THE COLORADO TRUST

ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

APRIL 2012

EVALUATION *Report*

Addressing Health Disparities Through Organizational Change

AN EVALUATION OF THE COLORADO TRUST'S EQUALITY IN HEALTH INITIATIVE

PREFACE

This report was prepared for The Colorado Trust by Community Science. It summarizes the evaluation team's findings to answer the initiative-level evaluation questions for the first cycle of grantees (Cycle 1) funded in 2005. The report also includes lessons learned for funders, health-related organizations and policymakers interested in cultural competency as a contributing strategy to ending health disparities.

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Community Science would like to thank Nancy Csuti, DrPH, Ginger Harrell, Chris Armijo, Gay Cook and Christie McElhinney of The Colorado Trust, and Erica Baruch and Suzy Shimasaki of The Partnership for Families and Children for their assistance and support, as well as all the Cycle 1 grantees for their time and cooperation.

LETTER FROM THE COLORADO TRUST

In December 2004, the board of trustees of The Colorado Trust asked staff to explore grantmaking to reduce racial and ethnic health disparities in Colorado. Extensive scanning conducted by staff pointed to the need for improved cultural competency as one of the most important elements in achieving equality in health. Trust staff knew early in the initiative planning that cultural competency would be a common thread running through all facets of the initiative. In April 2005, the board approved the five-year, $13.1 million dollar Equality in Health Initiative. The goal of the initiative was to address health disparities through the lens of organizational cultural competency. While the concept of cultural competency was one most people working in the field were familiar with, improving cultural competency at the organizational level was not. The Trust staff and board embraced the idea that rather than improving individual grantee staff members' cultural competence, only true organizational change would result in lasting cultural competency improvements that would, hopefully, improve the health and well-being of the communities served by grantees.

As the concept of organizational change leading to improvements in the population's health outcomes was untested, an extensive evaluation was designed. The purpose of this evaluation was to empirically test whether or not changes at the organizational level would, in fact, improve patients' health – and, as we believed, ultimately lead to reductions in health disparities.

This idea was a bold one, and the accompanying evaluation was highly complex. The evaluation showed that we were naïve in thinking there was a direct line between increased cultural competency and improved health outcomes. The revised conceptual models in this report clearly illustrate that. But – cultural competency did improve. Outcomes did improve. And the lives of many Coloradans were touched in ways that we never would have anticipated. Everyone who was part of this initiative knows that improving cultural competency is a lifelong journey that requires a lot of hard work, and yet yields great joys.

Now, more than six years since the start of this initiative, health disparities continue to exist in Colorado. But through the work of our grantees, a dent has been made in the problem. Grantee organizations are more culturally competent and many have policies and procedures in place that will not only ensure sustainability long after the staff involved in the initiative have moved on, but, as this evaluation shows, are predictors of improved health outcomes. New relationships with community members and organizations have been forged, relationships that are shown to be highly correlated with improved health outcomes. There is a long way to go before every Coloradan has equal health care opportunities. The grantees of the Equality in Health Initiative have helped to move Colorado further along the road.

It is our hope that the lessons shared in this evaluation will help others – funders, policy makers, and nonprofits – address issues of organizational cultural competency with the ultimate goal to eventually eliminate health disparities.

Nancy B. Csuti, DrPH
Director of Research, Evaluation & Strategic Learning

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ABSTRACT

In the coming decades, racial and ethnic minorities will constitute more than 50% of many states' populations – including that of Colorado. Individuals of racial and ethnic minority status are disproportionally affected by disease and disability and have poorer health outcomes than do their white counterparts.[1,2] These differences are disparaties in health. Even when minorities have the same insurance status, access, age income and chronic conditions, they still tend to receive lower-quality health care than the white population. Differences in access and quality constitute disparities in health care.[3] Shifts in population, coupled with current inequalities in health status and quality of care, clearly establish the need for addressing these disparities.

Recognizing the persistence of racial and ethnic health disparities, The Colorado Trust developed the Equality in Health Initiative in 2005. The Initiative provided funding for 14 organizations across the state of Colorado in the first funding cycle, supporting their efforts to reduce health disparities by addressing the needs of racial and ethnic minorities. The initiative intended to strengthen organizations' cultural competency so as to promote and ensure the following for racial and ethnic minority populations: 1) equality in treatment and medical services, 2) attainment of equal access to health care, 3) improvements of environmental conditions and 4) increased healthy behaviors. Grantees received technical assistance in three areas: cultural competency; program planning and implementation related to health disparities; and data collection and evaluation.

The Colorado Trust believed if grantee organizations' culturally competent practices improved through technical assistance, interventions and networking then short term health outcomes would improve as well, ultimately leading to reductions in health disparities. This evaluation examined this conceptual model to determine the role organizational cultural competency played in improving short-term health and health care outcomes for racial and ethnic minority groups.

Results showed that as grantees' cultural competency in the form of community relationships improved, so did their adaptations to their interventions as well as short-term health and health care outcomes. Cultural competency in the form of organizational policies and procedures predicted improvements in the short-term health and health care outcomes of service recipients. Based on the results of this evaluation, a new conceptual model was developed and is described in this report. Facilitating and challenging conditions to developing cultural competency are also outlined as well as lessons for funders, policy makers and grantees.

Conceptual Model for Relationship Between Cultural Competency and Short-term Outcomes, as Developed by The Colorado Trust

I. INTRODUCTION

Research findings suggest that the root causes of health disparities are many. From a large-scale perspective, the inequitable distribution of social, economic and environmental resources and conditions (the social determinants of health) contributes to health disparities in impoverished and marginalized groups.[4] At the system and individual levels, the health care system is complex and can be difficult to navigate, especially for individuals with limited English proficiency and health literacy.[5] The experiences of mistreatment and the resulting distrust of the health care system among some racial and ethnic minority communities have influenced the likelihood that they would seek care or advocate for their health.[5,6] Even if health care systems have sufficient resources for diverse consumers, health care staff are not always aware of the resources, how to use the resources or how to effectively serve minority consumers.[7]

Approaches that take into account individuals' backgrounds, resources and needs are required. For example, research indicates that organizations must identify the needs of the populations they serve, assess how well those needs are met, explore cultural and linguistic issues, and continually monitor these needs and the services they provide.[8,9] In essence, research findings suggest that cultural and linguistic competency is a critical element in reducing health disparities and increasing health equity.[8]

Cultural competency is defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency and among professionals that enables effective work in cross-cultural situations."[10,11] The value of understanding patients' and other health consumers' cultures and incorporating that understanding into their care is apparent. However, both the processes to help organizations build cultural competency and the impact of cultural competency on the health of the people they serve need further research and focus. The Equality in Health Initiative (the Initiative) targeted this gap in the field by supporting the development of health-related organizations' cultural competency to better focus on racial and ethnic health disparities in the populations those organizations serve.

This final cross-site evaluation report examines the Initiative's goals related to improving organizational cultural competency to address health disparities, using data collected and analyzed throughout the first cycle of grantees from 2005 through 2010. In Section 2 of this report is an overview of the Initiative and the evaluation methodology. Sections 3, 4 and 5 summarize the evaluation findings. Section 6 provides a succinct response to the evaluation questions based on the findings. The report concludes with Section 7, which synthesizes the lessons generated by this evaluation for health-related organizations, funders and policymakers interested in the role of cultural competency in reducing health disparities.

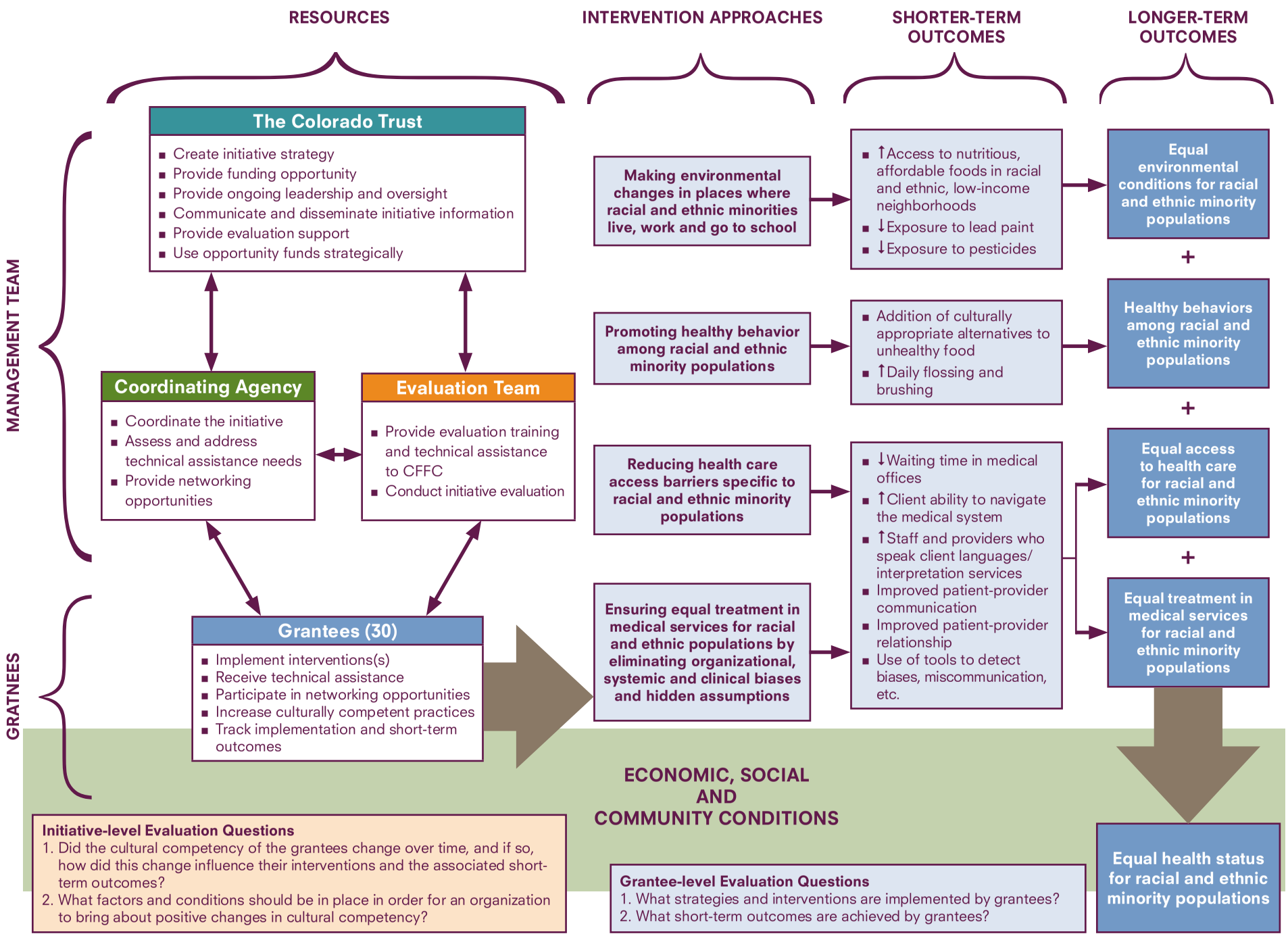
II. OVERVIEW OF THE INITIATIVE AND THE EVALUATION

Recognizing the persistence of racial and ethnic health disparities, The Colorado Trust (The Trust) developed the Initiative in 2005. The seven-year project was designed to fund up to 30 grantees across Colorado in support of their efforts to reduce health disparities by addressing the needs of racial and ethnic minorities. The Initiative's purpose was to help grantees strengthen their interventions and short-term health and health care outcomes for racial and ethnic minority populations related to: 1) equality in treatment and medical services, 2) attainment of equal access to health care, 3) improvement of environmental conditions and 4) promotion of healthy behaviors. The effort supported the cultural competency development of grantee organizations to achieve these shorter-term goals with the ultimate goal of attaining the longer-term outcome of equal health status for racial and ethnic minority populations. Figure 1 presents The Trust's logic model for the Initiative, which illustrates the desired pathway of change that the Initiative would facilitate.

The request for proposals (RFP) and contracts for the Initiative explained that it was designed to support grantee organizations' cultural competency development. The logic model to which grantees referred once awarded the grant, however, did not make the role of cultural competency in

Figure 1

Logic Model for Equality in Health: Addressing Racial and Ethical Health Disparities



addressing health disparities explicit. Consistent with existing literature,[8,9] The Trust – in addition to The Partnership for Children and Families (The Partnership) which served as the coordinating agency – provided grantees with resources and support to build their cultural competency. It was anticipated that strengthening organizational cultural competency would help grantees modify their intervention approaches to affect the short-term health and health care outcomes they had selected. After the first year of the grant, grantees gained a clearer understanding of the significance of cultural competency in the Initiative.

2.1 Composition of Grantees

The Initiative was open to community-based health centers or programs, clinics and government programs that provided health-related services. The Trust expected grantees to:

- Create, expand or strengthen efforts in their organizations to address health disparities affecting African Americans/Blacks, Hispanics/Latinos, Asians/Pacific Islanders and Native Americans (EIH-targeted groups)
- Participate in grantee networking activities throughout the life of the Initiative
- Collect appropriate project data to contribute to the evaluation of the Initiative
- Identify potential sources for continued financial support beyond The Trust.

Fourteen grantees (listed below) were funded in Cycle 1 of the grant (December 2005 through December 2010). These health-related grantee organizations were diverse in a number of ways:

- Location: metropolitan and rural
- Staff composition: racially and ethnically congruent and non-congruent with the target community's demographics
- Type of service provision: direct health service provider, health education organization or intermediary (such as an organization that trains physicians)
- Interventions and efforts of focus: health conditions that disproportionately affect racial and ethnic minorities, organizational capacity to provide services, access to local health services, consumer ability and knowledge to manage health.

Grantees in Cycle 1 Initiative Evaluation

- Asian Pacific Development Center
- Center for African American Health
- Children's Hospital Socio-cultural Training Program
- 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

In their grant proposals, grantees were asked to describe their organization's commitment to building cultural competency and addressing health disparities. More than one-third (38%) of the grantees indicated that they were already fairly culturally competent, their goals tended to revolve around strengthening health interventions to reduce health disparities or they were serving a growing demographic group in their community more than strengthening their organizational cultural competency. Nearly one-half (46%) of the grantees reported that their staff and leadership were committed to improving cultural competency. A small number of grantee organizations (15%) indicated that they had limited cultural competency awareness prior to the Initiative.

2.2 Evaluation Methodology

The purpose of the Initiative evaluation was to determine what role organizational cultural competency played in improving short-term health and health care outcomes for racial and ethnic minority groups. The evaluation was designed to answer the following questions:

1. ***Did the cultural competency of the grantee organizations change over time?***

2. ***If so, how did the changes influence the grantees' interventions and associated short-term health and health care outcomes?***

3. ***What factors and conditions should be in place for an organization to bring about positive changes in cultural competency?***

For a complete description of the evaluation methodology, please see Appendix A.

Assessment of grantees' cultural competency. The evaluation team based the cultural competency dimensions and domains assessed in the Initiative on a review of research literature about organizational cultural competency, particularly competencies necessary in health organizations.[10-14] The result was the evaluation of three dimensions of organizational competency, as illustrated in Figure 2.

Figure 2

Dimensions of Organizational Cultural Competency

Within the organizational and individual dimensions are seven domains of cultural competency:

- Board and staff professional development, advancement and involvement in the organization
- Staff and partner education and training in cultural competency and cultural issues
- Accessibility of services
- Community engagement to support planning, services and outreach
- Provision of services
- Collection and use of data to monitor interventions and health outcomes
- Organizational environment and infrastructure.

The Trust did not specify grantees should develop community relationships as part of their cultural competency, and grantees did not receive specific support to build this capacity. Based on the literature and knowledge that such relationships were critical for addressing health disparities, the evaluation team, The Trust and The Partnership developed measures and technical assistance strategies to address this dimension along with the organizational and individual dimensions.

Assessment of grantees' intervention adaptations. It was expected that strengthening grantee organizations' cultural competency would provide the knowledge and skills necessary to adapt their intervention approaches to more effectively serve racially and ethnically diverse populations. Grantees reported semi-annually the intervention adaptations they made to target each of the short-term health and health care outcomes they had selected. Examples of their intervention adaptations included:

- Advertising services provided in culture-based media outlets (for example, Spanish radio stations or African American newspapers)
- Hiring additional bilingual and bicultural staff members
- Offering transportation vouchers to services and low- or no-cost health screenings

- Partnering with community- and faith-based organizations to provide health education
- Providing culturally specific health promotion opportunities (such as Zumba classes or low-sodium recipes for various ethnic foods)
- Providing trainings on cultural competency and health disparities to staff and partners.

