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# Toward Health Equity for Asian American, Native Hawaiian, and Pacific Islanders: The Health Through Action Model

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**Keywords:** Health equity, health disparities for communities of color, capacity building, philanthropic investments in communities of color, racial equity, community capacity, advocacy capacity, Asian American, Native Hawaiian, and Pacific Islander communities

## Key Points

- Since 2009, the W.K. Kellogg Foundation has invested over \$100 million to foster racial healing and eliminate policies, practices, attitudes, and cultural messages that reinforce differing outcomes by race.
- Health Through Action represented an unprecedented level of investment targeting AA and NHPs. Embedded within the WKKF racial equity portfolio, it was the first time a private-sector foundation joined forces with a national AA and NHPI organization to acknowledge and address health disparities facing this population.
- HTA provided direct grants to seven AA and NHPI collaboratives and 11 AA and NHPI anchor organizations around the country to advance programmatic and advocacy health equity goals. Beyond these core grants, APIAHF flexibly directed additional resources toward a gamut of support that included national or regional trainings; customized technical assistance, tools and resources; and informal advice and coaching.
- Just four years later HTA partners were reporting meaningful progress toward increased community capacity to address AA and NHPI health disparities, with a couple of grantees rating gains made over the past four years as starting to “transform” local systems of care for AA and NHPs.

The mission of the W.K. Kellogg Foundation (WKKF) calls for “supporting children, families, and communities as they strengthen and create conditions that propel vulnerable children to

achieve success as individuals and as contributors to the larger community and society.” As Gail Christopher, WKKF vice president of program strategy, points out, in a society where children of color are disproportionately represented among the most vulnerable, identifying and removing racial barriers to equal opportunity “requires that, collectively, we heal the nation’s legacy of racism” (WKKF, 2013). In 2007 WKKF’s board of directors committed the foundation to being “an effective antiracist organization that promotes racial equity,” and in 2009 “racial equity” became a distinct program category that has to date invested upwards of \$100 million in fostering racial healing and eliminating policies, practices, attitudes, and cultural messages that reinforce differing outcomes by race.

Notably, all grantmaking at WKKF emphasizes not only a commitment to racial equity, but also a simultaneous commitment to community and civic engagement. The foundation acknowledges this dual commitment as critical to supporting communities in creating the conditions under which all children can thrive. This approach is aligned with growing acknowledgement in the field that transformation of systems of inequity must simultaneously incorporate a racial lens and be driven by communities of color and their allies (Keleher, 2012; Perry, 2012; Inouye, Estrella, & Foley, 2010).

Community-centered change can ensure that policy change is authentically informed by the

voices and needs of the communities it purports to serve (Themba, 2012; Pastor & Ortiz, 2009; Popchuk, 2006), but also then requires investments in building community capacity – particularly within communities of color – to serve as effective change agents toward this end. In fact, capacity building of change agents has been emphasized as critical in order to “reach sufficient scale to make a significant dent in socioeconomic or racial inequity” (Virtue, 2010, p. 5). Thus, true progress toward racial equity cannot simply be measured by policy wins that advance racial justice goals, but also by the strengthened capacity of individuals, organizations, and communities to engage in and shift the public discourse that shapes their lives.

This article offers findings and lessons learned from the WKKF’s \$16.5 million investment in capacity building via Health Through Action (HTA), a five-year initiative aimed at building capacity at the grassroots, regional, and national levels to address health inequities facing Asian American, Native Hawaiian, and Pacific Islander families and children. The HTA model provides an opportunity to examine how strategic investments in capacity building can strengthen community capacity and give voice to complex and diverse populations that are often overlooked or excluded from critical health disparity dialogues.

### **The Asian American, Native Hawaiian, and Pacific Islander Context**

The Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) population encompasses almost 19 million Americans who trace their heritage to more than 50 countries, speak more than 100 languages, practice a wide range of religious beliefs, and come from countless cultural traditions. The fastest growing racial or ethnic group, AA and NHPIs add a rich tapestry of history, beliefs, and traditions to our increasingly diverse U.S. culture. The extreme diversity within this population, however, also poses significant challenges to assessing and ensuring its health and well-being.

Data aggregated across such a wide range of people has made it challenging to identify health trends; this is exacerbated by chronic disease studies that fail to accommodate limited-English speakers in their data-collection methods (Wong,

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Gildengorin, Nguyen, & Mock, 2005). The limited data that exists on AA and NHPI health, however, suggest that AA and NHPIs are experiencing a wide range of health disparities stemming from a mix of poverty, cultural barriers, and language-access challenges that prevent them from obtaining health insurance and high-quality health care. Members of this population have higher rates of preventable diseases such as hepatitis B, tuberculosis, and certain cancers than do other racial groups (Asian Pacific Islander American Health Forum, 2009). Cancer is the leading cause of death for Asian Americans (Chen, M. 2005; Department of Health and Human Services, 2013), yet screening rates for cervical and colon cancers among Asian Americans have been among the lowest in the country (Department of Health and Human Services, 2007). Native Hawaiians and Pacific Islanders face disproportionately high rates of diabetes, estimated to be triple the rate of whites, and they are seven times more likely to be diagnosed with chronic liver disease than whites (Department of Health and Human Services, 2013). Nearly one in five AA and NHPIs lack health insurance, and 2010 census figures indicate Asians were the only racial group that had a statistically significant increase in its rate of uninsured people (DeNavas-Walt, Proctor, & Smith, 2009, 2011).

