Supporting Document Signature Sheet & Table of Contents

DY: 1 Quarter: 3 -	Select one: ☒ Domain 1 Milestone ☐ Key Issue	Select one: ☒Organizational Section: Cultural Competency & Health Literacy ☐Project: {List Project number & Name)
Content Owner: Juanita Lyde		Select one: ☐ Pre-Milestone Reporting Requirements ☒ Milestone Commitment Date Reporting Requirements ☐ Post Milestone Reporting Requirements
Domain 1 Milestone/ Key Issue Description:	Milestone 1: Finalize Cultural Competency / Health Literacy Strategy	
Supporting step Description (if applicable):	N/A	

Contents & Rationale for Conclusion

In support of the above milestone, the documentation showing achievement is as follows:

1. The Finger Lakes Performing Providers System's Cultural Competency / Health Literacy Strategy, including all Appendices.
2. IA's Meeting schedule template for all meetings related to the Finger Lakes Performing Provider System's Cultural Competency / Health Literacy Strategy in Quarter 3.

DSRIP Reporting Manager: Oswaldo

Date: 02/03/16

FLPPS
FINGER LAKES PERFORMING
PROVIDER SYSTEM

Cultural Competence and Health Literacy Strategic Plan

Acknowledgements

Finger Lakes Performing Provider System, Inc. (FLPPS), in collaboration with Coordinated Care Services, Inc. (CCSI), developed and shaped this Cultural Competence and Health Literacy (CC/HL) Strategic Plan to support the organization's implementation of New York State's Delivery System Reform Incentive Payment (DSRIP) program.

In addition, FLPPS would like to acknowledge the thoughtful input of community stakeholders who are invested in the development of the organizational strategies, policies, procedures and protocols necessary to ensure that cultural competence and health literacy principles are embedded throughout this document, including, but not limited to the FLPPS Cultural Competence and Health Literacy Committee (CC/HL Committee - regional key stakeholders with CC/HL expertise), Community Coalitions and Workgroups (i.e. Finger Lakes Health Systems Agency (FLHSA) Latino Health Coalition, African American Health Coalition, and the Partnership on the Uninsured), FLPPS Staff, Patients and Consumers (i.e. focus groups, community engagement forums and outreach).

We are also extremely appreciative of the 37 Partner organizations, representing a cross-section of FLPPS network Partners, including physical health, behavioral health and community-based organizations, who initiated the *Organizational Cultural Competence and Health Literacy Assessment*, of which 36 submitted the 43-page assessment tool in November 2015 and early December 2015[1]. We recognize the significant amount of effort devoted to the thoughtful completion of the assessment tool. Data from this process was analyzed to identify common themes and current gaps. The themes that emerged from this initial wave of responses were extremely helpful in shaping, guiding and prioritizing the goals and activities outlined in this strategy presented herein.

---

[1] Allegany Rehabilitation Associates (ARA); Ardent (Allegany/Western Steuben Rural Health Network, Inc.); Canisteo Valley Family Practice/Bruce MacKellar, MD PC; CareFirst NY, Inc.; Crest Manor Living & Rehabilitation Center; East House Corporation; Episcopal Church Home; Family Services of Chemung County; Finger Lakes Addictions Counseling and Referral Agency, Inc. (FLACRA); Finger Lakes Health; Finger Lakes Community Health; Genesee Council on Alcoholism and Substance Abuse, Inc.; Genesee Region Home Care Association – Lifetime Care; Gerould's Professional Pharmacy, Inc.; Hickok Center for Brain Injury; Ibero-American Action League; Jewish Home of Rochester; Lakeview Mental Health Services, Inc.; Legal Assistance of Western New York, Inc. (LawNY) – Rochester; Liberty Resources, Inc.; Monroe Community Hospital; Planned Parenthood of Central and Western New York, Inc.; Rochester Primary Care Network d/b/a Regional Primary Care Network (Rushville) RPCN; Rochester Regional Health Office of Community Medicine; S2AY Rural Health Network, Inc.; Steuben County; Strong Home Care Group; Strong Memorial Hospital; The Healing Connection, Inc.; Trillium Health; University of Rochester Medical Center; Villa of Hope; Wayne ARC; Wayne County Action Program, Inc.; Wyoming County Community Health System (WCCH); and YMCA of Rochester & Monroe County

Table of Contents

Appendices

Background and Introduction

The Delivery System Reform Incentive Payment (DSRIP) program aims to fundamentally restructure the health care delivery system in New York State, with a primary goal of reducing avoidable hospital use by 25% over five years. Over $6 billion dollars have been allocated to this transformative, statewide initiative, with payments tied to achieving specific results in system transformation, clinical outcomes and population health.

In the Finger Lakes region, more than 600 health care and community-based organizations (CBOs) have come together under the Finger Lakes Performing Provider System (FLPPS), with the initial purpose of implementing 11 projects intended to transform the current Medicaid service delivery system in critical areas. These projects include:

2.a.i Create an Integrated Delivery System Focused on Evidence Based Medicine and Population Health Management

2.b.iii ED Care Triage for At-Risk Populations

2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions

2.b.vi Transitional Supportive Housing

2.d.i. Implementing Patient Activation Activities to Engage, Educate and Integrate the Uninsured and Low/Non-Utilizing Medicaid Populations into Community Based Care

3.a.i Integration of Behavioral Health and Primary Care Services

3.a.ii Behavioral Health Community Crisis Stabilization Services

3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes

3.f.i Increase Support Programs for Maternal and Child Health (including high risk pregnancies)

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in both Clinical and Community Settings

Taken together, these projects comprise an ambitious scope of work with the potential to have a significant impact on both how people in the Finger Lakes region experience the health care system, and on the outcomes associated with the care they receive. However, while each of the individual DSRIP projects will utilize evidence-based practices, that in and of itself, will not be sufficient to ensure that the implementation achieves intended outcomes. Central to the success of each project, and to the DSRIP program as a whole, will be the ability to engage effectively with individuals in need.

As such, there must be a focused and sustained effort to create a system of care that is sensitive and responsive to different cultures, including the cultural attributes of priority groups and the varying degrees of health literacy among our patients/consumers.

In response, FLPPS has developed a CC/HL Strategic Plan that outlines the steps that must be taken over the next four years to ensure that the redesign of the Medicaid delivery system achieves the intended results.

FLPPS has established an organizational vision and guiding principles that are essential to its work. This CC/HL Strategic Plan will support this vision by defining strategies that ensure that the network of care created by FLPPS is grounded in attention to culture, language and health literacy necessary to improve patient outcomes and eliminate disparities.

Vision Statement

To create an accountable, coordinated network of care that improves access, quality and efficiency of care for the safety net patient population.

Guiding Principles

- **Focus on the Patient** - All decisions are weighed against the question "How will this impact the patient's/consumer's health care needs, cultural and linguistic preferences, and enable the provision of the right care, at the right place, at the right time?"
- **Strong Physician and Provider Leadership** - Physicians and other practitioners have representation and deep engagement in governance and leadership.
- **Accountability, Transparency and Trusting Partnerships** - Establish clear and open partnerships with regular, proactive communication to support the design and implementation of truly cost-effective, best practice care delivery.
- **Adaptability** - Develop the ability to continually transform based on patient/consumer needs and environmental changes. Recognize that there is no "best," there is only better.
- **Capacity and Capability for Managed Care of a Population** - Build the capacity to manage patients/consumers with varying disease states, health care and social needs across the continuum of care.

In developing a strategy for strengthening cultural competency and to address issues related to health literacy, FLPPS paid particular attention to groups that are especially vulnerable and where significant disparities exist. While health equity remains the ultimate goal of the health care delivery system, health disparities in disease incidence and prevalence, health outcomes, access to care and quality of care continue to persist within communities and populations throughout the United States. To better address these disparities it is essential that we acknowledge the complex interaction of cultural, economic, individual, linguistic, geographical, cognitive and social factors that guide healthcare utilization and health seeking behaviors among the most vulnerable groups living within the FLPPS region.

Cultural Competence: *A set of congruent behaviors, attitudes, and policies that come together in a system that enables that system to work effectively in cross-cultural situations. (Cross et al, 1989)*

The CC/HL Strategic Plan developed by FLPPS is framed by the following overarching goal: ***To promote Patient Voice and Patient Choice while ensuring high value, equitable care.***

Patient Voice refers to patients' wishes, preferences and values being respected, which underscores the need for care to be provided within a context that is culturally relevant and appropriate. The concept of Patient Voice also highlights the need to seek patient feedback in the Medicaid redesign process.

Patient Choice is defined as the action of informed decision making, whether it pertains to choice of hospital, provider, test, treatment or service. Patient Choice requires an innate understanding on the part of the consumer, which underscores the importance of health literacy and the need for communication that is clear and relatable.

Health Literacy: *The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. (Healthy People 2020)*

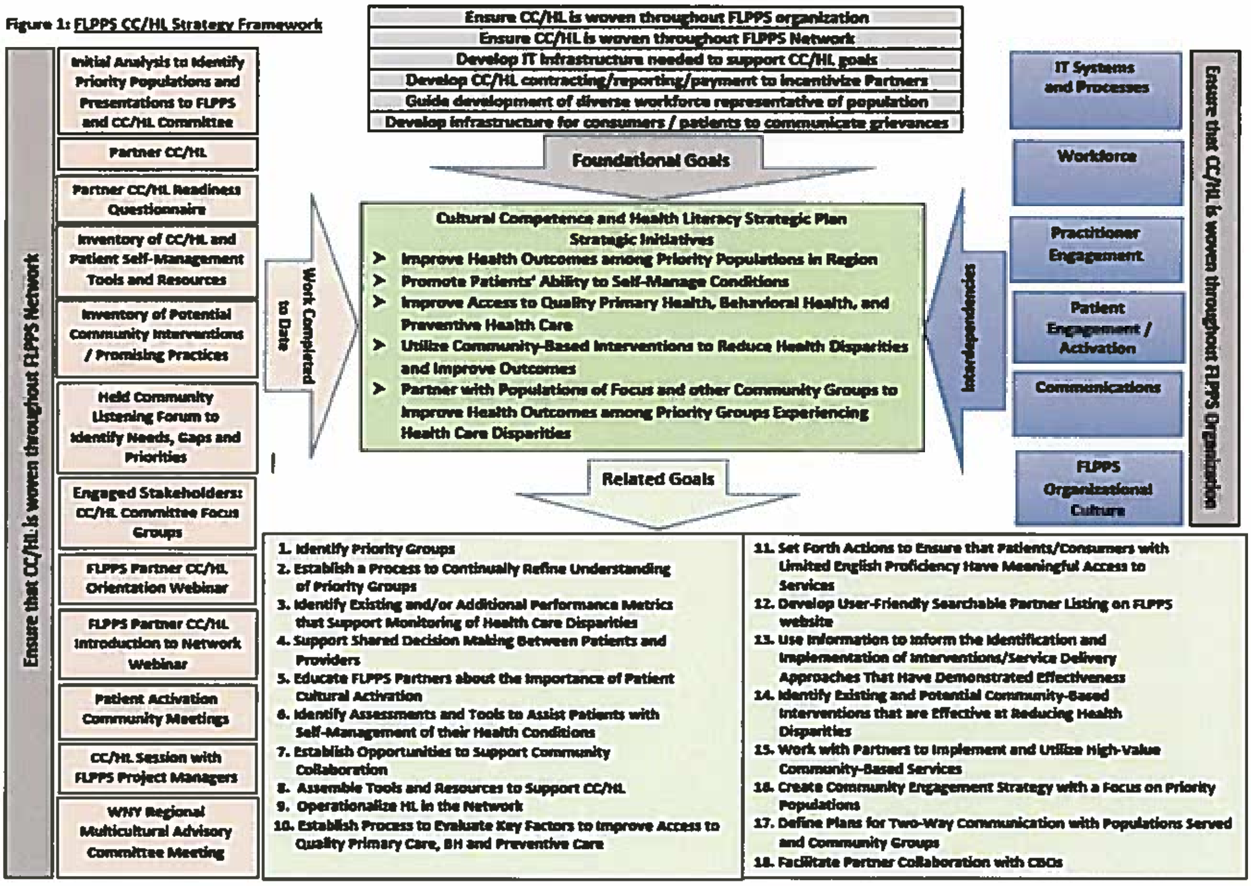
High Value Care refers to care that is based on the empiric impact on both cost and quality of life, and based on patient perceptions of value.

Equity speaks to the elimination of health disparities, which requires that attention is paid to the issues of cultural competence and health literacy, that resources are appropriately matched to the needs and culture of the patients.

Approach

As described in Figure 1: *Framework for Developing CC/HL Strategic Plan*, FLPPS has undertaken a number of activities intended to: (1) Enhance our understanding of the population served by the FLPPS network; and (2) Determine the status of the region in both understanding and managing cultural competence and health literacy. The sections that follow briefly review the extensive work that has been completed to date and highlight how these efforts have shaped the CC/HL Strategic Plan.

Figure 1: FLPPS CC/HL Strategy Framework



Cultural Competence and Health Literacy Strategic Plan
Strategic Initiatives

- Improve Health Outcomes among Priority Populations in Region
- Promote Patients' Ability to Self-Manage Conditions
- Improve Access to Quality Primary Health, Behavioral Health, and Preventive Health Care
- Utilize Community-Based Interventions to Reduce Health Disparities and Improve Outcomes
- Partner with Populations of Focus and other Community Groups to Improve Health Outcomes among Priority Groups Experiencing Health Care Disparities

1. Identify Priority Groups
2. Establish a Process to Continually Refine Understanding of Priority Groups
3. Identify Existing and/or Additional Performance Metrics that Support Monitoring of Health Care Disparities
4. Support Shared Decision Making Between Patients and Providers
5. Educate FLPPS Partners about the Importance of Patient Cultural Activation
6. Identify Assessments and Tools to Assist Patients with Self-Management of their Health Conditions
7. Establish Opportunities to Support Community Collaboration
8. Assemble Tools and Resources to Support CC/HL
9. Operationalize HL in the Network
10. Establish Process to Evaluate Key Factors to Improve Access to Quality Primary Care, BH and Preventive Care
11. Set Forth Actions to Ensure that Patients/Consumers with Limited English Proficiency Have Meaningful Access to Services
12. Develop User-Friendly Searchable Partner Listing on FLPPS website
13. Use Information to Inform the Identification and Implementation of Interventions/Service Delivery Approaches That Have Demonstrated Effectiveness
14. Identify Existing and Potential Community-Based Interventions that are Effective at Reducing Health Disparities
15. Work with Partners to Implement and Utilize High-Value Community-Based Services
16. Create Community Engagement Strategy with a Focus on Priority Populations
17. Define Plans for Two-Way Communication with Populations Served and Community Groups
18. Facilitate Partner Collaboration with CBOs

FLPPS Board Membership: FLPPS Board of Directors was established in December of 2014. The bylaws state that at least one member of the Board of Directors shall be a member of the patient/consumer population in the FLPPS region. This representation ensures the Board carries out its duties in a manner that reflects careful consideration of the patient/consumer population, including cultural and health literacy factors.

FLPPS CC/HL Committee: In 2015, FLPPS established a CC/HL Committee comprised of individuals with CC/HL experience from our Partner organizations, including healthcare and community based. The committee was convened to establish and monitor the process of CC/HL planning and implementation for the FLPPS network. The Committee meets bi-weekly at the FLPPS Central office.

Community Needs Assessment: During the DSRIP planning phase, and on behalf of FLPPS, the FLHSA completed a comprehensive Community Needs Assessment (CNA) in order to better define the cause and effect of deficiencies in regional system utilization and clinical outcomes. The team reviewed previous regional studies and reports, analyzed Medicaid data provided by the state, conducted 13 focus groups and 30 key informant interviews, and analyzed many other data sources. The process helped to identify healthcare gaps in the FLPPS region and informed the selection of DSRIP projects. The CNA described the FLPPS region along a number of dimensions important to the development of the CC/HL Strategic Plan. Key findings are recapped briefly below and a copy of the full CNA is included as **Appendix B.**

Priorities: The CNA identified four primary gaps in the Finger Lakes region: (1) The need for an Integrated Delivery System (IDS) to address chronic conditions; (2) The need for integration between physical and behavioral health; (3) The need to address social determinants of health; and (4) The need to support women, infants and children.

Disparities: Significant disparities exist among Black and Hispanic populations living in the Finger Lakes region, including higher rates of mortality and premature death. Evidence of disparities also extends to potentially avoidable hospitalizations. People of color have substantially higher rates of Prevention Quality Indicators (PQI), regardless of type.

Social Determinants of Health: According to regional stakeholders, social determinants of health are key influences on the health of the Medicaid population and significant contributors to population health. To improve access to quality primary health, behavioral health and preventive health care, addressing social determinants of health and socioeconomic barriers to health will be essential in improving health care disparities and achieving greater health outcomes.

Behavioral Health: Behavioral health conditions are prevalent in the FLPPS region, especially among the Medicaid population. Most notably, the region has a higher prevalence of depression, schizophrenia, and stress and anxiety disorders than the New York State Medicaid population as a whole. Additionally, the Medicaid population in the Finger Lakes region has over twice the rate of Attention Deficit Hyperactivity Disorder (ADHD). The cooccurrence of chronic conditions and other significant health concerns among the behavioral health population introduces further complexity in ensuring this subset of the population has access to the range of services needed to reduce the use of acute services.

Perinatal Health: Perinatal health is also an area of concern for the region. The FLPPS region historically experiences higher rates of infant mortality than either New York State or Upstate New York. Explanations for this phenomenon have been difficult to ascertain, as the region demonstrates relatively low rates of teen pregnancy (except in Monroe and Chemung counties) and higher percentages of parents receiving prenatal care.

Populations with Special Health Needs: The CNA identified a number of populations with special needs. In developing the CC/HL plan, these groups warrant particular focus. They include: Deaf and Hard of Hearing, Individuals with Intellectual and Developmental Disabilities, American Indian/Alaska Natives/Native Americans, Refugees and Rural Migrant Workers.

County-Specific Priorities: The CNA also leveraged a wealth of information gleaned from existing county-specific planning activities, which identified a range of local findings relative to health and wellness priorities, as well as gaps in the healthcare services delivery system and related essential social supports.

Identify and Describe Priority Groups: Building on the foundation of information that was assembled and analyzed through the CNA, additional steps were taken to identify and describe groups within the FLPPS region who are particularly vulnerable to poor health care outcomes. These steps included a thorough review of information describing potentially susceptible populations in terms of: (1) The number and distribution of the defined population; (2) Data on population-specific health care outcomes; (3) Access to quality care; and (4) The implications of CC/HL implementation. This information has been summarized in the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C).*** This report, discussed more specifically in Section A, was used to help shape the development of the CC/HL Strategic Plan.

CC/HL Introductory/Orientation Webinars: In the fall of 2015, three webinars were conducted and offered to all Partners in the FLPPS network. The webinars served to introduce CC/HL as part of the health care system's transformation, and informed on FLPPS' intended process and activities to integrate CC/HL into all aspects of FLPPS' operations and developing infrastructure.

Cultural Competence and Health Literacy Baseline among Provider Network: FLPPS established a baseline to inform the initiatives presented in the CC/HL Strategic Plan, asking the question: "Where do Partners within the FLPPS network currently fall along the CC/HL continuum?" To establish this metric, we asked Partners to complete an Organizational CC/HL Assessment. The assessment tool was developed by CCSI, and assesses the organizational structure, as well as key dimensions of cultural competence and health literacy. Thirty-seven Partner organizations, representing a cross-section of FLPPS' network Partners, initiated the Organizational Cultural Competence and Health Literacy Assessment. Ninety-seven percent submitted the 43-page assessment tool during the months of November and early December 2015. Data from this process was analyzed to identify common themes and current gaps, which are described in the document ***Organizational CC/HL Assessment: Partner Themes and Recommendations (Appendix E)***, and recapped briefly below. While preliminary in nature, these themes begin to identify some priority areas of focus.

Training Needed to Understand Cultural Attributes of Population Served: Partners reported high levels of discomfort in asking patients about their cultural attributes, either due to the fear of being intrusive or offensive, or being unclear of the value or requirement. While a fair percentage of respondents collected data on a minimum set of cultural attributes, several did not collect any. Further, a significant number did not understand the relationship between social determinants of health and patient experience, equitable care or improved outcomes. Having a staff reflective of the population served is critical to patient engagement and developing a clear understanding of cultural attributes of the population served will provide an indication of attributes they should be recruiting for in their staff, contractors/vendors and volunteers.

More Focus Needed to Understand Gaps in Language Accommodations: Some survey respondents, especially those serving migrant populations, made great efforts to provide services in a patient's preferred language, or referred patients to organizations able to accommodate their language needs. However, more often than not, providers were unable to define what languages, other than Spanish, where spoken by their patient population.

Need to Expand Performance Measurement Practices to Include Analysis by Subgroup: While some Partners appear to have Continuous Quality Improvement (CQI) processes in place, minimal attention is paid to the review of services and outcomes by cultural attributes and priority groups. Particular attention must be paid to the implementation, monitoring and evaluation of services to ensure that services meet clients' needs.

Need to Better Integrate CC/HL into the Organization: Although most Partners did not report having a budget or an assigned individual who is responsible to facilitate the adoption and weaving of CC/HL concepts and principles into the organization's infrastructure and service delivery, there is a certain level of interest and commitment to obtaining a better understanding of CC/HL, and willingness to work with FLPPS to incorporate these principles.

Complete Organizational Readiness Questionnaire: In parallel to the Organizational Cultural Competence and Health Literacy Assessment, all contracted Partners were asked to complete an ***Organizational Cultural Competence & Health Literacy Readiness Questionnaire (Appendix F).***

The data gathered through this process was reviewed and used to guide plan development. Partners cited difficulties in balancing the needs of the community with the requirements of funders and regulators. Many Partners reported their desire to improve outcomes for their patient population; however, many felt restricted by depleting fiscal resources, lack of workforce diversity, inadequate infrastructure, limited access to CC/HL training opportunities, changing funding focus and expectations, and minimal formalization of internal CC/HL policies. Further, Partners were unclear as to how to relate and integrate CC/HL/consumer culture and social determinants of health to clinical experience and service delivery. Partners are concerned about the possible adverse impacts of CC/HL implementation, including buy-in, cost and effort, and how this may further exacerbate limited resources and capacity. The need for technical assistance, training and infrastructure support was evident.

Community engagement is minimal in most cases. The inability to profile the attributes of their surrounding area prevents Partners from tailoring the organization's services to meet the specific needs of their patients/consumers. Increased knowledge of the community will improve the interactions and outcomes.

While Partners referenced the significance of their vision and mission statement in defining and driving the organization's provisions to meet the needs of their patients, staff and community, these tools often lacked language to support the incorporation of organizational CC/HL. This may provide some explanation as to why the Partners had difficulty connecting these concepts and practices to their patient and clinical interactions.

FLPPS Central Staff Training: All FLPPS Central staff members received CC/HL training. The training included self-awareness of one's own biases; organizational development; theory of change as it relates to embedding CC/HL into the organization, etc. This provided the framework for FLPPS Central to adopt, implement, formalize, monitor and evaluate their attempts of having an organization that is culturally competent and health literate -- a model for organizations within the FLPPS network.

Community Stakeholder Forums: Community engagement efforts began in 2014 with 13 "DSRIP Consumer Engagement Dimension" focus groups facilitated in urban (City of Rochester) and rural (regional) communities, conducted by the FLHSA DSRIP Team. The focus groups were supplemented by telephone-based, one-on-one, in-depth key informant interviews. Some of those interviews served to gather the stories from potential participants who never made it to a focus group session. Others targeted specific individuals with expertise or insight into one or more of the above topics, included among which were several providers mentioned during our focus groups as modeling positive behavior and providing extraordinary care.

A partnership of community organizations was formed with the New York State Department of Health Commissioner Dr. Howard Zucker's Minority Health Council to plan and produce the "Voice Your Vision: Rochester" session. On October 3, 2015, the "Voice Your Vision: Rochester" listening/engagement session was hosted, involving FLPPS, CCSI, FLHSA, and a number of community stakeholders and CBOs.

These experiences, further described below, presented an opportunity/forum to learn from patients/consumers, their experienced challenges/barriers to accessing quality healthcare and the possible solutions, in an effort to identify what is needed to strengthen, empower and sustain communities and ultimately improve health outcomes. The feedback, from patient/consumer voices, provided a better understanding of how to develop policies, allocate resources and support an infrastructure that works best for our community, which has been used to inform the development of the FLPPS CC/HL Strategic Plan.

"DSRIP Consumer Engagement Dimension" focus groups' data-driven themes and going-in intent were:

- Pregnant first-time mothers-to-be: intent = understanding prenatal care, or lack thereof
- Mothers of babies under age 3: intent = understanding their perceptions of emergency versus non-emergency pediatric needs
- Active behavioral health/frequent Emergency Department (ED) users: intent = understanding ED overuse by those with behavioral health issues]
- Frequent ED users without behavioral health diagnoses: intent = understanding ED overuse by those without behavioral health issues
- Chronic disease inpatients: intent = understanding how those with asthma, chronic obstructive pulmonary disease, diabetes or hypertension might, with proper preventative care, avoid hospitalization
- 30-day readmissions: intent = understanding how inpatients readmitted for the same condition might, with proper discharge instructions and follow-up care, avoid those readmissions
- Persons with recurring substance use disorder issues: intent = understanding the healthcare needs and experiences of those with chronic substance usage disorder
- One planned session gathered several members of the rural uninsured community to better understand their healthcare needs and experiences

"Voice Your Vision: Rochester" engagement/listening session convened to obtain a better understanding of:

- Healthcare challenges faced and/or barriers experienced by the community
- A vision, from the patient/consumer perspective, of how the patient's/community's health and well-being would/could improve, if challenges/barriers were addressed
- Existing community resources, services and assets that have been beneficial in assisting patients/communities to achieve better health outcomes
- Key community stakeholders

Topics discussed in small revolving groups were:

- Women's Health
- Taking Charge of Your Health *(health literacy, community education, social marketing)*
- Violence and Trauma *(a public health issue)*
- The Faith Community *(How the Faith Community impacts behavior change; their role in the community)*
- Seeking Services in the Community (*physical/mental and social services*)
- Youth and Adolescent Health
- Aging and Elder Care
- People with Disabilities *(deaf/hard of hearing, mobility challenges, blind/visually impaired)*
- LGBTQ Health
- Men's Health *(in a Barber Shop setting)*

Resonating Premises of Forums:

- Strengthening Patient-Provider/Healthcare Professionals cultural competence
    - Increase awareness/understanding of the intersection of poverty and health – social determinants of health
    - Increase understanding of stigma/perceptions associated with providing care
    - Increase understanding of how the social and emotional needs of individuals and health play a role in health-seeking behaviors and following up with health care needs
    - Increase awareness of patient knowledge/perceptions of different diseases
    - Increase awareness/sensitivity to challenges/barriers that may exist in accessing health care and social services
    - Encouraging shared decision-making
    - Encourage/support patient education

Section A:

Strategic Initiatives and Related Goals/Activities

CC/HL Strategic Initiatives, Foundational Goals and Interdependencies

To ensure the successful implementation of the outlined CC/HL Strategic Plan, CC/HL must not be viewed as stand-alone processes. Instead, efforts to strengthen practices relative to CC/HL will be integrated into all aspects of FLPPS operations and infrastructure development. In order to support the successful implementation of the activities outlined in this CC/HL Strategic Plan, FLPPS will establish/develop a supportive organizational infrastructure and create a mechanism to hold Partners accountable based on improved CC/HL practices, performance metrics, and improved patient outcomes and patient experience.

The following sections outline a set of specific goals and related activities that FLPPS may employ, to be implemented in a phased manner over the next four years. While necessarily detailed and specific, the plan is framed by the following overarching goal: ***To promote Patient Voice and Patient Choice while ensuring high value, equitable care.***

In reviewing this plan, it is important to note that the size and capacity of Partners may impact their ability to implement the activities, practices and strategies as presented within this CC/HL Strategic Plan; modifications will be made, as necessary, to reflect that these accommodations have been taken into consideration.

Strategic Initiative: Improve Health Outcomes among Priority Groups in the FLPPS Region

In developing a strategy for strengthening cultural competency and to address issues related to health literacy, we must pay particular attention to groups that are especially vulnerable and where significant disparities exist. This includes further examination of the disparities that each group experiences, along with continuous work with the community and identified priority groups through community stakeholder events, focus groups, hot spot analysis and patient engagement activities. In working with each priority group, the implementation of shared decision-making, patient self-management and cultural activation approaches are important to moving the system towards realizing the goal of **Patient Voice and Patient Choice**.

The goals and activities for this strategic initiative focus on continually refining our understanding of identified priority groups and their complexities, and identifying emerging and/or unidentified priority groups experiencing disparities through further data analysis and engagement with patients and communities.

To identify priority groups experiencing health care disparities within the FLPPS Region, empirical literature, peer-reviewed journals, census databases, public databases and regional data reports were examined, including:

- FLPPS DSRIP Community Needs Assessment
- NYS Medicaid Redesign Team Health Disparities Workgroup Report
- NYS County Prevention Agenda Data
- 2013 - 2017 Community Health Needs Assessments for Wayne County, Ontario County, Yates County, Seneca County, Cayuga County, Monroe County, Southeastern Steuben County, Chemung County, Livingston County, Allegany County, Genesee County, Orleans County, Wyoming County
- 2015 NYS Poverty Report
- ACT Rochester Community Report Cards
- Salient Medicaid Claims Data

Based on this analysis, the following populations were identified as priority groups based on their increased risk of poor health outcomes, as a result of social determinants of health, such as socioeconomic conditions (e.g., built environment, concentrated poverty, unemployment and the stressful conditions that accompany it), limited resources to meet daily needs, inadequate access to care, social norms and attitudes (e.g., discrimination, stigma, and distrust), limited education, inadequate availability of community-based resources, and language proficiency:

- African Americans
- American Indian/Alaska Natives
- Asian/Pacific Islanders

- Hispanics/Latinos
- Migrant and Seasonal Farmworkers (MSFWs)
- Refugees
- Individuals with Intellectual and Developmental Disabilities (IDD)
- Homeless
- Individuals w/ Mental, Emotional or Behavioral Health Disorders (MEB Disorders)
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S)
- Mothers, Infants & Children
- Deaf and Hard of Hearing
- Individuals and Families Living in Poverty

The ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)***, summarizes our findings and important information about each of these groups. The report was presented to the FLPPS CC/HL Committee on October 26, 2015, for review and input. This initial report will shape the implementation of the CC/HL Strategic Plan and Training Strategy, and will ultimately serve as an educational resource for providers, CBOs and Partners.

This report is a living document – one that we will continue to build on throughout the implementation of the CC/HL Strategic Plan.

GOAL #1: Identify Priority Groups experiencing health care disparities.

Activity: Identify, review and summarize data sources.

a. Review and analyze the ***FLPPS DSRIP Community Needs Assessment (Appendix B)*** and other data sources (e.g. County-Level Community/Health Assessments, Workgroup Reports, Regional Data Reports, Census/Public Databases, Salient Databases and NYS Prevention Agenda) to identify Priority Groups experiencing health care disparities.
b. Engage with community stakeholders to identify Priority Groups that are currently not and/or minimally represented in current data sources, such as Native Americans, homeless, LGBTQ, deaf and hard of hearing.
c. Conduct a literature review to identify implications for CC/HL.
d. Review findings from data sources with the CC/HL Committee for input and feedback.
e. Draft a report and summarize findings and important information about each of identified priority group.
f. Use findings to inform the CC/HL Strategic Plan.

Goal #1 Achievement Outcome Indicators:
- Priority Groups identified and summary report drafted
- Findings used to inform the CC/HL Strategic Plan

GOAL #2: Establish a process to continually refine our understanding of Priority Groups experiencing health care disparities.

Activity: Use data sources/information gleaned from the identification of Priority Groups and the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)*** to continuously refine the definition of Priority Groups experiencing health care disparities. Formal review should take place every two years, at minimum.

a. Conduct hotspot data analysis and GIS mapping to identify concentration areas (e.g., zip code, county by county, Naturally Occurring Care [NOCN]) experiencing disparities.
b. Engage with key community stakeholders to identify Priority Groups that are currently not and/or minimally represented in current data sources, such as Native Americans, Homeless, LGBTQI2-S, deaf and hard of hearing, vision loss and other hidden disabilities.
c. Engage with communities (e.g. focus groups, community stakeholder engagement forums, community listening sessions with patients/consumers, community health workers, and other stakeholders) within the FLPPS network to identify Priority Groups experiencing health care disparities.
d. Stratify Priority Groups per NOCN in collaboration with newly established NOCN CC/HL subcommittees and NOCN workgroups to refine understanding of Priority Groups on a sub-regional level, as related to the cultural nuances of each Priority Group.

Goal #2 Achievement Outcome Indicators:

- Additional unidentified and/or newly emerging Priority Groups identified every two years
- Community processes are used to further refine understanding of Priority Groups

GOAL #3: Identify existing and/or additional performance metrics that support the monitoring health care disparities among Priority Groups, by NOCN. Include CC/HL metrics on NOCN-specific performance dashboards.

Activity: Utilize performance metrics to identify and monitor health disparities among defined Priority Groups

a. Evaluate the organization's ability to stratify DSRIP performance metrics to highlight health disparities. Fill gaps, as needed, with additional performance metrics, as defined by the FLPPS CC/HL committee.
b. Include performance metrics, stratified by patient demographic variables and priority groups, on NOCN-Specific performance dashboards.
c. Establish CC/HL guidelines for NOCN-specific performance dashboards specially focused on disparities in health, social and behavioral determinants, access to care and quality of care.
d. Define and leverage incentives to hold Partners accountable for demonstrating progress in closing disparity gaps, based on improved CC/HL practices, performance metrics, improved patient outcomes and patient experience.

<u>Goal #3 Achievement Outcome Indicators</u>:

- CC/HL performance metrics identified and incorporated into NOCN-specific performance dashboards
- At least two (2) performance metrics related to elimination of disparities identified by each Partner within their scope of services
- Each Partner implementing interventions related to these performance metrics

GOAL #4: Support shared-decision making between patients and their healthcare providers, wellness self-management and patient self-advocacy approaches across the FLPPS network.

Activity: Develop guidelines for informing patients' choice in the selection of providers and services, through interpersonal communication, decision coaching/motivational interviewing and decision aids, which take patient initial/informed preferences into consideration.

a. Provide Partner/patient evidenced-based and community-defined evidence education related to shared-decision making, patient advocacy, and self-management of health/wellness to create health equity and address health disparities among priority groups.
    i. Establish a CC/HL resource repository, housed on the FLPPS website, for providers/Partners to access culturally relevant and appropriate, best and promising evidenced-based, and community-defined evidence self-management practices and resources for shared-decision making, and self-management of health/wellness, including culturally, linguistically and health literacy appropriate patient educational materials.
    ii. Establish a process to educate Partners, clinicians and other staff members that have contact with and serve patients/consumers regarding the impact that CC/HL may have on health, health seeking-behaviors, and ways to engage both Partners and patients in shared decision-making, so that encounters will be beneficial for both.

Goal #4 Achievement Outcome Indicators:

- 80% of contracted Partners participate in shared-decision making training by DSRIP Year 5
- Partners demonstrate an understanding of the concepts of shared-decision making and self-management health/wellness
- Care plans incorporate familial, individual and community strengths and interagency resources
- Patients demonstrate an understanding of the concepts of shared-decision making and self-management health/wellness as measured by patient experience survey

GOAL #5: Educate FLPPS Partners about the importance of patient cultural activation.

Activity: Host and facilitate modified learning collaborative sessions that focus on evidence-based and community-defined topics, such as motivational interviewing and the dynamics of power and privilege, and its impact on patient outcomes, particularly health disparities, as well as demystifying negative perceptions of Medicaid beneficiaries.

Goal #5 Achievement Outcome Indicators:

- 50% of Partners participate in cultural activation training by DSRIP Year 5
- Concepts of cultural activation embedded in Patient Rights and other relevant documents

Strategic Initiative Supporting Documentation:

- FLPPS Cultural Competence and Health Literacy Implementation Planning: Priority Groups Summary Report (Appendix C)
- A CQI Process that identifies Priority Groups experiencing health care disparities
- CC/HL Performance Measures Tracked by FLPPS
- CC/HL Dashboard - For Individual Partners and FLPPS Network
- Guidelines for informing patients about health/wellness self-management
- Shared-decision making protocols (implementation, monitoring and evaluating strategies) for Partners and patients
- Patient grievances

Strategic Initiative: Promote Patients' Ability to Self-Manage Conditions (Considering Cultural and Health Literacy Factors)

Implementation of shared decision-making, patient self-management and cultural activation approaches are important for realizing the goals of **Patient Voice and Patient Choice**. Culture affects how individuals communicate, understand and respond to any given intervention. As a result, we acknowledge the value of patient engagement, patient advocacy, patient-provider relationships and shared-decision making. The selection of assessments and tools to support patient self-management must be approached through a CC/HL lens, identifying those tools that are appropriate from a cultural, language and health literacy perspective.

The goals and activities for this strategic initiative focus on the identification of assessments and tools that incorporate CC/HL considerations and social determinants of health, recognizing local community cultural nuances, to support both Partners and patients in improving patient outcomes. Activities additionally focus on patient and community engagement in selection of tools and implementation.

GOAL #6: Identify assessments and tools to assist patients with the self-management of their health conditions. The tools will include appropriate cultural, language and literacy considerations.

Activity: Identify key factors driving health disparities, and identify resources to support providers in addressing them.

a. Use data/information gleaned from the identification of Priority Groups and the "Priority Groups Summary Report" as the baseline for the identification of assessments and tools to assist Partners and patients with the patients' self-management of their health conditions.

Activity: Conduct a comprehensive literature review and seek guidance from experts, as needed, to develop a comprehensive set of assessments, tools and other resources aimed at supporting and activating patients to manage their health conditions.

a. Identify brief tools for Partners to assist in assessing patient culture, health literacy and preferred language to facilitate care/service delivery through:
    i. Incorporation of culturally responsive interview techniques.
    ii. Patient-Provider/Partner collaboration, and identification of patient preferences, regarding inclusion of family/community members as an approach to decrease barriers to quality care.
    iii. Encouraging and assisting Partners to explore, acknowledge and incorporate patient's cultural nuances in care/service delivery, such as:
        - Cultural identity and acculturation (self-identification)
        - Membership in a sub-culture (culture within a culture)
        - Beliefs about health, healing, and help-seeking (cultural acceptance of behavior(s) related to health, healing and treatment practices)
        - Trauma and/or loss (stigma, discrimination, distrust, migration, relocation, and emigration)
        - Financial insecurity/poverty/limited resources
        - Inadequate access to care/resources
        - Educational level
        - Language proficiency/preferred language
        - Nationality (American-born/foreign-born)
        - Vision/hearing loss and hidden disabilities

Goal #6 Achievement Outcome Indicators:

- FLPPS Resource Repository includes a robust catalogue of assessments, tools and resources
- FLPPS conducts an annual review of resources, continually updating with new assessment tools as identified.

GOAL #7: Establish opportunities to support community collaboration, feedback and engagement in the development of strategies to identify assessments and tools that are culturally responsive, person-centered and will address social determinants of health.

Activity: Develop a process to review potential tools/resources with patients/consumers and providers to ensure that they are validated and appropriate for Priority Groups in terms of cultural, language and health literacy considerations.

a. Identify and form strategic alliances with existing community centers, CBOs, established cultural groups and gathering places (barber shops, churches, etc.).

b. Engage community leaders and members in the vetting process of assessments and tools to ensure that the tools are relevant and applicable to the diverse populations served within the FLPPS region.

c. Explore the cultural applicability of currently utilized assessments and tools, and their impact on health outcomes of the identified priority groups and subpopulations.

d. Assess and analyze assessments and tools, which:

    i. Support shared decision-making approaches to increase patient understanding of conditions and health status.

    ii. Acknowledge patients' sociocultural background.

    iii. Understand and incorporate relevant cultural factors while avoiding stereotypical "one-size-fits-all" approaches.

    iv. Identify culturally relevant concerns and issues.

    v. Mitigate negative influence of poor/decreased cross-cultural communication.

e. As necessary, tailor tools (with the authors' permission) according to the needs of the respective community/Priority Group/population.

f. Share culturally relevant best practices, including patient health/wellness self-management tools to share with providers to use with their patients/consumers.

Goal #7 Achievement Outcome Indicators:

- Processes are established for review and feedback on resources identified by patients/consumers, Partners and CC/HL Committee
- Resources identified are tailored as necessary to best meet local community needs

GOAL #8: Assemble tools and resources to support CC/HL principles.

Activity: Review literature on best/promising practices, training and technical assistance for integrating health care disparity elimination strategies, CC/HL into ongoing practices.

a. Identify patient/consumer- and provider-focused resources that will be most helpful in addressing identified priorities.

Activity: Develop an efficient way to catalogue and access CC/HL resources.

a. Create a repository on the FLPPS website that is easily accessible by providers and the provider network.

Activity: Establish a process to educate patients/consumers and Partners about the availability of these resources and to support their broad dissemination.

Goal #8 Achievement Outcome Indicators:

- FLPPS Resource Repository includes a robust catalogue of CC/HL tools and resources, in easily accessible, user-friendly formats
- FLPPS conducts an annual review of resources, continually updating with new resources as identified

GOAL #9: Operationalize health literacy in the network through the development, implementation, monitoring and evaluation of a health literacy plan.

Activity: Develop uniform health literacy standards, policies and procedures for FLPPS Central and the FLPPS network to ensure that *The Plain Writing Act of 2010* is upheld, to ensure that patient documents and educational materials are written in plain, easy-to-understand language.

a. Create and provide guidelines that detail the principles of the *Plain Writing Act of 2010* in accordance with health literacy.
b. Inform Partners of the *Plain Writing Act of 2010* to ensure effective implementation.
c. Monitor/Track Partners' implementation of the *Plain Writing Act of 2010* guidelines.

Activity: Develop uniform health literacy standards, policies and procedures for FLPPS Central and the FLPPS network to ensure that accurate, accessible, and actionable health information is targeted or tailored for the populations served.

a. Devise and schedule a training/professional development series for Partners, clinicians and other staff serving patients/consumers regarding health literacy topics, including:
    - Provider Patient/Communication - The use of health literacy strategies in interpersonal communications to ensure patient understanding and consideration of options
    - Health, Wellness and Medication Management - The use of health literacy strategies in incorporating shared decision-making and self-management approaches into practice
    - Informed Consent - The use of health literacy strategies to ensure patient understanding and consideration of their options relative to sharing of their health information

Activity: Integrate health literacy into planning, evaluation and quality improvement.

a. FLPPS will support Partners as they implement, and continuously improve, integrated health literacy into their organizational
b. FLPPS will support Partners in the adoption of various information presentation formats based on their service populations, for example:
    - Literacy rates of the population served
    - Education level of the population served
    - Language preferences of the population served
    - Cultural attributes of the population served
    - Consumer feedback

Goal #9 Achievement Outcome Indicators:

- FLPPS Health Literacy Plan developed, implemented and monitored against patient outcomes (performance tracked via dashboard metrics)
- Network Partners (80%) have developed and implemented their Health Literacy Strategic Plans

Strategic Initiative Supporting Documentation:

- FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)
- Community Meeting Documentation - agenda, presentation material/presentation summaries, meeting minutes/summary, attendee sign-in sheets
- Process toildentify, vet and validate assessment tools with Partners and patients
- Repository of CC/HL assessments, tools and resources to assist Partners in assessing the cultural and health literacy of their patients
- Community forums that promote and engage, patients, and stakeholders in two-way communication

Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health and Preventive Health Care (Considering Cultural and Health Literacy Factors)

Improving access to quality primary, behavioral health and preventive health care, is a continuous process that involves engagement with patients, communities, community stakeholders and Partners, as well as integration with the community. Effective interventions must include a recognition of key factors that impact disparities among priority populations. Specifically, when working to improve access to care, one must account for the complex interaction of cultural, economic, individual, linguistic, geographical, cognitive and social factors that guide health care utilization and health-seeking behaviors. Of great importance is the vetting of the selected interventions and strategies by the patients we serve, and the communities in which they live. In addition, the education of Partners is essential, to ensure that they are instruments in supporting and assisting patients in improving service utilization.

GOAL #10: Establish processes to evaluate key factors to improve access to quality primary care, behavioral health and preventive health.

Activity: Use data/information from the identification of priority groups and the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)*** as the baseline for the refinement of key factors associated with improving access to care.

a. Utilize implications for CC/HL outlined in the "Priority Groups Summary Report", as the framework for analyzing key considerations for improving access, engagement and quality of care for each population group through the lens of each group's culture profile and related barriers to access and/or engagement in services.

b. Use analyses to inform targeted strategies and interventions to address disparities.

Activity: Utilize FLPPS performance data, stratified by NOCN, Priority Group and services delivery areas (e.g. primary care, behavioral health and preventive care) to evaluate disparities and key factors associated with such disparities.

a. Continually measure and drive improvements to address disparities.

b. As needed, identify and analyze additional/new datasets and information resources that help to refine understanding of the key factors.

Activity: Engage with NOCNs to refine understanding of key factors associated with improving access.

a. Work with NOCNs define sub-regional nuances of each identified Priority Groups and to identify new/emerging populations of concern.

b. Work with NOCNs define additional metrics relative to local nuances important to assessing and understanding key factors associated with access.

Activity: Engage with local communities, including patients, to refine strategies to improve access to quality primary care, behavioral health and preventive health.

a. In collaboration with NOCNs, conduct focus groups and community listening sessions to share information and obtain input on the strategies to address access to care.

Goal #10 Achievement Outcome Indicators:

- Community-wide process and data analysis conducted and key factors associated with barriers to access are identified
- Findings used by network Partners to improve access to quality care, with progress reflected in performance metrics, stratified by Priority Groups

GOAL #11: Set forth actions to ensure that patients/consumers with Limited English Proficiency (LEP) have meaningful access to services that have incorporated cultural, linguistic and literacy factors.

Activity: Using available data sources, (e.g. U.S. Census, American Community Survey, client data, CBOs, government agencies, etc.) FLPPS will assess languages spoken of populations served within the FLPPS network.

Activity: As necessary, FLPPS will translate New York State mandated/compliance-related patient documents (e.g. Grievance Policy, HIPAA/Confidentiality, Consumer Rights) into Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille, (the top six languages spoken by individuals with LEP within New York State), as identified by the New York State Department of Labor, tailored to the FLPPS region.

Activity: As necessary, FLPPS will support Partners in offering New York State mandated/compliance-related patient print, audiovisual, and other forms of media content (e.g. Grievance Policy, HIPAA/Confidentiality, Consumer Rights, Consent/Release Forms, Discharge Documents, Prescription Information/Labels) in Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille and American Sign Language (the top six languages spoken by individuals with LEP within New York State), as identified by the New York State Department of Labor, tailored to the FLPPS region.

Activity: FLPPS will review internally-developed print, audiovisual, and other forms of media content with their Patient Advisory Committee (PAC) and/or via other expert stakeholders prior to dissemination.

Activity: FLPPS will establish a process to determine and reassess, at least every two years, the vital documents (including website content) that must be translated and/or updated.

Activity: FLPPS will compile and maintain a repository listing of local interpretive and translation services/resources for the populations served (e.g. oral interpretive resources, telephonic interpreting services, including contracts/arrangements with CBOs, individuals or vendors).

Activity: Provide mechanisms to support Partners with informing patients of their legal rights to request translation and interpretation services in their preferred language from healthcare facilities:

- Title VI of the Civil Rights Act of 1964
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and HealthCare
- HIPAA Regulations

Activity: FLPPS will provide Partners, clinicians, and other staff that interact and serve patients/consumers and family members, basic training on:

- The legal obligations to provide meaningful access to benefits and services to LEP individuals
- How to access/obtain/use/work with language assistance services (e.g. interpreters, language lines) in service delivery
- Documenting the language needs of LEP consumers/patients and the language services provided to them by the facility

Goal #11 Achievement Outcome Indicators:

- Partner handbooks are available in the preferred language(s) of the service population(s)/area(s), and include Patients' Rights
- Improved system utilization, including access to primary, behvioral health and preventive care by LEP populations

GOAL #12: Develop a user-friendly searchable listing of the FLPPS website that includes the description of Partner organizations, including contact information and website links, location, house, services provided, Medicaid acceptance, available language/interpretive services, and patient ratings using standardized measures.

Activity: Gather Partner data to post on FLPPS website.

Activity: Work with Partners to make listing widely available across their digital infrastructure, including website, electronic health records, care management systems, etc.

Activity: Establish a process which will prompt Partners, via automated reminders twice a year, to submit updated information to the resource directory.

Goal #12 Achievement Outcome Indicators:
- FLPPS and Partner websites enhanced to clearly display information in user-friendly formats
- Websites are routinely updated twice per year, more frequently as necessary, to incorporate FLPPS and/or Partner changes

GOAL #13: Use information from the identification of key factors associated with access to quality primary care, behavioral health and preventive health care, to inform the identification and implementation of interventions/service delivery approaches that have demonstrated effectiveness with Priority Groups, and incorporate CC/HL considerations and local nuances.

Activity: Under the direction of the CC/HL Committee, in collaboration with the Clinical Quality Committee, ensure that CC/HL is woven through the FLPPS network, as the foundational infrastructure from which to build effective DSRIP program implementation impacting indemnified priority populations.

Activity: Under the direction of the CC/HL Committee, in collaboration with the Clinical Quality Committee, establish processes and mechanisms to ensure that interventions/service delivery approaches are data-informed and community-driven, with attention to local cultural nuances and social determinants of health.

Activity: Under the direction of the CC/HL Committee, in collaboration with the Clinical Quality Committee, ensure that CQI processes are in place, to include focused attention on CC/HL throughout DSRIP program implementation.

Goal #13 Achievement Outcome Indicators:

- FLPPS organizational infrastructure in place to support activities

Strategic Initiative Supporting Documentation:

- FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)
- Community Meeting Documentation - agenda, presentation material/presentation summaries, meeting minutes/summary, attendee sign-in sheets
- A CQI Process that identifies key factors associated with improving access to care for patients in Priority Groups
- CC/HL dashboard template, highlighting CC/HL performance measures
- Community Forums with primary focus on access to quality primary health, behavioral health, and preventive health care
- Health Literacy Plan (implementation, monitoring, and evaluation strategies)
- Minutes/agendas of collaborative efforts, which identify and address social determinants of health and promotion of CC/HL principles

Strategic Initiative: Utilize Community-Based Interventions to Reduce Health Disparities and Improve Outcomes (Considering Cultural and Health Literacy Factors)

Community-based interventions that reduce health disparities and improve outcomes across the FLPPS region require an in-depth understanding of community, as well as Priority Groups and disparities impacting community. Work is needed to systematically conduct a thorough literature search to identify those interventions that have been shown to be effective with populations with a similar socio-demographic profile to the populations in our region. Additionally, a region-wide community exploration is needed to identify specific interventions shown to be effective in *our* communities as demonstrated through "practice-based evidence". To ensure that interventions truly recognize local cultural nuances and the complexity of our communities, a thorough vetting process involving patients and the community must be in place to best match interventions with each community and/or population group. Implementation of such interventions must be undertaken in a thorough manner, with support for training and CQI processes. Implementation of any new "pilot" interventions must include this support as well. Additionally, Partners and community stakeholders should have easy access to information describing these interventions and their applicability to assist in selecting the most appropriate intervention for their population of focus.

The goals and activities for this strategic initiative focus on continuous identification of disparities, comprehensive literature review and exploration to identify community-based interventions proven successful in addressing disparities and improving outcomes, both evidence-based and practice-based evidence, and engaging with patients and local communities to vet such interventions, to ensure a match with local cultural nuances. Goals also include awareness and implementation activities.

GOAL #14: Identify existing and potential community-based interventions that have been effectively shown to reduce health disparities among defined priority populations.

Activity: In concert with the development of the organization's Population Health Roadmap and implementation of Domain 4 projects, develop a directory of existing community-based interventions aimed at health status improvement, including documentation of program target populations.

Activity: As identified in project work plans, utilize performance metrics and analytic functionality to measure the impact of identified community-based interventions, with a specific focus on identified priority populations.

a. Use data to identify best practices and gaps in service delivery.

Activity: Conduct a comprehensive literature review and seek guidance from experts to define best-practices in community-based programming to fill identified gaps, including:

- Preventive health care delivery approaches, along with primary prevention/population health based strategies
- Community-based supportive services that address social determinants of health and operate in a manner that supports effective access to, and engagement in, primary care, behavioral health and preventive health care
- Approaches that integrate primary care and behavioral health care

Activity: The FLPPS CC/HL Committee and NOCNs will review interventions that appear to have promise for defined Priority Groups and communities.

a. Develop a compendium of high-value community-based services that NOCNs fill gaps in care.

b. Monitor the impact of community-based services over time and report using metrics included in the NOCN-specific performance dashboard.

Goal #14 Achievement Outcome Indicators:

- FLPPS Resource Repository established and includes a robust catalog of high-value community-based interventions

GOAL #15: Work with Partners to implement and utilize high-value, community-based programs that address health disparities among priority populations.

Activity: Promote the use of community-based programs shown to be effective, for example, community health workers, translators, case managers and peer support.

a. Using the FLPPS Information Technology (IT) ecosystem, create an effective tool to support providers in referring patients to appropriate community-based programs, taking into account a patient choice.

Activity: Monitor implementation, evaluate effectiveness, sustain effective activities, and improve or replace those that fail.

a. Continually assess the services along key performance metrics associated with CC/HL and disparities to determine effectiveness in improving patient outcomes and addressing disparities.

b. Work with community stakeholders and Partners to build capacity at the community levels to address needs and problems identified.

c. Create and sustain relationships between FLPPS and community Partners, with principles of co-learning, mutual benefit and long-term commitment, and incorporate community theories, participation and practices.

Strategic Initiative Supporting Documentation:

- FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)
- FLPPS DSRIP Community Needs Assessment (Appendix B)
- Completion of "Meeting Schedule Template" for all meetings that that have occurred with attendee list, minutes and presentation materials maintained on file
- List of community-based interventions to eliminate health care disparities
- Focus groups with consumers/patients
- Meeting agendas/minutes of Patient Advisory Committee
- Meeting agenda/minutes/materials for learning collaboratives that focus on community-based interventions that eliminate disparities

Strategic Initiative: Partner with Population of Focus and Other Community Groups to Improve Health Outcomes among Priority Groups Experiencing Health Care Disparities (Considering Cultural and Health Literacy Factors)

Patient Voice and Patient Choice are critical measures to capture, consider and incorporate into the health care system's transformative process. The FLPPS CC/HL Strategic Plan recommends multiple steps and methods that engage patients and their families, establishing mutual credibility, nurturing collaborative relationships and creating stakeholder buy-in. This process will collect information that will be used to: (1) Guide the enhancement of service delivery and increase health equity; (2) Disseminate materials to grow the health literacy of community stakeholders; and (3) Contribute to the elimination of health disparities and overall system improvements. To be effective, the methods established must be continuous and include mechanisms for routine feedback.

The goals and activities for this strategic initiative focus on developing and implementing the elements required for an effective two-way communication strategy between FLPPS and the populations and community groups in the FLPPS region.

GOAL #16: Create community engagement strategy with a particular focus on priority populations.

Activity: Convene a stakeholder group to inform, design/plan, monitor and evaluate the process. Community input will update and advise the enhancement of the FLPPS communication plans and improve the quality of policies, making them more practical and relevant to decrease barriers to care and improve outcomes.

a. FLPPS will develop a Community Stakeholder Group supported by FLPPS cultural competence senior-level staff.
b. The FLPPS Community Stakeholder Group will be comprised of:
    - Patients/consumers of services
    - CBOs
    - Faith-based organizations
    - Cultural brokers
    - Civic and neighborhood organizations
    - FLPPS representatives from the leadership group to serve in an advisory capacity
    - Representatives from the identified priority groups

Activity: The FLPPS Community Stakeholder Group will define Priority Groups whom FLPPS should communicate with – people, place, affiliation and cultural identity.

a. FLPPS Stakeholder Group will review the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)*** to identify and prioritize communication activities.
b. The FLPPS Community Stakeholder group will define methods of communication, employing social marketing approaches that incorporate the cultural nuances of the defined community.

Activity: FLPPS will engage the Patient Advisory Committees and Community Stakeholders Group in the creation of messages, and who best to deliver the information to and in what forums.

Activity: FLPPS will offer training and professional development opportunities for Partners, clinicians and staff on effective patient/consumer engagement approaches, and evidenced-based and community-defined evidence practices related to communications that address health disparities.

a. FLPPS will engage faith-based organizations to host educational opportunities and educate leaders on how they can engage their congregations in wellness self-management.

b. FLPPS will engage other organizations who are currently conducting outreach and education, to expand their content from general health to social determinants of health and CC/HL practices.

c. FLPPS will engage pharmacists and/or other providers/Partners prescribing medication, to translate prescriptions into preferred languages and formats for the population being served.

d. FLPPS will engender two-way communication via public forums and meetings by providing opportunities to explain to the community current news regarding the health care system, offer information, gather patient/consumer and community stakeholder feedback; demonstrate openness and transparency; and enable FLPPS Central to develop social networks.

Activity: FLPPS will create a process to evaluate impact and gather feedback.

Goal #16 Achievement Outcome Indicators:

- Key community stakeholders engaged in developing and implementing a communication strategy that incorporates essential elements of CC/HL informed approach
- Strategies evaluated to assess their reach/impact on identified Priority Groups

GOAL #17: Define plans for two-way communication with the populations served and community groups through the community stakeholder engagement forums.

Activity: FLPPS Community Stakeholder Group will define methods of communication that incorporate the cultural nuances of the defined community.

Activity: FLPPS will ensure all messages to the public are informed by consumers/patients, community, providers/Partners and data analysis. As applicable, messages should:

- Reduce stigma
- Be culturally informed
- Be respectful of cultural values
- Be available in accessible and alternative languages/formats
- Create environments where individuals can communicate /discuss concerns
- Be administered in different formats and locations
- Be jargon free

Activity: FLPPS will ensure that community meetings and forums are designated as "Safe Spaces" where all participants are encouraged to contribute, and are valued to present themselves as they feel comfortable.

a. Barriers to access to participate will be considered and necessary accommodations will be facilitated. Potential barriers are:
    - Meeting location
    - Transportation
    - Time of day
    - Language accessibility (e.g. LEP and Limited Reading Skills)
    - Mobility issues
    - Child care
    - Credibility within community

Activity: Feedback will be collected from stakeholders attending community meeting and forums. The information will be synthesized and then analyzed to draw out critical themes that will inform FLPPS' CQI process.

Activity: Create and implement a process that evaluates whether the messages were received and understood by the community and whether the engagement met its purpose.

a. Employ a CQI process.
b. Ensure timely feedback and next steps.
    i. Participants should be informed and given the opportunity to shape the next stages of the overall engagement process.

ii. Participants should be able to communicate during the process how stakeholders' input has influenced, contributed to, or improved the overall engagement outcomes.

FLPPS will plan for flexibility within the process. The focus should be retaining and developing meaningful engagement with the community: the context may change, stakeholders may challenge the purpose of the process, stakeholders may question the scope of the process, and stakeholders may question the scope of the objectives, methodology or require more information, more time or their own resources to co-design the process.

Goal #17 Achievement Outcome Indicators:

- Key community stakeholders engaged in developing and implementing community stakeholder engagement forums
- Community stakeholder engagement forums conducted in a CC/HL relevant manner and are accessible to representatives from priority groups
- Strategies for conducting forums evaluated to assess their reach/impact on identified priority groups

GOAL #18: Facilitate Partner collaboration with community-based organizations.

Activity: Educate Partners, clinicians and staff about the significance and importance of patient cultural activation.

Activity: In collaboration with CBOs, facilitate educational opportunities for Partners, focusing on topics such as:

- Population health and how their work contributes to health equity
- Acknowledging and understanding the cultural nuances of their patients/service population
- Understanding how illness is defined by their patients
- Understanding the value of stratifying patient health outcomes to improve health outcomes
- Understanding the value of evaluating the effectiveness of interventions to achieve goals and improve health outcomes

Activity: Collaborate with FLPPS' CC/HL Committee to establish guidelines in network Partner engagement with CBOs.

Activity: Host community learning/engagement sessions where CBOs will have the opportunity to present to Partner organizations the work they do, who are their consumers, any specialized service they offer, best practices and present the consumer outcomes achieved.

Activity: Support culturally tailored programs (e.g. diet, physical activity, and stress management) through CBOs and strategic alliances that train consumers in self-advocacy and wellness self-management, and train Partners in building trusting relationships with their patients.

Goal #20 Achievement Outcome Indicators:

- Key CBOs and stakeholders actively engaged with FLPPS
- Process for on-going/regular opportunities for collaboration between CBOs, FLPPS and the Partner Network established, aimed at improving patient experiences, health outcomes and eliminating disparities

Strategic Initiative Supporting Documentation:

- FLPPS Cultural Competency and Health Literacy Implementation Planning: Priority Groups Summary Report (Appendix C)
- Community Forums to Engage with the Community
- Meeting Agenda/Minutes of Patient Advisory Committee
- Two-Way Communication Plan with Population Served; Community Groups; Community Stakeholders
- Meeting Agenda/Minutes/Materials presented at community stakeholder meetings

Section B:
Foundational Goals and Related Activities

Rationale for Foundational Goals

To support the successful implementation of the CC/HL Strategic Plan, we recognize that cultural competence and its successes are dependent on an infrastructure that supports CC/HL goals. The foundational goals allow for the successful implementation of the CC/HL Strategic Plan in alignment with New York State Department of Health's (DOH) Approved Implementation Plan and the DOH's Requirements. Cultural competence and health literacy must not be viewed as stand-alone processes. Instead, efforts to strengthen practices relative to CC/HL must be integrated into all aspects of FLPPS operations and the infrastructure that is being developed (e.g. internal operations, IT structure, workforce strategies, and Partner relations). Interdependencies emphasize the essential collaboration and integration between FLPPS Operations, and the infrastructure necessary to ensure successful implementation, including interdependencies related to FLPPS organizational structure and FLPPS projects.

The foundational goals and activities focus on developing and implementing those key components of the FLPPS infrastructure that are necessary to support the CC/HL Strategic Plan, including ensuring that CC/HL is woven throughout FLPPS and its network.

FOUNDATIONAL GOAL #1: Ensure that CC/HL is woven throughout FLPPS Central.

Activity: FLPPS Central will complete an ***Organizational CC/HL Readiness Questionnaire (Appendix F)*** and ***Organizational CC/HL Assessment (Appendix D)***, the results of which will be used to inform organizational policies, practices and procedures, and identify training needs to ensure CC/HL practices are embedded throughout organizational operations.

Activity: FLPPS Central staff will receive regular CC/HL training to ensure staff remain knowledgeable of the most current CC/HL concepts, policies and processes.

Activity: FLPPS Central will establish an internal CC/HL Committee, responsible for operationalizing CC/HL activities.

a. FLPPS Central will designate a senior-level leadership position to oversee the internal CC/HL Committee. This individual will be the liaison between project managers and Partners, to ensure that CC/HL principles and concepts are woven into related activities.
b. FLPPS Central CC/HL Committee will provide advice and guidance to FLPPS in all areas pertaining to CC/HL.

Activity: FLPPS Central will develop an internal CC/HL strategic plan.

a. FLPPS Central will incorporate CC/HL concepts and principles into the internal CC/HL Strategic Plan.
b. FLPPS Central will reinforce the interdependencies of CC/HL concepts, principles and the work streams.
c. FLPPS Central will review the organization's vision, mission statement and guiding principles to ensure that CC/HL principles are incorporated.
d. FLPPS Central will identify the core CC/HL competencies as they exist within the organization and areas for improvement to formalize CC/HL goals.
e. FLPPS Central will secure technical assistance and support to ensure effective execution of their proposed CC/HL strategic plan.
f. FLPPS Central will develop internal processes and practices to ensure CC/HL is implemented, monitored and evaluated in all policies (e.g. human resources, fiscal, services, vendors, etc.).
g. FLPPS Central project managers will discuss their work streams with the CC/HL Committee twice a year, to review and identify CC/HL implications for recommendations and feedback.

h. FLPPS Central project managers will weave CC/HL feedback and recommendations into all projects.

Activity: FLPPS Central internal CC/HL Committee will review Partner reports to ensure that they reflect *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the National CLAS Standards) parameters to identify areas of improvement.

a. FLPPS Central project managers will provide feedback and recommendations to Partners and monitor progress.

Activity: FLPPS Central will expand its CC/HL Committee membership to include members from the population of focus.

a. FLPPS will utilize and collaborate with the Regional Multicultural Advisory Committee (RMAC) to support CC/HL processes and practices within the FLPPS network.

Activity: FLPPS Central will develop an internal Patient Advisory Committee, whose function will be to provide the patient/consumer lens to all CC/HL-related activities.

a. Patients/consumers will be represented on/included in FLPPS committees.

Activity: FLPPS Central will dedicate a definitive budget line item for CC/HL activities.

Foundational Goal #1 Achievement Outcome Indicators:

- FLPPS Central CC/HL Assessment completed
- FLPPS Central Organizational CC/HL Infrastructure established
- FLPPS CC/HL Strategic Plan developed, implemented and monitored
- CC/HL is woven into FLPPS Central organizational policies, practices and procedures
- A dedicated budget is in place for CC/HL activities

FOUNDATIONAL GOAL #2: Ensure that CC/HL is woven throughout the FLPPS Partnership.

Activity: FLPPS Partners will complete an ***Organizational CC/HL Readiness Questionnaire (Appendix F)*** and ***Organizational CC/HL Assessment (Appendix D***), the results of which will be used to inform their organizational policies, practices and procedures, and identify the targeted Partner groups for training and implementation support.

Activity: FLPPS Partners will designate a senior-level leadership position to oversee agency CC/HL within their organization.

Activity: FLPPS Partners will develop an internal CC/HL strategic plan.

a. FLPPS Partner agency will incorporate CC/HL concepts and principles into the internal CC/HL Strategic Plan.

b. FLPPS Partner agency will engages its constituents in CC/HL related activities.

c. FLPPS Partner agency will review the organization's vision and mission statement to ensure that CC/HL principles are incorporated.

d. FLPPS Partner agency will identify the core CC/HL competencies as they exist within the organization, and areas for improvement to formalize CC/HL goals.

Activity: Structure a process/system for each NOCN address CC/HL goals and objectives

Activity: Engage NOCNs to understand their communities, service and priority groups.

a. Each NOCN will provide input to the FLPPS Central CC/HL Committee.

Activity: Provide Partners with resources to educate and support CC/HL practices.

Foundational Goal #2 Achievement Outcome Indicators

- Network Partners' CC/HL Organizational and/or Readiness Assessments completed
- Network Partners have developed and implemented their CC/HL Strategic Plans and processes are in place for monitoring and evaluation
- CC/HL is woven into Network Partners' policies, practices and procedures
- Structure and processes are operational for intergration of CC/HL at the NOCN Level

FOUNDATIONAL GOAL #3: Ensure FLPPS IT ecosystem incorporates CC/HL principles into the data collection, data analysis and data management processes.

Activity: Create a data platform that is responsive to identified priority populations.

a. Provide the necessary technical assistance/support to ensure Partners have the internal infrastructure necessary to collect and use data relative to CC/HL and health care disparities.

b. Create mechanisms to hold Partners accountable for demonstrating progress in closing disparity gaps, based on improved CC/HL practices, performance measures, improved patient outcomes and patient experience.

c. Provide training and technical support to staff and network Partners on the cultural nuances of data collection, analysis and management, such as:
   - Data Collection Methods: CC/HL relevant primary and secondary data collection methods
   - Data Analysis: Meaningful use of data (purpose, benefit and value of data) to improve outcomes on the patient-level, Partner-level, community-level, organizational-level and policy-level
   - Data Management: CC/HL relevant policies, practices and procedures to ensure that the data/infrastructure is managed effectively

Activity: Ensure that the FLPPS data collection and management process incorporates CC/HL relevant data elements necessary for culturally responsive patient assessment, patient care planning, Partner performance management and network performance management as needed, to monitor outcomes and disparities among priority groups.

a. Require data collection efforts to incorporate Priority Groups and cultural attributes.

b. Analyze Partner performance on established outcomes, which will be stratified by Priority Groups to identify disparities.

Foundational Goal #3 Achievement Outcome Indicators:

- FLPPS data platform incorporates data elements relative to cultural attributes, especially idenitified Priority Groups
- FLPPS data infrastructure established to enable FLPPS to collect, analyze and report relevant data from Partners, to support work to identify and eliminate disparities and create health equity

FOUNDATIONAL GOAL #5: Use CC/HL to guide the development of a diverse workforce that represents the populations served.

Activity: Provide consultation to the FLPPS Workforce Operational Workgroup (WOW) to ensure the incorporation of CC/HL principles.

Activity: Track and monitor Partners' participation in culturally relevant and health literacy appropriate training as designated in the CC/HL Training Plan.

Activity: Analyze the FLPPS network's current workforce to identify workforce/staff needs reflective of the Priority Groups and communities served.

Activity: Incorporate improved workforce diversity and professional development as a key principle of its operating practices. Progress will be reported annually.

Activity: Assess the workforce's professional development needs regarding cross-cultural clinical interactions, and incorporating CC/HL into Partner policies, clinical practices, and staff approaches when engaging and serving patients/consumers.

a. Devise and schedule a training/professional development series for Partners, clinicians and other staff serving patients/consumers to address cross-cultural clinical interactions, and incorporating CC/HL into Partner policies, clinical practices and staff approaches when engaging and serving patients/consumers.

Foundational Goal #5 Achievement Outcome Indicators:

- Plan developed for recruitment, retention and promotion of workforce that represents the cultural groups represented within the FLPPS network
- Culturally competent and health literacy appropriate training provided for the workforce, as defined by training needs identified by the CC/HL Training Plan
- 80% of Partners will participate in culturally relevant and health literate appropriate training by DSRIP Year 5 End, as designated in the CC/HL Training Plan

FOUNDATIONAL GOAL #6: Ensure corporate compliance reporting mechanisms include CC/HL strategies.

Activity: Develop formal procedures for decision-making related to policies, practices and grievances, in accordance with state and federal law.

Activity: Develop and implement a multi-reporting process/system for patients/consumers to report grievances/complaints regarding network Partners, organizations or staff, that takes into consideration potential barriers (e.g. limited access/availability of patient reporting options, language, lack of confidentiality or anonymity, fear of retribution/denial of benefits or services):

- Web-based
- Verbal via phone/message line
- Mobile via text message
- Written
- In person via Ombudsman, navigators

<u>Foundational Goal #6 Achievement Outcome Indicators</u>:

- Patients/consumers are aware of and understand the grievance process, as measured by the patient experience survey
- 80% of patients indicating that they have used the process report ease of use, as measured by the patient experience survey by DSRIP Year 5 End; Phase In: 50% by DSRIP Year 4, and 80% by DSRIP Year 5 End
- 80% of patients and Partners indicating that they have used the process report that the process resulted in a mutually agreed upon positive outcome between patient and Partners by DSRIP Year 5 End; Phase In: 50% by DSRIP Year 4, and 80% by DSRIP Year 5 End
- Grievance complaints are tracked by Partners; grievance type and outcome are factored into Partners' performance metrics

Supporting Documentation for Foundational Goals:

- FLPPS Central CC/HL Assessment Report with Identifying Strengths and Areas for Improvement
- FLPPS Central CC/HL Strategic Plan
- FLPPS organizational structire depicting CC/HL principles at the executive-level
- Project plan (workflows) to weave CC/HL principles
- CC/HL dashboard that tracks project outcomes for effectiveness
- Meeting agendas/minutes/materials for FLPPS Central CC/HL Committee
- Meeting agendas/minutes/materials for Patient Advisory Committee
- CC/HL Network Partners Report, that identifies strengths and areas for improvement; update strategic plan
- Meeting agendas/minutes/materials for NOCN CC/HL Committee, any regional group addressing the cultural nuances of the region
- Data platform
- Partner contracts, that hold Partners accountable to demonstrating progress in closing disparity gaps, based on improved CC/HL practices, performance metrics, improved patient outcomes and patient experience

Section C: Interdependencies - CC/HL Strategic Plan and FLPPS Projects

Interdependencies: CC/HL Strategic Plan and FLPPS Projects

To be successful in implementing the plan outlined in the sections that follows, CC/HL must not be viewed as stand-alone processes. Instead, efforts to strengthen practices relative to CC/HL must be integrated into all aspects of FLPPS operations and the infrastructure that is being developed. The following work streams are essential to the implementation, evaluation and outcomes of the CC/HL Strategic Plan:

Information Technology Systems and Processes - *A key driver.*

A fundamental step in identifying which populations are most at risk, and where we are making progress in eliminating disparities, is to develop the capacity to collect, analyze and report on key performance metrics by cultural and sociodemographic dimensions including: race, ethnicity, English-language proficiency, sexual orientation/gender identity, disability, immigration status, housing status, and socioeconomic status (SES). Standardization of data across the network, its availability, how and in what format it is disseminated, and the timeliness will ensure a process to collect reliable data that is suitable for making continuous quality improvement decisions.

