

**A Snapshot of the Linguistic Needs of San Francisco Safety-Net Providers and
their Views on Foreign-Trained Health Professionals**



San Francisco Welcome Back:
International Health Worker Assistance Center
City College of San Francisco John Adams Campus
1860 Hayes St., San Francisco

Emily Galpern
Amanda Goldberg
Regina A. Lagman
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TABLE OF CONTENTS

Introduction	4
Background and Significance of Problem	4-9
San Francisco Demographics	5
Health Outcomes for Minorities and Immigrants	5-6
Health Workforce	7
Welcome Back Health Worker Assistance Center	7-8
Safety Net Health Centers	8-9
Community Assessment	9
Methodology	9-13
Community Assessment Instrument	9-10
Interview Questionnaire Development	10-11
Interview Site Selection Process	11-12
Characteristics of Clinics and Hospitals Sampled	12
Interview Procedures	12-13
Data Analysis	13
Limitations	13-14
Findings I: Linguistic Needs	15-20
Demographics	15
Top Languages Spoken by LEP Patients	16
Clinic/Hospital Capacity to Meet Language Need	16-18
Communicating with LEP Patients when Providers Cannot Speak Language	19
Difficulties Hiring Bilingual Staff	19
Level of Difficulty Hiring Ancillary Staff	20
Findings II: Perceptions of Foreign-Trained Health Professionals	20-22
Opinions of Foreign-Trained Health Professionals' Education and Skills	20-21
Benefits and Barriers to Hiring Foreign Trained Nurses and Physicians	21-22
Hiring Unlicensed Foreign-Trained Physicians and Nurses in another Capacity	22
Conclusions	23-24
Recommendations	24-26
Clinics and Hospitals	24
Welcome Back Programming	25
Policy	25-26
Lessons Learned	26
References	27
Appendices	28-77

APPENDICES

Appendix A Community Assessment Instrument	29-42
Appendix B San Francisco Safety Net Providers	43-47
Appendix C Letter to Administrators	48
Appendix D Thank You Letter to Administrators	49
Appendix E Code Book Supplement	50
Appendix F Quantitative Data Collection	51-56
Appendix G Qualitative Data Collection	57-75
Appendix H San Francisco Welcome Back Brochure	76-77

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INTRODUCTION

While those served by the safety net in San Francisco come from a multitude of cultures and speak many languages, there is a significant gap in the linguistic and cultural competence in health professionals serving these communities. In order to document that this gap truly exists, in fall of 2002, the Welcome Back Practicum Team conducted a community health assessment of ten safety-net clinics and hospitals in San Francisco. Our assessment purpose had two main objectives: 1) to document the need for linguistically competent health professionals in San Francisco and 2) to determine clinic and hospital administrators' attitudes and opinions of foreign-trained health professionals. The results of this assessment will aid our field study site, Welcome Back, in its statewide effort to build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities. The paper that follows includes the following sections: background and significance of the problem; Welcome Back agency description; and assessment methodology, results, limitations, discussion, and recommendations.

BACKGROUND AND SIGNIFICANCE OF PROBLEM

Setting a proper context for the community assessment requires an understanding of the multiple layers of information underlying its inception. These layers include demographic data regarding San Francisco's increasing diversity; the implications of being uninsured, especially as an immigrant, with respect to health and the U.S. health care system; the lack of minorities in the health workforce, an overview of the Welcome Back International Health Worker Assistance Center and its purpose, and finally a description of the role of safety net clinics in providing care to the under and uninsured.

San Francisco Demographics

According to the 2000 census data, as synthesized by Katz (2002), San Francisco's minority populations have increased over the last ten years and will continue to grow. The Hispanic/Latino and Asian/Pacific Islander populations increased by 13.4% and 16.6% respectively between the 1990 and 2000 censuses. Combined, these two groups comprise 45.3% of San Francisco's population (14.1% Hispanic/Latino and 31.2% Asian/Pacific Islander). Notably, 36.8%, or one in three San Franciscans, are foreign born, and a full 41.8% of this population speaks languages other than English at home. Thirteen percent of all San Francisco households are linguistically isolated, meaning they live in a home in which no one over the age of 14 speaks English without some difficulty (Katz, 2002).

Health Outcomes for Minorities and Immigrants

The growing diversity in San Francisco is especially noteworthy, because in the United States people of color and immigrants have disparate health outcomes when compared with their white counterparts. This well-documented pattern is evidenced by the disproportionate rate of disease, disability and death among specific racial and ethnic groups (Goode, 2001). People of color in the U.S. are underinsured and have less access to a primary source of health care. Over one-third of Latinos and about one-fifth of Asian Americans and Pacific Islanders nationally are without health coverage (Brown, Ojeda, Wyn, & Levan, 2000). Immigrants in particular are even less likely than other people of color to be insured, to have job-based medical insurance, or to have a regular source of health care. In fact, for adults alone, being a non-citizen was associated with a 2.5 percent reduction in Medicaid coverage, an 8.9 percent decrease in job-based insurance coverage, and an 8.5 percent increase in the probability of being uninsured in comparison with native citizens (Ku and Matani, 2001). With no health insurance, many racial

and ethnic minorities have less access to a regular source of care or to preventative services, affecting both their short and long-term health by exacerbating chronic conditions such as heart disease, diabetes and cancer by delaying diagnosis and reducing effective management and treatment (Brown, et. al., 2000).

While the discrepancy in health care and outcomes for racial and ethnic minorities and immigrants in the U.S. is undeniable, there is no single theory to explain the causality of health disparities. Healthy People 2010, which positions the elimination of health disparities as one of its top goals, points to the interaction between environmental factors, health behaviors, and genetics as causal links (U.S. Department of Health and Human Services, 2000). Additionally, while lack of insurance and consistent care certainly contribute to the disparity, the Agency for Healthcare Research and Quality (AHRQ) assert that the way people are treated (or the lack of treatment) because of their race or ethnicity affects their health outcomes (Addressing Racial and Ethnic Disparities in Health Care, 2000). As such, when providers do not have a comprehensive level of understanding for patients from a culture different from their own, the result may be patient dissatisfaction, poorer health outcomes, and ultimately, disparities in the quality of care (Academy Health, nd). However, it is important to acknowledge that the capacity to speak a language does not necessarily imply that one can understand a patient accurately and meaningfully or that one has the ability to understand the cultural context of the language (Bureau of Primary Health Care, nd). In order to reach the goal of increasing access and eliminating health disparities among minorities, culturally competent systems of health care delivery must be developed and sustained (TNPCA, nd). Research indicates that racial disparities in health can be reduced when patients have access to health care professionals with an understanding of cultural differences and when communication barriers are absent (Academy Health, nd).

Health Workforce

Data indicates that the racial and ethnic composition of California's health workforce do not reflect the state's population. With very few exceptions, health care providers are predominantly white. Although whites comprise less than 50% of California's population, they make up 70% of physicians and 79% of registered nurses (Dower et al, 2002). Latinos are significantly underrepresented throughout the health workforce. While over 30% of Californians are Latino, only four percent of physicians and four percent of registered nurses are Latino (Dower et al, 2002).

Cultural competence, defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" can reduce health disparities to care by improving clinician/patient communication and increasing trust (Brach & Fraser, 2000, p. 182). Ensuring that providers in health care settings reflect that of their patient population, is one step toward improving health outcomes for underserved communities (Dower et al, 2002).

Welcome Back Health Worker Assistance Center

While there are many solutions to increasing the cultural competency of health care providers, including removing barriers that prevent people of color from obtaining educations and encouraging them to enter the health field, or training current providers in cultural competence, the Welcome Back initiative was developed to address the issue of health disparities among immigrants and minorities through assisting foreign-trained health professionals living in the U.S. to become licensed to practice medicine here. Welcome Back's Mission is:

To build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities.