Assessment of grantees' short-term health and health care goals and outcomes.
The organizational outcome expected by The Trust was uniform across grantees – improved cultural competency. The short-term health and health care outcomes, on the other hand, were determined by the grantees based on the health-related issue they had decided to address. To manage the range of outcomes presented by grantees, the evaluation team organized the grantees' short-term health and health care outcomes into three categories which are consistent with the disparities in health care quality, access and conditions that racial and ethnic minorities experience:[1-3]

- Improved capacity of service recipients – to improve the ability of people in target groups to manage their health (such as increased health knowledge or meeting disease self-management goals)
- Increased accessibility – to increase the availability of services for people in the target groups (as in augmenting the number of clients served or patients screened)
- Improved clinical conditions – to affect the diagnosed health conditions of people the grantees served (that is, improved mental health or decreased blood sugar).

Assessment of technical assistance. As coordinating agency, The Partnership provided grantees with technical assistance around cultural competency, health disparities, and program planning, implementation and evaluation. It also created networking opportunities for the grantees. The Partnership provided technical assistance through three primary avenues: statewide training, peer-to-peer learning and individualized assistance. The technical assistance was designed to help grantees implement their grant efforts and address any challenges they encountered; develop a logic model articulating their goals and desired outcomes; track implementation and their short-term health and health care outcomes; report progress to The Trust; and use information from internal and external evaluations to make appropriate changes to their organizations and programs.

Sources of data. The following are the sources of data used for the evaluation:

- Semiannual and final progress reports, completed and submitted by grantees to The Trust from May 2006 to January 2011, which included health outcome data identified and collected by grantees (to assess intervention adaptations, short-term health and health care outcomes and technical assistance)
- Semiannual and final reports completed and submitted by The Partnership to The Trust from June 2006 to December 2010 (to assess technical assistance)
- Organizational cultural competency assessments completed in 2006, 2007 and 2009 by grantee staff and community members affiliated with the grantee organization (that is, anyone not employed by the grantee, including board members, community partners and volunteers. Assessments were not completed in 2008.) – see Appendix B for a copy of the assessment form (to assess cultural competency)
- Annual interviews conducted by the evaluation team with grantee staff and community members from 2006 to 2010 – see Appendix C for a copy of the most recent interview guide (to assess cultural competency, intervention adaptations, short-term health and health care outcomes and technical assistance).

The overall response rates for the organizational assessments in 2006, 2007 and 2009 were 75.4%, 58.3% and 60.3%, respectively. The overall response rates for the interviews in 2006, 2007, 2008, 2009 and 2010 were 84.6%, 75%, 79.5%, 67.9% and 79.5%, respectively (see Appendix D for the number of respondents from each grantee for the organizational assessments and interviews). The response rate was based on a target sample size of 10 people for the assessment in 2006 and 12 people in 2007 and 2009, and six people for the interview for each grantee, across 13 grantees. For smaller grantee organizations (such as Full Circle Inter-generational Project), the number of respondents was representative of the organization; for larger organizations (for example, Metro Community Provider Network), the number of respondents represented a smaller percentage of the organization.

2.3 Limitations

This report is based on grantees' organizational cultural competency assessments; in turn, these assessments are based on grantees' self-reported data and perceptions of a sample of grantee staff and community members who participated in the evaluation. Additionally, the evaluation team had to rely solely on grantees' collection and reporting of short-term health and health care outcome data. The evaluation team attempted to address these limitations by selecting participants for the evaluation that were representative of the different grantee organization staff and partners triangulating multiple sources of information, including The Partnership and at least three interviewees from each grantee organization. Within each grantee organization, a pattern emerged when there was convergence among interviewees' perceptions, reports from The Partnership and grantees' reports about their activities and results.

The unit of analysis for cultural competency change was the grantee organization, which was small (13 grantees). This small sample size had two limitations: 1) there was greater probability that the change observed was due to chance, despite statistical significance, and 2) the findings could not be generalized to a broader set of organizations. As such, further research and evaluation of efforts similar to the Initiative are necessary to expound on the findings reported here.

A final limitation was the lack of continuing communications about the role of cultural competence in the Initiative. Ideally, program and evaluation teams should collaborate as an initiative develops to ensure the continued alignment of the program design, logic model, technical assistance and measures of success. As discussed on pages 2 and 6, the role of cultural competency and the aspects selected for evaluation while shared with grantees at the beginning were not continually reinforced throughout. This made evaluating the Initiative more difficult. Strong collaboration and communication among The Trust, The Partnership and the evaluation team addressed this challenge and increased the alignment of all components of the Initiative after the first year.

III. EVALUATION QUESTION 1:
DID THE CULTURAL COMPETENCY OF THE GRANTEES CHANGE OVER TIME?

3.1 Organizational Policies and Procedures

Grantees' policies and procedures related to cultural competency improved over time; the change was initially rapid during the first year, and then stable between the middle and end of the Initiative. By the end of the Initiative, grantees reported that policies and procedures were in place in all domains except data collection and use. Grantees made the greatest gains in the education and training domain; the least change occurred in the area of data collection and use.

Grantees' policies and procedures related to cultural competency improved from the beginning to the end of the EIH Initiative. In 2006, grantees typically perceived their organizational policies and procedures between developed and in place; in 2007 and 2009, their organizational policies and procedures were between in place and practiced (see Figure 5). The change that grantees made in their policies and procedures between 2006 and 2009 was statistically significant (the likelihood that the change occurred by chance was very low).[a] When the seven domains are examined separately, it is clear that grantees' policies and procedures related to board and staff development, environment and infrastructure, community engagement, and education and training developed significantly from the beginning to the end of the Initiative.[b] Grantees' policies and procedures related to service provision, service accessibility, and data gathering and use did not change significantly over the course of the Initiative; grantees consistently perceived that these areas were either well developed or relatively less developed throughout the Initiative.

a *$t(9) = -3.26, p < .01$*

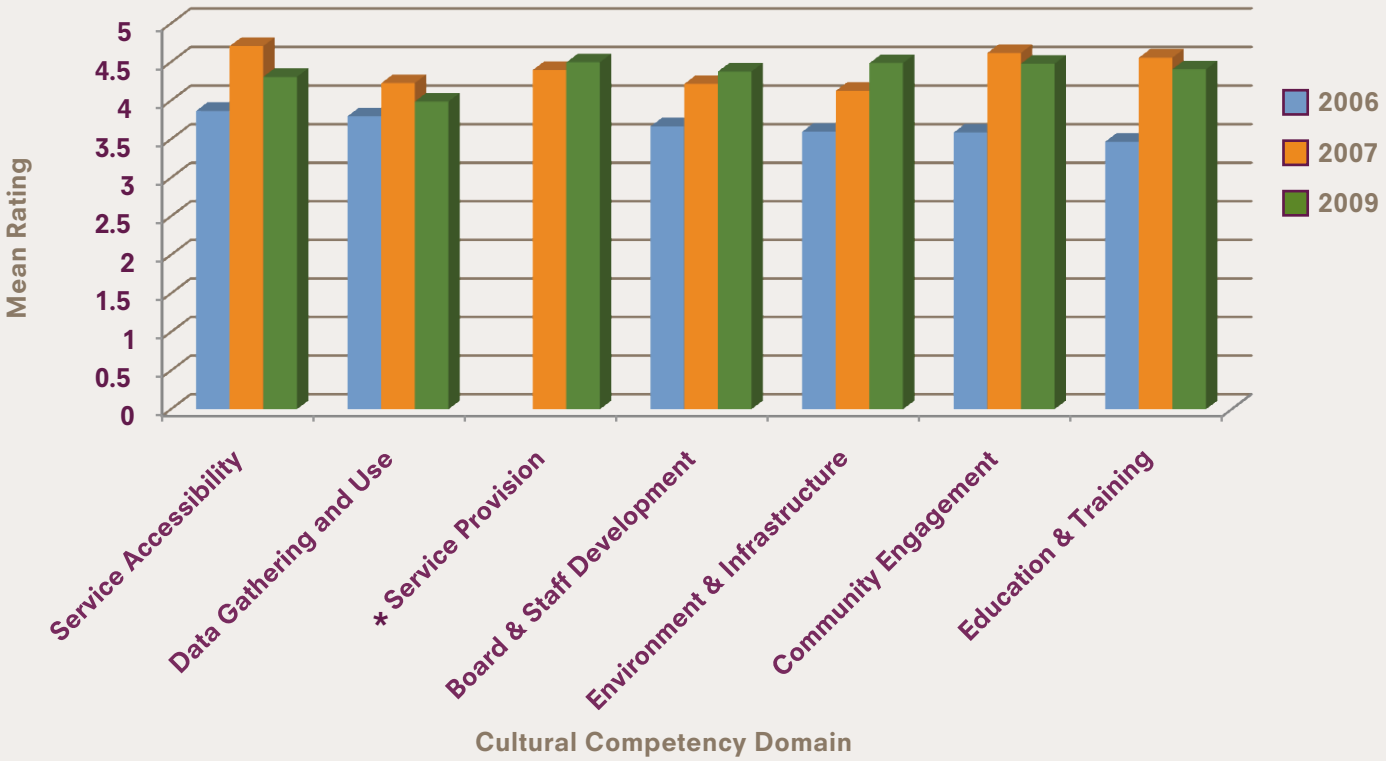
b *Education and training: $t(9) = -3.02, p < .05$; board and staff development: $t(10) = -4.12, p < .01$; environment and infrastructure: $t(8) = -5.16, p < .001$; community engagement: $t(7) = -3.20, p < .05$*

In both 2006 and 2007, grantees perceived their policies and procedures related to increasing service accessibility as most developed – they had the highest mean rating. During that time, they reported the greatest change in the area of education and training – there was the largest difference in mean rating. Two factors might have contributed to this latter trend. First, many of the grantees may have been more inclined to focus on the translation, interpretation and adaptation of their facilities; at the beginning, these changes were easier and less threatening than changes in the board, data collection and accountability systems. Second, both The Partnership and grantees demonstrated early interest in this area. The Partnership focused its initial technical assistance on the individual staff and professional development dimension, and grantees emphasized their desire to conduct cultural competency trainings and revise their health-related materials.

In 2009, grantees perceived their policies and procedures related to improving their organizational environment and infrastructure as most developed (as an example, designating staff and resources to ensure cultural competence); this was also the domain in which they reported the greatest and most positive change. It is very likely that one factor contributed to this trend: as the Initiative approached its final year, The Partnership focused its technical assistance on institutionalizing and sustaining the cultural competency changes that grantees had started in 2006.

Figure 3

Organizational-level Cultural Competency Across Grantees
n=13 grantees



1 = NOT BEING CONSIDERED, 2 = BEING CONSIDERED, 3 = BEING DEVELOPED, 4 = IN PLACE, 5 = PRACTICED

**Baseline (2006) data for service provision were not available. Specific items to assess service provision were added to the revised assessment and therefore, were measured only in 2007 and 2009.*

In every assessment period, the data collection and use domain was relatively less developed than were the other domains and was closer to being in place than practiced. Grantees reported challenges with infrastructure (such as databases or technology), costs and resources, and the capacity to use data for planning. These challenges were difficult to overcome because data collection and use were

not necessarily priorities compared to community outreach or programming. Some grantees requested technical assistance from The Partnership in data collection, particularly for gathering race and ethnicity data and data for their internal evaluations. In their final progress reports, approximately one-quarter of grantees reported that The Partnership had assisted them with interpreting data or collecting data on clients' perceptions of the services they had received.

In three domains – besides data collection and use – there was a negative change between 2007 and 2009; this change was negligible because the relevant policies and procedures remained within the same stage (for example, between in place and practiced).

3.2 Individual Staff Capacity and Professional Development

On average, respondents to the assessments considered the administrators and managers, direct service providers and support staff in their organizations at least moderately culturally competent, particularly in their participation in education and training activities and support for improving the organizational environment and infrastructure to ensure cultural competency. The ratings were lower in the board and staff development domain, perhaps because their participation in professional development activities was less apparent to the assessment respondents. Between 2007 and 2009, the average ratings across all the domains decreased slightly. Interview data and reports from The Partnership indicated that grantee staff developed new knowledge about the meaning of cultural competency and therefore, realized by the end of the Initiative that their organizational leaders and staff were perhaps not as culturally competent as they had thought previously.

Grantee staff comprised administrators and managers, direct service providers and support staff. Most grantees indicated that faculty, students, academic and research partners, and contracted service providers were not part of their organizations. In 2006, individual staff capacity and professional development were assessed using grantee staff's perceptions of their colleagues' cultural competency knowledge and skills. In 2007, the individual staff capacity section of the organizational assessment form was modified to align with the cultural competency domains assessed in the organizational policies and procedures section. Therefore, it is not possible to compare the ratings in 2006 to those in 2007 and 2009. Only 2007 and 2009 findings are included here.

Grantee staff that participated in the evaluation were asked to rate the cultural competency of the administrative and management, direct service provider and support staff positions in their organizations. Perceptions of the cultural competency of the staff in grantees' organizations did not change significantly over the course of the Initiative. In each assessment, administrators and managers, direct service providers and support staff at the grantee organizations demonstrated cultural competency moderately well (3) to very well (5), with an average rating of well (4). Staff members in all positions received the highest ratings for creating an organizational environment and infrastructure that supported cultural competency and for participating in cultural competency educational and training opportunities (see Table 1). Staff members received the lowest ratings in the domain of board and staff development.

The fact that all staff positions were rated highest in environment and infrastructure at the end of the Initiative indicated grantees' focus on sustaining cultural competency in their organizations; interview data confirmed these findings. Attending to sustainability of cultural competency changes – institutionalizing – was part of the job of administrators and managers. Support and other front-line staff were responsible for implementing the changes. Typically, when seeking services, service recipients interacted with a support staff member first. Consequently, it was critical that support staff have the capacity to convey to service recipients an organizational commitment to providing culturally

appropriate care. The ratings for education and training were consistent with The Partnership's focus on the individual dimension early in the Initiative and on grantees' interest in conducting or receiving training in cultural competency.

The relatively lower scores in the board and staff development domain might have been due to the respondents' limited knowledge of their board members, supervisors, peers or supervisees' participation in professional development activities. In general, professional development activities are decided and attended by individuals, unlike participation in organization-wide dialogues and trainings or behaviors toward racial- and ethnic-minority patients, which tend to be more apparent. In addition, the more grantees learned about cultural competency and health disparities, the more they might have realized how much they did not know and needed to develop, resulting in lower ratings in some of the domains in 2009.

Table 1

Average Ratings of Individual-level Cultural Competency Across Grantees n=13 grantees

CULTURAL COMPETENCY DOMAIN	Admin/Manager		Service Provider		Support Staff	
	2007	2009	2007	2009	2007	2009
Board and Staff Development (e.g., professional development related to cultural competency goals)	4.09	3.51	3.89	3.93	4.04	3.51
Education and Training (e.g., engaging in training to improve cultural competency)	4.47	4.26	4.50	4.35	4.43	4.30
Service Accessibility (e.g., working to minimize barriers to service accessibility)	3.87	3.60	4.08	4.12	4.32	4.31
Community Engagement (e.g., engaging community representatives in planning services)	4.16	4.20	4.21	4.20	4.23	4.14
Service Provision (e.g., providing culturally-based alternative treatments)	4.25	4.00	4.30	4.20	4.38	4.18
Data Collection and Use (e.g., using demographic data to monitor health outcomes)	4.22	4.06	4.24	4.03	4.08	3.81
Organizational Environment and Infrastructure (e.g., working to create an equitable environment)	4.42	4.55	4.37	4.40	4.57	4.53
Total average score across all domains	**4.21**	**4.20**	**4.23**	**4.12**	**4.29**	**4.12**

3.3 Community Relationships

The majority of grantees – if not all grantees – had working relationships with organizations that provided health and mental health services, social services and education, as well as with health practitioners, grassroots and volunteer groups, and community-based groups that worked with racial and ethnic minorities. Fewer grantees had relationships with organizations that provided social support to these groups, such as arts and cultural groups, neighborhood associations, recreational facilities or places of worship.

Community relationships were measured through the organizational assessment and interviews. Respondents rated whether their organizations had worked with specific types of groups to ensure high-quality services and health care to diverse populations and, if so, how effective the collaborations were. Generally, grantees had working relationships with a variety of local organizations to provide

support and services for their target groups. As shown in Figure 4, throughout the Initiative, the vast majority of grantees reported having working relationships with formal support systems (for example, health and mental health services or social service agencies), community-based organizations that work with the racial and ethnic minorities targeted by the Initiative, and grassroots and volunteer groups. In addition, respondents rated organizational community engagement practices highly (as described in 3.1).

Fewer grantees reportedly worked with organizations that provided social support (such as places of worship or tenant and neighborhood associations). Grantees with staff that reflected the populations they served (racially congruent organizations) described partnering with more social service and informal support organizations than did non-racially congruent grantee organizations. Racially congruent groups might have been more familiar with these organizations and have recognized their importance in their communities.

On average, grantees reported that they worked moderately well (3) to well (4) with other organizations and groups in the community. Grantees reported the strongest working relationships with health and mental health organizations, businesses, community-based organizations that work with racial and ethnic minorities, and social service agencies (average ratings 4.06 – 4.38). They worked least well with tenant and neighborhood associations and arts and cultural groups (average ratings 2.46 and 3.09, respectively). Grantees least frequently reported collaborating with these groups as well, which may have partially accounted for the lower average rating of relationship quality. In contrast, grantees had stronger relationships with groups they worked with more consistently and with which they shared goals and interests.

