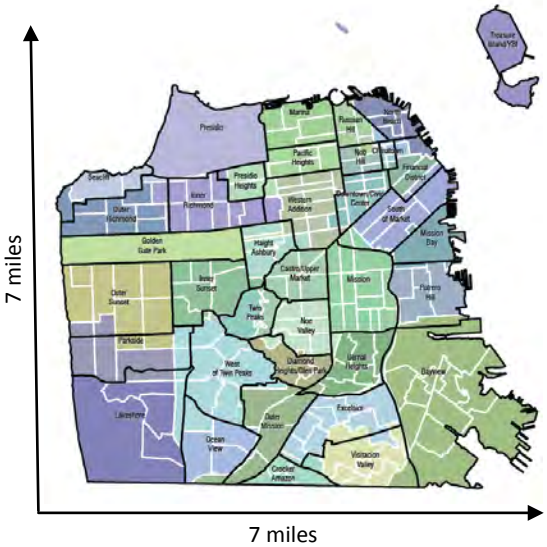
# Health Care Services Master Plan Task Force
## Connectivity

## OVERVIEW

The City and County of San Francisco occupies approximately 49 square miles. Within its footprint, providers offer a rich variety of health and wellness services to its diverse population of 805,235 residents.[i] Despite its relatively small size, however, many of San Francisco's more vulnerable residents still struggle to access the health care services needed to optimize their health outcomes.




Since its first meeting in July 2011, the Health Care Services Master Plan (HCSMP) Task Force has focused its discussions on issues of health care access, exploring the impacts of Health Reform, health insurance coverage, provider supply, health care finance, and the promise of health information technology and innovation to connect San Francisco residents to the care they need. Task Force members have also dialogued with community members who have cited their experience with these and additional barriers to health care access.

The current issue brief strives to address more fully access, or "connectivity," gaps in San Francisco's health care system as voiced by members of the public and the HCSMP Task Force. The brief will explore the potential geographic access barriers to care that exist despite San Francisco's small footprint and extensive transit system. The brief will also delve into connectivity gaps that result from residents' health literacy and cultural/linguistics needs versus the existing health care system's capacity to tailor care in a manner best suited to the patient. While health insurance coverage also affects an individual's ability to connect to health care services, please note that coverage issues will not be presented here. Please revisit the previous issue briefs on Health Reform and health care finance for more information.

## PHYSICAL CONNECTIVITY

### Geographic Proximity to Health Care Services

Research identifies geographic proximity as one of four key elements of health care accessibility.[ii, iii] Greater distances to health care services have been associated with poor health outcomes, including lower uptake of mammography screening,[iv] higher rates of asthma-related death, and lower cancer survival rates.[v] However, geographic accessibility is relative, particularly in the context of San Francisco, which occupies roughly seven square miles.

Geographic proximity to health care services is commonly measured in travel time and distance. In 2001, the average trip between home and health care in the U.S. was 10.2 miles and 22 minutes of travel.[vi] Not surprisingly, rural residents traveled further than urban residents (17.5 versus 8.3 miles) and rural trips took longer than urban ones (27.2 versus 20.7 minutes). In miles, San Francisco residents' distance

from home to health care would fall well below the national average, though this would not necessarily be the case for travel time – particularly for San Franciscans who rely on public transportation.

In the United Kingdom, "poor access" has been associated with any distance from home that exceeds between 24 and 50 miles for specialist hospital services, 10 miles for screening services, four miles for family planning clinics, and two and one-half miles for primary care.[x] However, there are no clear standards for ideal proximity for the various types of health care services. What does become clearer, as indicated above, is that there are benefits to having primary care closer to home.

Proximity to primary care services is associated with higher outpatient care utilization[xi] and lower emergency department use.[xii] In a study of the uninsured, a distance of five miles between a person's residence and the nearest safety net clinic constituted access to care.[xiii] In a study of children enrolled in Medicaid, those living more than one and one-half miles from their primary care physician used emergency rooms more often, [xiv] suggesting that when primary care is available close to home there is less reliance on costly emergency care.

Data suggest that when measuring pure geographic proximity, San Franciscans overall have better geographic access to health care services than other populations. Nearly all San Francisco residents, for example, meet the one and one-half mile marker for proximity to primary care referenced above – the shortest distance found in the literature – and *all* San Franciscans reside within five miles of primary care, also referenced above. However, measuring geographic proximity to the closest provider is but one measure of access and does not take into account the capacity of that provider to take additional patients, the types of insurance that provider accepts, or the provider's linguistic or cultural competence, among other factors.

**Neighborhood Safety: A Social Determinant of Health Impacting Health Care Access**

Availability and acceptability are key elements of health care access.[vii] Affecting availability and acceptability are issues of real and/or perceived safety. As was raised by the African American Health Equity Council at the March 22, 2012 meeting of the HCSMP Task Force, turf issues (the inability to travel into a neighborhood associated with a particular group or gang) may prevent some persons from seeking care at a nearby health care facility they might otherwise go to for care. A teen participant in the Mo' Magic program affirmed the influence of safety on health care, noting that people may actively seek services outside their neighborhood if they do not feel it is safe to do so close to home.[viii] In one study of the impact of neighborhood characteristics on access to medical homes for children, it was shown that children were far less likely to have access to a medical home if they were from unsafe neighborhoods.[ix] Sixty-one percent of children in neighborhoods perceived as unsafe had no primary care medical home; this is in clear contrast to neighborhoods perceived as safe where 61 percent of children did have a medical home.

