CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

The Impact of Cultural Competency Interventions at the County of Los Angeles Department of Public Health on the Provision of Services.

A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Public Administration in Public Sector Management and Leadership

By

Francisco Lizama

August 2020

The graduate project of Francisco Lizama is approved:

Dr. Paul D Krivonos	Date
Dr. Linda-Marie Sundstrom	Date
Dr. Henrik Palasani-Minassians, Chair	Date

California State University Northridge

Acknowledgements

To Dad and Snowball. I miss you. Amanda Soto, you are the epitome of love and strength. Thanks for adopting me into the Soto clan at 17 and teaching me the definition of family. Genaro Sandoval, you are the brother I never had but always wanted. Thanks for believing in me. Chi Nguyen, my soul friend, you changed my life in the most wonderful ways. Karen Tu and Mackenzie Domann, more than just two of my best friends, you'll forever be the happy hour of my day.

Table of Contents

Abstract

The Impact of Cultural Competency Interventions at the County of Los Angeles Department of Public Health on the Provision of Services.

By

Francisco Lizama

Master of Public Administration in Public Sector Management and Leadership

This study examines the impact of cultural competency interventions at the County of Los Angeles Department of Public Health (DPH) on the provision of services. The study compares cultural competency performance by the County of direct services rendered to clients by county employees who completed cultural competency trainings and those who have not. The impact is evaluated by comparing cultural competency performance as reported by clients of direct services by and its impact in the provision of services. The study analyses the success of cultural competency interventions by the Los Angeles County Department of Public Health. Success of the intervention is evaluated by establishing whether a correlation between organizational cultural competencies are correlated with high performance of cultural competencies at the time of service delivery to clients.

Introduction

Racial and ethnic disparities among minority groups are well documented (Betancourt et al., 2003). Among the multiple components contributing to racial and ethnic disparities, social-determinants of health such as living conditions, access to healthy foods, exposure to pollutants, and education levels are likely the primary reason (Betancourt et al., 2003). The largest undertaking by the federal government to achieve health equity in the U.S. was under Barack Obama through Affordable Care Act (ACA) (Susan L. Hayes et al., 2017). Although well-intentioned, large health disparities remain post implementation of the ACA (Adepoju et al., 2015). Many reasons were given for the under performance of the ACA, among them the abysmal rollout, loss of healthcare insurance by populations living just above the cutoff points eligibility for subsidies, poor planning, and failure in addressing language barriers (Cundiff et al., 2014; Kamerow, 2014; Mojtabai, 2019; Parekh, 2017). The inefficiencies of the ACA and consequences give the impression that somewhere along the way, planners and implementers lost sight of the purpose of the ACA, to assist minority populations experiencing health disparities at disproportionate rates. Mishaps like those of the ACA have led the academic literature, especially that of the healthcare field to study the barriers for efficient delivery of health services (Lopez-Littleton & Blessett, 2015). Barriers identified fall under one of two factors, the social and cultural (Betancourt et al., 2003). Examples of social factors are environmental stressors, socioeconomic status, and environmental stressors (Betancourt et al., 2003). Culture are the beliefs, values, and Social factors are environmental stressors, socioeconomic status, social factors such as environmental stressors and social economic status and cultural factors the beliefs, values, and traditions that influence human behavior(Borrego & Johnson lll, 2011). In view of the difficulty in separating the social and cultural factors from one another, and each

other, and acknowledging their strong link, the term sociocultural is utilized as an all-encompassing term (Betancourt et al., 2003). In studying the sociocultural barriers to health and how to best respond to them, the topic of cultural competence emerged in the literature. (Betancourt et al., 2003). A standard definition of cultural competency does not exist, partially because it is difficult to articulate one that encapsulates its multiple components (Lopez-Littleton & Blessett, 2015). For this paper, we will use the definition of cultural competence set forth by Rice (2007a), who defines a cultural competent public organization as "one that acknowledges and incorporates at all levels the importance of culture, assessment of cross cultural relation, vigilance towards the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptations of services to meet culturally unique needs" (p.43).

