

Becoming a Culturally Effective Organization: A Case Study of the Manchester Community Health Center

October 2016

I. Introduction

Manchester Community Health Center (MCHC), a federally qualified health center located in Manchester, New Hampshire, is one of many healthcare organizations in the United States that seek to fill the growing demand for low-cost, community-based health care. MCHC meets this need through a patient-centered medical home model that provides low-cost health services without compromising quality of care.

The city of Manchester is home to an increasingly diverse population, where disparities in access to care and health outcomes are prevalent. These health disparities are exacerbated by racial and socio-economic inequities in educational attainment, access to quality jobs, and neighborhood resources.¹ MCHC is attuned to these realities and has made the provision of quality care to all and the reduction of health disparities an ongoing organizational priority. This commitment is reflected in efforts to diversify its workforce and create an inclusive workplace and care environment. Yet systemic organizational change requires more than occasional cultural competency trainings or the hiring of staff from communities of color. Progress depends on the development and implementation of in-depth, multi-level integrated strategies that place MCHC on a path to becoming a *culturally effective organization*.²

This case study provides an overview of the key decisions, processes, and activities carried out by MCHC's leadership and Health Equity Team since 2013. Their groundwork establishes a path for the health center to increase its cultural effectiveness over time. Healthcare organizations around the U.S.—in small communities as well as large urban centers—will increasingly seek to become culturally effective organizations in order to improve their quality and equity outcomes. This case study reveals strategies appropriate for community health centers that are ready to embark on an organizational change process to deliver high quality care to all.

This report is a product of the Healthcare Employer Research Initiative, funded by the Administration for Children and Families (Grant #90PH0021). The goal of this initiative, a four-year partnership of the Institute on Assets and Social Policy at the Heller School for Social Policy and Management at Brandeis University with the New Hampshire Office of Minority Health and Refugee Affairs, was to identify New Hampshire healthcare employer needs, challenges, and best practices for increasing diversity in the healthcare workforce. This case study was co-produced by IASP and the Manchester Community Health Center in order to share strategies, processes, and lessons learned that might assist other employers in advancing this work. Additional support for this work was provided by grant #2488 from the Endowment for Health.

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Acknowledgement of reviewers: Paula Smith and Trinidad Tellez, MD

II. Background

Aligning Health Equity with Organizational Growth

“We want patients to enter our doors because it is their best choice for health care, not their only choice.”

- Selma Tarahija, Health Equity Coordinator

Established in 1993, MCHC currently serves over 15,000 patients, up from approximately 9,000 in 2011. The central headquarters on Hollis Street in downtown Manchester is now one of four sites offering patients integrated care and a medical home. In 2013, MCHC opened a satellite location on Tarrytown Road on the east side of the city adjacent to a major hospital. In November 2014, MCHC merged with Child Health Services, which serves 2,000 children using an intensive biopsychosocial model to address complex health issues. The fourth site, on the west side of Manchester, opened in December 2015 and will serve another 3,500 patients by the end of the second year.

As a result of this growth, the organization is in the process of merging several types of healthcare delivery models and organizational cultures, as well as continuing to expand its reach into the community and provide health care and preventive services in a range of settings.

Part of this expanded reach includes serving an increasing number of families from diverse backgrounds, many of whom live below the poverty line and speak limited English. Despite a successful track record in serving a diverse patient population for the past couple of decades, MCHC leadership recognized that more could be done to improve quality of care and reduce health disparities within these communities. In addition, rapid organizational growth and change required the health center to formalize and institutionalize its commitment to delivering culturally effective care, so that it no longer depended on the expertise and influence of individual providers and administrators. These organizational changes must be adopted by all members of the workforce, from front-line clerical staff to seasoned healthcare providers, to be effective. MCHC’s vision is to embed a commitment to health equity into policies, practices, and staffing patterns, so that these changes spread throughout all levels of the organization, becoming institutionalized and visible through improved patient and staff satisfaction and well-being over time.

