HIGHLIGHTS
of The Colorado Trust's Equality in Health Initiative Evaluation

Addressing Health Disparities through Organizational Change

≫ **Individuals of racial and ethnic minority status are disproportionately affected by disease and disability** and have poorer health outcomes than do their white counterparts.[1,2] Even when minorities have the same insurance status, access to health care, age and income, they tend to receive lower-quality health care for chronic conditions than do whites.

To reduce racial and ethnic health disparities in Colorado, The Colorado Trust supported an Equality in Health initiative. An evaluation of the first five-year cycle of this initiative (2005-2010) examined the work of 13 organizations working to reduce health disparities across the state by developing their cultural competency to advance equality in health care treatment and medical services, equal access to health care, improved environmental conditions and healthy behaviors. Grantees were from rural and metropolitan areas and included direct health service providers; community organizations that provide a range of services, including health care; and organizations that train and support physicians. Technical assistance was provided to assist grantees in these efforts, focusing on cultural competency, health disparities, outcome data collection and program planning.

≫ EVALUATION

The evaluation of The Colorado Trust's Equality in Health initiative was based on research literature about organizational cultural competency, and designed to examine grantees' cultural competency across three critical dimensions: organizational policies and procedures, individual staff capacity and professional development, and community relationships.[3,4,5,6] Within the first two dimensions, there were seven key areas of cultural competency assessed: (1) board and staff development, (2) education and training, (3) service accessibility, (4) community engagement, (5) service provision, (6) data collection and use, and (7) organizational environment and infrastructure. Also examined were the reported adaptations that grantees made to their programs, changes in the health of the racial and ethnic minorities grantees served, and factors that either helped or made it difficult to build organizational cultural competency.

❭❭ KEY FINDINGS

Evaluation findings revealed that health organizations must change in a comprehensive way to institutionalize and sustain their cultural competency. Initially, grantees did not view the work of building their cultural competency as organizational change work; instead, they typically focused on developing a program to serve a particular racial or ethnic group, or to strengthen their staff members' ability to work with diverse populations. Not all of the grantees' executive leadership was prepared to change their organizations' structures and processes, and some staff were resistant to changing the way they worked, so it took time to educate and engage the organizations' leadership and staff in carrying out the goals of the initiative.

Organizational change takes time. In this initiative, technical assistance, training and other supports were essential in helping the grantee organizations' leaders and staff navigate the complexity of individuals' biases; structural or systemic issues; and patients' and health consumers' diversity of cultures, languages and values related to health. For example, some grantees encountered the perception that minorities were getting "special treatment" because of the enhancement to the organizations' services.

Funders and policymakers also have an important role in leveraging their expertise, financial and social capital to assist organizations, from mobilizing organizations' leadership to building the organizations' capacity to collect and use race and ethnicity data to improve the quality of care for the populations they serve. Funders need to understand the continual, and often challenging, journey toward cultural competency and the role they can play in supporting health organizations on this journey. It also is important to engage policymakers who are involved in implementing the Affordable Care Act (ACA), as provisions of the ACA seek to reduce health disparities by building service providers' cultural competency and diversifying the health professions workforce.[7,8]

❭❭ LESSONS LEARNED

Key lessons learned through the evaluation of this initiative can help health organizations, funders and policymakers better understand how to meet the needs of an increasingly-diverse population and achieve equality in health.

Goals and expectations. Cultural competency within a health organization is a critical strategy for addressing health disparities. It is possible to observe changes within an organization to become culturally competent within a reasonable time period; however, it requires more time to improve health care outcomes for racial and ethnic minority groups (e.g., the use of preventive care).
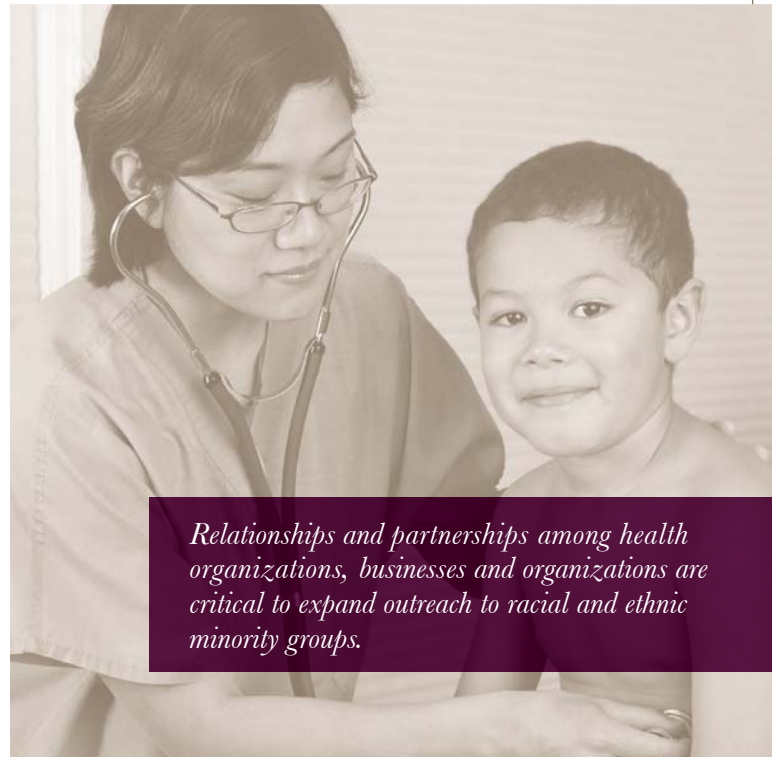
Relationships and partnerships among health organizations, businesses and organizations are critical to expand outreach to racial and ethnic minority groups.

