Version 1

December 28, 2015

AHI PPS
Cultural Competency and Health Literacy Strategy

Adirondack Health Institute

Table of Contents

Definitions of Key Terms

Culture:
The enhanced 2013 National CLAS (Culturally and Linguistically Appropriate Services) Standards for Health and Health Care refer to culture as "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical or sociological characteristics." ("What are the National CLAS Standards?" 2015).

Cultural Competence:
"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." (Cross et al, 1989).

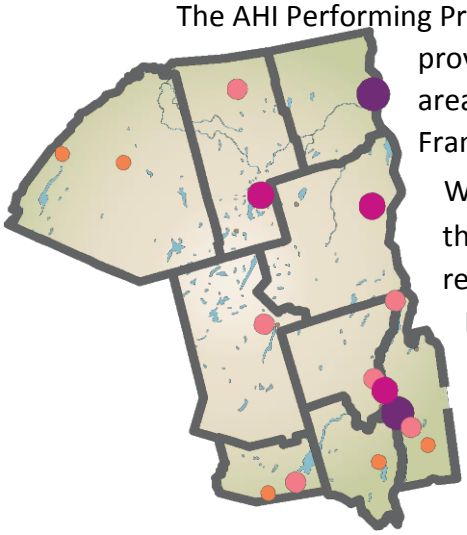
Health Disparities:
"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." ("Disparities," 2014).

Health Equity:
Attainment of the highest level of health for all people…requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of avoidable health and health care disparities. ("Disparities," 2014).

Health Literacy:
"The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." ("Health Literacy," 2015).

Social Determinants of Health:
The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. ("Social Determinants," 2015).

Introduction



The AHI Performing Provider System (PPS) is an integrated, multi-sector network of over 100 provider organizations serving individuals across an 11,000 square mile area of upstate New York, throughout all or part of Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, and Washington counties. Formed as a partnership to plan for and manage the health care restructuring in the northern New York/Adirondack region and administer the DSRIP (Delivery System Reform Incentive Payment) program, the AHI PPS spans nearly 11,000 square miles of a largely rural region, and has approximately 144,000 attributed Medicaid lives.

Total DSRIP Target Population:
(9-County Area, 2012)

	Clinton	Essex	Franklin	Fulton	Hamilton	Saratoga	St. Lawrence	Warren	Washington	Total
Dual Eligible Beneficiaries	4,108	1,917	2,583	3,675	136	5,986	5,256	2,971	2,262	28,894
Non-Dual Beneficiaries	15,247	6,277	10,097	14,213	548	24,736	22,757	10,060	9,826	113,761
Uninsured	5,908	3,813	6,152	5,536	338	15,168	12,663	6,833	6,753	63,164
Total Beneficiaries	**25,263**	**12,007**	**18,832**	**23,424**	**1,022**	**45,890**	**40,676**	**19,864**	**18,841**	**205,819**

The AHI PPS only covers a portion of Saratoga, St. Lawrence and Fulton counties, thus not all of this population is eligible to be attributed to the PPS

An Expanded Approach to Cultural Competence

Viewed through the lens of a traditional conceptualization of diversity and culture based primarily on race, ethnicity, and primary language spoken, the population served by our providers presents as largely homogenous. According to 2010 US Census Bureau data, on average, 93% of the total population identifies as white, and a North Country Population Health Improvement Program language study, also based on 2010 census data, concluded approximately 92% of individuals in the AHI PPS service area speak English as their primary language. This does not negate the importance of developing a strategy to increase accessibility and quality of care and services delivered within the PPS respective of minority groups represented in the remainder of the population; it does, however, indicate the drivers of health disparities in the AHI PPS are rooted in factors outside of race and linguistics.

Each county served by the PPS has greater percentages of rural areas, higher concentrations of elderly and disabled populations, higher rates of poverty, and lower rates of educational attainment than those of either Upstate New York or New York State as a whole. By embracing a broader definition of culture, such as that which is reflected in the *enhanced 2013 National Culturally and Linguistically Appropriate Services (CLAS) Standards for Health and Health Care*, we

recognize the value of approaching these defining characteristics of the PPS as culturally significant.

The National CLAS Standards for Health and Health Care Blueprint recognizes that "every patient-provider interaction is a cross-cultural interaction and that the scope of cultural competency in health care should expand to address multiple markers of difference" ("What are the National CLAS Standards?" 2015"). In order to effectively address health disparities in the AHI PPS, a comprehensive cultural competency and health literacy strategy must be inclusive of interventions tailored to the unique needs of the population it serves, in part by incorporating an enhanced understanding of culture into all related activities.

Increasing Patient and Provider Health Literacy Skills to Improve Health Outcomes

The CDC asserts "Health literacy skills are those people use to realize their potential in health related situations" ("Health Literacy," 2015). Research has consistently linked low health literacy skills with poorer health outcomes. According to the Agency of Healthcare Research and Quality (AHRQ) Universal Precautions Toolkit, approximately 12% of adults in the United States possess adequate health literacy skills to successfully navigate the complexity of our current health care system, and even those with excellent health literacy skills can struggle with comprehension and self-management in times of stress or severe illness ("AHRQ Universal Precautions Toolkit," 2015). Lower levels of educational attainment within the AHI PPS service area increase the potential for adults who live in this region to have limited capacity to understand and process written and verbal information about their health and health care, and to communicate effectively with providers.

Similarly to viewing all patient-provider interactions as cross-cultural, experts recommend assuming that everyone may have difficulty understanding information about their own health and healthcare, necessitating the cultivation of an organizational environment equitable to all individuals served. The AHI PPS will utilize training, education, and dissemination of evidence-based resources, such as The Institute of Medicine's 10 Attributes of Health Literate Health Care Organizations, and best practices to support partner organizations as they develop internal processes for implementing health literacy initiatives, including the creation of patient education and outreach materials designed to promote access to care and services for the target population.

Goal and Objectives

The primary goal of the AHI PPS Cultural Competency and Health Literacy Strategy is to align the capabilities and competencies of providers with the diverse and complex needs of the individuals to whom they provide care and services, as a means to address and reduce the occurrences of health disparities within the nine county PPS service region.

