



National  
Center  
for  
Cultural  
Competence

# Policy Brief 4

GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER ■ UNIVERSITY CENTER FOR EXCELLENCE AND DEVELOPMENTAL DISABILITIES

## **Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach**

### **Introduction**

The National Center for Cultural Competence publishes a Policy Brief series to facilitate the systematic incorporation of cultural and linguistic competence into organizational policy and structures. Policy Brief 4 is designed to provide health care organizations with the rationale for engaging communities in a culturally and linguistically competent manner. This brief provides guidance on prerequisite policies that serve as a foundation for infusing cultural and linguistic competence into community engagement.

### **Getting to Zero: Communities are Essential Partners**

#### *A Public Health Policy Imperative*

A long-standing and well-documented pattern of health disparities exists in the United States. This pattern is apparent in health care outcomes and utilization and is evidenced by the disproportionate incidence of disease, disability and death among specific racial and ethnic groups. In response to this critical problem, the U.S. Department of Health and Human Services (DHHS) launched the Initiative to Eliminate Racial and Ethnic Disparities in Health in 1998. Six areas of health disparity were identified as priority targets for intervention: cancer screening and management; cardiovascular disease; diabetes; infant mortality; HIV/AIDS; and child and adult immunizations.

The initiative has been significantly strengthened by public health policy. Recent federal legislation specifically allocates resources for the study, prevention and treatment of health disparities among racial and ethnic groups (PL 106-525, Minority Health and Health Disparities Research and Education Act of 2000). The National Center on Minority Health and Health Disparities at the National Institutes of Health was established by this law. The elimination of health disparities is a key public policy focus of Healthy People 2010, the set of goals and objectives designed by the DHHS to assist the nation achieve the vision of “Healthy People in Healthy Communities”. Healthy People 2010 states that “over the years, it has become clear that individual health is closely linked to community health...Likewise, community health is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community... Partnerships, particularly when they reach out to non-traditional partners, can be among the most effective tools for improving health in communities” (U.S. Department of Health and Human Services, 2000). Healthy People 2010 clearly articulates public health policy that recognizes the need to engage communities as essential partners in eliminating health disparities.

#### *Responding to the Challenge*

The Initiative to Eliminate Racial and Ethnic Disparities in Health has challenged the nation’s public health systems to create new approaches, including non-traditional partnerships, across diverse sectors of the community (Goode & Harrison, 2000; Davis et al., 1999; Mahan, 1997). The Health Resources and Services Administration’s Bureau of Primary Health Care (BPHC) continues to demonstrate leadership and innovation in response to this challenge. The BPHC is a national leader in delivering health care to underserved populations. Guided by a vision that everyone in the United States should have access to health care, the BPHC launched the

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*100% Access and 0 Health Disparities Campaign* in 1999. This vision has been championed by Dr. Marilyn Gaston, Associate Administrator for Primary Health Care, who states “..that every person, in every underserved community will have access to primary and preventive care...and that there will be no disparities in health status due to race, ethnicity or income...” (Buluran, 2000). The *100% Access and 0 Health Disparities* has been accepted as a goal of the Health Resources and Services Administration.

The *100% Access and 0 Health Disparities* campaign is multifaceted and offers innovative approaches to create and maintain broad-based partnerships to achieve its goals. Dr. Gaston states, “We cannot achieve the vision alone... We need the help of every state, every national organization, every business, every academic institution and committed people from communities across the country “ (Buluran, 2000). The Center for Communities in Action is coordinating the BPHC’s effort to establish partnerships with 500 communities as a strategy to realize the vision of *100% Access and 0 Health Disparities*. The BPHC also developed a conceptual model that delineates a wide array of potential partners that have a vested interest in improving community health. According to the BPHC, “an integrated, primary care-based health system will emerge when a community declares its desired outcomes, engages its key partners and aligns its assets. The result will be healthier communities all across America” (Buluran, 2000).

## Rationale for Cultural Competence in Community Engagement

### ■ *The complex nature of communities*

Establishing and sustaining broad-based community partnerships that embrace the vision of *100% Access and 0 Health Disparities* presents myriad benefits while simultaneously presenting unique challenges. One of the most fundamental challenges involves the complex nature of communities. Community is an elusive concept; it means different things to different people; and is defined differently in the literature for different purposes (Magrab, 1999). Several definitions of community follow.