The Los Angeles Department of Public Health (DPH) recognizes the importance of a culturally competent organization and is a strategic goal of the organization (County of Los Angeles Department of Public Health, 2019). Efforts to augment organizational cultural competence are supported through implementation of two trainings, Just Culture and Implicit Bias (County of Los Angeles Department of Public Health, 2019). Two On Program and policy formulation should be informed by those people who will be utilizing those services (County of Los Angeles Department of Public Health, 2019). Just Culture acknowledges the organization is not perfect, it sets to address the barriers to quality and efficient delivery of services by encouraging its workforce to report problems without fear of retaliation, creating an organizational culture focused on addressing problems rather than identifying who is to blame (Los Angeles County Department of Mental Health Office of the Administrative Deputy, 2017). Implicit Bias recognizes we all hold conscious and subconscious attitudes and stereotypes of groups of people that can color our decisions (County of Los Angeles Board of Supervisors,

2017). Implicit bias trainings bring the conscious and subconscious biases to the individual's awareness to prevent them from adversely affecting policy and delivery of public service (County of Los Angeles Board of Supervisors, 2017).

The topic of cultural competence is not new to public administration, it was first brough to the attention of public administrators in 1968 at the Minnowbrook conference (Lopez-Littleton & Blessett, 2015). However, the literature on cultural competence in public administration is small and in that sense in its infancy (Gooden, 2010). A standard definition and framework for cultural competence in public administration does not exist (Rice, 2007b). The lack of standard definition and framework for cultural competence is reflected in DPH's strategic plan (County of Los Angeles Department of Public Health, 2019). Part of DPH's goal to increase the organizational level of cultural competence is developing a framework for implementation. These study aims to assist DPH with their evaluation efforts by examining whether there is a difference in cultural competency demonstrated during service delivery between staff who completed their Just Culture and Implicit Bias training and those that have not.

Literature Review

The literature in cultural competency in public administration is in its infancy, in size, not age. First introduced at the 1968 Minnowbrook conference, some programs continue to pay little attention to topics on diversity and cultural competency (Lopez-Littleton & Blessett, 2015). Ironically, a lack of diversity among faculty is cited as a cause of minimal integration of cultural competencies in public administration programs (Gooden, 2010). When first introduced, cultural competency was focused on black-white health disparities but a lack of focus has prevented the discussion to expand in parallel to the changing demographics the U.S. has and continues to experience (Lopez-Littleton & Blessett, 2015). The demographics of the U.S. are transitioning from a white majority to a much more diverse cultural makeup (Weimer & Zemrani, 2017). In 2016 Non-Hispanic Whites made up 61.3% of the total population, this percentage is expected to drop to 44.3% by 2020 (Vespa et al., 2020). On the other hand the Asians and Hispanics making up 5.7% and 21.1% respectively in 2016 is estimated to grow to 9.1% and 27.5% by 2060 (Vespa et al., 2020). Growth in numbers represent a 2016 – 2060 growth of 101% for Asians and 93.5% for Hispanics (Vespa et al., 2020).

Cultural Competency and Academic Programs

Demographic shifts in the United States are far outpacing the response by public organizations to introduce institutional changes, such as cultural competence interventions to ensure quality and efficient service delivery to the populations served (Rice, 2007a). Efforts to increase organizational cultural competency plays a major role to ensure provision of services is equitable to all members of diverse populations served (Geron, 2002).

The healthcare field is the largest producer of literature on cultural competency (Lopez-Littleton & Blessett, 2015). The healthcare field as the largest producer of cultural competence

literature reflects the public and private sector demands it must meet (Cox & Blake, 1991; Lopez-Littleton & Blessett, 2015). The public sector makes cultural competency in service delivery a condition for eligibility of federal funding (Rice, 2007a). Private sector market pressure to compete for clients push healthcare providers to ensure they are able to serve a diverse clientele (Cox & Blake, 1991).

The private sector is cut throat and failure to effectively adapt and innovate in response to changes in the marketplace result in organizational dissolution (Ebener & Smith, 2015; Geissdoerfer et al., 2018). Business success is contingent on understanding the service you provide, to who, and using that knowledge to effectively market your business (Cox & Blake, 1991).

