Equality in Health Initiative Interim Evaluation Report for Cycle 2

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Executive Summary

Purpose. The Equality in Health (EIH) initiative-level evaluation is designed to answer the following questions:

1. Does the cultural competency of the grantees change over time?
2. If so, how does the change influence the grantees' interventions and the associated short-term outcomes?
3. What factors and conditions should be in place for an organization to bring about positive changes in cultural competency?
4. Does the cultural competency of the Colorado Foundation for Families and Children (CFFC) change over time? If so, how does this influence its technical assistance strategies and interventions? What factors and conditions should be in place for an organization like CFFC to bring about positive changes in cultural competency?

To evaluate changes in organizational cultural competency and short-term health outcomes, the evaluation team surveyed, conducted interviews with, and reviewed progress reports from grantees and CFFC between April 2007 and April 2008. Ten to 15 staff and affiliated community members from each organization were selected to participate in the evaluation. The evaluation team examined cultural competency across three critical components of an organization: 1) *organizational* policies and procedures, 2) *individual* staff capacity and professional development, and 3) *community* relationships. Related adaptations to services, changes in the health of people from the racial/ethnic groups of interest to the initiative—Black/African American, Hispanic/Latino, Asian/Pacific Islander, and Native American/American Indian (hereafter referred to as "EIH-targeted groups"), and facilitators and barriers to building cultural competency also were examined.

This interim cross-site report describes the cultural competency of Cycle 2 grantees and the technical assistance provided by CFFC to help grantees build their cultural competency over the first year of involvement in EIH. It is important to note that the findings have the following limitations: 1) one main source of data is self-report, and, therefore, reflects participants' perceptions, and 2) the representativeness of the sample varies by organization (i.e., the sample from larger organizations represents only a small proportion of the organization). Nevertheless, the report provides a springboard to generate discussion about how grantees can further strengthen organizational cultural competency, what additional assistance may be required of CFFC, and what additional information might be needed to deepen our collective understanding of organizational cultural competency and racial/ethnic health disparities.

Grantees' organizational cultural competency. Grantees appear to be moving toward the action stage of change in many domains of cultural competency. The vast majority of grantees reported implementing policies and procedures to reduce barriers to access to services and help build the capacity and cultural competency of staff. Specific strategies to achieve goals in these areas included translating materials, providing interpretation services, conducting ongoing trainings for staff and partners, and hiring and retaining diverse staff members. To a lesser degree, grantees reported active policies and procedures related to the domains of data gathering

and use to guide service provision and organizational environment/infrastructure to support cultural competency.

Cultural competency in terms of staff capacity and community relationships was not entirely consistent with the reported stages of development of organizational policies and procedures. According to evaluation findings, grantee staff in all positions demonstrate cultural competency at least moderately well. The greatest competency reported was in creating an organizational environment that ensures the equitable treatment of the EIH-targeted groups and in engaging in educational opportunities to develop cultural competency; staff members were perceived as least adept in minimizing barriers to access to care and engaging community representatives to enhance services. In contrast to these findings, organizational policies and procedures related to access were the most established in the grantee organizations, and policies and procedures related to the organizational environment and infrastructure were among the least established. Across the organizational, individual staff, and community levels, grantees appear to be developing in the domain of community engagement. Grantees tend to work most with organizations that provide services, community-based groups that serve EIH-targeted groups, and private practitioners, and less frequently with institutions that may serve and support specific racial/ethnic groups (e.g., arts and cultural organizations, neighborhood associations, and traditional healers).

CFFC's cultural competency and role. With a number of procedures and policies in place to build organizational cultural competency, CFFC continues to develop its own competency while helping strengthen that of grantees. CFFC representatives acknowledged that changes in their organization's cultural competency have enhanced staff research and technical assistance capacities, particularly in issues related to cultural competency. Based on analysis of CFFC's technical assistance summaries, aside from helping grantees with program implementation and progress reports, CFFC dedicates a relatively large proportion of assistance to grantee organizations' development of cultural competency plans, data collection protocols, and staff positions and committees dedicated to cultural competency. According to grantees, this support helps them with their work related to building cultural competency. In addition to the current support they receive, several grantees requested additional assistance with developing relationships with community groups and other EIH grantees, evaluating their interventions, obtaining educational resources related to cultural competency and health services best practices, marketing the EIH initiative, and completing progress reports.

Link between cultural competency and short-term health outcomes. Grantees set health goals ranging from providing preventive care and education to all clients/patients to providing indicated care to those with existing health conditions. The majority of grantees' short-term health outcomes were related to improving the health of individuals with a chronic condition and increasing clients'/patients' capacity to monitor and manage their health. To achieve these goals, grantees most frequently engaged in activities to adapt their service provision, access to care, and community engagement practices for EIH-targeted groups. Since implementing these strategies, approximately one-third of grantees reported beginning to see an increase in clients'/patients' comfort with and use of health services. However, as grantees have provided limited short-term health outcome data to date, we cannot empirically examine the impact of cultural competency on health outcomes. The extent to which changes in health are borne out in the data and are

associated with improvements in culturally competent organizational practices will be explored in the next report.

Facilitating and challenging conditions. In addition to the technical assistance that CFFC provides, support from their organization and the larger community has enabled grantees to strengthen their cultural competency strategies. Specifically, grantees are better able to build cultural competency in the context of an organizational environment that supports critical examination and ongoing development of cultural competency, as well as a community in which they can collaborate with other organizations to increase residents' knowledge and use of available health services. Conversely, insufficient organizational and community resources, difficulty collecting and using data to monitor the health of target groups, and an organizational environment not fully supportive of addressing racial and cultural issues impedes grantees' ability to build cultural competency.

Conclusion and recommendations. Grantees are working to implement and refine organizational policies and procedures, build staff capacity, and develop relationships with their local communities to bolster cultural competency. CFFC has provided cross-site trainings, opportunities for grantees to network and discuss strategies and challenges, and assistance tailored to meet grantees' unique needs. Grantees have found the assistance helpful in enhancing the cultural competency of their organizations. Although clear associations between cultural competency strategies, interventions, and short-term health outcomes cannot be determined at this time, some grantees report that they are beginning to see positive changes related to access to quality care for the communities they serve.

In addition to responding to specific grantee requests for additional assistance, we recommend that CFFC consider providing additional help to address the following: organizational environment and infrastructure, staff development, resistance to addressing cultural issues, deeper understanding of cultural competency and racial/ethnic health disparities, and the alignment of cultural competency efforts across key elements of organizations. CFFC might also provide additional assistance in identifying community resources and developing relationships with other community organizations, particularly those that form the social support system and help enhance quality of life for EIH-targeted groups.

The management team, particularly the evaluation group, should continue to work together to identify any additional information needed to deepen our collective understanding of the links between 1) the work of CFFC and advancements in cultural competency among grantees and 2) cultural competency and health disparities.

1. Introduction

The purpose of the initiative-level evaluation for The Colorado Trust (The Trust) Equality in Health (EIH) Initiative is to determine what role organizational cultural competency plays in reducing health disparities. The evaluation is designed to answer the following questions:

1. Does the cultural competency of the grantees change over time?
2. If so, how does the change influence the grantees' interventions and the associated short-term outcomes?
3. What factors and conditions should be in place for an organization to bring about positive changes in cultural competency?
4. Does the cultural competency of the Colorado Foundation for Families and Children (CFFC) change over time? If so, how does this influence its technical assistance strategies and interventions? What factors and conditions should be in place for an organization like CFFC to bring about positive changes in cultural competency?