MCHC recognizes that its greatest asset is its workforce. Innovative and quality programs and services to improve the health of a growing patient population are only as effective as the professionals that carry them out. MCHC’s theory of change requires improved strategies for staff recruitment, retention, and advancement to engage a workforce that reflects the diversity of the community by age, race, ethnicity, gender, and more. These workforce development and diversity strategies form the basis for growing an organization that is skilled at serving patients in culturally effective ways.

A Profile of MCHC in 2016

Patients:

- 15,000 served
- 88% earn less than the Federal Poverty Level
- 27% are uninsured
- 62 languages requiring interpretation
- Top languages spoken: Spanish, Arabic, Nepali, Portuguese, Bosnian, and Vietnamese.

Staff:

- 188 employees
- 54% are bilingual
- 32% are from diverse racial, ethnic, or linguistic backgrounds.

A Project in Context: History and Partnerships

In 2013, MCHC was awarded nearly \$200,000 from the Endowment for Health, New Hampshire’s largest health foundation, to establish a Center of Excellence in Culturally Effective Care. The purpose of this project was to take action to reduce racial inequities in access to care and health outcomes at the community health center, test and model strategies to further health equity at different levels of the organization, and share promising practices with other health and human service organizations in Manchester and beyond for maximum impact.

The Center of Excellence project could be viewed as a standalone initiative of a motivated healthcare organization. Instead, MCHC views the project as one initiative that fits within a larger effort and longer-term multi-stakeholder process to create a stronger, healthier, and more vibrant community in Manchester. The Center of Excellence stands on the shoulders of and benefits from decades of work led by civil rights, health equity, and immigrant rights organizations and initiatives. This critical, ongoing work by key community leaders intent on creating a more equitable community is where the story begins.

Over 20 years ago, efforts were brewing to address and support the growing racial and ethnic diversity of Manchester. In the early 1990s a coalition of community activists started the NH Minority Health Coalition, initially housed at MCHC. In addition, groups such as Southern New Hampshire Outreach for Black Unity (SNHOBUBU), the NAACP, and the Diversity Task Force out of the Office of Minority Health worked to raise awareness about the needs of communities of color and increase access to critical health and human services. In 2001, the Medical Interpretation Advisory Board (MIAB) was created, which brought together representatives of health care and community-based organizations to develop a system of medical interpretation including training, language diversity (American/Spanish sign language), and statewide access that is standards-based and cost effective.

In 2011, the MIAB was restructured into a new organization to reflect the expansion of health equity needs beyond those related to language access. The result was a statewide network of individuals and organizations working towards health and equity: the New Hampshire Health and Equity Partnership.³ MCHC leads the Health and Equity sub-committee focused on data, which provides a forum to engage key healthcare leaders to develop and implement best practices related to the collection and analysis of race, ethnicity, and language data. Another sub-committee focused on workforce diversity in healthcare brought together key partners from the NH Nursing Diversity Pipeline Project, led by the Endowment for Health, and the Health Profession Opportunity Project, led by the Office of Minority Health and Refugee Affairs and Ascentria Care Alliance. Together these workforce initiatives trained and placed hundreds of healthcare professionals of color in jobs in New Hampshire from 2011-2015.

The Brandeis University Healthcare Employer Research Initiative helped to document and disseminate best practices related to workforce diversity and, more broadly, cultural effectiveness in health care. In addition, Harvard Pilgrim Healthcare Foundation's Culture InSight program led a "Diversity and Cultural Competence Workshop" train-the-trainer initiative, which produced a network of NH-based facilitators skilled in leading cultural competency trainings. The organizations and initiatives named here represent just a few elements of the ongoing work—much of it driven and carried out by unpaid community leaders—for equity-informed policy making and program development across the state today.

