Health Access Collaborative

of Southeast Massachusetts, Inc.
Administrative office: 296 Wilson Avenue Quincy, MA 02170-1030 617 770-2003
E-mail: FredGrose@HealthAccessCollaborative.org * Web site: HealthAccessCollaborative.org
• *A nonprofit corporation dedicated to improving health care for persons with limited English.* •

Profile of Health Access Collaborative

HISTORY

In April 2000, senior management of major community-based organizations, hospitals, and community health centers in Fall River and New Bedford held discussions on how to improve services for persons with limited English proficiency. As a result, a plan was developed and Health Access Collaborative was created as a mechanism for organizations to pool their efforts in an ongoing collaboration to improve access to health and related social services in all facilities where persons with limited English seek services.

Initially, Health Access Collaborative was an unincorporated organization governed by a Steering Committee consisting of senior managers from participating organizations. Implementation of plans approved by the Steering Committee was coordinated by a professional staff person working in a consultant role. The strategy was to bring together the authority, skills, and resources necessary to make changes.

Health Access Collaborative of Southeast Massachusetts, Inc. was incorporated as a Massachusetts nonprofit corporation on October 12, 2001. In addition to strong consumer advocacy by health providers and community-based organizations (CBOs) representing their constituents, a region-wide perspective was included by earning direct participation of state legislators, who see the collaborative as a mechanism to assist vulnerable populations and to enhance the quality of life for all residents. Several legislators served as incorporators and two (Senator Menard and Rep. Rodriques) hold voting positions on the Board of Directors.

Incorporators of Health Access Collaborative of Southeast Massachusetts, Inc.

Name	Title	Organization
Wendy Bauer	VP Marketing and Planning	Saint Anne's Hospital
Lydia Breckon	Immigrant and Refugee Services	Catholic Social Services, Diocese of Fall River
Ronald B. Goodspeed, MD	President and CEO	Southcoast Hospitals Group
Fred Grose	President	Health Access Collaborative
Patricia A. Haddad	Representative	MA House of Representatives
Donny In	Minority Community Liaison	City of Fall River Housing
Robert Johnson	VP Performance Improvement	Southcoast Hospitals Group
Helena Marques	Executive Director	Immigrants' Assistance Center
Arlene McNamee	Executive Director	Catholic Social Services, Diocese of Fall River
Mario Medeiros	Project Director	Alcance Hispano
Joan M. Menard	Senator	Massachusetts Senate
Michael Metzler	President and CEO	Saint Anne's Hospital
Sambath Rim	Executive Director	Cambodian Community of Greater Fall River
Michael J. Rodrigues	Representative	MA House of Representatives
Alan Silvia	Executive Director	PYCO
David B. Sullivan	Representative	MA House of Representatives
Sheryl Turgeon	Executive Director	HealthFirst Family Care Center

The U.S. Internal Revenue Service designated Health Access Collaborative as a 501(c)(3) organization on March 25, 2002, which grants the collaborative a tax exempt status.

In May 2002, Blue Cross Blue Shield of Massachusetts Foundation awarded Health Access Collaborative a $50,000 grant to expand cultural competency, train administrative and clinical interpreters, and continue developing an ongoing community-wide network**.** Saint Anne's Hospital and Southcoast Hospitals Group provided $21,000. Goals of that grant were to:

- Increase the quantity and quality of advanced and supplemental medical interpreters in hospitals, health centers, and community-based organizations.
- Improve access to health care by increasing the number and quality of medical and administrative interpreters for community health centers, physician offices, hospitals, and CBOs in Southeast Massachusetts.
- Develop and conduct interpreter training that is customized to the specific needs of trainees and employers.
- Finalize and begin implementing our draft "Cultural Competency Plan" to accelerate the pace of institutional change within each participating organization and among members.
- Further develop Health Access Collaborative as an ongoing network representing principal parties concerned with health care and related social services for persons with limited-English proficiency.
- Serve as a model for (a) organizing communities to improve access in health care and related social services, (b) expanding cultural competency through routine working relations, and (c) advancing public policy by involving political leaders.

