# Cultural Competency and Health Literacy Strategic Plan: 2015–2016 Strategic Priorities

**Cultural Competency and Health Literacy Milestones:**

1. Prepare a strategic plan to assist in the integration of the knowledge, attitudes, and skills reflective of a cultural competent organization in order to help ensure that everyone receives equitable and effective health care services.
2. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).

## Introduction

Cultural competency is the ability to understand, appreciate and interact with persons from cultures and/or belief systems other than one's own, based on various factors: awareness of one's own cultural worldview, attitude towards cultural differences, knowledge of different cultural practices and worldviews, and cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.

The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients. Cultural competency is critical to reducing health disparities and improving access to high-quality health care. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research—in an inclusive partnership where the provider and the user of the information meet on common ground (Section 7.1, Approach to Achieving Cultural Competence, Millennium Collaborative Care PPS).

Health literacy is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Individuals must possess the skills to understand information and services and use them to make appropriate decisions about their health care needs and priorities. Health literacy incorporates the ability of the patient population to read, comprehend, and analyze information; weigh risks and benefits; and make decisions and take action in regards to their health care. The concept of health literacy extends to the materials, environments, and challenges specifically associated with disease prevention and health promotion.

According to *Healthy People 2010*, an individual is considered to be "health literate" when he or she possesses the skills to understand information and services and use them to make appropriate decisions about health (Section 7.2, Approach to Improving Health Literacy, Millennium Collaborative Care PPS).

Millennium Collaborative Care has prepared this document to articulate its initial strategy, objectives, and approach with regards to cultural competency and health literacy.

# Objective 1: Identify priority groups experiencing health disparities

## *Key Strategies*

Using the Community Needs Assessment (CNA) as a foundation, and including other tools like surveillance data to look at health outcomes by race and zip code, Millennium has uncovered health disparities among different cultural, socioeconomic, and linguistic groups by extracting profiles of Medicaid enrollees attributed to Millennium by race, ethnicity, primary language, and rural/urban status.

Four specific sources were used to identify priority groups experiencing health disparities:

1. Western New York Community Health Needs Assessment Delivery System Reform Incentive Payment (DSRIP) Program Volume One: CNA Summary 12/16/2014
2. New York State Health Equity Report, County Edition, January 2016, New York State Department of Health.
3. Striving for a Healthier Buffalo. A Community Health Needs Assessment for the Greater Buffalo, United Ministries (GRUM), Conducted by the Buffalo Center for Urban Studies, in partnership with the Greater Buffalo United Ministries. November 2014 and,
4. Patient Activation Hot Spot Analysis for Millennium Collaborative Care, Conducted by the Primary Care Research Institute – June 2015.

Key findings from each of these sources are detailed in the following sections.

### Western New York Community Health Needs Assessment

Our primary resource was the Western New York Community Health Needs Assessment which identified the following priority groups:

Western New York is an eight-county region with a 1.5 million population. In general, the African American and Latino/Hispanic population are the most at risk populations, as are people over age 65 and women of child-bearing age (14-44 years). All of these indicators correlate closely with measures of poverty as do levels of education attainment, single parent households and people born in a foreign country. The number of households without access to a motor vehicle is also another powerful indicator of the ability of people to meet their health needs.

Key observations across these indicators include:

- African-Americans are heavily concentrated in the cities of Buffalo and Niagara Falls and constitute a majority of the population in several zip codes including the hot spot zip codes of 14215, 14212, 14202, 14201, 14210, 14204, 14303, and 14301 in each city. African-Americans also live in other locations around the metropolitan area, such as Cheektowaga (14206).
- Latino/Hispanics follow a somewhat less concentrated residential pattern, with higher concentrations on Buffalo's West side (14207, 14213), Lackawanna (14218), and Niagara Falls (14301), but also in Dunkirk, Jamestown, Orleans County, and other rural areas elsewhere.
- Non-English speakers are distributed in a more complex pattern across the region. Many live in Buffalo, especially on the West Side, with its heavy refugee population, or in Lackawanna, where many Yemeni and other Middle Easterners live. There are other clusters of non-English speakers in Jamestown, in Amherst around the University at Buffalo and in Amish country in Cattaraugus County that may or may not be indicative of greater health needs.