## Connectivity Through Public Transportation

While San Francisco offers a rich array of health and wellness services within in relatively small geographic area, accessing health care services may still pose a challenge for some residents, particularly those for whom easily walking, biking, taking public transit, or driving to care is not an option. As illustrated by the table on the following page, this challenge may be especially acute for low-income San Franciscans who are more likely than wealthier residents to rely on public transportation.[xv]

**Adult San Francisco Residents by Regular Car Access and Federal Poverty Level (FPL)**

**Source: California Health Interview Survey, 2007**

| Car Status | 0-99% FPL | 100-199% FPL | 200-299% FPL | 300% FPL and Above | All |
|---|---|---|---|---|---|
| Has Car | 51.9% | 50.7% | 73.9%* | 90.6% | 79.6% (536,000) |
| Does not have car | 48.1% | 49.3% | 26.1%* | 9.4% | 20.4% (137,000) |
| TOTAL | 100% (88,000) | 100% (74,000) | 100% (63,000) | 100% (448,000) | 100% (674,000) |

* Percentage statistically unstable.

According to the *California Code of Regulations* in reference to the two-plan model of Medi-Cal Managed Care (which is San Francisco's Medi-Cal Managed care model), "Each plan must ensure that primary health care services provided through the plan are no more than 30 minutes travel time or ten (10) miles travel distance from each member's place of residence, unless the department has approved an alternative time and distance standard."[xvi, xvii] Applying this standard to health care services in San Francisco broadly, all primary care services are located within a 10 mile travel radius of where residents live; however, it is not clear that all residents – particularly those that rely on public transit – can travel to their health care destination(s) in 30 minutes or less.

Data from the 2007 California Health Interview Survey indicate that 20.4 percent of San Francisco respondents (137,000 persons) did not have access to a car for regular use.[xviii] Of those, 71.6 percent relied primarily on public transportation to get to the doctor's office.[xix] While the Healthy Development Measurement Tool (HDMT) indicates that all San Francisco residents live within ¼ mile of a local bus or rail link, *no available data indicates the degree to which public transit-reliant health care consumers are able to access necessary and preferred services within 30 minutes or less*. The HDMT acknowledges that availability does not necessarily equate with accessibility. For example, factors such as "cost, distance, perceived and actual safety, weather, pedestrian access and safety, traffic patterns, availability of bicycle lanes and racks, hours of operation" and more contribute to transit's perceived and actual accessibility – particularly for low-income persons.[xx]

**Usual Type of Transportation to Get to Doctor's Office, San Francisco Adults Without Regular Car Access**

**Source: California Health Interview Survey, 2007**

| Transit Mode | Percentage (n=137,000) |
|---|---|
| Personal Vehicle as Driver or Passenger | 6.1 |
| **Public Transportation** | **71.6** |
| Paratransit/Transit Provided by Health and Human Services | 3.5* |
| Walk or Ride Bike | 15.8 |
| Taxi/Other | 3.1 |

* Percentage statistically unstable.

While many San Franciscans – particularly those in more central locations – can likely access health care via transit within the optimal timeframe, others cannot – particularly when health care needs present at non-peak commute hours. Roughly one in every four (25 percent) Excelsior residents, for example, spends 60 minutes or more traveling to see a health care provider. [xxii] Community members at the September 22, 2011 and March 22, 2012 meetings of the HCSMP Task Force voiced similar concerns, citing transportation issues and travel time as barriers to care. Additionally, HDMT data show that only 35 percent of primary care facilities are within ¼ mile of a regional transit stop.[xxiii, xxiv] This finding may pose challenges to San Francisco, as facility proximity to public transit has been linked to emergency department use.[xxv, xxvi]

> **25 percent[xxi]**
>
> Roughly one in every four (25 percent) Excelsior residents spends 60 minutes or more traveling to see a health care provider.
>
> *Source: Chinese Progressive Association*

The table below presents estimated travel times between and within San Francisco neighborhoods via public transit. Neighborhoods in the "origin" column correspond with those areas identified as high need and in which the HCSMP Task Force held neighborhood meetings between September 2011 and March 2012. Neighborhoods[xxvii] associated with the "destinations" column are those in which San Francisco's non-profit hospitals – and, likely, higher concentrations of specialty care and other services that tend to cluster near hospitals – are located.

Please note that:

- Data presented below *do not* represent the exact amount of travel time needed to get from a neighborhood resident's home to a specific medical institution;
- Travel times presented below represent an *average of forecast trips* – including late night trips – expected between the neighborhoods on a typical *weekday*.

**Average Daily Transit Travel Times (Minutes/Trip)** to Hospital Neighborhood Locations**

**Source: San Francisco County Transportation Authority (SFCTA), SF-CHAMP 4.1, 2010**

*NOTE: Travel times below are approximate between neighborhoods. Times do not indicate exactly how long it would take a neighborhood resident to travel to a specific hospital location.*

| | Destinations | | | | | | |
|---|---|---|---|---|---|---|---|
| **Origin*** | **Downtown (e.g., Chinese, St. Francis)** | **Market/ Octavia (e.g., CPMC-Davies)** | **Mission (e.g., St. Luke's)** | **Pac Heights/ Marina (e.g., CPMC-Pacific)** | **Potrero Hill (e.g., SFGH)** | **Richmond (e.g., CPMC-California, Kaiser-French)** | **Western Addition (e.g., Kaiser, UCSF-Mt. Zion, St. Mary's)** |
| Bayview-Hunters Point | 38 | 41 | 38 | 64 | 31 | 70 | 54 |
| Market/Octavia | 16 | 13 | 21 | 31 | 31 | 39 | 21 |
| Mission | 25 | 21 | 18 | 45 | 31 | 51 | 34 |
| Mission (Outer) | 33 | 31 | 28 | 58 | 48 | 62 | 45 |
| Richmond | 38 | 39 | 51 | 32 | 63 | 16 | 27 |
| SOMA | 16 | 19 | 27 | 38 | 28 | 47 | 30 |
| Sunset | 28 | 25 | 37 | 48 | 55 | 35 | 33 |
| Western Addition | 24 | 21 | 34 | 25 | 44 | 27 | 18 |

* Neighborhood designations defined by SFCTA
** Travel times represent an average of forecast trips – including late night trips – expected on a typical *weekday*.