The current interim cross-site report presents evaluation findings for Cycle 2 grantees. Section 2 describes the evaluation methodology, and Section 3 describes the intervention that CFFC provides to strengthen grantees' organizational cultural competency. In Sections 4 and 5, we analyze and summarize the grantees' organizational cultural competency changes and progress toward health-related goals over their first year of involvement in EIH. Section 6 then discusses factors that facilitate and challenge grantee cultural-competency building. In Section 7, we provide conclusions and recommendations. The goal of the report is to provide an overview of trends in grantees' efforts to improve organizational cultural competency, which can inform future technical assistance and programmatic improvements to further enhance cultural competency and help reduce health disparities.

2. Evaluation Methodology

To evaluate the cultural competency of grantees, their progress toward program goals, and the technical assistance that CFFC provides to grantees, the evaluation team collects quantitative and qualitative data from grantee organizations and CFFC. The sources of data for the initiative-level evaluation are self-report assessments, interviews, and progress reports; all grantee organizations are required to participate in the evaluation. Organization staff with varying degrees of involvement with the EIH initiative as well as community members affiliated with the organizations complete the assessments and interviews. EIH project coordinators and CFFC technical assistance providers complete the progress reports. The multiple sources of information are used to corroborate and augment the self-report data that grantees and CFFC provide regarding their perceptions of their respective organizations.

2.1 Development of Assessment and Reporting Tools

The cultural competency assessment form was developed based on a review of the research literature about organizational cultural competency, particularly the areas that health organizations target to develop their competency[1,4]. The first draft was shared with The Trust and CFFC, and revisions were made based on their comments. The final draft was piloted with five community-based organizations that provided a range of services, including health, to EIH-targeted groups. One to 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. This version of the assessment first was administered in 2006 to Cycle 1 grantees.

Based on a review of baseline organizational cultural competency assessment findings and further review of the research literature, the evaluation team worked collaboratively with The Trust and CFFC to refine the assessment. The assessment questions were modified to increase congruence among cultural competency factors measured across the critical components of an organization; in addition, the response scales were modified to capture smaller degrees of change in cultural competency. This revised version of the assessment has been used since 2007.

Similarly, the evaluation team worked closely with CFFC and The Trust to develop the grantee progress reporting form. After reviewing the information submitted by grantees, we decided to revise the form to make more explicit the links between the grantees' cultural competency activities, interventions, and short-term health outcomes. As a result, cultural competency and logic model outcome tables were added to the progress reporting form in 2007. The current report is based on data collected from Cycle 2 grantees and CFFC from April 2007 to April 2008, the grantees' first year of involvement in EIH.

2.2 Data Collection Procedures

Three primary methods were used to collect data for the evaluation: self-report organizational cultural competency assessments, telephone interviews, and reports. The target sample size for each organization was 12 assessment participants and six interviewees, and we oversampled when possible to increase our chances of reaching the target number. EIH project coordinators from each grantee organization provided the evaluation team with a participant list of approximately 10 to 25 people (depending on the size of the organization; the smallest grantee organization provided us with a list of only ten people), which consisted of administrative/managerial, support, and service-provision staff and affiliated community members with varying levels of involvement in EIH. Therefore, the evaluation team selected eight to 12 staff members and two to three community members from each list. For the most representative sample possible, the team selected individuals from each position within the organization and people with varying degrees of familiarity with EIH. The participants were asked to consent to completing an assessment about the organization's cultural competency journey; they were informed that they also might be asked to complete the telephone interview.

Organizational cultural competency assessment. The assessment, administered online unless respondents preferred a paper version, measures 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 report 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;
- Access to quality care;
- Community engagement to support planning, services, and outreach;
- Service provision;
- Data gathering and utilization to monitor interventions and health outcomes; and
- Organizational environment and infrastructure.

This section consists of 22 items, with two to four items in each cultural competency domain. Respondents rate each item on the following scale: *not being considered* (1)*, being considered* (2)*, being developed* (3)*, in place* (4)*,* and *practiced* (5). Respondents also can select *don't know* or *not applicable* if they are unfamiliar with the policy/procedure or do not consider it relevant for their organization.

To assess individual staff capacity and professional development, staff and community members rate how well administrators/managers, faculty, direct service providers, students, support staff, academic/research partners, and contracted service providers exhibit cultural competency in domains similar to those found in organizational policies and procedures. Respondents rate each category of staff position, including the category to which they belong. This section of the assessment consists of 12 total items, with one to three items in each domain. Respondents rate each item on a five-point scale ranging from 1 *(not at all well)* to 5 *(very well).* Respondents also can select *don't know* or *not applicable* if they have not observed a particular aspect of cultural competency or if a particular staff position or partnership is not relevant for their organization.

To assess community relationships, respondents rate the extent to which their organization works well with 15 types of local organizations or groups to ensure high-quality services and/or health care to diverse populations. Respondents indicate whether their organization works with each partner and, if so, rate the quality of the partnership on a five-point scale ranging from 1 (*not at all well)* to 5 *(very well).* Respondents also can select *don't know* if they are unaware of a relationship.

A copy of the organizational cultural competency assessment form is included in Appendix A.

Telephone interviews. Interviews gather more in-depth perceptions of organizational cultural competency, associated health changes, and facilitating and challenging conditions. Specifically, interviewees are asked to discuss 1) changes in cultural competency at their

organization 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 of their organizational environment that facilitate and challenge building cultural competency. To further understand facilitating and challenging conditions, interviewees also are asked about factors outside of their organization itself such as grant-related support (i.e., The Trust grant funding, CFFC assistance). A copy of the interview protocol is included in Appendix B.

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

CFFC progress reports describe the specific technical assistance provided to help EIH grantees build their capacity to increase cultural competency, comply with reporting requirements, and monitor progress.

2.3 Grantee Response Rates

A 50% response rate for both the surveys and interviews was used as the threshold for analysis; therefore 10 of the 12 grantees are included in the analyses (see Table 1 for the response rate for each grantee site).

Table 1: Response Rates for Organizational Cultural Competency Assessment and Telephone Interviews, by Grantee Site

Grantee Site	*Organizational Assessment n (%)*	*Interviews n (%)*
Denver Indian Family Resource Center (DIFRC)	8 (67%)	6 (100%)
Inner City Health Center (ICHC)	8 (67%)	6 (100%)
Jefferson Center for Mental Health	9 (75%)	4 (67%)
Kids in Need of Dentistry (KIND)	4 (33%)	3 (50%)
Montrose School District, Northside Elementary School-Based Health Center	13 (100%)	6 (100%)
Poudre Valley Hospital Family Medicine Center	7 (58%)	2 (33%)

Grantee Site	*Organizational Assessment n (%)*	*Interviews n (%)*
Prowers Medical Center	9 (75%)	6 (100%)
Second Wind Fund	10 (83%)	4 (67%)
Total Oral Prevention Strategies (TOPS)	7 (70%)	4 (67%)
Valley-Wide Health Systems, Inc.	10 (83%)	3 (50%)
Western Colorado AIDS Project (WestCAP)	7 (58%)	4 (67%)
WIC Program at Upper Arkansas Area Council of Governments	8 (67%)	3 (50%)
TOTAL	100 (69%)	51 (71%)

3. CFFC's Cultural Competency and Technical Assistance

CFFC is responsible for providing technical assistance to EIH grantees through statewide trainings, peer-to-peer learning, and individualized assistance. Statewide trainings involve all grantees and address broad capacity needs. Peer-to-peer learning refers to the exchange of information among grantees. Individualized assistance is customized to the specific needs of each grantee. A question of interest to the EIH evaluation is whether and how CFFC cultural competency changes over time and how such changes might affect technical assistance to grantees. The following subsections of the report examine this question.

3.1 CFFC Cultural Competency

Eleven CFFC staff, approximately half of whom were affiliated with EIH, and two community members completed the organizational cultural competency assessment. Seven participants (five CFFC staff and two community members) completed telephone interviews.