This statewide initiative, funded by the California Endowment, began in 2001 and has three centers, located in San Francisco, San Diego, and Los Angeles. The centers offer counseling and educational programs to internationally trained health professionals, including assistance in obtaining appropriate licenses, credentials, orientation and job placement to work in the U.S. health care system. They also offer development of U.S.-specific leadership, management and advocacy skills. Although the actual number of internationally trained health care professionals living in California is not known, with very little outreach, the centers quickly attracted a participant base of almost 3,000 foreign-trained health professionals. The majority of the participants are trained as physicians and nurses, though the centers also serves many dentists, psychologists, speech therapists, pharmacists, and others in the health professions. Sixty-three percent of these participants are not currently employed in the health field. Sixty-five percent come from Spanish-speaking countries.

Safety Net Health Centers

Safety net centers provide the majority of health services to one in five Californians, often offering the only access to health care for low-income or uninsured people as well as serving a disproportionately high percentage of Medi-Cal patients and underserved racial and ethnic communities (Dower et al, 2002). The California Association of Public Hospitals and Health Systems (CAPH) define the safety net, sometimes called “open door providers,” as:

A hospital, academic medical center, community-based health center or other entity dedicated to assure the accessibility of cost-effective, high quality and culturally appropriate health care services required by law. Open door providers also ensure the availability of critical public goods, such as trauma and burn care, essential to the health and well-being of the public-at-large (1999), (Dower et al, 2002).

While most of these health facilities gear their services toward the communities they serve, primarily low-income, un/under-insured, and immigrants, the demographics of the medical staff are not necessarily ethnically or linguistically representative of their patients. Thus, these centers are potential places of employment for the internationally trained professionals of Welcome Back. If safety net providers do not have the appropriate health care professionals to provide particular health services, these services may not be available to vulnerable patient populations at all (Dower et al, 2002).

Community Assessment

The Welcome Back Practicum team's community assessment was a collaborative project with the San Francisco Welcome Back Center, although the interview tool developed will soon be used to gather data from health centers around the L.A. and San Diego locations. The S.F. Welcome Back center was interested in gaining a clearer picture of the linguistic gap between providers and patients among safety-net providers in San Francisco, the challenges to employing linguistically competent health professionals, and the attitudes clinic and hospital administrators hold towards foreign-trained health professionals. The assessment focused primarily on physicians and nurses as they make up the majority of Welcome Back's participants.

METHODOLOGY

Community Assessment Instrument

Structured key informant interviews were chosen as the assessment methodology for this project for a variety of reasons. The face-to-face administration of a survey tool in which the same set of questions were asked of each interviewee allowed us to obtain comparable

qualitative and quantitative data. Top administrators were selected as our key informants due to their broad perspectives on the needs of their clinics and hospitals and for the role they play in hiring providers. In-person interviews provided us with an opportunity to obtain a detailed and comprehensive understanding of medical directors' and nurse administrators' experiences and points of view from busy professionals who would be unlikely to attend a focus group or return a self-administered survey. In addition, conducting the interviews face-to-face allowed us to inform the health directors about Welcome Back's mission and activities, as most directors did not know the details about this new program. In order to gather the most complete information, we designed our questions to capture both qualitative remarks to open-ended questions as well as quantified answers to close-ended questions.

Our tool included a total of 32 questions (Appendix A). Quantitative questions were designed to capture general information about staff and the patients they served. For example, we wanted to know the number of staff; percentage of race and ethnicities of patients the providers served; percentage of primary languages spoken by staff; number of staff who were bilingual in primary languages spoken by patients; length of time it took to recruit staff who were fully bilingual; number of times when there was no language capacity to meet patient needs; and the number of foreign-trained nurses and physicians they had hired in the last 5 years. While the majority of these questions elicited quantitative answers, we welcomed and valued all comments as part of the qualitative data collection as well. Qualitative questions primarily asked administrators "do you have any comments" regarding the many quantified questions.

Interview Questionnaire Development

Working with both our Community Adjunct Faculty, Brenda Storey, Director of the San Francisco Welcome Back Center, and Mia Luluquisen, our Needs Assessment Instructor and

Consultant, we developed questions to capture information regarding both the linguistic needs and capacity within the health centers as well as the attitudes towards employing foreign-trained health professionals. We further refined the questions with the help of José Ramón Fernández-Peña, Director of the statewide Welcome Back initiative. We then pilot-tested the assessment tool with Joanna DeVito-Larson, a former Mission Neighborhood Health Center administrator. The pilot test helped us work on the design of questions, timing, and interview style of asking the questions.

Interview Site Selection Process

Our assessment focused on the safety net clinics and public hospitals in San Francisco. These safety net providers serve the majority of the uninsured in San Francisco and are potential places of employment for internationally trained professionals of Welcome Back. Most of these health facilities have services geared toward the communities they serve, which are primarily low-income and immigrants, but the demographics of the medical staff are not necessarily ethnically or racially representative of their patients. With our preceptor, we generated a list of the 21 San Francisco safety net health providers and the administrators' names, addresses, phone numbers, clinic hours, and website (Appendix B). We sent each of the administrators a letter in September 2002 (Appendix C), which described the Welcome Back Center and requested an interview for our community assessment. Each letter was followed-up with a telephone call to schedule a time for the interview if the administrator was interested in participating. Roma Guy, our Practicum Coordinator and Instructor, was instrumental in our success with contacting willing administrators. As our timeline did not allow us to interview all 21 clinics and hospitals, we employed a convenience sample, comprised of those administrators with whom we were able to schedule interviews. Of the 21 providers, we interviewed administrators at the following ten:

Table 1: List of Clinics and Hospitals Interviewed

Name of Clinic/Hospital
1. Laguna Honda Hospital
2. Lyon-Martin Women's Health Services
3. Maxine Hall Health Center
4. Mission Neighborhood Health Center
5. North East Medical Services
6. North of Market Senior Services Center
7. Ocean Park Health Center
8. St. Anthony Free Medical Clinic
9. San Francisco General Hospital
10. Tom Waddell Health Center

Characteristics of Clinics and Hospitals Sampled

Of the ten clinics, four received funding from the Department of Public Health (DPH), three are privately funded community clinics, one is both a DPH and community clinic, and two are public hospitals. In general, the clinics are much smaller than the hospitals. The average number of employees for the eight clinics is 55; actual numbers of employees ranges from 10 to 170. Both hospitals have over 1000 employees, SFGH with 5,000 and Laguna Honda with 2,000. The number of employees includes all staff, from executives to line staff, and covers both full and part-time employees.

Interview Procedures

Interviews were conducted from September 27 through November 6. All interviews took place at the clinics and hospitals in which the administrators worked, and lasted an average of 45

minutes. Most of the administrators interviewed were Medical/Clinic Directors or Nursing Administrators and, with the exception of two interviews, only one administrator was present at each interview. Each of the authors conducted the interviews. On a few occasions, interviews were conducted in pairs, with one person serving as the primary interviewer and the other as a recorder. On most occasions, when several interviews were scheduled on the same day, one interviewer was responsible for both administering the questionnaire and taking notes. Most interviews were tape-recorded so that we could review the tape to clarify any discrepancies within the notes. All interviews included an introduction of us as graduate students, Welcome Back as the organization with which we were affiliated, and an explanation of the community assessment purpose. All interviewees were offered a final copy of our report and invited to attend our presentation of the findings at the San Francisco Public Library. A thank you letter and invitation to the final presentation was sent to all administrators who participated (Appendix D).

