Black Leadership Kitchen Cabinet
Santa Clara County Public Health Department

A Call to Action

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From: Ruth Wilson, Richard Kos, Sonja Kos (Team SJSU)

TO: Mr. Walter Wilson, Black Leadership Kitchen Cabinet
MRS. ALMA BURRELL, Santa Clara County Public Health Department

Re: Draft Report: A Call to Action

Thank you for extending the deadline for this Call to Action Draft Report. It has been an honor to be a part of this collective effort to address the health care concerns of people of African and African American Ancestry in Santa Clara County.

We look forward to receiving your feedback from this draft, as needed, to meet your needs.

Respectfully,

Team SJSU
Purpose of this Call to Action

In 2013-2014, the Black Leadership Kitchen Cabinet (BLKC) collaborated with the Santa Clara County Public Health Department and other organizations to assess the health status of the African American community since its last review in 1999. This document is a Call to Action that, when incrementally and completely implemented, can result in dramatic improvements to health care provision, health care training, and the health status of people in the African/African Ancestry community of Santa Clara County.

State of the Valley and People of African Ancestry

The Silicon Valley, is among the wealthiest regions in our nation. Its wealth has been built through long-term investments in education and cultural values encouraging innovation, entrepreneurship, and the freedom and liberty afforded those who take risk to innovate, build, and transform the way people think, live and thrive. Santa Clara County is located in the Valley.

Since the Valley began its high tech transformation, its once vibrant African American population has shrunk (Insert chart). Immigrants who have strong educational backgrounds form the core of its new high tech workforce and, responding to corporate recruiters of high tech college graduates, they arrive prepared to enter the high tech job market.¹

Silicon Valley is exceptional. While the economy in other regions in our state and nation remained relatively stagnant, the Valley thrives. It represents:

- 1.1% of the state’s land mass
- 7.7% of its population
- 13.1% of California’s jobs
- 9.9% of California’s GDP
- 46.5% of IPOs
- 47.6% of venture capital
- 43.0% of mergers and acquisitions²

However, job growth and employment—driven by high tech business with some growth in health care, construction, community infrastructure, and other businesses—has not allowed all residents to share equally in the Silicon Valley’s economic success. According to the 2014 Silicon Valley Index report, gaps and disparities are more pronounced than ever.

² Ibid.
Income gains among ultra high-end technology skilled workers and investors are not present among low- and middle-skilled workers. Valley residents have witnessed sharp increases in homelessness. The percentage of households with mid-level incomes has flattened or decreased in Silicon Valley more than in the state and nation. These factors profoundly impact the health status and survival of African Americans.

Health care is a contested commodity in our nation. Those with money purchase insurance to buffer their risk of an illness incident and their opportunity to prevent illnesses before they become a threat to life and livelihood. Prior to Obamacare, citizens prioritized jobs that offered substantial health benefits, especially those citizens with children. Thus, health status is closely aligned with income and employment—two areas where Silicon Valley African American and African ancestry immigrant populations are particularly vulnerable.

The 2014 Silicon Valley Index report notes that the rate of health care coverage for unemployed residents ages 18-64 has decreased three percentage points since 2010. African Americans, the ethnic group experiencing the highest rate of unemployment and most decisive loss of jobs in the Valley, experienced declines in health care, challenges to pay for health care, and increasingly poor access to services provided by the Valley’s health care workers.

Nowhere are the gaps in health care and health status more persistent than among African Americans, and other people of color. Traditionally excluded in California, and the Valley, from access to middle and upper income jobs, housing opportunities, and start-up capital for innovative businesses, serious health disparities among African Americans persist.

The Clinical Encounter and People of African Ancestry

The authors of this Call to Action, informed by dozens of participant stories, pondered this particular question at length: what happens when African-American patients seek care? Are they treated in a way that will maximize their possibility of surviving long-term health challenges such as cancer or diabetes? This clinical encounter is where the rubber meets the road. Will the patient return and continue to persist until diagnosed and treated properly … or be discouraged and give up?

Americans of African Ancestry seeking health services for which they have insurance walk a narrow path. They cannot assume that health providers work in their interests. As a patient, they must compete for the time and expertise of the provider. Any incorrectly chosen or pronounced word or gesture, or any emotion the provider may not feel is appropriate, can result in less than optimal care, continued pain and discomfort, whether or not an MRI or X-ray will be ordered, and whether pharmacological and/or non-pharmacological treatment regimens will be included and explained in the search for a cure. While seeking care, the patient—not the provider—must assume the responsibility of understanding the provider’s cultural norms and nuances, communicate using those norms, and be aware of other culturally coded nuances that the patient may not know.
Under such circumstances, ineptitude on the part of professionally educated health workers can lead to less than optimal patient care.

The clinical encounter is filled with land mines. For the patient to challenge authority, and to persist against the provider’s resistance to extend time needed for patient care, could result in decrease in services, no free drug samples, or more medication (sedation) or, worse still, movement up or down the priority list for surgery or a transplant. These challenges to communicate are not resolved by having a translator.