Workforce - *Conscientious hiring and professional development.*

Workforce efforts should be made to hire a workforce that is reflective of and has experience working with marginalized populations; while paying particular attention to job requirements to ensure that the applicant pool is very diverse, and that individuals from diverse cultural groups are not subconsciously blocked from getting into the workforce (e.g. look for individuals who have experience working with the service population, but may not have academic qualifications that are not necessary in treating the patient). FLPPS principles encourage the continuous nature of professional development, which learning is a transformative process, as a facet of sound cross-cultural practices. Professional development must be grounded in the context of CC/HL, which characterizes the diffusion of professional knowledge to build sustainable work environments focused on improving the health outcomes of FLPPS' service populations.

Practitioner Engagement - *Training, education, and support.*

The CC/HL Committee of FLPPS Central will work closely with the Partner Relations Branch of FLPPS to ensure that cultural competency education and training of Partners is performed and evaluated periodically. Activities that serve to build the relationship between Partners and FLPPS will be reviewed through the cultural lens of the FLPPS CC/HL Committee for recommendations; while the FLPPS CC/HL Manager will ensure that activities are adhering to established FLPPS governing CC/HL policies and procedures.

Population Health Management - *A view of Priority Groups.*

The identification of key Priority Groups experiencing disparities as initiated through the CC/HL division will form a core component of high-risk priority groups targeted for the Domain 4 - Population Health Management projects. In addition, CC/HL will overlap with strategies and interventions implemented for Partners, patients and the wider community, to increase greater access to care, access to education of linguistic and culturally relevant and appropriate self-management and wellness tools, and primary and preventative care services, with staff that have undergone FLPPS approved cultural competency training and verified health literacy measures.

Clinical Integration - *Healing the WHOLE patient.*

The CC/HL division will also work with the clinical oversight branch of FLPPS to inform clinical protocols, particularly in the areas of care coordination and discharge procedures, to ensure that cultural nuances of patients in the FLPPS region are taken into consideration to a reasonable extent (e.g. the inclusion of linking/connecting patients to an identified resource, such as a CBO, faith-based organization/leader, or group to receive care and support upon discharge).

Patient Engagement and Activation - *"I am the expert on me"*.

Given the importance of cultural competence to patient engagement and activation, the CC/HL branch of FLPPS will work closely with the project managers and associated CC/HL committees and patient advisory groups/committees, to conduct coordinated patient and wider community education around the importance of ownership of health/healthcare decision-making, health insurance and knowledge about local primary and preventative care resources that are offered in relevant languages and with cultural considerations.

Communication - *Seeking to understand, then to be understood.*

Since many of CC/HL efforts are communication driven, there will be significant interdependency between the CC/HL Committee and the communication division of FLPPS. Both outward and inward facing communication documents, materials and correspondences should adhere to CC/HL policies and procedures. Public communication forums and social marketing initiatives, as initiated through FLPPS, will be influenced by recommendations from the CC/HL and Patient Advisory Committees. FLPPS communication strategy should also incorporate aspects of the CC/HL Strategic Plan to ensure successful implementation and achievement of milestones.

FLPPS Organizational Structure - *Representing the expectation.*

All aspects of FLPPS must be aligned to fully achieve CC/HL. This involves the alignment of certain elements that can be described as "hard" (strategy, structure, systems) or "soft" (shared values, skills, styles and staff). Policies, processes, organizational charts, reporting lines, formal processes, IT, etc. will influence and be influenced by CC/HL. For the CC/HL Strategic Plan to be effective these elements must be aligned and mutually reinforcing.

CC/HL Training

CC/HL training needs will focus on improving the current performance within the FLPPS network, and harness resources, knowledge and expertise in the community. These trainings will endeavor to ensure that skill sets exist amongst:

- Partner staff
- clinicians
- community stakeholders
- Patients/consumers

The skill sets learned will engender the improvement of health equity for all served; work to eliminate health disparities experienced by priority groups; support the optimization of the human resource capital amongst FLPPS providers; and empower patients/consumers to self-manage their personal health care.

CC/HL training and professional development of network Partners and their respective staff, as well as community stakeholders, will need to vary in delivery methods. Methods will include:

- e-Learning segments taken online
- On-site training, off-site programs
- Learning on-the-job
- Cohort-based webinars
- Community meetings and forums
- Other accessible and culturally considerate formats

Assessment of the FLPPS network's current CC/HL baseline was analyzed and training needs were identified through feedback collected from the:

- "CC/HL Organizational Self-Assessment" tool and "CC/HL Readiness Questionnaire" completed by network Partners
- Community stakeholder engagement forums
- Review of the region's health care system's supports, regulations/requirements and infrastructure

Some early identified Partner training needs were:

- Foundational CC/HL training to define, explain and process what CC/HL is and how to incorporate these concepts and approaches into all aspects of the provider's organization
- Board governance
- Drafting CC/HL policies

- Data collection and its meaningful use
- Continuous quality improvement processes
- Language accommodations
- Building a diverse and culturally respectful workforce
- Convening and tasking an internal CC/HL committee, Patient Advisory Board, Quality Assurance/Quality (QA/QI) Improvement committee
- Patient prescription literacy
- Patient rights and responsibilities
- Health literacy

Training opportunities, resources and materials will be promoted in multiple formats (e.g. FLPPS newsletter, emails, media, webinars, mailings, Partner communications) are made available via a repository located on the FLPPS website. Evaluation of trainings will be conducted to reveal successful experiences, areas that require improvement, and if new techniques, concepts, practices and information were properly incorporated and implemented among the participants and their organizations.

FLPPS regional gaps will be assessed periodically and on-going to determine area trends, and the corresponding training needs necessary for network professionals, community stakeholders and patients/consumers.

Implementation planning, compelling communications, dedicated participation and inspired teaching are essential.

Summary

The CC/HL Strategic Plan integrates the necessarily ambitious and aggressive set of goals and supporting activities that FLPPS will need to spearhead in order to achieve the objectives of the DSRIP initiative, and to transform how people in the Finger Lakes Region experience our health care system and the outcomes they receive. As noted above, this will require a focused and sustained effort to create a system of care, which is sensitive and responsive to the different cultures, including the cultural attributes of priority groups, as well as the varying degrees of health literacy among the residents of our region.

The Project Timeline (Appendix A) was created in order to provide guidance with respect to how the implementation of these activities will need to be sequenced over the next four years if we are to be successful. In considering the timing of the goals and associated activities, attention has been paid to identifying those that are (1) foundational in nature in that they create the infrastructure necessary for other work to take place; (2) the highest priority in terms of potential impact on **Patient Voice and Patient Choice**; and (3) important in creating the forward momentum and tangible progress needed to help build and maintain support for the CC/HL initiative. This timeline is intended to serve as a starting point from which the FLPPS leadership and Partners, CC/HL vendor, and community stakeholders will build as the work begins in earnest.

There are a few key elements that also warrant emphasizing:

- Successful implementation will require the intentional, coordinated, and consistent "marketing" of CC/HL, both internally and externally, so that stakeholders have a solid appreciation for the true value and impact of CC/HL as an integral component of the DSRIP initiative.
- The CC/HL Strategic Plan must be informed and progress gauged by the best possible data we can gather, and this information must be shared in ways that are useful, accessible and transparent for all constituencies. As such, it will be critical to begin to assemble and share information on disparities in key outcome areas as early as possible. While some data can be derived from the New York State Medicaid Data Warehouse using Salient, it will be important to incorporate other data sources as the project evolves.
- Finally, the CC/HL Strategic Plan must include opportunities for **Patient Voice and Patient Choice** in shaping the redesign of the Medicaid system so that it truly addresses those things that are most important to patients and the communities that support them. FLPPS has an important responsibility to foster these opportunities at critical junctures, from governance and project management structures, to the criteria used to

identify clinical approaches, tools and resources to be made available to patients to support their shared decision making and active participation in critical healthcare experiences.

The overarching goal for this CC/HL Strategic Plan, **"To Promote Patient Voice and Patient Choice, While Ensuring High Value, Equitable Care"**, provides a framework for FLPPS to transform the health care delivery system to become one that is responsive to the needs of its Partner network and populations served.

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Health Outcomes among Priority Groups the FLPPS Region (Considering Cultural, Linguistic and Literacy Factors)																
Goal #1: Identify priority groups experiencing health care disparities.																
Activity: Identify, review and summarize data sources.																
a. Review and analyze the FLPPS DSRIP Community Needs Assessment (Appendix B) and other data sources (e.g. County-Level Community/Health Assessments, Workgroup Reports, Regional Data Reports, Census/Public Databases,Salient Databases and NYS Prevention Agenda) to identify priority groups experiencing health disparities.																
b. Engage with community stakeholders to identify priority groups that arecurrently not/minimally represented in current data sources, such as Native Americans, Homeless, LGBTQ, Deaf and Hard of Hearing.																
c. Conduct a literature review to identify implications for cultural competenceand health literacy.																
d. Review findings from data sources with the CCHL Committee for input andfeedback.																
Draft a report and summarize findings and important information abouteach of identified priority groups.																
e. Use findings to inform the CCHL Strategic Plan.																
f. Update the *FLPPS Cultural Competency and Health Literacy Implementation Planning: Priority Groups Summary Report (Appendix C)* as we refine our understandingof priority groups experiencing health care disparities.																
Goal #1 Achievement Outcome Indicators:																
Priority Groups Identified and Summary Report Drafted																
Findings used to inform the CC/HL Strategic Plan																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Health Outcomes among Priority Groups the FLPPS Region (Considering Cultural, Linguistic and Literacy Factors)																
Goal #2: Establish a process to continually identify and refine our understanding of prioritygroups experiencing health care disparities.																
Activity: Use data sources/information gleaned from the identification of priority groups and the FLPPS Cultural Competency and Health Literacy Implementation Planning: Priority Group Summary Report (Appendix C) as the baseline for priority groups experiencing healthcare disparities																
a. Conduct hotspot data analysis and GIS mapping to identify concentration areas (e.g., zip code, county by county, NOCN) experiencing disparities.																
b. Engage with key community stakeholders to identify priority groups that are currently not and/or minimally represented in current data sources, such as Native Americans, Homeless LGBTQ12-S, Deaf and Hard of Hearing, Vision Loss and other Hidden Disabilities.																
c. Engage with communities (e.g. focus groups, community stakeholder engagement forums, community listening sessions with patients/consumers, community health workers, and other stakeholders) within the FLPPS network to identify priority groups experiencing health care disparities.																
d. Stratify priority groups per NOCN in collaboration with newly established NOCN CCHL sub-committees and NOCN Workgroups to refine understanding of priority groups on a sub-regional level, as related to the cultural nuances of each priority group.																
<u>Goal #2 Achievement Outcome Indicators:</u>																
Additional unidentified and/or newly emerging priority groups identified every 2 years																
Community processes are used to further refine understanding of priority																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Health Outcomes among Priority Groups the FLPPS Region (Considering Cultural, Linguistic and Literacy Factors)																
Goal #3: Identify existing and/or additional performance metrics that support the monitoring of health care disparities among priority groups, by NOCN. Include CCHL metrics on NOCN-specific Performance Dashboards.																
Activity: Utilize performance metrics to identify and monitor health disparities among defined priority groups.																
a. Evaluate the organization's ability to stratify DSRIP performance metrics to highlight health disparities. Fill gaps, as needed, with additional performance metrics, as defined by the FLPPS CCHL committee.																
b. Include performance metrics, stratified by patient demographic variables and priority groups, on NOCN-Specific Performance Dashboards.																
c. Establish CCHL guidelines for NOCN-specific Performance Dashboards specially focused on disparities in health, social and behavioral determinants, access to care and quality of care.																
d. Define and leverage incentives to hold partners accountable for demonstrating progress in closing disparity gaps, based on improved CCHL practices, performance metrics, improved patient outcomes and patient experience.																
Goal #3 Achievement Outcome Indicators:																
CCHL Performance Metrics identified and incorporated into NOCN-Specific Performance Dashboard																
At least two (2) performance metrics related to elimination of disparities identified by each partner within their scope of services																
Each partner implementing interventions related to these performance metrics																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	**2016**				**2017**				**2018**				**2019**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Strategic Initiative: Improve Health Outcomes among Priority Groups the FLPPS Region (Considering Cultural, Linguistic and Literacy Factors)																
Goal #4: Support shared-decision making between patients and their healthcare providers,wellness self-management and patient self-advocacy approaches across the FLPPSNetwork.																
Activity: Develop guidelines for informing patients' choice in the selection of healthplans, providers and other health care services, through interpersonal communication, coaching/motivational interviewing and decision aids, which take patient initial/informed preferences into consideration.																
a. Provide partner/patient evidenced based and community-defined evidenced related to shared-decision making, patient advocacy, and self-management of health/wellness to create health equity and address health disparities among priority groups.																
i. Establish a CCHL resource repository – housed on the FLPPS website, for providers/partners to access culturally relevant and appropriate best and promising evidenced-based and community-defined evidenced self-management practices and resources for shared-decision making and self-management of health/wellness, including culturally, linguistically and health literacy appropriate patient educational materials.																
ii. Establish a process to educate partners, clinicians and other staff members that have contact with and serve patients/consumers regarding the impact that CCHL may have on health, health seeking-behaviors, and ways to engage both partners and patients in shared decision-making – so that encounters will be beneficial for both.																

FLPPS CCHL Strategic Plan Timeline

<u>Goal #4 Achievement Outcome Indicators:</u>	
80% of partners participate in shared-decision making training by DSRIP Year 5	
Partners demonstrate an understanding of the concepts of shared-decision making and self-management health/wellness	
Care plans incorporate familial, individual and community strengths and inter-agencyresources	
Patients demonstrate an understanding of the concepts of shared-decision making andself-management health/wellness as measured by patient experience survey	

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	**2016**				**2017**				**2018**				**2019**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Strategic Initiative: Improve Health Outcomes among Priority Groups the FLPPS Region (Considering Cultural, Linguistic and Literacy Factors)																
Goal #5: Educate FLPPS partners about the importance of patient cultural activation.																
Activity: Host and facilitate modified learning collaborative sessions that focus on evidenced-based and community-defined topics such as motivational interviewing and the dynamics of power and privilege and its impact on patient outcomes, particularly health disparities, as well as demystifying negative perceptions of Medicaid beneficiaries.																
<u>Goal #5 Achievement Outcome Indicators:</u>																
50% of partners participate in cultural activation training by DSRIP Year 5																
Concepts of cultural activation embedded in Patient Rights and other relevantdocuments																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Promote Patients' Ability to Self-Manage Conditions (Considering Cultural, Linguistic and Literacy Factors)																
Goal #6: Identify assessments and tools to assist patients with the self-management oftheir health conditions. The tools will include appropriate cultural, language and literacyconsiderations.																
Activity: Implement a plan to identify key factors associated with disparities, and identify resources to address/overcome them.																
a. Use data/information gleaned from the identification of priority groups and the "Priority Groups Summary Report" as the baseline for the identification of assessments and tools to assist partners and patients with the patient's self-management of their health conditions.																
Activity: Conduct a comprehensive literature review and seek guidance from experts, as needed, to develop a comprehensive set of assessments, tools and other resources aimed at supporting and activating patients to manage their health conditions.																

FLPPS CCHL Strategic Plan Timeline

a. Identify brief tools for partners to assist in assessing patient culture, health literacy and preferred language to facilitate care/service delivery through: 1. Incorporation of culturally responsive interview techniques. 2. Patient-Provider/Partner collaboration, and identification of patient preferences, regarding inclusion of family/community members as an approach to decrease barriers to quality care. 3. Encouraging and assisting partners to explore, acknowledge and incorporate patient's cultural nuances in care/service delivery, such as: • Cultural Identity and Acculturation (Self-identification) • Membership in a Sub-Culture (Culture within a Culture) • Beliefs about health, healing, and help-seeking (cultural acceptance of behavior(s) related to health, healing and treatment practices) • Trauma and/or Loss (stigma, discrimination, distrust, migration, relocation, and emigration) • Financial Insecurity/Poverty/Limited Resources • Inadequate Access to Care/Resources • Educational Level • Language Proficiency/Preferred Language • Nationality (American-Born/Foreign-Born) • Vision/Hearing Loss and Hidden Disabilities																
Goal #6 Achievement Outcome Indicators:																
FLPPS Resource Repository includes a robust catalogue of assessments, tools and resources																
FLPPS conducts an annual review of resources, continually updating with new assessment tools as identified																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Promote Patients' Ability to Self-Manage Conditions (Considering Cultural, Linguistic and Literacy Factors)																
Goal #7: Establish opportunities to support community collaboration, feedback andengagement in the development of strategies to identify assessments and tools that areculturally responsive, person-centered and will address social determinants of health.																
Activity: Develop a process to review potential tools/resources with patients and consumers, providers to ensure that they are validated and appropriate for priority populations in terms of cultural, language and health literacy considerations.																
a. Identify and form strategic alliances with existing community centers, community based organizations, established cultural groups and gathering places (barber shops, churches, etc.).																
b. Engage community leaders and members in the vetting process of assessments and tools to ensure that the tools are relevant and applicable to the diverse populations served within the FLPPS region.																
c. Explore the cultural applicability of currently utilized assessments and tools, and their impact on health outcomes of the identified priority groups and subpopulations.																

FLPPS CCHL Strategic Plan Timeline

d. Assess and analyze assessments and tools, which: i. Support shared decision-making approaches to increase patient understanding of conditions and health status. ii. Acknowledge patients' sociocultural background. iii. Understand and incorporate relevant cultural factors while avoiding stereotypical "one-size-fits-all" approaches. iv. Identify culturally relevant concerns and issues. v. Mitigate negative influence of poor/decreased cross-cultural communication.																
e. As necessary, tailor tools (with the authors' permission) according to the needs of the respective community/priority group/population.																
f. Share culturally relevant best practices, including patient health/wellness self-management tools to share with providers to use with their patients/consumers.																
<u>Goal #7 Achievement Outcome Indicators:</u>																
Processes are established for review and feedback on resources identified by patients/consumers, partners and CCHL Committee																
Resources identified are tailored as necessary to best meet local community needs																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Promote Patients' Ability to Self-Manage Conditions (Considering Cultural, Linguistic and Literacy Factors)																
Goal #8: Assemble tools and resources to support CCHL principles.																
Activity: Review literature on best/promising practices, training and technical assistance for integrating health care disparity elimination strategies, cultural competence and health literacy into ongoing practices.																
a. Identify consumer- and provider-focused resources that will be most helpful in addressing identified priorities.																
Activity: Develop an efficient way to catalogue and access cultural competence and health literacy resources.																
a. Create a repository on the FLPPS website that is easily accessible by providers and the provider network.																
Activity: Establish a process to educate partners/consumers and partners about the availability of these resources and to support their broad dissemination.																
Goal #8 Achievement Outcome Indicators:																
FLPPS Resource Repository includes a robust catalogue of CCHL tools and resources, in easily accessible, user-friendly formats																
FLPPS conducts an annual review of resources, continually updating with new resources as identified																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health, andPreventive Health Care (Considering Cultural, Linguistic and Literacy Factors)																
Goal #9: **Operationalize health literacy (HL) in the network through the development, implementation, monitoring and evaluation of a health literacy (HL) plan.**																
Activity: Develop uniform health literacy standards, policies and procedures for FLPPS Central and FLPPS Network to ensure that The Plain Writing Act of 2010 is upheld, to ensure that patient documents/educational materials are written in plain, easy-to-understand language.																
a. Create and provide guidelines that detail the principles of the Plain Writing Act of 2010 in accordance with health literacy.																
b. Inform partners of the Plain Writing Act of 2010 to ensure effective implementation.																
c. Monitor/Track partners' implementation of the Plain Writing Act of 2010 guidelines.																

FLPPS CCHL Strategic Plan Timeline

Activity: Develop uniform health literacy standards, policies and procedures for FLPPS Central and the FLPPS Network to ensure that accurate, accessible, and actionable health information is targeted or tailored for the populations served.																
a. Devise and schedule a training/professional development series for partners, clinicians and other staff serving patients/consumers regarding Health Literacy topics, including: • Provider Patient/Communication – The use of HL strategies in interpersonal communications to ensure patient understanding and consideration of options • Health, Wellness and Medication Management – The use of HL strategies in incorporating shared decision-making and self-management approaches into practice • Informed Consent – The use of HL strategies to ensure patient understanding and consideration of their options relative to sharing of their health information																
Activity: Integrate health literacy into planning, evaluation and quality improvement.																
a. FLPPS will support partners as they implement, and continuously improve, integrated health literacy into their organizational																
b. FLPPS will support partners in the adoption of various information presentation formats based on their service populations, for example: • Literacy Rates of the Population Served • Education Level of the Population Served • Language Preferences of the Population Served • Cultural Attributes of the Population Served • Consumer Feedback																

FLPPS CCHL Strategic Plan Timeline

<u>Goal #9 Achievement Outcome Indicators:</u>																
FLPPS Health Literacy (HL) Plan developed, implemented and monitored against patient outcomes (performance tracked via dashboard metrics)																
Network Partners (80%) have developed and implemented their health literacy (HL) Strategic Plans																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health, andPreventive Health Care (Considering Cultural, Linguistic and Literacy Factors)																
Goal #10: Establish processes to evaluate key factors to improve access to quality primary care, behavioral health and preventive health.																
Activity: Use data/information from the identification of priority groups and the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)*** as the baseline for the refinement of key factors associated with improving access to care.																
a. Utilize i*mplications for cultural competence and health literacy* outlined in the "Priority Groups Summary Report", as the framework for analyzing key considerations for improving access, engagement and quality of care for each population group through the lens of each group's culture profile and related barriers to access and/or engagement in services.																
b. Use analyses to inform targeted strategies and interventions to address disparities.																
Activity: Utilize FLPPS performance data, stratified by NOCN, priority group and services delivery areas (e.g. primary care, behavioral health and preventive care) to evaluate disparities and key factors associated with such disparities.																
a. Continually measure and drive improvements to address disparities.																

FLPPS CCHL Strategic Plan Timeline

b. As needed, identify and analyze additional/new datasets and information resources that help to refine understanding of the key factors.																
Activity: Engage with NOCNs to refine understanding of key factors associated with improving access.																
a. Work with NOCN's define sub-regional nuances of each identified priority groups and to identify new/emerging populations of concern.																
b. Work with NOCN's define additional metrics relative to local nuances important to assessing and understanding key factors associated with access.																
Activity: Engage with local communities, including patients, to refine strategies to improve access to quality primary care, behavioral health and preventive health.																
a. In collaboration with NOCN's, conduct focus groups and community listening sessions to share information and obtain input on the strategies to address access to care.																
Goal #10 Achievement Outcome Indicators:																
Community –wide process and data analysis conducted and key factors associated with barriers to access area identified																
Findings used by network partners to improve access to quality care, with progress reflected in performance metrics, stratified by priority groups																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health, andPreventive Health Care (Considering Cultural, Linguistic and Literacy Factors)																
Goal #11: Set forth actions to ensure that patients/consumers with limited English proficiency (LEP) have meaningful access to services that have incorporated cultural, linguistic and literacy factors.																
Activity: Using available data sources, (i.e. U.S. Census, American Community Survey, Client Data, Community-Based Organizations, Government Agencies, etc.) FLPPS will assess languages spoken of populations served within the network.																
Activity: As necessary, FLPPS will translate NYS mandated/compliance R related patient documents into Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille - the top six languages spoken by individuals with Limited English Proficiency (LEP) within New York State, as identified by the New York State Department of Labor, tailored to the FLPPS region, e.g.: • Grievance Policy • HIPAA/Confidentiality • Consumer Rights																

FLPPS CCHL Strategic Plan Timeline

Activity: As necessary, FLPPS will support partners in offering NYS mandated/compliance related patient print, audiovisual, and other forms of media content in Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille and American Sign Language (ASL) - the top six languages spoken by individuals with Limited English Proficiency (LEP) within New York State, as identified by the New York State Department of Labor, tailored to the FLPPS region, e.g.: • Grievance Policy • HIPAA/Confidentiality • Consumer Rights • Consent/Release Forms • Discharge Documents • Prescription Information/Labels																
Activity: FLPPS will review internally-developed print, audiovisual, and other forms of media content with their Patient Advisory Committee (PAC) and/or via other expert stakeholders prior to dissemination.																
Activity: FLPPS will establish a process to determine and reassess, at least every two years, the vital documents (including website content) that must be translated and/or updated.																
Activity: FLPPS will compile and maintain a repository listing of local interpretive and translation services/resources for the populations served (e.g. oral interpretive resources, telephonic interpreting services, including contracts/arrangements with community-based organizations, individuals or vendors).																
Activity: Provide mechanisms to support partners with informing patients of their legal rights to request translation and interpretation services in their preferred language from healthcare facilities: • Title VI of the Civil Rights Act of 1964 • National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and HealthCare • HIPAA Regulations																

FLPPS CCHL Strategic Plan Timeline

Activity: FLPPS will provide partners, clinicians, and other staff that interact and serve patients/consumers and family members basic training on: • The legal obligations to provide meaningful access to benefits and services to LEP individuals • How to access/obtain/use/work with language assistance services (i.e. interpreters, language lines) in service delivery • Documenting the language needs of LEP consumers/patients and the language services provided to them by the facility																
<u>Goal #12 Achievement Outcome Indicators:</u>																
Partner handbooks are available in the preferred language(s) of the service population(s)/area(s), and include Patients' Rights																
Improved system utilization, including access to primary, behavioral health and preventive care by LEP populations.																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health, andPreventive Health Care (Considering Cultural, Linguistic and Literacy Factors)																
***Goal #12:* Develop a user-friendly searchable listing on the FLPPS website that includes description of partner organizations, including contact information and website links, location, hours, services provided, Medicaid acceptance, available language/interpretive services, and patient ratings using standardized measures.**																
Activity: Gather partner data to post on FLPPS website.																
Activity: Work with partners to make listing widely available across their digital infrastructure, including website, electronic health records, care management systems, etc.																
Activity: Establish a process which will prompt partners, via automated reminderstwice a year, to submit updated information to the resource directory.																
Goal #12 Achievement Outcome Indicators:																
FLPPS and partner websites enhanced to clearly display information in user-friendly formats																
Websites are routinely updated twice per year, more frequently as necessary, to incorporate FLPPS and/or partner changes																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	**2016**				**2017**				**2018**				**2019**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Strategic Initiative: Improve Access to Quality Primary Health, Behavioral Health, andPreventive Health Care (Considering Cultural, Linguistic and Literacy Factors)																
Goal #13: Use information from the identification of key factors associated with access toquality primary care, behavioral health and preventive health care to inform theidentification and implementation of interventions/service delivery approaches that havedemonstrated effectiveness with priority groups and incorporate CCHL considerations andlocal nuances.																
Activity: Under the direction of the CCHL Committee and in collaboration with the Clinical Quality Committee ensure that CCHL is woven through the FLPPS network, as the foundational infrastructure from which to build effective DSRIP program implementation impacting indemnified priority populations.																
Activity: Under the direction of the CCHL Committee and in collaboration with the Clinical Quality Committee. Establish processes and mechanisms to ensure that interventions/service delivery approaches are data-informed and community-driven, with attention to local cultural nuances and social determinants of health.																
Activity: Under the direction of the CCHL Committee and in collaboration with the Clinical Quality Committee, ensure that continuous quality improvement processes are in place, to include focused attention on CCHL throughout DSRIP program implementation.																
Goal #13 Achievement Outcome Indicators:																
FLPPS organizational infrastructure in place to support activities																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Utilize Community-Based Interventions to Reduce Disparities andImprove Outcomes (Considering Cultural, Linguistic and Literacy Factors)																
Goal #14: Identify existing and potential community-based interventions that have been effectively shown to reduce health disparities among defined priority populations.																
Activity: In concert with the development of the organization's Population Health Roadmap and implementation of Domain 4 projects, develop a directory of existing community-based interventions aimed at health status improvement, including documentation of program target populations.																
Activity: As identified in project work plans, utilize performance metrics and analytic functionality to measure the impact of identified community-based interventions, with a specific focus on identified priority populations.																
a. Use data to identify best practices and gaps in service delivery.																
Activity: Conduct a comprehensive literature review and seek guidance from experts to define best-practices in community-based programming to fill identified gaps, including: • Preventive health care delivery approaches, along with primary prevention/population health based strategies. • Community-based supportive services that address social determinants of health and operate in a manner that supports effective access to, and engagement in, primary care, behavioral health and preventive health care. • Approaches that integrate primary care and behavioral health care.																

FLPPS CCHL Strategic Plan Timeline

Activity: The FLLPS CCHL Committee and NOCNs will review interventions that appear to have promise for defined priority groups and communities.																
a. Develop a compendium of high-value community-based services that NOCNs fill gaps in care.																
b. Monitor the impact of community-based services over time and report using metrics included in the NOCN-specific performance dashboard.																
Goal #14 Achievement Outcome Indicators:																
FLPPS Resource Repository established and includes a robust catalog of high-value community-based interventions.																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Utilize Community-Based Interventions to Reduce Disparities andImprove Outcomes (Considering Cultural, Linguistic and Literacy Factors)																
Goal #15: Work with partners to implement and utilize high-value community-based programs that address heath disparities among priority populations.																
Activity: Promote the use of community-based programs shown to be effective, for example, community health workers, translators, case managers and peer support.																
a. Using the FLPPS IT ecosystem, create an effective tool to support providers in referring patients to appropriate community-based programs, taking into account patient choice.																
Activity: Monitor implementation, evaluate effectiveness, sustain effective activities, and improve or replace those that fail.																
a. Continually assess the services along key performance metrics associated with CCHL and disparities to determine effectiveness in improving patient outcomes and addressing disparities.																
b. Work with community stakeholders and partners to build capacity at the community levels to address needs and problems identified.																
c. Create and sustain relationships between FLPPS and community partners, with principles of co-learning, mutual benefit, and long-term commitment and incorporate community theories, participation and practices.																
Goal #15 Achievement Outcome Indicators:																
FLPPS Resource Repository established and includes a robust catalog of community-based interventions																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	**2016**				**2017**				**2018**				**2019**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Strategic Initiative: Partner with Population of Focus and Community Groups to Improve Health Outcomes among Priority Groups Experiencing Disparities (Considering Cultural, Linguistic and Literacy Factors)																
Goal #16: Create community engagement strategy with a particular focus on priority populations.																
Activity: Convene a stakeholder group to inform, design/plan, monitor and evaluate the process. Community input will update and advise the enhancement of the FLPPS Communication plans and improve the quality of policies - making them more practical and relevant to decrease barriers to care and improve outcomes.																
a. FLPPS will develop a Community Stakeholder Group supported by FLPPS Cultural Competence senior-level staff.																
b. The FLPPS Community Stakeholder Group will be comprised of: 1. Patients/Consumers of Services 2. Community-Based Organization 3. Faith-Based Organizations 4. Cultural Brokers 5. Civic and Neighborhood Organizations 6. FLPPS representatives from the leadership group to serve in an advisory capacity 7. Representatives from the identified priority groups																

FLPPS CCHL Strategic Plan Timeline

Activity: The FLPPS Community Stakeholder Group will define priority groups whom FLPPS should communicate with – people, place, affiliation, and cultural identity.																
a. FLPPS Stakeholder Group will review the ***FLPPS CCHL Implementation Planning: Priority Groups Summary Report*** to identify and prioritize communication activities.																
b. The FLPPS Community Stakeholder group will define methods of communication, employing social marketing approaches that incorporate the cultural nuances of the defined community.																
Activity: FLPPS will engage the Patient Advisory Committees and Community Stakeholders Group in the creation of messages and who best to deliver the information to and in what forums.																
Activity: FLPPS will offer training and professional development opportunities for partners, clinicians, staff effective patient/consumer engagement approaches and evidenced-based and community-defined evidence practices related to communications that address health disparities.																
a. FLPPS will engage faith-based organizations – to host educational opportunities and educate leaders on how they can engage their congregations in wellness self-management.																
b. FLPPS will engage other organizations who are currently conducting outreach and education – to expand their content from general health to social determinants of health and cultural competence and health literacy practices.																

c. FLPPS will engage pharmacists and/or other providers/partners prescribing medication – to translate prescriptions into preferred languages and formats for the population being served.																
d. FLPPS will engender two-way communication via public forums and meetings by providing opportunities to explain to the community current news regarding the health care system, offer information, gather patient/consumer and community stakeholder feedback; demonstrate openness and transparency; and enable FLPPS Central to develop social networks.																
Activity: FLPPS will create a process to evaluate impact and gather feedback.																
<u>Goal #16 Achievement Outcome Indicators:</u>																
Key community stakeholders engaged in developing and implementing a communication strategy that incorporates essential elements of CCHL informed approach																
Strategies evaluated to assess their reach/impact on identified priority groups																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Partner with Population of Focus and Community Groups to Improve Health Outcomes among Priority Groups Experiencing Disparities (Considering Cultural, Linguistic and Literacy Factors)																
Goal #17: Define plans for two-way communication with the populations served andcommunity groups through community stakeholder engagement forums.																
Activity: FLPPS Community Stakeholder Group will define methods of communication that incorporate the cultural nuances of the defined community.																
Activity: FLPPS will ensure all messages to the public are informed by consumers/patients, community, providers/partners and data analysis. As applicable, messages should: • Reduce Stigma • Be Culturally Informed • Be Respectful of Cultural Values • Be Available in Accessible and Alternative Languages/Formats: • Create environments where individuals can communicate /discuss concerns • Be Administered in Different Formats and Locations • Be Jargon Free																
Activity: FLPPS will ensure that community meetings and forums are designated as "Safe Spaces" where all participants are encouraged to contribute and are valued to present themselves as they feel comfortable.																

FLPPS CCHL Strategic Plan Timeline

a. Barriers to access to participate will be considered and necessary accommodations will be facilitated. Potential barriers are: • Meeting location • Transportation • Time of day • Language accessibility (e.g. LEP and LRS) • Mobility issues • Child care • Credibility within community																
Activity: Feedback will be collected from stakeholders attending community meeting and forums. The information will be synthesized and then analyzed to draw out critical themes that will inform FLPPS's continuous quality improvement (CQI) process.																
Activity: Create and implement a process that evaluates whether the messages were received and understood by the community and whether the engagement met its purpose.																
a. Employ a continuous quality improvement (CQI) process.																
b. Ensure timely feedback and next steps. 1. Participants should be informed and given the opportunity to shape the next stages of the overall engagement process. 2. Participants should be able to communicate during the process how stakeholders' input has influenced, contributed to, or improved the overall engagement outcomes.																

FLPPS CCHL Strategic Plan Timeline

<u>Goal #17 Achievement Outcome Indicators:</u>	
Key community stakeholders engaged in developing and implementing community stakeholder engagement forums	
Community stakeholder engagement forums conducted in a CCHL relevant manner and areaccessible to representatives from priority groups	
Strategies for conducting forums evaluated to assess their reach/impact on identified prioritygroups	

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Initiative: Partner with Population of Focus and Community Groups to Improve Health Outcomes among Priority Groups Experiencing Disparities (Considering Cultural, Linguistic and Literacy Factors)																
Goal #18: Facilitate provider collaboration with community-based organizations.																
Activity: Educate partners, clinicians and staff about the significance and importance of patient cultural activation.																
Activity: In collaboration with community-based organizations, facilitate educational opportunities for partners, focusing on topics such as: • Population health and how their work contributes to health equity • Acknowledging and understanding the cultural nuances of their patients/service population • Understanding how illness is defined by their patients • Understanding the value of stratifying patient health outcomes to improve health outcomes • Understanding the value of evaluating the effectiveness of interventions to achieve goals and improve health outcomes																
Activity: Collaborate with FLPPS's CC/HL Committee to establish guidelines in network partner engagement with community-based organizations.																
Activity: Host community learning/engagement sessions where community-based organizations will have the opportunity to present to partner organizations the work they do, who are their consumers, any specialized service they offer, best practices, and present the consumer outcomes achieved.																

FLPPS CCHL Strategic Plan Timeline

Activity: Support culturally tailored programs (e.g. diet, physical activity, and stress management) through community-based organizations and strategic alliances that train consumers in self-advocacy and wellness self-management and train partners in building trusting relationships with their patients.																
<u>Goal #18 Achievement Outcome Indicators:</u>																
Key community-based organizations and stakeholders actively engaged with FLPPS																
Process for on-going/regular opportunities for collaboration between CBO's, FLPPS and thePartner Network established, aimed at improving patient experiences, health outcomes and eliminating disparities																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
FOUNDATIONAL GOALS, ACTIVITIES AND ACHIEVEMENT OUTCOME																
Foundational Goal #1: Ensure that CC/HL is woven throughout FLPPS Central.																
Activity: FLPPS Central will establish an internal Cultural Competence Department, responsible for operationalizing CC/HL throughout FLPPS Central.																
a. FLPPS Central will designate a senior-level leadership position to oversee the internal CC/HL Committee. This individual will be the liaison between Project Managers and partners to ensure that CC/HL principles and concepts are woven into related activities.																
b. FLPPS Central CC/HL Committee will provide advice and guidance to FLPPS in all areas pertaining to CC/HL.																
Activity: FLPPS Central will develop an internal CC/HL strategic plan.																
a. FLPPS Central will incorporate CC/HL concepts and principles into the internal CCHL work streams.																
b. FLPPS Central will reinforce the interdependencies of CC/HL concepts, principles, and work streams.																
c. FLPPS Central will review the organization's vision, mission statement and guiding principles to ensure that CC/HL principles are incorporated.																
d. FLPPS Central will identify the core CC/HL competencies as they exist within the organization, and areas for improvement to formalize CC/HL goals.																

FLPPS CCHL Strategic Plan Timeline

e. FLPPS Central will secure technical assistance and support to ensure effective execution of their proposed CC/HL strategic plan.																
f. FLPPS Central will develop internal processes and practices to ensure CC/HL is implemented, monitored and evaluated in all policies (e.g. HR, Fiscal, Services, Vendors, etc.)																
g. FLPPS Central Project Managers will discuss their work streams and the CC/HL Committee twice a year, to review and identify CC/HL implications for recommendations and feedback.																
h. FLPPS Central Project Managers will weave CC/HL feedback and recommendations into all projects.																
Activity: FLPPS Central Internal CC/HL Committee will review partner reports to ensure that they reflect The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) parameters to identify areas of improvement.																
Foundational Goal #1 Achievement Outcome Indicators:																
FLPPS Central CC/HL Assessment completed																
FLPPS Central Organizational CC/HL Infrastructure established																
FLPPS CC/HL Strategic Plan developed, implemented and monitored																
CC/HL is woven into FLPPS Central organizational policies, practices and procedures																
A dedicated budget is in place for CC/HL activities																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Foundational Goal #2: Ensure that CC/HL is woven throughout the FLPPS Network.																
Activity: FLPPS Partners will complete an Organizational Cultural Competence &Health Literacy Readiness Questionnaire (Appendix F) and Organizational CulturalCompetence & Health Literacy Assessment (Appendix D), the results of which willbe used to inform their organizational policies, practices and procedures, and identify the targeted provider groups for training and implementation support.																
Activity: FLPPS Partners will designate a senior-level leadership position to oversee agency CC/HL within their organization.																
Activity: FLPPS Partners will develop an internal CC/HL strategic plan.																
a. FLPPS partner agency will incorporate CC/HL concepts and principles into the internal CC/HL Strategic Plan.																
b. FLPPS partner agencies will engage its constituents in CC/HL related activities.																
c. FLPPS partner agencies will review the organization's vision and mission statement to ensure that CC/HL principles are incorporated.																
d. FLPPS partners agency will identify the core CC/HL competencies as they exist within the organization, and areas for improvement to formalize CC/HL goals.																

FLPPS CCHL Strategic Plan Timeline

Activity: Structure a process/system for each NOCN to address CC/HL goals and objectives.																
Activity: Engage NOCNs to understand their communities, service and priority groups.																
a. Each NOCN will provide input to the FLPPS Central CC/HL Committee.																
Activity: Provide Partners with resources to educate and support CC/HL practices.																
Foundational Goal #2 Achievement Outcome Indicators:																
Network Partners' CC/HL Organizational and/or Readiness Assessments completed																
Network Partners have developed and implemented their CC/HL Strategic Plans and processesare in place for monitoring and evaluation.																
CC/HL is woven into Network Partners' policies, practices and procedures																
Structure and processes are operational for integration of CC/HL at the NOCN level																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Foundational Goal #3: Develop a data and information technology (IT) infrastructure that incorporates CC/HL principles into the data collection, data analysis and data managementprocesses.																
Activity: Create a data platform that is responsive to identified priority populations.																
a. Provide the necessary technical assistance/support to ensure partners have the internal infrastructure necessary to collect and use data relative to CCHL and health care disparities.																
b. Create mechanisms to hold partners accountable for demonstrating progress in closing disparity gaps, based on improved CCHL practices, performance measures, improved patient outcomes and patient experience.																
a. Provide training and technical support to staff and network partners on the cultural nuances of data collection, analysis and management, such as: • *Data Collection Methods*: CCHL relevant primary and secondary data collection methods. • *Data Analysis*: Meaningful use of data - purpose, benefit and value of data – to improve outcomes on the patient-level, partner-level, community-level, organizational-level, and policy-level. • *Data Management*: CCHL relevant policies, practices and procedures to ensure that the data/infrastructure is managed effectively.																

FLPPS CCHL Strategic Plan Timeline

Activity: Ensure that the FLPPS data collection and management process incorporates CCHL relevant data elements necessary for culturally responsive patient assessment, patient care planning, partner performance management and network performance management as needed, to monitor outcomes and disparities among priority groups.																
a. Require data collection efforts to incorporate priority groups and cultural attributes.																
b. Analyze partner performance on established outcomes, which will be stratified by priority groups to identify disparities.																
<u>Foundational Goal #3 Achievement Outcome Indicators:</u>																
FLPPS data platform incorporates data elements relative to cultural attributes, especially identified priority groups																
FLPPS data infrastructure established to enable FLPPS to collect, analyze and report relevant data from partners to support work to identify and eliminate disparities and create healthequity																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Foundational Goal #4: Integrate CC/HL into contracting and reporting payment processes.																
Activity: Create mechanisms to hold partners accountable to demonstrating progress in closing disparity gaps, based on improved CC/HL practices, performance metrics, improved patient outcomes and patient experience.																
a. Drawing on the data included in the dashboard, establish a process to measure and assess improved CCHL practices and patient experience.																
a. Assess partner performance along the following dimensions: • Use of health literacy strategies in interpersonal communications and confirmed understanding at all points of contact. • Addressing health literacy in high-risk situations, including care transitions and communications about medicines. • Providing easy access/resources to health information, services and navigation assistance.																
Foundational Goal #4 Achievement Outcome Indicators:																
FLPPS contracting and reporting schedule reflects metrics associated with partners' progress in improving CC/HL and addressing disparities																
Partner performance assessed along key CC/HL dimensions																

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Foundational Goal #5: Use CC/HL to guide the development of a diverse workforce that represents the populations served.																
Activity: Provide consultation to the FLPPS Workforce Operational Workgroup (WOW) to ensure the incorporation of CCHL principles.																
Activity: Track and monitor partners' participation in culturally relevant and health literacy appropriate training as designated in the CCHL Training Plan.																
Activity: Analyze the network's current workforce to identify workforce/staff needs reflective of the priority groups and communities served.																
Activity: Incorporate improved workforce diversity and professional development as a key principle of its operating practices. Progress will be reported annually.																
Activity: Assess the workforce's professional development needs regarding cross-cultural clinical interactions, and incorporating cultural competence and health literacy into partner policies, clinical practices, and staff approaches when engaging and serving patients/consumers.																
a. Devise and schedule a training/professional development series for partners, clinicians and other staff serving patients/consumers to address cross-cultural clinical interactions, and incorporating cultural competence and health literacy into partner policies, clinical practices, and staff approaches when engaging and serving patients/consumers.																

FLPPS CCHL Strategic Plan Timeline

<u>Foundational Goal #5 Achievement Outcome Indicators:</u>	
Plan developed for recruitment, retention and promotion of workforce that represent the cultural groups within the FLPPS network	
Culturally competent and health literacy appropriate training provided for the workforce, as defined by training needs identified by the CC/HL Training Plan.	
80% of partners will participate in culturally relevant and health literate appropriate trainings by Year 5 End; as designated in the CC/HL Training Plan.	

FLPPS CCHL Strategic Plan Timeline

Strategic Initiatives, Goals, Activities and Achievement Outcome Indicators	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
***Foundational Goal #6:* Ensure Corporate Compliance reporting mechanisms include CCHL strategies.**																
Activity: Develop formal procedures for decision-making related to policies, practices, and grievances in accordance with state and federal law.																
Activity: Develop and implement a multi-reporting process/system for consumer/patients to report grievances/complaints regarding network partners', organizations or staff, that takes into consideration potential barriers (e.g. limited access/availability of patient reporting options, language, lack of confidentiality or anonymity, fear of retribution/denial of benefits or services): • Web-Based • Verbal – Phone/Message Line • Mobile – Text Message • Written • In Person - Ombudsman, Navigators																
Foundational Goal #6 Achievement Outcome Indicators:																
Patients/consumers are aware of and understand the grievance process, as measured by the patient experience survey																
80% of patients indicating that they have used the process report ease of use, as measured by the patient experience survey by Year 5 End; Phase In: 50% by Year 4, and 80% by Year 5 End																
Grievance complaints are tracked by partners; grievance type and outcome are factored into partners' performance metrics																

FINGER LAKES HEALTH SYSTEMS AGENCY

COMMUNITY NEEDS ASSESSMENT

FINGER LAKES PERFORMING PROVIDER SYSTEM DELIVERY SYSTEM REFORM INCENTIVE PROGRAM FINAL GRANT APPLICATION

December 18, 2014

FLHSA
The community health fulcrum.

1150 University Ave. | Rochester, NY | 14607

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF MAPS

EXECUTIVE SUMMARY

The Finger Lakes Performing Provider System (FLPPS) region consists of 14 counties in Upstate & Western New York and covers approximately 330,000 Medicaid beneficiaries. The metropolitan center of the region is Rochester, N.Y., where both performing provider system (PPS) lead organizations are located. The needs of the population living in these areas cross a variety of issues and are not homogenously distributed. While many health care resources exist for residents of these counties, some services are scarce, including behavioral health support. Furthermore, the health and lives of residents in particular geographic pockets might benefit from additional resources. In order to better understand the health care needs of the FLPPS population, we reviewed previous regional studies and reports, analyzed Medicaid data provided by the state, conducted 13 focus groups and 30 key informant interviews, and analyzed numerous other data sources. As a result, we have identified four primary opportunities for the region:

- The need for an integrated delivery system to address chronic conditions
- The need for integration between physical and behavioral health care systems
- The need to address social determinants of health
- The need to support women and children

Chronic conditions are a leading cause of mortality and years of potential life lost (YPLL) in the FLPPS region. Numerous metrics of integration, including Prevention Quality Indicator (PQI) admissions and Potentially Preventable Emergency Department Visits (PPV) indicate that these chronic conditions could be more appropriately addressed by a system that better integrates primary care and preventative medicine into the treatment plans for individuals with asthma, COPD, cardiovascular conditions, and diabetes. The PQIs which are attributable to chronic disease (diabetes, respiratory, and heart) account for 85 percent of all potentially preventable inpatient hospitalizations in the FLPPS in 2012. A review of the available literature suggests that a coordinated and integrated health care delivery system is well-positioned to provide efficient and effective care to complex patients with chronic disease. When multiple conditions are present in a patient, as is often the case, the complexity of treating that individual rises. Our analyses indicate that having three comorbidities on a hospital admission results in an 18 to 24 percent increased risk of readmission within 30 days. Addressing these conditions through an integrated delivery system should result in improved outcomes for these individuals and reductions in preventable utilization.

As is common in the United States, the FLPPS region typically separates physical and behavioral healthcare into two separate, non-integrated systems. However, the need to integrate these networks in the FLPPS region is especially critical because of the higher-than-average prevalence of behavioral health conditions. Our analyses indicate a clear lack of integration between the two systems in this region and this service silo leads to poor outcomes for individuals. Not only do these individuals' behavioral health conditions influence their mental health, but these conditions have real consequences for their physical health as well. In fact, suicide was found to be the fifth leading cause of premature mortality in the FLPPS. Additionally, 24 percent of all Medicaid-only hospital discharges in 2012 were for a primary behavioral health diagnosis compared to just 8 percent and 3 percent of private insurance and Medicare discharges, respectively. Developing links between the behavioral and physical health care systems may ensure that Medicaid patients are seen in the appropriate setting and receive the most appropriate care for their conditions. Addressing these individuals holistically will likely not only improve their wellbeing but may also reduce costly care that might otherwise be avoided.

Discussions with regional stakeholders have identified socio-economic barriers health as a key influence in the health of the Medicaid population. Nationally, these health factors have recently come to prominence as researchers identify that these issues are significant contributors to population health. Availability of transportation was noted as a barrier to health, both by focus group participants and health care and community service workers throughout the region. In a survey of community based organizations, lack of transportation was the most frequently cited obstacle to clients receiving services, identified by over 20 percent of groups that reported barriers. A regression analysis comparing PPV rates and distance to emergency rooms identified that proximity was associated with PPV utilization in the FLPPS region. Housing resources were also identified throughout this process as a need throughout the region. For example, of individuals who were homeless at the time of admission to a psychiatric hospital, only 62 percent were connected with housing before their discharge. Addressing the socioeconomic barriers to health will be critical to the long term success of any programmatic efforts.

Infant mortality rates in the FLPPS region are generally higher than the New York State average, particularly in Allegany, Monroe, Orleans, and Yates Counties. Substance use admissions among newborns also appears to be unexpectedly high in several PPS counties. While infant mortality does appear to be a serious concern in the FLPPS region, other measures of perinatal health generally match New York state trends, including low birth weight, initiation of prenatal care, and birth defect rates. It is likely that social determinants of health, not captured in the data, are driving that statistic, which is evidenced by the disparity in health outcomes of African Americans and Latinos in Monroe County. Increasing support for women and children will have long term positive impacts on the health of the FLPPS population.

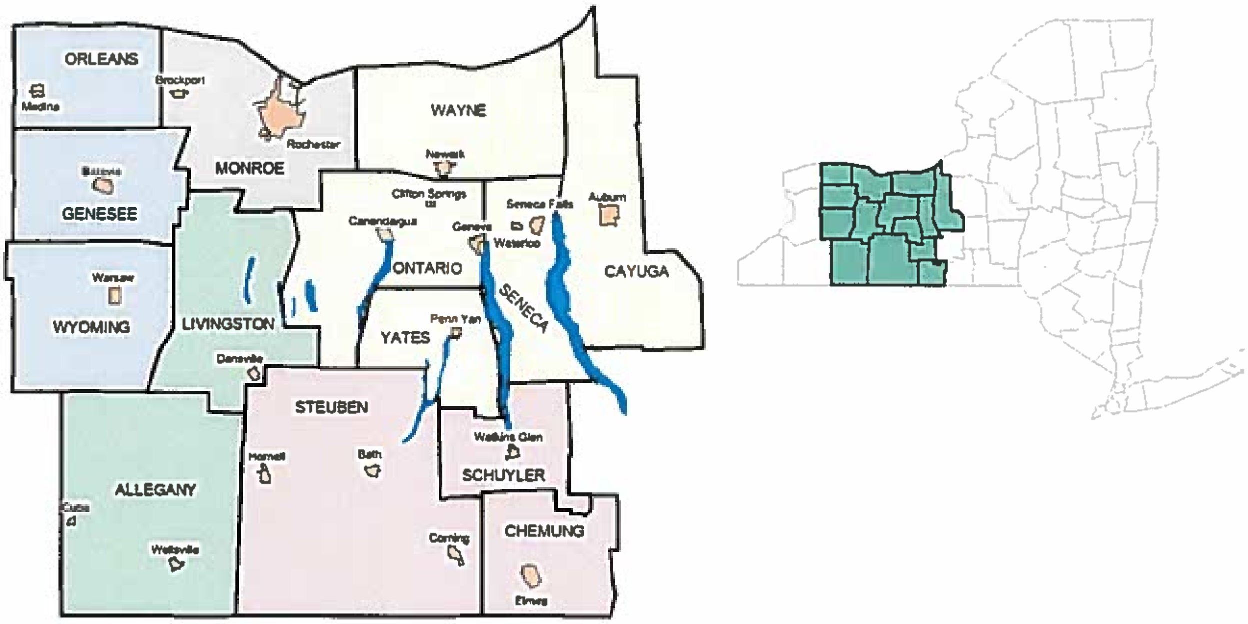
THE FINGER LAKES PPS REGION

The region that this analysis covers is comprised of 14 counties in the western portion of New York State. It is approximately 94 miles from the northern border along Lake Ontario to the Pennsylvania state line which is the southern boundary and 112 miles from east to west. One-fifth of 10,783 square miles in the region is lakes and rivers which often impede travel from one part of the region to another.

The region's 1.5 million residents live in a mix of urban and rural areas — Monroe County, which includes the city of Rochester, is the most densely populated with 1,132 people per square mile of land area while Allegany county is least densely populated with less than 48 people per square mile.

For planning purposes the region is subdivided into five "naturally occurring care network" (NOCN) areas.

- Monroe County is the most populous of the areas and contains almost half (48 percent) of the region's population.
- The Northeast NOCN — Cayuga, Ontario, Seneca, Wayne, and Yates counties — contains just over one-fifth of the region's population (342,000) and three smaller cities — Auburn, Canandaigua, and Geneva. This subarea is the center of the Finger Lakes and almost one-third of its territory is covered by water.
- The Southeast NOCN, which is just under 15 percent of the region's population, contains Chemung, Schuyler, and Steuben counties. Approximately one-quarter of the NOCN's residents live in the cities of Elmira, Corning, and Hornell.
- The counties of Allegany and Livingston make up the Southern NOCN, which includes a population of approximately 114,000 people, with about one of every 12 residents living in a college dormitory or a correctional facility.
- The Northwest NOCN, made up of Genesee, Orleans, and Wyoming counties and the city of Batavia, contains approximately one-tenth of the region's population.



Map 1 – The FLPPS Region

DESCRIPTION OF HEALTHCARE & COMMUNITY RESOURCES

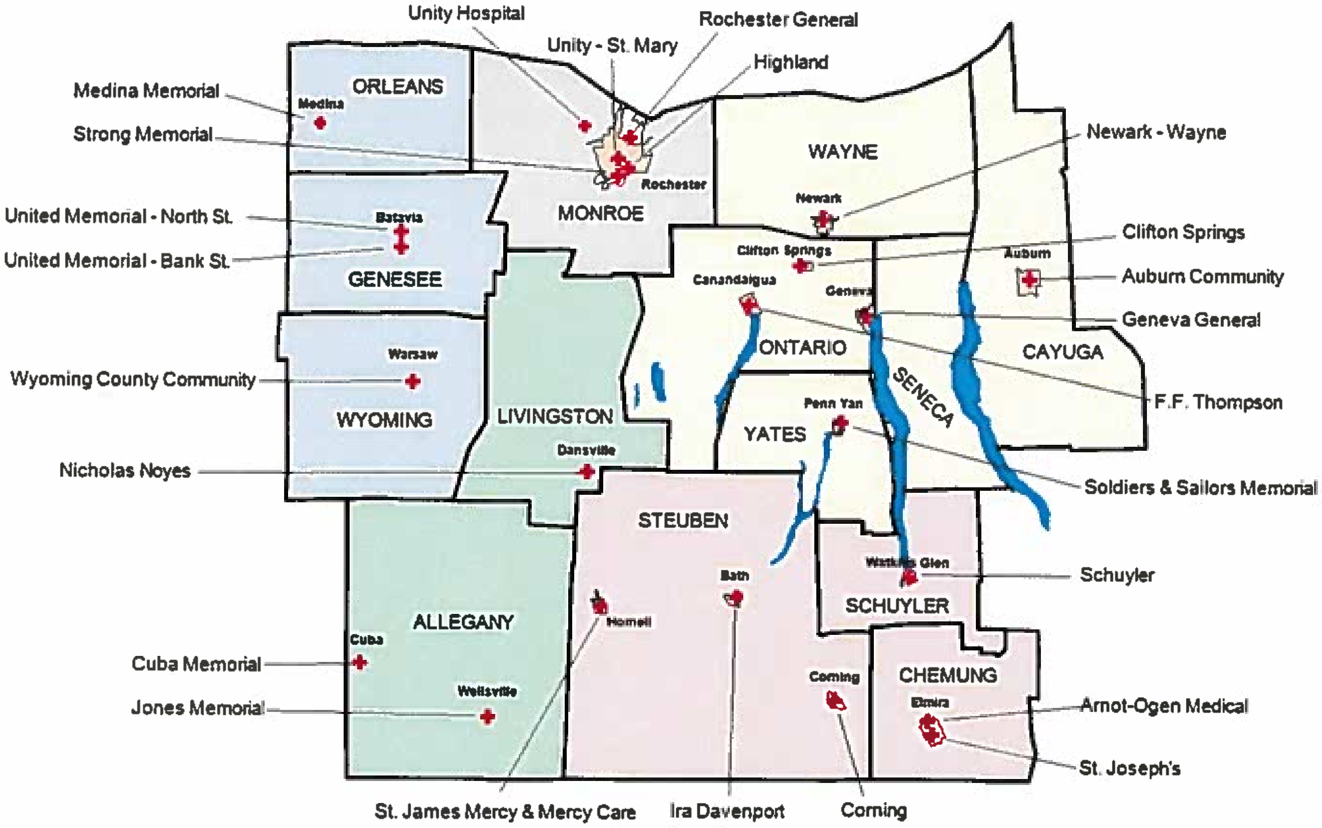
Health Care Resources

The fourteen counties to be supported by the FLPPS have numerous health care resources across the spectrum of acute care. While both physical and behavioral health resources do exist, access and availability vary throughout the region, with some areas lacking adequate access to both. Community based resources are available to much of the population, but again wide variation occurs in the number and types of services available by location.

Healthcare Resource Infrastructure

Acute Care Hospitals

The 14-county FLPPS region is home to 23 Acute Care Facilities. Additionally, the region has one of New York State's three "freestanding" emergency departments at the former site of Lakeside Hospital (now Strong West) which provides emergency care, as well as ambulatory surgery, radiology, and lab services in Brockport, Monroe County.



Map 2 – FLPPS Acute Care Facilities

The FLPPS Region contains a total of 3,843 acute care beds, 9,521 nursing home beds, 46 urgent care centers and 32 ambulatory surgical centers. The distribution of these resources is outlined in Table 1 and Table 2 by total count and per 100,000 population.

Table 1 – Healthcare Resources

Number of Health Care resources by county, FLPPS region, 2012

County	Ambulatory Surgery Centers	Urgent Care Centers	Number of Nursing Home Beds	Number of Acute Care Beds	FQHCs	Assisted Living Facilities	Hospice Beds[1]
Allegany	2	1	361	76	2	2	0
Cayuga	1	1	529	99	5	5	0
Chemung	4	5	736	466	0	4	0
Genesee	1	4	488	131	0	3	0
Livingston	1	3	354	72	2	2	0
Monroe	11	21	5,244	2,015	36	33	11
Ontario	4	3	623	399	1	6	4
Orleans	1	2	310	70	2	3	8
Schuyler	1	1	120	25	0	1	0
Seneca	0	2	280	0	1	1	0
Steuben	3	3	699	273	1	7	0
Wayne	1	0	561	120	3	3	0
Wyoming	1	0	218	62	1	1	0
Yates	1	0	196	35	4	3	0

DATA SOURCES: FLHSA Surveys, NY State Cost Reports

Table 2 – Healthcare Resource Rates

Health Care resources per 100,000 population by county, FLPPS region, 2012

County	Ambulatory Surgery Centers	Urgent Care Centers	Number of Nursing Home Beds	Number of Acute Care Beds	FQHCs	Assisted Living Facilities	Hospice Beds
Allegany	4.14	2.07	746.53	157.16	4.14	4.14	0.00
Cayuga	1.26	1.26	664.97	124.45	6.29	6.29	0.00
Chemung	4.50	5.62	827.79	524.12	0.00	4.50	0.00
Genesee	1.67	6.67	813.65	218.42	0.00	5.00	0.00
Livingston	1.54	4.63	546.21	111.09	3.09	3.09	0.00
Monroe	1.47	2.81	701.24	269.45	4.81	4.41	1.47
Ontario	3.69	2.76	574.09	367.68	0.92	5.53	3.71
Orleans	2.33	4.67	723.69	163.41	4.67	7.00	18.66
Schuyler	5.40	5.40	648.16	135.03	0.00	5.40	0.00
Seneca	0.00	5.66	793.09	0.00	2.83	2.83	0.00
Steuben	3.03	3.03	705.61	275.58	1.01	7.07	0.00
Wayne	1.08	0.00	603.47	129.09	3.23	3.23	0.00
Wyoming	2.39	0.00	520.39	148.00	2.39	2.39	0.00
Yates	3.95	0.00	773.36	138.10	15.78	11.84	0.00
NY State	N/A	N/A	746.53	289.00	N/A	4.14	0.00

DATA SOURCES: FLHSA Surveys, NY State Cost Reports

The Finger Lakes Health Systems Agency has for many years performed health planning including capacity analysis including but not limited to hospital and nursing home bed capacity. These have been exhaustive, complete planning analyses. While the timeline for DSRIP precludes studies of the depth that has traditionally been used, we fortunately have recent iterations of these complete analysis that encompass most of the counties in the FLPPS.

---

[1] These represent beds on hospice licenses only. The hospices have contracts for hospice services with nursing homes and hospices in scatter beds. These are also distinct from the unlicensed beds in homes for the dying in our region. Most hospice care is provided at the patient's place of residence.

Table 3 – Acute Care Facility Occupancy Rates and Medicaid Utilization

FLPPS Acute Care Facility Occupancy Rates, 2012

NOCN	Occupancy Rate	% Medicaid Days
Monroe	78.9	19.0%
Northeastern	43.1	10.3%
Northwestern	46.5	19.2%
Southern	23.9	14.0%
Southeastern	43.0	19.4%
FLPPS TOTAL	61.1	18.2%

*Excludes Newborns and Neonatal Beds

The Occupancy Rate, defined as the average Daily Census per 100 Certified Beds, of the hospitals in the Finger Lakes region is 61.2 and ranges from 15 percent to almost 80 percent, with the rural areas demonstrating generally lower occupancy rates than the hospitals in Monroe County. As a percentage of patient days, Medicaid is the expected primary payer for 18.2 percent of patient days in the FLPSS. A facility level table, detailing the occupancy rate and Medicaid Days is available in Appendix A.

Hospital bed capacity has been analyzed recently by both the 2020 Commission and the 2020 Performance commission. The initial 2020 Commission was a community convening of stakeholders to direct hospital bed expansion when the Berger commission defined a need for more beds in the Finger Lakes Region. FLHSA and the State came to a consensus on the need for bed expansion in 2008 with the recognition that trends would have demanded more capacity but the community stakeholders including the hospital systems agreed to lower targets with a commitment to invest in projects to lower the demand by expanding outpatient care. The initial study was followed by the 2020 Performance Commission whose regional work group composed of the stakeholders from the rural counties surrounding Monroe County evaluated and made recommendations on the capacity needs of their counties. Actual bed projections for the rural hospitals were looked at in total, rather than by individual hospital taking into account the capacity needed and the recommended service capabilities needed in the local hospitals. The conclusion was that rural institutions needed to consolidate with either each other or their referral institutions to meet the changing needs of their local community. The hospitals are currently implementing affiliation/consolidation activities to improve service and increase efficiency. Targets for bed closure would be anticipated to have small impact on total beds in the region but there is already shifting of capacity location and it is anticipated that licensed beds currently not staffed could potentially be closed permanently.

Nursing Home capacity was studied by the Sage Commission and was completed in 2011. It was a 2 year effort using computer simulations to project the Nursing Home bed need out to 2030 taking into account the desires of those who would be affected. The bed projections were accompanied by the proviso that they could only occur if alternate home based services were developed prior to bed closings to ensure the care needs of this population could be met. Since the publication of the report there have been 280 NH beds closed in primarily Monroe County. The projections predict that there is still a net excess of 431 beds in the 9 county study area. Chemung, with 176 excess beds, and Monroe, with 165 excess beds, are the two largest counties with potential closings. We however hesitate to define excess strictly on county borders as the proximity of counties and usual care patterns demonstrate frequent migration of patients from their Country of origin to receive care, yet stay in the broader region. Nursing home occupancy rates and new admissions are available by facility in Appendix A.

Table 4 – Nursing Home Occupancy Rates and Medicaid Utilization

Nursing Home Occupancy and Medicaid Utilization, 2012

	Occupancy		New Admissions	
NOCN	Occupancy Rate	% Patient Days Medicaid	Total	% Dual Eligible
Monroe	91.3	67.5	9,742	18.3
Northeastern	92.4	74.4	3,805	19.5
Northwestern	86.4	74.6	1,381	17.9
Southern	90.3	74.4	876	35.5
Southeastern	93.7	77.4	2,455	29.4
FLPPS Region	**91.4**	**71.1**	**18,259**	**20.8**

DATA SOURCE: NH Cost Reports

Urgent Care Centers (UCC)

The FLHSA also completed a survey of all urgent care centers in the fourteen county region, as identified through accrediting agencies and other online resources. One of the common concerns regarding the urgent care model is that the business models do not often support accepting Medicaid patients. While several of the urgent care centers in the FLPPS region are located in Article 28 facilities, and as such are required to serve the Medicaid population, 18 percent of urgent care centers will only accept Managed Medicaid (MMC) (13 percent only from certain insurers) but will not accept Medicaid FFS. Further details on Medicaid acceptance at urgent care centers are given in Figure 1.

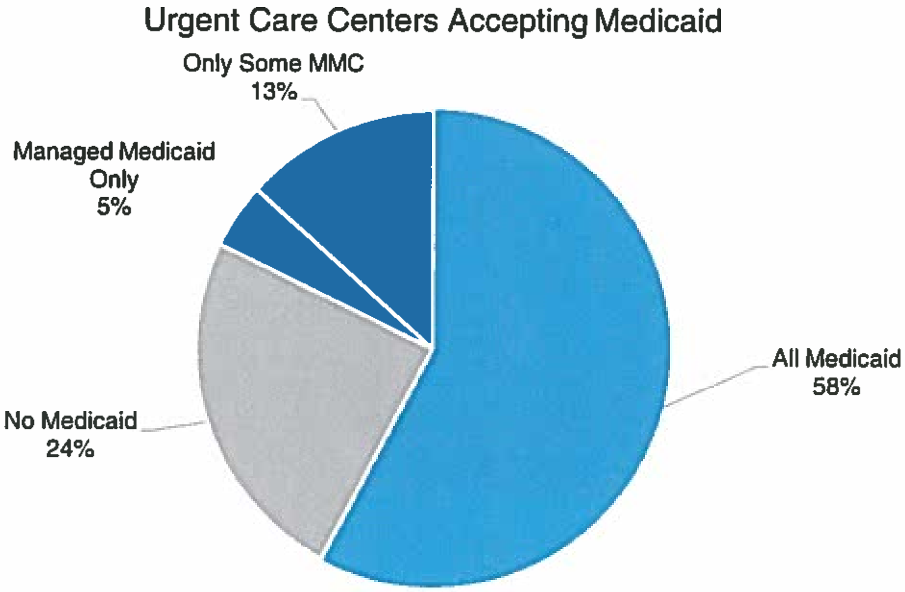


Figure 1 – Urgent Care Centers Accepting Medicaid

Federally Qualified Health Centers (FQHC)

There are 63 Federally Qualified Health Centers in the FLPPS region. FQHC's are vital points of access to primary care for many Medicaid patients, especially in rural areas. Nearly 60 percent of these facilities are in Monroe County, however the region does have five mobile providers that qualify as FQHCs and service multiple counties throughout the region. Chemung, Genesee, and Schuyler counties do not contain any FQHC's.

The Community Health Care Association of New York State recently ranked New York counties by both the need and sustainability of FQHC's. Among mixed urban and rural counties, Chemung ranked third in need and seventh in potential sustainability and Ontario ranked seventh in need and first in sustainability. Numerous other counties were ranked in terms of both need and sustainability for both rural counties and mixed urban rural counties. Additional information on the FQHC's is available from HRSA and a link to that information is included in Appendix C.

Figure 2 is adapted from that report (CHCANYS, 2013). According to this work, there is both need and justification for expansion of FQHCs in several areas of the FLPPS region.

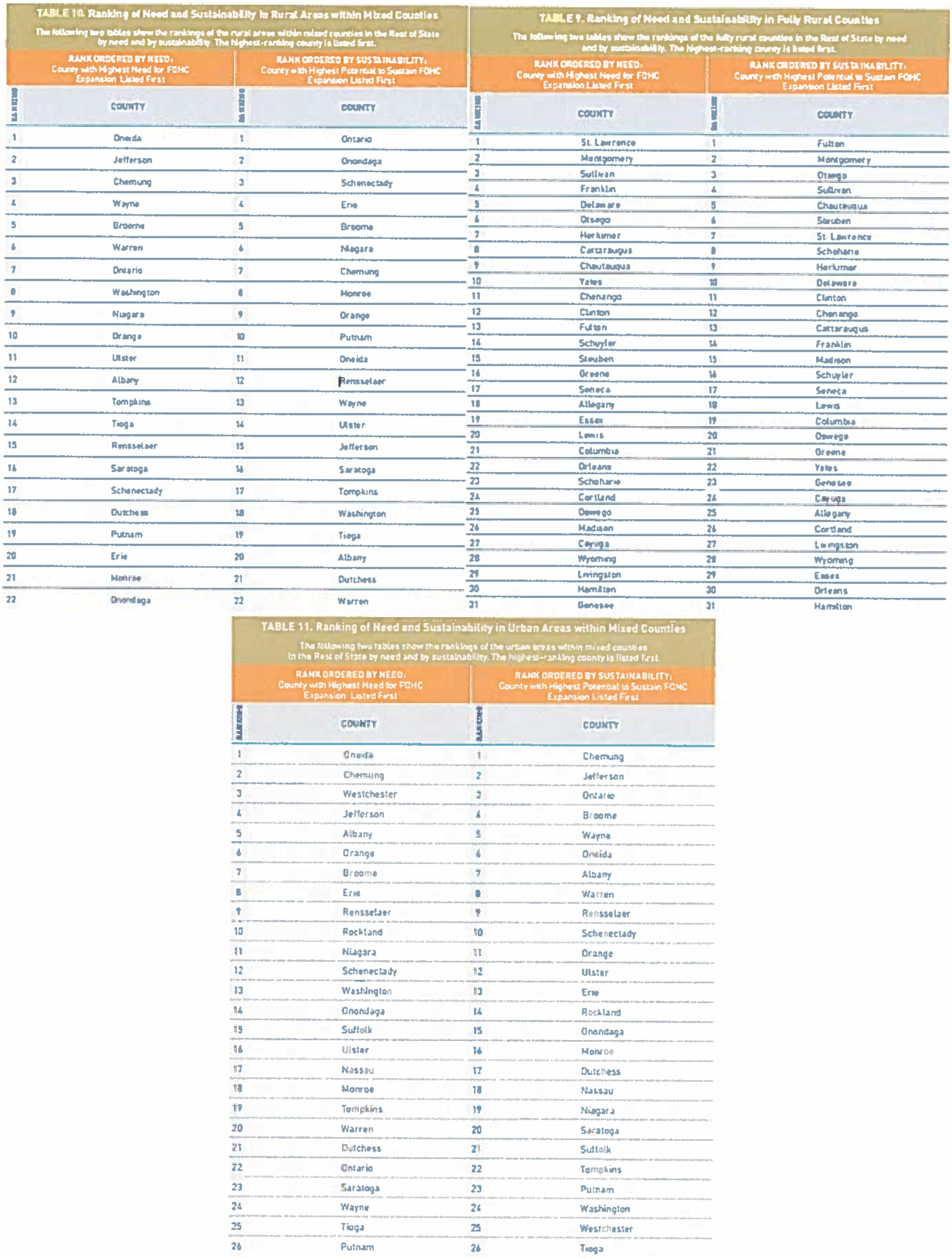


TABLE 10. Ranking of Need and Sustainability in Rural Areas within Mixed Counties

The following two tables show the rankings of the rural areas within mixed counties in the Rest of State by need and by sustainability. The highest-ranking county is listed first.

