

The Future of Diversity: A Forecasting Project with Kaiser Permanente

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THE FUTURE OF DIVERSITY

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ABSTRACT

Understanding diversity both at the organizational level as well as in the patient population impact the type of care given, as well as the quality and cost of that care. This project involves a case study of the Future of Diversity project conducted between the Northern California Diversity Department of Kaiser Permanente and the Institute for the Future. This work will help Kaiser Permanente expand the conversation around diversity throughout their organization and better prepare the workforce for the future impact of diversity. I applied an organizational anthropology lens to this project in order to highlight key concepts that IFTF can apply to projects with other clients who would like to explore how increasing diversity will influence their organization in the future.

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THE FUTURE OF DIVERSITY: INTRODUCTION TO THE PROJECT

This paper describes my graduate research with the Institute for the Future (ITF) and Kaiser Permanente (KP). I participated in this project with Jan English-Lueck a professor in the Department of Anthropology at San Jose State University. The project between ITF and KP examined how diversity will change in Northern California over the next ten years and how those changes are likely to affect KP as an organization. This work will help KP expand the conversation around diversity throughout their organization and better prepare the workforce for the future impact of diversity.

The Institute for the Future was established in 1968 by a group of former RAND Corporation researchers with grants from the Arthur Vining Davis Foundation and the Ford Foundation (Johansen 2009). The Institute works with a variety of organizations, to help them make more informed decisions about the future. Forecasting is ITF's specialty. They create detailed graphic thought maps which identify dilemmas that leaders will face in the future. With this forecasting tool organizations can better prepare their leadership and workforce in general to face the dilemmas of the future.

A forecast is defined as a "plausible, internally consistent view of what might happen" (Johansen 2007: 16). A forecast is not a prediction, it does not imply that something will happen and forecasting can be useful even if it does not come true. Forecasting provides traction for potential action. One component of the forecasting process is dilemma flipping, which is the ability to turn dilemmas into advantages and

opportunities. Dilemmas or challenges are different from problems, problems can be solved, dilemmas do not go away (Johansen 2009). Through creating a forecast about the future of diversity we looked at what could happen and then identified the dilemmas within those possibilities. In the KP Project we identified the dilemmas KP will face due to possible changes in diversity. Then we began the process of reframing the dilemmas to create opportunities out of challenges.

Futures work is about foresight. As I said before, foresight is not about solving problems, it is about being prepared to face the challenges of the future (Johansen 2007). That is precisely what this project aimed to do for KP. As a co-investigator with English-Lueck, I learned how the people actually conducting the research, managing the projects, selling the health plans and providing the services think about and apply the concept of diversity¹ in their daily work.

Although the primary project was conducted between IFTF on behalf of KP. I undertook a second project which was between myself and IFTF. My goal was to apply an organizational anthropology lens to this project in order to highlight some best practices for keeping ethnography relevant throughout the lifecycle of a project. This will help IFTF work with other clients who would like to explore how increasing diversity will influence their organization in the future.

The first section of this paper will describe the relationship and work done on the project between KP and IFTF. In this section I will explain the origin of the project, the key stakeholders, the research objectives and the process that we undertook to

create the final deliverable. This deliverable was a thought map about the future of diversity related to health and healthcare and KP's specific organizational strategic imperatives. KP will be able to use this map to expand their conversation about diversity throughout the leadership in their organization.

The second section of this paper will explore the concept of identity as it relates to diversity in a healthcare organization. In this section, I will show how the concept of identity affects the way that KP conducts research, how they allocate resources and dictate where clinics are located. Identity is a complex concept that requires attention in both the workforce and member populations of KP.

The third section of this paper will examine how understanding community affects both the KP workforce as well as accessibility and quality of services available to their members. The communities of practice within KP, for example, research, clinicians, and managers, each understands how diversity affects their work differently. Part of this understanding is having clarity about how the people they serve define the communities in which they live. Geography, language, and immigration are some of the forces that create communities of people. In order for KP to meet the needs of their members they first must understand who they are and how identities dictate their special needs, be they language assistance or access to specialized care.

Lastly, I will identify ways IFTF could apply their process with KP to other clients who are interested in understanding how diversity will affect their organization in the future. IFTF is an organization that works with clients of all kinds and diversity is

a concept that is increasingly important to all organizations. The ethnographic work done in this project will help IFTF create a conscious understanding of the process of working with other clients on the concept of diversity.

Central to this work is finding a way to explore the importance and complexity of a diverse population while always keeping business goals in mind. During the project we successfully connected the importance of diversity to the strategic imperatives of KP across all functional areas of the organization, thus enabling KP to expand the conversation beyond the department of diversity. In this way, KP can create a more cohesive strategy throughout the entire organization in order to address the diverse needs of their member population as well as their workforce.

WHO WAS INVOLVED AND WHAT DID WE DO?

In this project IFTF looked specifically at how diversity could change in the next ten years in Northern California as a region and how those trends would affect KP both in their workforce as well as how they serve their members. The work focused on KP's use of the concept of diversity throughout the different communities of practice within their organization. The project involved gathering input from brainstorming sessions, creating a signals database, conducting a series of semi-structured interviews and the generation of a graphic thought map for KP. Each of these components will be discussed later.

The main stakeholder in this project was the Northern California Department of Diversity of KP. The regional executive director of this department is Katherine

Haynes-Sanstad and she was the driving force behind the project. The Health Horizons program is one of three membership programs offered by IFTF. Health Horizons focuses on understanding the global health economy, user behavior, health and medical technologies, health care delivery system, and societal forces to identify and evaluate emerging trends, discontinuities, and innovations in the next three to ten years (Institute for the Future 2011). As a member of the Health Horizons program, Katherine Haynes-Sanstad was provided a copy of the Health Care 2020 (HC2020) map that was published by IFTF in 2009. This is a matrix map laying out the challenges and responses in healthcare over the next ten years. The HC2020 map was an IFTF driven map, not a client project and was presented to members of the Health Horizons Program one year before it was made available to the public. This map inspired Haynes-Sanstad to approach the Health Horizons team at IFTF about doing a KP specific map based on the HC2020 layout. The goal of the KP map would be to examine possible future scenarios for how the Northern California population will change in the next decade and how those changes will affect KP.

Jan English-Lueck, a professor of applied anthropology at San Jose State University with expertise in the concept of deep diversity, was contracted by IFTF to work on this project. As a masters student in the applied anthropology program at San Jose State University I was able to participate in this project as well. In July 2010 I accompanied Jan English-Lueck to a meeting at the IFTF offices in Palo Alto, in attendance was Katherine Haynes-Sanstad, as well as Miriam Avery, the project

manager; Rod Falcon, the Health Horizons program manager; and Brad Kreit, a Health Horizon's researcher. In this meeting Katherine Haynes-Sanstad explained that her goal for the project and the final map was to help the leadership at KP look at and understand diversity as it relates to the organization's larger strategic imperatives. She talked about the current opportunity for diversity to become part of a broader conversation within KP, its strategic imperatives and functional areas.

Miriam Avery began with a brainstorming session between members of the Health Horizon team and members of the department of diversity at KP. In this initial meeting two possible approaches for developing the map were discussed. The first approach was to begin from scratch and the second was to use the HC2020 map as a base and create an overlay specifically about KP. In January 2010 Avery organized the ideas from the initial brainstorming session and presented them to the Health Horizons team. At this point the team began to put together an extensive literature review to get the project started.

As with any project of this size, budgets are always a fact of life. A substantial part of the next phase entailed creating a budget that would allow the project to move forward. By April 2010 the budget was in place, Avery and Haynes-Sanstad met to discuss the literature review and next steps for the project. Ultimately it was decided that an overlay of the HC2020 map would make more sense than starting from scratch, as the HC2020 challenges seemed to be a good avenue to make diversity relevant for

KP. With the format and budget in place, we were ready to begin the process of creating the map.

My involvement with this project began in May 2010 when I met with English-Lueck to discuss the project. My first task was simply to become familiar with the Institute for the Future website as well as the website for the Future of Diversity project (Institute for the Future 2011). I also read the Healthcare 2020 literature which was the foundation of the KP project, and attended the annual Health Horizons conference put on by IFTF and the Health Horizons team. This conference gave me an orientation to the work of IFTF and forecasting in general, for these reasons it was extremely helpful to be able to attend.

One of my central tasks in this project was to work with English-Lueck to conduct a series of semi-structured interviews with several members of KP's workforce as well as to work on both the transcription and analysis of the interview data. We conducted 12 interviews over three months. We wanted to understand how KP employees related to the future impact of diversity for KP's Northern California region specifically as well as Northern California as a place in general. However, English-Lueck and I also participated in the larger IFTF forecasting process (explained below) which including signaling, an expert workshop and several brainstorming sessions, which contributed to the information layout design of the final product.

What Is Signaling?

Signaling is one of the first things done in any forecasting project. Signaling for this project was an exploration of how diversity, society, health and healthcare intersect. A signal is a data point that illustrates a potentially culturally disruptive process. We used current literature, media sources as well as ethnographic data to identify forces that will impact the way healthcare organizations approach diversity. Each researcher added their signals to a database on the project website so that everyone working on the project could be involved and comment. Avery set out guidelines to help our individual signaling process so that the signals we added to the database remained relevant to the larger project. We were to look at stories, data, trends, and ask “what's happening?” She asked that we look at what kind of diversity is emerging, and what forces are driving it. We were told to explore how these changes will impact health over the next decade, particularly in Northern California and how they will affect healthcare, particularly KP functions.