The Cultural Competency and Health Literacy Strategy for implementation within the AHI PPS will develop and evolve over the duration of the DSRIP program, based on stakeholder input and evaluation of outcomes. Initial objectives include:

- Assessing cultural competency and health literacy needs at the provider level, including existing organizational infrastructure, patient environment, accessibility of services, and awareness of inequities in current practices
- Building on the Community Needs Assessment completed as part of the 2014 DSRIP application process, identify priority groups experiencing health disparities within the PPS and determining appropriate targeted interventions
- Utilize the Community Needs Assessment, feedback from project beneficiaries, and provider input to identify barriers to accessing health care and other resources within the AHI PPS service area, work collaboratively with stakeholders to develop and implement initiatives to increase access
- Compare provider capacity with population need to determine gaps in services offered, collaborate with community based organizations to identify opportunities to utilize their expertise to support and enhance existing provider capabilities
- Developing meaningful metrics to evaluate and monitor the impact of cultural competency and health literacy initiatives at both the provider and patient level
- Ensuring diverse stakeholder representation in development of cultural competency and health literacy initiatives
- Coordinate initiatives regionally to ensure optimization of resources and minimize duplication of efforts
- Develop a strategy to embed *National CLAS Standards for Health and Health Care* and *10 Attributes of Health Literate Health Care Organizations* into the AHI PSS at the organizational level
- Facilitate development and acquisition of materials and resources which reflect principles of cultural competency and health literacy, such as patient self-assessment and self-management tools, education and outreach materials, and staff development opportunities, at the organizational level
- Communicate plans for PPS cultural competency and healthy literacy initiatives and activities with stakeholders; function as a catalyst for dialogue about addressing health disparities by applying principles of cultural competency and health literacy
- Gather data and stakeholder feedback to inform development of the AHI PPS Cultural Competency and Health Literacy Training Strategy, to be completed by June 30, 2016

AHI PPS Cultural Competency and Health Literacy Provider Needs Assessment

To ensure the AHI PPS Cultural Competency and Health Literacy Strategy and resulting initiatives are tailored to be most beneficial to the individuals served within the AHI PPS, an AHI PPS Cultural Competency and Health Literacy Provider Needs Assessment survey was distributed to 124 individuals representative of the leadership of PPS partner organizations. 38 responses were received, equating a response rate of approximately 30% of PPS partners. The survey consisted of 15 questions intended to provide the PPS with a better understanding of specific challenges being faced by PPS providers, and priority areas in need

of improvement, in regards to cultural competency and health literacy. Notable findings based on survey results include:

- 60% of respondents indicated their organization does not have an explicit strategy for incorporating health literacy principles into their daily practices
- 68% stated their organization does not have a method, such as a self-assessment, to determine an individual's level of health literacy
- When directed to select as many options as applicable out of 16 categories in which their organization would most benefit from customized cultural competency and health literacy strategies, top responses included:
    - Cognitive impairments, intellectual disabilities, or other special needs (54%)
    - Mental, emotional, or behavioral conditions (49%)
    - Socioeconomic status (46%)

Areas where providers indicated the lowest levels of need for support in regards to cultural competency and health literacy were:

- Race (16%)
- Sexuality (16%)
- Ethnicity (19%)
- Religion (19%)

Survey results suggest a correlation between groups facing the most severe health disparities in the AHI PPS, and areas in which providers recognize they could use additional support to better serve consumers. These results also indicate a need to ensure providers incorporate considerations of aspects of diversity which are less prevalent within the PPS service area, such as racial, ethnic, and religious differences, into their cultural competency strategy. While these factors are not the leading drivers of health disparities within the PPS, neglecting to address this segment of the population is short sighted and counterproductive to promoting health equity for all community members.

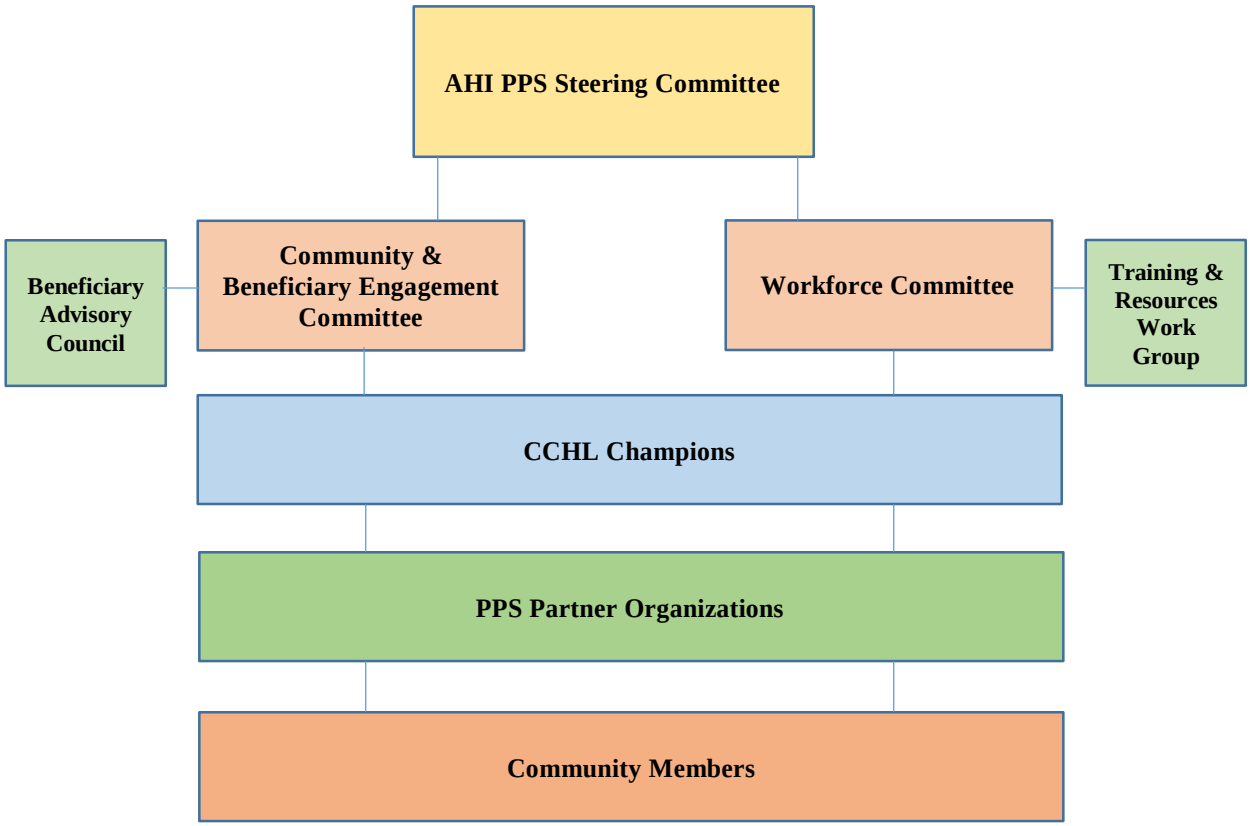
Information gathered through the survey was used to build the AHI PPS Cultural Competency and Health Literacy Strategy, and will serve as a touchstone as the PPS begins implementing related initiatives. The AHI PPS Cultural Competency and Health Literacy Needs Assessment survey will be given at least annually, and results will be used to measure progress on cultural competency and health literacy initiatives.