RANK ORDERED BY NEED: County with Highest Need for FQHC Expansion Listed First		RANK ORDERED BY SUSTAINABILITY: County with Highest Potential to Sustain FQHC Expansion Listed First	
RANKING	COUNTY	RANKING	COUNTY
1	Oneida	1	Ontario
2	Jefferson	2	Onondaga
3	Chemung	3	Schenectady
4	Wayne	4	Erie
5	Broome	5	Broome
6	Warren	6	Niagara
7	Ontario	7	Chemung
8	Washington	8	Monroe
9	Niagara	9	Orange
10	Orange	10	Putnam
11	Ulster	11	Oneida
12	Albany	12	Rensselaer
13	Tompkins	13	Wayne
14	Tioga	14	Ulster
15	Rensselaer	15	Jefferson
16	Saratoga	16	Saratoga
17	Schenectady	17	Tompkins
18	Dutchess	18	Washington
19	Putnam	19	Tioga
20	Erie	20	Albany
21	Monroe	21	Dutchess
22	Onondaga	22	Warren

TABLE 9. Ranking of Need and Sustainability in Fully Rural Counties

The following two tables show the rankings of the fully rural counties in the Rest of State by need and by sustainability. The highest-ranking county is listed first.

RANK ORDERED BY NEED: County with Highest Need for FQHC Expansion Listed First		RANK ORDERED BY SUSTAINABILITY: County with Highest Potential to Sustain FQHC Expansion Listed First	
RANKING	COUNTY	RANKING	COUNTY
1	St. Lawrence	1	Fulton
2	Montgomery	2	Montgomery
3	Sullivan	3	Otsego
4	Franklin	4	Sullivan
5	Delaware	5	Chautauqua
6	Otsego	6	Steuben
7	Herkimer	7	St. Lawrence
8	Cattaraugus	8	Schoharie
9	Chautauqua	9	Herkimer
10	Yates	10	Delaware
11	Chenango	11	Clinton
12	Clinton	12	Chenango
13	Fulton	13	Cattaraugus
14	Schuyler	14	Franklin
15	Steuben	15	Madison
16	Greene	16	Schuyler
17	Seneca	17	Seneca
18	Allegany	18	Lewis
19	Essex	19	Columbia
20	Lewis	20	Oswego
21	Columbia	21	Greene
22	Orleans	22	Yates
23	Schoharie	23	Genesee
24	Cortland	24	Cayuga
25	Oswego	25	Allegany
26	Madison	26	Cortland
27	Cayuga	27	Livingston
28	Wyoming	28	Wyoming
29	Livingston	29	Essex
30	Hamilton	30	Orleans
31	Genesee	31	Hamilton

TABLE 11. Ranking of Need and Sustainability in Urban Areas within Mixed Counties

The following two tables show the rankings of the urban areas within mixed counties in the Rest of State by need and by sustainability. The highest-ranking county is listed first.

RANK ORDERED BY NEED: County with Highest Need for FQHC Expansion Listed First		RANK ORDERED BY SUSTAINABILITY: County with Highest Potential to Sustain FQHC Expansion Listed First	
RANKING	COUNTY	RANKING	COUNTY
1	Oneida	1	Chemung
2	Chemung	2	Jefferson
3	Westchester	3	Ontario
4	Jefferson	4	Broome
5	Albany	5	Wayne
6	Orange	6	Oneida
7	Broome	7	Albany
8	Erie	8	Warren
9	Rensselaer	9	Rensselaer
10	Rockland	10	Schenectady
11	Niagara	11	Orange
12	Schenectady	12	Ulster
13	Washington	13	Erie
14	Onondaga	14	Rockland
15	Suffolk	15	Onondaga
16	Ulster	16	Monroe
17	Nassau	17	Dutchess
18	Monroe	18	Nassau
19	Tompkins	19	Niagara
20	Warren	20	Saratoga
21	Dutchess	21	Suffolk
22	Ontario	22	Tompkins
23	Saratoga	23	Putnam
24	Wayne	24	Washington
25	Tioga	25	Westchester
26	Putnam	26	Tioga

Figure 2 – CHCANYS Ranking of Sustainability and Need for FQHC's

Health Homes

Several health homes serve various counties within the FLPPS region. The primary provider of health home services in the region is Health Homes of Upstate New York (HHUNY), which serves 11 of the 14 counties in the region. The other health homes in the region only provide services to residents of specific counties and do not provide services to most of the rural areas.

Table 5 – FLPPS Health Homes

Health Homes in the FLPPS Regions	
County	**Health Homes Serving Each County**
Allegany	Chautauqua County Department of Mental Hygiene
Cayuga	Central New York Health Home Network, Onondaga Case Management Services, St. Joseph's Coordination Network
Chemung	Onondaga Case Management Services
Genesee	Health Homes of Upstate NY
Livingston	Health Homes of Upstate NY
Monroe	Greater Rochester Health Home Network, Health Homes of Upstate NY
Ontario	Health Homes of Upstate NY
Orleans	Health Homes of Upstate NY
Schuyler	Health Homes of Upstate NY
Seneca	Health Homes of Upstate NY
Steuben	Health Homes of Upstate NY
Wayne	Health Homes of Upstate NY
Wyoming	Health Home Partners of Western New York LLC
Yates	Health Homes of Upstate NY

DATA SOURCE; NYSDOH Website

County Health Departments

The county health departments in the fourteen counties also provide services to the Medicaid and uninsured populations. These services can be critical for persons requiring specific services but with little resources to obtain them. Table 6 and Table 7 outline these services at the county level.

Table 6 – County Health Department Services

	Health Department Services by County, FLPPS						
	Allegany	Cayuga	Chemung	Genesee	Livingston	Monroe	Ontario
Immunizations/clinics	X	X	X	X	X	X	X
TB Control/clinic			X		X	X	
STD Clinic/testing	X	X	X	X		X	
Nurse-Family Partnership						X	
HIV Testing	X	X	X	X		X	
Flu clinic/shots			X				X
Cancer screening	X		X		X		X
Licensed home care agency							
Pre-school program	X	X		X			
Well-child clinic							
Children w/special needs	X	X		X	X		
Prenatal services		X					
Child Health programs		X					
WIC	X	X	X		X		
Early Intervention	X	X		X	X		
Oral health		X	X				
Maternal/child health programs					X		

DATA SOURCE: County DOH Websites

Table 7 – County Health Department Services (cont.)

	Health Department Services by County, FLPPS (cont.)						
	Orleans	Schuyler	Seneca	Steuben	Wayne	Wyoming	Yates
Immunizations/clinics	X	X	X	X	X	X	X
TB Control/clinic	X		X		X		
STD Clinic/testing		X	X	X		X	
Nurse-Family Partnership							
HIV Testing	X	X	X	X		X	
Flu clinic/shots	X		X		X		
Cancer screening		X		X		X	X
Licensed home care agency			X				
Pre-school program		X	X				
Well-child clinic					X		
Children w/special needs		X		X	X		
Prenatal services							X
Child Health programs							
WIC							
Early Intervention		X		X			
Oral health							
Maternal/child health programs	X			X		X	

DATA SOURCE: County DOH Websites

Physical Health Care Workforce

Overall the FLPPS region has a much lower abundance of physicians, as measured by licensed physicians per 100,000 population than New York State. The only county with a higher number of physicians than New York State is Monroe County, where both FLPPS lead organizations and major medical centers are located. As availability of primary care and preventative services is important to DSRIP and the overall health of the population, we also reviewed the number of primary care physician (PCP) full-time equivalents (FTEs) and the ratio of PCPs to specialists. The FLPPS region demonstrates a lack of PCPs on this measure when compared to the state, with several counties demonstrating less than half of the PCP workforce than the state per capita. With regards to the licensure counts and rates, it is important to note that while licensure data is valuable to understanding workforce availability, it does not necessarily represent the number of individuals currently providing care within the scope of a particular license. This measure does not account for researchers or other practitioners who may not be actively treating patients but still maintain their license

Dentists and pharmacists are also underrepresented in the 14-county region. The availability of both of these services remains critical to ensuring patient centered care and preventing avoidable hospitalization. Overall the region does appear to have higher RN licensure rates than the state, a resource which could be leveraged to implement DSRIP programs.

There is significant variability in the availability of additional clinicians among the FLPPS counties. With the understanding that the development of programs will rely heavily on the available clinical workforce, there may need to be additional consideration given to sub-regional implementation to ensure program success.

The region also participates heavily in the training of physicians and future health care providers as it hosts 78 medical resident programs, which graduated 277 physicians in 2012, as well as 6 nurse practitioner programs and a pharmacy training program.

Table 8 – Healthcare Provider Availability

Availability of Providers by Licensure Type per 100,000 Population, 2012

County	All Physicians*	PCP FTE / 100,000 Pop	PCP*	All Other Specialties*	PCP / Spec Ratio	Dentists*	Pharmacists *	RN*
Allegany	97.8	46.1	63.4	34.4	1.84	20.3	60.9	1096.4
Cayuga	148.5	43.4	62.0	69.0	0.90	42.6	57.6	1295.9
Chemung	315.5	89.5	104.7	210.8	0.50	56.6	90.6	1445.8
Genesee	142.2	63.3	82.2	60.0	1.37	35.8	70.0	1543.0
Livingston	95.9	49.0	71.4	24.5	2.91	47.0	65.8	1399.6
Monroe	377.6	98.6	139.9	237.6	0.59	76.7	99.9	1305.3
Ontario	276.3	75.0	110.5	165.8	0.67	56.6	91.5	1557.3
Orleans	95.3	29.3	58.4	36.9	1.58	23.6	61.4	883.0
Schuyler	160.6	91.6	90.8	69.8	1.30	37.5	91.2	1147.5
Seneca	56.7	26.0	37.8	18.9	2.00	23.2	60.9	1027.2
Steuben	211.3	73.1	89.6	121.7	0.74	43.1	54.4	1225.2
Wayne	83.3	49.5	62.1	21.2	2.93	38.0	70.5	1155.0
Wyoming	121.7	64.1	71.8	49.9	1.44	26.4	79.1	1248.4
Yates	141.6	75.9	83.9	57.7	1.45	20.1	40.3	1301.0
NYS	**348**	**84.5**	**120**	**228**	**0.53**	**78.0**	**91.0**	**1093.0**

DATA SOURCE: Center for Health Workforce Studies
*Licenses per 100,000 Pop.

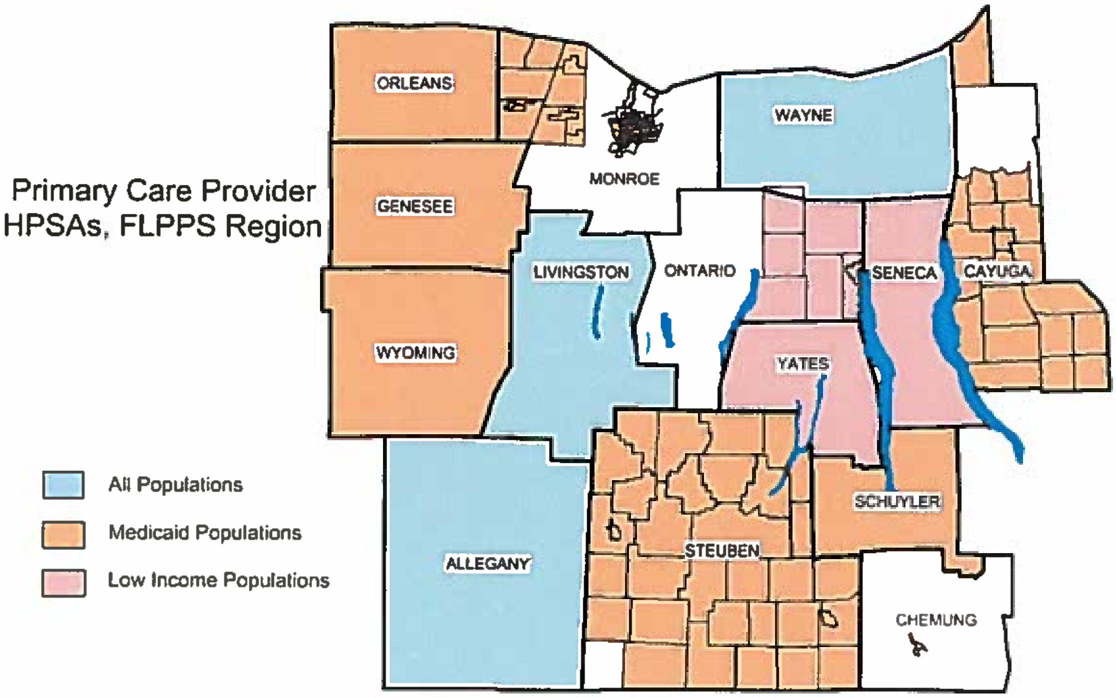
Table 9 – Healthcare Provider Availability (cont.)

Availability of Providers by Licensure Type, per 100,000 Population, 2012

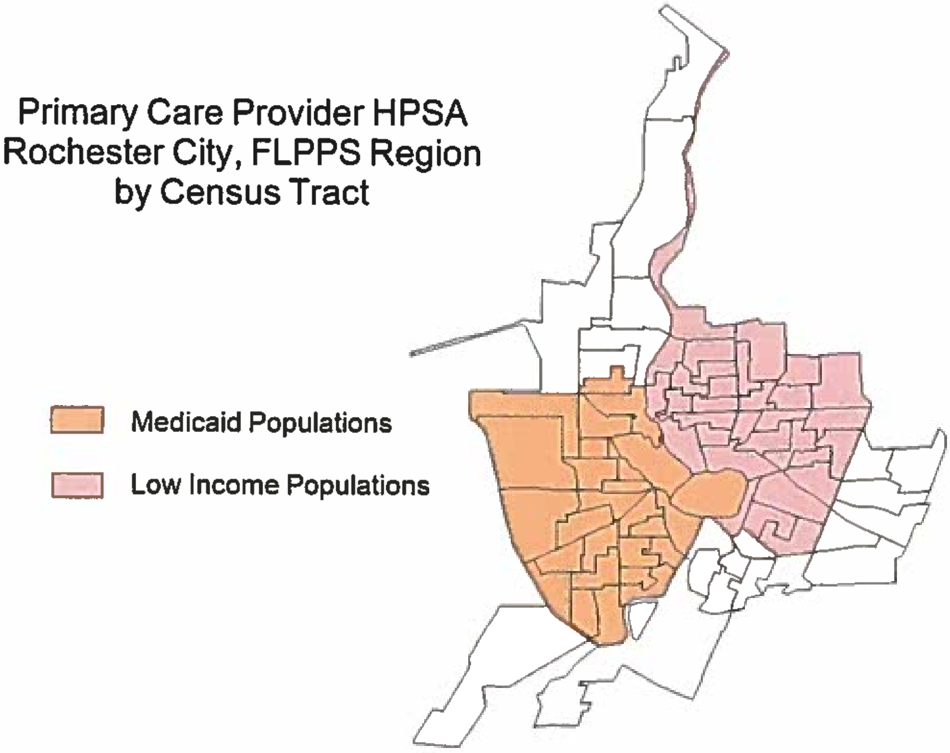
County	Physical Therapists*	Occupational Therapists*	Speech Language Pathologists*	Physician Assistants*	Nurse Practitioners*
Allegany	46.7	18.3	48.7	30.5	62.9
Cayuga	61.4	25.1	40.1	23.8	92.7
Chemung	69.1	44.2	156.2	40.8	104.2
Genesee	68.3	42.7	68.3	29.0	107.5
Livingston	67.4	43.9	101.9	45.5	73.7
Monroe	91.2	47.1	94.6	64.9	135.8
Ontario	94.3	88.7	89.6	51.9	135.8
Orleans	37.8	11.8	23.6	7.1	54.3
Schuyler	69.7	53.6	26.8	21.4	26.8
Seneca	40.6	63.8	26.1	23.2	37.7
Steuben	50.3	43.1	43.1	31.8	58.5
Wayne	79.2	59.6	79.2	36.9	70.5
Wyoming	50.3	26.4	57.5	35.9	47.9
Yates	44.3	108.8	36.3	12.1	149
New York State	80.0	47.0	71.0	61.0	76.0

DATA SOURCE: Center for Health Workforce Studies
*Licenses per 100,000 Pop.

The Health Resources and Services Administration (HRSA) identifies Health Professional Shortage Areas (HPSAs) through an application process that documents need for a particular service. Within the FLPPS region Allegany, Livingston, Orleans, Schuyler, Seneca, Wayne, Wyoming and Yates counties are listed as entire counties with HPSA PCP designations for either the entire population and/or the Medicaid population. Further, Cayuga, Genesee, Monroe, Ontario, and Steuben counties contain PCP HPSA's for various portions of their population. This strongly suggests that there is a PCP shortage throughout the FLPPS region.

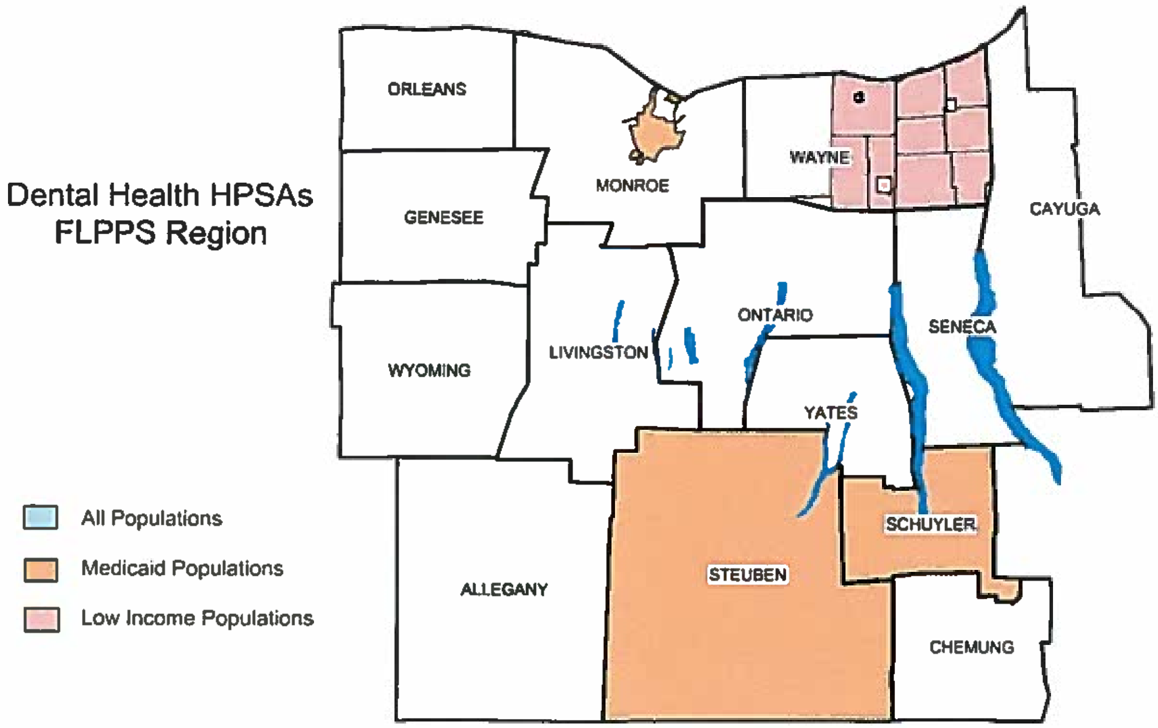


Map 3 – PCP HPSA's, FLPPS Region



Map 4 – PCP HPSA's, City of Rochester

Dental care is a primary area of concern for the Medicaid and Uninsured Populations. As identified in Map 5 below, there are numerous locations throughout the 14 counties that identify specific populations as needing additional dental health resources. Additionally, the HRSA data indicate that the institutionalized populations in FLPPS frequently experience dental provider shortages. While there are 888 dental licenses attributable to the FLPPS fourteen county region, only 211 unique billed providers had encounter or service claims in 2013 as identified in the Salient Medicaid claims database.



Map 5 – Dental Health HPSA's

One of the additional resources at our disposal is the FLHSA aggregated claims database. This database contains commercial, managed Medicaid and Medicare advantage claims from Excellus and MVP for residents in the majority of the FLPPS counties. One of the added benefits of this data source is that we can determine how many physicians in these counties are seeing Managed Medicaid patients. The providers in the rural communities are more likely to have Medicaid claims than those in the more urban communities. However, across the region, between 80 percent and 100 percent of the providers in our database accept Managed Medicaid. While this does not account for Fee-for-Service (FFS) Medicaid patients, it does demonstrate that the majority of providers are willing to accept Managed Medicaid patients in most of the regional counties.

Table 10 – PCP Providers with Medicaid Claims

Percentage Of Primary Care Providers With Managed Medicaid Claims, 2013[2]

County	Provider Specialty	PCPs With Claims	% Of PCPs With Claims
Chemung	Family Practice	18	100%
	Internal Medicine	29	76%
	Obstetrics & Gynecology	6	100%
	Pediatrics	10	100%
	Total	63	88%
Livingston	Family Practice	19	100%
	Internal Medicine	9	100%
	Obstetrics & Gynecology	2	100%
	Pediatrics	6	100%
	Total	36	100%
Monroe	Family Practice	145	91%
	Internal Medicine	296	85%
	Obstetrics & Gynecology	111	93%
	Pediatrics	173	94%
	Total	725	89%
Ontario	Family Practice	20	83%
	Internal Medicine	26	67%
	Obstetrics & Gynecology	9	100%
	Pediatrics	12	100%
	Total	67	80%
Schuyler	Family Practice	8	100%
	Internal Medicine	3	75%
	Obstetrics & Gynecology	1	100%
	Pediatrics	2	100%
	Total	14	93%
Seneca	Family Practice	6	100%
	Internal Medicine	4	100%
	Total	10	100%
Steuben	Family Practice	26	100%
	Internal Medicine	17	74%
	Obstetrics & Gynecology	4	100%
	Pediatrics	8	100%
	Total	55	90%
Wayne	Family Practice	14	93%
	Internal Medicine	14	93%
	Obstetrics & Gynecology	3	75%
	Pediatrics	9	100%
	Total	40	93%
Yates	Family Practice	13	100%
	Internal Medicine	1	33%
	Total	14	88%
	Totals	**1,024**	**89%**

DATA SOURCE: FLHSA Aggregated Claims Database

---

[2] Based on the November 2014 enrollment, almost two-thirds (63%) of the 14-county region's Medicaid Managed Care enrollment was in Excellus or MVP plans. However, the proportion varies substantially among the NOCN subareas from a high of 83% in Monroe Co to 0% in the SE NOCN. See Appendix A for enrollment by county and NOCN.

Behavioral Health Workforce

The behavioral health workforce will be a critical component to the success of DSRIP programs. The availability of this workforce varies by county. However, the region consistently measures below the New York state average availability of behavioral health care workforce. In fact, no counties exceed the New York state average rate for either psychiatrists or psychologists. This lack of doctoral level practitioners may have serious implications, both for their patients and the patients being seen by the mid-level practitioners' patients, given the potential lack of support structure. The choice of implementation methodology by program will certainly need to account for the skill sets of the available workforce in the region, as well as the differences in capabilities by license type.

Table 11 – Availability of BH Providers

Availability of Providers by Licensure Type, per 100,000 residents, 2012

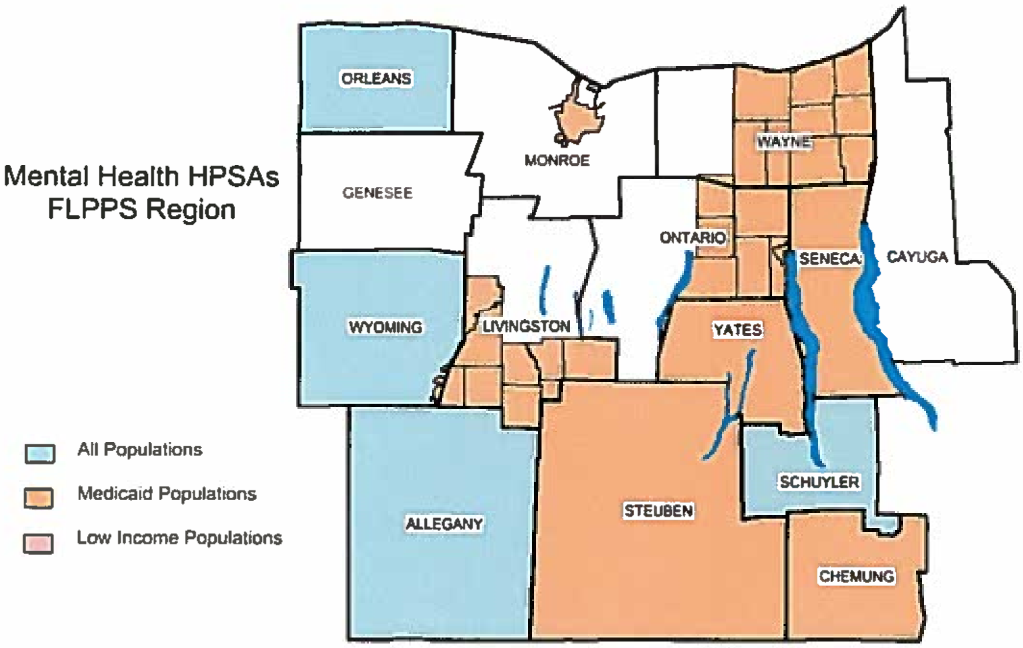
County	Psychiatrists*	MH Counselors*	Psychologists*	Social Workers*
Allegany	2.6	32.5	28.4	56.9
Cayuga	8.2	17.5	6.3	100.3
Chemung	25.1	21.5	13.6	156.2
Genesee	4.4	18.8	11.9	124.6
Livingston	0.0	20.4	17.2	125.4
Monroe	27.4	31.1	42.3	217.5
Ontario	18.4	26.4	29.2	177.3
Orleans	6.1	9.4	9.4	75.6
Schuyler	0.0	5.4	16.1	171.6
Seneca	11.3	17.4	0.0	130.6
Steuben	14.7	10.3	21.6	121.2
Wayne	4.2	31.5	5.4	118.2
Wyoming	6.2	9.6	2.4	107.8
Yates	21.0	16.1	8.1	96.7
New York State	36.0	21.0	52.0	234.0

DATA SOURCE: Center for Health Workforce Studies

*Licenses per 100,000 Pop.

It should be noted that the data in the table above represents a rate of licensed practitioners assigned to a county based on the address listed on said license. It is unclear if this address represents where a clinician works or where he or she lives. Furthermore, we do not have information on the number of hours worked by clinicians or in what settings they work (i.e. – a research setting vs. a clinical setting). As such, it is likely that these numbers do not perfectly capture provider availability from a patient's perspective. Indeed, feedback from local county mental hygiene directors suggested that the above numbers may in many cases overstate the number of available providers in a given county. Using their working knowledge of the available behavioral health resources and informal provider surveys, the county mental hygiene directors produced estimated FTE numbers by provider type. These estimates can be found in Appendix A. Despite these potential discrepancies, it is likely that the above license rates provide a reasonable estimate of BH provider availability, particularly for the purpose of comparing between counties and to the state as a whole.

HRSA also identifies MH HPSA's by a similar process as the PCP and dental health HPSA's. Through this process Allegany, Chemung, Orleans, Schuyler, Seneca, Steuben, Wyoming, and Yates counties are all identified, in their entirety as lacking mental health services. Cayuga, Genesee, Livingston, Monroe, Ontario, and Wayne counties are also identified as having subsets of their populations in need of additional mental health services. Within many of these counties, correctional facilities are identified as needing additional mental health services. Additionally, half of the 14 counties specifically identify the Medicaid population as being in need of additional mental health care. These identified gaps in the mental health care workforce could present serious challenges to any programs targeted to the behavioral health population.



Map 6 – Mental Health HPSA's

While the rates of licensure for the FLPPS region appear to be below the state average, there is an additional separate concern regarding the availability of these services specific to the Medicaid and uninsured populations. Wilk et al. found that nationally over 85 percent of psychiatrists were willing to see new patients, but only 44 percent were willing to accept Medicaid patients, essentially cutting the psychiatrist availability in half for those individuals (Wilk JE; et al., 2005). Both health care and community based providers reiterated to us through our local reviews of the CNA that a shortage of psychiatrists was also an issue in the FLPPS region.

One of the FLHSA's regional partners for the CNA is Coordinated Care Services Incorporated (CCSI) which is well connected with behavioral health providers in the FLPPS region and continuously conducts research to evaluate the resources available and needs of patients. They have developed an extensive database of programs that serve behavioral health clients. Within this database, 812 programs provide services from crisis intervention (17) to supported community housing (54). A table of all of the available resources is included in Appendix A.

Table 12 – Behavioral Health Resources by County

Behavioral Health Resources, 2014

County	Number of BH Resources
Allegany	37
Cayuga	45
Chemung	64
Genesee	36
Livingston	31
Monroe	213
Ontario	49
Orleans	30
Schuyler	25
Seneca	42
Steuben	54
Wayne	62
Wyoming	47
Yates	41
New York State	36

DATA SOURCE: CCSI BH Resource Database

Table 13 – Behavioral Health Resources

Number of BH resources by County, 2014

County	Advocacy/Support Services	Clinic Treatment	Crisis Intervention	Day Hab/ Day Services	Family Support Services Children & Family	Health Home Care Management	OMH 1915i Providers
Allegany	6	1	0	1	1	3	5
Cayuga	1	2	0	3	3	1	0
Chemung	4	3	2	2	1	2	2
Genesee	2	1	1	1	1	1	2
Livingston	3	2	0	1	3	1	4
Monroe	23	11	4	1	5	4	7
Ontario	2	2	1	2	1	2	2
Orleans	2	1	0	1	2	1	1
Schuyler	1	1	1	1	1	2	1
Seneca	2	2	0	0	1	2	2
Steuben	2	1	1	3	2	2	3
Wayne	3	1	1	1	2	1	4
Wyoming	5	2	1	1	2	2	5
Yates	2	1	2	1	1	2	4
FLPPS Region	58	31	14	19	26	26	42

DATA SOURCE: CCSI BH Resource Database

Table 14 – Behavioral Health Resource Rates

BH Resources per 100,000 Population by County, 2014

County	Advocacy/Support Services	Clinic Treatment	Crisis Intervention	Day Hab/ Day Services	Family Support Services Children & Family	Health Home Care Management	OMH 1915i Providers
Allegany	12.4	2.1	0.0	2.1	2.1	6.2	10.3
Cayuga	1.3	2.5	0.0	3.8	3.8	1.3	0
Chemung	4.5	3.4	2.2	2.2	1.1	2.2	2.2
Genesee	3.3	1.7	1.7	1.7	1.7	1.7	3.3
Livingston	4.6	3.1	0.0	1.5	4.6	1.5	6.2
Monroe	3.1	1.5	0.5	0.1	0.7	0.5	0.9
Ontario	1.8	1.8	0.9	1.8	0.9	1.8	1.8
Orleans	4.7	2.3	0.0	2.3	4.7	2.3	2.3
Schuyler	5.4	5.4	5.4	5.4	5.4	10.8	5.4
Seneca	5.7	5.7	0.0	0.0	2.8	5.7	5.7
Steuben	2.0	1.0	1.0	3.0	2.0	2.0	3.0
Wayne	3.2	1.1	1.1	1.1	2.2	1.1	4.3
Wyoming	11.9	4.8	2.4	2.4	4.8	4.8	12.0
Yates	7.9	3.9	7.9	3.9	3.9	7.9	15.8
FLPPS Region	3.7	2.0	0.9	1.2	1.7	1.7	2.7

DATA SOURCE: CCSI BH Resource Database, 2012 Population from ACS

Table 15 – Behavioral Health Resources (cont.)

Number of BH Resources by County, 2014 (cont.)							
County	Inpatient Psychiatric Unit of a General Hospital	Inpatient Rehab.	Partial Hospitalization	Outpatient Clinic	CPEP Crisis	Respite Services	Supported Housing Community Services
Allegany	0	0	0	1	0	1	3
Cayuga	1	0	0	2	0	2	3
Chemung	1	1	1	1	0	1	3
Genesee	0	1	0	2	0	0	1
Livingston	0	0	0	2	0	1	3
Monroe	3	2	3	13	1	0	14
Ontario	1	1	0	4	1	0	2
Orleans	0	0	0	1	0	0	2
Schuyler	0	0	0	1	0	0	2
Seneca	0	1	0	2	0	1	2
Steuben	0	1	0	4	0	1	4
Wayne	1	0	0	2	0	0	5
Wyoming	1	0	0	1	0	1	2
Yates	1	0	0	1	0	1	2
FLPPS Region	9	7	4	37	2	9	48

DATA SOURCE: CCSI BH Resource Database

Table 16 – Behavioral Health Resource Rates (cont.)

BH Resources per 100,000 Population by County, 2014 (cont.)							
County	Inpatient Psychiatric Unit of a General Hospital	Inpatient Rehab.	Partial Hospitalization	Outpatient Clinic	CPEP Crisis	Respite Services	Supported Housing Community Services
Allegany	0.0	0.0	0.0	2.1	0.0	2.1	6.2
Cayuga	1.3	0.0	0.0	2.5	0.0	2.5	3.8
Chemung	1.1	1.1	1.1	1.1	0.0	1.1	3.4
Genesee	0.0	1.7	0.0	3.3	0.0	0.0	1.7
Livingston	0.0	0.0	0.0	3.1	0.0	1.5	4.6
Monroe	0.4	0.3	0.4	1.7	0.1	0.0	1.9
Ontario	0.9	0.9	0.0	3.7	0.9	0.0	1.8
Orleans	0.0	0.0	0.0	2.3	0.0	0.0	4.7
Schuyler	0.0	0.0	0.0	5.4	0.0	0.0	10.8
Seneca	0.0	2.8	0.0	5.7	0.0	2.8	5.7
Steuben	0.0	1.0	0.0	4.0	0.0	1.0	4.0
Wayne	1.1	0.0	0.0	2.2	0.0	0.0	5.4
Wyoming	2.4	0.0	0.0	2.4	0.0	2.4	4.8
Yates	3.9	0.0	0.0	3.9	0.0	3.9	7.9
FLPPS Region	0.6	0.5	0.3	2.4	0.1	0.6	3.1

DATA SOURCE: CCSI BH Resource Database, 2012 Population from ACS

Community Based Resources

While health care resources are critical to the acute needs of patients, they are not the only factors in ensuring that patients are cared for in the most efficient and meaningful way. A litany of community based organizations (CBO) that support individuals in the Medicaid and uninsured populations exist in the FLPPS region. Unfortunately, the availability of these organizations has remained somewhat shrouded from the health care community. In order to identify these resources, the FLHSA asked our regional CBO's to complete an online qualitative survey. FLHSA staff also requested detailed data from the local 211 providers to help the FLPPS understand the diverse community based resources that are available to their patients to help improve their lives. As DSRIP encourages the increased interaction between community based resources and health care resources it will be important to understand not only where these types of resources exist, but also where they may be most needed throughout the region.

The Alliance of Information and Referral Systems (AIRS) 211 taxonomy separates various community resources into eleven basic taxonomic categories. The total number of programs providing services to the residents of FLPPS region is nearly 5,600. Of particular interest to DSRIP are the programs provided in the basic needs taxonomy, such as transportation, housing, and food.

Due to restrictions of the data set, we are unable to consistently provide service areas which are covered by the various community resources. What we are able to examine is the county of the parent agency's address. In order to provide a proxy for service area, we must assume that for many of these resources the parent agency provides services in the general vicinity of that location. There are limitations with this methodology, as several parent agencies identified as providing services to the region are located in other areas of the state, and in some instances, other areas of the country. Another confounding factor is that community-based prevention services are often grant funded and unsustainable over the long term. The resources listed here may be transient in nature and not available to residents in the long term. Among programs which are run by agencies located within the FLPPS Region, 36 percent are located in Monroe County, 13 percent are located in Steuben County and 10 percent are located in Chemung County. While many of the service regions for these organizations overlap the location of the parent agency may have significant influence as to both the penetration of those services in other areas and the understanding of local needs.

Table 17 – Community Based Resources by Type

211 Listed Community Resources by Taxonomy, 2014

Resource Type	Number of Programs in the FLPPS Region
Basic Needs	1,082
Consumer Services	142
Criminal Justice and Legal Services	162
Education	76
Environment and Public Health / Safety	77
Health Care	1,085
Income Support and Employment	195
Individual and Family Life	1,137
Mental Health and Substance Abuse Services	754
Organizational / Community / International Services	878

DATA SOURCE: 211 Resource Directories

The total number of programs available in the region is a basic indicator of the number of community resources available for residents needing sets of services, however, this methodology does not account for variability in staffing, operating hours and service area that clearly exist among these organizations. There are several counties that do appear to have a disproportionate number of programs to the county populations but because this model does not account for size and availability of programs, it is difficult to compare adequately across the region.

Table 18 – Community Based Resources by County

211 Listed Community Resources by County, 2014

Parent Agency County	Number of Programs	Percentage of FLPPS County Programs
Allegany	242	7%
Cayuga	135	4%
Chemung	331	10%
Genesee	70	2%
Livingston	112	3%
Monroe	1,233	36%
Ontario	244	7%
Orleans	33	1%
Schuyler	191	6%
Seneca	57	2%
Steuben	458	13%
Wayne	129	4%
Wyoming	30	1%
Yates	203	6%

DATA SOURCE: 211 Resource Directories

The 211 Resource Directories identify transportation resources for the region under several subcategories including: local transportation, long-distance transportation, transportation-expense assistance, transportation organizations, transportation passes and traveler's assistance. Obviously each subcategory provides a different type of service, not all of which are applicable to individuals needing transport for health services, but overall transportation needs are clearly an area of concern for the region, and was identified as the leading barrier for residents needing services by our CBO and behavior health survey respondents.

Table 19 – Transportation Resources by County

211 Listed Transportation Resources by County, 2014	
Parent Agency County	Number of Transport Programs
Allegany	15
Cayuga	3
Chemung	17
Genesee	8
Livingston	1
Monroe	21
Ontario	3
Orleans	0
Schuyler	12
Seneca	1
Steuben	30
Wayne	3
Wyoming	1
Yates	5
Counties Outside PPS	39

DATA SOURCE: 211 Resource Directories

Safe and stable housing is one of the social determinants of health which DSRIP aims to address. This is particularly true among individuals with severe and persistent mental illness (SPMI). A systematic review of the literature conducted in 2008 found that adequate housing was critical for this population and that providing permanent housing minimized harm and increased treatment seeking behavior(Kyle & Dunn, 2008). Monroe County completes an annual housing and homeless services report detailing the availability and need for housing in Rochester. A link to that report is available in Appendix C.

Table 20 – Housing Resources by County

211 Listed Housing Resources by County, 2014	
Parent Agency County	Number of Housing Programs
Allegany	33
Cayuga	15
Chemung	27
Genesee	12
Livingston	5
Monroe	75
Ontario	12
Orleans	8
Schuyler	17
Seneca	3
Steuben	42
Wayne	1
Wyoming	3
Yates	16
Counties Outside PPS	89

DATA SOURCE: 211 Resource Directories

The FLHSA completed a survey of both behavioral health and community based organizations to better understand their availability and their perception of barriers to care for the patients they serve in the FLPPS region. Forty six percent of behavior health organizations reported barriers preventing their patients from receiving the specific services they provided. The most commonly noted barrier was transportation, but the organizations also frequently noted a lack of personal motivation on behalf of patients to seek services and cited finances as a barrier as well. Additionally 8 percent of respondents noted that language and culture were barriers.

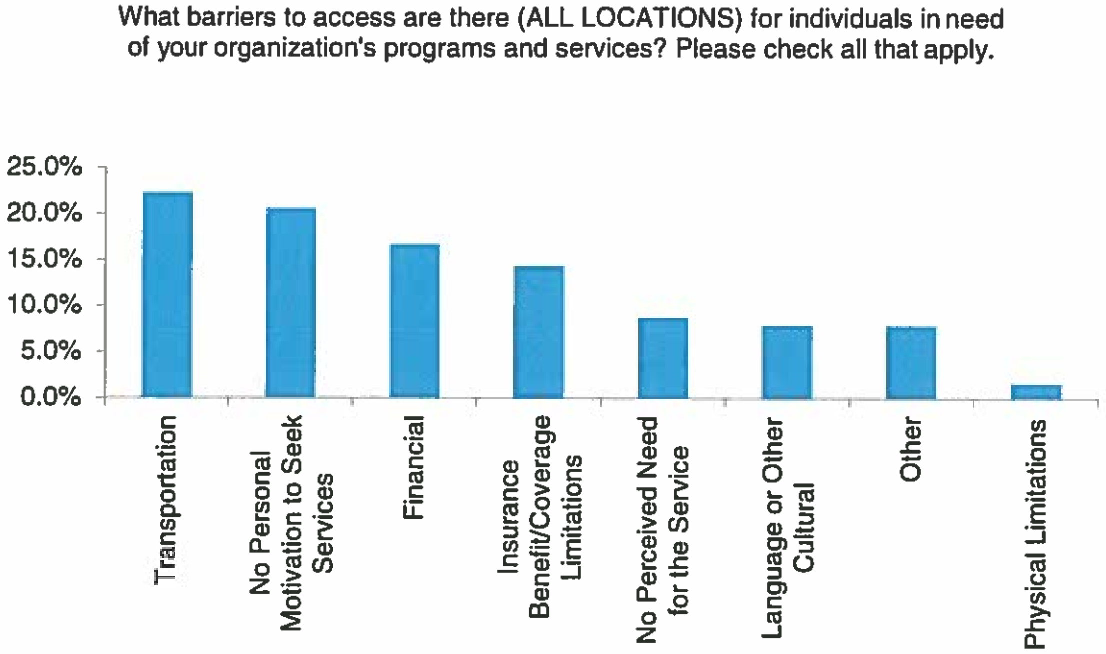

What barriers to access are there (ALL LOCATIONS) for individuals in need of your organization's programs and services? Please check all that apply.

Figure 3 – CBO - Barriers to Access

DATA SOURCE: FLHSA PPS Community based organization Survey

Few of the organizations serving the behavioral health population noted that they had active waiting lists with two very notable exceptions. The majority of responding Residential Mental Health and Community Residence programs noted that there was a wait list to receive services.

Thirty five percent of Community Based Organization survey respondents identified barriers for their clients. Among these, transportation and lack of personal motivation were again the leading obstacles reported. These providers also cited a lack of perceived need for a service, financial barriers, and insurance gaps in their communities. The similarities in the identified barriers between the two cohorts points to the true need to address some of these barriers for the population of the FLPPS.

In addition to the resources listed above, numerous resources assist individuals with other needs. Two of the most important types of community supports include libraries and religious organizations. The availability of libraries influences both an individual's access to information and their ability to communicate with providers. Collaborative partnerships with community organizations have been illustrated as a strategy to improving community health (Roussos & Fawcett, 2000) and have demonstrated success locally through collaborations with religious organizations. Indeed, Rochester has utilized partnerships with primarily African-American faith-based organizations, which are frequently located in neighborhoods with high rates of poverty, to address disparities in high blood pressure and encourage healthy habits at the community level. Understanding the availability of these resources and knowing how to leverage them in a patient centered model could have far-reaching positive impacts on health care in the FLPPS region.

Table 21 – Libraries and Religious Organizations by County

Libraries and Religious Organizations by County, 2014		
County	Libraries	Religious Organizations
Allegany	17	23
Cayuga	8	25
Chemung	6	9
Genesee	7	39
Livingston	9	33
Monroe	35	466
Ontario	11	44
Orleans	4	30
Schuyler	3	12
Seneca	5	19
Steuben	14	32
Wayne	13	64
Wyoming	9	12
Yates	5	24
TOTAL	146	832

DATA SOURCE: FLHSA Community Research

Domain 2 Metrics

Using the state provided avoidable hospital use metrics, it appears the Finger Lakes PPS has significant potential to improve the quality of patient care while reducing cost and improving health care system efficiency for the Medicaid population.

Potentially Preventable Emergency Department Visits

The use of the emergency department for the treatment of conditions which could have been potentially treated in a more effective and lower cost setting such as a primary care office or an urgent care center is a driver of avoidable hospital use in the Finger Lakes region. Specifically, the FLPPS has a higher PPV rate (calculated as a weighted average of the 14 county rates), both adjusted and unadjusted (38.83 per 100 population and 37.56, respectively) as compared to the statewide rate (36.43). Furthermore, when compared to all counties in New York State, nine of the 14 counties in the PPS have PPV rates that fall below the 80th percentile, meaning that only five of the counties in the region are among the top 20 percent of performers with regards to preventing avoidable ED use. Collectively, these findings suggest significant opportunities for improving patient care and reducing potentially preventable ED use.

Table 22 – PPV Rates

PPV Rates and County Rankings
(Out of 62 counties with reported data)

	Observed Rate	Unadjusted Rank	Adjusted Rate	Adjusted Rank
Monroe	37.98	31	34.76	18
Seneca	16.81	1	17.25	1
Ontario	25.84	6	25.82	6
Cayuga	41.34	35	42.18	37
Wayne	28.70	11	28.93	10
Orleans	36.76	26	36.93	28
Genesee	45.98	40	46.66	42
Livingston	24.73	5	24.87	5
Wyoming	33.50	16	35.36	22
Allegany	46.19	42	48.06	45
Steuben	48.17	47	49.92	47
Chemung	62.45	61	62.54	61
Schuyler	51.33	49	53.02	49
Statewide	36.43	22	N/A	N/A

▨ **Indicates rate is below the top 20% of performers**

DATA SOURCE: NY State Open Data

Potentially Avoidable Readmissions

Hospital readmissions may be an indication of suboptimal care around the time of an inpatient discharge. It appears that there is considerable opportunity to improve this facet of patient care for Medicaid recipients in the FLPPS. Using the unadjusted PPR rates provided by NYSDOH, this 14-county region has a facility-based weighted-average rate that is very similar to that of the state as a whole (6.26 readmissions per 100 at-risk admissions vs. 6.75). Additionally, most of the hospitals in the FLPPS perform worse on this metric in comparison to the highest performing facilities in New York State. Eighteen of the 22 facilities in the FLPPS have a PPR rate that is among the bottom 80 percent of performers in New York State, suggesting ample room for improvement across the vast majority of hospitals in the FLPPS.

Of note is the emphasis above on the unadjusted PPR rate. This focus was intentional due to the belief among the FLPPS CNA researchers that the unadjusted rate best captures the expected need of the patient population served by a given hospital. The adjusted rate, which was designed to isolate the quality of care delivered by a facility by controlling for a variety of patient-factors,(Goldfield et al., 2008) may mask differences in the baseline risk of the Medicaid populations being treated across counties and regions. The unadjusted rate, on the other hand, provides a more complete description of readmissions that captures both the quality of care delivered by a facility and the needs or complexity of the population it serves. As such, we believe the unadjusted rate to be most appropriate for the community needs assessment.

Table 23 – PPR Rates

PPR RATES BY FACILITY, 2011-2012 AVERAGE

Facility	Observed Rate	Unadjusted Rank	Adjusted Rate	Adjusted Rank
Arnot Ogden Medical Center	4.57	49	5.76	82
Auburn Community Hospital	4.75	54	4.88	36
Clifton Springs	8.22	154	5.8	85.5
Corning Hospital	4.3	40	4.79	33
Cuba Memorial Hospital	1.28	8	2.35	6
FF Thompson	5.95	100.5	7.82	169
Geneva General	4.06	34	4.84	34
Highland Hospital	4.26	38.5	5.12	48
Ira Davenport	4.26	38.5	3.56	13
Jones Memorial Hospital	3.97	28	5.71	79.5
Lakeside Memorial Hospital	5.1	70.5	6.49	121
Medina Memorial	8.22	153	6.02	94
Monroe Community Hospital	25	187.5	30.53	186
Newark-Wayne	4.87	59	4.9	37
Nicholas H Noyes	3.83	23	5.29	55
Rochester General	6.79	120	6.4	113.5
Soldiers And Sailors	7.23	139	3.64	15
St James Mercy	6.92	126	5.85	89
St Joseph's Hospital Elmira	6.72	117	4.33	21
Strong Memorial	7.83	148	5.65	76
Unity Hospital	5	65	4.52	25
Wyoming Community Hospital	5.07	68	4.16	19
Statewide	6.75	119	N/A	N/A

Indicates rate is below the top 20% of performers

DATA SOURCE: NY State Open Data

Potentially Preventable Hospitalizations (Adults)

Hospitalizations for conditions which potentially could have been treated in an outpatient setting represent another important measure of avoidable hospital use. Using the PQI rates provided by NYSDOH, it appears this is another area in which FLPPS could improve the quality of patient care for Medicaid recipients while promoting efficiencies. While both the unadjusted and adjusted rates of composite PQI admissions in the FLPPS are slightly below the statewide rate (1,624 PQIs per 100,000 population and 1,757 vs. 1,847), many of the counties in the PPS lag behind the highest performing communities. Namely, 11 of the 14 counties in the PPS have an adjusted or unadjusted overall PQI rate that is below the top 20 percent of counties in the state. Furthermore, it should be noted that the distribution of PQI rates across all counties in the state are highly skewed, resulting in the average statewide rate being higher than the median statewide rate. In other words, most counties have a lower PQI rate that the statewide average.

Collectively, it appears that there is considerable opportunity for improvement in the area of potentially preventable hospital admissions in the FLPPS.

Table 24 – PQI Rates.

PQI RATES BY COUNTY, 2011-2012 AVERAGE

County	Unadjusted Rate	Unadjusted Rank	Adjusted Rate	Adjusted Rank
Monroe	1611.265	30	1603.185	18
Wayne	1582.37	26	1827.685	34
Seneca	1629.125	31	2038.5	45
Cayuga	1869.855	47	2224.36	51
Yates	514.475	3	588.705	3
Ontario	1409.695	17	1634.565	19
Orleans	2049.16	53	2432.765	54
Genesee	1498.47	19	1700.275	23
Allegany	1213.375	11	1421.72	11
Wyoming	1754.755	38	2004.46	44
Livingston	1159.11	8	1445.81	12
Schuyler	2136.575	57	2504.025	59
Chemung	2181.77	60	2470.73	58
Steuben	1601.835	28	1882.34	38
Statewide	1846.9	46	N/A	N/A

Indicates rate is in the bottom 80% of performers
DATA SOURCE: NY State Open Data

Potentially Preventable Hospitalizations (Pediatric)

Separate metrics to identify potentially avoidable hospitalizations among the pediatric population have also been made available by the NYSDOH. Overall, FLPPS performance on this metric suggests that this is an area of strength for the 14-county region as both its unadjusted and adjusted rates are well below the statewide average (151 PDI admissions per 100,000 population and 194 vs. 323). However, it should be noted that PDIs are relatively rare events. As a result, many counties have PDI rates at or close to zero while a few have very high rates. This highly skewed distribution of PDI rates means that the statewide average is considerably higher that the statewide median, and therefore, most counties have a PDI rate lower than the state.

When examining where the individuals counties rank relative to the other counties in New York State, there appears to be greater room for improvement. Namely, nine of the 13 counties for which data were available rank in the bottom 80 percent of performers.

Table 25 – PDI Rates

PDI RATES BY COUNTY, 2011-2012 AVERAGE

	Unadjusted Rate	Unadjusted Rank	Adjusted Rate	Adjusted Rank
Monroe	154.945	31	140.52	15
Seneca	79.425	13	145.545	16
Ontario	53.145	6	79.14	6
Cayuga	130.565	23	213.79	31
Wayne	132.145	24	210.565	28
Orleans	22.36	2	34.045	2
Genesee	47.005	5	74.135	3
Livingston	71.825	10	126.88	11
Wyoming	172.06	35	336.725	45
Allegany	287.615	51	585.79	56
Steuben	169.395	34	332.105	42
Chemung	269.9	48	393.64	52
Schuyler	296.43	52	600.975	57
Statewide	323.19	54	N/A	N/A

Indicates rate is in the bottom 80% of performers
DATA SOURCE: NY State Open Data

A summary of the above and additional Domain 2 metrics are provided in the table below.

Domain 2 Metrics

Table 26 – Domain 2 Metrics

Worse than NYS Average	Better than NYS Average	Metric Pending	Data not available from NYS as of 12/16/2014

Domain Name	Value Type	Regional Value
Domain 2 – System Transformation Metrics		
A. Create Integrated Delivery System		
Potentially Avoidable Services		
Potentially Avoidable Emergency Room Visits	Per 100 persons	38.8
Potentially Avoidable Readmissions	Readmission Rate	6.26
PQI Suite – Composite of all measures	Per 100,000 pop	1,668.1
PDI Suite – Composite of all measures	Per 100,000 pop	189.7
Provider Reimbursement		
Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	Percentage of Reimbursement	39.1
System Integration		
Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange		Data N/A
Primary Care		
Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)		Data N/A
CAHPS Measures including usual source of care		Data N/A
Patient Loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)		
Access to Care		
HEDIS Access/Availability of Care; Use of Services		Data N/A
B. Implementation of care coordination and transitional care programs		
CAHPS Measures:		
- Getting Care Quickly (routine and urgent care appointments as soon as member thought needed)		
- Getting Care Needed (access to specialists and getting care member thought needed)		Data N/A
- Access to Information After Hours		
- Wait Time (days between call for appointment and getting appoint for urgent care)		
Medicaid Spending for Projects Defined Population on a PMPM Basis		
Medicaid spending on ER and Inpatient Services		Data N/A.
Medicaid spending on PC and community based behavioral health care		Data N/A
B. Implementation of care coordination and transitional care programs		
Performing Provider Systems will be required to meet all of the above metrics with the addition of the following:		
Care Transitions		
H-CAHPS – Care Transition Metrics		Data N/A.
CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers		Data N/A.
C. Connecting Settings		
Performing Provider Systems will be required to meet all of the above metrics for A and B.		

DESCRIPTION OF COMMUNITY TO BE SERVED

Demographics

The FLPPS is comprised of a diverse set of 14 counties (Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates) with a total of about 1.5 million residents, nearly half of which reside in Monroe County, the primary urban center in the region. The population of the region has remained relatively stable over the past several decades and demonstrates a 1.3 percent increase from 1992 through 2012. Particular groups, however, have seen substantial growth over the past decade. For example, the Hispanic and black, non-Hispanic populations in the FLPPS increased about 38 percent and 8 percent respectively between 2000 and 2010. This is in contrast to the white, non-Hispanic population which decreased about 2 ½ percent over the same time period. Also of note is that the population of individual born outside the US has increased by about 16 percent since 2000, yet this group remains relatively small as it accounts for only about 5 percent of the total FLPPS population (refer to Appendix A for further detail on population changes over time). Total county-level population trends are highlighted in the figure below.

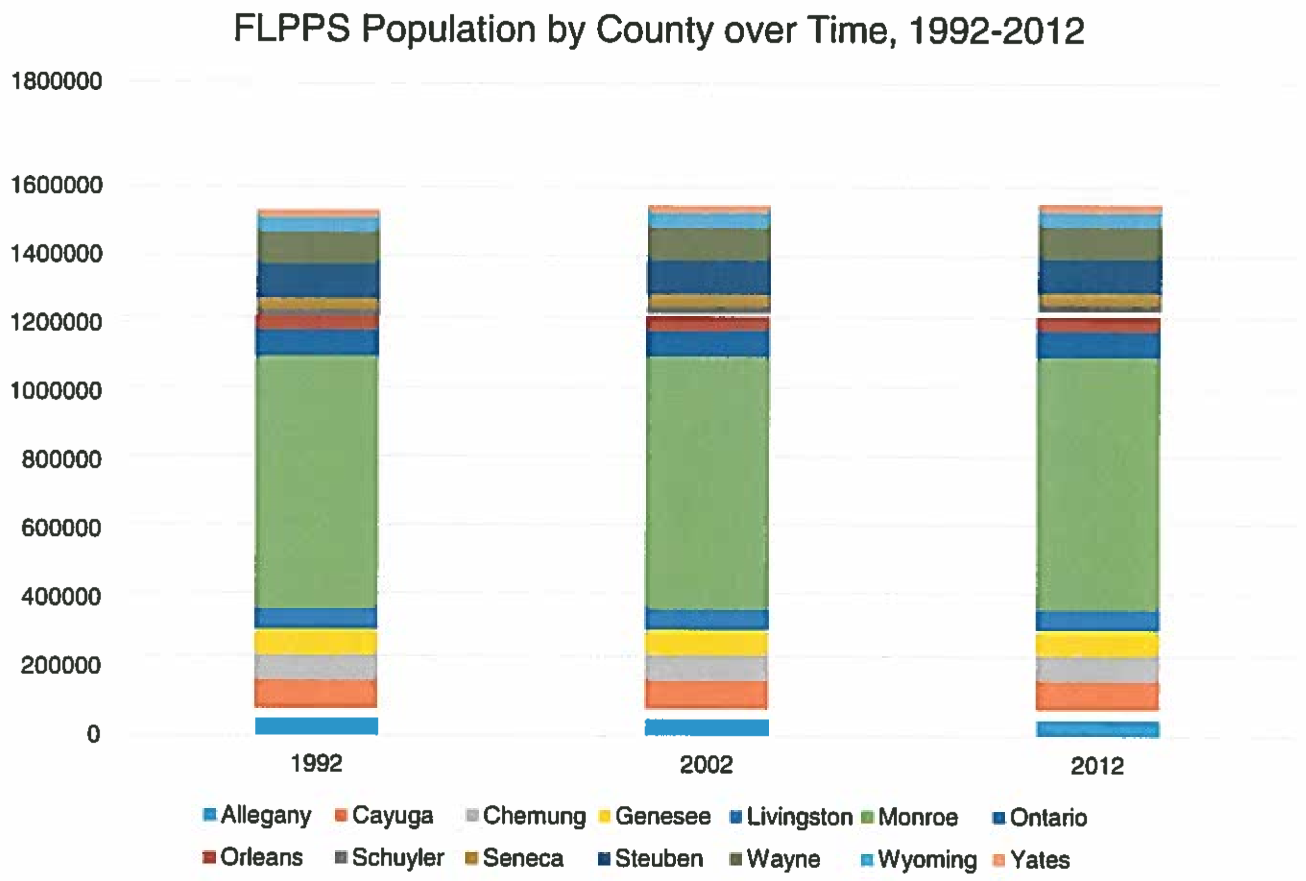
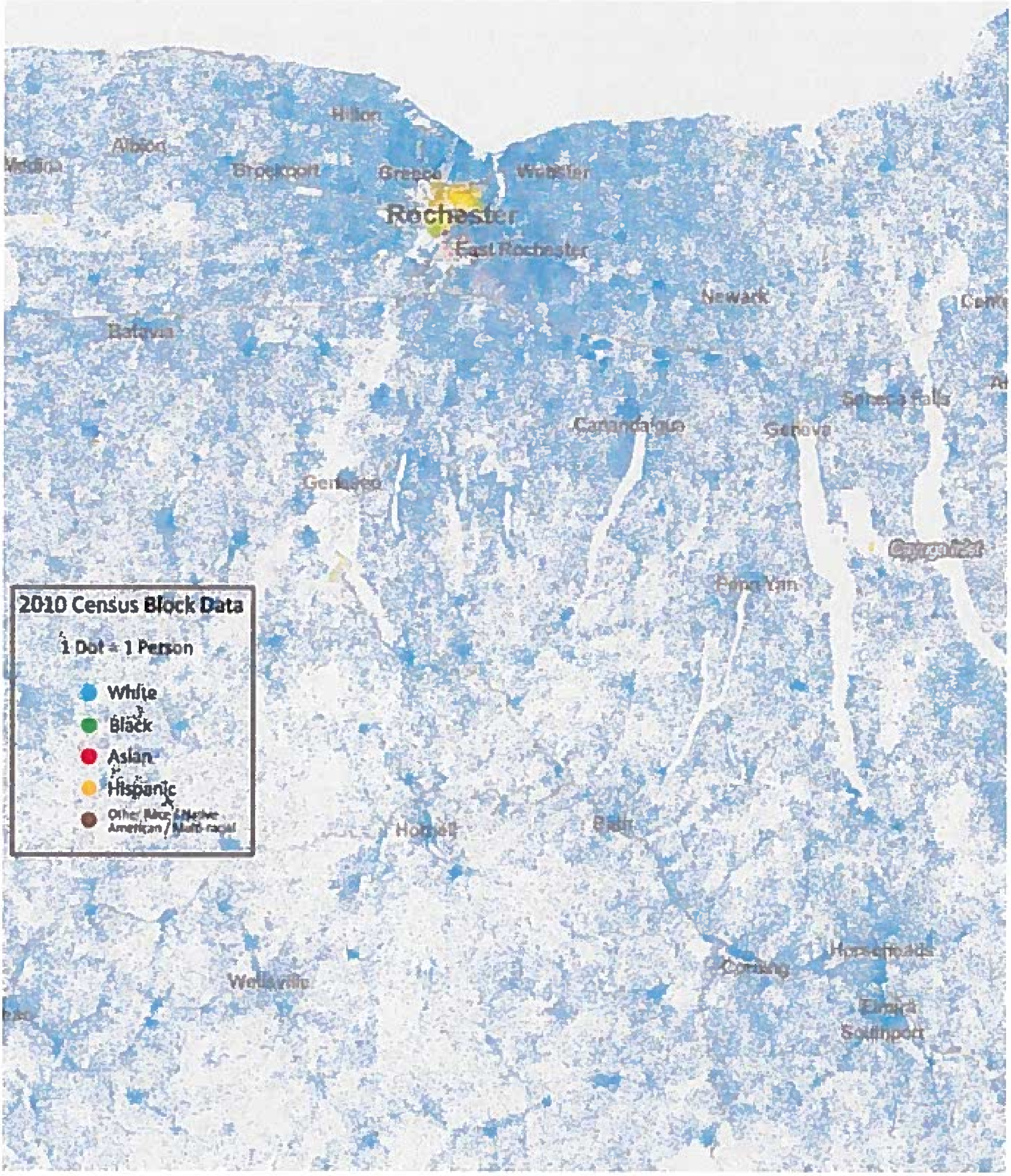


Figure 4 – FLPPS Population over Time

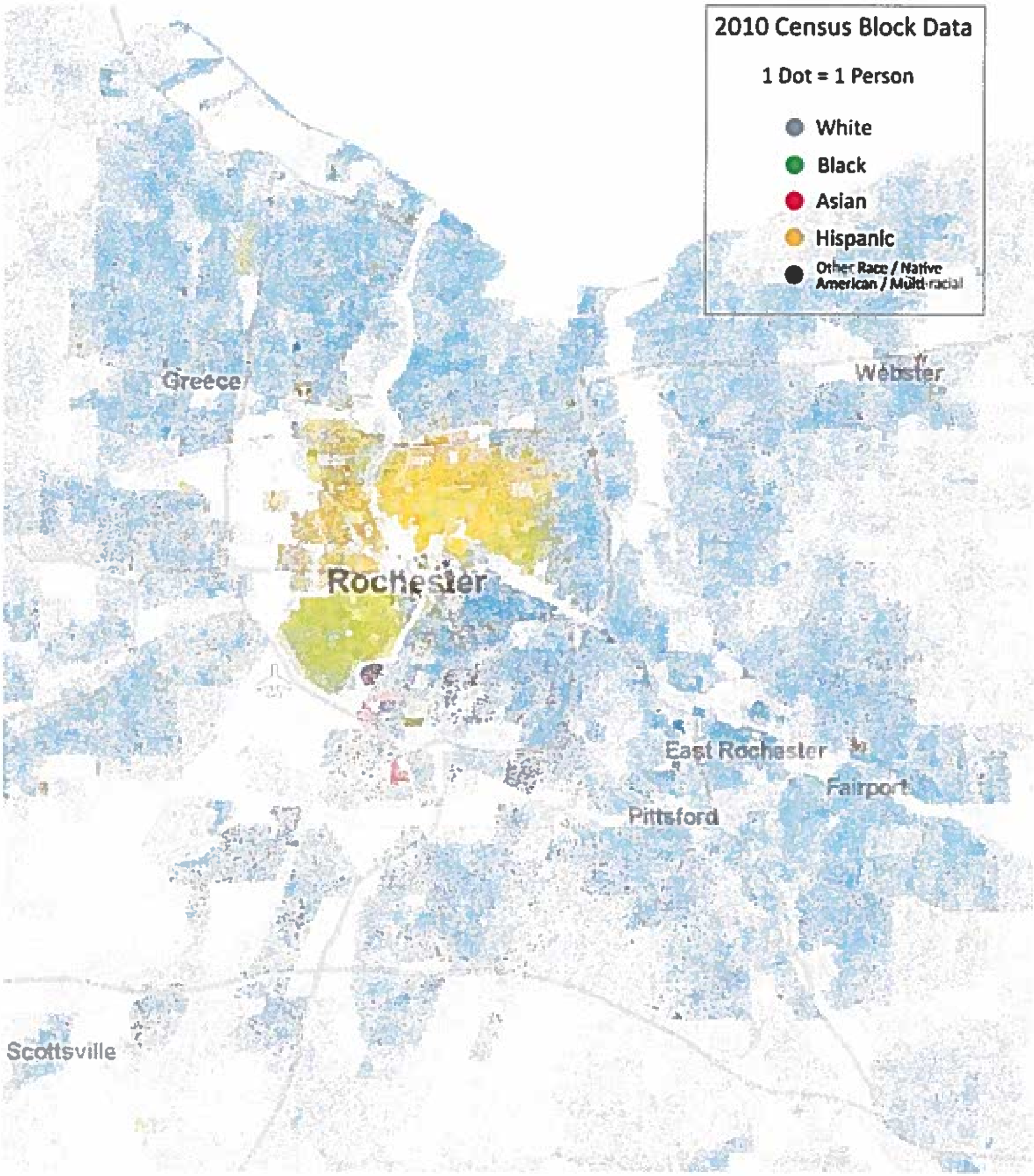
The FLPPS population appears to be racially and ethnically diverse, however the majority of the diversity is located in Monroe County, where the population identifies as 62 percent white, 22 percent African American and 6 percent Hispanic, while the remaining 14 counties identify as 92 percent white, 4 percent African American and 3 percent Hispanic. The dot maps below highlight the concentration of people of color in Monroe County, primarily within the City of Rochester.



Map 7 – Racial Dispersion, FLPPS

Source: Weldon Cooper Center for Public Service, University of Virginia (interactive map available at http://demographics.coopercenter.org/DotMap/

Further detail of the racial/ethnic geographic distribution of Monroe County residents is provided below.



Map 8 – Racial Dispersion, Monroe County

Source: Weldon Cooper Center for Public Service, University of Virginia (interactive map available at http://demographics.coopercenter.org/DotMap/

This map highlights the existence of substantial racial/ethnic segregation even within the city boundaries.

Consistent with the racial and ethnic composition of FLPPS county populations, the largest rate of non-English speakers is found in Monroe County (about 13 percent of the population aged 5 and older), with the most frequently reported non-English language spoken at home being Spanish. It should be noted, however, that only about 5 percent of the total county population reports speaking English less than "very well." Also of note is the relatively high rate of non-English speakers located in Yates County. Indeed, the percent of this county's population that speaks English less than "very well" is virtually identical to the much more ethnically diverse Monroe County. This population is predominately made up of individuals who report speaking "other Indo-European" languages. At an aggregate level, however, the population of non-English speakers in the FLPPS is much lower than New York state rates.

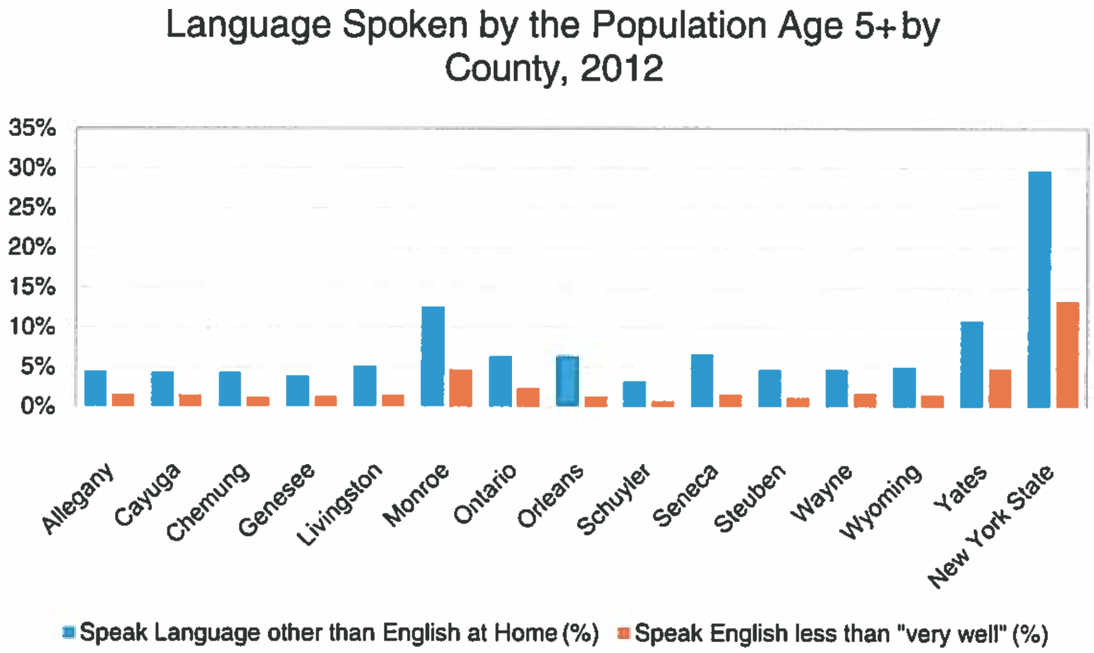


Figure 5 – Language Spoken by County

US Census Bureau: 2012 ACS 5-Year Estimates

The economic characteristics of individuals living in the FLPSS may also help provide an informative snapshot of the unique challenges facing this region. In 2012 the median income of the region ranged from $42,000 in Allegany County to $54,000 in Livingston County, with all counties demonstrating per-capita income below the New York state median income of $58,000. Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates counties all have greater than 10 percent of their population living below the poverty threshold, with four out of the 14 counties having a poverty rate above the state-wide average. Further details on the economic characteristics, including unemployment rates and occupation composition, of the FLPPS general county populations are provided in the table below.

