

Kaiser Permanente Policy Story, v3, No. 1

Improving Access to Healthy Food

Cassville, Pennsylvania had no local food options after a gas station market burned down in 2007. The closest grocery store was 15 miles away. In 2009, Betsy and Mark Whitsel built the 3,200 square-foot Cassville Country Store. Using a grant from the Pennsylvania Fresh Food Financing Initiative, the Whitsels purchased two coolers for fresh produce and a commercial refrigerated prep table for deli food. Local farmers stocked the produce coolers with tomatoes, peppers, eggs and apples. The sales of local corn grew to justify an additional storage unit.

The Pennsylvania Fresh Food Financing Initiative extended loans and grants to existing and new stores in underserved communities to increase the availability of fresh food. Researchers assessing the initiative's long-term impact in Pennsylvania found that Cassville Country Store added eight jobs to the local economy.¹

The Convergence Partnership, a philanthropic collaborative which Kaiser Permanente co-founded in 2005 to leverage our impact nationally, has done amazing things to promote healthy food access. Through the Convergence Partnership, Kaiser Permanente provided critical support to bring a successful state model, the Pennsylvania Fresh Food Financing Initiative, to scale in the new federal Farm Bill.



Policy Context

Obesity is a driving force behind the chronic disease epidemic in the United States. Research shows that in addition to helping control weight, eating a healthier diet—including more fruits and vegetables—may reduce the risk of cancer and other chronic diseases. Underserved rural and urban areas, however, often lack access to grocery stores and farmers markets that sell healthier foods.

Community-based initiatives to improve access to healthy food in America's food-insecure communities are included, for the first time, in the federal Agricultural Act of 2014 (also known as the Farm Bill).

The Farm Bill is the primary agricultural and food policy tool of the federal government and addresses issues such as nutrition, food stamps, conservation programs, and agriculture trade. In the passage of the 2014 Farm Bill, Congress authorized small but pioneering programs to promote access to healthy food in underserved communities.

The Challenge

Americans in too many low-income, rural communities—like Cassville, Pennsylvania—must travel long distances to access the fresh food they need to live healthy lives. In urban and suburban areas, residents of low-income communities face different but related challenges that make them especially vulnerable to obesity and its related chronic diseases:

- low-income neighborhoods frequently lack full-service grocery stores and farmers' markets;
- healthy food is often more expensive or of poor quality in low-income communities; and
- low-income communities have greater availability of fast food restaurants.²

“Kaiser Permanente is looking for ways to bridge the gap between the nutrition counseling we provide in the clinical setting and the unique challenges many low-income patients face in their communities where access and affordability are barriers to healthy food,” says Raymond J. Baxter, PhD, senior vice president for Community Benefit, Research and Health Policy, Kaiser Permanente.

Kaiser Permanente Solution

Kaiser Permanente is a member of the Convergence Partnership, which has worked with community leaders, advocates, and policy makers over several years to elevate healthy food access initiatives to federal policy. These efforts include:

- assisting federal policymakers in the development of the federal Healthy Food Financing Initiative (HFFI), which provides more than \$500 million in grants and tax credits to grocery stores, farmers markets, food hubs, and urban farms to address food deserts;
- providing a grant to evaluate the impact of HFFI investments. Researchers gathered data on how the Pennsylvania Fresh Food Financing Initiative affected rural Pennsylvanians, including mileage to a store and sales and employment gains;
- convening HFFI grantees in Washington, D.C., to promote peer learning and give grantees the opportunity to share their experiences through more than 120 visits to senators and representatives;
- encouraging the philanthropic community to adopt a cross-sector, cross-policy approach to healthy food access; and,
- launching the Food and Agriculture Policy Fund, a new collaboration of funders, to advance healthy food access and equity.

Outcomes

The Convergence Partnership's multi-year work to promote access to healthy food in underserved communities influenced two important provisions in the 2014 Farm Bill:

- the national Healthy Food Financing Initiative at the U.S. Department of Agriculture.
- the Food Insecurity Nutrition Incentive program, a new national program that features matching funds to farmers markets—up to \$20 million annually for five years—to create incentives for food stamp recipients to buy more fresh fruits and vegetables with their benefits.

