete mechanical elements but a transformational way of thinking and acting that pervades the entirety of a system's work. It is *organic change,* sometimes known as "complex adaptive" change (Hoft, 2004). Organic change involves a reconceptualization of the purpose of the system in relationship to its patients and community and an altered modus operandi for accomplishing that purpose. Perhaps the best current example of such reconceptualizations appear in challenges posed by Institute of Medicine (IOM) reports on how to significantly improve patient safety, reduce medication error, and reduce disparities. For example, Shortell (1996) defines an organized delivery system to be

> *a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.*

Within such systems, decision frameworks for the future are predicted to change to knowledge-based, patient-centered, and system-minded, all conceptual departures from the present. While in Chapter VI, subchapter 5, I suggest doubts about the utility of a largely transformational approach, I suggest here merely that these different forms and their results can be measured objectively.

As suggested above, on some issues, such as language access, advances can proceed quite mechanically, say, through the purchase of an interpreter service or the translation of printed materials. However, culturally competent performance constitutes a different way of understanding the role of the health care organization in the life of the served community. It best begins with action, with engagement of the community, the most frightening aspect of which, as I have discovered repeatedly, is meeting new and different people and learning from them. If the most important single step in cultural competency is, simply, to start and to pass through this boundary by meeting with cultural strangers, the next steps may be quite nonlinear and evolutionary, depending on what these strangers say and advise.

Increased cultural competence then flows from an intention, a policy, and an initial plan to become more culturally competent, no matter where the organization decides to start. The ensuing emergent steps and actions become, over time, integrated with one another and with other organizational policies, strategies, and solutions. The strategy cannot be aimed at merely one set of practices or workers or patients, but eventually pervades all operating units and at all levels. While some advances in cultural competence can be made mechanically, through a turn-key solution, the goal should be that cultural competence becomes organically embedded in organizational life. This can be measured.

When culturally competent performance becomes organic, through a pervasive incremental change process, then the ensuing solutions – the best practices—flow naturally from the way the organization approaches its work. The organiza-

tion then does not require external solutions and account-ability; it creates its own solutions to its goals for itself and its patients. It is in this sense that cultural competence, like politics, is local. Cultural competence becomes the web of action solutions emerging from ideas, needs, and purposes that are local to the organization and the communities and persons it serves. This quality can be measured.

12 Organizational Advances in Less Coherent or Self-Reflective Organizations

Creating organizational cultural competence requires sound concurrent organizational processes and structures. It is very hard for a health care plan or provider organization that has basic incompetencies in management, finance, or customer service to be experienced by its members or patients as culturally competent. It may be too much to expect that very troubled organizations can provide the leadership, focus, planning, financial and personnel support, accountability processes, and sustainability that will make C&L advances likely. Evidence of troubled organizations include

- bad financial status,
- lack of discretionary capital and operating resources,
- failure to install new technologies and new equipment in recent years,
- lack of executive stability, vision, involvement, time, or energy,
- lack of interest in grantsmanship to make advances,
- a survival-only stance,
- lack of interest in the changing community demographics or patterns of patient complaints, and
- lack of a sound negotiated order in the vertical structure between the system and its subunits (e.g., departments, facilities, functions).

Similarly, disorganization is a critical barrier in advancing cultural competence. Disorganization is evidenced by a lack of systematic self-reflection, strategic planning, strategic staffing, performance guidelines and measures, internal communications and auditing, and organized services. Hit-or-miss management that is highly individualistic and decentralized may have personally rewarding qualities, but it does not result in disciplined performance as an organization. These qualities can be measured.

In many organizations, there is a common but untested assumption that they are actually either culturally competent or somewhat more culturally competent than some other health care organizations. By not consciously challenging their own assumptions with data, organizations cannot even demonstrate where they are on their intended continuum of cultural competence. In the absence of such measurement, there is a common tendency to equate mission statements or the values expressed by policymakers and staff with the actual presence of culturally competent behaviors or practices. In many organizations, various business decisions and hiring patterns often seem at great odds with the

stated mission. Plans and provider organizations seldom direct, establish, measure, or reward culturally competent performance. In this context, it is difficult to conclude that an organization's true mission embraces increased cultural competence. For example, the cultural strength of many community health centers (CHCs) is in their own histories and their singular focus on their mission to serve the underserved. CHCs are specialty providers in 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

By design and history, they tend to have a more intimate relationship with their service population. Historically, some community health centers have produced, over time, many of the "best cultural practices" in health care delivery. In my experience, these practices have emerged less from some theoretical, experimental, or corporate model of cultural competency than from practical and appropriate solutions to service challenges between the organization and its communities. The better and more normalized the fit and continuous communication between organization and community, the more appropriate, effective, and cost effective the practices. CHCs tend to "short-circuit" the assessment, research, and design processes we frequently recommend to larger health care organizations.

However, in some CHCs, the earned or unearned reputation or self-description of being culturally competent is a powerful roadblock to organizational and personal progress. It leaves actual performance unexamined. An organization that does not routinely challenge its own internal claims to and assumptions about culturally competent performance eliminates the need for investment in advances. For example, in a recent annual meeting of primary care provider organizations, the keynote speaker noted that he did not have to address their cultural competence because they were, obviously, culturally competent. At our table, however, members quickly demurred:

We were when we served only Southeast Asians. But now that so many Farsi speakers have moved here, we don't know how to meet any of their needs.

CHCs organize themselves somewhat differently because one or more minority populations constitute the majority of their service population. Being local, of optimal size, culturally similar to or attached to the service population, and often federally supported, CHCs may enjoy a marginal economic advantage over their commercial counterparts in serving their specific service populations. Some of the advantage depends on whether they are defined as "dense-pack" or "loose-pack" (my terms). Community health centers that are dense-pack serve a narrowly defined and geographically compact service population, have a narrow mission, and have developed a specific cultural and linguistic affinity to that 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." Dense-pack situations enable CHCs to maintain their focus and achieve significant economies and efficiencies in their service approaches, procedures, staffing, and provision.

Community health centers 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 and, ultimately, be less culturally competent for some of their service subpopulations. Much like larger provider organizations, it may be quite costly for loose-pack CHCs to become and remain culturally and linguistically competent with diverse cultural communities.

One cannot assume that every community-based provider organization remains attached to its community roots. Serving the poor can form a basis of lucrative personal and organizational careers. Lack of external oversight by effective local communities can lead to granting special status to these organizations which is unwarranted by their actual attachments and performance (This is discussed further in Chapter VI, subchapter 1). Given the common gap between organizational mission and practice, the best place to look for cultural competence is in its real life measures and procedures for assuring culturally competent performance, including the real experiences of its patients.

Equally, there are health care organizations and systems that have a limited commitment to serving cultural minority populations, except as some required part of their business such as "giving back to the community," "doing our share for the poor" or "maintaining our nonprofit status." For such organizations, making a C&L advance tends to be done consciously but without commitment. Cultural competence then becomes a mechanical business advance like adding an MRI or transplant capacity. It is less a philosophical than a practical matter; given sufficient resources, it is likely to be pursued professionally but in a nonintegrated fashion. It will incorporate cultural minority populations into health care but not manage to incorporate the culture of the patient or community into health care decisions or to mobilize cultural strengths in the resolution of medical problems.

13 Tools to Measure Cultural Competency Advances

There are numerous useful health care organizational cultural competency self-assessment tools available in the public domain (Harper, 2006). The best of these tend to focus in detail on the formal aspects of organizational life and the presence or absence of policies, procedures, materials, services, workforce diversity, trainings, and so on. They provide a snapshot template of formal organization. My alternative emphasis in this paper has been on the emergent reality of organizational life through changing practices and performance, a more action-oriented lens through which to view organizational life. I know of no action-oriented template corollary to the more static tools currently in use.

I will comment briefly, however, on the common reliance on measured patient satisfaction as a surrogate for culturally competent performance. Customer satisfaction surveys, customer complaint data, and disenrollment rates constitute the main measures of an organization's performance and its patients' experience of that performance. Thus, essentially, the entire burden of measuring cultural competence

performance is borne by the customers and their willingness to report or act in response to that performance, resulting in questionable findings and conclusions.

It may seem contrary for an advocate of patient empowerment to deemphasize the role of patient satisfaction as an important measure of cultural and linguistic advances. I am not unmindful of the importance of patient satisfaction as a prerequisite to patients seeking routine and preventive care and developing long-term and balanced relationships with their care providers and organizations. In combination with other measures of effectiveness of care and service, patient satisfaction is quite important. However, patient satisfaction assessment tools seem singularly weak tools to measure the content and responses to their real experiences. It is difficult to construct service satisfaction tools for linguistic and cultural minorities that are appropriate for and make sense to them. The tools tend to reflect the American scientific/marketing view of how others view their world, certainly a form of potential cultural arrogance and error. Often, the language, the key concepts, the key experiences, and the underlying framework are simply wrong, to say nothing of low return rates and other confounding factors.

Moreover, patient satisfaction has been used excessively as a surrogate for quality and care outcome measurement, primarily because it is easy to collect and analyze such data; its value as a surrogate for quality is without evidence and some literature even suggests its relative worthlessness. Within impoverished and immigrant communities, the standard for satisfaction with care may be derived from patients' past experiences in their home countries and in the United States, a standard that may be considered unacceptable for these and all patients in this country by national health care authorities. The fact that C&L services satisfy a low standard of patient expectations is no cause for celebration. Patient satisfaction remains overestimated as a stand-alone outcome measure of cultural, linguistic, and other advanced services.

In looking at outcome measures, practitioners' experiences and patients' experiences may be the best measures of local success in cultural competency, both clinically and politically. I suggest that the objective and subjective content of those experiences are more revealing than the purely subjective, standard-free measurement of provider or patient satisfaction.

VI. Moving the Health Care Organization Toward More Cultural and Linguistic Competency

1. The Intersection of Community and Organization

2. The Relevant Cultures are Local to the Health Care Provider Organization

3. Anthropology and Community

4. Some Key Aspects of the Cultures of Health Care Organizations

5. Change Organizational Cultures or Organizational Practices?

6. Demystifying the C&L Challenge Facing Health Care Organizations

I hopefully have made the case that since organizational C&L advances can be and are observed and measured, they can also be made. I now turn to the nature of organizational change itself, particularly as manifested in health care organizations, huge and complex as they are. I offer an alternative formulation to certain theoretical approaches to planned organizational change and the mystification of the C&L challenge.

The findings and prescriptive conclusions from this examination of current health care systems and facilities are intended to be contrasted with other approaches to directed organizational change to address the questions "Do health care organizations operate as do organizations in other industries and as theory suggests?" and "To what degree is the issue of organizational cultural competency performance clouded by other issues?" The elements discussed in this chapter are not the only ones worthy of note, but space precludes the detailed consideration of others.

1 The Intersection of Community and Organization

Cultural competency is required to meet the needs and legitimate expectations of every individual seeking care, not only ethnic or racial minorities. Every person has cultural characteristics that must be attended to. For this reason, "empathy" for the patient, under the general medical-philosophical rubric of "patient-centeredness," is an insufficient response to the cultural and linguistic challenges posed to organizations. Concrete skills, evidenced knowledge, and continuous organization/community communications are required. The challenges include understanding local human social networks and how they operate, how to attach to them, and how to learn from them to benefit their members-as-patients, and thereby to align certain community and organizational interests. These are not insuperable or

even very costly challenges but require the commitment and investment of time and the willingness to take some risk, coming out from behind the organizational walls and entering the community and vice versa.

Unlike many other health care competencies that are independent of geographic location, such as surgery or radiology, organizational cultural competency is required at the intersection of the organization and the community or communities it serves. The content of the cultural competency is specific to the attributes of those communities and the individuals who compose them. *The relevant cultures and languages for C&L advances reside in the communities served by the facility.* To the degree that organizational C&L advances are somehow distant or divorced from these real communities and their real facilities, they run the danger of being irrelevant.

Cultural and linguistic performance in health care *must be designed for and measured against the patient populations actually being served at the facility level.*

> *The principal driver for hospitals is the community that they serve. Not-for-profit hospitals reflect the values, needs, and interests of their community. What determines how a hospital might change is directly dependent on how they define the community, the people they are serving.* — hospital administrator

Thus, two different executives directing two different hospitals operating with two different views of their served community will manage their organizations based on two very different sets of expectations and approaches to how they are going to shape their strategies for success.

> *If your organization is going to be successful in five years, then you have to be able to change quickly. You've got to get started today to get there. There's a good business reason to do that. There can be good, warm feelings in the organization about minorities, but it is central that your organization is able to conduct business in the language of people who are going to be buying your service. There are tremendous rates of growth in commerce in the Hispanic communities and Chinese communities, generally, and your hospital is not going to take advantage of that? Your margins are so large that you're not going to serve that half of your community? C&L isn't part of your financial strategy? Interesting.* — hospital administrator

2 The Relevant Cultures are Local to Each Health Care Provider Organization

To the degree that hospitals and other provider organizations are succeeding in a highly competitive marketplace of public, private, not-for-profit, and for-profit enterprises, they have to study and understand their local marketplace.

> *I would always look for two things -- what the community said it needed for services and what I needed for market penetration. Is there a need and will this create*

an expanding market? Will these folks who are currently unemployed become employed and have insurance? In the long run, I want these folks to come to this organization and seek their care here and care about it and invest in its success. You can't do that if they don't come to you, if they don't care about you. You are completely irrelevant to them unless you make it happen.
— hospital administrator

Demographics are only a start, not the end, of local inquiry. They tell you something about what is there in the community but they, alone, are not enough to build services on. For example, numbers of immigrants from particular countries in the service population will not automatically translate into the number of interpreters required or detail the health conditions or care expectations of those immigrants. They are only a point of departure for community engagement and inquiry; they direct provider organizations to whom they should seek out. The served communities change rapidly, due to factors including immigration waves, modernization, urbanization, age-graded demographics, and the different types of refugees (e.g., political, ethnic cleansing, war time, economic, permanent or temporary refugees) and families. For example, socialization of immigrants in their home countries and re-socialization to American life and institutions in specific communities over specific periods of time may be just as important as their cultures in determining their beliefs, understandings, and health and health care behaviors. Swift sensing of these distinctions and changes and swift responses to them are absolutely required, thus requiring constant community connections and communications.

From a service organization's perspective, active engagement with the community should produce cultural content, in the form of knowledge and relationships. As the community changes, the knowledge base and the relationships will also change. Thus, cultural competence, at the organizational level, is the active engagement with the served community, maintaining continuity, currency, trust, respect, and knowledge between the health care organization and the communities it serves.

Real community engagement poses a novel challenge for some organizations. However, that such engagement can be done and done well is evident when one observes the community health centers, the politicians, the small and large retail businesses, the schools, the beat-level police, the churches, and other public and private entities serving these same communities. They all quite deliberately engage with and attach themselves to the local communities and establish a long-term presence outside of their immediate walls for market, service, or other purposes. A brief sample guide to community engagement appears in American Institutes for Research (2005:148-163).

Community engagement cannot and should not be rushed to fill an immediate or short-term "project" or "initiative" gap but should take concerted effort over time. Whatever its pace, it produces benefits for care at every, even the smallest, stage of development. It begins to promote immediate organizational adaptation to changing community conditions. It is instantly transferable into practical principles and actions at the direct delivery level rather than remain-

ing diffused, theoretical, universalistic, and promising potential at some more remote level.

In the most cogent guides to cultural competency (see, for example, Wilson-Stronks and Galvez, 2007; Wynia and Matiasek, 2006; Wu and Martinez, 2006), *community engagement is routinely just one of the many parts of a proposed larger organizationwide cultural advance. However, I give it primacy due to its action orientation and demonstrated immediacy of benefits and rewards.* I do not disagree with the other elements but am less attached to them because engagement and its resulting actions will produce much of the required change on their own as the organization experiences the rewards of engagement.

The solutions to any one hospital's cultural and linguistic challenges will rest directly within the communities served by that organization – ethnic and racial cultures, religions, languages, drug subcultures, sexual subcultures, and disease-specific subcultures. Yet, over and over again, we find hospital leadership and hospital staff unable to get out of their conceptual and actual work silos to begin to engage these communities and learn from them more appropriate ways of perceiving and serving them.

Hospitals differ in how they discover and become attached to their community, however community is defined. In many public and nonprofit hospitals, the "community" is defined by the hospital charter and their public boards, whether elected or appointed. Such boards can reflect all or only a portion of the populations included in the community. They may or may not act as a conduit between community and hospital, both in terms of day-to-day relations and political involvement. Too often, hospitals rely on their formal community boards and advisory committees for community engagement and information when their membership is not necessarily or demonstrably representative of these community cultures. Membership on boards and community advisory committees is often determined more by formal community leadership and business interests than it is representative of the broad variation that exists within the community itself in terms of immigration, language, education, socioeconomics, employment, social networks, and so on. Organizations intending to engage the community need to tap into the natural leaders and varied cultural representative experts of the community itself, not merely its most economically successful actors, Simply, formal representation is not the same thing as community engagement.

Many community boards have been established hastily and without regard to desired system change. They falter due to a lack of "voice" on the boards or with executives, a lack of meaningful structural supports, and a lack of organizational commitment to incorporating their feedback. Individuals representing community interests and advocating for minority needs often feel burnt out and lack trust in the hospitals to do the right thing. This also causes problems because community boards without true voice and structural supports produce gripe sessions and further estrange the hospital from the community. In other instances, community members often begin to fail to show up to meetings and the community is present in name only.

Given the number of mergers and acquisitions among private, not-for-profit hospitals, there appears to be increasing numbers that either have no local community boards or whose community attachments have become more attenuated. Some hospital systems have substituted their own corporate board or regional boards for the community boards of the affiliated hospitals. As corporate headquarters, distant from their affiliated facilities, centralize their administrations, many have essentially dismantled much of what looks like community relations through community board representation or executive/community involvement and delegated those relationships to community relations specialists at the facility level or community relations and marketing departments at the corporate level. This has reduced the voice of the community and its consumers through "delocalization."

C&L efforts, in and of itself, are unlikely to come up to a health care system's or hospital's governing board as a specific program against which executive performance is to be measured. It is simply too small an issue in many places, depending on local conditions and demographics, political power, and economic issues. However, if an organization is going to pursue increased market penetration, community involvement, or community support, it is more likely that the executives will "nest" C&L in other concurrent values or other disease-specific campaigns. To the degree that C&L remains a stand-alone board initiative, "when that person or the champion goes away, the initiative goes away."

In the absence of the board bridging the engagement of organization and community, organizational staff with less seniority are frequently recruited or assigned to fill bridging relationships in which they lack expertise or understanding of the broader issues. They often offend community members by not recognizing the alienation they cause because they are either following orders or failing to have the organization follow through on actual or implied promises. Many health care provider organizations come to rely on their marketing and public relations departments to serve as the organization's bridge to the community. Unfortunately, these departments are more oriented to either one-way communications to the community about the hospitals' products or only find out about the community through formal survey of the community itself or, more frequently, only those patients who use the hospital and are willing to respond to survey, frequently a biased population. Reliance on surveying companies too commonly results in surveys conducted in too few languages, surveys replete with profound cultural insensitivity, and resulting information that corporate headquarters lacks the expertise to critique, analyze, or incorporate as new actionable knowledge.

Writings often suggest the need for community members to participate in the design of practical solutions. This is certainly an ideal and there are examples where this has worked wonderfully, particularly in solutions developed by community members and those health care organizational staff most like them. More commonly, what community representatives provide is a deeper and more concise expression of the concerns felt by community members and what alternative condition would work better, challenging the organization to become more imaginative, more inquisitive, and more flexible in creating solutions that did not exist before.

③ Anthropology and Community

Historically, I suggest that there has been excessive reliance on cultural and social anthropology printed materials and anthropology-based cultural competency training in the development of organizational cultural competency. There is no doubt that anthropological understanding can benefit health care provider organizations, providers, and their patients as long as it remains clear that such understanding is a generalization that may or may not be germane or applicable to any one patient, family, or community.

I applaud the shift, over the last forty years, in health care organizational reliance on anthropology conducted in home countries to that conducted in the United States, thereby better reflecting the ongoing lives, socialization, and generational changes of Mexican-Americans, Vietnamese-Americans, Chinese-Americans, and so on. I applaud even more those too-rare instances in which local anthropologists have been engaged specifically to conduct inquiries within the current service populations of the hospital or provider group in question. Anthropologists can provide insights into local culture at the granular level, into the social terrain and the bonds that tie members of the community to one another. They can suggest practical avenues and actions to address specifically local and well-defined concerns, at levels lower than, say, larger pervasive societal inequities and pathologies. Pursuing the course of local anthropological inquiry should not be restricted to a single "snapshot" delivered to the health care organization. Once begun, it needs to continue until it is organically replaced by actual organization-community engagement.