According to interviewees, their organizations often collaborated with other groups to:

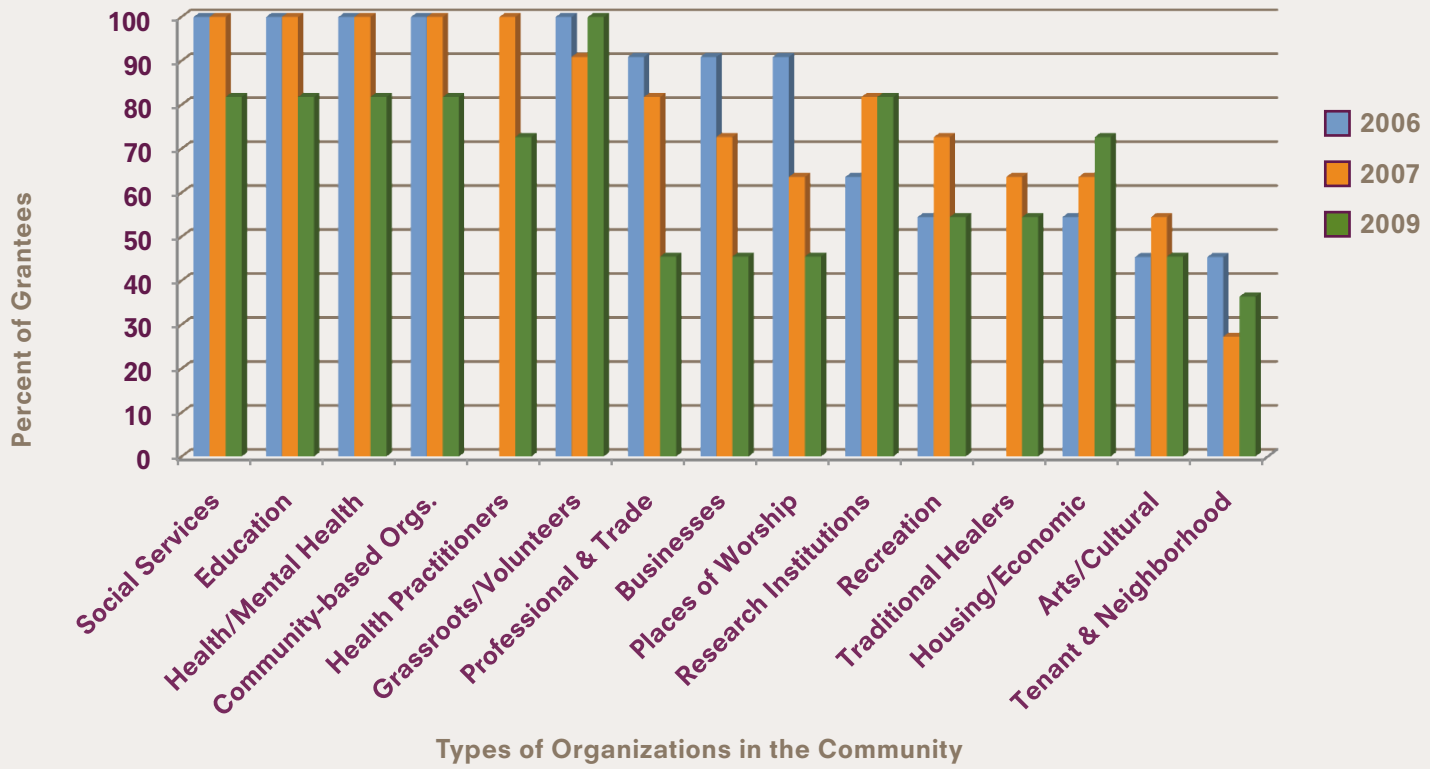
- Conduct outreach (as an example, to disseminate information)
- Increase access for people with limited resources (such as to get translation and interpretation assistance)
- Refer clients or patients to partner organizations for services
- Collaborate to fill service gaps
- Partner to better position themselves for grants
- Participate in or serve on coalitions, committees or councils with other organizations.

There were several factors that contributed to positive relationships with other groups:

- Grantees had strong, positive reputations and credibility in the community (they were respected, trusted, responsive and connected to the people they served)
- Grantees were deliberate in building relationships with other organizations (for example, they had set aside time for this process)
- Grantees shared partner organizations' interests, missions and goals and were working toward mutual benefit
- Grantees were supportive of other organizations and inclusive.

Figure 4

Grantee's Working Relationships With Local Organizations n=11 grantees*



* *Only 11 grantees had sufficient data to analyze their organizational policies and procedures; therefore, the total number of grantees included in this analysis is less than the total number of Cycle 1 grantees. Health practitioners and traditional healers were added to the revised assessment; consequently, baseline data about relationships with these groups are not available.*

IV. EVALUATION QUESTION 2:

HOW DID THE CHANGES INFLUENCE GRANTEES' INTERVENTIONS AND ASSOCIATED SHORT-TERM HEALTH AND HEALTH CARE OUTCOMES?

Grantees were asked to describe in progress reports to The Trust their intervention adaptations and short-term health and health care outcomes. To empirically examine the relationship between organizational cultural competency, grantees' intervention adaptations (such as community outreach, health education, exercise classes or interpreting assistance) and short-term health and health care outcomes, the evaluation team analyzed these data along with the grantees' changes in cultural competency over the course of the Initiative.

4.1 Short-term Outcomes

Grantees reported a number of adaptations to their program interventions and positive changes in short-term outcomes over the course of the Initiative. Changes occurred most in community engagement and service provision activities, as well as in accessibility and capacity outcomes.

The 13 grantees identified 37 short-term health and health care outcomes, which are organized into the following categories (see also Section 2.2):

- Capacity of Service Recipients (awareness, education and skill building for health promotion or self-management of chronic conditions)
- Accessibility (access to preventive care for the general population [universal] or care for those at increased risk of disease [selective])
- Clinical Conditions (improvement in health indicators for those with a diagnosed condition [indicated]).

Table 2 shows the frequency of the short-term health and health care outcomes that grantees had selected and monitored in each category.

Table 2

Frequency of Short-term Outcomes Monitored By Grantees
n=37 short-term outcomes

CATEGORY OF SHORT-TERM OUTCOMES	Number (%) of Short-term Outcomes Across All Grantees
Accessibility (e.g., increase in the number of clients served, increase in number of patients screened)	16 (43.2%)
Capacity of Service Recipients (e.g., increased health knowledge, meeting disease self-management goals)	12 (32.4%)
Clinical Conditions (e.g., improved mental health, decreased blood sugar)	9 (24.3%)

Data were standardized to examine the influence of cultural competency and intervention adaptations on the short-term health and health care outcomes of grantees' service recipients over time. For each outcome, the evaluation team aggregated the data from the grantees' progress reports into scores for each year (2006 to 2010, as available) and calculated the percent change from year to year. The number of outcomes for which data were available changed every year (see Table 3). The baseline was the first year of reported data.

Table 3

Self-reported Changes in Short-term Health and Health Care Outcomes
n=37 outcomes

OUTCOME TYPE	Average Change From Baseline to 12 Months	Average Change From Baseline to 24 Months	Average Change From Baseline to 36 Months	Average Change From Baseline to 48 Months
Accessibility	+ 80T (n = 16)	+ 195% (n = 12)	+ 174% (n = 11)	+ 135% (n = 7)
Capacity of Service Recipients	- 12% (n - 9)	+ 22% (n = 7)	+ 43% (n = 6)	+ 145% (n = 5)
Clinical Conditions	- 21% (n = 7)	+ 5% (n = 5)	**	**

* *The change from baseline to the end of the Initiative (48 months later) across the 37 short-term health and health care outcomes was not statistically significant. Because of the small number of selected outcomes for some categories (Clinical Conditions), limited amount of data available for some years (48 months after baseline) and goals, and the small number of goals set for the outcomes, the evaluation team did not run statistical tests on changes from baseline or changes in goal attainment by outcome category.*

** *Sample size for these cells was too small to include.*

Table 4

Self-reported Progress Toward Goals for Changing Short-term Health and Health Care Outcomes n=37 outcomes

OUTCOME TYPE	Average % of Goal Attained as of 12/2008	Average % of Goal Attained as of 12/2009	Average % of Goal Attained as of 12/2010
Capacity of Service Recipients	80% (n = 3)	100% (n = 3)	100% (n = 3)
Accessibility	72% (n = 3)	88% (n = 5)	88% (n = 4)
Clinical Conditions	**	50% (n = 3)	42% (n = 2)

** *Sample size for these cells was too small to include.*

4.2 Grantee Organizations' Intervention Adaptations

The findings suggest that cultural competency changes might have a greater, quicker and more direct influence on health care (that is, increasing access to care, health knowledge and self-management skills) than on improving clinical conditions. Effecting clinical outcomes would require deliberate cultural competency improvements in health treatment and delivery services.

The average change in short-term health and health care outcomes varied from year to year, as shown in Table 3. The greatest increase from baseline was in the access to care category (for example, the number of people served). The least change from baseline occurred in the clinical conditions category (as in the score or measure used to assess the clinical condition [e.g., depression, blood sugar level]).

Furthermore, the team calculated the percentage of goal attainment for grantees that set targets for particular short-term health and health care outcomes; Table 4 indicates that not many grantees set such targets. The greatest goal attainment occurred in outcomes pertaining to increasing service recipients' capacity to manage their health; the least goal attainment occurred in outcomes pertaining to improving service recipients' clinical health conditions.

To determine the adaptations that grantees made in their interventions to impact their desired short-term health and health care outcomes, grantees' reported interventions were coded by cultural competency domain. Table 5 presents the number and percent of short-term health and health care outcomes for which grantees made one or multiple adaptations to their interventions.

Grantees most frequently adapted their service provision (as in providing health education to racial and ethnic minority groups) and community engagement interventions (such as collaborating with local organizations to provide services). The grantees reported making at least one adaptation to the way they provided services to address 31 of the 37 short-term outcomes, and they made at least one adaptation to their method of outreach to the community in order to impact 17 of the short-term outcomes. The adaptations least frequently made were related to board and staff development (for example, engaging diverse staff in planning services) and environment and infrastructure (such as dedicating funds to cultural competency). The grantees reported changing their board and staff development practices and their environment and infrastructure to address only two of the 37 short-term outcomes.

Table 5

The Number and Percent of Short-term Health and Health Care Outcomes for Which Grantees Made One or Multiple Adaptations to Their Interventions n=37 outcomes

CULTURAL COMPETENCY DOMAIN	Percent of Outcomes for Which One Intervention Was Adapted	Percent of Outcomes for Which Multiple Interventions Were Adapted	Total Percent of Outcomes for Which Adaptations Were Made
Service Provision (e.g., providing health education and support to EIH-targeted groups)	43.2% (16)	5.4% (2)	83.7% (31)
Community Engagement (e.g., collaborating with local organizations to provide services)	43.2% (16)	2.7% (1)	45.9% (17)
Service Accessibility (e.g., providing interpretation services)	24.3% (9)	10.8% (4)	35.1% (13)
Data Collection and Use (e.g., collecting client race and ethnicity data)	27.0% (10)	5.4% (2)	32.4% (12)
Education and Training (e.g., training staff to help patients obtain health insurance)	29.7% (11)	2.7% (1)	32.4% (12)
Board and Staff Development (e.g., engaging staff reflective of the target communities in delivering intervention)	5.4% (2)	0	5.4% (2)
Environment and Infrastructure (e.g., dedicating financial resources to provide culturally specific services)	5.4% (2)	0	5.4% (2)

These findings are not surprising because grantees might have found it easier to adapt their community engagement and service provision activities than to change internal organizational components, such as the infrastructure and staff development needed to provide culturally competent services. Additionally, the connection between service provision, outreach and their consumers' health might have been more obvious to grantees than the connection between their organizations' infrastructure and consumers' health.

4.3 Determination of Relationships

Strong community relationships and organizational policies and procedures are critical to adapting interventions and making gains in improving health care.

Throughout the Initiative, grantees indicated that reaching out to and communicating with people in a culturally appropriate way enabled their organizations to appreciate the needs and health disparities of their clientele and to provide more tailored and accessible services. In turn, grantees expected service recipients to become more trusting of the organizations and more engaged in managing their own health, which ultimately would improve the health of the target communities. As one grantee explained,

"If [people] don't feel they are understood, they won't go back [for care]. [The changes have] enabled us to assist [clients] through the process – talking to and educating them, prevention, getting them into exams, further treatment when necessary – without stepping over cultural boundaries that might not make them want services. We must consider culturally what's happening and the best way to get [them] care." After implementing enhancements in cultural competency, grantees observed positive changes in the short-term health and health care outcomes they had selected, such as increases in the number of patients served, more self-management of health, increased use of preventive care, healthier behaviors, and decreases in patients' blood pressure, blood sugar and weight.

The team conducted correlational and regression analyses to empirically test relationships between grantee organizations' cultural competency, adaptations to their interventions, and short-term health and health care outcomes. Staff capacity and organizational policies and procedures were negatively correlated with making changes in education and training; grantees that perceived themselves as more culturally competent in these two dimensions were less likely to adapt their educational and training activities.[c] Relationships with local organizations (such as health service providers) were positively correlated with adaptations (for example, staff development and training changes) and with changes in short-term outcomes; grantees that partnered with other organizations were more likely to adapt their interventions and to make progress in their short-term health and health care outcomes.[d] The five grantees that reported attaining 75% or more of their goals adapted the way they interacted with and served the targeted groups. The most common adaptations were:

- Reaching out to target groups through local media (for example, radio and television) and at cultural events
- Providing health education in culturally relevant ways (through community health fairs, Bible studies or luncheons)
- Partnering with local organizations familiar to and trusted by target groups to provide health screenings and other services at convenient locations
- Collecting data to determine satisfaction with services provided.

Furthermore, statistical tests were conducted to determine whether cultural competency predicted changes in short-term health and health care outcomes as collected by grantees over time. This analysis helped determine the effect of organizations' cultural competency on service recipients' health. Established organizational policies and procedures positively predicted greater progress in grantees' short-term outcomes after two years.[e] This relationship continued to be significant after accounting for the number of cultural competency domains that grantees addressed to adapt their interventions. This finding indicated that the development of policies and procedures were necessary to impact short-term health and health care outcomes. The other two dimensions – individual staff capacity and professional development, and community relationships – did not predict progress in short-term outcomes.

Figure 5 illustrates the expected impact of cultural competency on health disparities. This conceptual model is based on the Initiative logic model and on the understanding of the Initiative's aims. This simple model assumes that the cultural competence knowledge and skills acquired would lead to adaptations in interventions, which, in turn, would lead to improved short-term health and health care outcomes.

Figure 5a graphically depicts the relationships tested in the Initiative evaluation. The evaluation findings suggested a more complex model and process than depicted in The Colorado Trust's conceptual model. There are different domains of cultural competency – organizational policies and procedures, individual staff capacity and professional development, and community relationships – all are important to ensure adaptations to interventions that better serve racial and ethnic minority groups so as to affect service accessibility, individuals' capacity to manage their health and improvement in clinical conditions. (The degree to which these three domains are statistically correlated cannot be determined because of the small number of grantees.)

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c *Organizational dimension: $r = -.55, p < .01$; individual dimension: $r = -.53, p < .05$*

d *$r = .60, p < .001$*

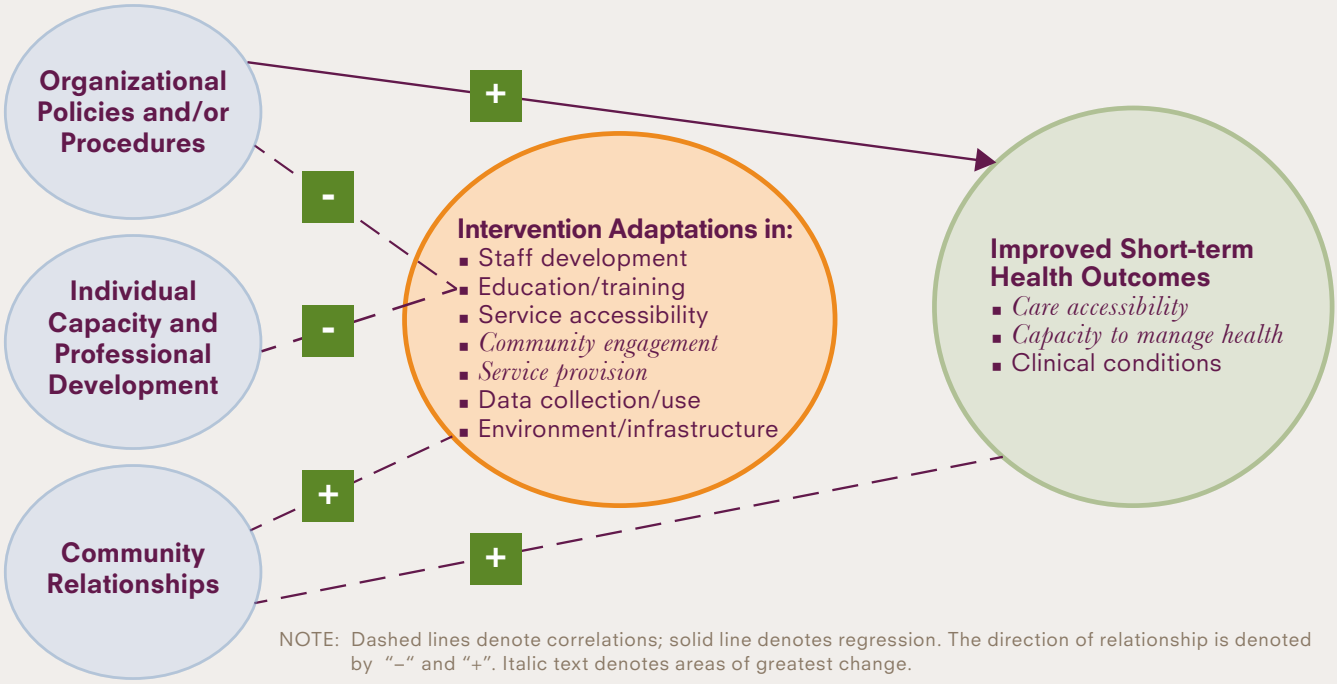
e *$F_{7,17} = 4.94, p < .05$, Adjusted R-square = .65*

Figure 5

The Colorado Trust's Conceptual Model for Relationship Between Cultural Competency and Short-term Health Outcomes

Figure 5a

Revised Conceptual Model based on the Relationships Found Among Cultural Competency, Adaptations to Interventions and Short-term Health and Health Care Outcomes



NOTE: Dashed lines denote correlations; solid line denotes regression. The direction of relationship is denoted by "–" and "+". Italic text denotes areas of greatest change.