The language and cultural translation needs of our community are more complex than those patients for whom Spanish is the language of choice. Spanish has its base in Latin, as do much of the words and cultural ideas intrinsic to the English language. This is not the case for African language speakers. For example, African ancestry patients from Nigeria, Kenya, or Ethiopia, who may have learned English in primary or secondary schools, still face cultural and communication barriers during the clinical encounter. Even when a “translator” is present, there is no guarantee that a full understanding of the biomedical concepts and cultural expectations of the clinical encounter have been achieved. The 2013-2014 African & African Ancestry survey results indicate the need for training in cultural competency for health workers, and self-advocacy training for people of African Ancestry.3

African American/African Ancestry patients disappointed during the clinical encounter are less likely to follow prescribed treatments, keep records of adverse effects, or return to follow up for an appointment and call their health provider when symptoms persist. In the interim, illnesses continue to erode their health, reducing the probability of recovery when, if ever, they return for treatment.

Health care workers also have needs. American-born and foreign-born providers overcame enormous barriers to have the opportunity to train and work in America. They competed to gain admission to college, become certified, and secure a job in the health care, a high status industry. They, too, want to maintain their earned privileges.

African American and African Ancestry citizens need culturally competent health workers when they enter the health care system. They need training in how to advocate for themselves during the clinical encounter. They need health care pamphlets and videos that reflect their cultural realities and those of the health care system in which they seek care. To continue the exclusionary practices reported in the 2013-2014 qualitative and quantitative public health survey cannot be tolerated.

Reflecting Upon the 1999 Demographic Study

We have found it instructive in preparing this Call to Action to reflect upon the findings in the 1999 study by Mason Tillman Associates: A Demographic Profile of the African American Community in San Jose and Santa Clara County. The report was prepared for the African American Resource Leadership Council and lays out in clear detail a number of health-related community demographics as well as recommended strategies to improve the lives of the county’s African-American community. In fact, the impetus for the 2014 health study was a need, identified in early 2013 by the Black Leadership Kitchen Cabinet, to update the Mason Tillman report with current quantitative and qualitative data.

The 1999 Mason Tillman report highlighted a number of health-related concerns that persist to this day, including the following:

INFANT MORTALITY AND PRENATAL CARE

• African American infant mortality rates declined substantially, in the 1990's, from 24.1% in 1990 to 12.9% in 1995. However, that rate is still higher than for any other ethnic group living in the County.
• Between 1993 and 1997, more than 21% of the City of San Jose’s pregnant African American females received late or no prenatal care. Inadequate prenatal care is correlated with birth outcomes such as low birth weight and infant mortality.

Today, information from the Santa Clara County Dept. of Public Health’s Black Infant Health program indicates:

- African-American women are four times more likely to experience life threatening health complications from pregnancy than Caucasian women, regardless of their socioeconomic status
- African-American babies are twice as likely to be low in birth weight (less than 5 pounds 8 ounces) than those of other racial or ethnic groups
- African-American babies are almost three-times as likely to die in their first year of life

CANCER INCIDENCE

• Between 1991 and 1995, African American women living in the County had relatively low early-stage and high late-stage breast cancer rates, suggesting that African American women are not engaging in early detection practices.
• During the period from 1992 through 1996, the County’s African-American males had the highest prostate cancer rate, at 234.6 per 100,000.
• From 1990 to 1995, African American males living in the County had the highest lung cancer rate of any group, at 90.1 per 100,000.
Information from the 2014 African/African-Ancestry Assessment includes the following findings:

- Cancer incidence rates among the African/African Ancestry community are higher than the county averages for most common cancers. Similar disparities exist in terms of cancer mortality rates. Or, stated more directly, individuals of African/African Ancestry are more likely to get many types of cancer and, if they get any cancer, they are more likely to die from it, than other groups.
- People of African Ancestry experience higher incidence and mortality rates than whites for many types of cancer. Additionally, African Ancestry individuals receive less preventive and routine healthcare services, and thus are more likely to be diagnosed at higher stages of cancer.

More Insights from the Call to Action Stakeholder Team

There is a very strong need for culturally appropriate policies for disseminating known solutions to health care disparities. Current practices in Santa Clara County have produced an environment in which a privileged group of management decision-makers dominate policy, often without an understanding of the diversity of groups in the health systems they are being paid to manage and for whom they should develop policy.

On the other hand, many members of our community require support and direct advocacy for “stepping up” to more assertively direct their own health care decisions. Moreover, the health care providers with whom we interact in the privacy of an examination room need to be systematically and empathetically trained in cultural competency so that they may respond properly and comprehensively to the unique and real needs of our community.

New policies must help people flourish. Policy affects health directly; in fact, each of us is a product of policy. Moreover, policies drive behavior – and behaviors, of course, drive policy. We must all acknowledge, however, that racial stratification is embedded in the system’s policies, and county health policies in particular have perpetuated disparities. This affects, for example, how long providers spend with patients of different backgrounds based on biases. Stated even more directly, African people are experiencing negative effects of racism in a very real way: patients lose time for critical care if they are not immediately welcomed into the system. A short window of time can make a big difference in mortality and morbidity outcomes.