Table 27 – FLPPS Economic Characteristics by County

FLPPS General Population Economic Characteristics by County, 2012

				Field of Occupation Among Those who are Employed				
	Median Household Income ($)	**People Living Below the Poverty Threshold (%)**	**Unemployed (%)**	**Management, Business, Science and Arts (%)**	**Service (%)**	**Sales or Office (%)**	**Natural Resources, Construction, and Maintenance (%)**	**Production, Transportation, and Material Moving (%)**
Allegany	42,095	17.1	8.8	32.2	19.3	20.5	12.5	15.6
Cayuga	50,950	12.2	8.2	29.6	19.3	23.2	11.6	16.3
Chemung	48,128	16	7.2	32.7	20	25.1	8.1	14.1
Genesee	51,734	11.8	7.4	30.4	18.9	22.3	12.5	15.8
Livingston	54,244	11.6	5.7	34.6	16.4	23.4	13	12.5
Monroe	52,700	14.6	7.9	41.6	17.2	24.8	5.8	10.6
Ontario	56,455	9.6	6.5	37.9	17.3	24	9.1	11.7
Orleans	50,113	13	9.9	26.7	17.9	22.6	13.6	19.2
Schuyler	47,869	9.4	6.2	30.4	20.6	22.9	12.9	13.2
Seneca	49,155	11.9	5.9	31.3	17.2	23.4	11.2	16.9
Steuben	46,519	15.1	9.1	33.7	18.1	20.8	11.6	15.8
Wayne	53,497	11.3	7.5	33.4	16.2	21.5	11.3	17.5
Wyoming	50,635	10.5	7.4	28.3	17.6	22.1	15.5	16.5
Yates	48,245	16	5.5	32.3	17.7	22.5	14	13.4
New York State	57,683	14.9	8.7	38.4	19.8	24.7	7.5	9.6

US Census Bureau: 2012 ACS 5-Year Estimates

Consistent with the variation in economic indicators, counties also show considerable differences across social characteristics. For example, the percent of the population with a high school degree or less ranges from over 52 percent in Allegany County to about 36 percent in Monroe County. Furthermore, all but two counties in the FLPPS (Monroe and Ontario) have a larger percentage of their population with a high school degree or less than the state-wide rate.

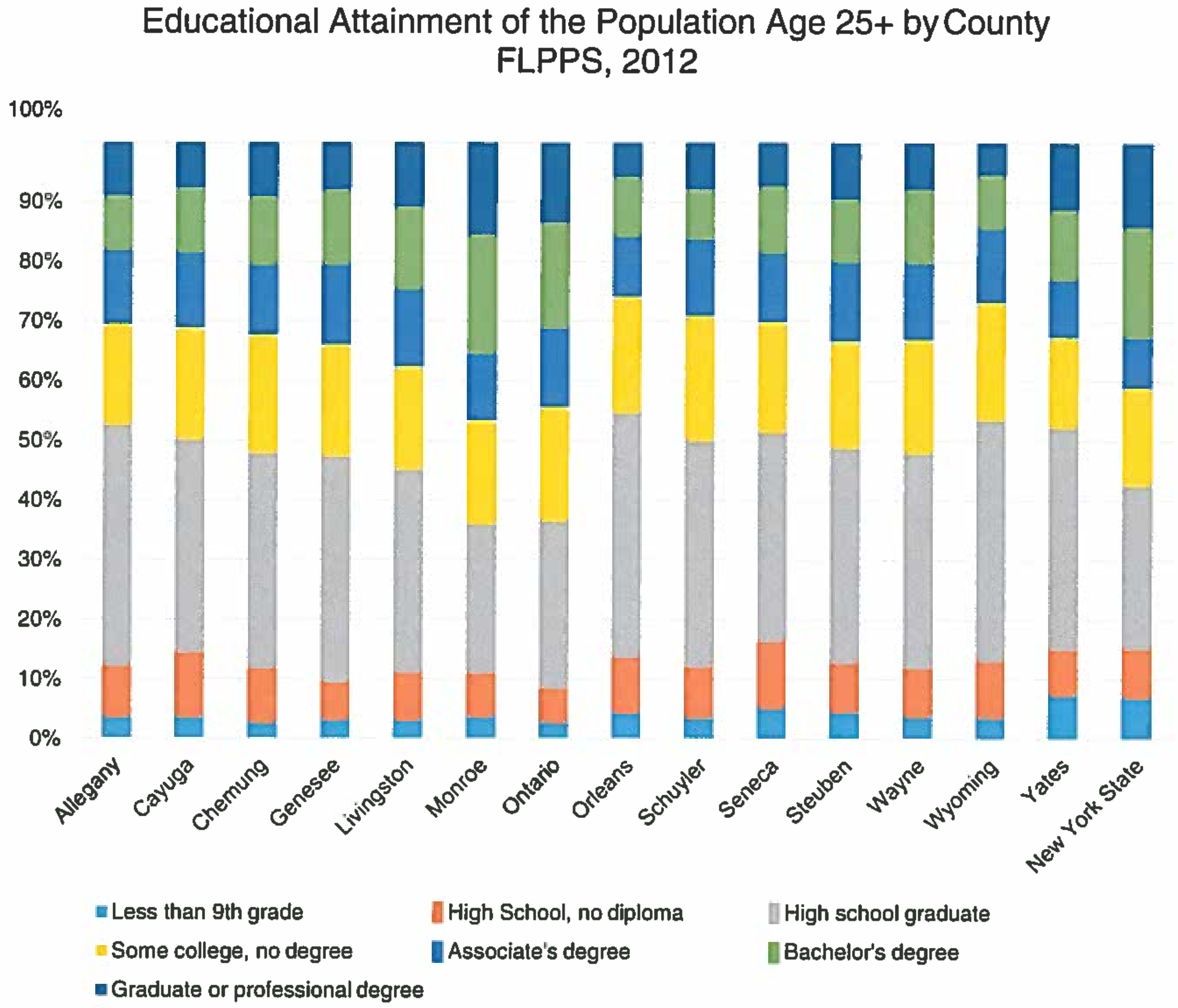


Figure 6 – FLPPS Educational Attainment by County

Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

Significant portions of the FLPPS are also dealing with debilitating levels of morbidity. As the chart below demonstrates, the percent of the non-institutionalized population that is disabled ranges from 11.4 percent in Livingston County to 15.5 percent in Steuben County. Interestingly, all counties in the FLPPS have higher rates of disability than the state-wide rate.

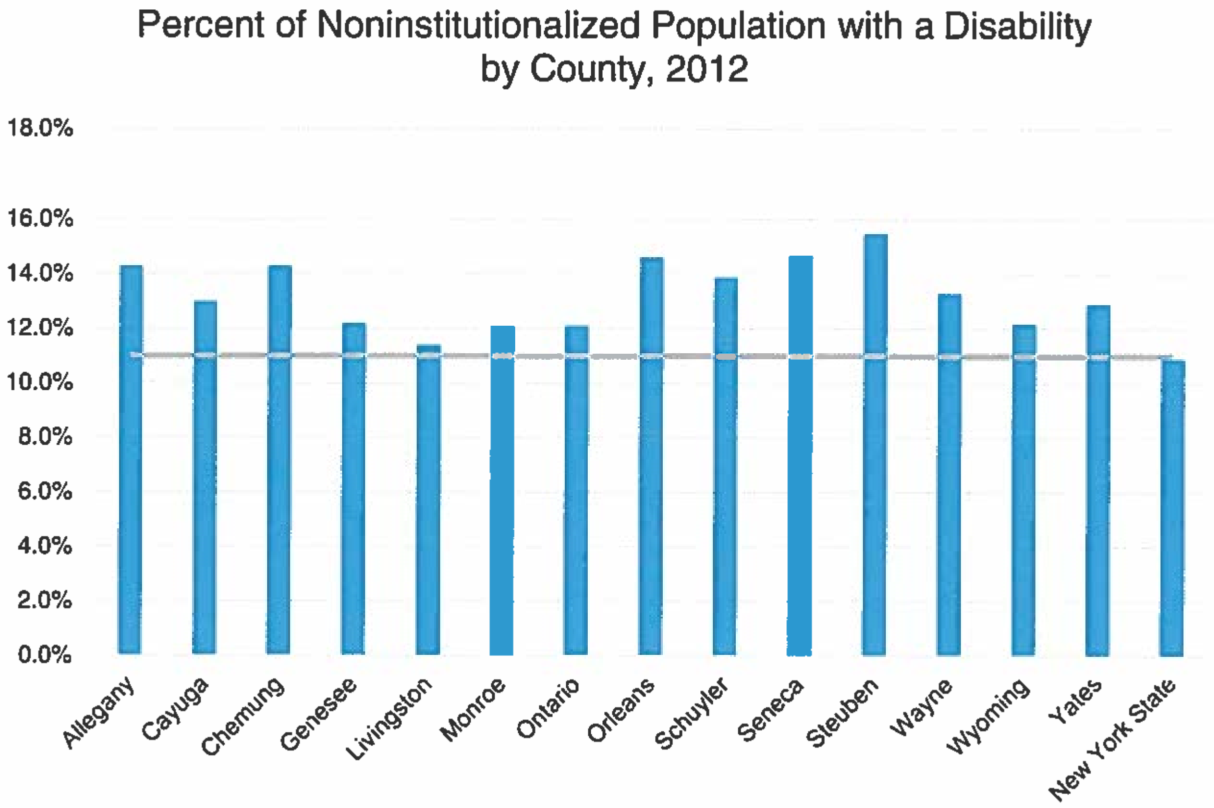


Figure 7 – Percent of Population Disabled

Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The apparently high prevalence of disability in the FLPPS may be related to the aging its population. From 1992 to 2012 the number of persons over age 65 has increased by nearly 40,000 and accounts for 15.4% of the region's total population.

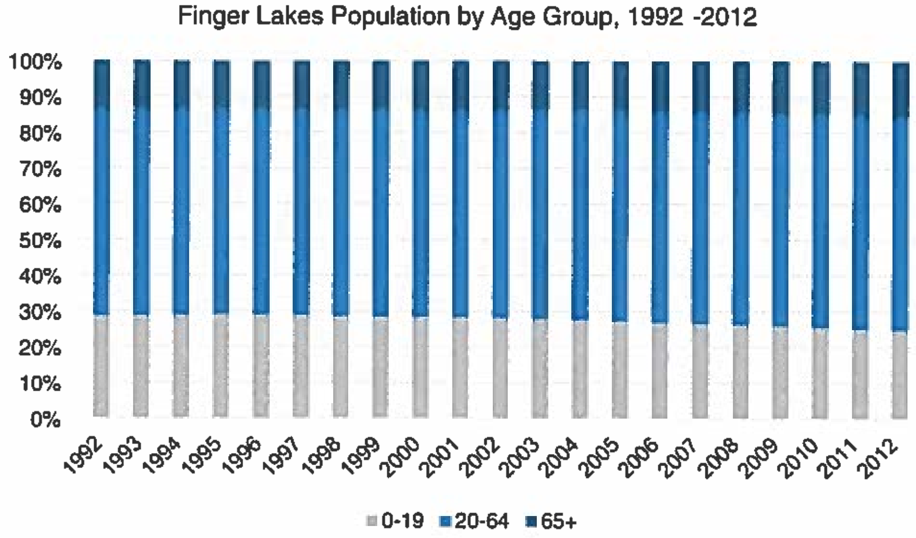


Figure 8 – FLPPS Population by Age Group

DATA SOURCE: US Census Bureau

From 2011 to 2013, the number of Medicaid beneficiaries, measured by average monthly enrollment increased in the

FLPPS region by 32 percent and came to represent 20 percent of the region's population. An additional 8 percent of the region's population is uninsured, with eight of the fourteen counties having uninsured rates higher than the upstate New York average (9.1 percent). (Refer to Appendix A for further information regarding the health insurance status of the FLPPS population). As a result of the Affordable Care Act, including the health exchanges and increased pressure to have health insurance coverage (i.e. - individual mandates), we expect the number of uninsured persons to decrease and the number of persons covered under Medicaid to increase in 2014 and for that trend to continue throughout the life of the DSRIP program. Early numbers provided by the New York State Exchange indicate that over 28,000 individuals signed up for Medicaid across the FLPPS region. Of those, over 24,500 were previously uninsured. A county by county analysis is presented in Table 28. While it is unclear how many of these individuals maintained coverage, the Exchange represents a new access point for persons to become enrollees in Medicaid. Therefore it is anticipated that the percentage of individuals in the region who will be impacted will only increase over the life of the program. The Medicaid population does appear to be centralized in the City of Rochester, however, all counties in the region have significant number of Medicaid enrollees to care for.

Table 28 – Medicaid Applications through HIE's by County

Medicaid Applications Through Health Insurance Exchanges Through April 15, 2014		
County	Medicaid Enrollment Applications Through the Exchange	Number Uninsured at Time of Application
Allegany	790	672
Cayuga	1,621	1,443
Chemung	1,611	1,434
Genesee	997	857
Livingston	905	787
Monroe	13,169	11,457
Ontario	1,876	1,595
Orleans	742	638
Schuyler	467	406
Seneca	572	480
Steuben	2,076	18,27
Wayne	2,144	18,44
Wyoming	793	658
Yates	527	453
FLPPS Region	28,290	24,551

FLPPS
FINGER LAKES PERFORMING
PROVIDER SYSTEM

CULTURAL COMPETENCE & HEALTH LITERACY IMPLEMENTATION PLANNING: PRIORITY GROUPS SUMMARY REPORT

OCTOBER 2015

Background/Rationale

"Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances"[1]. While health equity remains to be the ultimate goal of the healthcare delivery system, health disparities in disease incidence and prevalence, health outcomes, access to care and quality of care continue to persist within communities and populations throughout the United States. Individuals, families and communities that have systematically experienced economic and social adversities continue to encounter greater barriers to optimal health as they navigate the healthcare system[2]. To better address these barriers it is essential that we acknowledge the complex interaction of cultural, economic, individual, linguistic, geographical and social factors that guide healthcare utilization and health seeking behaviors among the most vulnerable populations within the Finger Lakes Performing Provider System (FLPPS) Region.

While promoting health equity within a patient-centered framework that "prompts providers to make a conscious effort to view patients in terms of their individual characteristics rather than group membership"[3], our goal is to transform the way healthcare is delivered to more than 300,000 Medicaid beneficiaries within the Finger Lakes Regions through:

- Addressing and Eliminating Health Disparities
- Improved Access to Quality Primary, Behavioral and Preventative Healthcare
- Reduction in Avoidable Emergency Room Visits

Cultural competence is important on all levels – individual, intrapersonal, organizational, community and public policy; culture affects how we communicate, understand and respond. As we encounter patients from diverse backgrounds and nationalities, it is critical that we understand the unique perspectives and beliefs of the patients in order to enhance the quality of care we provide. "The solution may lie in the cultural and ethnic frames within which the community sees itself. Where race may define and confine, culture, ethnicity, and spirituality may liberate and refine".[4]

In developing a strategy for strengthening cultural competency and to address issues related to health literacy, we must pay particular attention to groups that are especially vulnerable and where significant disparities exist. In this document, we cover several subpopulations of focus, with an eye toward describing:

- How many individuals fall into these groups and how they are distributed across the region;
- What we currently know about the disparity in health care outcomes for each of these populations of focus; and
- Implications for the development of a cultural competence and health literacy implementation plan.

---

[1] Brennan Ramirez, L.K., Baker, E.A., & Metzler, M., 2008.
[2] U.S. Department of Health and Human Services, 2011.
[3] Agency for Healthcare Research and Quality, 2014. Improving Cultural Competence to Reduce Health Disparities for Priority Populations.
[4] Airhihenbuwa, C.O., & Liburd, L., 2006.

We consider this to be a living document – one that we anticipate continuing to build on throughout the implementation planning process and that will ultimately serve as an educational resource for providers, community based organizations, and other regional partners.

Methodology

In an effort to identify vulnerable populations within the Finger Lakes Performing Provider Systems (FLPPS) Region, empirical literature, peer-reviewed journals, census databases, public databases and regional data reports were examined, including:

- FLPPS DSRIP Community Health Needs Assessment
- NYS Medicaid Redesign Team Health Disparities Workgroup Report
- NYS County Prevention Agenda Data
- 2013 – 2017 Community Health Needs Assessments for Wayne County, Ontario County, Yates County, Seneca County, Cayuga County, Monroe County, Southeastern Steuben County, Chemung County, Livingston County, Allegany County, Genesee County, Orleans County, Wyoming County
- 2015 NYS Poverty Report
- ACT Rochester Community Report Cards

Based on the data reviewed the following populations were identified as vulnerable based on their increased risk of poor health outcomes, as a result of poverty, limited resources, inadequate access to care, limited education and language proficiency: African Americans, American Indian/Alaska Native, Hispanics/Latinos, Migrant and Seasonal Farmworkers (MSFWs), Individuals with Intellectual and Developmental Disabilities, Homeless, Individuals w/ Mental, Emotional or Behavioral Health Disorders (MEB Disorders), Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), Mothers, Infant & Children, and Individuals Living in Poverty.

The sections that follow attempt to synthesize important information about each of these groups so that it can be used to help shape the development of the Cultural Competence and Health Literacy (CC/HL) implementation and training strategies. It is not intended to be a comprehensive review of all available data, rather to focus on the descriptive elements most relevant to this purpose. In addition, while this document addresses issues specific to each of the above populations, they are clearly not mutually exclusive.

Individuals with Behavioral Health Conditions

The Numbers

Across the FLPPS Region, over 253,000 individuals covered by Medicaid have received services or medication for some type of mental health or substance use disorder issue at some point during the past 5 years. The breakdown by county and NOCN is outlined below:

Table 1: Individuals with Prior Behavioral Health Service Use (2014)[5]

	# of Individuals	Gender		Race						
		Male	Female	White	Black	Hispanic	American Indian	Asian	Multiple Races	Unknown
Region Wide	**253,635**	**112,069**	**141,566**	**160,715**	**51,081**	**26,944**	**562**	**3,961**	**7,436**	**2,936**
%		*44%*	*56%*	*63%*	*20%*	*11%*	*0%*	*2%*	*3%*	*1%*
Western NOCN	**20,670**	**9,128**	**11,542**	**18,154**	**909**	**717**	**89**	**44**	**611**	**146**
Genesee	7,953	3,452	4,501	6,896	395	254	63	23	260	62
Orleans	7,531	3,421	4,110	6,339	450	377	23	8	286	48
Wyoming	5,186	2,255	2,931	4,919	64	86	3	13	65	36
Monroe NOCN	**132,481**	**58,991**	**73,490**	**53,765**	**46,022**	**22,628**	**341**	**3,640**	**4,020**	**2,065**
Monroe	132,481	58,991	73,490	53,765	46,022	22,628	341	3,640	4,020	2,065
Southern NOCN	**16,820**	**7,535**	**9,285**	**15,773**	**223**	**515**	**12**	**44**	**181**	**72**
Allegany	8,127	3,649	4,478	7,979	36	22	2	7	56	25
Livingston	8,693	3,886	4,807	7,794	187	493	10	37	125	47
Southeastern NOCN	**34,117**	**14,826**	**19,291**	**30,209**	**1,763**	**680**	**57**	**104**	**1,095**	**209**
Chemung	17,266	7,537	9,729	14,033	1,551	555	40	73	890	124
Steuben *	16,851	7,289	9,562	16,176	212	125	17	31	205	85
Finger Lakes NOCN	**49,547**	**21,589**	**27,958**	**42,814**	**2,164**	**2,404**	**63**	**129**	**1,529**	**444**
Wayne	14,044	6,167	7,877	12,038	702	667	8	40	444	145
Ontario	13,770	5,940	7,830	11,344	711	1,185	10	52	367	101
Yates	3,983	1,706	2,277	3,723	39	119		2	68	32
Seneca	5,182	2,283	2,899	4,752	95	159	18	12	117	29
Cayuga	12,568	5,493	7,075	10,957	617	274	27	23	533	137
* Southeast Steuben falls in the Southeastern NOCN; for data presentation purposes, Steuben in total is included										

What we Know About Disparities in Outcomes

Compared to the population as a whole, individuals suffering from mental illness or substance abuse disorders experience poorer health outcomes in a number of critical areas. Of particular importance to this initiative are outcomes associated with higher rates of hospitalization, use of emergency room services and repeat or potentially avoidable admissions. Data highlighting issues of concern for our region are summarized briefly below.

Inpatient / Outpatient Transitions – Rates of Timely Connection to Care Post-Discharge are Low

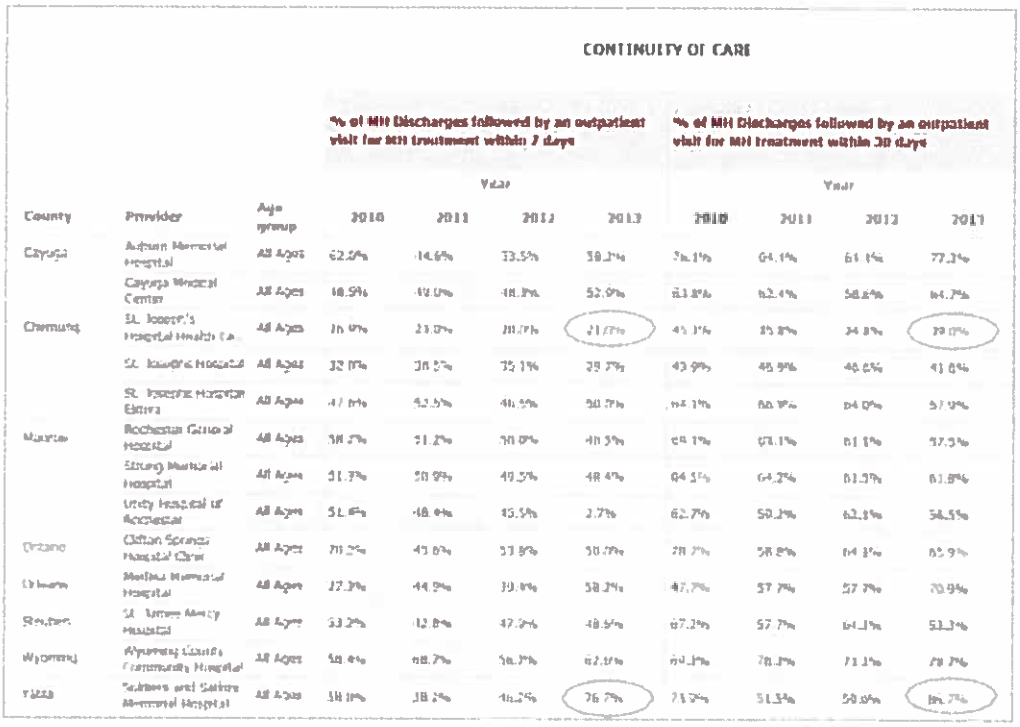
Effective transitions between levels of care are critical to reducing readmission rates and promoting continued recovery. However, for individuals hospitalized for mental health issues, there is much to be done to strengthen the connection between our inpatient and outpatient systems.

---

[5] Salient Medicaid Data System – No PHI version – CY 2014a

Care Continuity - % Receiving Mental Health Outpatient Treatment within 7 or 30 Days of Discharge

On average, across our region, just 50% of individuals leaving inpatient care have an outpatient appointment within 7 days of their discharge from inpatient mental health care, with significant variation among inpatient providers[6]. While the data shown below are specific to the Medicaid fee-for-service population, it is likely that this pattern of care likely extends across other payors.



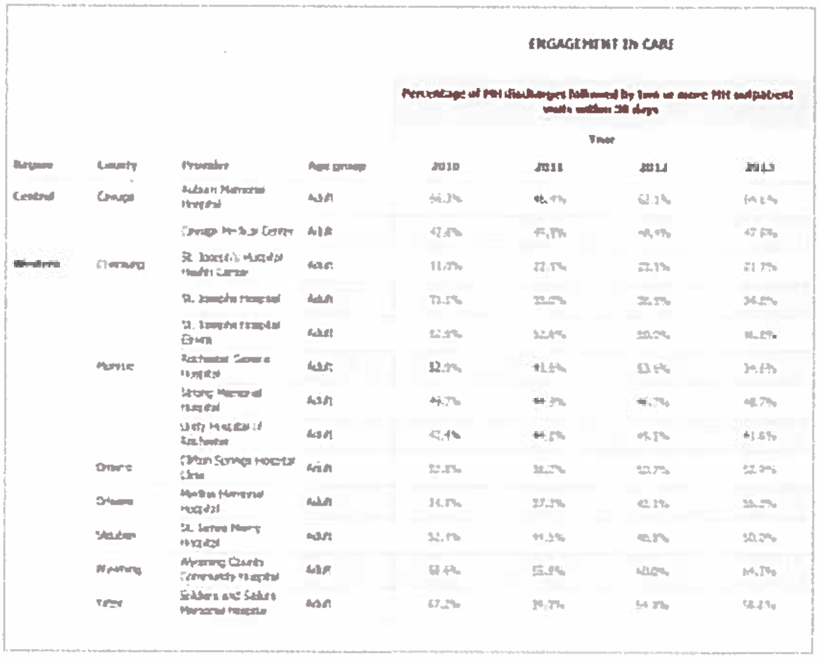
CONTINUITY OF CARE

% of MH Discharges followed by an outpatient visit for MH treatment within 7 days

% of MH Discharges followed by an outpatient visit for MH treatment within 30 days

Engagement in Care - % with at least two mental health outpatient visits within 30 days of discharge

Connection to ongoing mental health outpatient treatment following discharge is also quite low[7], indicating a need to engage this population in the types of community-based services that reduce the risk that mental health conditions will escalate the point where acute care is needed.



ENGAGEMENT IN CARE

Percentage of MH discharges followed by two or more MH outpatient visits within 30 days

---

[6] NYS OMH BHO Portal 2013a

[7] NYS OMH BHO Portal 2013b

Potentially Avoidable Hospitalizations

In addition to hospitalizations for issues related to their mental health our substance use disorder conditions, it is important to understand the extent to which individuals with mental illness are hospitalized for other physical health concerns – particularly those that might be avoided if earlier more coordinated care is provided in the community. The table below looks at the rate of preventable hospitalizations (PQIs)* among individuals with mental illness[8].

PQIs Among Individuals with an Active or Past Behavioral Health Diagnosis (2009)

	PQIs - All		PQIs - Respiratory		PQIs - Diabetes	
	% Current BH Dx	% Current or History of BH Dx	% Current BH Dx	% Current or History of BH Dx	% Current BH Dx	% Current or History of BH Dx
Western NOCN						
Genesee	38.8%	53.5%	50.5%	73.4%	34.8%	47.2%
Orleans	33.1%	50.9%	33.6%	63.7%	42.4%	54.5%
Wyoming	31.5%	62.8%	37.6%	83.5%	27.9%	42.7%
Monroe NOCN						
Monroe	40.6%	53.7%	43.4%	67.0%	35.1%	44.8%
Southern NOCN						
Alleghany	33.4%	44.1%	41.6%	57.8%	37.5%	52.5%
Livingston	39.2%	54.9%	43.3%	65.9%	36.6%	59.1%
Southeastern NOCN						
Chemung	35.9%	53.5%	39.9%	68.5%	24.0%	35.2%
Steuben	35.3%	51.9%	40.3%	65.0%	32.6%	38.3%
Finger Lakes NOCN						
Wayne	36.7%	47.5%	40.1%	59.2%	31.5%	36.2%
Ontario	41.5%	55.6%	46.8%	74.8%	39.7%	50.3%
Yates	43.4%	59.5%	46.2%	73.1%	N/A	
Seneca	40.9%	57.6%	N/A*		N/A	
Cayuga	34.5%	58.5%	37.5%	75.7%	33.0%	50.9%

*** # of admissions too small to permit calculations**

As illustrated above, within the FLPPS region, a significant portion of potentially avoidable hospital admissions occur among individuals who have (or have had) a behavioral health condition. For example, in Genesee County, 53.5% of all inpatient admissions classified as PQIs were for individuals with behavioral health conditions. Among PQIs within the respiratory category, the percentage is even higher – 73%. While the information above is somewhat dated, we don't anticipate that findings would be substantially different if the analysis were to be repeated today.

---

* Prevention Quality Indicators (PQIs) are a set of measures developed by the Agency for Healthcare Research and Quality (AHRQ) to assess the quality of outpatient care for "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are measured as rates of admission to the hospital for these conditions in a given population.

[8] NYSDOH OHSM from SPARCS data extracted December 2010

Use of Emergency Department Care

As cited in the Community Needs Assessment completed to support FLPPS planning efforts, the lack of ongoing, integrated, and patient centered outpatient care for individuals with behavioral health conditions likely contributes to the high volume of ED visits and inpatient hospitalizations that can be attributed to these diagnoses. Across the FLPPS region, Behavioral health conditions are the third most frequent primary diagnoses clusters seen in the ED. In addition, many of the visits with a primary diagnosis of symptoms or injury may be attributable to individuals with a behavioral health condition.[9]

Implications for Cultural Competence and Health Literacy

Organizations focused on promoting recovery and wellness for individuals with mental illness have become increasingly attuned to the importance of cultural competence and health literacy. As outlined in Mental Health America's Position Statement 18: Cultural and Linguistic Competency in Mental Health Systems –"identification and treatment of mental health and substance use conditions requires a full understanding of the culture and language of the person and an ability to relate successfully to the person through culture and language. Thus, culture and language are indispensable means of communication, and when barriers exist, they must be addressed for prevention and treatment to be effective. Most importantly, cultural competence requires training and self-criticism to combat stereotypes, such as the legacy of racism and ethnic prejudice in America, the condemnation of diverse sexual orientations in prior mental health diagnostic systems, and other cultural biases and prejudices."

Other important factors to consider in developing a cultural competence and health literacy strategy designed to improve engagement and outcomes for individuals with mental illness outlined in this position paper and noted elsewhere in the extensive literature on this topic include:

- Culture influences many aspects of mental illness, including how individuals communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment.
- The cultures of the clinician and the service delivery system also influence diagnosis, treatment, and service delivery.
- The cultures of racial and ethnic minorities impact the types of mental health services they need. Service delivery environments that are not sensitive to the cultural nuances of the population they serve may discourage individuals from seeking services and receiving the care they need.
- Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty. Racism and discrimination are stressful events that adversely affect health and mental health. This places minorities at risk for mental disorders such as depression and anxiety.
- Mistrust of mental health services is an important reason deterring minorities from seeking treatment. Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.
- Health literacy, (defined as "the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions") is clearly important to

---

[9] Finger Lakes Health Systems Agency, 2014.

improving health outcomes. However, decision-making capacity can be complicated by many issues, including literacy/language skills, cultural differences, age-related physical, emotional and cognitive changes and disabilities, and individual challenges that affect listening, learning and remembering.

Individuals with Intellectual and Developmental Disabilities

The Numbers

Across the FLPPS Region, just over 15,000 persons covered by Medicaid have a history of having received services for a developmental disability paid by Medicaid. The breakdown of individuals by county and NOCN is outlined below:

Table 1: Individuals with Prior Developmental Disabilities Service Use[10]

	# of Individuals	Gender		Race						
		Male	Female	White	Black	Hispanic	American Indian	Asian	Multiple Races	Unknown
Region Wide	**15,247**	**8,875**	**6,372**	**11,549**	**2,021**	**874**	**20**	**138**	**316**	**329**
%		*58%*	*42%*	*76%*	*13%*	*6%*	*0%*	*1%*	*2%*	*2%*
Western NOCN	**1,144**	**640**	**504**	**1,021**	**42**	**29**	**2**	**2**	**22**	**26**
Genesee	446	252	194	406	6	15	2	1	9	7
Orleans	417	235	182	355	30	12			11	9
Wyoming	281	153	128	260	6	2		1	2	10
Monroe NOCN	**7,044**	**4,103**	**2,941**	**4,151**	**1,756**	**691**	**15**	**115**	**136**	**180**
Monroe	7,044	4,103	2,941	4,151	1,756	691	15	115	136	180
Southern NOCN	**991**	**580**	**411**	**944**	**8**	**15**	**0**	**5**	**5**	**14**
Allegany	462	262	200	452	1	2		1	2	4
Livingston	529	318	211	492	7	13		4	3	10
Southeastern NOCN	**2,019**	**1,143**	**876**	**1,833**	**80**	**19**	**1**	**5**	**37**	**44**
Chemung	1,047	599	448	897	70	15	1	3	32	29
Steuben *	972	544	428	936	10	4		2	5	15
Finger Lakes NOCN	**4,049**	**2,409**	**1,640**	**3,600**	**135**	**120**	**2**	**11**	**116**	**65**
Wayne	1,120	691	429	987	41	27	1	4	33	27
Ontario	1,141	688	453	985	47	68		5	28	8
Yates	329	190	139	311	6	2			6	4
Seneca	497	284	213	461	7	13	1		12	3
Cayuga	962	556	406	856	34	10		2	37	23

* Southeast Steuben falls in the Southeastern NOCN; for data presentation purposes, Steuben in total is included

These data represent the unique number of persons who have received any service under the purview of the NYS Office of Persons with Developmental Disabilities. The race/ethnicity characteristics of the population varies among the counties and NOCN's, with the Monroe NOCN population served being comprised of 59% white persons, while the population served in the balance of the NOCN's is comprised of 89-95% white persons.

Data related to utilization of Medicaid services for calendar year 2013 for this population show that in addition to using OPWDD Medicaid services, a significant number of individuals utilized inpatient and/or emergency room services. Across the region, a total of 3,707 persons with developmental disabilities were treated in hospital emergency rooms and released (no inpatient admission) and 1,217 persons received inpatient services for a medical and/or behavioral health condition.

---

[10] Salient Medicaid Data System – No PHI version – CY 2014b

What we Know About the Population Overall

The developmental disabilities population is comprised of persons who have a disability that is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment or autism, or a condition that is closely related and results in similar impairment of general intellectual functioning or adaptive behavior. There is a wide range of severity in the degree of impairment for this population. The population being identified with developmental disabilities continues to increase. According to the CDC, the prevalence of any DD among children in 1997–2008 was 13.87%. Over this time period, the prevalence of DDs has increased 17.1%. The increase ranges among disabilities, with autism showing a 289.5% increase in prevalence.[11]

The population has a wide range of cognitive, behavioral, medical and physical impairments and/or needs that each impact upon access to, and the delivery of, health care services. This includes factors such as:

- Communication barriers, such as the use of adaptive technology for communication or limitations in spoken language and/or understanding;
- Environmental/structural barriers even when facilities are handicap accessible;
- Behavioral issues that could negatively impact the individual's cooperation for tests, injections, etc.;
- Environmental issues that may involve sensory challenges (e.g., lighting, sound, smells) that interfere with a patient's ability to effectively participate in the visit;
- A shortage of time for providers to accommodate adults with I/DD who may have communication and behavioral difficulties that create challenges to patient assessment and treatment.

What we Know About Disparities in Healthcare Outcomes

Comprehensive data related to the overall health status of persons with DD are lacking. The U.S. Public Health Service is unable to report on the health status of adults with DD on a truly representational basis. The health of the general population is routinely monitored through national surveys, but the health of adults with DD is not. People with DD remain largely undetected in population health surveillance.

Data regarding overall health outcomes are limited to certain studies. Based upon multiple studies, the CDC has noted that adults with intellectual/developmental disabilities (ID/DD) experience poorer health outcomes than people without ID/DD. Persons with ID/DD are more likely to live with complex health conditions; have limited access to quality healthcare and health promotion programs; have poorly managed chronic conditions; be obese and have mental health problems and use psychotropic medications.[12]

---

[11] National Core Indicators NASDDDS and HSRI, 2014a.
[12] National Core Indicators NASDDDS and HSRI, 2014b.

The National Core Indicators[13] measure performance of public systems for people with ID/DD. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals with developmental disabilities and their families. Measures are obtained through consumer and family/guardian surveys. Data for all states from the National Core Indicators show:

- Individuals living with their families and those living independently are less likely to receive preventive care:
    - After controlling for demographic factors, African American and Hispanic respondents were less likely than White, Non-Hispanic respondents to have had a physical exam in the past year
    - African Americans were less likely than Whites to have had a dentist visit in past year
    - Household income is a significant predictor of access to care; income is a bigger predictor than race and ethnicity
- Differentials exist in Mental Illness/Psychiatric Disorders:
    - White respondents are more likely to be diagnosed with mood disorder and/or anxiety disorder
    - African American and Hispanic respondents more likely to be diagnosed with psychotic disorders

Select Core Indicators for New York State (2013/14) show:

- 53% of respondents were reported to take at least one medication for mood disorders, anxiety, behavior challenges and/or psychotic disorders
- 59% of respondents were reported to overweight or obese

Implications for Cultural Competence and Health Literacy

- Family members/care givers play a central role in the health care of persons with developmental disabilities. Building relationships with the family/caregiver as well as the consumer is essential to providing effective healthcare. Both want to be treated with respect and dignity, in ways that make them feel valued and understood.
- Acknowledge the diversity within – not all families or consumers share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.). Recognize the culture of the particular "disability" along the family's racial or ethnic cultural identity.
- Develop an understanding of each patient and their family/caregiver as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently. Family/caregivers and consumers have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.

---

[13] National Core Indicators NASDDDS and HSRI (National Association of State Directors of Developmental Disabilities Services and Health Services Research Institute), FY 2013/14

- Inquire about patient preferences – communication methods, any environmental considerations (e.g. lighting, noise levels) that may be needed to facilitate the visit or modify the surroundings.
- There is a wide spectrum of developmental disabilities and degree of severity of impairment. Inquire accordingly to best assess the approach and plan for sufficient time for any visit.
- Written materials should be prepared at an appropriate literacy level. Written materials may need to be modified to accommodate needs.

Homeless Persons

The Numbers

Across the FLPPS Region, just over 1,600 persons were identified as being homeless on a single night (January 29, 2014), according to the Point-in-Time Count (PIT). On an annual basis, each homeless continuum of care across the nation conducts the PIT during the last week in January, providing an unduplicated one night estimate of both sheltered and unsheltered homeless populations in each community. The chart below shows the total number of persons identified by the PIT count by each continuum of care in the FLPPS region.

Table 1: Homeless Persons – January 2014 Point in Time Count[14]

	# of Homeless Persons	# of Homeless Households	Family Households			Single Adult Households		Youth Only Households	Subpopulations Reported		
			Children Under Age 18	Persons Ages 18-24	Persons Over Age 24	Persons Ages 18-24	Persons Over Age 24	Children Under Age 18	Severely Mentally Ill	Chronic Substance Abuse	Domestic Violence
Region Wide	1,625	1,242	347	76	161	240	780	21	398	352	261
Western NOCN	88	55	29	4	15	1	39	0	0	0	4
Genesee N/A											
Orleans	88	55	29	4	15	1	39	0	0	0	4
Wyoming N/A											
Monroe NOCN	838	620	202	58	84	138	338	18	153	139	118
Monroe	838	620	202	58	84	138	338	18	153	139	118
Southern & Southeastern NOCNs	512	419	79	12	43	80	296	2	204	166	118
**Allegany, Livingston, Steuben, Chemung, Schuyler	512	419	79	12	43	80	296	2	204	166	118
Finger Lakes NOCN	187	148	37	2	19	21	107	1	41	47	21
**Wayne, Ontario, Yates, Seneca	92	83	8	1	4	9	69	1	32	36	7
Cayuga	95	65	29	1	15	12	38	0	9	11	14

* Southeast Steuben falls in the Southeastern NOCN; for data presentation purposes, Steuben in total is included

**Numbers reflect the HUD Continuum of Care Designation which includes multiple counties

The above data represent the unique number of persons who were residing in an emergency shelter, transitional housing for the homeless or in a place not meant for human habitation. The PIT count is believed to be an underrepresentation of the extent of homelessness in the community as the count does not include persons at imminent risk of homelessness or those who have no fixed residence and move between family and friends on a temporary basis.

What we Know About the Population Overall:

Across the region, 1,242 households were identified as homeless in the 2014 PIT count. Of this total, 74% were households comprised of a single adult and 26% were family households (at least one adult and child). Of the total number of homeless persons, 23% were children under the age of 18, including 21 unaccompanied youth. The most frequently reported subpopulations were severely mentally ill, chronic substance abuse and domestic violence. It should be noted that the proportion of family and single households is driven by the homeless system bed configuration and capacity in each community and the degree to which unsheltered persons are identified in the PIT count varies among communities.

---

[14] HUDexchange.info – NYS Annual Homeless Assessment Reports

The extent/duration of homelessness among this population varies widely – from first time homeless episodes of a short duration to chronic homelessness, extended over many years, with frequent episodes of homelessness, often for long durations of time. The homeless population is almost exclusively persons with a low SES – SSI/SSDI recipients, TANF or Safety Net recipients, those with marginal levels of earned income and persons with no income or public benefits when they enter the homeless system (pending applications, sanctioned). Most are Medicaid recipients or Medicaid eligible.

Many homeless persons face multiple barriers to obtaining and maintaining housing, as well as other community services and supports. Housing barriers include a history of multiple evictions, younger adults with no prior rental history, challenges related to mental illness, substance use disorders and other disabilities, limited employment options related to low educational attainment and/or lack of skills, access to transportation or child care and often times limited basic life skills necessary to maintain adequate housing (e.g. budgeting, housekeeping). Many have histories of trauma (past and present) that compound these barriers.

What we Know About Disparities in Healthcare Outcomes

The Institute of Medicine describes the relationship between homelessness and health in its report titled "Homelessness, Health, and Human Needs"[15]: *"there are three different types of interactions: 1) Some health problems precede and causally contribute to homelessness, 2) others are consequences of homelessness, and 3) homelessness complicates the treatment of much illness. Of course, certain diseases and treatments cut across these patterns and may occur in all three categories."* Yet, only a very limited number of attempts have been made to assess the prevalence of chronic disease among national samples of homeless persons; more typically, prevalence studies have been conducted in central cities and/or are disease-specific.

Poor health outcomes have been documented in many of these studies of homeless populations across the country, particularly among the chronically homeless, who experience multiple episodes of homelessness over extended periods of time. The Health Disparities and Inequalities Report (2011) from the Centers for Disease Control & Prevention (CDC)[16] documents that socioeconomic status and living conditions have a direct influence on health and "inadequate housing contributes to infectious and chronic disease and injury and can affect child development adversely."

Select indicators from various studies[17] are shown below to highlight poor health outcomes and the estimated extent of chronic health conditions among many persons experiencing homelessness. It should be recognized that while these studies may have limitations and are not generalizable to all homeless persons in the country, it is well documented that homeless persons suffer disproportionately from chronic medical conditions. Studies conducted of various cohorts of homeless persons in a number of locations in the country have shown:

- Among people experiencing homelessness, 31-46% report having a chronic medical problem.
- Substance abuse is estimated to affect 40-60% of the population. Among those with substance abuse problems, the prevalence of chronic medical illnesses is estimated at 53%.

---

[15] Institute of Medicine, 1988.
[16] Centers for Disease Control and Prevention, 2011.
[17] Michael Reese Health Trust, 2011.

- Prevalence of particular diseases among homeless people range widely depending on the sub-population assessed. High prevalence of HIV at 9-19%, hypertension at 30-60% and latent TB infection at 32-43% have been consistently documented.
- Homeless adults are hospitalized 4-5 times the rate of the general population for medical issues and 100 times more frequently for psychiatric causes.
- Homeless patients and substance abusers have been found to be the heaviest utilizers of emergency department services.
- Studies at Boston City Hospital and San Francisco General Hospital found that 26-28% of all inpatient admissions at these public hospitals were for patients experiencing homelessness.
- A national study of all VA healthcare facilities found that homeless individuals occupied 26% of acute care beds.
- Among homeless adults served by the 19-city Robert Wood Johnson homeless health care project, clinic staff reported that 31% of clients had been diagnosed with one or more chronic physical disorders.
- Among those clients seen in the clinics more than once, 40% had at least one chronic disease; the most common chronic diseases diagnosed among homeless adults included: hypertension and heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, diabetes, dental problems, and neurological disorders.
- Numerous studies have documented that the mortality rates among homeless people are 3-4 times greater than the general population. The average age at the time of death has consistently been in the mid-forties.

Implications for Cultural Competence and Health Literacy

- The "homeless" population is a very diverse population, with different experiences and views. Develop an understanding of each patient as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently. Patients have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.
- The urgency of having basic needs met must first be acknowledged and addressed; persons must first be engaged in meeting these needs before they are willing to accept services to address other needs.
- Mistrust of services is an important reason deterring persons who are chronically homeless from seek any services, including housing or health care except for at times of urgent need.
- The stigma associated with homelessness needs to be addressed. People become homeless for many different reasons and caution must be taken to not appear to place blame on the individual for the circumstances they are in.
- Building relationships are essential to providing effective healthcare. Patients want to be treated with respect and dignity, in ways that make them feel valued and understood.
- Acknowledge and understand the cultural norms and relationship dynamics – personal, interpersonal and intrapersonal; understand the culture of being chronically homeless and the relationships and supports many find among peers in homeless encampments and other unsheltered situations.

- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.).

Individuals with Living in Poverty

The Numbers

More than 217,000 individuals across the FLPPS region are living in poverty. Poverty rates are highest within the City of Rochester (nearly 34% of the population), but are also significant in several of the more rural areas of our region. Female headed households with children are considerably more likely to be living in poverty (58.5% in the city of Rochester and between 32% and 50% in the counties across the region). The breakdown by county and NOCN is outlined below[18]:

	County Poverty Rate	# Living in Poverty	Age Group[1]			% Living in Poverty			
						By Race			By Female Head of Household w/Children
			<18	25+	65+	White	Black	Hispanic	
Region Wide		217,260	71,514	110,404	16,109				
Western NOCN									
Genesee	13.6%	7,996	2,523	4,033	511	11.8%	46.0%	42.2%	39.5%
Orleans	16.0%	6,303	2,115	3,422	457	15.8%	N/A	32.1%	42.6%
Wyoming	10.9%	4,145	1,163	2,506	442	9.9%	N/A	N/A	37.9%
Monroe NOCN									
Monroe	15.8%	113,961	38,250	56,102	7,571	10.1%	36.3%	38.7%	44.6%
City of Rochester	*33.9%*	*68,263*	*26,058*	*32,675*	*3,048*	*22.8%*	*41.3%*	*45.8%*	58.5%
Southern NOCN									
Allegany	16.9%	7,338	2,458	3,774	456	16.9%	N/A	42.4%	54.6%
Livingston	14.8%	8,710	2,142	3,946	840	13.8%	N/A	54.0%	36.6%
Southeastern NOCN									
Chemung	16.2%	13,365	4,581	6,955	962	13.7%	46.2%	23.5%	49.6%
Steuben*	16.9%	16,440	5,995	8,884	1,176	16.4%	29.2%	35.4%	43.0%
Finger Lakes NOCN									
Wayne	11.4%	10,413	3,666	5,450	822	10.2%	31.5%	18.5%	39.7%
Ontario	10.6%	11,141	3,072	5,668	1,043	9.3%	44.6%	34.5%	32.7%
Yates	16.3%	3,913	1,478	2,045	347	16.1%	N/A	N/A	38.0%
Seneca	11.8%	3,816	895	2,333	446	10.8%	N/A	N/A	32.7%
Cayuga	12.8%	9,719	3,176	5,286	1,036	12.1%	N/A	21.2%	35.0%

* Southeast Steuben falls in the Southeastern NOCN; for data presentation purposes, Steuben in total is included

(1) Age groups are not mutually exclussive

Data Source: New York State Community Action Association - NYS Poverty Report. Issued March 2015

What we Know About Disparities in Healthcare Outcomes

As described by the World Health Organization, "living in poverty has immediate and far-reaching consequences. It puts people in a position that makes them vulnerable to disease, violence, and death. It excludes individuals and communities, denying them a voice in the policies and decisions that shape their lives, making them powerless and without the capacity to improve their lives."[19] The impact of poverty on health outcomes is profound, an issue that is particularly relevant to FLPPS given the high

---

[18] NYS Community Action Association - New York State Poverty Report: Issued March 2015

[19] WORLD HEALTH ORGANIZATION, 2015

rate of poverty in our region. While much of that poverty is concentrated in the City of Rochester (which has the second highest poverty rate in the nation's 25 largest metro areas – second only to Detroit), multigenerational poverty is also quite prevalent in some of the more rural areas of the region. Within the City of Rochester, the rate of poverty is most heavily concentrated in the following neighborhoods (as defined by zip code)[20]:

Rank NYS	Rank US	Zip Code	Population	% Living in Poverty
5	#311	14605	14,418	69%
23	#741	14608	12,362	55%
24	#748	14604	1,683	55%
43	#1,167	14611	19,774	47%
48	#1,310	14621	35,977	45%
73	#2,576	14613	15,078	35%

Individuals and families living in neighborhoods where the rate of poverty is significant face a number of challenges that can lead to poorer health outcomes, including exposure to violence and more limited access to affordable, healthy food options. The rate of obesity is increasing faster among black and Hispanic populations than among whites. Black and Hispanic people often live in neighborhoods with fewer transportation and low-priced food options[21].

In addition to these challenges, it is also important to consider the impact of the "culture of poverty," and in particular, multi-generational poverty on health outcomes and health seeking behavior. As described by Ruby Payne, author of Bridges out of Poverty, families who have lived in poverty for multiple generations have a culture with different values, habits, and lifestyles than middle class families. For example, families in generational poverty believe in fate because they feel they don't have a choice in what happens to them: "being proactive, setting goals and planning ahead are not a part of generational poverty... (families) often don't have the tools to organize their lives. . . It's difficult to think about planning for a future when you and your family are hungry today."[22]

Implications for Cultural Competence and Health Literacy

While this report aims to describe populations of particular focus for the FLPPS in the development of a comprehensive and effective strategy to strengthen provider practices in the areas of cultural competence and health literacy, these populations are clearly not mutually exclusive. African American and Hispanic members of our community are more likely to be living in poverty. In addition, the rate of mental illness is higher among individuals living in impoverished communities. Accordingly, considerations outlined in the sections of this document specific to these populations are equally applicable here. However, it will also be important to consider the additive impact that poverty has on the ability of individuals and families to seek the types of preventive services important to achieving better health outcomes. As we work to architect a plan to increase culture competence and health literacy, we must be mindful of both the practical as well as the cultural dimensions of poverty– particularly multigenerational poverty. This can range from ensuring the individuals have the ability to obtain the basic supplies needed to address medical conditions, to appreciating that individuals living in poverty are often operating in crisis mode (or the "tyranny of the moment") given the significant

---

[20] ZipAtlantis.Com, 2013.

[21] Dubowitz, T., Heron, M., Bird, C.E., Lurie, N., Finch, B.K., Basurto-Davila, R., Hale, L., & Escarce, J.J., 2008.

[22] StratisHealth, 2015.

obstacles they face in their day-to-day survival. As such, the ability to think longer term for many areas, including taking care of their health, is compromised. To be successful, a cultural competence and health literacy assessment strategy will also need to examine how well we are addressing the needs of individuals living in poverty.

Maternal & Child Health

What we Know About the Population

Maternal and child health (MCH) care is the health service provided to mothers (women in their child bearing age) and children. The targets for MCH are all women in their reproductive age groups, i.e., 15 - 49 years of age, children, school age population and adolescents. Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. For many women, pregnancy often serves as the gateway into health care. By the time a woman starts thinking about becoming pregnant, it is often too late to prevent many of the risk factors associated with chronic disease. Women of reproductive age face unique challenges when preventing and treating chronic disease. Over half of all women of child bearing age have one or more serious risk factors for developing a chronic disease. The annual medical costs for treating pregnancy-related complications prior to delivery total over one billion dollars. In addition to monetary expense, chronic conditions experienced during pregnancy take a great toll on the health of a mother and her baby.

As the prevalence of obesity and diabetes continues to grow and an increasing number of women choose to delay pregnancy, women may become increasingly vulnerable to risk factors that can complicate pregnancy, including obesity, diabetes, smoking and high blood pressure. Women who are not at a healthy weight *prior* to pregnancy are at a higher risk for pregnancy-related complications including, gestational diabetes, cesarean section, fetal distress and early neonatal death. The most common pregnancy related chronic condition is Gestational Diabetes Mellitus (GDM), a form of glucose intolerance which occurs during pregnancy. As the leading cause of hospitalizations before delivery for pregnant women, GDM complicates 4 percent of pregnancies annually.

Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. These health risks may include:

- Hypertension and heart disease
- Diabetes
- Depression
- Genetic conditions
- Sexually transmitted diseases (STDs)
- Tobacco use and alcohol abuse
- Inadequate nutrition
- Unhealthy weight

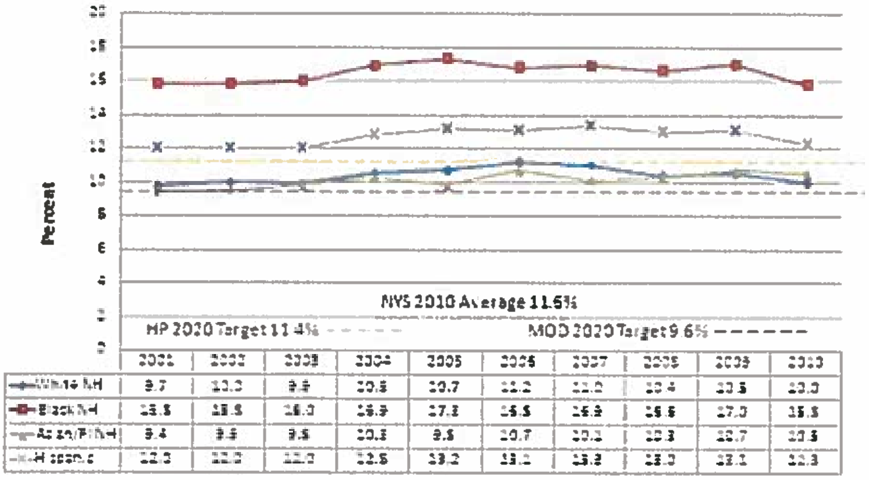
The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.[23]

What we Know About Disparities in Outcomes

The social determinants that influence maternal health also affect pregnancy outcomes and infant health. Racial and ethnic disparities in infant mortality exist, particularly for African American infants. Child health status varies by both race and ethnicity, as well as by family income and related factors, including educational attainment among household members and health insurance coverage.

The Prevention Agenda 2013 – 2017, New York States Health Improvement Plan is an action plan to address and reduce health disparities due to race, ethnicity, and/or socioeconomic attributes. "Improving the health of mothers and babies is an important public health priority for New York State. Key population indicators of maternal and infant health, including low birth weight, prematurity and maternal mortality, have not improved significantly over the last decade in New York, and in some instances have worsened. Even in measures where trends are improving, such as reductions in adolescent pregnancy rates and infant mortality rates, there are significant and persistent racial, ethnic and economic disparities."[24]

Percentage of Premature Births by Race/Ethnicity, New York State Residents, 2001-2010



According to FLHSA, the FLPPS region infant mortality rate is higher than the New York State rate and the Upstate New York rate without a clear indication of the root cause[9]. In terms of racial and ethnic disparities in infant mortality, Monroe County Health Department data from 2008 – 2010 clearly shows that "African American and Latinos were between three and four times higher than white residents".

---

[23] HealthyPeople2020, 2015.

[24] NYS Department of Health, 2012.

Implications for Cultural Competence/Health Literacy

- Identification and validation of literacy-assessment tools for children and caregivers, including those with LEP
- Determination of the effectiveness and the role of rapid health literacy screening tools for individuals and populations to evaluate the impact of interventions on improving quality of care
- Understanding developmental aspects of health literacy and transitions to self-care: understanding the progression of health literacy skills from childhood through young adulthood and parenthood and the role of health literacy in transitioning to adult care and functional independence
- Assessment of the parent-child dyad with respect to health literacy over time: the transition from total parent care through modeling, teaching, supervision, and oversight to total care by the child/adolescent/young adult and how that varies according to health activity and population and provider characteristics
- Assessment of how the variability in access and quality of children's health care is affected by caregivers' health literacy
- Exploration of health literacy's relationship to health disparities: the relationship between socioeconomic disparities and health literacy, and between LEP and literacy skills, and how health literacy may mediate the effect of social disparities on health outcomes
- Understanding the role of health literacy in designing and assessing quality metrics
- Study of the use of patient assessments of care to measure and improve quality of communication between providers and patients and families with low literacy
- Exploration of the quality of current provider-patient/caregiver communication and its impact on pediatric care and safety
- Evaluation of methods for training health care professionals in clear health-communication techniques

African Americans

What we Know About Disparities in Outcomes

"Over the years, there has not been a significant reduction in African American's mortality and morbidity rates. African Americans' historic experience with the healthcare system has been marked by health inequities and a shortage of preventive interventions that fully address the population's social, economic and environmental situations".[25] African Americans continue to experience health care challenges and disparities at disproportionate rates in comparison to other racial/ethnic groups. Although African Americans have genetic predispositions to some diseases and illnesses, health inequities are often attributed to underlying economic, environmental and social factors that many have limited control over. As a result, it is essential that we acknowledge the complex interplay of these factors. For example, individuals living in poverty are more likely to reside within underprivileged neighborhoods with a high prevalence of crime/violence, have limited access to nutritious foods due to the high presence of food deserts, fast-food restaurants and limited availability of grocery stores, limited financial resources and higher proportions of older homes.[25] Each of these factors are known to have adverse effects on the health of individuals and the community as a whole, which social issues become public health issues. African Americans are 3 times more likely than Whites to be living in poverty[26], indicating that the negative impact of living in poverty is greater for African Americans. However, evidence also suggests that healthcare inequities for African Americans persist above and beyond the impact of poverty.[27]

Within the FLPPS Region, cancer, heart disease, homicide, accidents and stroke are the leading causes of years of potential life lost (YPLL), which closely mirror the leading causes of death among African Americans: cancer, heart disease, stroke, kidney, diabetes, accidents and COPD.[9,28]

Key Findings:

Within New York State:

- African American infant mortality rates were 3 – 4 times higher than Whites[9]
- African Americans have the highest diabetes prevalence among adults (13.8%)[25]
- African Americans have the highest rate of newly diagnosed HIV cases (65.7%)[25]
- African Americans have the highest rate of congestive heart failure hospitalizations (60.4%)[25]
- African Americans have the highest rate of strokes (26.7%)[25]
- African Americans have the highest cancer mortality rates – breast (28.5%), cervical (4.6%), colorectal (18.7%)[25]
- African Americans are 3 times more likely to be living in poverty than Whites [27]

---

[25] Treuhaft, S., & Karpyn, A., 2010.
[26] ACT Rochester, 2015.
[27] Lin, A.C., & Harris, R.K., 2009.
[28] Finger Lakes Health Systems Agency – "What's Goin' On", 2014.

Nationally:

- African Americans were 2 times more likely than Whites to have diabetes[29]
- African Americans had the highest rate of heart disease and stroke compared to all racial/ethnic groups[29]
- African Americans had the highest rates of hypertension in comparison to Whites; the percentage of African Americans who had control of their high blood pressure was lower than compared to Whites[29]
- African Americans had higher rates of obesity than other racial/ethnic groups[29]
- African Americans had higher rates of homicide than other racial/ethnic groups[29]

Implications for Cultural Competence/Health Literacy

- "Many African Americans have either a religious orientation or a viewpoint grounded in African American social and cultural history, which may emphasize a holistic approach to health and health care".[30]
- "Home or natural remedies are commonly known and are used by African Americans, particularly among the elderly".[30] These practices are traced back to cultural historical traditions, when standard medical treatments/care were not afforded to African Americans resulting in common healing practices/home remedies being passed down through generations.
- Inquire about patient preferences – salutations, language, health options/practices, social support, etc.
- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.).
- Develop an understanding of each patient as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently. Understand patients' religious or spiritual commitments and how these influence their perception of physical, mental health, disability, death and various approaches to treatment and prevention.
- Understand that patients have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine the appropriate course of treatments or communication techniques.
- Building relationships are essential to providing effective healthcare. Patients want to be treated with respect and dignity, in ways that make them feel valued and understood.

---

[29] Centers for Disease Control and Prevention, 2015.

[30] Eiser, A.R., & Ellis, G., 2007.

Hispanics/Latinos

As the fastest growing population and largest ethnic group in New York State, healthcare professionals and providers can benefit from acknowledging and understanding the diversity within this population. Hispanic/Latino is defined as any person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[31] Nationally, 74% of Mexicans, 62% of Puerto Ricans, 80% of Cubans, 88% of Central Americans speak a language other than English at home – 33% of Hispanics indicate that they are not fluent in English.[32]

What we Know About Disparities in Outcomes

Nationally, more than 50% of Hispanic, low-income working families have a parent without a high school equivalency degree, compared with 16% of non-Hispanic whites.[33] Within the FLPPS Region, low-income families face significant barriers to quality care – lack of insurance coverage, inadequate healthcare and high costs, resulting in delayed treatment further compounding health issues.[9] Of all racial-ethnic groups, Hispanics have the lowest health insurance rates.[25] These underlying factors are may be linked to the health disparities experienced within this population:

- Hispanic/Latino Infant mortality rates 3 – 4 times higher than Whites[9]
    - In Monroe County, Latinos experience 3 times the infant mortality rate of Whites--12.9 deaths per 1,000 live births, compared to 3.9 deaths per 1,000 births among Whites. There are also more Hispanic/Latino infants (10%) born with low weight than Whites (7%).[34]
- Highest rates of obesity are among Hispanic Women, Infant & Children (WIC) participants aged 2 - 4 and Hispanic/Latino high-schoolers.[25]
- Hispanics/Latinos reported the highest percentage of fair or poor mental health when compared to all other racial/ethnic groups[25]
- HIV/AIDS mortality rates 10 times higher than Whites[25]
- New HIV/AIDS cases 6 times higher among Hispanics/Latinos than Whites[25]
- Hispanic/Latino diabetes prevalence, hospitalizations and mortality rates higher than Whites[25]
    - Hispanic/Latino children and adults 3 times more likely to be hospitalized for asthma
    - Hispanic/Latino asthma-related ED visits were 3 times higher than Whites

While health disparities among Hispanics/Latinos mirror those of other racial/ethnic groups, studies have shown that culture and language is central to their health beliefs, practices and habits.[35] Culture shapes patient perceptions of illness and health. Within Hispanic/Latino culture there is a strong sense

---

[31] Agency for Healthcare Research and Quality, 2014. Categories and Definitions Promulgated by the Office of Management and Budget (OMB) and the U.S. Bureau of the Census.

[32] U.S. Department of Health and Human Services – Office of Minority Health, 2015.

[33] Population Reference Bureau, 2015.

[34] Finger Lakes Health Agency Systems – "Nuestra Salud", 2014.

[35] University of California Irvine - ScienceDaily, 2007.

of community, family, faith/religion, respect and trust. Family members are sought for guidance when making decisions about health, and families are conscientious about how health status/information (i.e. illness, disease) is communicated to others.[36] As a population that defines illness and disease within the context of their culture - defining and describing ailments and symptoms using cultural terms as opposed to modern medical terminology - using appropriate language and literacy levels are vital aspects of providing quality patient care. Studies have shown that communication barriers are associated with poor/lower health education, poor doctor-patient relationships and lower patient satisfaction.[35]

Implications for Cultural Competence/Health Literacy

- Mutual respect and trust are the foundation of Hispanic/Latino relationships. Building relationships are essential to providing effective healthcare. Patients want to be treated with respect and dignity, in ways that make them feel valued and understood.
- Inquire about patient preferences – salutations, language, health options/practices, social support, etc. Inquiring about the health habits and language preferences of Hispanic/Latino patients can assist in planning effective health communication and health care plans.
- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.). Be mindful of language choices.
- Acknowledge and understand the cultural norms and relationship dynamics – personal, interpersonal and intrapersonal.
- Develop an understanding of each patient and/or family/caregiver as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently.
- Patients have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.

---

[36] Centers for Disease Control and Prevention, 2015.

American Indian/Alaska Natives

Within the United States, there are currently 566 nationally recognized tribes, of which 8 reside within New York State – Cayuga Nation of New York, Oneida Nation of New York, Onondaga Nation of New York, St. Regis Mohawk Tribe, Seneca Nation of New York, Shinnecock Indian Nation, Tonawanda Band of Seneca Indians of New York and Tuscarora of New York; while these individuals are identified as American Indians/Alaska Natives they prefer to be acknowledged by their tribal affiliation.[37] Approximately 57% of American Indians/Alaska Natives live in urban areas, while the remainder reside within rural areas. Although American Indians/Alaska Natives account for less than 1% of the population of New York State, New York State is one out of ten U.S. states with the largest American Indian/Alaska Native population.[25] Within the FLPPS Region, there are over 11,000 individuals who identify as at least partially Native American.

What we Know About Disparities in Outcomes

While the health disparities of American Indians/Alaska Natives mirror those of other racial/ethnic groups, the underlying economic, environmental and social factors are unique – due to a lack of financial resources and remoteness of the communities - limiting access to adequate care. "Lower life expectancy and the disproportionate rates of disease among American Indians/Alaska Natives are rooted in economic adversity and poor social conditions, such as lower education levels, poverty, discrimination and cultural differences".[38] As a result, it is necessary that we acknowledge their presence and healthcare needs:

Within New York State:

- American Indian/Alaska Native adults (28%) and children (38%) experienced high rates of poverty; which are 3 times higher than Whites.[25]
- American Indians/Alaska Natives are likely to die as a result of heart disease, cancer, diabetes, chronic lower respiratory diseases or unintentional injury.[25]
- American Indian/Alaska Native Women, Infant & Children (WIC) participants aged 2 – 4 and high schoolers had high rates of obesity.[25]

Nationally:

- In 2011, the percentage of American Indian/Alaska Native adults living in poverty was among the largest compared with non-Hispanic whites.[39]
- In 2010, prevalence of unemployment among adults aged 18-64 years was highest among non-Hispanic blacks (16.5%) and American Indian/Alaska Native (15.8%).[39]
- In 2011, the prevalence of not completing high school among adults aged 25 years and older was the second largest for American Indians/Alaska Natives --second to Hispanics and similar to African Americans.[39]

---

[37] National Conference of State Legislatures, 2015.
[38] Indian Health Service, 2015.
[39] Centers for Disease Control and Prevention, 2013.

- In 2011, American Indian/Alaska Native and non-Hispanic white adults were among those with the largest prevalence, frequency, and intensity of binge drinking, compared with other racial/ethnic populations.[39]
- Although the 2009 overall suicide rates for American Indian/Alaska Native were similar to those of non-Hispanic whites, the 2005–2009 rates among adolescent and young adult American Indians/Alaska Natives aged 15–29 years were substantially higher. In addition, American Indian/Alaska Natives experienced higher rates of depression and co-occurring conditions than any other ethnic group - untreated depression is the leading cause of suicide.[39]

Implications for Cultural Competence/Health Literacy

- A community-based and culturally appropriate health care approach can accommodate the needs of tribal populations and their cultures, by respecting cultural beliefs, values and acknowledging traditional tribal health practices as an integral component of the health care delivery system.[40]
- Respect and acknowledge non-traditional healing and health practices. Spirituality and healing is embedded within American Indian/Alaska Native culture.
- Mutual respect and trust are the foundation of American Indian/Native American relationships. Building relationships are essential to providing effective healthcare. Patients want to be treated with respect and dignity, in ways that make them feel valued and understood.
- "Interconnectedness"- spirituality, healing, traditions and community are valued. Acknowledge and understand the cultural norms and relationship dynamics – personal, interpersonal and intrapersonal.
- Develop an understanding of each patient and/or family/caregiver as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently.
- Inquire about patient preferences – salutations, language, health options/practices, social support, etc. Inquiring about the health habits and language preferences of patients can assist in planning effective health communication and health care plans.
- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.).
- Patients have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.

---

[40] Northwest Portland Area Indian Board, 2005.

Migrant and Seasonal Farmworkers (MSFWs)

According to the National Agricultural Workers Survey,[41] there are approximately 2.4 million agricultural workers employed on farms and ranches in the U.S.. Migrant and seasonal farmworkers are the fabric of our agricultural system, interwoven within many rural communities throughout the U.S. Within New York State, the Finger Lakes Region has the highest concentration of migrant and seasonal farmworkers – represented by diverse ethnicities and nationalities, such as Hispanic/Mexican American (84%), Haitian (7%), Puerto Rican (6%), African American (2%) and Central American (2%), which 86% report Limited English Proficiency (LEP) and prefer to speak Spanish.[9,42] Due to the mobile nature of their lifestyle, this population has been historically undercounted and underrepresented. "In 2011, the National Center for Farmworker Health reported that there were 112,827 farmworkers and their dependents working/living in New York State".[42]

What we Know About Disparities in Outcomes

Most migrant farmworkers earn annual incomes below the federal poverty level, "the average individual farmworker income ranged from $12,500 to $14,999 and the average total family income ranged from $17,500 to $19,999".[40] "The toll of work on their lives - the arduous nature of farm work, poverty status, crowded living arrangements, poor working conditions and regular travel across state lines into relatively unfamiliar areas -- cannot be underestimated".[43] Basic survival needs –food, shelter, income - are contingent on their work performance and production, posing an even greater challenge of having to prioritize their personal health and/or family's needs. Also, factors such as unstable residency, citizenship status, lack of transportation, language/literacy barriers, fear of losing their job, fear of deportation, long work days and lack of sick/personal days creates an greater challenge accessing social services, Medicaid and adequate healthcare.[44]

- "Children of migrant farmworkers also experience a variety of health risks and conditions. Primary care physicians have rated Mexican American migrant children 2 – 3 times more likely to have poor or fair health as opposed to good or excellent health, compared to non-migrant children. Intestinal parasites, nutritional deficiencies, dental problems, diarrhea, exposure to pesticides and hearing loss are common". [44]
- "Migrant farmworkers experience occupational hazards, such as demanding physical labor, contact with poisonous plants and chemicals, extreme weather conditions, increasing their risk of pesticide-related illnesses, respiratory illness, musculoskeletal disorders and compromised reproductive and oral health".[44]
- HIV/AIDS has become a growing concern in the migrant and seasonal farmworkers population, which research has shown an increased risk of HIV/AIDS due to lack of education, perceptions about the disease and their susceptibility contributing to later stages of diagnosis. "Without health insurance and easy access to primary care, farmworkers are less likely to receive HIV prevention

---

[41] National Center for Farmworker Health, Inc., 2012.
[42] Fingers Lake Community Health, *n.d.*
[43] New York State Department of Health – AIDS Institute, 2007.
[44] Nichols, M., Stein, A. D., & Wold, J. L., 2014.

education or to be screened for communicable diseases such as HIV, sexually transmitted diseases, and tuberculosis, and receive appropriate care".[44]

Implications for Cultural Competence/Health Literacy

- "To improve the overall quality of life and health status for migrant and seasonal farmworkers, policy issues must be addressed at the national, state and local levels. Public policy decision makers must ensure that migrant and seasonal farmworkers are identified as a priority group in need of health care and supportive services so that adequate dedicated resources are provided for them".[44]
- Adopt policies that allow medical services and medication, through Medicaid, the Ryan White CARE Act, and/or the AIDS Drug Assistance Program (ADAP), to be provided across State lines.[44]
- Develop and implement policies and practices that are based on an understanding and respect for different cultural values, beliefs, norms, religions and experiences.
- "Language barriers between provider and patient can lead to a multitude of problems, including incomplete patient medical histories, misdiagnosis, unnecessary tests, missed opportunities for patient education, poor patient compliance, nonadherence to prescribed medications and/or not taking medications according to instructions, higher levels of patient dissatisfaction, underutilization of health services and treatment failure".[44]
- Building relationships are essential to providing effective healthcare. Patients want to be treated with respect and dignity, in ways that make them feel valued and understood.
- Inquire about patient preferences – salutations, language, health options/practices, social support, etc.
- Increase our awareness and understanding about the stigma and discrimination faced by migrant and seasonal farmworkers.
- "Increase opportunities for MSFW representation on advocacy groups and consumer advisory boards associated with health and social services, by holding meetings at non-traditional venues and hours".[44]
- Increase our awareness and understanding of their basic survival needs – food, shelter and safety – while acknowledging that additional services may be needed (i.e. transportation, social services, housing, education and vocational training, extended/after office hours, legal etc.). Establish collaborative partnerships with linkage resources/services, while maintaining a degree of confidentiality.
- Communication and trust is key – building a rapport is essential. We must be able to communicate with them in a way that they understand; listen to their concerns and follow-up.
- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.).
- Develop an understanding of each patient as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently. Patients have needs beyond their health

conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.