Organizational policies and procedures. At least half of respondents described policies and/or procedures in the following domains as *in place* or *practiced* at CFFC:

- Board and staff development to ensure recruitment and retention of a culturally diverse leadership body and workforce;
- Engagement of and support for staff at all levels of the organization in decision-making and in improving their cultural competency;
- Education and training of staff and partners and review of materials and strategies to ensure cultural appropriateness;

- Community engagement to increase the involvement of Blacks/African Americans, Hispanics/Latinos, Asians/Pacific Islanders, and Native Americans (hereafter referred to as EIH-targeted groups) in planning and provision of services;
- Facilitation of service provision, specifically the dissemination of information to educate other providers about providing culturally competent services; and
- Organizational environment and infrastructure development to ensure the organization has a system to ensure cultural competency.

Almost half of the respondents also indicated that CFFC has begun to address the adaptation of its facilities to ensure a more welcoming environment for everyone. Only a small percentage of respondents—primarily community members—described any particular policy or practice as unfamiliar (i.e., *don't know*) or *not applicable* to CFFC.

Analysis of interview responses supports the pattern that emerged from the survey findings. Interviewees agreed that cultural competency has become more central to CFFC's values and practices. For example, interviewees suggested that the development of a system of accountability for ensuring cultural competency has formalized the process of building such competency. Additionally, interviewees reported that CFFC's hiring of diverse staff exemplifies the organization's commitment to cultural competence and that both staff and board members have increased opportunities to develop cultural competency through retreats, review of articles, and discussions.

As reflected in the survey findings and according to most interviewees, CFFC's current cultural competency efforts focus on its internal environment, infrastructure, and processes. Interviewees repeatedly mentioned an example of this internal focus: the development of benchmarks by staff to monitor the organization's cultural competency. Interviewees described the adoption of these benchmarks by CFFC's board as an indicator of significant progress.

Interviewees reported that the organization's next step is to focus on its external relationships, communications, and processes. This may explain why half of survey respondents described policies and procedures to make their public materials more culturally appropriate as *being considered* or *being developed*.

Individual staff capacity and professional development. Assessment respondents rated the degree to which each type of staff position at CFFC, including their own staff position, demonstrated cultural competency in various domains. Respondents rated those staff persons who provide assistance to organizations and communities with which CFFC works highly on the following: their engagement in training activities and understanding of different cultures, and their participation in professional development, mentoring, and coaching activities aimed at helping everyone advance professionally and with respect to cultural competency.

Community relationships. When asked about CFFC's collaborations with other local organizations, more than half of assessment respondents reported that CFFC has relationships with health and mental health services, community-based organizations, social service agencies, educators and educational institutions, research institutions, and local grassroots and volunteer

groups. The participants indicated that CFFC works *moderately well* to *very well* these groups. In contrast, about one-third of respondents reported that CFFC does not work with traditional healers or private health practitioners, and about one-half did not know if a relationship existed with these groups. The majority of respondents also did not know about relationships between CFFC and seven groups: places of worship, arts and cultural groups, recreation services, tenant and neighborhood associations, housing and economic development organizations, local businesses, and professional and trade associations.

Facilitators and challenges. Interviewees discussed both facilitators and barriers to the development of CFFC's cultural competency. All interviewees agreed that the organizational environment is open and that staff members feel comfortable addressing issues related to cultural competency. Interviewees tended to attribute CFFC's cultural competency efforts to both an increase in staff members' commitment to creating a culturally competent organization and concern about the delivery of quality services to diverse communities. In response to this commitment and concern, more people are attending the cultural competency learning activities organized by CFFC's Cultural Sensitivity Committee.

The following challenges to the development of cultural competency were reported: time constraints; competing demands and interests; continued resistance among some employees; and loss of momentum because cultural competency is less a destination than a journey, with ongoing room for improvement.

3.2 Scope of Technical Assistance

Based on a review of progress reports, CFFC provided technical assistance in a number of ways (e.g., site visits, telephone calls, emails, and in-person training) and areas (i.e., cultural competency, health disparities, and evaluation) for grantees. Specific technical assistance activities are described in greater detail below.

Statewide trainings. Statewide trainings were provided on two occasions in 2007. The first took place on May 23 and focused on: organizational dialogues on race/ethnicity, behavior change interventions, using race/ethnicity data to improve programs, cultural competency "backlash," community planning and implementation, and patient navigation. The second statewide training occurred on October 3 and 4; this 1.5 day training focused on defining cultural competency, developing the skills of cultural competency leaders and advocates within an organization, and examining biases.

Peer-to-peer learning. Peer-to-peer learning is designed to provide participants the opportunity to reflect on their cultural values, beliefs, and biases by posing a question to guide a dialogue. Peer-to-peer learning sessions took place after statewide trainings. Two peer-to-peer learning sessions were conducted in 2007. The first session took place on May 24; grantees completed and discussed their responses to a cultural and social values questionnaire. The second learning session occurred on October 5, and involved reading and reflecting on the paper, "How I Learned to Treat My Bias," by Manoj Jain.

CFFC also facilitated conference calls to support peer learning. One set of calls was designed for grantee organization staff members who serve as cultural competency/diversity coordinators. CFFC also facilitated conference calls for grantees to discuss interpretation services and challenges. Approximately one-half of grantees participated in the calls held in February and March 2008.

Individualized technical assistance. CFFC provides tailored technical assistance in response to the specific needs of grantees. CFFC provided technical assistance in the areas of health disparities, evaluation, and the various domains of cultural competency (i.e., board and staff development, education and training, access to care, community engagement, service provision, data gathering and utilization, and organizational environment and infrastructure). CFFC also helped grantees with grant-reporting requirements and program implementation. According to CFFC reports, the following types of individualized technical assistance were provided in 2007 and 2008:

<u>Health Disparities</u>

- Providing literature and resources related to health and health disparities among particular racial/ethnic/cultural groups (*n* = 5 grantees; 41.7% of Cycle 2 grantees).

<u>Evaluation</u>

- Building grantees' capacity to evaluate their interventions (*n* = 2; 16.7%).

<u>Cultural Competency</u>

- Developing cultural competency plans (*n* = 11; 91.7 %);
- Developing and/or strengthening data collection protocols, analyses, and use, particularly on the collection of race and ethnicity data (*n* = 11 grantees; 91.7%);
- Providing feedback and resources to assist organizations in their review and enhancement of cultural competency training and knowledge (*n* = 6; 50%);
- Providing resources related to cultural competency (*n* = 4; 33.3%); and
- Discussing ways to increase community engagement (*n* = 2; 16.7%).

<u>Grant Implementation</u>

- Intervention planning (e.g., logic models) and progress reporting (*n* = 12; 100 %); and
- Collaborating with cultural competency staff/committee (*n* = 11; 91.7%).

3.3 Usefulness of CFFC's Technical Assistance

Although we asked all persons that we interviewed about CFFC's technical assistance, few interviewees from each grantee organization were familiar with CFFC, most likely because of the stratified sampling method that involves selecting participants with varying degrees of involvement in the initiative. To supplement interview responses, grantee progress reports from 2007 and 2008 also were reviewed to glean information regarding CFFC's technical assistance. Grantees reported receiving types of technical assistance consistent with the assistance described in CFFC's progress reports. In general, grantees described CFFC's technical assistance as helpful to developing the cultural competency of staff members and planning intervention

strategies. Grantees typically reported that the following types of assistance and materials received from CFFC helped further their work: support; educational materials and resources for generating internal discussions and trainings; research literature; and assistance with developing cultural competency plans, goals, missions, and logic models. Some grantees also commented on the balance between CFFC's use of the EIH cultural competency framework and appreciation for the uniqueness and experience of the grantee organization. Two grantees appreciated CFFC's sensitivity to their current capacity and beliefs around the development of cultural competency. An additional grantee described initially feeling that CFFC providers did not adapt technical assistance to the grantee organization's culture and experience, describing the assistance as "scripted;" however, as the working relationship developed, CFFC began to tailor its technical assistance to the grantee's needs and strengths.