As grantees' cultural competency in the form of community relationships improved, so did their adaptations to their interventions and progress in the short-term health and health care outcomes of their service recipients. As grantees' cultural competency in the form of organizational policies and procedures and staff capacity developed, adapting education and training activities to enhance services decreased.

The evaluation found that grantee organizations' cultural competency in the form of organizational policies and procedures predicted improvements in the short-term health and health care outcomes of service recipients. This finding suggested that a solid organizational foundation and infrastructure that ensured cultural competency was necessary to improve the health of racially- and ethnically-underserved groups. No correlations were found between organizational policies and procedures and staff capacity in relation to improved short-term health and health care outcomes, or between intervention adaptations and short-term outcomes.

V. EVALUATION QUESTION 3:

WHAT FACTORS BRING ABOUT POSITIVE CHANGES IN ORGANIZATIONS' CULTURAL COMPETENCY?

Interviewees from grantee organizations were asked to reflect on factors that facilitated or challenged their organizations' ability to strengthen organizational cultural competency. A number of key factors emerged from the analysis of interview responses: 1) resources that the EIH grant provided, 2) organizational resources, 3) organizational environment and leadership, 4) community relations and context and 5) access issues. The developmental framework in Figure 6 illustrates these facilitating and challenging factors throughout the Initiative. The framework is based on timelines grantees created at the end of the Initiative to reflect on their five years of work.

5.1 Conditions that Facilitate the Development of Organizational Cultural Competency

In order for grantees to improve their organizations' cultural competency, the following conditions must be present: funds and staff dedicated to this purpose; technical assistance (especially availability of facilitation, training and peer exchange); supportive organizational structures and processes; resources to increase access to services (such as interpreting and translation assistance); and community relationships. For lasting change, it is important to give attention to the internal and external factors that can impact sustained increases in organizational cultural competency.

The Partnership's technical assistance. Most grantees (85%, n = 11) noted that the technical assistance provided by The Partnership helped facilitate the development of their organizations' cultural competency. Grantees noted that The Partnership team generally was supportive of their efforts, available when they needed assistance and helped guide grantees' efforts. They were most likely to cite resources provided by The Partnership as helpful (resources such as trainings, tools and materials). As one interviewee stated, "[It is] helpful to have someone over your shoulder to help and coach you." One interviewee felt that the learning circles and statewide trainings allowed them to "explore our own cultural experiences and have a cross-cultural exchange." Another person explained, "The biggest impact has been the cultural competency trainings [The Partnership] has allowed [us] to attend. It has helped create good professional networks across the state, and it has helped [us] grow in terms of cultural competency."

The Initiative grant. Six grantees (46%) noted during interviews and 12 grantees (92%) indicated in their final progress reports that the EIH funding contributed to their increased cultural competency. In general, the funding enabled these grantees to dedicate time and staff to their organizations' cultural competency. It helped them focus on cultural competency, making it a more explicit and intentional component of their organizational development. Specifically, the funding provided resources for training and conference attendance; supplies and resources (for example, websites or interpretation sets); partnership development with outside organizations and community representatives; salary and training support (as for a grant coordinator or for hiring or training bilingual staff); outreach to clients and patients (disease specific classes, community outreach); and payment for interpreters. Approximately one-third of grantees also indicated that the Initiative helped them develop organizational policies and procedures that reflected cultural competency. As one interviewee stated, "[The Trust] has been patient with us in getting started and overcoming obstacles."

Other interviewees explained further what they had gained over the course of the grant:

"It's the fourth year of the grant, and [we're] partly becoming more aware and confident [in being] able to work in the community and having a strong place at the table to talk about cultural competency."

"The grant has helped make a permanent change in how health care is delivered in the area. Without the grant, the quality of health care would have remained stagnant."

Organizational environment and leadership. Informal and formal organizational structures continued to contribute to increased cultural competency. Informal structures (such as an open environment for discussing cultural competency and related issues) and formal structures (committees, workgroups and meetings) were reported by more than 75% (n = 10) of grantees. Additionally, they indicated what environmental factors supported ongoing cultural competency development, including leadership and staff commitment, infrastructure to implement cultural competency efforts, focus and motivation, and efforts to build sustainability. A number of interviewees described how the climate of their organizations encouraged candid dialogue, which, in turn, challenged their organizations to continue developing cultural competency:

"[The environment] allows the discussions in a fundamental way. African American staff that serve African Americans is not equivalent to cultural competency, so we are questioning if we are on the right track with customers. We are aware of how culture impacts behavior and experiences."

"We have articulated values and beliefs, one of which is open and honest communication. Another value is reflecting on one's own practice. So part of the culture is to be able to talk about things. We are a learning community, engaging in reflective practice."

". . . A lot more awareness of cultural competency, specifically that it applies to everyone and how it applies to us as an association, and helping us along a path of understanding how to be better and more consistent at keeping it at the forefront."

Four grantees reported that their organizations' leadership (management, board of directors) contributed to their organizations' open environment. Two of the grantees experienced changes in leadership; interviewees said that the new leaders' commitment to cultural competency encouraged more dialogue about it.

Community relations. According to progress reports, six grantees (46%) cited community relations as a factor facilitating the development of cultural competency. Grantees seemed to have learned about, reached out to and developed relationships with the communities they served. Grantees reported understanding the importance of collaborating with other organizations to sustain their efforts and to ensure that service needs were met. Grantees also noted that major community events afforded them: 1) the opportunity to establish partnerships and collaborate with other organizations in the community; 2) greater exposure; and 3) the opportunity to build relationships with immigrant communities. Interviewees explained the importance of understanding the communities they served:

"Effectively communicating with people who are different and understanding and honoring their culture help them feel cared about, comfortable, and creates an environment that helps them navigate the health system and make behavioral changes."

"[Clients feel] more comfortable coming into an environment that has an understanding of their cultural differences, so they will advocate for themselves more and get their needs met."

Interpreters and bilingual staff. In progress reports, five grantees (38%) reported that having access to interpreters and bilingual staff increased communication and trust with clients. As one interviewee stated, "[We] wanted to help everyone and not close the door on someone just because they do not speak English or are not from our culture." In addition, grantees indicated that the increased language capacity aided clients' understanding of services and care, and helped them understand clients' needs. Interviewees explained the benefits:

"There have been times when [our] interpreters or translators have been at the emergency room, and having interpreters made a huge difference. There are positive comments from both patients and doctors."

". . . Quality health care in terms of being able to provide qualified interpreters and translators. If you have proper interpretation, you know how to provide better treatment."

5.2 Conditions that Challenge the Development of Organizational Cultural Competency

Feedback from the grantees suggested that an organization's ability to be culturally competent is tied to internal organizational dynamics, as well as to external conditions such as community perceptions. Grantees found that lack of staff time or resources to devote to cultural competency development; a lack of diversity among the board, staff or volunteers; and resistance to change among staff and the community can hinder positive changes in organizational cultural competency.

Inadequate resources and support. Most grantees (n=12, 92%) reported that financial limitations were a barrier to building cultural competency. Four of these grantees discussed the impact of limited resources on increasing the accessibility of their services, which is an important aspect of cultural competency. Explaining the difficulty of meeting the increased demand in services that their organization was experiencing, one interviewee remarked, "[We are] a victim of our own success, meaning – the more trust we build with cultural groups, the more resources ethnic groups need." Another organization reported that it did not have adequate funding for patient vouchers for low-cost services to make care more affordable; still another reported that community needs exceeded its available resources. Reflecting on financial resources, an interviewee stated, "When the money goes away, I don't think it will affect the cultural competency of the organization, but how we work on it, and that's the challenge next year." Some grantees also noted that insufficient support to build organizational capacity was a challenge. Approximately one-third of grantees reported that the technical assistance and trainings they received did not fully address their organizations' structure and capacity, or that the instruction did not focus broadly enough on the multiple types (physical, mental) and causes of health disparities (such as systemic causes). Grantees expressed concern that training, technical assistance and some aspects of their programming would be difficult to maintain after the Initiative ended.

Organizational structure and climate. When the organizational environment did not allow staff to candidly discuss cultural competency – anonymously or not – the development of cultural competency was hindered. Six grantee organizations (46%) reported experiencing difficulty getting "buy-in" from certain staff and board members. In progress reports and interviews, grantees expressed concern that continued staff resistance to cultural competency and racial and ethnic health disparities would impede progress. Grantees also said that competing organizational demands made finding time difficult to build cultural competency (for example, attending trainings). Lack of clear direction or understanding about the organizational changes required to build cultural competency slowed the development process for some grantees. Interviewees explained the benefits of candid discussion:

"The increased participation [in cultural competency discussion] has removed a lot of apprehension, fear and anxiety. If you can communicate with people in a way that they can understand, you can help people make their own choices."

"People don't like to admit that they don't understand things, but when they come together, they can voice their frustrations, and this leads to great discussions that need to continue in order to create awareness that leads to knowledge."

Contextual factors. Finally, grantees identified outside influences that created barriers to cultural competency efforts. Four grantees (31%) noted that community perceptions about their organizations' services and clientele seemed to create resentment from English-speaking community members; apparently, some believed Spanish-speaking community members were getting more or better services. One grantee organization experienced conflict between its cultural competency staff and the larger organization, as well as between the organization and the community. One representative from the organization explained, ***"I think the whole episode helped other staff see actual barriers in the community instead of perceived. We had a meeting yesterday with the hospital system, and what has been perceived by many people in the past as a racial barrier was actually a system barrier."***

Low staff, board and volunteer diversity. Two grantees reported that their staff, board or volunteer base lacked diversity (racial, ethnic and bilingual). In addition, two other grantees indicated that staff turnover prevented cultural competency development. Organizations noted that there were not many bilingual individuals in their area or that the community was primarily White. As one interviewee said, ***"... Individual biases will always challenge [cultural competency] as we get new staff or uncover biases with current staff, but I think [bias] is impossible to eliminate completely."***

VI. CONCLUSIONS AND RECOMMENDATIONS

During the Initiative, grantees developed their cultural competency – first building cultural competency, then finding ways to embed and sustain it in their organizations. Organizations made changes across the three dimensions (organizational policies and procedures, individual staff and professional development, and community relationships) and seven domains (board and staff development, education and training, service accessibility, community engagement, service provision, collection and use of data, and organizational environment and infrastructure). Based on the analyses of the organizational cultural competency assessment, grantee interviews and progress reports, the conclusions regarding the three overarching evaluation questions are as follows.

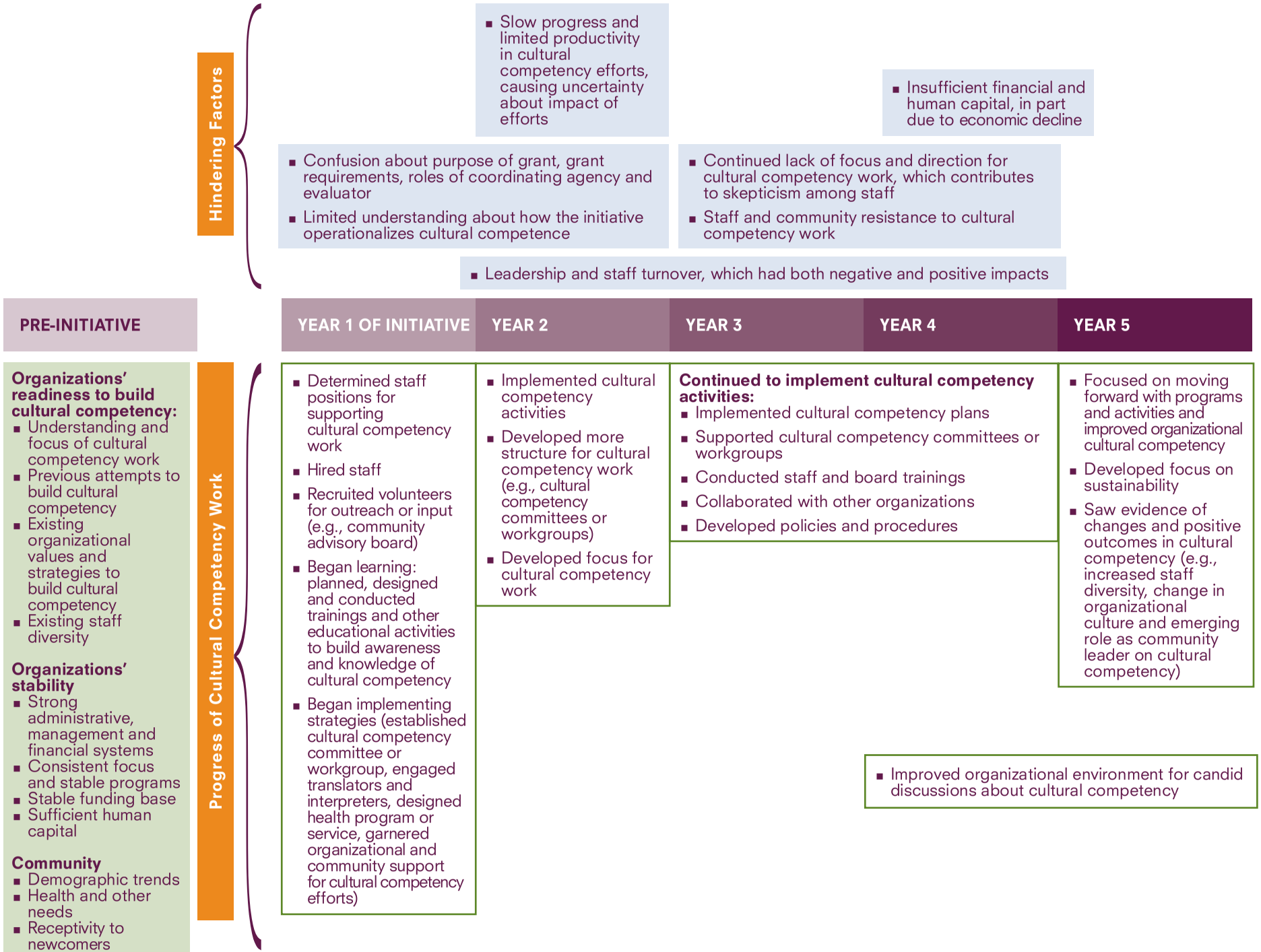
1. Did the cultural competency of the grantees change over time?

Yes, grantees' organizational cultural competency improved. The most change was apparent early in the Initiative; the level of change stabilized in the second half of the Initiative. Grantees made the greatest improvements in the areas of increasing the accessibility of their services; reaching out to the community and engaging community representatives in service planning; and regularly participating in education and training to increase their cultural competency. Grantees made less progress in collecting and using data to inform their work and plan services; developing their organizational environment and infrastructure to support cultural competency; and ensuring board and staff had reflected the populations served were recruited, hired, retained and engaged in leadership in the organization. The relatively little change in the areas of collecting and using data and in strengthening organizational infrastructure might have been an indication of the resource challenges that grantees described (financial and technological).

The general perception was that organization staff was at least moderately culturally competent. Staff members engaged in education and training to develop their cultural competency and helped make their organizational environment welcoming to the diverse communities they supported. The staff was less adept or had less influence in helping their colleagues develop professionally. All staff positions were rated highest in environment and infrastructure at the end of the Initiative, indicating that organizations were focused on sustaining cultural competency after the grant had ended.