“I don't think the Healthy Food Financing Initiative would have happened absent the investments of the Convergence Partnership,” said Judith Bell, president, PolicyLink. To date, the HFFI and similar efforts have helped bring hundreds of millions of dollars in public and private sector resources—grants, loans, and tax credits—to healthy food access projects across the country.

Practical Implications and Transferability

The new Farm Bill provisions are a crucial step in helping individuals in low-income, underserved communities reduce their risk of chronic disease and maintain a healthy lifestyle. Health care organizations can make a difference by identifying and engaging with local initiatives to strengthen healthy food access and ensure that this access translates to better health. Learn more about HFFI local initiatives at: <http://www.acf.hhs.gov/programs/ocs/programs/community-economic-development/healthy-food-financing>

For more information, please visit:

Kaiser Permanente Institute for Health Policy at <http://www.kp.org/ihp>

¹ The PA Fresh Food Financing Initiative, “Case Study of Rural Grocery Store Investments,” The Reinvestment Fund, Philadelphia, PA, June, 2012, http://www.trfund.com/wp-content/uploads/2013/06/FFFI_Impact_RuralPA.pdf, (accessed March 25, 2014).

² Food Research and Access Center, “Why are Low-Income and Food-Insecure People Vulnerable to Obesity?” <http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/> (accessed March 25, 2014).

Kaiser Permanente Policy Story, v3, No. 2

Kaiser Permanente's Qualified Bilingual Staff Model

When 18-year-old Willie Ramirez was rushed to a Florida hospital on January 22, 1980, his family had no idea that linguistic and cultural barriers would lead to a devastating misdiagnosis.¹ Willie arrived at the hospital comatose, and his Spanish-speaking Cuban family told doctors he was “intoxicado,” a word that is used when a person feels ill after eating or drinking. But the doctors did not understand the word “intoxicado,” erroneously thinking that Willie was “intoxicated,” or overdosing on drugs. Doctors ordered toxicology tests. The family insisted that drugs were not involved, but did not push the doctors out of respect for authority figures. It took doctors two days to discover his true diagnosis, an intracerebellar hematoma. By then, damage to Willie’s brain was so severe that he was left quadriplegic.

Willie Ramirez’ story was widely-reported, and brought attention to the medical tragedies that can occur because of linguistic and cultural barriers between providers, patients, and their loved ones. In light of these stories, health care systems are coming to understand the importance of using qualified interpreters to ensure the safety, equity, and quality of health care.

Policy Context

The United States health care system is adapting to better serve an increasingly diverse patient population. In particular, health care organizations are designing care that meets the needs of patients who have limited



Graduates and faculty of Kaiser Permanente's Qualified Bilingual Staff Model program.

English proficiency. Two major federal initiatives have been enacted to ensure that patients with limited English proficiency receive high quality care: Title VI of the Civil Rights Act of 1964, which requires recipients of federal funding to provide language assistance services; and the Culturally and Linguistically Appropriate Services (CLAS) standards, developed by the Office of Minority Health in 2000. CLAS requires health systems to provide language assistance and materials translated in patients’ preferred languages, among other standards for delivering culturally and linguistically appropriate care.

The Challenge

Willie Ramirez’ story shines light on the serious consequences that arise when patients, and their family members and friends, do not have access to providers who understand their language and culture. For example, patients with limited English proficiency tend to have longer hospital stays and are at greater risk of infections, falls and pressure ulcers due to these long stays.² Providing bilingual interpreters is one way to ensure quality care for patients with limited English proficiency, but not every patient has access to interpreters. In some cases, not enough interpreters are available due to supply or affordability. Other times, systems rely on untrained bilingual staff or patients’ family members and friends to act as

interpreters. Systems need to think creatively to increase patients' access to well-trained, high quality interpreters.