When asked what additional technical assistance grantees would like to receive, seven grantees recommended that future technical assistance address the following areas:

- Internal program evaluation (e.g., data collection, reporting, and analysis/interpretation);
- Obtaining additional educational materials and trainings related to cultural competency and cultural differences related to specific health practices;
- Developing relationships/partnerships with local health and/or different racial and ethnic groups;
- Identifying best practices and models in the development of cultural competency and delivery of culturally appropriate health services;
- Facilitating collaboration and exchange of information among grantees;
- Marketing the EIH initiative locally; and
- Completing progress reports.

4. Grantee Cultural Competency

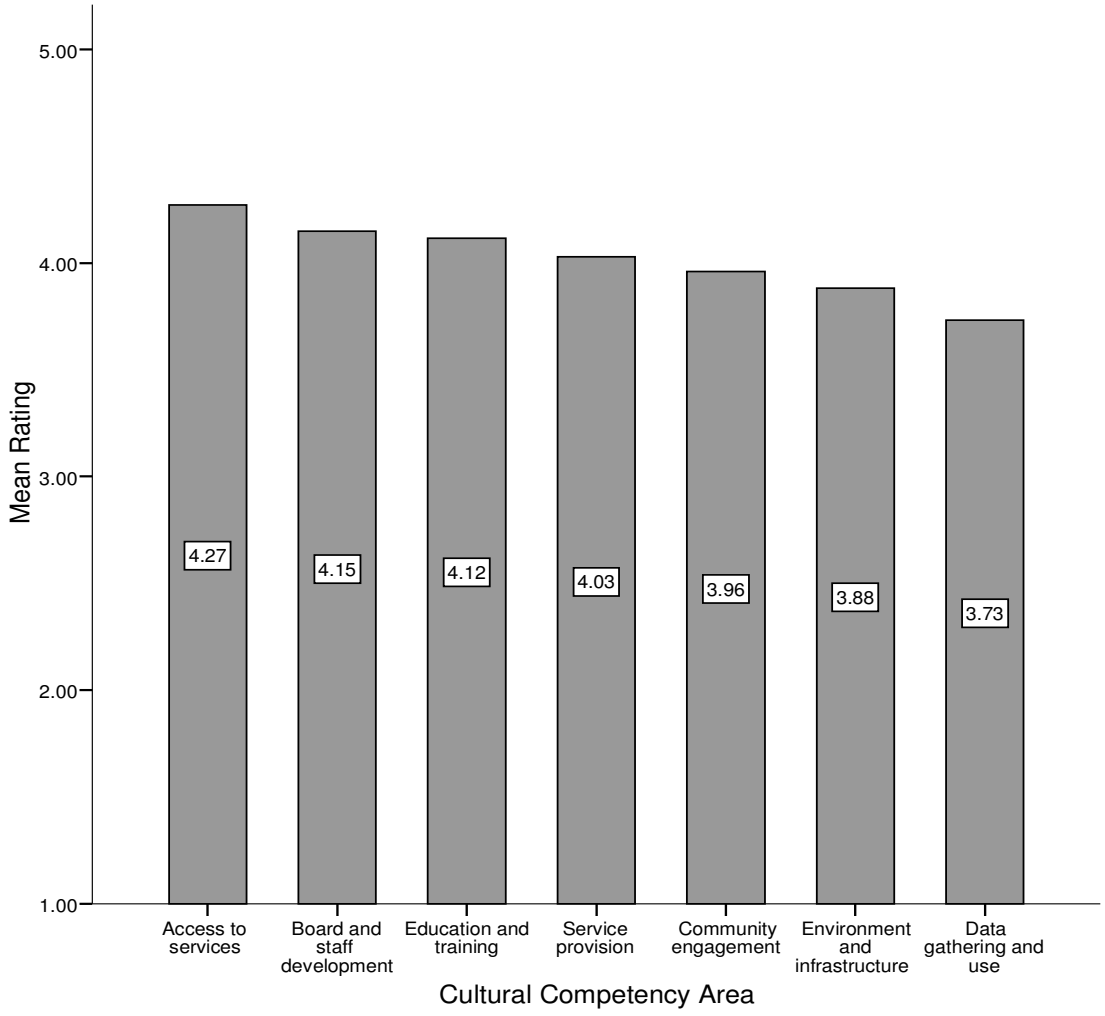
Depending on organization size, eight to 12 administrative, support, and service-provision staff members and two to three affiliated community members were asked to complete the organizational cultural competency assessment survey; six survey respondents from each organization subsequently were asked to participate in telephone interviews (refer to Section 2 for a complete explanation of evaluation procedures). On one end of the spectrum, the number of respondents represented the entire grantee organization; on the other end of the spectrum, the number of respondents represented a small proportion of the grantee organization's staff. Because of this range of representativeness, we relied on other sources (e.g., grantee progress reports) to detect any inconsistencies; we also interpreted the data cautiously to avoid inaccurate generalizations.

Only grantees with at least a 50% survey and interview response rate were included in our cultural competency analyses. Therefore, the survey findings reported in this section reflect 10 of 12 grantee organizations.

4.1 Organizational Policies and Procedures

Stage of policies and procedures that reflect cultural competency. Based on survey findings, all grantees are practicing various aspects of cultural competency. For all domains of cultural competency, respondents described policies and/or procedures as *being developed* (3)*, in place* (4)*,* or *practiced* (5), with policies and procedures most typically described as in the *developed* to *in place* range. The scores suggest that policies and procedures in the domains of access and staff development are most established (i.e., *in place*), while policies and procedures in such domains as organizational environment/infrastructure and data gathering/use are in slightly earlier stages of development. Figure 1 displays the mean score for each domain of cultural competency at the organizational level. (See Table 2 for the individual items that comprise each cultural competency domain.)

Figure 1: Organizational-level Cultural Competency Across Grantees



Percentage of grantees with cultural competency policies and procedures in place or practiced. We examined respondents' ratings to determine the percentage of grantees with specific policies and/or procedures *in place* or *practiced* for each cultural competency domain. A policy or procedure was considered to exist within an organization if at least 50% of the organization's respondents described the policy/procedure as *in place* or *practiced*. Table 2 displays the percentage of grantees with each organizational cultural competency policy/procedure. At least half of the grantees have active policies and procedures in the domains of access to services, education and training, board and staff development, and community engagement; among the most frequently reported were:

- Adapting facilities and services to minimize barriers to access for EIH-targeted groups by ensuring availability, affordability, and/or acceptability (100.0%);
- Recruiting, hiring, retaining, and promoting staff, faculty, and/or students who reflect the demographic characteristics of the EIH-targeted groups (90.0%);
- Conducting ongoing, regular education activities and trainings to improve the cultural competency of staff and partners (90.0%);
- Providing and using professional interpreters for clients (80.0%); and
- Translating signs, telephone menus, forms, and administrative information (80.0%).

Not only have most grantees implemented such policies/procedures, but similarly, policies/procedures related to access to services, board and staff development, and education and training are farthest along the cultural competency continuum, as suggested by the average ratings for these domains. Further evidence from grantee progress reports and interviews identify the following as common achievements across grantees in their first year of involvement in EIH, supporting the assessment findings: increased participation in cultural competency trainings; improved language competency (e.g., interpretation services, translated materials); and adaptations to health services and preventive education to increase their cultural appropriateness and accessibility. The majority of grantees considered their cultural competency efforts a response to the recognized needs of the communities they serve.

