Robert Wood Johnson Foundation

Published: December 1, 1998
Program Results Report
Grant ID: ASB

Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care

An RWJF national program

SUMMARY

One of the most significant changes affecting health care in the United States is the increasing racial and ethnic diversity of the population.

Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care was a national program of the Robert Wood Johnson Foundation (RWJF) that aimed to sharpen the focus on the implications of culture, language, race, and ethnicity on access to health care.

Key Results

Opening Doors supported 23 projects in rural and urban areas in 11 states.

The funded projects fell into two categories:

- Service projects to reduce sociocultural barriers. The program funded several replicable models that exemplified cost-effective strategies to reduce sociocultural barriers to care.
- Research projects to identify the sociocultural barriers to health care and strategies to reduce them.

The accomplishments of the *Opening Doors* program and its projects include:

- Affecting direct services in rural and urban settings in 11 states across the country by:
  - Using community outreach workers.
  - Providing interpreter services.
  - Changing policies and practices that created barriers.
- Training health staff through:
  - Developing cross-cultural curricula for medical students.
  - Providing community-based training opportunities for residents.

- Offering cultural competency training for agency staff and board members.

- Improving use patterns, such as:
  - Reducing unnecessary emergency room visits in a rural immigrant community.
  - Increasing patient enrollment in an urban, hospital-based HMO where interpreters and outreach workers were available for immigrants.
- Developing policy recommendations regarding:
  - Cultural competency in managed care.
  - HMO compliance with state standards for access to reproductive health care.
  - Cultural and linguistic competency in interpreter services.

Funding

The program was authorized by the RWJF Board of Trustees in January 1992 for $4 million. It was co-sponsored by the Henry J. Kaiser Family Foundation.

About This Report

This report was produced by the national program office and edited by the Program Results Reporting Unit.

SOCIOCULTURAL BARRIERS TO HEALTH CARE

The proportion of the population that belongs to the four minority groups counted by the U.S. Census Bureau—American Indian, Asian and Pacific Islander, Black, and Hispanic—will increase from 25 percent in 1990 to 32 percent by 2010 and 48 percent by 2050.

Already, "minority majorities" exist in New Mexico and Hawaii, and in some of the most populated areas in the United States, such as central Chicago, Detroit, Miami, and New York City. California will have a minority majority by the year 2000, and Texas by 2010.

Welcoming immigrants and native-born members of racial and ethnic minority groups is one of the greatest challenges facing health care organizations.

- Disparities exist in health status, access, and quality of care for these groups compared with the majority population.
- Many minority groups have shorter life spans and higher rates of infant mortality.
- As of writing of this report, 31 percent of minority adults, ages 18 to 64, lacked health insurance, compared with only 14 percent of white adults in the same group.

- Some minority groups are more likely to receive care in a hospital emergency room and are less likely to receive important preventive services.
- Of Americans who have visited a doctor in the past year, minority adults (29 percent) were less likely to receive preventive care services, such as blood pressure tests, Pap smears, or cholesterol readings, compared with white adults (26 percent), according to the National Comparative Survey of Minority Health Care, The Commonwealth Fund, 1995.

In addition to the obvious need for health insurance, people of diverse racial and ethnic minority groups face substantial nonfinancial barriers to care, such as:

- Language and communication barriers.
- Medical practices that differ from their own beliefs and traditions.
- Fear and mistrust of health care institutions.
- Lack of knowledge about how to navigate the system.

Sociocultural barriers to health care are created by differences between patients and providers in areas such as:

- **Language and nonverbal communication,** including nonproficiency in English, degree of formality and openness in conversation, eye contact, and the role of silence in cross-cultural encounters.

  For example, a Latina arrives at a primary care unit with a feverish three-year-old and an 11-year-old daughter. Because the mother speaks no English, the young girl is forced to serve as translator. The child has difficulty understanding the doctor's questions about "fever" and "pain," and does not have the English vocabulary to translate the information her mother provides.

- **Health practices and beliefs,** including patients' reliance on alternative therapies and spiritual healers, differences in understanding the causes of illness, and religious beliefs that contradict Western medical practices.