*Community leaders note that AA and NHPIs, perceived as a “quiet” minority group, have traditionally not been a part of critical health-policy discussions – both because of their low overall visibility and because the dire health status of smaller, vulnerable ethnic subpopulations is masked within aggregated data.*

Addressing these disparities has presented another layer of challenge. Community leaders note that AA and NHPIs, perceived as a “quiet” minority group, have traditionally not been a part of critical health policy discussions – both because of their low overall visibility and because the dire health status of smaller, vulnerable ethnic subpopulations is masked within aggregated data. Raising voices for change and gaining a meaningful seat at policymaking tables has also been a barrier for AA and NHPIs given large numbers of first- and second-generation AA and NHPIs, some of whom come from countries without a strong democratic tradition and are therefore new to western practices of political representation and advocacy. Many AA and NHPI immigrants and refugees – and the organizations that support them – are still struggling to cover basic survival needs and thus have little to no capacity for advocacy.<sup>1</sup>

<sup>1</sup> Yen Le Espiritu's *Asian American Panethnicity: Bridging Institutions and Identities* (1992, Temple University Press) provides a detailed history of the origins of the Asian American panethnic racial category (which has since morphed into an even bigger and more complex AA and NHPI category). The book offers rich discussions of the power that can come from advocating within a panethnic identity as well as the challenges that arise for the individual communities that are “lumped” together under such a broad label. The authors of this article also developed a learning paper that explores current issues in AA and NHPI panethnic coalition building (Inouye & Estrella, 2012):

### Health Through Action for AA and NHPIs

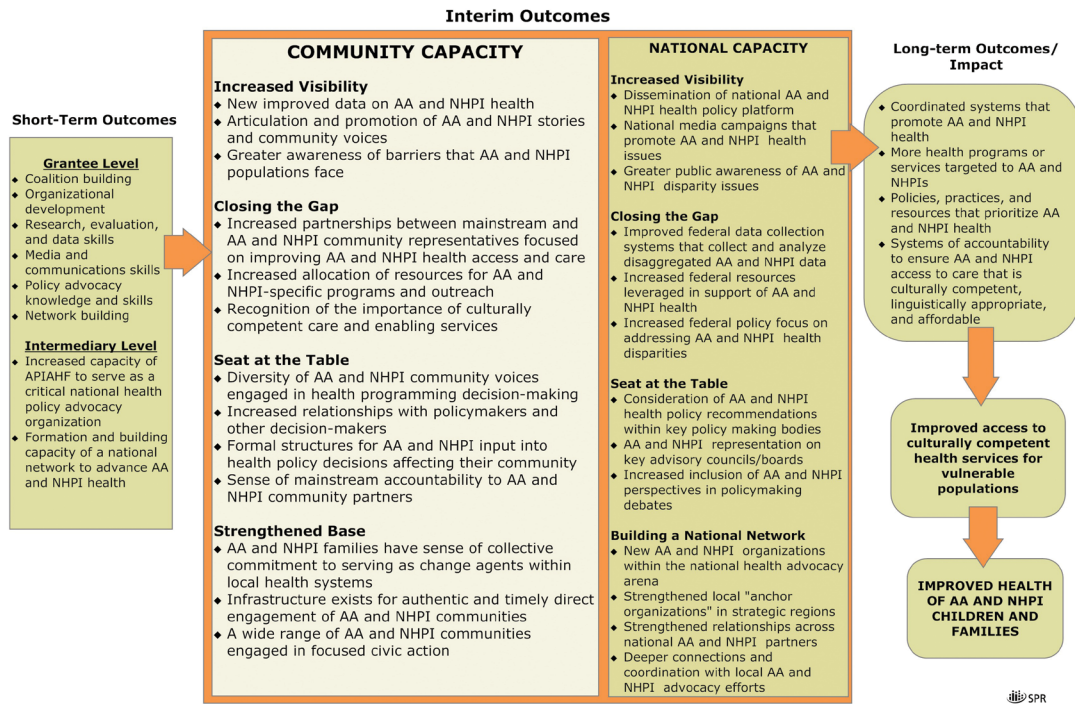
Launched in 2007, Health Through Action represented an unprecedented level of investment targeting AA and NHPIs. Embedded within the WKKF racial equity portfolio, it was the first time a private-sector foundation joined forces with a national AA and NHPI organization to acknowledge and address health disparities facing this population.

The capacity-building focus came from the community itself. Prior to HTA's launch, the foundation convened a listening session with longtime AA and NHPI health leaders who specifically described a need for capacity building in six key areas: (1) coalition building; (2) organizational development; (3) research, evaluation, and data analysis; (4) strategic communications; (5) policy advocacy; and (6) network building. “These areas,” explained Al Yee, the original WKKF program officer for HTA, “were shared as what was needed to get [the AA and NHPI community] to a point where they could be stronger advocates for health for their local communities and on a national level” (Inouye, Law, & Estrella, p. II-13).

With the Asian Pacific Islander American Health Forum (APIAHF) as a regranting and technical assistance intermediary, HTA provided direct grants to seven AA and NHPI collaboratives and 11 AA and NHPI anchor organizations around the country to advance programmatic and advocacy health-equity goals. Beyond these core grants, APIAHF flexibly directed additional resources toward a gamut of support that included national or regional trainings; customized technical assistance, tools and resources; and informal advice and coaching. Capacity building focused on the six areas described previously, provided by a mix of national and local consultants and trainers as well as APIAHF staff. Support was intentionally unstructured to honor “where grantees were at” and accommodate the wide range of baseline capacity within HTA communities.

Throughout, APIAHF also biannually convened all grantees to share challenges and promising

<http://www.spra.com/admin/PDFFile/hta%20building%20panethnic%20coalitions%20paper.pdf>

**FIGURE 1** Health Through Action Evaluation Framework

strategies and ultimately build a robust AA and NHPI health-equity network. The grantees also leveraged their growing advocacy capacity and collective power by participating in national advocacy campaigns. Through HTA, the APIAHF itself also received a portion of resources to build its own capacity as a national advocacy leader charged with advancing a national policy agenda aimed at improving the health and well-being of AA and NHPI communities.

