GRANT MAKERS IN HEALTH

Cultivating Culturally Competent Organizations:

Making the Transition for Health Equity

In an environment characterized by increasing cultural diversity, health philanthropy continues to develop new approaches to promote health equity. As foundations learn from past work, that field is shifting. In the early 1990s, health philanthropy directed attention and resources to programs seeking to build the cultural and linguistic competency of providers to improve quality of and access to care for vulnerable communities. Now funders are increasingly focused on tackling the social and community determinants that shape health – that is, the conditions in which people are born, grow, live, work, and age (WHO 2008). As the field evolves, key opportunities exist for health funders to guide the transition to new strategies to address disparities and promote health equity.

CULTURAL AND LINGUISTIC COMPETENCY: A FIRST STEP

Spurred by growing cultural diversity in the United States, the Institute of Medicine conducted a study 10 years ago to examine disparities in the health services provided to different racial and ethnic communities. Findings indicated significant disparity in both the types and quality of services received by different racial groups (IOM 2002). These conclusions inspired efforts to overcome language barriers affecting quality of care and bolstered new plans for funding cultural and linguistic competency initiatives across the nation. These programs have focused prominently on improving patient-provider communication and patient satisfaction through the use of interpreters and cultural competency training for health providers. In 2003, for example, the Robert Wood Johnson Foundation implemented *Hablamos Juntos*, an initiative to improve patient-provider communication in eight states with large Spanish-speaking populations. An evaluation of *Hablamos Juntos* illustrated the positive impact of an interpreter on patients' perceptions of their doctor's communication ability and satisfaction with care (Moreno and Morales 2010).

SOCIAL DETERMINANTS OF HEALTH: A NEW DIRECTION

While there has been a focus on health system concerns, accumulating research and experience have demonstrated that a number of economic and social factors, including education, income, housing, occupation, and neighborhood environment, deeply influence the health of communities. When people live in neighborhoods fraught by violence, struggle to secure employment, and have limited access to healthy food, the quality of their health declines (McGinnis et al. 2002). Addressing these conditions is a complex task that calls for different approaches than those used to increase cultural and linguistic competency. Dealing with complex community factors requires collaborating across sectors, as well as inventing creative strategies within the health system.

Many health care providers understand the need to address the social determinants of health to promote patient health but feel they have limited capacity to do so. An increasing number of community health centers, however, have adopted innovative approaches to strengthen social conditions affecting health that extend beyond providing medical services. For example, Sea Mar Community Health Centers, in the state of Washington, created a program to provide scholarships to high school and college students from migrant farmworker families (Institute for Alternative Futures 2012). These children, who often face great challenges in completing their education, are more likely to succeed academically as a result of receiving scholarship, a key predictor of adult health.

BUILDING ORGANIZATIONAL CULTURAL COMPETENCY

The field's evolution from an individual care setting-based focus to a community-oriented determinants lens presents an opportunity to capitalize on the potential of community health centers and other organizations to reduce health disparities. Situated between individuals and systems, neighborhood organizations function as a crucial intervention point given the range of their interaction with community residents. Research suggests that the quality and experience of the contact between communities and organizations can affect whether or not individuals seek care (Wilson-Stronks and Galvez 2007). Similar to building the cultural and linguistic competency of an individual provider, cultivating the cultural competency of an organization positions that agency to respond more effectively to the needs of diverse communities and improve their health.

➤ ***A Vision for Culturally Competent Organizations*** – Culturally competent organizations share a common thread

of valuing the complexity of cultural diversity. This complexity includes differences in gender, sexual orientation, race, socioeconomic status, religious affiliation, physical and mental ability, and language, among other dimensions. Given the range of these factors, cultural competency does not require an organization to be versed in the terminology and history of every community; rather, the goal is for the organization to embrace an inclusive perspective toward all types of cultural difference. In practice, a culturally competent organization has the capacity to integrate into its systems a set of behaviors, attitudes, and policies that serves a cross-cultural setting (Brownlee and Lee 2012).

How does an organization develop its cultural competence? Becoming culturally competent is a process an organization actively undertakes, as opposed to an outcome, and is one that involves fundamental changes to its framework. Turning inward to conduct a cultural self-assessment of processes and practices is an important step to identify aspects of its culture that can be adapted and updated to reflect a more global approach.

