Connecting Colorado

Overcoming the Disconnects that Lead to Health Disparities

A policy brief from the Colorado Institute of Public Policy at Colorado State University

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Executive Summary
For Policymakers and other Decisionmakers

As Colorado moves forward with healthcare reforms, both comprehensive and targeted, integrating a discussion of health disparities can lead to more successful outcomes. Health disparities are persistent differences in health outcomes (i.e., access, disease, disability, and death) across many areas of health over time because of race, ethnicity, gender, gender identity, sexual orientation, geography, environment, workplace, education, or socioeconomic status.[1]

While adequate health insurance is a vital piece of the healthcare puzzle, it is important to remember that addressing the problem of the uninsured and underinsured will not eliminate health disparities. Because health disparities stem from diverse sources, they are better addressed through broader solutions that respect these complex causes and consequences. Such solutions would need to move beyond the healthcare system to address the health-related structural limitations evident in transportation, employment, education, housing, public safety, public assistance, and many other policy arenas.

This policy brief seeks to provide insight on the array of issues that contribute to health disparities, with a particular emphasis on breakdowns in communication, understanding, and information among stakeholders. The Colorado Institute of Public Policy brought together over 50 community leaders serving and representing Asian, African American, Native American, Latino, lower income, disabled and aging, LGBT (lesbian, gay, bisexual, and transgendered), and rural communities[2] (see Appendix). A lack of integration and breakdowns in communication between communities and decisionmakers were the overwhelming themes of the many dialogues. These breakdowns, or

"disconnects," result in decisions and actions that may appear appropriate and helpful to one group of stakeholders, but inappropriate or even problematic to other stakeholders. This policy brief represents the synergy of concerns around disconnects as voiced by these diverse communities. It also represents community visions of ways to reconnect and address health disparities, and includes these visions in a template for collaborative discussions of policy and practice.

> *While adequate health insurance is a vital piece of the healthcare puzzle, it is important to remember that addressing the problem of the uninsured and underinsured will not eliminate health disparities.*

The health disparities disconnects these communities identified exist among policymakers, grantors, government agencies, mainstream health providers, researchers, communities, and consumers. Reconnecting policymakers with other health stakeholders creates opportunities to develop new policy processes, and opportunities to develop new policy content.

Policy development can be improved by addressing specific disconnects related to communication and collaboration between policymakers and other stakeholders. To avoid unintended consequences, policymakers can:

- Communicate with stakeholders across the state, not just those immediately available;

- Communicate with the stakeholders most directly affected by the policies, the consumers, and their advocates;

- Communicate with communities and consumers early on in the policy development process, not just when testimony is needed;

- Allow sufficient time for trust to develop among diverse communities, consumers, and policymakers; and

- Continue to communicate with communities and consumers during the implementation and evaluation of a policy, to address any problems that arise.

Some disconnects that exist between researchers and communities have direct implications for policymakers as well. When policymakers seek to base their decisions on research, they can overcome research disconnects by considering:

- Whether the communities researched had a voice in developing the research study and interpreting its findings;

- Whether the research adequately accounts for the differences among diverse subpopulations;

- Whether the research considers the systemic issues of health disparities, not just specific diseases or treatments; and

> *"Disconnects" result in decisions and actions that may appear appropriate and helpful to one group of stakeholders, but inappropriate or even problematic to other stakeholders.*

- Whether the research makes assumptions about the communities being studied, as inaccurate assumptions may adversely influence study results.

Many disconnects suggest opportunities for policy improvement, not just policy process improvement. Possibilities for improving funding and finance include:

- Creating flexibility in funding streams, including grant programs, to allow for holistic approaches to service delivery;

- Ensuring that public insurance programs allow coverage of culturally traditional practices, as well as mainstream services;

- Addressing the increasing complexity of Medicare and Medicaid reimbursement practices, as well as the low reimbursement rates for service providers; and

- Developing funding streams that are assured for multiple years, to make a sustainable impact on the disparities being addressed.

Other health disconnects identified suggest that policies focused on the integration of issues and systems will have greater success, such as:

- Seeking policy solutions that bridge different policy domains;

- Exploring the consequences of and solutions to multiple, conflicting, or overlapping policies that target the same kids, families, and consumers;

- Developing policies that increase partnerships among diverse communities, government agencies, and mainstream providers;

- Engaging faith-based and other community leaders in addressing health disparities at the local level; and

- Institutionalizing cultural competency and awareness by seeking to increase and support long-term, inclusive partnerships between healthcare providers and diverse communities.

Health disparities developed over a long time, and solutions will take a long time to fully succeed. Nonetheless, the disconnects between policymakers and other health stakeholders create an opportunity to address health disparities in immediate and concrete ways. The full policy brief covers many places to reconnect stakeholders. These points are grouped into two overarching themes:

- **Integration:** moving beyond the buzzword to clearly define comprehensive opportunities that cross systems, communities, and cultures.

- **Communication:** recognizing and addressing the complexities of dialogue between different stakeholders and cultures.

Within these themes, disconnects are framed according to their implications for specific actors, including *policymakers, researchers, grantors, providers,* and *state agencies*.

Introduction: What are Health Disparities?

The United States and Colorado lag behind in the provision of health care and health outcomes. The United States is ranked 37th in the world by the World Health Organization—next to Slovenia and Costa Rica[3]—on overall health system performance, taking into account health outcomes such as life expectancy, child survival, fairness, and responsiveness. Within a country that ranks so low, Colorado has some of the poorest health outcomes. For example, out of the 50 states, Colorado ranks 44th in childhood vaccination rates, the proportion of children without health insurance, and the number of women who do not receive prenatal care.[4]

What these overall numbers do not reveal is that the burden of poor health falls disproportionately on some groups. The health disparities experienced by these groups can be understood as persistent differences in health outcomes (i.e., access, disease, disability, and death) across many areas of health over time because of race, ethnicity, gender, gender identity, sexual orientation, geography, environment, workplace, education, or socioeconomic status.[1]

Health disparities also incorporate the prevalence of specific diseases. Diabetes, the ninth leading cause of death in Colorado, occurs in African Americans and Latinos at nearly twice the state average rate of 18.3 per 100,000. Other diseases with greater prevalence in Latinos are chronic liver disease, cervical cancer, and injuries, including those related to motor vehicle crashes.