### HTA Evaluation Framework

HTA was ambitious in magnitude and scope, focusing on simultaneously building the capacity of individuals, organizations, regional coalitions, and national networks as a strategy for addressing persistent health inequities facing AA and NHPI families and children. To capture this complexity, Social Policy Research Associates (SPR) developed a multilevel evaluation framework. (See Figure 1.)

The innovation within this framework lies in an articulation of interim outcomes highlighted in

the middle of the framework. These are theorized to be (1) the logical results of investments in individual skill building and organizational development, and (2) important community-level precursors to shifts in policy and practice that meaningfully address systemic inequities. While the importance of community capacity has been raised as a factor in building racial justice movements, specific measures for what this "capacity" looks like – broadly and within the AA and NHPI community in particular – have largely been unexplored.

This article therefore focuses on highlighting HTA's intermediate, community-level outcomes:

- How did strategic investments in organizational and collaborative capacity building lead to shifts in how communities were positioned to advance change?
- Within HTA, what is the evidence that advocacy skill building led to increased visibility of AA and NHPI community health contexts

## *The focus was also on the larger “so what” of WKKF’s multimillion-dollar capacity-building investment. How did these changes in knowledge and skills link to larger, long-term goals of addressing health disparities facing AA and NHPI children and families?*

and concerns and to changes in the quality and availability of AA and NHPI health data, greater attention to AA and NHPI health disparities, and targeted resources for closing the disparity gap?

- How did these investments lead to more “seats at the table” for AA and NHPI community leaders and a strengthened panethnic community base of support? How did this translate to AA and NHPIs having a meaningful voice in the policy debates that affect the health of their families and children?

Findings reported in this article draw upon a wide range of primary and secondary data gathered over the course of this five-year, multilevel cluster evaluation. Among the key data were baseline and final site visits to HTA grantees, annual telephone interviews with grantees and APIAHF staff, biannual observations of key HTA meetings, grantee capacity surveys administered at three points in the grant period, semiannual grant reports, and two rounds of interviews with national health advocates, academic researchers, and federal agency representatives to gain an external perspective on the impact of HTA.

### **Results: From Strong Collaboratives to Stronger Communities**

At the close of this initiative, grantees unanimously agreed that HTA helped strengthen their capacity to address health disparities in their

communities.<sup>2</sup> While the scope of this article precludes us from sharing a detailed account of the specific changes in knowledge and skills over the course of HTA, the cluster evaluation documented greater organizational stability across almost all HTA partners as well as the formation of sustainable, regional AA and NHPI health collaboratives across the country. Moreover, pre- and post-capacity survey results reveal that a strong majority of grantees demonstrate increased knowledge and skills in the six targeted capacity areas articulated on the left-hand side of the HTA evaluation framework (see Figure 1.)

While these presented critical short-term evidence of success, the focus was also on the larger “so what” of WKKF’s multimillion-dollar capacity-building investment. How did these changes in knowledge and skills link to larger, long-term goals of addressing health disparities facing AA and NHPI children and families?

To address this question, SPR analyzed changes in HTA community capacity (see Figure 2) using an evaluation tool that borrowed a 15-point scale used by the Annie E. Casey Foundation’s Making Connections initiative. The tool measured community change in five distinct developmental stages:

1. Maintaining business as usual,
2. Building awareness of and demand for change,
3. Exploring new approaches and small-scale changes,
4. Refining, coordinating, and increasing the impact of strategies, and
5. Effective approaches taking hold and transforming business as usual.

<sup>2</sup> In discussing results, we are narrowly focusing on communities where the HTA four-year collaboratives were embedded, given the level of financial and technical assistance support for these grantees (\$150,000 a year for four years). These collaboratives were in Hawaii, California, Arizona, Ohio, Texas, Georgia, and New York.