Ethnocentric policies do not produce optimal health in a multiethnic community. Policies must consider cultural context since deeply embedded in policy is a cultural worldview. As a result of healthcare-related policies and practices in Santa Clara County, too many people in our community have been undervalued – or devalued. We demand the right to be self-determined and this Call to Action, which will be a living document, is a platform upon which to assert that right.
A Call to Action: Shared Responsibility

This Call to Action addresses disturbing trends in the health status and health delivery of services to the Silicon Valley’s African/American and African Ancestry communities. It is not a timid and humble request for assistance. Like a drumbeat, it aims to reverberate from the top to the bottom of our society. It is an assertive, forward-thinking, data-informed listing of mechanisms for effective collaboration and lasting change on three fronts:

• A Call to Action for the elected leaders of this prosperous and nationally prominent county;
• A Call to Action to the members of the African-American community for which these actions will serve;
• A Call to Action for change agents in the county’s extensive healthcare provision and training system.

This Call to Action is presented with urgency and purpose from taxpaying, influential, deeply connected, devoted, and long-term residents of this county. We present our expectations in a spirit of unwavering optimism that is nonetheless informed by the sobering realities of historical injustices and shameful (and largely preventable) health outcomes that have impacted our proud community.

A Call to Action: Fostering Institutional Change to Eliminate Health Disparities

This Call to Action recognizes that while institutions such as the county’s elected leadership and health care systems will never change viewpoints and processes overnight, we nonetheless expect change to occur in a sustained and results-focused manner. We know that such change only occurs through positive working relationships, the equitable distribution of resources, sustained vigilance, and measured accountability.

We aim to direct and control resources to improve the lives of our community members, with full support and minimal interference from the institutions now in place.

Health disparities can – and must – be narrowed in this wealthy county. The research document accompanying this Call to Action notes the following: “with few exceptions, the African/African Ancestry community experiences higher rates of sickness and death than other racial/ethnic groups, and often receive a lower quality of healthcare for many diseases and treatments for these diseases. According to the World Health Organization and other leading health organizations, health inequities are mostly a result of social conditions that affect individuals. These “social determinants of health” are the conditions in which people are born, grow, live, work and age, including the health system that
responds to their needs. Many, if not all, of the social determinants that cause health inequities between groups of people are unfair and avoidable.”

Our clear objective is to positively, strategically, and incrementally disrupt “business as usual” in Santa Clara County. The priceless benefits to our community – and all county residents by extension – are absolutely worth the effort.

A Call to Action: What We Demand

We demand that steps be taken to address these shortcomings:

Within six months:

Call a meeting with City, County, Foundation Directors and others with resources and vested interest in addressing the health concerns of Santa Clara County’s citizens of African and African American Ancestry, which have been summarized in this document and discussed in greater detail in the 2013-2014 African and African Ancestry Demographic Profile.

Within 18 months:

1. Develop and issue a Request For Proposal that address the need for developing continuing education training modules leading to certification in effective communication with patients of African and African American Ancestry.

2. Develop and issue a Request For Proposal for the development of health information with images of people of African and African American Ancestry and containing printed materials and videos that teach best practices for navigating the health delivery system and the clinical encounter.

3. Develop and issue a Request For Proposal to develop and train certifiable Health Advocates for People of African and African American Ancestry.

4. Create a certificate in cultural competency for health professionals who provide services to populations of African/African American Ancestry.

5. If one does not exist, develop a training program for African language translators that identify specific components of the clinical encounter for which there are currently no translations. Hire translators to address this problem.

Within 5 years:

1. Develop more aggressive, culturally informed intervention programs to decrease obesity among African ancestry youth in elementary, secondary and high schools by 5 percent.
2. Develop and implement more aggressive and culturally infused intervention programs among adult African and African Ancestry diabetics.

3. Reduce the incidence of diabetes among African and African Ancestry populations by 10%.

4. Reduce mortality by strokes and heart attacks among African and African Ancestry Americans by 5%.

5. Work with local community organizations to increase the number of disease prevention and health maintenance messages in bulletins and newsletters produced by nonprofit organizations with African and African ancestry membership.

6. Increase by 20 percent the number of culturally competent health professionals of African and African American Ancestry with experience and knowledge of working in health care facilities.


8. Monitor the health status of people of African and African American ancestry and issue a yearly bulletin to the A/AA Ancestry stakeholders that informs the AAA community of actions taken by the public health department to address the above issues and the resulting outcomes.

**Immediately:**

1. Develop and sustain a fully operating Afrocentric Health Care Center available to all who wish to seek care at that facility.

**Closing Thoughts**

The problems we address here did not just “happen”. For too long, however, we have not been a prominent part of the dialogue to improve health outcomes in this county. This Call to Action represents the beginning of a reversal of that pattern. Santa Clara County is a world-recognized leader in many fields. “Getting it right” here is vitally important. With that in mind, this Call to Action expects – and demands – that *institutional* change will occur for the benefit of the African-American community and therefore, by extension, to the county community as a whole. Healthy communities are united communities.