Figure 6

Developmental Changes Experienced by Grantees



Grantees developed relationships with a number of local organizations. Most grantees worked with groups in formal health services and support systems along with more informal supportive groups such as community-based organizations serving racial and ethnic minority groups targeted by the Initiative; their strongest relationships were with these types of formal and informal groups, as well. Fewer grantees partnered with places of worship, cultural groups or other natural supports for diverse racial and ethnic groups. Grantees partnered with other local organizations to strengthen outreach, access to services, referrals and grantee organizations' resources. The grantees' reputation, as well as shared goals, support, inclusiveness and a mutually beneficial relationship helped the groups work well together.

2. If so, how did the changes influence grantees' interventions and the associated short-term outcomes?

There was evidence that grantee organizations' cultural competency development was related to the improvement of short-term health and health care outcomes of the populations those grantees served, as well as to the degree they had adapted their interventions. Most frequently, those adaptations were a result of enhanced service provision and community engagement to achieve their selected short-term outcomes. They least frequently made changes in board and staff development or organizational infrastructure, suggesting that those areas supported organizations' overall work but were not direct strategies that affected the short-term health and healthcare outcomes grantees had selected. Grantees saw the most change in accessibility to care outcomes and the least change in clinical condition outcomes of the populations they served. At the end of the Initiative, grantees that had set goals for building the capacity of their service recipients to manage their own health achieved their goals (for example, educating a certain number of community members); the least progress was made toward achieving goals related to clinical conditions (such as maintaining clients' blood sugar levels within a healthy range).

Grantees that reported more developed organizational policies and procedures and greater staff capacity were less likely to adapt their educational and training activities to impact the short-term health and health care outcomes they had selected. Organizations that perceived themselves as more culturally competent might have placed less emphasis on training staff around particular interventions than did organizations that saw themselves as less culturally competent. In contrast, grantees with community relationships with local organizations were more likely to adapt their interventions (such as making changes in training and staff development) and see improvements in their short-term health and health care outcomes than were grantees without these relationships. The importance of developing strong relationships with other organizations and groups in the community to more effectively promote the health of racial and ethnic minorities is consistent with existing research.[1,2,9] Additionally, cultural competency of organizational policies and procedures positively predicted greater progress in grantees' short-term health and health care outcomes. This finding indicated that an organization must develop its policies and procedures to better reflect cultural competency in order to make a positive impact on the health of the racial and ethnic minority consumers it serves. It is important to note, however, that a single evaluation study is not conclusive and that further exploration is needed to understand fully the relationship between cultural competency and health disparities.

3. What factors and conditions should be in place for an organization to bring about positive changes in cultural competency?

Internal resources such as leadership commitment and a well-equipped staff, as well as external resources such as support from the community, are necessary for an organization to develop its cultural competency.

In order for positive cultural competency changes to occur, grant funding and technical assistance are not sufficient. Other conditions should be in place.

The first condition is a supportive organizational climate. Leadership that is committed to building the organization's cultural competency is important for instituting change, and a committed staff is necessary for implementing the changes. Additionally critical are having clear focus and direction – or strategy – for how the organization will change to develop cultural competency and having the

infrastructure to sustain these changes. Having strong community relations is another significant condition. A deep understanding of the communities served (the community's assets, health and other needs; its history and languages); partnerships with formal institutions (as an example, health clinics) and social support networks (such as places of worship or traditional healers); and the knowledge and skills to engage community representatives in decisionmaking about the community's needs seem to impact health outcomes. These capacities allow an organization to increase the accessibility of its services and eventually influence the organization's operations and practices.

VII. LESSONS LEARNED FOR THE FIELD

As racial and ethnic diversity grows in this country, health-related organizations that provide health care or related services – such as the Initiative grantees – must understand and adapt to new and expanding client groups. Evaluating the Initiative reveals clearly that such organizations must change in a comprehensive way in order to institutionalize and sustain their cultural competency. Additionally, the evaluation provides important lessons for those funders who seek a better understanding of the journey toward cultural competency and who want to increasingly appreciate the critical role they can play in supporting health-related organizations on this journey.

Finally, the evaluation offers lessons for a third group of people – policymakers who are involved in implementing the Patient Protection and Affordable Care Act (PPACA). The PPACA will not only bring insurance coverage to more than 30 million people, but additionally will adopt strategies for reducing health disparities.[15,16] Although the Initiative began before the PPACA, it includes findings that reinforce the Act's following mandates:

- Information regarding health care and health education must be provided to recipients in accessible terms and language
- All federally-funded programs under the PPACA must collect data on each target group's race, ethnicity, primary language, disability status and gender
- The effort to achieve equity in health and health services must involve community outreach, training in cultural competency and efforts to reduce language barriers.

Sections 7.1, 7.2 and 7.3 summarize the lessons for health-related organizations, funders and policymakers, respectively. Some of the lessons apply to all three categories of users and, as such, may appear duplicative; however, the role that each type of user plays in applying the lessons differs.

7.1 Lessons for Health-related Organizations

The Initiative evaluation yielded six important lessons for health-related organizations in communities that are rapidly becoming racially and ethnically diverse.

1. Health-related organizations must be ready to engage in cultural competency work; otherwise, it is likely that any improvements they make will not be sustainable.

Achieving cultural competency is a journey or a means to an end for health-related organizations.17 The results are both improved organizational capacity to provide culturally appropriate services (that is, systemic change) and improved short-term health and health care outcomes (such as outcomes related to quality and accessibility of care and improvement in individuals' clinical conditions) for the diverse populations the organizations serve. In the long-term, the racially- and ethnically-diverse people served may even experience reduced health disparities and health status equal to their counterparts.

To become a culturally-competent organization is not an easy task. It requires serious commitment from an organization's leadership and a clear understanding of the hard work ahead. Health-related organizations must be ready to embark on the journey. Indicators of readiness include:

- A thorough understanding by leadership and staff that improving cultural competency means profound, comprehensive changes in leadership, operations and structures

- Previous efforts that have created positive attitudes about broadening cultural competency
- Clear commitment to this goal by the organization's leadership
- Obvious benefits to a majority of the organization's leadership and staff (for example, cost-savings due to increased efficiency in responding to service recipients with limited English proficiency or fewer emergency situations because service recipients trusted the staff enough to follow their instructions thoroughly)
- Stable financial, administrative and staffing systems and absence of competing priorities, such as an urgent push for fundraising, insufficient staff support and leadership turnover.

If health-related organizations find that they do not reflect the above indicators, it behooves them to first engage in some activities to prepare for the journey. For instance, staff members committed to cultural competency could collect and present information to their organization's leadership about the benefits of becoming culturally competent in order to secure the leadership's commitment. Further, an organization's executive director could engage a skilled facilitator to discuss what went awry in the organization's previous attempt to become culturally competent in order learn from the mistakes and shift negative attitudes about cultural competency.

The Trust did not assess organizations' readiness for developing their cultural competency before awarding the grants for the EIH Initiative. Some of the grantees' executive directors were not ready for systemic changes, making positive changes in cultural competency more challenging to institutionalize in their organizations. One grantee consistently struggled with financial challenges, which made focusing on cultural competency issues problematic for leadership and staff. Consequently, that grantee's cultural competency work "died down towards the second half of the Initiative due to limited capacity to carry out the work, and it is anticipated that [they] won't engage in direct training for as long as the organization struggles to fund positions and retain staff," according to the grantee's final report to The Trust. Another grantee faced tremendous resistance to change from its leadership, and its cultural-competency building activities were not well received. In addition, misalignment between this organization's goals and success measures and those of the Initiative , as well as their staff members' lack of responsiveness to the cultural competency assessment made balancing the Initiative's priorities with those of the organization a frustrating experience for the grantees.

2. Health-related organizations must understand that improving their cultural competency means deep, comprehensive changes in leadership's understanding, approach and discourse regarding cultural competence, as well as in the operations and structures that allow organizations to better respond to their communities' growing diversity. Cultural competency is much more than just modifying a particular health intervention, program, service or department.

As mentioned above, an indicator of readiness is a thorough understanding by an organization's leadership and staff that improving cultural competency means profound, comprehensive changes in leadership, operations and structures. The Initiative evaluation found grantee organizations without such readiness made less progress in strengthening organizational cultural competency; those grantees placed more focus on increasing resources for their health interventions or on the cultural competency of individual staff members than on strengthening their organizational system. Furthermore, the evaluation found that organizational policies and procedures – the foundation of an organization – impacted short-term health and health care outcomes; simply adapting interventions did not impact outcomes.

Health-related organizations committed to becoming culturally competent must target all facets of the organization, including leadership and staff development, education and training, service accessibility, service provision, community engagement, data collection and use, and organizational environment and infrastructure as part of building the organizations' cultural competency. The Initiative evaluation found that grantees often directed their cultural-competency building activities to a limited set of domains, namely education and training, service accessibility, and community engagement. Less progress was made in the domains of data collection and use, for example. Some grantees focused their efforts on translating written material into other languages, providing interpretation and adapting their facilities – perhaps because these changes were initially easier and less threatening than changes in board

composition, data collection and accountability systems. While these changes are important, they are not sufficient to institutionalize and sustain an organization's improvements in cultural competency.

3. Organizations whose leaders and staff share the same race or ethnicity as their client populations still must work on all domains of cultural competency and not assume that racial or ethnic congruity is sufficient.

Grantee organizations whose leaders and staff shared race or ethnicity with the people they served believed that cultural competency was an integral part of their mission and practices. They also tended to believe their organizations were culturally competent, especially because their staff understood the cultures of the people they supported and had relationships with community leaders. Consequently, they were more inclined to focus on interventions and services (such as diabetes management or exercise programs) than on organizational changes, not understanding that congruity and its help with outreach are important but not sufficient to build a culturally-competent organization. By the end of the EIH Initiative, these grantees reported that the Initiative had helped them appreciate the complexity of cultural competency.

Organization-wide policies and procedures must reflect not only congruity but all the other aspects of cultural competency, as well. These include leadership development, effective collection and use of race and ethnicity data, broad community engagement, allocation of financial resources for interpreting and translation, building of a welcoming environment, and creation and dissemination of culturally appropriate informational materials. The grantee organizations whose leaders and staff shared race or ethnicity with the people they served had credibility in the community and could offer insights to other grantees. It is important to ensure, however, that they do not lose focus on continually building their infrastructure for developing cultural competency.

It is also crucial to note that cultural differences and diversity exist within the same general racial or ethnic groups. For example, Americans of Chinese, Korean, Japanese, Thai, Vietnamese, Pacific Islander and other national origins are all referred to as Asian, despite enormous cultural, religious and linguistic differences. Among less diverse racial and ethnic groups, differences can be more subtle and, therefore, harder to discern. In all cases, for true cultural competency to develop, leadership and staff must understand that cultural variations exist and are important. Generalizations are dangerous – they can mask uncommon differences within racial and ethnic populations. These differences can have a direct impact on health awareness and behaviors.

4. A health-related organization must develop relationships with other organizations in the community in order to deepen and expand its reach and responsiveness to the racial- and ethnic-minority populations it serves.

Community relationships play a key role in building the cultural competency of a health-related organization. The Initiative had a positive impact on the number of grantees that instituted policies and procedures to assist them in engaging communities (as in the use of community advisory committees or hiring and training community health workers from the target groups to assist with health education and screening). This positive impact suggested that community connections enabled grantees to better understand and respond to the health needs of the community in areas such as service referrals, disseminating information and collaboration to fill service gaps. Additionally, the evaluation found that grantees' short-term health and health care outcomes improved as their community relationships improved. In a broader context, the findings revealed that even though organizational and individual capacities to promote and support cultural competency were essential, they were not sufficient without strong community connections.

Many health-related organizations do not consider relationship building as part of building their cultural competency. In addition, many organizations do not have policies or procedures for developing and conducting these relationships, gaining relevant feedback and information from partner organizations, and using that information to inform their program planning, implementation and evaluation.

Relationships with two types of organizations are critical: 1) organizations that make up formal systems, such as schools, health and mental health services, and social services; and 2) social support

organizations, formal and informal, that are trusted by racial and ethnic minority groups to deepen the health-related organization's outreach and services, such as neighborhood associations and arts and cultural institutions. All the Initiative grantees had relationships of the former type. Fewer grantees had relationships with the second type of organization; yet, these types of organizations can be effective for reaching target populations because they can influence group norms about health. The Initiative's grantees with staff members that reflected the populations they served (that is, they were racially congruent) partnered with more social support, non-health-related organizations than did non-racially congruent grantee organizations. Racially congruent groups might have been more familiar with and have recognized the importance of these organizations in their communities.

5. In order for health organizations to understand the populations they serve, to connect demographic factors with these populations' health outcomes and to design culturally sensitive interventions, it is imperative that they develop systems for collecting and using relevant data on race, ethnicity and primary language.
This was perhaps the most challenging task for grantees, yet the management of racial, ethnic and other cultural data is essential to cultural competency. It enables health professionals to monitor the health conditions of those they support, connect demographic factors with clients' health conditions and outcomes, and to tailor their interventions. In fact, the PPACA requires organizations that receive federal funding to manage relevant data effectively. To comply, organizations must have appropriate staff and resources. Not only must they gather data efficiently, they must also maintain appropriate infrastructure (such as a shared server and reliable database programs) and sufficient human resources (for instance, staff trained in database management, technical support, data analysis, and the use of pertinent data in planning and development).

Interviews and progress reports revealed to the Initiative evaluators that several grantees had found developing the necessary systems for collecting race and ethnicity data difficult and daunting. This critical domain changed the least over time. At best, processes and procedures were in place rather than actively practiced at the end of the Initiative. Frequently challenging was finding a data collection and management tool that fit the grantees' data needs for both the EIH grant and the rest of the grantees' programs. Health-related organizations must resist implementing a data system for specific projects that target racial and ethnic minorities; alternatively, they should view such a system as an overall organizational need and asset that would improve their services to all the people they serve.

6. The process of developing cultural competency is not linear. Indeed, organizations and staff can feel less culturally competent as they deepen their appreciation of cultural competency and begin to understand the complexity of the cultural learning process.
As leadership and staff of health-related organizations begin to discover the full range of skills and insights demanded for full cultural competency, they often rethink their own cultural perceptions and approaches to positive change. Staff may begin to see themselves as less culturally competent than they had once thought. Yet, by closely examining their underlying attitudes and opinions, they will likely see that this realization is a natural and positive part of developing cultural competency. Indeed, this pattern was observed frequently in the Initiative evaluation.

7.2 Lessons Learned for Funders

The Initiative evaluation yielded 10 important lessons for funders supporting the development of cultural competency in organizations providing health care and health-related services.

1. Funders must communicate clearly to grantees that improving their cultural competency approach and discourse regarding cultural competence, as well as in the operations and structures that allow organizations to better respond to their

communities' growing diversity. Cultural competency is much more than just providing funds for organizations to modify a particular health intervention, program, service or department.

Funders should encourage grantees to focus on three dimensions – their organizations' policies and procedures, staff capacity, and community relationships – in addition to all other facets of their organizations, including leadership and staff development, education and training, service accessibility, service provision, community engagement, data collection and use, and organizational environment and infrastructure, as part of building cultural competency.

The Initiative evaluation found that many of the grantees did not fully understand that the goal of the Initiative was to develop cultural competency by effecting organizational change. The Trust did not convey this aim clearly and explicitly in the beginning of the Initiative; by the second year, communication around the importance of organizational cultural competency and systemic change sharpened. Nevertheless, some of these grantees realized at the end of the Initiative that accomplishing this task meant changing their organizations' policies, procedures and practices. They reported that if they had understood this sooner, they would have started engaging their boards and executive directors earlier in the Initiative.

As discussed in Section 2, several factors contributed to the misunderstanding about the goals and objectives of the Initiative:

- The U.S. Department of Health and Human Services Office of Minority Health definition of cultural competency was used for the Initiative.[11] However, over time, grantees came to other understandings of cultural competency, as there neither is a single standard definition nor agreed-upon methods for measuring cultural competence in the field
- The Trust did not thoroughly assess grant applicants' understanding of cultural competency as part of the grant review process
- The goals and expectations were not clearly and consistently communicated to grantees throughout the Initiative.

When funders communicate the goals of a cultural competency initiative, they can potentially avoid this kind of misunderstanding if they emphasize organizational change, give examples of what such change entails and explain clearly that the creation of culturally competent interventions, programs and services is only part of the process.

2. Funders must support technical assistance to prepare grantees for cultural-competency building and to secure leadership and staff commitment.

When staff members of a grantee organization believe they are reasonably culturally competent, they may not be prepared nor even see the need for comprehensive changes in their organization's policies and procedures. Of the five Initiative grantees that had judged themselves to be culturally competent at the outset of the Initiative, two made significant progress in developing clear policies and procedures for infusing cultural competency into their organizational operations. The other three grantees focused instead on refining their health interventions or translating their health-related materials to serve a new group of people. This indicated that funders need to think carefully about staff members' beliefs concerning their level of cultural competency and readiness to change – including the possibility of engaging technical assistance providers to help identify any competency "blind spots."