AHI PPS Cultural Competency and Health Literacy Strategy Operational and Governance Structure: An Integrated Approach

Just as principles and standards of cultural competence and health literacy must be embedded in all aspects of a provider organization's operations in order to positively impact the experience of individuals served, the AHI PPS chose not to annex its cultural competency and health literacy strategy into a solitary committee as a reflection of the need for an integrated methodology to

cultural competency and health literacy strategy implementation at the PPS level. Roles of each group vested with responsibility relative to the CCHL Strategy are defined below.

AHI PPS CCHL Operational and Governance Structure



Steering Committee, Community & Beneficiary Engagement Committee, and Workforce Committee:

- The workforce Committee and the Community & Beneficiary Engagement Committee have joint responsibility for the AHI PPS Cultural Competency and Health Literacy Strategy (See Appendix A for Committee Member Lists). Decision making approval will be sought from the Steering Committee when needed.

Workforce Committee, Training & Resources Work Group

- The Training & Resources Workgroup is responsible for shepherding the PPS Training Strategy. The Workgroup will be approving training requests and part of the approval process will include vetting for inclusion or specifically ensuring cultural competence and incorporating CLAS standards where appropriate.

Community & Beneficiary Engagement Committee, AHI PPS Beneficiary Advisory Council

- Comprised of individuals who receive Medicaid and who are participating in DSRIP project development, the Beneficiary Advisory Council will provide feedback and guidance reflective of specific community needs and vet materials intended for community members.

Cultural Competency and Health Literacy (CCHL) Champions

- Organizations within the AHI PPS have been asked to assess internal resources to determine if there is an individual or individuals who have demonstrated leadership in promoting health literacy. An individual or group from at least one organization in each of

the nine counties served by the AHI PPS will be selected to function as a Cultural Competency and Health Literacy (CCHL) Champion for their organizations and other participating organizations within that county.

- CCHL Champions will become regional experts on cultural competency and health literacy, with training and education support from the AHI PPS.
- The CCHL Champions will work collaboratively with the Community and Beneficiary Engagement Committee and the Workforce Committee to develop and plan for the implementation of cultural competency and health literacy initiatives within the AHI PPS at the provider level, seeking approval as needed.
- CCHL Champions will be the driving force for implementation of CCHL initiatives throughout PPS partner organizations.

AHI CCHL Task Force

- AHI has convened a Cultural Competency and Health Literacy (CCHL) task force, consisting of staff members from the Communications, Health Home, Enrollment Assistance Services and Education (EASE), and Community Engagement departments, who will be responsible for developing and leading health literacy initiatives within the organization.

Leveraging Existing Resources

In the nearly 30 years since its inception, AHI has established itself as a leader in building and sustaining community partnerships. This rich history of collaboration and convening stakeholders provides AHI with a robust foundation of internal resources and external partnerships which can be leveraged to advance and optimize the regional impact of the AHI PPS cultural competence and health literacy initiatives.

As part its 2014 DSRIP application, AHI identified existing programs and partnerships, listed below, which could be utilized in such a capacity:

- The Adirondack Rural Health Network (ARHN) is a coalition of 17 health care provider organizations, representing seven counties within the AHI PPS, who work collaboratively to identify community health needs and support local strategies to improve care.
- ARHN's Community Health Planning Committee with 15 participants including public health departments and hospitals focusing on New York State's Prevention Agenda and health disparities
- AHI's Enrollment Assistance Services and Education (EASE) Department with Education & Outreach staff who have conducted professional trainings with 1,431 staff at 456 different organizations educating them about the NY State of Health Marketplace and other insurance options including Child Health Plus and Medicaid.
- The North Country Population Health Improvement Program (NC PHIP) promotes the state's Triple Aim of improving regional health care, population health, and lowering health care costs and supports the state's Prevention Agenda and DSRIP. The NC PHIP is a collaborative tasked with convening 14 stakeholder across multiple sectors groups to help accomplish this goal. The NC PHIP includes 6 counties: Warren, Washington, Hamilton, Essex, Franklin, and Clinton. Combined the estimated population (according to the U.S Census) is 306,856.

The role of AHI's existing programs and partnerships in development and implementation of AHI PPS Cultural Competency and Health Literacy strategy will be determined by participating stakeholders, and will likely change and grow over the course of DSRIP project implementations.

Implementation of Enhanced National CLAS Standards

The AHI PPS will be utilizing the Enhanced National CLAS Standards as both guidance for developing and implementing cultural competency and health literacy, and as metrics for evaluating outcomes. The Enhanced National CLAS Standards are comprised of 15 standards, grouped into four domains, which provide a foundation for conceptualizing the policies, procedures, and actions necessary to "address the importance of cultural and linguistic competence at every point of contact throughout the health care and health services continuum" ("What are the National CLAS Standards?" 2015). The first standard, also designated as the Principal Standard, summarizes the goal of the Standards as a whole, which is to enable organizations to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" ("What are the National CLAS Standards?" 2015).

The National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, is an extensive document published in April 2013 by the Office of Minority Health of U.S Department of Health and Human Services, to explain the purpose of each standard and outline strategies for implementation within different organizations. This document will serve as the primary source of content and direction for cultural competency and health literacy initiatives within the AHI PPS.

AHI PPS will choose specific CLAS standards to focus on each year. Strategies and initiatives to increase the incorporation of National CLAS Standards into PPS partner organizations will vary based on organizational mission, structure, and target population. The AHI PPS Cultural Competency and Health Literacy Strategy focuses on connecting partners with resources, including the *National Standards for CLAS in Health and Health Care: A Blueprint for Addressing and Sustaining CLAS Policy and Practice*, which will support provider organizations to adapt and develop strategies specific to their organization's needs.

Ten Attributes of Health Literate Health Care Organizations

In their 2012 discussion paper, Ten Attributes of Health Literate Health Care Organizations, Brach et al. determine and define facets of health care organizations which "make it easier for people to navigate, understand, and use information and services to take care of their health". The paper offers an explanation of each attribute and basis for identifying it as such, along with elaborating on steps to be taken by an organization intending to improve their organizational level and understanding of health literacy. The principles and methodology described in the *Ten Attributes of Health Literate Health Care Organizations* will be used in conjunction with the Enhanced National CLAS Standards to increase providers' health literacy skills and knowledge, and to inform development of organizational systems to institutionalize relevant concepts.

Health Disparities within the AHI PPS

Summary of Health Disparities

While health disparities within the AHI PPS do reflect some similarity to those experienced by groups across New York State, demographic differences must be considered to sufficiently address regional issues. As previously mentioned, relative to Upstate New York and New York as a whole, the AHI PPS region is characterized by lower educational attainment, higher unemployment rates, an aging population, higher disability rates, lower household incomes, higher poverty rates, and a vastly rural composition. Each of these attributes can increase the incidence of significant health disparities. Mental health and substance abuse are significant issues, affecting at least a third of the Medicaid population, and driving significant emergency department utilization across the region. Poverty in the Adirondacks is exceptionally severe. Of those in poverty, there are greater proportions at or below 138% of the Federal Poverty Line (FPL) and 200% FPL compared to Upstate New York.