Data Analysis

We collected both quantitative and qualitative data and coded it using a code book supplement (Appendix E) and entered it into EXCEL spreadsheets (Appendix F & G). Analysis of the quantitative data included calculating means and percentages and making comparisons to highlight important outcomes. Both quantitative and qualitative results were reviewed to reveal trends among the clinics and hospitals. The results of this analysis appears following the limitations section below.

LIMITATIONS

Even though we surveyed half of the pool of community clinics and public hospitals in San Francisco, 10 is still a small sample size. The 15 weeks of the semester was not enough time

to interview an administrator at each clinic and analyze such a large amount of data. In addition, many of the administrators we contacted did not respond to our letter and phone calls requesting an interview.

We also did not include nurse practitioners in our questions about physicians, as we had originally intended. This oversight is important to note because many patients see nurse practitioners as their primary care provider rather than doctors, and assessing their bilingual capacity is important in understanding clinics' and hospitals' linguistic competency.

Interviews were only conducted with administrators rather than a cross-section of staff. Therefore, our findings are limited to their perspective and knowledge. For example, we were not able to analyze the data we collected concerning the length of time it takes to hire staff, whether foreign-trained physicians and nurses had applied for job positions in the last five years, and administrators' experiences employing foreign-trained physicians and nurses in their original profession. Many administrators did not know the answers to these questions because they were not in charge of hiring, they could not break down their answers into the way we had structured the questions, or they were familiar with information concerning nurses and not physicians. We did not include data from these questions in our findings because our N/A and unknown category was too large for adequate analysis.

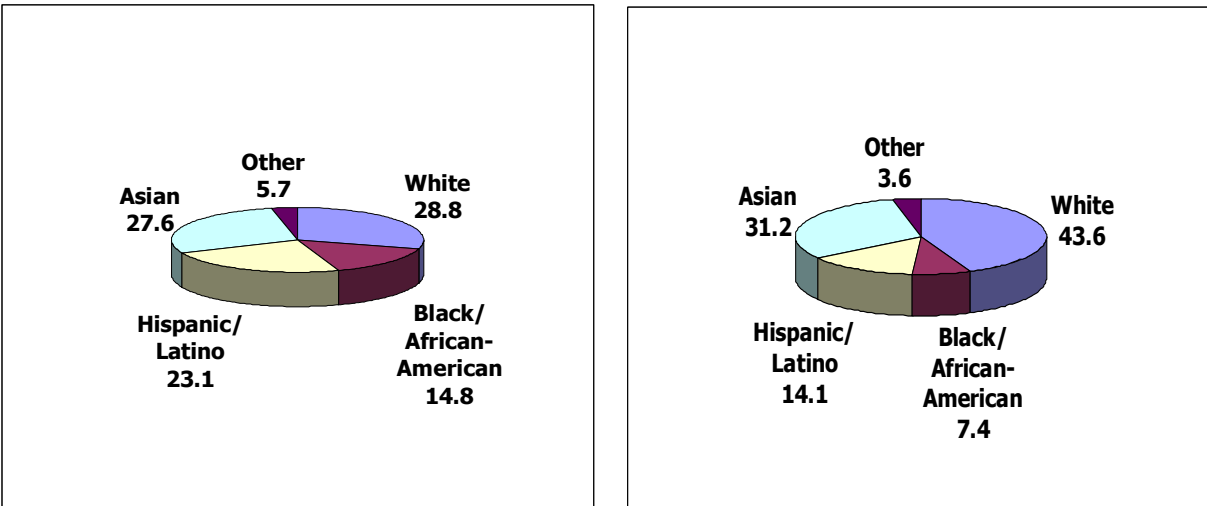
Finally, bias may have been introduced because interviews were conducted by three separate interviewers, sometimes in pairs and sometimes individually. In addition, we identified that we were working with Welcome Back and explained their mission, and this may have influenced interviewees' answers because we clearly had a positive attitude toward foreign-trained health professionals.

FINDINGS I: Linguistic Needs

Demographics

The first component of our community assessment was to determine the linguistic needs of the patient population of the clinics and hospitals we interviewed. As a first step in this process, we asked administrators to break down the ethnicities of their patient population. **Figure 1** shows the patient population of the clinics and hospitals we surveyed compared with the population of San Francisco. There is a higher percentage of Latinos and African Americans in the patient population than in San Francisco as a whole, with African Americans being twice as high and Latino almost 10% higher. More than 70% of the patient population is comprised of people of color, compared to 56% in San Francisco. Our findings mirror the literature in showing that safety net health providers are serving a disproportionately high number of people of color, many of whom are immigrants and limited-English speakers.

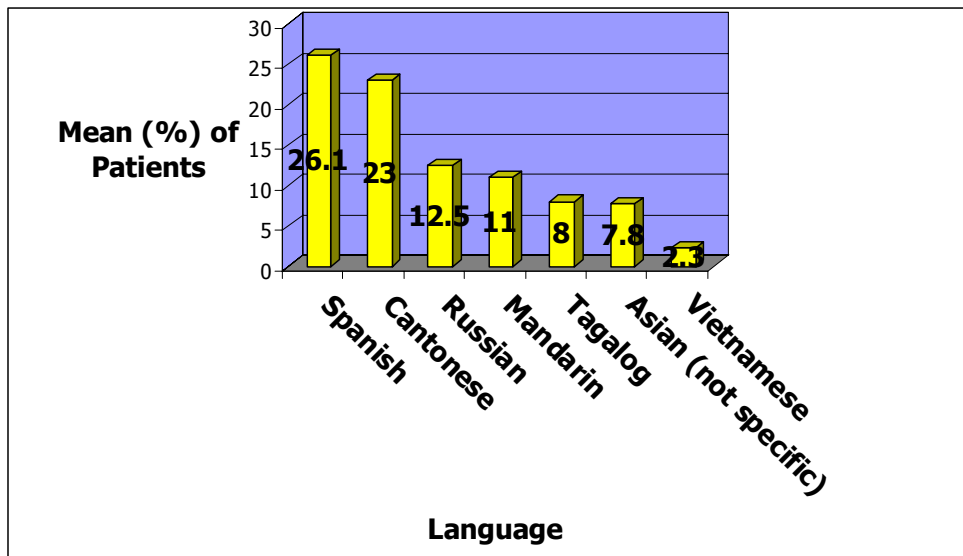
Figure 1: Sample Patient Population and San Francisco Residents



Top Languages Spoken by LEP Patients

Next we asked clinics about the top three languages spoken by limited-English proficient (LEP) patients. **Figure 2** shows Spanish and Asian languages as the primary languages spoken, much like the LEP population of San Francisco. Asian languages included Cantonese, Mandarin, Tagalog, and Vietnamese. Several clinics were unable to be specific about Asian languages spoken, and we grouped these under the category “Asian Not Specific.” One clinic has a small percentage (<1) of Portuguese speakers. We calculated the mean percentage and determined the range of LEP patients speaking the top three languages. The mean percentage of all LEP patients speaking the top language, whatever that language is, is 32% (range 4-85%); speaking the 2nd top language is 9% (range 1-23%); and speaking the 3rd top language is 2.6% (range <1-7%).

Figure 2: Top languages spoken by LEP patients



Clinic/Hospital Capacity to Meet Language Need

In order to determine the language capacity of clinic and hospital staff, we asked how many people in each staff position spoke the top three languages of LEP patients. **Table 2** shows the mean percentage and range of each staff position able to speak the top three languages.