## CONNECTIVITY THROUGH HEALTH LITERACY, LANGUAGE, AND CULTURE

### Health Literacy + Connectivity

**Overview**

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[xxx] Lack of health literacy is linked to:

- Limited ability to interpret and act on medication labels, thereby increasing the incidence of medication errors;
- Difficulty understanding and following provider directions;
- Reduced likelihood of seeking preventive care;
- Increased hospitalization and use of emergency services;
- Poorer health outcomes; and
- Higher mortality rates.[xxxi]

In short, limited health literacy acts as a barrier to health care access and improved health outcomes.

**39 percent[xxviii, xxix]**

Estimated number of African Americans in San Francisco with a health literacy level equivalent to the 8th grade or below. According to the Rapid Estimate of Adult Literacy in Medicine (REALM), persons with health literacy skills at the 7th or 8th grade level (23.4 percent of African Americans in San Francisco) will struggle with most patient education materials; persons with health literacy skills between the 4th and 6th grade levels (10.1 percent of African Americans in San Francisco) will need to receive materials tailored to a limited-literacy audience and may struggle with prescription labels; persons at the 3rd grade health literacy level or below (5.7 percent of African Americans in San Francisco) may not be able to read even limited-literacy materials, will need repeated oral instructions, and may need additional help (e.g., illustrations, audio recordings, etc.) to act on health information appropriately. *Please note that health literacy data is not available for other racial/ethnic groups in San Francisco.*

**San Francisco Out Performs State in Literacy, Though May Fare More Poorly than Nation in *Health* Literacy**

**Indirect Estimate of Percent of Persons Age 16+ Lacking Basic Literacy Skills (General)**
**Source: 2003 National Assessment of Adult Literacy**

| San Francisco County (n=629,606) | California (n=26,029,840) |
|---|---|
| 18 | 23 |

Results from the 2003 National Assessment of Adult Literacy (NAAL) indicate that only 12 percent of US adults are proficient enough to use health information effectively.[xxxii] In addition, NAAL found that 36 percent of US adults have either basic (22 percent) or below basic (14 percent) health literacy skills. Indirect estimates of San Francisco's general prose literacy skill level suggest that San Francisco residents may fare more poorly than national numbers suggest: Eighteen percent of San Franciscans lack even basic prose literacy skills.[xxxiii, xxxiv] While San Francisco County residents perform better than California as a whole (23 percent of state residents lack basic literacy skills), these numbers suggest that San Francisco's more vulnerable populations may lack access to understandable health information on which they can base their health decisions.

**Certain Populations More Susceptible to Limited Health Literacy and Related Outcomes – Including San Francisco's Vulnerable Populations**

Research also suggests that certain populations – including those constituting San Francisco's vulnerable populations – are more likely to experience limited health literacy, subjecting them to poorer health outcomes and health inequities.[xxxv] For example:

- Older adults. The NAAL found that older adults (age 65+) had lower average health literacy skills than younger groups.[xxxvi] Other research supports this finding. For example, one study found that two-thirds of US adults age 60 or older have inadequate or marginal health literacy skills and that 60 percent of patients at one public hospital could neither read nor understand basic materials (e.g., prescription instruction labels). This reality is of note in San Francisco, where nearly half of all adults are projected to be age 50 or older by 2030;[xxxvii]
- Minority populations;
- Immigrant populations, a concern given San Francisco's substantial immigrant population. Compared to California, for example, San Francisco has a lower percentage of residents who were born in the United States (see table at right);[xxxviii]
- Low-income persons; and
- People with chronic mental and/or medical conditions.

**Immigration Status**
**Source: 2009 American Community Survey**

| | San Francisco (Percent) | California (Percent) |
|---|---|---|
| Native | 65.9 | 73.1 |
| Foreign Born | 34.1 | 26.9 |

Education alone cannot explain a person's degree of health literacy. Someone with a high level of educational attainment, for example, may still have difficulty understanding complicated health insurance enrollment forms and accessing and navigating the health care system. While education explains health literacy skills to some degree, health literacy "comes from a convergence of education, cultural and social factors, and health services."[xxxix] Having some degree of background knowledge in health – combined with a person's ability to listen, ask questions, and advocate for oneself – also impacts an individual's health literacy level. Limited English proficiency, as well as differences in culture, influences the degree to which an individual can access health care services and understand and act on health information.

**Efforts to Increase Health Literacy**

Various federal policy initiatives promise to address health literacy. Health Reform, for example, incorporates health literacy into professional training requirements, streamlines enrollment procedures for public insurance programs and the state health benefit exchanges, and requires that health plans provide beneficiaries with clear coverage information that is easy to understand.[xl] (A recent poll indicates that this latter provision is among the most popular offered by Health Reform.) Such efforts align well with the US Department of Health and Human Services' National Action Plan to Improve Health Literacy, which sets forth seven unified health literacy goals and strategies for the country. These efforts, combined with Health Information Technology and Clinical Health Act's (HITECH) goal to provide meaningful and useful health information

**Health Literacy Resources**

The Health Resources and Services Administration offers numerous health literacy resources on its website.

to patients, health literacy-related Healthy People 2020 objectives, and efforts at the hospital- and provider-level suggest that health literacy has come to the forefront of the health care community's consciousness; however, to protect and promote the health of its most vulnerable populations, San Francisco must be vigilant about providing health information – and health service access – to consumers in an appropriate and understandable way.

## Linguistic Connectivity

### Limited English Proficiency Limits Health Care Access

A patient's ability to communicate with a health care provider in a common language impacts his/her likelihood of accessing needed services and ability to act on health information successfully. According to the Institute of Medicine:

> *Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.*[xli]

**Linguistic Competence**

The capacity to communicate effectively and convey information in a manner that is easily understood by diverse audiences.

*Source: National Center for Cultural Competence*

Considered a risk factor for health disparities, limited English proficiency (LEP) – defined by the US Census as speaking English "less than very well" [xlii] – has also been associated with decreased satisfaction with services, increased incidence of misdiagnosis, longer hospital stays, and poorer health outcomes.[xliii] Research also suggests that language barriers may reduce LEP participation in the California Health Benefit Exchange (CHBE), again limiting access to health care for which LEP individuals will be eligible.[xliv] According to the UCLA Center for Health Policy Research and the California Pan-Ethnic Health Network, for example, an estimated 110,000 LEP Californians may fail to enroll in the CBHE if outreach efforts do not target this population effectively.