Currency, locality, accuracy, continuity, and individuation are the key measures of successful inquiry. Local anthropology is beneficial because it tends to rely far less on published generalizations and accepted formulations and seeks a deeper array of local sources. If it constructs "community-based participatory research," it supports even more community voice, local capacity building, and continuity of engagement (Lonner, 2000a). Local anthropology may not have to rely on academics as much as talented bridging people in the organization and/or the community who can observe and explain local realities and convey them in narratives accessible and useful to others. In effect, there are strategic persons in both settings who can perform this work and disseminate discoveries to their constituents. These persons are not likely to be identified by rank, position, or formal role, but by network and familial attachments and individual talents. The emphasis should be on 1) the community's own view of its own strengths and needs and 2) the continuous development of a knowledge base upon which individual and joint actions can be taken.

To the degree that local anthropology provides the context and content of cultural competency training, it has value. While it can bridge or guide some initial relationships between the hospital players and the community players, it should not substitute for true personal engagement. This approach is the least expensive in that it relies far less on elaborate, large-scale, classroom-based "training" programs than on the natural development of interpersonal relationships between provider organization staff and community

members at a pace that is acceptable in any interpersonal development that is also trans-cultural, trans-class, trans-linguistic, and so on. The new relationships must, for often an extended period of time, remain between individuals from both organization and community; that is, such relationships are seldom readily transferred to entire organizations. It takes far more time and patience to develop and experience understanding, mutual respect, and trust between organization and community than between individuals from within each setting. In many cultures, agreements and understandings based on personal relationships are not readily transferred to offices or agents.

Absent such extensive organizational engagement with members from served cultural communities, health care organizations seem condemned to rely on extensive and inappropriate stereotyping of the "Cultural Other." That is, provider staff will tend to assume, without evidence, that the patient in front of them is "behaviorally ethnic" and reflects the cultural norms ascribed to the group. Without continuous and relatively deep engagement with the cultural communities in which the hospital and health care providers are embedded, these providers and their organizations will not be sensitive to the great and important variations within these cultural communities.

4 Some Key Aspects of the Cultures of Health Care Organizations

I now turn to the often underestimated role of organizational culture in supporting or resisting mandated change. Too often, organizations are treated as "things," mere social machines that can be compelled to respond in specific ways to changing political tides. By implication, this tendency devalues one important body of cultural value; in doing so, it makes the increased valuation of other cultures less likely.

In cross-cultural health care, there are at least three cultures involved – *the culture(s) within the served community, the culture(s) of the health care organization, and the culture(s) of providers*. All three cultures have deep historical roots, beliefs, values, relationships, and behaviors that can be construed only as internal strengths – identity, cohesion, belonging, purpose, and reward. Concurrently, they protect their members and, in some instances, weaken their ability to respond properly to novel challenges. That is, key strengths of cultures are their obduracy and persistence over time. While they do change, they do so slowly and often with great reluctance and resistance. All cultures must be accorded value and respect and tampered with only very carefully and as absolutely necessary to accomplish important social ends.

A. The Conservatism of Organizational Cultures

When I suggest that attention needs to be paid to both community and organizational cultures, I am not suggesting that these cultures are organized on the same set of principles. Authority, power, hierarchy, communications, and so on operate quite differently in formal and non-formal social organizations. But some aspects of culture are quite similar.

One of the great strengths of both organizational and community culture is its persistence or "conservatism" over time. As it orders perception, memory, meaning, explanation, relationship, and other factors over time, culture is inherently conservative. That is, it devalues flexibility, mutability, and change in favor of constancy, reliability, predictability, and caution. Such ponderous, slowly moving conservation of form (e.g., hierarchy, structure, reward) generates its great strengths over time and its resistance to change.

Equally, both organizational and community cultures are somewhat opaque. Were they transparent to newcomers and outsiders, they would quickly become invaded and altered by them. Instead, cultures remain largely invisible to newcomers and outsiders (as well as to many insider members). This opaqueness produces a series of soft but powerful "defenses in depth," for instance through different languages, authority structures, and communications processes. Neither will allow the outsider into its many private arenas where the issues are (or are not) addressed and decisions are (or are not) made. These defenses explain why it can to so difficult for outsiders to identify and engage those who make, influence, or negotiate decisions desired by outsiders.

The literature on organizational cultures is immense and cannot be summarized here. Below, I will reflect on some organizational features that, in my own research, I found significant in shaping C&L advances and can be considered cultural rather than merely situational in nature.

B. Change Effectiveness within Organizational Cultures

There are a decreasing number of stand-alone, autonomous hospitals, clinics, or even provider organizations. Two-thirds of the hospitals in the country are now part of some larger macrosystem. Increasingly, all such organizations are part of, owned by, directed by, financed by, or constrained by some larger system such as a county government, a hospital corporation or alliance, an HMO, a managed health care plan and its network, or a major employer-as-purchaser. While single facilities are, ultimately, responsible for their own care practices, their capacity and readiness to meet new challenges are strongly shaped by the macrosystems of which they are a part. "Culture" at the large health care system level is likely to be something more diffuse than that of its individual hospital/clinic facilities, more along the lines of a few specific but universal requirements – e.g., organizational financial survival, employee safety, and hierarchical management.

Macrosystems determine, in part, the degree to which individual hospitals set their own tone versus a system tone. Some systems are extraordinarily rigidly run.

This can make it very tough for individual facilities and their boards who are trying to deal with local conditions. And culture and diversity fit very much into what we mean by "local conditions." — hospital administrator

Large health care systems commonly present themselves to the public as coherent corporate or public systems in which headquarters' decisions on matters such as quality of care and service pervade downward throughout the organization

to the operating unit level through tangible supports, incentives, disincentives, and accountability processes. However, many of these systems are relatively new and their operating principles still uncertain. Many present highly idiosyncratic features, highly individualized and fluid arrangements, and quite autonomous facilities, all based on different histories, cultures, perspectives, priorities, leadership, finances, communities, responses to external demands, and so on. Even the most established systems reflect great complexity and routinely confound their permanent staff members.

Larger corporations define their future in terms of regional, statewide, multistate, or national presence. Such scale combined with geographic distance, in and of itself results in increased complexity and the need to delegate significant authority to lower levels. This produces inconsistencies both at the system level and from region to region and facility to facility. In some large corporations, regions and individual facilities appear to operate with almost total autonomy on "minor local" matters such as C&L.

In these large systems where power is distributed, one indicator of the relative impact of systemwide executive mandates is what system functions are subject to such mandates. In examining a handful of large systems, we found that true systemwide mandates are few, mission-critical, and doable. These include the overall information management system (including electronic medical records), communications, billing and financial record keeping, mergers and acquisitions, and new technologies. These integrative control functions enable the system to talk to itself and keep control of its expenses and income. From a structural point of view, the systems insist on iron discipline over these functions through tight vertical/horizontal authority matrices.

Within such systems, relative ranges of freedom accorded to certain functions and facilities may reflect considered and deliberate system strategies, unresolved system tensions, negotiated agreements during the formation and maturation of the system, prioritized concerns, or the inevitable structural tensions within all bureaucratic systems between command-and-control and distributed powers and accountability. In some systems, there is a stated desire but some inability to exercise command-and-control. Instructions are sent out as putative mandates, but, if unaccompanied by auditing, incentives, and disincentives, are quite often ignored, particularly if the instructions run counter to other mandates accompanied by true accountability.

Changes on the macrosystem-level commonly occur in the policy arena, where paper relationships are changed – for instance strategies, scenarios of a desired future, plans, tools, trainings, data recording and sharing, compliance and performance auditing of practices, generic training, and internal marketing of values and practices. The way in which these center-based changes actually trickle down to organizationally peripheral facilities and their providers and patients is, variously, through awareness raising, delegation of authority, assignment of resources, and the operational features of subordinate organizations. The concrete operational "trickle down" effects may be hard to observe, may be long delayed, and may never, in fact, occur. System-directed progress is often strongly limited by the great political, financial, and operational autonomy retained by member health care facilities and their many forms of resistance to change. Thus, true macrosystem change is slow and uncertain.

Cultural and linguistic competency is seldom if ever one of a macrosystem's core mandated mission-critical functions. The notion of cultural and linguistic mandates is probably a misrepresentation of reality in most large systems, based, in part, on some text in mission and planning statements. Mission-critical control functions in macrosystems seldom include cultural and linguistic performance, something generally seen as optional, voluntary, and idiosyncratic. Few non-technology solutions to C&L challenges require authorization or oversight from systemwide authorities. In a number of hospital systems, the responsibility for creating and managing cultural and linguistic advances is delegated to individual departments, such as Human Resources, Public Relations, Media, Government Relations, Community Relations, Community Benefits, Mission Integration, Clinical Integration, Quality Assurance, and, for a few, an actual Culture and Language Department or Office. In large systems, these departments tend to be horizontal authorities, peripheral and distant from both core operations and vertically mandated issues. Commonly, cultural and linguistic advances constitute only part of such a department's or an individual's responsibilities. What they determine to do will be constrained by personal experience, content-area expertise, vision, perceived need, threat, or opportunity, resources, relationships, and span of authority.

I conclude that *C&L competency advances within macrosystems are accomplished primarily, perhaps solely, at the local direct-service facility level, where the organization and the served community intersect, where the providers touch the patients.*

C. Organizational Culture and Locale

Large health care systems tend not to be change-effective in general, but in their specific locales and classes, such as specific affiliate hospitals, among certain classes of workers, and among some subset of system actors rather than universally across the system. In any system C&L project, only certain small parts of the organization are truly engaged. Locale is one critical aspect of change, no matter whether one is looking at multiple organizations, persons, and efforts within geographic boundaries; within corporate hospital and medical groups; or among multiple stakeholders in specific communities, such as counties, medical associations, professional associations, advocacy organizations, academia, and government. C&L advances are particular to local conditions, individuals, networks, capacities, and readiness. They have not yet proved interchangeable across hospitals, systems, associations, or communities.

Smaller health care systems and individual facilities operating in narrower geographic areas are likely to be more change-effective. At the community and subregional levels, change can be far more rapid, based on smaller bureaucracies, more rapid communications, tighter interpersonal and inter-professional networks, increased inclusiveness, more focused local inquiry, deeper and longer relationships with the served communities, more detailed operational solu-

tions, and a history and intense desire to find or build self-sustaining solutions independent of fluctuations in larger remote headquarters organizations. Microsystems are small enough that a single well-placed individual can make a significant difference based on individual interests, relationships, and power.

In these local facilities, the "system" can be defined as the coming together of local parts, interconnections, and purpose. While such systems can be broken down into parts that are interesting in and of themselves, the real power of systems analysis lies in the way the parts come together and are interconnected to fulfill some purpose. In these smaller and more local settings, the actual content of a C&L project within a facility or locale may be less impactful than the very fact of the project itself and the support of key staff as opportunistic change agents with important personal relationships with key systems executives and other influential people. In the projects that we studied, the objective success or failure of a project seemed to have little relationship to concurrent or subsequent macrosystem change. Most project managers reported that they had no idea what their macrosystem's operational departments and/or affiliate hospitals would or would not do with their project findings and/or products. They claimed no responsibility for effective internal dissemination to the rest of the system outside of their own units. They had no plan and lacked the contacts and connections to explore broader operational dissemination.

D. The Health Care Culture(s) and Conditions, Not the Patients, as the Problem

Since the cultural challenge in health care organizations is posed by the presence of the ethnic, racial, and other minorities in health care organizations, it is natural and all too-common to think of these patients as the problem. Wrong. While American society has established, licensed, and continues to support health care professions and organizations, not one of the societal reasons would support the notion that these professions and organizations are there, primarily, to serve themselves. Their purpose is to serve patients, in the same way that restaurants exist to feed customers, not enhance the lives of chefs and waiters. Yet, as we all know, restaurants go out of business all the time for failing to properly hear and understand their customers and claiming to know more about what tastes good than do their diners.

In health care, culture is not a problem to be overcome, but a basic attribute and, often, strength of human societies and their individual members. It is also a basic and powerful attribute of organizations, associations, and professional guilds, like those for lawyers, judges, doctors, nurses, priests and rabbis, teachers, social workers, police, and even policy advocates. It provides ways of thinking, seeing, hearing, understanding, explaining, behaving, and communicating. Culture benefits the members in these societies by organizing their perception of the world and their place in it and by specifying ways of acting that result in value, order, and predictability.

In health care, I suggest that the cultural problem is not in the patients, but in the systems and organizations themselves. Many of us know the stories of good and great charitable hospitals who consider themselves to be culturally competent but cannot actually demonstrate it if challenged and who are appalled when situations blow up in their faces about what some of their staff truly do. The same is true for numerous community health centers, migrant health centers, and rural health centers, when surveys and incidents reveal the depth of cultural incompetence within organizations designed specifically to serve the powerless.

Health care professions and organizations have logics, interests, and priorities often quite distinct from the consumers of their services. The roles of the medical professions and health care organizations are constantly emerging. I suggest that it is very dangerous to pursue C&L changes in health care organizations while carrying out-of-date understandings of the health care industry, its many organizational types, and its financial, legal, marketplace, and inter-professional situations. Change agents who operate as if these hard facts did not exist will find themselves at great risk in their organizations; however, they can readily discover the "hard facts" in their own locales merely by inquiring carefully among internal experts.

This paper, as my editors would remind me, is not the place to attempt to delineate these interacting forces shaping organizational behaviors. Here I merely suggest that external and internal change agents need to become and remain current about these forces as they manifest themselves in their location. For example, among the major conditions governing the desire, capacity, and readiness to become more culturally competent are the divergent culture(s) within medicine alluded to earlier, the medicalization of social problems, the privatization of public services, and the corporatization of health care.

i. The Divergent Culture(s) within Medicine

The health care professions and organizations contain powerful, and not always helpful, cultural attributes. We all talk about the cross-cultural challenge between health care providers and minority populations. Physicians and administrators frequently identify patients, their families, and/or their communities as "the problem," seemingly unaware that their own lack of preparedness and/or unwillingness in caring for culturally and linguistically diverse populations is itself a major obstacle. I suggest that the challenge arises less because health professions and organizations are governed predominantly by Euro-Americans and more because these professions and organizations constitute a special and powerful culture in American society.

What is the culture of the health care (or any other caring) industry? Many of the disciplines that provide the professional person-power for the health care industry are drawn to the ethic of care, one individual to another. Some of the disciplines are drawn to the industry as an industry like any other, providing an important societal function and providing economic and career opportunities that, until recently, were considered pretty secure in our dog-eat-dog world.

There are aspects of the medical arts culture that are worthy of attention when attempting to recruit for interest in C&L.

> *The underlying values of medicine that are part of its unexamined or unacknowledged culture swamp all of this humanistic stuff.* — health care plan administrator

The profession of medicine possesses many of the hallmarks of a true and highly unusual culture (Lonner, 2000b):

- a deep collective history,
- a complex and well-maintained social, bureaucratic, and corporate structure,
- an elaborate belief system based on science, objectivism, atomism, and ethics,
- a pervasive technology, based on statistical probabilities of interventions and outcomes, a search for machine-like perfection, quantification and computerization, and routinization of procedures and guidelines,
- a specialized and rationalized economy,
- special beliefs, values, language, and practices codified into laws, oaths, standards, and individual professional practices,
- a complex and specialized self-governing division of labor, specialization, powers, procedures, roles, rules, and rewards,
- an elaborate system for recruitment, socialization, control, and retention of members,
- special ways of seeing (e.g., the body as a machine, explicable through highly technical devices and tests which see into the functioning of the body, its organs, and its cells),
- an ongoing conceptual debate between reliance on technology and humanism,
- social license to actually invade the body and mind and to compound and issue drugs, and
- a government-sanctioned authority to exclude alternative beliefs, practices, and practitioners.

The health care industry itself, apart from any single profession or health care organization, is itself a special and very powerful culture within the American society and contains numerous subcultures. *The health care industry as a culture occupies a special place in society, quite different from the culture(s) of its patients, regardless of their ethnicity or social class. The industry is essentially mechanical, technical, financial, and actuarial, whereas its patients are none of these.*

> *What I sense in mainstream health care is the great cultural and socioeconomic chasm between our patients and these organizations. You can try to create some algorithms for people there to deal with these patients but it is a much different kind of interaction than what these organizations are used to.*
> — family practice medicine faculty member

The health professions, trade associations, provider organizations, and plans define for themselves much of their own environment. They exercise considerable influence on governments, markets, legal systems, and financing systems.

The industry exercises power not only over its environment but also over its patients, particularly under managed care. While there may be powerful racial, ethnic, and other discriminatory forces at work, at the core, the issues are money and power. Lavizzo-Mourey and Mackenzie (1996) argue that

> *...the socioeconomic divide that may exist between the culture of managed care systems and the cultures of vulnerable populations acts as a formidable non-financial barrier to care.*

Rosenbaum, et al. (1997), suggest that

> *...the very characteristic that gives managed care its power -- the promise of care -- also gives the system a powerful reason to discriminate against patients who are considered costly, difficult, and, above all, undesirable. At their extreme, managed care plans' control can result in the segregation of certain racially identifiable enrollee groups into health care systems that are less accessible and of poorer quality than are plans offered to other organization members...these differentials in treatment may have no legitimate business basis.*

They list many readily-observable and widely reported types of discrimination, including

- *refusal to participate in Medicaid;*
- *selective marketing;*
- *failure to collect needed data and conduct needed assessments;*
- *maintaining segregated waiting rooms and hospital wards;*
- *imposing arbitrary caps on the number of publicly insured patients;*
- *failure to make information about programs and services language-accessible;*
- *intimidating certain types of patients to discourage them from seeking services;*
- *location or relocation of services to make them less accessible;*
- *diverting publicly insured patients away from closest urgent care facilities;*
- *policies that require all appointments to be made by telephone;*
- *service reductions that fall with unequal weight on minority groups;*
- *practice guidelines that disproportionately curtail care to minority patients;*
- *selective and limited service areas;*
- *avoiding contracts with providers traditionally serving minority patients;*
- *discriminatory selection and formation of provider networks and physicians;*
- *discriminatory provider credentialing processes;*
- *segregated provider networks;*
- *denying basic plan information (consumer satisfaction, provider list, access, quality) to members until after enrollment;*

- *different methods (excluding certain coverages, benefits, or rules) of service (e.g., length of time for prior authorization); and*
- *exercising broad and vague authority to seek disenrollment for "noncompliant" patients (commonly defined as those who fail to keep appointments or do not follow instructions); and creating barriers to access which becomes "they never ask for services."*

When compelled to reform one or more of these and similar practices, professions and organizations typically take an objectivist analytic stance toward the challenge. Thus, for many, the challenge of "culture" and "cultural competence" becomes just another empty box to be filled with systematic and elemental information, stereotypes, conventions, procedures, practices, techniques, and mnemonics suitable for classroom teaching opportunities. Culture is not taken on its own terms but recast and reduced to look like other mastered challenges (e.g., chronic care management, nuclear medicine, psychopharmacology, biogenetics), menus of practices that fit well within the current paradigms of allopathic medicine and health care delivery.

This objectivist-reductionist approach, a cultural phenomenon in itself, is quite seductive and is not restricted to medicine and nursing. It also appears among many investigators of, advocates for, and trainers/consultants in cultural competence, usually in the form of complex list making – lists of contrasting cultural elements and variables, lists of cultural practices and beliefs, and lists of recommended organizational and clinical elements and practices. These encourage the incorporation/subordination of patients' cultures into the health care culture as a way of doing the prescribed work better within the existing reductionist professional and industrial paradigms rather than considering alternative paradigms.

It is critical here to turn briefly to the impact of being poor before addressing the impact of being poor and, concurrently, a member of a minority population. National studies distinguish the relative influence of poverty or ethnicity on the transactions between health care organizations and the ethnic minority uninsured, privately insured, and publicly insured populations and communities. Poverty accentuates the relative power imbalance between the organization and the patient. Poverty, as an aspect of social class, reduces the range of choice within the enrollment and treatment contexts to the vanishing point; the choices of the poor within their shared condition become far more homogeneous than for socioeconomic classes with greater resources. The poor may engage in negative patterned behaviors because they lack the power or latitude to respond with more personal, group, or cultural variation.

I am troubled in our use of the term "the poor." Typically, "the poor" conjures up unwarranted stereotypes that link poverty to "poor culture," "poor ability," and so on. It has also been used to suggest that there is a "culture of poverty" as if absolute or relative poverty were a permanent characteristic of populations and produced value systems, behaviors, and aspirations at odds with those of the larger society. While there are, no doubt, self-perpetuating, synergistic internal forces that work to the detriment of "poor" individuals, families, and communities and may produce

some local intergenerational effects, the notion of a fixed permanent underclass with its own distinct culture seems contrary to the experience of financial and geographic mobility in this society.

Too commonly and without concrete evidence, health care organizations link low-income populations with characteristics that are problematic for the way that these organizations design and deliver care, such as

- transportation problems,
- difficulty in keeping appointments at clinics with 8 am to 5 pm hours,
- lack of child care,
- limited or no leave from work to keep appointments,
- low reimbursement rate,
- medical compliance issues,
- insurance coverage problems,
- multiple and severe social and health needs,
- language, literacy, and conceptualization difficulties, and
- differences of appearance and behavior in medical offices.

An alternative explanation would be that these organizations have been designed from within a too-narrow repertory of actual possible alternatives and to suit the presumed expectations and demands of their own employees and their view of a "typical community" or "ideal organization," rather than designed to meet the specific needs of their actual consumers. Thus, to focus much attention on the attributes of the relatively powerless, while poignant, does not seem promising. It seems to place the burden for the cultural and social issues on the powerless rather than on the powerful.