- Persons over 65 years reside in a still different pattern, with a lower portion of older persons in the central cities and a much higher percentage in the suburbs of Buffalo, such as Amherst, Clarence and Elma and in Lewiston (outside of Niagara Falls). Other areas with a higher proportion of seniors are scattered across more rural areas in the region.
- Women of childbearing age (15-44 years) reflect a crucial category of potential health care needs. However, outside of a concentration in the City of Buffalo and relative dearth of such women in the Erie County suburbs, there is no clear pattern of residential distribution.
- Poverty status is perhaps the most important indicator of health care needs. In the region, 15% of the population lives below federal poverty level compared to 10% for the State. People at 200 percent of the federal poverty level are overwhelming concentrated in the cities of Buffalo and Niagara Falls and widely across the Southern Tier counties of Chautauqua, Cattaraugus and Allegany in both small cities and rural areas. These areas also have excessively high rates of children under 18 living in poverty (30% in Chautauqua County). In June 2014, the US Census Bureau ranked the City of Buffalo as the 4$^{th}$ poorest city in the nation, where nearly 27 percent of the population lives in poverty, nearly two thirds under 200% of the federal poverty level.
- The median household income in WNY is $49,304, 15% below the New York State median of $58,003. Erie County is 13% below the State median; however the City of Buffalo is 47% below the NYS median. Niagara County is 17% below the State median; however the City of Niagara Falls is 44% below the NYS median. Most rural counties are 27% below the state median and some small cities in rural area are 46% below the state median.
- Educational attainment is an underlying factor for poverty status and, by extension, health care need. Lowest rates of high school completion are concentrated in Buffalo and Niagara Falls, and across the Southern Tier counties. Orleans County also has lower rates for persons with high school diplomas.
- Foreign born people may have greater health care needs as a result of dislocation from their places of origin. However circumstances can vary widely. Immigrant and refugee populations in Buffalo and Lackawanna or migrant farm labor populations in Orleans County likely have higher needs. Foreign born people in Amherst are likely to be students or faculty at the University at Buffalo or work in industries where benefits include health insurance.
- Households without access to a vehicle provide a crucial indicator of the ability of people to obtain access to health care services. Where a vehicle is absent and given the poor state of public transit across the region, getting to appointments and filling prescriptions are onerous, sometimes impossible tasks. As with many other indicators, concentrations of households with no vehicle are in the cities of Buffalo and Niagara Falls and along the Southern Tier. The region ranks last among upstate regions for households without access to a vehicle.
- In Western New York the population with disability is 103,347 or 11% of the total. This is almost double the state percentage. The disability percentage is high in every county and ranges from a low of 9% in Genesee County to a high of 14% in Orleans County.
- The unemployed civilian population over 16 is 5%, which is low compared to 9% at the state level. The population over 16 not in the labor force is comparable to the state (37%). The employed population with a disability is three times the state rate (3% vs 1%).

Source: *Western New York Community Health Needs Assessment*. Delivery System Reform Incentive Payment (DSRIP) Program Volume One: CNA Summary 12/16/2014 pgs. 13 and 15

### 2016 New York State Health Equity Report

To support this information we used the New York State Health Equity Report, County Edition, January 2016 New York State Department of Health. This report is a tool to raise awareness about the health of racial and ethnic populations and to develop and evaluate the effectiveness of evidence-based interventions for improving health outcomes.

This report highlights among the challenges that:

- The Black non-Hispanic population of New York State suffers disproportionately from numerous health problems compared to other racial and ethnic groups. Selected health indicators that pose challenges for this group include:
- Teen pregnancy rate for Black non-Hispanics was 44.6 per 1,000 females ages 15-17 years, more than five times the rate for White non-Hispanics and 20 times that of Asian-Pacific Islander non-Hispanics. The rate was also well above New York Stare's Prevention Agenda teen pregnancy rate objective of 25.6 per 1,000 females.
- During 2011-2013, the New York State Black non-Hispanic infant mortality rate at 9.3 per 1,000 live births was more than twice that of White non-Hispanics and Hispanics as well as nearly four times that of Asian/Pacific Islander non-Hispanics.
- Among Hispanics who died in New York State during 2011-2013, 56.3 percent died prematurely (before the age of 75). The only group with a higher percentage of premature death was Black non-Hispanics (58.1 percent).