COMMUNITY-WIDE PERSPECTIVE

In most communities, there are numerous organizations dedicated to providing services that directly affect the health of their constituents. Even though hospitals, health centers, and physician offices may be the first providers that come to mind when health care issues are discussed, many community-based organizations (CBOs) are crucial partners in local health delivery systems. While the role of CBOs may be acknowledged in health care plans and policy statements, they are frequently overlooked when discussions on access to health care turn to improving the quality and availability of interpreter services. Even leaders who are knowledgeable and committed to immigrant issues often overlook the actual and potential roles of CBOs in improving access to health care.

Members of Health Access Collaborative share the view that (a) each organization has an important role in improving health, cultural sensitivity, and quality of life throughout the area, and (b) a collaborative network of close, routine working relations can be an effective mechanism to help each organization achieve its goals. Hospitals, community health centers and physician offices in Fall River and New Bedford provide a wide range of clinical services and related social services such as health information. But every day hundreds of area residents who lack proficiency in English turn to their community-based organizations for general health information, explanation of instructions on prescriptions and medical orders, and having interpreters accompany them to medical appointments. In Southeast Massachusetts, staff of Alcance Hispano, Catholic Social Services, Immigrants' Assistance Center, Khmer Family Resource Center, and PYCO have a long history of helping their clients overcome linguistic and cultural barriers to accessing health care. The Cambodian Community of Greater Fall River was active in 2001 and helped create Health Access Collaborative.

Health care organizations provide trained medical interpreters and some bilingual staff to alleviate communication problems but the need is far greater than health care providers can address alone because of the lack of reimbursement. Also, many persons with limited English and important cultural views about health care are reluctant to communicate openly with providers but will instead rely on CBO staff where they feel comfortable. Working together, CBO staff and health care professionals can better address the needs of their patients/clients and benefit their respective organizations. Hospitals save money if their highly trained medical interpreters reduce the time they spend on interpreting about administrative tasks, and hospitals benefit when CBO staff provide consumer information. CBOs benefit from their staff being

better informed about health issues and from improving the interpreter skills of their bilingual staff. It is a community partnership in which everyone benefits.

The members of Health Access Collaborative want to have staff who have appropriate levels of interpreting skills readily available wherever persons with limited English may need health and related social services.

SUBSTANTIAL CHANGES IN ORGANIZATIONS

Organizations implement substantial change when such change is needed to achieve their individual goals, and collaboration is successful to the extent that it helps members **achieve mutually beneficial goals**. One of the primary purposes of creating Health Access Collaborative is to accomplish organizational goals that aren't feasible for any member organization acting alone. Collaboration is the most cost effective means of (a) training and using interpreters, (b) creating working relations among service providers and CBOs that will help each fulfill its respective role, and (c) improving the effectiveness and cultural sensitivity of the delivery system as a whole.

Community-based organizations represent the largest segment of Health Access Collaborative, which gives small organizations a stronger voice in health issues than would be possible otherwise. But the most important organizational outcome will be the mutual understanding of members' respective roles that will come from routine working relations. We all need each other, and the network built around interpreter services provides a vital mechanism to pool our efforts.

CURRENT BOARD OF DIRECTORS

The Board of Directors of Health Access Collaborative is made up of senior managers of participating organizations, elected officials, consumers, and other community leaders. The current board is listed below.

Name	Title	Organization
Frances Fuller, Chair	Director, Oncology & Specialty Services	Southcoast Hospitals Group
Wendy Bauer	VP Marketing and Planning	Saint Anne's Hospital
Ellen Banach	VP External Relations	Southcoast Hospitals Group
Stuart Forman	President and CEO	Greater New Bedford Community Health Center
Fred Grose	President	Health Access Collaborative
Helena Marques	Executive Director	Immigrants' Assistance Center
Arlene McNamee	Executive Director	Catholic Social Services, Diocese of Fall River
Mario Medeiros	Project Director	Alcance Hispano
Joan M. Menard	Senator	Massachusetts Senate
Michael J. Rodrigues	Representative	MA House of Representatives
Alan Silvia, Vice Chair	Executive Director	PYCO
Sheryl Turgeon	Executive Director	HealthFirst Family Care Center
Marin Vat	Executive Director	Khmer Family Resource Center
Denise Wright	Clinical Manager	SSTAR

TRAINING PROGRAMS

Our training programs are designed to implement systemic changes in organizations by addressing the unique roles of employees, managers, board members and physicians. For example, a successful process of creating systemic change has to have strong support from senior management and board members. These policy makers need training that focuses on their responsibility to achieve cultural competency as individuals and as organizations. Cultural competency of an organization should be apparent as soon as patients and clients walk in the door, so all employees — administrative and clinical — need training that fits their specific positions. The training should benefit careers of employees as a significant byproduct.