### LEP a Particular Health Access Concern for San Francisco's Diverse Population

Given the diversity of San Francisco's population, linguistic connectivity to health care poses a particular challenge to the population's health. According to the 2010 American Community Survey, for example, among San Franciscans ages five and older who do not exclusively speak English at home, 53.6 percent are LEP; 24.1 percent of *all* San Franciscans age five and older speak English less than very well. This data emphasizes 2009 data from the California Health Interview Survey in which 59.7 percent of San Francisco adult respondents (n=323,000) claimed to speak English less than very well.[xlv] Please note that San Francisco adults fare slightly better than adults in the state overall, 63.3 percent of whom speak English less than very well.[xlvi]

**53.6 percent**

Among San Franciscans age five and older *who do not exclusively speak English at home*, 53.6 are LEP.

*Source: American Community Survey, 2010*

Patients' native language also influences health care provider selection. As illustrated in the table below, preliminary data from San Francisco's Chinese Progressive Association indicate that a provider's familiarity with the patient's language and culture rates among the top three reasons Excelsior and Chinatown residents cite for choosing their health care provider.[xlvii, xlviii] Apart from language and culture, proximity to home and insurance coverage also constituted top reasons for provider selection.

**Excelsior and Chinatown Survey Respondents Citing Provider "Familiarity with Language and Culture" Among Top Three Reasons for Selecting a Particular Provider**

**Source: Chinese Progressive Association, 2011**

| | Respondents by Group | | | |
|---|---|---|---|---|
| | Excelsior | Chinatown | Seniors | All |
| Provider Familiarity with Patient's Language + Culture | 24.5% | 41.3% | 36.3% | 26.2% |

**Innovations Offer Promise to Increase Linguistic Connectivity**

Providers have piloted numerous innovations to increase access for and improve the health outcomes of LEP populations. Please note that the innovations discussed below do not constitute an exhaustive list.

Shared Remote Interpreters via Phone and Video Medical Conferencing

Shared networks of trained interpreters promise to increase health care access at minimal cost. The Health Care Interpreter Network (HCIN), for example, is a cooperative of eight California public hospitals sharing trained health care interpreters through an automated video/voice call center.[xlix] Through the HCIN, more than 60 interpreters are available to provide member hospitals with interpretation services in Spanish, Cantonese, Mandarin, Vietnamese, Lao, Mien, Thai, Cambodian, Hmong, Korean, Russian, Farsi, Armenian, Tongan, and Hindi. American Sign Language is available on HCIN video stations through Language Line Services. In addition, Spanish interpreters offer assistance beyond traditional work hours, offering patients greater access to timely, flexible care. While participation in shared networks of interpreters is not free, research suggests that such interventions are cost-effective relative to the expenses associated with emergency and follow-up care.[l]

**Policies Advancing Linguistic Connectivity**

- Civil Rights Act of 1964 (Title IV): Health care providers accepting federal funds must ensure health care accessibility, even to LEP populations.
- National Standards on Culturally and Linguistically Appropriate Services (CLAS) Standards (Standards 4 through 7): Reinforce the Civil Rights Act of 1964 by detailing how to provide compliant language assistance services.
- Health Reform: Advances linguistic connectivity in numerous ways. For example, by requiring federally-supported providers, to the extent possible, to capture culturally and linguistically specific data on population served; requiring that health plan information be presented in culturally and linguistically appropriate way; and more.

*Sources: Health Affairs, 30, no. 10 (2011)*
*HRSA Website*

Recorded Hospital Discharge Instructions in Patients' Native Language

Children's Hospital Central California provides non-English speak patients with a recording of their discharge instructions in their native language; the hospital also provides this service to English-speaking patients with limited literacy skills. For up to two weeks post-discharge, patients and their families may access these instructions as needed via a password-protected telephone mailbox. According to the Agency for Healthcare Research and Quality, the program has "been used by a higher-than-expected number of patients and family members, has reduced gaps in comprehension, and has generated high levels of patient/family satisfaction."[li]

**Increasing Linguistic Connectivity: A San Francisco Example[lii, liii]**

To ensure the culturally and linguistically competent provision of health care services, San Francisco General Hospital (SFGH) and all community oriented primary care (COPC) clinics offer interpretation services in 45 different languages to LEP patients. Available from 8am – 12am seven days per week, SFGH's Interpreter Services Department affords both entities access to interpretation through various methods including in-person interpreting (10 different languages), telephone-based interpreting, videoconferencing interpreting, and a back-up interpreter system used as needed to reach "on call" language bank interpreters and telephonic agency services.

## Cultural Connectivity

### Limited Cultural Connectivity Negatively Impacts Patient Experience and Health Outcomes

Linked closely to language is culture, or the "thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" that impact how health information may be received.[liv] Cultural disconnects between patients and health care providers have been linked to unequal clinical treatment, particularly for racial and ethnic minorities, which can result in lower patient satisfaction, lack of trust in the provider (and therefore limited adherence to treatment), and poorer health outcomes.[lv, lvi] In addition, lack of cultural competency in patient-provider interactions can be experienced as discrimination. A study of HIV-positive patients, for example, found that many had experienced discrimination in care, which was associated with higher rates of depression, more severe AIDS-related symptoms, and lower general health (self-report).[lvii]

**Cultural Competence**

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

*Source: US Department of Health and Office of Health and Human Services, Office of Minority Health*

## Broad Definition of "Culture" Needed to Most Appropriately Serve San Francisco's Diverse Population

San Francisco's diverse population represents a rich mix of races and ethnicities (see table on next page); however, members of other cultural groups – and *overlapping* cultural groups – also call the city home. The US Department of Health and Human Services, Health Resources and Services Administration (HRSA) identifies a series of cultural groups and subpopulations (see box, right) with identified health care needs, all of which exist in San Francisco. San Francisco, for example, has prominent lesbian, gay, bisexual, and transgender (LGBT) communities and is home to a national Center of Excellence for Transgender Health. The city also has a significant homeless population, many of whom present with co-occurring disorders such as mental health and substance use issues as well as chronic medical conditions.