  For example, an Ethiopian couple, recent immigrants to the United States, bring their baby to a pediatrician in the Seattle area. The pediatrician proceeds to warn them about the dangers of exposing their newborn to second-hand smoke.

  Speaking through an interpreter, the mother asks whether some smoke is okay. It takes some time before the doctor realizes that she wants to burn incense—a traditional ritual surrounding childbirth in her culture.

- **Role of family members in decision-making,** such as reliance on elders, men, or the whole family to make decisions on behalf of the patient, which may affect the informed consent process and confidentiality, and can delay time-sensitive medical procedures.

Two examples: a hospital nurse is perplexed when an African-American child is brought in for routine visits by different family members each time.

In another example, during a check-up, the wife of a migrant worker (and mother of four girls), refuses information on family planning, explaining that her husband wants her to continue becoming pregnant until she has given him a son.

- **Patients' knowledge and expectations of the health care system,** including:
  - Lack of knowledge of the value of preventive services.
  - Confusion about how and where to seek care.
  - Fear of providing personal or medical information based on experience (particularly for immigrants who are undocumented and refugees who were persecuted in their native countries).
  - Mistrust among African Americans and other groups who believe they may unknowingly be part of a study or experiment.

    For example, a doctor prescribes a new medication for a 10-year-old African-American boy who has asthma. Although the doctor talks to the boy, his mother, and grandmother about how the medicine works and about potential side effects, the women are concerned that the child is being used as a "guinea pig" for what they believe is an experimental drug.
- **The culture and complexity of the health care system,** which create obstacles for patients, such as:
  - Complex eligibility rules.
  - Imposing health care facilities.
  - Long waits for appointments.
  - Inconvenient hours for working people.
  - The history and reputation of an organization's responsiveness to minority communities.

    For example, a woman who is a member of a managed care plan must travel from her home in Brooklyn to Manhattan for her hospital appointments, but must obtain her medications from the plan's pharmacy in Brooklyn.

    Or, in Chicago, residents of an African-American community prefer to wait up to six hours for care at a county hospital rather than visit a clinic in their neighborhood that has a reputation for rude staff and disrespectful treatment of patients.

Meanwhile, residents of an Appalachian community fear being admitted to a large medical center where other residents have died.

REDUCING SOCIOCULTURAL BARRIERS TO HEALTH CARE

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation created *Opening Doors: Reducing Sociocultural Barriers to Health Care* in 1992, at a time when comprehensive health care reform was being widely debated.

The foundations recognized that even when health care is available and affordable, certain groups face nonfinancial obstacles to care, resulting in poorer access to care and health outcomes among racial and ethnic minority groups in the United States.

The foundations aimed to sharpen the focus on the implications of culture, language, race, and ethnicity on access to health care.

The RWJF Board of Trustees authorized the program in January 1992 for $4 million. The program supported 23 projects in rural and urban areas in 11 states.

OUTCOMES OF SERVICE PROJECTS

Opening Doors funded several replicable models that exemplified cost-effective, strategies to reduce sociocultural barriers to care.

Some examples of the models are:

Shared Language Services in an Ethnically Diverse Community

Asian Health Services, a community health center in Oakland's Chinatown, established an innovative project to weave interpreter services into the new landscape of managed care.

The Asian Health Services Language Cooperative is a county-wide pool of interpreters and translation services in seven languages. Health providers in Alameda County could subscribe to the 24-hour service on a monthly or hourly basis. The project established an interpreter development program to recruit, train, and test potential interpreters.

Results

At least 120 interpreters were trained. In addition, the project trained 250 practitioners to recognize language and cultural barriers and work effectively with interpreters.

The challenge for health care organizations in the future will be financing such translation services.

Family Planning Outreach and Education Man-to-Man

The Nuestra Decision Project, sponsored by Community Health of South Dade, Inc., Florida, trained and deployed male farm workers as family planning health promoters in their communities.

Armed with 350 hours of training, the men:

- Visited homes.
- Lead educational group sessions.
- Assisted their neighbors to gain access to community health resources for family planning, prenatal care, children's health, and care for men.