Following is a summary of our past, present and proposed training programs:

1. Cultural competency/interpreter training: 5/2002 - 9/2003

In May 2002, Blue Cross Blue Shield of Massachusetts Foundation (BCBSMAF) awarded Health Access Collaborative a $50,000 grant to expand cultural competency, train administrative and clinical interpreters, and continue developing an ongoing community-wide network. Saint Anne's Hospital and Southcoast Hospitals Group provided $21,000 cash plus in-kind contributions to support goals of the collaborative. Community health centers and CBOs also provided in-kind contributions.

The project was very successful. We far exceeded all the training goals, and we developed and conducted two other substantial projects that emerged during the grant period and were added to the original work effort. We more than doubled the level of training proposed in the grant, which has had a direct and immediate impact on patient care, efficiency in providing services, and for further collaboration. The original plan was to conduct two classes to meet specific needs of bilingual staff who routinely perform advanced and basic interpreting in health care and community-based organizations. We actually conducted five classes. Our plan called for training 40 interpreters: 14 advanced and 26 basic skills. We recruited participants and scheduled 107 training slots, 19 of which had to be canceled by their employers just days before start of class due to severe budget reductions at two community health centers.

Our results are stated primarily in terms of the number of training slots, and secondarily as number of individuals, because slots are a better representation of the opportunities and costs involved in providing training. Some staff will fill slots in two or three classes, which indicates staff graduating from basic to advanced skills and the development of careers. Budget cuts presented severe obstacles for employers to give staff time off from work to attend classes that extend over many weeks, which can also create dissension within departments. In spite of these obstacles, training for 88 slots was completed in the period of November 21, 2002 to October 4, 2003. Of the 88 slots, 29 represented advanced training for persons working as staff or per diem interpreters for hospitals; we had planned for 14 such slots. Of these advanced slots, 14 were filled by persons who previously had been doing interpreting but were new to the skill level required by our hospitals for medical interpreting. Thus the training made a substantial contribution to the pool of available interpreters, to quality care, and to the careers of bilingual persons in our area.

Of the 88 training slots, 57 represented basic training for persons who were routinely pressed into interpreting in their administrative and social/clinical positions, though they had no formal interpreter training. We had planned for 26 basic slots for these positions. These bilingual staff don't interpret in life-threatening situations or critical-care situations, but they provide services that are essential to patients and clients in hospitals, community health centers, and community-based organizations. A common response from most of them was that before the class they hadn't realized how much they didn't know about interpreting, medical terminology, and their own language. They had thought they were doing a good job with the interpreter aspect of their position. Demonstrating to students the need for

serious professional training was an objective of our basic classes, and the sessions were successful in leading staff to an objective appraisal of their actual skill level and getting them to build on their basic foundation. A related finding was that dedicated staff routinely provide important interpreter services without training that they are eager to get once they understand what good interpreting is.

The need for two other courses emerged during the above training and were implemented. Many bilingual staff members were educated solely or mostly in the US and haven't had the advantage of much formal education in their ethnic language. A customized, ten-session class in general Portuguese fluency was conducted from June - September 2003. from 4:45 to 7:15 PM. Given that the class was held during the summer months and in the evening, it attracted ten committed students who wanted to improve their language skills for professional and personal reasons. The class instructor (Connie Gamboa, Interpreter Services Coordinator at Charlton Hospital) was equally committed to advancing skills of Portuguese speakers.

Often bilingual staff want to improve their fluency skills for general conversation, reading, and listening. But they don't have time to work, go home take care of the kids, fix dinner, and rush out to a class. So we arranged classes to be convenient, focus on general fluency, include medical terminology, and provide personal satisfaction with coworkers and other health care workers. The classes were a successful experiment, in which we concluded that such skill development needs to be integrated into staff development in which students are tested and rewarded for their efforts.

The second course that was added dealt exclusively with body systems. It was given to advanced medical interpreters, who met for a total of 12 hours on two consecutive Saturdays.