Lesbian, Gay, Bisexual, Transgender & Questioning (LGBTQ)

Although differences in health outcomes by race and ethnicity, sex, and poverty status are historically well-documented, this has not been the case with individuals of the LGBTQ community. For our purposes, the term LGBTQ refers to people who identify as Gay, Lesbian, Bisexual, Transgender, and Questioning. Lesbian refers to those who identify as women who have sex with women, Gay refer to those who identify as men who have sex with men (MSM), Bisexual refers to those who identify as people who have sex with both men and women, Transgendered refers to those who identify as living and expressing themselves in a gender that is opposite to their original genetic sex, and Questioning refers to those who have yet to identify their actual sexual preference or expression.

What we Know About Disparities in Outcomes

LGBTQ individuals represent a diverse spectrum of races, ethnicities, social classes and cultural groups. However, based on their sexual orientation they are not equally recognized and/or afforded the same opportunities as other Americans (e.g. lack of health insurance, employee sponsored health benefits, ineligible for certain family planning health services). "Research suggests that LGBTQ individuals face health disparities linked to societal stigma, discrimination and denial of their civil and human rights. Discrimination against LGBTQ persons has been associated with high rates of psychiatric disorders, substance abuse and suicide".[45] Although sexual behavior is a contributor of health outcomes, societal and structural inequities play a major role in this population's health disparities.

The Institute of Medicine emphasized the need for collection of gender identity and sexual orientation data on federally supported surveys.[46] Due to limited data collection on sexual orientation and gender identity, the nature of these health disparities in the LGBTQ community are still in question".[47] As a result, we can only estimate the full extent/impact of health disparities within LGBTQ populations:

- LGBTQ adults are least likely to have health insurance coverage compared to heterosexual adults.[48]
- LGBTQ adults are more likely to delay or not seek medical care.[48]
- LGBTQ adults are more likely to receive health care services in emergency rooms.[48]
- LGBTQ adults are more likely to delay or not get needed prescription medicine.[48]

Recent studies have examined the health care of lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations and have found clear disparities among sexual minority groups. These disparities seem to be broad ranging, with differences identified for health conditions (e.g., asthma, diabetes, cardiovascular disease, or disability), health behaviors such as smoking cigarettes and heavy drinking, and healthcare access and service utilization. Among US adults, those who identified as LGBTQwere more likely to smoke cigarettes, consume more amounts of alcohol on a regular basis and report higher rates of psychological distress than those who identified as heterosexual.[49] In addition, 4.6% of the overall U.S. population has self-reported a suicide attempt, which that rate is 2 – 4 times higher (10

---

[45] HealthyPeople2010 - Lesbian, Gay, Bisexual, and Transgender Health, 2015.

[46] Institute of Medicine - Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011.

[47] U.S. Department of Health and Human Services – Office of Minority Health, 2013. *Improving Data Collection for the LGBTCommunity.*

[48] Krehely, J., 2009.

[49] U.S. Department of Health and Human Services, 2014. *National Health Statistics Report*

– 20%) for lesbian, gay and bisexual individuals. By comparison, 41% of transgender or gender non-conforming individuals have attempted suicide.[50]

Implications for Cultural Competence and Health Literacy

- "Health surveys cannot continue to treat populations in isolation: Members of the LGBTQ community who are members of other populations that are recognized as suffering from health disparities must be allowed to identify themselves fully on surveys, including their sexual orientation and gender identity".[49]
- For better understanding of this community we need to create an inclusive safe space; a place where all patients are welcome, safe and included. We must be mindful to ensure that health education materials are relevant to the respective populations (i.e. imagery, language, etc.).
- Inquire about patient preferences – salutations, language, health options/practices, social support, etc. to aid in planning effective health communication and health care plans.
- Acknowledge the diversity within – not all patients share the same values, beliefs and habits (i.e. dietary habits, faith/religion, language, etc.).
- Acknowledge and understand the cultural norms and relationship dynamics of your patient – personal, interpersonal and intrapersonal.
- Develop an understanding of each patient and/or family/caregiver as an individual – every patient experiences disease, illness, life circumstances, trauma and pain differently.
- Patients have needs beyond their health conditions – serve as a linkage to other resources. Asking the right questions will help determine appropriate course of treatments or communication techniques.
- It is necessary to acknowledge the unique perspectives of this population – history of inequality through oppression, discrimination and stigma – to better understand how they interact with society, within their communities and with the healthcare system.
- Members of the LGBTQ community may have a harder time accessing the health care system due to fear of discrimination. In addition, their apprehension of accessing the health care system may be further compromised due to a lack of inclusion within our current health care system. For example, a lesbian couple may be unable to make health and/or end-of life decisions for each other, due to policies that do not acknowledge their union in the same manner as a heterosexual couple.
- Lack of engagement in the health care system may continue to result in poor preventative care, further perpetuating LGBTQ health disparities.

---

[50] Malone, L., 2014.

References

1. Brennan Ramirez, L.K., Baker, E.A., & Metzler, M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008. http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf
2. U.S. Department of Health and Human Services. (2011). HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care. http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf
3. Agency for Healthcare Research and Quality. (July 2014). Improving Cultural Competence to Reduce Health Disparities for Priority Populations. http://effectivehealthcare.ahrq.gov/ehc/products/573/1934/cultural-competence-protocol-140709.pdf
4. Airhihenbuwa, C.O., & Liburd, L. Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender, and Power. (2006). Health Education & Behavior, Vol. 33 (4): 488-501. DOI: 10.1177/1090198106287731
5. Salient Medicaid Data System – No PHI version – CY 2014a. Unpublished data from Coordinated Care Services, Inc. Internal Data Source.
6. NYS OMH BHO Portal 2013a. Unpublished data from Coordinated Care Services, Inc. Internal Data Source.
7. NYS OMH BHO Portal 2013b. Unpublished data from Coordinated Care Services, Inc. Internal Data Source.
8. NYSDOH OHSM from SPARCS data extracted December 2010. Unpublished data from Coordinated Care Services, Inc. Internal Data Source.
9. Finger Lakes Health Systems Agency. (2014). *Community Needs Assessment – Finger Lakes Performing Provider System Reform Incentive Program Final Grant Application.* http://www.flhsa.org/uploads/pages/pdf/FINAL%20CNA%20Report%2012-18-14.pdf
10. Salient Medicaid Data System – No PHI version – CY 2014b. Unpublished data from Coordinated Care Services, Inc. Internal Data Source.
11. National Core Indicators NASDDDS and HSRI, 2014a. NYS NCI CoC Charts Generated and Analyzed.
12. National Core Indicators NASDDDS and HSRI, 2014b. NYS NCI CoC Charts Generated and Analyzed.
13. National Core Indicators NASDDDS and HSRI (National Association of State Directors of Developmental Disabilities Services and Health Services Research Institute), FY 2013/14. NYS NCI CoC Charts Generated and Analyzed.
14. HUDexchange.info – NYS Annual Homeless Assessment Reports. NYS CoC Reports Generated and Analyzed.
15. Institute of Medicine – Committee of Healthcare for Homeless People. (1988). Homelessness, Homelessness, Health, Health, and Human Needs. http://www.ncbi.nlm.nih.gov/books/NBK218232/pdf/Bookshelf_NBK218232.pdf

16. Centers for Disease Control and Prevention. (2011). CDC Health Disparities and Inequalities Report — United States, 2011. Morbidity and Mortality Weekly Report, 60, 1 – 116. http://www.cdc.gov/mmwr/pdf/other/su6001.pdf
17. Michael Reese Health Trust. (2011). The Chicago Housing for Health Partnership Project Related Documents. http://www.healthtrust.net/content/reports-publications/chicago-housing-health-partnership-project-related-documents-6283
18. New York State Community Action Association. (2015). New York State Poverty Report. http://nyscommunityaction.org/wp-content/uploads/2014/03/2015-Poverty-Report-w-50th-logos-for-online.pdf
19. World Health Organization. (2015). Health Topics: Poverty. http://www.who.int/topics/poverty/en/
20. ZipAtlantis.Com. (2013). Zip Codes with the Highest Percentage of Population Below Poverty Level in New York. http://www.zipatlas.com/us/ny/zip-code-comparison/population-below-poverty-level.htm
21. Dubowitz, T., Heron, M., Bird, C.E., Lurie, N., Finch, B.K., Basurto-Davila, R., Hale, L., & Escarce, J.J. (2008). Do Neighborhood Economic Conditions Influence the Consumption of Fruits and Vegetables? Rand Corporation, RB-9375. http://www.rand.org/content/dam/rand/pubs/research_briefs/2008/RAND_RB9375.pdf
22. StratisHealth. (2015). Understanding Poverty in Minnesota: Increasing the cultural competence of healthcare providers serving diverse populations. http://www.culturecareconnection.org/documents/InformationSheet_Poverty.pdf
23. HealthyPeople2020. (2015). Maternal, Infant and Child Health. http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health
24. New York State Department of Health. (2012). *New York State Minority Health Surveillance Report 2012.* *https://www.health.ny.gov/statistics/community/minority/docs/surveillance_report_2012.pdf*
25. Treuhaft, S., & Karpyn, A. (2010). The Grocery Gap: Who Has Access to Healthy Foods and Why It Matters. *The Policy Link.* http://thefoodtrust.org/uploads/media_items/grocerygap.original.pdf
26. ACT Rochester. (2015). Racial and Ethnic Disparities in the Greater Rochester Region. http://www.actrochester.org/sites/default/files/ACT%20Rochester%20Report%20on%20Racial%20and%20Ethnic%20Disparities.pdf
27. Lin, A.C., & Harris, R.K. (2009). *The Colors of Poverty: Why Racial & Ethnic Disparities Persist.* (#16, January 2009). http://www.npc.umich.edu/publications/policy_briefs/brief16/PolicyBrief16.pdf
28. Finger Lakes Health Systems Agency. (2014). "What's Goin' On" – Report on Local Health Disparities Commissioned by the African American Health Coalition 2014. http://www.flhsa.org/uploads/pages/pdf/AAHC%20Disparities%202014%20Final.pdf
29. Centers for Disease Control and Prevention. (2015). Black or African American Populations. http://www.cdc.gov/minorityhealth/populations/REMP/black.html#Disparities
30. Eiser, A.R., & Ellis, G. (2007). Viewpoint: Cultural Competence and the African American Experience with Health Care: The Case for Specific Content in Cross Cultural Education. *Academic Medicine, 82*(2), 176 – 183.

http://www.mopaonline.org/uploads/9/4/5/9/9459095/cultural_competence_and_the_african_american_experience_with_health_care_-_the_case_for_specific_content_in_cross-cultural_education.pdf

31. Agency for Healthcare Research and Quality. (October 2014). Categories and Definitions Promulgated by the Office of Management and Budget (OMB) and the U.S. Bureau of the Census. http://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata1tab1-1.html
32. U.S. Department of Health and Human Services – Office of Minority Health. (2015). *Profile of Hispanics/Latinos.* http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64
33. Population Reference Bureau. (2015). *Race/Ethnic Income Gap Growing Among U.S. Working Poor Families.* http://www.prb.org/Publications/Articles/2015/working-poor-families.aspx
34. Finger Lakes Health Systems Agency. (2014). "Nuestra Salud" – Report on Local Health Disparities Commissioned by the Latino Health Coalition 2014. http://www.flhsa.org/uploads/pages/pdf/LHC%20Disparities%202014%20Final.pdf
35. University of California Irvine – ScienceDaily. (November 14 2007). *Language Barriers Adversely Impact Health-Care Quality.* *http://www.sciencedaily.com/releases/2007/11/071113132304.htm*
36. Centers for Disease Control and Prevention. (2015). *Building Our Understanding: Culture Insights; Communicating with Hispanic/Latinos.* http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/hispanic_latinos_insight.pdf
37. National Conference of State Legislatures. (2015). Federal and State Recognized Tribes. http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx
38. Indian Health Service. (2015). Indian Health Disparities. https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Disparities.pdf
39. Centers for Disease Control and Prevention. (2013). CDC Health Disparities & Inequalities Report – American Indian & Alaska Native Populations: Examples of Important Health Disparities. http://www.cdc.gov/minorityhealth/populations/REMP/aian.html#Contributing
40. Northwest Portland Area Indian Board. (2005). A National Roundtable on the Indian Health System and Medicaid Reform. http://www.urban.org/research/publication/national-roundtable-indian-health-system-medicaid-reform/view/full_report
41. National Center for Farmworker Health, Inc. (2012). Farmworker Health Factsheet: Demographics. http://www.ncfh.org/uploads/3/8/6/8/38685499/fs-migrant_demographics.pdf
42. Finger Lakes Community Health. (n.d.). Farmworker Services. http://flchealth.org/your-experience/
43. New York State Department of Health – AIDS Institute. (2007). *Migrant and Seasonal Farmworkers: Health Care Access and HIV/AIDS in this Population.* http://www.health.ny.gov/diseases/aids/providers/reports/migrant_farmworkers/docs/heatlhcareaccess.pdf

44. Nichols, M., Stein, A. D., & Wold, J. L. (2014). Health Status of Children of Migrant Farm Workers: Farm Worker Family Health Program, Moultrie, Georgia. American Journal of Public Health, 104(2), 365–370. http://doi.org/10.2105/AJPH.2013.301511
45. HealthyPeople2010. (2015). Lesbian, Gay, Bisexual, and Transgender Health. http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
46. Institute of Medicine - Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. http://www.ncbi.nlm.nih.gov/books/NBK64806/pdf/Bookshelf_NBK64806.pdf
47. U.S. Department of Health and Human Services – Office of Minority Health. (2013). *Improving Data Collection for the LGBT Community.* http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=57
48. Krehely, J. (2009). How to Close the LGBT Health Disparities Gap. Center for American Progress. https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt_health_disparities.pdf
49. U.S. Department of Health and Human Services. (2014). National Health Statistics Report: Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013. *National Health Statistics Report, 77*(July 15 2014), 1-10.
50. Malone, L. (2014). Transgender Suicide Attempt Rates Are Staggering. http://www.vocativ.com/culture/lgbt/transgender-suicide/

Cultural Competence and Health Literacy Assessment

GENERAL INFORMATION

1. Please fill in the following Team information:

Provider Name

Street Address

City **State** **Zip**

President/CEO/Administrator Name

President/CEO/Administrator Title

Email Address

Phone Number

Where do you provide services? ***(check all that apply)***

☐ **Private Practice (single/multi-partners)**
☐ **Public/Safety-Net Hospital**
☐ **Private Hospital**
☐ **Community-Based Clinic/FQHC/PCMH**
☐ **Home/Community-Based Services (HCBS)**
☐ **Other - Write In**

What types of services do you provide? ***(check all that apply)***

☐ **Primary Care**
☐ **Specialty Care - Type**
☐ **Mental/Behavioral Health Care**
☐ **Non-Medical Prescribed Opiate (NMPO) Abuse Treatment**
☐ **Other - Write In**

2. List names and titles of those completing this form:

3. Has your organization participated in a cultural competence* training in the last twelve months?

○ **Yes**
○ **No**

4. Comments ***(please include the topics, content, and objectives covered in the training)*****:**

5. Please fill in the following information regarding your contact person(s) who we can reach regarding this assessment tool:

Primary Contact Person **Title**

Phone Number

Email Address

Additional Contact Person **Title**

Phone Number

Email Address

ORGANIZATIONAL PROFILE

6. **Briefly describe your organization's Mission, Vision and Value Statements** ***(paste in existing written material as appropriate):***

Mission Statement ☐
Vision Statement ☐
Value Statement ☐

7. **Does your organization's Mission Statement include Cultural Competence (CC)* and Health Literacy (HL)*?**

○ Yes
○ No

8. Is there a management level person accountable for Cultural Competence and Health Literacy activities

○ Yes
○ No

9. What is the name and title of the person accountable for Cultural Competence and Health Literacy activities?

☐

10. **Does your organization have the following:** ***(check all that apply)***

☐ Dedicated budget* for CC and Health Literacy activities
☐ Written CC and Health Literacy plan with objectives*, strategies*, and implementation timetable
☐ The organization does not have either of these in place

11. Does your agency require periodic review and updates of its written Cultural Competence and Health Literacy plan?

Not At All	Seldom	Sometimes	Often	N/A
○	○	○	○	○

ORGANIZATION INFORMATION

12. Please provide us with a brief description of the following positions as it relates to your organization. What's the primary responsibility of these individuals? Are these decision-making positions?

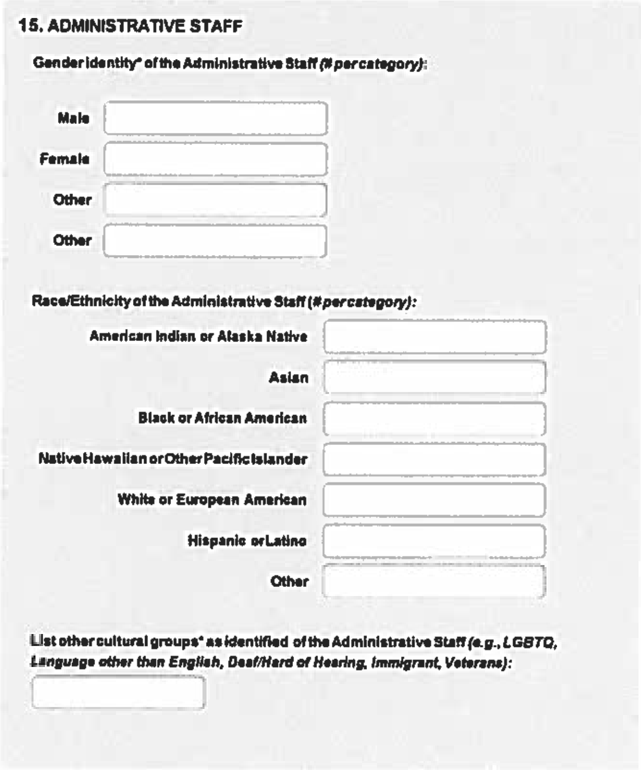
	Description:	Do these positions have the power to make decisions on behalf ofthe organizations processes, procedures and policies?	
		Yes	No
ADMINISTRATIVE*: ***(e.g., President, Chief Executive, Administrator, Director, Office)***			
[redacted]			
SUPPORT*: ***(e.g., Receptionist, Office Manager, Secretary, Transcriptionist, Assistant, Coordinator)***			
[redacted]			

13. Please paste below a copy of your organizational chart and identify clearly where the positions represented above "fit" into the chart.

☐

14. Please fill in the following information:

Total number of staff in the organization ☐
Total number of consumer/patients served last year ☐
Total number of consumer/patient encounters last year ☐



15. ADMINISTRATIVE STAFF

Gender identity* of the Administrative Staff *(# per category)*:

Male

Female

Other

Other

Race/Ethnicity of the Administrative Staff *(# per category)*:

American Indian or Alaska Native

Asian

Black or African American

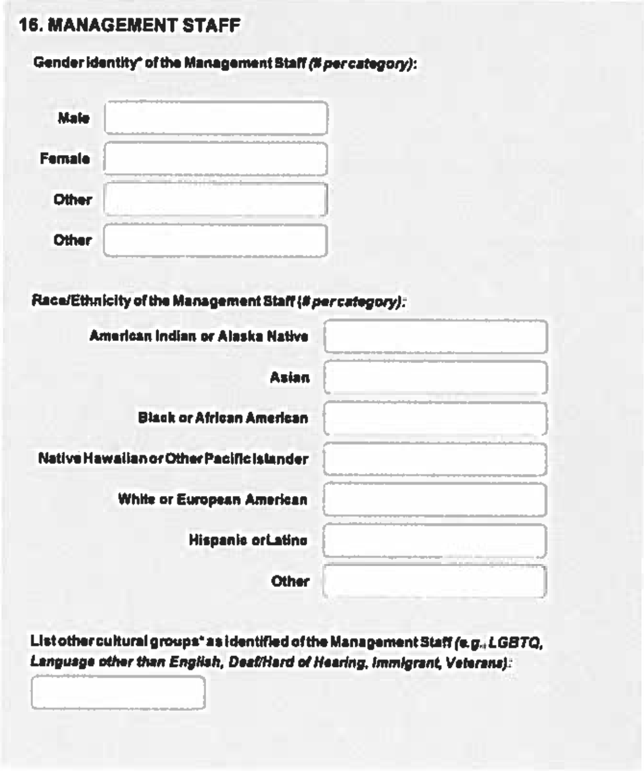
Native Hawaiian or Other Pacific Islander

White or European American

Hispanic or Latino

Other

List other cultural groups* as identified of the Administrative Staff *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:



16. MANAGEMENT STAFF

Gender identity* of the Management Staff *(# per category)*:

Male

Female

Other

Other

Race/Ethnicity of the Management Staff *(# per category)*:

American Indian or Alaska Native

Asian

Black or African American

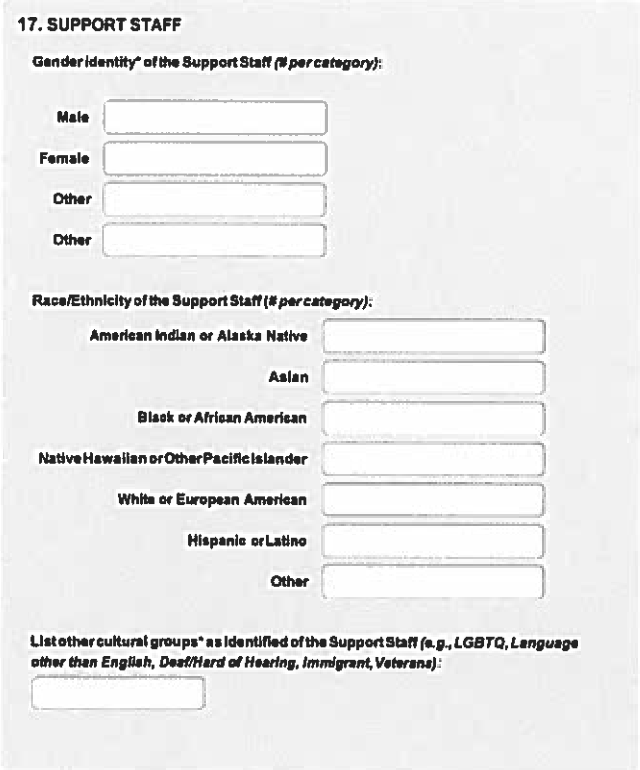
Native Hawaiian or Other Pacific Islander

White or European American

Hispanic or Latino

Other

List other cultural groups* as identified of the Management Staff *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:



17. SUPPORT STAFF

Gender identity* of the Support Staff *(# per category)*:

Male

Female

Other

Other

Race/Ethnicity of the Support Staff *(# per category)*:

American Indian or Alaska Native

Asian

Black or African American

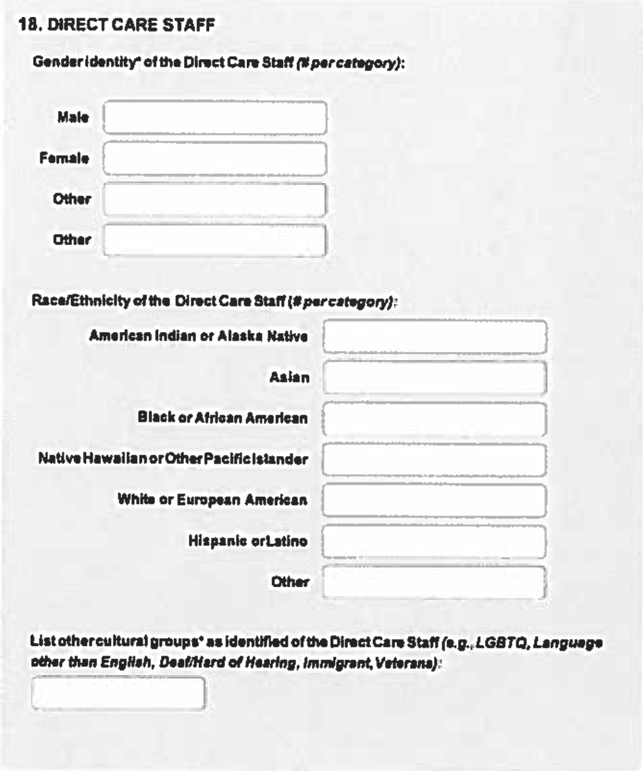
Native Hawaiian or Other Pacific Islander

White or European American

Hispanic or Latino

Other

List other cultural groups* as identified of the Support Staff *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:



18. DIRECT CARE STAFF

Gender identity* of the Direct Care Staff *(# per category)*:

Male

Female

Other

Other

Race/Ethnicity of the Direct Care Staff *(# per category)*:

American Indian or Alaska Native

Asian

Black or African American

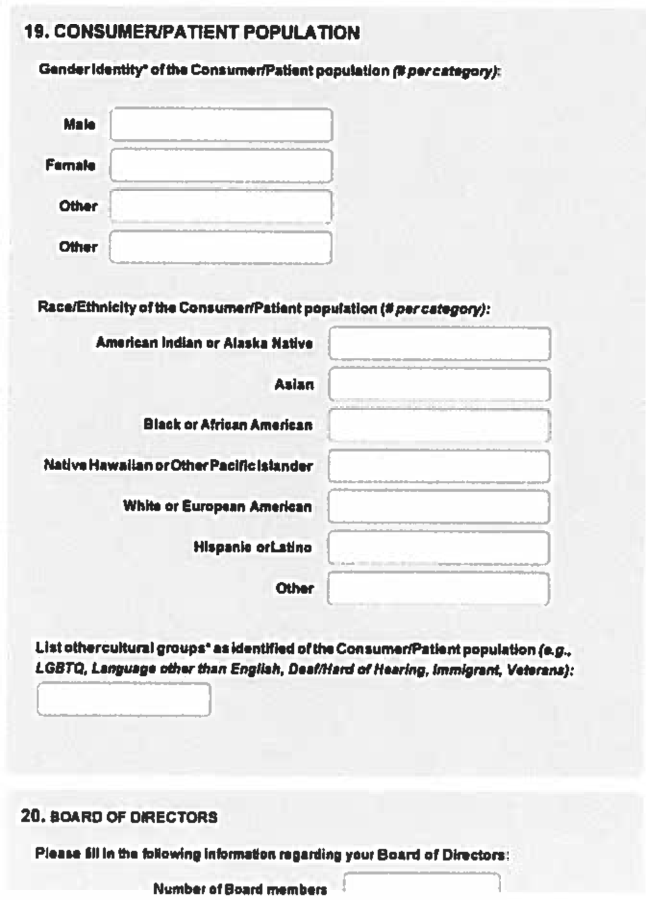
Native Hawaiian or Other Pacific Islander

White or European American

Hispanic or Latino

Other

List other cultural groups* as identified of the Direct Care Staff *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:



19. CONSUMER/PATIENT POPULATION

Gender identity* of the Consumer/Patient population *(# per category)*:

Male
Female
Other
Other

Race/Ethnicity of the Consumer/Patient population *(# per category)*:

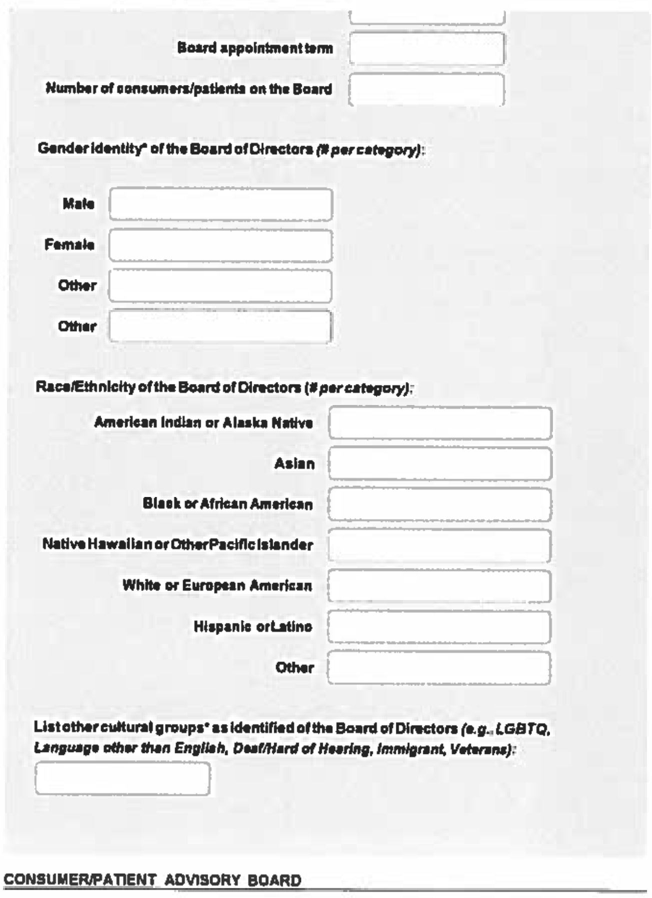
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or European American
Hispanic or Latino
Other

List other cultural groups* as identified of the Consumer/Patient population *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:

20. BOARD OF DIRECTORS

Please fill in the following information regarding your Board of Directors:

Number of Board members



Board appointment term
Number of consumers/patients on the Board

Gender identity* of the Board of Directors *(# per category)*:

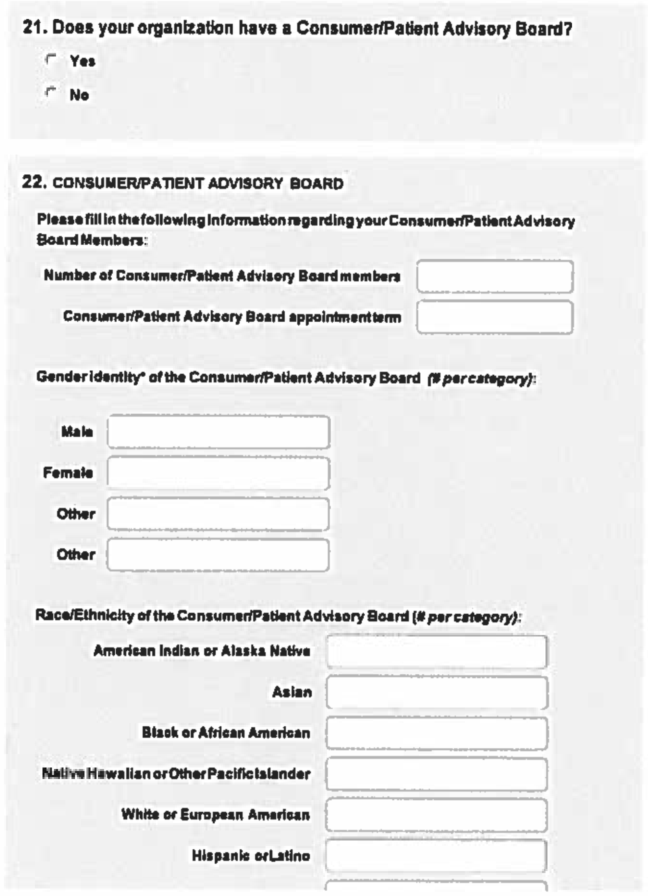
Male
Female
Other
Other

Race/Ethnicity of the Board of Directors *(# per category)*:

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or European American
Hispanic or Latino
Other

List other cultural groups* as identified of the Board of Directors *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:

CONSUMER/PATIENT ADVISORY BOARD



21. Does your organization have a Consumer/Patient Advisory Board?

○ Yes
○ No

22. CONSUMER/PATIENT ADVISORY BOARD

Please fill in the following information regarding your Consumer/Patient Advisory Board Members:

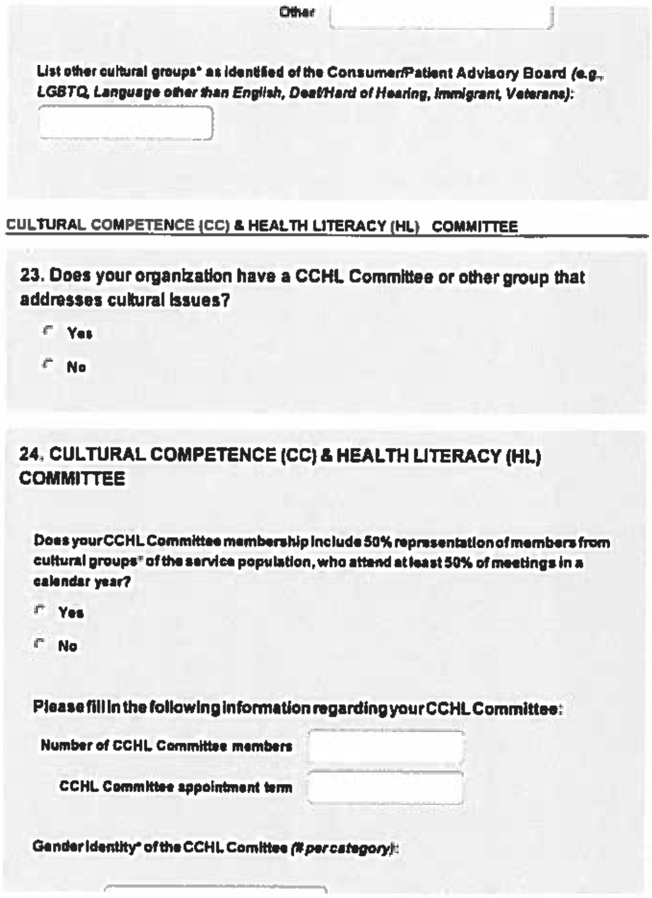
Number of Consumer/Patient Advisory Board members
Consumer/Patient Advisory Board appointment term

Gender identity* of the Consumer/Patient Advisory Board *(# per category)*:

Male
Female
Other
Other

Race/Ethnicity of the Consumer/Patient Advisory Board *(# per category)*:

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or European American
Hispanic or Latino



Other

List other cultural groups* as identified of the Consumer/Patient Advisory Board *(e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:

CULTURAL COMPETENCE (CC) & HEALTH LITERACY (HL) COMMITTEE

23. Does your organization have a CCHL Committee or other group that addresses cultural issues?

○ Yes
○ No

24. CULTURAL COMPETENCE (CC) & HEALTH LITERACY (HL) COMMITTEE

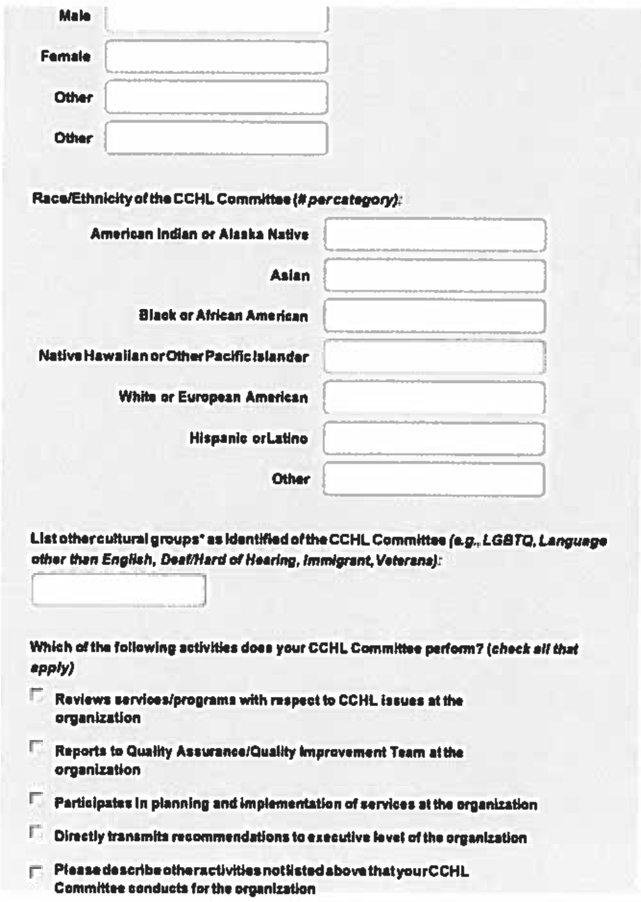
Does your CCHL Committee membership include 50% representation of members from cultural groups* of the service population, who attend at least 50% of meetings in a calendar year?

○ Yes
○ No

Please fill in the following information regarding your CCHL Committee:

Number of CCHL Committee members
CCHL Committee appointment term

Gender identity* of the CCHL Comittee *(# per category)*:



Male

Female

Other

Other

Race/Ethnicity of the CCHL Committee (*# per category*):

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White or European American

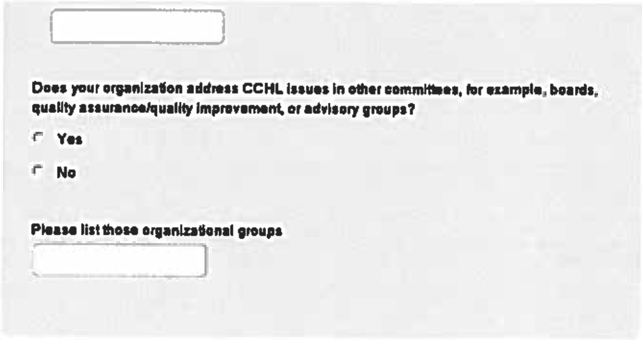
Hispanic or Latino

Other

List other cultural groups* as identified of the CCHL Committee (*e.g., LGBTQ, Language other than English, Deaf/Hard of Hearing, Immigrant, Veterans)*:

Which of the following activities does your CCHL Committee perform? (*check all that apply)*

☐ Reviews services/programs with respect to CCHL issues at the organization
☐ Reports to Quality Assurance/Quality Improvement Team at the organization
☐ Participates in planning and implementation of services at the organization
☐ Directly transmits recommendations to executive level of the organization
☐ Please describe other activities not listed above that your CCHL Committee conducts for the organization

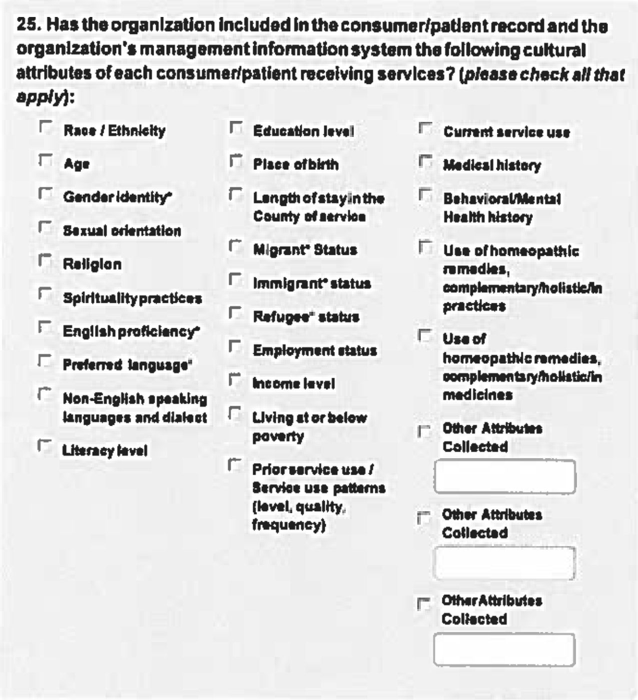


Does your organization address CCHL issues in other committees, for example, boards, quality assurance/quality improvement, or advisory groups?

○ Yes
○ No

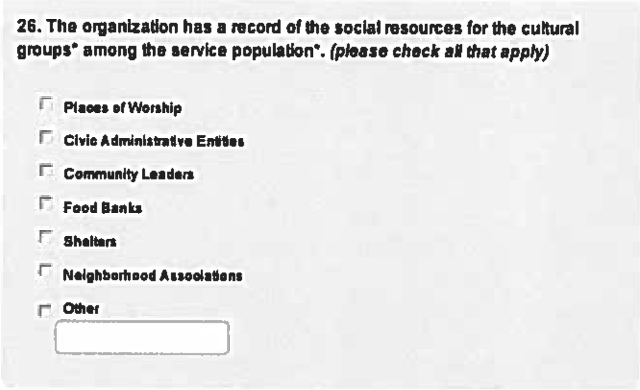
Please list those organizational groups

NEEDS ASSESSMENT



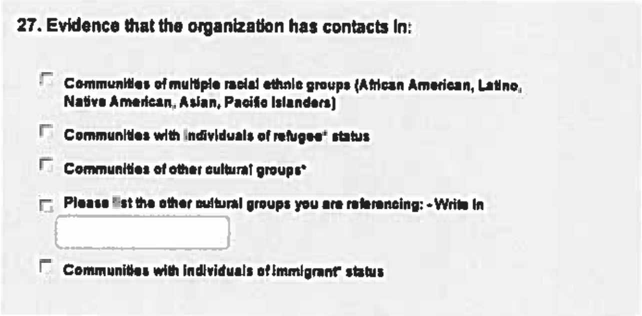
25. Has the organization included in the consumer/patient record and the organization's management information system the following cultural attributes of each consumer/patient receiving services? (*please check all that apply*):

☐ Race / Ethnicity
☐ Age
☐ Gender identity*
☐ Sexual orientation
☐ Religion
☐ Spirituality practices
☐ English proficiency*
☐ Preferred language*
☐ Non-English speaking languages and dialect
☐ Literacy level
☐ Education level
☐ Place of birth
☐ Length of stay in the County of service
☐ Migrant* Status
☐ Immigrant* status
☐ Refugee* status
☐ Employment status
☐ Income level
☐ Living at or below poverty
☐ Prior service use / Service use patterns (level, quality, frequency)
☐ Current service use
☐ Medical history
☐ Behavioral/Mental Health history
☐ Use of homeopathic remedies, complementary/holistic/in practices
☐ Use of homeopathic remedies, complementary/holistic/in medicines
☐ Other Attributes Collected
☐ Other Attributes Collected
☐ Other Attributes Collected



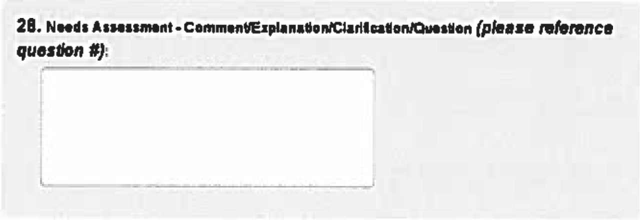
26. The organization has a record of the social resources for the cultural groups* among the service population*. (*please check all that apply)*

☐ Places of Worship
☐ Civic Administrative Entities
☐ Community Leaders
☐ Food Banks
☐ Shelters
☐ Neighborhood Associations
☐ Other



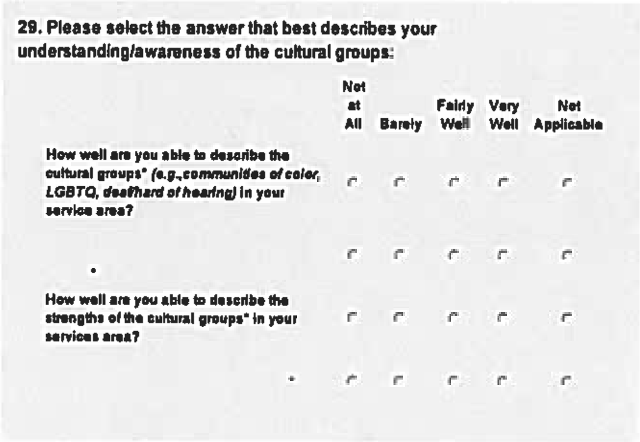
27. Evidence that the organization has contacts in:

☐ Communities of multiple racial ethnic groups (African American, Latino, Native American, Asian, Pacific Islanders)
☐ Communities with individuals of refugee* status
☐ Communities of other cultural groups*
☐ Please list the other cultural groups you are referencing: - Write in
☐ Communities with individuals of immigrant* status



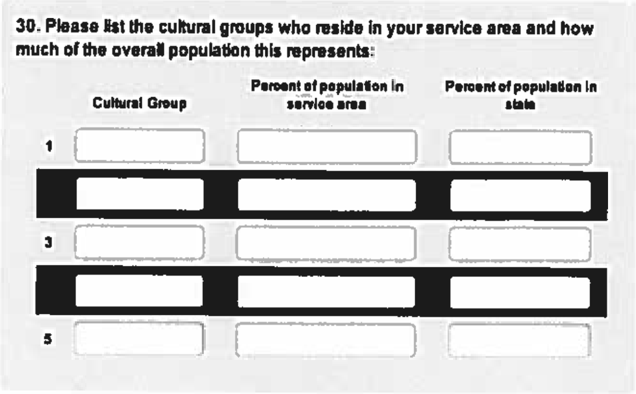
28. Needs Assessment - Comment/Explanation/Clarification/Question *(please reference question #)*:

KNOWLEDGE OF COMMUNITIES



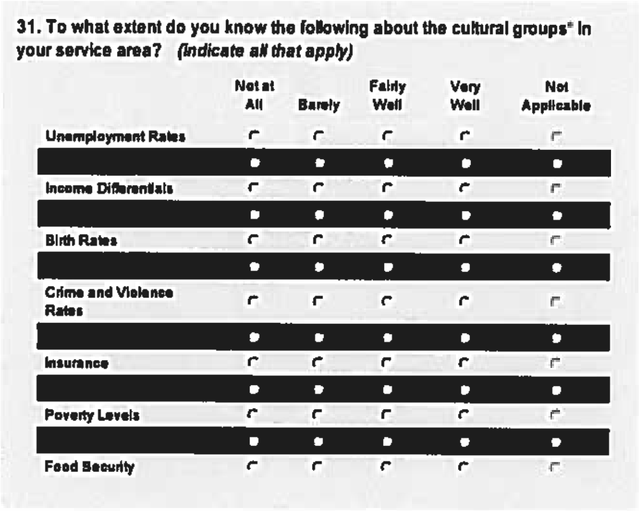
29. Please select the answer that best describes your understanding/awareness of the cultural groups:

	Not at All	Barely	Fairly Well	Very Well	Not Applicable
How well are you able to describe the cultural groups* *(e.g.,communities of color, LGBTQ, deaf/hard of hearing)* in your service area?	○	○	○	○	○
•	○	○	○	○	○
How well are you able to describe the strengths of the cultural groups* in your services area?	○	○	○	○	○
•	○	○	○	○	○



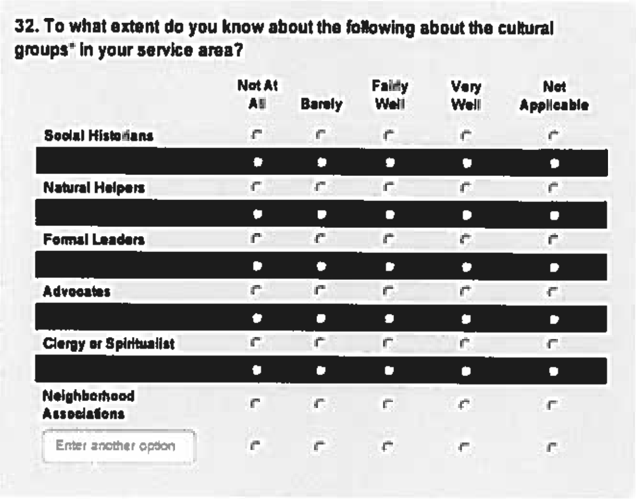
30. Please list the cultural groups who reside in your service area and how much of the overall population this represents:

	Cultural Group	Percent of population in service area	Percent of population in state
1			
3			
5			



31. To what extent do you know the following about the cultural groups* in your service area? *(indicate all that apply)*

	Not at All	Barely	Fairly Well	Very Well	Not Applicable
Unemployment Rates	○	○	○	○	○
	○	○	○	○	○
Income Differentials	○	○	○	○	○
	○	○	○	○	○
Birth Rates	○	○	○	○	○
	○	○	○	○	○
Crime and Violence Rates	○	○	○	○	○
	○	○	○	○	○
Insurance	○	○	○	○	○
	○	○	○	○	○
Poverty Levels	○	○	○	○	○
	○	○	○	○	○
Food Security	○	○	○	○	○



32. To what extent do you know about the following about the cultural groups* in your service area?

	Not At All	Barely	Fairly Well	Very Well	Not Applicable
Social Historians	○	○	○	○	○
	○	○	○	○	○
Natural Helpers	○	○	○	○	○
	○	○	○	○	○
Formal Leaders	○	○	○	○	○
	○	○	○	○	○
Advocates	○	○	○	○	○
	○	○	○	○	○
Clergy or Spiritualist	○	○	○	○	○
	○	○	○	○	○
Neighborhood Associations	○	○	○	○	○
Enter another option	○	○	○	○	○

33. Please answer the following questions:

	Not at All	Barely	Fairly Well	Very Well	Not Applicable
Do you know the prevailing beliefs, customs, norms, and values of the cultural groups* in your service area?	○	○	○	○	○
	○	○	○	○	○
Do you know social service problems that can be addressed by natural networks of support within the groups of color?	○	○	○	○	○
	○	○	○	○	○
Do you know how the causes of mental illness are viewed by the cultural groups* in your service area?	○	○	○	○	○
	○	○	○	○	○
Do you understand the conceptual distinction between the terms "immigrant*" and "refugee*"?	○	○	○	○	○
	○	○	○	○	○

34. Does the organization's management information system include data regarding the vulnerable populations in your service area?

○ Yes

○ No

35. Please mark all that you have identified:

☐ African American

☐ Hispanic

☐ Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)

☐ Individuals and Families Living in Poverty

☐ Institutionalized (Incarcerated/Imprisoned Persons)

☐ Migrant Farm Workers

☐ People Living with Disabilities

☐ Homeless

☐ Maternal Health – Pregnant Women

☐ Maternal Health – children under 5

☐ Maternal Health – children aged 6-19

☐ Other

☐ Other

☐ Other

36. Has the organization identified the attributes of the above vulnerable groups?

○ Yes

○ No

37. Please mark all the attributes that you have identified:

☐ Living at or below poverty

☐ Homeless

☐ Insured

☐ Uninsured

☐ Institutionalized

☐ Limited English Proficiency*

☐ Cancer

☐ Cardiovascular Disease

☐ Diabetes

☐ Persons living with HIV

☐ Disability

☐ Mental, Emotional, Behavioral Health Disorder

☐ Emergency Room Admissions

☐ Acute Care Utilization

☐ Public health indicators of health status

☐ Other

☐ Other

☐ Other

INFORMATION EXCHANGE

38. The organization has the following in place to address how information is shared with the consumer/patient and consumer: *(check all that apply)*

☐ Information is available that respects cultural values

☐ Educational information* is provided to the community in different formats and languages

☐ Information reflects community literacy levels

☐ Information is available at key places* in the community

☐ Legal documents and key documents are understandable to individuals with Limited English Proficiency (LEP)*

☐ Legal and key documents are understandable to individuals with Limited Reading Skills (LRS)*

39. All vital/pertinent forms and educational materials are translated into languages other than English. Vital/pertinent forms include, but are not limited to: *(Check all that apply)*

☐ Intake forms

☐ Consumer/Patient Bill of Rights

☐ Consent/Release forms

☐ Confidentiality Statements

☐ Prescription Information

☐ Appointment Reminder Cards

☐ Organization Contact Information

☐ Organizational Marketing Materials (e.g., brochures, pamphlets, website, organization information)

☐ Health Insurance Privacy Protection Act (HIPAA) forms

☐ Letters containing important information regarding participation in a program, notices pertaining to the reduction, denial, or termination of services or benefits

☐ Notices pertaining to the right to appeal such actions or that require a response from beneficiaries

☐ List other vital/pertinent forms

40. ALL vital/pertinent materials and forms provided to consumers/patients, are interpreted from the appropriate cultural perspective, as measured by satisfaction surveys, focus groups, consumer/patient advisory committee, collaboration with community social resources/informal supports, etc.: ***(Check all that apply)***

☐ Intake forms
☐ Consumer/Patient Bill of Rights
☐ Consent/Release forms
☐ Confidentiality Statements
☐ Prescription Information
☐ Appointment Reminder Cards
☐ Organization Contact Information
☐ Organizational Marketing Materials (e.g. brochures, pamphlets, website, organization information)
☐ Health Insurance Privacy Protection Act (HIPAA) forms
☐ Letters containing important information regarding participation in a program, notices pertaining to the reduction, denial, or termination of services or benefits
☐ Notices pertaining to the right to appeal such actions or that require a response from beneficiaries
☐ List other vital/pertinent forms

41. Information to educate those you serve and the community at large about physical/behavioral health and culture is available in:

☐ Different formats*
☐ Languages of the service area
☐ Reading levels

42. Culturally relevant and appropriate materials offered to the consumer/patient is written to reduce stigma and is:

☐ In different languages
☐ At literacy levels of individuals in your service area
☐ At reading levels of individuals in your service area
☐ Adapted to satisfy the cultural nuances of individuals in your service area

43. Information regarding consumer's/patient's rights: ***(check all that apply)***

☐ Is available in different languages
☐ Reflects literacy levels
☐ Respects cultural values
☐ Is in different formats

44. Information Exchange - Comment/Explanation/Clarification/Question ***(please reference question #):***

RESOURCES AND LINKAGES

45. Does your organization work collaboratively with programs that provide....

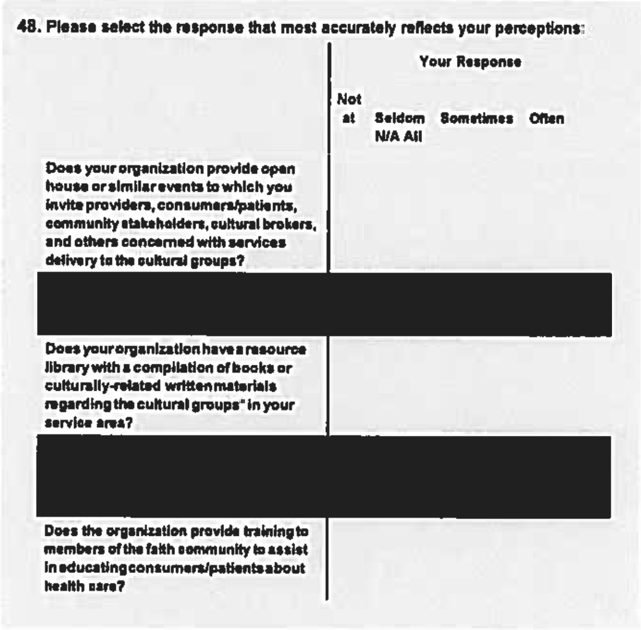
	Not at All	Barely	Fairly Well	Very Well	N/A
Employment Training	○	○	○	○	○
[redacted]	○	○	○	○	○
Housing	○	○	○	○	○
[redacted]	○	○	○	○	○
Maternal/Child Health Services	○	○	○	○	○
[redacted]	○	○	○	○	○
Public Health Services	○	○	○	○	○
[redacted]	○	○	○	○	○
Child Welfare Services	○	○	○	○	○
[redacted]	○	○	○	○	○
Criminal Justice System	○	○	○	○	○
[redacted]	○	○	○	○	○

46. Please select the response that most accurately reflects your perceptions:

	Your Response				
	None	A N/A Few	Some	Many	
Does your organization have linkages with institutions of higher education, e.g., colleges, universities, or professional schools that could provide you with accurate information concerning the cultural groups in your service area and the disparities.	○	○	○	○	○
[redacted]					
Does your organization have linkages with advocates for cultural groups* in the community in your service area, who give you reliable information regarding community opinions about diverse & important issues?	○	○	○	○	○
[redacted]					

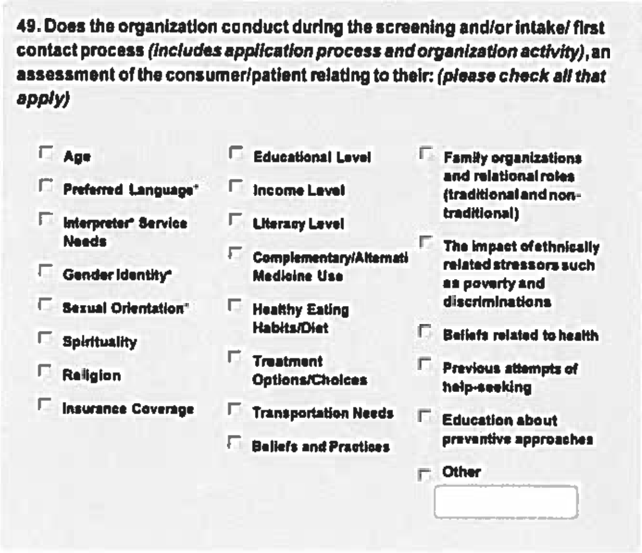
47. Has your organization conducted or participated in a needs assessment utilizing providers offering services to the cultural groups* in your service area?

Never	Once or twice	A few times	A number of times	N/A
○	○	○	○	○



48. Please select the response that most accurately reflects your perceptions:

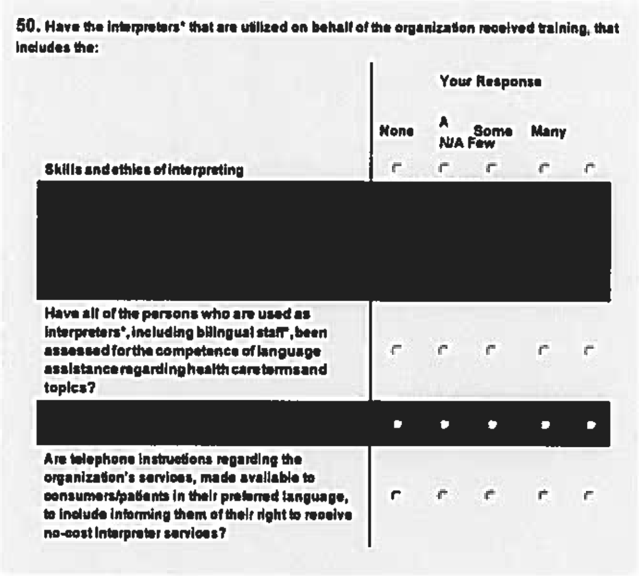
	Your Response				
	N/A	Not at All	Seldom	Sometimes	Often
Does your organization provide open house or similar events to which you invite providers, consumers/patients, community stakeholders, cultural brokers, and others concerned with services delivery to the cultural groups?					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Does your organization have a resource library with a compilation of books or culturally-related written materials regarding the cultural groups* in your service area?					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Does the organization provide training to members of the faith community to assist in educating consumers/patients about health care?					



49. Does the organization conduct during the screening and/or intake/ first contact process *(includes application process and organization activity)*, an assessment of the consumer/patient relating to their: *(please check all that apply)*

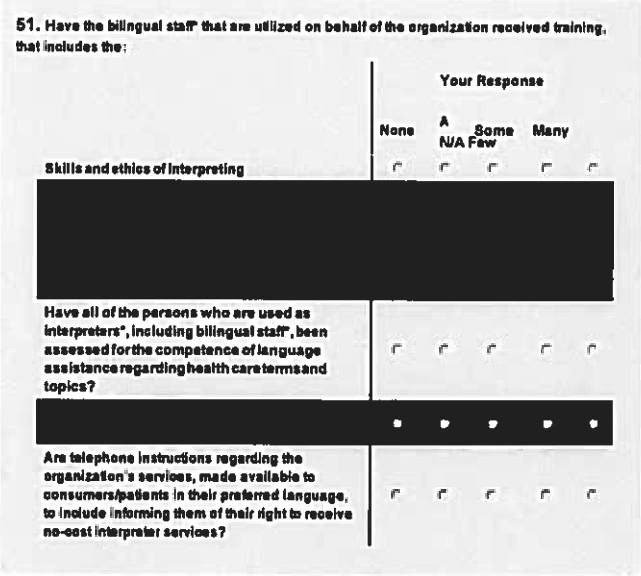
- ☐ Age
- ☐ Preferred Language*
- ☐ Interpreter* Service Needs
- ☐ Gender Identity*
- ☐ Sexual Orientation*
- ☐ Spirituality
- ☐ Religion
- ☐ Insurance Coverage
- ☐ Educational Level
- ☐ Income Level
- ☐ Literacy Level
- ☐ Complementary/Alternati Medicine Use
- ☐ Healthy Eating Habits/Diet
- ☐ Treatment Options/Choices
- ☐ Transportation Needs
- ☐ Beliefs and Practices
- ☐ Family organizations and relational roles (traditional and non-traditional)
- ☐ The impact of ethnically related stressors such as poverty and discriminations
- ☐ Beliefs related to health
- ☐ Previous attempts of help-seeking
- ☐ Education about preventive approaches
- ☐ Other

SERVICES



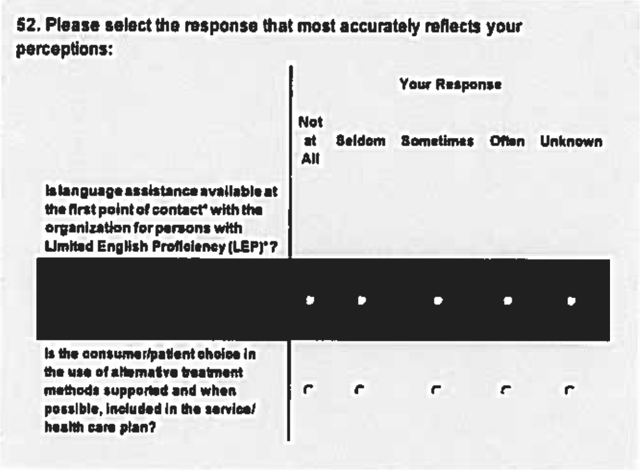
50. Have the interpreters* that are utilized on behalf of the organization received training, that includes the:

	Your Response				
	None	N/A	A Few	Some	Many
Skills and ethics of interpreting	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Have all of the persons who are used as interpreters*, including bilingual staff*, been assessed for the competence of language assistance regarding health care terms and topics?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Are telephone instructions regarding the organization's services, made available to consumers/patients in their preferred language, to include informing them of their right to receive no-cost interpreter services?	○	○	○	○	○



51. Have the bilingual staff* that are utilized on behalf of the organization received training, that includes the:

	Your Response				
	None	N/A	A Few	Some	Many
Skills and ethics of interpreting	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Have all of the persons who are used as interpreters*, including bilingual staff*, been assessed for the competence of language assistance regarding health care terms and topics?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Are telephone instructions regarding the organization's services, made available to consumers/patients in their preferred language, to include informing them of their right to receive no-cost interpreter services?	○	○	○	○	○

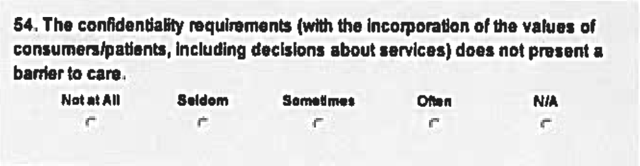


52. Please select the response that most accurately reflects your perceptions:

	Your Response				
	Not at All	Seldom	Sometimes	Often	Unknown
Is language assistance available at the first point of contact* with the organization for persons with Limited English Proficiency (LEP)*?					
[redacted]					
Is the consumer/patient choice in the use of alternative treatment methods supported and when possible, included in the service/ health care plan?	○	○	○	○	○

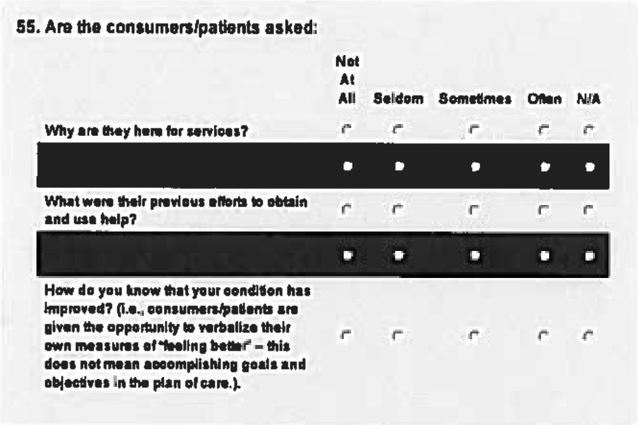
53. Does the consumer/patient care plan take into consideration the following attributes/social determinants*: *(check all that apply)*

- ☐ Age
- ☐ Preferred Language*
- ☐ Interpreter* Service Needs
- ☐ Gender Identity*
- ☐ Sexual Orientation*
- ☐ Spirituality
- ☐ Religion
- ☐ Insurance Coverage
- ☐ Educational Level
- ☐ Income Level
- ☐ Literacy Level
- ☐ Alternative Medicine Use
- ☐ Healthy Eating Habits/Diet
- ☐ Treatment Options/Choices
- ☐ Transportation Needs
- ☐ Beliefs and Practices
- ☐ Family organizations and relational roles (traditional and non-traditional)
- ☐ The impact of ethnically related stressors such as poverty and discriminations
- ☐ Beliefs related to health
- ☐ Previous attempts of help-seeking
- ☐ Education about preventive approaches
- ☐ Other



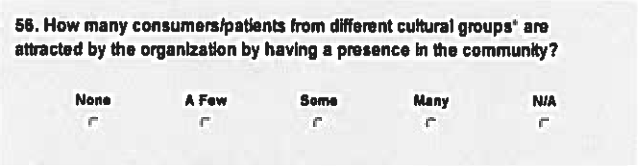
54. The confidentiality requirements (with the incorporation of the values of consumers/patients, including decisions about services) does not present a barrier to care.

Not at All	Seldom	Sometimes	Often	N/A
○	○	○	○	○



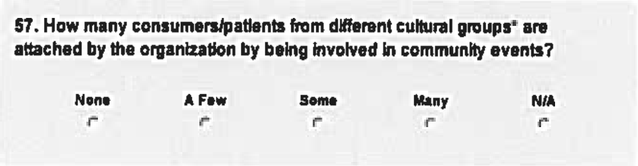
55. Are the consumers/patients asked:

	Not At All	Seldom	Sometimes	Often	N/A
Why are they here for services?	○	○	○	○	○
[redacted]					
What were their previous efforts to obtain and use help?	○	○	○	○	○
[redacted]					
How do you know that your condition has improved? (i.e., consumers/patients are given the opportunity to verbalize their own measures of "feeling better" – this does not mean accomplishing goals and objectives in the plan of care.).	○	○	○	○	○



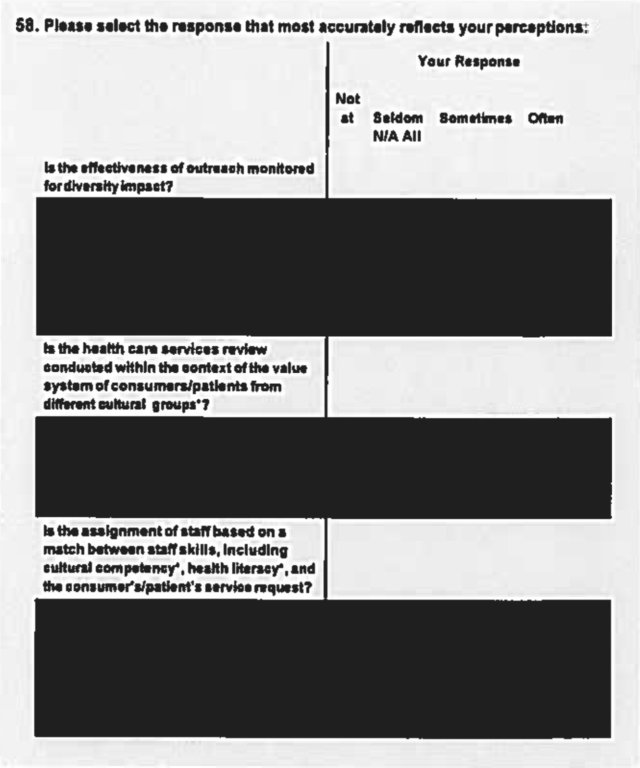
56. How many consumers/patients from different cultural groups* are attracted by the organization by having a presence in the community?

None	A Few	Some	Many	N/A
○	○	○	○	○



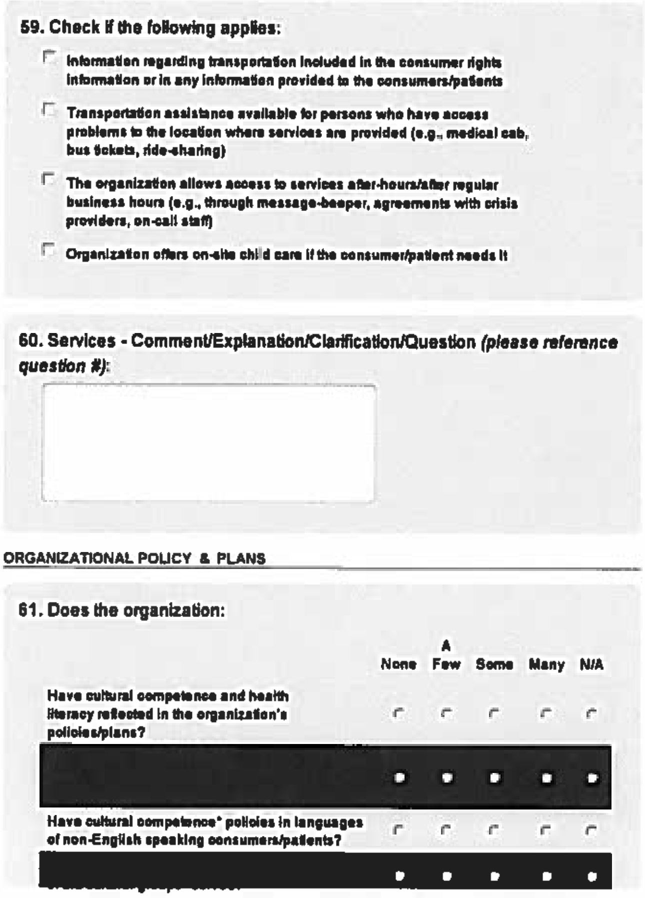
57. How many consumers/patients from different cultural groups* are attached by the organization by being involved in community events?