Health care workers function in an environment in which exchanges between clients are very likely to cross cultural lines of relation, language, and other customs (Lopez-Littleton & Blessett, 2015). A lack of cultural competence can limit the populations that will consider using your services. Caucasians use hospice care facilities at significantly higher rates than ethnic minorities (Doorenbos & Schim, 2004). Low levels of cultural competence among workers in hospice facilities are attributed for the low number of ethnic minorities utilizing hospice services (Doorenbos & Schim, 2004). Overall a healthcare organization with high cultural competencies will provide higher quality services (Lopez-Littleton & Blessett, 2015). To ensure their students are competitive in the healthcare market, healthcare curriculums have incorporated cultural competency trainings (Lopez-Littleton & Blessett, 2015).

Culture Competency and Federal Policy

The federal government in recognition of the importance of cultural competency in the delivery of public services has introduced procedural and policy level interventions (Rice,

2007a). Executive Order 13166 signed by President Bill Clinton in 2000 required any agency receiving federal funding ensure their services were accessible by people with limited English proficiency (LEP) (Executive Order 13166, 2000). The importance of communication between client and provider were recognized by the federal government on the Civil Rights Act of 1964 (Adepoju et al., 2015). On July 2011 the U.S. Department of Health and Human Services (HHS) Office of Minority Health released their action plan to reduce racial and ethnic disparities (Department of Health & Human Services, 2011). Social determinants of health and resulting health inequalities and premature death between 2003 and 2006 created a burden of $1.24 trillion (Department of Health & Human Services, 2011). The HHS also looked to revise their current guide on Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) (Department of Health & Human Services, 2011; U.S. Department of Health & Human Services, 2018). As responsible stewards of public funds with specific guidance in utilization of funds HHS released the CLAS document aimed to provide equitable access to health services by increasing cultural knowledge and preferred communication sensitivities by those providing health services (U.S. Department of Health & Human Services, 2018).

Cultural Competency and the Affordable Care Act

The Affordable Care Act (ACA) of 2010 was the most significant action by the federal government to address health discrepancies across the U.S. (Susan L. Hayes et al., 2017). It is also a good example of the importance of cultural competency in the delivery of public services. Although the ACA was backed by good intentions, oversight by those responsible for planning and implementation stifled its potential.

The ACA was an attempt to address the historically high numbers of uninsured individual living in the U.S. (Susan L. Hayes et al., 2017). At the time when the ACA was adopted, 48

million Americans were living in the U.S. uninsured (McIntyre & Song, 2019). The uninsured rate gap disproportionally affected minority groups (Susan L. Hayes et al., 2017). Support for ACA highly by partisan and did not receive a single Republican vote (Kamerow, 2014). Democrats and Republicans disagreed with a key provision of the ACA extending Medicaid eligibility to all individuals living at or below 138% of the poverty line (Institute of Medicine, 2014). Through vicious opposition from Republicans the ACA survived and was signed into law by Barack Obama in 2010 (Kamerow, 2014). To bridge the uninsured gap the ACA was broken down into three objectives, (1) increase health insurance coverages rates in the U.S., (2) reduce rising health care insurance costs through reform, and (3) improve the quality of service provided (Silvers, 2013).

Implementation of the ACA would be completed in phases from 2010 through 2020 (Ebener & Smith, 2015). Some provisions took effect upon the ACA being signed into law such as an extending the age dependents could remain on their parents insurance to 26 (Institute of Medicine, 2014). Key provisions, albeit some of the more controversial would be effective at the start of 2014. By January 1, 2014, every eligible US citizen and legal resident had to enroll in a healthcare plan meeting minimum requirements or face penalties come tax time (National Council of State Legislatures, 2011).

What started as a law with standard protocols applicable across all states was dealt a blow by the Supreme Court when it decided to make Medicaid expansion an optional provision to the states in the U.S. (Silvers, 2013). Immediately 14 states selected not to expand Medicaid putting a dent on the efforts to reduce the uninsured rate (The Henry J. Kaiser Family Foundation, 2014).

Initially the ACA proved effective in reducing the national uninsured rate (Institute of Medicine, 2014). The uninsured rate was reduced from 17.7% at the time the ACA was adopted

to 10.2% in 2017 after its strongest provisions came into effect (U.S. Census Bureau, 2019). Studies comparing Medicaid-expansion states vs non-expansion states found a greater increase in insurance coverage (Congressional Digest, 2016; Courtemanche et al., 2019; Susan L. Hayes et al., 2017).