…the business end of operating health care service delivery gets a lot of consideration and attention, at the expense of community health needs. And doing business this way, which is to hide behind the resource limits… opens a door to discrimination based on race and color…most of the decision-making is ethnocentric. A lot of this is also based on class and isn't just based on ethnicity (Putsch, 1997).

Given the attributes of the medical culture depicted above, combined with the general lack of patient choice or control over plan or provider, there is a considerable power imbalance between any provider (or provider organization) and any patient, limiting the ability of the patient to influence the content and manner of his care. This imbalance in power is more acute for someone who is or is ascribed to be a member of a "minority" population. Irish's definition (1993) of "minority" is helpful here:

The terms "majority" and "minority" … refer to the power relationships within a society, not numerical magnitudes within a population…

Why is "power" a relevant issue? To the degree that minorities, however defined, lack the power to influence standards and practices of health care service, power becomes a salient issue. Unless informed about, willing, and able to take

advantage of legal and procedural remedies, minorities have been unable to alter standards and their implementation. They have relied far more on defensive or passive resistance, that is, rejecting health care services and advice by failing to behave in accord with medical advice. Pinderhughes (1989) notes many forms of resistance such as opposition, passive aggression, manipulation, accommodation, dependency on and identification with the aggressor because patients feel powerless and believe they have no other choice. These behaviors, while adaptive, can also be quite costly in terms of resulting service.

When one uses these behaviors, one may gain a sense of power on the one hand but be handicapped on the other.

Unpacking the concept of the "relatively powerless" leads to another realization – that the cultural problems experienced by racial, ethnic, and economic minorities confronting the cultures of the medical professions and health care organizations are a significant exacerbation of the problems posed to clients or patients from majority populations who, simply by being labeled as patients by the health care culture, constitute a somewhat less relatively powerful class. That is, all patients find themselves in a relatively powerless state. Patients themselves can be considered to be a minority group if we consider a viewpoint that defines "minority" in terms of relative power.

Every patient has a culture – values, beliefs, expectations, resources, and practices – that must be recognized by and incorporated into health care services. Yet, I suggest a pervasive cultural gap between medicine and all of its patients. This appears clearly in the numerous efforts over the last 30 years to introduce (or re-introduce) physicians to provider-patient communications and, more currently, to patient-centeredness. Buchwald, et al., (1994) point out that

Just because the client looks and behaves much the way you do, you assume there are no cultural differences or potential barriers to care.

If readers doubt this more universal cultural gap, I invite them to examine their own relationships to their providers and ask themselves how much their own provider perceives and understands their beliefs and fears, home life situations, community supports, understanding of body functions, and so on. I invite them to recall how well or poorly these providers communicated with them or their parents at end-of-life and other crises and took their personal histories into consideration.

If it is difficult for providers to be culturally competent with patients from the same racial or ethnic group, social class, economic class, educational class, language group, and so on, how much more difficult is it to be culturally competent when the patients are people of different color or other appearance, new immigrants, refugees, poor people, illiterate people, people with different religions and beliefs, people with different dress, people who cannot speak or write or understand spoken or written English, people who are substance abusers, people who are gay, lesbian, or transsexual, people who are disfigured or disabled, people who have no concept of Western medicine, medical systems, and scientific thought, people who have whole and entire health care

beliefs and practices unknown in the United States or long-abandoned in the United States, and so on? These factors all pose a tremendous exacerbation of the more general cultural challenge posed by any patient in a medical setting.

The movement toward cultural competency and language access may be usefully seen within the context of the Institute of Medicine reports calling for vastly increased "patient-centeredness" in health care. This change, viewed as a sea change by its national advocates, is, I believe, recognition of the major and growing gap between providers and their patients and between provider organizations and their patients, within which the cultural minorities constitute a special but not entirely different challenge.

ii. Medicalization of Community Social Problems

Many social and behavioral issues have been defined by the health care system/industry or government as medical in nature, thus increasing the reach of medicine into society, producing a variety of effects. Given the huge and growing social expenditures for and the often weak impact of health status products (outside of public health and sanitation), what are the appropriate and doable roles and boundaries for this "industry"? Can or should the industry be a broad-ranging social agency or narrowly defined medical machine? Can or should it stimulate community support activity in the very real life problems that jeopardize health care and health status? Can the industry substitute for the lack of needed community supports for health – employment, education, housing, and so on? Or, given its special but narrow skills and closed-system financial base, do its services remain divorced from those issues that strongly influence the health of individuals and communities?

Many organizations seem to have great difficulty in reaching out deeply into the communities that surround them. Often, health care organizations appear like islands in the sea of community. Surrounded by businesses and residences, they remain quite distinctive by their great size and wealth, their science and technology, their highly educated professionals, and their processing of human beings. Many of those who work at higher levels in these organizations do not live in the community and many of those who work at lower levels in the organizations do live in the community but have little influence in their organizations. Thus, these organizations are quite unlike their patients and the community.

Those that recognize and try to provide additional, non-medical supports to their patients often "medicalize" their solution by creating health care organizational supports that are redundant to what these patients have or should have in their own communities. Many build support groups inside the organizations, rather than enhance support groups in the community. However, some also develop practice models that incorporate and capitalize on the strength of other, similarly situated members of the same community, helping to resolve patients' problems through much better understanding and the engagement of community support (Lonner, 2001).

iii. Privatization of the Public's Health Care

In health care, unlike other industries, many if not most consumers are not the actual purchasers of the service; that is, it is not the patients who pay the provider for the service, but employers, government, insurers, plans, and others. I suggest, based on experience, that the greater the gap between the service and the payment, the less responsive the service provider needs to be. That is one reason so many purchasers insist on patient satisfaction surveys, to try to discover what, in other services, would appear immediately, in other industries, in sales reports and profit and loss statements.

Since the inception of managed care in government health care programs, we have witnessed the privatization of the public health service sector along with a decline in the influence, control, and direct services of public health departments. Under Medicare and Medicaid, large proportions of beneficiaries have been assigned to corporate managed health care plans and insurance companies that, in turn, assign care to a variety of provider organizations. The responsibility for the health of the elderly and of the poor has been delegated to corporate entities of various kinds (Gold, 2006; Hurley, 2006).

Privatization may have increased the gaps between patient and provider and, perhaps, between the social organizations and the social goods they were intended to produce; it may have contributed to the current state of indifference by some organizations to the need for increased cultural competence and language services. If the consumers were truly able to exercise more control over where to place their health dollars, there would be more corporate market responsiveness and competition in the arenas of cultural competence and language services.

iv. Corporatization of Health Care Organizations

The chief imperative for both public and private provider organizations is to survive increasingly intense competition among numerous types of provider organizations and by location. Even though their legal charters and financial structures are quite different from one another, there is intense direct competition for patients, contracts, capital, and providers, in different locations, between public hospitals, HMOs, for-profit hospitals, and not-for-profit hospitals. Increasingly, they are coming to resemble one another in terms of governance structures, management structures, financial controls, information systems, contracting and purchasing procedures, marketing strategies, mergers and acquisitions, and so on. Their fates are determined by vast market forces and changing purchaser (e.g., government, employer, insurers, and plans) strategies largely beyond their control.

It is unwise to assume anything about the mission or practices of for-profit and not-for-profit hospitals and hospital systems based only on the differences in their charters. In their great competition for market share, external financing, appropriate scale, and cost containment, the approaches and organizational consequences for not-for-profit and

for-profit companies appear to converge markedly. It is often hard to tell the difference between the two without a guidebook. It is manifest every day as some not-for-profit health care corporations and plans are roundly criticized for creating billions of dollars in reserves while providing similar levels of uncompensated care to the poor as do some for-profit corporations.

According to a recent GAO report (2005), while publicly owned hospitals provided, on average, twice as much uncompensated care as did not-for-profit hospitals, the difference between not-for-profit hospitals and for-profit hospitals was statistically insignificant. In some not-for-profit corporations, their "community benefits" departments subsume more and more responsibility for community outreach, language services, cultural competency, corporate sponsorship of community events, and so on. I suggest that this delegation, while useful in the near-term, may be less about advanced service than the need to qualify these activities for corporate tax exemption and cost reduction purposes.

The many new emergent forms of provider organizations, plans, and contractual relationships among them now have more variations than there are industry names to describe them. This corporatization process has tended to result in the "delocalization" of health care organizations from the communities suggested earlier. These organizations, whether hospitals, clinics, plans, or other provider organizations, appear to be more responsive to non-local interests and priorities than to the communities they serve. This is a problem for most large corporations and franchise organizations, no matter what their product. But the health care industry seems slower or later than some other industries to recognize the need to tailor its messages and products to the communities it serves. Thus, it is hard to find the center, some points of leverage within this inchoate system, where internal or external pressure could predictably produce C&L and other advances.

⑤ Change Organizational Cultures or Organizational Practices?

Below, I recommend the contrarian view that health care organizations begin to make C&L advances through immediate practical actions rather than through internal cultural transformation. This mechanical conclusion is, indeed, contrary to my own initial prejudices about organizational change and desire to witness transformational change, but derives from observations in the real world of health care organizations. I would feel more confident in sharing my contrarian advice were I attached to some reliable theory of action that explained how such organizations become stimulated to change, how phenomena such as quality advances actually occur, if, in fact, they do. However, the bulk of organizational theory has focused far more on the forces that maintain stability and coherence over time than on those that disrupt or change these features.

Currently, provider organizations in the United States seem marked by two opposing characteristics: the need to change constantly (due to finance, technology, and other forces) and the impulse to resist those changes that challenge key cultural concerns (such as professional autonomy or humane

service). This tension makes it very difficult for those wishing to produce directed change (such as advocates, regulators, and philanthropy) and dangerous for insider change agents (such as individual physicians and community-oriented staff).

I suggest that what gives health care organizations their current surface appearance of orderliness in the midst of constant internal and external change is their culture (e.g., the values, expectations, hierarchy, relationships, and division of labor described earlier) which is like a DOS program running unseen in the background while countless practical changes are occurring in the observable foreground. As a consequence, they are concurrently less orderly and more conservative than they tend to present themselves. The same may be true for all of the great judicial, educative, and military institutions on which our society relies.

So, in the midst of our complaints about the nation's non-system of care, physicians, nurses, and others show up for work, patients show up for care, everyone struggles over finance, and things seem orderly. Yet when you ask for simple and modest change, like C&L services, medication error reduction, or an electronic health record, it seems like the whole enterprise rises against you, saying "No, not now, maybe later, why us, why this?" (Mort Sahl once described the difference between Republicans and Democrats: Republicans believe that nothing can be done for the first time, while Democrats believe that it can, just not now.) Change seems to require arguments aimed more at organizational cultural interests than merely practical operational concerns.

Many involved in change agency in health care advocate that the first step in any quality advance (e.g., patient safety, patient-centeredness, or diversity) requires transforming the center, the "organizational culture" itself, directly. Considerable attention is currently being paid in hospitals, hospital systems, and health care literature to the issue of "transforming" organizational culture, whatever that is construed to be. A cursory review of the health care literature reveals references to "cultures" such as patient safety, quality, worker safety, patient-centeredness, family-centeredness, diversity, leadership, communications, accountability, information, ownership, recognition, engagement, a positive work environment, and consumer-driven health care.

I am uneasy when representatives of macrosystems talk about the need and/or plan for directed system-level cultural change. It often appears that a new and formal organizational focus on "culture" (e.g., safety, diversity, quality, etc.) is actually a way of 1) deferring concrete operational action well into the future, 2) emphasizing marketing more than service, and 3) focusing far more inwardly on the system itself than on the providers and patients it is to support. From both a policy and operations perspective, I am concerned about a wide-shared goal of *organizational cultural transformational change* that results in the development of concurrent pervasive changes in C&L values and orientation within leadership and staff. While this may be a sound goal and approach in some types of organizations, it seems a frail approach to change in many contemporary large health care organizations.

It is unclear exactly what is meant by an "organizational culture" of anything, except as a shorthand way to express

some heightened awareness and some possible acceptance of certain values. Equally, one cannot simply grab nor attempt to grab one's own culture or organizational culture by the throat and demand that it change. Culture is built up over time in a mostly evolutionary rather than revolutionary fashion. One can however demand that behaviors change, regardless of culture.

Many transformational projects focus entirely on the preparation rather than the journey itself or its destination. I see no necessary linkage between organizational cultural change that uses language alone to embrace such values as "more diversity" and "cultural appropriateness and sensitivity" and subsequent or consequent changes in behaviors, practices, and services. The pursuit of organizational cultural change for its own sake without objective, substantive, and near-term patient benefits seems somewhat aimless and self-indulgent. Investing time and energy in "organizational culture change" as if it were a manageable "thing" sometimes seems frequently more aimed at improving employee satisfaction than patient care.

Building organizational "cultural capacity" through, for example, a sensitivity or diversity training process, without a specific action plan that taps that capacity, seems without much merit. The contrast between "capacity" and "action" is a "which comes first, chicken or egg?" paradox with many suggesting that the organizational cultural change must precede practical behavioral changes.

> *Although cultural change was seen as the most important strategy for improving safety, the lesson gleaned from other industries was not to focus on the organizational culture itself, but on making safe behaviors a regular part of every day practice (McCarthy and Blumenthal, 2006:3).*

While cultural transformation appears a prevalent approach in health care and methods to encourage such transformation through planning, capacity building, education, training, recruitment, hiring, procedures, and reward systems are widespread, they have not yet proved to be successful in the absence of immediate, concrete, and reward-producing changes in practices; the transformation process remains both indirect and uncertain in its effect. My concerns are that 1) cultural transformation, as an isolated phenomenon, may not be possible to accomplish and 2) if accomplished, it may produce no near-term or intermediate-term gains for providers or their patients.

The critical elements missing here are *action* and *timeliness*. The "cycle times" between a new organizational appreciation of the need for a cultural change and the time that any benefit accrues to a patient frequently seem extremely long, especially in large complex organizations. Time as calculated and experienced by organizations is quite different from time as experienced by providers and patients. What pace is acceptable or possible in organizational terms may be quite unacceptable in human terms, particularly when personal health is at stake.

Equally, a model of organizational transformational cultural change that suggests a need for total or significant interpenetration or overlap of organization and community

cultures is probably neither realistic (from a change agent perspective) nor desirable (from a cultural perspective). What may be more realistic and desirable is the creation of a *middle ground* where some parts of the vital needs, desires, and abilities of each overlap and interact, without demanding significant and immediate cultural change in either as a practical prerequisite. In the case of health care services, the middle ground is that space in which providers can deliver adequate and appropriate care and patients can benefit optimally in terms of access to care, quality of care, and health status. In this middle ground, all learn how to adapt to practical concerns, communicate clearly, and learn what is required.

Much of a health care organization's culture may not be required to change to provide better quality performance to patients, but each organization's cultural strengths should be captured and its limitations accounted for in the same way we would do when engaging other cultures and for instance, its networks, values, beliefs, behaviors, rules, customs, and symbols. If we assume that organizational transformational cultural change is desired or required and that it can be directed, we must then ask how such change occurs. In some settings, asserting success in "the culture of…" seems merely rhetorical as if, by considering something collectively at the executive or managerial level, a change has been accomplished. In other settings, cultural change is composed of and demonstrated by linked changes in strategic plans, policies and procedures, allocation of resources and incentives, and systems of individual and collective accountability. The latter approach suggests that in health care, as in most other organizational settings, cultural change begins with (frequently externally mandated) altered practices whose results come to pervade and extend both understanding and action over time (Seiden and Barach, 2006).

This process is similar to that of "boot camps" where compelling and rewarding individuals to change their behaviors with one another creates identification with a group culture and its own consequent self-perpetuating feedback process of rewards. This approach appears to be commonly adopted in the area of patient safety, for example, in which initial mechanical solutions to specific patient safety problems are intended to produce downstream organic improvements based on changing staff perceptions of problems, solutions, and mutual support. These mechanical solutions include new behaviors and techniques; assertive communication among team members; standardized and simplified practices, processes, and procedures to reduce variation; forcing functions to constrain individual variation; universal auditing for adherence; and tying these advances to other key organizational outcomes, such as patient safety, clinical outcomes, risk reduction, waiting times, productivity, efficiency, effectiveness, and satisfaction.

When cultural tampering is required, it is most effective to start with behaviors, the instrumental side of life in which action takes place. In both the organization and the community, both must give way somewhat in their behaviors to make sure that needed health care action takes place. In my earlier book (Lonner, 2000b), I suggested that cultural competency is to create a middle ground between community and organization, provider and patient, that does not

assault the core culture of either – the greater the assault, the greater the resistance. For an organization, the middle ground may require the provision of C&L services, expansion of community outreach and primary care services, engagement of community knowledge and understanding, and recruitment of staff from within the recipient population. For the community and its members, it may require accommodation of state insurance requirements, health plan procedures, appointment scheduling processes, engagement with hospital representatives, and reduced utilization of emergency rooms for primary care purposes.

Any "culture of…" emerges from the individual and collective actions of such persons over time, rather than from conceptualizing a new "organizational culture." In case studies of organizational patient safety, McCarthy and Blumenthal (2006) demonstrate that there is a science of patient safety and an array of tools that can be used to understand and improve safety. This science and these tools have been translated into successful practices that have demonstrated rewarding improvements in patient safety (Silow-Carroll et al. 2007). I suggest that C&L efforts, as a quality advance, may be close behind, at least in some of these aspects.

In a commentary on the McCarthy and Blumenthal article in the Commonwealth Fund Newsletter, Paul Schyve, senior vice president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), discusses what he calls the "hard" phase of developing and maintaining a new culture at the organizational level.

> *Why is this the "hard" phase? A culture is defined by the customary beliefs, values, and behaviors -- including traditions -- shared by members of a group. These policies, values, and behaviors are intertwined, often serving to justify and reinforce each other. It is difficult, therefore, to change one (e.g., behaviors) without making corresponding changes in the others. In fact, these traditions -- policies, values, and behaviors -- literally become part of our personal identities as pharmacists, nurses, and physicians. No wonder changing the existing culture is hard; we are asking health care professionals to change not only their traditional ways of thinking and doing but their images of themselves. That is why many health care organizations, after translating some of the science and tools into safe practices and implementing them, have begun to feel they have "hit the wall" of culture change…while the redesign systems can build safety into the "blunt and" of the system, the physician, nurses, pharmacists, and other health care professionals have a new role. It is to create safety at the "sharp end" -- in their interactions with individual patients.*

At some macro policy level (e.g., legislators, associations), the marketing of alternative service paradigms and preferable values may produce paradigm change among policymakers, while at the organizational level (that is, providers, provider organizations, and systems), everything seems to *begin* with altered practices. For example, the policy goal of reducing racial discrimination in education becomes busing; the policy goal of integrating the armed forces, higher education, and the employment workforce for minorities or women become changed recruitment targets and practices; the policy goal of community crime reduction becomes

community policing practices; and the health care policy goals of patient safety (e.g., Institute of Medicine and Institute for Healthcare Improvement) are translated into very specific revised practices and measures within hospital wards, emergency rooms, and surgical suites by disciplinary and interdisciplinary groups, managers, and accrediting and regulatory bodies.

Changed behaviors and practices will produce changed perceptions and beliefs as individuals and groups reflect on their own experiences with and rewards from changed behaviors and practices. Changing behaviors and practices occurs through changing workflow, technology, policies and procedures, the behaviors of allied departments and practitioners, and so on, all helping to reshape behaviors and practices. Each initial mechanical change in practice and behavior will likely result in the growing appreciation of the other allied and independent issues, ambitions and actions to resolve them. This also may produce uncertain effects, but they will be built on immediate and direct experience, for better or worse.

Thus, *I suggest that organizational, even transformational cultural change may not produce practical change but is produced by practical change.* For example, March (2006) analyzed the change processes in health care systems, particularly the roles of clinical guidelines, protocols, and pathways in quality improvement. The model that she presents is instructive when thinking of C&L activities as a quality improvement. Clinical guidelines are evidence-based recommendations about the most appropriate clinical choices, treatments, and care of people with specific diseases and conditions. Based on the best available evidence, they usually reflect a consensus that has been reached or approximated by experts on the care of a particular patient population. Protocols, in contrast, are detailed procedures for how to implement guidelines, and pathways are broader frameworks for organizing the care of patient populations. Protocols focus on what is to be done and pathways focus on who should do it and when it should be done. Implementing these tools fosters the culture of quality within health care organizations.

C&L, as a quality advance, should reflect a parallel approach. C&L services 1) need to be provided with flexibility, specificity, and tailoring to specific populations, persons, and situations, 2) should be based on the best available expert evidence available at the time, 3) should rely on protocols and often complex pathways to ensure appropriate solutions, and 4) should be somewhat divorced from the vagaries and variability of individual provider behavior and focus on organizational, structural, and team elements in the provision of consistent care to patients.