Table 2: Means and ranges of staff positions who speak top languages

	<u>Top Language</u>	<u>2nd Top Language</u>	<u>3rd Top Language</u>
Front Desk	N=8 Average: 50.3% Range: 0-100	N=8 Average: 30% Range: 0-99%	N=7 Average: 2.6 Range: 19.7%
Medical Assistant	Average: 85.8% Range: 0-100%	Average: 37.4 Range: 0-100	Average: 20.4 Range: 0-100%
RNs/LVNs	Average: 47.4% Range: 0-100%	Average: 21.1% Range: 0-99%	Average: 2% Range: 0-14%
Physicians/NPs	Average: 40.4% Range: 0-100%	Average: 13.1% Range: 0-99%	Average: 5.7% Range: 0-20%

For the top language and second top language, N=8 because the interviewees at the two hospitals, both nursing administrators, did not have information on total staff's bilingual ability. N=7 for the third the third top language because, in addition to the two hospital "unknowns," another clinic did not have more than two languages spoken by LEP patients.

We compared the mean percentage of LEP patients speaking the top two languages to the mean percentage of each staff position able to speak those languages. Because the mean percentage of patients speaking the top 3rd language was so small (2.6%), we did not include it in our analysis). **Figure 3** shows the percentage of clinics in which the mean percentage of staff who speak a top language meets the mean percentage of patients speaking that same language, which we will refer to as the staff to patient language ratio. In other words, because the mean percentage of LEP patients speaking the top language is 32%, all clinics who had equal to or more than 32% of front desk staff able to speak the top language of their LEP patients were included in this graph. Overall, front desk staff and MAs/MEAs have a greater capacity to meet the language needs of LEP patients than nurses and physicians, with physicians the least likely to

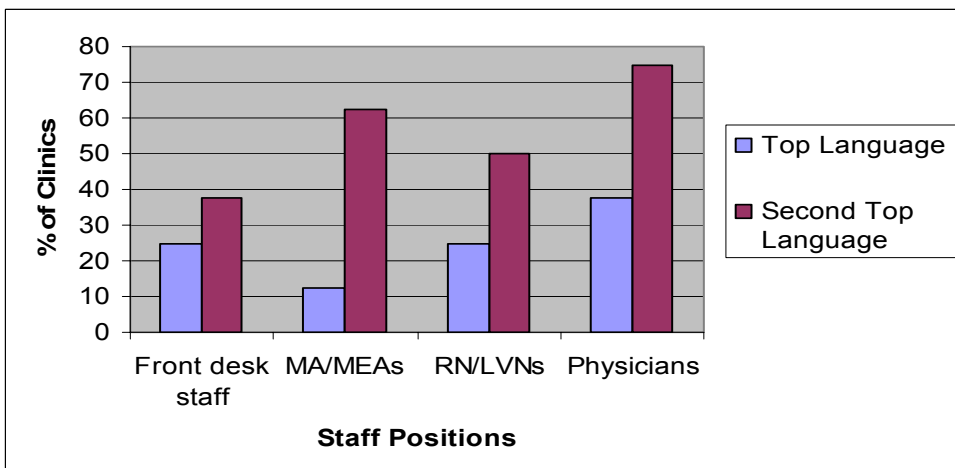
be bilingual. The higher the level of responsibility, the lower the language capacity. It is also important to note that even when staff is bilingual, they are not necessarily bicultural.

Figure 3: Clinics proficient in top languages spoken by LEP patients



As you can see from **Figure 3**, many clinics are not able to meet the staff to patient language ratio. Of those clinics who cannot, most of them have *no one* in the identified staff position who can speak the top languages of LEP patients. **Figure 4** shows the percentage of clinics in which no one in the identified staff positions can speak the top languages. Again, physicians are the least likely to be bilingual and have the highest rate of having no one in their position able to speak the top languages.

Figure 4: Clinics in which no staff in identified positions speak top languages of LEP patients



Communicating with LEP Patients when Providers Cannot Speak Language

Clinics use several different modes to speak with patients when providers cannot communicate with LEP patients. Eight clinics bring in other staff members, such as front desk and clerical staff, health workers, and other clinical staff; four clinics use a telephone translator system; two clinics use trained-in house interpreters; and six clinics use other means, such as family members, volunteers, or a translator brought by a patient. One administrator mentioned that she would rather have other staff translate than an interpreter because when patients know there is a staff-person who speaks their language, they always ask for them no matter what the person's position. Clinics used the aforementioned modes of translation an average of 34 times a month, with a range from "zero to one time" a month to "hundreds of times" a month.

Difficulties Hiring Bilingual Staff

Administrators stated that retaining bilingual staff is a challenge because they often get recruited elsewhere for better pay. In addition, it is easier to find bilingual staff than bicultural staff. They would rather have staff who are both bilingual and bicultural, but some find that bilingual/bicultural staff are not able to speak English well enough to communicate with other staff and all patients. One administrator said, "...cultural competence is important. We may find staff that have the language skills but not the culture of the patients. Therefore, they may not know the specifics of the language, like when to use the formal or informal, and may not understand the values and beliefs and cultural issues like appropriate body language...[also] they may not know indigenous population's herbs or spiritual beliefs." Two other administrators stated difficulty in finding people who are willing to work with a homeless patient population. Several also mentioned that there is not a large enough pool of bilingual candidates to choose from.

Level of Difficulty Hiring Ancillary Staff

In addition to front desk staff, MA/MEAs, nurses and physicians, nine out of ten clinics employ ancillary staff such as health educators, dieticians, or case managers. In all cases but one, administrators judged hiring bilingual ancillary staff “as difficult” or “more difficult” than hiring front desk staff, MA/MEAs, RN/LVNs, and physicians. Only one administrator said it is “less difficult.” Administrators stated that bilingual social workers, case managers, health educators, and lab technicians are hard to find. One medical director said that her clinic had been looking for a social worker bilingual in Spanish for eight months.

FINDINGS II: Perceptions of Foreign-Trained Health Professionals

Opinions of Foreign-Trained Health Professionals’ Education and Skills

The second component of our assessment was to determine attitudes of clinic and hospital administrators towards foreign-trained health professionals (FTHPs). **Table 3** shows whether administrators felt that the education and skills of foreign trained nurses and physicians is better, equal or worse than that of those trained in the U.S. Some administrators would not use our scale and answered “different,” which we coded as N/A. Virtually no administrators felt that either the skills or education of foreign-trained nurses or physicians is better than that of those who were U.S. trained. Several administrators felt that their education and skills are equal to that of those trained in the U.S. The most informative data we collected regarding this question was qualitative. One administrator who chose “equal” on our scale commented, “I’d say a foreign-trained physician’s skills are equal overall, but may be even better because they have a better cultural understanding than people trained in U.S. in terms of their way of thinking and exposure to culture.”

However, more than half of the administrators said that foreign-trained nurses and physicians’ skills and education were either worse, different, dependent on what country they were trained in, or they did not know. In particular, 30% said that a foreign-trained nurse’s education is “different;” 50% said that a foreign-trained nurse’s education depends on where they were trained; 10% said a foreign-trained physician’s education is “different;” 30% said a foreign-trained physician’s education or skills depends on where they were trained. One administrator who said, “different” commented, “Some foreign-trained physicians who claim to be physicians would not meet the minimum standards in this country—they’re “health workers.” With regard to foreign-trained nurses’ education, another administrator who chose “worse” said, “It’s not so much a lack of training as it is a lack of resources; they are not familiar with medicines we have and procedures we do here; they have a different standard of care.”