By 2019 however, the uninsured rate began rise again (U.S. Census Bureau, 2019). Good intentions are not enough to successfully implement policy. A lack of cultural competency in program design and implementation put into question exactly what information public health officials were communicating to federal officials (Parekh, 2017).

A lack of cultural competency in program design and implementation created blind spots for the ACA. Evidence of the lack of preparation by officials leading ACA implementation began with an abysmal rollout which hurt the public's perception of the ACA (Cundiff et al., 2014; Parekh, 2017). Nine out of 10 adults have difficulty understanding information provided in healthcare facilities (Parekh, 2017). This is a problem the federal government is aware of and is reflected in provisions found in the Civil Act of 1964 as well as mandatory LEP requirements accompanying federal funding that ensure health literacy assistance is provided (Adepoju et al., 2015; Rice, 2015). Efforts were not made to educate the public on complicated concepts such as premiums and deductibles crucial in making informed choices for healthcare coverage in the online healthcare marketplace (Parekh, 2017). Public health workers providing direct service to clients were not prepared to translate the ACA and its requirements to the public (Parekh, 2017).

Even though the ACA benefited many individuals, there were those who were actually hurt by the ACA. Individuals falling just outside the cutoff points of eligibility for subsidies still could not afford health insurance and now were also responsible for penalties at tax time (Kamerow, 2014). Some of the individuals falling off the cutoff points were able to afford health

insurance prior to the ACA but could no longer afford them as their rates doubled (Kamerow, 2014).

The ACA was passed with good intentions behind it. Good intentions, however, do not make successful programs, good program planning does. In midst of pushing the ACA through congress, the most important piece was forgotten, the populations of need. Planning through a cultural competent lens looks to prevent poor program planning by linking directly linking the work with the population it intends to reach (Weimer & Zemrani, 2017).

Cultural Competency Definition

Due to the small and fragmented literature on cultural competency, there is little consensus on its definition. Without a standard definition of cultural competency that encapsulates its multiple components, a link to standard measurable actions behaviors, and observations is impossible to establish (Lopez-Littleton & Blessett, 2015). Unsurprisingly, a lack of a standard definition in the literature is accompanied with the absence of a standard framework of study (Lopez-Littleton & Blessett, 2015).

The Cultural Diversity Institute (CDI) released a cultural competency self-assessment guide for public organizations. CDI defines cultural competency as, "A set of congruent behaviors, attitudes and policies that come together in a system, agency or professional that enables that system, agency or profession to achieve cultural diversity and to work effectively in cross-cultural situations" (Van Ngo, 2000).

This study will use the definition proposed by Rice (2007a), who defines a cultural competent public organization as "one that acknowledges and incorporates at all levels the importance of culture, assessment of cross cultural relation, vigilance towards the dynamics that

result from cultural differences, expansion of cultural knowledge, and adaptations of services to meet culturally unique needs" (p.43).

Cultural Competency and Los Angeles County Department of Public Health

Increasing organizational competencies is one of the primary goals of DPH (County of Los Angeles Department of Public Health, 2019). DPH recognizes cultural competency is a crucial factor in achieving health equity among Los Angeles County residents (County of Los Angeles Department of Public Health, 2019). A risk-averse bureaucracy is a barrier to policy and procedural level changes the County of Los Angeles Department of Public Health Strategic Plan 2018 – 2023 aims to achieve (County of Los Angeles Department of Public Health, 2019; Daft, 2012; Wang & Feeney, 2016). DPH's strategic plan proposes changes.

The many lessons of the ACA are reflected in the County of Los Angeles Department of Public Health Strategic Plan 2018 – 2023. Equity is the foundation in which the strategic plan builds on (County of Los Angeles Department of Public Health, 2019). By June 30, 2018 DPH moved forward with implementation of department wide mandatory implicit bias and cultural competency trainings (County of Los Angeles Department of Public Health, 2019). Implicit bias are conscious and subconscious attitudes and stereotypes about groups of people we all have (County of Los Angeles Board of Supervisors, 2017). Implicit biases can color our decisions and are detrimental to policy and services provided by public agencies (County of Los Angeles Board of Supervisors, 2017). Implicit bias trainings are tools to prevent detrimental decision making by public servants (County of Los Angeles Board of Supervisors, 2017). A just culture is that recognizes public organizations are not perfect, staff may not report problems for fear of retaliation, but failure to address internal problems result in unsatisfactory service delivery (Los Angeles County Department of Mental Health Office of the Administrative Deputy, 2017). By

adopting a just culture policy and training staff, DPH looks to empower staff to report problems without fear of retaliation (Los Angeles County Department of Mental Health Office of the Administrative Deputy, 2017). Through adoption of the just culture policy, DPH looks to create a culture focused on problem solving, not identifying who to blame (Los Angeles County Department of Mental Health Office of the Administrative Deputy, 2017).