As part of the *Opening Doors* project, Community Health of South Dade expanded its clinic hours and remained open until 9:00 p.m. two days a week.

The evening clinics, which were staffed by male providers, provided educational sessions and support groups for people with diabetes and substance abuse problems, in addition to medical services.

Results

The project saw an increase in:

- Women entering prenatal care in their first trimester.
- Men accompanying their partners to these visits and bringing their children to the clinic.
- Women seeking family planning services.
- Men seeking health care services for themselves.

Reaching an Isolated Immigrant Community

Redding, a rural community in Northern California, is home to 2,500 Southeast Asian refugees, mainly from Laos.

In the early 1990s, only 36 percent of Southeast Asian two-year-olds in Redding were up-to-date with their immunizations.

In addition, members of the isolated immigrant community regularly relied on the emergency rooms for nonemergency care, rather than using available primary care services.

Shasta Community Health Center's affordable approach to the problem was to:

- Develop a dedicated appointment and communication line in the Mien language.
- Provide patients with interpreter services.
- Offer health education to consumers, with an emphasis on preventive care.

Results

Through two new part-time interpreters and a new full-time outreach worker from the community, the health center reached this population, in many cases, for the first time.

The staff established a unique alliance with the community's shaman, the traditional spiritual healer, to whom doctors refer cases that are spiritual in nature.

The shaman was particularly helpful in treating numerous cases of post-traumatic stress disorder.

As a result of these actions:

- The immunization rate of two-year-old Southeast Asians in Redding rose to 93 percent.
- The number of visits by Southeast Asians to the health center increased 30 percent.
- Hospital emergency room visits by Southeast Asian families decreased 20 percent.

Links Between a Medical Center and Community

The Seattle-based Community House Calls project at Harborview Medical Center addressed the gap in cultural practices between individual providers and institutions, on the one hand, and immigrants, on the other hand.

"Caseworker/cultural mediators" were bilingual, bicultural members of the health care team who helped Cambodians and East Africans navigate the health and social services systems.

They worked as interpreters in the hospital and as outreach workers to assist families in the community. Armed with palm-top computers to maintain records on the spot, they provided information to the health care team and administrators about patients' practices, beliefs, and living circumstances.

"Community advisers"—usually older, trusted community members who may or may not speak English—worked closely with the cultural mediators.

Results

The clinics participating in Community House Calls saw an increase in patient enrollment in Harborview's HMO, while HMO enrollment in other Harborview clinics leveled off or declined.

To publicize what it learned, Community House Calls created an electronic database on the Internet, EthnoMed, which offered information on culture, language, health, illness, and available community resources for the diverse groups living in Seattle.

Formerly Homeless Women as Community Health Workers

Located between the Tenderloin and Mission districts in San Francisco, the Homeless Prenatal Program hired and trained formerly homeless women to reach out to women living on the streets, and in parks, single-room-occupancy hotels, and shelters.

The community health workers referred women who were in their final trimester of pregnancy and those who were post-partum to the AfterCare Project.

Results

This program helped pregnant women cope with their pregnancies and take care of their babies, while providing referrals for health care, housing, substance abuse treatment, food, immunizations, family planning, and other services.

Of the 110 births to women in the AfterCare Project, 99 babies, or 90 percent, were of normal birth weight.

RESEARCH STRATEGIES AND FINDINGS

Opening Doors funded several research projects that incorporated cross-cultural strategies to:

- Obtain information on health care use in underserved communities, assess sociocultural barriers to care.
- Measure the effectiveness of culturally and linguistically appropriate health care strategies.

Many replicable research models and strategies emerged that could be used to identify and reduce sociocultural barriers to health care.

Face-to-Face and Telephone Interviews with Asian Americans

The Association of Asian Pacific Community Health Organizations, Oakland Calif., identified cultural barriers for Chinese and Vietnamese women through face-to-face

interviews with 500 women in Houston and telephone interviews with 1,000 women in New York and Chicago. Community participation was essential to the research design.