FIGURE 2 HTA Community Capacity Scoring Tool

	Maintaining Business as Usual			Building Awareness of and Demand for Change			Exploring New Approaches and Small-Scale Changes			Refining, Coordinating, and Increasing the Impact of Strategies			Effective Approaches Taking Hold and Transforming Business as Usual		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Visibility	<ul style="list-style-type: none"> <li>AA &amp; NHPIs are largely an 'invisible' population.</li> <li>A sense persists that AA &amp; NHPIs are the 'model minority' when it comes to health.</li> <li>Health systems believe that that AA &amp; NHPI population numbers do not yet present a 'critical mass' to warrant specific attention or resources.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI communities are engaged in education efforts and beginning to tell their stories via, for example, digital story banks.</li> <li>The mainstream community is beginning to acknowledge the diversity of AA &amp; NHPI populations.</li> <li>Health systems are starting to understand shortcomings of aggregated data.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI community partners are actively working to place stories in local media or journals.</li> <li>AA &amp; NHPI community partners are generating new data on AA &amp; NHPI health (e.g., through surveys or analysis of existing data).</li> <li>AA &amp; NHPI community partners are seeking out opportunities to present at non-AA &amp; NHPI conferences or meetings.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI community is engaged in strategic and coordinated communications efforts to promote AA &amp; NHPI perspectives in policy debates affecting them.</li> <li>AA &amp; NHPI community organizations are positioned as 'go to' resources on AA &amp; NHPI health.</li> <li>Issues and needs of the most vulnerable AA &amp; NHPI ethnic subpopulations are expressed.</li> </ul>			<ul style="list-style-type: none"> <li>Mainstream health systems and policymakers prioritize AA &amp; NHPI issues and needs, irrespective of the perception of size of population relative to other racial and ethnic groups.</li> <li>Broader community has an understanding of the diversity of AA &amp; NHPI populations, their assets, and the challenges they face.</li> </ul>		
Closing the Gap	<ul style="list-style-type: none"> <li>Local community places little focus on health disparities facing local AA &amp; NHPI populations and/or underestimates health disparity risk factors.</li> <li>Few resources exist to address AA &amp; NHPI barriers to care (e.g., translated material, in-language outreach).</li> <li>Data are not systematically gathered on AA &amp; NHPI health and/or not disaggregated by ethnic subpopulation.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI partners are exploring replicable strategies/models for addressing root causes of AA &amp; NHPI health disparities.</li> <li>AA &amp; NHPI partners are exploring collaborations that bridge culturally based care.</li> <li>AA &amp; NHPI partners are beginning to externally make the case for addressing disparities (e.g., through research, white papers, advocacy, education campaigns).</li> </ul>			<ul style="list-style-type: none"> <li>Investments being made in ethnic specific-service partners to support their capacity to facilitate culturally based education and services.</li> <li>Active coordination of services is beginning to address medical and cultural dimensions of health.</li> <li>Culturally appropriate health outreach and education is leading to increased community-member knowledge of health prevention strategies.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI community organizations are serving as strong culturally based service partners within local communities.</li> <li>Community partnerships are being formalized through shared resources, memorandums of understanding, etc.</li> <li>Culturally based outreach and service strategies are replicated.</li> <li>New programs or clinics focused on AA &amp; NHPI community health are explored and pursued.</li> </ul>			<ul style="list-style-type: none"> <li>Evidence exists of sustainable long-term collaboration focused on improving AA &amp; NHPI health access and care.</li> <li>New and improved systems exist for gathering, analyzing, and reporting disaggregated data on AA &amp; NHPI health.</li> <li>Meaningful levels of resources are funneling down to programs and services targeted to AA &amp; NHPI health.</li> <li>AA &amp; NHPI families are taking specific actions to promote their health.</li> </ul>		
Seat at the Table	<ul style="list-style-type: none"> <li>Health system decision-makers (policymakers, public health system representatives, medical system administrators, etc.) are largely unaware of AA &amp; NHPI community organizations.</li> <li>AA &amp; NHPI community organizations are primarily focused on program implementation and see little value in engaging in broader systems change work.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI partners are beginning to actively voice community concerns across a range of local and regional health-related groups.</li> <li>Regular AA &amp; NHPI advocacy begins resulting in two-way communication with key decision-makers with jurisdiction over AA &amp; NHPI health.</li> </ul>			<ul style="list-style-type: none"> <li>Health system decision-makers are initiating contact with AA &amp; NHPI groups to provide one-time input on policy development or implementation.</li> <li>AA &amp; NHPI community representatives are called upon as advisors and community partners within local health systems.</li> </ul>			<ul style="list-style-type: none"> <li>Formal structures are put in place for regular AA &amp; NHPI input into health policy decisions affecting community members (e.g., advisory councils, standing meetings).</li> </ul>			<ul style="list-style-type: none"> <li>A sense of mainstream health system accountability to AA &amp; NHPI partners exists.</li> <li>AA &amp; NHPI partners feel confident that the diversity of AA &amp; NHPI voices are being represented in decision-making on health policy and programs.</li> </ul>		
Strengthened Base	<ul style="list-style-type: none"> <li>Networks of AA &amp; NHPI organizations are loose or nonexistent and individuals have little sense of common mission.</li> <li>AA &amp; NHPI populations are generally unaware of systems or policies that affect their ability to access quality care and realize optimal health.</li> <li>AA &amp; NHPI populations only rarely advocate for community issues with federal, state, and local officials.</li> </ul>			<ul style="list-style-type: none"> <li>More networks of AA &amp; NHPI community organizations establish ties to AA &amp; NHPI families and individuals with a shared sense of mission for change.</li> <li>More AA &amp; NHPI individuals have greater knowledge of health systems and how to navigate them.</li> <li>More AA &amp; NHPI individuals are trained to be change agents within local health systems.</li> </ul>			<ul style="list-style-type: none"> <li>AA &amp; NHPI individuals and families are periodically engaged in focused civic action (e.g., letter-writing campaigns, social media campaigns, testimony).</li> <li>AA &amp; NHPI organizations are piloting strategies for building and mobilizing a base for change (e.g., strategic partnerships, networking, social media).</li> </ul>			<ul style="list-style-type: none"> <li>Infrastructure exists for quickly communicating with and mobilizing regional AA &amp; NHPI communities.</li> <li>Tested tools, strategies, and tactics can be drawn upon to maximize efficiency in ongoing advocacy.</li> <li>Efforts are focusing on building capacity of individuals from the AA &amp; NHPI community to lead change efforts.</li> </ul>			<ul style="list-style-type: none"> <li>A broader AA &amp; NHPI community culture of empowerment and action exists, prompting advocacy on a range of issues.</li> <li>A sustainable network of AA &amp; NHPI community organizations exists, with a sense of collective mission to advance AA &amp; NHPI health.</li> <li>AA &amp; NHPI communities feel connected to national AA &amp; NHPI health movements.</li> </ul>		

Using this rubric, we then took the four theorized measures of community capacity – increased visibility of AA and NHPIs and their health issues, greater acknowledgment and focus on closing the

gap of AA and NHPI health disparities, increased AA and NHPI seats at the table, and a strengthened base of AA and NHPI community support – and laid them along the 15-point continuum.

### Stories of Success: Increased Visibility

- In Texas, as a result of HTA-funded cancer screenings, the “State of Health: Houston and Harris County” report for 2009 was able to include comparative infection and incidence data on Asians for the first time.
- In Georgia, after being left out of a 2008 state-level report on racial health disparities, the HTA coalition collected 1,200 in-language surveys on health-access experiences of 12 Atlanta-area ethnic communities. The state subsequently used this data to publish an addendum to its disparities report on AA and NHPIs.
- Arizona’s HTA coalition, in partnership with Arizona State University, published a widely disseminated 2011 *Data Book on the State of Asian Americans and Pacific Islanders in Arizona*.
- Bangladeshi, Nepalese, Chinese, Filipino, Japanese, Korean, Pakistani, and Vietnamese community health concerns were gathered into a 2011 policy report that informed New York policymakers about the potential impact of the Affordable Care Act on the state’s AA and NHPI population.
- Ohio’s HTA coalition gathered data and developed the first *Report on the Status of Ohio’s Asian and Pacific Islanders*, which was presented to the governor in 2010.