Less than half of grantees described the following policies/procedures in the domains of service provision, organizational environment and infrastructure, and data gathering and utilization as *in place* or *practiced*:

- Disseminating information to educate other providers about providing culturally competent services to the EIH-targeted groups (40.0%);
- Understanding, providing, and/or teaching culturally-based complementary and alternative treatments (40.0%);
- Developing and implementing a cultural competency plan (40.0%);
- Developing and implementing policies and procedures to ensure accountability to cultural competency goals (30.0%);
- Using demographic data on staff, faculty, and/or students from EIH-targeted groups to monitor diversity (30.0%);
- Disseminating information in a culturally appropriate way to educate health consumers from EIH-targeted groups (20.0%); and

- Collecting, analyzing, and using information about patients' perceptions of the organization's cultural competency (20.0%).

Likewise, average ratings (see Figure 1) also showed policies/procedures in the domains of data gathering and use and organizational environment are less established in the grantee organizations than are the other domains of cultural competency. Respondents from approximately one-half of the grantee organizations tended to perceive policies and procedures in these domains as under consideration or development.

Table 2: Percentage of Grantees with Policies and Procedures that Reflect Cultural Competency

Policy or procedure	*% of grantees with policy/procedure* in place *or* practiced *(n)*
Board and Staff Development	
Recruiting, hiring, retaining, and promoting staff, faculty, and/or students who reflect the demographic characteristics of the EIH-targeted groups	90.0 (9)
Providing professional development opportunities and incentive awards to encourage staff and/or faculty to improve their cultural competency	60.0 (6)
Engaging staff, faculty, and/or students from EIH-targeted groups in decision making, planning, design, and provision of services	50.0 (5)
Recruiting and retaining board members reflective of EIH-targeted groups	50.0 (5)
Education and Training	
Conducting ongoing, regular education activities and trainings to improve the cultural competency of staff and partners	90.0 (9)
Developing and reviewing education, training, and health materials and strategies to ensure cultural appropriateness and competency	50.0 (5)
Access to Services	
Adapting facilities and services to minimize barriers to access by ensuring availability, affordability, and/or acceptability	100.0 (10)
Providing and using professional interpreters for clients	80.0 (8)
Translating signs, telephone menus, forms, and administrative information	80.0 (8)
Providing professional translation of outreach, education, and health-related materials	60.0 (6)
Community Engagement	
Engaging representatives from EIH-targeted groups in planning services and outreach	70.0 (7)

Policy or procedure	*% of grantees with policy/procedure* in place *or* practiced *(n)*
Partnering with community organizations that support the EIH-targeted groups to plan, outreach, and provide services	60.0 (6)
Hiring, training, and using community health workers from EIH-targeted groups to assist with outreach, health education, and screening	60.0 (6)
Service Provision	
Promoting healthy practices and behaviors in a culturally appropriate way	80.0 (8)
Disseminating information to educate other providers about providing culturally competent services to the EIH-targeted groups	40.0 (4)
Understanding, providing, and/or teaching culturally-based complementary and alternative treatments	40.0 (4)
Disseminating information in a culturally appropriate way to educate health consumers from EIH-targeted groups	20.0 (2)
Data Gathering and Utilization	
Using demographic data on consumers from EIH-targeted groups to plan services, monitor health outcomes, and detect health disparities	50.0 (5)
Using demographic data on staff, faculty, and/or students from EIH-targeted groups to monitor diversity	30.0 (3)
Collecting, analyzing, and using information about patients' perceptions of the organization's cultural competency	20.0 (2)
Organizational Environment and Infrastructure	
Allocating funds in the budget to ensure cultural competency	60.0 (6)
Designating a staff person or position to ensure culturally competent practices	50.0 (5)
Developing and implementing a cultural competency plan	40.0 (4)
Developing and implementing policies and procedures to ensure accountability to cultural competency goals	30.0 (3)

4.2 Individual Staff Capacity and Professional Development

Grantee organization staff comprise administrators/managers, direct service providers, and support staff; grantees tended to indicate that faculty, students, academic/research partners, and contracted service providers are not applicable to their organization.

All grantees described their administrators/managers, direct service providers, and support staff as demonstrating cultural competency in the *moderately well* (3) to *well* (4) range.

The findings, presented in Table 3, show that:

- Staff members in all positions received the highest ratings in creating an organizational environment and infrastructure that supports cultural competency (average scores, 4.32 – 4.34) and participating in cultural competency educational and training opportunities (average scores, 3.99 – 4.10).
- Staff members received the lowest ratings in the domains of increasing access to services (average scores, 3.39 – 3.76) and community engagement (average scores, 3.61 – 3.69).
- With the exception of staff development, differences in the cultural competency domains across administrators/managers, direct service providers, and support staff were small, suggesting a general perception of all types of staff as moderately culturally competent.

Table 3: Average Ratings of Individual-level Cultural Competency across Grantees, by Cultural Competency Domain

Cultural Competency Domain	*Administrators/ Managers*	*Direct Service Providers*	*Support Staff*
Staff development	4.11	3.62	3.54
Education and training	4.05	4.10	3.99
Access to services	3.39	3.76	3.63
Community engagement	3.61	3.67	3.69
Service provision	3.75	4.01	3.97
Data gathering and utilization	3.70	3.80	3.53
Organizational environment/infrastructure	4.32	4.34	4.32
Total average score, across all domains	3.85	3.90	3.81

4.3 Community Relationships

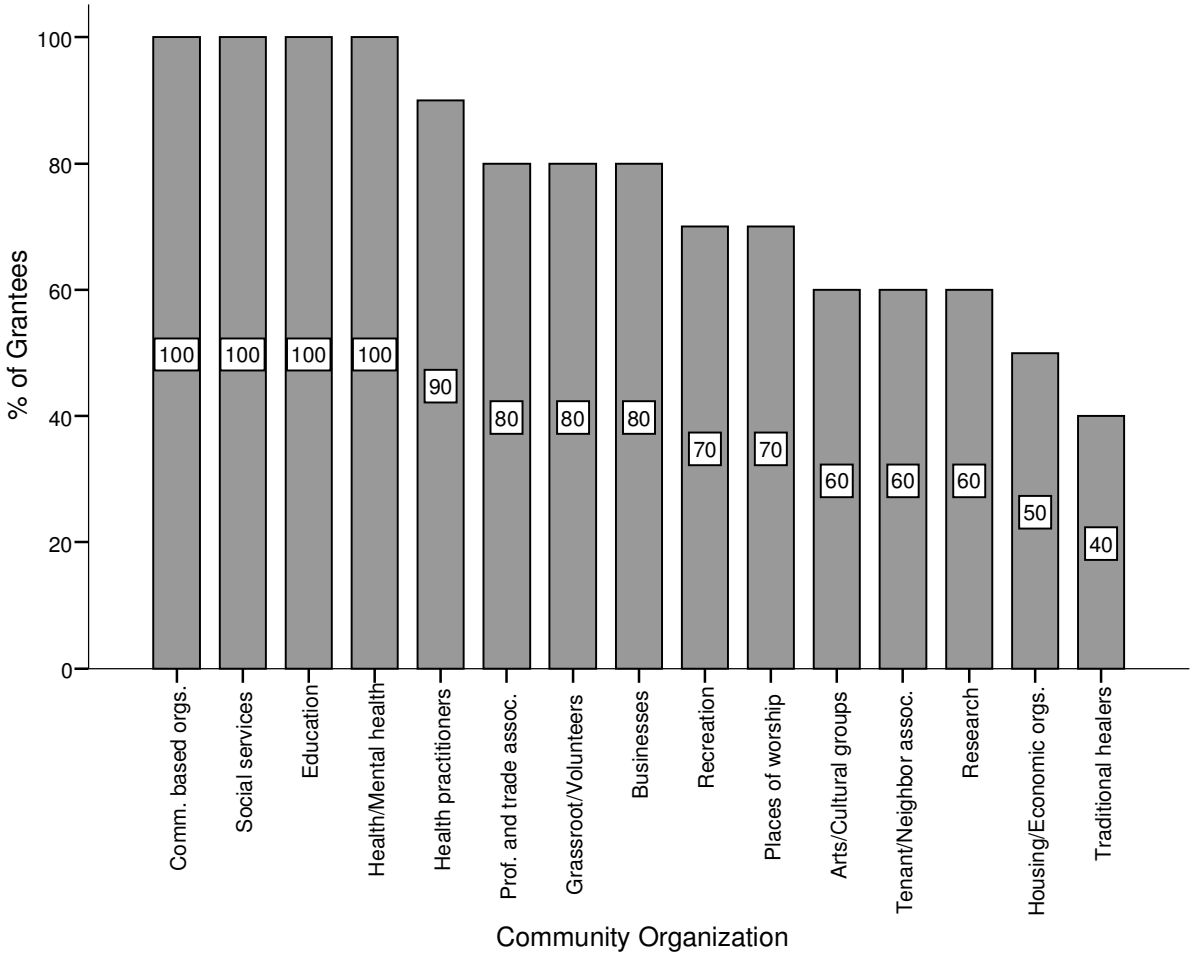
Based on survey findings, grantees have working relationships with a variety of organizations in the community to provide support and services for the EIH-targeted groups that they serve. Grantees reported that they work *fairly well* (2) to *very well* (5) with local organizations; average ratings fell in the *moderately well* (3) to *well* (4) range. As shown in Figure 2, all 10 grantees reported working relationships with:

- Community-based organizations that work with EIH-targeted groups,
- Social service agencies,
- Educators and educational institutions, and
- Health and mental health services.

Grantees reported working *well* with these organizations; the working relationship with health/mental health services was rated most highly (average rating, 4.13).

Less than two-thirds of grantees reported working with arts and cultural groups, housing organizations, research institutions, and traditional healers. The working relationships with these groups were rated in the *moderately well* to *well range*.

Figure 2: Working Relationships with Different Institutions, by Percentage of Grantees



5. Organizational Cultural Competency, Interventions, and Short-Term Health Outcomes

Part of this evaluation requires an examination of how changes in grantee organizations' cultural competency influence interventions and associated short-term outcomes. Given the variety of short-term outcomes, the outcomes were clustered into five categories: Universal, Selective, Indicated, Capacity, and Patient-provider Interaction.

Consistent with prevention science literature[2,5], *universal* outcomes are related to preventive care that all individuals need (e.g., regular exams, immunizations); *selective* outcomes are related to health care for individuals who are at increased risk of developing a disease or disorder (e.g., screenings for mental illness, cancer, or Hepatitis); *indicated* outcomes are related to health care for individuals with an existing physical or mental health condition (e.g., diabetes management, medication). *Capacity* outcomes refer to goals to increase individuals' ability to attend to their health through knowledge, skills, and awareness of preventive strategies and health conditions. *Patient-provider interaction* refers to goals related to patient satisfaction with services. The majority of grantees aimed to improve indicated and capacity outcomes (see Table 4, first column).

Then, we examined the grantees in each cluster of outcomes to determine which cultural competency domain(s) they attempted to affect in order to achieve those outcomes. We reviewed grantees' progress reports and coded their activities according to those domains. We found that grantees most frequently reported adaptations in service provision, access to services, and community engagement. Table 4 shows the percentage of grantees in each category of short-term outcome (i.e., universal, selective, indicated, and capacity) that reported making changes in the specific cultural competency domains.

Table 4: Organizational and Service Adaptations Made to Achieve Short-Term Health Outcomes

Health Outcome (%, N of grantees)	Cultural Competency Domains (%, N of grantees)						
	Staff development	*Education & training*	*Access*	*Community engagement*	*Service provision*	*Data*	*Org. infrastructure*
Universal (30%, 3)	0	0	66.7% (2)	0	100% (3)	33.3% (1)	0
Selective (30%, 3)	0	33.3% (1)	33.3% (1)	66.7% (2)	66.7% (2)	0	0
Indicated (50%, 5)	0	40.0% (2)	40.0% (2)	20.0% (1)	80% (4)	40.0% (2)	0
Capacity (60%, 6)	0	33.3% (2)	33.3% (2)	33.3% (2)	83.3% (5)	16.7% (1)	0
Patient-	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Health Outcome (%, N of grantees)	Cultural Competency Domains (%, N of grantees)						
	Staff development	*Education & training*	*Access*	*Community engagement*	*Service provision*	*Data*	*Org. infrastructure*
Provider Interaction							

Note: The grantee that fell into the patient-provider interaction this category did not have a sufficient assessment and interview response rate to be included in the current analyses.

As grantees are in the early stages of their interventions, they only are beginning to collect health outcome data. Thus, we cannot empirically determine the relationship between their cultural competency strategies and adaptations and changes in short-term outcomes at this time. However, in addition to quantitative data, we also ask grantees to reflect on the relationship between cultural competency and health disparities and describe health changes that they have observed in their target populations. Similar to the finding that grantees have made efforts to increase access to care to achieve desired short-term health outcomes (as displayed in Table 4), approximately one-third of grantees suggested that improved organizational cultural competency will increase clients' access to quality care, which over time, will improve clients' health and knowledge about disease risk. Additionally, one-third of grantees have observed an increase in clients' comfort and use of services over the last year. As grantees collect short-term health outcome data, we can determine empirically the relationship between the grantees' changes in cultural competency, their interventions, and short-term health outcomes.

6. Conditions that Facilitate Positive Changes in Cultural Competency

Interviewees from grantee organizations were asked to reflect on factors that facilitate their organizations' ability to strengthen cultural competency. Grantees also discussed facilitating factors in their progress reports. Three factors emerged from our analysis of the interviews and progress reports: 1) CFFC's assistance, 2) community collaboration and outreach, and 3) organizational environment.

6.1 CFFC Technical Assistance

CFFC serves as a source of support and direction for grantees. For example, CFFC has assisted grantees with developing logic models and cultural competency plans, and over one-half of grantees reported that CFFC has helped them progress in their efforts to improve their organizations' cultural competency. Grantees also have found trainings for their board and staff members helpful for increasing cultural competency knowledge and skills. Section 3.3 describes the scope and impressions of CFFC's technical assistance in greater detail.

6.2 Community Collaboration and Outreach

Support from local organizations and interaction with community members also helps grantees build their cultural competency capacity. The majority of grantees indicated that the opportunity to network and collaborate with fellow EIH grantees and other local organizations has increased cultural competency knowledge. Additionally, participation in community events helps grantees reach out to the communities they serve, enabling the target communities and grantees learn more about each other.

6.3 Organizational Environment

Informal and formal organizational structures also enable grantees to increase cultural competency. For half of the grantees, informal structures such as a supportive, open organizational climate facilitate candid discussion of cultural issues. Furthermore, approximately one-third of grantees found that administrative, board, and staff buy-in to cultural competency as an organizational priority is critical to achieving their competency and health goals. Approximately one-third of grantees also noted that formal structures such as a staff position dedicated to ensuring cultural competency and organizational meetings in which cultural competency is discussed help the organizations work toward achieving their initiative goals.

7. Challenging Conditions

Grantees also were asked to reflect on factors that challenge cultural competency. Three factors emerged from our analysis of the interviews and progress reports: 1) inadequate resources, 2) data-related needs, and 3) organizational structure and climate.

7.1 Inadequate Resources

A primary challenge to enhancing organizational cultural competency is inadequate human capital, time, financial, and community resources. One-half of grantees expressed frustration that their organizations have had difficulty hiring and retaining diverse and bilingual staff members, which has impeded their ability to meet the needs of their clients. One-half of grantees also suggested that scheduling conflicts and limited time prevent otherwise interested staff from participating in activities to develop cultural competency. In addition to inadequate internal resources, some grantees—especially those that described themselves as geographically isolated—also noted difficulties finding providers and other local partners to support their work.