To find out where the Chinese and Vietnamese families live and what questions were appropriate to ask, project staff:

- Studied U.S. Census data.
- Spoke with apartment managers.
- Met with local community groups.
- Held focus groups.
- Generated wide publicity about the planned survey through ethnic newspapers, radio, and television.

Preliminary Findings

Preliminary findings indicated that health use patterns differ for Vietnamese and Chinese populations. However, for both populations, access to health care—measured by the rate of annual physician contact and the rate of annual well check-ups—was much lower than the national average.

The findings also showed that the longer a family resides in the United States, the better its access to health care. Women, ages 40 to 49, from both ethnic groups had the least access to care among all women.

A National Telephone Survey on a Very Personal Topic

The Alan Guttmacher Institute, Washington, conducted a telephone survey of low-income and minority women between the ages of 18 and 34 to assess their attitudes and experiences in seeking reproductive health services.

They compared attitudes and experiences among low-income women from three racial/ethnic groups - non-Hispanic white, African-American, and Hispanic.

With the support from the National Coalition of Hispanic Health and Human Service Organizations, Washington, and the National Black Women's Health Project, Washington, the Guttmacher Institute held focus groups to gain insight into the issues before conducting the national telephone survey.

Specially trained, bilingual women conducted the interviews, which generated a 90 percent response rate. The study found that women from all racial and ethnic groups were committed to obtaining and using contraceptives.

Findings

Some 86 percent of respondents reported making a visit for gynecological services in the past year, and 83 percent were currently using a contraceptive method.

Those who were the most satisfied with their gynecological care were the most likely to use a contraceptive.

The experiences that were most important to women in terms of predicting satisfaction were:

- Encountering staff who were courteous, helpful, and respectful, and who made an effort to determine their needs.
- Having a provider whose gender matched their preference.
- Obtaining care in a clean and well-organized facility.

Community Researchers Trained to Identify Barriers to Care

To find out why half of all residents were going outside their own community for health care services, the Westside Health Authority, a community-based coalition of providers and grassroots organizations in Chicago, turned to the best source of information—community members.

Nine unemployed African-American community women were trained by a university researcher to observe, document, and analyze the behaviors of patients and providers to identify sociocultural barriers to care in four health clinics.

Findings

What they found were a host of subtle, yet significant barriers:

- An "Adult Medicine" sign in the window of a new clinic was ambiguous to patients more accustomed to words like "clinic," "health," and "community."
- In other sites, patients felt violated when staff asked them personal questions loudly enough for people in the waiting area to hear. Patients were unclear about what clinic staff members' jobs were, and felt frustrated when they could see staff members sitting idle as they waited to be seen by a clinician.
- Some patients' children were unruly because of the lack of play areas and supervision.
- Patients were frightened by receiving negative test results in the mail and, as a result, would not call for follow-up exams.
- Clinic staff members were annoyed at what they perceived as the rude and demanding behavior of patients.

Based on these findings, the clinics undertook numerous changes:

- The "Adult Medicine" sign now reads "Health Care for the Community."
- Community advocates helped facilitate communication between staff and patients.
- Personnel wore nametags.
- Play areas were established for children and were supervised.
- Clinics telephone patients and explained lab results directly.

All the trained observers were able to find employment after the research project was over.

The Impact of Medicaid Managed Care on Access to Reproductive Health Care

The Center for Reproductive Law and Policy, New York, under the project Focus on Access, Information, and Reproductive Rights: Health Care Reform, assessed the quality and availability of reproductive health services under Medicaid managed care in New York state.

The project:

- Conducted seven focus groups of primarily African-American and Latina Medicaid managed care enrollees.
- Surveyed 52 providers at 32 clinics.
- Reviewed member handbooks from 23 Medicaid managed-care plans. interviewed 16 leading policymakers and health care advocates in the state.

Findings

- The project discovered that many sociocultural barriers to reproductive health care for women on Medicaid may be exacerbated by inherent structural features in managed care. These include:
  - Requirements for prior approval for specialty care.
  - Primary care "gatekeepers" who manage a patient's health care.
  - Long waits for obstetrical appointments.
  - Member handbooks that are difficult to understand.
  - A lack of interpreters for non-English-speaking women.