Using evidence of success emerging from across HTA communities, SPR developed specific indicators of progress that were grouped into the five developmental stages of the Making Connections tool.

At the close of HTA, collaborative leaders assessed their community capacity in 2012 and, after reviewing baseline evaluation data gathered on their community, also assigned a score to their capacity when HTA was launched in 2007. The self-assessment scores from each collaborative were then triangulated against scores independently assigned by SPR and by APIAHF staff, and then recalibrated. The final, recalibrated scores measured community capacity at baseline in 2007 and at the close of the grant in 2012. Using qualitative analysis software, SPR also systematically reviewed and coded all grantee reports, docu-

menting 842 examples of activities and outcomes that served as supporting evidence of increased community capacity across the four intermediate outcome areas over the course of HTA.

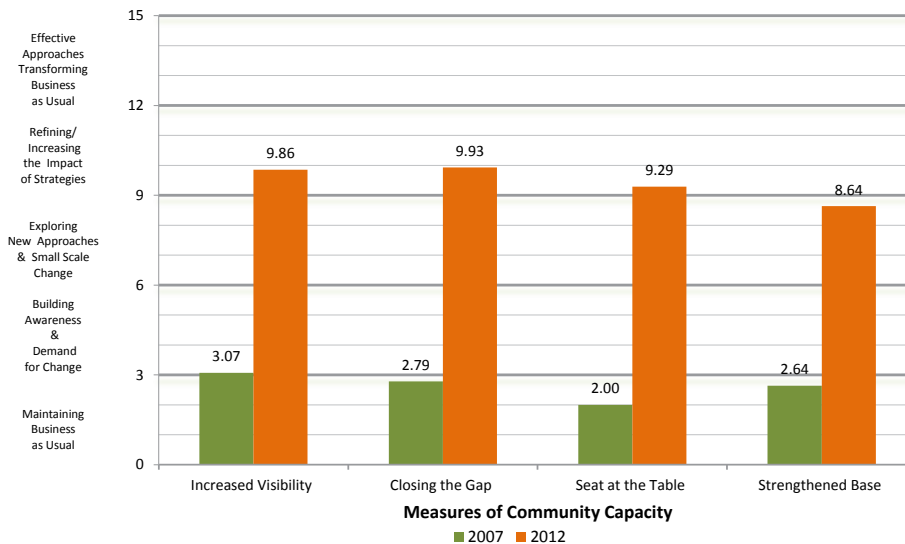
The results are striking (see Figure 3). When HTA was launched in 2007, HTA collaboratives reported that, on average, their communities had little capacity to address the health and well-being of AA and NHPI populations, with scores ranging from 2 to 3.5 reflecting communities “maintaining business as usual.” By 2012 almost all communities reported a complete transformation. On average, as a cohort, the final community capacity scores fell in the range of 8.5 to 10, at the high end of the “exploring new approaches and small-scale changes” category. In some cases, collaboratives reported multifold increases of 300 percent to 400 percent over baseline.

To illustrate the depth of this transformation, the following four sections present a more detailed analysis of changes within each dimension of community capacity.

#### *Interim Outcome No. 1: Increased Visibility of AA and NHPI Health Issues*

In 2007 one of the most commonly cited challenges was a lack of “visibility” of AA and NHPI populations and their health issues. Some community leaders described the challenge as a lack of “critical mass” in terms of population numbers to warrant health system attention or resources. Others shared that their community was also falling victim to a “model minority myth” that assumes that “all Asians are healthy” and subsequently overlooks the vulnerability within specific AA and NHPI subpopulations. Overwhelmingly, HTA communities shared that this situation was compounded by a lack of disaggregated data on their population and that many health issues, like hepatitis B, were flying under the radar of mainstream health systems and – in some cases – under the radar of the AA and NHPI community itself.

Four years later, HTA collaboratives reported substantial progress in raising visibility of their local AA and NHPI communities and their health needs, particularly among targeted groups such

**FIGURE 3** Changes in Community Capacity Across HTA Sites (2007-2012)

as policymakers and public-health administrators. While acknowledging a need for greater investment in raising visibility within the broader mainstream to foster public will for future policy change addressing AA and NHPI health disparities, grantees reported outcomes that included:

- **New data on AA and NHPI health.** In response to limited or no disaggregated data on AA and NHPI health, one of the most significant contributions to increased visibility was the generation of new community-level data through in-language surveys, community focus groups, or tracking of screening data. All grantees reported outcomes in this area.
- **New reports and publications.** Another area of strategic investment was in amplifying AA and NHPI community voice or data through formal reports or publications that were then disseminated to targeted and mainstream audiences. Examples include peer-reviewed journal articles, policy reports to legislators and decision-makers, and demographic fact sheets.
- **Increased media and social media presence.** Leveraging communication skills gained through HTA, grantees reported increased social media presence and media placement

(including articles and television segments profiling AA and NHPI events and organizations, op-eds highlighting AA and NHPI voices on impending policies, and news stories that included HTA grantee perspectives).

- **Increased conference and meeting presentations.** As their capacity and networks grew, HTA grantees increasingly served as ambassadors for the AA and NHPI community through presentations at more than 80 regional and national conferences, including large events sponsored by the National Institutes of Health and the American Public Health Association. Topics focused on illuminating challenges AA and NHPis face within the health system and sharing innovative models of care for AA and NHPI communities.