Despite this rich history and ongoing efforts to reduce health and social inequities across New Hampshire, disparities persist. MCHC's President and CEO sees the health center as a key community institution that has the potential to advance this work internally, develop solutions to pressing social and health inequities, partner with other healthcare organizations and systems, and achieve greater levels of community health and change over time.

Prior to the Center for Excellence grant award, MCHC already had multiple strategies in place to ensure health access for populations experiencing disparities such as interpretation services, a diverse workforce, cultural competency trainings, and strategies to analyze data and identify disparities. However, for many years this work was done on a relatively small scale, and key leaders within the organization were the driving force. It was clear that to maintain and improve this level of quality as the community and organization grew, this health equity work needed to be institutionalized. Initially following the "Roadmap to Reduce Disparities" framework developed by the Robert Wood Johnson Foundation,⁴ the plan for the Center of Excellence was based on performing a systematic analysis of the health center's structure, with multiple stops to look at critical components for organizational change such as linking quality and health equity and securing buy-in.

III. Elements of a Culturally Effective Organization: From Theory to Practice

Framework for a Culturally Effective Organization



Source: Doupé Gaiser et al., (2015).

As MCHC worked to address health equity within their organization, they implemented strategies in each of the seven areas illustrated in the framework above: leadership, policies and procedures, data collection and analysis, community engagement, language and communication access, staff cultural competence, and workforce diversity and inclusion.

This framework was developed in 2015 by the Brandeis Healthcare Employer Research Initiative. MCHC adopted the framework as a tool to conceptualize and communicate about their interrelated strategies to create an inclusive and effective workplace environment for all patients and staff. This section describes key activities that MCHC pursued in each area and identifies key questions, challenges, and opportunities that organizations should consider as they develop their own path to becoming a culturally effective organization.

Leadership

Key Question: How can we develop health equity leaders and champions within our organization?

As described above, MCHC's President and CEO provided leadership and strategic direction which enabled the organization to prioritize and commit resources to this work. Although many of the objectives and strategies described here fall under the purview of existing departments or might otherwise be seen as responsibilities of Human Resources, the Quality Improvement committee, or the Medical Director, MCHC hired a full-time Health Equity Coordinator and established an internal Health Equity Team to oversee and coordinate this work.

The role of the Health Equity Coordinator is to implement this work in collaboration and partnership with the Health Equity Team and other management-level staff, reporting back to and incorporating ongoing feedback from the President and CEO. Health Equity Team members act as champions within the different departments of the organization to disseminate key messages about the project as well as act as the eyes and ears for the Health Equity Coordinator to share real-time examples of challenges, needs, and opportunities facing each department. MCHC honored their champions by recognizing them at an all-staff meeting and giving them a chance to speak about health equity from their own perspective. This created broad staff buy-in and stimulated a series of informal conversations within teams and departments, which complemented the work of formal cultural competency trainings (see below).

Highlighted Strategy:

Employ or designate a Health Equity Coordinator to oversee the implementation of steps towards organizational cultural effectiveness.

In the fast-paced world of healthcare delivery, managers and staff operate in a high pressure environment and are constantly working to balance priorities of quality outcomes, patient satisfaction, and cost efficiencies. As MCHC observed, in this setting, it can be challenging to introduce yet another priority, and not all staff will be early adopters or champions of health equity. Some staff members actively resisted change and questioned the decision to focus on cultural effectiveness as an organizational priority. Leadership development takes time and can be cultivated and reinforced by the other activities described in this case study. Creating different conceptual and practical entry points into the topic helped to bring people along. For example, while some managers and staff related to the idea of disparities of data and patient outcomes, others resonated with values-based concepts of social justice and community health. These multiple but consistent messages over time enabled staff to step up as leaders within their own areas of expertise, interest, and practice.

Organizational Policies and Procedures

Key Question: How can we institutionalize health equity through policies and procedures?