Interacting with the signals database was extremely easy and very helpful for me as a first time signaler. In addition to the guidelines for signaling, Avery provided us with tags which were directly related to KP’s strategic imperatives. We applied these tags to our signals as we created them. For example, one signal titled “Doctors, Hospitals Clash Over Faith” reads:

“Nearly 1 in 10 primary care physicians has experienced a conflict over patient care policies with a hospital or practice affiliated with a religion, researchers from the University of Chicago reported online in the Journal of General Internal Medicine. Such entities hold about one-fifth of all U.S. hospital beds,

according to the report. About 43% of primary care physicians have practiced in religion-affiliated hospitals, and about 19% of them experienced conflicts stemming from policies that, for instance, prohibit certain reproductive and end-of-life treatments, the researchers' cross-sectional survey found.”

This signal was given the following tags: conflict, enabling performance through people, end-of-life, policy and regulation, reinventing medical practice, reproductive treatments, workforce planning and politics.

This process allowed each researcher to search the signals database efficiently and make direct connections to the relationship of the data to the larger project. As a virtual brainstorming process it was very efficient. Contributors did not have to be in the same place at the same time, each person could add content as their schedule permitted and for this reason the signals database grew rapidly. The guidelines provided by Avery helped ensure all the researchers were signaling and applying tags similarly.

The evolution of the signals database influenced the signals I created. For example, my first signal was about the role of trust in healthcare, a screen shot of what this signal looks like on the project website can be seen in Appendix A. This signal is about the patients’ potential experience in a clinical setting. As time went on I began to see examples of how diverse signals could be and I looked at other trends, outside of the clinical experience, as potential forces for changing diversity.

In a later signal I wrote about employer sponsored healthcare and the startup culture of the Bay Area. It was based on personal experience of setting up a health plan for a startup company in San Francisco. The owners of this business are two healthy young men, 37 and 26 years old. When asked what type of coverage they desired, they

both agreed that a Health Maintenance Organization (HMO) was out of the question. They preferred a Preferred Provider Organization (PPO) because they believed it gave them more flexibility. This experience led me to ask questions about their definition flexibility and how their definition would align with KP's services. A 2009 report from the Kaufmann Foundation showed that most job creation was coming from new small businesses and startups (Stangler and Litan 2009).

From my personal experience and the Kaufman Foundation report I was able to create a signal about the healthcare needs of the small business and startup business community. The relationship between new kinds of business owners and their need to purchase healthcare plans for their employees will affect to whom KP markets their health plan in the future. The signaling process was helpful in preparing for the expert workshop which was phase two of this project. The early brainstorm sessions as well as the signaling process are all very important to the expert workshop. These events prepare the research team to help situate the experts with the concept of forecasting and foresight.

What Did The Experts Say?

Expert workshops are used as a form of expert opinion aggregation. These workshops often include a group of 12 to 25 participants who are thought to be experts at understanding a possible future in a particular area (Johansen 2007). The expert workshop took place at the Institute for the Future one day in early August 2010. The expert panel was made up of academics, graduate students, researchers, human resource

professionals, scientists, and clinicians. The participants ranged in age, ethnicity, gender, and profession.

After a brief introduction from Avery, Haynes-Sanstad spoke to the group about how KP currently approaches issues around diversity and emphasized the importance of leadership support in this discussion. “Cultural agility” was the key concept Haynes-Sanstad introduced to the members of this workshop. Cultural agility means suspending assumptions in order to meet the needs of the individual in front of you. However, cultural agility does not only apply to individuals, organizations themselves must also be culturally agile. The organization must build cultural agility into its systems in order to enable the individuals within to also be culturally agile.

From this orientation we moved into the first activity which was a “sticky exercise” (see Appendix B). This is a brainstorming exercise that the facilitators of the workshop used to generate ideas within the group about the future forces of diversity in California related to health and healthcare. We were all given a pad of giant sticky notes and a marker, then we were asked to write down our ideas and observations about the forces that will shape diversity in California over the next ten years. After several minutes of jotting down our ideas, we presented them to the group and our sticky notes were placed on the wall by the moderators.

The orderly presentation of each person’s idea soon became a larger, less orderly, but very fruitful discussion about the issues being raised. People wrote additional stickies as the conversation continued and before we knew it the entire wall

was covered. The passion and interest in the topic from the workshop participants was in full force by the end of this exercise. This exercise was a very effective way to get people thinking and talking about the future forces.

The rectangular sticky notes are the individual workshop participant ideas. The moderators clustered related forecasts and added a hexagon shaped sticky note at the center of each cluster. The final product of the sticky note exercise can be seen in Appendix B. The following categories emerged and became an important part of the interview analysis and map layout.

- (1) infrastructural declines
- (2) backlash (politics and new tensions)
- (3) global flows
- (4) painful legacies
- (5) navigating cost barriers
- (6) new forms of identity
- (7) empowerment of people and networks
- (8) environmental justice
- (9) workforce tensions
- (10) blended realities

The next session of the expert workshop was an introduction and explanation of the HC2020 map and its relationship to the future of diversity project. I mentioned before that the HC2020 map is an IFTF generated map that is often the basis for client

work. In the overview of this map the IFTF team discussed how people in specific domains will respond to the identified challenges. This is slightly different from the goal of this workshop where we were specifically looking at forces shaping diversity in Northern California and how they will impact the strategic imperatives of KP. The afternoon discussions focused on questions about how these forces intersect with the challenge areas from the HC2020 map.

After the expert workshop, there were two follow up meetings with the IFTF participants, English-Lueck and myself. The results of the sticky note clustering exercise were used to help recall the discussions from the day of the workshop. With this data we were more easily able to transfer the big ideas from the workshop into the draft layouts of the map. Through signaling and the expert workshop we gathered an enormous amount of ideas and data points to begin the construction of the map. The interviews were the next big component of the data gathering phase.

How Do KP Employees Use Diversity In Their Work?

A key component to this project was understanding how each stakeholder group viewed diversity in relation to their work within KP. Although KP, and specifically the department of diversity, was the largest stakeholder, there were several smaller stakeholder groups within KP that were important to consider. These groups included KP employees in the areas of research, clinical care, community benefits, health plan sales, healthcare reform, MediCal (California's Medicaid program) as well as members of the leadership on both the regional and national level. Therefore, the interview

process began by creating a list of key internal stakeholders with the help of Haynes-Sanstad.²

We began emailing the people on this list to ask for their participation in the project and many people responded immediately, excited to be part of this research. Others were unable or unwilling to participate but referred us to others within KP whom they thought would be helpful in our research. This snowball sampling strategy was very effective; we were able to secure 12 interviews with a diverse group of people over three months. Our timeline was tight and the scheduling logistics were somewhat difficult. We were located in the South Bay Area and our interviewees were located throughout the greater Bay Area so all but one interview was conducted over the phone. Often interviews were conducted as conference calls, never ideal, but in this case removing the geography barrier allowed us to move forward with the interview process in a very timely manner.

Initially, phone interviews seemed to relieve some stress about getting a geographically diverse sample. Unfortunately, this turned out not to be the case for us. Although the research refers to all of Northern California we had a disproportionate number of interviews from the Bay Area. We realized this problem in the middle of our interview process but were unable to secure interviews with any of the people on the list who worked outside of the greater Bay Area in the necessary time frame. To expand on this work it would be helpful to gather information about the workforce as well as membership populations in some of the more rural parts of Northern California.

We also had one specific sampling bias in that we did not interview any Latino members within KP's work force. This was troublesome considering that immigration, specifically Latino immigrants, and the majority-minority shift in California demographic trends came up in nearly every interview and at every analysis meeting. This could have been avoided had we checked specifically for ethnicity in our sampling process earlier in the project. Fortunately, we did have a Latino perspective in the research process both at the expert workshop and within the IFTF research team.

The interview protocol (Appendix C) was relatively straight forward, it included questions about each interviewee as an individual as well as the work they each did at KP. The interview questions worked very well for the most part, however we did run into some difficulty with the wording of one question in particular. Our first interviewee disclosed her race and ethnicity and the connection she made between her own identity and the work she was doing in diversity research. It was through her voluntary disclosure of this information that we realized we needed to get all of the interviewees to identify their personal connection to diversity as a concept and the diversity conversation at KP.

The question we asked was "How do you, yourself, identify with the concept of diversity?" Some people came right out and identified race, gender, ethnicity, age and spoke about how these factors influenced their work at KP. In fact, one interviewee identified as a Caucasian female and followed by saying she doesn't feel that she "has any diversity" in herself but she can help the conversation by being present and

engaging in the larger dialogue of why diversity issues are important. Understanding each individual's connection to diversity allowed us to have more in depth conversations about how each person used their personal connection to diversity in their work at KP.

What Were The Final Stages?

The final stages of this project entailed several brainstorming sessions with IFTF researchers, English-Lueck and myself. IFTF researchers from the Tech Horizons team joined the project in the final stages, their familiarity with the map creation process was key because these meetings focused on information architecture and layout.

As in the expert workshop, we utilized the sticky note exercise to generate ideas about map layout and sort through the signals in the database to create clusters of information that needed to be represented on the map. Information visualization is one, if not the most important, component of a thought map. The sticky notes allowed us to have tangible engagement with the data. We were all familiar with the signals database, however, English-Lueck and I were able to provide more detailed information about the interview data during the layout meetings for those who were not part of the interview phase of the research. This facilitated clustering and narrowing signals toward a final version of the map. As Avery explained to me in a conversation after the project, “we use layout as a sort of proxy for scoping. You know what you intend to present dictates

what you consider in scope, sometimes it can feel sort of cart before the horse and this map felt like that.”