#### *Interim Outcome No. 2: Closing the AA and NHPI Health-Access Gap*

When HTA was launched, collaboratives described access to care as a driving factor for health disparities within their communities. Across the board, collaborative members tied this challenge to a lack of local capacity to address the cultural, linguistic, and/or financial barriers faced by large-immigrant and refugee AA and NHPI popula-

### Stories of Success: Closing the Gap

- California's Asian Health Services' patient-navigation model expanded to serve additional vulnerable communities such as the Vietnamese, Cambodian, and Mien populations.
- In Hawaii, the Kalihi Valley now benefits from a Medical-Legal Partnership Program, which provides legal advocacy to address key social determinants of poor health such as language access, housing, and transportation.
- In Georgia, the lead agency for the HTA grant has tripled its client base and opened a charity clinic recognized by the Georgia Department of Human Resources – the first clinic in the state to have a primarily Asian language-speaking staff.
- HTA partners in Texas received a Cancer Prevention and Research Institute of Texas Prevention Service grant to provide almost \$1 million for cancer screening and prevention services targeting the Houston-area AA and NHPI community.
- In partnership with the Maricopa County Department of Public Health, the Arizona HTA coalition created a program in which community volunteers follow up with AA and NHPI individuals with chronic hepatitis B infection.

tions. While some HTA grantees had established partnerships to varying degrees with mainstream health systems, in most communities little existed in the way of health-system policies, programs, or dedicated resources for AA and NHPI health issues. Further, HTA grantees unanimously agreed that mainstream health systems were not knowledgeable about AA and NHPI culture and history. Even in 2007, however, most grantees also reported the presence of organizations that were serving as critical bridges to vulnerable AA and NHPI communities and that could be potentially employed to address health disparities.

Just four years later, HTA partners were reporting meaningful progress toward increased community capacity to address AA and NHPI health disparities, with a couple of grantees rating gains made over the past four years as starting to “transform” local systems of care for AA and NHPs. Grantees shared that the next step was to secure ongoing

funding for some of the efforts started through HTA. Specific indicators of success at the close of HTA included:

- **Expanded programs and services.** Multiple HTA grantees reported significantly greater capacity to better serve larger numbers of AA and NHPs in their respective communities as a result of expanded facilities or infrastructure improvements, increased staffing, or additional or improved programs targeting the most vulnerable AA and NHPI populations. More than 60 new or expanded programs were documented, focusing most prominently in key areas of disparity such as hepatitis B, early childhood/parenting, cancer, and women's health.
- **Increased community-health outreach and education.** HTA partners collectively held over 48 community-education events, including two-day summits and large-scale health fairs, meetings, and town halls along with smaller-scale presentations, workshops, and intimate gatherings at AA and NHPI churches. New in-language fact sheets, brochures, and other resource databases also contributed to filling the information gap for AA and NHPs.
- **Replication of patient-navigation and health care-access models.** HTA partners also heavily invested in promoting patient navigation support to ensure that vulnerable AA and NHPs were connected with critical health services. These targeted extremely vulnerable ethnic populations and took innovative forms such as a cancer treatment and support group model in Texas and the informal engagement of Micronesian “aunties” in the Kalihi Valley of Hawaii.
- **Increased provider education and training.** With the aim of deepening culturally competent practice among mainstream providers, HTA grantees reported more than 60 examples of small- and large-group trainings of diverse stakeholders including physicians, clinic health staff, community health workers, nutritionists, senior advocates, interpreters, child care providers, and medical and nursing students. In addition, HTA grantees reported developing culturally based health tools for providers such as menus, pregnancy planners, and child development assessment measures.

### *Interim Outcome No. 3: More AA and NHPI Seats at the Table*

Across the four measures of community capacity, this was the area that saw the biggest jump. At HTA's launch, grantees almost unanimously described as a major challenge the lack of AA and NHPI representation in health policy dialogues and decision-making. In some regions, like Ohio and Arizona, this was integrally tied to a lack of visibility of their community due to smaller population numbers. In regions like New York, Georgia, and California, the challenge was more rooted in the diversity of AA and NHPI groups and resulting politics that interfered with a coordinated AA and NHPI voice. In almost all cases, local panethnic AA and NHPI networks were just emerging and HTA grantees were just beginning to map key community stakeholders to help address AA and NHPI health.

By 2012, almost across the board, HTA collaboratives described themselves as “go to” organizations for those seeking input of AA and NHPI communities in their regions. Looking at trend data, we documented a marked jump in seats at decision-making tables midway through HTA, as AA and NHPI collaboratives were able to translate early relationship building with policymakers and other health system partners into meaningful opportunities to provide input into policies and programs affecting AA and NHPI communities. Seats at the table took multiple forms:

- **Formal health policy seats.** Especially toward the close of HTA, grantees were increasingly asked to serve as AA and NHPI representatives on key federal and state-level advisory councils that were responsible for policy implementation. We documented more than 50 examples of HTA partners on various health committees, boards, and coalitions, as well as 11 examples of government appointments. In some cases HTA grantees were the only AA and NHPI voices at the table, providing input on topics such as health care reform implementation or culturally responsive outreach and education.
- **One-time input on public policies or programs.** As “go to” organizations, especially at

### Stories of Success: Seats at the Table

- Three of the seven HTA collaboratives are now part of their regional Office of Minority Health's Health Equity Councils.
- HTA grantees in Texas, Georgia, and Ohio served as organizing bodies to host regional White House meetings of federal officials and AA and NHPI organizations from surrounding states to discuss policy issues affecting the AA and NHPI community.
- In New York, collaborative members have been appointed to key advisory roles, including the state's Medicaid Redesign Team Health Disparities Workgroup, the Health Care Reform Stakeholder Advisory Committee, and the Office of Health Insurance Program's Advisory Board.
- In Ohio and Arizona, HTA collaborative members now sit on newly formed AA and NHPI advisory councils to the Governor's Office.

the local level, HTA collaborative members were regularly asked to provide input on new programs or policies under consideration by regional decision-makers. Here, issues extended beyond the health arena to include transportation, women's issues, and economic development.