- The project developed a public-policy framework, including a blueprint for statutory protections, to overcome nonfinancial barriers to reproductive health care for New York state residents.

LESSONS LEARNED

Over the course of the last five years, the *Opening Doors* national program office and the foundations' grantees have gained valuable insight into the issues that combine to create sociocultural barriers to health care. In addition, the program office and the grantees have learned important lessons about how to reduce such barriers.

Lessons Learned About Sociocultural Barriers

1. **Lack of respect is a major sociocultural barrier to health care.** All 23 grant projects found through focus groups, interviews, and surveys that most patients, regardless of their racial or ethnic identity, believe that health care personnel do not respect them.

   This lack of respect is evidenced by:

   — The absence of "active" listening when patients are talking.

   — The inappropriate use of eye contact and other nonverbal forms of communication.

   — The absence of basic courtesies, such as not using "Mr." or "Mrs." when addressing a patient by name.

   Patients also perceive that health care personnel are judgmental and dismissive regarding patients' customs and beliefs simply because they are different from their own.

   Whether actual or perceived, this lack of respect creates a very real barrier between patients and providers.

2. **Systemic barriers come in all shapes and sizes; some are obvious, some are not.** The policies and practices of a health care organization often can alienate the very patients it is trying to serve.

   Some of these barriers may be easy to change. For example, the placement of clear and easy-to-read signs in the reception area sends a message to patients that their patronage is appreciated, as do name tags that identify staff members and the creation of a play room for visiting children.

   Other systemic barriers are more subtle and require changes in the culture of the organization. Such systemic changes may include the establishment and enforcement of strict patient confidentiality procedures or the creation of a system that encourages patients to make helpful suggestions or file complaints.

Lessons Learned About Strategies to Reduce Sociocultural Barriers

3. **Community health workers can reduce sociocultural barriers.** Ten *Opening Doors* service projects involved community health workers serving as liaisons between health care personnel and community members.

   The projects learned that community health workers are much more effective than books and journal articles at sensitizing health care personnel to the culture and beliefs of their patients.

   The projects also discovered that the quality and availability of training for community health workers is an important factor affecting the success of community outreach efforts, as is having the support for the outreach program of the sponsoring health care organization's top administrators.

   Finally, the projects learned that community health worker programs are more successful when they have a strong, identifiable link to a primary care provider organization, such as a community health center, than when their only link is to a community-based group.

4. **Interpreters can reduce sociocultural barriers.** Three *Opening Doors* service projects involved the use of trained language interpreters to facilitate communication between patients and providers.

   They learned that health care personnel must be trained in how to work effectively with interpreters. In addition, interpreters can play different roles—from cultural mediators, who serve as patient advocates, to translation specialists, who limit their involvement to that of objective interpreters in clinical settings.

   Regardless of which role interpreters play, and regardless of whether they work on a volunteer or paid basis, all interpreters must receive professional training.

5. **Outreach and interpreter services build patient loyalty and make sense financially.** While the most important thing to remember about community health workers and interpreters is that they can reduce sociocultural barriers to care, these personnel also can positively affect a health care organization's bottom line.

   For example, one project discovered that unnecessary emergency room visits declined among its patients after it began relying on a community health worker.

   In another case, a large percentage of patients who visited a medical center's two clinics that employed community health workers also elected to join the medical center's health maintenance organization.

6. **Cultural sensitivity training for providers and other staff can reduce sociocultural barriers.** The projects learned that sensitivity training programs are most effective when all levels of personnel are involved in planning them, as opposed to relying entirely on outside consultants who are unfamiliar with the organizational culture.

In addition, it is necessary to establish a clear purpose for the training and to link the lessons learned in the training sessions to each participant's daily work routine.

7. **Reducing sociocultural barriers requires changes in the very culture and mission of a health care organization.** The *Opening Doors* projects learned that such changes cannot be made in a piecemeal fashion.