Priority Groups Experiencing Health Disparities

Data, such as that collected through Community Health Assessments, the AHI 2014 Community Needs Assessment, and studies conducted as part of the North Country Population Health Improvement Program (PHIP), has consistently identified the same groups within the AHI PPS who experience the most significant health disparities. The AHI PPS CCHL Provider Needs Assessment survey produced similar results. Through reviewing the data, summarized in charts and graphs contained in Appendix B, in conjunction with input from the AHI PPS Community and Beneficiary Engagement and Workforce Committees, the AHI PPS has identified the following priority groups experiencing health disparities:

Priority Group	Corresponding Figure in Appendix B
• Individuals living below the Federal Poverty Line (FPL)	Figure 1
• Individuals whose racial, ethnic, and/or linguistic attributes place them in the extreme minority group of the approximate 6%-8% of the population served by the AHI PPS who do not identify as white and English speaking, particularly individuals living in "Section 240 Minority Areas", which are service areas with non-white populations of 40% or more. In the AHI PPS, these areas include: o St. Regis Mohawk (St. Lawrence County)- primarily comprised of Native Americans living on the Akwesasne Reservation. o Fort Ann (Washington County) o Dannemora (Clinton County)	Figure 1
• Individuals with uncontrolled mental health and substance abuse issues (also major drivers of Emergency Department utilization)	Figure 2
• Individuals residing in the seven of nine counties covered by the PPS which are more than 50% rural	Figure 3
• Elderly Individuals	Figure 4
• Disabled Individuals	Figure 4

Community Based Interventions to Reduce Health Disparities

Existing community based interventions, identified through preliminary research and input from PPS members, to reduce health disparities for the target priority groups include:

- Community Action Programs, such as Warren-Hamilton Counties Community Action Program, Adirondack Community Action Programs, Inc., Washington County Economic Opportunity Council, and the Joint Council for Economic Opportunity
    - Operate food pantries, employment resources, emergency assistance programs, childcare and education programs, and multiple other programs and services which connect community members living in poverty within the AHI PPS with vital resources.
- The American Indian Health Program, St. Regis Mohawk Tribe Office of Economic Development, and St. Regis Mohawk Health Services
    - Organizations offering health services, economic development programs, and other resources to Native Americans
- Council for Prevention, HFM Prevention Council, Seaway Valley Prevention Council, Essex County Prevention Team, and other prevention focused organizations
    - Offer education, resources, and services to prevent and reduce substance abuse, suicide, and other behavioral health issues.
- Adirondack Rural Health Network
    - Convenes partners across healthcare and community service sectors to address health disparities faced by rural populations
- Southern Adirondack Independent Living Center, North Country Center for Independence, andother Independent Living Centers
    - Resources and advocacy for individuals with disabilities
- Senior Planet North Country
    - In association with Older Adults Technology Services (OATS), Senior Planet North Country connects senior citizens with technology and related instruction, allowing them to better navigate an increasingly digital world. Programs include education on accessing and utilizing patient portals to optimize communication with primary care providers.

With input from stakeholders, additional community based interventions to reduce health disparities will be identified, outreach will be conducted to build new partnerships with community based organizations, and new programs will be developed when appropriate. Other community based interventions will be derived from DSRIP project activities, such as contracting with community based organizations to utilize community navigators for patient activation and engagement activities, developing a regional crisis stabilization team, and increasing mental health and substance abuse services and infrastructure.

Key Factors to Improve Access to Care

Health disparities within the AHI PPS are exacerbated by the many barriers to accessing health care. The rural geography can make it challenging for community members to get to appointments, especially when taking into consideration the lack of public transportation opportunities and the likelihood that low socioeconomic status can be a factor in accessing and

maintain reliable personal transportation. The need for additional affordable transportation, for both medical and non-medical needs, is extremely significant in this region and cannot be overstated. Transportation coordinated and reimbursed through NYS Medicaid is widely used, but PPS partners have expressed that there are challenges around the program, including lack of drivers and difficulty procuring same day appointments. Feedback from partners has also emphasized that Medicaid transportation alone is insufficient to meet the health and wellness needs of community members, as it does not provide transportation to non-medical resources, such as grocery stores and social service departments.

A significant portion of the AHI PPS is designated as Health Professional Shortage Area in primary care, dental care and psychiatry by the federal government. Increased access to primary care is a significant need across the region. Lack of primary care is likely a driver of high rates of emergency department utilization and potentially preventable hospitalizations. The majority of the counties within the AHI PPS lag behind Upstate New York on basic access to care, including preventative measures, indicating a significant opportunity to improve primary care access and utilization (Appendix B:Figure 5).

Challenges experienced by individuals seeking care as a result of cultural differences and/or poor health literacy skills can function as a deterrent to utilizing preventative care services. Therefore, key factors for improving access to care within the AHI PPS include:

Strengthening Capacity and Reach of Primary and Preventative Care Services

- Increasing the number, capacity, and accessibility of primary care practices and other providers of preventative health care services within the AHI PPS
- Implementing activities to connect individuals to a primary care physician and encourage relationship building between providers and individuals served through use of the medical home model
- Promoting telemedicine initiatives and other innovative strategies for increasing availability of care in locations without sufficient medical providers
- Using EHRs and HIT platforms to enhance collaboration and care coordination

Addressing Social Determinants of Health

- Identifying and building upon existing community resources which address social determinants of health such as housing, transportation, employment, education, and childcare
- Developing a regional plan to connect beneficiaries to essential resources, primarily through DSRIP project activities
- Connecting uninsured individuals with health care coverage

Improving Communication and Quality of Interactions between Providers and Individuals Served

- Training and educating providers and staff members on cultural competence and health literacy standards, and supporting them to develop strategies to embed National CLAS Standards throughout their organizational components

- Educating community members about their rights and responsibilities as health care consumers, and providing them with appropriate resources and tools for self-management of chronic conditions
- Supporting patient navigator and/or patient advocate initiatives

It is also recognized the barriers to accessing care impact groups experiencing health disparities in different ways. For example, challenges surrounding transportation may different for an individual living in poverty than they are for a physically disabled individual or someone living in an isolated rural area. With input from community members and PPS partners, strategies will be developed to tailor initiatives to improve access to care to the specific needs of target populations.