None	A Few	Some	Many	N/A
○	○	○	○	○



58. Please select the response that most accurately reflects your perceptions:

	Your Response				
	Not at All	Seldom	Sometimes	Often	N/A
Is the effectiveness of outreach monitored for diversity impact?					
[redacted]					
Is the health care services review conducted within the context of the value system of consumers/patients from different cultural groups*?					
[redacted]					
Is the assignment of staff based on a match between staff skills, including cultural competency*, health literacy*, and the consumer's/patient's service request?					
[redacted]					



59. Check if the following applies:

- ☐ Information regarding transportation included in the consumer rights information or in any information provided to the consumers/patients
- ☐ Transportation assistance available for persons who have access problems to the location where services are provided (e.g., medical cab, bus tickets, ride-sharing)
- ☐ The organization allows access to services after-hours/after regular business hours (e.g., through message-beeper, agreements with crisis providers, on-call staff)
- ☐ Organization offers on-site child care if the consumer/patient needs it

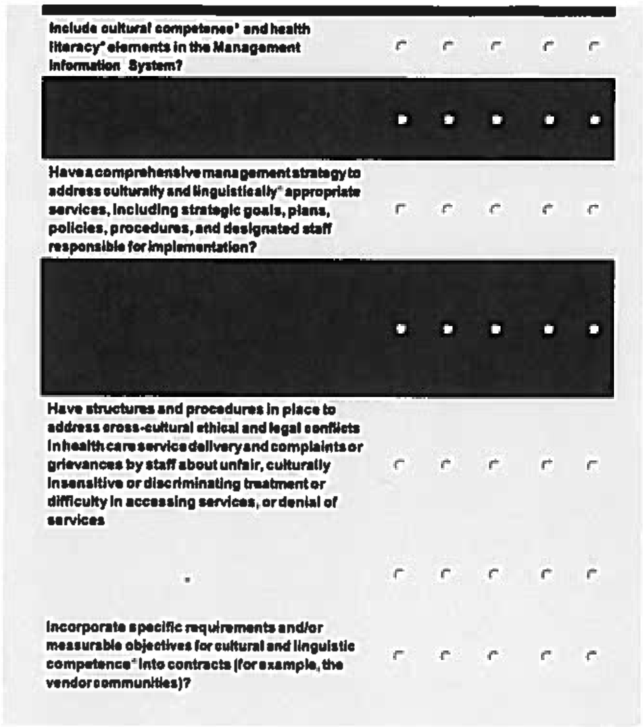
60. Services - Comment/Explanation/Clarification/Question ***(please reference question #)*****:**

☐

ORGANIZATIONAL POLICY & PLANS

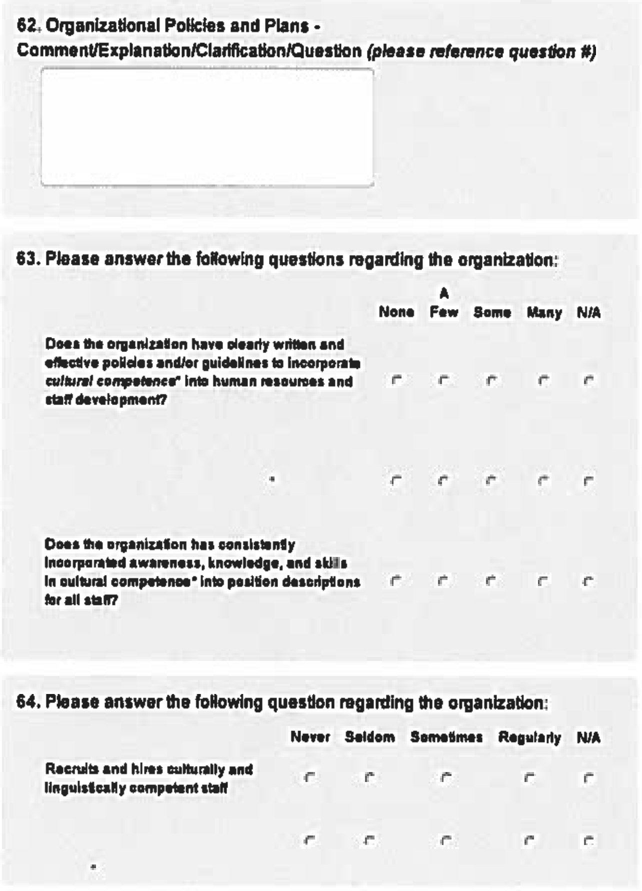
61. Does the organization:

	None	A Few	Some	Many	N/A
Have cultural competence and health literacy reflected in the organization's policies/plans?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Have cultural competence* policies in languages of non-English speaking consumers/patients?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]



[redacted]

Include cultural competence* and health literacy* elements in the Management Information System?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Have a comprehensive management strategy to address culturally and linguistically* appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation?	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Have structures and procedures in place to address cross-cultural ethical and legal conflicts in health care service delivery and complaints or grievances by staff about unfair, culturally insensitive or discriminating treatment or difficulty in accessing services, or denial of services	○	○	○	○	○
*	○	○	○	○	○
Incorporate specific requirements and/or measurable objectives for cultural and linguistic competence* into contracts (for example, the vendor communities)?	○	○	○	○	○



62. Organizational Policies and Plans - Comment/Explanation/Clarification/Question ***(please reference question #)***

☐

63. Please answer the following questions regarding the organization:

	None	A Few	Some	Many	N/A
Does the organization have clearly written and effective policies and/or guidelines to incorporate *cultural competence** into human resources and staff development?	○	○	○	○	○
*	○	○	○	○	○
Does the organization has consistently incorporated awareness, knowledge, and skills in cultural competence* into position descriptions for all staff?	○	○	○	○	○

64. Please answer the following question regarding the organization:

	Never	Seldom	Sometimes	Regularly	N/A
Recruits and hires culturally and linguistically competent staff	○	○	○	○	○
*	○	○	○	○	○

Recruits and hires staff with bilingual* skills	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Recruits and hires natural helpers or other non-credentialed individuals from the cultural groups* served by the organization as para-professionals	○	○	○	○	○
*	○	○	○	○	○
Disseminates employee orientation information that includes the organization's policy on cultural and linguistic competence*	○	○	○	○	○
*	○	○	○	○	○
Has and disseminates culturally competent* training materials	○	○	○	○	○
* *	○	○	○	○	○
Has cultural competence* and health literacy* training as an on-going practice including methods of evaluation, feedback, and accountability	○	○	○	○	○
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

The organization staff routinely discuss barriers to working across cultures	○	○	○	○	○
*	○	○	○	○	○

65. The organization has administrative/management staff that are representative of the consumers'/patients' cultures and languages

None	A Few	Some	Many	N/A
○	○	○	○	○

68. The organization's allocation of fiscal resources is sufficient to meet the unique needs and preferences of culturally and linguistically diverse populations through: ***(check all that apply)***

☐ The delivery of services and supports

☐ The collection and analysis of data categories that are useful and reflect the actual diversity among cultural groups* in the service area/region

☐ Program monitoring, quality assurance, and evaluation

☐ Annual consumer/patient satisfaction survey

☐ Annual staff satisfaction surveys

☐ Feedback mechanisms are in place to facilitate necessary budgetary adjustments

69. Fiscal Support - Comment/Explanation/Clarification/Question ***(please reference question #):***

OUTCOMES REGARDING CULTURAL COMPETENCE

66. Please answer the following questions regarding the organization:

	Never	Seldom	Sometimes	Regularly	N/A
Incorporates awareness, knowledge, and skills in cultural competence* into performance appraisals for all staff	○	○	○	○	○
*	○	○	○	○	○
Incorporates cultural competence* into all continuing professional education, and other training sessions offered, to clinical and other professional staff	○	○	○	○	○
*	○	○	○	○	○
Includes cultural competence* and health literacy* training in the organization's fiscal management	○	○	○	○	○

FISCAL SUPPORTS

67. The organization has clearly written, consistently implemented and effective policies/and or guidelines to incorporate *cultural competence into the allocation of fiscal resources that address the needs of culturally and linguistically diverse groups.**

None	A Few	Some	Many	N/A
○	○	○	○	○

70. SATISFACTION SURVEYS

The organization collects the following as it relates to staff: ***(check all that apply)***

☐ Staff satisfaction surveys regarding employment

☐ Grievances/complaints

☐ Retention rates of "minority" employees

☐ Employee attrition

☐ Staff disciplinary actions

☐ The above data broken is out by race/ethnicity, gender and age

☐ Staff satisfaction survey is conducted annually

☐ Staff satisfaction survey is anonymous

☐ Staff satisfaction survey addresses cultural concerns as it relates to the working environment

71. Consumer/patient satisfaction surveys are conducted: ***(check all that apply)***

☐ In person

☐ In writing

☐ Telephone surveys *(NOTE: when telephone surveys are used it should be performed by an "outside" objective group and the consumers/patients anonymity should be protected)*

72. Satisfaction Surveys

	Not at All	Seldom	Sometimes	Often	N/A
Outcome data is analyzed and summarized for specific cultural groups* within programs/organization *(at a minimum by race/ethnicity, gender, and age, preferred language)*	○	○	○	○	○
[redacted]	●	●	●	●	●
Results of staff satisfaction survey are reviewed with the Cultural Competence Committee	○	○	○	○	○
[redacted]	●	●	●	●	●
Results of the staff satisfaction survey are reviewed by the Quality Assurance/Quality Improvement team	○	○	○	○	○
[redacted]	●	●	●	●	●
Consumer/patient satisfaction surveys are a key feature of program evaluation	○	○	○	○	○

SERVICE QUALITY EVALUATION

73. The Quality Assurance/Quality Improvement team includes consumers from the cultural groups* of the service population* *(including, but not limited to, consumers of color)* and culturally competent staff

Not At All	Seldom	Sometimes	Often	N/A
○	○	○	○	○

74. If gaps in the quality of services are delivered and discovered through the review of data, corrective actions and other monitoring processes are identified, implemented, evaluated to assure compliance and quality.

Not at all	Seldom	Sometimes	Often	N/A
○	○	○	○	○

75. Outcome Data Collection

	Not At All	Seldom	Sometimes	Often	N/A
Utilization patterns are collected – types of formal services used by the different cultural groups	○	○	○	○	○
[redacted]	●	●	●	●	●
The organization assesses consumer's/patient's cultural attributes and takes initiative to address non-medical barriers by providing appropriate referrals or extra support as needed	○	○	○	○	○
[redacted]	●	●	●	●	●

76. The organization assesses evidence of consumer/patient retention as evidenced by: *(check all that apply)*

☐ No-Show rates

☐ Drop-Out rates

☐ Other - Write In

77. Outcome data on cultural user groups are transmitted to:

	Not at All	Seldom	Sometimes	Often	N/A
The QA/QI department/team/staff	○	○	○	○	○
[redacted]	●	●	●	●	●
Person designated and responsible for the organization's cultural competence*	○	○	○	○	○
[redacted]	●	●	●	●	●
The organization uses the data collected above to identify and or modify goals and objectives to eliminate racial and ethnic disparities among the consumers/patients having difficulties are seeking help	○	○	○	○	○

78. Service Quality - Comment/Explanation/Clarification/Question (please reference question #):

HEALTH LITERACY

79. Health Literacy

	Never	Seldom	Sometimes	Regularly	N
Does the organization decide which information and services work best with different situations and people?	○	○	○	○	
[redacted]	●	●	●	●	
[redacted]					
Does the organization assess whether staff has the appropriate competency regarding health literacy*?	○	○	○	○	
[redacted]	●	●	●	●	
Does the organization monitor staff progress to increase their health literacy competency?	○	○	○	○	
	○	○	○	○	
Does the organization confirm the health literacy* level of understanding of the consumer/patient at all points of contact?	○	○	○	○	
[redacted]	●	●	●	●	
Does the organization design and distribute printed content to the consumer/patient that is in their preferred language*?	○	○	○	○	
[redacted]	●	●	●	●	
Does the organization design and distribute, and display* *(in consumer/patient common areas, like waiting rooms, examine rooms, reception areas)* audiovisual content to the consumer/patient that is easy to understand and act on?	○	○	○	○	
[redacted]	●	●	●	●	
Does the organization address health literacy* in high-risk situations, including care transitions and communication about medications?	○	○	○	○	

[redacted]	●	●	●	●
At all levels of the organization has staff agreed to support changes to improve consumers/patient understanding?	○	○	○	○
[redacted]	●	●	●	●
Does staff avoid using medical jargon when communicating with consumers/patients *(e.g., not using words like anticoagulant, hypertension, NPO)*?	○	○	○	○
[redacted]	●	●	●	●
Does staff ask consumers/patients to state key points in their own words *(i.e., teach-back method)* to assess understanding of care instructions?	○	○	○	○
[redacted]	●	●	●	●
Is the name of the organization/practice/department/program clearly displayed on the outside of the building and front door?	○	○	○	○
[redacted]	●	●	●	●
Does staff review medications with consumers/patients at least annually and after any significant medical event to ensure concordance between patient and clinical recommendations?	○	○	○	○
[redacted]	●	●	●	●

[redacted]				
Does staff contact consumer/patient between office visits to ensure understanding or to follow up on plans made during the visit?	○	○	○	○

80. Health Literacy - Comment/Explanation/Clarification/Question *(please reference question #)*

CCHL ORGANIZATIONAL SELF-ASSESSMENT – Process and Format

81. What are your comments, questions, feedback regarding this CCHL Organizational Self-Assessment Tool process and/or format?

82. Do you have any concerns or requests for technical assistance as you plan your organizational strategies for further integrating cultural competence and health literacy into internal structures, policy/practices, and service delivery?

FLPPS
FINGER LAKES PERFORMING
PROVIDER SYSTEM

Organizational
Cultural Competence (CC) &
Health Literacy (HL) Self-Assessment Tool

2015 Partner Themes & Recommendations

Introduction

The Organizational Cultural Competence (CC) and Health Literacy (HL) Self-Assessment Tool, which was developed by Coordinated Care Services, Inc. (CCSI) on behalf of Finger Lakes Performing Provider System (FLPPS), was administered to a total of 37 partner organizations, of which 36 submitted this assessment during November and early December (See Attachment 1). The initial group of participating partners represented a cross-section of FLPPS network partners, consisting of physical health, behavioral health and community-based organizations. Data from this process were analyzed to identify common themes and current gaps, and then used to guide the goals and activities in the CC/HL Strategic Plan.

The Organizational CC & HL Self-Assessment Tool is designed to:

- Serve as a Self-Assessment to Guide and Evaluate Cultural Competence and Health Literacy Within Your Organization
- Provide Essential Information Concerning Your Organization's Structure and Function
- Serve as a Data Collection Tool which will Support Database Development
- Provide Organizations with a Series of Questions That Can Help Continue the Performance Improvement and Management Journey
- Serve as a Roadmap for Organizations to Improve the Organization's Cultural Competence and Health Literacy Serve as a Process Document to develop a Culturally Competent Strategic Plan – Short, Medium and Long-Term Goals
- Assist FLPPS in meeting the CC/HL deliverables. To transform the way health care is delivered to more than 300,000 Medicaid beneficiaries in the Finger Lakes region through:
    - Improved access to quality primary, behavioral health, and preventative health care
    - Reduction in avoidable emergency room visits
    - Addressing and Achieving Health Equity and the Elimination of Health Disparities

Furthermore, this CC/HL Self-Assessment process will aid the Partner with:

- Identifying successes and opportunities for improvements
- Jump-starting a change initiative or energize current initiatives
- Energizing their workforce
- Focusing the organization on common goals
- Aligning their resources with organizational strategic objectives
- Delivering world-class results

Network Need

We are extremely appreciative of the 37 partner organizations representing a cross-section of FLPPS network partners, consisting of physical health, behavioral health and community-based organizations, who initiated the Organizational Cultural Competence and Health Literacy Assessment, which 36 submitted the 43-page assessment tool during the months of November 2015 and early December 2015. We recognize the significant amount of effort devoted to the thoughtful completion of the assessment tool. Data from this process were analyzed to identify common themes and current gaps. The themes that emerged from this initial wave of responses were extremely helpful in shaping, guiding and prioritizing the goals and activities outlined in FLPPS CC/HL Strategic Plan.

After analyzing and reviewing the Wave 1 Group of Partners' responses that completed the Organizational CC/HL Self-Assessment Tool, findings suggest that FLPPS Partners will require access to consultation, translation of materials, standardize templates of critical forms, professional development and training curricula, and an IT infrastructure that will support the infusion of cultural competence and health literacy into the FLPPS network.

Integrating CC/HL into the Organization

Although most Partners do not have a budget or an assigned individual whose responsibility it is to facilitate the adoption and weaving of CC/HL concepts and principles into the organization's infrastructure and service delivery, there is a certain level of interest and commitment to getting a better understanding of cultural competence and health literacy, and willingness to work with FLPPS to incorporate these principles. Partners recognized that the CC/HL process requires a deeper view into the organizational structures, processes, and practices. Many Providers expressed their readiness to embrace the opportunity that this CC/HL Self-Assessment experience would provide them. Within the responses, it resonated that cultural competence and health literacy was never a "serious" priority from other funders, and the support that FLPPS will provide was never offered on such a large scale before.

The approaches to support CC/HL within the Partner organizations were often informal, nuanced and detached/segmented efforts. Organizational considerations and activities for cross-cultural and health literate ethical and legal structures and processes will need to be more formally infused and integrated into the organizational culture, practices, policies, and procedures.

RECOMMENDATIONS:

1. ***CC/HL Strategic Planning (initiating and incorporating CC/HL within the organization)***
    a) *Provide template examples of the elements of a CC/HL Strategic Plan*
    b) *Discuss the connection of CC/HL to all aspects of the organization*

   c) *Review the organization's Vision and Mission statement and ensure that CC/HL are included in the language*
   d) *Identify the core competencies as they exist within the organizations and areas in which require support, and improvement to generate goals for the plan*
   e) *Technical assistance with effective execution of the activities described in the plan*
2. ***Organizational Governing Board***
   a) *Development: recruitment of members that represent the service population and consumer/patient amongst the membership.*
   b) *Processes: establish the role of the Board as it relates to CC/HL governance within the organization*
   c) *Purpose: Increase knowledge of CC/HL of the Board to equip them with an understanding of the organization's purpose, targeted service population, service array, strategic partners, etc., and how all of this connects to the culture of the community it serves and the organization's mission and goals*
3. ***Partners require assistance with drafting language that establishes and formalizes CC/HL into the organization through written policies, specifically: HR, Fiscal/Budgetary, Services, Outcomes, IT, Governance, Contractors/Vendors, etc.***
4. ***Assistance with establishing processes to monitor and evaluate the implementation of the policy and its impact on the organizational community and service population.***

Community Profile Assessment

Partners reported high levels of discomfort in asking the cultural attributes of their patients, due to the sense of being intrusive, offensive, or unclear of the reasoning/value, not required to ask, or unsure how to ask. For example, information about a patient's sexual orientation, gender identity, religion/spirituality, race, and ethnicity were seen as offensive, and very often individuals completing the survey did not see how the answers to these questions related to providing services. Some Partners even questioned if it was legal to ask these questions.

A moderate percentage of the Partners collected a minimum set of cultural attributes; however, several did not collect any, and a significant amount did not collect nor connect the importance of the social determinants of health to the patient's experience, equitable care and great outcomes.

Partners could not "profile" who was in their population of focus. Patients were mostly identified by the type of health care insurance they had and in homogeneous groupings. The majority of Partners in the rural counties initially thought that there was no need for cultural competence, because over 90 percent of their population was White/Caucasian. However, once they were engaged in conversations around granularity and social determinants of health they quickly agreed and saw value in CC/HL. Of special note, even for those Partners who collected some data on cultural attributes, they could not identify their vulnerable groups or priority populations. Data was not disaggregated nor stratified by cultural attributes. Therefore disparities in health care were not identified nor tracked.

RECOMMENDATIONS:

5. ***Data Collection and Analysis Training***
    - *Methods: interviews, surveys, forms, experiments and testing, direct observation, etc.*
    - *Recording: demographics, language, reading levels, service use, no call/no show rates, follow-up appointment, cultural attributes, supports (family and community), outcomes, etc.*
    - *Analysis: Purpose and benefit (meaningful use).*

Language Accommodations

There were a few Partners especially those in the rural counties and serving the Migrant population that made great efforts of providing services in the patient's preferred language or referring patients to someone who can accommodate their language needs. However, for the most part, although there was a general sense that there were individuals in their service area who have Limited English Proficiency (LEP) there was not any certainty as to what languages other than Spanish that were spoken by patients in the service area.

RECOMMENDATIONS:

6. ***Community Assessment of current and emerging languages within the FLPPS region.***
7. ***Data collection of languages and cultures present within NOCNs.***
8. ***Effective policies/and or guidelines to incorporate linguistic competence into the allocation of fiscal resources that address the needs of culturally and linguistically diverse groups.***
9. ***Credentialing (CCHI – Certification Commission for Healthcare Interpreters, National Board of Certification for Medical Interpreters, RID – Registry of Interpreters for the Deaf, etc.).***

Human Resources

Having a staff reflective of the population served is a challenge for most. We recognize that this will be a challenge for almost all of our Partners. However, possessing a clear understanding of cultural attributes of the population served will give Partners an indication of attributes they should be recruiting for in their staff, contractors/ vendors, and volunteers. There was not a consistency in identified training participation that would address these region-wide challenges – identifying priority groups; identifying cultural attributes of the service population; modifying/tailoring services that are culturally relevant and appropriate; ensuring that social determinants of health are considered in service delivery - that allows for the enhancement of patient experience and equitable outcomes. There were not many established mechanisms in place to keep current staff updated on changes in demographics within the population of focus and the region. For those Partners that have delineated Human Resource functions did not have CC/HL in policies, procedures, job descriptions or performance appraisals. Partners will require substantial support to address these needs. Working with FLPPS to embed CC/HL into their organizations will be essential for Partners to have a workforce that can deliver culturally relevant and appropriate services.

RECOMMENDATIONS:

10. ***Understanding of Health Literacy and creating environments that supports health equity to eliminate disparities within the network***
11. ***Other training topics as derived from on-going assessment of the needs and gaps in the knowledge/skills/awareness/understanding of the providers and their respective workforce***

Performance Measurement

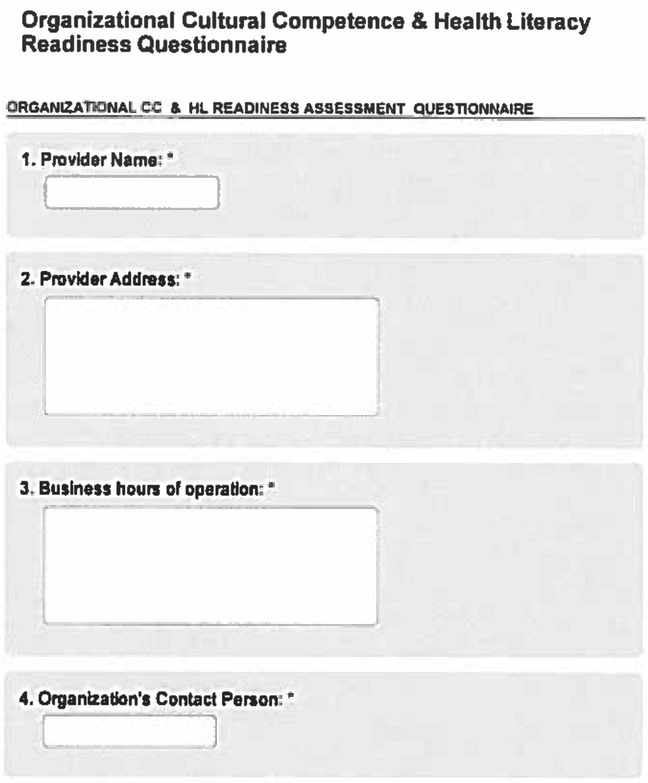
A limited number of the partners have a continuous quality improvement process in place. Even for those who have, minimal attention is paid to the review of services and ensuing outcomes by cultural attributes and priority groups. Particular attention must be paid to the implementation, monitoring and evaluation of services to ensure that services meet the clients' need. FLPPS must support partners through learning collaborative and dedicated training that will allow them to apply/ensure these processes within their organization.

RECOMMENDATIONS:

12. ***Review and analysis should be conducted by the organization's internal QA/QI, Patient/Consumer Advisory Board, CC/HL Committee, in conjunction with management and Board of Directors***

Attachment 1

	WAVE 1 - PARTNER LIST	NOCN	SUBMITTED ASSESSMENT TOOL
1	Hickok Center for Brain Injury	Monroe	✓
2	Wayne ARC [Parent]	Finger Lakes	✓
3	Planned Parenthood of Central and Western New York, Inc. [Parent]	Monroe	✓
4	Liberty Resources, Inc.	Monroe	✓
5	Canisteo (aka Bruce MacKellar MD PC)	Southeastern	✓
6	East House Corporation [Parent]	Monroe	✓
7	Wyoming County Community Health System (WCCH) [Parent]	Western	✓
8	PART OF UR MEDICINE	Monroe	✓
9	Lakeview Mental Health Services, Inc.	Finger Lakes	✓
10	Trillium Health [Parent]	Monroe	✓
11	Family Services of Chemung County [Parent]	Southeastern	✓
12	Steuben County [Parent]	Southeastern	✓
13	Legal Assistance of Western New York, Inc. (LawNY) - Rochester	Monroe	✓
14	Monroe Community Hospital	Monroe	✓
15	The Healing Connection, Inc.	Monroe	✓
16	Finger Lakes Community Health [Parent]	Finger Lakes	✓
17	Genesee Council on Alcoholism and Substance Abuse, Inc. [Parent]	Western	✓
18	Crest Manor Living & Rehabilitation Center	Monroe	✓
19	YMCA of Rochester & Monroe County	Monroe	✓
20	CareFirst NY, Inc.	Southeastern	✓
21	Gerould's Professional Pharmacy, Inc. [Parent]	Southeastern	✓
22	Finger Lakes Addictions Counseling and Referral Agency, Inc. (FLACRA) [Parent]	Finger Lakes	✓
23	Episcopal Church Home	Monroe	✓
24	Ardent (Allegany/Western Steuben Rural Health Network, Inc.)	Southern	✓
25	Villa of Hope [Parent]	Monroe	✓
26	Finger Lakes Health [Parent]	Finger Lakes	✓
27	Wayne County Action Program, Inc.	Finger Lakes	✓
28	Ibero-American Action League	Monroe	✓
29	S2AY Rural Health Network, Inc.	Southeastern	✓
30	Genesee Region Home Care Association [Parent]	Western	✓
31	Allegany Rehabilitation Associates (ARA) [Parent]	Southern	✓
32	Jewish Home of Rochester	Monroe	✓
33	Rochester Primary Care Network d/b/a Regional Primary Care Network (Rushville)	Monroe	✓
34	Newark-Wayne ED.	Monroe	✓
35	Charles Settlement House	Monroe	Not Submitted
36	UR Medicine [Parent]	Monroe	✓
37	Rochester Regional Health Office of Community Medicine	Monroe	✓



Organizational Cultural Competence & Health Literacy Readiness Questionnaire

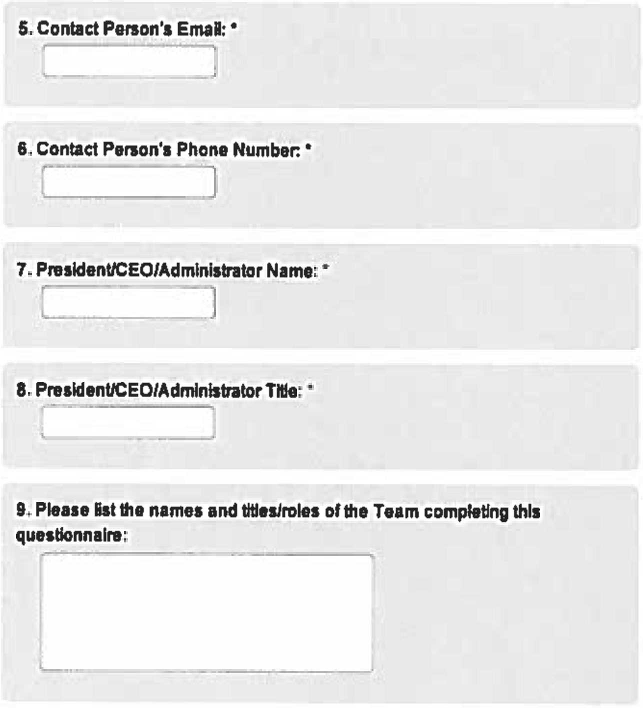
ORGANIZATIONAL CC & HL READINESS ASSESSMENT QUESTIONNAIRE

1. Provider Name: *

2. Provider Address: *

3. Business hours of operation: *

4. Organization's Contact Person: *



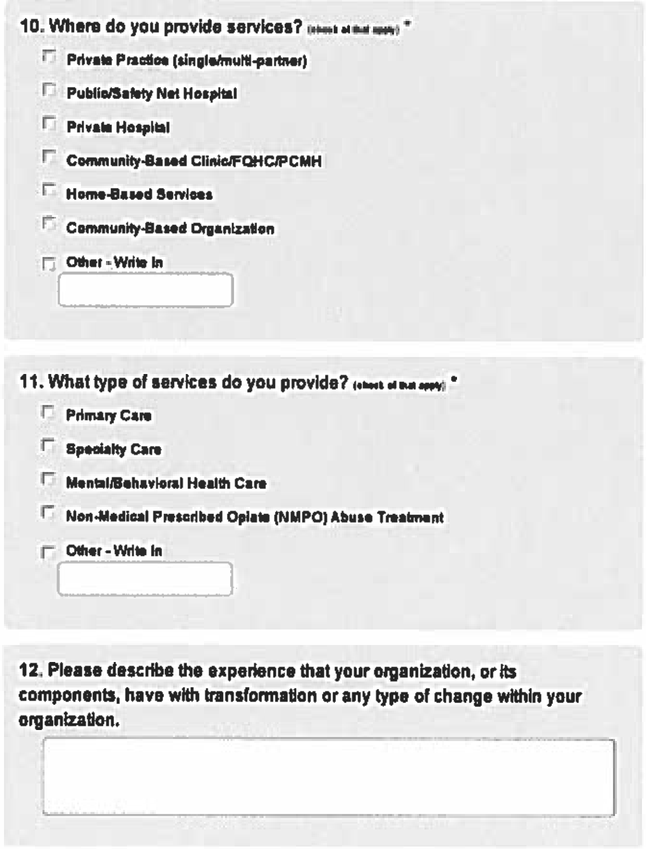
5. Contact Person's Email: *

6. Contact Person's Phone Number: *

7. President/CEO/Administrator Name: *

8. President/CEO/Administrator Title: *

9. Please list the names and titles/roles of the Team completing this questionnaire:



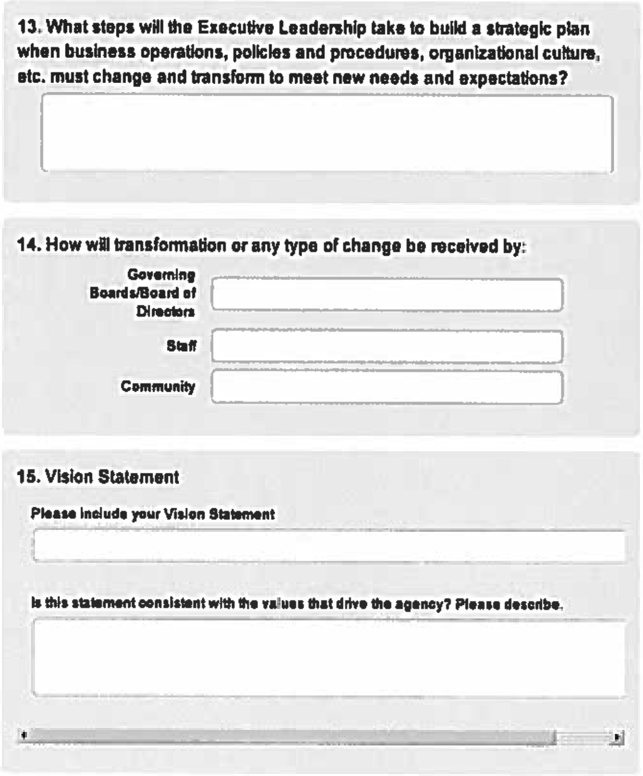
10. Where do you provide services? (check all that apply) *

- ☐ Private Practice (single/multi-partner)
- ☐ Public/Safety Net Hospital
- ☐ Private Hospital
- ☐ Community-Based Clinic/FQHC/PCMH
- ☐ Home-Based Services
- ☐ Community-Based Organization
- ☐ Other - Write In

11. What type of services do you provide? (check all that apply) *

- ☐ Primary Care
- ☐ Specialty Care
- ☐ Mental/Behavioral Health Care
- ☐ Non-Medical Prescribed Opiate (NMPO) Abuse Treatment
- ☐ Other - Write In

12. Please describe the experience that your organization, or its components, have with transformation or any type of change within your organization.



13. What steps will the Executive Leadership take to build a strategic plan when business operations, policies and procedures, organizational culture, etc. must change and transform to meet new needs and expectations?

14. How will transformation or any type of change be received by:

Governing Boards/Board of Directors

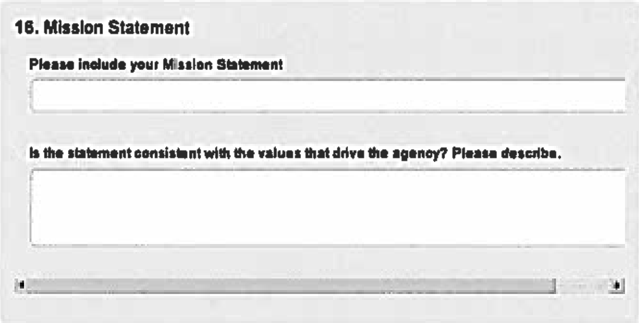
Staff

Community

15. Vision Statement

Please include your Vision Statement

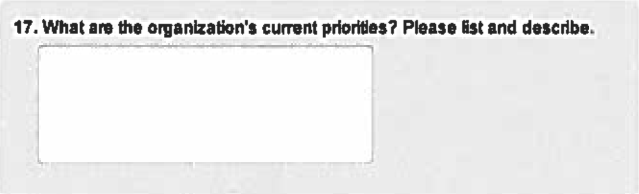
Is this statement consistent with the values that drive the agency? Please describe.



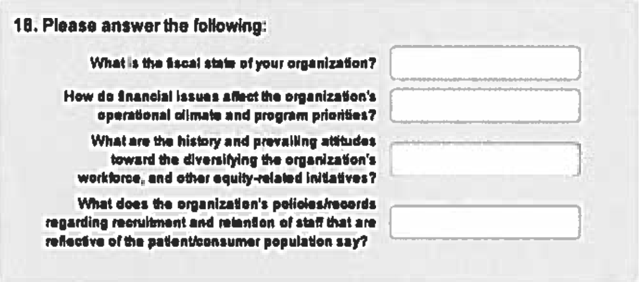
16. Mission Statement

Please include your Mission Statement

Is the statement consistent with the values that drive the agency? Please describe.



17. What are the organization's current priorities? Please list and describe.



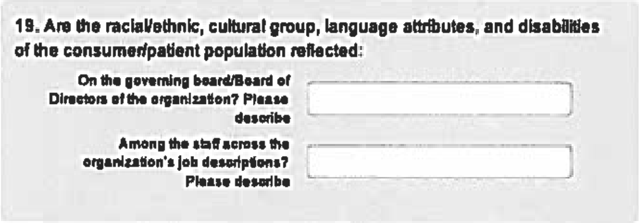
18. Please answer the following:

What is the fiscal state of your organization?

How do financial issues affect the organization's operational climate and program priorities?

What are the history and prevailing attitudes toward the diversifying the organization's workforce, and other equity-related initiatives?

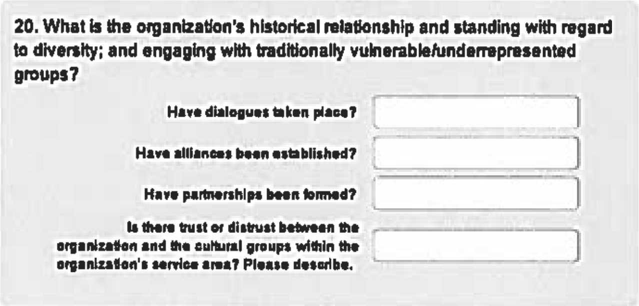
What does the organization's policies/records regarding recruitment and retention of staff that are reflective of the patient/consumer population say?



19. Are the racial/ethnic, cultural group, language attributes, and disabilities of the consumer/patient population reflected:

On the governing board/Board of Directors of the organization? Please describe

Among the staff across the organization's job descriptions? Please describe



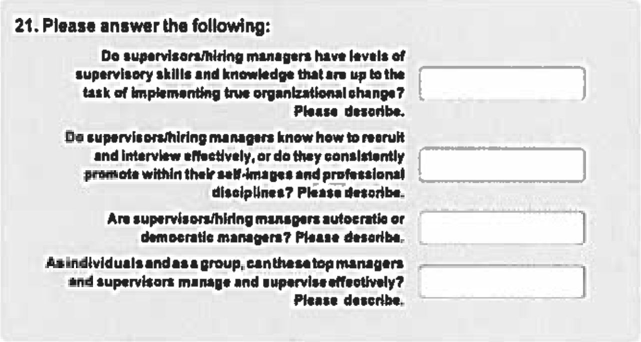
20. What is the organization's historical relationship and standing with regard to diversity; and engaging with traditionally vulnerable/underrepresented groups?

Have dialogues taken place?

Have alliances been established?

Have partnerships been formed?

Is there trust or distrust between the organization and the cultural groups within the organization's service area? Please describe.



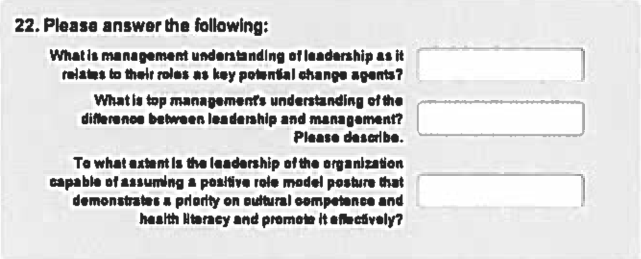
21. Please answer the following:

Do supervisors/hiring managers have levels of supervisory skills and knowledge that are up to the task of implementing true organizational change? Please describe.

Do supervisors/hiring managers know how to recruit and interview effectively, or do they consistently promote within their self-images and professional disciplines? Please describe.

Are supervisors/hiring managers autocratic or democratic managers? Please describe.

As individuals and as a group, can these top managers and supervisors manage and supervise effectively? Please describe.

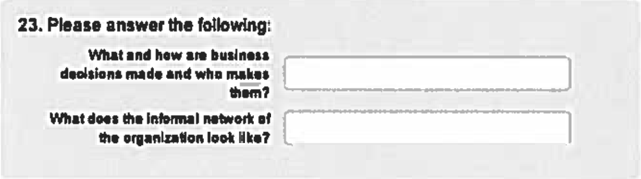


22. Please answer the following:

What is management understanding of leadership as it relates to their roles as key potential change agents?

What is top management's understanding of the difference between leadership and management? Please describe.

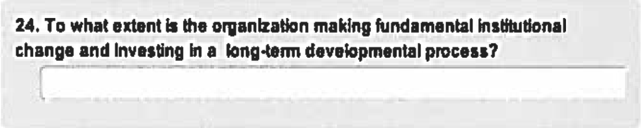
To what extent is the leadership of the organization capable of assuming a positive role model posture that demonstrates a priority on cultural competence and health literacy and promote it effectively?



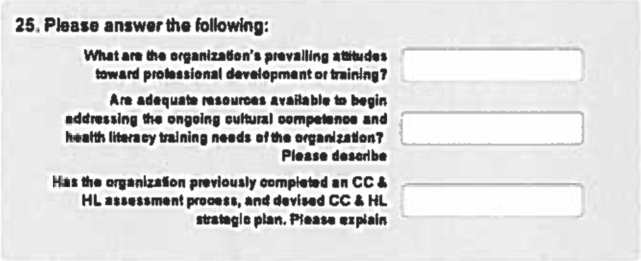
23. Please answer the following:

What and how are business decisions made and who makes them?

What does the informal network of the organization look like?



24. To what extent is the organization making fundamental institutional change and investing in a long-term developmental process?

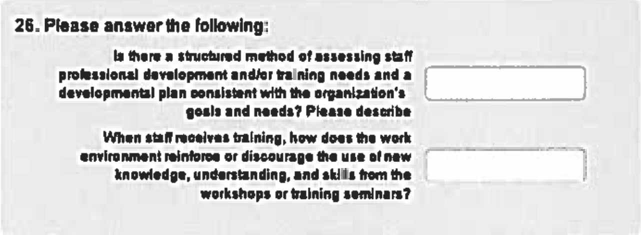


25. Please answer the following:

What are the organization's prevailing attitudes toward professional development or training?

Are adequate resources available to begin addressing the ongoing cultural competence and health literacy training needs of the organization? Please describe

Has the organization previously completed an CC & HL assessment process, and devised CC & HL strategic plan. Please explain



26. Please answer the following:

Is there a structured method of assessing staff professional development and/or training needs and a developmental plan consistent with the organization's goals and needs? Please describe

When staff receives training, how does the work environment reinforce or discourage the use of new knowledge, understanding, and skills from the workshops or training seminars?

27. Please answer the following:

What are the organization's resources for evaluating programs? Please describe.	
What are some of the data elements in your management information system? Please list.	
Do these elements include the social determinants of health?	

Selected Performance Measures for FLPPS CC/HL Dashboard

Selected Performance Measure for FLPPS CC/HL Dashboard	Description	Source	Reportable for DSRIP Project	Detail Required	Reference Page in Delivery System Reform Incentive Payment (DSRIP):
Age-adjusted preventable hospitalizations rate per 10,000	To track the reduction in reliance on inpatient services by FLPPS region over time.	FLPPS/DSRIP Medicaid Spending on ER and Inpatient Services; Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	4.a.iii.; 4.b.ii	Calculated and displayed for each vulnerable population	48
Potentially avoidable Emergency Room Visits	To track the reduction in reliance on ER use by the FLPPS region over time	FLPPS/DSRIP Potentially Avoidable Emergency Room Visits	2.a.i.; 2.b.iii.; 2.b.iv; 2.b.vi	Calculated and displayed for each vulnerable population	25
Follow-up after hospitalization for mental illness - within 7 days & within 30 days (composite of 2 measures)	To assess the success of the FLPSS region in providing continuity of care for those discharged from a mental health inpatient admission	FLPPS/DSRIP Follow-up after hospitalization for Mental Illness - within 30 days; Follow-up after hospitalization for Mental Illness - within 7 days	3.a.i.; 3.a.ii;3.a.v.	Calculated and displayed for each vulnerable population	34
Controlling High Blood Pressure	To track the percentage of population who are successful in controlling high blood pressure	FLPPS/DSRIP Controlling High Blood Pressure	Recommended by CC/HL committee due to high prevalence and impact on vulnerable populations	Calculated and displayed for each vulnerable population	38
Comprehensive Diabetes care/screening – All four tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor; composite of 2 measures)	To track the percentage of the population (with Diabetes) that is effectively managing the disease.	FLPPS/DSRIP Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%); Comprehensive Diabetes screening - All Three Tests (HbA1c, dilated eye exam, nephropathy monitor)	Recommended by CC/HL committee due to high prevalence and impact on vulnerable populations	Calculated and displayed for each vulnerable population	41
Screening for Clinical Depression and follow up	To track success in addressing clinical depression needs when identified in screening	FLPPS/DSRIP Screening for Clinical Depression and follow-up	3.a.i.; 3.a.ii;3.a.v.	Calculated and displayed for each vulnerable population	35
Well Care Visits in the first 15 months (5 or more visits)	To track the success of the region in linking newborns to health services	FLPPS/DSRIP Well Care Visits in the first 15 months (5 or more Visits)	3.f.i	Calculated and displayed for each vulnerable population	35
Initiation of Alcohol and Other Drug Dependence Treatment (initiation and 2 visits within 44 days; composite pl 2 measures)	To track success of system in engaging individual in Alcohol or Drug treatment when the need is identified	FLPPS/DSRIP Engagement of Alcohol and Other Drug Dependence Treatment (initiation and 2 visits within 44 days)	3.a.i.; 3.a.ii;3.a.v.	Calculated and displayed for each vulnerable population	35
Adult access to Preventive or Ambulatory Care 20 to 65 and older (composite of 3 measures)	To track the success of the region in linking adults to routine health services	FLPPS/DSRIP Adult Access to Preventive or Ambulatory Care - 20 to 44 years; Adult Access to Preventive or Ambulatory Care - 45 to 64 years; Adult Access to Preventive or Ambulatory Care -65 and older	2.a.i; 2.b.iii; 2.b.iv; 2.b.vi	Calculated and displayed for each vulnerable population	27
Patient experience survey (composite measure)	To track the success of the region in providing patients with an appropriate health care services experience (getting timely appointments, care and health information.	TBD-many items/measures exist within FLPPS/DSRIP (e.g., C&G CAHPS by PPS for uninsured)	Relevant to all, specific composite components reported to 2.d.i	Calculated and displayed for each vulnerable population	Multiple pages
Health Literacy (QHL13, 14 and 16)	To assess change in health literacy over time	FLPPS/DSRIP Health Literacy (QHL13, 14, and 16)	Recommended by CC/HL committee due to high impact on vulnerable	Calculated and displayed for each vulnerable population	40

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. 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.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

OMH U.S. Department of Health and Human Services Office of Minority Health

www.ThinkCulturalHealth.hhs.gov

THINK CULTURAL HEALTH

The Case for the Enhanced National CLAS Standards

> *Of all the forms of inequality, injustice in health care is the most shocking and inhumane.*
> *—Dr. Martin Luther King, Jr.*

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

Bibliography:

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://www.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). The economic burden of health inequalities in the United States. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

National Partnership for Action to End Health Disparities. (2011). National stakeholder strategy for achieving health equity. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care. Retrieved fromhttp://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020: Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

U.S. Department of Health and Human Services, Office of Minority Health (2011). National Partnership for Action to End Health Disparities. Retrieved from http://minorityhealth.hhs.gov/npa

World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/

Federal Plain Language Guidelines

March 2011

Revision 1, May 2011

PlainLanguage.gov

Improving Communication from the Federal Government to the Public

Introduction

The Plain Language Action and Information Network (PLAIN) is a community of federal employees dedicated to the idea that citizens deserve clear communications from government. We first developed this document in the mid-90s. We continue to revise it every few years to provide updated advice on clear communication. We hope you find this document useful, and that it helps you improve your writing — and your agency's writing — so your users can:

- find what they need,
- understand what they find; and
- use what they find to meet their needs.

We've divided the document into five major topics, although many of the subtopics fit within more than one topic. We start with a discussion of your audience because you should think about them before you start to write your document or your web content. In fact, you should start to think about them before you start to plan. From there we move to organization, because developing a good organization is important during your planning stage. Next, we discuss writing principles, starting at the word level and moving up through paragraphs and sections. This is the most extensive topic. We follow principles of writing documents with principles of writing for the web. We conclude with a short discussion of testing techniques.

When we first wrote this document, we were primarily interested in regulations. We've broadened our coverage, but the document still bears the stamp of its origin. If you have a suggestion about something we should add to address other types of writing, or have a comment on this edition, contact us at www.plainlanguage.gov/contactus.cfm.

Revision 1 Changes

We have not made any substantive changes in revision 1. We fixed the footer, corrected a few misspelled words, and modified our choice of words to be more concise. We made the formatting more consistent in Section V – Test. We added a few more references to outside publications. And, we changed the file name of this document to make it more descriptive and user-friendly.

Table of Contents

I. Think about your audience

One of the most popular plain language myths is that you have to "dumb down" your content so that everyone everywhere can read it. That's not true. The first rule of plain language is: ***write for your audience.*** Use language your audience knows and feels comfortable with. Take your audience's current level of knowledge into account. Don't write for an 8th grade class if your audience is composed of PhD candidates, small business owners, working parents, or immigrants. Only write for 8th graders if your audience is, in fact, an 8th grade class.

Make sure you know who your audience is – don't guess or assume.

a. Identify and write for your audience

You have to grab your audience's attention if you want to get your ideas across. Let's face it, people want to know just what applies to them. The best way to grab and hold someone's attention is to figure out who they are and what they want to know. Put yourself in their shoes; it will give you a new perspective. (Read Identify your users and their top tasks for more information.)

Tell your audience why the material is important to them. Say, "If you want a research grant, here's what you have to do." Or, "If you want to mine federal coal, here's what you should know." Or, "If you are planning a trip to Rwanda, read this first."

Identifying your audience will do more than ensure that you write clearly. It will also help you focus on the audience's needs. Start out by thinking about what your audience knows about the situation now. Then, think about how to guide them from their current knowledge to what you need them to know. To help you do this, try answering the following questions:

- Who is my audience?
- What does my audience already know about the subject?
- What does my audience need to know?
- What questions will my audience have?
- What's the best outcome for my agency? What do I need to say to get this outcome?
- What's the best outcome for our audience? What do I need to say to get this outcome?

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 93-96.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p.9.

b. Address separate audiences separately

An important part of writing for your audience is addressing separate audiences separately. Many documents address more than one audience. Documents that mix material intended for different audiences may confuse readers. By addressing different audiences in the same place, you make it harder for each audience to find the material that applies to them. In regulations, this may make it difficult for each audience to comply with your agency's requirements.

The following example shows a regulation that treats each regulated group separately in its own subpart, rather than mixing all the groups together in the same subpart. For an example of a rule that does not address separate groups separately, see 5 CFR 1320 (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=5:3.0.2.3.9&idno=5 this link takes a long time to load).

Title 40 — Protection of Environment

Chapter I — Environmental Protection Agency

Part 745 — Lead-Based Paint Poisoning Prevention In Certain Residential Structures

* * *

Subpart E — Residential Property Renovation

(Firms renovating structures)

* * *

745.84	Information distribution requirements.
745.85	Work practice standards.
745.86	Recordkeeping and reporting requirements.

* * *

Subpart F — Disclosure Of Known Lead-Based Paint And/Or Lead-Based Paint Hazards Upon Sale Or Lease Of Residential Property

(Sellers/Lessors)

745.107	Disclosure requirements for sellers and lessors.
745.110	Opportunity to conduct an evaluation.
745.113	Certification and acknowledgment of disclosure.

* * *

Subpart L — Lead-Based Paint Activities

(Training programs)

745.225	Accreditation of training programs: target housing and child-occupied facilities.
745.226	Certification of individuals and firms engaged in lead-based paint activities: target housing and child-occupied facilities.
745.227	Work practice standards for conducting lead-based paint activities: target housing and child-occupied facilities.

* * *

Subpart Q — State And Indian Tribal Programs

(States and Tribes)

* * *

745.324	Authorization of State or Tribal programs.
745.325	Lead-based paint activities: State and Tribal program requirements.
745.326	Renovation: State and Tribal program requirements.
745.327	State or Indian Tribal lead-based paint compliance and enforcement programs.

Sources

- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, p. 4.
- Redish, Janice C., *How to Write Regulations and Other Legal Documents in Clear English*, 1991, American Institutes for Research, Washington, DC, p. 17.

II. Organize

Organization is key. Start by stating the document's purpose and its bottom line. Eliminate filler and unnecessary content. Put the most important information at the beginning and include background information (when necessary) toward the end.

a. Organize to meet your readers' needs

People read documents and visit websites to get answers. They want to know how to do something or what happens if they don't do something and they want to gain this knowledge quickly-. Organize your document to respond to these concerns.

Think through the questions your audience is likely to ask and then organize your material in the order they'd ask them. For regulations and other complex documents, create a comprehensive table of contents. Your table of contents should be a reliable road map that users can follow to quickly find the information they need.

Chronological organization

Regulations frequently address processes. Chronological organization is best for process information: you fill out an application to get a benefit; you submit the application; the agency reviews the application; the agency makes a decision on the application. Present the steps chronologically, in the order your user and your agency will follow them. The table of contents below is organized in a logical sequence for a grant program.

Organized chronologically
Part 791–Gifted and Talented Students
Subpart A: How the Grant Program Works
Sec. 791.1 What is the Gifted and Talented Students Education Program? 791.2 Am I eligible for a grant? 791.3 What activities are appropriate for grant funding?
Subpart B: How to Apply for an Award
791.10 Where do I write to obtain a grant application? 791.11 What materials do I need to submit to be considered for a grant? 791.12 Where do I send my application?

Organized chronologically
791.13 When is my application due?
Subpart C: How the Secretary Makes an Award
791.20 How will the Secretary evaluate my application?
791.21 What selection criteria does the Secretary use?
Subpart D: Grantees' Rights and Responsibilities
791.30 Under what conditions may I use my grant award?
791.31 What are my responsibilities for serving students and teachers in private schools?

General first, exceptions, conditions, and specialized information later

Another useful organizing principle is to put general information first, with specialized information or exceptions to the general information later. That way the material that addresses most readers in most situations comes first. For some documents, this will work well along with a chronological organization. In others, it may be the primary organizing principle.

Here's an example of an administrative regulation that combines both organizing principles:

Organized chronologically, and with general first
Part 725 – Claims For Benefits Under The Federal Mine Safety And Health Act
General
725.1 What does this program cover?
725.2 What special terms do I need to know to understand this part?
Who is Covered
725.201 Who is entitled to benefits under this program?
725.202 How long can my benefits last?
725.203 Are my dependents entitled to benefits?
725.204 How long will their benefits last?

Organized chronologically, and with general first
725.205 Am I still eligible if I am convicted of a felony?
How to Apply for Benefits
725.301 How do I file a claim?
725.302 Can other people give evidence on my behalf?
725.303 Are there any time limits for filing my claim?
725.304 Can I modify or withdraw my claim?
How to Appeal Agency Decisions
725.401 Can I appeal a decision if I don't agree with it?
725.402 How do I file an appeal?
725.403 How long do I have to file an appeal?
725.404 What types of evidence must I submit?
725.405 What happens if I won't get a medical examination?

Limit levels to three or fewer

Crafting documents with four, five, or even more levels makes it difficult for your audience to keep track of where they are in the structure of your document. You should address this problem in your initial structuring of the document. Dividing your document into more pieces at the top levels should allow you to limit subdivisions below the major level to two. The Office of the Federal Register recommends that regulations contain no more than three levels, noting that more than three levels make regulations hard to read and use.

Address separate audiences separately

If you have more than one audience for your document, address each one separately. No one wants to have to wade through material meant for someone else. For more discussion of this issue, see the section Address separate audiences separately.

Sources

- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, p. 70 (C).
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 3-5.

- Office of the Federal Register, *Document Drafting Handbook*, 1998, §1-23, www.archives.gov/federal-register/write/handbook/ddh.pdf.
- Redish, Janice C., *How to Write Regulations and Other Legal Documents in Clear English*, 1991, American Institutes for Research, Washington, DC, pp. 12-21.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p. 15.

b. Address one person, not a group

Remember that even though your document may affect a thousand or a million people, you are speaking to the one person who is reading it. When your writing reflects this, it's more economical and has a greater impact.

Singular nouns and verbs prevent confusion about whether a requirement applies to individual users or to groups. In the following example, the user might think that each applicant must file applications at several offices.

Confusing plural	Clearer singular
Individuals and organizations wishing to apply must file applications with the appropriate offices in a timely manner.	You must apply at least 30 days before you need the certification. a. If you are an individual, apply at the State office in the State where you reside. b. If you are an organization, apply at the State office in the State where your headquarters is located.

In addressing a single person, you can avoid awkwardness by using "you" to address the user directly, rather than using "he or she" or "his or her."

Confusing plural	Clearer singular
The applicant must provide his or her mailing address and his or her identification number.	You must provide your mailing address and identification number.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, p. 114.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, p. 70.
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC, p. 62.

c. Use lots of useful headings

The best-organized document will still be difficult for users to follow if they can't see how it's organized. An effective way to reveal your document's organization is to use lots of useful headings. Headings are also critical for effective web pages (see Writing for the web). You should use headings liberally on the web to help your user accomplish top tasks.

Types of headings

There are three types of headings –

Type of heading	What it is	How it looks
Question Heading	A heading in the form of a question	Why Do We Use Headings?
Statement Heading	A heading that uses a noun and a verb	Headings Help Guide a Reader
Topic Heading	A heading that is a word or short phrase	Headings

Question Headings are the most useful type of heading, but only if you know what questions your audience would ask. Most people come to government documents with questions. If you know those questions, use them as headings. They will help the audience find the information they are looking for quickly. Using the question-and-answer format helps your audience scan the document and find specific information.

Statement Headings are the next best choice because they are still very specific.

Topic Headings are the most formal; many times management is more comfortable with them. But sometimes they're so vague that they just aren't helpful. Topic Headings such as "General," "Application," and "Scope" are so vague they may confuse the user. For example, "Application" might mean an application to your agency from someone reading your document. But it might as easily mean what the document applies to.

Short headings that aren't very helpful to the user	Informative headings capture the user's questions
§ 254.11 Indian Rights.	§254.11 How do the procedures in this part affect Indian rights?
§ 254.12 Applications.	§ 254.12 How do I apply for a grant under this part?
§ 254.13 Multi-tribal grants.	§ 254.13. When must I submit my application?
§ 254.14 Administrative requirements.	§ 254.14 Can a multi-tribal organization submit a single grant request?
§ 254.15 Appeals	§ 254.15 What special information do I need for an application by a multi-tribal organization?
	§ 254.16 Must each tribe in a multi-tribal organization submit certification forms and budgets?
	§ 254.17 If I receive a grant under this part, what requirements must I follow?
	§ 254.18 What reports must I submit after receiving a grant?
	§ 254.19 How can I appeal administrative actions under this part?

In the example above, the section headings in the right column are more informative than the short topic headings in the left column. Additionally, breaking the material into more sections allows us to capture the entire content of each section in its heading. A document with lots of informative headings is easy to follow because the headings break up the material into logical, understandable pieces.

Use headings to help develop your document's structure

It's often useful to start writing your document by developing the headings, structuring them to your audience's concerns. This approach can also reveal major groupings of information that you might want to identify with centered headings.

Broad topic headings are the first step in organizing the document	**Specific topics add the second level of organization**
Qualifications of permittees and lessees	Who may hold leases and permits? Can foreign citizens hold permits or leases? How do I file evidence of my qualifications? Can I amend my qualifications statement?
Bonding requirements	Must I file a bond with my permit or lease? Where do I file my bond? What types of bonds are acceptable? How does BLM establish bond amounts? When does BLM terminate my liability under a bond?

Headings can be too long

Headings should not be so long that they overwhelm the material in the section itself. Avoid headings with one-word answers. With rare exceptions, headings should be shorter than the content that follows them.

Heading overwhelms content	**Content should be longer than headings**
Do I have to file a newspaper notice of my activities before I begin operations? Yes.	**Must I publish a public notice?** You must publish a notice of your operations in a local newspaper before you begin.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, p.14-16.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, p. 70 (C).
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 10-12, 27.
- Office of the Federal Register, *Document Drafting Handbook*, 1998, MMR-2. www.archives.gov/federal-register/write/handbook/.

d. Write short sections

Short sections break up material so it appears easier to comprehend. Long, dense sections with no white space are visually unappealing, and give the impression your document is difficult to understand. Short sections appear easier to comprehend, and help you organize your document more effectively.

Short sections also give you more opportunity to insert informative headings in your material. Remember that boldface section headings give your reader the best roadmap to your document. Long sections are impossible to summarize meaningfully in a heading. When you write short sections, each heading can give the reader information about the entire contents of the section.

Long, dense paragraph	Shorter paragraphs, easier to follow
§ 2653.30 Native group selections. (a) Selections must not exceed the amount recommended by the regional corporation or 320 acres for each Native member of a group, or 7,680 acres for each Native group, whichever is less. Native groups must identify any acreage over that as alternate selections and rank their selections. Beyond the reservations in sections 2650.32 and 2650.46 of this Part, conveyances of lands in a National Wildlife Refuge are subject to the provisions of section 22(g) of ANCSA and section 2651.41 of this chapter as though they were conveyances to a village corporation.	**§ 2653.31 What are the selection criteria for Native group selections and what lands are available?** You may select only the amount recommended by the regional corporation or 320 acres for each Native member of a group, or 7,680 acres for each Native group, whichever is less. You must identify any acreage over 7,680 as alternate selections and rank their selection. **§ 2653.32 What are the restrictions in conveyances to Native groups?** Beyond the reservations described in this part conveyances of lands in a National Wildlife Refuge are subject to section 22(g) of ANSCA as though they were conveyances to a village. **§ 2653.33 Do Native group selections have to share a border?** Yes, selections must share a border. The total

Long, dense paragraph	Shorter paragraphs, easier to follow
(b) Selections must be contiguous and the total area selected must be compact except where separated by lands that are unavailable for selection. BLM will not consider the selection compact if it excludes lands available for selection within its exterior boundaries; or an isolated tract of public land of less than 640 acres remains after selection. The lands selected must be in quarter sections where they are available unless exhaustion of the group's entitlement does not allow the selection of a quarter section. The selection must include all available lands in less than quarter sections. Lands selected must conform as nearly as practicable to the United States lands survey system.	area you select must be compact except where separated by lands that are unavailable for selection. We will not consider your selection if: (a) It excludes lands available for selection within its exterior boundaries; or (b) An isolated tract of public land of less than 640 acres remains after selection. **§ 2653.34 How small a parcel can I select?** Select lands in quarter sections where they are available unless there is not enough left in your group's entitlement to allow this. Your election must include all available lands in areas that are smaller than quarter sections. Conform your selection as much as possible to the United States land survey system.

Sources

- Kimble, Joseph, *Lifting the Fog of Legalese,* 2006, Carolina Academic Press, Durham, NC, pp. 11, 165-174.
- Murawski, Thomas A., *Writing Readable Regulations,* 1999, Carolina Academic Press Durham, NC, pp. 9-10.

III. Write your document

With a relatively small amount of effort and in a relatively short amount of time, you can significantly improve traditionally-written material.

a. Words

Words matter. They are the most basic building blocks of written and spoken communication. Choose your words carefully – be precise and concise.

1. Verbs

Verbs tell your audience what to ***do***. Make sure they know ***who*** does what.

i. Use active voice

Active voice makes it clear who is supposed to do what. It eliminates ambiguity about responsibilities. Not "It must be done., but "You must do it." Passive voice obscures who is responsible for what and is one of the biggest problems with government documents. Don't confuse passive voice with past tense.

In an active sentence, the person or agency that's acting is the subject of the sentence. In a passive sentence, the person or item that is acted upon is the subject of the sentence. Passive sentences often do not identify who is performing the action.

Passive voice	Active voice
The lake was polluted by the company.	The company polluted the lake.
New regulations were proposed.	We proposed new regulations.
The following information must be included in the application for it to be considered complete.	You must include the following information in your application.
Bonds will be withheld in cases of non-compliance with all permits and conditions.	We will withhold your bond if you don't comply with all permit terms and conditions.
Regulations have been proposed by the Department of Veterans Affairs.	The Department of Veterans Affairs proposed new regulations.
The permit must be approved by the agency's State office.	Our State office must approve your permit.

More than any other writing technique, using active voice and specifying who is performing an action will change the character of your writing.

How do you identify passive sentences?

Passive sentences have two basic features, although both may not appear in every passive sentence.

- A form of the verb "to be" (for example: are, was, were, could be) and
- A past participle (generally with "ed" on the end).

Use passive voice when the law is the actor

In a very few instances, passive voice may be appropriate. For example, when one action follows another as a matter of law, and there is no actor (besides the law itself) for the second action, a passive sentence may be the best method of expression. You might also use passive when it doesn't matter who is doing an action.

> ***For example:***
>
> If you do not pay the royalty on your mineral production, your lease will be terminated<

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 173-175.
- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, pp. 643-644.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 24-26.
- Garner, Bryan A., *Garner's Modern American Usage*, 2003. Oxford University Press, Oxford and New York, pp. 892-893.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 73-75.
- Office of the Federal Register, *Document Drafting Handbook*, 1998, p. MMR-5. www.archives.gov/federal-register/write/handbook/ddh.pdf.
- Redish, Janice C., *How to Write Regulations and Other Legal Documents in Clear English*, 1991, American Institutes for Research, Washington, DC, p. 26.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, pp. 19–20.

ii. Use the simplest form of a verb

The simplest and strongest form of a verb is present tense. A document written in the present tense is more immediate and less complicated. Using the present tense makes your document more direct and forceful. The more you use conditional or future tense, the harder your audience has to work to understand your meaning. Writing entirely in the present tense saves your audience work and helps make your point clearly.

Don't say	Say
These sections describe types of information that would satisfy the application requirements of Circular A-110 as it would apply to this grant program.	These sections tell you how to meet the requirements of Circular A-110 for this grant program.

Even if you are covering an event that occurred in the past, you can clarify the material for your user by writing as much as possible in the present tense.

Don't say	Say
Applicants who were Federal employees at the time that the injury was sustained should have filed a compensation request at that time. Failure to do so could have an effect on the degree to which the applicant can be covered under this part.	You may not be covered under this part if: a. You were a Federal employee at the time of the injury; and b. You did not file a claim at that time.

Occasionally, of course, you may need to use other tenses. For example, National Environmental Policy Act (NEPA) documents frequently refer to what may happen in the future if certain events occur. But use tenses other than the present only when necessary for accuracy.

iii. Avoid hidden verbs

Use the strongest, most direct form of the verb possible.

Verbs are the fuel of writing. Verbs give your sentences power and direction. They enliven your writing and make it more interesting. Too often, we hide verbs by turning them into nouns, making them less effective and using more words than we need. Hidden verbs are a particular problem in government writing.

What are hidden verbs?

A hidden verb is a verb converted into a noun. It often needs an extra verb to make sense. So we write, "Please make an application for a personal loan" rather than "Please apply for a personal loan."

Hidden verbs come in two forms. Some have endings such as *-ment, -tion, -sion,* and *-ance* or link with verbs such as *achieve, effect, give, have, make, reach,* and *take*. Often, you will find a hidden verb between the words "the" and "of."

Hidden Verb	Uncovered
To trace the missing payment, we need to carry out a review of the Agency's accounts so we can gain an understanding of the reason the error occurred.	To trace the missing payment, we need to review the Agency's accounts so we understand the reason the error occurred.
If you cannot make the payment of the $100 fee, you must make an application in writing before you file your tax return.	If you cannot pay the $100 fee, you must apply in writing before you file your tax return.
This means we must undertake the calculation of new figures for the congressional hearing.	This means we must calculate new figures for the congressional hearing.
The production of accurate statistics is important for the committee in the assessment of our homelessness policy.	Producing accurate statistics is important to the committee in assessing our policy on homelessness.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 176-178.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, p.38 (14.)
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC., p.71 (D.4).
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC., p.21.
- Wright, Nick, *Hidden Verbs*, at www.plainlanguage.gov/howto/wordsuggestions/hiddenverbs.cfm.

iv. Use "must" to indicate requirements

The word "must" is the clearest way to convey to your audience that they have to do something. "Shall" is one of those officious and obsolete words that has encumbered legal style writing for many years. The message that "shall" sends to the audience is, "this is deadly material." "Shall" is also obsolete. When was the last time you heard it used in everyday speech?

Besides being outdated, "shall" is imprecise. It can indicate either an obligation or a prediction. Dropping "shall" is a major step in making your document more user-friendly. Don't be intimidated by the argument that using "must" will lead to a lawsuit. Many agencies already use the word "must" to convey obligations. The US Courts are eliminating "shall" in favor of "must" in their Rules of Procedure. One example of these rules is cited below.

Instead of using "shall", use:

- "must" for an obligation,
- "must not" for a prohibition,
- "may" for a discretionary action, and
- "should" for a recommendation.

The following example demonstrates how much clearer language can be if you follow these suggestions.

Don't say	Say
Section 5511.1 Free Use of Timber on Oil and Gas Leases a. Any oil or gas lessee who wishes to use timber for fuel in drilling operations shall file an application therefore with the officer who issued the lease. b. The applicant shall be notified by registered mail in all cases where the permit applied for is not granted, and shall be given 30	**Section 5511.1 Free Use of Timber on Oil and Gas Leases** a. You must file an application to use the timber on your oil or gas lease for fuel. File the application with our office where you got your lease. b. We will notify you by registered mail if we reject your application. You must file an appeal of that decision within 30 days. c. You must notify any settler, by

Don't say	Say
days within which to appeal such decision. c. Where the land is occupied by a settler, the applicant shall serve notice on the settler by registered mail showing the amount and kind of timber he has applied for.	registered mail, that you have applied to use timber from your lease. Include in your notice the amount and the kind of timber you intend to use as fuel.

Many legal scholars have written about the problem of "shall." Read a brief summary of several arguments at: www.plainlanguage.gov/howto/wordsuggestions/shallmust.cfm.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 183-184.
- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, pp. 939-942.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 105-106.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, pp. 159-160.
- US Courts, *Federal Rules of Appellate Procedure*, 2009, US Government Printing Office, Washington, DC. www.uscourt.gov/uscourts/rulesandpolicies/rules/ap2009.pdf.
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC, p. 64.

v. Use contractions when appropriate

While many legal authorities say that contractions don't belong in legal writing, Bryan Garner, a leading authority on legal writing, advocates their use as a way to make legal writing, including opinions and rules, less stuffy and more natural. Contractions make your writing more accessible to the user. Research shows that that they also enhance readability (DaNielsen and Larosa, 1989).

"Write as you talk" is a common rule of writing readably, and the best way to do that is to use contractions. People are accustomed to hearing contractions in spoken English, and using them in your writing helps people relate to your document.

Use contractions with discretion. Just as you shouldn't bullet everything on a page, you shouldn't make a contraction out of every possible word. Don't use them wherever possible, but wherever they sound natural.

Don't Say	Say
No pilot in command of a civil aircraft may allow any object to be dropped from that aircraft in flight that creates a hazard to persons or property.	If you are a pilot in command of a civil aircraft, don't allow any object that creates a hazard to persons or property to be dropped from that aircraft during flight.

Sources

- DaNielsen , Wayne A. and Dominic L. Larosa, A New Readability Formula Based on the Stylistic Age of Novels, 33 *Journal of Reading* (1989), pp. 194, 196.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 49-50.
- Garner, Bryan A., *The Elements of Legal Style*, 2002, Oxford Univ. Press, Oxford and New York, pp. 81-82.

2. Nouns and pronouns

Nouns add substance and direction. Pronouns engage your audience. Don't complicate things by using words they won't understand or abbreviations that confuse them.

i. Don’t turn verbs into nouns

The bulk of government and technical writing uses too many noun strings – groups of nouns “sandwiched” together. Readability suffers when three words that are ordinarily separate nouns follow in succession. Once you get past three, the string becomes unbearable. Technically, clustering nouns turns all but the last noun into adjectives. However, many users will think they’ve found the noun when they’re still reading adjectives, and will become confused.

Bring these constructions under control by eliminating descriptive words that aren’t essential. If you can’t do that, open up the construction by using more prepositions and articles to clarify the relationships among the words.

Avoid nouns strings like these	Instead, say
Underground mine worker safety protection procedures development	Developing procedures to protect the safety of workers in underground mines
Draft laboratory animal rights protection regulations	Draft regulations to protect the rights of laboratory animals
National Highway Traffic Safety Administration’s automobile seat belt interlock rule	The National Highway Traffic Safety Administration’s interlock rule applies to automotive seat belts

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 192-193.
- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, pp. 601-602.
- Garner, Bryan A., *Garner’s Modern American Usage*, 2003, Oxford University Press, Oxford and New York, p. 557.
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC, p. 71.
- Zinsser, William, *On Writing Well*, 6th edition, 2001, HarperCollins, New York, pp.77-78.

ii. Use pronouns to speak directly to readers

Pronouns help the audience picture themselves in the text and relate better to your documents. More than any other single technique, using "you" pulls users into your document and makes it relevant to them. When you use "you" to address users, they are more likely to understand what their responsibility is. Using "we" to refer to your agency makes your agency more approachable. It also makes your sentences shorter and your document easier to read.

Don't say	Say
Copies of tax returns must be provided.	You must provide copies of your tax returns.

Writing for an individual forces you to analyze carefully what you want the reader to do. By writing to an individual, you will find it easier to:

- Put information in a logical order
- Answer questions and provide the information that your user wants to know
- Assign responsibilities and requirements clearly

Be sure to define "you" clearly.

Don't say	Say
Facilities in regional and district offices are available to the public during normal business hours for requesting copies of agency records.	If you are a private citizen, you can get copies of our records at any regional or district office<

Define "you" by any of the following methods:

- State in the beginning of the document who the user is — "This regulation tells you, the loan applicant, how to secure a loan."
- Define "you" in the Definitions section — "You" means a loan applicant.
- Where you address different users in different parts of the document, define "you" in each context — "How do different types of borrowers apply for a

> loan? If you are a small business, you must submit< If you are an individual, you must submit<"

It's especially important to define "you" when writing to multiple audiences.

Don't say	Say
Lessees and operators are responsible for restoring the site. You must ensure that<	Lessees and operators are responsible for restoring the site. If you are the lessee, you must monitor the operator to ensure that. If you are the operator, you must conduct all operations in a way <

If you use a question-and-answer format, you should assume that the user is the one asking the questions. Use "I" in the questions to refer to the user. Use "we" in the responses to represent your agency.

Don't say	Say
Submission of applications.	How do I apply?

By using "we" to respond to questions, you state clearly what your agency requires and what your agency's responsibilities are. You also avoid the passive voice and use fewer words. You can define "we" in the definitions sections of your document if that will help the user.

Don't say	Say
Loan applications will be reviewed to ensure that procedures have been followed.	We review your loan application to ensure that you followed our procedures.
The Office of Consumer Affairs will process your application within 30 days after receipt.	We'll process your application within 30 days of receiving it.

Make sure you use pronouns that clearly refer to a specific noun. If a pronoun could refer to more than one person or object in a sentence, repeat the name of the person or object or rewrite the sentence.