7.2 Data-Related Needs

Although grantees appear to recognize the importance of data to help guide their interventions and monitor progress, some grantees identified data collection and utilization as a significant barrier to their work. Approximately one-third of grantees have had difficulty gathering client data, particularly demographic data such as race/ethnicity and primary language

spoken. An additional grantee also reported difficulty using data effectively for planning and service provision.

7.3 Organizational Climate

An organizational environment that is marked by limited buy-in and interest impedes cultural-competency building. For example, one-half of grantees suggested that resistance to change among some staff has impeded efforts to discuss and address cultural competency. These grantees experience difficulty engaging staff members in cultural competency efforts and recognition of biases. Generally, grantees have found that their staff members are at different levels of readiness for change, which the organization must consider in working to advance cultural competency.

8. Conclusion and Recommendations

Based on our findings, grantees are developing organizational policies and practices, staff capacity, and community relationships and are gradually moving toward the action phase of building cultural competency. A coordinating agency such as CFFC, which is committed to developing its own cultural competency, can use its increased knowledge and expertise to help support grantees' development. As grantees continue to work to enhance their organizational cultural competency and interventions to promote the health of the communities they serve, the evaluation team recommends that:

1. CFFC continues to build its cultural competency to assist grantees' development and use grantees' experiences to inform CFFC's work (i.e., benefit from a bidirectional learning relationship);
2. CFFC helps grantees develop and work to institutionalize cultural competency by addressing a) organizational infrastructure, b) staff development, and c) community relations and resources;
3. CFFC helps grantees develop a deeper understanding of cultural competency and racial/ethnic health disparities;
4. The evaluation team works collaboratively with CFFC to develop a process for determining the proportion of technical assistance provided to grantees to better determine the relationship between technical assistance and grantee progress; and
5. The evaluation team continues to work collaboratively with CFFC, grantees, and The Trust to ensure that sufficient health data are collected to determine the link between organizational cultural competency, adapted interventions, and short-term health outcomes.

The findings and recommendations are described in greater detail below.

8.1 Summary of Findings

Based on our findings, EIH grantees are developing organizational policies and procedures, building staff capacity, and developing relationships with their local community to support cultural competency efforts.

CFFC's role in facilitating cultural competency. Our findings suggest that a coordinating agency working on its own cultural competency is in a better position to provide technical assistance to grantees related to such competency. CFFC participants acknowledged that changes in their organization's cultural competency have enhanced staff research and technical assistance capacities, particularly for issues related to cultural competency. Aside from helping grantees with program implementation and progress reports, CFFC's dedicates a large portion of its assistance to grantee organizations' development of cultural competency plans, development of data collection protocols, and establishment of staff positions and committees dedicated to cultural competency. According to grantees, these technical assistance activities support their work around building cultural competency to improve the health outcomes of the populations they serve.

Changes in grantees' organizational cultural competency. Based on their assessment of cultural competency, grantees are approaching the action stage of building cultural competency in all domains. Grantees reported making the most progress in implementing policies and procedures around access to services and board and staff development; slightly less progress has been made in the domains of data gathering and utilization and organizational environment and infrastructure.

These findings suggest that grantees are best equipped to undertake the following activities to achieve their goal of reducing health disparities: adapt facilities, recruit diverse staff, conduct trainings and educational activities to increase cultural competency, and provide professional interpretation and translation services. Grantees appear slightly less capable of making internal structural and operational changes (e.g., creating an accountability system for ensuring cultural competency) and using data to inform their decision-making. Consistent with recent literature[2], collecting data related to race and ethnicity is necessary to design and test interventions to reduce health disparities; however, challenges and concerns exist regarding such data collection.

The findings also demonstrate a general perception that staff members are culturally competent but still need to continue to develop their competency. Staff members tend to engage most in contributing to the organizational environment and engaging in training and educational opportunities related to cultural competency, and least in minimizing barriers to access to care and engaging community representatives and organizations to better serve EIH-targeted groups. These findings regarding individual staff capacity are in contrast to the aforementioned organizational-level findings in which policies and procedures related to access are more established than are those related to the organizational infrastructure.

Consistent with findings at both the organizational and individual staff levels, grantee organizations are developing relationships with other local community organizations. Relationships were most commonly reported between grantees and service agencies (health,

mental health, and social services), community-based organizations, educational institutions, and private practitioners. Least commonly reported were relationships with traditional healers, housing and economic development organizations, tenant and neighborhood organizations, arts and cultural groups, and research institutions. This pattern of relationship building could be considered predictable; most of the grantees likely are accustomed to working primarily with groups that enhance their service provision. To reach deeper into EIH-targeted communities, however, grantees may have to consider partnerships with groups that do not provide services, but are part of social support networks or that can help increase knowledge and understanding of the multiple positive and negative influences on the health of people of color.

Link between cultural competency, grantee' interventions, and short-term health outcomes. Grantees reported that they are becoming more aware of the importance of race, ethnicity, and culture in health and health care. Grantee organizations aim to increase EIH-targeted groups' use of preventive health services, improve the health of those at risk of or with existing health conditions, and increase the target groups' capacity to manage and advocate for their health. The organizations particularly are using strategies to adapt service provision, access to care, and community engagement approaches to achieve these goals. It will be important to use the health data that grantees will provide to empirically determine which types of cultural competency changes and strategies are associated with particular short-term health outcomes.

Conditions that facilitate or challenge changes in cultural competency. A grant can help catalyze changes in cultural competency; technical assistance and training can help support the change process. In addition, an organization must have an environment open to addressing cultural competency, which means that the organization's staff must be willing to engage in and support the process. Without adequate organizational support, change agents can be limited to those directly involved in cultural competency initiatives, making change stop short of reworking organizational structure and operations. Other factors that can hinder building cultural competency include insufficient internal and community resources and difficulty utilizing data to guide decision-making and service provision. As mentioned above, grantee organizations have experienced least success in the area of making internal structural and operational changes to support cultural competency and gathering and utilizing data related to the health of EIH-targeted groups.

8.2 Recommendations

Ongoing technical assistance. It is important for CFFC to use their expertise to inform grantees' work and grantees' experiences to inform ongoing technical assistance and development. Some grantees requested the following additional assistance to increase their cultural competency capacity and refine their health interventions:

- Internal program evaluation (e.g., data collection, reporting, and analysis/interpretation),
- Obtaining additional educational materials and trainings related to cultural competency and cultural differences related to specific health practices,
- Developing relationships/partnerships with local health and/or ethnic groups,

- Identifying best practices and models in development of cultural competency and the delivery of specific culturally appropriate health services,
- Facilitating collaboration and exchange of information among grantees,
- Marketing the EIH initiative locally, and
- Completing progress reports.

In addition to grantee requests for specific types of future assistance, the evaluation findings in this report suggest other assistance needs. To help grantees continue to build their cultural competency over the next year, we recommend that The Trust and CFFC consider providing assistance in the following areas:

- *Staff development and organizational environment and infrastructure*. These areas are important for institutionalizing cultural competency within organizations. To further develop these areas, grantees will need help with addressing resistance among some staff members. Some interviewees described difficulties engaging colleagues in cultural competency efforts and recognizing prejudices.

- *Alignment of cultural competency efforts.* Aligning efforts across the key aspects of an organization also is important for institutionalizing cultural competency. Currently, the evaluation findings suggest that cultural competency development is not consistent across all elements of grantee organizations. For instance, although grantees perceived active organizational policies and procedures in particular domains of cultural competency (e.g., access), their perceptions of staff members' competency in these domains were mixed; similarly, staff members were rated highly in other areas of competency (e.g., organizational environment and infrastructure) that were less developed in terms of policies and procedures. To help improve the health of communities, grantees may need assistance ensuring that their internal structure, staff, and relationships with the community support their organizations' development of cultural competency.