Organizational "culture change" then becomes the end state of having gone well past some awareness "tipping point" to some important and demonstrably new web of behaviors. Such cultural change is actively created, nurtured, and sustained through the active involvement of all levels of the organization to make the desired changes happen. From this perspective, C&L is not an initiative, like a program aimed at prenatal diabetes, but is a more permanent and pervasive process of change in the practical relationship between organization and community, provider and patient.

As a consequence of this emphasis on behaviors preceding cultural changes, requiring organizational cultural change to precede C&L advances seems less appropriate. C&L, as a basic core service in health care communications and management, is not so special as to call the core organizational culture into the highest relief. Behavioral solutions, once substantially accomplished, will raise and alter these core aspects of organizational culture on their own. What is needed is an initial organizational bridgehead that can be widened in different directions as organizational rewards are generated. Theoretically, where the organization starts in changing certain behaviors and practices may be less important than that it starts.

As it is now, the other problems confronting health care organizations (e.g., finance, regulation, technology, staffing) are so immense and threatening that, in most locations, C&L issues cannot even get on the radar screen. Requiring organizational cultural change on behalf of C&L performance, in the absence of sound and shared "business cases," significant infrastructure investments, and implementation and standardization of practices and performance within and without the system, will find no welcoming audience.

In sum, the better place to start organizational culture change is with new behaviors and practices that result in more direct contact with minority people and their issues and the solutions to those issues. Rather than starting with the complexity of cultural competency, organizations should start with their most simple and immediate challenge; however simple their simplest solution is, it will become difficult in the accomplishment as with every other change in health care delivery. C&L simplicity will result in its own complexity soon enough in the course of doing the work, as alternative solutions are proposed, selected, implemented, tested, amended, abandoned, adopted, and expanded. It is in the dealing with this complexity that organizational perceptions and understandings will change. In other words, as cultures, organizations and individuals become what they do, and what they learn for themselves, they produce permanent "sticky habits," a reasonable working definition of a practical organizational culture.

Pilot C&L projects become the "nose of the camel" inside the organizational tent. It will be difficult to push that nose back out of the tent, but it may be a very slow and tentative process to make major, ubiquitous, inevitable, and permanent advances through the summing of changed practices and behaviors. In the absence of significant external pressures and resources, it may take large systems and facilities literally decades to become significantly more culturally and linguistically competent. And that is a shame.

⑥ Demystifying the C&L Challenge Facing Health Care Organizations

One of the benefits of increased academic, consulting, regulatory, accrediting, and advocacy interest in C&L issues is that it has parsed out key organizational issues and C&L solutions in great detail. Unfortunately, providing this detail has made the road to success look far more daunting to health care organizations than it has to be and has immobilized some tentative health care organizational sponsors. "You mean, we have to study all that!? And then we have to do all that!?" It has also tended to discourage organizations from taking immediate, direct, concerted, and sustained action on behalf of patients and providers.

Health care organizations and professions can fend off the demand for C&L advances by claiming that "cultural competency" is too ineffable, undefined, risky, complex, and mystifying to act upon except through lengthy strategic planning and extensive training and consensus-building. Similar arguments for fending off, for instance, electronic records, clinical guidelines, same-day access, bar coding, radio frequency identification, computerized order entry, team care management, surgical site identification, telemedicine, and collective bargaining, have all proved, in the end, merely to be aspects of a generalized resistance to change that always requires effort to overcome. I suggest that the same approaches to overcoming or bypassing such resistance must be used for C&L advances.

My goal here is not to further mystify either cultural competency or organizational change but to approach both as the "normal" work within health care organizations. If this same change template is relied upon, some organizational and personal resistance will be reduced from the implacable to the merely practical. Yes, there are many complex practical challenges to be overcome, but they are no different than the practical challenges posed by other changes.

C&L solutions should look like other changes being implemented in health care in terms of the practical effects on behaviors and procedures in hospital settings and professional offices. There will be issues such as strains and stresses, technical and procedural resistance, financial and labor management issues, and coordination crises, but, in effect, they should still be experienced as "business as usual" in a continually changing industry and set of professions. This understanding is necessary if we are to demystify the challenge of cultural competency and C&L services.

Interestingly, needed organizational C&L advances appear less in devising a C&L solution than in the *application of existing solutions* to any one particular system or facility, given the particularities of factors like organizational culture, leadership, finance, competency, readiness, politics, bureaucratic structure, and communities served. C&L solutions are very seldom merely appended as turnkey responses to demand but must be tailored or hybridized to meet organizational specifics. The innovation is in the bringing of a solution into the organization or system and either making it work for the organization or tailoring it to work for the organization.

The relationship between health care organizations and their C&L solutions is highly patterned, rather than accidental. Surprisingly, once internal discussions have moved from "Should we do this?" to "How would we do this?" the pattern of implementation appears to be based less on structural features (e.g., public vs. private, urban vs. rural, resource-rich or resource-poor, affiliated or stand-alone, public or private) than on particular features of the organization, such as actual locale, values, history and experience of change, capacity, leadership, and expertise. In our meta-evaluation of language advance projects, once the initial C&L "sale" had been made, organizational participants rapidly came to focus on the practical operational issues and action items, things they could take into their homes sites, organizations, and associations. It was only the practical specifics, the operational details they adopted, that distinguish among them.

Individual personal and political expressions of C&L values, objectives, and objections within organizations cover the expectable range. However, without direct evidence in any one organization, one should not confuse resistance to a proposed C&L action as resistance to the values or patients involved. In our experience, much content of the C&L debate within organizations is not oppositional but procedural, political, financial, and operational, and focused on priority, resources, evidence, and plans. I call these "techno-bureaucratic" issues, that is, technical issues that require concerted collaborative bureaucratic assent and action.

Project level C&L advances in organizations and systems have encountered techno-bureaucratic problems with different roots – a project proposal submitted and awarded without extensive consultation of widely separated but involved parties; technical issues whose parameters were not recognized early on; data systems designed to perform certain functions but unable to be quickly or inexpensively modified for other functions; overly-optimistic ambitions for the production of adequate evaluative data; underestimation of the costs to meet technical standards; conflicts between system and regional authorities; imbalance in authority among involved departments, management levels, and project staff; imbalance between project fidelity and adaptability; failures in outsourcing; lack of internal expertise as a guide and check; and organizational "turf." While "turf" as a bureaucratic topic has declined in popularity in management literature over the last twenty-five years, it can be quite real and deadly (to projects, if not participants) within health care organizations and systems.

Resistance frequently results from the lack of internal political preparation. If successful negotiations with key individuals in key departments or functions have not been conducted prior to demands being placed on their organizational resources or procedures, their understandable resistance to change can cripple or long delay any advance. This is no truer for C&L advances than it is for any other advance that places new, different, or unexpected demands on resources, personnel, and procedures. While the organizational issues are manifold, they are in no way dissimilar in scale, form, or content from many other quality and performance issues and, therefore, they can be managed.

VII. Making the Organizational Case for Investments in C&L Advances

1. The Need to "Sell" Cultural and Linguistic Competencies to Health Care Organizations
2. Packaging and Marketing C&L to Specific Health Care Audiences
3. An Array of Cases and Their Evidentiary Bases

1   The Need to "Sell" Cultural and Linguistic Competencies to Health Care Organizations

Having started with the end of the story, how to measure C&L advances, we have explored the meaning of cultural competency at the intersection between organization and community and some situational and cultural issues within organizations that need to be considered by change agents. Having argued that organizational C&L advances can be made by attending to organizational conditions and culture, I now address the first terrible challenge – actually selling C&L to indifferent, unaware, and preoccupied health care systems. Everything that happens after that initial sale has been made can be determined by the normal, if routinely difficult, processes of planned change in health care organizations.

I have seen and come to believe that culturally and linguistically appropriate services are profoundly needed to optimize the benefits of medical care. I believe that such services are a good thing by definition and on their face.

Cultural competence is not an end in itself. It is often advocated as an aspect of political performance, that is, major organizations formally recognizing each culture in our society in some symbolic way. But cultural competence is also very practical. Formal recognition of cultural differences, without a consequent health status outcome, would not be a compelling argument for the expenditure of public funds in its behalf. Cultural competence is a key element in the health care industry's fulfillment of its societal goal of optimizing public health status. In this sense, cultural competence is like immunizations, annual physicals, and prenatal care. The most compelling claim for cultural competence is that of a required aspect of effective health care. It is a tool, like many other tools in biomedicine, to get to the desired outcomes -- a significant difference in the health status of individuals, communities, and populations. It is a tool to enable patients to benefit maximally from modern scientific medicine.

In a larger sense, it is a required tool to make cost/benefit sense of the preceding investments in health care organizations, biomedical professions, and modern technology. That is, it makes no sense to develop the medical infrastructure to produce national health status outcomes and then cripple that potential by lack of tools required to engage large segments of the public.

This would be a waste of resources, similar to having the capacity to do heart surgery without investing in the critical aseptic techniques in the operating theater.

The expenditure of public funds on behalf of poor and minority populations is to have these persons, families, and populations become and remain healthy, productive, and self-sustaining members of American society. Means of achieving this goal include personal health maintenance and primary preventive care. This requires health care organizations to be competent in understanding and incorporating the cultural strengths and diversity of the populations into their own care (Lonner, 2000b:4).

But, unfortunately, however true my beliefs are, they are also irrelevant. Alone, they are unlikely to persuade health care providers to change their practices or health care administrators to invest significant resources in these advances. My arguments, without the evidence that these decision makers require, are far more likely to be heard as special pleading on an issue that the organizational audiences are not required to embrace. There simply remains too little compelling argument or evidence to many decision makers to change their practices and investments (Lonner and Solís, 2006).

In the harsh financial environment of American health care, C&L services are seen by many in the provider and insurer sectors as an unfunded mandate, much like many other demands placed on human services by federal and state governments-as-purchasers-and-regulators. Some unmeasured but significant level of individual and organizational resistance to providing C&L services is based specifically on the lack of funding attached to these mandates.

Even when funding is theoretically bundled into current contracts, no one suggests that such contracts actually identify the specific funds or that they are applied and adequate to the visible or invisible demand. Cultural competence is, theoretically, a responsibility for every person and department in an organization or system; therefore, organizations and systems nominally invested in cultural advances would logically develop appropriate practices and standards that place the ownership of and responsibility for cultural competence at every point in the management and delivery of care. However, there is a pronounced tendency in plans, provider organizations and systems, and providers to delegate the responsibility for cultural competence (and its assurance) downward or elsewhere in their systems.

Health care plans tend to delegate responsibility to partnering provider organizations. In turn, provider organizations delegate responsibility to the physicians and all other direct care providers, such as nurses, nurses aides, case managers, dentists, pharmacists, health educators, and mental health staff. In many organizations, the actual responsibility for cultural competence is further delegated to medical assistants, dental assistants, pharmacy technicians, laboratory staff, customer service representatives, receptionists, eligibility workers, billing clerks, and outreach workers, in other words those who are youngest, least educated, least trained, lowest paid or rewarded, least empowered, and least supervised, mentored, and monitored in the health care delivery system.

The unfunded mandate, then, appears not only from federal authority to state authority, but from county governments to their public hospitals, from private hospital systems to their affiliated or owned hospitals, from health care plans to their plan partners, and from hospital corporations to their operating units. The unfunded mandate is delegated downward to each succeeding lower level until its reaches direct service operations and their weak financial bases. Like other unfunded mandates (e.g., scholastic achievement), C&L services will need some solution that ties increased funding to increased performance accountability. In the meantime, C&L advances need to be sold to different audiences using different "cases" relying on evidence each finds necessary, credible, germane, and compelling.

② Packaging and Marketing C&L to Specific Organizational Audiences

Health care professionals (administrative and clinical) must be sold on the relative costs and benefits of proposed C&L advances. Rather than sharing only one organizational business interest, such as "market advantage," executives, managers, and providers are separately governed by and responsive to a number of very different interests, dependent on 1) the role and function each performs and 2) what kind of organization in what part of the industry is involved. What is relevant, even compelling, for one may be of minimal interest to an adjacent or comparable colleague. Each, then, may constitute a quite different audience for the C&L cases. As in the marketing of any product or services, one cannot assume what case will appeal to which audience; each must be tested. Useful considerations in approaching these audiences appear in recent presentations by Quan (2002, 2005), Goode (2006), and Wellpoint (2002).

The narrower self-interests of the individual professionals and/or functions within large health care organizations will be engaged by only some of the cases made for the C&L change. Marketing, finance, technical, clinical, quality, legal, risk, and mission-oriented individuals and functions may each require a different objective or potential gain in order to become interested enough in a proposed change to become engaged and supportive. For instance, examples abound of information technology departments embracing some ethnic/racial identification and language services advances. IT folks always want to be ahead of the curl of the technology wave (e.g., data elements, audio/video capacity, interoperability, connectivity), but can be otherwise indifferent to inherent C&L values and purposes. If the C&L solutions meet or advance their separate needs, their interests will become attached to some aspect of the solution, just not its core care and service purposes.

Similarly, marketing departments are becoming proponents for specific C&L advances for very sound reasons other than social justice, patient care, or health status.

If we can find a rationale for marketing, then we don't have to claim that C&L services are good on their face or that they reduce costs. We can say that it's good for market share. That's going to resonate differently from

place to place, and is very dependent on the management team and where the CEO is coming from.
— marketing administrator

In large systems, sustainable C&L advances are probably directly dependent on necessary ties to other departments, functions, and corporate purposes.

I think the market approach and the service approach are essentially the same. The reason why they want to provide good services is because they want to capture the market, so they go hand-in-hand.
— hospital administrator

A more sophisticated understanding of these changing marketplaces and where individual hospitals, systems, and executives/owners are positioning themselves for the future is needed. "Business cases" need to be developed to specific perspectives such as for the CEO, CFO, COO, HR, IT, medicine, nursing, quality, or legal perspectives. Not everyone (e.g., individual, department, function, level, organization) will agree with or draw the same conclusions from case examples. Each interest needs its own cases; those remain to be discovered by inquiring within each function – "What answer to what question would convince you to consider and support a C&L advance? What are the implications of such a decision on what you want and need to do?"

Without concrete evidence, it is dangerous to assume that any organizational person or function, by virtue of who one thinks they or their vital interests are, will be automatically a friend of or an enemy to C&L advances. All have specific interests that need to be engaged and accounted for, in terms of possible attachment to primary, secondary, or even byproduct aspects of C&L solutions.

Proponents of C&L advances need to be quite clear about each of the cases that could support each of the ingredients of the proposed change, that is, whatever will "float the boat" for any person or function. These should be used in concert to gather in more parts of the organization. I encourage any change agent to interview within each important organizational class to elicit their motivations and hopes and then feed product information back into those very motivations. C&L idea marketers appear increasingly aware of the need to "repackage" their cases for C&L services to move their varied audiences. Repackaging includes focusing on specific audience motivations, interests, needs, and organizing information and concepts that accord with specific professional frameworks and organizational functions. Success with any one of these interests may provide a sufficient system or facility beachhead to sponsor and initiate a C&L advance.

For example, while public policy advocates continue to argue effectively for C&L as a civil and legal rights issue, many are concurrently repackaging the C&L message to accord with pragmatic health care industry advocates who approach it primarily as issues related to quality, care, health disparities, risk, or medical communications. In some ways, selling the C&L cases to different individuals or functions is a kind of shell game, similar to the marketing of pickup trucks. For anyone marketing anything, the challenge is what will get you in the door, what will grab the attention of your various

intended audiences. Marketers on television seldom simply show the product for sale; they surround the object with other attractions and symbols. There is a difference between what is being marketed and what is actually sold.

The key here is not to tell each audience what you want them to hear, but what they tell you they need to hear. Selling C&L advances to different parts of the organization, using rationales that are specific to each of them, can contribute to the "pervasive incrementalism" encouraged in preceding sections of this paper, that is, support, for different reasons, of advances that are concurrent, overlapping, and mutually supportive. As one reviewer of an early draft of this paper asked, "What aspects of cultural competency correspond to what interests? How can cultural competency be framed as an opportunity for each of them?"

Thus, selling the C&L case on the issue of social justice or health care disparities reduction or marketplace advantage or quality improvement or patient safety or risk reduction has very little to do with the actual technical and behavioral changes inherent in the actual solution; that is, people should not confuse the case with the actual solution. For example, in the shift from paper to electronic medical records, the cases focused on factors like higher quality recording, shared and rapid access to patient information, and reduced projected costs. The actual solution required numerous committees, considerable cost in terms of hardware and software, much rewiring, extensive training, system crashes, software redesign, cost overruns, and so on, all predictable and unavoidable aspects of most critical advances.

Repackaging contains certain challenges:

- narrowing the conceptual and practical issues to single dimensions (when they are in reality complex, multidimensional, and interactive),

- narrowing the organizational consideration only to those issues within the experience and insightfulness of the packagers, rather than more powerful mission-critical issues that better market research might reveal,

- stifling or masking consideration of unavoidable issues, and

- limiting the range of innovation and possibilities.

In the meta-evaluation we conducted, it was primarily individual facilities or units that successfully sold local and quite specific business cases. Absent the large-scale return on investment case, non-economists, such as hospital clinicians and local administrators, had to devise their own locally persuasive cases. Each collected and analyzed only those data required to support the particular business case(s) required by the values and concerns of their own local executives and managers. They penciled out their own gains within their own specific purposes and locations, not related to anything larger or more universal. In some locales, the gains couched as increased productivity enhancements were likely to become permanent and become part of the base budget and operations. For example, in a pediatric clinic in one facility in a very large health system, the pediatricians, based on worker productivity rather than their true clinical quality concerns, penciled the local business case for interpreter services out.

We ended up with the first interpreter because we really did absolutely meticulous accounting of how many medical assistants got pulled in for interpreting. Considering what the medical assistants cost and the need to keep them in their job descriptions, we could prove it was cost effective to hire interpreters instead. — physician

3 An Array of Cases and Their Evidentiary Bases

The following represent a number of the concrete and/or speculative "cases" to be made for C&L advances and competency:

Disparities
- Public health
- Equity and social justice
- Return on Social Investments
- Corporate social responsibility

Quality
- Care
  - Informed participation
  - Informed consent
  - Humane care
  - Patient-centered
  - Patient empowerment
  - Medication compliance
  - Behavioral compliance
- Service
  - Community marketing
  - Competitive advantage

Patient satisfaction
- Provider satisfaction

Safety
- Patient
- Provider

Organization

Risk
- Health status
- Malpractice
  - Medical error
  - Misdiagnosis
- Organizational liability
- Accreditation and licensing
- Insurance
- Credibility and reputation
- Civil rights liability
  - State and federal law and regulation
- Contract compliance liability
  - Medi-Cal
  - Managed health care plans

Access
    Eligibility
    Primary care
    Urgent care
    Procedures
        Assessment
        Treatment

This paper is not the venue in which to present the saliency of and issues within each and all of these cases. Touching on some of them here is intended merely to demonstrate that they are legitimate and, if properly evidenced and argued, potentially persuasive to very different important audiences.

A. The Disparities Case

Cultural and linguistic advances are often marketed as resolving some aspect of the policy issue of disparities in health access, health care, and health status that is currently very politically and morally prominent. Cultural and linguistic services are often suggested as one of the many remedies required to address these disparities; however, the attention to disparities has not yet resulted in widespread significant adoption of this remedy. There is a likely evidentiary gap perceived between the problem and this remedy among others. I suggest that cultural and linguistic advances are a necessary but insufficient answer to some unknown portions of this issue.

The national statistical reports on disparities in health access, health care, and health status are real and profound in their implications on the well being of American citizens and residents. Reports are able to disaggregate national population data down to counties, regions, populations, and health care plans with increasing detail. While this tells us where, how large, and within what populations patterns of disparity are found, it does not tell us the interacting causes of these specific disparities nor identify the solutions at the community or organizational level. In other words, disparities measurement does not immediately define or direct the nature of solutions. Solutions can be as broad as national health insurance and single payer systems or as detailed as focused outreach into and engagement of the local Eritrean or Ukrainian community.

There are many forces that act in concert to produce health care and health status disparities at the community/facility level. Below, I outline certain factors resulting in disparities in local health care and health status merely as placeholders. The list is not exhaustive, because I know that most discussions of this subject among knowledgeable insiders at the service provider and community level have an agreeable "yes, but..." quality. "Yes, I agree with you but it is more complicated than you have presented it."

One particular complication in disparities measurement is the synergy among class (e.g., socioeconomic status), race, and ethnicity. Although this paper cannot explore the historical and political implications of income stratification, people of color in the United States have experienced discrimination not only in health care but also, for instance, education, housing, employment, and income. Many people of color, activists, and others view the term "poor" as a negatively loaded term and use "low-income" as a more respectful and accurate term. It may not reflect, however, the true misery and relative social powerlessness at the lower rungs of "low-income." Because large numbers of people of color occupy the lower levels of the income strata, it is not surprising that some of those who work in the health care industry fail to distinguish the differences or frequently make assumptions based on one attribute or the other. The synergy of class, race, and ethnicity underlies a powerful impulse to stereotype and leads to many inappropriate and unevidenced health care programs, outreach efforts, withholding of information from patients, or modifications of clinical treatments.