Once we had a basic layout Avery created an excel spreadsheet as a mock draft of the map so we could play with the language. The map was two sided, the forces shaping diversity against the challenges facing health and health care on one side and the strategic implications for KP on the other. One meeting focused on word-smithing some of the language on the front side of the map. The word-smithing exercise was intended to transform the language we had in the draft versions of the map into clearer statements about the signal. The trick was to be concise, articulate and non-repetitive, a much harder task than I anticipated. For example, in one instance we started with “increasing demand for (and complexity of) language-specific services” and through the word-smithing exercise it became “personalized language specific care vs. generalized translation services (i.e. central call center set-up).” On the final draft of the map there is simply a graph showing the percentage of language other than English used at home and states that “primary care is the front line of cultural agility.”

The next phase subjected the updated language to a series of dot voting. Dot voting is a method for narrowing down the information on the draft. Avery began creating drafts of the map in excel spreadsheets so that we could see the layout of information in the challenge response format. Through dot voting we narrowed down the data so that the map included the most important and relevant pieces of information for the space allotted. This process was much faster than word-smithing, however still

difficult at times because all of the content was important and relevant in one way or another. With our editing and dot voting complete Avery took the draft for another round of editing with Haynes-Sanstad as well as some other members of the Health Horizons team.

Within IFTF there were different kinds of participation on this project. Some people, Avery and Brad Kreit for example, created content in the earlier stages, while others were essential to the editing process. Vivian Distler, an IFTF researcher, joined us towards the end of the project for editing. Both Vivian Distler and Rod Falcon went back through the draft and did their own round of dot voting as an additional check, they then made further changes. Avery explained that Haynes-Sanstad was heavily involved in the editing process as well, more so than in previous client work for IFTF, this involvement was immensely helpful in the content quality of the final product.

The final deliverable for this project was a thought map about the future impact of diversity in Northern California for KP. The thought map is a visual tool designed to tell stories about possible futures for diversity and health. KP will use this map to expand the conversation about diversity throughout their organization. Originally the map was to be used at the regional level, however members of the National Strategy department for KP heard about the project and became interested in the possibilities. So while we worked, the focus of the project shifted to the national level and because of this development we needed an additional phase of input from the national leadership of KP. Due to this change in audience we were slightly behind schedule. However, the

input and interest from national strategy was an exceptional compliment to the project and potential impact of this work. The map construction process was complex and intense at times but the output was an incredibly thought provoking tool that will be undeniably useful on many different levels in an organization like KP.

The ethnographic data collected throughout the project highlighted the complexity of new identities and communities as forces that will have a significant impact on health and healthcare in the next ten years. As anthropologists, our main goal was to keep the ethnographic data visible throughout IFTF's forecasting process so that the data would be accurately reflected in the final thought map. From participation in this project I was able to create both an outline of IFTF's process (Appendix D) as well as identify some best practices for maintaining the integrity of the data for "bottom up forecasting." This paper and its appendices will enable IFTF to identify and incorporate ways to maintain the integrity of the ethnographic data throughout the forecasting process in future client work.

HOW IS IDENTITY CONNECTED TO CARE DELIVERY?

Identity can be defined as the similarities and differences between individuals and others (Whyte 2009). Identity is not only how people conceptualize themselves in society but also how society views the individual.³ This is important in the context of healthcare because patients may only have a very narrow opportunity to identify themselves, usually by traditional identity categories like gender, age, race, ethnicity. From this, primary care physicians apply a more general label for each patient. For

example, nationality, immigrant status, language and religion can all shape how someone who might be labeled “Latino” or “Asian” would actually self-identify.

Furthermore, identity can change depending on where, who and what a person is doing at any particular moment in time. Someone might identify differently in a healthcare setting than in a social, professional or educational setting.

Anthropologists understand identity through interactions; how someone acts out an identity rather than just how they describe their identity (English-Lueck 2002). Since patient-centered care is at the heart of KP’s 2004 Thrive Campaign, launched to promote their commitment to total health, preventative care and an integrative care system, KP must be prepared to understand and serve more complex identities as the Northern California population becomes more diverse. This means looking beyond the traditional diversity categories of gender, race, ethnicity and socio-economic status (SES).

The Thrive Campaign is evidence of the transition in healthcare from a “disease centered model of care” to a “patient centered model of care” focusing on the patients’ needs and wants (Stanton 2002). Cheryl, who works in language access, talked about the challenge of creating a “patient-centered care message” in her interview when she said “there is probably a level of PR fear there as well. This is an organization that really believes that it treats all of its members the same and to uncover something that indicates that maybe we don't is frightening.” Although frightening from a public

relations perspective, health care organizations will only be able to offer quality patient-centered care when they understand the fluid nature of identity.

Do Traditional Demographic Categories Fall Short?

Individual identity, especially race and ethnicity have been closely linked with health beliefs, care practices, and care preferences (Whyte 2009). Although race and ethnicity are not new identity categories, particularly in health research, they are rarely problematized and so they are hard to pull apart. Judith, a clinician who works in the Chinese module at the KP clinic in San Francisco explained that language modules, which consolidate bilingual physicians and staff into a specialized care module, are high quality, cost effective, efficient and result in improved compliance. She thinks this model should exist in different areas for different groups, saying “if there is a Vietnamese community put a Vietnamese module in that area.” However, she expressed concern about “...the multi-cultural group, people whose parents are from different ethnic backgrounds. We need to make them understand that we appreciate that they are from different cultures and they need to understand their risk in terms of health from all parts of their heritage.”

The mixed race category is becoming increasingly important in our society and matters a great deal in both research and care delivery. Language modules are one response to providing culturally appropriate care for a diverse member population. However, language specific modules are problematic in the context of mixed-race or multiethnic identities. Just because someone lives in a predominantly Vietnamese area

does not mean that they necessarily identify as 100% Vietnamese or want to receive their healthcare in Vietnamese. KP will need to problematize identity categories in order to gather accurate data and increase effectiveness and quality of care.

The increase of mixed-race and multicultural identities is highly evident in the census report. In 1977 the Office of Management and Budget (OMB) issued Statistical Policy Directive Number 15, "Race and Ethnic Standards for Federal Statistics and Administrative Reporting." The four categories were: American Indian or Alaskan Native, Asian or Pacific Islander, Black, and White. Hispanic origin and not of Hispanic origin were also added as additional ethnic groups. By the 2000 census people were able to identify with more than one group for their racial identity. There were 15 check box response categories and three write-in areas. Only about two percent of Americans identified with more than one race in the 2000 Census, but the percentage was much higher for children and young adults and was predicted to increase in 2010 (U.S. Census Bureau 2010). This cultural shift in thinking about race as a less fixed identity category began in 2000 and was intensified in the 2010 census which shows a 32% increase in people who identified as two or more races. The data suggests that the mixed-race or mixed-ethnicity category is growing rapidly and should be addressed in health research (U.S. Census Bureau 2011).

Research shows that the age group that identifies most often as mixed-race in California is people under 29 (Lopez 2001). This data suggests that the mixed-race category will continue to grow in the future and is an important consideration for KP as

they develop strategies to grow their membership among young people. This point was echoed in an interview with Carrie who works in Community Benefits. When asked how Northern California might change over the next ten years. She said “there is going to be a increasing number of multi-cultural children over the next ten years. Those who are children now will be adults in ten years and making their own healthcare decisions. So far questions about how to meet the needs of the multi-cultural or mixed-race population have not been asked.”

The research community must develop a method for identifying and including these new populations in the research. We heard this in an interview with Amy, a research scientist, she also spoke about mixed-race and multi-cultural people as she explained,

“..we don’t understand very well how they identify themselves and why. We also don’t understand very well how to study them as a population because they don’t fit into a box. We also don’t know a lot about what’s going on with them in terms of health care and outcomes because often they are actually removed from analyses because we can’t put them in a box. And that’s increasing, the proportion of people who are of mixed race and report themselves as being, I mean obviously there is a lot of intermixing already within the US, but to the extent that people are of mixed race and report themselves as such, that is an area of research that is not well studied in terms of what that means for people’s risks for disease, for how they view themselves, how they view the health care system, how they interact with the health care system...”

Definition and valid measurement are among the most significant problems surrounding race or ethnicity in health research because neither of these categories are

well defined, in fact the two terms are often used synonymously (Bhopal and Donaldson 1998, and Gravlee and Sweet 2008).

In 1997 The International Committee on Medical Journal Editors published its first statement on language for research on race and ethnicity saying “the definition and relevance of race and ethnicity are ambiguous. Authors should be particularly careful about using these categories” (Bhopal and Donaldson 1998). Race and ethnicity can be valuable categories providing important genetic, sociocultural or behavioral components of individual health. In fact, a compelling argument in public health for research based in race and ethnicity is that it provides information about causal factors of disease and can shed light on environmental versus genetic factors (Gravlee and Sweet 2008). However, race as a category is laden with bio-confusion as it is used in health research and health practice, as well as the population at large. The use of race and ethnicity in health research often conflates environmental and genetic factors. Clearer definitions and protocol for measuring race and ethnicity categories will lead to more valuable information about health access, outcomes and care preferences. We need new methods of categorizing and counting so that health research can accommodate the complexities of race and ethnic identities.

Who Are The New Identity Groups And How Do We Reach Them?