**Sampling of Cultural and "Special Population" Categories**

- Age
- Gender
- Race/Ethnicity
- LGBT
- Homeless
- Public Housing Residents
- People with Disabilities (Incl. People with Mental Health Issues)
- Farm Workers/Migrant Workers

*Source: HRSA Website*

**San Francisco Population by race and ethnicity, 2000 to 2010**

| Race and Ethnicity[lviii] | San Francisco, 2000 | | San Francisco, 2010 | | Trend |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | 2000 -2010 |
| **Total Population** | **766,733** | | **805,235** | | ↑ |
| White | 385,728 | 49.7 | 390,387 | 48.5 | ↓ |
| Asian | 239,565 | 30.8 | 267,915 | 33.3 | ↑ |
| Hispanic or Latino (of any race) [lix] | 109,504 | 14.1 | 121,774 | 15.1 | ↑ |
| Black or African American | 60,515 | 7.8 | 48,870 | 6.1 | ↓ |
| Some other race | 50,368 | 6.5 | 53,021 | 6.6 | ↑ |
| Two or more races | 33,255 | 4.3 | 37,659 | 4.7 | ↑ |
| American Indian and Alaska Native | 3,458 | 0.4 | 4,024 | 0.5 | ↑ |
| Native Hawaiian or other Pacific Islander | 3,844 | 0.5 | 3,359 | 0.4 | ↓ |

*Source: US Census 2000 and 2010*

## Well-trained and Diverse Workforce Central to Increasing Cultural Connectivity

Cultural groups, however defined, require health care services tailored to their needs if they are to access appropriate care and maximize their health outcomes. Optimizing health requires bridging the patient-provider culture gap by developing a well-trained and diverse health care workforce. Demand for such workforce development has been voiced in recent locally-focused health needs assessments, such as those focusing on Maya children and youth as well as an assessment of the mental health needs of at-risk youth in the Bayview-Hunters Point neighborhood.[lx, lxi]

Developing a Well-Trained and Culturally Competent Workforce

Research suggests that cultural competency training can improve the knowledge, attitudes, and skills of health care providers.[lxii] Such training has also been shown to increase patient satisfaction with health care services; however, the evidence base for cultural competency training's impact on patient health outcomes is less clear given a lack of high quality research.[lxiii] Even so, the push toward development of a well-trained and culturally competent workforce is clear. The National Standards on Culturally and Linguistically Appropriate Services (CLAS), for example, devote Standards 1 through 3 to the theme of cultural competency.[lxiv, lxv] Beyond CLAS standards, HRSA, National Centers of Excellence, and other entities are working to compile best practice information in terms of appropriate delivery of health care services to specific populations. San Francisco leads this charge in many ways, serving as home to National Centers of Excellence devoted to women's health, transgender health, and HIV health services. HRSA also cites SFDPH's best practice guidelines for providing HIV/AIDS services to transgender persons.[lxvi]

**CLAS Standard 1**

"Health care organizations should ensure that patients/consumers received from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language."

*Source: Office of Minority Health*

Health Care Workforce Diversity

The *National Prevention Strategy* cites increasing diversity within the prevention workforce as one factor necessary to eliminate health disparities and facilitate the provision of culturally competent care.[lxvii] According to the *Strategy*, "The workforce should not only be culturally competent but also sufficiently diverse to reflect underlying community characteristics (e.g., race/ethnicity, culture, language, disability)…A well-trained, diverse, and culturally competent workforce helps enhance development and delivery of prevention programs and patient-centered care."

Increasing diversity within in the health care workforce may offer the added benefit of increasing the provider supply in traditionally underserved areas while increasing access to culturally competent care tailored to the needs of the resident community. Research has found, for example, that minority physicians in California are more likely than white physicians to practice in Medically Underserved Areas, Health Professional Shortage Areas, and communities with higher proportions of minority and/or low-income residents.[lxviii] Please note, however, that Latinos and African Americans are underrepresented among California physicians relative to the prevalence of those racial/ethnic groups in the state's general population.[lxix] Other ethnic groups – among them Samoan, Cambodian, and Hmong/Laotian – are also underrepresented.

Despite California's patient-provider culture gap, state bodies such as the California Health Workforce Development Council have identified cultural responsiveness and sensitivity as a cross-cutting theme in its work, making the case for increased diversity in the health care workforce. In addition, the California Medical Board Survey – mandated by California State Bill 1586 (enacted in 2001) – provides important physician-reported data on race/ethnicity and language fluency to gauge the degree to which California providers reflect the patients they serve.

## PRELIMINARY POLICY CONSIDERATIONS

*Recommendations: The Health Care Services Master Plan shall include policy recommendations to promote an equitable and efficient distribution of health care services in the City; the elimination of healthcare service gaps and medically underserved areas; and the placement of Medical Uses within the City in a manner that is consistent with the character, needs and infrastructure of the different neighborhoods, and that promotes and protects the public health, safety, convenience, and general welfare.* ***San Francisco Ordinance No. 300-10***

The HCSMP Task Force is an advisory body charged with developing possible HCSMP recommendations informed by data and community feedback. The San Francisco Department of Public Health (SFDPH) will consider these possible recommendations for inclusion in the final HCSMP. However, given the collective expertise of the Task Force – and given that Task Force discussions will likely yield ideas beyond the scope of the HCSMP – SFDPH presents below a series of policy considerations that may inform both the HCSMP's development as well as San Francisco's broader health planning efforts.