Kaiser Permanente Solution

Patients with limited English proficiency need linguistic services at each point of contact in our system, including call centers, hospitals, pharmacies and medical offices. Through the Qualified Bilingual Staff Model, Kaiser Permanente identifies bilingual staff members of all types—such as doctors, nurses, medical assistants, and receptionists—assess their language skills, and provides them with comprehensive training based on their level of linguistic competency. Staff members can attain three levels of QBS training:³

1. **Level 1, language liaison.** Staff converse in English and the patient's preferred language, and provide directions, simple instructions, and interpretation that does not require medical terminology.
2. **Level 2, language facilitator.** Staff are able to give simple medically and/or non-medically related instructions within their scope of practice, conduct simple translations, and provide interpretation in simple clinical encounters.
3. **Level 3, designated interpreter.** Staff can conduct more complicated translations, provide interpretation in simple- to moderately-complex clinical encounters, and can act as interpreters in a group, class or conference setting.

A defining characteristic of the Qualified Bilingual Staff Model is its focus on developing both linguistic *and* cultural competency. Interpreters must be proficient in both English and another language, and they must also understand the cultural context of the languages and the health beliefs and values of the patients they serve.

Outcomes

As of 2013, over 11,000 staff members in all seven of our regions have trained in the program. The Qualified Bilingual Staff program has positively impacted workplace culture because it emphasizes the importance of each staff member playing a role in

delivering linguistically and culturally appropriate care. “We are seeing enhanced morale and a greater sense of responsibility among our staff,” says Gayle Tang, senior director of National Diversity and Inclusion. “Staff members really feel like they are serving as part of a team, and that they are accountable to one another in providing quality care and services.” In 2006, the program won the National Committee for Quality Assurance's Recognizing Innovation in Multicultural Health Care Award. In 2013, Kaiser Permanente received the National Corporate Leadership Award from the Migration Policy Institute, recognizing our leadership in providing culturally and linguistically appropriate health care and services.

Practical Implications and Transferability

The Qualified Bilingual Staff model can help health systems deliver high quality interpretation services in a cost-effective manner by making use of staff already on hand. Key enablers of the program include: obtaining leadership buy-in, having program administrators on-site, forging partnerships with labor, management and clinicians, and fostering organizational commitment to education, training, assessment, and program monitoring.

Kaiser Permanente is sharing the Qualified Bilingual Staff Model with our community partners across the nation by offering consultation, training, and technical assistance to organizations who want to adopt it. For more information, visit: kpqbs.org.

For more information, please visit:

Kaiser Permanente Institute for Health Policy at <http://www.kp.org/ihp>

¹ Price-Wise, G. (2008, November 19). Health Affairs Blog. *Language, Culture, And Medical Tragedy: The Case of Willie Ramirez*. <http://healthaffairs.org/blog/2008/11/19/language-culture-and-medical-tragedy-the-case-of-willie-ramirez/>

² Agency for Healthcare Research and Quality. “Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals: What We Know About Safety and Limited English Proficiency.” <http://www.ahrq.gov/professionals/systems/hospital/lepguide/lepguidesumm.html#what>

³ *Ibid.*

Kaiser Permanente Policy Story, v3, No. 3

Capturing the Patient Voice: Video Ethnography as a Tool to Transform Health Care

A team arrives at a hospital with video cameras to interview and shadow senior patients and their families throughout their care experience. One team member asks questions about patients' interactions with their doctors, their understanding of medication instructions, and which resources they most needed. Another team member speaks with caregivers and observes the discharge planning process. The team's final product is not headed to a theater or documentary film festival. It is part of a comprehensive quality improvement effort that uses a technique called video ethnography to help redesign health care around patient and family member needs.

Policy Context

The Triple Aim is a framework developed by the Institute for Healthcare Improvement to enhance patients' experience of care, improve population health, and reduce the cost of care. As the population ages and rates of chronic illness rise, health systems will need to make a more concerted effort to understand the experiences and preferences of older patients, many of whom have complex care needs.