Training and Education for Providers

A comprehensive strategic plan for training and education of staff members within provider organizations will be detailed in the AHI PPS Cultural Competency and Health Literacy Training Strategy, to be submitted to DOH at the completion of DY2 Q1 (6/30/16). The Cultural Competency and Health Literacy Provider Needs assessment, distributed on November 30, 2015, is serving as a starting point to analyze training and education needs at the provider level. Based on the needs of the identified priority groups experiencing particularly significant health disparities and the objectives of the AHI PPS Cultural Competency and Health Literacy Strategy, areas of focus for a provider training and education strategy will include:

- Enhanced National CLAS Standards for Health and Health Care and utilizing the National CLAS Standards Blueprint
- Understanding and developing the Ten attributes of a Health Literate Organization
- Examining personal attitudes, beliefs and biases about other cultures and how to avoid allowing those biases to impede effective interactions with individuals served
- Bridges Out of Poverty and Bridges to Health and Health Care, which are evidenced based methodologies for improving outcomes of individuals living in generational poverty by examining the different values, perspectives, and "hidden rules" of socioeconomic classes from an individual, institutional, and community perspective
- Shared decision making, particularly using the SHARE approach
- Motivational Interviewing
- Teach back methods to ensure patients' understanding of information
- Behavioral health and substance abuse
- Trauma Informed Care
- Alzheimer's and dementia core competencies
- Palliative Care
- Awareness of disability issues and the impact of physical and intellectual disabilities on a an individual's ability to access health care services

Communication Plan

Generating dialogue and meaningful information sharing are key elements of the AHI PPS' plan for communicating with and to stakeholders about cultural competency and health literacy initiatives. A multi-channel methodology, similar to that described in the AHI PPS Community Engagement Plan will be utilized for CCHL related communications. Key components are noted below, but are

not representative of all outlets to be employed for cultural competency and health literacy communications.

AHI Communications Resources

The AHI website and social media accounts will function as main vehicles for external information sharing. Meeting materials, event calendars, project specific documents, and extensive other resources are currently available through the website, and a listing of cultural competency and health literacy resources will be forthcoming. AHI's communications department will assist with developing other appropriate means of communication, including printed materials, press releases or other media involvement. A member of the communications department sits on the CCHL Task Force, to ensure all internal and external communications are created with consideration of cultural competency and health literacy standards. Program specific social media accounts may also be utilized for cultural competency and health literacy related information dissemination.

Meetings with Community Groups/Community Forums

Community forums will be held by the AHI PPS for the express purpose of engaging community members on DSRIP relevant topics, including cultural competency and health literacy, barriers to accessing care, and strategies for increasing use of preventative and primary care services. However, barriers to accessing care within the AHI PPS region, such as lack of transportation, may also function as barriers to participation in community forums. To address this concern in the short term, members of the AHI PPS have and will attend meetings of existing community groups, such as the Long Term Care Council, the North Country Population Health Improvement Program collaborative, and the Washington County Head Start Policy Council, in order to meet community members where they are geographically. As part of a long term community engagement strategy, the AHI PPS will explore non-traditional means of convening community members, such as holding community forums via teleconference, a method utilized by politicians in the region, and/or virtual community forums using social media and other internet platforms.

HealthyADK

HealthyADK is a website launched through AHI's North Country Population Health Improvement Program (NC PHIP). HealthyADK's purpose is to create a common understanding of community needs, gaps and priorities that will advance the well-being of communities across the North Country region. The website features up-to-date sources of population health and socio-economic data, reports describing the region and current efforts, promising practices for improving population health, and several additional resources. HealthyADK will be utilized to obtain data for developing cultural competency and health literacy initiatives and as a repository for best practices, training content and data generated through those initiatives.

AHI PPS Steering, Community & Beneficiary Engagement and Workforce Committees

The AHI PPS Steering Committee and its subcommittees are comprised of representatives from a diverse cross section of PPS partners. Committee involvement in cultural competency and health literacy strategy planning promotes two-way communication with provider organizations. Both subcommittees which are tasked with contributing to the AHI PPS Cultural Competency and Health

Literacy Strategy, have discussed cultural competency and health literacy during DY1 Q3 meetings, ensuring community participation in strategy development.

Beneficiary Advisory Council

The AHI PPS Beneficiary Advisory Council presents an opportunity to facilitate information sharing, dialogue, and to encourage input and feedback from individuals who the DSRIP projects are intended to reach. Additional opportunities to collaborate with project beneficiaries on development of the AHI PPS cultural competency and health literacy strategy will continue to be pursued, and Beneficiary Advisory Council members will play a key role in identifying these opportunities.

Assessments and Tools for Self-Management

Educating and empowering health care consumers to meaningful participate in the management of their own health and health care is essential for improving population health outcomes. It was also noted by a high percentage of respondents to the AHI PPS Cultural Competency and Health Literacy Provider Needs Assessment survey that there is a need for many PPS partner organizations to identify and implement health literacy screening tools in their practices.

A variety of tools and resources exist which can be utilized to assist providers with assessing the health literacy levels of their patients, allowing them to ensure they communicate with patients in ways that support comprehension and positive health behaviors. Self- assessments exist to facilitate an individual's understanding of their own skills and areas where they may need support regarding managing health and health care. Examples of tools and assessments for use by providers and consumers include:

- The Newest Vital Sign, a 6 question assessment which asks consumers to respond based on reading a nutrition label ("The Newest Vital Sign," 2010).
- Short Assessment of Health Literacy-Spanish and English, Rapid Assessment of Adult Literacy in Medicine-Short Form, and Short Assessment of Health Literacy for Spanish Adults, all available through the Agency for Healthcare Research and Quality ("Health Literacy Measurement Tools," 2015).
- Test of Functional Health Literacy in Adults (TOFHLA), a reading comprehension test ("Literacy S-TOFHLA," 2015).
- ETS Health Activities Literacy Tests, which are designed to assess the literacy skills adults need to perform activities related to the well-being of themselves, their family members, and their community. ETS offers a full-length test and a locator test ("Test Content for Health Activities," 2015).

As the AHI PPS Cultural Competency and Health Literacy Strategy moves forward into implementation of initiatives to support its objectives, specific evidence-based resources for patient self-assessment and self-management will be identified, vetted, and shared with partner organizations. Building on the data in the Community Health Needs assessment conducted by the AHI PPS in 2014, providers and community members will be surveyed to determine health care conditions of greatest concern, which will help to identify specific conditions for which health literacy tools and resources may be most needed.

Evaluation of Outcomes

Monitoring and evaluating the impact of cultural competency and health literacy initiatives on health outcomes for those identified as priority groups experiencing health disparities is integral to ensuring the AHI PPS strategy is sufficient and effective. It is equally important to assess and measure progress within provider organizations as a result of strategic implementation. Additional assessments, metrics and other means of evaluating outcomes and areas in need of improvement may be developed as implementation progresses.

Feedback will be sought from the North Country PHIP Evaluation Manager, PPS Cultural Competency/ Health Literacy Champions, staff members of provider organizations, and community members to inform changes or amendments to the existing evaluation strategy as needed.

CG-CAHPS Survey and Provider Specific Satisfaction Surveys

The Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CG- CAHPS) survey includes metrics to evaluate the patient experience, communication between providers and patients and overall patient satisfaction, which can be used to assess the impact of cultural competency and health literacy initiatives have on beneficiaries ("Clinician & Group," 2015). Existing provider specific satisfaction surveys can be used to measure progress at the organizational level.