## LAND USE-SPECIFIC POLICY CONSIDERATIONS

The Task Force may wish to recommend that SFDPH consider including the following in the final HCSMP:

- Explore the possibility of incentivizing Medical Use projects that demonstrate the provision of culturally and linguistically competent services via policies (e.g., adoption of and adherence to CLAS Standards) and workforce development efforts (e.g., training).
- Explore the possibility of incentivizing Medical Use projects that demonstrate participation in a health care interpreter network or other means of providing timely patient access to interpretation services.
- Explore the possibility of incentivizing Medical Use projects that hire staff who reflect the diversity – and needs of – the patient population and are members of the community they serve. For example, staff should reflect the racial/ethnic diversity of the patient population and/or have expertise in addressing the population's identified health needs (e.g., expertise in the provision of HIV/AIDS services).

## POLICY CONSIDERATIONS RELEVANT TO BROADER HEALTH PLANNING EFFORTS

The Task Force may wish to recommend that SFDPH consider the following in its broader health planning efforts:

**Federal Level**

- Support the development of patient-centered medical home models in which the provider best suited to the patient's primary health need (e.g., mental health, transgender health needs, etc.) may serve as the interdisciplinary team lead.

**State Level**

- Ensure that the CHBE is designed to meet the accessibility needs of California's vulnerable populations, including those with specific cultural, linguistic, and health literacy concerns.

**Local Level**

- Support the recommendations of the Municipal Transit Authority's Transit Effectiveness Project, which is expected to positively impact passenger travel times on high ridership routes, including those that service San Francisco's major health care facilities.
- At intake, providers or qualified clinic staff should assess the health literacy and cultural/linguistic needs of the patient, so that care may be tailored to each patient's needs.
- Building on the model of the National Physician's Post-Exposure Prophylaxis Hotline, expand the availability of provider "warm lines" to foster the exchange of information – including best practice information on the provision of culturally competent services – in San Francisco.

## LISTED ACRONYMS

| Acronym | Definition |
|---|---|
| AHRQ | Agency for Healthcare Research and Quality |
| CHBE | California Health Benefit Exchange |
| CLAS Standards | Culturally and Linguistically Appropriate Services Standards |
| COPC | Community-Oriented Primary Care |
| HCIN | Health Care Interpreter Network |
| HCSMP | Health Care Services Master Plan |
| HDMT | Healthy Development Measurement Tool |
| HITECH | Health Information Technology and Clinical Health Act |
| HRSA | Health Resources and Services Administration |
| LEP | Limited English Proficiency, or Limited English Proficient |
| LGBT | Lesbian, Gay, Bisexual, Transgender |
| NAAL | National Assessment of Adult Literacy |
| REALM | Rapid Estimate of Adult Literacy in Medicine |
| SFDPH | San Francisco Department of Public Health |
| SFGH | San Francisco General Hospital |

[i] US Census Bureau. 2010 Census. http://factfinder2.census.gov/main.html. (Accessed 3/12/12.)

[ii] Ray N, Ebeener S, "AccessMod 3.0: computering geographic coverage and accessibility to health care services using anisotropic movement of patients." International Journal of Health Geographics 2008, 7:63. http://www.ij-healthgeographics.com/content/7/1/63 (Accessed 3/24/12.)

[iii] The three remaining key elements of health care accessibility include availability, financial accessibility, and acceptability. These elements were addressed in previous issue briefs and/or are discussed in the pages that follow.

[iv] Hyndman JC, Holman CD, Dawes VP, "Effect of distance and social disadvantage on the response to invitations to attend mammography screening." J Med Screen, 2000; 7(3): 141-5. http://jms.rsmjournals.com/content/7/3/141.full.pdf. (Accessed 3/24/12.)

[v] Jordan H, Roderick P, Martin D, Barnett S, "Distance and rurality and the need for care: access to health services in South West England." International Journal of Health Geographics 2004, 3:2 http://www.ij-healthgeographics.com/content/3/1/21 (Accessed 3/24/12.)
[vi] Probst JC, Laditka SB, Wong J, Johnson AO, "Effects of residence and race on burden of travel for care: cross sectional analysis of the 2001 US National Household Travel Survey." BMC Health Serv Res. 2007; 7: 40. http://www.biomedcentral.com/1472-6963/7/40 (Accessed 3/24/12).
[vii] Ray N, Ebeener S, "AccessMod 3.0: computering geographic coverage and accessibility to health care services using anisotropic movement of patients." International Journal of Health Geographics 2008, 7:63. http://www.ij-healthgeographics.com/content/7/1/63 (Accessed 3/24/12.)
[viii] Mo' Magic focus group conducted by SFDPH on March 15, 2012.
[ix] Aysola J, Orav EJ, Ayanian JZ, "Neighborhood Characteristics Associated with Access to Patient-Centered Medical Homes for Children." Health Aff, November 2011, vol. 30, no. 11 2080-2089. http://content.healthaffairs.org/content/30/11/2080.full#T2. (Accessed 3/24/12.)
[x] Jordan H, Roderick P, Martin D, Barnett S, "Distance and rurality and the need for care: access to health services in South West England." International Journal of Health Geographics 2004, 3:2 http://www.ij-healthgeographics.com/content/3/1/21 (Accessed 3/24/12.)
[xi] Hadley J, Cunningham C, "Availability of Safety Net Providers and Access to Care of Uninsured Persons." Health Serv Res. 2004 October; 39(5): 1527–1546. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361082/?tool=pubmed (Accessed 3/24/12.)
[xii] Ludwick A, Fu R, Warden C, Lowe R, "Distances to Emergency Department and to Primary Care Provider's Office Affect Emergency Department Use in Children." Acad Emerg Med, May 2009, Vol. 16, no. 5. http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00395.x/pdf (Accessed 3/24/12.)
[xiii] Hadley J, Cunningham C, "Availability of Safety Net Providers and Access to Care of Uninsured Persons." Health Serv Res. 2004 October; 39(5): 1527–1546. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361082/?tool=pubmed (Accessed 3/24/12.)
[xiv] Ludwick A, Fu R, Warden C, Lowe R, "Distances to Emergency Department and to Primary Care Provider's Office Affect Emergency Department Use in Children." Acad Emerg Med, May 2009, Vol. 16, no. 5. http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00395.x/pdf (Accessed 3/24/12.)
[xv] San Francisco Department of Public Health. "Proportion of Households Without a Motor Vehicle." Healthy Development Measurement Tool. http://thehdmt.org/indicators/view/51. (Accessed 3/9/12.)
[xvi] California Code of Regulations, Title 22, Section 53885, "Travel Distance Standards." http://weblinks.westlaw.com/result/default.aspx?cite=22CAADCS53885&db=1000937&findtype=L&fn=%5Ftop&pbc=DA010192&rlt=CLID%5FFQRLT28804265110123&rp=%2FSearch%2Fdefault%2Ewl&rs=WEBL12%2E01&service=Find&spa=CCR%2D1000&sr=TC&vr=2%2E0. (Accessed 3/12/12.)
[xvii] Please note that eligible beneficiaries may elect to seek care beyond the specified time/distance standard if desired.
[xviii] California Health Interview Survey, 2007. https://askchis.org. (Accessed 3/5/12.)
[xix] Please note that, for San Franciscans who have regular access to a car, CHIS does specify the percentage reliant on public transportation to get to the doctor's office. Given the range of transportation modes available, it is likely that at least some persons with regular car access still use transit to access health care, particularly for routine, non-emergency services.
[xx] San Francisco Department of Public Health, Healthy Development Measurement Tool. http://thehdmt.org/indicators/view/52 . (Accessed 3/12/12.)
[xxi] Chinese Progressive Association. "Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco." Draft Report, March 2012.
[xxii] Chinese Progressive Association. "Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco." Draft Report, March 2012.
[xxiiixxiii] San Francisco Department of Public Health, Healthy Development Measurement Tool. http://www.thehdmt.org/indicators/view/112. (Accessed 3/24/12.)
[xxiv] Please note that most people do not use regional transit to access their health providers.