KEY LESSONS

for Policymakers, Health Organizations, and Funders

Addressing Health Disparities through Organizational Change

Key lessons learned through the evaluation of The Colorado Trust's Equality in Health initiative – shown to the right at-a-glance and detailed on pages 2 and 5 – can help health organizations, funders and policymakers better understand how to meet the needs of an increasingly-diverse population and achieve equality in health.

Improving health outcomes (e.g., decreased depression, better blood sugar levels, etc.) for racial and ethnic minority groups takes longer still, requiring shifts in individual, organizational, system and community practices, as well as in the social determinants of health. As such, it is important for everyone involved in such a change effort to establish reasonable goals.

Framing organizational cultural competence. To ensure commitment to cultural competence among an organization's leadership, staff and partners, and respond to communities' needs, funders should encourage a focus on organizational policies and procedures, staff capacity and community relationships. As health organizations delve into the complexities of building their cultural competence, they will start to realize their limitations; consequently, funders should be prepared for a non-linear trend in achieving cultural competency, encouraging grantees and evaluators alike to fully explore, identify and eventually overcome barriers to desired outcomes. As well, policymakers should emphasize the link between cultural competency and health care quality improvement for everyone in the community, not only racial and ethnic minorities.

Assessment, monitoring and evaluation. Achieving cultural competency in health organizations means showing improved organizational capacity to provide culturally-appropriate services and improved short-term health and health care outcomes for the diverse populations those organizations serve. In other words, the strategy of building cultural competency must be linked to the desired result of better health. Further, organizations require different strategies for building cultural competency for different types of health (e.g., improving management of chronic health conditions) and health care (e.g., increasing affordability of care) goals. Funders must be clear with grantees about the outcomes they expect to see in terms of both cultural competency and short- and long-term changes in health and health care.

Leadership and staff perceptions. When the executive leadership and staff members of a health care organization believe that they are already fairly culturally competent, they may not see the need for changes in their organization's policies and procedures, and therefore may be unprepared to make changes. While the racial and ethnic diversity of the leadership and staff is critical, it is not sufficient for sustaining a culturally competent organization, nor does it indicate an understanding of the complexities of race, ethnicity and culture. Leadership and staff should acknowledge the significance of variations even within racial, ethnic and cultural groups – generalizations (i.e., not recognizing distinctions within a group) and a color-blind approach can mask differences within racial and ethnic populations that directly impact health awareness and behaviors.

Data management and use. The collection, management and use of racial, ethnic, language and other culture-related data (e.g., traditional foods and norms about health practices) are essential to achieving cultural competency. Health organizations should include data collection (e.g., connecting demographic factors with patients' or clients' health conditions and outcomes) in their interventions, thereby helping to monitor trends in their communities' health disparities. Section 4302 of the ACA requires the collection of five types of demographic data: race, ethnicity, sex, primary language and disability status. As such, it is incumbent on funders and policymakers to underscore the importance of data collection and its use in building cultural competency. To better practice cultural competency and align with the ACA, health organizations should be prepared to purchase the right software and hardware; generate a system for collecting and using data for planning and decision making; and train staff to accurately gather race, ethnicity, language and other culture-related data.

Community relations. Relationships and partnerships among health organizations, businesses and community-based organizations are critical to expand outreach to racial and ethnic minority groups and to attend to the various factors that impact health. Equality in Health grantees were more inclined to develop and strengthen relationships and partnerships with organizations such as hospitals, schools and social services than they were with businesses and organizations that provide informal support, such as neighborhood or resident associations and faith-based organizations. However, to gain relevant feedback and broad-based support, health organizations should develop policies and procedures for developing and sustaining relationships and partnerships with informal support groups to better inform their program planning, implementation and evaluation.

GOALS & EXPECTATIONS

POLICYMAKERS		

Funders and other stakeholders should have realistic expectations about achieving organizational cultural competency. Improvements in organizational cultural competency and service delivery can be expected to result in a five-year initiative, for example, while health and health care outcomes may take longer to achieve.

≫≫ **It is important for policymakers and funders** to plan for multiyear funding and capacity building support. Developing an organization's ability to provide information in a culturally and linguistically appropriate manner; collect data on race, ethnicity and primary language; reach out to communities; and implement cultural competency trainings requires ongoing efforts.

≫ **Funders** should clearly define the types of organizations they are targeting. When grantees are overly disparate in terms of the kinds of health services they provide or the focus of their cultural competency work, difficulties arise in applying uniform standards of performance.