Strategic direction and oversight in healthcare organizations is typically formalized through written policies and procedures. Without written guidelines about policies, cultural effectiveness—and quality of care—is dependent on staff discretion and organizational culture. Many of the health equity procedures MCHC had been following were part of organizational culture but had not been elevated to the level of institutionalized policy. With the additional focus and personnel provided by the Endowment for Health grant, the organization engaged in a policy inventory process. First, the Health Equity Coordinator worked with the President and CEO and the Human Resource Director to identify existing policies that related to health equity in each of the seven areas described in this case study. Then the Coordinator worked with managers and champions in each area to determine the extent to which these policies were understood by staff and/or implemented in day-to-day patient care. Based on this analysis, the Health Equity Coordinator developed recommendations for updating existing policies or creating new ones. MCHC will work to incorporate this information into staff training and tools located on their intranet so that staff can continue to learn about how health equity is institutionalized in organizational policies. These resources will ensure that everyday practices carried out by staff in different departments are consistent with the organizational priority to ensure culturally effective care.

Highlighted Strategy:

Conduct a policy inventory to assess the extent to which policies address or further health equity and identify new policies to fill gaps.

MCHC found that a key challenge in this area is a lack of evidence-based performance measurement tools (see data collection and analysis below).⁵ MCHC managers were not well equipped to assess the extent to which equity policies are implemented in everyday practice. At the same time, MCHC learned that managers should be highly engaged in the policy inventory process, so that over time they can see the implementation of everyday policies and procedures in their department through a lens of health equity. As the field of health equity evolves, organizations and researchers will need to develop and utilize concrete evaluation tools to test the effectiveness of policies and practices to reduce health disparities and improve workplace environments.

Data Collection and Analysis

Key Question: How can we move beyond measuring patient-level outcomes and begin to measure organizational-level outcomes related to cultural effectiveness, equity, and quality?

Health equity can begin to be assessed by determining whether there are disparities in the processes or outcomes of care within the organization. This requires the capacity to examine patient-level data, whether for health outcomes or patient satisfaction, and stratify by race, ethnicity, and/or primary language. As part of this project, MCHC's President and CEO and Chief Medical Officer attended the Massachusetts General Hospital Health Disparities Leadership training. This informed MCHC's efforts to strengthen its systems for analyzing patient outcome data to understand health disparities by disease area and by key populations, to develop more tailored health interventions.

As part of the Center of Excellence project, MCHC chose to focus on diabetes because two key populations had worse health outcomes for diabetes than the rest of the patient population: Arabic- and Spanish-speaking patients. In response, the health center developed a focused set of interventions to target those two populations. They hired two community health workers, one from each community, to provide direct support, navigation assistance, and health education to patients with elevated A1C levels. MCHC also revised their patient satisfaction survey, which is provided in 10 languages, to include race and ethnicity questions so that the organization can assess whether satisfaction scores vary for different populations.

MCHC leadership and the Quality Improvement team are beginning to utilize a wider range of data to assess quality measures for both patients and staff. From 2014-2015, the Southern New Hampshire Area Health Education Center conducted a series of seven stakeholder focus groups to better understand the perceptions and needs of the community. The focus groups were designed to gain feedback from community health workers and interpreters, community leaders, and patients who speak Arabic, Spanish, Nepali, Vietnamese, and English. An interpreter assisted in collecting feedback from the focus groups for non-English speakers. The focus groups asked patients about their experience within the community of Manchester, perceptions about community resources, opportunities to capitalize on strengths, and ways to address challenges. Patients offered praise and constructive feedback regarding the following themes: quality, interpreters, welcoming environment, discounted costs of care, transportation, referrals, dental, front desk, appointments/access to care, and staff. Findings from these focus groups helped to inform MCHC leadership about departments that were working well and areas that needed improvement to create the best experience for patients. For example, as a Federally Qualified Health Center, MCHC follows federal poverty guidelines on an annual basis to establish sliding scale fee discounts for uninsured and underinsured patients to make their care affordable. In the focus groups, patients expressed gratitude for the availability of these discounts. In addition, as a result of patient feedback, MCHC developed and implemented customer service and cultural competency training for staff.