Groups and communities can form identities around biology. For example, activist groups around AIDS include people with the disease, people who knew or know people with the disease and people who associated themselves as at risk for

getting the disease. This creation of a shared identity associated with AIDS is an example of a biosocial community (Rose 2007). The availability of information and social networking with services like 23andme and information resources such as WebMD, could lead to the formation of more biosocial communities. KP already has a robust web presence among its members through KP.org which provides an opportunity to play a large role in connecting people in biosocial communities. Currently KP provides opportunities for people to gather for education and support around various diagnosis, but not everyone wants or is able to access such support groups.

A cancer diagnosis can impact a person's physical well being as well as their social and emotional well being. The National Cancer Institute estimates that in 2006 there were approximately 11.4 million people who have had or now have cancer living in the United States and estimate as many as 1,529,560 new cancer cases in 2010 (American Cancer Society 2010). People must adjust to *being a cancer patient* or *being a cancer survivor*. Support groups have traditionally been the vehicle for finding a new self identity after a life changing diagnosis like cancer. However, sometimes there are racial and socio economic barriers to accessing these support groups. For example, often breast cancer support groups offered by hospitals are made up of middle and upper class white women (Mathews 2000) which can make women who don't fit this profile feel excluded.

Creating virtual support groups that bring women together from different places will allow them to share their experiences, the meaning they have found and the coping

mechanisms they have developed. This creates a shared model of the breast cancer experience, a model separate from the one given by the biomedical community (Mathews 2000). With more people using the internet to gather information about their health and the web presence and services KP already provides members, there is an opportunity to extend services further into the virtual realm by creating virtual support groups for a more diverse population with a more diverse set of needs.

Virtual support can be helpful for a variety of chronic conditions which can be highly disruptive and often invisible. For example, conditions such as Multiple Chemical Sensitivity (MCS) can put an enormous amount of responsibility on the individual to manage their condition (English-Lueck 2010). People who suffer from such conditions could benefit from a healthcare provider who supports them outside of a clinical appointment. Virtual support is one way providers can engage with patients between appointments regardless of location. Not only could patients check in with their care provider, they could also create a network of support by connecting with others suffering from the same condition.

Gay Becker's book *Disrupted Lives* explores how people use narratives to make sense of medical disruptions and understand meaning and identity in their new situation. Her interview with a woman named Michelle is a wonderful example of an unrecognized biosocial identity. Michelle sought invasive medical treatment for her infertility and although she was finally able to get pregnant, the pregnancy was difficult as were labor and delivery. Here is what Michelle said:

“I went to a parenting group but nobody had a story like mine. They don’t have groups for women who have gone through high risk infertility pregnancies. These women didn’t relate to me and I didn’t relate to them. They acted like pregnancy was a piece of cake and meanwhile here I was planning to go through it again” (Becker 1997: 85).

Michelle’s story is not uncommon especially as trends show that more women are having children later. This fact alone places these women in a high risk category.

Medical technology both in treatment and in diagnostics have led to the medicalization of new conditions and this trend will likely continue. Infertility is an example of this. According to the Center for Disease Control 11.9% of women between the ages of 15 and 44 received infertility services in 2002 (Center for Disease Control 2002). Becker shows how infertility disrupts a person’s life both physically and emotionally. Michelle identified as a person with high risk infertility and looked for support related to that identity (Becker 1997).

Procedures like infertility treatment can create the need for ongoing support similar to the needs of patients with a chronic or terminal diagnosis. Creating online or virtual support groups and education forums provides an opportunity for members to participate actively or silently in these groups. Creating opportunities for members to connect based on self-identification helps form communities that provide extra support outside of the clinical setting.

Does Identity Influence Care Delivery And Allocation of Resources?

Since KP is a highly evidence based organization understanding identity categories and conducting relevant research is a crucial prerequisite for developing care

delivery strategies. In an interview with a clinician named Deborah, she explained that “so much research is done on white men so cardiac prevention programs are often based on white men. But, for example, women respond differently to aspirin so treatments need to be different. People respond and test differently.”

Collecting information outside of the more traditional identity categories could uncover gaps in access to care, quality of care and overall health outcomes. Data about emerging identities will affect how KP allocates resources as well as how they structure care delivery and clinic locations. Mixed-race, obesity, and lesbian, gay, bisexual, transgender (LGBT) identity groups were mentioned by interviewees across all professional categories as significant emerging identities for the future of Northern California. In one interview Deborah, a clinician, explained that further that,

“the biggest group that doesn't come in is the high BMI group when you get the BMIs of 40 or 45 that population doesn't want to come in, so I'm not sure, that is sort of a type of diversity, the very obese, and their feelings about the care they receive and the attitudes of the providers affect their willingness to come in for the care that they need. So we have some pilots that we're trying right now to see if we can provide a safe protected way to treat this population where they don't get weighed and nobody comments on their weight and we just are addressing their cancer issues. And they have large size gowns so we're trying to learn how to reach those most at risk based on their population type.”

Studying complex new identities in health research will enable KP to uncover areas where patients are not currently receiving optimal care and how people are interacting or in some cases, not interacting, with the healthcare system.

The National Task Force on the Prevention and Treatment of Obesity found that obese patients receive fewer preventative screening procedures when they visit their physician. Deborah's example is further evidence that obese patients may avoid preventative care out of fear of discrimination or judgement. Since obese patients are likely to have more health issues than non-obese patients, a physician could feel there is not enough time to address all issues in a single appointment. With clinical appointments averaging around 18 minutes it is possible that patients with more complex cases feel they are not getting the care they need or the care they desire (Commonwealth Fund 2006). Regardless of the reason, if patients are not receiving the care they want, a reasonable response is to avoid the clinical setting.

Patient preference and perception of care is an important factor in this conversation. One research scientist talked about provider matching as a way that KP is embracing diversity in their care delivery practices. KP is "trying to let people match up with the kind of clinicians that they want and showing them pictures so that they can, if they want somebody if its an African American, if they'd prefer to be with an African American physician, they try to arrange that." How would this solution work for the emerging identity groups? What does an obese member look for in a care provider? What would a LGBT member look for in a provider matching scenario? Cheryl spoke about the problems with provider matching in her interview,

"I think that there is also this notion that we need to staff up, if the Latino population is going to go up then we need more Latino doctors, I think there are a lot of assumptions there that that's going to work first of all in terms of a culture match, because that's not always going to

happen. People are in different places, different generations, different immigration time frames and so there is a big assumption there, but I think also its more about just preparing everyone to be equally, Katherine Haynes-Sanstad has the phrase of cultural agility, that everyone needs to be equally prepared and culturally agile to serve the members regardless of what race/ethnicity they are in relation to that member.”

Cultural agility is a concept that is useful in addressing the fluid nature of identity.

Every clinician should be equally prepared to work with all patients. Additionally, the organization as a whole needs to be agile enough to include complex identities.

Wayne, who works in community benefits, talked about the importance of the diversity of people’s experiences around care delivery and allocation of resources. To meet member needs, KP must understand the experiences that go beyond traditional diversity categories. Diversity of experience includes past medical experience which can shape how and when a patient seeks care as well as life style identities which include anything from recreation (cyclist, walker, runner, foodie, gamer, etc...) to place (city person, suburban, country, mountain) to occupation (techie, farmer, teacher), among other things.

Lifestyles that embrace technology and information have different needs.

According to the Pew Research Center, Generation X, people age 33-44, are most likely to bank, shop and look for health information online (Pew Internet and American Life Project 2009). Genetic testing has created a place where people can get a medical diagnosis or pre-diagnosis which can alter their perception of self. The company 23 and Me offers genetic screening for \$199.00 which allows anyone who can afford it to be

tested for up to 97 diseases with one swab of the cheek. The 23 and Me website promotes the ability to “make better life choices, engage in more rigorous surveillance practices and prepare for serious illness” (23andMe 2011).

With strong notions of individual responsibility in the American health care system, services like 23 and Me allow an individual to get information about their own biology, which may lead to feelings of genetic responsibility (Rose 2007). The diagnostic technology, like genetic testing, can create identities for people not only of disease but also of the possibility of disease. This information could change decisions they make in their everyday life as well as the social expectations of the decisions they will need to make in the future (Whyte 2009). Identity influences the kind of healthcare people want and need.

HOW DOES COMMUNITY CORRELATE WITH HEALTH STATUS?

Community is a very general term that can be applied to almost any group of people. Communities are formed around neighborhoods with neighborhood associations, playgrounds and community centers. Communities also exist around athletics, for example there is a community of Giants fans in San Francisco, very different from the community of A’s fans in Oakland. There can also be community around education, each school is a community involving parents, students, teachers, administrators and support staff. Community can also form around religion, language and politics. Health is another category that can build community. An anthropological

perspective in this project can tease apart the different meanings of community in both KP's workforce and their membership.

Just as KP members belong to several kinds of communities, KP employees must also negotiate different communities at work. For example, the research community is different from the clinical community within KP. Each community, or silo as many of our interviewees referred to them, has different ideas about how and why the concept of diversity matters at work. Understanding the different kinds of communities, both member and workforce, brings clarity to the diversity conversation.

Ethnographic research is a highly effective method for understanding different communities. The interviews we conducted in this project provided insight into the various communities within KP's workforce and allowed us, as researchers, to gain an understanding of the different perspectives on diversity and how it is applied. Amy, a research scientist talked about the importance of increasing the lines of communication across the different silos so each department is more aware of what KP is doing. This awareness can facilitate the effort to identify common goals across the larger organization.