Source: New York State Health Equity Report, County Edition, January 2016, New York State Department of Health

### Striving for a Healthier Buffalo: A Community Health Needs Assessment for the Greater Buffalo United Ministries

We found additional support identifying priority groups in our third tool, Striving for a Healthier Buffalo: A Community Health Needs Assessment for the Greater Buffalo United Ministries (GRUM) conducted by the University at Buffalo Center for Urban Studies in partnership with GRUM. These findings were important because they also concluded that:

- The Buffalo Medicaid and Medicare eligible population is overrepresented in Buffalo City and the East Side and West side neighborhoods where Blacks and Latinos are located.
- The health outcomes among Blacks and Latinos, including length and quality of life, are the lowest in Erie County. This is reflected in a number of health inequalities including premature death, infant mortality, low birth weight, diseases of the heart, cerebrovascular disease, diabetes, chronic lower respiratory disease and preventable hospitalizations, among others.
- Although Greater Buffalo has one of the top ranked health care systems in New York State and in the United States, it has not been able to successfully devise and implement a strategy to effectively deliver health care services to the Black and Latino communities. The two prime performance indicators of the failure of the Greater Buffalo health care system are the levels of premature death and infant mortality rates among Blacks and Latinos.
- Health inequalities in the Greater Buffalo community cannot be eliminated without the radical transformation of the Buffalo City's East Side. Health inequalities are geographically rooted and

overrepresented in Buffalo City's East Side neighborhoods, where the majority of the Black population resides. For example, the five zip codes identified by the Erie County Department of Health as most at-risk for serious chronic diseases (14204, 14206, 14211, 14212 and 14215) are all on the East Side. These are also the same five zip codes from which the Erie County Department of Health draws 73% of its clinical patients.

- Health literacy is an issue. It has two dimensions that must be addressed. The first is the perception that people understand health issues when they do not. This matters because it gives the individual a false sense of confidence. This problem is most dramatically revealed in the discussion over hypertension. When asked to rate their knowledge of chronic diseases, the respondents rated their understanding of hypertension or high blood pressure the highest, while rating the understanding of kidney disease near the bottom. However, the problem is people do not understanding that the poorly managed treatment of high blood pressure will lead to kidney disease.
- GRUM's top priority is to bolster access to health care and improve the quality of that care among blacks and Latinos between the ages of 18-64 who are eligible for Medicaid, have one or more chronic disease and are at-risk of acquiring another chronic disease. The 229 respondents identified themselves as 72.8% African American; 6% African; 18.1% Latino; 1.3% White; 0.9% other people of color.

Source: *Striving for a Healthier Buffalo: A Community Health Needs Assessment for the Greater Buffalo United Ministries.* Pgs. 10-13 November 2014.

### Patient Activation Hot Spot Analysis

Finally, we used the *Patient Activation Hot Spot Analysis for Millennium Collaborative Care,* conducted by the Primary Care Research Institute, June 2015. Patient activation will be closely tied to primary care, so Primary Care Service Areas (PCSAs) are used to summarize the analysis. Their rationale included that in order for a zip code to be a candidate as a Hot spot area, it had to have at least 100 Millennium-attributed Medicaid lives to insure a focus on zip code areas with sufficient Medicaid population.