Reflecting on key questions can help identify practices that support or hinder an inclusive culture:

- What is the purpose of the practice under review?
- How might that practice be or be perceived to be a barrier to access by certain communities?
- Who might be excluded by this practice? Who might be privileged by it?
- What value is placed on the practice? What are the underlying assumptions to this value?
- Should the existing practice be maintained? How might it be revised to reflect inclusivity? (Buchanan 2001).

PHILANTHROPIC EFFORTS

➤ ***The Colorado Trust's Equality in Health Initiative*** – Several years ago, The Colorado Trust recognized that true organizational change would result in sustainable improvements to cultural competency and ultimately close the gap in health disparities. In 2005 it created the Equality in Health Initiative, which funded 26 nonprofit organizations and institutions to develop their capacity and skills to provide culturally effective services in order to promote equality in treatment and medical services, equal access to care, improvements in environmental conditions, and increased healthy behaviors. Grantees received technical assistance to develop their organizational cultural competency, capacity for program planning and implementation related to health disparities, and data collection and use.

The initiative's Cycle One grantees revised and created new policies related to board and staff professional development, and increased accessibility and provision of services, cultural competency education and training for staff and partners, and organizational environment and infrastructure. As a result, 43 percent of grantees reported increased accessibility of services, 32 percent reported increased skills and capacity of their clients, and nearly 25 percent reported improved client health conditions such as better mental health outcomes and reduced blood sugar (Woods and Lee 2012).

➤ ***REACH Healthcare Foundation's Cultural Competency Initiative*** – In 2008 REACH Healthcare Foundation embarked on a journey to reduce barriers that contribute to health disparities in six counties in Kansas by building the cultural competence of 29 health and human service organizations. Through this effort, REACH's Cultural Competency Initiative seeks to facilitate infrastructural change within organizations to develop their capacity to meet the diverse and changing needs of communities. This approach includes an ecological perspective of the interactions between an organization's policies – that can either support or hinder cultural competency – and its staff's understanding of and commitment to integrating cultural competency into their work. Before providing funding to grantees, REACH underwent a self-assessment of its own grantmaking, policies, and procedures to ensure that the foundation itself models the values inherent to the initiative's approach. Since then, REACH has funded 29 grantee organizations to measure change in several indicators related to their cultural competency, including organizational policies and procedures, leadership support of cultural competency, staff attitudes and skills, and client services. The foundation has also expanded efforts to create program sustainability by engaging other funders in the Greater Kansas City area. Additionally, the foundation plans to establish a cohort of nonprofit leaders who will promote organizational cultural competency building beyond the initiative.

CONCLUSION

As the field evolves, it is worthwhile to consider where it has been and where it is headed. Individual-level cultural competency initiatives demonstrated that it is necessary, but not sufficient, to improve patient experience with the health system by building the skills of providers. With a new focus on transforming the community and social determinants of health, the field is poised to address disparities in a new, comprehensive way. Building the cultural competency of organizations serves as a key transitional step to develop the capacity of agencies that regularly engage with communities to better shape their health.

SOURCES

Brownlee, Tim, and Kien Lee, "Building Culturally Competent Organizations," <http://ctb.ku.edu/en/tablecontents/section_1176.aspx>, 2012.

Buchanan, Anne, "Towards an Inclusive Organizational Culture: Applying a 'Diversity Lens,'" < http://www.evaluationtoolsforracialequity.org/evaluation/tool/doc/002_dev_inclusion_applying_diversit_lens.pdf>, 2012.

Institute for Alternative Futures, *Community Health Centers Leveraging the Social Determinants of Health*, <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>, March 2012.

Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2002).

McGinnis, J. Michael, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs,* 21:78-93, March-April 2002.

Moreno, Gerardo, and Leo S. Morales, "Hablamos Juntos (Together We Speak): Interpreters, Provider Communication, and Satisfaction with Care," *Journal of General Internal Medicine*, 25(12):1282-1288, 2010.

Wilson-Stronks, Amy, and Erica Galvez, *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*, <http://www.jointcommission.org/assets/1/6/hlc_paper.pdf>, 2007.

Woods, LaKeesha, and Kien Lee, *Addressing Health Disparities Through Organizational Change Evaluation Report*, <http://www.coloradotrust.org/attachments/0001/7552/EIH_Final_Report.final.4-9-12.pdf>, 2012.

World Health Organization (WHO), "Social Determinants of Health," <http://www.who.int/social_determinants/en/>, 2008.