MCHC identified the need to establish and implement clear guidelines for the collection of data and to dedicate organizational resources (staff expertise and time) to regularly analyze and share data. MCHC found that data is most useful when it is accessible and presented in meaningful ways to staff and members of the community to improve understanding of why race, ethnicity, and language data are collected. Results should inform quality interventions, and if communicated clearly, all members of the organization will begin to learn how to connect the information gained from useful data to their everyday interventions and actions at the health center.

Highlighted Strategy:

Collect race, ethnicity, and language data for patients and stratify patient satisfaction and health outcome measures to determine whether disparities exist and where care can be improved.

Community Engagement

Key Question: How can we engage different stakeholders in the community—including those not well served by the existing system—to create culturally effective programs and services?

For MCHC, community engagement involves both outreach and in-reach. MCHC's goal is to provide an open door for all who need healthcare assistance. This requires extensive outreach in the community to ensure that all potential patients are aware of what the organization has to offer. MCHC engages with stakeholders in the community to learn about the specific health needs of diverse populations and responds when possible by partnering on initiatives to identify and improve the social and economic conditions that enable healthy environments and lifestyles.

MCHC achieves in-reach by inviting leaders of color and people who represent underrepresented populations to take positions of power where they can engage in decision making and guide the strategic direction of the organization. As a Federally Qualified Health Center, MCHC assures that at least 51% (a majority) of all Board members are patients of the health center. Federal legislation also requires that the composition of the board accurately reflect the diversity of the patients being served and the diversity of the service area by age, ability, race and ethnicity. Through active recruitment of diverse patients and community members for board leadership, 40% of MCHC's board members are representative of diverse communities.

MCHC is also currently supporting the Equity Leaders Fellowship, a New Hampshire initiative designed to develop leaders of color to serve on boards and committees and bring an equity lens to their work.⁶ MCHC's President and CEO provided input into the program proposal and curriculum, serves as faculty by co-teaching a class on Board participation, and hosts fellows for a 6-month non-voting Board shadowing experience on the MCHC Board of Directors. This program represents a critically important aspect of community engagement: intentional initiatives designed to develop leaders of color and place them in strategic decision-making positions in the community.

The health center plans to further enhance community engagement over time. Patients and community members appreciated being included in the focus groups referenced above and expressed a desire to have the opportunity to give feedback more often. MCHC understands the importance of this element of the framework for becoming a culturally effective organization, yet recognizes challenges in achieving meaningful levels of engagement. Without meaningful exchanges between the health center and the community it serves, the organization could easily pursue priorities and offer services that do not align well with the needs of the community. Community leaders and patients provide a valuable perspective and have in-depth knowledge of what works when it comes to their health care. As MCHC evolves, the center will continue to partner with a range of individuals and organizations in Manchester to address the root causes of health disparities.

Language and Communication Access

Key Question: How can we go beyond providing basic infrastructure, such as interpreters and translated forms, to address health literacy and ensure meaningful access to health and healthcare?

MCHC's patients speak 62 different languages and many require communication assistance, such as interpretation and translation of written materials. Since 1993, MCHC has utilized in-person interpretation services to provide quality care to patients with limited English. These services are provided primarily by the 10 on-staff (in-house) interpreters and supplemented for rare languages by contracted hourly interpreters. In cases where in-person interpretation is unavailable (typically due to urgent unplanned appointments or walk-ins), over-the-phone interpretation is used.

Highlighted Strategy:

Create a Board of Directors that accurately reflects the diversity of the patients being served and the diversity of the service area, by age, ability, race, and ethnicity.