- Hot spots for the uninsured (UI) within our service area are located within Red Zones which are more than 150% of the regional rate (above 11.6%). The UI Hot spot/Red Zone pattern seems to be in urban and rural lower incomes areas. They include: Wellsville 14739, Olean/Cuba (14779, 14748, 14711, 14735, 14753, 14755); Southern Tier (14091, 14138, 14042, 14129, 14719); Jamestown/Westfield (14772,14757); South Buffalo/Lackawanna (14202, 14201, 14210, 14204); Eastside Buffalo (14215, 14212); Westside Buffalo (14207, 14213); W. Seneca/Cheektowaga (14206); Southtowns (14081); Niagara Falls, N. Tonawanda (14303, 14301); Albion/E. Orleans (14098); and Warsaw (14098).
- This assessment also provides information on Non-Utilizing (NU) Hot Spots. The maps they provide displays Red Zone and Yellow Zone hot spot zip codes relative to the Western New York regional non-utilization rate of 14%. Red Zones are more than 150% of the regional rate (above 21%). The NU Red Zone pattern seems to be the opposite of the UI pattern. Medicaid population in suburban and rural more affluent areas are more likely to be non-utilizers. The Yellow Zone zip codes have UI rates are between 120% and 150% of the WNY rate (between 16.8% and 21%).
- The estimated uninsured population in these zip codes is 115,676.

Source: *Patient Activation Hot Spot Analysis for Millennium Collaborative Care*. Conducted by the Primary Care Research Institute, June 2015

The findings further revealed factors causing poor health outcomes among identified population groups (e.g., lack of a regular source of primary care, high emergency department (ED) utilization rates, disease complexity factors).

The research findings of these four assessment tools will continue to provide us with a clearer understanding of the critical populations identified in prime areas for working with Millennium-attributed Medicaid lives within our PPS.

### *Continuing to Uncover Gaps in Services*

We began in June 2015 and continue the outreach through forum/focus groups including the "Voice of the Consumer" Sub-Committee conducted by Millennium's community-based team. These meetings are opportunities to gain information from Medicaid consumers on gap in services and barriers to receiving available services in the eight-county region of Western New York. The zip codes represented in our Gaps in Services Analysis correspond to 78% of the zip codes represented in the PAM hot-spotting data. The Gap in Services zip codes are: 14094, 14120, 14207, 14213, 14225, 14150, 14020, 14215, 14211, and 14304.

The issues identified in the Gaps in Services Analysis were broken down into 6 (six) categories:

- Community – Issues aligned with existing CBO efforts or could be created amongst CBOs;
- Department of Social Services (DSS) – Issues/suggestion/ complaints;
- Government/Legal- Issues relating to patients right's, government regulations;
- MCC – Issues that will be directly impacted by MCC projects;
- Medicaid Program – Issues regarding Medicaid policies;
- Transportation – Issues/complaints with Medicaid Transportation;

Meetings have been held with the Erie County DSS and New York State Medicaid Transportation contractor to share this feedback.

## Objective 2: Identify Contractor

### *Key Strategies*

Develop and issue a request for qualifications (RFQ) and then a request for proposal (RFP) from qualified agencies to spearhead Millennium's cultural competency and health literacy program. Selected contractor will be responsible for development, implementation, and operation of a comprehensive cultural competency and health literacy program.

Evaluate RFP responses and select qualified entity to operate cultural competency and health literacy program on behalf of Millennium.

## Objective 3: Contractor will survey community-based organizations (CBOs), health practitioners, and support staff to gain further knowledge of the reasons for under-utilization of healthcare services; obtain suggestions for improving access to primary and behavioral health services; and shed light on the services roles and capabilities of these CBOs

### *Key Strategies*

Selected contractor will survey and canvass CBOs, both those with a long tradition of serving at-risk communities and those that are emerging, particularly in new/immigrant neighborhoods.

Millennium will issue a survey instrument requesting practitioners and provider representatives to complete a self-assessment that will help gauge health literacy and cultural competency training needs.

Contractor will work with the various county social service departments and conduct a gap assessment to:

- Compare health disparities of specific targeted populations with linguistic and other cultural competency determinants among community providers
- Evaluate accessibility of services at those locations where target populations receive care
- Identify roles and extent to which CBOs are involved in serving target populations
- Identify, with the assistance of Millennium's cultural competency and health literacy champion and other county social service commissioners, how the social determinants of care impact health and what collaborations can be identified within the various county departments
- Identify and communicate with residents living in hotspot neighborhoods by working with groups like the Mobile Safety Net
- Identify, via existing assessments from county social services experts in resettlement, opportunities to learn more about immigrant and refugee population needs
- Develop findings to spur future actions