- **Organizers of community forums.** Many HTA grantees were asked by legislators or state or federal agencies to organize AA and NHPI community forums. These fostered relationships with the community and, by design, were also formal opportunities initiated by health decision-makers to understand the issues facing the AA and NHPI community and hear input or feedback on specific issues affecting their communities.

### *Interim Outcome No. 4: Strengthened AA and NHPI Base for Change*

For most HTA grantees, the AA and NHPI community landscape was dramatically different when HTA was launched. In 2007 there were few examples of widespread AA and NHPI civic engagement within the HTA communities, with only one grantee reporting a track record of AA and NHPI community organizing. Most HTA

### Stories of Success: Strengthened Base

- In California, the HTA coalition collected more than 5,700 petition signatures in support of health care reform and presented these to U.S. Rep. Barbara Lee.
- Multiple HTA coalitions brought busloads of AA and NHPis to their respective state capitols, raising community concerns related to language access, implementation of health care reform, and improved data-collection systems.
- In New York, HTA partners testified at the Healthy People 2020 Regional Meetings for Regions I and II and the People's Hearing on Health Reform regarding health issues facing AA and NHPis.
- To foster a sense of community unity and empowerment, 1,500 Atlanta-area residents annually walk a two-mile stretch of highway, waving American flags and raising their voices for change.

communities were still laying the foundation for encouraging a sense of collective AA and NHPI identity among populations that had historically identified with their respective ethnic groups. None had invested in addressing interethnic tensions or conflict within their respective AA and NHPI communities. When describing their communities in 2007, HTA grantees spoke of cultural barriers related to specific ethnic groups either not coming from a cultural tradition of advocacy or, worse, having a substantial fear of government repercussions for speaking out. Further, approximately half were facing challenges related to brokering relationships with certain vulnerable subpopulations in their areas, such as Pacific Islanders or recent refugee populations.

By 2012 HTA collaboratives reported significant progress in strengthening a base of support for ongoing and future systems change endeavors, including:

- **Strengthened community-level relationships.** As a result of HTA-supported community-building activities and events designed to build unity (e.g. community conversations, convenings of local leaders, and cultural events), grantees observed cross-ethnic healing and

understanding, panethnic identity development, and an acknowledgement of shared issues and priorities.

- **Increased community-level advocacy capacity.** As they were building their own advocacy capacity, collaboratives simultaneously invested in strengthening the advocacy knowledge and skills of their broader communities. Almost 50 such activities were reported, where community members were provided with tools, resources, and training on media and communications, social-change strategies, and the political process. For many, this was their first exposure to the political process.
- **Increased community organizing and mobilization.** Perhaps the greatest indicator of a strengthened base within HTA communities was the application of new advocacy knowledge and skills in local, state, and even national action. Over the course of HTA, the evaluation documented 90 such instances, including statewide advocacy days, mobilizations and demonstrations, public hearings and testimonies, letter-writing campaigns, and petition development and distribution.

It is critical to note that all of the community-level outcomes described above were reinforced and amplified by HTA efforts that were simultaneously occurring at the national level. These included, for example, APIAHF raising visibility of AA and NHPI health at the national level through high-profile events and publications; advocating for changes to federal data-gathering protocols at the Centers for Disease Control; establishing relationships with representatives at the White House, Congress, and U.S. Department of Health and Human Services; and spearheading national mobilization in support of health policies benefiting AA and NHPI communities. Although not covered in this article, the synergy between local and national capacity building is an essential factor in considering how to support a sustainable movement toward AA and NHPI health equity.

### Lessons Learned for Building Community Capacity for Change

The magnitude of the W.K. Kellogg Foundation's historic investment in AA and NHPI health has

provided fertile ground for learning about how to catalyze and support capacity building for change. While various learning topics are covered in other publications, this article highlights aspects of the HTA funding model that grantees said facilitated their success at the community level. These aspects of the model may be helpful to other funders interested in advancing racial equity goals for communities of color:

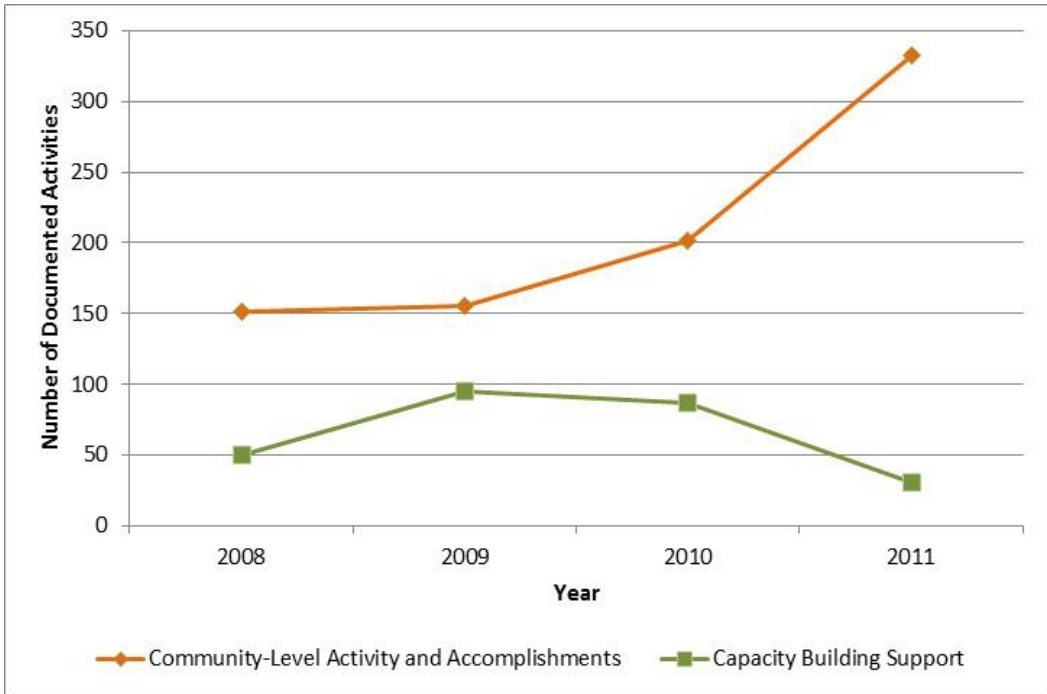
- **Operating within a culturally based and asset-focused paradigm.** Whereas “capacity building” within vulnerable communities can easily become deficit-oriented in approach, HTA was strongly built upon a recognition of the assets AA and NHPI communities had to offer. By WKKF both engaging APIAHF as the funding and technical assistance intermediary and dedicating meaningful resources towards AA and NHPI organizations themselves, HTA was able to bring to bear intimate knowledge of AA and NHPI contexts within health policy advocacy and implementation efforts. Further, HTA grantees were able to leverage a level of community trust that could be seamlessly transferred to tapping into authentic community leadership and mobilizing otherwise disconnected community members in collective action.
- **Focusing on building capacity to make the case for change.** The HTA capacity-building model strongly emphasized building capacity for interpreting, gathering, and advocating for data on AA and NHPI health. This focus was particularly relevant and critical given the AA and NHPI context, where a persistent “model minority myth” assumes that AA and NHPs are healthy and where public data systems do not adequately capture population-based data to prove otherwise (either aggregating ethnic groups into one category that masks the nuances of vulnerable subpopulations or grouping AA and NHPI data into an “other” category). According to multiple HTA partners, the generation of community-based data was therefore an essential factor in not just raising visibility of AA and NHPI health issues, but ultimately in making the case for greater policymaker attention, greater infusion of resources targeting AA

*It is critical to note that all of the community-level outcomes described above were reinforced and amplified by HTA efforts that were simultaneously occurring at the national level.*

and NHPs, and for having seats at policymaking tables where community concerns are being discussed.

- **Acknowledging the time and resource investment required for change strategies that lead with community voice.** HTA grantees placed a strong value on having community at the center of change efforts – AA and NHPI community voices were seen as essential on the front lines of advocacy. This was described as a strong facilitator of success, as many health decision-makers were moved to action after hearing community stories of struggle within the health system. This priority, however, introduced a level of complexity as HTA partners devoted significant effort toward representing community interests while navigating the diversity of language, culture, and basic readiness to engage in systems change within the AA and NHPI population. Because this level of resources is not typically accounted for within funder-sponsored capacity-building efforts, WKKF’s significant investment was described as extremely valuable for allowing capacity-building investments to extend beyond grantee organizations to the AA and NHPI communities they represent and serve.
- **Supporting panethnic collaborative development.** One of the strongest facilitators of success has been WKKF’s decision to invest in the formal organization of AA and NHPI groups into collaboratives that authentically represent and provide easy access to information about the needs of this diverse community. This was a somewhat unexpected outcome, given that the extreme diversity of AA and NHPI languages

**FIGURE 4** Relationship Between HTA Capacity-Building Support and Community-Level Activity



and cultures can present challenges to panethnic work. Yet by the end of the initiative almost all HTA collaboratives were overwhelmingly seen as “go to” organizations in their regions for information, advice, and input on AA and NHPI health. Many agreed that coming forward as a unified coalition of multiple organizations representing multiple ethnic groups provided a way for outsiders (such as policymakers and public health officials) to feel that they were reaching the broader AA and NHPI community. Further, it provided a neutral “entry point” for those who may otherwise be reluctant to invest the time to navigate through the diversity of AA and NHPI ethnic groups or the complexity of regional AA and NHPI politics. All recognized that the speed with which HTA collaboratives have been able to gain mainstream visibility and seats at the table would not have been possible if they were funded as a single organization.

- **Providing multiyear funding to allow time for capacity-building investments to come to**

**fruition.** Across all four areas of community capacity described previously, the evaluation documented an exponential growth of activity and accomplishments in the second half of HTA. In part, this upward trend corresponded to the opportunity that presented itself in 2010 as health care reform captured national attention. Many grantees, however, also emphasized that 2010 also represented a turning point in their own capacity to leverage this window of opportunity. The first two years were described as primarily dedicated to activities such as collaborative development, community data gathering, and establishing relationships across a range of partners and policy “targets.” HTA grantees underscored that had the funding come to an end after this initial period of investment, they would not have had the same level of accomplishment. The inverse relationship between community-level activity and accomplishments against documented instances of HTA capacity-building support over the four years of HTA (see Figure 4) emphasizes the importance of WKKF’s multiyear investment. As

one grantee observed, it was important for the funder to recognize that this work “is a marathon, not a sprint” (Inouye, Law, & Estrella, p. II-35).

## Conclusion

Ultimately, the changes in community capacity discussed in this article are still intermediate outcomes that are envisioned as a bridge to the level of systems change that improves the health outcomes of AA and NHPI communities. As much as HTA has served as a launching point to this end, by the close of HTA all grantees viewed themselves at a mid-point in their journey. As HTA resources ended in 2012, HTA partners emphasized the importance of sustaining, leveraging, and amplifying the progress made. As shared by one HTA partner at a final networking meeting of partners, “More needs to be done. ... Can we all look at our community members in the eyes and say that their health is better because of us yet? That [will be] the ultimate barometer.”

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