Table 3: Opinions of foreign-trained nurses and physicians’ education and skills

N = 10	Nurses		Physicians	
	Education	Skills	Education	Skills
Better	0	1	0	0
Equal	4	4	2	3
Worse	3	3	4	2
N/A or unknown	3	2	4	5

Benefits and Barriers to Hiring Foreign Trained Nurses and Physicians

In our questions with scaled answers about FTTHPs’ skills and education, we invited administrators to make qualitative comments. They illuminated that there are both benefits and barriers to hiring foreign-trained nurses and physicians in their original professions. Barriers include the opinion that the skills and education of FTTHPs are worse than that of U.S. trained

health professionals, that FTHPs do not have appropriate licensure to work as physicians and nurses in the U.S., that many of them have limited English skills, that many are not familiar with the U.S. healthcare system and its protocols, and that there is often a lack of technological resource in the country in which they are trained so they need to learn the technical components of the U.S. healthcare system.

In terms of benefits, FTHPs often have a better cultural understanding and greater linguistic competency with LEP patients, and many have experience working with limited resources. One administrator stated that FTHPs might work more effectively with patients who do not fit a westernized model; for example, they can understand patients' desire for herbal remedies rather than prescriptions.

Hiring Unlicensed Foreign-Trained Physicians and Nurses in Another Capacity

We asked administrators about employing foreign-trained nurses and physicians in another capacity when they did not have licensure in their original profession. Four out of ten clinics and hospitals had hired foreign-trained nurses in another capacity, as MAs, CNAs, LVNs, a community outreach worker, and a health worker. All four said that these employees exceeded or met the job expectation, and that they would be very likely to hire them in their original profession if they obtained their licensure.

Six out of ten clinics had hired physicians in another capacity, as an EKG tech, a case manager, as RNs, and as a clerical worker. 83% (5 out of 6) said that the foreign-trained physicians exceeded or met the job expectation. Only two clinics would be very likely to hire them if they obtained their licensure in their original profession, two clinics said they would be “somewhat likely,” one clinic said “not likely,” and one clinic was N/A or unknown.

CONCLUSIONS

From our findings, we drew several conclusions. First, approximately 50% of all clinic patients are LEP. This is especially noteworthy because, in general, the language capacity of staff does not reflect that of their patients. In some clinics, there is *no one* in specific staff positions able to speak the top languages spoken by LEP patients.

Often, across the four areas of staff investigated (front desk, MA/MEAs, RN/LVNs, and physicians), physicians in particular are the least likely to be bilingual. Many providers have to use some mode of translation in order to communicate with patients and, in two cases, this happens many times a day. We did not expect administrators to admit that they use family members for translation purposes because it is illegal to do so. Some did, however, include family members as one way they ensured translation for patients, which leads us to believe that even more do so but would not say.

Administrators have difficulty recruiting and retaining bilingual staff in general and bilingual/bicultural staff in particular. Many clinics also have difficulty hiring ancillary staff to provide supplemental support to primary medical care.

Administrators felt that there are both challenges and assets to employing foreign-trained physicians and nurses in their original professions. Many felt that FTHPs' skills and education is different than those who are U.S. trained and dependent on where they were trained. It is clear that FTHPs need assistance in improving their skills and/or becoming familiar with the U.S. health care system.

Finally, administrators are satisfied with the job performance of unlicensed FTHPs working in another capacity. In particular, all who employed foreign-trained nurses in another capacity would be very likely to hire them if they obtained their nursing licensure. In comparison, only one-third of those who employed foreign-trained physicians in another

capacity would be very likely to hire them if they obtained their M.D. This could be due to the fact that there is a nursing shortage, or possibly results from the experience or conception that foreign-trained nurses are easier to work with or more flexible than foreign-trained physicians due to physicians' difficulty adjusting to status changes or to the U.S. health care system.

RECOMMENDATIONS

Drawing from our conclusions, we offer recommendations in three areas: for clinics and hospitals, for Welcome Back's program design, and for policy work.

Clinics and Hospitals

We found that many clinics and hospitals do not break down their patient population into specific ethnic and linguistic categories. For example, while many knew the percentage of Asian patients at their clinics, they were not able to specify the countries of origin or languages spoken. Many did not do so because they were not required to report specific categories to their funders. We recommend, however, that clinics track this information because they must have accurate information in order to begin to properly address linguistic needs.

In addition, in order to understand the linguistic gaps among staff, as well as to inform hiring, clinics must determine the percentage of bilingual staff needed to achieve language parity with their clientele. For example, a clinic could decide that for every 10% of patients who speak Cantonese, the clinic will hire at least one physician who is bilingual in Cantonese. Clinics will have to determine this ratio depending on their clinic size. For some clinics, it may be that only five percent of patients speaking a particular language necessitate a bilingual provider in that language, for others it may be 20%. Regardless, health centers need to have an overall plan for how they will communicate with limited English proficient patients.

Welcome Back Programming

A concern of administrators was that FTHPs might not have the necessary English skills to communicate with all patients and other staff. Therefore, we feel it is important that Welcome Back continue to encourage participants to improve upon their English language skills. Administrators also expressed concerns that foreign-trained physicians and nurses would not be familiar with U.S. medical protocols and technology. It would be helpful for Welcome Back to convene focus groups to learn specific areas in which clinic and hospital staffs believe FTHPs need skill upgrades. Welcome Back can then use this information to develop and implement programs to ensure that their participants are marketable.

As almost half of all clinics and hospitals had hired unlicensed FTHPs to work outside of their original professions in other capacities such as MAs or health educators, and all were satisfied with their performance in these positions, Welcome Back should encourage participants to apply for positions outside their original professions. FTHPs working in other health care positions are beneficial for participants, as a way to upgrade their familiarity with the U.S. health care system, and for the clinics and hospitals as a way to fill some of their language gaps.

Policy

We recommend that Welcome Back advocate for state and federal funders to require detailed ethnic and linguistic breakdowns. This may require additional resources so that clinics and hospitals can upgrade their data collection methods.

Overall, it is important to advocate for funding to assist safety net providers in meeting the needs of LEP patients as well as to advocate for the planning and development of approaches to increase the number of bilingual providers.

As one administrator said, “A place like Welcome Back is long overdue. It should have existed a long time ago, especially in California with our diversity. We need more policy to deal with the shortage of culturally competent professionals in health.”

LESSONS LEARNED

Our team learned quite a few lessons after undertaking this community assessment. If we were to conduct the assessment again, we would have the same two people conducting each interview to ensure consistency in asking and interpreting questions rather than going in different formations of pairs or individually. There are many ways our tool needs to be improved, and if we had conducted additional pilot tests, we may have determined this sooner and made appropriate changes to have more valid and reliable interview questions. In addition, data clean-up and analysis took much longer than we had expected, and we would allocate more time in the future for this part of the assessment process. Finally, we learned that community assessment is a complicated process that requires a great deal of experience and that, at the moment; we are far from experts in conducting community assessments.

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APPENDICES

Appendix A

Community Assessment Instrument

COMMUNITY ASSESSMENT Welcome Back Center, San Francisco, Fall 2002 Interview Questions for Health Clinic Directors (With Coding Instructions)

Name of Clinic: _____ (See Code Book Supplement)

Interviewee Name: _____

Interviewee Title: _____

Check one: _____ DPH Clinic (1) _____ Community-based Clinic (2)
 _____ Both (3) _____ Public Hospital (4)

Today's Date: _____

Interviewed By: _____

INTRODUCTION:

- Thank you
- Grad students/work with WB
- WB is trying to help FTHP achieve parity
- End goal to have larger pool
- Different aspects of program to help FTHP
 - Obtain licensure
 - Learn English
 - Learn about us health care system
- Funded by Cal Endow
- Partnership between CCSF and SFSU
- Over 700 clients in SF Bay
- Information will be reported in aggregate; no staff or clinic names associated w/info
- Value your comments
- Ok to tape record interview? I'll ask you this again on the tape.