Differences in health outcomes can also be seen in rates of death. African Americans have the highest rates of death from illnesses such as heart disease, cerebrovascular disease, HIV/ AIDS, kidney disease, septicemia (infection of the blood), and cancer overall, plus specific

cancers of the lung, breast, colon, and prostate. Additionally, the African American infant mortality rate is higher than that of any other population in Colorado.[5]

As a state, Colorado has long been aware of its health disparities, and has responded with increased policy, programming, and funding efforts, such as:

- Creating the Office of Health Disparities in the Colorado Department of Public Health and Environment;

- Convening an Interagency Health Disparities Leadership Council;

- Creating multiple grant programs that address health disparities, including private foundation grants and publicly funded grants; and

- Holding annual health disparities conferences and a 2006 mental health disparities summit.

Colorado's health providers and communities have also responded to health disparities. The mainstream health system has developed culturally specific programs to better serve communities. Diverse communities have partnered with the mainstream health system or created their own organizations to undertake community-based health education and promotion, screening, assessment, and treatment. Rural areas have developed collaborative models to maximize limited resources. Across the state, providers and communities have developed more preventative and holistic approaches to health.

Despite these significant efforts, a recent report from the Office of Health Disparities reveals enduring health disparities.[5] When the Colorado Institute of Public Policy brought together over 50 leaders of affected communities (see the Appendix for a list of organizations) to discuss why health disparities continue to exist, the overarching theme was the lack of successful connections between their communities and the many other stakeholders in the health system.

These disconnects can best be defined as breakdowns in communication, understanding, and information. They result in decisions and actions that may appear appropriate and helpful to one group of stakeholders, but inappropriate or even problematic to other stakeholders. These same disconnects, however, illuminate opportunities to address health disparities by reconnecting affected stakeholders, including:

> Throughout Colorado, providers and communities are actively addressing health disparities. They are pursuing grants, partnering with mainstream providers, talking to policymakers, hosting health fairs, developing educational materials, conducting screenings and assessments, and providing direct services.

- *Policymakers*: legislators and other elected officials, as well as high-level decision-makers who shape the direction and funding of the health system;

- *Government agencies*: state and local offices who manage the funding streams, oversight, and regulations associated with the health system and related systems;

- *Grantors*: public and privately funded grant programs;

- *Mainstream healthcare providers*: hospitals, physicians, and other medical providers;

- *Researchers*: evaluators, academics, health epidemiologists, and others in public and private research settings;

- *Communities*: advocacy organizations, culturally traditional service providers, and leaders from different cultural groups, LGBT (lesbian, gay, bisexual, and transgendered) communities, rural areas, and the aging and disability communities; and

- *Consumers*: all those affected by health disparities.

This policy brief reports on the disconnects among these stakeholders, and approaches each disconnect as an opportunity to address health disparities in Colorado. It is intended to provide a roadmap for stakeholders who want to address health disparities and overcome disconnects that create barriers to successful change.

Health disparities disconnects, and the opportunities they create, can be divided into two main issues: **integration** and **communication**.

Integration, in the context of health disparities, is about recognizing the many facets of the problem. Health disparities go beyond healthcare issues, and they cannot be solved by the healthcare system alone. Affected communities are integral to developing successful solutions that can improve outcomes.

Improving **communication** underlies many possible solutions to health disparities, and its absence can be detected in the disconnects discussed by stakeholders. Legitimate communication starts early, creates a shared language, is responsive to each other's concerns, and provides opportunities for mutual learning and collaboration.

Within the integration and communication themes, sub-themes specify disconnects among different sets of stakeholders. While not every sub-theme is relevant to every type of stakeholder, all of the stakeholders and leaders in health disparities play a role in shaping overall solutions. Through partnership, health consumers, stakeholders, and leaders can accomplish lasting change in Colorado.

Integration: Inclusive Partnerships Across Systems

Discussions of health outcomes often focus on increased access to health care through expanded insurance coverage, either through private or public programs. However, insurance alone will not solve problems such as

inadequate transportation or distrust of the medical system, both of which may contribute to health disparities. Health disparities are complex, arising from not only the healthcare system, but also from inequalities in transportation, employment, education, housing, public safety, public assistance, and many other policy arenas. The structural and financial limits inherent in these various public systems further inhibit more effective responses to health disparities.

Health disparities also arise from personal factors such as race, ethnicity, gender, gender identity, sexual orientation, age, and disability/ability. These factors affect the prevalence of disease, the ability to access services, and the appropriateness of mainstream health services. In addition, location plays a significant role in health disparities, with environmental issues and geographical isolation affecting health outcomes.

Communities that experience health disparities recognize this complexity and understand that unless policies, practices, and funding are integrated, attempts to address health disparities will fail. They recognize that a comprehensive response is the best opportunity to decrease health disparities. "Integration" is a frequent buzzword in current policy circles—but what does it really mean for health disparities?

Integration is about moving beyond the healthcare system.

Policymakers who pursue integrated solutions to health disparities may find that the most successful solutions bridge different policy domains, such as incorporating healthcare literacy into education programs, developing transportation policy with an eye toward healthcare access, and alleviating environmental health hazards. Additionally, they may consider the consequences of multiple, conflicting, or overlapping policies. For example, programs for the disabled have different and overlapping age ranges, making it difficult for parents and consumers to determine not only which programs are available to them, but also which programs best meet their needs.