Warren (1978) defines community as:

“a framework for living rather than as a political jurisdiction—a complex network of people, institutions, shared interests, locality, and a sense of psychological belonging”.

Webster’s Dictionary (1994) defines community as:

“an interacting population of various kinds of individuals in a common location; a body of persons of common interests scattered through a larger society; and joint ownership or participation”.

These definitions offer different perspectives and share a commonality that have particular relevance for community engagement efforts: they provide a framework from which to examine the variables that both benefit and challenge the process of engaging communities to achieve *100% Access and 0 Health Disparities*.

**Community Diversity.** The definition of community as *an interacting population of various kinds of individuals in a common location* addresses the challenges to community engagement posed by the growing diversity within the U.S. communities. Reports from the Census Bureau indicate that the nation is more racially and ethnically diverse in the year 2000 than it was in 1990. Since 1990, diverse racial and ethnic groups have increased from approximately one-fourth to one-third of the U.S. population. This trend is expected to continue. The Census Bureau projects that in 2030, diverse racial and ethnic groups will comprise 40% (or two-fifths) of the total U.S. population.

Factors impacting community diversity involve more than race and ethnicity. Other factors include, but are not limited to, geographic location, population density, population stability, (e.g. rates of in-migration, out-migration, interstate migration, and immigration) (Campbell, 1996), the age distribution of population, social history, inter-group relationships, and the social, political and economic climates. Still other factors influence diversity among individuals and groups, such as language, nationality, acculturation, assimilation, age, gender, sexual orientation, education, literacy, socio-economic status, political affiliation, religious or spiritual beliefs and health beliefs and practices. A thorough understanding of these factors and respect for their

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relevance are necessary for effective community engagement. Countless benefits can result when community diversity is acknowledged, valued and honored as an underpinning for partnerships to achieve *100% Access and 0 Health Disparities*.

**Community Leadership.** The definition of community as *a body of persons of common interests scattered through a larger society* suggests that challenges exist in increasing the number and capacity of community partners or key stakeholders to lead efforts for improved health. However, the leadership committed to eliminating health disparities should not rest solely within the domain of public health. Mahan, in *Surrendering Control to the Locals*, states “effective leadership usually involves relinquishing or sharing power... at many levels.” Shared power is an integral principle of leadership development and an essential element for community engagement (Kouzes & Posner, 1990; Covey, 1996; Melaville & Blank, 1991, Lipman-Blumen, 1996). The complex nature of this nation’s communities requires leadership approaches that are multifaceted and culturally competent. Such approaches must have the capability to engage diverse constituencies at multiple levels within any given community. Concerted efforts should be directed toward cultivating leadership in natural, informal, support and helping networks within communities. These efforts may include, but not be limited to, neighborhood, civic and advocacy associations; local/neighborhood merchants; local business alliance groups; ethnic, social, religious groups; faith-based organizations; spiritual leaders and healers; and ethnic and public interest media, etc. Research studies have demonstrated what many people know from experience—that feeling empowered to make a substantive contribution and to influence outcomes leads to a greater sense of satisfaction and improved performance (Kouzes & Posner, 1990). When others are strengthened and enabled to accomplish extraordinary things on their own, the original sphere of leadership is enhanced (Kouzes & Posner, 1990). “Nurturing leadership is as important as leadership itself” (Williams & Taylor, 1994). Cultivating and increasing leadership capacity is an indispensable strategy for engaging diverse communities in the goal to eliminate racial and ethnic disparity in health.

**Community Investment.** The definition of community as *joint ownership or participation* examines the challenges of soliciting and obtaining community investment and ownership for the health of all its members (Centers for Disease Control & Prevention, 1997). The social, political and economic climates of each community will present a different contextual reality for community engagement. Communities are often fraught with the problems of resource inequity among and between groups, politicalization, special interest factions, and entrenched ways of viewing and dealing with problems. Bringing about the shared vision of *100% Access and 0 Health Disparities* among such disparate community stakeholders is a daunting but essential endeavor. “Sharing a view of the future represents the most important context for community effectiveness. Vision encompasses the values, promise, and hope that energizes and amalgamates persons of diverse views and backgrounds to a common end” (Magrab, 1999).