Once grantees understand that cultural-competency building is about comprehensive changes, as described in the first lesson, some of their leaders (such as board members or executive directors) and staff may be resistant to the process. Funders must support technical assistance in the early stages of a cultural competency initiative to determine the potential for such resistance and develop strategies for addressing this challenge.

3. Funders should consider how they could leverage organizational changes by engaging organizations' leaders in a dialogue – early in the process – about the significance and meaning of building cultural competency.

The Initiative evaluation consistently found that a grantee's leadership played a pivotal role in advancing or hindering the organization's cultural competency. About halfway through the Initiative, The Trust invited grantees' executive directors to a breakfast meeting. The purpose was to assert the Initiative's goals and remind the executive directors of the commitment they had made to those goals when they accepted the grant awards. This meeting did not change grantees' trajectories (in other words, those grantees demonstrating negative results continued to do so). At that point, it might have been too late to engage the executive directors, or perhaps the organizational changes warranted were too significant for the executive directors to implement.

Before the grants are awarded, as well as throughout the grant period, funders can assist grantees in gaining the support of their leadership by communicating directly to leaders about the true meaning of cultural competency.

4. As part of grant obligations, funders must include the expectation of relationship building and strategic partnerships and work with their grantees to create strategies for outreach and collaboration as part of the normal operation of the grantee organization.

As explained in lesson four in Section 7.1, community relationships play a key role in building the cultural competency of a health organization. Many organizations do not have policies or procedures for developing and conducting these relationships, gaining relevant feedback and information from partner organizations, or for using that information to inform their program planning, implementation and evaluation. Nevertheless, funders should make this dimension an expected goal and measure of the cultural competency efforts they fund. They must be prepared to finance technical assistance to support the development of this new skill set and to connect this dimension to the other two dimensions – organizational policies and procedures, and staff capacity and professional development.

Additionally, as explained in the lessons for health-related organizations, relationships with organizations that make up formal systems, along with social support organizations (formal and informal), that are trusted by racial and ethnic minority groups are critical. It is important for funders to distinguish the two types of organizations and expect grantees to develop relationships with both.

5. Funders need to be aware that the process of developing cultural competency often is not linear. A decrease in perceived cultural competency can occur as organizations gain a better understanding of the nature of cultural competency and the complexity of its process. Funders should require their evaluators and grantees to thoroughly examine the reasons for the decrease in order to learn from the information rather than reach inaccurate conclusions.

As explained in lesson six in Section 7.1, an assessment of a grantee organization's own cultural competency may change as the grantee staff members gain a better understanding of the complexity of the competency-building process through dialogue with funders, exposure to technical assistance and internal conversations. As a result, funders may see a decrease in a grantee organization's self-perception of cultural competency. They should not determine the decrease as a negative trend without closer examination of the underlying factors; in fact, they would do well to recognize the decline as a natural part of the process of developing cultural competency.

6. Funders have the responsibility to provide grantees dedicated resources and technical assistance for developing systems to collect and use data on race and ethnicity.

Without a foundation partner emphasizing the importance of collecting race, ethnicity and primary language data, this component of cultural competency is likely to be a low priority. Funders must be aware that typically data collection and use are not seen as high priority or as a feasible part of cultural-competency building. Accordingly, they should work with grantees to develop this capacity.

7. The funder's program and evaluation officers, in collaboration with the technical assistance provider and evaluator, must develop expected outcomes for cultural competency and health and health care that are clear, measurable, and aligned with grantmaking and technical assistance strategies.

Given the importance support plays in developing an accurate understanding of organizational changes necessary for grant organizations to meet the needs of racial and ethnic minority communities, funders first must be clear about the short- and long-term outcomes they expect in cultural competency and in health and health care. To provide this clarity, foundation program and evaluation officers need to work with the technical assistance provider and evaluation consultant to ensure that: 1) the expected outcomes communicated to grantees are readily understood, actionable and measurable; and 2) grantmaking, technical assistance and evaluation strategies are aligned and consistent.

8. As part of the grantee selection process, funders should set selection criteria that exclude organizations not yet ready to engage in the work of building cultural competency, or be prepared to help the organizations become ready.

As described in lesson one in Section 7.1, becoming culturally competent requires serious commitment from an organization's leadership and a clear understanding of the hard work ahead. The grantee organizations selected for a cultural competency initiative must be capable of achieving both cultural competency and improved health care outcomes. This requires that selection criteria include an analysis of the grantee's readiness level to accomplish the work necessary to obtain these outcomes. In other words, only those organizations with the capacity and readiness to reach the established goals for organizational cultural competency and health care outcomes should be selected for participation in the Initiative. Stated yet another way, funders should be prepared to provide specific technical assistance to help organizations become ready. Two important ways to accomplish this are: 1) engaging the grantees' leadership, as described in lesson three above; and 2) helping grantees anticipate and develop strategies to deal with staff resistance from the outset of their efforts, as mentioned in lesson two.

9. In the initial planning and conception of cultural competency initiatives, funders must clearly define the types of organizations they are targeting. When grantees are overly disparate in terms of the kinds of services they provide or have diluted the focus of their cultural competency work, difficulties arise in applying uniform standards of performance.

The Initiative's goal was to improve the organizational cultural competency of health related organizations as a strategy for reducing health disparities. It required grantees to identify cultural competency outcomes and relate these outcomes to short-term health outcomes. This relationship was a major component of the evaluation. Three of the Cycle 1 grantees did not provide any health-related services. Two of these grantees' goals were to educate and train health professionals, including medical students and physicians, rather than affect particular health outcomes among racial and ethnic minority populations. One grantee was made up of several collaborative organizations; therefore, one organization had to be selected to be the subject of The Partnership's technical assistance and the evaluation's organizational assessment. This organization's goal was to strengthen providers' and community members' access to interpreting and translation assistance. Consequently, the grantees, The Partnership and the evaluation team experienced tensions in balancing grant expectations with the grantees' original plans.

10. It is important for funders to have realistic expectations when they define expected outcomes for a cultural competency initiative. Improvements in cultural competency and health care delivery can be anticipated from five-year initiatives like EIH. Having an impact on clinical health outcomes is more difficult and relies on a variety of factors beyond the reach of an initiative such as this; it may not be feasible to expect changes in clinical outcomes in such an initiative.

Cultural competency is critical to ending health disparities, but improving the actual health outcomes of disadvantaged groups requires a long-term process of change in organizational, staff, community and patient practices, as well as in the social determinants of health. Although funders can reasonably expect a five-year initiative to effect changes in health care – such as better program participation by racial and ethnic minority groups and increased compliance with treatment regimens – longer-term initiatives are needed to achieve improved clinical outcomes, even among program participants.

To achieve short-term outcomes in accessibility of care and in service recipients' self-management of health, grantees most frequently changed their service provision activities. As a result, they demonstrated changes, including increased participation of Latino mothers in health education programs and improved compliance among diabetic patients. Health or clinical outcomes, such as improved blood pressure or blood sugar levels, were much less common, given the type of adaptations grantees made to their interventions to impact the short-term health outcomes they had selected.

A key part of setting realistic expectations is developing a logic model or conceptual model that shows that improvements in clinical outcomes come at the end of a long causal chain that begins with the implementation of cultural competency strategies. Increased provider knowledge and understanding of health disparities and the cultures and perspectives of those they serve enable providers to better care for their patients; in turn, people in the target communities gain increased accessibility to care, understand their health better and use services more consistently. Over time, this leads to improvements in clinical outcomes.

7.3 Lessons for Policymakers

The Initiative evaluation yielded six important lessons for policymakers who are involved in implementing the mandates contained in the PPACA.

1. Policymakers should plan for multiyear funding and capacity-building support because building an organization's ability to provide information in a culturally and linguistically appropriate manner; collecting data on race, ethnicity and primary language; reaching out to communities; and implementing cultural competency trainings are not one-time events.

Integration of cultural competency into an organization's policies, procedures and practices ensures that the changes are institutionalized and sustained, instead of just being a "project of the day."[17]

As explained in lesson three in Section 7.2, at first the Initiative grantees did not view the work of building their cultural competency as organizational change work; instead, they perceived it as a project or activity. Not all the grantees' leaders were prepared to change their organizations' structures and processes, and some staff were resistant to changing the way they worked. Hence, it took time to educate and engage them in carrying out the goals of the Initiative. Additionally, strategic relationships take time to cultivate; trust must be built and mutual benefits identified. Service providers are more apt to collaborate with other service providers – as the EIH evaluation findings indicated. The time needed to shift organizational norms and build relationships with other organizations beyond service providers is why multiyear funding and capacity building support are essential. Organizational change takes time, and technical assistance, training and other support are necessary to help organizations' leaders and staff navigate the complexity of individuals' biases (for example, resentment about why minorities are getting "special treatment"), structural or systemic issues (such as unaffordable insurance coverage or lack of transportation to get to services) and cultural differences (values about preventive care).

2. It is important for policymakers to link Section 4302 of the PPACA on data standards to cultural competency building and develop guidelines that include extensive technical assistance and training for building health-related organizations' capacity to meet the standards.

Section 4302 of the PPACA requires data standards (collection, analysis and reporting) for five demographic categories: race, ethnicity, sex, primary language and disability status. The capacity to collect these data should be part of building an organization's cultural competency. An efficient and effective method for collecting race and ethnicity data was a challenge for Initiative grantees. By assisting health-related organizations to purchase the right software and hardware equipment,

establishing systems for collecting and using data for planning and decisionmaking, and training staff, grantees will enable organizations to comply with the PPACA.

3. Policymakers should emphasize the link between cultural competency and health care quality improvement for everyone in the community.

One of the reasons for resistance among some grantee staff was the belief that being culturally competent benefited only the racial and ethnic minorities those grantees served. An effective way to change this perception is to identify cultural competency as a key component of productive interactions between providers and all service recipients. One of the six tenets of quality improvement is patient-centered care, and in order to provide such care, the provider has to understand the patient or service recipient's culture, social context and specific needs. This means working with the patient or service recipient to make decisions about his or her own care.[18] The provider also must be able to communicate effectively with the patient or service recipient by using terms that can be easily understood or by speaking in the person's own language. Framing cultural competency in terms of patient-centered care can reduce a provider's concern that they are not sensitive to people from different cultures. Instead, it reinforces the important concepts that every patient or service recipient is unique and that providers have to develop skills in order to respond to each patient's or service recipient's specific needs.

4. 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.

The Partnership discussed the CLAS standards with some of the Initiative grantees for whom language access was a major issue. Those grantees used the standards to guide their policy development; in fact, one grantee adopted an organizational policy to use the CLAS standards to guide their work. Currently, the standards are promoted by the federal Office of Minority Health and serve as a framework for guiding cultural competence building. Four of the 14 CLAS standards that are related to language access are federal requirements for all recipients of federal funds, while the other standards are recommended for adoption. Making the CLAS standards mandatory will help promote their use as a basis for guiding the development of cultural competency. The CLAS standards should be transformed into a set of strategies, outcomes and measures that health-care organizations, funders and evaluators can use to design and assess cultural competency building programs.

5. Policymakers should fund research and evaluation of cultural competency initiatives to further develop the definition and measures for cultural competency.

Despite extensive theoretical work on the definition and practice of cultural competence, not enough is understood about assessing, building and evaluating it. The Initiative's evaluation revealed different views about cultural competency among the people interviewed. Some said cultural competency rested in staff diversity and training, translation of materials and help with interpreting data. Many of the grantees emphasized changes in individuals, without discussing organizational changes at all.

More research and evaluation of cultural competency initiatives are needed to identify evidence-based and promising practices and to develop appropriate measures. Studies of how the CLAS standards have been applied will be useful, as well. Most important is the generation of knowledge about what is necessary to be considered sufficiently culturally competent (for example, satisfying a minimum number of the CLAS standards and, if so, which of the 14 would provide an acceptable constellation of competencies), and what the stages and steps are to achieve this state.

6. Policies related to immigration and health care coverage can impact organizations' development of cultural competency; therefore, it would behoove policymakers to understand such policies in their development of strategies, initiatives and guidelines for building organizations' cultural competency.

In addition to internal organizational challenges to building cultural competency (such as concerns about leadership or staff commitment), grantees that worked extensively with immigrant and low-income populations consistently encountered two issues. The first was that undocumented immigrants were not allowed by law to receive any services supported in any degree by federal or state funds. The

state of Colorado denies most non-emergency state benefits to illegal immigrants 18 years old and older; people who apply for benefits must show proof of legal residency. The second issue was the lack of affordable health coverage among low-income and unemployed individuals.

As immigration policies and the implementation of the PPACA continue to evolve, it will be important, as part of cultural competency development, to educate the leaders and staff of health-related organizations and to correct any wrong assumptions about the groups they may serve. Additionally, immigrants and low-income families require instruction to develop a more accurate understanding about their rights to health care.

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APPENDIX A:

EVALUATION METHODOLOGY

Development of Assessment and Reporting Tools

To develop the cultural competency assessment form, the evaluation team reviewed the research literature about organizational cultural competency, particularly the areas that health organizations target to develop their competency.[4,10,11] The assessment is consistent with CLAS standards6 and the Health Resources and Services Administration's (HRSA) Organizational Cultural Competence Assessment Profile.[3] The Colorado Trust (The Trust) and The Partnership for Families and Children (The Partnership) reviewed the first draft of the form, and the evaluation team made revisions based on their comments. The final draft was piloted with five community-based organizations that provided a range of services, including health services, to EIH-targeted groups (that is, Black/African/African American, Hispanic/Latino, Asian/Pacific Islander and Native American/American Indian). One or two representatives from these organizations completed the assessment form, answered questions about the comprehensiveness and clarity of the concepts and items, and made suggestions for improvement. The version of the assessment administered to Cycle 1 grantees in 2006 is an indication of their feedback.

The evaluation team worked collaboratively with The Trust and The Partnership to refine the assessment. Further revisions represented a review of findings from the baseline organizational cultural competency assessment, reflections on what we had learned from the first two years of Cycle 1 grantees' work and a further review of the research literature. The team modified the assessment questions to increase consistency in the cultural competency factors measured across the three critical components of an organization: organizational policies and procedures, individual staff capacity and professional development, and community relationships. In addition, we adjusted the response scales to capture smaller degrees of change in cultural competency. The evaluation team administered this revised version of the assessment to Cycle 1 grantees in 2007. The revised assessment's internal consistency was $\alpha = .95$; the Cronbach's alphas for the Organizational, Individual and Community scales were $\alpha = .90$, .96, and .91, respectively.

Similarly, the evaluation team worked closely with The Partnership and The Trust to develop the grantee progress reporting form, which was used in 2005 and 2006. After reviewing the information submitted by grantees, we decided to revise the form to make the links between the grantee organizations' cultural competency activities, their interventions, and short-term health and health care outcomes more explicit. As a result, the team added cultural competency and logic model outcome tables to the progress reporting form in 2007.

Data Collection Procedures

We used three primary methods to collect data for the evaluation: self-report organizational cultural competency assessments, telephone interviews and grantee reports. EIH project coordinators from each grantee organization provided the evaluation team with a participant list of approximately 11 to 30 people (depending on the size of the organization) that included administrators and manages, support and service-provision staff, and affiliated community members with varying levels of involvement in EIH. The target sample size for each grantee organization was 10 assessment participants and six interviewees in 2006; in 2007, we increased the target number of assessment participants to 12. Some of the smaller grantee organizations had fewer than 12 staff members, which meant we selected everyone. We relied on grantee progress reports and other sources to detect any inconsistencies; we also interpreted the data cautiously to avoid inaccurate generalizations.

To get the most representative sample possible, the evaluation team selected individuals from each position within their organizations and people with varying degrees of familiarity with EIH; we oversampled to increase our chances of reaching the target number. For consistent longitudinal data, it was important to select staff and community members again who had participated in previous assessments. We asked participants to consent to completing an assessment about their organization's cultural competency journey, and we informed them of the possibility of needing to complete the telephone interview, as well.

Organizational cultural competency assessment. The assessment, administered online unless respondents preferred a paper version, measured cultural competency across three key components of an organization: 1) organizational policies and procedures, 2) individual staff capacity and professional development, and 3) community relationships. To assess organizational policies and procedures, respondents reported their perceptions of organizational policies and procedures in the following areas or domains:

- Board and staff professional and cultural competency development
- Education and training in cultural competency and issues
- Service accessibility
- Community engagement to support planning, services and outreach
- Service provision
- Data collection and use to monitor interventions and health outcomes
- Organizational environment and infrastructure.

This section of the assessment form consisted of 17 items in the 2006 assessment form; the revised form in 2007 consisted of 22 items with two to four items in each cultural competency domain. Respondents rated each item on the following five-point scale: not being considered (1), being considered (2), being developed (3), in place (4) and practiced (5). In the revised version, we added the options don't know or not applicable, in case the respondents were unfamiliar with the policies and procedures or did not consider it relevant for their organization. We calculated cultural competency scores for each domain if at least 50% of respondents selected 1 to 5 for the questions. The average of the cultural competency score across the seven domains yielded the organizational component scores for 2006, 2007 and 2009.

