



Montefiore
HUDSON VALLEY
COLLABORATIVE

Cultural Competency and Health Literacy Strategy



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THIS STRATEGY WAS CREATED IN COLLABORATION WITH THE NATHAN KLINE INSTITUTE, CENTER FOR RESEARCH ON CULTURAL AND STRUCTURAL EQUITY IN BEHAVIORAL HEALTH.

INTRODUCTION

MHVC PPS understands that combating health disparities by addressing the social determinants of health is a key aspect of our charge in transforming care in the lower Hudson Valley. We understand that the purpose of DSRIP is to lay the foundation for value-based Medicaid payments and that these value-based payments function to incentivize preventive health care. To connect these allied charges in an effort to 1) address the social determinants of health, and 2) promote preventative health care, we acknowledge the importance and intrinsic value of a cultural competency and health literacy (CC/HL) strategy. Prior to submitting our implementation plan for generating our CC/HL strategy, we completed a community needs assessment. Though this assessment was designed to capture the broad concerns of the communities served by our PPS, in writing this CC/HL strategy, we paid particular attention to aspects of the findings which we could address with a targeted strategy.

Our thinking process progressed through three stages:

Stage 1: Identifying Need Domains

We reviewed our community needs assessments (CNA), including a thorough and in-depth review of the key findings. We reviewed all of the hot spotting that had been done, in tandem with an assessment of the existing available resources and ongoing activities in our PPS, along with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards).

Included in the Charts Section are highlights of a few of the documents we reviewed:

- Map of CNA survey respondents and identified hotspots
- List of community identified top health issues
- Member roster analysis data sorted by county & zip code- areas of highest attribution
- Member roster analysis data sorted by racial and ethnic identity

We elucidated two broad domains, including **“communicating to the community”** and **“emphasizing community-defined quality of care,”** which we then used as a basis for the strategy.

We also identified the following specific high-need populations that we will be prioritized in our strategy implementation:

- Low income
- Uninsured or low utilizers
- Non English speaking
- Individuals with mental health diagnosis
- Chronic disease sufferers

Stage 2: Identifying Theoretical Constructs

Effectively communicating to the community means employing culturally competent and health literate strategies, engaging in information sharing with other providers, two-way communication, and remaining responsible to populations with limited English proficiency (LEP), as well as considering reading level and the necessity to use plain language. At the same time, emphasizing community-defined quality of care means engaging patients and

activating families, partners, and key supports by participating in shared decision making around developing care plans. In activating families, providers also have to commit to self-reflection and see themselves as partners in their relationship with their patients, meaning that providers examine their own biases and work to expand the scope of their own understanding. **From these two broad domains, we pinpointed theoretically supported constructs that would require further exploration among the stakeholders in our PPS, including engagement, stigma, trauma-informed care, shared decision making, and cultural competency/health literacy.** These constructs can be measured by the Provider/Staff Capacity Survey, a key tool of the assessment of this CC/HL strategy that can be found in Appendix III.

Stage 3: Researching Resources in the Community

Finally, in order to build out from our review of the needs assessment and our identification of key theoretically-supported constructs, **we conducted focus groups and in-depth interviews with clients and community-based providers, and attended community forums** (see Appendix 4 for a detailed accounting of the individuals and groups with whom we spoke). We did this work in order to build a strategy based on resources already present in our PPS, but also to examine and expand our thinking about cultural competence.

Through these assessment and evaluation efforts, our findings from the community needs assessment were affirmed. The needs of the identified high-need groups are locally being addressed with population-specific services. These efforts are already underway within our PPS catchment and can be utilized as a resource:

Community services:

- ✓ An example of linking **faith-based organizations** with education initiatives can be found at the Hudson Valley/Rockland/Westchester Chapter of The Alzheimer's Association:

"We have hired a diversity outreach specialist. She's been covering Westchester for two years now with a focus on African American and Latino outreach. Her job has been to implement faith-based outreach programs, specifically getting churches involved in "Purple Sundays," where leaders of the congregation encourage the whole congregation to get involved and raise awareness. Other staff have been involved in faith-based outreach as well, including reaching out to churches and synagogues to offer education efforts."

- ✓ An example of engaging in **two-way communication** can also be found at the Hudson Valley/Rockland/Westchester Chapter of The Alzheimer's Association:

"We were awarded a diversity grant from the state and based on that money, we'll have four brand new positions that are especially for Latino outreach. There have been a few pockets of exponential growth of Spanish speaking people in the Hudson Valley, especially in Newburgh, which is now 47% Latino – this is a huge change from 10 years ago. We'll put two of the new people in Newburgh and the others in Westchester."

- ✓ An example of initiatives emphasizing **prevention services** can be found on the "Population Health Committee" at St. Luke's Cornwall Hospital.

"This committee is facilitated by IPRO, a Medicare quality improvement company for New York State. On the committee, IPRO's work is focused on care transition initiative, which looks to improve the communication and coordination of care as patients' transition between the

care settings during an exacerbation of their chronic illness. The goal of these initiatives is to reduce hospital 30-day readmissions for FFS Medicare beneficiaries.”

Work with priority groups:

- ✓ An example of focused attention to working with individuals with **limited English proficiency** (LEP) can be found at The Greater Hudson Valley Family Health Center:

“We have a lengthy medical interpreter program through which we certify bilingual individuals as medical interpreters, and we’ve noticed that smaller medical offices don’t have bilingual staff, so access to medical interpreters at these smaller offices is a needed resource.”