(Intro written out is on last page)

1. How many employees do you have? (*in clinics such as Haight/Ashbury, specify only health clinic, not including substance-abuse program/other programs*)

employees _____ (#)

2. We'd like to know a little more the community of patients you serve. Can you give us a breakdown of the races and ethnicities of your patient population and also a ballpark percentage for each group? (Make sure to break down Asian groups)

a. race/ethnicity: _____ % _____

b. race/ethnicity: _____ % _____

c. race/ethnicity: _____ % _____

d. race/ethnicity: _____ % _____

e. race/ethnicity: _____ % _____

f. race/ethnicity: _____ % _____

g. race/ethnicity: _____ % _____

h. race/ethnicity: _____ % _____

i. race/ethnicity: _____ % _____

j. race/ethnicity: _____ % _____

3. Given that ethnic breakdown, we'd like to ask you about the linguistic skills of your patient. Of the *limited English-proficiency* patients you have, what are the three primary languages spoken? What percentage of your patients speak each of these languages?

a. Language A _____ % _____

b. Language B _____ % _____

c. Language C _____ % _____

(data entry - see code book supplement languages in order from greatest percent to least)

4. We'd like to talk about the challenges of hiring and recruiting. Now that we know the top languages spoken, I'd like to ask you about specific staff who are *fully bilingual* in English and the following languages.

4a. How many ___ staff (insert one of the following staff positions) are <i>fully bilingual</i> in _____(Language A)	# who speak language	“Out of... “ (total # of each staff position) (enter as a percentage)
Front Desk staff		
MAs		
RNs/LVNs		
Physicians		

4b. How many ___ staff (insert one of the following staff positions) are <i>fully bilingual</i> in _____(Language B)	# who speak language	“Out of... “ (total # of each staff position) (enter as a percentage)
Front Desk staff		
MAs		
RNs/LVNs		
Physicians		

4c. How many ____ staff (insert one of the following staff positions) are <i>fully bilingual</i> in _____ (Language C)	# who speak language	“Out of... “ (total # of each staff position) (enter as a percentage)
Front Desk staff		
MAs		
RNs/LVNs		
Physicians		

Comments:

5. We’d like to know how long it takes to recruit specific staff who are fully bilingual:

When recruiting <i>fully bilingual</i> ____ staff (insert one of the four staff positions), how long does it take to find someone who speaks _____ (Language A)?	Length of time (Refer to SCALE #1)
5a. Front Desk	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
5b. MAs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
5c. RNs/LVNs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
5d. Physicians	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4)

	_____ N/A (9)
--	---------------

Comments:

6. For the same staff, how long does it take to find someone who speaks _____ (Language B)?	Length of time (Refer to SCALE #1)
6a. Front Desk	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
6b. MAs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
6c. RNs/LVNs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
6d. Physicians	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)

Comments:

7. Again, for the same staff, how long does it take to find someone who speaks _____ (Language C)?	Length of time (Refer to SCALE #1)
7a. Front Desk	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
7b. MAs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
7c. RNs/LVNs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
7d. Physicians	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)

Comments:

8. How long does it take to find ____ staff (insert one of the four staff positions), who speak <u>English only</u> ?	Length of time (Refer to SCALE #1)
8a. Front Desk	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
8b. MAs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
8c. RNs/LVNs	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)
8d. Physicians	_____ < 1 month (1) _____ 1-3 months (2) _____ 3-6 months (3) _____ > 6 months (4) _____ N/A (9)

Comments:

8. What problems do you encounter in recruiting and hiring bilingual staff?

9. We know a lot of health clinics employ ancillary staff such as health educators, dieticians or nutritionists, and licensed social workers. In terms of language needs, is it:

(Refer to SCALE #2)

- Less difficult (1)
- As difficult (2)
- More difficult (3)
- Impossible (4)
- N/A or unknown (9)

to hire for these positions as it is for the 4 previous positions (front desk, MAs, etc.)?

Comments:

10. When you don't have language capacity to communicate with patients, what resources do your providers use?

(Only say the following when a PROMT is needed)

- a. Use trained interpreters **in-house** (1)
- b. Use trained interpreters **out of house** (2)
- c. Use other staff members, such as MAs, front desk staff, etc. (3)
- d. Other _____ (4, please specify in comments)

(If N/A, SKIP to Q.12)

Comments:

11. How many times a month does it occur that you don't have language capacity?

 times per month (total for all languages and all types of resources)
(enter #, categorize later)

12. The majority of Welcome Back's clients are physicians and nurses. So, we want to ask you about your opinions and experiences with foreign-trained physicians and nurses. Let's start with questions about nurses.

In your opinion, do you feel a foreign-trained nurse's *education* is: (Refer to SCALE #3)

 Better (1) Equal (2) Worse (3) or Don't Know (4)

than someone who was trained in the U.S.

Do you have any comments about that?

13. In general, do you feel that the *skills* of a foreign-trained nurse working in a community-based health center are

 Better (1) Equal (2) Worse (3) or Don't Know (4)

than someone who was trained in the U.S., or

Do you have any comments about that?

14. In the last 5 years, when you have had job postings for nurses, have you had foreign-trained nurses apply for positions?

_____ Yes (1) _____ No (0) *(If NO, SKIP to Q. 18)*

15. (If yes) Did they have appropriate licensure to be able to work in your clinic?

_____ Yes (1) _____ No (0)

16. Of the nurses you employed in the last 5 years, how many obtained their education outside the U.S.?

_____ *(If zero, SKIP to Q. 18)*
(enter #, Code later)

17. (If >0) Overall, how satisfied were you with their job performance(s)? (Refer to SCALE #4)

_____ Not satisfied at all (1)
_____ Somewhat satisfied (2)
_____ Satisfied (3)
_____ Very satisfied (4)
_____ N/A or unknown(9)

Comments:

18. Have you had the opportunity to hire foreign-trained nurses in another capacity (for example, hiring a foreign-trained nurse as a medical assistant)?

_____ Yes (1) _____ No (0) *(If NO, SKIP to Q. 22)*

19. (If yes) In what position were or are they employed at your clinic?

employed as _____ (enter as words, code later)

20. Overall, what is your opinion of the job performance of these foreign-trained nurses working in other positions? (Refer to SCALE #5)

- Exceeded job expectation (1)
- Met job expectation (2)
- Met minimal job expectation (3)
- Performed below job expectation (4)
- N/A or unknown (9)

Do you have any comments about that?

21. If these individuals (foreign-trained nurses working in other positions) obtained their license to work in their original profession, how likely would you be to hire them as nurses?

(Refer to SCALE #6)

- very likely (1)
- likely (2)
- somewhat likely (3)
- not likely (4)
- N/A or unknown (9)

Do you have any comments about that?

Now I'm going to ask you the exact same set of questions about physicians.

22. In your opinion, do you feel a foreign-trained physician's *education* is: (Refer to SCALE #3)

- Better (1) Equal (2) Worse (3) or Don't Know (4)

than someone who was trained in the U.S., or

Do you have any comments about that?

23. In your opinion, do you feel that the *skills* of a foreign-trained physician working in a community-based health center are: (Refer to SCALE #3)

Better (1) Equal (2) Worse (3) or Don't Know (4)

than someone who was trained in the U.S., or

Do you have any comments about that?

24. In the last 5 years, when you have had job postings for physicians, have you had foreign-trained physicians apply for positions?

Yes (1) No (0) *(If NO, Skip to Q. 28)*

25. (If yes) Did they have appropriate licensure to be able to work in your clinic?

Yes (1) No (0)

26. Of the physicians you employed in the last 5 years, how many obtained their education outside the U.S.?

(If zero, Skip to Q. 28)
(enter #, code later)

27. (If >0) How satisfied were you with their job performance?