To assess individual staff capacity and professional development in 2006, staff and community members rated how well administrators and managers, direct service providers, support staff, and academic and research partners exhibited cultural competency in domains similar to those found in the section on organizational policies and procedures. In 2007, this section of the assessment further incorporated faculty, students and contracted service providers. Respondents rated each category of staff position, including the category to which they belonged. This section of the assessment consists of 12 total items with one to three items in each domain. Respondents rated each item on a five-point scale, ranging from 1 (not at all well) to 5 (very well). Additionally, respondents could select don't know or not applicable if they had not observed a particular aspect of cultural competency or if specific staff positions were not relevant for their organizations. The evaluation team calculated cultural competency scores for each domain and for each position if at least 50% of respondents had selected 1 to 5 for the questions. The average of the cultural competency score across the seven domains and the staff positions yielded the individual component score for 2007 and 2009. Given the revisions to the organizational assessment, the individual skill and knowledge items from the 2006 version of the assessment were not sufficiently comparable to be aggregated and compared to the 2007 and 2009 scores.

To assess community relationships, respondents rated the extent to which their organizations had worked with various types of local organizations to ensure high-quality services and health care to diverse populations. In the 2007 revised assessment, we added private practitioners and traditional healers to the list of organizations and also required respondents to rate the quality of their working relationships on a five-point scale ranging from 1 (not at all well) to 5 (very well). Respondents could select don't know if they were unaware of a relationship. We calculated cultural competency scores for each type of local organization if at least 50% of respondents indicated that their organization worked with the local organization. The local organizations were clustered into the following groups: supportive services (such as social service agencies, educators and educational institutions), health services (health and mental health services or private practitioners), economic organizations (professional and trade organizations or local businesses), and informal or social support organizations (as examples, places of worship, arts and cultural groups). The total number of partnerships that grantees established with the 15 types of organizations and within each category of organization yielded the community total scores for 2006, 2007 and 2009.

The use of mean substitution minimized the impact of missing organizational assessment data. For items with less than 50% missing data, the evaluation team calculated the mean score. The respective mean then replaced missing responses.

Telephone interviews. These interviews gathered more in-depth perceptions of organizational cultural competency, associated health changes, and facilitating and challenging conditions. Specifically, the team asked interviewees to discuss 1) changes in cultural competency in their organizations and the factors that prompted these changes, 2) the impact of changes in cultural competency on their organization's ability to address health concerns of target communities and on community health outcomes, and 3) conditions in their organizational environment that facilitated or challenged the development of cultural competency. To further understand facilitating and challenging conditions, the evaluation team questioned interviewees about factors outside of grantee organizations, such as grant-related support (for example, The Trust grant funding or The Partnership assistance). Culture-based grantee organizations (such as organizations with racial or ethnic congruence between the staff and communities served) answered additional case study questions about their approaches to cultural competency to better understand the cultural competency development process in such organizations.

Reports. Grantees and The Partnership submitted progress reports to The Trust every six months. In these reports, grantees described current activities and progress toward the cultural competency and short-term health outcomes outlined in their logic models. They also reported any short-term health outcome data they had collected by race and ethnicity. Grantees discussed factors and conditions that had facilitated progress toward outcomes, challenges, lessons learned, accomplishments and their consent procedures for collecting or accessing client health data. Finally, grantee progress reports outlined useful technical assistance, as well as needs for additional technical assistance.

To determine the health interventions that grantees used to build toward their desired short-term health outcomes, the evaluation team coded the reported interventions by cultural competency domain. For example, collaborating with a community organization to provide clinical care to Asian American residents was coded as a community engagement intervention adaptation. For each short-term health outcome, a score of 0 (none), 1 (one adaptation) or 2 (multiple adaptations) was given for each domain to indicate the extent of changes grantees had made to address the health of the people they served. The short-term health outcomes were clustered into three categories by type of outcome: capacity to manage health, accessibility to care and clinical improvement in diagnosed health condition. For each outcome, we aggregated the data by year and standardized by calculating: 1) the percent change from baseline (such as the first year of reported data) to 12, 24, 36 and 48 months after baseline and 2) the percentage of goal attainment annually for the outcomes in which grantees had set benchmarks. The following are examples of how the team calculated the health outcome scores:

Change from baseline:

Accessibility outcome

In 2007, 300 people served; in 2008, 450 people served
Percent change = (x2 – x1)/x1 * 100 = (450 - 300)/300 * 100 = 50% increase

Capacity outcome

In 2007, 1000 health education materials distributed; in 2008, 730 health education materials distributed
Percent change = (730 – 1000)/730 * 100 = - 37%, or 37% decrease

Clinical outcome

In 2007, percent of clients with A1C levels below 7.0 was 30; in 2008, percent of clients with A1C levels below 7.0 was 55
Percent change = (55 – 30)/30 * 100 = 83% increase

Goal attainment:

Goal: Proportion of Latino clients served reflects the 15% Latino population in the community.
Achieved in 2008: 13% of clients were Latino.
Percent goal attainment = .13/.15 = .87, or 87%

The Partnership progress reports described the specific technical assistance provided to EIH grantees to build their capacity to increase cultural competency, comply with reporting requirements and monitor progress. The Partnership reported information about the statewide, peer-to-peer and individualized technical assistance they provided to grantees in the areas of cultural competency, health disparities and evaluation.

Data Analysis Procedures

Using mean-level statistics, the evaluation team examined the grantee organizations' cultural competency development, adaptations to their interventions and services, and short-term health outcomes. Descriptive analyses determined grantees' degree of cultural competency development, and the evaluation team repeated measures t-tests to determine if grantee organizations' cultural competency had changed significantly over time. We used correlations and regressions to determine significant relationships between cultural competency components, grantees' adaptations to their interventions and services, and short-term health outcomes. The unit of analysis was the grantees (N = 13) for determining changes in organizational cultural competency and was health outcomes (N = 37) when determining the influence of cultural competency on adaptations in services and interventions and on health outcomes.

Statistics of Key Findings

3.1 Organizational Policies and Procedures

ASSESSMENT PERIOD	Mean (*SD*)	Mean Difference (*SD*)	*t* (*df*)
2006 – 2007			
2006	3.58 (.39)	0.88 (.40)	5.86 (6)***
2007	4.46 (.19)		
2007 – 2009			
2007	4.45 (.17)	-.09 (.40)	-0.49 (4)
2009	4.36 (.38)		
2006 – 2009			
2006	3.57 (.39)	0.77 (.59)	2.89 (4)*
2009	4.34 (.36)		

*p < .05, **p < .01, ***p < .001

DOMAIN BY ASSESSMENT PERIOD	Mean (*SD*)	Mean Difference (*SD*)	*t* (*df*)
SERVICE PROVISION			
2007	4.39 (.35)	0.06 (.44)	0.36 (7)
2009	4.45 (.31)		
SERVICE ACCESSIBILITY			
2006	3.87 (.49)	0.55 (.77)	2.02 (7)
2009	4.42 (.45)		
DATA GATHERING AND USE			
2006	3.86 (.68)	0.16 (1.02)	0.46 (8)
2009	4.02 (.63)		

Table continued on next page...

DOMAIN BY ASSESSMENT PERIOD	Mean (*SD*)	Mean Difference (*SD*)	*t* (*df*)
BOARD AND STAFF DEVELOPMENT			
2006	3.62 (.47)	0.63 (.51)	4.12 (10)**
2009	4.25 (.41)		
ENVIRONMENT AND INFRASTRUCTURE			
2006	3.62 (.27)	0.81 (.47)	5.16 (8)***
2009	4.44 (.44)		
COMMUNITY ENGAGEMENT			
2006	3.49 (.50)	0.89 (.79)	3.20 (7)*
2009	4.38 (.52)		
EDUCATION AND TRAINING			
2006	3.59 (.53)	0.81 (.79)	3.09 (8)*
2009	4.41 (.58)		

*p < .05, **p < .01, ***p < .001

3.2 Individual Staff Capacity and Professional Development

VARIABLE	Mean (*SD*)	Mean Difference (*SD*)[a]	*t* (*df*)
2007 - 2009 ASSESSMENTS			
2007	3.99 (.17)	-.02 (.24)	-0.25 (8)
2009	3.97 (.25)		
STAFF DEVELOPMENT	3.75 (.49)	-0.46	-2.48 (6)*
EDUCATION AND TRAINING	4.29 (.41)	.08	0.64 (9)
SERVICE ACCESSIBILITY	3.94 (.37)	-0.27	-2.04 (7)
COMMUNITY ENGAGEMENT	4.06 (.45)	-0.15	-0.85 (6)
SERVICE PROVISION	4.20 (.52)	-0.01	-0.07 (8)
DATA COLLECTION AND USE	4.05 (.44)	-0.16	-0.96 (6)
ENVIRONMENT AND INFRASTRUTURE	4.53 (.37)	.32	2.59 (8)*

*p < .05

[a] *The mean difference for the test of change over time was the difference in the average individual cultural competency score between 2007 and 2009. For each domain of cultural competency, the mean difference was calculated by subtracting the overall 2009 individual cultural competency average of 4.21 from the average score for each domain.*

4.3 Determination of Relationships

Correlations Among Cultural Competency, Adaptations to Activities and Changes in Short-term Health Outcomes

VARIABLE	Org. Policies and Procedures	Individual Staff Capacity	Community Relationships
STAFF DEVELOPMENT ADAPTATION	-.14	-.09	.42*
EDUCATION AND TRAINING ADAPTATION	-.55**	-.53*	.36*
ACCESSIBILITY ADAPTATION	-.07	-.04	.36
COMMUNITY ENGAGEMENT ADAPTATION	-.08	-.09	.61**
SERVICE PROVISION ADAPTATION	-.24	-.37	.62**
DATA COLLECTION AND USE ADAPTATION	-.09	.05	-.13
ENVIRONMENT AND INFRASTRUCTURE	-.07	-.06	-.29
CHANGE IN SHORT-TERM HEALTH OUTCOME FROM BASELINE TO 24 MONTHS	.03	-.53	.87**

*p < .05, **p < .01; N = 37

Effect of Organizational Policies and Procedures on Changes in Short-term Health Outcomes, Controlling for Adaptations in Activities

VARIABLE	*SS*	*df*	*MS*	*F*	*p*	η^2
MAIN EFFECT Organizational policies and procedures	17.31	7	13.38	4.30	.001	.37
CONTROLLING FOR ADAPTATIONS Organizational policies and procedures	17.05	7	2.44	4.94	.02	.38
Number of domains in which interventions were adapted	1.23	1	1.23	2.50	.15	.03

APPENDIX B:

ORGANIZATIONAL CULTURAL COMPETENCY ASSESSMENT FORM

The Colorado Trust
Equality in Health Initiative

Organizational Cultural Competency Assessment

A primary objective of the Equality in Health (EIH) Initiative is to reduce racial and ethnic health disparities by improving organizations' cultural competency. The aim of this assessment is to learn about [INSERT NAME OF ORGANIZATION]'s movement toward the goal of enhancing its cultural competency to serve a specific target population or populations. The specific target populations of interest to the Initiative are African Americans/Blacks, Hispanics/Latinos, Asians/Pacific Islanders and Native Americans. [INSERT NAME OF ORGANIZATION] may be targeting one or more of these groups; when you come across the term "EIH-targeted racial/ethnic groups" in this assessment, please think about the specific racial/ethnic group(s) that [INSERT NAME OF ORGANIZATION] is targeting through the EIH grant.

Your answers should reflect your honest perceptions about [INSERT NAME OF ORGANIZATION] and its staff. Only the evaluator for the Equality in Health Initiative will see your responses. There are no right or wrong answers. Your answers will be combined with those from other people in [INSERT NAME OF ORGANIZATION] to give an overall picture of the organization's cultural competency.

1. Please indicate whether policies and/or procedures for the following strategies are being considered, developed, already in place or practiced at [INSERT NAME OF ORGANIZATION]. In the event that the strategy is not relevant to [INSERT NAME OF ORGANIZATION] for whatever reason, please indicate N/A for not applicable. If you have no idea about the status of that particular strategy, please indicate D/K for don't know. Circle the best response based on your current knowledge.

KEY:

1 = Policies and/or procedures for the strategy are not being considered as far as you know.

2 = Policies and/or procedures are being considered for the strategy (for example, the idea has been discussed at decisionmaking meetings, ideas have been solicited from the staff).

3 = Policies and/or procedures are being developed for the strategy (for example, a draft has been shared, someone has the task of writing them).

4 = Policies and/or procedures are in place for the strategy (for example, the decisionmakers have approved them).

5 = Policies and/or procedures are being practiced for the strategy (for example, they are included in staff orientation; there are known rewards for compliance and consequences for non-compliance).

N/A = This strategy is not applicable to the organization.

D/K = You don't know about the status of policies and/or procedures related to the strategy, including whether they are being considered, developed or are already in place or practiced.

	NOT BEING CONSIDERED	BEING CONSIDERED	BEING DEVELOPED	IN PLACE	PRACTICED	NOT APPLICABLE	DON'T KNOW
a. Recruit and retain board members or administrative faculty who reflect the demographic characteristics of the EIH-targeted racial/ethnic groups	1	2	3	4	5	N/A	D/K
b. Recruit, hire, retain and promote staff, faculty and/or students who reflect the demographics of the communities served	1	2	3	4	5	N/A	D/K
c. Engage staff, faculty and/or students from EIH-targeted racial/ethnic groups in decisionmaking, planning, design and provision of services	1	2	3	4	5	N/A	D/K
d. Provide professional development opportunities and incentive awards to encourage staff and/or faculty to improve their cultural competency	1	2	3	4	5	N/A	D/K
e. Conduct ongoing, regular education activities (e.g., trainings, dialogues, facilitated discussions, readings) to improve the cultural competency of:							
■ Board members	1	2	3	4	5	N/A	D/K
■ Staff	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Partners	1	2	3	4	5	N/A	D/K
f. Continuously develop and review education, training and other health-related materials and strategies to ensure cultural appropriateness and competency	1	2	3	4	5	N/A	D/K
g. Provide and use professional interpreters for clients	1	2	3	4	5	N/A	D/K
h. Adapt facilities and services to minimize barriers to access for EIH-targeted racial/ethnic groups by ensuring:							
■ Availability (e.g., alter hours, add locations, decrease waiting times)	1	2	3	4	5	N/A	D/K
■ Affordability (e.g., provide services for free or at reduced cost)	1	2	3	4	5	N/A	D/K
■ Acceptability (e.g., create a welcoming environment)	1	2	3	4	5	N/A	D/K

	NOT BEING CONSIDERED	BEING CONSIDERED	BEING DEVELOPED	IN PLACE	PRACTICED	NOT APPLICABLE	DON'T KNOW
i. Hire, train and use community health workers, promotoras or paraprofessionals from EIH-targeted racial/ethnic groups to assist with outreach, health education, screening and other related tasks	1	2	3	4	5	N/A	D/K
j. Engage representatives from EIH-targeted racial/ethnic groups in planning services and outreach (e.g., advisory committee, focus groups)	1	2	3	4	5	N/A	D/K
k. Partner with community organizations that support the EIH-targeted racial/ethnic groups to outreach, plan and provide services	1	2	3	4	5	N/A	D/K
l. Use or train staff/students to use demographic data on patients/consumers from EIH-targeted racial/ethnic groups to plan services, monitor health outcomes and detect health disparities	1	2	3	4	5	N/A	D/K
m. Collect, analyze and use information about patients' perceptions of organizations' cultural competence	1	2	3	4	5	N/A	D/K
n. Establish an infrastructure for promoting and supporting cultural competency by: ■ Developing and implementing a cultural competency plan ■ Designating a staff person or position to ensure culturally competent practices ■ Allocating funds in the budget to ensure cultural competency	1 1 1	2 2 2	3 3 3	4 4 4	5 5 5	N/A N/A N/A	D/K D/K D/K
o. Understand and provide or teach culturally based complementary and alternative treatments (e.g., adapt services so they are more compatible with the beliefs, values and experiences of the EIH-targeted racial/ethnic group)	1	2	3	4	5	N/A	D/K
p. Develop and implement policies and procedures to ensure accountability to cultural competency goals	1	2	3	4	5	N/A	D/K

	NOT BEING CONSIDERED	BEING CONSIDERED	BEING DEVELOPED	IN PLACE	PRACTICED	NOT APPLICABLE	DON'T KNOW
q. Disseminate information to educate other providers and/or educators about providing culturally competent services to the EIH-targeted racial/ethnic groups	1	2	3	4	5	N/A	D/K
r. Disseminate information in a culturally appropriate way to educate health consumers from EIH-targeted racial/ethnic groups	1	2	3	4	5	N/A	D/K
s. Translate signs, telephone menus, forms and other administrative information	1	2	3	4	5	N/A	D/K
t. Provide professional translation of outreach, education and other health-related materials	1	2	3	4	5	N/A	D/K
u. Use demographic data on staff, faculty and/or students from EIH-targeted racial/ethnic groups to monitor diversity	1	2	3	4	5	N/A	D/K
v. Promote healthy practices and behaviors in a culturally appropriate way	1	2	3	4	5	N/A	D/K

2. Please indicate if [INSERT NAME OF ORGANIZATION] works with the following types of organizations by circling Y for yes, N for no or D/K for don't know. If yes, rate the extent to which [INSERT NAME OF ORGANIZATION] works well with them on a scale of 1 to 5, where 1 is not well at all and 5 is very well. If you do not know how well your organization works with the following types of organizations, please circle D/K.