Policymakers who seek integrated solutions to health disparities may also succeed by focusing on systemic barriers. While dialogue around health disparities can often focus on personal choices, communities that experience these disparities recognize that barriers within healthcare, education, transportation, and other systems are equally associated with poor health outcomes. For example, increasing the use of telemedicine in rural areas may address geographical barriers to specialized services, but it will not alleviate the systemic problems of recruiting and retaining practitioners in rural areas, a lack of diagnostic equipment, private insurance plans without participating providers, or limited numbers of providers who take Medicaid and Medicare.

The systemic barriers that exist within the Medicaid and Medicare systems are another example of the inability of any one stakeholder to single-handedly address health disparities. Proposals to expand eligibility for these programs will be ineffective if the services cannot actually be provided to those who need them. Currently, the complexity of the Medicaid, Medicare, and private insurance reimbursement systems often overwhelm providers throughout the state and result in clinics failing to receive proper reimbursement. As providers are reimbursed for only two-thirds of their service costs for children, the elderly, the disabled, and others who pay through public insurance programs, it is not surprising that many providers limit the number of Medicaid and Medicare recipients they will see. An integrated solution would address both service eligibility and availability.

Policymakers and the public might also consider the unintended health consequences of those policies outside the health arena. An integrated approach to policymaking recognizes that many issues, including minimum wage, domestic partnerships, and secondary education spending restrictions have direct impacts on the health outcomes of Colorado residents. Understanding possible health consequences comes from exploring policies in partnership with many stakeholders, including diverse communities and their advocates.

> *Overall, respect for and connections among multiple kinds of knowledge, shared by community providers, mainstream providers, researchers, and policymakers, are needed to address health disparities in Colorado.*

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When *providers* pursue solutions to health disparities, they too can move outside the healthcare system to partner with programs such as TANF (Temporary Assistance to Needy Families), Workforce Centers, Child Welfare, Juvenile and Criminal Justice, and other service delivery sectors. For patients with complex needs, the many different systems can be overwhelming. When cultural disconnects are also present, the number of barriers may be impossible for many patients to overcome. Providers who partner across systems can help ensure that their patients are not overwhelmed by case managers, appointments, and expectations from many different directions. Many communities already have collaborative health service models to build upon, such as collaborations between private and public providers or between emergency and long-term care providers. The next step for such collaborations is to move beyond the healthcare system. Models such as Systems of Care[6] and Medical Home[7] provide some guidance to providers whose patients have complex and chronic health problems interrelated with non-health needs.

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As *grantors* and *policymakers* seek to address health disparities, they can overcome disconnects with diverse providers by creating funding that goes beyond specific diseases and direct services. While numerous grantors and state agencies have produced reports that identify the many drivers of health disparities, in practice their funding streams, whether grants or public financing, do not always enable a holistic approach. Many grants are limited to specific diseases, screening only, outreach without accompanying service delivery, or direct services without outreach or education. The fee-for-service approach of public and private insurance is another impediment to holistic treatment.

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As *researchers* seek to understand health disparities, they can reconnect with communities by collecting data that identifies possible needs for holistic funding. Working with communities to identify drivers of health disparities, study them, and report findings to policymakers is an important part of justifying funding and policy improvements that will go beyond the healthcare system. Such an approach also allows researchers to go beyond academic questions and address issues of interest to policymakers and communities.

Integration is about bridging mainstream providers and diverse communities.

The formal healthcare system does not always successfully engage the communities they serve. Partnerships between *providers* and organizations in diverse communities are

important for many reasons. Partnerships with trusted community leaders, such as faith-based organizations, increase the likelihood that consumers will use services. For example, the Center for African American Health in Denver hosts a diabetes awareness class that regularly fills to capacity, even though the program is publicized only through the faith-based community. Mainstream service providers in the same region have difficulty filling their diabetes maintenance classes, despite marketing through local healthcare providers.

Grantors and *providers* can use existing models as guides to create bridges between providers and their patients. Some health centers have successfully developed culturally based programs, such as the *Promotoras* model[8] developed in the Latino community and advocate or navigator models in other communities, all of which increase the cultural competency of a healthcare system and the trust that consumers have in it. Systemic models, like Medical Home and Systems of Care, indicate ways to connect a range of natural and formal system supports to meet the needs of diverse consumers.

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As some mainstream providers have already learned, the bridges between mainstream providers and diverse communities cannot be temporary. Too often, individual providers develop cultural competency and knowledge that is not transferred to the larger organization. When those providers retire or move, the capacity of the system to meet the needs of its diverse communities changes abruptly. *Public health schools*, *grantors*, *state agencies*, and *policymakers* who help to drive the direction of the healthcare system can institutionalize cultural competency and awareness. Ongoing training for providers and required institutional capacity can be part of how providers structure their practices. Permanent bridges also require a diversity of

healthcare practitioners from which consumers can choose, suggesting that recruitment programs that bring diverse practitioners and staff into the healthcare system are part of reconnecting patients and providers.

Bridges between mainstream and community *providers* are also important. Currently, many community healthcare providers feel that they compete with each other or with mainstream providers for the funds needed to provide education, advocacy, and direct services to those affected by health disparities. Taking the necessary time to build trust between community providers and mainstream systems may help to decrease competition and increase collaboration. It can also develop trust and shared goals between providers and communities. *Policymakers* can build bridges by ensuring that public healthcare funding like Medicaid and the Children's Health Plan Plus have sufficient flexibility to cover culturally traditional medical services, such as those provided in many Native American communities.

Overall, respect for and connections among multiple kinds of knowledge, shared by community providers, mainstream providers, researchers, and policymakers, are needed to address health disparities in Colorado.

Integration is when health and mental health policies go hand in hand.

Mental health and physical health integration has particular relevance to populations experiencing health disparities in part because these same populations can encounter context-specific stressors and anxieties, such as racism, ageism, discrimination from doctors or others in society, or internalized homophobia (self-hate). These stressors can contribute to increased prevalence of low self-esteem, anger, anxiety, depression, and suicidal thoughts.[9]

Mental health providers working with diverse communities recognize that mental health symptoms may manifest as physical health issues. This "somatization" of mental health needs is common in some cultures. Successful treatment occurs when providers recognize the physical symptoms and connect their clients to mental health services. Instead of treating services as primary and secondary, *policymakers*, *grantors*, and *providers* may find greater success when they recognize the equal importance of both physical and mental health.