(Row labels: POLICYMAKERS, FUNDERS, HEALTH ORGANIZATIONS)

ASSESSMENT, MONITORING & EVALUATION

≫ **As part of the grantee selection process, funders** should set selection criteria for different levels of organizational "readiness" to engage in the work of building cultural competency and decide which level is acceptable for the initiative. A readiness assessment will be useful before confirming which organizations to fund. Funders might also consider providing some assistance to those organizations that are not yet ready, to help them prepare for a future funding opportunity.

≫ **The funder's staff,** in collaboration with the technical assistance provider and evaluator for their cultural competency initiative, must develop expected outcomes for cultural competency _and_ health that are clear, based on research and best practices, measurable, and aligned with grantmaking and technical assistance strategies.

≫≫ **Policymakers and funders** should support more research and evaluation of cultural competency initiatives to further develop the definition and measures of cultural competency, and to identify evidence-based and promising practices for building organizations' cultural competency.

(Row labels: POLICYMAKERS, FUNDERS, HEALTH ORGANIZATIONS)

LEGEND

≫ **POLICYMAKERS**   ≫ **FUNDERS**   ≫ **HEALTH ORGANIZATIONS**

FRAMING ORGANIZATIONAL CULTURAL COMPETENCE

POLICYMAKERS	Policies related to immigration and health care coverage can impact organizations' development of cultural competency. **Policymakers should help organizations** understand such policies in their development of strategies, initiatives and guidelines for building organizational cultural competency.	The Culturally and Linguistically Appropriate Services (CLAS) standards provide a consistent and useful framework for guiding cultural competency-building efforts. **Policymakers should promote** and require adherence to these standards.	**Policymakers, funders and health organizations** should emphasize the link between cultural competency and health care quality improvement for everyone in the community. Framing cultural competency in terms of patient-centered care can effectively reduce the resistance that stems from belief that being culturally competent only benefits the racial and ethnic minorities being served. Instead, emphasizing equity for all reinforces the notion that every patient or service recipient is unique, and that providers must develop skills to respond to each patient's specific needs.
FUNDERS	**Funders** need to clearly communicate, and health organizations should understand, that improving cultural competency comprises organizational policies and procedures, staff capacity and community relationships. Cultural competency is much more than just providing funds or modifying a particular health intervention, program, service or department.	Developing cultural competency is not a linear process. As grantees continually deepen their knowledge and understanding of cultural competency, they may come to realize that they are less culturally competent than they thought they were. **Funders need to be aware** of this likelihood, and encourage evaluators and grantees alike to explore, identify and overcome factors that limit their organizational cultural competency.	
HEALTH ORGANIZATIONS			

LEADERSHIP & STAFF PERCEPTIONS | DATA MANAGEMENT & USE | COMMUNITY RELATIONS

POLICYMAKERS		**It is important for policymakers** to be aware of Section 4302 of the Affordable Care Act regarding data standards to build cultural competency, and develop guidelines that include technical assistance and training for building health organizations' capacity to meet the standards.	
FUNDERS	**Funders** should consider how to encourage organizational changes by engaging grantees' leadership and staff about the significance and meaning of building cultural competency.	As part of building grantees' cultural competency, **funders should provide resources** and technical assistance to enable grantees to develop systems to collect and use data on race, ethnicity, language and other culture-related information.	**As part of grant obligations, funders** should include the expectation of relationship building and strategic partnerships, and encourage strategies for outreach and collaboration as part of the normal operation of the grantee organization.
HEALTH ORGANIZATIONS	**Organizations** whose leaders and staff share the same race or ethnicity as the populations they serve still must work on enacting organizational policies and procedures, enhancing staff skills and strengthening community relationships in order to continuously promote and sustain cultural competency, not assuming that racial or ethnic congruity is sufficient.	**In order for health-related organizations** to understand the people they serve, to connect demographic factors with their patients' or clients' health outcomes and to design culturally-sensitive interventions, they need to develop systems to collect and use data on race, ethnicity, language and other cultural factors.	**A health organization** should develop relationships with other organizations to expand its reach and responsiveness to the racial and ethnic minority populations it serves. Such partnerships can increase an organization's capacity to provide accessible and culturally appropriate services and support for diverse communities.

Equality in Health Initiative Evaluation Grantees

Asian Pacific Development Center
Center for African American Health
The Children's Hospital Colorado
Clayton Family Futures

Colorado Community Health Network
Comunidad Integrada/Integrated Community
Full Circle Inter-Generational Project

Marillac Clinic
Metro Community Provider Network
Rural Communities Resource Center

Summit Community Care Clinic
Telluride Foundation
Women's Resource Center

≫ END NOTES

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[7] Henry J. Kaiser Family Foundation. Summary of new health reform law. http://www.kff.org/healthreform/upload/8061.pdf. Updated May 18, 2011. Accessed May 18, 2011.

[8] U.S. Department of Health and Human Services. HHS *Action Plan to Reduce Racial and Ethnic Health Disparities*. Washington, DC; 2011.

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