## Objective 4: Easily understood, culturally sensitive materials are available

### *Key Strategies*

Working in concert with Millennium, cultural competency and health literacy contractor will reach out to Medicaid Managed Care Organizations, local literacy groups, Millennium project leaders, behavioral health professionals, agencies serving the developmentally disabled, home health care agencies, and others (e.g., $P^2$ Collaborative of WNY) to obtain recommendations on the following:

- Language-appropriate patient engagement materials
- Techniques for engaging patients with low literacy rates
- Use of teach-back methods in patient-centered medical homes and other settings
- Assessments and tools to assist patients with self-management of conditions
- Other tools for promoting health literacy

Engage a "Voice of the Consumer" Sub-Committee in each of the three sub-regions (North, Central, and South) and the CBO Task Force to assist in the health literacy improvement effort. Members of these groups will:

- Review patient education materials

- Make recommendations to improve patient communications
- Provide plain language suggestions to enhance patient understanding of written materials (e.g., prescriptions, discharge plans, educational materials, treatment orders)

Develop and finalize plan for distributing health literacy materials via the Millennium website and at primary care practices, mental health clinics, drug and alcohol treatment centers, hospital EDs, and agencies serving the developmentally disabled.

## Objective 5: Prepare cultural competency and health literacy strategy

### *Key Strategies*

Utilizing findings from cultural competency gap assessment, evidence-based cultural competency approaches, and health literacy-related recommendations, contractor will prepare draft cultural competency and health literacy strategy, including planned training initiatives and community-based interventions to reduce health disparities and improve outcomes.

Submit proposed cultural competency and health literacy strategy to Clinical Quality Committee, CBO Task Force and "Voice of the Consumer" Sub-Committee for their review. Amend plan to reflect recommendations.

Submit cultural competency and health literacy strategy, including training plan, to Board of Managers for approval and post approved strategy on Millennium website.

**We felt it important to ensure that we were including patients in this process, so in addition to reviewing the assessments included below for the data on what health issues are listed we also considered what issues patients told us are important to them in order to make these improvements to their health and most importantly to encourage their involvement.**

We began this process by reviewing the WNY Community Health Needs Assessment and in particular the key findings identified through the stakeholder and community engagement process, Section VII (c). Here is what the consumers shared:

- Follow-up care and more responsive staff were among the most common answers as to what consumers/patients are seeking, and they identified their health problems as: obesity, diabetes, mental health issues, cancers, smoking and heart disease. The most important health care needs cited include mental health care, primary and preventive care, and health education.

In the community conversations, the following issues were identified:

- Communication is a problem for Medicaid patients who may not fully understand a doctor's instructions or explanations, either because the doctor speaks too technically or because the patient speaks another language.
- Provider sensitivity to cultural differences is seen as a need.
- Providers cited poverty as the overriding and most pervasive issue driving health care in our region.
- Chronic diseases are a pervasive issue. Diabetes, asthma, cardiac disease, pulmonary conditions, addiction and other chronic conditions are other prevalent in the population and evident in emergency departments.
- Lifestyle issues are also understood as a driver of healthcare need. Rates of tobacco use, especially among Medicaid enrollees, poor diet, lack of exercise, and dangerous behaviors, means training tools should focus on obesity, diabetes, cardiac disease, cancer, lung problems, as well as HIV and sexually transmitted diseases and unwanted and teenage pregnancy.

- Compliance with prescription drugs and other doctors' orders was another important theme. Research reveals a huge gap between what providers write in the clinic and what patients take at home. Cost is a barrier, but so is confusion on the part of patients.

**In order to address the concerns raised by the consumers, we have identified the following assessments and tools to assist patients with self-management of conditions in order to substantiate completion of the milestone, the first four of which we have already begun to implement within the Millennium PPS.**

## *Assessment and Tools*

- **The Cultural Linguistically Appropriate Services Survey (CLAS) tool** was developed in collaboration with others in our PPS. This is an organizational survey which was designed to assist healthcare providers and organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations. The survey was sent out to 813 organizations. The aggregate information gathered will help us in understanding what kind of assessments and tools we would need to assist patients and what kind of training tools we need to help providers and their staff. We are currently evaluating these findings.
- **Patient Activation Measures (PAM®) and Engagement:** The PAM assessment is used to determine whether a person is highly activated in their health, or not at all. Their activation level (1-4 as defined below) will allow the healthcare system to understand the needs of the individual, so that they can be assisted in improving and maintaining their health. This tool is used in the community as part of an introduction to a conversation about health and health habits. The Community Health Worker who administers the assessment will also connect the individual to preventative health programs and primary care.