Don't say	Say
After the Administrator appoints an Assistant Administrator, he or she must <	After the Administrator appoints an Assistant Administrator, the Assistant Administrator must <

Sources

- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, p. 643.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, p. 50.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 33-38.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p. 22.
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC.

iii. Minimize abbreviations

One legal scholar calls abbreviations a "menace to prose" (Kimble, 2006). Abbreviations were once intended to serve the audience by shortening long phrases. However, abbreviations have proliferated so much in current government writing that they constantly require the reader to look back to earlier pages, or to consult an appendix, to puzzle out what's being said.

Use "nicknames"

The best solution is to find a simplified name for the entity you want to abbreviate. This gives readers meaningful content that helps them remember what you're talking about. It may be a bit longer, but the gain in clarity and ease of reading is worth it. In most cases, you don't need to "define" this nickname the first time you use it, unless you are using lots of different nicknames. Especially when you are using a nickname for the major topic of your document, don't insult your users and waste their time. For example, in a paper about Resource Advisory Councils, don't tell them that when you say "Council" you mean "Resource Advisory Council."

For	Instead of	Consider
Engineering Safety Advisory Committee	ESAC	the committee
Small-quantity handlers of universal wastes	SQHUW	waste handlers
Fire and Police Employee Relations Act	FPERA	the Act

If everyone knows an abbreviation, use it without explanation

There's a short list of abbreviations that have entered common usage. When you use them, don't define them, you're just taking up space and annoying your user. But make sure the abbreviation you're using is on the list. Examples include IBM, ATM, BMW, PhD, CIA.

A closely related guideline is, "don't define something that's obvious to the user." Most federal agencies, when writing a letter responding to an inquiry, insist on defining the agency name, as in, "Thank you for writing to the Federal Aviation Administration (FAA) about your concerns <" The letterhead says the name of the agency. The person wrote to the agency, and now the agency is writing back. The user is ***not*** going to be confused about what FAA means!

If you must abbreviate

Of course, there are some situations in which you can't avoid an abbreviation. Always define an abbreviation the first time you use it, for example, "The American Journal of Plain Language Studies" (AJPLA). And limit the number of abbreviations you use in one document to no more than three, and preferably two. Spell out everything else. If you've used abbreviations for the two or three most common items, it's unlikely that the other items occur so frequently you can't spell them out every time.

When you are considering whether to use an abbreviation, or how many you can get away with in a document, remember that they should make it easier for your users. If they make it harder, you have failed to write for your audience.

Sources

- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, pp. 447-448.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 46-48.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, p. 155.

3. Other word issues

Be concise – leave out unnecessary words. Don't use jargon or technical terms when everyday words have the same meaning. Use words and terms consistently throughout your documents.

i. Use short, simple words

Vocabulary choice is an important part of communicating clearly. While there is no problem with being expressive, most federal writing has no place for literary flair. People do not curl up in front of the fire with a nice federal regulation to have a relaxing read.

Government writing is often stodgy, full of long, dry legalisms and other jargon. Federal government writing is no exception. H.W. Fowler summed up these recommendations for making word choices in his influential book, *The King's English,* first published in 1906. He encouraged writers to be more simple and direct in their style (quoted in Kimble, 2006).

- Prefer the familiar word to the far-fetched.
- Prefer the concrete word to the abstraction.
- Prefer the single word to the circumlocution.
- Prefer the short word to the long.
- Prefer the Saxon word to the Romance word.

Kathy McGinty (www.plainlanguage.gov) offers tongue-in-cheek instructions for bulking up your simple, direct sentences.

> There is no escaping the fact that it is considered very important to note that a number of various available applicable studies ipso facto have generally identified the fact that additional appropriate nocturnal employment could usually keep juvenile adolescents off thoroughfares during the night hours, including but not limited to the time prior to midnight on weeknights and/or 2 a.m. on weekends.

And the original, using stronger, simpler words:

> More night jobs would keep youths off the streets.

In making your word choices, pick the familiar or frequently used word over the unusual or obscure. There are many lists of complex words and suggested substitutes, for example www.plainlanguage.gov/howto/wordsuggestions/simplewords.cfm. See also the lists in Kimble (2006).

Sources

- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, pp. 11, 165-174.
- McGinty, Kathy, *Nine Easy Steps to Longer Sentences*, www.plainlanguage.gov/examples/humor/9easysteps.cfm.

ii. Omit unnecessary words

Wordy, dense construction is one of the biggest problems in government writing. Nothing is more confusing to the user than long, complex sentences containing multiple phrases and clauses. Unnecessary words come in all shapes and sizes, and it's difficult to put them into distinct categories. To address the problem, writers must become more critical of their own writing. They must consider whether they need every word.

Unnecessary words waste your audience's time on the web as well. Remember, great web content is like a conversation. Omit information that the audience doesn't need to know. This can be difficult for a subject matter expert, so it is important to have someone look at the information from the audience's perspective. (See Write web content for more information on writing for the web.)

One place to start working on this problem in your own writing is to watch out for "of," "to," "on," and other ***prepositions***. They often mark phases you can reduce to one or two words.

Don't say	Say
a number of	several, a few, many
a sufficient number of	enough
at this point in time	now
is able to	can
on a monthly basis	monthly
on the ground that	because
an amount of X	X
be responsible for	must
in order to	to

Often, you can omit ***redundant words***.

Don't say	Say
The X Department and the Y Department worked together on a joint project to improve <	The X and Y Departments worked on a project to improve <

In this statement, you don't need "joint." You don't even need "together." Saying that X *and* Y worked on a project says it all. "Joint" and "together" are both redundant.

Similarly, we often use **excess modifiers** such as *absolutely, actually, completely, really, quite, totally*, and *very*. But if you look closely, you'll find that they often aren't necessary and may even be nonsensical.

Don't say	Say
Their claim was totally unrealistic.	Their claim was absurd.
It is particularly difficult to reconcile the somewhat differing views expressed by the management team.	It is difficult to reconcile the differing views expressed by the management team.
Total disclosure of all facts is very important to make sure we draw up a total and completely accurate picture of the Agency's financial position.	Disclosing all facts is important to creating an accurate picture of the Agency's financial position.

Avoid ***doublets and triplets.*** English writers love to repeat the same concept by using different words that say the same thing.

Don't say	Say
due and payable	due
cease and desist	stop
knowledge and information	(either one)
begin and commence	start

Other ways to omit unnecessary words include eliminating hidden verbs, using pronouns, and using active voice. See the guidance on those three topics (Avoid hidden verbs, Use pronouns to speak directly to readers, and Use active voice) for more information.

Here's an example that uses several of the techniques discussed above to cut a 54 word sentence down to 22 words, with no loss of meaning.

Don't say	Say
If the State Secretary finds that an individual has received a payment to which the individual was not entitled, whether or not the payment was due to the individual's fault or	If the State Secretary finds that you received a payment that you weren't entitled to, you must pay the entire sum back.

Don't say	Say
misrepresentation, the individual shall be liable to repay to State the total sum of the payment to which the individual was not entitled.	

Omitting excess words can cut documents significantly. Be diligent in challenging every word you write, and eventually you will learn to write not only clearly, but concisely.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 43, 40, 34.
- Kimble, Joseph, *Lifting the Fog of Legalese*, Carolina Academic Press, 2006, Durham, NC, pp. 93, 170.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p. 25.

iii. Dealing with definitions

We have ONE rule for dealing with definitions: ***use them rarely***.

Definitions often cause more problems than they solve. Uniformly, writing experts advise keeping definitions to a minimum (Dickerson 1986, Garner 2001, Kimble 2006). If you can't avoid them, use as few as possible. It's better to take the time to rewrite to avoid needing to define a term. If you must use definitions, follow the guidelines below:

Give common words their common meanings and don't define them.

Never define a word to mean something other than its commonly accepted meaning.

Reed Dickerson, in his landmark book, *Fundamentals of Legal Drafting* (1986), has this advice for legal drafters:

> It is important for the legal draftsman not to define a word in a sense significantly different from the way it is normally understood by the persons to whom it is primarily addressed. This is a fundamental principle of communication, and it is one of the shames of the legal profession that draftsmen so flagrantly violate it. Indeed, the principle is one of the most important in the whole field of legal drafting.

Mr. Dickerson's advice applies to any government communication, not just to legal drafters.

Morris Cohen, in *Reason and Law* (1950), explains, "Whenever we define a word < in a manner that departs from current customary usage, we sooner or later unwittingly fall back on the common use and thus confuse the meanings of our terms."

Furthermore, readers are likely to forget that you'd assigned some common word a new meaning, and when they come upon the word later in your document they assign the common meaning, rather than your specialized one. Here are some unnecessary definitions.

Commonly understood words you probably didn't need to define
Bicycle means every device propelled solely by human power upon which a person or persons may ride on land, having one, two, or more wheels, except a manual wheelchair.
Degrade means to lessen or diminish in quantity, quality, or value.
Age means how old a person is, or the number of elapsed years from the date of a person's birth.

And here are some examples of definitions that conflict with customary usage – you should avoid these at all costs.

Commonly understood words with uncommon meanings	How uncommon meanings might confuse readers
Pages means paper copies of standard office size or the dollar value equivalent in other media	Ten pages into the document, how do you think the average user would respond if asked to define "page"?
Coal deposits mean all Federally owned coal deposits, except those held in trust for a Native American tribe.	So if coal is held in trust for a Native American tribe, it isn't coal?
Dead livestock. The body (cadaver) of livestock which has died otherwise than by slaughter.	So if you slaughter it, it isn't really dead?

When possible, define a word where you use it

Avoid long sections of definitions at the beginning or end of your document. Go back to Rule One. Rewrite to try to eliminate the need for most definitions.

If you must have a definition section, put it at the beginning or the end

Place definitions at the end, in spite of tradition. In placing definitions at the end, you allow your user to go right to the text, rather than having to go through less important material. In definition sections, don't number the definitions, but list them alphabetically. This makes it easier for users to find a definition, and usually makes it easier for you to change your definition section later.

Never include regulatory or other substantive material in definitions

Not only is this common sense — your user doesn't expect substantive material in the definitions section — but for regulations it's a requirement of the Office of the Federal Register.

Consider this "definition" in Title 43 Part 3480 — Coal Exploration and Mining Operations:

> *Maximum economic recovery (MER)* means that, based on standard industry operating practices, all profitable portions of a leased Federal coal deposit must be mined. At the times of MER determinations, consideration will be given to: existing proven technology; commercially available and economically feasible equipment; coal quality, quantity, and marketability; safety, exploration, operating, processing, and transportation costs; and compliance with applicable laws and regulations. The requirement of MER does not restrict the authority of the authorized officer to ensure the conservation of the recoverable coal reserves and other resources and to prevent the wasting of coal.

Hiding in this long passage is the definition, "Maximum economic recovery (MER) means the mining of all profitable portions of a leased Federal coal deposit, based on standard industry operating practices." All the rest of the material belongs in the substantive parts of the regulation.

Don't define words you don't use

Again, this seems obvious. But writers seem to automatically define terms they think they might use, but don't. This can be very confusing for the audience, who expects to read something about the topic but can't find it in the document.

Sources

- Cohen, Morris, *Reason and Law*, 1950, The Free Press, Glencoe, IL, p.77.
- Dickerson, Reed, *Fundamentals of Legal Drafting*, 1986, 2nd edition, Little, Brown and Company, Boston and Toronto, pp. 137, 144.
- Flesch, Rudolf, *How to Write in Plain English, A Book for Lawyers and Consumers*, 1979, Harper and Rowe, New York, pp. 58-69, 79.
- Garner, Bryan A., *A Dictionary of Modern Legal Usage*, 2nd edition, 1995, Oxford University Press, Oxford and New York, p. 257-258.

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 97-99.
- Kimble, Joseph, *Lifting the Fog of Legalese*, Carolina Academic Press, 2006, Durham, NC.
- Office of the Federal Register, Document Drafting Handbook, 1998, § 8.15. www.archives.gov/federal-register/write/handbook/ddh.pdf.

iv. Use the same term consistently for a specific thought or object

You will confuse your audience if you use different terms for the same concept. For example, if you use the term "senior citizens" to refer to a group, continue to use this term throughout your document. Don't substitute another term, such as "the elderly" or "the aged." Using a different term may cause the reader to wonder if you are referring to the same group.

Don't feel that you need to use synonyms to make your writing more interesting. Federal writers are not supposed to be creating great literature. You are communicating requirements, how to get benefits, how to stay safe and healthy, and other information to help people in their lives. While using different words may make writing more interesting, it may decrease clarity.

v. Avoid legal, foreign, and technical jargon

What do we mean by jargon? Jargon is unnecessarily complicated, technical language used to impress, rather than to inform, your audience.

When we say not to use jargon, we're not advocating leaving out necessary technical terms; we are saying to make sure your other language is as clear as possible. For example, there may not be another correct way to refer to a brinulator valve control ring. But that doesn't prevent you from saying "tighten the brinulator valve control ring securely" instead of "Apply sufficient torque to the brinulator valve control ring to ensure that the control ring assembly is securely attached to the terminal such that loosening cannot occur under normal conditions." The first is a necessary use of a technical term. The second is jargon.

Special terms can be useful shorthand within a group and may be the clearest way to communicate inside the group. However, going beyond necessary technical terms to write in jargon can cause misunderstanding or alienation, even if your only readers are specialists. Readers complain about jargon more than any other writing fault, because writers often fail to realize that terms they know well may be difficult or meaningless to their audience. Try to substitute everyday language for jargon as often as possible. Consider the following pairs. The plainer version conveys technical information just as accurately as and more clearly than the jargon-laden version.

Don't say	Say
riverine avifauna	river birds
involuntarily undomiciled	homeless
The patient is being given positive-pressure ventilatory support.	The patient is on a respirator.
Most refractory coatings to date exhibit a lack of reliability when subject to the impingement of entrained particulate matter in the propellant stream under extended firing durations.	The exhaust gas eventually damages the coating of most existing ceramics.

When you have no way to express an idea except to use technical language, make sure you define your terms. However, it's best to keep definitions to a minimum. Remember to write to communicate, not to impress. If you do that, you should naturally use less jargon. For more on definitions, see Dealing with definitions.

Legal language

Legal language in regulations and other documents is a major source of annoying jargon. Readers can do without archaic jargon such as "hereafter," "heretofore," and "therewith." Professor Joseph Kimble (2006), a noted scholar on legal writing, warns that we should avoid those words and formalisms that give legal writing its musty smell. He includes in his list of examples the following words:

above-mentioned
aforementioned
foregoing
henceforth
hereafter
hereby
herewith
thereafter
thereof
therewith
whatsoever
whereat
wherein
whereof

Another term that is losing its popularity in legal circles is "shall." Obviously, it's especially important in regulations to use words of authority clearly, and many top legal writing experts now recommend avoiding the archaic and ambiguous "shall" in favor of another word, depending on your meaning. Read more about "shall" in Use "must" to convey requirements.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 188-191.
- Garner, Bryan A., *Garner's Modern American Usage*, 2003, Oxford University Press, Oxford and New York, pp. 472-473.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, pp.173-174.

vi. Don't use slashes

Apart from fractions, the slash has almost no good uses. "And/or" is a classic example. In most cases, writers mean *either* "or" or "and." But they don't want to take the time to decide which they mean, so they push the job off on the audience. That makes their writing ambiguous. As an author, you should decide what you mean. In the few cases — and there do seem to be very few — where you truly mean both, write out "either X, or Y, or both."

Often when writers use slashes, a hyphen is more appropriate to join equal or like terms, as in "faculty-student ratio."

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, p. 163.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, pp. 155-156.

b. Sentences

Choose your words carefully. Start with your main idea – don't start with an exception. Word order does matter, so place your words carefully. Keep it short; it's not a crime to use lots of periods.

1. Write short sentences

Express only one idea in each sentence. Long, complicated sentences often mean that you aren't sure about what you want to say. Shorter sentences are also better for conveying complex information; they break the information up into smaller, easier-to-process units.

Sentences loaded with dependent clauses and exceptions confuse the audience by losing the main point in a forest of words. Resist the temptation to put everything in one sentence; break up your idea into its parts and make each one the subject of its own sentence.

Don't say	Say
Once the candidate's goals are established, one or more potential employers are identified. A preliminary proposal for presentation to the employer is developed. The proposal is presented to an employer who agrees to negotiate an individualized job that meets the employment needs of the applicant and real business needs of the employer.	Once we establish your goals, we identify one or more potential employers. We prepare a preliminary proposal to present to an employer who agrees to negotiate a job that meets both his and your employment needs.

Complexity is the greatest enemy of clear communication. You may need to be especially inventive to translate complicated provisions into more manageable language. In the following example, we have made an "if" clause into a separate sentence. By beginning the first sentence with "suppose" (that is, "if") and the second sentence with "in this case" (that is, "then") we have preserved the relationship between the two.

Don't say	Say
If you take less than your entitled share of production for any month, but you pay royalties on the full volume of your entitled share in accordance with the provisions of this section, you will owe no additional royalty for that lease for prior periods when you later take more than your entitled share to balance your account. This also applies when the other participants pay you money to balance your account.	Suppose that one month you pay royalties on your full share of production but take less than your entitled share. In this case, you may balance your account in one of the following ways without having to pay more royalty. You may either: a. Take more than your entitled share in the future; or b. Accept payment from other participants.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 163-165.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 19-21.
- Kimble, Joseph, *Guiding Principles for Restyling the Federal Rules of Civil Procedure (Part 1)*, Michigan Bar Journal, September 2005, pp. 56-57. www.michbar.org/journal/pdf/pdf4article909.pdf.
- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, p. 96.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, p. 77.
- Office of the Federal Register, *Document Drafting Handbook*, 1998, MMR-5. www.archives.gov/federal-register/write/handbook/ddh.pdf.
- Redish, Janice C., *How to Write Regulations and Other Legal Documents in Clear English*, 1991, American Institutes for Research, Washington, DC, pp. 29-32
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p. 28.

2. Keep subject, verb, and object close together

The natural word order of an English sentence is subject-verb-object. This is how you first learned to write sentences, and it's still the best. When you put modifiers, phrases, or clauses between two or all three of these essential parts, you make it harder for the user to understand you.

Consider this long, convoluted sentence:

> If any member of the board retires, the company, at the discretion of the board, and after notice from the chairman of the board to all the members of the board at least 30 days before executing this option, may buy, and the retiring member must sell, the member's interest in the company.

In essence, the sentence says:

> The company may buy a retiring member's interest.

All the rest of the material modifies the basic idea, and should be moved to another sentence or at least to the end of the sentence.

Many sentences in regulations include "if-then" provisions. Often, "if" defines who is covered by a provision. Start your sentence with the "if" provision, and then list the "then" provisions. If the provision is complex, and especially if there are several different "if" provisions, use a different sentence for every "if," or consider using an if-then table.

Consider this complex regulatory provision:

> We must receive your completed application form on or before the 15th day of the second month following the month you are reporting if you do not submit your application electronically or the 25th day of the second month following the month you are reporting if you submit your application electronically.

While still complex, the table is a significant improvement:

We must receive your completed application by the following dates:

If you submit your form ...	**We must receive it by ...**
Electronically	the 25th of the second month following the month you are reporting
Other than electronically	the 15th of the second month following the month you are reporting

For more information on tables, see Use tables to make complex material easier to understand.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 23-24, 102.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 77-78.
- Office of the Federal Register, *Document Drafting Handbook*, 1998, MMR-6. www.archives.gov/federal-register/write/handbook/ddh.pdf
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p.32.

3. Avoid double negatives and exceptions to exceptions

We're accustomed to thinking and speaking positively. When we write in the negative, we place another stumbling block in audience's way and make it more difficult for them to understand us. When you're going to meet a friend at the airport, do you say, "If you fail to arrive by 5:00, I cannot pick you up," or do you say, "You have to arrive by 5:00 if you want me to pick you up"?

When you write a sentence containing two negatives, they cancel each other out. Your sentence sounds negative, but is actually positive. As Rudolph Flesch (1979) says, these sentences require "a mental switch from no to yes."

Don't say	Say
No approval of any noise compatibility program, or any portion of a program, may be implied **in the absence of** the agency's express approval.	You must get the agency's express approval for any noise compatibility program or any portion of a program.

Here are some expressions that signal double negatives.

Change the double negative	To a positive
no fewer than<	at least
has not yet attained	is under
may not<until	may only<when
is not<unless	is< only if

Many ordinary words have a negative meaning, such as *unless, fail to, notwithstanding, except, other than, unlawful (un-* words*), disallowed (dis-* words*), terminate, void, insufficient*, and so on. Watch out for them when they appear after ***not***. Find a positive word to express your meaning.

Don't say	Say
An application for a grant does not become void unless the applicant's failure to provide requested information is unreasonable under the circumstances.	An application for a grant remains active if the applicant provides the information we request within a reasonable time.

Exceptions to exceptions

An exception that contains an exception is just another form of a double negative. That makes it even harder for the user to puzzle out. Rewrite the sentence to emphasize the positive.

Don't say	Say
Applicants may be granted a permit to prospect for geothermal resources on any federal lands except lands in the National Park System, unless the applicant holds valid existing rights to the geothermal resources on the National Park System lands listed in the application.	You may be granted a permit to prospect for geothermal resources on any federal lands. This includes lands in the National Park System only if you hold valid existing rights to the park lands listed in your application.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 178-180.
- Flesch, Rudolf, *How to Write in Plain English, A Book for Lawyers and Consumers*, 1979, Harper and Rowe, New York, p. 95.
- Garner, Bryan A., *Guidelines for Drafting and Editing Court Rules*, 1996, Administrative Office of the US Courts, Washington, DC, pp. 30-31.
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC, pp. 75-76.

4. Place the main idea before exceptions and conditions

When you start a sentence with an introductory phrase or clause beginning with "except," you almost certainly force the reader to re-read your sentence. You are stating an exception to a rule before you have stated the underlying rule. The audience must absorb the exception, then the rule, and then usually has to go back to grasp the relationship between the two. Material is much easier to follow if you start with the main idea and then cover exceptions and conditions.

Don't say	Say
Except as described in paragraph (b), the Division Manager will not begin the statutory 180-day review period for the program until after the preliminary review determines that your submission is administratively complete.	The Division Manager will not begin the statutory 180-day review period for the program until the preliminary review determines that your submission is administratively complete. However, see paragraph (b) for an exception.

In the first version, the audience has to decide whether to jump immediately down to paragraph (b) or continue reading to the end of the sentence. This means the audience is focusing on reading strategy, not on your content.

There is no absolute rule about where to put exceptions and conditions. Put them where they can be absorbed most easily by readers. In general, the main point of the sentence should be as close to the beginning as possible.

Usually use the word ***if*** for conditions. Use ***when*** (not ***where***), if you need ***if*** to introduce another clause or if the condition occurs regularly.

If an exception or condition is just ***a few words***, and seeing it first will avoid misleading users, put it at the beginning instead of the end.

Don't say	Say
With your grant application you must submit a resume containing your undergraduate, graduate, and any other professional education, your work experience in the field of health care, and the name, and phone number of current and previous employers in the health care field, ***unless you have already submitted this information.***	***Unless you have already submitted an up-to-date resume,*** you must submit a resume containing your undergraduate, graduate, and any other professional education, your work experience in the field of health care, and the name, address and phone number of current and previous employers in the health care field.

If an exception or condition is *long* and the main clause is *short*, put the main clause first and then state the exception or condition.

Don't say	Say
Except when you submitted an identical application for an education grant in the previous year and you received full or partial grant for that year's program, we will schedule a hearing on your application.	We will schedule a hearing on your application, ***except when you submitted an identical application for an education grant in the previous year and you received full or partial grant for that year's program.***

If a condition and the main clause are ***both long***, *foreshadow* the condition and put it at the end of the sentence. If there are several conditions, lead with "*if*" or a phrase such as "*in the following circumstances.*"

Don't say	Say
If you, or an interested party, requests that the hearing be held at the educational institution where you plan to instruct program participants, and the hearing room is both handicapped-accessible and large enough for at least 100 people, we may, at our discretion, hold the hearing at that location, after adequate public notice.	We may hold a hearing at the educational institution where you plan to instruct program participants *if*: a. You, or an interested party, request the location; b. The hearing room is large enough for at least 100 people and handicapped-accessible; and c. We can give adequate public notice.

Use a list (like the example above) if your sentence contains multiple conditions or exceptions. Here's how the first example, above, could be rewritten.

Don't say	Say
With your grant application you must submit a resume containing your undergraduate, graduate, and any other professional education, your work experience in the field of health care, and the name, and phone number of current and previous employers in the health care field, ***unless you have already submitted this information.***	***Unless you have already submitted an up-to-date resume,*** you must submit a resume containing: • Your undergraduate, graduate, and any other professional education; • Your work experience in the field of health care; and • The name, address and phone number of current and previous employers in the health care field.

Use numbers or letters to designate items in a list if future reference or sequence is important (for example, in a regulation). Otherwise, use bullets.

Make implied conditions explicit by using **if**.

Don't say	Say
A party must make advance arrangements with the hearing officer for the transportation and receipt of ***exhibits of unusual bulk***.	***If your exhibits are unusually bulky***, you must make advance arrangements for transporting them with the hearing.

Avoid using an exception, if you can, by stating a rule or category directly rather than describing that rule or category by stating its exceptions.

Don't say	Say
All persons except those 18 years or older must<	Each person under 18 years of age must<

But use an exception if it avoids a long and cumbersome list or elaborate description.

Don't say	Say
Alabama, Alaska,< and Wyoming (a list of 47 states) must	Each state except Texas, New Mexico, and Arizona must<

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 166-167.
- Garner, Bryan A., *Guidelines for Drafting and Editing Court Rules*, 1996, Administrative Office of the US Courts, Washington, DC, pp. 5-9.
- Office of the Federal Register, *Drafting Legal Documents*, 1998, § 7. www.archives.gov/federal-register/write/legal-docs/
- Wydick, Richard, *Plain English for Lawyers*, 5th edition, 2005, Carolina Academic Press, Durham, NC, pp. 46-47.

5. Place words carefully

Sloppy word placement can cause ambiguity. To reduce ambiguity:

- Keep subjects and objects close to their verbs.
- Put conditionals such as "only" or "always" and other modifiers next to the words they modify. Write "you are required to provide only the following," not "you are only required to provide the following."
- Put long conditions after the main clause. Write "complete form 9-123 if you own more than 50 acres and cultivate grapes," not "if you own more than 50 acres and cultivate grapes, complete form 9-123."

In the left column below, it's difficult to figure out which words relate to the forest products, which to the tribe, and which to the payments. The right column eliminates this problem by dividing the material into shorter sentences and pulling together the words about each provision.

Confusing word placement	Clearer construction
Upon the request of an Indian tribe, the Secretary may provide that the purchaser of the forest products of such tribe, which are harvested under a timber sale contract, permit, or other harvest sale document, make advance deposits, or direct payments of the gross proceeds of such forest products, less any amounts segregated as forest management deductions pursuant to section 163.25, into accounts designated by such Indian tribe.	If a tribe (you) asks us, we will require purchasers of your forest products to deposit their payment into an account that you designate. a. You can instruct us to deposit advance payments as well as direct payments into the account. b. We will withhold from the deposit any forest management deductions under section 163.25.

You will eliminate many potential sources of ambiguity by writing shorter sentences. The less complex the sentence, the clearer the meaning and less chance that ambiguity will creep in. Still, you must watch how you place words even in short sentences. In the example below, the audience may have to read the original statement several times to realize that we don't mean, "If you really want to have a disability <"

Ambiguous construction	Clearer construction
If you are determined to have a disability, we will pay you the following:	If we determine that you have a disability, we will pay you the following:

Sources

- Garner, Bryan A., *Garner's Modern American Usage*, 2003, Oxford University Press, Oxford and New York, pp. 566-567.

c. Paragraphs

Write short paragraphs and include only one topic in each paragraph.

1. Have a topic sentence

If you tell your readers what they're going to read about, they're less likely to have to read your paragraph again. Headings help, but they're not enough. Establish a context for your audience before you provide them with the details. If you flood readers with details first, they become impatient and may resist hearing your message. A good topic sentence draws the audience into your paragraph.

We often write the way we think, putting our premises first and then our conclusion. It may be the natural way to develop our thoughts, but we wind up with the topic sentence at the end of the paragraph. Move it up front and let users know where you're going. Don't make readers hold a lot of information in their heads before they get to your point.

Also, busy readers want to ***skim*** your document, stopping only for what they want or need to know. You can help them by giving each paragraph a good introduction. Readers should be able to get good general understanding of your document by skimming your topic sentences.

A side benefit of good topic sentences (and good headings) is that they help you see if your document is well-organized. If it isn't, topic sentences make it easier for you to rearrange your material.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 65-66.

2. Use transition words

A topic sentence may provide a transition from one paragraph to another. But a transition word or phrase (usually in the topic sentence) clearly tells the audience whether the paragraph expands on the paragraph before, contrasts with it, or takes a completely different direction.

Bryan Garner (2001) divides transition words into three types:

Pointing words: words like *this, that, these, those,* and *the.*

Pointing words – especially *this* and *that* — refer directly to something already mentioned. They point to an antecedent. If your preceding paragraph describes the process of strip mining, and your next paragraph begins with "this process causes<," the word *this* makes a clear connection between paragraphs.

Echo links: words or phrases echo a previously mentioned idea.

Echo links often work together with pointing words. In the example above, you've just written a paragraph about how strip mining removes the top surface of the land to get at the coal under it. If you then begin the next paragraph with "this scarring of the earth," the words "scarring of the earth" are an echo of the mining process described in the previous paragraph.

Explicit connectives: words whose chief purpose is to supply transitions (such as *further, also, therefore*).

Explicit connectives between sentences and paragraphs can be overdone, but more often we simply overlook using them. Being too familiar with our own material, we think they aren't needed. Readers, on the other hand, find them helpful in following our train of thought. Here are some examples from Bryan Garner.

- ***When adding a point***: also, and, in addition, besides, what is more, similarly, further
- ***When giving an example***: for instance, for example, for one thing, for another thing
- ***When restating***: in other words, that is, in short, put differently, again

- *When introducing a result*: so, as a result, thus, therefore, accordingly, then
- *When contrasting*: but, however, on the other hand, still, nevertheless, conversely
- *When summing up*: to summarize, to sum up, to conclude, in conclusion, in short
- *When sequencing ideas*: First,<Second,<Third,<Finally,<

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 67-71.

3. Write short paragraphs

Long paragraphs discourage your audience from even trying to understand your material. Short paragraphs are easier to read and understand. Writing experts recommend paragraphs of no more than 150 words in three to eight sentences. Paragraphs should never be longer than 250 words. Vary the lengths of your paragraphs to make them more interesting. As with sentence length, if all paragraphs are the same size your writing will be choppy.

There is nothing wrong with an occasional one-sentence paragraph.

Using short paragraphs is an ideal way to open up your document and create more white space. In turn, this makes your writing more inviting and easier to read. It also gives you the opportunity to add more headings.

Long, dense paragraph	Material divided into four paragraphs
Flu Medication A specific vaccine for humans that is effective in preventing avian influenza is not yet readily available. Based upon limited data, the CDC has suggested that the anti-viral medication Oseltamivir (brand name-Tamiflu) may be effective in treating avian influenza. Using this input, the Department of State has decided to pre-position the drug Tamiflu at its Embassies and Consulates worldwide, for eligible U.S. Government employees and their families serving abroad who become ill with avian influenza. We emphasize that this medication cannot be made available to private U.S. citizens abroad. Because of this, and because Tamiflu may not be readily available overseas, the State Department encourages American citizens traveling or living	**Flu Medication for Government Employees** A specific vaccine for humans effective in preventing avian influenza is not yet readily available. Based on limited data, the CDC suggested that the anti-viral medication Oseltamivir (brand name-Tamiflu) may be effective in treating avian influenza. Using this input, the Department of State decided to pre-position the drug Tamiflu at its Embassies and Consulates worldwide, for eligible U.S. Government employees and their families serving abroad who become ill with avian influenza. **Flu Medication for Private Citizens** We emphasize that we can't make this medication available to private U.S. citizens abroad. Because of this, and because Tamiflu may not be readily available overseas, the State Department

Long, dense paragraph	Material divided into four paragraphs
abroad to consult with their private physician about whether to obtain Tamiflu prior to travel, for use in the event treatment becomes necessary, or whether Tamiflu is readily available in the country where they reside. Americans should also be aware of the potential health risk posed by counterfeit drugs, including those represented as Tamiflu, by internet scam artists or in countries with lax regulations governing the production and distribution of pharmaceuticals. In addition, the Department of State has asked its embassies and consulates to consider preparedness measures that take into consideration the fact that travel into or out of a country may not be possible, safe or medically advisable. Guidance on how private citizens can prepare for a "stay in place" response, including stockpiling food, water, and medical supplies, is available on the CDC and pandemicflu.gov websites.	encourages American citizens traveling or living abroad to consult with their private physician about whether to get Tamiflu before they travel, whether to use if treatment becomes necessary, or if Tamiflu is readily available in the country where they live. **Counterfeit Drug Warning** Americans should also be aware of the potential health risk posed by counterfeit drugs, including those represented as Tamiflu, by internet scam artists or in countries with lax regulations governing the production and distribution of pharmaceuticals. **Additional Precautions** In addition, the Department of State has asked its embassies and consulates to consider preparedness measures that consider that travel into or out of a country may not be possible, safe or medically advisable. Guidance on how private citizens can prepare for a "stay in place" response, including stockpiling food, water, and medical supplies, is available on the CDC and pandemicflu.gov websites.

In addition to breaking material into more, shorter, paragraphs, consider using a heading for each paragraph, as we did in this example.

See also Cover only one topic in each paragraph.

Sources

- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 72-73.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 24-25.

4. Cover only one topic in each paragraph

Limit each paragraph or section to one topic to make it easier for your audience to understand your information. Each paragraph should start with a topic sentence that captures the essence of everything in the paragraph.

Don't say	Say
a. Notice of a bid advertisement shall be published in at least one local newspaper and in one trade publication at least 30 days in advance of sale. If applicable, the notice must identify the reservation within which the tracts to be leased are found. Specific descriptions of the tracts shall be available at the office of the superintendent. The complete text of the advertisement shall be mailed to each person listed on the appropriate agency mailing list.	a. Thirty days before the sale, we will publish a notice advertising bids. The notice will be in at least one local newspaper and in one trade publication. It will identify any reservation where the tracts to be leased are located. b. We will share information about this process in two other ways. We will mail the advertisement to each person on the appropriate agency mailing list. We will also provide specific descriptions of the tracts at the superintendent's office.

Putting each topic in a separate paragraph makes your information easier to digest.

d. Other aids to clarity

Examples help your readers understand your points. Break up lots of text with lists and tables. Including an illustration can be more helpful than describing it.

1. Use examples

Examples help you clarify complex concepts, even in regulations. They are an ideal way to help your readers. In spoken English, when you ask for clarification of something, people often respond by giving you an example. Good examples can substitute for long explanations. The more complex the concept you are writing about, the more you should consider using an example. By giving your audience an example that's relevant to their situation, you help them relate to your document.

Avoid using the Latin abbreviations for "for example" (e.g.) and "that is" (i.e.). Few people know what they mean, and they often confuse the two. Write out the lead-in to your example: "for example" or "such as."

The Internal Revenue Service makes extensive use of examples in its regulations throughout 26 CFR Part 1, the regulations on income taxes. The Environmental Protection Agency also uses examples in its regulations. Here's one from 40 CFR Part 50, Appendix H – Interpretation of the 1-Hour Primary and Secondary National Ambient Air Quality Standards for Ozone.

EPA example
Suppose a monitoring station records a valid daily maximum hourly average ozone value for every day of the year during the past 3 years. At the end of each year, the number of days with maximum hourly concentrations above 0.12 ppm is determined and this number is averaged with the results of previous years. As long as this average remains "less than or equal to 1," the area is in compliance.

Sources

- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 45-46.

2. Use lists

Vertical lists highlight a series of requirements or other information in a visually clear way. Use vertical lists to help your user focus on important material. Vertical lists:

- Highlight levels of importance
- Help the user understand the order in which things happen
- Make it easy for the user to identify all necessary steps in a process
- Add blank space for easy reading
- Are an ideal way to present items, conditions, and exceptions

Don't say	Say
Each completed well drilling application must contain a detailed statement including the following information: the depth of the well, the casing and cementing program, the circulation media (mud, air, foam, etc.), the expected depth and thickness of fresh water zones, and well site layout and design.	With your application for a drilling permit, provide the following information: • Depth of the well; • Casing and cementing program; • Circulation media (mud, air, form, etc); • Expected depth and thickness of fresh water zones; and • Well site layout and design.

Vertical lists are also helpful in clarifying the chronological order of steps in a process. With these lists, consider numbering the items to suggest the order of steps.

Vertical list suggests the correct order of events
When a foreign student presents a completed Form I-20: 1. Enter the student's admission number from Form 94; 2. Endorse all copies of the form; 3. Return a copy to the student; and 4. Send a copy to the Immigration and Naturalization Service.

However, you can over-use vertical lists. Remember to use them to highlight important information, not to over-emphasize trivial matters. If you use bullets, use solid round or square ones. Bullets are not the place to be overly creative. Large creative bullets with strange shapes tend to distract the reader and may not display properly on some computer systems.

Your lists will be easier to read if you:

- Always use a lead-in sentence to explain your lists;
- Indent your lead-in sentence from the left margin; and
- Use left justification only – never center justification.

Don't say	**Say**
Classroom supplies: • A tablet • A pen or pencil • The paperwork you sent us when you first applied for class	Classroom Supplies When you come to class, you should bring the following – • A tablet • A pen or pencil • The paperwork you sent us when you first applied for class.

In the example above, the lack of a lead-in sentence on the left makes it unclear who is to bring the supplies. The lead-in sentence on the right clarifies who is responsible for bringing supplies. Indenting the list under the lead in sentence makes it easier to see how the information is chunked. Use parallel construction and make sure each of the bullets in a list can make a complete sentence if combined with the lead-in sentence.

The following example is a list that is not parallel:

You must submit:

- Your application,
- Recommendation letter, and
- Mail it express mail.

The bullet "Mail it express mail" does not work with the rest of the list. The other items are nouns, but this is a verb. It isn't something to submit. It's a separate part of the instructions.

Sources

- Charrow, Veda R., Erhardt, Myra K. and Charrow, Robert P. *Clear & Effective Legal Writing*, 4th edition, 2007, Aspen Publishers, New York, NY, pp. 181-182.
- Garner, Bryan A., *Legal Writing in Plain English*, 2001, University of Chicago Press, Chicago, pp. 100, 125.
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 25, 81-84.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, p. 34.

3. Use tables to make complex material easier to understand

Tables help your audience see relationships that are often times hidden in dense text. And for most readers, it's not necessary to understand all possibilities and conditions, only those that apply to the reader's situation.

Probably the most useful type of table is the "if-then" table. An "if-then" table organizes the material by a situation (if something is the case) and the consequence (then something else happens). The rewritten regulation in the "if-then" table below is far clearer than the dense text it replaces. It also makes the document appear less dense and easier on the eye.

Dense text from 25 CFR 163.25

§ 163.25 Forest management deductions.

a. Pursuant to the provisions of 25 U.S.C. 413 and 25 U.S.C. 3105, a forest management deduction shall be withheld from the gross proceeds of sales of Indian forest land as described in this section.
b. Gross proceeds shall mean the value in money or money's worth of consideration furnished by the purchaser of forest products purchased under a contract, permit, or other document for the sale of forest products.
c. Forest management deductions shall not be withheld where the total consideration furnished under a document for the sale of forest products is less than $5,001.
d. Except as provided in § 163.25(e) of this part, the amount of the forest deduction shall not exceed the lesser amount of ten percent (10%) of the gross proceeds or, the actual percentage in effect on November 28, 1990.
e. The Secretary may increase the forest management deduction percentage for Indian forest land upon receipt of a written request from a tribe supported by a written resolution executed by the authorized tribal representatives. At the request of the authorized tribal representatives and at the discretion of the Secretary the forest management deduction percentage may be decreased to not less than one percent (1%) or the requirement for collection may be waived.

If-then table

§ 163.25 Will BIA withhold any forest management deductions?

We will withhold a forest management deduction if the contract for the sale of forest products has a value of over $5,000. The deduction will be a percentage of the price we get from the buyer. The following table shows how we determine the amount of the deduction.

If ...	and ...	then the percentage of the deduction is ...
a tribe requests an increase in the deduction through a tribal resolution	they send us a written request	the percentage requested by the tribe.
an authorized tribal representative requests a decrease in the deduction	we approve the decrease	the percentage requested, with a one percent minimum.
an authorized tribal representative requests a waiver of the deduction	we approve the waiver	waived.
none of the above conditions applies		the percentage in effect on November 28, 1990, or 10 percent, whichever is less.

You can use variations on the if-then table to clarify other types of complicated provisions. Which of the following would you rather read?

Dense text from 25 CFR 163.17

§ 163.17 Deposit with bid.

(a)A deposit shall be made with each proposal for the purchase of Indian forest products. Such deposits shall be at least:

(1) Ten (10) percent if the appraised stumpage value is less than $100,000 in any event not less than $1,000 or full value whichever is less.
(2) Five (5) percent if the appraised stumpage value is $100,000 to $250,000 but in any event not less than $10,000; and
(3) Three (3) percent if the appraised stumpage value exceeds $250,000 but it any event not less than $12,500.

If-then table

§ 163.17 Must I make a deposit with my bid?

You must include a deposit with your bid to buy Indian forest products, but the amount of the deposit varies.

If the appraised stumpage value is ...	**you must deposit ...**	**and the minimum amount of the deposit is ...**
less than $100,000	ten percent of the stumpage value	$1,000
between $100,000 and $250,000	five percent of the stumpage value	$10,000
over $250,000	three percent of the stumpage value	$12,500

If-then tables are powerful tools for simplifying complicated material. And tables generally use many fewer words that a straight textual explanation would use.

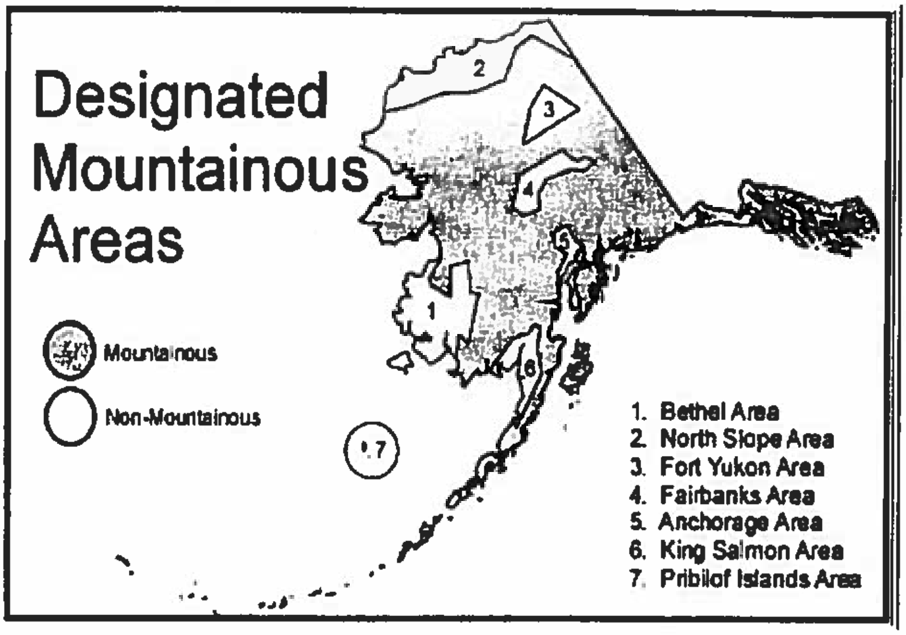
Sources

- Kimble, Joseph, *Lifting the Fog of Legalese*, 2006, Carolina Academic Press, Durham, NC, p.70(B).
- Murawski, Thomas A., *Writing Readable Regulations*, 1999, Carolina Academic Press Durham, NC, pp. 39-44.
- Office of the Federal Register, *Document Drafting Handbook*, 1998, MMR4. www.archives.gov/federal-register/write/handbook/.
- Securities and Exchange Commission, *Plain English Handbook*, 1998, Washington, DC, pp.49-52.

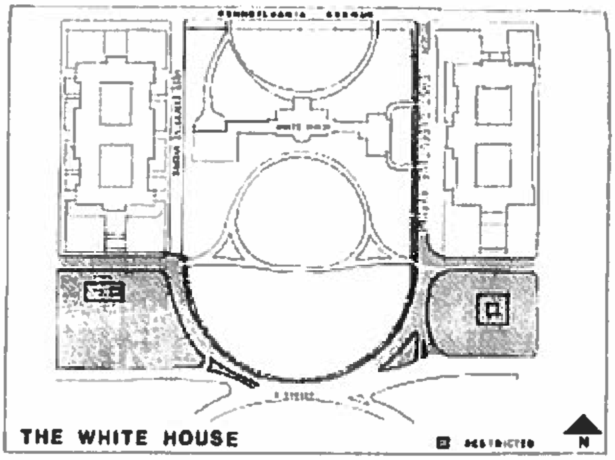
4. Consider using illustrations

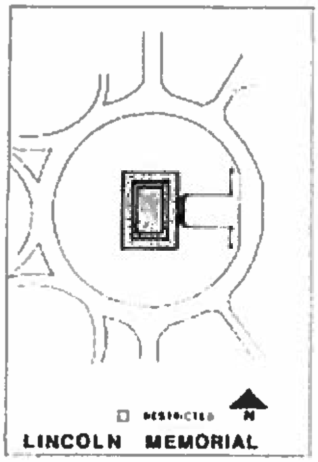
While government pamphlets and similar items intended for the public usually include many illustrations, illustrations rarely appear in letters or regulations. However, even in these documents, you can use illustrations to good effect. Consider these examples from regulations.

Federal Aviation Regulations in 14 CFR part 95 contain illustrations of mountainous areas which are subject to special flight restrictions, such as this illustration of mountainous areas of Alaska:



National Park Service regulations at 36 CFR part 7.96 includes pictures of areas in Washington, DC, where activities are controlled, such as these drawings of the White House and Lincoln Memorial:





14 CFR 1221.102 establishes the NASA Seal.

FIGURE A

The NASA Seal

<u>TECHNICAL DESCRIPTION</u>:

The official seal of the National Aeronautics and Space Administration is a disc of blue sky strewn with white stars. To the left, there is a large yellow sphere bearing a red flight vector symbol. The wings of the vector symbol envelope and cast a brown shadow upon it. A white horizontal orbit also encircles the sphere. To the right, there is a small light blue sphere. A white band which circumscribes the disc is edged in gold and is inscribed with "National Aeronautics and Space Administration U.S.A." in red letters.

Appendix B to 40 CFR Part 50 illustrates the measurement principle and calibration procedure for measuring carbon monoxide in the atmosphere.

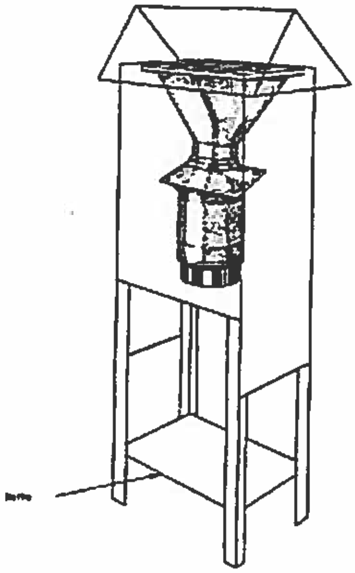


Figure 1. High-volume sampler in shelter.

50 CFR section 216.95 illustrates the official mark for "Dolphin-safe" tuna products.

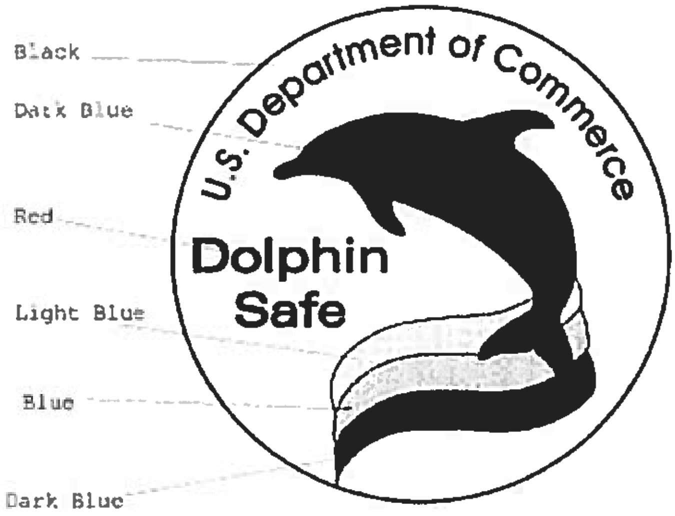


Figure 1.

5. Use emphasis to highlight important concepts

Use ***bold and italics*** to make important concepts stand out. While it is difficult to use these techniques in regulations, emphasis helps bring out important points in other documents. Limit emphasis to important information, otherwise you'll dilute its impact.

PUTTING EVERYTHING IN CAPITAL LETTERS IS NOT A GOOD EMPHASIS TECHNIQUE. ALTHOUGH IT MAY DRAW THE USER'S ATTENTION TO THE SECTION, IT MAKES IT HARDER TO READ. AND IN AN ELECTRONIC ENVIRONMENT IT'S CONSIDERED SHOUTING. Similarly, underlining will draw the user's attention to the section, but it makes it hard to read. Besides, in an electronic environment, people expect underlined text to be a link. ***It's better to use bold and italics for important issues.***

6. Minimize cross-references

Nothing is more annoying than coming upon cross-references in reading material. Cross-references frustrate any attempt to write clearly and simply. Most users consider them a bother, and just skip over them. This can be a problem when the document is a regulation. Numerous cross-references can confuse users and make them less attentive to your message. They may also overtax your users' short-term memory. Imagine the work it would take a user to puzzle out just this one short section from our tax regulations (26 CFR 1.1(h)-1).

Regulation with many confusing cross-references
"Section 1250 capital gain — (i) *Definition.* For purposes of this section, *section 1250 capital gain* means the capital gain (not otherwise treated as ordinary income) that would be treated as ordinary income if section 1250(b)(1) included all depreciation and the applicable percentage under section 1250(a) were 100 percent."

On the other hand, repeating bulky material over and over can be equally annoying to users. So there is a place for cross-references, but the challenge is to not overdo them.

How to minimize cross-references

There are several ways to deal with cross-references. The best is to organize your material so you can ***eliminate the need for cross-references.*** Often, you are forced to resort to a cross-reference because the material isn't organized the way it should be, so material that belongs together is instead found in distant sections. However, given the complexity of some documents, it won't be possible to eliminate them all. If a cross-reference refers to ***brief material,*** just repeat that material and get rid of the cross-reference. Sometimes, careful thought may reveal that you've included an ***unnecessary cross-reference.***

If the cross-reference is to ***lengthy material*** that, if included, would make the wording long and complicated, you may have to refer users to another section. Typically, this would include long descriptive material, such as a long list of items or a list of requirements that you want to apply to a new situation.

Be sure that the reference you insert clearly describes the referenced material. That way, users can decide if they need to read it to know how the rule affects them. Sometimes just including the title of the referenced section is enough.

Let's look at an example from the National Park Service.

A requirement with several cross references
Section 45. May I camp in a national park? If you hold one of the vehicle entry passes listed in Section 18 for entry into a national park, you may camp in that park. But you may not sleep in a tent if the park has declared one of the animal danger levels described in paragraphs (c) through (h) of Section 51, and the campsite is not covered by an animal emergency plan as described in Section 52.

In this excerpt, the first cross-reference is to brief material, so you can just repeat it here. The second cross-reference is to a long list of information; it's probably clearest to keep the cross-reference. The third cross-reference probably isn't necessary — the camper needs to know whether there is an animal emergency plan, but not the details of the plan contained in Section 52. Following these principles, the final text could read:

Two of three cross-references eliminated
Section 45. May I camp in a national park? If you hold a daily, weekly, or annual vehicle entry pass for a national park, you may camp in that park. But you may not sleep in a tent if the park has declared one of the animal danger levels described in paragraphs (c) through (h) of Section 51, and the campsite is not covered by an animal emergency plan.

Another treatment

If you believe you must include cross-references, consider putting them at the end of the text, like a reference, rather than in the middle. This is less disruptive to the user, and less annoying. It gives users a chance to absorb your main message before your references elaborate on it. As an example, if you need to keep the second and third references in the national park example above, you might write it this way:

Cross-references at end of passage
Section 45. May I camp in a national park?

Cross-references at end of passage
If you hold a daily, weekly, or annual vehicle entry pass for a national park, you may camp in that park. But you may not sleep in a tent if the park has declared an animal danger level and the campsite is not covered by an animal emergency plan. (See paragraphs (c) through (h) of Section 51 for animal danger levels.) (See Section 52 for animal emergency plans.)

Referring to another agency's regulations

If you want to require users to comply with certain requirements of another federal agency, which they would not otherwise have to do, you have to meet the requirements of the Office of the Federal Register (OFR). A federal agency may cross-reference the regulations of another federal agency only if the OFR finds that the reference meets one of the conditions specified in 1 CFR 21.21. You can find a discussion of these conditions in the OFR's *Drafting Legal Documents* under Cross References.

Referring to other material in regulations

A cross-reference to material that does not appear in the *Federal Register* or the Code of Federal Regulations is called an "incorporation by reference" by the Office of the Federal Register. The OFR has very specific rules that agencies must follow to do incorporation by reference. You will find them in 1 CFR part 51 and Chapter 6 of the OFR's *Document Drafting Handbook.*

Avoid these situations

Multiple cross-references in one section. Multiple cross-references make your user's head spin, and you will fail to deliver any useful information. Reorganize your material to eliminate the cross-references, or at least to keep them to no more than one in each section.

Unnecessary cross-references put in to ensure that your users don't miss something that applies to them. You won't know where to stop cross-referencing. You should presume that users will familiarize themselves with your document to see what applies to them. Make sure your table of contents and headings are informative enough that users can find everything they need.

Cross-referencing definitions. Adding a cross-reference to a definition for the convenience of the audience may create a problem if you don't continue to repeat it every time you use the word.

If you say	Then you can't later just say
a corporation as defined in Section 1 (when Section 1 clearly applies to your regulation and defines a corporation as having, for example, at least 50 employees)	a corporation (some users may think the 50-employee limit doesn't apply here.)

The "boomerang." Rudolf Flesch (1979) named this particularly insidious cross-reference. It's a reference that refers to the section it's found in. It sends users on a futile hunt for another section of the same number, until they finally realize you are referring to the same section they were reading in the first place. If you mean "listed in paragraph (h) of this section" say it that way. The Office of the Federal Register's *Document Drafting Handbook* tells you the proper way to refer to something in the same section of a regulation.

The "all-inclusive" cross-reference. It's no help to your audience to say something like "As a permittee, you must comply with sections 542.6 and 543.10, and all other applicable laws and regulations." What exactly does the term "all other applicable laws and regulations" cover? Do you expect your reader to become a legal scholar and go out and research the answer to that question? This form of cross-reference reflects a lazy writer. And it's not likely to achieve much.

The never-ending story cross reference. This is the cross-reference that refers the reader to another section containing another cross-reference, which takes the reader to yet another section containing another cross-reference, and so on forever and ever. If you can't follow the web of references, why do you think your audience will?

Final thoughts

Whether you use a cross-reference or repeat the material in the new location, you must remember to update the information if something in the cross-referenced material changes.

There is no hard and fast rule about when it's reasonable to use a cross-reference. It depends on the purpose of the cross reference and the bulk of the material referenced. The bottom line is that you should minimize them to the extent possible.

Sources

- Flesch, Rudolf, *How to Write in Plain English, A Book for Lawyers and Consumers*, 1979, Harper and Rowe, New York, pp. 82-93.
- Office of the Federal Register, Document Drafting Handbook, 1998, 1-15. www.archives.gov/federal-register/write/handbook/ddh.pdf.

7. Design your document for easy reading

We want our documents to help the audience get information, comply with requirements, and apply for benefits with the minimum possible burden. Documents that appear cluttered and dense create a negative reaction in the minds of our readers. We've heard many times from readers that when they get a dense, uninviting document from the government, they often put it in the "to be read later" pile, even though they know they should read it right away.

Document design is an important part of developing an effective document. Documents that are easy on the eye are far easier to understand than more traditional styles. You can use design elements to highlight important points and to ensure your user reads the most important parts of the document.

Even with regulations and the limits of publishing in the Code of Federal Regulations, you can replace blocks of text with headings, tables, and lists to create more white space. Short sentences and sections will also break up a regulation into visually manageable chunks. You will help your audience by making the main points readily apparent and grouping related items together. The easier it is for your audience to get through the regulation, the more likely it is they will comply with its requirements.

Here are a few brief guidelines for good document design:

- Have five or six sections on each printed page (about two on each typewritten page)
- Use lists and tables often, but don't overuse them and don't have lists within lists
- Use ragged right margins where possible, rather than fully justifying your text

Sources

- Schriver, Karen, *Dynamics in Document Design: Creating Text for Readers*, 1996, John Wiley and Sons, Hoboken, NJ.

IV. Write for the web

This section refers to the audience as users since that is a more common term in the web community. To effectively communicate with your web users, you must use plain-language techniques to write web content. This section will explain the differences between print and web writing and how to create sites that work for your users.

a. How do people use the web?

People use the internet to easily find, understand, and use information to complete a task. Unlike print media, people do not read entire web pages. They scan instead. Nielsen and Morkes, in a famous 1997 study, found that 79 percent of their test users always scanned any new page they came across; only 16 percent read word-by-word.

Even with more people using the web, the percent of content that is read on a website has not increased by much. Here are some facts to consider when writing web content:

- In a 2008 study, based on analysis of 45,237 page views, Nielsen found that web users only read about 18% of what's one page.
- As the number of words on a page goes up, the percentage read goes down.
- To get people to read half your words, you must limit your page to 110 words or fewer.

What do web users look at?

Since we know web users scan web pages, we need to learn what they look at.

Users often scan pages in an F pattern focusing on the top left side of the page, headings, and the first few words of a sentence or bulleted list. On average, users only read the first two words on each line. Also, users can decide in as little as five seconds whether your site is useful to them.

Here is an image of one of the eye tracking pages. The red shows where the user looked the most:

Sources

- www.useit.com/alertbox/percent-text-read.html
- www.customercarewords.com/what-it-is.html
- ***Eyetracking Web Usability***, New Riders Press, December 14, 2009
- www.uie.com/articles/five_second_test/

b. Write for your users

Think about how well your website allows customers to get something done.

- Customers come to your site to perform a task.
- They come because they expect to get self-service.

People come to your website with a specific task in mind. If your website doesn't help them complete that task, they'll leave.

You need to identify the mission — the purpose — of your website, to help you clarify the top task your website should help people accomplish.

c. Identify your users and their top tasks

In order to write for your users, you need to know who they are! Here are some general tips to help you identify your users:

- Listen to user questions — what do your visitors ask when they send you an email or call your office?
- Talk to users and ask them what they want.
- Analyze your web metrics to figure out what people are looking for on your website:
    - What are your most-visited pages and where do people spend the most time?
    - What top search phrases do people use?

There are many techniques to help you learn about your users. For details and best practices visit www.usability.gov.

Source

- www.customercarewords.com/how-it-works.html

d. Write web content

After identifying your users and their top tasks, it is time to actually write web content. If you think it would be easy to just duplicate information you've written for print documents, you are wrong. While the information is helpful, it's not in the right format for the web. Remember, people scan web pages and only read about 18 percent of what's on the page! This means you need to cut whatever you have in print form by 50 percent!

Good web content uses:

- **The inverted pyramid style.** Begin with the shortest and clearest statement you can make about your topic. Put the most important information at the top and the background at the bottom.
- **Chunked content.** Don't try to pack everything into long paragraphs. Split topics up into logical sections separated by informative headings.
- **Only necessary information:** Use only the information your users need to achieve their tops tasks. Omit unnecessary information.

Remember:

Your content is **NOT** clear unless your users can:

- Find what they need
- Understand what they find
- Use what they find to meet their needs

Source

- Nielsen, Jakob, *Designing Web Usability: The Practice of Simplicity* (and other works), 1999, New Riders Publishing, Indianapolis.
- McGovern, Gerry, *Killer Web Content: Make the Sale, Deliver the Service, Build the Brand* (and other works), 2006, A&C Black.
- Redish, Janice, *Writing Web Content that Works*, 2007, Morgan Kaufmann Publishers, San Francisco.

e. Repurpose print material for the web

Don’t cut and paste the text of print documents to create web content. People are more likely to leave your webpage, potentially costing you time and money, because they will not take the time to find what they are looking for.

Print writing is different from web writing. Print is very linear and narrative driven. In print, you can go into great detail about mundane things like eating breakfast. If you are a great writer, that can be an interesting story. But, those interesting stories don't work on the web. Instead they slow down web users who are trying to accomplish a task.

Jakob Nielsen (useit.com) explains that “Web users want ***actionable*** content; they don’t want to fritter away their time on (otherwise enjoyable) stories that are tangential to their current goals.”

Because the web is “action-oriented,” you need to repurpose your print document.

Pick out necessary information in your print document that will help your web users and create a new web page.

- Keep the most important and clear message at the top of the web page
- Chunk your content into logical sections
- Use headings to help users navigate the content
- Highlight key facts in a bulleted list
- Explain complex instructions in a visually appealing If/Then table.

Source

- www.useit.com/alertbox/print-vs-online-content.html

f. Avoid PDF overload

Posting PDF versions (PDFs) of original documents on your site would seem to be an obvious alternative to re-writing your content in web-format. Unfortunately, this would work against your goal of retaining users. Posting too many PDF documents on your website can work against you. The Nielsen group has done multiple studies on PDFs and has consistently found that users hate them and try to avoid reading PDFs at all costs.

PDF files:

- Are slow to open and can sometimes crash a computer if they are too large
- Are difficult for some screen users to read
- Can make a user lose the website if they open in the same window

If you need to post a PDF use a gateway page — a web page that includes information about the PDF, including.

- What it's about
- How large the file is
- Who might find the information helpful

Remember to follow 508-compliance guidelines when using PDFs. See www.section508.gov for more information on 508-compliance.

Source:

- www.useit.com/alertbox/20030714.html

g. Use plain-language techniques on the web

We discussed plain-language techniques early in the guidelines. These techniques apply to web writing as well. Please refer to the specific section in the table of contents.

When writing web content

USE:

- Logical Organization
- Informative Headings
- Active Voice
- Use Pronouns
- Common Words
- Use lists and tables

AVOID:

- Jargon and legalese
- Hidden Verbs
- Passive Voice
- Long sentences or paragraphs
- Abbreviations
- Unnecessary Words
- Information the user doesn't want

h. Avoid meaningless formal language

Many government websites and letters contain meaningless formal language such as flowery welcome messages and "we hope you get a lot out of our program" messages. Using this type of language wastes space and your users' time. It conveys the impression that you are insincere. Don't waste your users' time. Instead, get directly to the point. Remember, time is money on the web. Keep your important information at the top of a web page. Don't bury it under fluff messages.

Here is a brief list of meaningless filler phrases:

- Thinking outside the box
- Value added
- Best practice
- For all intents and purposes
- Touch base
- Integrating quality solutions
- Promoting an informed and inclusive multicultural society
- Strategically engaging schools, community organizations, and so on . . .

Source

- Redish, Janice, *Writing Web Content that Works*, 2007, Morgan Kaufmann Publishers, San Francisco.
- www.contentini.com/writing-better-tips/

i. Write effective links

Links are about both content and navigation. Effective link names are key to satisfying your customers. The Eyetracking Studies showed links written in plain-language were the most effective. Plain-language links are written clearly so that the user understands exactly where the link will take them.

- Link names should be the same as the page name linked to.
- Don't use the full name of a document or program as a link name.
- Be as explicit as you can — too long is better than too short.
- Make the link meaningful. Don't use "click here" or "more."
- Don't embed links in text. It just invites people to leave your text!
- Add a short description when needed to clarify the link.

Remember, some of your users might be visually disabled. Do not use "Click Here" or "Click the green button" links. Make sure your links are accessible to all users. You want to use links that clearly explain the content of the page it links to. If your link says "Annual Reports," then destination page must be titled "Annual Reports."

Sources

- McGovern, Gerry, *Killer Web Content: Make the Sale, Deliver the Service, Build the Brand* (and other works), 2006, A&C Black.
- Nielsen, Jakob, *Designing Web Usability: The Practice of Simplicity* (and other works), 1999, New Riders Publishing, Indianapolis.
- www.useit.com/alertbox/nanocontent.html

V. Test

Testing your documents should be an integral part of your plain-language planning and writing process, not something you do after the fact to see if your document (or your website) is a success. It's especially important if you're writing to hundreds, thousands, or even millions of people.

The information gained in testing can save time in answering questions about your document later. Although we refer to "documents" in this section, use these same techniques to test individual web pages or complete websites. In fact, we recommend testing websites, documents, brochures, applications, mobile websites, videos, social media, and public affairs messages.

When should I start testing?

Start as soon as you have enough material to test. Don't wait until your website has been coded or your document is complete. You can test your new material using a Word or PowerPoint document; you can test a large website or document in sections. You can also test existing websites and documents.

Test as early as you can in the project, whether you're creating something new or making revisions. Test, make corrections based on feedback, and test again. Plan to test at least twice. This process of testing, revising, and re-testing is called "iteration." Iteration is part of what makes usability testing so effective.

What types of testing are available?

You can use several techniques to help you improve your document so that the final version will be successful:

- Paraphrase Testing: individual interviews, best for short documents, short web pages, and to test the questions on a survey
- Usability Testing: individual interviews, best for longer documents and web sites where finding the right information is important; also best for forms – see www.usability.gov
- Controlled Comparative Studies: large scale studies where you don't meet the people but you collect statistics on responses; use paraphrase testing and usability testing on a smaller scale first

Focus groups are discussions in which you learn about users' attitudes and expectations more than about whether they can find and understand information. Therefore, they are more relevant to understanding your audience before you write than to testing. For more on focus groups, see www.usability.gov/methods/analyze_current/learn/focus.html.

a. Paraphrase Testing

One-on-one paraphrase testing sessions with users work best for short documents, short web pages, and when testing the questions on a survey.

Paraphrase testing will tell you what a reader thinks a document means and will help you know if the reader is interpreting your message as you intended. (See VBA testing success)

Try to conduct 6 to 9 interviews on each document.

Ask the participant to read to a specific stopping point, known as a cue. Each time the participant reaches a cue, ask the participant to tell you in his or her own words what that section means. Take notes, writing down the participant's explanation in the participant's words. Do not correct the participant. When you review your notes later, wherever participants misunderstood the message, the document has a problem that you should fix.

Ask additional, open-ended questions.

- What would you do if you got this document?
- What do you think the writer was trying to do with this document?
- Thinking of other people you know who might get this document:
    - What about the document might work well for them?
    - What about the document might cause them problems?

This last question is important because sometimes people are more comfortable telling you what they think others might find confusing, rather than admitting that they don't understand something themselves.

Don't ask yes/no questions.

You won't get much usable information from that type of question.

With only 6 to 9 participants, paraphrase testing will not take a lot of time, and the time invested is worth it. Taking the time to test your document and change it based on what you learn may save you hundreds of hours later answering questions from your users or producing a second document clarifying the first one.

For longer documents where finding information is also important do usability testing. Usability testing is the best technique for booklets, regulations, and web sites. With usability testing, you test the document as a whole, not just individual paragraphs.

b. Usability Testing

One-on-one usability testing sessions with users work best when the participant actually uses the document to find and understand information.

Usability testing is the best technique for documents where people have to find the information before understanding it. (See National Cancer Institute testing success)

When should I test?

You can conduct usability testing at any time that you have a draft. After you make changes based on the first round of usability testing, you can conduct a second round to see if your changes solved the problems you found without introducing new problems.

Who should I test?

You need to find three people to test your website or document.

Identify who your intended readers are. For example, individuals searching for medical information; taxpayers and tax professionals looking for forms; travelers wanting a passport.

Develop simple criteria and find three people who match them. For example, for travelers, the criteria might be: Adult U.S. citizens who haven't applied for or renewed a passport lately. The criteria don't need to be complicated.

Using your network of colleagues, friends, and family, find three people who, more or less, meet the criteria and will give you an hour of their time. Don't use members of your own team, but employees from a different team down the hall may be fine.

You're not required to get any special permission to do a usability test with only three people. Set aside a morning to conduct your test, and give each of the volunteers an appointment, one hour apart from each other.

What happens in a typical session?

A typical usability test session lasts about one hour with these parts:

- **Introduction.** You make the participant comfortable, explain what will happen, and ask a few questions about the person to understand their relevant experience.
- **Scenarios.** You give the participant very short stories suggesting they have a need for specific information and then you watch and listen as they find that information and tell you what they understand from what they found.

  An example of a scenario for the FAA web site might be:

  > *You have a private pilot's license and you just moved to a new city. Find out if you need to tell FAA about your new address. If you do, find out how to do that.*

  You can also ask participants for their own scenarios. What would they come to the document you are testing to find out? Then watch and listen as they look for and try to understand the information.

  Typically, you ask people to "think aloud" as they work so you hear their words for what they are looking for and you hear how they understand what they find.
- **Debriefing.** At the end, you can ask neutral questions about the experience and follow up about any specific words or phrases.

What variations are there?

Variations on the one-on-one usability test:

- **Two people working together** (co-discovery). Their discussion is an easy form of think aloud.
- **Several people working independently** at the same time followed by a group discussion. This speeds up the time you spend in usability test sessions, but it only works if you have several usability test note-takers so you have someone watching and listening to each participant before you bring all the participants together for the discussion.
- **Comparative usability tests.** You can include different versions of your document. Because you have a small number of people, it is best to have each person work with both versions. You have to alternate which version people start with.
- **Remote moderated usability testing.** With web-based tools, you do not have to be in the same place as the participant. These tools allow you to draw participants from a wide geographic range without travel costs.

- **Remote unmoderated usability testing.** You can have large numbers of people participate through remote testing tools. (For federal agencies, this may require clearance through OMB.)

Where can I learn more?

Almost anyone can conduct a simple usability test and fix problems that you see the volunteers encounter. Use these resources to help learn how.

Books

Barnum, Carol. *Usability Testing Essentials: Ready, Set… Test!*, Morgan-Kaufmann/Elsevier, 2011.

Chisnell, Dana, and Rubin, Jeff. *The Handbook of Usability Testing, 2nd edition* (http://www.wiley.com/WileyCDA/WileyTitle/productCd-0470185481,descCd-DOWNLOAD.html)

Krug, Steve. *Rocket Surgery Made Easy (http://www.sensible.com/rocketsurgery/index.html)*

Courses

Web Manager University (WMU) offers webinars, seminars, and one- and two-day courses in usability topics.

"Conducting Usability Testing in the Wild" presented by Dana Chisnell (free archived WMU webinar)

Conferences

Usability Professionals' Association Annual Conference

Nielsen Norman Group conferences

User Interface Engineering holds an annual conference and training events

Additional resources:

Webcontent.gov

Usability.gov

Usability Professionals Association has local chapters which offer training and networking events

c. Controlled Comparative Studies

Collect quantitative data on how well the general public uses your final document.

Controlled comparative studies can be done in several different ways, but they all have similar characteristics. Before you do a controlled study, you should know what results you will consider a success. For instance:

- Do you want more calls regarding a certain program?
- Do you want fewer calls asking for clarification?
- Do you want more people to return an application or a payment?
- Do you want fewer errors on forms people fill out?

Having answers to these questions will help you determine whether your document is successful. Controlled comparative studies are often called A/B testing. You have two (or more versions) of your page – A, B, etc.

Websites and web pages.

Set your web server to send each on a specific schedule (every other call to the page, or one today and the other tomorrow, or one for a certain longer period and the other for the next equal period). Just be sure you can track whatever measure you want by which version the web site visitor saw.

Paper documents.

Send a small test group of people the new version of your document. Let's say you're sending the new version to 700 people. You should also send 700 people, your control group, the old document. Track the responses to all 1400 documents and compare the results. Note that it is much easier to test results when people return a written response than when you try to track the number of phone calls you receive. (If you have a statistician or actuarial staff, they can tell you how many people you should use to make your study scientifically valid. If your agency doesn't have an expert on staff to help you, statistics books will give you a formula to determine a good sample size for your study.)