It is evident DPH sought to equip their workforce to better serve Los Angeles County residents. First it looks to augment organizational cultural competencies through implicit bias and cultural competency trainings. In recognition that increased cultural competencies may lead staff to recognize system level problems of the organizations, it sought to empower staff to identify these problems through their implementation of a just culture policy. DPH understands policy and institutional change are necessary to ensure equity in distribution of services and opportunities (County of Los Angeles Department of Public Health, 2019).

DPH's strategic goal of increasing organizational level cultural competence includes development of an implementation and evaluation framework (County of Los Angeles Department of Public Health, 2019). DPH's development of an implementation and evaluation framework reflects the underdeveloped literature on cultural competence in public administration (Gooden, 2010). This study looks to support DPH's evaluation efforts by evaluating if staff who completed implicit bias and cultural competency as well as just culture trainings demonstrated significantly higher cultural competencies than staff who had not completed the trainings.

- H1: Staff who completed implicit bias, cultural competency, and just culture trainings demonstrated significantly higher cultural competencies during delivery of public services vs staff who had not completed the trainings.

- Ho: Completion of implicit bias, cultural competency, and just culture trainings had no effect on cultural competencies demonstrated by staff at the time of service delivery.

Methods

Data will be collected utilizing two assessment tools of the Cultural Competency Self-Assessment Tool (CCSAT). The CCSAT is guide from the CDI to assist organizations understand, evaluate, and increase organizational level cultural competency (Van Ngo, 2000). To assess an organization's cultural competency in service delivery, service evaluation tool #7 is recommended (Weimer & Zemrani, 2017). Tool #7 analyzes cultural competencies by agency staff in service delivery by examining indicators of cultural competency in staff preparedness, assessment instruments, communication, environment of service delivery, outreach, preparedness to service a diverse population, evaluation, and community integration in planning (Van Ngo, 2000). Performance will be analyzed by collecting client feedback using Tool #8 of the CCSAT. Tool #8 will assess clients' observation of cultural competencies demonstrated by DPH staff at the time of service delivery (Van Ngo, 2000).

The study will be completed at the DPH division of Maternal, Child, and Adolescent Health Programs (MCAH), who currently fund 159 positions (County of Los Angeles Chief Executive Office, 2020). Convenience sampling will be used to select 30 staff who completed the implicit bias, cultural competency and just culture trainings and 30 who did not. A client from each staff person participating in the study will be asked to complete a client feedback form post-service. Clients will fall into two groups, 30 will fall into the category of receiving services by a staff who completed implicit bias, cultural competency, and just culture trainings, and 30 who were provided services by a staff member who did not complete the trainings.

The independent variable of interest is whether completion of DPH's implicit bias, cultural competency, and just culture trainings increase organization cultural competency. A cultural competent public organization is defined is defined by Rice (2007a) as "one that

acknowledges and incorporates at all levels the importance of culture, assessment of cross cultural relation, vigilance towards the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptations of services to meet culturally unique needs" (p.43).

The dependent variable is cultural competency performance by DPH. One method for evaluating cultural competency post-intervention at the time of service delivery is to go straight to the client (Weimer & Zemrani, 2017). After the intervention, assessments like tool #8 assist in determining the level of cultural competent service delivery (Weimer & Zemrani, 2017).

To test the hypothesis, a two-sample t-test will be used. The decision to use a two-sample t-test was based on the ordinal level of measurement of our data and hypothesis of difference between means of two groups. The independent variable is nominal in measure, used to group staff as either staff who completed training and staff who did not complete training. The dependent variable is an ordered measure, representing the ordinal of measurement. The independent variable is dichotomous, in other words, they are mutually exclusive, staff either belong to one group or the other. Observations are independent, data from one group has no relationship to the data of the other, participants are not able to participate on both groups.