- **Population health:** Million Hearts® Tool (Ohio State University) is a Millennium Collaborative Care partnership with the UB School of Nursing and Greater Buffalo United Ministries, which is a group of 58 churches. Million Hearts aims to prevent heart attacks and strokes by:
    - Improving access to effective care.
    - Improving quality of care for the ABCs of heart health:

  - Aspirin when appropriate
  - Blood pressure control
  - Cholesterol management
  - Smoking cessation

- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription and adherence to appropriate medications for the ABCs

- We have also begun the consumer-driven process of developing a community patient education brochure **"A Guide for Your Medical Visits."** This tool will serve as a template for use as we seek to provide education to consumers using a variety of formats, using their guidance as part of the design of these tools.

### Health literacy:

- **The Patient Education Materials Assessment Tool (PEMAT)** is a systematic method to evaluate and compare the understandability and action-ability of patient educational materials. It is designed as a guide to help determine whether patients will be able to understand and act on information. Separate tools are available for use with print and audiovisual materials.

Source: *The Patient Education Materials Assessment Tool (PEMAT) and User's Guide.* October 2013. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html

**We are aware that there is no one tool that is universal for everyone. We have researched and evaluated a variety of other tools for our trainings that will provide us with a diverse set of self-management training tools for patients, providers and for staff. These include:**

### Patient training tools:

- California HealthCare Foundation's "Helping Patients Help Themselves: How to Implement Self-Management Support"
- California HealthCare Foundation's "Coaching Patients for Successful Self-Management"

  - DocTalk Form (visit preparation form)
  - How's Your Health (visit preparation link)

### Provider and staff training tools:

- American Academy of Family Physicians' "Improve Care with Patient Self-Management Support"
- American Medical Association's "Self-Management Strategies for Vulnerable Populations"
- Motivational interviewing: This is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles—expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change).
- The INTERACT "Stop and Watch" form is used by facility/home care agency staff and families to identify any sort of early change in a patient's condition, and subsequently intervene prior to an overall decline and hospitalization.

- MI Reminder Card (Am I Doing This Right?): This tool helps the users keep the attention on the patients.

Author(s): Ric Kruszynski, Paul M. Kubek, Deborah Myers, and Jeremy Evenden. Publication Year: 2012 Publisher City: Cleveland Publisher Name: Center for Evidence-Based Practices at Case Western Reserve University

### Maternal and child health tools and assessments being evaluated for use:

- Intake tools (following MICHC program) initial screening that ties the client's needs and perceptions into creating a home visiting plan
- CAGE / CAGE- AID tool screens for ETOH & substance abuse
- PHQ 2/9 and Edinburgh tool screens for depression
- Ages and stages tool – developmental screen
- Human trafficking screen through the international center
- HITs screen for domestic violence