There are numerous other ways of collecting quantitative data. For instance, you can record what percentage of your "before" letters generates correct responses compared to your "after letters," or what percentage of each letter results in your customer calling you asking for an explanation.

Before you do a controlled comparative study, you should do paraphrase testing or usability testing and change you document based on what you learn in these smaller scale studies. Controlled comparative studies (especially for paper documents) are best near the end of the process. This is because controlled testing will tell you if the new document is a success, but it won't tell you why it is or isn't a success.

d. Testing Successes

We offer two examples of federal agency success with testing. If you have other examples, please let us know.

1. Paraphrase Testing from the Veterans Benefits Administration

The information was so general that it would have generated calls:
Veterans Benefits Administration tested a letter in which users appeared to understand every word. However, when asked what they would do if they got this letter, most people said they would call VBA's toll-free number.

The letter was about a replacement check sent because the original check was out of date. The letter said, "You will receive the new check shortly." Readers indicated that they would call if they didn't receive the check at the same time as the letter. Changing the sentence to show an approximate date they would receive the check eliminated countless phone calls.

A "term of art" that VBA thought veterans understand would have caused readers to take the wrong action:
When testing a multi-use letter, some readers were confused by the term "service-connected disability." To VBA it means that a veteran has a disability that can be traced back to time in military service." Protocol tests showed that one veteran thought it meant a disability that happened at work. Another thought it meant you had to be injured while in the military, but not necessarily while on duty. Another thought you had to have gotten the disability during combat for it to be considered service-connected.

When each reader was asked a general question about understanding the letter, they all said that it was clear. Yet several would have done something other than what VBA wanted because they had a different definition of "service-connected." To solve this problem, VBA explained the phrase so that everyone was working from the same definition.

Adding a word to make something more legally sufficient would have caused readers to give incorrect information:
A team working on a form wanted to use the question, "When were you last (gainfully) employed?" They felt that the term "gainfully employed" would gather more legally sufficient and accurate information than just the word "employed."

Testing showed that readers used at least three different definitions of "gainful" employment:

- Any job
- A job that provides benefits or where you can put money away

- A job that keeps you above poverty level

In fact, research showed that different government agencies may have different definitions of "gainful." But, more importantly, because each reader had a different definition of the word, the agency would have gotten less accurate information if the word had been in the document.

Remember, the goal of paraphrase testing is to ensure that your audience understands your document, and therefore, won't have to call you for an explanation. Although this technique is very valuable, it probably isn't worth the time to test documents that go to only one or a very few people.

2. Usability Testing from the National Cancer Institute

The information was good, but the title confused people.

A team at the National Cancer Institute tested a brochure on skin cancer prevention. They wanted to make sure that the information, title, and design images worked together well. One of the important messages was that even people with dark skin can get skin cancer. People understood the information in the brochure, but said that the title, "People of Color Get Skin Cancer, Too," made them think it was only for African-Americans.

The team changed the title to "Anyone Can Get Skin Cancer" (along with some other changes from the usability test recommendations) and tested it again. This time, when people were asked who the information in the brochure was for, they correctly identified many different people. More importantly, they all said that the information was "for them," too.

The team included both plain language experts and medical subject matter experts. This case study illustrates three points:

- Plain language experts test their work.
- Even a small change can make a big difference in the success of the project.

Retesting after you make a change is important. The second test may validate your decisions; it may also suggest additional changes.

Resource Title	Type of Resource	Authors	Synopsis	
Caring for the Vulnerable: Perspectives in Nursing Theory, Practice and Research, 2nd Edition	Book	Mary de Chesnay; Barbara A. Anderson	Caring for the Vulnerable explores vulnerability from the perspective of individuals, groups, communities, and populations, and addresses the implication of that vulnerability for nurses, nursing, and nursing care. Presents a basic structure for caring for the vulnerable, and forms a theoretical perspective on caring for doing so within a cultural context, with the ultimate goal of providing culturally competent care. Theoretical and research chapters advance to chapters offering learning experiences for nursing students and practitioners. As nurses are the crucial link between those who are vulnerable, and those with access to solutions, it provides ideas for how nurses might advocate for the vulnerable on a policy level. Written specifically for nurses, by nurses, Caring for the Vulnerable is a timely and necessary response to the culturally diverse vulnerable populations for whom nurses must provide appropriate and precise care.	
Race Talk and the Conspiracy of Silence: Understanding and Facilitating Difficult Dialogues on Race	Book	Derald Wing Sue	Learn to talk about race openly, honestly, and productively. Most people avoid discussion of race-related topics because of the strong emotions and feelings of discomfort that inevitably accompany such conversations. Rather than endure the conflict of racial realities, many people choose instead to avoid the topic altogether, or remain silent when it is raised. Race Talk and the Conspiracy of Silence: Understanding and Facilitating Difficult Dialogues on Race puts an end to that dynamic by sharing strategies for smoothing conversations about race in a productive manner. A guide for facilitating and participating in difficult dialogues about race, author Derald Wing Sue – an internationally recognized expert on multiculturalism, diversity, and microaggressions – explores the characteristics, dynamics, and meaning behind discussions about race as well as the hidden "ground rules" that inhibit honest and productive dialogue. Through emotional and visceral examples, this book explains why conversations revolving around racial issues are so difficult, and provides guidelines, techniques, and advice for navigating and leading honest and forthright discussions. Readers will develop a stronger ability to build rapport with people unlike themselves, and discover how not talking about race impacts society as a whole.	
Pedagogy of the Oppressed: 30th Anniversary Edition	Book	Paulo Freire; Donaldo Macedo	First published in Portuguese in 1968, Pedagogy of the Oppressed was translated and published in English in 1970. The methodology of the late Paulo Freire has helped to empower countless impoverished and illiterate people throughout the world. Freire's work has taken on especial urgency in the United States and Western Europe, where the creation of a permanent underclass among the underprivileged and minorities in cities and urban centers is increasingly accepted as the norm. With a substantive new introduction on Freire's life and the remarkable impact of this book by writer and Freire confidant and authority Donaldo Macedo, this anniversary edition of Pedagogy of the Oppressed will inspire a new generation of educators, students, and general readers for years to come.	https://libcom.org/files/FreirePedagogyoftheOppressed.pdf
Diversity, Equity, Inclusion: Strategies for Facilitating Conversations on Race	Book	Caprice Hollins; Ilsa Govan	Facilitating conversations about race often involves tension, as both the facilitators and participants bring emotional experiences and their deeply held values and beliefs into the room. Diversity, Equity and Inclusion: Strategies for Facilitating Conversations on Race guides facilitators through a process of becoming comfortable with the discomfort in leading conversations about racism, privilege and power. This book walks you through the important steps to create a foundation where participants feel brave enough to take risks and share their stories and perspectives. It guides you through strategies for engaging participants in courageous conversations with one another in ways that don't shame and blame people into understanding. This book is a useful tool for individuals, organizations and college professors who are interested in learning techniques for guiding their audience through dialogue whereby they become open to listening to one another for understanding rather than holding on to old beliefs and maintaining a posture of defense. Readers will learn how the dynamics of race show up in cross cultural spaces, including the unique challenges faced by facilitators of color and white facilitators. In addition, we explore how to identify and counter white privilege in the dialogue between participants. Both novice and experienced facilitators will learn helpful strategies for leading conversation that result in people recognizing their role as change agents in ending oppression.	

Health & Social Justice: Politics, Ideology & Inequity in the Distribution of Disease, 1st Edition	Book	Richard Hofrichter	"Health and Social Justice" draws on the growing body of recent literature to offer a comprehensive collection of articles written by a panel of expert contributors who represent a broad range of fields sociology, epidemiology, public health, ecology, politics, organizing, and advocacy. Each article explores a particular aspect of health inequalities and demonstrates how the sources of health inequalities are rooted in injustices associated with racism, sex discrimination, and social class. This important book examines the political implications of various perspectives used to explain health inequities and explores alternative strategies for eliminating them. "Health and Social Justice" covers a broad spectrum of topics. It: analyzes the politics of health inequities; shows how market values often dominate over collective needs for well being; examines the politics of methodology and its implications for research and public policy; critiques the ideological implications of contemporary health promotion as a model for public health; reviews approaches that influence the social determinants of health; evaluates strategies drawn from the European experience, and others, aimed at eliminating health inequities; proposes principles for action and research; analyzes the role of the mass media in influencing the conceptualization of public health issues.	
Mastering Public Health: Essential Skills for Effective Practice, 1st Edition	Book	Barry S. Levy, Joyce R. Gaufin	Mastering Public Health will enable you to improve your performance and productivity within your organization and with the people and the communities you serve. Designed for new and seasoned public health workers alike, this user-friendly guide focuses on the day-to-day practical skills and competencies that are often not taught in educational or training programs. It is a how-to book with tools, techniques, tips, checklists, and other resources that will assist you in developing your competencies in the areas of communication, administration and management, and leadership. Using this book will enable you to be more effective in many areas of your work, including: Communicating with the Public; Advocating for Programs and Policies; Speaking and Writing; Being Culturally Competent; Planning, Budgeting and Obtaining Funding; Recruiting and Developing Employees; Improving Quality and Initiating and Sustaining Change; and Creating a Vision and Inspiring Others. The 60 contributors to this book are experts in public health as well as in the fields of education and organizational management. They have worked in federal, state, and local government agencies as well as non-governmental organizations, academic and research institutions, and consulting organizations. In their chapters, commentaries, and textboxes, they share their expertise and experience and describe best practices. Their personal stories illustrate real-world challenges they faced and successes they achieved.	
The Inclusion Dividend: Why Investing in Diversity & Inclusion Pays Off	Book	Mark Kaplan; Mason Donovan	In today's increasingly diverse, global, interconnected business world, diversity and inclusion is no longer just the right thing to do, it is a core leadership competency and central to the success of business. Working effectively across differences such as gender, culture, generational, race, and sexual orientation not only leads to a more productive, innovative corporate culture, but also to a better engagement with customers and clients. The Inclusion Dividend provides a framework to tap the bottom line impact that results from an inclusive culture. Most leaders have the intent to be inclusive, but translating that into a truly inclusive outcome with employees, customers and other stakeholders requires a focused change effort. The authors provide straightforward advice on how to achieve the kind of meritocracy that will result in a tangible dividend and move companies ahead of the competition. With a foreword by Ana Duarte McCarthy, Chief Diversity Officer of CitiGroup.	
The Diversity and Inclusion Handbook	Book	Sondra Thiederman	Why should diversity and inclusion matter to you and your organization? The answer lies in that one thing we all strive for: SUCCESS. When team members of all backgrounds are included, valued, and respected for their uniqueness and what they have to contribute, they truly are more creative, more committed, more collaborative, and more motivated to participate to the fullness of their potential. They move from a collection of untapped individuals to a productive US focused on common goals and collective achievement. Helping you reach that level of success is what this book is all about! This powerful handbook by respected expert Sondra Thiederman will guide you through the three key dimensions of diversity and inclusion each of which contributes to the ultimate goal of individual and organizational success. Whether you are a small task team or a large multi-national organization, an US climate and culture is one that translates differences into direction, uses the talents of everyone, and is energized to accomplish common goals with excellent outcomes. So, be prepared to learn from what you are about to read in the Diversity and Inclusion handbook. And, most important, to turn this information into action and, ultimately, into success.	

The Loudest Duck: Moving Beyond Diversity While Embracing Differences to Achieve Success At Work	Book	Laura A. Liswood	Written in an accessible style, The Loudest Duck is a business fable that offers an alternate view of a multicultural workplace through the use of practical stories and cultural anecdotes. For instance, the Chinese teach their children, "The loudest duck gets shot," a viewpoint that gets carried into adulthood, while many Americans are taught, "The squeaky wheel gets the grease." As a result, you find two distinct ways of doing business, neither one being necessarily the right or better way. By understanding others' viewpoint, you can understand how better to work with them.	
Blindspot: Hidden Biases of Good People	Book	Mahzarin Banaji; Anthony Greenwald	In Blindspot, Mahzarin Banaji and Anthony Greenwald explore hidden biases that we all carry from a lifetime of experiences with social groups – age, gender, race, ethnicity, religion, social class, sexuality, disability status, or nationality. "Blindspot" is a metaphor to capture that portion of the mind that houses hidden biases. The authors use it to ask about the extent to which social groups – without our awareness or conscious control – shape our likes and dislikes, our judgments about people's character, abilities, and potential. In Blindspot, hidden biases are revealed through hands-on experience with the method that has revolutionized the way scientists are learning about the human mind and that gives us a glimpse into what lies within the metaphoric blindspot – the Implicit Association Test. The title's "good people" are the many people – the authors included – who strive to align their behavior with their good intentions. The aim of Blindspot is to explain the science in plain enough language to allow well-intentioned people to better achieve that alignment. Venturing into this book is an invitation to understand our own minds.	
Social Injustice & Public Health, 2nd Edition	Book	Barry S. Levy; Victor W. Sidel	This second edition of Social Injustice and Public Health is a comprehensive, up-to-date, evidence-based resource on the relationship of social injustice to many aspects of public health. With contributions from leading experts in public health, medicine, health, social sciences, and other fields, this integrated book documents the adverse effects of social injustice on health and makes recommendations on what needs to be done to reduce social injustice and thereby improve the public's health. Social Injustice and Public Health is divided into four parts: (1) The nature of social injustice and its impact on public health; (2) How the health of specific population groups is affected by social injustice; (3) How social injustice adversely affects medical care, infectious and chronic non-communicable disease, nutrition, mental health, violence, environmental and occupational health, oral health, and aspects of international health; and (4) What needs to be done, such as addressing social injustice in a human rights context, promoting social justice through public health policies and programs, strengthening communities, and promoting equitable and sustainable human development.	
Seeing Patients: Unconscious Bias in Healthcare. 1st Edition	Book	Augustus A. White, III; David Chanoff	This book takes on one of the few critically important topics that haven't figured in the heated debate over health care reform—the largely hidden yet massive injustice of bias in medical treatment. In Seeing Patients White draws upon his experience in startlingly different worlds to make sense of the unconscious bias that riddles medical treatment, and to explore what it means for health care in a diverse twenty-first-century America. This book brings together insights from the worlds of social psychology, neuroscience, and clinical practice to define the issues clearly and, most importantly, to outline a concrete approach to fixing this fundamental inequity in the delivery of health care.	
Microagressions in Everyday Life: Race, Gender & Sexual Orientation	Book	Derald Wing Sue	A transformative look at covert bias, prejudice, and discrimination with hopeful solutions for their eventual dissolution. Written by bestselling author Derald Wing Sue, Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation is a first-of-its-kind guide on the subject of microaggressions. This book insightfully looks at the various kinds of microaggressions and their psychological effects on both perpetrators and their targets. Thought provoking and timely, Dr. Sue suggests realistic and optimistic guidance for combating—and ending—microaggressions in our society.	

Microaggressions & Marginality: Manifestation, Dynamics, Impact	Book	Derald Wing Sue	A landmark volume exploring covert bias, prejudice, and discrimination with hopeful solutions for their eventual dissolution. Exploring the psychological dynamics of unconscious and unintentional expressions of bias and prejudice toward socially devalued groups – this book takes an unflinching look at the numerous manifestations of these subtle biases. It thoroughly deals with the harm engendered by everyday prejudice and discrimination, as well as the concept of microaggressions beyond that of race and expressions of racism. This book features contributions by notable experts presenting original research and scholarly works on a broad spectrum of groups in our society who have traditionally been marginalized and disempowered. The definitive source on this topic, Microaggressions and Marginality features: In-depth chapters on microaggressions towards racial/ethnic, international/cultural, gender, LGBT, religious, social, and disabled groups; Chapters on racial/ethnic microaggressions devoted to specific populations including African Americans, Latino/Hispanic Americans, Asian Americans, indigenous populations, and biracial/multiracial people; A look at what society must do if it is to reduce prejudice and discrimination directed at these groups; Discussion of the common dynamics of covert and unintentional biases; and Coping strategies enabling targets to survive such onslaughts. Timely and thought-provoking, Microaggressions and Marginality is essential reading for any professional dealing with diversity at any level, offering guidance for facing and opposing microaggressions in today's society.	
"Why Are All the Black Kids Sitting Together in the Cafeteria? And Other Conversations About Race	Book	Beverly Daniel Tatum	Walk into any racially mixed high school and you will see black youth seated together in the cafeteria. Of course, it's not just the black kids sitting together-the white, Latino, Asian Pacific, and, in some regions, American Indian youth are clustered in their own groups, too. The same phenomenon can be observed in college dining halls, faculty lounges, and corporate cafeterias. What is going on here? Is this self-segregation a problem we should try to fix, or a coping strategy we should support? How can we get past our reluctance to talk about racial issues to even discuss it? And what about all the other questions we and our children have about race? Beverly Daniel Tatum, a renowned authority on the psychology of racism, asserts that we do not know how to talk about our racial differences: Whites are afraid of using the wrong words and being perceived as "racist" while parents of color are afraid of exposing their children to painful racial realities too soon. Using real-life examples and the latest research, Tatum presents strong evidence that straight talk about our racial identities-whatever they may be-is essential if we are serious about facilitating communication across racial and ethnic divides. We have waited far too long to begin our conversations about race. This remarkable book, infused with great wisdom and humanity, has already helped hundreds of thousands of readers figure out where to start.	
Waking Up White, And Finding Myself in the Story of Race	Book	Debby Irving	For twenty-five years, Debby Irving sensed inexplicable racial tensions in her personal and professional relationships. As a colleague and neighbor, she worried about offending people she dearly wanted to befriend. As an arts administrator, she didn't understand why her diversity efforts lacked traction. As a teacher, she found her best efforts to reach out to students and families of color left her wondering what she was missing. Then, in 2009, one "aha!" moment launched an adventure of discovery and insight that drastically shifted her worldview and upended her life plan. In Waking Up White, Irving tells her often cringe-worthy story with such openness that readers will turn every page rooting for her-and ultimately for all of us.	
A Handbook of Business Transformation Management Methodology	Book	Axel Uhl; Lars Alexander Gollenia	This book provides an integrative Business Transformation Management Methodology, the BTM, with an emphasis on the balance between the rational aspects of transformation and the often underestimated emotional readiness of employees to absorb and accept transformation initiatives. The BTM is a response to the limitations of single methods and management approaches that have always been adopted separately from each other. Comprising four phases - Envision, Engage, Transform, and Optimize - the methodology integrates discipline-specific technical and methodological expertise from transformation-relevant subject areas. The BTM provides guidance and support for transformation projects by bringing together the disciplines of Meta, Strategy, Value, Risk, Transformational IT, Program and Project, Organizational Change, Business Process, and Competence and Training Management. While Strategy, Value, and Risk Management set the course for a business transformation, the other disciplines enable the transformation process. It incorporates topics such as business transformation culture, values, and communication, as well as formal and informal structures and roles needed for a successful transformation approach. Additionally, a wide range of theory is discussed to help understand the phenomenon of transformation with new insights from case studies that helped to develop the methodology that is offered here.	Book Chapter Sample: http://www.ashgate.com/pdf/SamplePages/A-Handbook-of-Business-Transformation-Management-Methodolog-CH2.pdf

FLPPS
FINGER LAKES PERFORMING
PROVIDER SYSTEM

Cultural Competence and Health Literacy Strategy

Process Plan

"Promoting Patient Choice and Patient Choice, While Ensuring High Value, Equitable Care."

Appendix K – CC/HL Process Plan

December 2015

MILESTONE 1: FINALIZE CULTURAL COMPETENCY/ HEALTH LITERACY STRATEGY

PROCESS PLAN

Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Cultural Competence/Health Literacy in health care includes the ability of staff and their organizations to understand and integrate these factors into the service delivery and infrastructure of the health care system. The goal of culturally competent/health literate health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy. Some common strategies for improving the patient-partner interaction and institutionalizing changes in the health care system, as described in the FLPSS CC/HL Strategic Plan include:

1. Standardizing data collection regarding cultural attributes
2. Provide interpreter and translation services
3. Recruit and retain staff that either come from or have experience working with priority populations
4. Provide training to increase cultural awareness, knowledge, and skills
5. Partner with community-based organizations
6. Incorporate culture-specific attitudes and values into health practices and plans
7. Include family and community members in health care decision making
8. Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials
9. Evaluation of data and outcomes and continuous quality improvement processes

Cultural Competence and Health Literacy workgroup will develop a process for policy, procedure and desired CC and HL standards. These will be operationalized at the FLPPS Central and Partner level.

Organizational Infrastructure Tasks:

1. Invest in long-range fiscal planning to promote and infuse cultural competence.
2. Create an environment that reflects the populations served.
3. Develop outreach strategies to better engage and sustain community relationships and social networks.

Organizational Tasks:

4. Commit to cultural competence and health literacy (CC and HL); cultural competence and health literacy must be at the executive leadership of the organization.
5. Review and update vision, mission, and value statements to incorporate the principles and concepts of cultural competence.
6. Address CCHL in the strategic planning processes.

Governance Tasks:

7. Assign a Senior Staff at the Leadership Level of the organization to oversee the organizational development of culturally responsive practices, demonstrated behaviors in personnel, and services.
8. Develop culturally competent and health literate governing and advisory boards and committees/work groups.
9. Create a cultural competence and health literacy committee comprised of culturally-diverse representatives of the community and organization.

Planning Tasks:

10. Utilize and/or contract with cultural competence and health literacy subject matter experts/consultants to advise, define, and assist in the planning, implementation and evaluation processes.
11. Engage customers/patients/clients, staff, and the community in the planning, development and implementation of culturally responsive and appropriate and health literate "services".
12. Develop a cultural competence strategic plan with timeframes for implementation, modification.
13. Review and develop policies and procedures to ensure that cultural competence and health literate is embedded and woven throughout all organizational activities.

Evaluation and Monitoring Tasks:

14. Create demographic profiles of the community, clientele/patients/customers, staff, and board.
15. Conduct and organizational self-assessment of cultural competence and health literacy.
16. Establish and use continuous quality improvement (CQI) methods to monitor, analyze, evaluate, and adjust the activities, practices, approaches, and policies related to the outcomes the data presented.

Workforce and Staff Development Tasks:

17. Develop staff recruitment, retention, and promotion strategies that reflect the population(s) served.
18. Create training plans and curricula that address cultural competence and health literacy.
19. Evaluate staff performance on culturally congruent and complementary attitudes, knowledge and skills.
20. Give culturally congruent and health literate supervision.

A process will be developed to allow for the weaving of CC and HL elements into all project strategies that will be embedded into the organizational infrastructure of FLPPS and support DSRIP outcomes.

Organizational Tasks:

1. Develop CC and HL guiding principles and identify questions that every project must meet.
2. Explore the interdependencies within the organization and the interplay of CC and HL and the organizational departments/projects/programs.
3. Determine how to best to implement CC and HL principles, incorporate methods, and embed processes into organizational policy/governance, departments, programs, projects, and activities.
4. Identify CC/HL implications for recommendations and feedback.
5. Monitor and evaluate data as part of the CQI process.

Community Engagement:

6. Create opportunities for community stakeholder feedback through surveys, meetings, focus groups, and committees (CC and HL Committee, Patient Advisory Committee).
7. Bi-directional communication within and between organization and community stakeholders regarding the impact of CC/HL overlay with service delivery, infrastructure implications, activities and associated outcomes related to decreased ER utilization, improved health equity and care through access, and the elimination of disparities.

Information Technology Tasks:

8. Develop a standardized data collection/management process and template to be used across the organization. Data elements will serve multiple projects.
9. Monitor outcomes and disparities among priority groups.
10. Bi-directional communication between and within the organization and community stakeholders regarding the impact of CC/HL overlay with service delivery, infrastructure implications, activities and associated outcomes related to decreased ER utilization, improved health equity and care through access, and the elimination of disparities.

Identify key factors to improve access to quality primary, behavioral health, and preventive health care

The FLPPS CC/HL Strategic plan outlines goals and activities related to increasing access to and the use of evidence-based preventive services and improving health literacy among the priority populations. These goals and activities also relate to key factors that improve access to quality primary, behavioral health, and preventive health care. Initial key factors that improve access to quality primary, behavioral health and preventive health identified by FLPPS are: 1) access to information on organizations / facilities / providers that administer quality primary care, behavior health and preventive health care, 2) utilization of effective community-based programs that address health disparities, and 3) improving health literacy.

<u>Access to information on organizations / facilities / providers that administer quality health care</u>

To promote access to quality primary care, behavioral health and preventive health care FLPPS will develop a user-friendly searchable listing on the FLPPS website that includes description of partner organizations, including contact information and website links, location, hours, services provided, Medicaid acceptance, available language/interpretive services, and patient ratings using standardized measures.

- FLPPS will gather partner data to post on the FLPPS website and work with partners to make listing widely available across their digital infrastructure, including website, electronic health records, care management systems, etc.
- FLPSS will also establish a process which will prompt partners, via automated reminders twice a year, to submit updated information to the resource directory.

<u>Utilization of effective community-based programs that address health disparities</u>

FLPPS will work with partners to implement and utilize high-value community-based programs that address heath disparities among priority populations.

FLPPS will promote the use of community-based programs shown to be effective, for example, community health workers, translators, case managers and peer support.

a. Using the FLPPS IT ecosystem, create an effective tool to support providers in referring patients to appropriate community-based programs, taking into account patient choice.
b. In concert with the development of the organization's Population Health Roadmap and implementation of Domain 4 projects, develop a directory of existing community-based interventions aimed at health status improvement, including documentation of program target populations.
c. As identified in project work plans, utilize performance metrics and analytic functionality to measure the impact of identified community-based interventions, with a specific focus on identified priority populations.

The use of data to identify best practices and gaps in service delivery will be vital.

a. FLPPS will conduct a comprehensive literature review and seek guidance from experts to define best-practices in community-based programming to fill identified gaps, including:
    - Preventive health care delivery approaches, along with primary prevention/population health based strategies.
    - Community-based supportive services that address social determinants of health and operate in a manner that supports effective access to, and engagement in, primary care, behavioral health and preventive health care.
    - Approaches that integrate primary care and behavioral health care.

The FLPPS CCHL Committee and NOCNs will review interventions that appear to have promise for defined priority groups and communities.

a. Develop a compendium of high-value community-based services that NOCNs fill gaps in care.

b. Monitor the impact of community-based services over time and report using metrics included in the NOCN-specific performance dashboard.

FLPPS will monitor implementation, evaluate effectiveness, sustain effective activities, and improve or replace those that fail.

a. Continually assess the services along key performance metrics associated with CCHL and disparities to determine effectiveness in improving patient outcomes and addressing disparities.

b. Work with community stakeholders and partners to build capacity at the community levels to address needs and problems identified.

c. Create and sustain relationships between FLPPS and community partners, with principles of co-learning, mutual benefit, and long-term commitment and incorporate community theories, participation and practices.

Improving Health Literacy:

To meet the health literacy needs of patients/consumers FLPPS will set forth actions to ensure that patients/consumers with limited English proficiency (LEP) have meaningful access to services that have incorporated cultural, linguistic and literacy factors. FLPPS will also operationalize health literacy in the network through the development, implementation, monitoring and evaluation of a health literacy plan.

Using available data sources, (i.e. U.S. Census, American Community Survey, Client Data, Community-Based Organizations, Government Agencies, etc.) FLPPS will assess languages spoken of populations served within the network.

As necessary, FLPPS will translate NYS mandated/compliance related patient documents into Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille - the top six languages spoken by individuals with Limited English Proficiency (LEP) within New York State, as identified by the New York State Department of Labor, tailored to the FLPPS region, e.g.:

- Grievance Policy
- HIPAA/Confidentiality
- Consumer Rights

FLPPS will support partners in offering NYS mandated/compliance related patient print, audiovisual, and other forms of media content in Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille and American Sign Language (ASL) - the top six languages spoken by individuals with Limited English Proficiency (LEP) within New York State, as identified by the New York State Department of Labor, tailored to the FLPPS region, e.g.:

- Grievance Policy
- HIPAA/Confidentiality
- Consumer Rights
- Consent/Release Forms
- Discharge Documents
- Prescription Information/Labels

A process will be established to determine and reassess, at least every two years, the vital documents (including website content) that must be translated and/or updated.

The FLPPS Patient Advisory Committee (PAC) and/or other expert stakeholders will review internally-developed print, audiovisual, and other forms of media content prior to dissemination.

FLPPS will compile and maintain a repository listing of local interpretive and translation services/resources for the populations served (e.g. oral interpretive resources, telephonic interpreting services, including contracts/arrangements with community-based organizations, individuals or vendors).

Mechanisms to support partners with informing patients of their legal rights to request translation and interpretation services in their preferred language from healthcare facilities will be provided:

- Title VI of the Civil Rights Act of 1964
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and HealthCare
- HIPAA Regulations

FLPPS will develop uniform health literacy standards, policies and procedures for FLPPS Central and FLPPS Network to ensure that The Plain Writing Act of 2010 is upheld, to ensure that patient documents/educational materials are written in plain, easy-to-understand language.

a. Create and provide guidelines that detail the principles of the Plain Writing Act of 2010 in accordance with health literacy.
b. Inform partners of the Plain Writing Act of 2010 to ensure effective implementation.
c. Monitor/Track partners' implementation of the Plain Writing Act of 2010 guidelines.

Partners, clinicians and other staff serving patients/consumers regarding Health Literacy topics will receive training/professional development related to:

- Provider Patient/Communication – The use of HL strategies in interpersonal communications to ensure patient understanding and consideration of options
- Health, Wellness and Medication Management – The use of HL strategies in incorporating shared decision-making and self-management approaches into practice
- Informed Consent – The use of HL strategies to ensure patient understanding and consideration of their options relative to sharing of their health information

Partners, clinicians, and other staff that interact and serve patients/consumers and family members will also receive basic training on:

- The legal obligations to provide meaningful access to benefits and services to LEP individuals
- How to access/obtain/use/work with language assistance services (i.e. interpreters, language lines) in service delivery
- Documenting the language needs of LEP consumers/patients and the language services provided to them by the facility

FLPPS will integrate health literacy into planning, evaluation and quality improvement.

a. FLPPS will support partners as they implement, and continuously improve, integrated health literacy into their organizational
b. FLPPS will support partners in the adoption of various information presentation formats based on their service populations, for example:
    - Literacy Rates of the Population Served
    - Education Level of the Population Served
    - Language Preferences of the Population Served
    - Cultural Attributes of the Population Served
    - Consumer Feedback

The aforementioned list only serves as an initial list of key factors that improve access to quality primary, behavioral health, and preventive health care as FLPPS recognizes that improving access to quality primary, behavioral health and preventive health care is a continuous process that involves engagement with patients, communities, community stakeholders and partners, as well as integration with community. Effective interventions must include a recognition of key factors that impact disparities among priority population. Specifically, when working to improve access to care, one must account for the complex interaction of cultural, economic, individual, linguistic, geographical, cognitive and social factors that guide health care utilization and health-seeking behaviors. Of great importance is the vetting of the selected interventions and strategies by the patients we serve and the communities in which they live. In addition, the education of partners is essential, to ensure that they are instruments in supporting and assisting patients in improving service utilization. FLPPS intends to collaborate with the patient population and the community to identify additional key factors that improve access to quality primary, behavioral health, and preventive health care. Other key factors listed in relevant literature[1] reviewed by FLPPS and will be vetted by stakeholders are:

- Increasing/Bolstering the Health Workforce
- Timeliness of Care
- Using Telehealth
- School-based health centers
- Outreach programs
- Public Awareness Campaigns
- Health Insurance Coverage

To support the continuous process of improving access to quality primary, behavioral health and preventive health care FLPPS will establish processes to continue to evaluate the key factors. This process will involve the use of data/information from the identification of priority groups and the ***FLPPS CC/HL Implementation Planning: Priority Groups Summary Report (Appendix C)*** as the baseline for the refinement of key factors associated with improving access to care.

a. Utilize *implications for cultural competence and health literacy* outlined in the “Priority Groups Summary Report”, as the framework for analyzing key considerations for improving access, engagement and quality of care for each population group through the lens of each group’s culture profile and related barriers to access and/or engagement in services.

b. Use analyses to inform targeted strategies and interventions to address disparities.

Utilize FLPPS performance data, stratified by NOCN, priority group and services delivery areas (e.g. primary care, behavioral health and preventive care) to evaluate disparities and key factors associated with such disparities.

a. Continually measure and drive improvements to address disparities.

b. As needed, identify and analyze additional/new datasets and information resources that help to refine understanding of the key factors.

Engage with NOCNs to refine understanding of key factors associated with improving access.

a. Work with NOCN’s to define sub-regional nuances of each identified priority groups and to identify new/emerging populations of concern.

---

[1] Healthy People 2020 (https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services), National Conference of State Legislators (http://www.ncsl.org/documents/health/RuralHealth_PolicyOptions_1113.pdf) and the US Dept. of Health and Human Services (http://www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html)

b. Work with NOCN's to define additional metrics relative to local nuances important to assessing and understanding key factors associated with access.

Engage with local communities, including patients, to refine strategies to improve access to quality primary care, behavioral health and preventive health.

a. In collaboration with NOCN's, conduct focus groups and community listening sessions to share information and obtain input on the strategies to address access to care.

FLPPS will use information from the identification of key factors associated with access to quality primary care, behavioral health and preventive health care to inform the identification and implementation of interventions/service delivery approaches that have demonstrated effectiveness with priority groups and incorporate CC/HL considerations and local nuances.

Under the direction of the CC/HL Committee and in collaboration with the Clinical Quality Committee FLPPS will ensure that CC/HL is woven through the FLPPS network, as the foundational infrastructure from which to build effective DSRIP program implementation impacting indemnified priority populations.

The CC/HL Committee, in collaboration with the Clinical Quality Committee, will establish processes and mechanisms to ensure that interventions/service delivery approaches are data-informed and community-driven, with attention to local cultural nuances and social determinants of health.

The CC/HL Committee and Clinical Quality Committee will ensure that continuous quality improvement processes are in place, to include focused attention on CC/HL throughout DSRIP program implementation.

Develop a process to design, implement, monitor and evaluate a Health Literacy plan to be operationalized throughout the FLPPS administration and its provider network. The plan will focus on key groups experiencing health disparities. A key aspect of the plan will be the development of a process for FLPPS to support partner organizations in the revitalizing of key patient care documents and patient education materials.

Infrastructure Tasks:

1. Conduct a service area assessment of the populations present and their related attributes
2. Develop uniform health literacy standards, policies and procedures
3. Create translated templates of vital patient documents and educational materials into the appropriate languages and reading levels (including ASL and Braille) representative of the populations served.
4. Compile and maintain a repository listing of local interpretive and translation services/resources for the populations served (e.g. oral interpretive resources, telephonic interpreting services, including contracts/arrangements with community-based organizations, individuals or vendors).
5. Develop resource listing (web, electronic, and paper copy) that includes descriptions of area service organizations, which includes contact information and website links, location, hours, services provided, Medicaid acceptance, available language/interpretive services, and patient ratings using standardized measures.

Organization Tasks:

6. Relate service delivery to language access, cultural appropriateness of patient engagement, service delivery (ER usage rates) and outcomes (disparities elimination)
7. Translate NYS mandated/compliance related patient documents into Spanish, Chinese, Russian, Italian, Korean, French (Haitian) Creole, including Braille - the top six languages spoken by individuals with Limited English Proficiency (LEP) within New York State, as identified by the New York State Department of Labor
8. Vet/review all print, audiovisual, and other forms of communication and media content with community stakeholder committees prior to dissemination (e.g. CC and HL and Patient Advisory committees)
9. Establish a process to determine and reassess, at least every two years, the vital documents (including website content) that must be translated and/or updated.

Patient Engagement Tasks:

10. Ensure that accurate, accessible, and actionable health information is targeted and/or tailored for the patient/consumer.
11. Inform patients of their legal rights to request translation and interpretation services

Workforce and Staff Development Tasks:

12. Develop staff recruitment, retention, and promotion strategies that reflect the population(s) served
13. Create training plans and curricula that address health literacy
14. Evaluate staff performance on health literacy and complementary attitudes, knowledge and skills.
15. Give culturally congruent and health literate supervision

Define plans for two-way communication with the populations served and community groups through community stakeholder engagement forums

FLPPS Community Stakeholder Group will define methods of communication that incorporate the cultural nuances of the defined community.

FLPPS will ensure all messages to the public are informed by consumers/patients, community, providers/partners and data analysis. As applicable, messages should:

- Reduce Stigma
- Be Culturally Informed
- Be Respectful of Cultural Values
- Be Available in Accessible and Alternative Languages/Formats:
- Create environments where individuals can communicate /discuss concerns
- Be Administered in Different Formats and Locations
- Be Jargon Free

FLPPS will ensure that community meetings and forums are designated as "Safe Spaces" where all participants are encouraged to contribute and are valued to present themselves as they feel comfortable.

a. Barriers to access to participate will be considered and necessary accommodations will be facilitated. Potential barriers are:
    - Meeting location
    - Transportation
    - Time of day
    - Language accessibility (e.g. LEP and LRS)
    - Mobility issues
    - Child care
    - Credibility within community

Feedback will be collected from stakeholders attending community meeting and forums. The information will be synthesized and then analyzed to draw out critical themes that will inform FLPPS's continuous quality improvement (CQI) process.

FLPPS will create and implement a process that evaluates whether the messages were received and understood by the community and whether the engagement met its purpose.

a. Employ a continuous quality improvement (CQI) process.

b. Ensure timely feedback and next steps.

    1. Participants should be informed and given the opportunity to shape the next stages of the overall engagement process.

    2. Participants should be able to communicate during the process how stakeholders' input has influenced, contributed to, or improved the overall engagement outcomes.

Identify assessments and tools to assist patients with self-management of conditions

FLPPS will identify key factors driving health disparities, and identify resources to support providers in addressing them.

a. Use data/information gleaned from the identification of priority groups and the "Priority Groups Summary Report" as the baseline for the identification of assessments and tools to assist partners and patients with the patients' self-management of their health conditions.

Comprehensive literature reviews will be conducted and guidance from experts will be used, as needed, to develop a comprehensive set of assessments, tools and other resources aimed at supporting and activating patients to manage their health conditions.

a. Identify brief tools for partners to assist in assessing patient culture, health literacy and preferred language to facilitate care/service delivery through:
    1. Incorporation of culturally responsive interview techniques.
    2. Patient-Provider/Partner collaboration, and identification of patient preferences, regarding inclusion of family/community members as an approach to decrease barriers to quality care.
    3. Encouraging and assisting partners to explore, acknowledge and incorporate patient's cultural nuances in care/service delivery, such as:
        - Cultural Identity and Acculturation (Self-identification)
        - Membership in a Sub-Culture (Culture within a Culture)
        - Beliefs about health, healing, and help-seeking (cultural acceptance of behavior(s) related to health, healing and treatment practices)
        - Trauma and/or Loss (stigma, discrimination, distrust, migration, relocation, and emigration)
        - Financial Insecurity/Poverty/Limited Resources
        - Inadequate Access to Care/Resources
        - Educational Level
        - Language Proficiency/Preferred Language
        - Nationality (American-Born/Foreign-Born)
        - Vision/Hearing Loss and Hidden Disabilities
        -

Opportunities will be established to support community collaboration, feedback and engagement in the development of strategies to identify assessments and tools that are culturally responsive, person-centered and will address social determinants of health.

FLPPS will develop a process to review potential tools/resources with patients and consumers, providers to ensure that they are validated and appropriate for priority populations in terms of cultural, language and health literacy considerations.

a. Identify and form strategic alliances with existing community centers, community based organizations, established cultural groups and gathering places (barber shops, churches, etc.).
b. Engage community leaders and members in the vetting process of assessments and tools to ensure that the tools are relevant and applicable to the diverse populations served within the FLPPS region.
c. Explore the cultural applicability of currently utilized assessments and tools, and their impact on health outcomes of the identified priority groups and subpopulations.
d. Assess and analyze assessments and tools, which:
    i. Support shared decision-making approaches to increase patient understanding of conditions and health status.
    ii. Acknowledge patients' sociocultural background.
    iii. Understand and incorporate relevant cultural factors while avoiding stereotypical "one-size-fits-all" approaches.
    iv. Identify culturally relevant concerns and issues.
    v. Mitigate negative influence of poor/decreased cross-cultural communication.

e. As necessary, tailor tools (with the authors' permission) according to the needs of the respective community/priority group/population.

f. Share culturally relevant best practices, including patient health/wellness self-management tools to share with providers to use with their patients/consumers.

FLPPS will assemble tools and resources that support CC/HL principles by reviewing literature on best/promising practices, training and technical assistance for integrating health care disparity elimination strategies, cultural competence and health literacy into ongoing practices. Identified cultural competence and health literacy resources will be efficiently cataloged and easily accessible. Partners and consumers will be educated on the availability of these resources and to support broader dissemination of these resources.

Below is a list of tools and resources that FLPPS has started to assemble to support patient's ability to self-manage conditions:

Resource Title	Type of Resource	Audience	Authors
The Patient Voice Principles: What Patients Want and Need Most	Website	Patients	Patient Voice Institute

National Association of the Deaf (NAD): Resources - Health Care and Mental Health Services	Websites /Tools	Patients	National Association of the Deaf
Foundation for People with Learning Disabilities: Publications (Reports, Briefings, Informational Booklets)	Website/ Tools	Patients/ Service Providers	The Foundation for People with Learning Disabilities
Affordable Care Act (ACA) Language Services	Website/ Tools	Patients/ Service Providers	Language Scientific
The Patient Education Materials Assessment Tool (PEMAT) and User's Guide: An Instrument To Assess the Understandability and Actionability of Print and Audiovisual Patient Education Materials	Website/ Tools	Patients/ Service Providers	Agency for Healthcare Research & Quality (AHRQ)
Patient and Consumers Wellness and Self-Management Tools	Website/ Tools	Patients/ Service Providers	Agency for Healthcare Research & Quality (AHRQ)
SAMHSA-HRSA Center for Integrated Health Solutions: Wellness Strategies Resources	Website/ Tools	Patients/ Service Providers	Substance Abuse and Health Services Administration (SAMHSA)

Resource Title	**Type of Resource**	**Audience**	**Authors**
Self-Management Taking Charge of Your Health	Journal Article	Patients	FamilyDoctor.org
Health Information on the Web: Finding Reliable Information	Journal Article	Patients	FamilyDoctor.org
Medical Errors: Tips to Help Prevent Them	Journal Article	Patients	FamilyDoctor.org
Best Practices: Wellness Self-Management: An Adaptation of the Illness Management and Recovery Program in New York State	Journal Article	Patients/ Service Providers	Anthony Salerno, Ph.D.; Paul Margolies, Ph.D.; Andrew Cleek, Psy.D.; Michele Pollock, M.S.W; Geetha Gopalan, Ph.D., LCSW; and Carlos Jackson, Ph.D

Resource Title	Type of Resource	Audience	Authors
Wellness Self-Management Personal Workbook	Manual	Patients	NYS Office of Mental Health (NYSOMH); The Urban Institute of Behavioral Health (UIBH)
Community Health Booklet: A Self-Care Decision Guide When Healthcare Access is Limited	Manual	Patients/ Service Providers	Champlain Valley Area Health Education Center
Six Steps Towards Cultural Competence: How to Meet the Healthcare Needs of Immigrants and Refugees	Manual	Patients/ Service Providers	Minnesota Public Health Association's Immigrant Health Task Force
Mental Illness Stigma: What is it? What are its effects? How can it be reduced?	Manual	Patients/ Service Providers	Scattergood Foundation
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide	Manual	Patients/ Service Providers	The Joint Commission
A Dictionary of Patients' Spiritual & Cultural Values for Health Care Professionals	Manual	Patients/ Service Providers	HealthCare Chaplaincy

Identify existing and potential community-based interventions that have been effectively shown to reduce health disparities among defined priority populations.

In concert with the development of the organization's Population Health Roadmap and implementation of Domain 4 projects, FLPPS will develop a directory of existing community-based interventions aimed at health status improvement, including documentation of program target populations.

As identified in project work plans, FLPPS will utilize performance metrics and analytic functionality to measure the impact of identified community-based interventions, with a specific focus on identified priority populations.

FLPPS will conduct a comprehensive literature review and seek guidance from experts to define best-practices in community-based programming to fill identified gaps, including:

- Preventive health care delivery approaches, along with primary prevention/population health based strategies.
- Community-based supportive services that address social determinants of health and operate in a manner that supports effective access to, and engagement in, primary care, behavioral health and preventive health care.
- Approaches that integrate primary care and behavioral health care.

The FLLPS CCHL Committee and NOCNs will review interventions that appear to have promise for defined priority groups and communities.

c. Develop a compendium of high-value community-based services that NOCNs fill gaps in care.

d. Monitor the impact of community-based services over time and report using metrics included in the NOCN-specific performance dashboard.

FLPPS will work with partners to implement and utilize high-value community-based programs that address heath disparities among priority populations. FLPPS will promote the use of community-based programs shown to be effective. FLPPS has started the process to identify these programs and has developed a preliminary list that includes the following:

- Community Health Workers,
- Translators,
- Case managers and,
- Peer support

The implementation of high-value community-based programs that address health disparities will be monitored and evaluated for effectiveness. Activities shown to be effective will be sustained and those that fail will be improved or replaced.

d. Continually assess the services along key performance metrics associated with CCHL and disparities to determine effectiveness in improving patient outcomes and addressing disparities.

e. Work with community stakeholders and partners to build capacity at the community levels to address needs and problems identified.

f. Create and sustain relationships between FLPPS and community partners, with principles of co-learning, mutual benefit, and long-term commitment and incorporate community theories, participation and practices.

Establish a process to create a multimode repository of community-based organizations to increase access to care.

Organizational Tasks:

1. Conduct an on-going literature review and seek guidance from other experts as needed to develop a comprehensive set of assessments, tools, and other resources aimed at supporting and activating individuals to manage their health conditions.
2. Ensure that the tools being adopted are appropriate and meet mandated/regulatory requirements.
3. Compile and maintain a repository listing of tools and community resources

Community Engagement Tasks:

4. Establish patient/consumer experience standardized measures and the method to collect the data.
5. Develop a strategy to educate the organization, community stakeholders and patients about the availability of these resources and support their broad use

Develop a plan for public transparency of provider level data to drive public accountability and motivate providers to adopt effective CC and HL measures that are directly tied to patient data outcomes

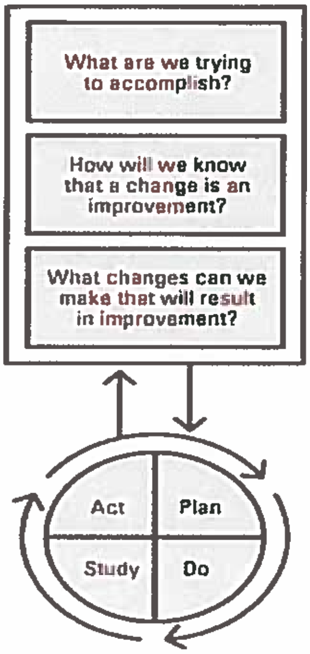
FLPPS will identify existing and/or additional performance metrics that support the monitoring of health care disparities among priority groups, by NOCN. The performance metrics will be utilized to identify and monitor health disparities among defined priority groups.

FLPPS will evaluate a provider's/organization's ability to stratify DSRIP performance metrics to highlight health disparities. FLPPS will provide assistance to fill gaps, as needed, with additional performance metrics, as defined by the FLPPS CC/HL committee.

The performance metrics, stratified by patient demographic variables and priority groups, will be listed on NOCN-Specific Performance Dashboards. These dashboards will be made available to the public.

FLPPS will define and leverage incentives to hold partners accountable for demonstrating progress in closing disparity gaps, based on improved CCHL practices, performance metrics, improved patient outcomes and patient experience.

Establish a process to engender PDSA cycles to evaluate the effectiveness of the strategy and resulting data outcomes to devise further innovations and improvements to the strategy.



Plan - hypothesis formation
Do - implement the new process with data collection
Study - interpret the results
Act - decide what to do next based on the results

Planning Tasks (Plan):

1. Conduct a comprehensive literature review and seek guidance from other experts as needed to identify community-based interventions proven successful in eliminating disparities and improving outcomes.
2. Evaluate the current data collection methods. Determine which data variables are missing.
3. Provide training and technical support to staff on data collection, analysis and management.
4. Incorporate/include patient CC/HL assessment data into the data management system as a standardized dataset.
5. Create a process to evaluate bi-directional communication impact and gather stakeholder feedback.
6. Define performance measures.

Implementation Tasks (Do):

7. Task community stakeholder committees with monitoring and informing the operationalization of the organization's CC and HL Strategic Plan.
8. Vet/review all print, audiovisual, and other forms of communication and media content with the community stakeholder committees.
9. Track and monitor providers' participation in culturally relevant and health literacy appropriate health literacy training as developed and presented by the workforce vendor.
10. Develop and utilize an infrastructure where consumers/patients can communicate grievances (e.g. unethical behavior, unfair policy or treatment, etc.).

Evaluation Tasks (Study):

11. Host focus groups with various provider types to understand barriers to successful implementation of CC/HL efforts.
12. Conduct an annual audit to ensure that CC and HL patient data are being collected.
13. Analyze provider performance on established outcomes, which will be stratified by priority populations to identify disparities.

Quality Improvement Tasks (Act):

14. Utilize data collected from the identified standardized patient CC/HL assessment and performance metrics to develop the public report card.

15. Develop guidelines for the public report card - on progress related to disparities in health, social and behavioral determinants, access to care and quality of care.
16. Drawing on the data included in the dashboard, FLPPS will establish a process to measure and assess improved CC/HL practices and patient experience

Explanation of Data Standards for Race, Ethnicity, Sex, Primary Language, and Disability

HHS examined current Federal data collection standards, adequacy of prior testing, and quality of the data produced in prior surveys; consulted with statistical agencies and programs; reviewed Office of Management and Budget (OMB) data collection standards and the Institute of Medicine (IOM) Report *Race, Ethnicity, and Language Data Collection: Standardization for Health Care Quality Improvement* and built on its members' experience with collecting and analyzing demographic data[i, ii]. HHS also paid special attention to current data collection policies for major HHS surveys and those of the Census Bureau.

Explanation of Data Standards

The following criteria guided the development of data standards for each of the required variables:

1. Evidence-based and demonstrated to have worked well in practice for national survey data collection.
2. Represent a minimum data standard, with agencies permitted to collect as much additional detail as desired, provided that the additional detail could be aggregated back to the minimum standard.
3. Standards mandated by Office of Management and Budget (OMB) would serve as the starting point for any minimum standard.
4. Standards would be for person-level data collection, where respondents either self-report information or serve as the most knowledgeable respondent for all persons in a household survey.

I. Data Collection Standards and Rationale for Selection

A. Race and Ethnicity

The starting point for the race and ethnicity data collection standards is OMB's current government-wide standard, issued in 1997 after a comprehensive public engagement process and extensive field testing. The principles underlying these government-wide standards are described below. The justifications for these principles are described by OMB in detail at http://www.whitehouse.gov/omb/fedreg_1997standards/.

- Self-identification is the preferred means of obtaining information about an individual's race and ethnicity, except in instances where observer identification is more practical. The surveyor should not tell an individual who he or she is, or specify how an individual should classify himself or herself.
- To provide flexibility and ensure data quality, separate questions for race and ethnicity should be used wherever feasible. Specifically, when self-reporting or other self-identification approaches are used, ethnicity is asked first, and then race. The standard acknowledges that this standard might not work in other contexts (e.g., administrative records.)
- The specified race and ethnicity categories provide a minimum set of categories except when the collection involves a sample of such size that the data on the smaller categories would be unreliable, or when the collection effort focuses on a specific racial or ethnic group.
  - The OMB minimum categories for race are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.
  - The OMB minimum categories for ethnicity are: Hispanic or Latino and Not Hispanic or Latino.
- When self-reporting or other self-identification approaches are used, respondents who wish to identify their multi-racial heritage may choose more than one race; there is no "multi-racial" category.
- OMB encourages additional granularity where it is supported by sample size and as long as the additional detail can be aggregated back to the minimum standard set of race and ethnicity categories.
- Any other variation will have to be specifically authorized by the OMB through the information collection clearance process. In those cases where the data collection is not subject to the information collection clearance process, a direct request for a variance should be made to OMB.

The categories for HHS data standards for race and ethnicity are based on the disaggregation of the OMB standard used in the American Community Survey (ACS) and the 2000 and 2010 Decennial Census. The data standard for race and ethnicity is listed below. Race and ethnicity data collection applies to survey participants of all ages.

Ethnicity Data Standard

Categories

Are you Hispanic, Latino/a, or Spanish origin
(One or more categories may be selected)

a. ___No, not of Hispanic, Latino/a, or Spanish origin
b. ___Yes, Mexican, Mexican American, Chicano/a
c. ___Yes, Puerto Rican
d. ___Yes, Cuban
e. ___Yes, Another Hispanic, Latino, or Spanish origin

} These categories roll-up to the Hispanic or Latino category of the OMB standard

Race Data Standard	Categories
What is your race? *(One or more categories may be selected)*	
a. ___White *b. ___Black or African American* *c. ___American Indian or Alaska Native*	These categories are part of the current OMB standard
d. ___Asian Indian *e. ___Chinese* *f. ___Filipino* *g. ___Japanese* *h. ___Korean* *i. ___Vietnamese* *j. ___Other Asian*	These categories roll-up to the Asian category of the OMB standard
k. ___Native Hawaiian *l. ___Guamanian or Chamorro* *m. ___Samoan* *n. ___Other Pacific Islander*	These categories roll-up to the Native Hawaiian or Other Pacific Islander category of the OMB standard

Rationale for Race and Ethnicity Data Standards

As a result of the 1997 HHS data inclusion policy, the basic OMB standard is already included in most HHS data collection initiatives. The new HHS data standards for race and ethnicity include additional granularity, but all categories roll-up to the OMB standard. However, because additional granularity in the race and ethnicity categories is important for documenting and tracking health disparities, large federal surveys such as the National Health Interview Survey (NHIS), Current Population Survey (CPS), and the ACS have implemented such a more granular strategy, particularly for Hispanic and Asian subpopulations.

Accordingly, the new data standards for race and ethnicity are a slightly modified version of the ACS and Decennial Census questions. These items provide additional granularity for Hispanic (four additional categories) and Asian subpopulations (7 additional categories) beyond the OMB minimum standard categories. The race and ethnicity categories for the ACS and recent Decennial Census have been tested and structured to increase response rates, validity, and reliability [iii]. The more detailed ACS and recent Decennial Census race categories roll up to the OMB standard five categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. As with OMB standards, respondents are also instructed to mark all categories that apply (i.e. they may be able to select more than one racial category). The ACS and Decennial Census ethnicity categories roll up to the OMB standard categories: Hispanic or Latino and Not Hispanic or Latino [iv] [v]. Respondents are also able to select more than one ethnicity category. The recommended standard is in conformance with the methods, logistics, practices and limitations of HHS major surveys, where population estimates are the goal.

HHS agencies may request permission from OMB during the Paperwork Reduction Act clearance process to add a write-in option of "other" to interviewer-administered surveys. This respondent-specified race must then be coded by the agency to the OMB and HHS standards before results are publically reported.

go to top

B. Sex

The data standard for sex is male and female. Sex data collection applies to survey participants of all ages.

Sex Data Standard

What is your sex?

a. ___Male
b. ___Female

Rationale for Sex Data Standard

For the purpose of this report, the category of sex was defined as biologic sex. Sexual orientation and gender identity were considered as separate concepts. The Department has developed a data progression plan for collecting sexual orientation data and has conducted gender identity data collection listening sessions.

go to top

C. Primary Language

The standard for primary language is a measure of English proficiency. The recommended question is based on that used on the ACS. The question applies to survey participants aged five years and above.

Data Standard for Primary Language

How well do you speak English? (5 years old or older)

a. ___Very well
b. ___Well
c. ___Not well
d. ___Not at all

The primary language data standard represents a minimum standard and the question and answer categories cannot be changed. Additional questions on language may be added to any survey as long as the minimum standard is included.

Optional Granularity

For agencies that wish to collect data on the specific language spoken, the Data Council recommends collecting data on language spoken at home. The recommended survey items are used in the ACS (see below). Collecting this additional information would be optional and at the discretion of the agency, if information on specific language was desired.

Data Collection for Spoken Language

1. *Do you speak a language other than English at home? (5 years old or older)*
    a. ___Yes
    b. ___No

For persons speaking a language other than English (answering yes to the question above):

2. *What is this language? (5 years old or older)*
    a. ___Spanish
    b. ___Other Language (Identify)

For agencies that desire to collect information on specific languages beyond Spanish, and have sufficient sample sizes to support such estimates, HHS would publish on the HHS website a list of the ten most prevalent languages spoken in the U.S., as reported by ACS. These would roll up to the "Other Language" category, and provide technical notes to assist in coding. Spanish as a category is reported about 60 percent of the time in the ACS[vi].

Rationale for Primary Language Data Standard

The survey item selected for the minimum standard is based on the ACS, which assesses both English proficiency and language spoken other than English, and has been collected by the Census Bureau since 1980.

For statistical, planning, analytical and research purposes, disparities have been associated with English language proficiency rather than specific language spoken. For clinical purposes relating to an individual, specific language and proficiency would both be needed. This recommendation is consistent with language recommendations from the Institute of Medicine report *Race, Ethnicity, and Language Data Collection: Standardization for Health Care Quality Improvement*.

Several HHS surveys currently collect data on language or English proficiency primarily in the preliminary screening phase of in person or telephone interview surveys for administrative purposes in surveys, to determine how or in what language the interview would be administered. It is not the intent of this standard to disrupt those screening practices.

go to top

D. Disability Status

The six item set of questions used on ACS and other major surveys to gauge disability is the data standard for survey questions on disability. Note the age thresholds for survey participants for the different disability questions.

Data Standard for Disability Status

1. *Are you deaf or do you have serious difficulty hearing?*
    a. ___Yes
    b. ___No

2. *Are you blind or do you have serious difficulty seeing, even when wearing glasses?*
    a. ___Yes
    b. ___No

3. *Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old and older)*
    a. ___*Yes*
    b. ___*No*

4. *Do you have serious difficulty walking or climbing stairs? (5 years old and older)*
    a. ___*Yes*
    b. ___*No*

5. *Do you have difficulty dressing or bathing? (5 years old and older)*
    a. ___*Yes*
    b. ___*No*

6. *Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years older and older)*
    a. ___*Yes*
    b. ___*No*

The six-item disability standard represents a minimum standard and the questions and answer categories cannot be changed. Additional questions on disability may be added to any survey as long as the minimum standard is included. If the ACS changes the disability questions in the future, HHS will revisit the standard and modify as necessary.

Rationale for Disability Data Standard

The six item set of questions used on the ACS and other major surveys to measure disability was developed by a federal interagency committee and reflects the change in how disability is conceptualized consistent with the International Classification of Functioning, Disability, and Health. The question set defines disability from a functional perspective and was developed so that disparities between the 'disabled' and 'nondisabled' population can be monitored. The question set went through several rounds of cognitive and field testing and has been adopted in many federal data collection systems. OMB has encouraged the use of this question set by other federal agencies conducting similar population studies due to the extensive testing used in the development of these measures, including the findings that alternative measures did not test as well. Cognitive testing of these questions revealed that the six questions must be used as a set to assure a meaningful measure of disability [vi].

go to top

[i] OMB (Office of Management and Budget). (1977). *Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting.*

[ii] IOM (Institute of Medicine). (2009). *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press.

[iii] Alberti, N. (2006) *The 2005 National Census Test: Analysis of the Race and Ethnicity Questions*. Final Report, 2005 National Census Test Analysis. U.S. Census Bureau

[iv] Office of Management and Budget. (1997a) *Recommendation from the Interagency Committee for the Review of the Racial and Ethnic Standards to the Office of Management and Budget Concerning Changes to the Standards for Classification of Federal Data on Race and Ethnicity*, Federal Register: 62: 36873-36946, July 9.

[v] Office of Management and Budget. (1997b) *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, Federal Register: 62: No.210, October 30.

[vi] Shin, Hyon B. and R. Kominski. (2010). *Language Use in the United States: 2007*, American Community Survey Reports, ACS-12. U.S. Census Bureau, Washington, DC.

[vii] Brault, M, S. Stern, D. Raglin. (2007). *Evaluation Report Covering Disability*, American Community Survey Content Test Report P.4. U.S. Census Bureau, Washington, DC.

Last Modified 2/26/2014 6 19 00 PM

Glossary of Terms

Action Steps: The specific efforts that are made to reach the goals your agency has set. Action steps are the exact details of your action plan. They should be concrete and comprehensive (Community Tool Box, 2015). Source Link: http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/identify-action-steps/main

Attested Provider/Partner: There are over 600 health care and community based organizations who have committed through an attestation document to partner within FLPPS to transform this system. These partners are representative of all care settings that serve the Medicaid population (FLPPS). Source Link: https://flpps.files.wordpress.com/2014/10/flpps-faq_12915.pdf

Attribute: a quality or feature regarded as a characteristic or inherent part of someone or something.

Benchmark: An observable indicators of progress in reaching or measuring the goal. For instance, a benchmark related to the provision of training on cultural and linguistic competence might be: 100% of system of care staff have received mandated CLC training by January, or within 6 months of hiring. Suggestion/Alternate Definition: Benchmark - A standard, or a set of standards, used as a point of reference for evaluating performance or level of quality.

CLAS Standards: The National Culturally and Linguistically Appropriate Services (CLAS) in Health and - standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States (HHS, 2015). Source Link: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Consumer Rights (Healthcare): Bill of Rights and Responsibilities to establish a stronger relationship of trust among consumers, health care professionals, health care institutions, and health plans by helping to sort out the responsibilities of each of these participants in a system that promotes quality improvement. The

Consumer Bill of Rights has three goals: (1) to strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health, (2) to reaffirm the importance of a strong relationship between patients and their health care professionals, and (3) to reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status (Agency of Healthcare Quality & Research, 2015). Source Link: http://archive.ahrq.gov/hcqual/cborr/exsumm.html

Cultural Competence:

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al, 1989). Source Link: http://nccccurricula.info/culturalcompetence.html
- The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring service delivery to meet patients' social, cultural and linguistic needs (The Commonwealth Fund, 2002). Source Link: http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf
- The ability of an individual or organization to accommodate the needs presented by consumers and communities with diverse languages, modes of communication, customs, beliefs, and values (American Cancer Society, 2010). Source Link: http://www.acscan.org/pdf/healthcare/implementation/factsheets/hcr-cultural-comptency.pdf

Culture: The shared attitudes, behaviors, beliefs, customs, history, institutions, and values of a group of people. Culture is a system of rules that are the base of what we are and affect how we express ourselves as part of a group and as individuals. We all develop in some type of culture. Our environment determines what we learn, how we learn it, and the rules for engaging with others. These rules are transmitted from one generation to the next and are often adapted to the times and locale (Community Tool Box, 2015). Source Link:

http://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main

DSRIP: Delivery System Reform Incentive Payment – The New York State Medicaid Redesign Team (MRT) is redirecting Medicaid funds to projects that radically transform the Medicaid delivery system, referred to as the Delivery System Reform Incentive Payment program. DSRIP will incentivize health care and community-based providers to form regional collaborations and implement innovative system transformation. The overarching objective of DSRIP is to improve clinical outcomes and reduce avoidable hospital use by 25% over five years (FLPPS, 2015). Source Link: https://flpps.files.wordpress.com/2014/10/flpps-faq_12915.pdf

DSRIP Domain Areas: Overarching ***areas*** in which Delivery System Reform Incentive Payment (*DSRIP)* strategies are categorized:

- Domain 1: Overall Project Progress
- Domain 2: System Transformation
- Domain 3: Clinical Improvement
- Domain 4: Population-Wide

FLPPS: Finger Lakes Performing Provider System – New York State is divided into 25 Performing Provider Systems (PPS) based on geography and regional care delivery. Each PPS is comprised of health care providers and community-based organizations who have agreed to partner in transforming the healthcare delivery system for Medicaid recipients in their region (FLPPS, 2015). Source Link: https://flpps.files.wordpress.com/2014/10/flpps-faq_12915.pdf

FLPPS Central: Finger Lakes Performing Provider System (FLPPS) internal office administration/staff.

Grievance: A written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to compliance/standards of quality care (CMS, 2015). Source Link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-42.pdf

Health Disparity: A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage (HHS, 2014). Source Link: http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Healthcare Disparities: are differences among population groups in the availability, accessibility and quality of health care services aimed at prevention, treatment and management of diseases and their complications. These include screening, diagnostic, treatment, management and rehabilitation services. Source Link: http://guides.lib.umich.edu/sw634Disparities

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (IOM, 2004). Source Link: https://iom.nationalacademies.org/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf

HIPAA: Health Insurance Portability and Accountability Act, a 1996 Federal law that restricts access to individuals' private medical information - gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal law that requires security for health information in electronic form (HHS, 2015). Source Link: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

NOCN: Naturally Occurring Care Network – A geographic sub-region in the Finger Lakes Performing Provider System (FLPPS). There are five Naturally Occurring Care Networks (NOCN) within the Finger Lakes Performing Provider System (FLPPS). Each NOCN represents a geographic area within the 13 county region: (1) Western NOCN = Genesee, Orleans, and Wyoming Counties, (2) Monroe NOCN = Monroe County, (3) Southern NOCN = Northwestern Steuben, Allegany and Livingston Counties, (4) Southeastern NOCN = Southeastern Steuben and Chemung Counties, and (5) Finger Lakes NOCN = Wayne, Ontario, Yates, Seneca and Cayuga Counties (FLPPS, 2015). Source Link: http://flpps.org/nocns/

Patient Centered Medical Home (PCMH): A way of organizing primary care that emphasizes care coordination and communication to provide patients with timely, well-organized and integrated care, and enhanced access to teams of providers within a health care organization (NYS DOH, 2015). Source Link: https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_glossary.pdf

Performing Provider Systems (PPS): Entities that are responsible for performing a DSRIP project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group (NYS DOH). Source Link: https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_glossary.pdf

Person(s) Responsible: The specific individual(s), team(s), agency and/or system(s) responsible for completing a specific task.

Population Health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Priority Group: A group with unique health care needs or issues that require special attention (Agency of Healthcare Research and Quality, 2014). Source Link: http://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap10.html

Roles: are the positions team members assume or the parts that they play in a particular operation or process.

Responsibilities: are the specific tasks or duties that members are expected to complete as a function of their roles. They are the specific activities or obligations for which they are held accountable when they assume—or are assigned to—a role on a project or team.

Shared-Decision Making: A process in which patients and healthcare professionals, including providers, clinicians and nurses, collectively explore, compare and decide on health care options, treatments and care plans through meaningful dialogue about patient preferences and values. It is a key component of person-centered care.

Time Frame: a period of time in which tasks, activities or projects are recommended/scheduled to occur or be completed.

Triple Aim: The Triple Aim framework serves as the foundation for organizations and communities to successfully navigate the transition from a focus on health care to optimizing health for individuals and populations (Institute for Healthcare Improvement, 2015). **http://www.ihi.org/Topics/TripleAim/Pages/default.aspx**

Vulnerable Populations: A group of people defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified as at-risk for health disparities. Examples include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness. It may also include rural residents, who often encounter barriers to accessing healthcare services. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care. Their health and healthcare problems intersect with social factors, including housing, poverty, and inadequate education (AJMC, 2006). Source Link: http://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13Suppl/Nov06-2390ps348-s352

Frequently Used Acronyms

ASL: American Sign Language

CBO: Community-Based Organization

CC/HL: Cultural Competence/Health Literacy

DSRIP: Delivery Incentive Reform Incentive Payment Program

FQHC: Federally Qualified Health Center

FLPPS: Finger Lakes Performing Providers Systems

HHS: United States Office of Health and Human Services

HIPPA: Health Insurance Portability and Accountability Act

HPSA: Health Professional Shortage Areas

HRSA: Health Resources and Services Administration

IDS: Integrated Delivery System

LEP: Limited English Proficiency

MCO: Managed Care Organization

MEB: Mental, Emotional or Behavioral Disorder

NOCN: Naturally Occurring Care Network

PAC: Patient Advisory Committee

PAM: Patient Activation Management

PCP: Primary Care Physician

PPS: Performing Provider Systems

PPV: Potentially Preventable Emergency Room Visits

PDI: Prevention Quality Indicators – Pediatric

PQI: Prevention Quality Indicators – Adults

SAMHSA: Substance Abuse and Mental Health Services Administration

SNF: Skilled Nursing Facility

TP: Target Population

UDS: Universal Data Set

References

Agency of Healthcare Quality and Research. (2015). *Consumer Rights (Healthcare).* Retrieved from Agency of Healthcare Quality and Research: http://archive.ahrq.gov/hcqual/cborr/exsumm.html

AHRQ. (2014). *Research Findings.* Retrieved from Agency of Healthcare Research and Quality: http://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap10.html

American Cancer Society. (2010). *Healthcare Implementation Factsheets.* Retrieved from American Cancer Society: http://archive.ahrq.gov/hcqual/cborr/exsumm.html

Centers for Medicare and Medicaid Services. (2015). *Medicare: Provider Enrollment and Certification.* Retrieved from CMS: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-42.pdf

Finger Lakes Performing Provider System. (n.d.). Retrieved from https://flpps.files.wordpress.com/2014/10/flpps-faq_12915.pdf

Health and Human Services. (2015). *Health Insurance Portability and Accountability Act.* Retrieved from Guidance Materials for Consumers: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Healthy People 2020. (n.d.). Retrieved from Healthy People.gov: http://www.healthypeople.gov/

HRET. (n.d.). *Transforming Health Care Through Research and Education.* Retrieved from http://www.hret.org/

Insignia Health. (2015). *The PAM Survey: Patient Activation Measure Tool.* Retrieved from Insignia Health: http://www.insigniahealth.com

Institute of Medicine. (n.d.). *Health Literacy: A Prescription To End Confusion.* Retrieved from National Academies of Sciences:

https://iom.nationalacademies.org/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf

Kansas University. (2015). *Strategic Planning: Identify Action Steps*. Retrieved from The Community Tool Box: http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/identify-action-steps/main

Medicaid Redesign Team: Health Disparities Work Group. (n.d.). *Redesigning New York's Medicaid Program*. Retrieved from New York State Department of Health: http://www.health.ny.gov/health_care/medicaid/redesign/health_disparities_workgroup.htm

New York State Department of Health. (n.d.). *DSRIP for Provider and Professionals*. Retrieved from Delivery System Reform Incentive Payment (DSRIP) Program: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

New York State Department of Health. (n.d.). *Medicaid Redesign: DSRIP*. Retrieved from Delivery System _care/medicaid/redesign/dsrip/

New York State. (n.d.). *Prevention Agenda 2013-2017: New York State's Health Improvement Plan*. Retrieved from New York State Department of Health: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

New York State. (n.d.). *Salient Performance Data*. Retrieved from New York State Department of Health: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data/salient_performance_data.htm

Office of Minority Health. (n.d.). *National CLAS Standards.* Retrieved from U. S. Department of Health and Human Services Office of Minority Health: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Reid-Rose, L., & Rosenthal, H. (2015). Advancing Cultural Competency in the Era of Healthcare Reform. New York Association of Psychiatric Reabilitation Services, Inc.

Rochester Area Community Foundation. (n.d.). *Our Community Report Card.* Retrieved from ACT Rochester: http://www.actrochester.org/highlights/our-community-report-card-0

The Triple Aim. (2015). Retrieved from Institute for Healthcare Improvement: http://www.ihi.org/Topics/TripleAim/Pages/default.aspx

University of Michigan. (2012). *Health Care Disparities: Health Disparity v. Health Care Disparity.* Retrieved from University of Michigan: http://guides.lib.umich.edu/sw634Disparities

Vulnerable Populations. (2006, November 01). Retrieved from AJMC Managed Markets Network: http://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13Suppl/Nov06-2390ps348-s352