> *Those managing the healthcare system and providing direct services will benefit themselves and their patients by increasing their partnerships with culturally diverse communities.*

them, and may never realize their eligibility for public insurance programs. *Policymakers* and *grantors* have addressed this disconnect by supporting health promotion activities designed and implemented by local communities, such as the health screening booths that the Colorado Asian Health Education and Promotion operates at cultural events throughout the Denver-metro area. These types of successful practices should be continued and expanded.

Integration is when health information is accessible inside and outside the formal healthcare system.

In rural areas where public health regions are very large, public health nurses face constraints different from their urban counterparts. A rural public health nurse cannot typically visit everyone who needs health information, nor is the nurse likely to be located in a place equally accessible to all rural constituents. Consequently, the *public health system* can enhance its promotion and prevention practices by partnering with the existing community infrastructure to ensure that information programs are accessible and accepted by local communities. Rural primary care physicians are an important part of this infrastructure, as they treat patients of all ages and health conditions.

In urban communities, providing health information through the formal medical system is not always sufficient. If consumers do not trust their mainstream health providers, they may never learn about the screening, prevention, and treatment services available to

Integration is about recognizing and adapting to different cultures and needs.

Each community is unique, and each culture has different strengths to draw upon. When approaches to health disparities are too prescriptive, whether due to legislation, funding policies, or provider practices, they limit the ability of the healthcare and related systems to build on the strengths of different cultural groups.

Many *providers*, *state agencies*, *policymakers*, and *grantors* address the need for "cultural competency" in a general way, with day-long classes or other all-purpose resources. For diverse communities, "cultural literacy" or "cultural awareness" are perhaps more appropriate descriptions, as no one can be competent in all cultures. Those managing the healthcare system and providing direct services will benefit themselves and their patients by increasing awareness of cultural issues, even as they recognize that cultural literacy includes building capacity to interact successfully with many cultures. Partnerships with cultural communities, in addition to classes or readings, can greatly enhance cultural literacy.

Policymakers and *grantors* can support this process through strength-based approaches, such as creating incentives for providers to interact with and learn from diverse communities.

2. Many differences exist within each broad category, and these differences are not trivial. For example, the census category of Asian/Pacific Islander includes Japanese, Korean, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, Other

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Excerpt: from *Coping in a World Not of Our Making – One American Indian Woman's Story*
As told by Theresa

For American Indians, discrimination has a long history, and unresolved grief plays out in the way in which we cope with life today. This historical trauma underlies many of the health and mental health challenges we face. My grandpa told me when I went to boarding school that I would be taught to be ashamed of who I was. He said I would be taught to forget our ancestors and our ways of living with the earth and the rest of creation. He told me about this because that is what they did to him at a boarding school in Pennsylvania.

My grandpa was a full blood Oglala/Sicangu Lakota who was a medicine man in training and was not supposed to be educated in the white man's ways. He was punished severely for speaking Lakota and practicing traditional ceremonies. Many of our medicine people were sent to mental hospitals because they heard and saw spirits when they were doing their healing ceremonies that put Native peoples back in balance.

The teachings of our ancestors are very important in keeping the circle whole. These teachings guide the delivery of care in a more holistic and less individualistic way. The collective approach works because if one person is sick in the family, everyone is sick.

People see our symptoms of alcohol and substance abuse and blame the victim, but they fail to see the historical trauma and unresolved grief. We must live with our enemy and we must cope in a world not of our making. There are many of us who will continue to practice the teachings of our grandfathers and grandmothers, so that our people may live for the next seven generations and beyond.

Excerpted from The Colorado Trust's online *Report on Mental Health Disparities*. December 2006. Online copies available at
http://www.thecoloradotrust.org/index.cfm?fuseaction=onlinePub.article&onlinePubID=12

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Many *researchers* fail to recognize the diversity of racial, ethnic, and cultural differences. The lack of specificity in data collection is a common concern across racial and ethnic communities, and also for the LGBT communities. Racial or ethnic data collection that only considers broad categories such as "African American" and "Asian/Pacific Islander" fails to recognize two important points:

1. Members of almost any racial or ethnic community may be from either the United States or another country. This difference in origin leads to disparate health needs and cultural expectations.

Pacific Islander, Asian Indian, Chinese, Filipino, and Other Asian.[10] Not only do the health problems of these different ethnic groups differ, due to historical traditions and geographical variations, but previous healthcare experiences and trust in formal healthcare systems will also differ based on the culture of origin.

When large data categories are used, researchers sometimes fail to capture physiological differences, as well. And because data is a bridge between providers and patients, missing data may prevent providers from recognizing the unique needs of the communities in which they practice.

The LGBT communities have a similar problem. Medical information forms rarely include a place to indicate sexual orientation or gender identity, and this missing data increases the potential for poor communication and, ultimately, poor service. Failure to collect the information also has consequences for research and funding, as data about the specific needs of LGBT populations is largely lacking. Without documenting sexual orientation and gender identity, demonstrating health disparities and identifying specific needs for these communities is difficult.

Unfortunately, when *researchers* connect to diverse communities and identify the full range of sub-populations, another problem arises. Unless the researcher is studying a very large population, it is likely that there will be too few people in the sub-populations to use some common data analysis techniques. Rural communities also experience this problem, as they often have too few people to analyze quantitatively. When addressing health disparities, the researcher's task is two-fold: to find other ways to study populations where the needs are high, even if the total numbers are low, and to educate *policymakers* and others about the value of qualitative findings in these situations.

Integration is about the diversity of staff at all levels.