Community investment in this vision will require health care organizations to:

- establish and maintain trust among community partners/members when there may be a history of adversarial relationships;
- effectively and equitably share limited resources among competing needs;
- share power and ensure that the contributions of community partners/members are valued and respected; and
- use varied communication modalities and technologies to provide community partners/members with full and timely access to information.

Achieving the visions of “Healthy People in Healthy Communities” and the elimination of health disparities require the capacity to engage individuals and groups in the community settings where they actually work, worship, play, learn and live.

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### ■ *Community Solutions for Community Problems*

Research studies that include focus groups of community members often report findings about health beliefs and practices that otherwise, unknown and unattended, might undermine costly interventions. Several studies have found that many African-American men and women prefer to receive cancer screening services from their own physicians instead of screenings at clinics or health fairs. Until these African-American men and women were asked about their thoughts and beliefs, health care organizations knew only that their interventions and public health messages were not as effective in reaching this population (Williams, Abbott, Taylor, 1997 & Barber et al, 1998). Health care organizations cannot afford to ignore the expertise and solutions within the communities they serve. Two organizations that have exemplified culturally competent approaches to community engagement include Sunset Park Family Health Center in Brooklyn, New York and the Multnomah County Health Department in Portland, Oregon. See page 9 for additional listings and more information.

### ■ *Supporting the Economic Well Being of Communities*

The viability of any community is inextricably linked to the social-emotional, physical and economic well being of all of its members. Improving the health of individuals from racial and ethnic groups often involves improving the environments in which they live, including the economic climate within communities. Warren (1978) defines five basic functions of communities, one of which is production-distribution-consumption. This refers to a community's ability to participate in the process for goods and services in a manner that is desirable for its inhabitants. Health care organizations seeking to engage communities should incorporate the concept of reciprocity, and should know to what extent they themselves contribute to the economic viability of the community (e.g. purchase of goods and services from local merchants and hiring members of the community) (Mason, J., 1996). The literature cites practices that support reciprocity as being effective, and recognizes the need for economic benefits and exchange of resources as a foundation for successful community engagement.

### ■ *Funders Require Community Participation*

There is a growing emphasis on community and consumer participation among grant makers and other entities that fund health, mental health, social service and related research programs. These funders also stress the importance of using cultural and linguistic competence to engage communities and attain their meaningful participation. Many federal and state government agencies require programs to involve communities and consumers in order to receive grant funding. Within the federal government, the Health Resources and Services Administration; the Agency for Healthcare Research and Quality; the National Institutes of Health; the National Institute on Disability, Rehabilitation and Research; the Administration on Children and Families; the Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Administration all have specific program guidance and mandates for community participation. The Robert Wood Johnson Foundation, John D. and Catherine T. MacArthur Foundation, and Annie E. Casey Foundation also require that grant recipients demonstrate active community participation in planning and implementing the community projects funded by these foundations.

## Summary

In summary, the complex and diverse nature of communities mandates approaches to community engagement that are culturally and linguistically competent. To successfully engage communities, health care organizations must understand:

- their own organizational culture, and the cultures of their personnel;
- the diverse cultures represented within the communities they serve;
- the social, political and economic climates of communities within a cultural context; and
- the inherent ability of communities to recognize their own problems, including the health of its members, and intervene appropriately on their own behalf.

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Most importantly, health care organizations must demonstrate the capacity to effectively use this knowledge to develop and administer policy, structures, procedures and practices to meet the needs of culturally and linguistically diverse populations.

A major principle of cultural competence involves extending the concept of self-determination beyond the individual to the community (Cross et al., 1989). This guiding principle is particularly relevant to community engagement. The National Center for Cultural Competence embraces a conceptual framework and model for achieving cultural competence based on the Cross et al. definition. Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice/service delivery and systematically involve consumers/families.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

## Community Engagement: Policy Implications for Primary Health Care Organizations

Health care organizations should give careful consideration to the values and principles that govern their participation in community engagement. This checklist is designed to guide them in developing and administering policy that supports cultural and linguistic competence in community engagement.