   Rather, a true commitment to meeting the needs of diverse patients means making changes across the board—in mission statements, strategic plans, job descriptions, internal policies, and practices.

   Such changes may be difficult in some complex health care organizations, where changing one policy may have adverse effects elsewhere in the organization.

8. **Community involvement early on is a necessary component in any attempt to change the status quo.** Strong community ties proved to be a major factor influencing the success of the *Opening Doors* projects.

   The projects that had a demonstrated commitment from community organizations before they began had less difficulty getting started and had to make fewer time-consuming modifications as their programs progressed.

   Conversely, those projects that had to develop community relationships as part of their program found the going much more difficult. New collaborations and partnerships require extensive nurturing to build trust and compatibility before the real work can be undertaken successfully.

Lessons Learned from the Research Projects

9. **Researchers must go the extra mile to address the issues and complexities that arise when studying minority populations because even a slight change in the wording of a question can make a crucial difference.**

   Many existing survey instruments were created using mostly white, middle-class populations. But when these surveys are administered to groups of diverse ethnicity and socioeconomic status, the results often are skewed.

   Opening Doors' research projects confronted many challenges as they sought to carry out minority health studies, but many important lessons have emerged.

10. **Involve community leaders and local organizations in all aspects of the study.** This includes involving them in crafting the study design, recruiting study respondents and interviewers, analyzing the results, and disseminating the findings.

11. **Don't simply translate English questions into other languages.** Instead, find out the best questions to ask in the respondents' native languages because a health study's central questions and premises often do not translate well to a minority culture.

12. **In general, match interviewers to the research subjects' culture and primary language.** Often, matching genders is also important. Elicit the interviewer's feedback on the survey instrument during the interview training process. Keep interviews brief—20 to 40 minutes at most.

13. **Avoid intimidating research subjects.** When working with respondents who may be anxious about their residency status or who may have experienced government persecution in their native countries, make sure interviewers do not appear to be government officials.

14. **Deploy innovative outreach strategies.** When conducting surveys of low-income, minority populations, enlist the help of community members and organizations to reach potential participants.

    If conducting telephone surveys, which are more effective in reaching middle and upper classes, expect many telephone numbers to be outdated or disconnected.

AFTERWARD

Sociocultural barriers to health care are not new, and they are not going away. As the proportion of minorities in the United States grows, sociocultural barriers will become more visible.

Health providers; federal, state, and local governments; and consumer and professional trade organizations must seek to reduce sociocultural barriers to health care to better the health outcomes of people from diverse ethnic and racial backgrounds.

Based on the lessons learned from *Opening Doors*, there are steps that can be taken to reduce sociocultural barriers to health care on a local, regional, and national basis.

- **Health providers should increase their involvement overall in reducing sociocultural barriers to health care by:**
  - Collecting data on patients' language, ethnicity, race, country of origin, length of residence in the United States, and family composition.
  - Hiring bilingual staff and/or interpreters if warranted by the percentage of the non-English speaking client base.
  - Translating written materials and signs into native languages.
  - Networking with community organizations and creating meaningful roles for community members within health care organizations and clinics.
- **Public agencies, state and federal governments, and national health care trade associations should increase their involvement in reducing sociocultural barriers to health care by:**

- Creating funding streams to support community health workers and interpreters. Program evaluations and cost-benefit analysis should be supported as well to assess their value.
- Developing guidelines and standards, particularly in state Medicaid managed care contracts, for interpreter services, translation of materials, staff training in cultural sensitivity, and community outreach. Requirements should be based on a formula that takes into account the percentage of the client population that speaks a particular language.
- Promoting community education efforts to inform Medicaid recipients about where to go for health care, how to access the system, and what services are included. Brochures, patient manuals, and flyers should be translated into the languages of the groups to be targeted and written at an appropriate educational level.

- **Research institutions and their funders conducting minority health studies should:**
  - Involve community leaders and organizations in all aspects of studies.
  - Require researchers conducting studies of racial and ethnic minority groups to collaborate with representatives of the study population as interviewers, interpreters, observers, and data analysts.

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