The results of the study will have inherit limitations of convenience sampling. The results of study cannot be generalized to the population of interests. The number of participants from each group that will chose to participate in the study is not yet know and may lead to under-representation or over-representation of groups in the sample. Conveniences sampling increases the risk of sampling error and volunteer bias in the sample.

Conclusion

Cultural competency will play a major role in efficient policy formulation and program implementation. DPH is making inroads in creating a culturally competent workforce and it is reflected in their current strategic plan (County of Los Angeles Department of Public Health, 2019). Even though cultural competency is not a new subject in public administration, the study of the topic in the public administration literature is in its infancy (Lopez-Littleton & Blessett, 2015). DPH is taking innovative steps to develop a framework of creating a culturally competent workforce (County of Los Angeles Department of Public Health, 2019). This study looks to support DPH's efforts evaluating their current level of competency post department wide trainings and assessing performance at the clients' end. The study looks to add to the knowledgebase in the literature from which other studies can continue to build from.

References

Adepoju, O. E., Preston, M. A., & Gonzales, G. (2015). Health Care Disparities in the Post–Affordable Care Act Era. *American Journal of Public Health*, *105*(S5), S665–S667. https://doi.org/10.2105/AJPH.2015.302611

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302.

Borrego, E., & Johnson lll, R. G. (2011). *Cultural Competence for Public Managers: Managing Diversity in Today' s World* (1 edition). Routledge.

Congressional Digest. (2016). Impact of Obamacare on coverage. *Congressional Digest*, *95*(3), 7–32.

County of Los Angeles Board of Supervisors. (2017, April 18). Addressing Implicit Bias Countywide. *Supervisor Mark Ridley-Thomas*. https://ridley-thomas.lacounty.gov/index.php/addressing-implicit-bias-countywide/

County of Los Angeles Chief Executive Office. (2020, April 28). *County of Los Angeles 2020-21 Recommended Budget, Volume 1*. https://ceo.lacounty.gov/wp-content/uploads/2020/04/2.-2020-21-Recommended-Budget-Volume-One-Online.pdf

County of Los Angeles Department of Public Health. (2019). *County of Los Angeles Department of Public Health Strategic Plan 2018-2023: Revised July 2019*. http://publichealth.lacounty.gov/plan/docs/DPHStrategicPlan20182023RevJuly2019.pdf

Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., Zapata, D., & Fazlul, I. (2019). The Three-Year Impact of the Affordable Care Act on Disparities in Insurance Coverage. *Health Services Research*, *54*, 307–316. https://doi.org/10.1111/1475-6773.13077

Cox, T. H., & Blake, S. (1991). Managing Cultural Diversity: Implications for Organizational Competitiveness. *The Executive*, *5*(3), 45–56.

Cundiff, J., McCallum, T., Rich, A., Truax, M., Ward, T., & Havelka, D. (2014). Healthcare.gov: Opportunity out of Disaster. *Journal of Information Systems Education*, *25*(4), 6.

Daft, R. L. (2012). *Organization Theory and Design* (11 edition). Cengage Learning.

Department of Health & Human Services. (2011). *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care* [Data set]. American Psychological Association. https://doi.org/10.1037/e553842012-001

Doorenbos, A. Z., & Schim, S. M. (2004). Cultural competence in hospice. *American Journal of Hospice and Palliative Medicine*, *21*(1), 28–32. https://doi.org/10.1177/104990910402100108

Ebener, D. R., & Smith, F. L. (2015). *Strategic Planning: An Interactive Process for Leaders*. Paulist Press.

Executive Order 13166. (2000). Executive Order 13166—Improving Access to Services for Persons With Limited English Proficiency. *Federal Register*, *65*(159). https://www.govinfo.gov/content/pkg/FR-2000-08-16/pdf/00-20938.pdf

Geissdoerfer, M., Vladimirova, D., & Evans, S. (2018). Sustainable business model innovation: A review. *Journal of Cleaner Production*, *198*, 401–416. https://doi.org/10.1016/j.jclepro.2018.06.240

Geron, S. M. (2002). Cultural Competency: How Is It Measured? Does It Make a Difference? *Generations: Journal of the American Society on Aging*, *26*(3), 39–45. https://doi.org/10.2307/26555159