In addition, the health center provides over 70 core forms (such as intake, procedure consents, releases of information, commonly used patient letters and others) in 9 languages and makes other forms of communication assistance available to patients who are blind, deaf, visually or hearing impaired, or who have other communication barriers. These accommodations are provided in accordance with Title VI of the Civil Rights Act of 1964;⁷ the Americans with Disabilities Act of 1990;⁸ and Section 504 of the Rehabilitation Act of 1973.⁹

As a result of the Center of Excellence initiative, MCHC has identified several strategies for improving language and communication access. First, the center revised the patient satisfaction survey, available in the top 9 languages spoken by patients, to include questions regarding satisfaction with the interpreter services. Second, with the center's growth and expansion, the organization recognizes a need to implement a more formal assessment for in-house bilingual staff to ensure language proficiency in medical terminology. Third, the center is exploring strategies to measure and document health literacy levels of all patients. These strategies represent a shift away from the concept that providing language assistance through interpretation and translation is enough. Instead, as MCHC seeks to reduce health disparities, ensure meaningful access, and improve quality of care, it will work to measure and enhance the quality of communication that patients have with the center at all stages in the care process.

Highlighted Strategy:

Provide a range of interpretation and translation services and ensure that staff members are continuously trained in how to provide optimal communication access.

Staff Cultural Competence

Key Question: How can we make cultural competency education more accessible and relevant to staff at all levels of the organization?

As part of the Center of Excellence project, MCHC committed to training all existing staff at all levels of the organization in cultural competence. In addition, the Health Equity Team established a system to ensure ongoing professional development and integration of cultural competence training into orientation for new staff members. The Health Equity Coordinator and Community Health Worker, who is also a member of the Health Equity Team, participated in the "Diversity and Cultural Competence Workshop" train-the-trainer program offered by Harvard Pilgrim Healthcare Foundation's Culture InSight and used that content as a basis for the MCHC training.

Highlighted Strategy:

Require and offer cultural competency training for staff at all levels of the organization.

After piloting the training with the Health Equity Team, MCHC hosted a full 2-hour staff meeting on health equity and the center's commitment to becoming a culturally effective organization. At this meeting, staff completed a short survey indicating whether they had previously participated in cultural competency training. Fifty-two percent of staff had never engaged in such training, and only 30% had participated in a related training within the previous two years.

From January through May 2016, the Health Equity Coordinator and Community Health Worker delivered trainings twice a week at different times to accommodate varying staff schedules and to ensure that over 220 staff had the opportunity to attend two modules. MCHC contracted with Southern NH Area Health Education Center to offer providers and other clinical staff professional development credit (Continuing Medical Education credits or Continuing Education Units) for participating. One of the most common barriers to effective training is time and cost. MCHC lost an estimated \$27,000 by closing its doors so that all 18 providers could attend these trainings. However, management was confident that investing in training their current workforce would pay off in improvements down the road.

Since the initial all-staff meeting, providers have reached out to the Health Equity Team with requests for information and resources on specific issues relating to diversity, culturally effective care, and fostering an inclusive workplace environment. For example, a request was made for more information and training regarding working with transgender individuals. A different request was made to address workplace bullying. Cultural competence trainings act as an entry-point for staff members to begin learning and thinking about broader issues of cultural effectiveness and equity. Assigning the Health Equity Team as a conduit for staff requests and questions means that the health center now has institutionalized the process for people to request information, engage in ongoing learning, and provide the highest possible quality of care.

Workforce Diversity and Inclusion

Key Question: How can we improve staff satisfaction and ensure opportunities for career advancement and upward mobility for all staff?

MCHC has historically employed a diverse staff to respond to the needs of the community, and many health professionals seek out job opportunities at the health center because of its reputation for having a diverse staff and patient population. Yet there were few formalized procedures in place to ensure diversity and inclusion as a priority at all levels of the organization. The Human Resource department is now collecting race, ethnicity, and language data on all staff. This provides the capacity to develop a scorecard indicating how representative the organization's workforce is of the patient population and the wider community and to track improvement over time.