AHI PPS Cultural Competency and Health Literacy Provider Needs Assessment

As discussed earlier, a 15 question survey was created to assess PPS partner organizations existing cultural competency and health literacy initiatives and identify training needs as well as service gaps. This survey will be repeated annually to measure provider improvement by comparing data gathered over the course of the DSRIP program.

Enhanced National CLAS Standards

Existing metrics will be utilized and assessments will be developed to enable providers to measure their progress with implementing the 15 Enhanced National CLAS Standards.

Conclusion

The AHI PPS is committed to addressing health disparities and promoting the delivery of readily accessible, culturally competent care and services within in its nine county coverage area. The health outcomes of individuals residing within the AHI PPS service area are inherently linked to defining regional demographic, geographic and socioeconomic characteristics. By framing its approach to developing and implementing a cultural competency and health literacy strategy within an expanded definition of culture, the PSS has positioned itself to support providers to improve health equity by customizing efforts to meet the unique needs of the target population. The AHI PPS Culturally Competency and Health Literacy Strategy will be reviewed at least annually to ensure relevance and efficacy.

References

AHRQ Universal Precautions Toolkit. (2015, November). Retrieved from http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

Clinician & Group. (2015) Retrieved from https://cahps.ahrq.gov/Surveys-Guidance/CG/index.html

Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center. Retrieved from http://nccccurricula.info/culturalcompetence.html

Disparities. (2014). Retrieved from http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Health Literacy (2015, November). Retrieved from http://www.cdc.gov/healthliteracy/

Health Literacy Measurement Tools (Revised). (2015, December). Retrieved from http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile. (The Lewin Group, Inc, 2002, April). Retrieved from http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf

Learn about health literacy. (2015, September 30). Retrieved from http://www.cdc.gov/healthliteracy/learn/index.html

Literacy S-TOFHLA: Test of Functional Health Literacy Assessment (TOFHLA). (2010, July). Retrieved from http://www.rcmar.ucla.edu/rcmar_wiki/Literacy_S-TOFHLA.html

Social Determinants of Health. (2015). Retrieved from http://www.who.int/topics/social_determinants/en/

Ten Attributes of Health Literate Health Care Organizations. (2012, June). Retrieved from http://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

Test Content for Health Activities Literacy Tests. (2015). Retrieved from https://www.ets.org/toefl/institutions/about

The Newest Vital Sign. (2010, June). Retrieved from http://www.pfizer.com/health/literacy/public_policy_researchers/nvs_toolkit

What are the National CLAS Standards?. (2015, December). Retrieved from https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Appendix A: Membership Lists for AHI PPS Sub-Committees Governing the Cultural Competency and Health Literacy Work Stream

AHI PPS Community & Beneficiary Engagement Committee Member List			
Member Name		**Title**	**Affiliated Organization**
Tess	Barker	President & CEO	Planned Parenthood of the North Country New York, AHI PPS
Jocelyn	Blanchard	Director of Navigator Services	Southern Adirondack Independent Living Center (SAIL)
Crystal	Carter	Director	Clinton County Office for the Aging, AHI PPS, Adirondacks ACO
Sr. Charla	Commins	Executive Director	Catholic Charities of Saratoga, Warren & Washington counties, AHI PPS
Kim	Cook	Director	Open Door Mission, AHI PPS
Janet	Mann	Care Management Support Coordinator	Northern Adirondack Medical Home, AHI PPS, Adirondacks ACO
Marty	Mannix	Community Member	AHI PPS, Adirondacks ACO
Tracy	Mills	Senior Director, Planning & New Business Development	Glens Falls Hospital, AHI PPS
Megan	Murphy	Community Health Services Director	AHI
Claire	Murphy	Executive Director	Washington County EOC, AHI PPS
Tammie	Pagaeu	Director	Clinton County DSS, AHI PPS
Ashley	Patenode	Community Member	AHI PPS
Paul	Raino	Community Member	AHI PPS, Adirondacks ACO
Cynthia	Reynolds	VP of Transformation and Clinical Quality	HHHN, AHI PPS, Adirondacks ACO
Joe	Riccio	Director of Communication	Adirondack Health, AHI PPS, Adirondacks ACO
Brenda	Stiles	Director of Care Management and Quality	CVPH, AHI PPS, Adirondacks ACO
Katie	Strack	Director of Public Health	Franklin County Public Health, AHI PPS
Mary	Thompson	Operations Manager/Navigator Manager	The Family Counseling Center of Fulton County, AHI PPS

Appendix A (Continued): Membership Lists for AHI PPS Sub-Committees Governing the Cultural Competency and Health Literacy Work Stream

AHI PPS Workforce Committee Member List			
Member Name		**Title**	**Affiliated Organization**
Linda	Beers	Director of Public Health	Essex County Public Health
Marti	Burnley	Vice President Human Resources	Hudson Headwaters Health Network
Debbie	Couture	Care Manager	Behavioral Health Services North
Michelle	Law	School Support Assistant	Franklin-Essex-Hamilton BOCES
Becky	Leahy	Executive Director	North Country Home Care Services
Michelle	LeBeau	Chief Operating Officer/Chief Nursing Officer	University of Vermont Health System - CVPH
Michael	Lee	Chief Human Resources Officer	Adirondack Health
Darlene	Lewis	Vice President, Human Resources	Canton-Potsdam Hospital
Mark	Lukens	Interim CEO	Behavioral Health Services North
Megan	Murphy	Director, Community Health Services	AHI
Elizabeth	Parsons	Director of Human Resources	Fort Hudson Health System
Sadie	Spada	CEO	The Adirondack Arc
Kathy	Tucker	Vice President & Area Director HS7 North Country	1199 SEIU
Diane	Wildey	Dean of Special Academic Services	SUNY Adirondack
Karen	Zanni	Assistant Professor, School of Nursing	SUNY Empire State College

Appendix B: Graphs from the AHI PPS 2014 Community Needs Assessment, used as a basis for identifying priority groups experiencing health disparities

Figure 1: Race, Ethnicity, and Income in the AHI PPS

PINK indicates poorer performance relative to Upstate New York; ** indicates comparison made to NY State.
Data source: American Community Survey, 5-Year Estimate, 2008-2012.