Finally, the socioeconomic and class structure of the health professions and organizations mirrors the society at large, with Euro-American physicians and administrators commonly occupying the highest stratum and people of color largely occupying the lower and lowest strata; these differences become manifest in some resulting policies and practices. Disparities in health care and health status, as measured phenomena across ethnic, racial, and low-income populations and in specific locales, are the combined result of many factors. Poverty among any ethnic or racial group is unhealthy as evidenced by *environmental* level factors:

- substandard or overcrowded housing
- unsafe neighborhoods
- higher risk of exposure to toxic waste
- limited access to fresh vegetables and fruits
- less economic security, health insurance, and/or pension benefits
- difficulty in taking time off work for illness or health care visits
- social stress
- class and racial discrimination
- lack of supportive resources (e.g., public safety, schools, transportation services, social organizations, and discretionary income) and networks
- challenging community, social, and economic conditions (e.g., depressed local economic climate, seasonal employment, unemployment, underemployment, or intergroup conflict)

There are *health care industry* and *organizational* factors:

- availability, affordability (e.g., direct costs, premiums, co-pays, and deductibles relative to local wages, employment, and subsidies), range, quality, and accessibility of providers, hospitals, community health centers, clinics, and pharmacies
- race-concordant, ethnicity-concordant, or language-concordant providers
- language barriers
- cultural barriers
- hours open relative to patients' work and life schedules
- physical plant condition
- active and passive racism, and differential and stereotypic perceptions and treatment of patients by providers

- effective and ineffective community outreach and engagement
- waiting times
- provider productivity standards

There are larger *state* and *community* factors:

- availability, accessibility, and affordability of primary or supplemental health care insurance
- Medicaid and other eligibility rules
- funding patterns and support of the uninsured and underinsured
- contract requirements and compliance auditing
- market conditions as perceived by health care plans, hospitals, and provider organizations (e.g., attractive and unattractive service populations)

Finally, there are *behavioral* and *lifestyle* factors that shape health services use and health status at the community and individual level:

- smoking, obesity, and substance use and abuse
- exercise
- health literacy
- self-care
- traditional and alternative medicine
- perceptions and use of Western medicine
- ability to be medically compliant
- reliance on hospital outpatient services for routine and preventive care
- reliance on emergency departments for non-urgent care
- knowledge and acceptance of the American health care system and its practices.

In terms of this behavioral category, it is very important to understand those factors that constrain the ability of individual patients and their families to comply with treatment plans that call for alterations in the patient's diet, exercise, housing and environmental conditions, reliance on medications, occupational life, daily activities, and social life. Treatment plans may interfere significantly with patient, family, social, and community life and if they cannot be materially and culturally supported, the patient may not benefit from what is, theoretically, the ideal treatment plan. Treatment plans must take into account and build upon these aspects of the patient's life or the potential health status of the patient will be compromised. This leads to the need to embed in the treatment plan the understanding of the patient in the context of her family and community life. For example, what does it take for a low-income renter to rip out his rental apartment's carpeting to improve the breathing of his asthmatic child?

It is critically important to remember that immigrant patients, whether recent immigrants or long-term settled residents, are shaped not just by their culture, however defined, but also by their socialization. That is, many immigrant patients have been socialized to seek and use health care resources in their home countries. In this socializa-

tion process, each person has been taught specific current ways to seek and use medical care and medications. This accounts for some major differences reported by providers providing health care services to, for example, Ukrainian immigrants and Mexican immigrants. Each has grown up in a different society where medical care and medications are sought, acquired, and used quite differently. Many who have grown up with Soviet-style medicine have been taught to demand health care services vociferously and continue to do so when seeking care from American providers. Many who have grown up in more Third World settings tend to defer to medical authority and to not understand why they need prescriptions to obtain antibiotics, why the physicians routinely ask them "hundreds" of questions, and why, when they go to a physician because they are suffering from a viral infection, they go home with neither a shot nor a pill. These are not deep cultural matters but reflect their socialization in the health care delivery system of their home countries or areas. Many patients are quite confused, even disoriented, when they encounter the American health care system.

In order to benefit optimally from health care services in the United States, they must experience some re-socialization in the communities in which they have transited or settled. This socialization to American health care delivery is experienced differently depending on whether they are, for instance, very recent immigrants, longer-term immigrants, refugees, settled minorities, inner city populations, or rural populations. And it is not made easy by either provider or purchaser organizations.

The systematic reduction of health access, care, and status disparities requires a greater and more detailed understanding of the local root causes of such problems and, essentially, targeted and homegrown C&L solutions for them. While these are national problems, some of their practical applied solutions are local. For instance, national initiatives such as financing, workforce recruiting, and training, while very supportive and necessary are, generally speaking, insufficient, nonresponsive to changing local conditions, and produce long-deferred benefits for patients.

B. Clinical Versus Administrative Cases

As the authors of some recent excellent papers published by The Commonwealth Foundation point out (Goode, 2006), there is insufficient scientific evidence to link cultural and linguistic services with improved health-seeking behaviors and/or health status outcomes. I am certain that these benefits do accrue, because "You know it when you see it" in the exam rooms and halls of more culturally competent organizations and in the exchanges between their patients and clinical/support staff; but I cannot prove it with compelling evidence.

A small number of clinical/academic researchers continue to study the "clinical case," the very difficult technical and conceptual task of causally linking various forms of C&L services with better patient health status outcomes. Requiring C&L to tie directly to patient health status outcomes produces such a long and fragile chain of causation that such research, if

funded at the correct scale and published in peer-reviewed journals, is still likely to be found deficient by their intended clinical/scientific audiences. Consistent with other findings on the often limited relationship between clinical condition-specific research findings and the adoption of desired resulting clinical practices by industry and professions, it is unlikely that the clinical evidentiary case for C&L services, however rigorous, could alone sway the health care industry and professions at this point in history.

Currently, sufficient clinical studies have not been mounted or concluded to unequivocally make those cases, that is, separate from location, disease type, intervention type, department, cultural or linguistic service, or patient attributes and to the standard that is frequently applied to other clinical or service advances. Clinical/ academic research has not yet provided clinical evidence of sufficient rigor and scale to overcome the very popular medical and organizational counter-argument that the provision of C&L services is a "patient benefit" or an "unfunded mandate" nor demonstrated that formal, coordinated, universal, and tested C&L services are required for medical management, patient safety, or the prevention of avoidable medical or medication errors.

Alternative cases and measures are needed to demonstrate to these organizations that they cannot meet their contracted, mandated, and self-defined goals without such services, that is, some type of "business case." Currently, in selling health system C&L demonstration projects, the administrative business case seems stronger than the clinical outcomes case. Even clinical researchers acknowledge that it is likely that, in some health care organizations, the administrative business case alone, independent of clinical outcomes, has been made or is being made, based on the experiences of providers and patients in seeking and providing increased reliable, timely, and appropriate C&L services at a manageable cost, suggesting that this case alone can sway some organizational decision makers.

Administratively-evaluated C&L projects are devised, most commonly, by mid-level administrators in health care provider organizations or plans. Recognizing the clinical necessity of C&L services for patients, providers, and organizations, they devise and implement solutions aimed at providing more universal access to quality C&L services. The evaluative questions posed and answered by administratively directed health systems projects tend to be very focused, immediate, and continuous. At each stage of development, they focus on a handful of key questions directed specifically at "Is this the correct method? Does it respond to the demand? Is it cost effective? Does it reduce costs? Can it be made sustainable?" In sum, their purpose is to make the administrative business case for C&L. They focus directly on the provision of information specifically required by their own health care systems executives to make the programmatic and financial decisions to sustain these advances.

Many, if not most hospitals, public or private, in the consideration of their business cases for C&L, base their rationales for C&L services solutions on *substitution rather than new investment*. Some will discover and build on presumed, underutilized internal C&L strengths within their existing workforce, such as bilingual employees. Others will rational-

ize the use of new technologies to replace lower productivity with higher productivity at minimal cost. Some hospitals attempt to provide better service or care at the same or lesser cost, constrain the growth rate of future costs, and improve productivity, efficiency, and timeliness.

That's music to CEO ears. If that business case can be made, I think it can get in. — hospital executive

However, practically every C&L solution, even those designed to be ultimately substitutive or cost-neutral, requires the initial investment of significant internal or external resources – cash, staff time, space, and system accommodations (e.g., policy, procedures, training, testing, software design). In reality in many locales, these requisite significant new resources are not made available to support these C&L solutions. The "savings" or "efficiencies" are reported through paper and pencil exercises only, and the only thing that truly happens is that internal resources are accounted for differently. But persuasive substitutions are predictive of a higher likelihood of sustainability; if the resource base remains stable, so should the advances.

To the degree that many organizational C&L advances are based on pilot projects rather than significant enterprise-wide commitment, many may not be of a sufficient scale to pencil out solutions that enable them to be available to the entire facility or system or be sustained after the project period. To have a significant win, there must be a greater internal investment and a more persuasive, evidence-based administrative case. Failure to make larger investments or provide persuasive evidence provides executives with avenues to defer larger or wider implementation decisions for considerable periods of time.

Ideally, advances would, concurrently, make both the administrative and the clinical case, neither of which, alone, appear to constitute a persuasive case for large numbers of health care administrators, medical committees, and their decisions. Combined cases would also include embedding C&L within current and larger health systems priorities such as patient safety, medication error, disparities, quality, liability, technologies, and marketing. Below, we briefly discuss some of these cases.

C. Return on Social Investments

Many of the arguments used to resist or defer action on C&L advances solutions are actually surrogates for more basic, legitimate financial concerns over provider productivity, timeliness of service, and affordability. Actual "affordability" varies widely across settings, from very easy for private hospital systems to less easy for safety-net hospitals and very difficult for solo and small practice practitioners. The affordability challenge will not be solved until providers agree that C&L barriers are sufficiently related to their own efficacy, patient safety, and patient health status and then raise the priority of this concern in the face of all the other important and legitimate issues that they confront in their practices, organizations, and professions. Providers are justifiably frustrated at not being more effective in countering the many social and economic forces that affect the health care and health status of their patients, but within the

walls of their private clinic or hospital practices is one place where their influence and action could be quite effective.

In the debate over the affordability issues, many of the arguments have been framed incorrectly and thus have produced incorrect results. For example, health care administrators, too commonly, have come to view C&L services narrowly as 1) marketing tools to increase their organizations' patient satisfaction scores, 2) community benefits to meet some social goal defined as "charity," and/or 3) stand-alone practices to limit institutional exposure to liability or community complaint. These views define such services as a nice "extra" or gift to patients rather than as an attribute absolutely required for the success of all preceding investments in 1) patient care and 2) providers, provider organizations, and managed health care plans.

The health care enterprise that precedes the actual encounter between a provider and a patient is huge and complex. Visualize for a moment the limited English proficient (LEP) and/or minority patient at the outlet tip of a funnel. The body of the funnel contains huge social investments in hospitals, academic medical centers, medical education, nursing education, technologies, professions, pharmaceuticals, and insurance. The entire purpose of these investments is to benefit the patient at the tip: the encounter(s) with the provider(s). The preceding investments are to culminate in 1) a sound assessment and diagnosis, 2) consensus over the right course of treatment and patient compliance with that treatment (e.g., surgery, radiation, medication, or physical therapy) and/or 3) behavioral and lifestyle change (e.g., diet, exercise, work, sleep, substance use).

What if, just at that point, when an effective intervention is required, the funnel of effective communication information to and from the patient is blocked or narrowed? That is what too often happens with minority and LEP patients. If one conducts observations routinely in hospitals and clinics, interviews providers and patients, and analyzes the case studies of failed trans-cultural communication, one cannot avoid the conclusion that, just at the point where medicine is to become effective through mutual understanding and trust between provider and patient, it is too frequently broken by language, health literacy, and cultural gaps, making the preceding investments futile.

One basic argument for C&L services is the avoidance of this tremendous waste of preceding social investments in health care. Not providing necessary C&L services is like building airports and aircraft, hiring flight and ground crews, and selling tickets, but not fueling the planes. Huge investments are made, but nothing happens. Given the disproportional scale between these huge preceding investments and the small relative incremental costs of C&L services, the resulting waste appears ludicrous.

D. The Business Cases

Policy advocates, health care administrators, and clinicians continue to express the need for "making the business case for C&L," couched as cost savings, marketplace return on investment, substitute efficiencies, local competitive advantage, or productivity gains. Many who have looked at

marketplace business cases and competitive market advantage reject the *laissez-faire* notion that "market forces will require and determine C&L services."

Market forces do not work particularly well in American health care economics, even those focused on quality advances in patient safety. The payers far more than the consumers drive what services are provided and, thus, patient experiences and voices are not particularly corrective. Indeed, it is almost universally the case that both corporate and government investments in health care and health status improvements have to be couched and calculated in costs savings terms rather than their benefits to recipients' well being.

Unfortunately, one of the peculiarities of health care financing and delivery is that C&L costs, like the costs of preventive care, often accrue in one ledger (e.g., the hospital or the provider office) and the benefits in another (e.g., Medicaid or managed care plan). So, for example, the costs for C&L services to a specific patient may be borne by a hospital but the benefits of that service may accrue to that patient's managed health care plan, in terms of reduced unnecessary utilization or improved health status. This dichotomy of ledgers occurs at every level and location within our health care system and organizations. It is an artifact of the way health care is currently financed and, thus, cannot be wished away. It is only in more closed systems, such as HMOs, where the costs and benefits accrue to the same larger organization.

Most C&L policy and operational advocates have wisely abandoned the notion or argument that investments in C&L services will either reduce current costs or more than pay for themselves in the long run. In this, they mirror the findings from many other advances (such as the electronic health record, new technologies, and pay-for-performance) that show investments may produce significant gains in other measures or ledgers but not in cost reductions. Indeed, C&L services may result in increased utilization of some services, costly in some ledgers but beneficial in others. Take, for example, the corollary and pervasive advance of the electronic health record:

> *Electronic health record (EHR) advocates argue that EHRs lead to reduced errors and reduced costs. Many reports suggest otherwise. The EHR often leads to higher billings and declines in provider productivity with no change in provider-to-patient ratios. Error reduction is inconsistent and has yet to be linked to savings or malpractice premiums. As interest in patient-centeredness, shared decision making, teaming, group visits, open access, and accountability grows, the EHR is better viewed as an insufficient yet necessary ingredient. Absent other fundamental interventions that alter medical practices, it is unlikely that the U.S. health care bill will decline as a result of the EHR alone* (Sidorov, 2006, emphasis added).

However, there remain numerous possible internal business cases to be made within specific hospital, clinic, or geographic settings. External/community and internal/systems C&L advocates are making numerous business cases to their various organizational audiences – retrospective, prospective, liability, cost-benefit, cost-effectiveness, opportunity costs, marketing and competitive advantage (or disadvan-

tage), minimal versus optimal compliance, insourcing versus outsourcing services, implementation versus maintenance, opportunity costs, systems costs, organizational costs, individual costs, and so on.

These cases have not been collated to determine

- how many cases there are,
- to whom different business cases are relevant,
- what the assumptions and foundations of various cases are,
- how the cases are actually made (methods, data, findings),
- how well made these cases are (or are required to be),
- how they deal with negative findings on cost-effectiveness and outcomes,
- how they calculate the opportunity costs for investing in C&L versus investing the same money in the next best priority, and
- how to calculate the marginal costs, that is, how much more is needed to create specific measured outcomes as health care systems currently measure desired or required outcomes.

E. The Marketing Case

The dependency on marketing interests may produce funded C&L advances more rapidly and comprehensively than some other impulses, to the degree that it is intended to increase any one system's local market share or competitiveness. Some of the most well known cultural and linguistic advances at the system level (the "means") appear based on marketing "ends," driven by the interest to enlarge and capture an overlooked niche in an increasingly competitive marketplace.

For example, the well designed community health center (CHC) model often coincides exactly with the cultural and linguistic requirements of the target populations and the marketing goals of certain larger private systems. In the ideal "dense-pack" CHC model, each clinic is designed and constructed for and around a particular and sizeable culturally and/or linguistically and geographically homogeneous patient population, producing some economies of scale and effort. The services are designed for specific ethnic groups – for instance to identify language needs at first point of contact, to maintain contact through appointment reminders and no-show reductions, and to provide C&L services throughout through a bilingual worker model – using a continuous quality improvement (CQI) approach to constant system change. Providers (physicians, nurses, medical assistants, technicians, and pharmacists) and support staff at these clinics are recruited or self-selected based on their cultural and language affinity.

The CHC model within a large facility or system will work for certain communities and facilities. To make such clinics financially worthwhile means the marketing effort will have to embrace literally thousands of persons within a specific language group, to aggregate a sufficient critical mass to warrant making an investment. The result is

an entirely different kind of localized, ethnically-based or culturally-based health care system, tucked within a larger, more general system for more heterogeneous populations. There are demonstrated, if proprietary, business cases for such approaches within large health care systems with special concentrations of ethnic/language groups.

This is the epitome of practicality. Examples emerge from the best hospitals, community health centers, federally qualified health centers, Indian health centers, and migrant health centers that have, to greater and lesser degrees, continuously accommodated to the changing characteristics of their racially, ethnically, linguistically, sociologically, and economically diverse communities and service populations. Equally, there are fine examples of historically responsive public hospitals, academic, and religiously-based medical centers that, over time, have acquired these same culturally-responsive attributes. Indeed, in 2006, we observed the continued creation of hospital-sponsored (e.g., Maimonides Hospital in Brooklyn and St. Vincent's Hospital in New York), ethnically-specific clinics to serve specific populations near where they reside. While these more culturally advanced enterprises generally appear in certain public and nonprofit situations, they also appear in large HMOs and elsewhere (Schlesinger and Gray, 2006).

Most provider organizations that have achieved high levels of proficiency and ubiquity within their walls, most commonly community health centers, public hospitals, public health departments, and academic medical centers, have done so based less on external funding than on their long histories of under compensated care to their communities and their willingness to "eat the costs" of C&L services to the tune of hundreds of thousands, if not millions, of dollars per year. Such organizations have developed their C&L solutions as a direct response to the natural forces flowing within the communities that they serve and within their organizations. They did not derive their sense of the problem or the solutions from externally imposed requirements, existing models, theoretical concepts, or external investments, but from an examination of the needs of their patients and providers and their own responsibilities and capabilities.

Natural forces (e.g., demographics, marketplace) continue to shape the increasingly competitive environment and organizational responses to it, generating increased convergence in their resulting approaches and decisions. In public and private systems, each hospital or system, in establishing its own place in the future markets for health care, takes a somewhat different tack in matching itself to the changing nature and demographics of the communities they serve or intended to serve. Even public hospitals have to market themselves to remain competitive, to compete directly for their managed care patients with private hospitals. Some will market to get more Medicaid patients, others will do just the reverse. These differences are difficult to grasp. One public hospital executive suggested that

we want to attract this population. It is very difficult for us to effect health status change, but, if we can posture ourselves with a particular linguistic population, we can get

repeat visits and have people come to us. That way, we can actually affect outcomes and that helps our bottom line.

That is a peculiarly closed system understanding of what is, in reality, an open system of care. Alternatively, a teaching hospital administrator said,

We do not want to improve our market share with this [Medicaid, uninsured] population. That is not what we want, believe me. We're doing this because it's the right thing to do, but not because we want to increase it. Quite the opposite.

These natural forces and responses may lead to some greater convergence on the perceived need or appearance to be providing more and better C&L services to gain local competitive advantage.

F. The Quality Case

Another case concerns quality of care and services. C&L and quality are commonly linked in discussions about C&L services. However, there is little specificity in what is meant by "quality." Naïvely, I used to think of quality as an independent good that everyone accepted and was pursuing as the highest value in care – "the right thing to do, virtue as its own reward"— with its own face validity, such as correct surgical site identification. Similarly, I thought of the ability of providers and patients to communicate with one another "in clear" about matters that were important to both as an absolute value and as necessary to achieve a goal that was shared by both: the optimal health status of the patient.

What I began to comprehend was that some on the operational side of the "health care quality" business are becoming more cautious in their use of the term "quality" because of the difficulties of defining it, measuring it, advocating for it, justifying expenditures, or understanding its impact on other values. As an organizational attribute, quality is similar to other organizational issues of health status or health disparities; none is a stand alone, absolute, or independent value, but is based on its relationship to other organizational or functional values.

Quality is a relative value in competition with other values (e.g., access, cost, return on investment, or provider productivity) of both health care professions and organizations. In some sense, quality becomes a surrogate for other, deeper agendas that appear essentially financial or political in nature. Because quality is in competition in these agendas, it must be "penciled out" in terms of concrete costs, benefits, returns on investment, and other measures of other values important to persons and organizations. Said differently, quality becomes, for some, just another commodity, not an end in itself but a means to other ends.

When hospitals are pursuing quality, they're doing it both for its own sake and for marketplace competitiveness and reimbursement. — community benefits manager

Quality, as a means, is pursued through processes that demonstrably improve patient outcomes, patient safety, and so on. In terms of concrete operations, however, quality is frequently pursued through processes that improve organizational methods, such as reducing unwanted variability and waste, increasing efficiency, increasing productivity, increasing competitiveness, improving marketing success, and meeting community demand, however defined. Quality can be assessed based on the role that it plays in the economic survival, organizational sustainability, community and marketplace competition, and professional autonomy of the organization. In this sense of return on investment, quality is neither a set of practices nor their end state, but processes that advance the rationality, efficiency, productivity, waste reduction, satisfaction, and competitiveness of either an organization or profession.