### Behavioral health commonly used screenings by Millennium partner agencies:

- **Patient Health Questionnaires (PHQ):** The PHQ assessments are validated diagnostic depression assessment tools which are used to assess high-risk or "red-flag" patients who may have unexplained physical symptoms, may appear sad or stressed, or may have a loss of interest in activities. The score on the questionnaire indicates diagnosis and severity. Two versions are commonly used:
    - **PHQ-2:** A two-question assessment used to screen for depression. If the patient answers yes on either question they are asked to complete the more extensive PHQ-9 version.
    - **PHQ-9:** A follow-up to the PHQ-2; a more comprehensive screening for depression that includes nine questions.
- **General Anxiety Disorder (GAD) Tools:** This easy to use self-administered patient questionnaire is used as a screening tool and severity measure for generalized anxiety disorder. GAD instruments are validated diagnostic screening assessment tools which are commonly used in two versions below:
    - **GAD-2** is a two-question screening tool that identifies whether a more detailed screen for anxiety is warranted.
    - **GAD-7** is a seven-question screening tool that identifies whether a complete assessment for anxiety is indicated.
- **Duke Health Profile** (DUKE): A 17-item generic self-report instrument containing six health measures (physical, mental, social, general, perceived health, and self-esteem), and four dysfunction measures (anxiety, depression, pain, and disability). Items were derived from the 63-item Duke-UNC Health Profile, based upon face validity and item-remainder correlations. The DUKE is presented as a brief technique for measuring health as an outcome of medical intervention and health promotion.
- **Screening, Brief Intervention and Referral to Treatment:** (**SBIRT**) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT utilizes motivational interviewing techniques and some common screens listed below. After a person takes the screenings below, they may be shown to be at risk of substance use disorders/alcohol abuse and the trained Behavioral Health Specialist would intervene and refer out to treatment if necessary.

- **The Alcohol Use Disorders Identification Test (AUDIT**), developed in 1982 by the World Health Organization, it is a simple 10-question screen that can help identify people at risk of alcohol problems.
- The **CAGE questionnaire**, the name of which is an acronym of its four questions, is a widely used screening test for problem drinking and potential alcohol problems (alcoholism). Two "yes" responses indicate that the possibility of alcoholism should be investigated further.
- **Drug Abuse Screen Test (DAST-10)** is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than eight minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth.

**Self-management assessments and tools commonly used by Millennium partners:**

- The Plate Method (available in different languages): Simple and effective way to manage blood glucose levels and lose weight.
- Blood Pressure Log: Personal tool for tracking and analyzing blood pressure measurements.
- Blood Glucose Log: Personal log where a patient tracks blood glucose levels and learns how food, medication, rest and exercise can affect their blood sugar.
- Personal Safety Plan: A personal plan that helps guide patients through difficult moments and keep them safe.
- Diabetes Zones for Management Guide: Divides various signs and symptoms into green, yellow and red management zones. Green indicates good control over the condition. Yellow indicates caution and suggests steps to get back on track. Red indicates a medical crisis which requires a physician intervention.
- Patient Activation Measure (PAM): Developed to assess an individual's knowledge, skills and confidence for self-management.

**For patients:**

- The Readiness Ruler, a tool to help patients assess how important the change is to them right now, and how confident they are about making the change.

    - Source: *Readiness Ruler* by Center for Evidence-Based Practices at Case Western Reserve University. 2010. Publisher City: Cleveland, Ohio. Publisher Name: Center for Evidence-Based Practices, Case Western Reserve University.

## Objective 6: Provide education and tools to help providers and their professional staffs address health care disparities and improve health outcomes for all patients; develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)

### *Key Strategies*

Issue an RFP from CBOs to serve as trainers for Millennium's cultural and health literacy program. A minimum of 12 CBOs, representative of the three sub-regions of the PPS (North: Niagara and Orleans Counties; Central: Erie, Genesee, and Wyoming Counties; South: Allegany, Cattaraugus, and Chautauqua Counties), will be selected.

Select CBOs responding to survey based on their capabilities and the extent to which they serve under-served population groups and communities that were identified in previous research (Milestone #1).

Working with IT team, contractor will develop content for website-based cultural competency and health literacy learning platform.

Contractor will develop a comprehensive plan for providing in-person and web-based cultural competency and health literacy training to representatives of CBOs (please note that faith-based communities are included as CBOs).

- Develop a PowerPoint presentation that summarizes the cultural competency/health literacy strategic planning process
- Conduct a series of four webinars that clearly articulate and engage providers relative to the cultural competency strategic vision and training objectives
- Begin web-based training process with the *Advancing Cultural Competence in the Public Health & Health Care Workforce Program.* This program is a part of NYS Department of Health Learning Management System. The webinars will present fundamental concepts on cultural and linguistic competence for medical and public health professionals and lay the foundation for the more comprehensive continuing education which recognizes the need for continuing cultural competency/health literacy education. Participants will receive continuing education credits for each individual course completed and a certificate if they complete the entire series.
- Develop and disseminate relevant news items relating to the cultural competency/health literacy strategic plan on Millennium's website
- Partner with local libraries to provide access to health literacy and other relevant health education

Recruit cultural competency champions for Millennium-affiliated providers, agencies, and CBOs.