Figure 1 illustrates the complexity of the concept of community. This figure attempts to rank the hierarchy of importance of different forms of community for different sectors of KP as an organization. For example, demographic communities (like census categories) might matter more in research because it can be more easily counted. However professional communities may be more important for the health plan

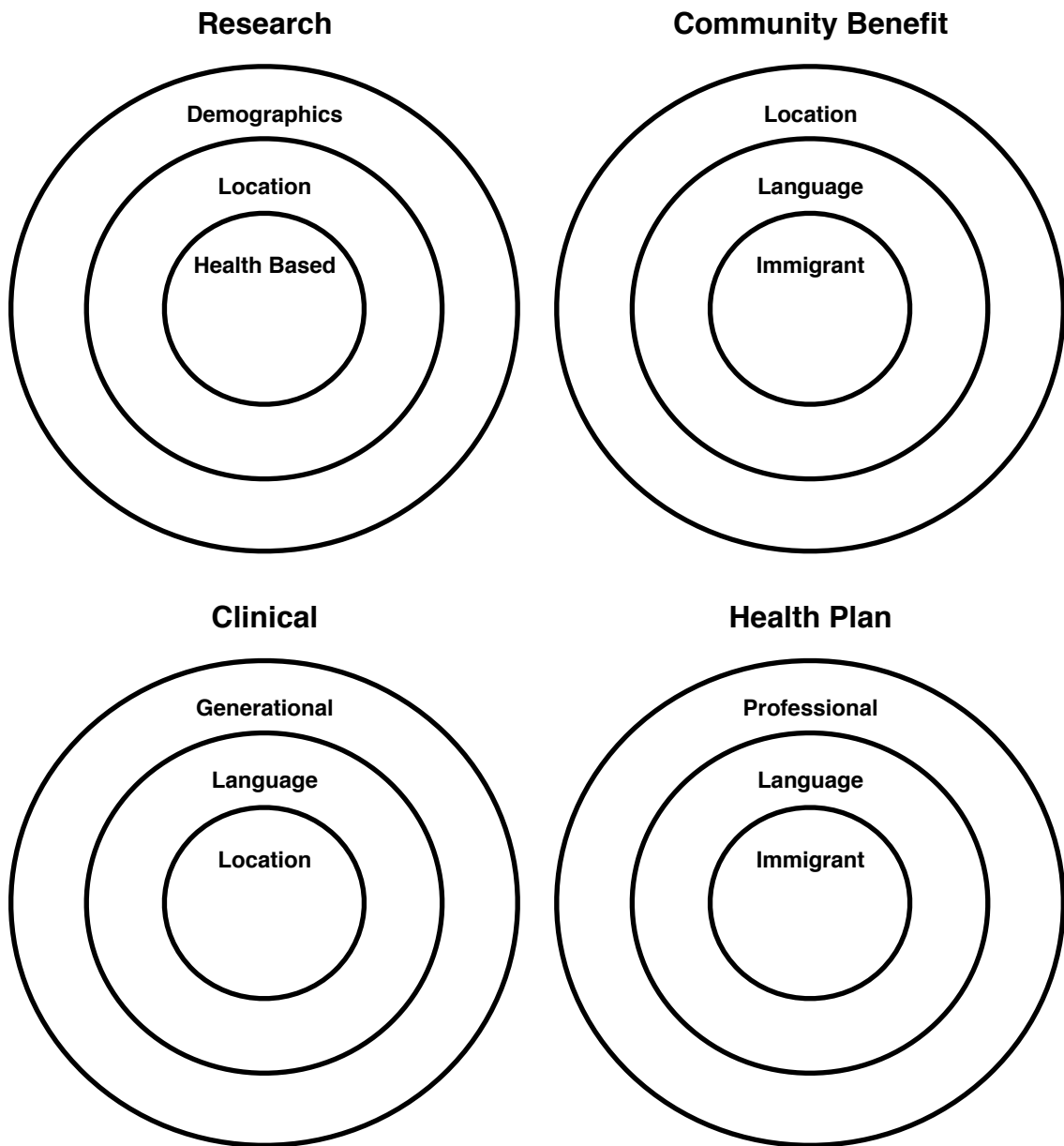


Figure 1: Alternative Concepts of Community From Different Organizational Perspectives.

group because they are likely selling KP health plans to employers. This figure highlights how different communities of practice within KP think about the concept of community differently based on the mandates of their particular position.

In this section I will focus on the differences between urban, rural and virtual forms of community through an exploration of place, immigrant groups, and language communities. Additionally, I will look at how the different communities of practice within KP approach the challenges of reaching these different member populations. Teasing apart both workforce and member concepts of community will enable KP to provide efficient, relevant patient centered care to all members.

How Do Place And Access To Services Intersect?

Place plays a significant role in the services KP provides because regional divisions are at the core of their organizational structure. Keep in mind that for this project we were focused on the Northern California region of KP, other regions of the organization have very different experiences. In addition, each region has its own internal regional differences. The differences throughout the Northern California region became apparent in our interviews. The urban communities of the Bay Area and the rural communities farther north had different needs and problems particularly in the areas of access to resources and use of technology to get information.

Access to information and the resources necessary to act on that information can vary between different place based communities. Without reasonable access to resources patients cannot make recommended changes. Clinicians must look at all of

the factors impacting a patient's ability to understand and comply with treatment plans. For example, poorer neighborhoods often have higher associations with poorer health. These neighborhoods can have structural barriers to healthy eating such as fewer retail options, fewer food shopping choices, and less income that limit the opportunity for individual behavioral change. For the poor, it is more economical and accessible to eat low nutrient, high density food on a tight budget (Moffat 2010). Additionally, a poorer neighborhood has a lower tax base which can mean fewer city parks and recreation areas for exercise. Higher crime rates make play and activity such as bike riding or running outside less likely (Chang 2006). All of these location based factors can lead an entire community to live a less healthy lifestyle.

Location of health services as well as location of everyday needs is important in understanding barriers to compliance with medical advice. Amy, a research scientist, said the history of a place, and the location of health care services in relation to the people, matters. Geographic boundaries often define a community and can be deeply rooted in the history of a place. The location of public transportation, commercial businesses, job opportunities and schools all play a part and affect access to services. Lawrence, who works in Community Health Initiatives, believes KP must think more about culturally competent care in communities. An example would be working with local groups such as bodegas or farmers markets to ensure KP members are getting their needs met or at least being heard.

Where Are The Invisible Communities?

One example of historical differences between communities in Northern California is the awareness of and experience of the LGBT community. Wayne, who works in Community Benefits, explained that as a region of KP, Northern California goes as far north as Sacramento, with another 10-15 counties north of that and includes three to five million people. He said,

“These communities are mainly semi-rural and KP is not well configured to care for populations outside of the large urban communities. We have one office, one hospital to serve a population group within five miles of those. What does it mean for these people to relate to KP? This will require understanding distances and perceptions of what is the value derived relative to traveling distances to see specialists or have diagnostic workups not available in smaller settings. We don't know what that means, or have experience working with rural or semi-rural.”

There is often less awareness of LGBT health issues in rural Northern California compared to the urban centers of the Bay Area where significant LGBT communities exist. Past research shows that not only are lesbian women less likely to seek out preventative care due to previous negative experiences, there are also significant health disparities between lesbian women and heterosexual women in preventative care and health outcomes (Bergeron and Senn 2003). Providing information and tools to clinic staff and care providers in rural areas with less visible LGBT communities is one way to address this disparity.

Throughout our interviews people commented on how inclusive the KP community is regarding employees. Wayne, explained how KP not only supported one

of their own physicians through the gender transition process but also celebrated that person as a champion of diversity within the organization. This kind of workforce diversity sends a strong message to the member population. However, it is important to ask if this diversity is celebrated in certain regions of Northern California and not others. KP must make sure both their services and their message of inclusiveness are accessible to the LGBT population outside of the urban centers of the Bay Area.

The transgender community, although part of the LGBT category, faces unique health risks. The structural and cultural barriers to care are intensified for transgendered people. Access to primary care as well as specific gender related care can be difficult for a transgendered person to find (Jenner 2009). Transgender care can be very personal for the provider as well as the patient. Providers must address their personal moral and religious position in caring for transgender patients. A physician must be completely comfortable performing life changing irreversible procedures for these patients. Some physicians have trouble performing such procedures if they do not personally believe it is necessary (Jenner 2009). If a provider is uncomfortable caring for a patient, the patient will be uncomfortable receiving care from that provider (Hutchinson *et al.* 2006).

Extending services for LGBT members in the rural parts of this region is important but the physicians in these areas must also be comfortable caring for the needs of transgender patients. This could mean more education about the needs of these patients as well as how to address these needs. It could also mean support in reconciling

with personal beliefs or questions about providing gender related treatments.

Additionally, all staff members that interact with patients should be educated about and sensitive to the diverse circumstances and needs of all patients, including LGBT (Jenner 2009). This sensitivity extends to building infrastructure as well. Physical surroundings can affect a patient's experience in the clinical setting. Gender neutral bathrooms are just one example of infrastructure changes that would help a transgender member (Jenner 2009).

How Does Technology Change Healthcare Services?

It is important for KP to focus on the diversity within the rural parts of Northern California but also not lose sight of the fast paced changes of the urban centers. For example, in San Francisco and the Silicon Valley there is a large startup community primarily around technology innovation. The people in this community are often young entrepreneurs and operate outside of the traditional 8-5 work day. Carrie, who works in Community Benefits explains in her interview,

“People are going to want to get care when they want their care not through the traditionally defined hours of 8-5, when we've normally been operating. That may actually be a good thing for us, it may provide us with a lot more flexibility and may help also in terms of the recruitment of new clinicians. I think that you recruit folks who are younger a lot of those folks will want more flexible hours whether it be that they're not a morning person so they want to go on shift from 12-8 and maybe we can actually create that opportunity so that you can have care whenever you want it that is actually good quality care. Not that kind of care where you wonder if that resident has had any sleep in the past 48 hours kind of care.”