While partnership with diverse communities is vital, disconnects will remain so long as the people who make policy and funding decisions, manage the system, and provide services do not reflect those in need of services. It is increasingly common to hear about the need for diverse providers, such as those who represent varied ethnic and cultural communities, the LGBT communities, or have personal experience with disabilities. Efforts to recruit and retain such

providers are underway, though more programs are needed. However, diversity can expand beyond providers. If the staff and board members at foundations, public agencies, and policymaking bodies reflect those affected by health disparities, the decision-making of those organizations may be more connected to the communities they seek to support.

As many organizations have learned from experience, successfully integrating diverse staff does not mean bringing in people who have different backgrounds and then asking them to adapt to mainstream culture. Rather, staff from diverse backgrounds need to be supported in remaining connected to and advocates for their own cultures and communities. The organization can help maintain this bridge by supporting the dual "hats" that such staff wear.

Communication: Opportunities for Learning and Collaboration

A lack of integration in the health arena can be at least partially attributed to disconnects in communication and collaboration among policymakers, public managers, grantors, mainstream providers, researchers, diverse communities, and consumers. When decisions are made without including directly affected stakeholders, those decisions are likely to have negative unintended consequences. Active communication can reconnect communities and patients with providers, policymakers, grantors, and researchers.

Communication is about starting early, before important decisions are made.

Most state agencies and foundations in Colorado create their own approaches to grant funding. One strength common to most *grantors* is the excellent communication, often including technical assistance, that occurs at two

important times in the funding process:

- When a request for proposals (RFP) is released; and

- When a community organization is funded.

Unfortunately, many important decisions are made prior to those two moments. Before releasing an RFP, *grantors* select funding priorities, set limitations on what will be funded, determine whether they will allocate any flexible funds to projects "outside the box," limit the years of funding permitted, determine the types of information required by the RFP, create the reporting and evaluation requirements for the grants, and set the time frame for responding to the RFP. Communities can experience disconnects between their needs and grantors' priorities and processes when these decisions are made with little or no communication. A well-intentioned grant oriented toward disease-specific service delivery can miss the mark for communities whose biggest needs include prevention, health promotion, community education, advocacy, support for collaborative efforts, and organizational capacity building. Communities also experience disconnects when RFPs prioritize the number of patients served. For some populations, such as those in rural areas or with specific disabilities, the needs are great even when the numbers are small.

Communities may also struggle to build the required collaborations during the short time between the RFP release and the grant deadline. A tight grant proposal timeline can be a serious impediment to building the trust necessary for a successful, inclusive collaborative effort. Communities engaged with grantors prior to the release of an RFP may also be able to identify additional needs.

Finally, communities may need support to collect data that demonstrates community needs. This

> *Ultimately, early communication in the funding process is a vital means of meeting community and patient needs.*

data is often necessary for service delivery grants. Communities may also require technical assistance in collecting the evaluation data required by grantors. Mutual respect and understanding is needed as well, since data collection can be slower in communities with less capacity, where realistic deadlines may be longer and the community may require more support than other grantees.

Ultimately, early communication in the funding process is a vital means of meeting community and patient needs. Early connections between *grantors* and the communities they seek to fund have tremendous potential to help grantors achieve even better results when addressing health disparities.

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Researchers can also improve their results by communicating with community members from the very beginning of their studies. Researchers make important decisions early on, formalizing the limits of the research question and the techniques they will use to answer the question. A researcher who fails to work with the community may come to culturally inappropriate conclusions. For example, researchers have shown that Latina teens have higher pregnancy rates then other groups, and suggested specific public health responses. However, researchers need to engage the affected communities to determine the appropriate public health response. If the community does not view all teen pregnancies as problematic, the traditional responses of abstinence or safe sex will likely fail. A public health intervention might instead focus on ensuring healthy futures for all teens, including those who have children, through programs that provide education, job opportunities, and prenatal care. Successful interventions occur more frequently when communities are connected to and involved in the research design and implementation.

Researchers have many tools available to increase their collaboration with diverse communities. Formal approaches such as Community Based Participatory Research[11] provide roadmaps with clearly defined principles for involvement, points within the research process where communities can engage, and

and champion appropriate health disparities policies. Many policymakers, for example, recognize that collaboration and conversation with stakeholders includes talking to groups across the state, not just those immediately available. They also recognize the need to connect beyond large mainstream or state

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Creating Inclusive Organizations
Arthur McFarlane II

Too often, people of color in organizations end up being "representatives" of their "group." There is no "group," but rather many diverse interests and communities. Psychologically, being a token sends the message that the organization doesn't value diversity—or value that individual. In practical terms, it means less time for people of color to do their assigned work, because they are constantly being harnessed as the token voice.

This gets right to the heart of disparities in the workforce: We must work to create more inclusive, diverse organizations. More healthcare workforce diversity can lead to:

- Better and more frequent communication with the communities that agencies serve.
- More trust between organizations and communities.
- Increased information sharing.
- Better programming and better service delivery.

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examples from previous studies. Unfortunately, if *grantors* do not recognize the importance of these participatory research approaches, they cannot be used, as they typically require more time and funding. For example, a research project that hires and trains community members to design and implement a survey might well require more initial time and funding than a traditional project. But the result may be better data. Members of the community will be trusted more than graduate students or other surveyors, and they will better understand and capture the context of the community. The improved data can lead to more informed policymaking and service provision. A second benefit is increased community capacity to address additional needs.

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Policymakers have become more skilled in working with affected communities to develop

agencies to engage individual consumers affected by health disparities and their culturally traditional providers and advocacy organizations. When education about health disparities occurs early in the policymaking process, policymakers will find more opportunities to create flexible healthcare policies that better accommodate diverse needs.

Communication is about continuous dialogue.

After new policies are made, it is important to engage communities in implementation and evaluation. True collaboration is continuous. *Policymakers* recognize this when they propose new legislation with an evaluation requirement that includes consumer satisfaction and community participation components. These evaluations help identify and address

unintended consequences, expand successful policies, and revise unsuccessful policies. This dialogue, however, must allow enough time for new policies or grants to succeed. Evaluations are important, but communities cannot be expected to show lasting change when a one-time evaluation occurs a year after a program begins. *Policymakers* and *grantors* can explore longer funding and evaluation periods to help communities make meaningful progress.