Not satisfied at all (1)
 Somewhat satisfied (2)
 Satisfied (3)
 Very satisfied (4)
((N/A or unknown)) (9)

Comments:

28. Have you had the opportunity to hire foreign-trained physicians in another capacity (for example, hiring a foreign-trained physician as a medical assistant)?

_____ Yes _____ No *(If no, SURVEY IS DONE – go to wrap up)*

29. (If yes) In what position were or are they employed at your clinic?

employed as _____ (enter as words, code later)

30. Overall, what is your opinion of the job performance of these foreign-trained physicians working in other positions? (Refer to SCALE #5)

- _____ Exceeded job expectation (1)
- _____ Met job expectation (2)
- _____ Met minimal job expectation (3)
- _____ Performed below job expectation (4)
- _____ N/A or unknown (9)

31. Do you have any comments about that?

32. If these individuals (foreign-trained physicians working in other positions) obtained their license to work in their original profession, how likely would you be to hire them as physicians? (Refer to SCALE #6)

- _____ very likely (1)
- _____ likely (2)
- _____ somewhat likely (3)
- _____ not likely (4)
- _____ N/A or unknown (9)

Comments:

That was our last question. Before we wrap up, is there anything you'd like to add?

Closing:

- **Thank you**
- **Help WB:**
 - Document staffing challenges**
 - Need for creating accelerated training programs for FTHP**
 - Policy work around licensing criteria**
 - Secure more funding to help FTHP enter US health care system**
- **Long run—you will have larger pool**
- **Do you have any questions for us about Welcome Back or our community assessment?**
- **We will be presenting our results to our class on Wednesday December 11th at the San Francisco Public Library between 1 and 4pm. You are welcome to come to this presentation and we will also send you a copy of our final community assessment results.**

INTRODUCTION

Thank you for taking the time to meet with us. As you know, we are graduate students getting our MPH at San Francisco State University, and we are currently working with Welcome Back. You may have read in the packet that Welcome Back is trying to help foreign-trained health professionals enter the U.S. health care system. We are trying to achieve parity between the diverse population of California and health care providers. Our end goal is to have a larger pool of physicians and nurses and other health professionals who speak the language and understand the culture of clinic patients. We have many different aspects of our program to help foreign-trained health professionals obtain licensure, learn English, and learn about the U.S. health care system. Welcome Back is funded by the California Endowment and a partnership between City College of San Francisco and SFSU. We currently have over 700 clients in the SF Bay Area.

All of the information you give us will be reported in aggregate, and no staff names or clinic names will be used associated with specific data. We want you to know that while many of our questions are quantitative, we really value your comments and want to encourage you to make them at any time. Sometimes we will specifically ask if you have comments, but feel free to jump in with thoughts even when we don't ask.

CONCLUSION

Thank you again for taking the time to meet with us. This interview will provide Welcome Back with data that will be very helpful to the program. It will help us document the staffing challenges that health clinics face in serving underserved populations, and document the need for creating accelerated training programs for foreign-trained health professionals,. It will also help us with policy work around licensing criteria for foreign-trained health professionals and allow our program to secure more funding to help them enter into the U.S. health care system. In the long run, hopefully you will have a larger pool of people to recruit from who speak the language and understand the culture of your patients.

Appendix B

Table 4: San Francisco Safety Net Providers

Medical Clinic/Center	<u>Name of Director/Postion</u>	Address/Phone/Website/Hours
<u>Castro Mission Health Center</u>	Dr. Jane Bailowitz, Medical Director	3850 17 th St., San Francisco, CA 94114-2031 (415) 487-7500 http://www.dph.sf.ca.us/chn/HlthCtrs/castro-mission.htm Clinic Hours By appointment Monday through Friday 8am-12pm and 1pm-5pm plus Tuesday 5pm-8:30pm
Chinatown Public Health Center	Dr. Alexander Moy, Medical Director	1490 Mason St., San Francisco, CA 94133-4222 (415) 705-8500 http://www.dph.sf.ca.us/chn/HlthCtrs/Chinatown.htm Clinic Hours Monday through Friday 8:00am-5:00pm Drop-In Clinic Monday, Tuesday, Wednesday, Friday, 8 am – 11 am, 1 pm – 4 pm Closed Thursdays & third Wednesday (Can only take first 20 patients)
Haight-Ashbury Free Medical Clinic	Beryl Shaw, Director Ms. Lara Sallee, Director of Women’s Health Services	558 Clayton St., San Francisco, CA 94117-2907 (415) 487-5632 http://www.hafci.org/ By Appointment Only Monday 1:00 PM – 9:00 PM Tuesday – Thursday 9:00 AM – 9:00 PM Friday 1:00 PM – 5:00 PM Services provided on an appointment basis only.
Laguna Honda Hospital	Mary Louise Fleming, RN, MSN, Senior Associate Hospital Administrator	375 Laguna Honda Blvd., San Francisco, CA 94116-1411 (415) 759-3380

Medical Clinic/Center	<u>Name of Director/Postion</u>	Address/Phone/Website/Hours
Lyon-Martin Women's Health Services	Ms. Doretha Williams-Flournoy, Executive Director Dr. Lisa Pratt, Medical Director	174 Market St., Suite 201 San Francisco, CA 94102-5800 (415) 565-7667 http://www.sfccc.org/clinics/lmwhs.htm Hours: Mon and Thu 8:30 AM – 5:00 PM drop-in; Wed 11:00 AM – 7:00 PM; Tues and Fri 8:30 AM – 5:00 PM by appointment
Maxine Hall Health Center	Dr. Marcellina A. Ogbu, Center Director	1301 Pierce St., San Francisco, CA 94115-4005 (415) 292-1311 http://www.dph.sf.ca.us/chn/HlthCtrs/Maxine_Hall.htm Clinic Hours Monday, Wednesday, Friday 8am-5pm Tuesday, Thursday 8am-7pm Drop-In Clinic No appointment Necessary Frist come, first served Mon, Tues, Wed 12pm, Thurs, Fri 8am, Tuesday 4pm
Mission Neighborhood Health Center	Ms. Gladys Sandlin, Executive Director Dr. Antonia Sacchetti, Medical Director	240 Shotwell St., San Francisco, CA 94110-1323 (415) 552-3870 http://www.sfccc.org/clinics/mnhc.htm Mon-Fri. 8:00 – 5:30 pm
Native American Health Center	Mr. Dan Tatum Executive Director	56 Julian Ave., San Francisco, CA 94103 (415) 621-8051 http://www.dph.sf.ca.us/chn/HlthCtrs/NativeAmerican.htm Clinic Hours Monday through Friday 9am-5:00pm
North East Medical Services	Ms. Linda M. Yu Bien, MSPH, Executive Vice-President Dr. Daniel Chan, Medical Director	1520 Stockton St., San Francisco, CA 94133 (415) 391-9686

Medical Clinic/Center	<u>Name of Director/Postion</u>	Address/Phone/Website/Hours
North of Market Senior Services Center	Ms. Gay Kaplan, Executive Director	333 Turk St., San Francisco, CA 94102-3703 (415) 885-2274 http://www.dph.sf.ca.us/chn/HlthCtrs/NorthMarket.htm Clinic Hours Monday-Friday 9:00am – 12:00pm, 1:00pm - 5:00pm Drop-In hours Tuesday 1:00pm – 2:00pm, Friday 9:00am – 11:00am
Ocean Park Health Center		1351 24 th Avenue, San Francisco, CA 94122-1616 (415) 753-8100 http://www.dph.sf.ca.us/chn/HlthCtrs/OceanPark.htm Clinic Hours Monday through Friday, 8am-5pm Women’s Clinic Wednesday, 1pm-5pm Prenatal Clinic Friday, 8am-12pm Drop-In Immunization Hours Monday, Wednesday, Thursday, Friday, 8am-11am Tuesday, 1pm-4pm
Potrero Hill Health Center	Dr. Michael Drennan, Medical Director	1050 Wisconsin St., San Francisco, CA 94107-3328 (415) 648-3022 http://www.dph.sf.ca.us/chn/HlthCtrs/PotreroHill.htm Clinic Hours Monday through Friday 8:30am-5:30pm
San Francisco Free Clinic	Dr. Richard Gibbs, Executive Director	4900 California St., San Francisco, CA 94118 (415) 750-9894