If C&L is seen as a process that is related to one or more of these other important organizational values and not done simply for its own sake, it will lead some to "pencil it out" in support of some local business case. Every health care organization I have talked to focuses on a different purpose or set of purposes or values that C&L might advance. It also requires its own logic, evidence, measures, and analysis to determine what it is going to do. And larger system authorities driven by different non-local purposes and values require answers that are specific to those purposes and values.

Therefore, it is surprising that, in some large health care systems that publicize widely that they have made the quality business case for C&L services, each subsidiary unit, facility, or region must still make its own business case to tap internal resources for its own local advances. If they truly defined C&L as an investment in quality, why is it that they are not examining C&L closely in terms of the health outcomes, cost savings, and other gains in which they are interested?

Given this general disinterest in gains attributable to C&L, I remain unconvinced that decision makers in large health care plans/provider organizations define C&L advances as a quality matter. It may be that the quality these systems are pursuing is defined less in terms of inherent internal concerns than external benefits such as marketplace advantage, community pressure, governing board pressure, contract compliance, cost containment, accreditation and certification, and legal liability. External pressures are applied by different sources including purchasers, health care plans, Medicare, Medicaid, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Office of Civil Rights (OCR), and state regulations. External pressure, in the absence of powerful financial incentives and/or enforced accountability, might not, in the end, be a very powerful force in advancing C&L services as an inherently quality issue.

Having a negative oversight situation can produce either positive or negative results. A lot depends on how people respond to an OCR, CMS [Center for Medicare and Medicaid Services], or JCAHO review. Some people will respond by getting angry for decades, which will impede any kind of progress. Or they will do only what they absolutely have to do, at a minimum, to keep the cops off the door. Some, who disagree that something is an appropriate standard, will wait to be told to do it differently before they'll do it. Others will respond, initially with anger, and then with enlightenment. Others will be fearful that they are going to get clobbered, if they don't get in there first. — hospital administrator

G. The Patient Benefit or Charity Case

For the longest time, C&L services have been understood, misunderstood, and marketed as a patient benefit. Indeed, to the degree that they are underwritten by health care systems' community benefits departments and charitable foundations, "patient benefit" is the justification for C&L services as a charitable contribution. This perspective reduces C&L services to a charitable or community benefit when they are actually a necessary ingredient to patient care comparable to surgical aseptic technique, hand washing, or correct patient identification.

C&L services are likely to be a necessary ingredient to support all hospital and provider purposes and functions, and constitute a critical aspect for all of the other, sometimes invisible, interests present in the exam room, such as the provider, the hospital, the corporation, the risk manager, the purchaser/payer, the medical insurer, the malpractice insurer, the family, the community, the employer, and society (Bowen and Kaufert, 2000). Reducing them to an optional, externally funded, charitable contribution may sustain a short-term project advance but is unlikely to result in a self-sustaining, centrally funded, and mandatory operational advance.

H. The Legal Requirement Case

In making the case for cultural and linguistic advances, it is not proved possible to rely on the power of statutes, regulations, contracts, or accreditation standards alone to move the mass of health care organizations forward in any significant way. Those organizations that respond to legal duress are typically those that are actually the target of a suit or complaint. While the potential threat of external enforcement captures the short-term attention of some systems' decision makers, no paper threat has proved to be self-enforcing, and few enforcement bodies have exercised their explicit or implicit authority to insist that the legal or contractual requirements be met. Enforced compliance is not equivalent to system buy-in. Mandates can actually become a barrier, when they come without specificity, expert technical assistance, and resources. Much like internal executive mandates failing to touch the ground from the top, external mandates can also fail.

VIII. A Guide for Organizational Change Agents

1. The Point is to Start
2. Leadership and Laggard Organizations
3. Minimalism, Formalism, Voluntarism and Deferral in the Service of Change
4. System/Organizational Leaders and Issue Leaders
5. Leadership from the Center or the Periphery
6. Leadership from the Middle

Let us assume that you are an executive sponsor, mid-level issue leader, or C&L project-level change agent who has successfully sold your organization, department, facility, or unit on one or more cases to create a C&L advance.

First, congratulations. Second, you are now confronted with the hard contexts of organizational life and how they need to be finessed in order to succeed. You need to start, but where and how? Do you need an organizational assessment? Do you need a community assessment? Do you need a SWOT (strengths, weaknesses, opportunities, and threats) analysis? Do you need a capacity and readiness study? Do you need a logic model? Do you need a strategic plan or an operational plan? Do you need to wait for executive direction or a new line in the budget? Let us go back a few steps to gain our bearings.

1 The Point is to Start

To draw a sketch of a cat or house, it really doesn't make any difference where you start; keep at it and you will have, eventually, some better or worse picture of that cat or horse. Similarly, to make C&L advances in your organization, it doesn't make any difference where you start as long as you start. That is not exactly right, is it? Surely, in making C&L advances, some places are better starting places than others. That's why consultants were invented, to help you decide. However, what is most frustrating is how organizations can avoid starting and how many superficially legitimate techniques they can employ to avoid starting while still appearing to start.

Much as I fear that many health care organizations will begin and end with the most minimal mechanical initial C&L steps and plan, not starting at all is a far worse alternative. Some insist that starting requires a lengthy and detailed planning and assessment process. If you absolutely must have a major planning process to proceed because that is how your organization or mind works, please do have such a planning process, but realize that your plan will inevitably change very early in the game once you have started your first two or three steps.

However, if you can simply hire your first interpreter or go out of your building into the community and meet your first minister or community association chair, that is a very large

step in the right direction. *But the point is to start.* Organizational indifference married to ignorance and inertia is what got us and keeps us where we are now, still hesitating to put our proverbial toe in the water. What are we so afraid of? The people on the other side (in the organization or in the community) are just human beings. If we are smart, curious, inquisitive, careful, and aware, meeting with them should not prove fatal.

I am adamant on this matter because that is where our own field observations and analysis directed us. When we began our meta-evaluation of language access advances for The California Endowment, we began by wandering down an unhelpful path based on standard theories of directed organizational change and pursued standard categories of phenomena such as strategy, tactics, logic models, executive buy-in and leadership, outcome measurement, performance review, scale, sequencing, location, and pace. But the evidence we were collecting kept pointing us to categories that were far more location-specific, such as processes, patterns, unanticipated opportunities, discoveries, relationships, connections, connectors, networks, alliances, learning, boundary crossing, centers of gravity, and center vs. periphery change.

We shifted our evaluation focus from "Are these projects making expectable progress?" to "What is all of this evidence a study of?" This shift refocused us from the almost religiously held and career-rewarding attachment to formal strategic planning and logic models to something far more intuitive, informal, emergent, innovative, flexible, inclusive, and responsive to the times and conditions. In effect, our evidence and findings backed us into other theories – chaos, complexity, and emergent change. We had great difficulty in melding the concrete controlling reality of organizational hierarchy and power with the competing reality of rampant chaos and constant change in each organization's external environment, a continuing unresolved contest between order and change and structure and chaos.

Many evaluators suggest that the inevitable consequence of such an emergent approach leaves one with only process measures. However, what we found appear to be more fundamental elements specific to making C&L advances in a variety of mildly interested health care systems and facilities. What we found were significant changes in capacity, readiness, support, learning, exchange, networking, expertise, action, opportunism, surprise, and process-as-product, all dependent on tangible changes in specific internal and external conditions.

We found that, while logical and orderly, the strategic organizational planning approach to directed change often founders on the shoals of the "best-laid plans," where controls over necessary elements and stability of conditions over time and geographic and bureaucratic distance prove illusory. Too many health care organizations confuse planning with action. In many instances, the plan is merely an exercise or statement of intent produced by some organizational parties with no downstream effect on other organizational parties responsible for actual operations. There is a tendency to focus heavily on extensive planning that can go on seemingly forever, consuming large quantities of executive and managerial time and producing a considerable

amount of paper. This tendency for extensive preparatory time to build capacity and readiness also seems to produce the tendency to extensively defer taking any concrete action on behalf of patients and their providers.

It is wasteful and time consuming to create major plans or change strategies that are either 1) context-free (that is, an ideal script of actions assumed to be workable in any organization anywhere) or, conversely, 2) highly condition-dependent (that is, a script for action where the planners are aware that they lack sufficient local knowledge, authority, or resources). I suggest that the best strategies focus on the very first few steps in creating designed change and a protocol for how to manage initial responses, opportunities, and obstacles creatively. Indeed, among the systems we analyzed, the greatest, but still unmeasured, advances are not those that were planned but those that were unanticipated, serendipitous, and opportunistic.

Cultural competency defined as emerging from the increasing interaction (e.g., conversation, problem solving, employment, outreach, etc.) between the health care organization staff and the community members starts with some changed but focused practices in some initially narrow lines of ambition and then takes on its own life as rewards are seen to emerge from the initial investment in time and mutual risk in newly perceived ambitions and opportunities. These initial steps generate immediate, new, and self-generating rewards but do not provide "the big picture" of ultimate C&L performance. The C&L plan is a very general road map to guide only the first two or three steps in the pursuit of a goal. The actual form of implementation becomes very labile and flexible in the face of emergent obstacles, opportunities, and new champions.

I suggest the desirability for organizations to start and to take any action in any place that will produce some immediate rewards for providers and patients and some lessons for future steps. Once they experience positive returns of their efforts, they will find energy and avenues for additional advances that meet their local needs. Like starting to paint on an empty canvas, it is possible to apply paint anywhere as a beginning and, over time, to fill in the empty spaces and to paint over where one is unhappy with initial efforts. This is the narrative that explains the relative success of what we now consider C&L models and centers of excellence. Few, if any, start with a master plan for C&L services or extensive capacity building. Most of them sense a need, plug-in an obvious immediate solution, learn by doing and testing and modifying it, evaluate it, and then make it a permanent part of their services. Features common to these models are a focus on pragmatic first steps, the development of organizational capacity on an as-needed or when-needed basis (i.e., not too far in advance or excessive to the initial need or demand), and the disallowance of large-scale or strategic planning to defer taking immediate action.

Starting with a practical action suggests that the first action will, of necessity, result in many others, most of which cannot be accurately predicted far in advance. In the absence of a complete strategic and implementation plan, the organization will be presented quickly with a number of bisecting paths or decision trees, where the first decision based on im-

perfect knowledge results in numerous succeeding decisions, all based on real local conditions and contingencies, internal conditions and probabilities, discoveries, opportunities, obstacles, partial successes, and the passage of time. Natural forces will dictate the organization's progress.

But this does not mean that C&L advances must rely on organizational chance. By focusing on real actions, any road-map for organizational action on culture and language will attempt to meet several performance criteria:

- Affordability and sustainability for the hospital, plan, or provider,
- Universal accessibility: it can be easily accessed by every patient, provider, and every care team member,
- Appropriateness to the needs of each situation (complex, dangerous, routine) and of the persons involved (providers, patient, family members, and so on),
- Timely and demonstrably adequate to the need,
- Routine, not special; it is standard, automatic, planned, and scheduled, and does not requiring individual initiative,
- Technically supported as needed,
- Continuity between hospital and community care,
- Continuous assessment of gaps, utilization, quality, and effectiveness, and
- Specifically tied to other, larger ongoing value-driven and accreditation-dependent ambitions such as disparities reduction, patient safety, liability reduction, community service, and quality improvement and assurance.

Thus, we are not resigned to progress defined in tiny, fragmented, and peripheral increments, the sum of a little C&L advance here and another over there. When I suggest the need to start, I do not suggest pursuing one isolated or peripheral project at a time, but an approach across a broad front of action at a pace and scale that are doable. As with more advanced C&L organizations, success is achieved by *pervasive incrementalism*. Earlier, I suggested that *changing practices would lead to organizational cultural change;* here, I suggest that *a combination of mechanical changes can lead to more fundamental, self-sustaining organic change.*

I also suggest that there is more promising ground for action, where numerous organizations, separately or in concert, initiate a number of *concurrent, overlapping, and mutually supportive initiatives* and advances that, pursued logically over time, create *interdependence, synergy, and emergent place-based innovation*. It is not just a scattering of seeds but the beginning of a garden. These will combine to produce an initial flow of rewards to the organizations and their staff members that is sufficient to create and maintain a permanent and effective internal constituency. That constituency will prove necessary to continue the underlying processes of learning, adapting, and combining with others.

② Leadership and Laggard Organizations

Your change agency work will clearly be affected by whether your organization is a C&L leadership organization (having a history of making concrete advances) or a laggard organization (having no such history or very limited advances). How does one explain the great distance between C&L leadership and laggard organizations in addressing the needs of their cultural minority patients? I suspect that C&L leadership organizations, whether community health centers, public medical centers, academic medical centers, or religious hospitals, did not set out to become leaders or models. These leadership organizations simply developed the attributes and practices that they came to understand were required to meet the health needs of the service populations they were determined to serve. They experimented, through trial-and-error, with various local solutions and kept those that seemed to work and that now constitute models of best practice. They have, with difficulty and *chutzpah*, eaten the costs to come up with their solutions to serve the perceived needs within their service populations.

Most organizations, other than these obvious leaders, will desire to be somewhere in the middle where minimally acceptable performance and costs are balanced and risks are minimized. There is a powerful disinclination, even disincentive, among health care provider organizations and/or managed health care plans to be the first significant investors in the potentially unreimbursed high costs of providing C&L services. Being a leader or model implies a commitment to risks and costs that few would happily embrace. To the degree that these organizations are competing with one another in the marketplace and seek to be in middle of the pack in the regulatory, accreditation, and contract compliance worlds, none would seek to be very far in advance or behind.

Behind these are those who are tentatively putting a toe in the water, in advance of projected enforced regulations and audits, in order to demonstrate more and earlier responsiveness to the perceived need. Some provider organizations and plans will soon become quite concerned about being perceived as laggards on the continuum of required performance and local competitiveness and will rush at least minimal solutions into place. And others will merely wait until the external incentives and disincentives become irresistible.

Laggard organizations seem content to live with a slow, non-urgent, shallow, decentralized, diffused, and unresourced response to the perceived demand or duress. This is probably both due to and produced by a lack of real intention at the center. It requires that tangible change come from some organizational periphery, whether that is peripheral departments, affiliate hospitals, affiliated clinics, or individual actors and departments within some affiliates.

One of the key reasons that more universal organizational C&L advances have not been made in the face of governing statutes, regulations, contract requirements, and accreditation standards is that such change tools are not self-enforcing. In the absence of accountability standards, performance auditing, and resulting rewards and punishments, these tools are just more pieces of paper. Responsibility is delegated

downward and away (e.g., affiliates, contractors, partners, plan networks) and becomes diffused in the welter of day-to-day operations. Delegating responsibility enables organizational leaders to avoid embracing and underwriting C&L values and practices by merely requiring subsidiary bodies to perform and report differently. That process bypasses the opportunity to create a permanent, knowledgeable internal executive and managerial constituency and leadership.

In the relative absence of an enforced standard and/or audited performance, some systems and hospitals will move toward C&L services more rapidly than others. This pace will depend on their understanding of their market niche in their community, their internal finances, their local resources, the diversity of their workforce, the awareness level of their executives, the changing demographics of their locales, and their perception of external pressures.

For example, public hospitals are more likely to 1) support C&L services as a policy, 2) fund these services through overhead and deficits, and 3) lack the financial capacity to fully fund these services during economic downturns. However, there is a high degree of variability in C&L commitment and performance among public hospitals, based on their location, size, service population, history, leadership, procedures, physician pressure, political pressure, internal resistance, financial condition, and labor agreements. Equally, large urban hospitals, general hospitals, and university-affiliated hospitals are more likely to provide C&L services. By contrast, for-profit and not-for-profit hospitals are less likely to support such services without first calculating competitive marketplace issues, local marketing, relative financial well being, the requirement for some to demonstrate charitable contributions to the community, and the values of the "owners" (e.g., religious orders) and executives.

Large hospital systems appear to be differentiated by the degree to which they perceive themselves to be operating under some form of external duress regarding C&L performance; it is the individual hospitals with these systems, after all, that bear most of the legal, liability, accreditation, and direct service risks. There is little evidence of much internal demand for C&L advances at the system level. The perception of internal demand seems considerably more diffuse at the system level because actual C&L services demand is felt primarily at the hospital level (e.g., patients, providers, community, local government). Thus, *most large systems have the resources but lack the sense of pressure, while their affiliated hospitals feel the pressure but lack the resources.*

Categorically, all large private hospital systems and HMOs have sufficient resources to underwrite their own C&L advances and at the requisite scale. What would stimulate them to do so lies in the *competitive and coercive environments* in which these systems live their lives. As these systems consider their own C&L position *vis a vis* these environments, their C&L solutions will likely "collapse to the mean"; that is, they will come to resemble one another considerably in terms of their solutions and costs. Some of that appears to be happening now, particularly as they share C&L solutions, tools, and vendors with one another.

Turning a hospital macrosystem is like turning an oil super-tanker. First, it must actually be able to see new small objects at or beyond the immediate horizon. Second, it cannot be turned except slowly and continuously, almost imperceptibly. As a researcher, I often feel that I need time-lapse photography to measure macrosystems change, such as

- What new discussions are including C&L?
- Are the discussions shifting their emphasis from "Should we?" to "How do we?" – that is, from an ideological to a technical approach to C&L services?
- Is the issue moving from a precontemplation stage to a contemplation stage?
- Which new executive or department is expressing interest?
- What strategic planning language is being inserted in downstream action plans?
- Is there any new investment applied to this new interest?

Many large provider organizations (e.g., hospitals, clinics, physician groups) lack the necessary vision of either the C&L challenge or reliable roadmaps to action. They have not challenged themselves to question certain current practice models that may not serve the patients, providers, themselves, or payers well. The lack of such insights inhibit their efforts as they see only piecemeal aspects of the challenge in front of them – for example, a tiny internal interpreter service here, a minimalist training and testing program there, or a small community outreach there. Effective C&L advances would require

- coherent organizational power and influence focused on this organizationally minor issue,
- application of significant operational financial resources over time,
- integration with larger and equally or more complex concurrent advances,
- cohesion between clinical and organizational administration on this issue,
- bulk solutions that assure quality oversight, uniform standards, policies, procedures, and practices, and widespread operational rewards,
- the inclusion of numerous departments and functions, and
- the involvement of external experts, internal experts, and communities.

In some much larger and non-local systems, there are signs of some increased executive involvement, some limited corporate coinvestment in advances, and some increased focus on system change versus single facility change. These are seen to be the result of different impulses:

- the sense that something is going on and wanting to get in on it at an early stage or not be left behind,
- the changing demographics within their markets and their political implications,
- peer pressure,
- linkages of C&L to other quality of care and quality of services issues, and

- predictions of JCAHO, National Committee for Quality Assurance (NCQA), and other quality accountability actions.

Shifting our perspective from non-local health care systems to individual hospitals, a hospital's place on the bell curve of awareness of and activities on behalf of limited English proficient and culturally distinct patients is directly determined by

- their contact with an OCR complaint,
- the demographics of the community they are serving,
- how many different languages and cultures they have to deal with routinely,
- the number of languages that meet threshold requirements,
- their available resources,
- the method by which they decide, internally, to allocate their resources,
- what they considered to be higher and lower priorities,
- the degree to which they perceive the power of regulations and contract requirements, and
- the range of freedom and/or support they have from larger system authorities.

Factors that contribute to an organizational response to suggested C&L advances include

- the existing arrangements for providing C&L services,
- the level of satisfaction with these arrangements,
- the age of the providers (resulting in desire for or resistance to advances and/or their supportive technologies, such as patient identifiers, video medical interpretation, remote audio interpretation, the web product EthnoMed, translation devices, or translated materials),
- the existing efficiency of provided services,
- the pressures felt by providers seeking to increase their productivity and reduce waiting times,
- the influence of providers over organizational policy, resources, and practices,
- the reported initial experiences by early adopters,
- the speed and ubiquity of implementation,
- the ease and adequacy of the solutions,
- the capacity and interest in key support departments and functions,
- local leadership commitment to the advance,
- a history of rapid acceptance of change,
- a history of competent implementation of change, and
- a culture of flexibility.

Over time in the leadership hospitals, there appears a growing and more eager internal capacity (but not necessarily tangible resources) within the organization to make advances permanent, larger, and more sophisticated. This is evidenced by the following phenomena:

- Increased executive and staff awareness of and interest and involvement in these advances,
- Increased staff skills in and knowledge about the subject,
- Greater numbers of change agents working in concert,
- Executive commitment to the advance,
- Increased numbers of "converts" within the organization,
- Issue champions throughout numerous organizational areas and levels,
- Internal budget reallocations toward the advance,
- Braiding advances into the base budgets of operating departments,
- Commitments made by adjacent departments and units,
- Raised expectations in the minds of key constituents,
- Promises made or advertised to constituents,
- Changes embedded in basic policies, procedures, practices, and technologies,
- Enterprisewide and partnershipwide advances, not just units or buildings, and
- Appropriate scale and ubiquity of the advances.