The Challenge

At the heart of improving the health care delivery system is a thoughtful understanding of patient experience. Health systems typically gather information on patient and family experience by fielding surveys, conducting focus groups, and inviting patients to serve on advisory committees. These activities, however, may not be sufficient for deepening understanding of certain patients' experiences. For example, elderly patients and those with chronic



illness often cannot take part in these activities. To achieve patient-centeredness, health systems must find new ways to ensure that all patients' voices are heard.

Kaiser Permanente Solution

For decades, social scientists have used a research method called ethnography to study human experience and culture. The term traditionally referred to a practice in which researchers live within a culture for a long period to study it. Today, ethnography can describe activities where researchers spend less time—days, or even hours—observing and interacting with participants in areas of their everyday lives. Kaiser Permanente uses a video-based form of ethnography to bring patient perspectives into our quality improvement processes. “Video ethnography” combines observations and in-depth interviews of patients, caregivers, and other staff with video recording, qualitative analysis, and quality improvement planning.

Kaiser Permanente uses video ethnography to identify unmet patient and family member needs. “Since we began using video ethnography in 2008, it has made a real impact in helping us see with new eyes, deepening our understanding of the patient and family experience in ways that uniquely complement our other methods for gathering data,” says Estee Neuwirth, PhD, director of evaluation, Kaiser Permanente Care Management Institute.

Video Ethnography in Action

Many of Kaiser Permanente's projects that use video ethnography focus on the experiences of seniors and those with multiple chronic illnesses. For example, a team in our Northwest region shadowed a woman in her eighties—call her Sarah—for an entire day at a Kaiser Permanente medical center. Sarah came in for a routine check-up with her primary care physician. The team observed that Sarah valued seeing her doctor face to face, but by the end of the day she was exhausted by the journey to the clinic. In addition to the office visit, she waited for lab tests, spent time in waiting rooms, and eventually missed lunch, which was typically provided by her assisted living facility. The team also noticed that Sarah was not prompted to bring a caregiver or family member with her into the exam room. During Sarah's visit, it became clear that she had some memory loss and didn't remember that she had a heart attack several months earlier.

As happens with many seniors, Sarah's visit with her doctor required complex coordination between herself, her assisted living facility, her family, and Kaiser Permanente. These types of insights helped the team identify simple improvements—such as encouraging patients to invite family and/or caregivers to the clinic visit—to transform care.

Other examples of video ethnography projects include:

Effective Care for Heart Attack Patients: In our Southern California region, video ethnography was used to increase the use of the evidence-based practice of therapeutic hypothermia (lowering a patient's body temperature to reduce the risk of brain damage) after a heart attack. Some providers were uncomfortable with the treatment, fearing that it might be painful for patients and that the potential discomfort might outweigh the clinical benefits. Through video ethnography, patients shared that they did not remember undergoing hypothermic treatment, putting providers at ease and enabling the use of this effective therapy.

Improving Palliative Care: Our Colorado region used video ethnography to transform care for patients with serious illness. Video interviews with palliative care patients clarified the nature of patients' fear and uncertainty. The tool helped support the need for social workers in the care process.

Focusing on Social Supports: Our Northern California Performance Excellence group uses video ethnography to study social care in the medical setting. The group hopes to understand patient needs such as transportation and community support, enabling them to build a structure to provide high-needs patients with necessary non-medical services.

Practical Implications and Transferability

Kaiser Permanente's Care Management Institute has developed an in-depth toolkit to help teams apply video ethnography, keeping overhead low by using inexpensive video equipment and simplified qualitative analytic techniques. To spread knowledge and expertise across our system, we disseminate this toolkit and conduct "train the trainer" sessions. By making video ethnography a routine part of quality improvement activities, health systems can use the voices of patients, families, and staff more fully to transform care.

To learn more about our approach to video ethnography, visit <http://kpcmi.org/ethnography/video-ethnography-tool-kit.pdf> and <http://www.youtube.be/D0cHAK2rpOg>.

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