Medical Clinic/Center	<u>Name of Director/Postion</u>	Address/Phone/Website/Hours
SFGH Medical Center	Sue Currin, Chief Nursing Officer Leslie Holpit, RN, MSN, Manager, Nursing Systems Retention & Recruitment	1001 Potrero Ave., 2A35, San Francisco, CA 94110-3518 (415) 206-5077 http://www.dph.sf.ca.us/chn/HlthCtrs/GeneralMedSFGH.htm
SFGH Family Health Center	Dr. Lori Kohler, Medical Director	995 Potrero Ave., San Francisco, CA 94110-2859 (415) 206-5252 http://www.dph.sf.ca.us/chn/HlthCtrs/FamilyHCSFGH.htm Clinic Hours Monday through Friday 8am-5pm
SFGH General Medical Clinic	Dr. Dean Schillinger, Medical Director	1001 Potrero Ave., San Francisco, CA 94110-3518 (415) 206-8492 http://www.dph.sf.ca.us/chn/HlthCtrs/GeneralMedSFGH.htm Clinic Hours Monday through Friday 8am-12pm and 1pm-5pm Tues Evening Clinic 5pm-9pm
Silver Avenue Health Center	Dr. Marie Palazuelo, Medical Director	1525 Silver Ave., San Francisco, CA 94134-1229 (415) 715-0300 http://www.dph.sf.ca.us/chn/HlthCtrs/Silver.htm Clinic Hours Monday through Friday, 8am-5pm By appointment Monday & Wednesday
South of Market Health Center	Mr. Charles Range, Executive Director	551 Minna St., San Francisco, CA 94103 (415) 626-2951 http://www.sfccc.org/clinics/smhc.htm
Southeast Health Center	Dr. Robert Franklin, Medical Director	2401 Keith St., San Francisco, CA 94124-3231 (415) 715-4000

Medical Clinic/Center	<u>Name of Director/Postion</u>	Address/Phone/Website/Hours
St. Anthony Free Medical Clinic	Mr. Gail Priestley, Director	105-107 Golden Gate Ave., San Francisco, CA 94102 (415) 241-8320 http://www.sfccc.org/clinics/safmc.htm Hours: M, T, Th, Fri. 8:00 – 12:00, 1:00 – 4:30; Wed 8:00 – 12:00 Offers free drop-in care on a first-come, first-serve basis. Appointments are available.
Tom Waddell Health Center	Dr. Barry Zevin, Medical Director	50 Ivy St., San Francisco, CA 94102-4506 (415) 554-2950 http://www.dph.sf.ca.us/chn/HlthCtrs/TomWadell.htm Urgent Care Clinic 1 st Floor Monday through Friday, 8:30am-7:30pm Saturday, Sunday and Holidays 9am-4:45pm, Closed Tuesday 12:30-2:00pm

Appendix C

Letter to Administrators

Mary Louise Fleming, Senior Executive Hospital Administrator
Laguna Honda Hospital Administration
375 Laguna Honda Blvd.
San Francisco, CA 94116-1499

September 9, 2002

Dear Ms. Fleming:

The San Francisco Welcome Back Center: International Health Worker Assistance Center was successfully launched in March, 2001. This past spring, you may recall receiving an informational packet describing our program. The mission of the Center is to build a bridge linking the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities. The Center is a partnership between Community Health Works, the Regional Health Occupations Resource Center, the City College of San Francisco, and San Francisco State University.

We are currently conducting a community assessment to document the linguistic needs of community health clinics and other safety net providers in the San Francisco Bay Area. As we assist health professionals from immigrant communities in either becoming licensed or retrained in an alternative health profession, we ask them to make a personal commitment to working with underserved and immigrant communities. Because you are a safety net provider serving these communities, it is important for us to understand your needs for health professionals who speak the language and understand the culture of your patients. As part of our assessment, I am working with Roma Guy, Vice President of the San Francisco Health Commission and instructor in the MPH Program at SFSU. Roma has three graduate students (Regina Lagman, Amanda Goldberg, Emily Galpern) who will be assisting me on this project. They will be conducting interviews with the Directors of safety net clinics in September and October.

We will be calling soon to set up a time for an interview with you or your designee. Please note that the data collected in this assessment will only be used and reported in aggregate. We hope that you will help us in our commitment to reduce health disparities by bringing the resources of foreign-trained health professionals to community clinics in San Francisco.

Sincerely,

Brenda Storey, MSW, LCSW
Director, San Francisco Welcome Back Center

cc: Roma Guy, MSW, Instructor
Department of Health Education, San Francisco State University

Appendix D

Thank You Letter to Administrators

San Francisco Welcome Back Center

*City College of San Francisco
John Adams Campus
1860 Hayes Street, Room 221
San Francisco, CA 94117-1220
Phone (415) 561-1833
Fax (415) 561-1948
info@e-welcomeback.org*



July 28, 2003

Linda M. Yu Bien
North East Medical Services
1520 Stockton St.
San Francisco, CA 94133

Dear Linda,

Thank you for taking time to meet with us. Your input for our community assessment is vital in helping us document the staffing challenges that you have in serving diverse populations. In the long run, the Welcome Back Center looks forward to providing a larger pool of health professionals who speak the language and understand the culture of your patients.

We would like to invite you to hear our results of the assessment, which will be held on:

Wednesday, December 11, 2002

12:30-1:30pm

San Francisco Civic Center Main Library

100 Larkin St. at Grove, Latino Room A

We will mail you a copy of the reported results.

If you have additional questions about the SF Welcome Back Center, please feel free to call us at: (415) 561-1833. We look forward to seeing you on the 11th.

Sincerely,

Amanda Goldberg, Emily Galpern, Regina A. Lagman
Graduate Students in Master of Public Health, San Francisco State University

cc: Brenda Storey, MSW, LCSW, Director, San Francisco Welcome Back Center
Roma Guy, MSW, Instructor, SFSU

Appendix E

Code Book Supplement

Table 5: Clinic and Hospital Codes

Code #	Name of Clinic/Hospital	Interviewer's Initials
1	Ocean Park Health Center	RL & AG
2	SF General Hospital Medical Center	RL
3	North of Market Senior Services Center	EG
4	St. Anthony Free Medical Clinic	EG
5	Laguna Honda Hospital	RL & EG
6	Lyon-Martin Women's Health Services	AG
7	Tom Waddell Health Center	EG
8	Mission Neighborhood Health Center	AG
9	North East Medical Services	RL
10	Maxine Hall Health Center	AG

Table 6: Language Codes

Code #	Language
1	Spanish
2	Cantonese
3	Vietnamese
4	Tagalog
5	Russian
6	Mandarin
7	Korean
8	Japanese
9	Thai
10	Laotian
11	Cambodian
12	Asian
13	Chinese
14	Portuguese

Appendix F
Quantitative Data Collection

Appendix G

Qualitative Data Collection

Appendix H

San Francisco Welcome Back Brochure