Unlike the large hospital systems, there is great variability in the ability of individual hospitals to enact large-scale significant C&L advances even though they need to do so.

Our guys have had several blows to the solar plexus that have shaken them out of some of the routine patterns that they got into. They are now looking at improved performance as a matter of, not just thriving, but survival. There is a different edge to it than there has ever been before and we're at a particular era where they are working real hard to maintain community support. This is one of the issues that's integral to that. Many hospitals have for many years really ignored their community and it's only now that some certain public and private hospitals seem to be engaged very actively in regenerating or developing that community support and discovering what their political and business base really is. Some of these leaders have been out there saying to folks, "You know, there's a real business case here, as well. Who the hell do you think your patients are going to be, for the next 20 and 30 years?" And, "Oh, by the way, you know all these workforce shortages? Where the hell do you think you're going to get staff?" So they're beginning to get a much clearer picture of their real environment. The 2000 census came along and blew a lot of people away. — hospital administrator

The result of all the foregoing is a handful of leadership organizations (most of whom, self-reflectively, view their own advances as inadequate, provisional, and resource-poor), a larger and growing number in the middle (most of whom are just starting their first action), and a very large number of laggards (waiting for change to be required by market competition, law, regulation, contracts, and accountability systems). Advances need to be marketed differently to each of these three classes of organizations, since they obviously do not respond to the same arguments, interests, or values in the same ways and may not be similarly situated.

As noted above, large hospital systems and HMOs hesitate to significantly invest their own internal operational funds into developing and sustaining C&L advances among and within their affiliated hospitals. Most seem to take minimalist and formalist stances (see section 3 below) to these advances, keeping them voluntary and on as slow a track as their affiliates desire and can independently afford. They themselves appear to be taking a far more deliberative approach, bureaucratically tying the changes to larger, more diffuse, and deferred values and strategies.

3 Minimalism, Formalism, Deferral, and Voluntarism in the Service of Change

Let us assume that your organization (or some part of it) has been sold on the need for C&L advances and has determined to make a start. You need to know that there is a general tendency for hospitals, hospital systems, HMOs, and managed health care plans (and perhaps government agencies) to minimize their responses to internal and external C&L demands to the least possible level through minimalism, formalism, deferral, and voluntarism (as well as delegation to others, as discussed earlier).

Minimalism is the approach that provides the smallest and most peripheral response to a C&L challenge, for example, placing the smallest investment in the most peripheral location in the organization or purchasing the least expensive service to meet the most minimum audited requirements. Characteristics of minimalist approaches include

- weak model and measurement of the need/demand,
- organizational response based on complaint data only,
- low competency and performance standards,
- placement in the most remote subunit,
- smallest pilot level of actual effort (e.g., pocket guides to other cultures),
- reliance on external investors,
- reliance on capturing lowest-cost internal resources, and
- not subject to executive audit.

Formalism is the approach that defers actions with direct benefit to providers and patients until bureaucratic processes are complete – for instance, change in mission statement; strategic planning; operational planning; interdepartmental negotiations; design, consensus-building and sign-off on new policies and procedures; standards-setting; training development; workforce and union negotiations over duties and compensation; space allocation; legal review; facilities review; technology review; negotiation with partners; and contracting. Characteristics of formalism include

- changes primarily on paper (e.g., plans, policies, or marketing materials),
- authority and responsibility delegated outside of facility clinical and quality assurance operations,
- unaudited policies, procedures, and practices, and
- lack of clinical or service evaluation.

Health care systems commonly evaluate the outcomes of advances in those categories of interests they value most. It is revealing that most evaluation of C&L advances tends to be aimed primarily within administrative categories – cost containment, productivity, efficiency, marketing – rather than patient or provider outcomes.

Deferral is the approach (or lack of it) that defers the provision of new or revised services to provider and patients for long periods of time. Characteristics of deferral include

- multiyear community and/or patient needs assessments, capacity self-assessments, staff awareness trainings, and staff recruitment changes,
- voluntary compliance,
- delegation to few, small, peripheral, distant, and underresourced pilot sites and contractors,
- very long timelines for accomplishment, and
- tentative commitment to the organizational implications of demonstrated outcomes, positive or negative.

Voluntarism is the organizational approach that allows but does not require subunits to participate in advances or pilots, but does require them to bear the bureaucratic, operational, and financial costs of their participation, if any. This is particularly burdensome when the units or facilities with the least resources are confronting the greatest demand for C&L services and are caught between the proverbial "rock and a hard place," the most ready but with the least capacity.

One of the "benefits" of taking a minimalist, formalist, deferred, and voluntaristic approach is that while it produces few tangible or in-depth C&L outcomes, it also produces little or no bureaucratic resistance or "blowback." Conversely, concrete changes, even at the facility level, with regional, system, or other power implications, can produce real blowback.

> *What they keep doing is making the changes so minimal that they're hardly even there. If you make them almost invisible where you barely appear as a wart on the hide of the hospital so that they wouldn't flip you off, or the system, that you can be busy and happy and your work is done and you're meeting your contract or your grant obligations, but in fact nothing is really changing because it's too easy, because it's so small. Let's not put any expectations on anybody. Let's make this to the lowest possible standards that we can possibly apply. Let's use methods that are easy to pass. — C&L change agent*

Some systems not under specific external duress (e.g., OCR compliance agreement or legal settlement) appear to be satisfied in having within their boundaries only one significantly progressive example of meeting C&L needs. It is as if having a model hospital unit, service, or department; a model hospital; a model region; or a model technology (e.g., web-based glossary or translated patient materials) that appears to meet some of the standards for acceptable C&L performance will deflect present and future criticism of the inadequacies of the entirety of the system. It is as if they constructed a model or platform to which they could

point and/or on which they could build in the future if and when external or internal pressures increase.

One very common approach of large systems to C&L challenges is to solve them simply, uniformly, and least expensively. For example, in providing for language interpretation services, numerous hospitals have turned and are turning to "bulk" solutions that may move a system rapidly forward in responding to demands framed as "volume." Bulk solutions, all with an eye to meet the demands at lowest cost, include single or multiorganizational contracts with vendors for face to face medical interpretation, external telephonic and video interpretation, internal telephonic and video interpretation, mass interpreter testing and training of bilingual dual role workers, inclusion of community and hospital provider group physicians in mass telephonic interpretation contracts. These are, by definition, positive, necessary, and immediate, but probably insufficient responses to both the environmental forces and the real demand. Whether underwritten by managed health care plans or provider organizations, bulk solutions are chosen to respond to the *minimum standards* applied by or anticipated from external forces.

Some large systems intend to rely on known or newly discovered internal resources (e.g., bilingual and bicultural employees, training units, and community outreach personnel) at the systems or affiliate level for project success. Relying on such "insourcing" is attractive because costs are known, constrained, and internalized, ensuring some prospect of sustainability; control can be exercised over performance; and insourcing increases system capacity, by definition. The risk is that quality based on content area expertise, timeliness, and competency may be compromised. The critical issue for insourced solutions is the degree to which these internal "resources" have preceding demonstrated expertise and experience and meet relevant current standards of knowledge and performance.

Large systems' responses to C&L challenges tend to direct the quality of C&L services toward the "mean minimum," a level of quality that suffices to meet the industry-determined balance among minimized cost, inconvenience, and blowback; maximized productivity and coverage; and acceptable measured outcomes of provider and patient satisfaction. That level of quality is likely to be in no way commensurate to the actual need for open, complete, accurate, and effective communication, understanding, and trust between providers and their patients. In other settings, this has been called "the curse of the good enough." These tendencies are inevitably created when *business-driven priorities* invade the realm of *service-driven values*.

4 System/Organizational Leaders and Issue Leaders

Whether or not your organization's intended C&L advance appears in its planning documents or policies and procedures, it still requires a leader of some kind to drive it. That is, written plans are not self-executing. Equally, organizations do not direct or take actions; key individuals do, either separately or together. Experience suggests:

A. Do not look to the executive leadership of the organization for issue leadership at the organizational level. Many suggest that systemwide quality advance at the organizational level requires the active endorsement and involvement of the highest-level executive leadership. While this is certainly a valuable element where it appears, if it is considered a necessary element, it may be predictive of failure in those systems where it is absent. Where it is present, it will not prove sufficient without other elements.

B. Executive leadership is less meaningful from the perspective of positional authority than in terms of more effective action features: clearly and continuously enunciated vision and values, license to invest some resources, establishing a C&L priority, providing license to change, ensuring some form of performance accountability, and supporting followers at the facility and system level.

> *Leadership can set up a culture that makes it okay for people out there on the fringes to make the change. They can make it okay to collaborate and for people to work together and to be creative and then it can work out there. But if you have this strongly rigid organization where you can't cross over and you can't talk to the cubicle across the hall about something and just solve a problem then I don't know how you can make major change and improvement. I can't imagine how to recommend where to start to make that cultural change or the key pieces that need to be in place, because this process here hasn't been wildly successful! Just the opposite. If successful change is based almost exclusively on persons and personal relationships, then without a culture that supports that, you can't win. — hospital change agent*

C. Ideally, C&L advances will receive the engagement and license of the system's Chief Executive Officer as well as the Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, and Chief of Nursing at the corporate and facility level(s). Positive movement on C&L within systems is likely to be dependent on the executive commitment to resolving much larger disparities, quality, or marketing-to-community issues. But 1) executive leadership often lacks the intention, resources, or expertise to create and sustain significant C&L advances, while 2) mid-level and peripheral managers lack the power to compel an effective executive leadership action.

D. Typically, executive leadership will provide license, mandate, resources, or expectations, but delegate most of the responsibility (and, hopefully, accountability) for the design and accomplishment of such advances to second or third

tier executives and managers in peripheral departments or affiliated organizations, such as hospitals or clinics.

E. Executive mandate or buy-in does not necessarily imply an effective executive order. Real mandate is best evidenced by, for example,

- an actual dollar investment in a project,
- supporting the people who are champions for the issue,
- committing the tangible support and collaboration of allied departments to create the necessary ingredients for a system change,
- redirecting clerical and project management support to the advance,
- changing specific priorities for the use of resources,
- "making room" for the project in terms of space, policies, and procedures,
- involvement in project activities and updates,
- establishing performance and accountability measures for project success,
- providing access to project personnel to discuss implementation issues,
- raising the voice of project personnel in the administrative structure (e.g., assigning the project and the service to a particular member of the executive team),
- correctly assigning new services to an operational department,
- projecting sustainability by including the costs in the permanent base budget,
- creating a CQI expectation on future advances and sustainability (to insure against this merely being an initiative), and
- including the advances in the hospital's strategic plan dealing with technology.

F. Do not hope to capture the attention or commitment of all executive leadership at the corporate or hospital level. One "angel" on the executive team, if the right person and/or function, may be sufficient to support second or third tier managers in implementing a change, overcoming resistance from other executives, departments, functions, or key individuals, and protecting the change agents. Executive sponsorship does not require concordance among all executives, only one or two key persons may suffice. Yet unrelated power conflicts between executives can seriously hamper C&L advances as "collateral damage."

G. Continuity of executive sponsorship is required to ensure the stickiness of advances. Personnel and positional changes within the top of the executive pyramid create great uncertainty below. Executive personnel changes can slow or even derail sustainable C&L advances, when such advances are largely person-based, rather than team-based, mission-based, operations-based, or audit-based.

H. Commonly, it is agreements, "conspiracies," and struggles among local facility and/or mid-level managers, both supportive and resistant, that will determine the size, scale, pace, content, and sustainability of an advance. In

this scheme of things, executives often appear irrelevant or tangential to progress.

From an action perspective, you may want to examine your organization's typical leadership style to guide your own approach to C&L advances. Column A is more voluntaristic and passive, Column B is more active and demanding.

Column A	Column B
Give consent	Express system ownership
Rely on external dollars	Make internal coinvestments
Start an initiative (if...then)	Require a permanent change
Pilot/incubate changes	Require systemwide change
License/permission to subordinates	Mandate to subordinates
Delegated to facilities	Embedded everywhere
Emergent project	Comprehensive strategic plan
Instant ad hoc solutions	Significant prefunding planning
Describing performance	Accountability standards/procedures
Optional/tolerate change	Disciplined change
Influence change	Demand change
Low priority	High priority
Market-driven	Quality-driven
Tactical	Strategic
Policies	Operations

In sum, critical change individuals can be system or facility executive sponsors or their immediate subordinates, department heads or their immediate subordinates, unit managers, influential clinicians, special projects personnel, and so on. Leadership may be *positional* ("I have the authority") or *issue*-based ("I am committed to this and will take action from where I am") or both. When positional and issue leadership coincide in the same person(s) – a rarity – it proves to be a powerful combination.

On C&L issues, there is commonly some significant power differential between *positional executive leaders* and *issue leaders* within the organization. It is not that some executives are uncommitted to the issue, merely that, by comparison with the other issues requiring their attention, C&L is commonly too small a concern to warrant their direct involvement.

For the purposes of change leadership, while positional leadership is certainly helpful, issue leadership may be far more important. The effectiveness of issue leadership depends on 1) where and how forcefully within the organization such leaders can reach, formally and informally,

to influence decisions, 2) how strategic the discussions are or can be with others in authority, and 3) the limitations on their span of control, influence over operations, and access to key persons and discretionary resources.

> *When I think of systems change, I look for two things. One is to find someone who is truly passionate about whatever project they're working on, a champion. But that is not enough. Second is where that person stands within that big system, whether that person is tightly wrapped around and really can't do anything or is able to navigate relatively easily. A lot of times, that really depends on the person, if that person is savvy enough to get unwrapped. He or she will need to be able to go through the red tape somehow and grab something to work with. It really comes down to an individual, but seeing the individual within the system.*
> — hospital change agent

In contrast to positional leaders, issue leaders are those persons who can and do move others to action, based on their location in the organization; their command of the subject matter; their flexibility in the face of new evidence; their ability and willingness to learn rapidly and take advantage of opportunities; their understanding of larger issues and ability to think strategically; their ease in communicating values, issues, and distinctions in varied settings to varied audiences; their experience and reputation; their personal and professional relationships throughout the organization; and their focused determination.

5 Issue Leadership from the Center or the Periphery

In advance of concrete evidence, it is important to not confuse a public, for-profit, or not-for-profit hospital macrosystem with any of its freestanding hospital or clinic members, affiliates, partners, or contractors. For example, as alluded to earlier in this paper, hospital corporations provide important unifying and centralizing functions for certain key aspects of their member hospitals, particularly financial and technological. In these aspects, there is strength in numbers, efficiencies of scale, and ability to shift resources from stronger members to weaker members to construct more overall capacity.

However, the independence and/or weakness of member hospitals within a corporation can be considerable. Hospitals are separately accredited, must manage their own financial resources, must adapt separately to changing requirements, must resolve their own labor management and internal cultural and political situations, and must find their own way in engaging and serving their local community. Stimulating or directing change in these environments requires some accounting for these different interest areas and sources of countervailing power.

All large systems can be characterized as having *centers* and *peripheries*, whether they are large multihospital corporations, large health departments, or individual hospitals. Depending on the focus of interest (or unit of analysis, in research terms), a system center can be composed of

its executives and their various departments. Or it can be composed of its corporate or agency headquarters with its affiliated hospitals, clinics, and functions as at the periphery. Among the affiliated hospitals, the larger and richer hospitals may be considered a center and the smaller and financially weaker hospitals and convalescent centers as at the periphery. Comparably, at the hospital level, the administrative and clinical executive may be considered the center and its departments, functions, and units at the periphery.

Within all of these centers and peripheries are individuals considered to be at the top, middle, or bottom. Between and among these individuals, functions, and levels, there are often significant gaps or boundaries in the transmission of communications (e.g., mandates, outcomes, requests, and solutions marketing). These gaps and boundaries require a "medium" through which to transmit information – formal/informal, paper, electronic, interpersonal, and so on.

> *We don't have a good system for communicating these advances internally. You get these wonderful things happening at different places because there is a lot of energy in the system over this. What people don't know that the other person is doing it. We don't share best practices in a real positive way. We are better at advertising our advances externally than internally. What's missing are both formal and informal linkages, from region to region and communicating at a higher level in the organization. So nothing is evenly distributed across facilities. And then there is not a strategy for pulling together.*
> — system change agent

One key unresolved issue is how to use the "medium," if there is one, to communicate between the center and the periphery. The medium consists of the intervening bureaucracy, often a barrier to communications bridged often only by serendipitous interpersonal relationships. In our meta-evaluation, I was constantly surprised (I learn slowly) by 1) the degree to which interpersonal and inter-silo problems have placed major advances and facilities in immediate jeopardy and 2) how critical key persons in key relationships were to making what should have been purely "organizational" advances. I found these systems advances to be *directly dependent on and indistinguishable from these interpersonal relationships*. Without such interpersonal communication, I see much flailing and gesturing to one another across the vast organizational and cultural distances in hospital systems and within the smaller distances at the hospital level.

The obstacles to sharing C&L advances within a large system suggests significant caution in expecting 1) systemwide advances from local solutions and pilots or 2) facility-based advances from system initiatives. In addition to systems not trickling benefits down to their facilities, there are few examples yet of facility advances floating up to their larger system.

> *There is a huge gap between headquarters and the regions, because the headquarters office is becoming very, very oriented toward change on paper as opposed to actual change. It is out of touch with the community and with real hospitals and what they can actually do.*
> — system change agent

A. Changes from the Center

Generally, large systems' C&L initiatives are intended to develop and incorporate advances at their periphery, such as affiliated hospitals, departments, clinics, and units. Some macrosystems would like to claim that all of their facilities at the periphery provide required services in an appropriate way; however, in general, such systemwide uniformity is limited to "mission-critical" advances, such as computer and communications technology, financial reporting, and billing. In mission-critical functions,

> *I don't think you can start to make a sizable change unless you have support from the center or from the core. Given all the problems we had with IT, it had to be driven with a strong mandate from a senior person to push those changes and make all the different departments and IT all agree and work together because they were all fighting to maintain the* status quo *every which way. So that, to me, was a perfect example of why you can't make a major organizational change unless you have leadership driving it*. — hospital administrator

Since C&L is not considered mission-critical in most settings (see, for example, Ebeler et al., 2002), such an "executive-dependent" model places non-mission-critical C&L advances at great risk in most large organizations.

Most multifacility systems suggest that it is not their role to *produce* C&L quality advances, merely to *encourage* their affiliated facilities to do and report what is needed. Thus, when these systems attempt to create a systemwide solution, they tend not to require the use of the solution, only to market it widely internally and support those who voluntarily choose to use it and pay for it. Similarly, most systems tend to invent few advances, but rely on individual facilities to sense their own unmet demand or need, devise and fund their own solutions, and implement them. These center authorities view their system role as guidance.

Commonly, C&L advances at the multifacility or large-facility center seem to have a fairly limited initial impact at subordinate or peripheral levels:

- Most advances are not intended by their authors to result in immediate or proximate new or improved services to beneficiaries or organizational transformation but in initial steps and products (e.g., development and implementation of assessment tools, training tools, trainings, audit tools, language services, surveys, and web-based tools).
- Most systems' C&L advances are too small to rise to the level of continuous executive involvement, awareness, interest, or investment.
- Few advances are accompanied by definitive administrative or clinical evaluation of their effects, but produce findings that are formalistic, limited, tentative, preliminary, pilot, and often indirect.
- Few advances directly address the financial and operational issues determining sustainability of the advance at either the system or affiliate level.

- The system provides little of the critical content area expertise in C&L matters needed to shape practical solutions in specific locations; system expertise lies elsewhere.

Our meta-evaluation found many instances where changes at the system center (e.g., mission statement or strategic plan) appear to have no net effect at the periphery, that is, where patient care actually occurs. Systems personnel often express frustration at the lack of movement on C&L issues at the subordinate or peripheral organization level. *System-level* projects tend to produce only incipient *facility-level* C&L advances. I liken it to the experience of driving in the desert; ahead, we see thunderheads and rain falling from thousands of feet, but when we arrive, no rain has reached the ground. I suggest that some successful system-level advances will remain at the system level, creating the potential but not the actuality of ground-level advances. On occasion, they may produce more significant effects for the single facility used as a laboratory for pilot projects.

Change emanating from the large system center remains a thin reed on which to base enterprisewide C&L advances.

B. Changes from the Periphery

There are numerous examples of C&L issue leadership being born or housed at the organizational periphery – operating regions, subregions, hospitals, and clinical units impatient with their large-system overseers and/or certain local conditions and taking independent action on behalf of C&L services. These local issue leaders see a great gap in knowledge and span of control at the system center level and take advantage of the gap to provide needed services. These tend to bypass much higher authorities entirely to form their own linkages at the informal and local level. Within these more local systems, there are numerous people at the middle and periphery who are somehow involved in cultural and language advances.