Location of services as they related to the diversity in schedules within different sectors of the economy, and the different age groups of KP's membership are also important to consider in this discussion.

The internet adds a dimension to the definition of community by allowing people to gather and share ideas and information online. KP already has a strong presence on the internet with KP.org and many patients use this resource to enhance their experience. However, throughout our interviews people expressed concern about members who were unable or uninterested in accessing the internet. As Barbara, a research scientist, said in her interview,

“Problems may also arise around the digital switch. Moving everything online might work for one group but it can alienate others from the robust services KP can provide. This is a division between the dinosaurs and the new wave. Web friendly services appeal to a younger healthier membership base, but it is important not to leave out the older members in this transition. Not everyone, members and staff, will embrace the shift to managing their health online.”

The organization must be able to provide equal service for members who embrace technology to manage their healthcare as well as those who do not or can not.

Use of technology in healthcare services is affected by unequal access and differential use of technology. David, who works in technology development, explained that “people are grouped differently in e-health disparities research than in other kinds of disparities research. We must look at sub populations that don't fit with the way the data has been translated. We can't generalize about larger populations when we are talking about e-health disparities.”

Accessing health information online can be a powerful tool for those who have the resources and education to understand and use the information they find on the internet. According to a Pew Research Center publication there are differences in who looks for health information online.

Table 1 – Who accesses health information online?

Likely to Access Health Information Online	Unlikely to Access Health information online
Women	African Americans and Latinos
Whites	Adults living with disability
Ages 18-49	Ages 65 and older
At least some college educations	High school education or less
Higher income households	Lower income households

Source: (Fox 2011)

David explained that technology is one of the biggest factors in e-health disparities research. He said that access to technology, age, socio-economic status, education and language are important factors to consider but they do not necessarily align with race/ethnicity. Some KP members do not have access to technology, others are unable to understand the health information they find on the internet. According to a study done by Gretchen K. Berland, *et al.* (2001), the average reading level needed to gather meaningful health information from internet sources is at least a tenth grade

reading level in English and at least a ninth grade reading level in Spanish. Those members who can not reasonably access health information and resources online need the same quality of care through other methods.

On the other hand, some KP members are embracing technology through the use of smart phones and apps. In our interview with Carrie she explained that,

“We need to pay attention to the changing ways people prefer to access their information, new technologies for example. People are going to want their care when they want it, how they want it and KP needs to be able to deliver. This means more flexibility for both the KP workforce and the member population. They should consider flextime as a way to make KP attractive to young clinicians as well as young professionals.”

There is an opportunity through mobile technology for KP to increase access to their services by reaching out to their membership on a mobile platform. With a growing “app culture” (Purcell *et al.* 2010) KP may be able to assist their membership by providing a mobile application that can help patients find the answers they need without scheduling a clinical appointment.

Clearly communities around place have a significant impact on the services KP provides. Both the organization and the member perspectives on community matter in connecting quality service with community needs.

How Does Power And Trust Differ Between Communities?

One of the most common factors cited by our interviewees regarding diversity in Northern California in the coming decade was immigration and the need to provide quality culturally competent care for immigrant members. One of our interview questions asked each interviewee to describe their personal connection to the concept of

diversity. Through this question we learned that there are many members of KP's workforce who identify through first hand or familial connections with the experience of immigration. For some, these experiences inspire the work they do at KP. The varied perspectives by KP employees of immigrant communities in Northern California will influence the strategies undertaken to address the needs of these communities. Not every clinician will have personal connections with an immigrant community, but every clinician in Northern California will likely treat a member of an immigrant community.

One issue to consider in this is that power and trust in healthcare can vary widely between cultures. Immigrant patients unfamiliar with the American healthcare system or the English language must trust their clinician more than other patients, and are in a structurally inferior position (Griman 2009). In some circumstances these patients must trust their physicians, often blindly, in order to get the care they need.

Beverly explained that,

“Other healthcare systems do not work the same way as the US system. Immigrants might not be used to making doctors appointments for preventative care, they may rely on family for care until it is dire and then go to the hospital. Key to this work is getting the same message out across all languages. We need to make sure people are able to get the same services and the same quality of service for the money they are paying compared to other member's who have a language or system familiarity advantage.”

Information about what services are available and how to access them must be conveyed in a culturally sensitive way so that potential members who are unfamiliar with the US healthcare system will be able to access the resources they are paying for.

Patients who feel inferior power differentials with their physicians or who do not understand their diagnosis or treatment plan may not ask questions for clarification. It is important for clinicians, in the more powerful position, to take the time to ensure that patients understand what they need to do in order to take care of themselves. Judith explained, “most patients will say that they understand you or just say “yes” to you as the doctor because of the power they perceive you have and it’s important to make sure that they repeat back what you have told them so you know they understand what you’ve said.” This is one strategy to try to bridge the doctor – patient divide.

I have already talked about cultural agility as an important component of KP’s approach to diversity in their membership population. Cultural competency is another important concept in this conversation. A culturally competent healthcare system is one that “acknowledges and incorporates the importance of cultural assessment of cross cultural relations, vigilance toward dynamics that result from cultural differences, expansion of cultural knowledge and adaptation of service to meet culturally unique needs” (Betancourt *et al.* 2003). Cultural competency is increasingly important as populations grow more diverse ethnically, culturally, and linguistically.

A classic example of the importance of cultural competency can be seen in Anne Fadiman’s *The Spirit Catches You and You Fall Down*. This is the story of the Lee family, refugees from Laos living in Merced California. The Lee’s thirteenth child, Lia is diagnosed with severe epilepsy and the clash of language barriers, cultural barriers and misunderstandings between doctors prescribed care and parent’s understanding lead

to devastating outcomes for Lia Lee. Referring to Lia's diagnosis, Fadiman explains the difference between Lia's parents understanding of her illness and the Resident's explanation,

“Foua and Nao Kao have no way of knowing that Dan had diagnosed it as epilepsy, the most common of all neurological disorders. Each had accurately noted the same symptoms, but Dan would have been surprised to hear that they were caused by soul loss, and Lia's parents would have been surprised to hear that they were caused by an electrochemical storm inside their daughter's head that had been stirred by the misfiring of aberrant brain cells” (Fadiman 1997: 28)

Knowledge of Lia's parents explanation of her disease and the cultural meaning of soul loss is crucial to understanding the families experience caring for Lia and her illness. Although the hospital staff tried to help Lia's mother understand the treatment plan and care instructions, the cultural and linguistic barriers were significant and ultimately the gaps in knowledge between the two cultures meant that Lia's care was compromised.

Related to this, Judith, a clinician, said that one area within KP that needs more attention is bilingual prescription labels. If the instructions for complying with a treatment plan are not accessible for the patient or their family they cannot comply. Additionally this clinician suggested videos dubbed in different languages so patients can see and hear examples of their treatment plan.

An anthropological analysis of perception of power in different communities can reveal layered barriers to access effective service. While health professionals are socialized to see themselves as helpers, not gatekeepers, the reality is that they fill both roles (Grimen 2009). Doctor and patient are not necessarily equal, the role of doctor

implies expert or authority on the topic of health. Understanding how to exercise power in the role of clinician is important and changing with increasing access of new technologies. KP must be prepared to deal with a wide spectrum of members.

What Will Change With Healthcare Reform?

Certainly lack of insurance or under insurance can be major barriers to healthcare for many immigrants in the United States. Often immigrants work in the informal work sector where there is less financial security and less opportunity to get benefits through an employer (Chavez *et al.* 1992). Lack of Unfamiliarity with the way health insurance works and how to access all of the services available through a KP insurance plan can also be a major barrier to care. Beverly explained that “it is important to educate brokers on how to utilize health care services. This work includes aspects of enrollment, marketing, making sales documents and helping non-English speakers understand the US healthcare system.” These brokers should also be able to communicate to new members how they can access the services available to them.

The connection between insurance accessibility and healthcare reform will be a factor in KP’s changing membership and their potential membership growth. According to the UCLA Center for Health Policy Research, up to 2.13 million previously uninsured or underinsured non-elderly Californians will be eligible for coverage, either through an expansion of the MediCal program or through the new California Health Benefit Exchange by 2014 (Pourat *et al.* 2011).

Many people we interviewed spoke about the challenges KP will face serving new members covered under healthcare reform. Kathy, who works in healthcare reform, said:

“The biggest challenge KP will see in the next ten years is the growth in membership due to healthcare reform. KP needs to understand the uninsured population better in order to be prepared for this. But KP is well positioned for healthcare reform because they are already operating in an integrated system which is what healthcare reform is pushing for. It will be important to look at the newly insured whom they have already been serving in emergency rooms.”

We also spoke with George who works in the MediCal Strategy department. He explained that they anticipate seeing a change in membership with healthcare reform and the change in MediCal eligibility requirements. He expects they will begin to see more men who are a bit younger and with slightly different clinical needs. A preview of this new population can be seen in the existing emergency room data. The majority of emergency room visits happen among MediCal, Medicare and uninsured groups (Johnson 2008).

Clearly, KP is anticipating a significant change in their member population due to healthcare reform. A concern about unfamiliarity with serving the uninsured and working poor came up in more than one interview. However, it is likely that KP has been serving these groups through their emergency rooms for many years. The real challenge is reaching newly insured people to provide the integrative approach to robust preventative services that KP offers its membership.