Continuous communication is important not only for policymakers, but also for *providers*. People with multiple and complex needs, a common occurrence in the disability and aging communities, can be overwhelmed by the multiple case managers and providers who are "gatekeepers" to different services. Ongoing communication among patients and their many providers, as well as communication among those providers, is necessary to ensure that the complexities of the system do not result in breakdowns of care. Ongoing communication between providers and with patients is also necessary due to the commonly used hospitalist model, where patients in hospitals for an extended time have doctors rotate off their cases every few days.

> *After new policies are made, it is important to engage communities in implementation and evaluation.*

One of the barriers to frequent and ongoing communication is high staff turnover in the healthcare system. The quality of the healthcare system is dependent upon the training and experience of staff. Decisionmakers at all levels can help retain health staff by improving compensation and work environments.

Communication is about learning and adapting to other cultures and expectations.

For some immigrants, health care is a much more private issue than in the United States; for others, health care is a community issue. *Providers* can support better patient health outcomes by approaching health care from the perspective of their patients, whether it means taking time to build trust so that patients can talk about their needs, or taking time to engage a patient's support network. Patients from the Native American communities or from other countries may have learned to fear and distrust any kind of authority.

Communicating directly with the patient, even when other family members are involved, is also an important part of treating the patient with respect, regardless of age or disability. Programs like the Consumer Directed Care program[12] for developmentally disabled patients allow consumers and their families to drive the dialogue and decisions with their providers. Similar empowerment can happen outside such targeted programs through providers who engage their patients in continuous communication.

For mainstream healthcare *providers*, culturally based agencies or advocacy groups that support those affected by health disparities can serve as a bridge to consumers. For example, providers who have developed cultural literacy around Asian cultures may better recognize that physical ailments are sometimes manifestations of mental health needs. Communication with diverse communities may also help providers to move toward building on cultural strengths to address their patients' needs. When providers communicate with and increase their understanding of diverse cultures, it typically improves their patients' compliance rates and follow-up visits, ensuring that needed treatment is received and avoiding potentially serious and expensive health problems.

Communication is about speaking the same language and understanding each other.

At the most basic level, *providers* and patients need to speak the same language. However, communication is about more than being linguistically competent, it is also about understanding each other. Interpretation is a largely unregulated profession; when interpreters lack medical knowledge, they cannot fully bridge the gap between provider and patient. When only some medical forms or materials are translated, patients have incomplete information. Patients who face complicated, confusing, or partial medical forms may find it more difficult to trust and interact with their providers.

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When *policymakers*, *grantors*, and *providers* use different jargon, not only can they fail to communicate successfully among themselves, they may also fail to communicate well with the communities and consumers they seek to help. For example, the definition of "community-based" may differ depending on the stakeholder who uses it. For a grantor or government agency, it may mean services that are delivered in the community, while a cultural organization may define it as services that are delivered by the community.

For communities, part of speaking the same language is having opportunities to learn about policymaking and funding processes. Although community representatives may be asked to testify in response to a specific piece of legislation, their involvement in the policy process is often limited. *Policymakers* can reconnect with communities by creating more opportunities for them to learn about and be

> *"Community-based" may differ depending on the stakeholder who uses it. For a grantor or government agency, it may mean services that are delivered **in** the community, while a cultural organization may define it as services that are delivered **by** the community.*

involved in the study of policy problems, the development of solutions, and the drafting and implementation of legislation. Successful policies will result from increased communication and collaboration between those most affected by the policy and the decisionmakers who can and do make a difference.

Conclusion: Overcoming the Disconnects that Lead to Health Disparities

Addressing health disparities is complex, but the first step is to improve the integration and communication among stakeholders. The need to recognize and engage the full diversity of voices, whether in policymaking, provision of services, or research was clearly expressed during our information collection process. Communities and consumers understand health disparities through a unique expertise that cannot be replicated or replaced by the knowledge of policymakers, government agencies, mainstream providers, researchers, or grantors.

Research that occurs without communication cannot accurately inform policy. When policy and funding occur without communication, they cannot appropriately support and drive practice. When service provision occurs without communication, it cannot improve the health outcomes of those most affected by health disparities. When healthcare changes occur without integration across systems, they address only a piece of the bigger problem. Communication and integration can foster comprehensive solutions to Colorado's health disparities.

Just as real as health disparities disconnects are the willingness and capacity of health system

stakeholders to reconnect. Throughout Colorado, providers and communities are actively addressing health disparities. They are pursuing grants, partnering with mainstream providers, talking to policymakers, hosting health fairs, developing educational materials, conducting screenings and assessments, and providing direct services. Any policymaker, researcher, grantor, or mainstream provider who reconnects with culturally diverse communities, including rural, aging, or LGBT communities, can play an important role in finding long-term solutions to health disparities.

Endnotes

[1] Adapted from the Colorado Interagency Health Disparities Leadership Council definition of health disparities, based on definitions provided by the National Institute of Health and other leading health organizations.

[2] The most commonly used definition of rural is by county. A county with a metropolitan statistical area (community with population of 50,000 or more) is considered metropolitan, or urban. Those counties without MSA's are usually considered rural. In many western states, there are counties designated as 'frontier.' A frontier county has six or fewer people per square mile. Over one third of Colorado counties (23 of 64) are designated as frontier.

[3] World Health Organization. *World Health Report 2000, Statistical Annex.* 2000. Available at: http://www.who.int/whr/2000/en/index.html. Accessed February 12, 2007.

[4] Colorado Health Foundation. *Colorado Health Report Card.* 2006. Available at: http://www.coloradohealth.org/welcome/. Accessed February 13, 2007.