### Checklist to Facilitate Cultural Competence in Community Engagement

Does the health care organization have:

- a mission that values communities as essential allies in achieving its overall goals?
- a policy and structures that delineate community and consumer participation in planning, implementing and evaluating the delivery of services and supports?
- a policy that facilitates employment and the exchange of goods and services from local communities?
- a policy and structures that provide a mechanism for the provision of fiscal resources and in-kind contributions to community partners, agencies or organizations?
- position descriptions and personnel performance measures that include areas of knowledge and skill sets related to community engagement?
- a policy, structures and resources for in-service training, continuing education and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- a policy that supports the use of diverse communication modalities and technologies for sharing information with communities?
- a policy and structures to periodically review current and emergent demographic trends to:
  - determine whether community partners are representative of the diverse population in the geographic or service area?
  - identify new collaborators and potential opportunities for community engagement?
- a policy, structures and resources to support community engagement in languages other than English?

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# For More Information...

## **Bureau of Primary Health Care Community Engagement Initiatives**

**Communities in Action**  
<http://bphc.hrsa.gov/CCA>

**Faith Partnership Initiative**  
<http://bphc.hrsa.gov/faith>

**Multnomah County Health Department**  
Lillian Shirley, Director  
1120 SW 5th, 14th Floor  
Portland, Oregon 97204  
Phone: (503) 988-3674  
Fax: (503) 988-3676  
<http://www.multnomah.lib.or.us/health/index.html>

**Sunset Park Family Health Center**  
Dinah Surh, Administrator  
Sunset Park Family Health Network  
150 55th Street, Sector #14  
Brooklyn, NY 11220  
Work Phone: (718) 630-7215  
Fax: (718) 630-6828  
E-Mail: [dsurh@lmcmc.com](mailto:dsurh@lmcmc.com)

## **Other Community Engagement Initiatives**

**Friendly ACCESS**  
The Lawton & Rhea Chiles Center for Healthy Mothers and Babies  
University of South Florida  
College of Public Health  
MDC 56  
13201 Bruce B. Downs Blvd.  
Tampa, FL 33612-3806  
E-mail: [friendlyacces@childescenter.org](mailto:friendlyacces@childescenter.org)

## **Haddington Community Health Project Collaborative**

For further information on partnership activities, contact:  
Rickie Brawer  
Regional Director, Community Services  
Main Line Health  
100 Lancaster Avenue  
Medical Science Building  
Wynnewood, PA 19096-3498  
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Fax: (610) 526.8099

**The Muskegon Community Health Project**  
<http://www.mchp.org>

## **Communities Can!**

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**National Heart, Lung, and Blood Institute**  
Salud para su Corazon (Health for your Heart)  
<http://www.nhlbi.nih.gov>  
E-mail: [NHLBIinfo@rover.nhlbi.nih.gov](mailto:NHLBIinfo@rover.nhlbi.nih.gov)

## **Centers for Disease Control and Prevention HIV Prevention**

<http://www.cdc.gov>  
1600 Clifton Rd.  
Atlanta, GA 30333  
Phone: (800) 311-3435  
Phone: (404) 639-3311



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### About the



The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Child Development Center and is housed within the Department of Pediatrics of the Georgetown University Medical Center. The BPHC funds one project of the NCCC. The NCCC operates under the auspices of Cooperative Agreement #U93-MC-00145-06 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), HRSA, DHHS.

The NCCC is a collaborative project between the Georgetown University Child Development Center and the following Federal government agencies:

### Health Resources and Services Administration

#### **Maternal and Child Health Bureau (MCHB)**

- Division of Services for Children With Special Health Needs
- Sudden Infant Death Syndrome and Other Infant Death Program
- Division of Research, Training and Education (DRTE)
- Healthy Tomorrows Partnership for Children Program/DRTE

#### **Office of Minority Health**

- HRSA Cultural Competence Committee

#### **Bureau of Primary Health Care (BPHC)**

- Office of Minority & Women's Health
- National Health Service Corps (NHSC)
- Division of Loan and Scholarship Repayment/NHSC
- Office of Pharmacy Affairs

Other target BPHC programs include Community Health Centers, Migrant Health Centers, Health Care for Homeless grantees, Healthy Schools, Healthy Communities grantees, Health Services for Residents of Public Housing, Primary Care Associations and Offices.

The NCCC also has a partnership with Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child, Adolescent and Family Branch through another Cooperative Agreement.

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