A culturally competent and culturally agile workforce will positively affect the service KP provides in the diverse Northern California region. In their own workforce

KP can aim to mirror the population they serve. This will create a built in system of resources for internal KP communities to draw on in order to understand the diversity of the member population.

How Do KP Communities of Practice Approach Language Differences?

Communities based around language can coincide with immigrant communities but this is not always the case. The children and grandchildren of immigrants born in the United States have more complex language patterns. For example, language communities can include monolingual as well as multilingual people. Understanding communities based around language is important for KP as language will continue to be a significant component in healthcare for the foreseeable future in California.

According to the Public Policy Institute of California the number of immigrants has grown from 1.8 million to almost 10 million between 1970 and 2009 (Johnson 2011). The American Community Survey by the United States Census for California shows that 55% of immigrants between 2005 and 2009 came from Latin America (U.S. Census Bureau 2011). This level of immigration means that KP's membership in Northern California will continue to grow in linguistic diversity over the next decade.

In our interviews we spoke with Judith, a physician who is Chinese herself and bilingual. She believed that first hand bilingual care is the best strategy to meet the needs of a linguistically diverse population. However, we also interviewed Cheryl who works in Language Access and has personal connections with immigration in her family. In her work she must think about the linguistic needs of the member population

from a broader perspective. She talked about being able to meet the needs of any language request from Mandarin to Spanish to American Sign Language. These representatives of two different communities of practice within KP have different ideas about how to serve communities of language in the member population.

We know that the research shows that linguistic barriers to care can have negative impacts on communication and trust between patient and provider, which can ultimately lead to poor health outcomes (Betancourt *et al.* 2003). How long a person or a family has been in California will impact both language skill and preference. As discussed in the identity section, language preference may change with the circumstances. An individual who immigrates from Mexico could prefer to speak Spanish at home, English at work and possibly Spanglish, a California creation which blends Spanish and English, as they move between places (English-Lueck 2002).

In healthcare, language skill and preference matter a great deal. As Cheryl said in her interview “a patient may be functionally bilingual but revert back to a familial language under times of stress.” Anyone who has traveled in a foreign country without knowing the language knows how vulnerable it feels to be unable to communicate. Cheryl points out that health issues can contribute to higher levels of stress and vulnerability without a language barrier. If language is also an issue, then stress is compounded in the clinical appointment and can impact communication, time, cost, and ultimately quality of care and outcome for the patient.

What Are Barriers To Providing Care In Different Language Communities?

In 2003 the California legislature passed Senate Bill 853, which requires commercial health plans to provide language services. The state's Department of Managed Health Care (DMHC) is responsible for creating the regulations which will ensure health plan and provider compliance (Au *et al.* 2009). Cost of language services were a concern for many of our interviewees and we heard several opinions about how to deal with this issue throughout our interviews. Cheryl talked about a potential program that would increase access to quality interpreter services. She says that they are,

“building a business case to implement remote video interpretation across the region. So what that entails is really gathering the quantitative data to understand the demand for interpretation services and what is the potential cost benefit in terms of a return on investment of that type of technology. And what the technology is, is essentially using video conferencing technology to allow access to virtual in person interpreter. What that enables us to do is centralize our staff interpreters, increase their productivity because they don't have to physically be in the exam room and travel to that exam room to provide service. Instead they are doing it from almost a video call center format. And then of course that expands access to qualified services.”

Interpreters are not the only element of cost that concerns Cheryl. She also spoke about the length of clinical appointments for non-English speakers when they do have access to a medical professional who speaks their language. She said “if a person gets in a room with a medical professional who speaks their language they may need to talk longer because of a buildup of information from extended periods of time not being able to tell someone what is happening to them.”

Greater access to interpreter services is one way to reduce the information overload experienced by non-English speaking patients when they are unable to see a physician who speaks their language. However, Judith argued that interpreter call centers do not solve the cost problem. She said,

“Use of an interpreter in call center situations can also be more difficult than necessary. There is more room for error because of interrupting for translation of each sentence than if you are just talking to someone who speaks the same language. Language education will always be a factor - both patients and physicians. Being able to provide first hand native language care will improve the quality of care as well as service and satisfaction of members.”

There is an obvious discrepancy in the perspectives of the bilingual physician versus a member of the language access department. For truly bilingual physicians it is likely easier, faster and cheaper to care for a non-English speaking patient themselves but there are not enough bilingual physicians to serve the diverse and immense language needs of Northern California. Both Judith and Cheryl agree that more training is needed for the clinical staff before KP could offer truly competent bilingual care without interpreter services.

It may be unreasonable to expect to have a bilingual physician in every location for every language spoken in Northern California, but Wayne, who works in Community Benefits, had some ideas about how to address the diversity of the patient population with the current KP workforce. He said “with a workforce this big, KP has a chance of already having experts in diverse arenas; they should use this to their advantage, to be more nimble but that they need to know who and where those people are in order to draw on their knowledge and skills.”

One of the greatest challenges in the new language requirements for California health plans is creating information technology systems that support and manage data about primary written and spoken languages (Au *et al.* 2009). Technology is one way KP can use the infrastructure in place to create a system to document and share language preference so patients can have access to bilingual clinicians. Information about a patient's preferred or primary language prior to an appointment can cut costs by allowing a clinic to prepare appropriate resources before the patient arrives. The clinic can schedule the appointment on a day when bilingual staff are present or arrange to have the technology for call center services available.

Lawrence, who works in Community Health Initiatives said "the community benefits staff needs to be more diverse in their language skills. Showing up with a bunch of young white women limits credibility and ability to understand what is going on in the communities. Community benefits staff, more than care delivery staff, needs to be diverse." Diversity within the workforce, especially within the leadership, has been recognized as one of the three major sociocultural barriers that contribute to disparities in healthcare. Without a diverse workforce, policies, procedures and delivery systems are created which do not account for the diversity in the patient population. Clinical barriers exist when sociocultural differences between patients and care providers are not taken into account (Betancourt *et al.* 2003). If patients feel their doctor does not understand where they are coming from, they are less likely to trust the doctor's advice, resulting in overall poor health outcomes. Language is an important

component of healthcare across many levels: access to care in the clinical setting, access to information about KP services, access to prescriptions and care plans after the clinical appointment.

In this section I have unpacked some of the different meanings of “community” in relation to both KP’s workforce as well as their member population. The interviews we conducted in this project allowed us, as researchers, to gain an understanding of each communities’ perspective on diversity and how that perspective is applied. This awareness can facilitate the effort to identify common goals across the larger organization.

HOW DID ETHNOGRAPHY CONTRIBUTE TO THIS PROJECT?

In his book *Ethnography: Step by Step*, David Fetterman describes ethnography as "the art and science of describing a group or culture" (2010: 11). In this project we conducted ethnographic field work to understand KP as an organization in order to help IFTF create the thought map. However, we also used ethnography to understand IFTF’s structure so that we could identify some best practices for maintaining the integrity of ethnographic data throughout their process for bottom up forecasting. The value added of ethnography is gaining a holistic perspective of the organizations structure and functions while uncovering multiple interpretations of reality that exist within the organization.

The interviews we conducted for this project were only one element of the ethnographic data we collected. Other ethnographic data included the personal

experiences of the IFTF research team in the healthcare system, with KP as well as other insurance companies and care providers. The information we each shared in this discussion proved to be valuable ethnographic data for the signaling process and expert workshop. Additionally, much of the data gathered from the expert workshop was rooted both in the life and work experiences of the participants. Professional and personal experiences helped create the ideas you saw on the sticky exercise discussed earlier in this paper (see Appendix B). The signals database also included ethnographic data, as evidenced by the signal I wrote based on my personal experience of setting up a health plan a startup company in the Bay Area.

Throughout this research English-Lueck and I were able to keep the ethnographic data visible in each step of IFTF's process, which proved to be a valuable addition to the overall project. As a member of this research team I was able to observe IFTF's process in a way that they could not because I had an outsider's perspective. From this position, I identified the following best practices for maintaining the integrity of the data for client based forecasting projects.

- **Have dedicated team members to organize and analyze the ethnographic data throughout the project.**

One of the key project strategies that helped to maintain the integrity of the ethnographic data was having team members dedicated to the conducting and analyzing the interview data throughout the entire process. English-Lueck and I focused a great deal on the interview process, therefore we were more familiar with the ethnographic

data than other team members and we were able to bring that information to the entire forecasting and map creation process. Ultimately our dedication to the ethnographic data helped to keep the information on the final map relevant to the clients needs, an essential part of creating a valuable forecasting tool. Keeping the ethnographic data heavily integrated throughout the IFTF process will produce a better end product for the client.

- **Interview throughout the process and revise analytical focus on conversations as they become richer and more nuanced.**

We began conducting interviews during the signaling phase, which allowed us to create signals based on ideas from the interviewees. Additionally, we were able to incorporate insights from early interviewing into the expert workshop. With constant analysis of the data we were able to manipulate the interview protocol to get richer data from the interviews.

- **Integrate different disciplinary content and link back to individual experience and organizational imperatives.**

The IFTF team is made up of a diverse group of research professionals. The diversity of expertise on the research team was a key component to the success of this project. By integrating the different disciplinary content and connecting it back to the larger organizational imperatives, we were able to gather a completely different kind of ethnographic data within the team.

An applied organizational anthropology lens can be used to help understand the concept of diversity in other kinds of organizations. Our process as applied anthropologists enabled us to gain a holistic picture of concepts that affect diversity across the different layers of KP's workforce and imagine how these concepts can be translated to better understand their changing client population. KP is already working toward being a more culturally agile organization. This forecasting tool has identified new ways of understanding the stakeholder groups in the diversity conversation as well as helping to start that conversation with KP's leadership. Additionally, the concepts of identity and community can be applied to other IFTF research in order to gain a deeper understanding of the concept of diversity for clients outside of the healthcare field.