	Clint.	Essex	Frank.	Fult.	H'lton	S'toga	St. Lawr.	Warr.	Wash.	Upstate New York	New York State
Race/Ethnicity											
White	92%	93%	84%	96%	97%	95%	94%	97%	94%	**82%**	**66%**
Black	4%	3%	6%	2%	1%	2%	3%	1%	3%	**9%**	**16%**
Asian	1%	<1%	1%	1%	<1%	2%	1%	<1%	<1%	**4%**	**7%**
(AI/AN)	<1%	<1%	5%	<1%	0%	<1%	<1%	<1%	<1%	**<1%**	**<1%**
Hispanic	3%	3%	3%	2%	1%	3%	2%	2%	2%	**10%**	**20%**
Education											
Percent with < HS education	15.7%	12.0%	15.6%	15.2%	10.9%	6.7%	12.9%	9.4%	13.3%	**11.1%**	**15.1%**
Percent with Assoc. Degree or Higher**	30.9%	35.1%	28.9%	25.5%	36.5%	48.6%	32.0%	38.8%	26.5%	**NA**	**41.1%**
Employment and Income											
Median HH income	$50,522	$47,400	$45,702	$45,333	$51,595	$67,712	$43,745	$54,909	$50,864	**$54,125[a]**	**$57,683**
Unemployed	7.9%	8.2%	9.3%	9.9%	4.9%	6.2%	10.6%	7.2%	9.8%	**7.7%**	**8.7%**
In poverty (below 100% FPL)	14.3%	12.4%	17.6%	16.5%	8.8%	6.5%	18.5%	11.1%	12.7%	**11.2%**	**14.9%**
Below 138% FPL	21.0%	19.2%	25.6%	24.6%	13.0%	10.6%	25.9%	17.0%	19.9%	**16.6%**	**21.5%**
Below 200% FPL	31.9%	31.3%	36.8%	37.3%	25.0%	18.1%	38.4%	26.9%	32.6%	**25.7%**	**31.6%**

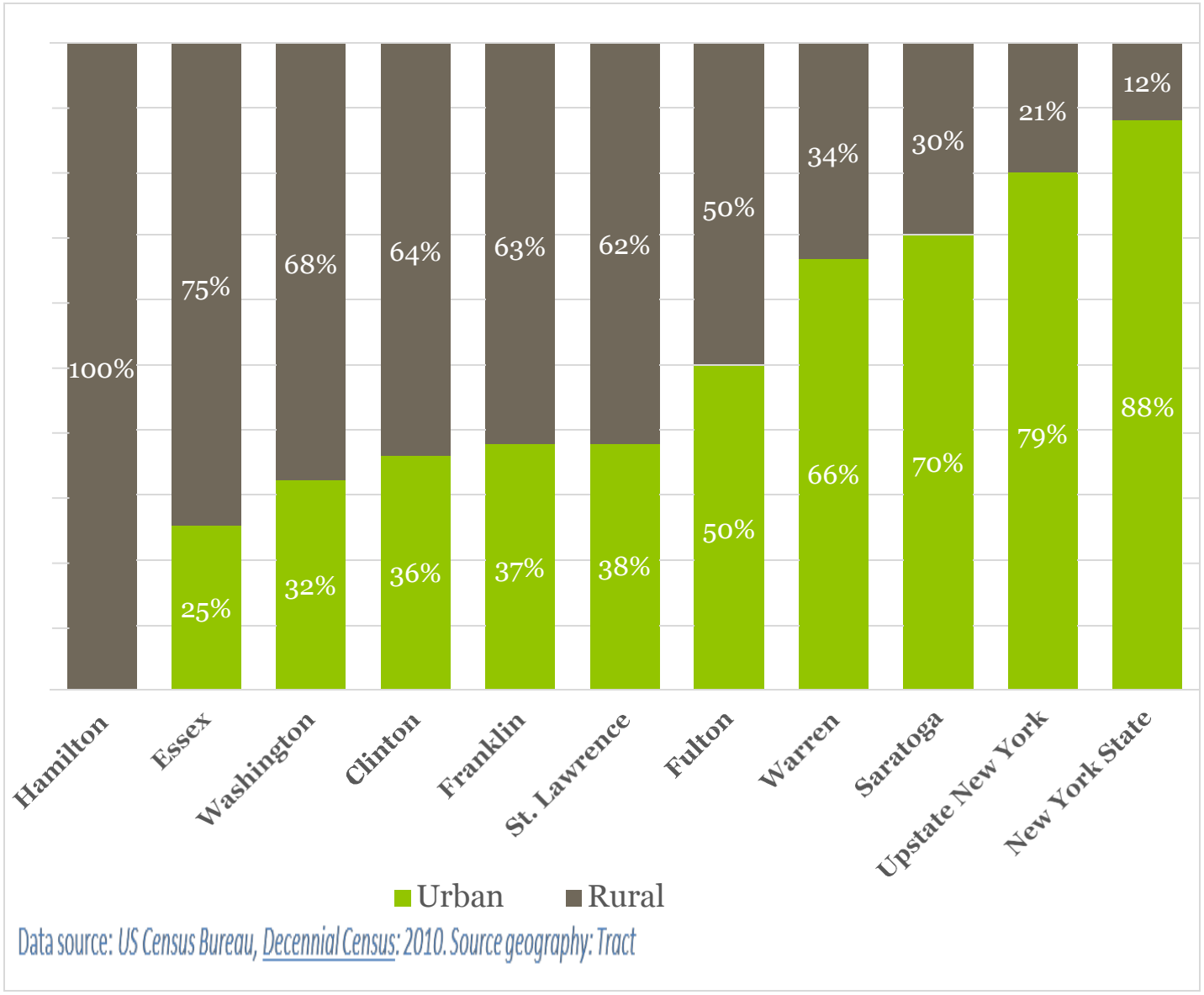
Figure 2: 2012 ER Visits per Member by Condition and County

(only top 10 conditions per county shown; Visits/Member = Visits/Medicaid beneficiary in the county with condition) ● = Mental Health/Substance Abuse Condition

	Clinton	Essex	Franklin	Fulton	Hamilton	Saratoga	St. Lawrence	Warren	Washington
● Major Personality Disorders	3.5	3.7	7.1	3.3		3.6	3.7	2.2	4.3
● Post Traumatic Stress Disorder	2.6	1.9	3.0	2.2		2.2	2.9	1.6	1.8
● Chronic Mental Health Diagnoses - Moderate	2.1	2.0	2.4	2.1		1.9	2.4	1.5	2.0
● Bi-Polar Disorder - Severe	2.4			2.4		1.9	2.7	1.9	1.9
● Delirium Tremens	2.0			2.1		2.1	2.0	1.5	
History of Percutaneous Transluminal Coronary Angioplasty	1.9		2.8	2.1		1.6			
● Depressive Psychosis - Severe	1.9	1.8					1.9	1.3	1.4
Chronic Cardiovascular Diagnoses - Minor	3.4		2.4	2.5					
● Drug Abuse Related Diagnoses	2.4			2.6		2.8			
● Chronic Stress and Anxiety Diagnoses		1.8	2.1		0.6		2.0		
● Schizophrenia					1.2	1.4	2.1	1.4	
History of Myocardial Infarction		2.3				1.4			1.6
● Bi-Polar Disorder		2.4	2.6						
Atrial Fibrillation		2.1						1.4	1.5
● Opioid Abuse							2.4		1.8
Status Asthmaticus				1.9			2.1		
Asthma			2.1		0.5			1.3	
● Cocaine Abuse		2.1						1.8	
Angina and Ischemic Heart Disease		1.9							1.6
● Other Significant Drug Abuse - Continuous			2.8						
● Eating Disorder	2.7								
Unstable Angina			2.4						
Other Chronic Pulmonary Diagnoses				1.9					
● Chronic Alcohol Abuse									1.7
● Conduct, Impulse, Other Disruptive Behavior Disorders						1.5			
● Depression					0.5				
Hypertension					0.4				