At the same time, workforce diversity is more than a numbers game. The center is now looking at workforce diversity from a wider perspective. This includes developing strategies to create a welcoming and inclusive workplace and to ensure that health professionals from all backgrounds are meaningfully engaged in their work and in the organization. This will include investigating and measuring staff satisfaction.

In addition, as discussed under community engagement, having professionals of color in decision-making and leadership roles is critical to health equity. Although 32% of MCHC staff members are from diverse racial, ethnic, or linguistic backgrounds and 54% are bilingual, 100% of the senior level officers and directors are non-Hispanic white. Approximately 25% of the management team identifies as an immigrant or person of color. So although MCHC has a diverse workforce overall, the next phase of this work within the health center will include reducing barriers to upward mobility and increasing leadership opportunities. This includes intentional strategies to ensure that professionals from diverse backgrounds have equal access to career advancement and progressively responsible roles in health care.

Highlighted Strategy:

Collect race, ethnicity, and language data for patients and staff and assess extent to which the workforce at different levels of the organization is representative of the patient population and community.

IV. Lessons for the Field

Healthcare organizations seeking to improve quality and advance equity will find themselves at different starting points. The framework “elements of a culturally effective organization” is not a linear model. Rather, it offers some principles that organizations can use to guide their work. Based on the experience of MCHC, organizations must take into account their unique needs, strengths, and organizational practices as they start the work of becoming more culturally effective. Despite the complexities and the long-term nature of these types of organizational change, MCHC has accomplished something in each element of the framework and has set in motion a larger-scale change process that will continue into the future. The following lessons are designed to inform other organizations that choose to embark on this journey.

Getting Started

Organizational change is a lengthy, complex process, and making progress on some elements creates opportunities for change and innovation in other areas. Therefore, it is critical that organizations just start somewhere—anywhere—utilizing available resources, while pursuing a longer-term plan.

- ▶ Articulate your vision at the start of the process and seek input from Board members and staff on how they would go about achieving this vision to gain early internal “buy-in”
- ▶ Use available data to document and communicate about needed improvements
- ▶ Form an agency implementation team that includes senior managers to identify training and resources needs and to serve as a sounding board for staff to problem solve
- ▶ Form an external advisory team (MCHC’s team included experts from Brandeis University, Southern NH Area Health Education Center, and the NH Office of Health Equity (formerly the Office of Minority Health and Refugee Affairs)) for outside perspective and to draw on other experiences
- ▶ Engage external partners. This is a community endeavor that will succeed best if supported by community members including patients, partner healthcare organizations, funders, advocates, and thought leaders

Planning to Institutionalize Strategies

The healthcare field is fast paced and always changing. Organizations must adapt strategies to the existing organizational culture while simultaneously challenging it. For example, MCHC offered cultural competency training in timeslots that matched the 20-minute clinical encounter schedule but did not exempt providers from participating, despite busy schedules.

- ▶ As you implement a new strategy, create a plan for where it will be housed, who will be responsible for it, and account for the resources that will be required for sustainability
- ▶ Create communication channels that can reinforce culture change and that are consistent with the many ways that information travels among staff (for example: top-to-bottom, bottom-up, through team-based care, and/or in occupationally defined circles)
- ▶ Generate a shared sense of readiness for reaching for the goal of organizational cultural effectiveness through consistent leadership messages and action.
- ▶ Sustain commitment to change through written policies and continued engagement of leadership including senior management and the Board of Directors

Measuring Outcomes

Efforts to become a culturally effective organization are equally as important and beneficial for staff satisfaction and retention as they are for patient satisfaction and health outcomes. These organizational and field-level improvements in knowledge and practice have positive implications for the long-term employment prospects of health professionals of color as well as for the reduction of health disparities. Some areas in which an organization’s cultural effectiveness can be measured include:¹⁰