Having never worked with IFTF prior to this project, I was constantly learning about how they, as an organization, move through the process of creating a client map. Although IFTF has expertise in forecasting, having applied anthropologists with backgrounds in organizational and medical anthropology on the team, who were focused on collecting, analyzing and maintaining the ethnographic data throughout the forecasting and map creation process was very valuable. This process allowed us to maintain a connection with broader futures thinking and the main stakeholder's objectives.

Notes

1. Although I use the term diversity throughout this work it is important to recognize that diversity is largely a human resources (HR) legacy term. Future work on this subject should include an exploration of other terms to explain and explore the concept of diversity outside of the old HR parameters.
2. Due to the terms agreed upon with the Institutional Review Board of San Jose State University pseudonyms have been used for all Kaiser Permanente employee interviews. However, the actual names of all research team members are used throughout this project report.
3. Identity is a very complex concept in Anthropology. The term has been used to discuss both sameness as well as note differences between individuals. For some, identity is an unconscious component of personality, this can be seen in the work that Margerate Mead and Ruth Benedict did in the Culture and Personality School. In this school of thought culture is thought of as an understanding of experiences which construct personality (McGee and Warms 2004). However, Frederk Barth changed the way we think about the concept of identity. In his work, *Ethnic Groups and Boundaries: The Social Organization of Culture Difference*, he showed that identity is contextual, it is something that people create depending on how they view a

particular identity framework (Barth 1969). My use of the concept of identity in this project is rooted in the ideas presented by Barth.

4. In Anthropology race is largely understood to be a social construct. That is to say that there is nothing absolute about race compared, for instance, to absolutes about objects that are studied by physicists. In his work *Race, Language, and Culture*, Franz Boas explained that there is nothing biologically real about race, rather it is that we, collectively, agree and accept that race exists that makes it real. Even as a social construction race has real consequences in that it shapes the way we see ourselves and others (Boas 1940). However, it is also important to recognize that race as a social construct that inaccurately describes human variation, for example there is a physical reality of genetic variation that is very relevant in medical research. People who work in this area must juggle the complexities of genetic and developmental variation with these cultural constructs.

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Appendix A: Example of a Signal Entry

- Create Signal
- Newest Signals
- Potential Expert List
- Community Directory
- Logout

[View](#)
[Edit](#)

Role of Trust in healthcare: provider/patient relationships

Submitted by *Jill Griffith* on *Thu, 07/15/2010 - 16:35*

Care delivery demographics education and income status Making Information Actionable Patient engagement poverty Quality Improvement Reinventing Medical Practice relationships Transforming Service trust

A 2009 Gallup Poll suggests that there are "trust deficits" among less financially secure Americans and Americans who have encountered racial biases. The 2008 National Healthcare Disparities report shows that different racial, ethnic and socioeconomic groups use healthcare differently. Specifically, Asians and Hispanics showed lower use of most health care services. Blacks showed lower use of routine care, outpatient mental health care, and outpatient HIV care and higher use of emergency departments and hospitals. Lower SES (socioeconomic status) was connected to lower use of routine care and outpatient mental health care and higher use of emergency departments, hospitals, and home health care.

Due to lack of trust in the healthcare system or their provider, people in certain demographics may not access care. Building trust between patient and provider may lead to an increase in use of services. Building trust may prevent feelings of alienation from particular groups of members. This Gallup Poll also points out that social relationships are important to personal wellbeing. A connection or relationship between providers and patients could increase levels of trust.

Sources & URLs:

<http://www.gallup.com/poll/124580/Trust-Varies-Income-Education-Race-Age...>

Gendered health differences: lifetimes of hormones, and "gendered medicine"

The Buddhist Health Study

Health-Care Seeking Among Latino Immigrants

Religious and Cultural Perceptions about HIV/AIDS Among Muslims in the US

Doctors, Hospitals Clash Over Faith

mo

Tag Cloud

aging beliefs

Buddhism capacity care delivery caregiving chronic illness care competence complementary therapies conflict

Connecting Work and Health

cosmetic surgery cultura competence culture demographics

disparities Economics education and income status employers Enabling

Meeting Notes

Diversity elements of HC2020 Challenges

Notes from June 25 Meeting

Phase 1 Literature Review Resources)

Health and Healthcare 2020

Kickoff Map Brainstorm

more

Recent Comments

- Author: Miriam Lueck Avery on: Stuck with race, a problematic placeholder for diversity
- Another interesting perspective on this from the...
- Author: Jan English-Lueck on: Even in Northern California, access to care is highly uneven
- NPR reported on a concrete example of this...

Appendix B: Sticky Note Exercise



Appendix C: Expert Interview Protocol

A Diverse Future for Kaiser Permanente, Expert Interview Protocol
(Dr. Jan English-Lueck, Jillian Griffith)

These informational interview questions are designed to capture expertise about particular parts of Kaiser Permanente Northern California that might give insight to rethinking how diversity is conceptualized and applied. These insights will inform the creation of a “thought map” that will facilitate discussion on a strategic plan for diversity. The work is being done by the Institute for the Future in cooperation with applied anthropologists at San Jose State University. The information is not confidential within the team, since attribution of area expertise is critical to understanding organizational strengths and weakness, but will be handled confidentially in any publications outside of the team context. Objectives for this project include:

1. Collecting information that reflects different expertise across the operations of Kaiser Permanente Northern California
2. Documenting how diversity is used by different stakeholders within the organization.
3. Gathering information that will inform a forecast on diversity that will inform a strategic plan.
4. Providing opportunities for SJSU students to learn about institutional life and forecasting as an ethnographic applied methodology.

Population. Experts working in the Kaiser Permanente Northern California.
Interviews will be conducted in the interviewee's workplace.

Materials

1. Instrument, pens and notebook
2. Recording device and spare batteries
3. Watch
4. Two copies of the consent form

Preamble

[explained to interviewees] This is a project to learn about how people working in KP need to understand diversity in their work. Your answers to our questions will help the Institute for the Future work with KP to think about the role of diversity in your overall strategic thinking. Within our team, we will need to know who said what in order to assess how diversity is understood within the organization. The team working on this project consists of the Health team at the Institute for the Future, medical anthropologists from San Jose State and Katherine Haynes-Sanstad, KP's Northern California regional executive director for diversity. However, outside the analysis team, any information you reveal will be held confidential

[Informed consent] I would like you to look at the consent forms I have brought. One copy is for you, and another for me. Because this is an informational interview designed to help us understand KP as an organization, we will be using real position titles and places in our discussions. You might think about this as we talk. If at any time, you decide something you have talked about should be omitted, all you have to do is ask, and that information shall be deleted from any transcript or production. I would like your permission to record the interview on which we will take extensive notes. Those notes will be housed at the Institute for the Future and used to help us understand the future of diversity. As you can see, if publications emerge from this project beyond internal discussion, your identity and information will be strictly confidential and anonymous. Your contribution will be combined with library research and expert panels to create a “thought map” that will help Dr. Haynes-Sanstad and KP better understand the future of diversity within KP’s culture. Any questions you have can be directed to Dr. Jan English-Lueck, Department of Anthropology, San Jose State University. She can be contacted at (408) 924-5347 or Jan.English-Lueck@sjsu.edu. Additionally, there are phone numbers for the Anthropology department Chair, Dr. Darrah, and the AVP for Graduate Studies and Research, Dr. Stacks, should you have any problems.

Instructions to interviewers

You will be responsible for making a digital audio recording of this informational interview and creating notes on the key points made by the expert.

Interview protocol:

1. Please describe the work you do here at KP.
2. How do you, yourself, identify with the concept of diversity?
3. I would like you to think about the work you do here. In that context, how would you define diversity?

Probe: Can you tell me of a time when you had to consider how your work would have an impact on different target populations. What happened?

4. From your perspective, how has KP itself changed as a diverse organization?

Probe: Can you tell me of time when the diversity of your colleagues and staff at KP mattered in your work? What happened?

Probe: Can you tell me about a time when the diversity of members, or the communities you serve mattered in your work? What happened?

5. When you think about the future of Northern California, about 10 years from now, how can you imagine diversity changing?

Probe: How do you think that would affect your work?

Probe: How do you think that would affect KP?

Probe: What changes would you like to see?

Probe: What changes would pose a challenge?

Probe: What kinds of things will drive diversity to change over the next ten years?

APPENDIX D: IFTF's Client-Based Forecasting Project Procedures

- **Signaling** is one of the first things done in any forecasting project. Signaling for this project was an exploration of how diversity, society, health and healthcare intersect. We used current literature, media sources as well as ethnographic data to identify forces that will impact the way healthcare organizations approach diversity.
- **Expert workshops** are used as a form of expert opinion aggregation. These workshops often include a group of 12 to 25 participants who are thought to be experts at understanding a possible future in a particular area (Johansen, 2007).
- **Semi-Structured Interviews** are used to gain a deeper understanding of stakeholder perspectives.
- **Word-smithing exercise** is intended to transform the language in the draft versions of the map into clearer statements about the signal. The trick was to be concise, articulate and non-repetitive.
- **Dot voting** is a method for narrowing down the information on the draft. Through dot voting we narrowed down the data so that the map included the most important and relevant pieces of information for the space allotted.
- **Editing process** is done by IFTF team members who have not been as involved in the beginning stages of the process. These team members go back through the draft before the dot voted omissions to provide input and make changes.