[xxv] A study of children enrolled in Medicaid found that there was a 27 percent reduction in emergency department use among patients who were assigned to a primary care provider located immediately adjacent to a public transit stop.
[xxvi] Ludwick A, Fu R, Warden C, Lowe R, "Distances to Emergency Department and to Primary Care Provider's Office Affect Emergency Department Use in Children." Acad Emerg Med, May 2009, Vol. 16, no. 5. http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00395.x/pdf (Accessed 3/24/12.)
[xxvii] Neighborhood designations defined by the San Francisco County Transit Authority.
[xxviii] Physical Health Committee of the San Francisco African American Community Health Equity Council. "Community Diagnosis Report of the Physical Health Committee of the African American Community Health Equity Council: A Project of the Black Coalition on AIDS/Rafiki Wellness." December 2011.
[xxix] The Physical Health Committee of the San Francisco African American Community Health Equity Council (AACHEC) surveyed community members to establish their levels of health literacy between April and November 2011. AACHEC conducted this descriptive study at two health clinics located in predominantly African American neighborhoods in San Francisco as well as at community organizations, civic groups, and community events. Survey conductors administered the Rapid Estimate of Adult Health Literacy (REALM) to a total of 158 African American respondents living in San Francisco. Please note that REALM was not administered to a random sample, meaning that results may not be representative of San Francisco's African American population.
[xxx] National Network of Libraries of Medicine. "Health Literacy." http://nnlm.gov/outreach/consumer/hlthlit.html. (Accessed 1/25/12.)
[xxxi] Koh H., Berwick D., Clancy C., Baur C., Brach C., Harris L., and Zerhusen E. "New Federal Policy Initiatives to Boost Health Literacy Can Help the Nation Move Beyond the Cycle of Costly 'Crisis Care.'" Health Affairs no. 2 (2012). http://content.healthaffairs.org/content/early/2012/01/18/hlthaff.2011.1169.full.pdf+html.
[xxxii] The National Assessment of Health Literacy is a project of the US Department of Education. The 2003 assessment was administered to more than 19,000 adults age 16 and older.
[xxxiii] National Center for Education Statistics. "State and County Estimates of Low Literacy." http://nces.ed.gov/naal/estimates/index.aspx. (Accessed 1/25/12.)
[xxxiv] The National Center for Education Statistics explains its calculation of indirect estimates of limited literacy at the state and county level: "These estimates were developed using statistical models that related estimated percentages of adults lacking [basic prose literacy skills (BPLS)] in counties sampled for the 2003 National Assessment of Adult Literacy (NAAL) and the 1992 National Adult Literacy Survey (NALS) to county characteristics, such as levels of educational attainment and race/ethnicity distributions. Based on the results of these models, [the National Center for Education Statistics] derived BPLS literacy estimates for all states and counties in the United States and produced user-friendly tables to compare literacy estimates across states or counties and across years." http://nces.ed.gov/NAAL/estimates/index.aspx. (Accessed 1/25/12.)
[xxxv] National Network of Libraries of Medicine. "Health Literacy." http://nnlm.gov/outreach/consumer/hlthlit.html. (Accessed 1/25/12.)
[xxxvi] Kutner M., Greenberg E., Jin Y., Paulsen C., White S. The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy. September 2006. http://nces.ed.gov/pubs2006/2006483.pdf.
[xxxvii] State of California, Department of Finance. *Population Projections for California and Its Counties 2000 – 2050, by Age, Gender, and Race/Ethnicity*. Sacramento, California, July 2007.
[xxxviii] American Community Survey, 2009.
[xxxix] Institute of Medicine. "Health Literacy: A Prescription to End Confusion." Report Brief. April 2004. http://www.iom.edu/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf.
[xl] Koh H., Berwick D., Clancy C., Baur C., Brach C., Harris L., and Zerhusen E. "New Federal Policy Initiatives to Boost Health Literacy Can Help the Nation Move Beyond the Cycle of Costly 'Crisis Care.'" Health Affairs no. 2 (2012).
[xli] Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academy Press, 2002.
[xlii] Hasnain-Wynia R., Yonek J., Cohen A., and Restuccia J. *Improving Care for Individuals with Limited English Proficiency: Facilitators and Barriers to Providing Language Services in California Public Hospitals*. October 2009. Funded by the California Endowment.