[5] Hunsaker J, Krause EMS, Carrington JM, Hester NM. *Racial and Ethnic Health Disparities in Colorado 2005.* Denver, Co: CDPHE; 2005.

[6] Systems of Care is a model that emerged from the mental health system and is now more widely used. It advocates the partnership of multiple service agencies with families, working together to provide individualized care and supports designed to help children and families achieve safety, stability, and permanency in their homes and communities. Stroul BA, Friedman RM. System of Care Concept and Philosophy. In: Stroul BA, ed. *Children's Mental Health: Creating Systems of Care in a Changing Society.* Baltimore, Md: Paul H. Brookes Publishing Co.; 1996.

[7] According to the Colorado Department of Public Health and Environment, a "Medical Home is not just a building, house or hospital, but a team approach to providing health care. A Medical Home originates in a primary healthcare setting that is family-centered and compassionate. A partnership develops between the family and the primary healthcare practitioner. Together they access all medical and non-medical services needed by the child and family to achieve maximum potential." Available at: http://www.cdphe.state.co.us/ps/genetics/glossary.html. Accessed February 12, 2007.

[8] *Promotoras* refers to "a person who, with or without compensation, provides a bilingual liaison between healthcare providers and patients through activities that include assisting in case conferences, providing patient education, making referrals to health and social services, conducting needs assessments, distributing surveys to identify barriers to healthcare delivery, making home visits, and providing language services." Available at: http://www.dshs.state.tx.us/rls/chw/pubs/HSCChapter48010803.pdf Accessed February 13, 2007.

[9] The Center for Systems Integration & Bridging Cultures, Improving Performance. *Policy Brief on Mental Health Disparities in Colorado.* Denver, Co: The Colorado Trust; 2007.

[10] Grieco EM, Cassidy RC. Overview of Race and Hispanic Origin. In *Census 2000 Brief.* 2001.

[11] Community-based participatory research is a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities." Available at: http://www.sph.umich.edu/chsp/program/index.shtml Accessed March 20, 2007.

[12] More information about Colorado's Consumer Directed Care program is available at the Consumer Directed Attendant Support Program website: http://www.chcpf.state.co.us/HCPF/Syschange/cdas/cdasindex.asp Accessed March 7, 2007.

Appendix
Organizations Represented in Health Disconnects Community Meetings

Allied Jewish Federation of Colorado

The Arc of Colorado

Asian Pacific Development Center

Boulder County Aging Services Division

Centennial Colorado Area Health Education Center

The Center

Center for African American Health

La Clínica Tepeyac

Colorado Anti-Violence Program

Colorado Asian Health Education and Promotion

Colorado Association of Local Public Health Officials

Colorado Community Health Network

Colorado Consumer Health Initiative

Colorado Department of Public Health and Environment

Colorado Health Foundation

Colorado Health & Hospital Association

Colorado Gerontological Society

Colorado Organization for Latina Opportunity and Reproductive Rights

Colorado Progressive Coalition

Colorado Rural Health Center

Denver Indian Family Resource Center

Denver Two Spirit Society

Family Voices of Colorado

Gill Foundation: Gay & Lesbian Fund for Colorado

Inter-generational Full Circle Project

Jewish Family Service of Colorado

The Legal Center for People with Disabilities and Older People

Mile High United Way

Moffat Family Clinic

Rocky Mountain Prevention Research Center

Rose Community Foundation

Rural Communities Resource Center

Senior Answers and Services

Spanish Peaks Regional Health Center

Spring Institute for Intercultural Learning

Swedish Medical Center

University of Colorado Health Sciences Center

University of Colorado Hospital

Valley-Wide Health Systems

Western Colorado Area Health Education Center

9News USA TV

Bringing Health Disparities into Public Policies and Practices

A Template for Initiating and Expanding Dialogue

As Colorado moves forward with healthcare reforms, both comprehensive and targeted, integrating a discussion of health disparities into policy and practice dialogues can lead to more successful outcomes. *Health disparities* can be understood as persistent differences in health outcomes (i.e., access, disease, disability, and death) across many areas of health over time because of race, ethnicity, gender, gender identity, sexual orientation, geography, environment, workplace, education, or socioeconomic status.

This template can be used by:

- *Individuals* seeking to better understand a policy or practice from the perspective of health disparities.

- *Groups and organizations*, including legislatively mandated commissions and councils, seeking to better understand each other's perspectives on health disparities within the context of policies and practices.

- *Policymakers* seeking to build bridges with communities and other stakeholders as they address health disparities.

This template can be used with:

- Policies and practices that *have implications for health outcomes*, such as healthcare reform, other healthcare, human services, education, transportation, employment, housing, public safety, and public assistance policies, as well as other policies that might have intended or unintended health consequences.

- Policy and practices *of many types*, such as bills, statutes, regulations, state or local agency practices, grantor policies, or programs in public and private settings.

This template can be used to:

- *Develop new policies* and practices that incorporate key health disparities issues.

- *Explore existing policies* and practices to ensure that health disparities issues are included and identify areas for improvement.

- *Create dialogues* between diverse stakeholders to explore differing perceptions of new or current policies and practices.

Template components include:

- *Questions*: Questions are based on themes from the CIPP policy brief, *Connecting Colorado*. Each question illuminates important components of policies and practices.

- *Scoring*: Scores range from 1 to 3 as described below. Each person or group may score the same policy differently. Exploring why the scores are not the same is an important part of policy dialogue.
    - **1**: The policy addresses the question.
    - **2**: The policy addresses elements of the question; there is room for improvement.
    - **3**: The policy has not addressed most or all elements of the question.

- *Comments*: Comments allow groups to share different perspectives on the same policies in greater detail.