- *Engaging the community*, especially those institutions that are not typical candidates for improving service provision, but play a key function in social support, quality of life, and knowledge about communities. Institutions and groups such as faith groups, tenant and neighborhood associations, arts and cultural groups, and traditional healers often are trusted sources of information and significant sources of support for various communities. Through engagement of these institutions, the change process expands from one potentially limited to service providers and recipients, to one that takes on a community-building approach to understand and address social and environmental determinants of health. Assistance with identifying local resources and developing community relationships particularly is important as grantees with strong community ties noted that such support is critical to developing culturally-appropriate interventions.

- *Continued exploration of cultural competency and racial/ethnic health disparities*. One of the reported strengths of grantees is ongoing engagement in educational activities to increase their cultural competency. Grantees have expressed the need and desire to continue to learn about the cultural experiences, values, and alternative treatments for the

target populations they serve as well as about the relationships between culture, race, ethnicity, and health. As grantees move forward, it will be important to help them develop a thorough understanding of the meaning of cultural competency, health disparities among various racial/ethnic groups, and cultural and social factors to consider and integrate into care to effectively serve their target communities.

Determining the link between technical assistance and grantee progress. The findings indicate parallel growth in CFFC and grantee cultural competency and a link between the two. The evaluation team needs to work more closely with CFFC and, perhaps, grantees, to identify any additional data needed to more deeply and accurately understand the types of support that help advance grantees' cultural competency. (Note that this effort is currently in progress as the evaluation team and CFFC engage in dialogue about the latter's reporting of its progress.)

Determining the link between organizational cultural competency, interventions, and health outcomes. Preliminary findings suggest that most grantees are focusing on improving the health of those with chronic conditions and increasing people's ability to attend to their health and reduce the risk of disease; grantees most frequently have employed strategies to increase access to care and adapt services to meet the unique needs of EIH-targeted groups. To expand on these preliminary findings, we must continue to collect and analyze data that shed light on the link between organizational cultural competency and health disparities. The evaluation team will analyze the longitudinal health data that grantees will collect to help us better understand the relationship between the various cultural competency domains and short-term health outcomes.

9. References

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Appendix A

Organizational Cultural Competency Assessment

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 through changes in organizations' cultural competency. The aim of this assessment is to learn about [INSERT NAME OF ORGANIZATION]'s movement toward the goal to enhance its cultural competency to serve a specific target population or populations. The specific target populations of interest to the EIH 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. Your responses only will be seen by the evaluator for the Equality in Health Initiative. 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 or not 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, or if you have no idea about the status of that particular strategy, please indicate D/K for don't know. Please circle the best response based on your current knowledge.

   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 (e.g., the idea has been discussed at decision-making meetings, ideas have been solicited from the staff)
   3 = Policies and/or procedures are **being developed** for the strategy (e.g., a draft has been shared, someone has been tasked to write them)
   4 = Policies and/or procedures are **in place** for the strategy (i.e., they have been approved by the decision-makers)
   5 = Policies and/or procedures are being **practiced** for the strategy (e.g., 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 the policies and/or procedures related to the strategy, including whether or not it is being even considered, developed, 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

	Not being considered	Being considered	Being developed	In place	Practiced	Not applicable	Don't Know
b. Recruit, hire, retain, and promote staff , faculty, and/or students who reflect the demographic characteristics 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 at all levels of organization in decision making, 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:	1	2	3	4	5	N/A	D/K
- *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)							
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

	Not being considered	Being considered	Being developed	In place	Practiced	Not applicable	Don't Know
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 plan, outreach, 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 strategies and 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 the organization's 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	1	2	3	4	5	N/A	D/K
• Designating a staff person or position to ensure culturally competent practices	1	2	3	4	5	N/A	D/K
• Allocating funds in the budget to ensure cultural competency	1	2	3	4	5	N/A	D/K
o. Understand and provide or teach culturally-based complementary and alternative treatments (e.g., adapt services to become more compatible with the beliefs, values, and experiences of the EIH-targeted racial/ethnic groups)	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
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	1	2	3	4	5	N/A	D/K

	Not being considered	Being considered	Being developed	In place	Practiced	Not applicable	Don't Know
consumers from EIH-targeted racial/ethnic groups							
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, and D/K for don't know. If **yes**, rate the extent to which [INSERT NAME OF ORGANIZATION] works well them on a scale of 1 to 5, where 1 *is not well at all* and 5 is *very well*. If you don't know how well your organization works with the following types of organizations, please circle D/K.

	Does your organization work 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	1	2	3	4	5

	Does your organization work with:	Not well at all		Moderately well		Very well
	N D/K					
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
m. Research institutions (i.e., academic or non-academic that help inform the organization's work by providing research	Y	1	2	3	4	5

	Does your organization work with:	Not well at all		Moderately well		Very well
support and evidence-based strategies)	N D/K					
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, 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 for not applicable. If you have not had the opportunity to observe any of these people actions and therefore, don't know how well they do it, just circle D/K for don't know.

    - Administrators/managers include people who make decisions, set policies, and/or direct activities (e.g., executive director, board member, director of program, director of training, department 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 (e.g., physicians, nurse, health educator)
    - Students include professional, graduate, and residents
    - Support staff are people who carry out and/or support the services (e.g., person who arranges appointments, 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 (e.g., companies or agencies that subcontract with the organization to help provide services to the target population)

Our administrators/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
	1	2	3	4	5	N/A	D/K
a. Understand and provide culturally-based complementary and alternative treatments (e.g., adapt services to become 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	1	2	3	4	5	N/A	D/K

Our administrators/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
	1	2	3	4	5	N/A	D/K
partners - Contracted service providers	1	2	3	4	5	N/A	D/K
d. Actively work to minimize barriers to access to care for EIH-targeted racial/ethnic groups by increasing: *availability* (e.g., hours, location), *affordability* (e.g., pro-bono services, sliding 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
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							

Our administrators/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
	1	2	3	4	5	N/A	D/K
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	N/A
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							

Our administrators/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
	1	2	3	4	5	N/A	D/K
- 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
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 reflective of the racial/ethnic groups served to help the staff 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							

Our administrators/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
	1	2	3	4	5	N/A	D/K
- 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 B

Key Informant Interview Guide (Initial)

The Colorado Trust
Equality in Health Initiative

Key Informant Interview Guide (Initial)

Hello. This is _____from the Association for the Study and Development of Community (ASDC). I am calling in regards 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 ORG. NAME HERE] and if these changes result in reducing racial and ethnic health disparities.

Is this still a convenient time for you? **[If not, ask for a new day/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 ORG. 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 purely 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 ORG. NAME HERE].

   PROBE: What does your position entail?

   PROBE: Length of time at the organization

   PROBE: Background/training

   For COMMUNITY members: First, please briefly describe your affiliation with [INSERT ORG. 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. *We know that change takes time and [INSERT ORG. NAME HERE] only has been working on the Equality in Health initiative for a short time, but* What aspects of and/or changes in cultural competency have emerged or occurred in your organization?

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

3. What do you think prompted these aspects of cultural competency to emerge or occur?

4. How have these aspects of cultural competency 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?

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

   PROBE: specific examples

6. 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

7. 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 grant funding allowed [INSERT ORG. 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?

8. 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 three 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?

   PROBE: Specific examples

b. 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?

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

   PROBE: Specific examples

D. Lessons Learned

9. 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

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

10. Do you have any other comments?

PROBE: Is there anything else about the cultural competency of your organization that you feel it 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!