[xliii] Jacobs E., Sanchez-Leos G., Rathouz P., and Fu P. "Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients with Limited English Skills." *Health Affairs*. 30, No. 10 (2011): 1930-1938. http://content.healthaffairs.org/content/30/10/1930.full?ijkey=IMlBLJYyuNUbw&keytype=ref&siteid=healthaff.
[xliv] Gans D., Kinane C., Roby D., Graham-Squire D., Needleman J., Jacobs K., Kominski G., Dexter D., and Wu E. *Achieving Equity by Building a Bridge from Eligible to Enrolled*. Los Angeles, CA: UCLA Center for Health Policy Research and California Pan-Ethnic Health Network, 2012. http://www.healthpolicy.ucla.edu/pubs/files/enrolledpbfeb2012.pdf.
[xlv] California Health Interview Survey, 2009. http://askchis.org/. (Accessed 2/21/12.)
[xlvi] California Health Interview Survey, 2009. http://askchis.org/. (Accessed 2/21/12.)
[xlvii] Chinese Progressive Association. "Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco." Draft Report, March 2012.
[xlviii] CPA administered its survey to Excelsior and Chinatown residents between April and August 2011. Please note that CPA used a convenience sampling method and that all preliminary findings constitute descriptive statistics.
[xlix] "Health Care Interpreter Network." California HealthCare Foundation. July 2010. http://www.chcf.org/projects/2009/health-care-interpreter-network. (Accessed 2/21/12.)
[l] Jacobs E., Sanchez-Leos G., Rathouz P., and Fu P. "Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients with Limited English Skills." *Health Affairs*. 30, No. 10 (2011): 1930-1938.
[li] Agency for Healthcare Research and Quality (AHRQ). "Hospital Provides Non-English-Speaking Patients with Recording of Discharge Instructions in Native Language, Leading to Improved Comprehension and High Satisfaction." AHRQ Health Care Innovations Exchange. http://www.innovations.ahrq.gov/content.aspx?id=2869. (Accessed 2/21/12.)
[lii] San Francisco General Hospital Foundation. "Interpreter Call Center and Video Medical Interpretation (VMI)." http://sfghf.net/programs/vmi.html. (Accessed 4/9/12.)
[liii] San Francisco Department of Public Health Certification Statement for Cultural Competence Provisions. http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliv/SanFran/8CulturalCompRevised.pdf. (Accessed 4/9/12.)
[liv] US Department of Health and Human Services, Office of Minority Health. "What is Cultural Competency?" http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11. (Accessed 2/22/12.)
[lv] Smedly B., Stith A., Nelson A. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Institutes of Medicine. 2003.
[lvi] Ngo-Metzger Q., Telfair J., sorkin D., Weidmer B., Weech-Maldonado R., Hurtado M., Hays R. *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective*. Commonwealth Fund pub. No. 963. October 2006.
[lvii] Thornburn B., Bogart L., Delahanty D. "Health-Related Correlates of Perceived Discrimination in HIV Care." *AIDS Patient Care and STDs*, 2004 18(1): 19-26.
[lviii]The percentages represent the proportion of the total population that identifies with the corresponding race/ethnicity category. For the US Census people were able to mark more than one race category. Additionally Hispanic origin is an ethnicity that is calculated separate from race categories. The percents, therefore do not add up to 100%.
[lix] The 2000 and 2010 Census report that people of Hispanic origin may be of any race and were asked to answer the question on race by marking one or more race categories shown and their percentage is calculated independently from the other race categories. For the US Census ethnic origin is considered to be a separate concept from race.
[lx] Perez Rendon A. *The Health and Mental Health of Maya Children and Youth in San Francisco*. Instituto Familiar de la Raza, Indígena Health and Wellness Collborative. November 2011.
[lxi] Flynn S., Weber K. *Mental Health Needs for At-Risk Youth in the Bayview-Hunters Point Community*. Masters of Nonprofit Administration Requirement, University of San Francisco. December 2011.
[lxii] Beach M., Price E., Gary T., Robinson K., Gozu A., Palacio A., Smarth C., Jenckes M., Feuerstein C., Bass E., Powe N., Cooper L. "Cultural Competency: A Systematic Review of Health Care Provider Educational Intervention." *Med Care*. 2005 April; 43(4): 356-373.

[lxiii] Lie D., Lee-Rey E., Gomez A., Bereknyei S., Braddock C. "Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research." *Journal of General Internal Medicine*. 26(3): 317-325. 2010.
[lxiv] US Department of Health and Human Services, Office of Minority Health. "National Standards on Culturally and Linguistically Appropriate Services (CLAS)." http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. (Accessed 3/2/12.)
[lxv] CLAS standards are mandated for federally funded hospitals and clinics. For private facilities not federally funded, CLAS compliance supports accreditation through the Joint Commission on the Accreditation of Healthcare Organizations.
[lxvi] San Francisco Department of Public Health. *Transgender HIV/AIDS Health Services: Best Practices Guidelines*. http://www.careacttarget.org/library/tgguidelines.pdf. (Accessed 3/2/12.)
[lxvii] National Prevention Council. *National Prevention Strategy: America's Plan for Better Health and Wellness*. June 16, 2011. http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.
[lxviii] Grumbach K., Odom K., Moreno, G., Chen E., Vercammen-Grandjean C., Mertz E. *Physician Diversity in California: New Findings from the California Medical Board Survey*. Center for California Health Workforce Studies. University of California, San Francisco. March 2008.
[lxix] Grumbach K., Odom K., Moreno, G., Chen E., Vercammen-Grandjean C., Mertz E. *Physician Diversity in California: New Findings from the California Medical Board Survey*. Center for California Health Workforce Studies. University of California, San Francisco. March 2008.