DOES YOUR ORGANIZATION WORK WELL WITH:		NOT WELL AT ALL		MODERATELY WELL		VERY WELL
a. Social services agencies	Y N D/K	1	2	3	4	5
b. Educators and educational institutions (e.g., teachers, schools, colleges)	Y N D/K	1	2	3	4	5
c. Health and mental health services	Y N D/K	1	2	3	4	5
d. Community-based organizations that work with EIH-targeted racial/ethnic groups	Y N D/K	1	2	3	4	5
e. Professional and trade associations (e.g., chamber of commerce)	Y N D/K	1	2	3	4	5
f. Local grassroots and volunteer groups	Y N D/K	1	2	3	4	5
g. Local businesses (i.e., immigrant- and non-immigrant-owned)	Y N D/K	1	2	3	4	5
h. Recreation facilities and services	Y N D/K	1	2	3	4	5
i. Tenant and neighborhood associations	Y N D/K	1	2	3	4	5
j. Housing and economic development organizations	Y N D/K	1	2	3	4	5
k. Places of worship	Y N D/K	1	2	3	4	5
l. Arts and cultural groups	Y N D/K	1	2	3	4	5

DOES YOUR ORGANIZATION WORK WELL WITH:		NOT WELL AT ALL		MODERATELY WELL	VERY WELL	
m. Research institutions (i.e., academic or non-academic that help inform the organization's work by providing research support and evidence-based strategies)	Y N D/K	1	2	3	4	5
n. Private health practitioners	Y N D/K	1	2	3	4	5
o. Traditional healers	Y N D/K	1	2	3	4	5
p. Other (please specify): _____ _____	Y N D/K	1	2	3	4	5

3. Based on what you have observed, please rate how well the administrators/managers, faculty, direct service providers, students and support staff employed by the organization, academic/research partners and contracted service providers perform the following actions on a scale of 1 to 5, where 1 is not well at all and 5 is very well. If your organization does not include people from these categories, just circle N/A (not applicable). If you have not had the opportunity to observe any of these people in action and therefore, do not know how well they do, just circle D/K (don't know).

- Administrators/managers include people who make decisions, set policies and/or direct activities (for example, executive director, board member, director of program, director of training, depart ment chair, dean).
- Faculty include professors (assistant, associate, professor) who are not in administration.
- Direct service providers include people who provide health services to clients and patients (for example, physicians, nurses, health educators).
- Students include professionals, graduate students, and residents.
- Support staff are people who carry out and/or support the organization (for example, the person who arranges appointments, the mental health coordinator, immunization coordinator, nursing assistant, receptionist).
- Academic and research partners are people who help inform the organization's work by providing research support and evidence-based strategies.
- Contracted service providers are people contracted by the organization to provide services (for example, companies or agencies that subcontract with the organization to help provide services to the target population).

Our administrator/manager, direct service provider, support staff and academic partners are able to….	NOT WELL AT ALL	MODERATELY WELL			VERY WELL	NOT APPLICABLE	DON'T KNOW
a. Understand and provide culturally based complementary and alternative treatments (e.g., adapt services to be more compatible with the beliefs, values, customs and norms of the EIH-targeted racial/ethnic groups)							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
b. Engage in and support activities (e.g., dialogues, trainings, readings) conducted by the organization to improve its cultural competency							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
c. Engage representatives from the EIH-targeted racial/ethnic groups in planning/designing services, outreach and educational materials							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
d. Actively work to minimize barriers to care for EIH-targeted racial/ethnic groups by increasing: availability (e.g., hours, location), affordability (e.g., pro-bono services, sliding-scale fees), and acceptability (e.g., creating a welcoming, culturally sensitive environment, translating materials)							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K

Our administrator/manager, direct service provider, support staff and academic partners are able to....	NOT WELL AT ALL	MODERATELY WELL			VERY WELL	NOT APPLICABLE	DON'T KNOW
e. Make the effort to understand the expectations and satisfaction of individuals from EIH-targeted racial/ethnic groups							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
f. Recognize that one's own cultural background has an effect on interactions with people of a different racial/ethnic background							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
g. Receive feedback from clients and colleagues about how to improve interactions with people of different racial/ethnic backgrounds							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
h. Speak the languages used by the EIH-targeted racial/ethnic groups							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
i. Use demographic data on patients/consumers from EIH-targeted racial/ethnic groups to plan strategies and services, monitor health outcomes and detect health disparities							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K

Our administrator/manager, direct service provider, support staff and academic partners are able to….	NOT WELL AT ALL	MODERATELY WELL			VERY WELL	NOT APPLICABLE	DON'T KNOW
j. Participate in professional development and incentive reward opportunities to achieve goals related to cultural competency							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
k. Mentor and coach staff members from the racial/ethnic groups served to help them advance in the organization							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K
l. Work to create an environment that values, respects and ensures the equitable treatment of individuals from the EIH-targeted racial/ethnic groups							
■ Administrators/managers	1	2	3	4	5	N/A	D/K
■ Faculty	1	2	3	4	5	N/A	D/K
■ Direct service providers	1	2	3	4	5	N/A	D/K
■ Students	1	2	3	4	5	N/A	D/K
■ Support staff	1	2	3	4	5	N/A	D/K
■ Academic and research partners	1	2	3	4	5	N/A	D/K
■ Contracted service providers	1	2	3	4	5	N/A	D/K

4. How long have you worked for [INSERT NAME OF ORGANIZATION]?
   - ☐ Less than 1 year
   - ☐ 1 to 5 years
   - ☐ More than 5 years

5. What is your gender?
   - ☐ Female
   - ☐ Male

6. What is your age?
   - ☐ 18-35
   - ☐ 36-49
   - ☐ 50-65
   - ☐ 65+

7. Please describe how you identify yourself racially/ethnically.

APPENDIX C:

KEY INFORMANT AND FINAL INTERVIEW GUIDES

The Colorado Trust
Equality in Health Initiative

Key Informant Interview Guide

Hello. This is _____ from the Association for the Study and Development of Community (ASDC). I am calling in regard to the interview we have scheduled for today. Thank you for agreeing to be interviewed for the Equality in Health (EIH) initiative evaluation. The purpose of this interview is to explore the changes in cultural competency over time of [INSERT ORGANIZATION NAME HERE] and if these changes have resulted in reducing racial and ethnic health disparities.

Is this still a convenient time for you? [If not, ask for a new day and time.] Are you located somewhere you feel free to speak with me?

You have been selected as a representative of your organization to be interviewed. The information you provide will be used to inform the Colorado Trust and [INSERT ORGANIZATION NAME HERE] about how organizations like yours use cultural competency in their work with diverse racial and ethnic groups surrounding equal access to care and improved health outcomes.

The information you provide me today will never be connected directly to you in our reports. Information will be combined with other interviews from your organization and other organizations participating in the EIH Initiative. We also may use quotations to highlight interview themes, but again, the information will never be connected directly to you. Answering the questions is voluntary, and you can skip a question or stop the interview at any time.

Do you have any questions before we begin?

Okay, let's get started…

A. Role in Organization

1. For STAFF members: First, please briefly describe your role in [INSERT ORGANIZATION NAME HERE].

    PROBE: What does your position entail?
    PROBE: Length of time at the organization
    PROBE: Background and training

    For COMMUNITY members: First, please briefly describe your affiliation with [INSERT ORGANIZATION NAME HERE].

    PROBE: Specific examples of activities, services provided, etc.
    PROBE: How was the partnership established?
    PROBE: What is your role in the community organization?

For this interview, we will be using two terms, "cultural competency" and "health disparities." Cultural competency refers to "a set of behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations." Health disparities refers to "the gaps in the quality of health and health care across racial and ethnic groups."

B. Context: Organizational Setting

I'd like to explore more about cultural competency and your organizational setting.

2. What specific changes, if any, have you seen over the last year in [INSERT ORGANIZATION. NAME HERE]'s cultural competency?

   PROBE: Specific examples of changes in the organizational/structural, individual/professional, and community dimensions, along with specific details about how they know changes have occurred (for example, hiring culturally diverse staff members or staff trainings on cultural competence).

3. What do you think prompted these changes?

4. How have these changes affected your organization's ability to address the health concerns and disparities of people of African/African American, Hispanic/Latino, Asian/Pacific Islander, and/or Native American background?

   PROBE: Specific examples
   PROBE: How does building cultural competency help reduce health disparities?

   a. To what degree do policies and procedures exist in [INSERT ORGANIZATION NAME HERE] to disseminate information in a culturally competent way to educate clients/health consumers from these backgrounds?

      PROBE: Not being considered, being considered, being developed, in place, practiced

5. What impact do you think the changes in cultural competency have had on the health outcomes of the EIH-targeted racial and ethnic groups?

6. In your opinion, how does the environment or climate of [INSERT ORGANIZATION NAME HERE] allow the staff to candidly discuss and address issues related to cultural competency?

   PROBE: Specific examples

7. In your opinion, what, if any, factors or conditions challenge your organization's ability to become culturally competent?

   PROBE: Specific examples

C. Support and Resources

I'd like to discuss your opinion about the resources your organization has received to implement your Equality in Health Initiative project.

8. I don't know how much you know about The Colorado Trust grant, and if you don't feel that you can answer this question, it's okay. What has The Colorado Trust grantfunding allowed [INSERT ORGANIZATION NAME HERE] to do that it could not have done or has not done before?

   PROBE: Did this assist with cultural competency activities? Did this assist with your work on health disparities?

9. Do you know about the technical assistance providers from the Colorado Foundation for Families and Children (CFFC) who help support the Initiative? If yes, ask the next four questions. If not, skip to "D. Lessons Learned."

Note: If the interviewee is not familiar with CFFC, mention Chris, Erica, Carol, and/or Joanne.

a. What types of technical assistance have you received from CFFC over the last year?

PROBE: Specific examples

b. How has the technical assistance changed over the last year?

PROBE: Specific examples

c. How has the assistance helped in terms of the cultural competency of your organization?

PROBE: What did you like most about the support? What were the greatest benefits?

d. In general, what additional assistance do you wish [INSERT ORGANIZATION NAME HERE] had received?

PROBE: Specific examples

D. Lessons Learned

10. What lessons do you feel your organization has learned about building cultural competency and reducing health disparities?

E. FOR INDIRECT STAFF AND COMMUNITY MEMBERS ONLY

11. Would you feel comfortable referring people to [INSERT NAME OF ORGANIZATION] for services?

PROBE: If yes, why?
If no, why not?

F. Other Comments About the Organization

12. Do you have any other comments?

PROBE: Is there anything else about the cultural competency of your organization that you feel is important for me to hear?

PROBE: Do you have any questions for me or anything else you would like to talk about in relation to the Equality in Health Initiative?

Thank you again for your time and participation!

The Colorado Trust
Equality in Health Initiative

Key Informant Interview Guide (Final)

Hello. This is _____ from Community Science. I am calling in regard to the interview we have scheduled for today. Thank you for agreeing to be interviewed for the Equality in Health (EIH) Initiative evaluation. The purpose of this interview is to explore the changes in cultural competency over time of [INSERT ORGANIZATION NAME HERE] and if these changes have resulted in reducing racial and ethnic health disparities.

Is this still a convenient time for you? [If not, ask for a new day and time.] Are you located somewhere you feel free to speak with me?

Your name has been selected as a representative of your organization to be interviewed. The information you provide will be used to inform The Colorado Trust and [INSERT ORGANIZATION NAME HERE] about how organizations like yours use cultural competency in their work with diverse racial and ethnic groups surrounding equal access to care and improved health outcomes.

The information you provide me today will never be connected directly to you in our reports. Information will be combined with other interviews from your organization and other organizations participating in the EIH Initiative. We also may use quotations to highlight interview themes, but again, the information will never be connected directly to you. Answering the questions is voluntary, and you can skip a question or stop the interview at any time.

Do you have any questions before we begin?

Okay, let's get started…

A. Role in Organization

1. **For STAFF members:**

For previous interviewees: **State previous description of their role; ask if the role still is accurate and if anything has changed.**

For new interviewees: First, please briefly describe your role in [INSERT ORGANIZATION NAME HERE].

PROBE: What does your position entail?
PROBE: Length of time at the organization
PROBE: Background/training

For COMMUNITY members:

For previous interviewees: **State previous description of their role; ask if the role still is accurate and if anything has changed.**

For new interviewees: First, please briefly describe your affiliation with [INSERT ORGANIZATION NAME HERE].

PROBE: Specific examples of activities, services provided, etc.
PROBE: How was the partnership established?
PROBE: What is your role in the community organization?

B. Context: Organizational Setting

I'd like to explore more about cultural competency and your organizational setting.

SUMMARIZE THE ORGANIZATION'S REPORTED CHANGES IN CULTURAL COMPETENCY OVER THE YEARS AND REVIEW WITH INTERVIEWEE.

2. What specific changes, if any, have you seen over the last year in [INSERT ORGANIZATION NAME HERE]'s cultural competency?

   PROBE: Specific examples of changes in the organizational/structural, individual/professional and community dimensions, as well as specific details about how they know the changes occurred (for example, hiring culturally diverse staff members or staff trainings on cultural competence).

   PROBE: If interviewee reports no changes: What are the reasons for the lack of changes? How is little evident change different from past years when you did see change?

3. What do you think prompted these changes?

SUMMARIZE THE ORGANIZATION'S AREAS OF STRENGTH AND ITS CONSISTENT POLICIES AND PROCEDURES, INDIVIDUAL DEVELOPMENT, AND COMMUNITY PARTNERSHIPS NOTED IN ASSESSMENT.

FOR EACH LEVEL OF CULTURAL COMPETENCYCC, REVIEW THE AREAS OF STRENGTH AND ASK:

4. What are some examples of these:
   - Policies and procedures?
   - Individual capacities?
   - Community relationships?
     i. Review the reported quality of the relationships and ask:
        1. Please describe the nature of these relationships.
        2. What has made you work well or not very well with particular groups?

Overall probes for question 4.

PROBE: How can you tell that they exist and are active in your organization?
PROBE: How would they be evident to others?

5. **For administrators/managers:** Are there any examples (such as written policies or translated material) that you can send us?
   - Did you give anything to The Partnership for Children and Families that they can share with us?

6. How have these changes affected your organization's ability to address the health concerns and disparities of people of African/African American, Hispanic/Latino, Asian/Pacific Islander, and Native American background?

   PROBE: Specific examples
   PROBE: How does building cultural competency help reduce health disparities?

7. What impact do you think the changes in cultural competency have had on the health outcomes of the EIH-targeted racial and ethnic groups?

   PROBE: Specific examples of what cultural competency strategies were used that affected outcomes and how they did so.

8. In your opinion, how does the environment or climate of [INSERT ORGANIZATION NAME HERE] allow the staff to candidly discuss and address issues related to cultural competency?

   PROBE: Specific examples (internal and external factors)

9. In your opinion, what, if any, factors or conditions challenge your organization's ability to become culturally competent?

   PROBE: Specific examples (internal and external factors)

SUMMARIZE THE ORGANIZATION'S AREAS OF DEVELOPMENT AND ITS LOWEST SCORES IN ORGANIZATIONAL, INDIVIDUAL AND COMMUNITY DOMAINS.

FOR EACH LEVEL OF CULTURAL COMPETENCY, REVIEW THE AREAS FOR DEVELOPMENT AND ASK:

10. What are the organization's plans to continue to build cultural competency in these areas, if they are applicable?
    If there are no plans, ask: What would you recommend to help develop these areas?

SUMMARIZE ANY INCONSISTENT AREAS (for example, the item is endorsed for only one year or a year is skipped in Table 1 of the profile) AND ASK:

What are your impressions of the areas of cultural competency that people did not consistently agree existed strongly in your organization?

PROBE: Possible reasons or explanations for the inconsistencies?

C. Support and Resources

I'd like to discuss your opinion about the resources your organization has received to implement your Equality in Health Initiative project.

11. I don't know how much you know about The Colorado Trust grant, and if you don't feel that you can answer this question, it's okay. What has The Colorado Trust grantfunding allowed [INSERT ORGANIZATION NAME HERE] to do over the last five years that it could not have done or has not done before?

    PROBE: Did this assist with cultural competency activities? Did this assist with your work on health disparities?

12. How will your organization sustain its cultural competency efforts after the EIH grant ends?

    PROBE: What practices do you think will remain in place?
    PROBE: What do you think will be hardest to maintain? What do you recommend to help sustain these efforts begun through EIH in your organization?

D. Other Comments About the Organization

13. Do you have any other comments?

    PROBE: Is there anything else about the cultural competency of your organization that you feel is important for me to hear?

    PROBE: Do you have any questions for me or anything else you would like to talk about in relation to the Equality in Health Initiative?

Thank you again for your time and participation!

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