Gooden, S. T. (2010). Social Equity in Public Administration: The Need for Fire. In R. O'Leary, D. M. Van Slyke, & S. Kim (Eds.), *The Future of Public Administration around the World* (pp. 53–58). Georgetown University Press; JSTOR. https://www.jstor.org/stable/j.ctt2tt4cr.11

Institute of Medicine. (2014). *The Impacts of the Affordable Care Act on Preparedness Resources and Programs: Workshop Summary*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK241401/

Kamerow, D. (2014). How will we know if Obamacare has "worked"? *BMJ: British Medical Journal*, *349*. https://www.jstor.org/stable/26518594

Lopez-Littleton, V., & Blessett, B. (2015). A Framework for Integrating Cultural Competency Into the Curriculum of Public Administration Programs. *Journal of Public Affairs Education*, *21*(4), 557–574.

Los Angeles County Department of Mental Health Office of the Administrative Deputy. (2017, September 13). *Just Culture—Los Angeles County*. http://file.lacounty.gov/SDSInter/dmh/1041070_100_05.pdf

McIntyre, A., & Song, Z. (2019). The US Affordable Care Act: Reflections and directions at the close of a decade. *PLOS Medicine*, *16*(2), e1002752. https://doi.org/10.1371/journal.pmed.1002752

Mojtabai, R. (2019). Insurance Loss in the Era of the Affordable Care Act: Association With Access to Health Services. *Medical Care*, *57*(8), 567–573. https://doi.org/10.1097/MLR.0000000000001150

National Council of State Legislatures. (2011). *The Affordable Care Act: A Brief Summary* (States Implement Health Reform, pp. 1–2). National Council of State Legislatures. http://www.ncsl.org/portals/1/documents/health/HRACA.pdf

Parekh, A. K. (2017). Public Health Communications: Lessons Learned From the Affordable Care Act. *American Journal of Public Health; Washington*, *107*(5), 639–641. http://dx.doi.org.libproxy.csun.edu/10.2105/AJPH.2017.303737

Rice, M. F. (2007a). Promoting Cultural Competency in Public Administration and Public Service Delivery: Utilizing Self-Assessment Tools and Performance Measures. *Journal of Public Affairs Education*, *13*(1), 41–57.

Rice, M. F. (2007b). A post-modern cultural competency framework for public administration and public service delivery. *International Journal of Public Sector Management*, *20*(7), 622–637. https://doi.org/10.1108/09513550710823524

Rice, M. F. (2015). *Diversity and Public Administration: Theory, Issues, and Perspectives* (2nd ed.). Routledge.

Silvers, J. B. (2013). The Affordable Care Act: Objectives and Likely Results in an Imperfect World. *Annals of Family Medicine*, *11*(5), 402–405. https://doi.org/10.1370/afm.1567

Susan L. Hayes, Pamela Riley, David C. Radley, & Douglas McCarthy. (2017, August). *Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? 2017*. Reducing Racial/Ethnic Disparities in Access to Care. https://doi.org/10.15868/socialsector.28158

The Henry J. Kaiser Family Foundation. (2014, April 7). How Will the Uninsured Fare Under the Affordable Care Act? *The Henry J. Kaiser Family Foundation*.

https://www.kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/

U.S. Census Bureau. (2019, September 26). *Health Insurance Historical Tables—HIC Series*. The United States Census Bureau. https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html

U.S. Department of Health & Human Services. (2018, November 14). *National CLAS Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. National CLAS Standards.

Van Ngo, H. (2000). *Cultural Competency: A Self-Assessment Guide for Human Service Organizations*. http://fcssaa.org/?mdocs-file=3409

Vespa, J., Medina, L., & Armstrong, D. M. (2020). *Demographic Turning Points for the United States: Population Projections for 2020 to 2060.* (No. P25-1144; Population Estimates and Projections, p. 15). U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf

Wang, S., & Feeney, M. K. (2016). Determinants of Information and Communication Technology Adoption in Municipalities. *American Review of Public Administration; Parkville*, *46*(3), 292. http://dx.doi.org.libproxy.csun.edu/10.1177/0275074014553462

Weimer, N., & Zemrani, A. (2017). Assessing The Level of Cultural Competencies in Public Organizations. *Public Administration Quarterly*, *41*(2), 273–296.