> *These are not the same people that you would talk to if you wanted someone who can make decisions and give you money. These are people who have it as a passion and do what they can do where they are.*
> — hospital administrator

Successful practical advances appear frequently at the periphery, based on local impulses, local leaders, local arguments, and some small shifting of local resources. Many of these changes have produced significant benefits to specific units, providers, and their patients. In these peripheral settings, the "organizational culture" is the sum of the values and real operations of provider organizations at the points closest to the direct delivery of service, that is, *the periphery of the organization, but the center of the service*. In proceeding with a pragmatic, facility-based, staff-based, or unit-based C&L advance, the most important elements include clear expectation setting, the empowerment and coaching of mid-level operational leaders, a focus on exact operations, the provision of effective tools, and the provision of streamlined rules and measures.

Many large-system C&L advances are pursued through pilot or demonstration projects in peripheral locations. One great strength of demonstration projects in these locales is that they tend to be highly disciplined in nature. Regardless of the degree to which they can or will remain faithful to their design and implementation, they tend to have clear lines of hierarchy and authority and follow a precise documented script of tasks, assignments, tools, procedures, timelines, and outcomes. At the end of the pilot period, they can report their effects and become permanent advances in these locations.

While often lacking the authority, technology, and resources to create significant local advances and very limited influence over its sister affiliates or the corporate system above, the periphery can bring significant expertise to its own problems and solutions:

- problem understanding,
- solution understanding,
- direct experience,
- patient issues,
- physician and nursing issues and operations,
- technology issues,
- relationships with community,
- local leadership,
- local power relationships and bureaucracies,
- problem and outcome assessment,
- local vendors,
- staff capacities and readiness.

I think change comes from the periphery. Hospital by hospital, setting by setting. It's going to come from the communities that the hospital serves. As they look at their marketplace survival in their settings, because they're affiliates, not owned. Accreditation is still at the hospital level, licensing is still at the hospital level, they're going to have to make their own way. Everything is determined by the areas in which those hospitals are lying. — hospital administrator

There are few instances of executive generosity in directing center resources to peripheral locations as system incubators for C&L purposes. It is common for both systemwide and local C&L departments and projects to lack their own discretionary resources. This places the burden on local facilities to "do for themselves." At these levels, organizational personnel have limited discretion, having perceived a problem, to apply required resources to their solution. Most have to present a persuasive case to some local authorities who control some local resources and procedures. Many must leverage or piggyback on to the advances made by other departments, such as information technology, distance learning, patient care services, and education.

I don't have my own budget. All I can do is try to influence. Anything that I do, I need to get permission, I need to find different ways, I need to find financial resources. I am competing with all of my colleagues for money. — system change agent

Facility-level advances, often externally funded, are frequently represented as system incubators. In terms of *incubators*, facilities receive some funds and license to test an advance in an environment sheltered provisionally from certain staffing, funding, and procedural constraints; pilot projects can avoid much of the resistance that major implementation projects encounter. In this more protective and nurturing environment, energy is poured into an activity that, if proven successful, *might* be exported to other environments internal or external to the host system.

Systems tend to delegate incubated solutions down to their affiliated facilities or units without any specific plan about what these facilities would do with them. Systems seem to be always starting, but not finishing, their advances. In our meta-evaluation, I could not determine whether any system-supported C&L advance is intended to be the first step and/or the final step. It is possible that the system assignment of some C&L projects to specific peripheral sites is intended less to *start* advances at the periphery than to *keep* the advances at the periphery. While it may be a purely accidental rather than intentional assignment, the frequency of these odd assignments suggests some other underlying purpose or pattern.

Most change agents in our meta-evaluation were quite hesitant to suggest that their pilot advances in specific facilities were really the incubators of larger systems solutions. Respondents suggested that there was as much or as little likelihood that other macrosystems would replicate these advances as that their own system's facilities would. Within a larger system, only certain locations are likely to benefit from the application of C&L experiences and lessons learned elsewhere. This suggests 1) the unhappy utility of a serial facility-by-facility approach based less on centralized mandates and models than on local leadership and local community conditions and 2) the lower probability of success by starting with all units of entire organizations at once. This is consistent with findings from other studies of quality improvement (Weiner, 2006).

In terms of the impulse to start down the path to C&L services, responsibility for a system advance could be usefully placed *anywhere* in the system; that works in theory, but not very well, apparently, in practice. Placing such projects in peripheral services distant from operations or at the wrong level in the system will severely constrain their potential growth, replication, impact, and sustainability.

In the absence of strong system-facility communication and integration, it may be far more valuable (or just simply necessary, as a default strategy) to focus attention at the subregional, facility, and unit levels to try to advance or even stimulate the system, rather than expecting the system to effectively stimulate the peripheral facilities. The roots of system change may rely less on top-down strategic C&L initiatives than on the system summing numerous smaller initiatives at the local hospital periphery, the "tail wagging the dog," or the "followers taking the lead." Mintzberg (1994:287) notes the same phenomenon.

Strategic thinking cannot be concentrated at one center. Therefore, the dichotomy has to be collapsed in the opposite way: the implementers have to become the formulators. Implementation is turned on its head so that strategy is effectively made by the people who imple-

ment it. They champion proposals that may prove strategic and thus shift the direction of the organization.

He goes on to identify six principles in governing change from the periphery:

• *Strategies grow initially like weeds in a garden, they are not cultivated like tomatoes in a hothouse. The process of strategy formation can be over-managed; sometimes it is more important to let patterns emerge than to force an artificial consistency upon an organization prematurely. The hothouse, if needed, can come later. The strategies can take root in all kinds of places, virtually anywhere people have the capacity to learn and the resources to support that capacity. Sometimes an individual or unit in touch with a particular opportunity creates his, her, or its own direction. This may happen inadvertently, when an initial action sets a precedent. Even senior managers can fall into strategies by experimenting with ideas until they converge on something that works. At other times, a variety of actions converge on a strategic theme through the mutual adjustment of various people, whether gradually or spontaneously. And then the external environment can impose a pattern on an unsuspecting organization. The point is that organizations cannot always plan when their strategies will emerge, let alone plan the strategies themselves.*

• *Such strategies become organizational when they become collective, that is when the patterns proliferate to pervade the behavior of the organization at large. Weeds can proliferate and encompass the whole garden; then the conventional plants may look out of place. With a change of perspective, the emergent strategy, like the weed, can become what is valued.*

• *The processes of proliferation may be conscious but need not be; likewise they may be managed, but need not be. The processes by which the initial patterns work their way through the organization need not be consciously intended, by formal leaders or even informal ones. Patterns may simply spread by collective action, much as plants proliferate themselves. Of course, once strategies are recognized as valuable, the processes by which they proliferate can be managed, just as plants can be selectively propagated.*

• *New strategies, which may be emerging continuously, tend to pervade the organization gradually.*

• *To manage this process is not to preconceive strategies but to recognize their emergence and intervene where appropriate. The weed that seems capable of bearing fruit is worth watching, indeed sometimes even worth building a hothouse around. To manage in this context is to create the climate within which a wide variety of strategies can grow and then to watch what does in fact come up. The strategic initiatives that do come up may in fact originate anywhere, although often they do so low down in the organization, where the detailed knowledge of products and markets resides. In fact, to be successful in some organizations,* these initiatives must be recognized by a middle-level manager and championed by combining them with each other or

with existing strategies before promoting them to the senior management. *But it must not be too quick to cut off the unexpected: sometimes it is better to pretend not to notice an emerging pattern to allow it more time to unfold. Likewise, there are times when it makes sense to let the organization adapt to the initiative rather than vice versa.* (Mintzberg, 1994:287-289)

If, indeed, change really begins by some implementation at the periphery and then expands, through a variety of means in the middle, to the hopefully reinforcing or non-hostile center, it makes a big difference where and how in the periphery the advance starts. But both public and private systems tend to place their C&L advances in exceedingly peripheral locations. Experience suggests that whatever analysis produced this assignment may have been faulty, that some locations on the periphery were not sound beginning points, due to various forms of techno-bureaucratic resistance ("we weren't consulted, early on, on these demands for our time and effort"), technical inappropriateness, procedural obstacles, union issues, lack of local leadership buy-in, intervening bureaucratic authorities, lack of connection to the center or even to peripheral counterparts, lack of resources, or very active and absolute resistance.

We think it's just working just fine, we don't want to change it, there's no point in changing it. We don't want to put any more work into this, it's just fine. This is our program, we designed it, you're messing with what we own.
— regional administrator

While each such facility, department, or unit lies at the periphery of the larger organization, it, theoretically, becomes the base upon which more organizationwide adoption becomes possible through extension, emulation, or replication by adjacent units and providers. But that works better in theory than in practice. For example, one peripheral department was unable to diffuse its advance throughout the hospital and ancillary clinics where they were located, much less instill change at the core of the system.

We're not yet "there" in that "it's caught on like wildfire." In a way that's disappointing, but it's also a reality that for something to really catch on like wildfire, it just has to knock your socks off. Sometimes people don't realize they have a problem (or) that they're missing something until you demonstrate it to them. And that's part of the challenge.
— change agent

Newly acquired expertise may be limited to its locale and may not be transferred or considered transferable to other peripheral facilities or to the center itself. Within a larger multihospital system, C&L advances in one hospital or clinic tend to remain "local" and "condition-specific" due to the following:

• issues of locale and distance from direct operations with influence on the center,
• concentration of minority groups,
• the scale of certain ethnic minority markets,
• its special investment in marketing to very specific employed minority populations,

- its use of a specific service model for these populations,
- its reliance on the strengths and weaknesses of in-house, facility-based skills.
- its concentration of qualified bilingual and bicultural staff in these clinics,
- the ethnic, philosophical, and generational makeup of its providers,
- its history of cultural shifts, paradigm shifts, and quality advances,
- the difficulty in separating out the effects of different combined advances,
- the lack of compelling evaluation findings,
- the lack of a sound communications medium to share discoveries, and so on.

Many peripheral issue leaders, departments, levels, and organizations have proved not to be sufficient champions for system change; given their vulnerabilities, lack of executive support, relative powerlessness, distance from the center, and lack of control over resources, some of their advances either fade away or succeed but remain invisible to the center. Powerful independent but peripheral leaders far from the corporate or professional center often find themselves unable to navigate their issues to the center, because their sound advances lack traction outside of their own peripheral location and, thus, do not influence the center.

Ultimately, it is the linkages between system and affiliate, center and periphery, and affiliate with affiliate that determine what can migrate from one level or environment to another. The linkages depend on lines of communication, key persons, key personal relationships, silos of culture and power, power differentials, and jealous management of personal or positional power in the organizational "medium" that lies between the center and the entire periphery. In our meta-evaluation, I found little evidence that advances at the periphery have affected, in any significant way, the understandings or investments of the center or other parts of the periphery. I conclude that *there has been no reliable way to communicate these advances from the periphery to the center, as if there were no medium through which the message could be effectively transmitted*. Where such transmission did occur, it was based largely on the serendipitous interpersonal/ professional relationships between peripheral personnel, mid-level managers, and issue leaders at the regional or corporate level (see number 6 below).

In conclusion, it may be unfair to expect or require peripheral advances to be the engine or model of system change. Peripheral changes, while of great success and benefit to many providers and patients, may simply remain peripheral. As a consequence, C&L change from the extreme periphery remains a weak, but, perhaps, the only approach to larger system change in some systems.

6 Leadership from the Middle

The state of modern organizations, whether hospital systems, health maintenance organizations, universities, or large manufacturers, suggests that there are many "centers" within any one organization (e.g., executive managers, boards of directors, professional classes, regional authorities, shareholders, or faculty groups) where the power to act, veto, or shape resides. This suggests both risks and opportunities in initiating C&L advances.

For example, in some language services projects, the lack of executive "parental" involvement placed the contractual relationships between subordinate individuals and departments in jeopardy, allowed some parties to unilaterally veto required actions, and disabled project personnel from seeing or effectuating solutions to what should be very minor and negotiable issues among employees pursuing the success of the organization as the organization defined that success on paper. On the other hand, such alternative centers of power allow room for local innovation and development below the radar of executive oversight.

In these settings, pressure for C&L advances emerges frequently from the *middle*, from providers and units overwhelmed with the need for such services. It is common for individual facilities and even individuals within systems to "pencil out" and implement their own solutions and not wait for executive or corporate approval or support. Some have to find their own local resources, given systems reluctance and resistance.

In our meta-evaluation, many of the tangible advances appear based on key mid-level authorities, issue leaders in oddly placed organizational locations with unusual motivations, experiences, and, most important, *relationships with certain influential organizational individuals* and willing to take risks for advances largely outside of their traditional position description or career line. Most of them were not recruited or hired for project purposes, but were existing employees assigned or self-assigned to the projects. Their independent intelligence and initiative appeared to be a critical piece in long-term organizational advances.

As suggested above, executive leaders may provide important symbols, rhetoric, and license in the support of C &L advances, but it often appears that the subordinate managers are the true issue leaders. The common focus on executive leadership may be disproportionate when the more important questions may be around "followership," that is, the ability of subordinate executives and managers to work singly and in concert with one another as followers-as-leaders to meet the explicit and implicit expectations of chief executive officers and boards of directors to take actions and effectuate advances. The absence of direct positional leadership allows for the opportunity of followers-as-issue-leaders.

Leaders and followers literally co-create, co-constitute, leadership… But students of leadership still tend to focus on leaders and shortchange followers…. Leaders should be look at only in tandem with their followers. Without followers nothing happens… leaders and followers share responsibility for leadership, bad as well as good…. None of us is off the hook. (Kellerman, 2004:226)

C&L advances are frequently both led and staffed by the middle – third and fourth tier managers, operations personnel, clinicians, or research physicians. The impulse to advance C&L services is more likely to bubble up from within more peripheral departments and/or lower-level facility-based but influential positions, such as quality directors, medical directors, nursing managers, diversity directors, or community relations managers.

> *It's the C&L-identified person, advocates within the third or fourth tier of authority. Because that's where advocacy is alive. Those are the true positions for change.* — hospital administrator

These individuals are the "sparkplugs" inside of the organization who dedicate their time, content expertise, passion, skills, and so on to the advance without a distinctly separate agenda, license, or mandate relating to the larger system. The challenge for such mid- and lower-level personnel is to 1) get and retain access to one or more senior executives who sit on the executive team, 2) demonstrate the tie between the "small matter" of C&L services and the much larger ambitions and impulses of the system/facility, and 3) "pencil out" a low-cost, low-risk provisional solution. This is the required linkage between leadership and concrete impacts of the direct operational level.

> *Policy is this ethereal meaningless thing, until it touches that patient or that particular operational unit. Leadership is germane only when it produces or prevents a concrete desired result.* — change agent

In one patient safety case study reported by McCarthy and Blumenthal (2006), the change approach was to lead organizational cultural change by empowering local facilities and frontline staff with improvement tools, methods, and initiatives.

> *If you give caring professionals the luxury of time and focus, respect and empowerment of all disciplines, and the concepts and techniques of patient safety, the teams will design and implement process improvement far beyond what we, the leaders, could have possibly envisioned. The goal is to create a self-correcting organism. Senior managers and clinical leaders can promote effective culture change by fostering a "bottom-up approach" that empowers frontline staff to take responsibility for safety.* (McCarthy and Blumenthal, 2006:25)

The success of *issue-leadership-at-the-middle* is dependent on the degree to which 1) mid-level players, roles, or settings have connections to and influence on both superior and subordinate operations and departments and 2) they have some control over key resources. This process of engagement from the middle may influence key executives and managers to move from indifferent outsiders to internal champions.

These mid-level followers-as-issue-leaders become the true stalwarts in a revised "end state" vision regarding C&L, services. While these change agents sometimes appear to other organizational managers as somehow organizationally disloyal due to their C&L attachments, I see them and they see themselves as totally loyal to the ultimate success of the organization that, in turn, is based upon implementing solu-

tions to serious issues. The most effective of these followers are those who can 1) see and understand the solution, 2) see and understand the changing sources and relationships of power and risk in the organization, 3) modify their roles, actions, and products to make organizational success and project success appear to be one and the same, and 4) have the courage necessary to good "followership."

The quality and value of C&L advances is directly dependent on the activities of fairly unique "sparkplugs"; they may be or report to the issue leaders. They are needed and appear where the system, organization, or facility is like a powerful machine at rest. It has the potential, readiness, and capacity to be started, to move from passivity to activity, and then to produce work as long as the sparkplug continues to feed it with energy and direct it through expectations.

These persons combine, in themselves, leadership, relationship, energy, and intellectual skills absolutely required to turn C&L projects into successes. Where such persons are missing or where the positions are filled merely by "conveners," often very part-time or volunteer, the resulting C&L advances seem weak and unpromising. While high-quality project designs *alone* will not produce high-quality products, such high-quality personnel can turn not very distinguished C&L projects into high-quality advances.

The single most important investment in C&L change at the system or facility level is in these sparkplug functions. Projects that are based purely on volunteers, part-time staff, or frontline staff have been seen to stumble badly due to the lack of time commitment; the lack of control over resources, policy, procedure, and practice; the lack of connection to executive or management authority; the lack of requisite content area expertise or the imagination to acquire it; and the lack of organizational change expertise and/or the ability to obtain it. Lowest-level personnel are simply not prepared, by education or experience, to have grounded responses to the challenges that they encounter. As a result, much of the change assigned to them in some organizations remains disjointed, uneven, uninformed, and minimalist.

A very few C&L sparkplugs appear in the executive operations of macrosystems; when they do, the results are powerful. Generally, however, they appear among the more local mid-level staff of large systems. The motivation for even starting a C&L advance at the more local operational level may rest with one or more energetic, determined, and influential individuals impatient with the current pace and products of more ephemeral changes. Successful sparkplugs occupy somewhat empowered or influential positions within their organizations or departments or are directly accountable to and supported by someone who is so empowered.

Many large systems-level sparkplugs for C &L advances are located in areas that are seen as "policy-driven" rather than "operationally-driven." The sparkplugs tend to see themselves and be seen by others as facilitating the information flow of new policies or providing technical assistance and information to other "action" elements within their structure. Some are located in positions within the organization that are not recognized (e.g., they are seen as project workers) or are not part of the "operational" structure where

concrete practices occur. Some feel disempowered because of their peripheral positions.

> *It's hard because of the fact that there's a bit of a barrier that X and I have in any department that's an operational department. I don't think we could have convinced anybody else to take this on... I can't say I'm an expert at knowing what the key departments are, who those key leaders are – Maybe if we had a meeting with each hospital with those key department heads it might have helped. I'm not sure. I think they might have just blown us off. We did identify a VP lead, and that person was a sponsorship ministry-type person. We didn't have, probably, the backbone at the top to say, "It has to be somebody who's more operational."*
> — system change agent

Sparkplugs focus primarily on reducing the resistance to introduced changes and getting all the players to operate in a consistent and coordinated way. Stated more simply, they try to make the new services or practices easy, convenient, and routine. The challenges that confront them in hostile or indifferent settings are many:

- timing and organizational readiness (the change agent, the executive, or the environment are at different stages of readiness),
- the need for both systemic and systematic approaches to change,
- the need to recruit or motivate leadership and champions at different levels and locations within the organization,
- the need to recruit other agents with expertise and clinical, management, change, research, and mentoring skills and roles,
- the need for avenues for communication, integration, and coordination,
- the need for assistance in the design and implementation of new protocols and pathways (e.g., new staff positions, new contracts, testing and training, establishing reimbursement, redeploying some staff, leveraging internal resources, and so on),
- the need for methods and persons to overcome techno-bureaucratic problems, and
- the need for a continuous quality improvement process as initial changes promote the discovery of additional needed changes in C&L and community services.

Over time, many issue leaders and sparkplugs have become extremely anxious in their situations, resulting frequently in abandonment not only of the C&L advance but of their employment. In the meta-evaluation, it was surprising to see the number of key C&L project personnel, including those permanent organizational employees merely temporarily assigned to these time-limited projects, leaving their employment or planning to leave their employment as a direct result of their personal inability to overcome the interpersonal and organizational barriers their project encountered.

Many expressed their despair at discovering that their organizations could not accommodate these changes. It was not the content of the change, that is, C&L services, cultural competency, or responsiveness to minority needs, which characterized this new view of the organization, but the larger failure to overcome interpersonal bureaucratic problems and competing financial concerns to truly improve the quality of the organization's product. Focusing more on the organization's commitment to its mission and social product than on its financial and competitive success demonstrates that these change agents, however identified and recruited to the advance, were themselves peripheral to the organization.

Some second tier positional leaders also literally "wear out" in their change efforts, particularly if they are concurrently facing newly hired executives, revised corporate values and ambitions, symbolic rather than real executive buy-in, change in their positions and power, job insecurity and control issues among their associates, the loss of key staff, the lack of executive buy-in among affiliates, the passive-aggressive resistance of affiliates, the retirement and other loss of key executive champions and managerial allies, limited prospects for funding, overpromised expertise, incorrect project site selection, lack of followers, and, ultimately, loss of belief. These forces of chaos or entropy combine to slow certain projects to a crawl or even dead stop.

In sum, however, *the brightest prospects for successful change seem to emerge from multiple, overlapping, self-sustaining, and mutually supportive advances initiated in a significant peripheral location (e.g., site, department, function) led by a change agent with strong professional and interpersonal attachments to influential and stable executive champions in the organization's high-middle (e.g., region, operations) functions.*

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Thomas D. Lonner, PhD
tlonner@qualityhealth.org

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