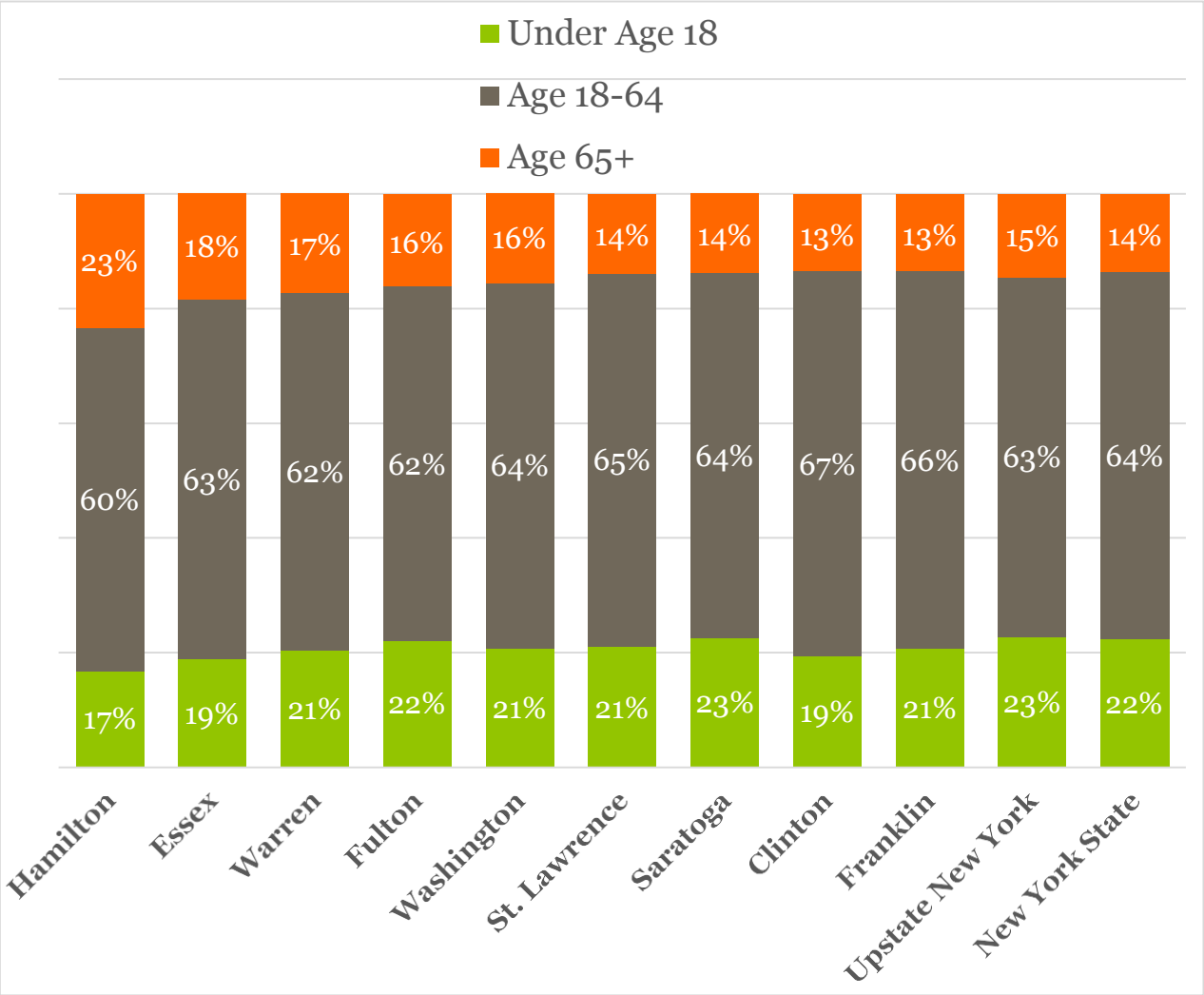
Appendix B (Continued): Graphs from the AHI PPS 2014 Community Needs Assessment, used as a basis for identifying priority groups experiencing health disparities

Figure 3: Urban vs. Rural % of Population
(2010, 9-County Area, Upstate New York, New York State)



Appendix B (Continued): Graphs from the AHI PPS 2014 Community Needs Assessment, used as a basis for identifying priority groups experiencing health disparities

Figure 4: Age by County



% Disabled by County

13.4%	14.4%	12.8%	16.4%	12.6%	15.2%	10.1%	12.8%	13.1%	N/A	10.9%

Data source: American Community Survey, 5-Year Estimate, 2008-2012.

Appendix B: Graphs from the AHI PPS 2014 Community Needs Assessment, used as a basis for identifying priority groups experiencing health disparities

Figure 5: Access to Health Care within the AHI PPS

	Clint.	Essex	Frank.	Fult.	H'lton	S'toga	St. Lawr.	Warr.	Wash.	Upstate New York
Adults with health ins. (Age-Adj, %)*	88.2	86.5	80.4	84.9	86.7	90.1	88.1	91.3	88.1	**89.9**
Adults with regular health care providers (%)****	83.7	77.8	76.8	82.4	78.9	90.2	81.9	85.1	86.2	**84.6**
Adults with dental visits in past year (Age-adjusted, %)*	67.3	68.0	64.9	64.9	66.1	71.8	66.4	74.3	61.0	**72.7**
Women >=40 who had mammograms in the past two years (Age-Adj, %)*	82.4	79.5	79.0	80.1	79.8	79.3	79.2	82.4	76.3	**81.9**
Women who had pap tests in the past three years (Age-adjusted, %)*	95.0	80.9	83.0	79.1	84.0	82.3	79.4	83.5	82.3	**82.6**
Adults >= 50 who ever had sigmoidoscopies or colonoscopies (Age-Adj, %)*	75.8	69.0	67.2	68.9	69.9	71.8	65.8	72.2	69.3	**68.4**
Adults >=65 who had flu shots in the past year (Age-Adj, %)*	78.6	72.6	64.6	69.6	75.6	70.1	74.1	77.8	74.0	**76.0**
Adults >= 65 who ever had pneumonia vaccinations (Age-adjusted, %)*	81.0	76.2	63.8	64.8	76.3	70.8	70.2	75.8	72.2	**71.2**

GREEN indicates poorer performance relative to Upstate New York; Data source: * BRFSS 2009,****BRFSS 2013