- ▶ Patient and employee satisfaction disaggregated by race/ethnicity and language status
 - Patient satisfaction scores
 - Patient complaints or grievances
 - Diverse employee satisfaction scores
 - Employee discrimination complaints
- ▶ Human Resource statistics disaggregated by race/ethnicity and language status
 - Staff hiring, retention, and advancement rates
 - Demographic composition of senior leadership and Board of Directors
 - Proportion of diverse employees at each job level

Resources

Despite significant commitment from the CEO, MCHC would not have been able to pursue this particular set of intentional, multi-faceted strategies had it not been for the Endowment for Health's grant support. The following resources are recommended to support this early phase of implementation.

- ▶ Full-time or dedicated part-time Health Equity Coordinator position
- ▶ Commitment of other staff time to participate on an inter-departmental team and implement or modify agency procedures as needed
- ▶ Input from outside experts including one-time trainings (such as the Disparities Solutions Center) and ongoing technical assistance (Brandeis University's Institute on Assets and Social Policy provided information and co-created tools throughout the project)
- ▶ Seed support from a range of foundations for specific activities rather than sole support from one funder

Research

Further research is needed to develop better measures to document progress and account for the complex interactions between the elements of organizational cultural effectiveness and patient, staff, and community outcomes. Questions for future research include:

- ▶ How can we facilitate opportunities and reduce barriers to occupational mobility, taking into account variations in experience by race, ethnicity, and primary language?
- ▶ How can patient and staff outcomes be linked?
- ▶ Which assessments and tools are effective at tracking progress towards overall organizational cultural effectiveness and quantifying links to quality?
- ▶ Who benefits most within an organization and within the community when an organization becomes more culturally effective?
- ▶ How does an increase in cultural effectiveness affect a healthcare organization's bottom line? What are the costs and benefits to the community?

V. Moving Forward

Since 2013, MCHC has made steady progress towards the goal of becoming a culturally effective organization despite rapid and complex organizational growth. Highlights include:

- ▶ Establishment of a Health Equity Team with representatives from all departments
- ▶ Implementation of cultural competency training, which integrates concepts of health equity, for all levels of staff
- ▶ A Community Health Worker pilot project to improve health in communities of color
- ▶ Integration of race, ethnicity, and language data standards in increasing numbers of data points managed by the Quality Improvement team
- ▶ Initial work on an inventory of health equity policies in concert with Human Resources
- ▶ Initial work on workforce and leadership development strategies

But there is more work to do. As MCHC solidifies its identity as a large health center with four sites and thousands of patients, cultural effectiveness must remain at its core. This will require all staff members to engage in deeper levels of health equity work and to both recognize and actively develop a new culture of organizational cultural effectiveness.

"A few key leaders and staff in our organization have been engaged in, and waded around in, health equity work for a long time. My vision is that 100% of our staff, from managers to check-in staff, will be immersed in health equity concepts and strategies. I want 100% of our staff joining us in this pool and being able to speak to how our work impacts our community's health disparities and how we are working to narrow the gap so that everyone has an equal opportunity for a good quality of life, starting with the most basic component, good health."

- Kris McCracken, President and CEO

Endnotes

¹ Norton, S. and Delay, D. Health and Equity in New Hampshire: 2103 Report Card (2013). Retrieved from: <http://www.nhpolicy.org/UploadedFiles/Reports/HealthEquity2013.pdf>; Snapshots of Social and Economic Wellbeing by Race and Ethnicity in our Community (2004). Manchester Health Department. Retrieved from: <https://www.manchesternh.gov/portals/2/Departments/health/Snapshots%20092404%20Social%20Econ.%20Well%20Being%20in%20our%20Community.pdf>; Greater Manchester, New Hampshire Health Improvement Plan, 2015-2020 (2016). Manchester Health Department. Retrieved from: <https://www.manchesternh.gov/Portals/2/Departments/health/GManCHIP.pdf>

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