2. Cultural competency planning: 5/2002 - 4/2003

BCBSMAF awarded a $15,000 planning grant to the Family HealthCare Center at SSTAR and HealthFirst Family Care Center to collaborate on identifying the need to train staff on cultural practices that affect the delivery of health care. Health Access Collaborative was a partner in this planning project and provided staff support on all aspects of the work. Representatives of local hospitals, CBOs, and the Fall River Public Schools had active roles in designing and conducting the needs assessment. The result was the determination that all staff, managers, and board members needed training that was customized to their specific functions in the organization. Based on the outcome of this planning phase, BCBSMAF awarded the implementation grant listed below.

3. Cultural competency training: 5/2004 - 4/2005

BCBSMAF awarded a $35,000 planning grant to SSTAR and HealthFirst to create a systemic and sustained cultural competency program, through which the respective board of directors will require board members and employees to successfully complete initial and ongoing training on patients' cultural practices appropriate to each person's role in (a) achieving broad institutional missions, and (b) in the direct provision of services. Health Access Collaborative is continuing its role as a collaborative partner in the project by providing expanded staff support.

The work of the SSTAR-HealthFirst project is being coordinated with other cultural competency work of the collaborative, and all organizational members of the collaborative are serving important roles. For example, as a kickoff to this project, a cultural competency leadership forum was held on June 16, 2004 in which local health care providers and community-based organizations were represented by senior management, board members, and technical staff. The event was cochaired by the CEOs of the two local hospital organizations, who discussed their policies and specific programs. The president of Blue Cross Blue Shield of Massachusetts Foundation described statewide cultural competency efforts, and concluded that Health Access Collaborative was unique in the level of direct involvement by sen-

ior management of the major organizations that serve persons with limited English. The keynote speaker (Eric Hardt, MD) demonstrated the urgent need and cost efficiency of overcoming communication barriers in health care.

Each speaker supported the need for their organization and the collaborative as a whole to answer the question ‘What should our cultural competency programs (including interpreting) be accomplishing five years from now?’ To address this question, the collaborative will coordinate a process among senior managers and their staffs to document current best practices and describe a range of recommended programs with measurable indicators that organizations can adapt to their unique situations. The purpose of the analysis and documentation is to foster an ongoing dialogue among persons who have the authority and technical expertise to make significant advances in cultural competency throughout our communities.

4. Cultural competency/interpreter training: 2005

Blue Cross Blue Shield of Massachusetts Foundation awarded a $40,000 cultural competency grant expand results of the SSTAR-HealthFirst project by conducting comparable training for our other member organizations that provide health care and social services to persons with limited English. The 2005 work effort is also funded by Saint Anne's Hospital, Southcoast Hospitals Group, and Harvard Pilgrim Health Care Foundation. Emphasis will be placed on programs and policies that result in (a) systemic changes, and (b) builds a network of close, routine working relationships among health care providers and community-based organizations. CBOs will be partners in training and conducting ongoing programs to improve access and quality of services provided to persons with limited English and diverse cultural perspectives regarding health care.

The major components of the BCBSMAF grant are as follows:

A. Policy development among community leader to implement systemic changes
B. Best practices for cultural competency and interpreter services
C. Conduct extensive training programs
    1. Expand medical interpreting for advanced, intermediate, and basic interpreter
    2. Expand cultural competency training for all levels in participating organizations
D. Collaborative planning and implementation of projects
    1. Institutionalize professional medical interpreter services in health centers
    2. Build career ladders among collaborative members

Anticipated Outcomes:

The broad organizational outcome (goal) of the project is to reduce barriers to health care by creating a systemic and sustained cultural competency program, through which the management and boards of the respective organizations will require the following:

- Board members and employees will demonstrate an understanding of cultural practices appropriate to each person's role in (a) achieving broad institutional missions, and (b) in the direct provision of services.
- Priority will be given to recruiting and building a workforce that represents the cultural composition of the populations served.
- Cultural competency training will be part of orientation for new employees, and all employees will be required to successfully complete continuing cultural competency training as part of their annual review.
- Ongoing, active involvement of independent advocates of major ethnic communities will result in positive feedback.
- Analysis of patient satisfaction surveys and focus groups will indicate positive feedback from patients.

- The quantity and quality of advanced and supplemental medical interpreters will be increased in hospitals, health centers, and CBOs.

Prepared by Fred Grose
5/05/05