Using results of gap assessments and other findings, develop priority target list of providers, agencies, and CBO sites for cultural competency and health literacy training.

- Work with the county library systems to provide easy-to-access sites for consumer information and resources
- Work with the Homeless Alliance to ensure that we are reaching as many people as possible from the critical segments of our population
- Work with senior centers, Head Starts, and daycare organizations to reach under-served members of the community
- Include Medical Answering Services LLC, and WNY Transportation Management in cultural competency/health literary training for drivers and telephone personnel

Develop a training plan in conjunction with the Workforce Development Work Group to ensure that cultural competency and health literacy are integrated into each aspect of the workforce strategy; the plan will be inclusive of all staff—retrained, hired, or redeployed.

Develop training plan for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in the cultural competency strategy.

Work with the practitioner engagement team to engage and encourage collaboration by identifying the cultural competency/health literacy connections with NCQA patient centered medical home standards to illustrate the linkages which include:

- PCMH 2 Element C: Culturally & Linguistically Appropriate Services whose entire element is dedicated to assessing diversity and language needs of patients

- PCMH 3 Element C: Assessing patients for health literacy which requires a practice to demonstrate that they are assessing their patients for health literacy
- PCMH 4 Element A, Factor 4: Social determinants of health which ask practices to choose a social determinant of health as criteria for identifying patients that need care management; the key dependency here is that the practices must be capturing this information in order to identify patients who are eligible

Develop training plans for other non-clinical segments of the workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches.

- Workstream touchpoints in all Millennium PPS projects include: Integrated Delivery System (2ai milestones 1, 3, 11); ED Care Triage for At-Risk Populations (2biii milestone 1); patient navigators 2biii milestone 3, 3a & 3c); Hospital-Home Collaborative Solutions (2bviii milestones 3 and 4); Implementation of Patient Activation Activities (2di milestones 1–8, 11–15); Behavioral Health Community Crisis Stabilization Services (3aii milestones 1 and 2); Disease Management of Cardiovascular Health (3bi); Support for Maternal & Child Health (3fi milestone 3); Mental, Emotional and Behavioral Well-Being (4ai); and Reduce Premature Births (4di).

Working with health professional students and residents (i.e., medical, nursing, dental, etc.) we will:

- Provide health literacy and cultural competency training for these interns who will be assigned to Millennium as a part of affiliation agreements
- Advocate adding health literacy and cultural competency training to their school and residency curriculum

Working in concert with cultural competency champions, schedule onsite cultural competency and health literacy training that will be provided by trained CBO representatives as well as by contractor.

Begin onsite training at Millennium partner sites, including primary care practices, behavioral health agencies, addiction treatment centers, CBO service sites, etc., directed to practitioners and staff and focused on the core component, health-literate care.

- Provide cultural competency and health literacy training to Millennium staff
- Identify five pilot sites for cultural competency and health literacy to begin

Populate cultural competency and health literacy learning platform with lessons learned and continue to build educational resources on the website.

Perform an evaluation of cultural competency and health literacy training initiative to pinpoint any gaps and needed improvement to strengthen training before proceeding to the next training phase. Use pre- and post-training assessments that will include proof of impact to determine effectiveness. Impact evaluation will help us answer key questions and help us assess our outcomes. It allows us to ask what works, what doesn't, for whom, where, why and for how much. It assesses the changes that can be credited to a particular intervention, in this case Cultural Competency and Health Literacy training, as both intentional and unintentional outcomes. Impact evaluation is structured to answer the question: how would outcomes such as participants' behavior have changed if the intervention had not been undertaken? This is a critically important consideration for this effort.

Review progress and issue first quarterly report to Millennium Board of Managers, "Voice of the Consumer" Sub-Committee, and CBO Task Force on number of partners receiving training, participant-level data, description of training providing training outcomes, health literacy materials that have been developed and tested by consumer input, and other cultural competency and health literacy activities.