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Policy/Practice: _____

	Questions	Scoring	Comments
1.	**Integration: To what extent...**		
a.	Does the policy bridge different policy systems, such as transportation and health? If not, should it? What systems could be included?	1 2 3	
b.	Does the policy address existing policies that are duplicative, conflicting, or otherwise overlapping?	1 2 3	
2.	**Communication: To what extent...**		
a.	Does the policy include engagement of diverse communities and consumers in the implementation of the legislation?	1 2 3	
b.	Does the policy include an evaluative component? If so, does it engage communities and consumers in the evaluation?	1 2 3	
c.	Is there a mechanism for providers and diverse communities to learn from one another?	1 2 3	

Template term definitions (alphabetical, based on the *Connecting Colorado* Policy Brief)

Community and culturally based groups are providers and other organizations who are based in local, and sometimes diverse, communities. They are staffed by and supported by the community members.

Community involvement is the engagement of local and diverse stakeholders, including consumers, who are directly affected by policies, through active participation in meetings, decision-making, review of materials, or other key activities.

Culturally traditional services are healthcare and other services that emerged from diverse communities and may not exist within the mainstream health system. For example, sweat lodges are a historically and culturally traditional response to health and mental health needs in some Native American cultures.

Diverse communities include Asian American Pacific Islander, African American, Native American, Latino, lower income, disabled, aging, LGBT (lesbian, gay, bisexual, and transgendered), and rural communities, all of whom are affected by health disparities.

Engagement is when stakeholders have an opportunity to inform and participate fully, including being part of advisory or governance boards and providing early and ongoing input on many aspects of the policy.

Evaluative components are the mechanisms for stakeholders, including policy implementers, to determine if a policy is meeting its intended goals such as formal evaluations, audits, and public feedback opportunities.

Flexible funding is when funding streams ensure accountability through outcomes or performance measures, rather then sharply limiting the types of needs that the funds can cover. Flexible funding is more likely to meet diverse needs and achieve good outcomes then narrowly defined funding streams.

Colorado Institute of
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Policy/Practice: _____

	Evaluation Questions	Scoring	Comments
3.	**Policy Process: To what extent…**		
a.	Were diverse stakeholders involved in developing the policy, including those outside the Denver-metro area?	1 2 3	
b.	What type of research, if any, is the bill based on? For example, who lead the research and how was the community involved?	1 2 3	
4.	**Funding, Financing, and Budgets: To what extent…**		
a.	Does the policy increase or decrease the complexity of funding streams like Medicaid or grant programs?	1 2 3	
b.	Does the policy create a flexible funding stream or increase the flexibility of existing funding streams?	1 2 3	
c.	Does the policy encourage or allow funding for culturally traditional services?	1 2 3	
d.	Does the policy encourage or allow provision of integrated services by community and culturally based groups?	1 2 3	

Template term definitions (alphabetical, based on the *Connecting Colorado* Policy Brie**f)**

Funding streams are the mechanisms by which policies and practices are publicly or privately funded.

Implementation of a policy is the ongoing process of putting in place and governing the people, equipment, activities and other components of a policy to accomplish the intended goal.

Mechanisms for learning in this context could be joint training sessions, shared governance roles, co-located staff, or any other approaches that help differing stakeholders learn about and with each other.

Policies (and practices) include such things as bills, statutes, regulations, state or local agency practices, grantor policies, programs in public and private settings,

Providers include mainstream and community-based organizations providing health promotion, screening, treatment, and other services.

Research is the methodical collection and analysis of information that helps to understand a problem and/or possible solutions, including evaluations, health epidemiology studies, and academic studies. "Evidence-based" research is often called for by policymakers, but it can be too narrowly defined to include the holistic solutions to health disparities that communities believe are needed. Community-based participatory research is another type of research. It engages communities fully in the design, implementation, and reporting of research findings.

Systems, in this context, are the multiple policy domains that are relevant to health disparities, such as health and health financing, human services, education, transportation, employment, housing, public safety, and public assistance, criminal justice, and many others.

Colorado Institute of
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Bringing Health Disparities into Public Policies and Practices
A Template for Initiating and Expanding Dialogue

Tell me more. The Colorado Institute of Public Policy brief, *Connecting Colorado: Overcoming the Disconnects that Lead to Health Disparities*, provides insight on the diverse array of issues that contribute to health disparities. Over 50 community leaders serving and representing Asian, African American, Native American, Latino, lower income, disabled and aging, LGBT (lesbian, gay, bisexual, and transgendered), and rural communities.

A lack of integration and breakdowns in communication between communities and decision makers were the overwhelming themes of many dialogues. The policy brief represents the synergy of concerns around disconnects and the ways in which to reconnect. The key integration and communication disconnects are:
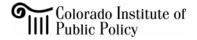
> **Integration**, in the context of health disparities, is about recognizing the many facets of the problem. Health disparities go beyond just healthcare issues, and they cannot be solved by the healthcare system alone. Affected communities are essential to finding solutions and improving outcomes. Specifically, integration:

> - Moves beyond the healthcare system to create holistic policy solutions;
> - Bridges mainstream providers and diverse communities;
> - Ensures that health and mental health policies go hand in hand;
> - Makes health information accessible inside and outside the healthcare system;
> - Recognizes and adapts to different cultures and needs; and
> - Creates diverse staff at all levels.

> Improving **communication** underlies many of the possible solutions to health disparities and the absence of appropriate communication can be detected in the disconnects that exist among stakeholders. Legitimate communication:

> - Starts early, before important decisions are made;
> - Maintains continuous dialogue, not one-time opportunities to connect;
> - Learns and adapts to other cultures and expectations; and
> - Helps partners speak the same language and understand each other.

Why a template? This is a "hands-on" practical tool to encourage effective problem solving within a group and among multiple stakeholders. It is also a work in progress. Please go to the CIPP website www.cipp.colostate.edu/people to view the most recent version and download the policy brief.

Colorado Institute of
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About the Colorado Institute of Public Policy

The Colorado Institute of Public Policy (CIPP) at Colorado State University was created to provide information for effective public problem solving. It brings together local practitioners and academic researchers to contribute to public policy discourse involving interactions among the environment, agriculture, and people in the Rocky Mountain West. More information is available online at www.cipp.colostate.edu.

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