- ✓ An example of expanding **mental health** services to include mobile crisis and **peer supports** can be found at Access: Supports for Living.

“We have a new mobile mental health team in Ulster County that is 95-98% percent staffed with people with lived or shared experience. Training with Intentional Peer Support (IPS), including the Core Training, Co-reflection, and Advanced Training, was required for the mobile Ulster team. It was a wonderful training experience for all of the staff that attended – it was very valuable and everyone came out of there wanting more. We have had the opportunity to Skype with the IPS trainers, so we can continue the dialogue with them to make sure that we’re on the right track. We already have some staff interested in becoming IPS Facilitators in February of 2016.”

- ✓ An example of working with **chronic-disease sufferers** in the self-management of their illness can be found at The HOPE Center at St. John’s Riverside Hospital.

“Within the HIV community, this has been a topic that we’ve talked about since 1999/2000, when we first saw meds come out. If people didn’t manage their meds, they were going to die. So we began talking early on about self-management as a concept. However, we are still using tools, like pillboxes and reminder calls, which we had early on. Even though we now we have access to a variety of tools through electronic communication, small providers like us don’t have the financial resources to step into that realm in a way that we can also meet our HIPPA requirements.”

Support for our vision of Cultural Competency in Context

As these examples demonstrate, good community-based, culturally competent, and health literate work is already underway in our PPS. In broadening our awareness of these initiatives, we also learned that our notion of “conventional” cultural competency needed to expand based on the reality that individuals working on the ground, in community-based organizations, were thinking about cultural issues in a very broad way. By “conventional” cultural competency, we mean to point to what has been the charge of CC/HL strategies in the past: emphasizing religion, language, and race. We found that providers on the ground in our PPS were working to understand their clients in a much more nuanced, yet broad way. From being aware of how generational issues intersect with geographic differences (St. Luke’s Cornwall Hospital), to participating in LGBT training for people working with older adults and applying for diversity grants in order to hire new staff especially for Latino outreach in Newburgh (Alzheimer’s Association), to seeing how a mother might have a hard time focusing on her viral load (being HIV-positive) because she is most worried about keeping her children fed and keeping her housing (The HOPE Center) – these were the kinds of “cultural” issues that providers in our PPS were tackling on a daily basis. To protect their good work, we realized that our CC/HL strategy needed to refocus what it could mean to be “culturally competent.”

On cultural competency, Kay Scott, Director of The HOPE Center at St. John’s Riverside Hospital had this to say:

“We...took advantage of training...early on called ‘cultural competency’ and now called ‘cultural humility.’ I like that phrase [cultural humility] better because it suggests how **it’s not just about communicating in Spanish, for example; it’s more about looking at a person’s whole life** and asking myself how I can help [that person] achieve their best life – their best life being how they want their life to be. **[As providers,] we have to ask how we can contribute toward that life.** I have found taking that lens to be much more helpful for all of the staff. It normalized for all of us that **there’s no way we’re going to know all there is to know about someone, so the best place we can stand is from that place of not knowing.**”

Cultural competency means coming from a place of not knowing, with the allied understanding that, if it’s not working for both of us, it’s not working. This means that we have to find a way to leverage our individual expertise – our own, as providers, with our clients, as experts in their own lives. In coming from a place of not knowing, and in being responsible to each other’s individual expertise, **we ask**: we ask ourselves, we ask each other, and we ask the individual person. This is the foundation for “cultural competency,” as it is broadly understood in this strategic plan. Having conversations about what an individual is worried about, for example feeding her children and staying in her home, and therefore being able to back into the issue of viral load suppression - this is cultural competency *in context*. Being culturally competent *in context* is how providers can have conversations with their clients that address the social determinants of their clients’ health.

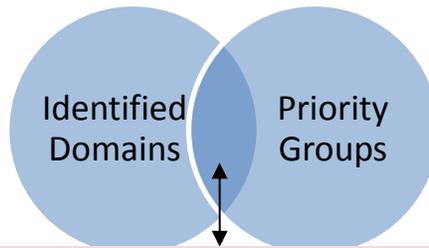
Though heartened by our findings and emboldened by our new understanding of cultural competency *in context*, our investigative work also pointed to gaps in our communities’ efforts. We learned that smaller community-based organizations might struggle to afford new technologies for two-way communication (especially texting services) that are HIPPA-compliant. We also noticed that there was scarce mention of low-income populations, which suggests a potential need to include financial empowerment initiatives in our service delivery. We also recognize that systemic gaps persist, including the need to better integrate criminal justice experts and representatives from the housing industry as components of preventative health care that is informed by an understanding of the social determinants of health.

How we put Cultural Competency in Context into Practice

To encourage and facilitate the work already underway, and to begin to close these community-level and systemic gaps, as a PPS we have to promote and support effective communication with the community and we have to prioritize community-defined care. In so doing, we have to ensure that the providers working in our PPS are culturally competent *in context*. We can do that by linking and aligning community-specific information to community-based resources, efforts that we understand are the backbone of an effective cultural competency/health literacy strategy. Therefore, the remainder of this document will lay out our strategy for organizing and connecting the flow of information and resources related to mitigating the social determinants of health within our PPS.

With careful examination of our data and thoughtful reflection on the needs of our patients, this strategy is divided into two major sections to signify the entities that are responsible for carrying out the activities within this strategy: the **provider organizations** and our **MHVC CC/HL Workgroup**. Each section is sub-divided into three areas of effort: **data collection**, **organizational activity** and

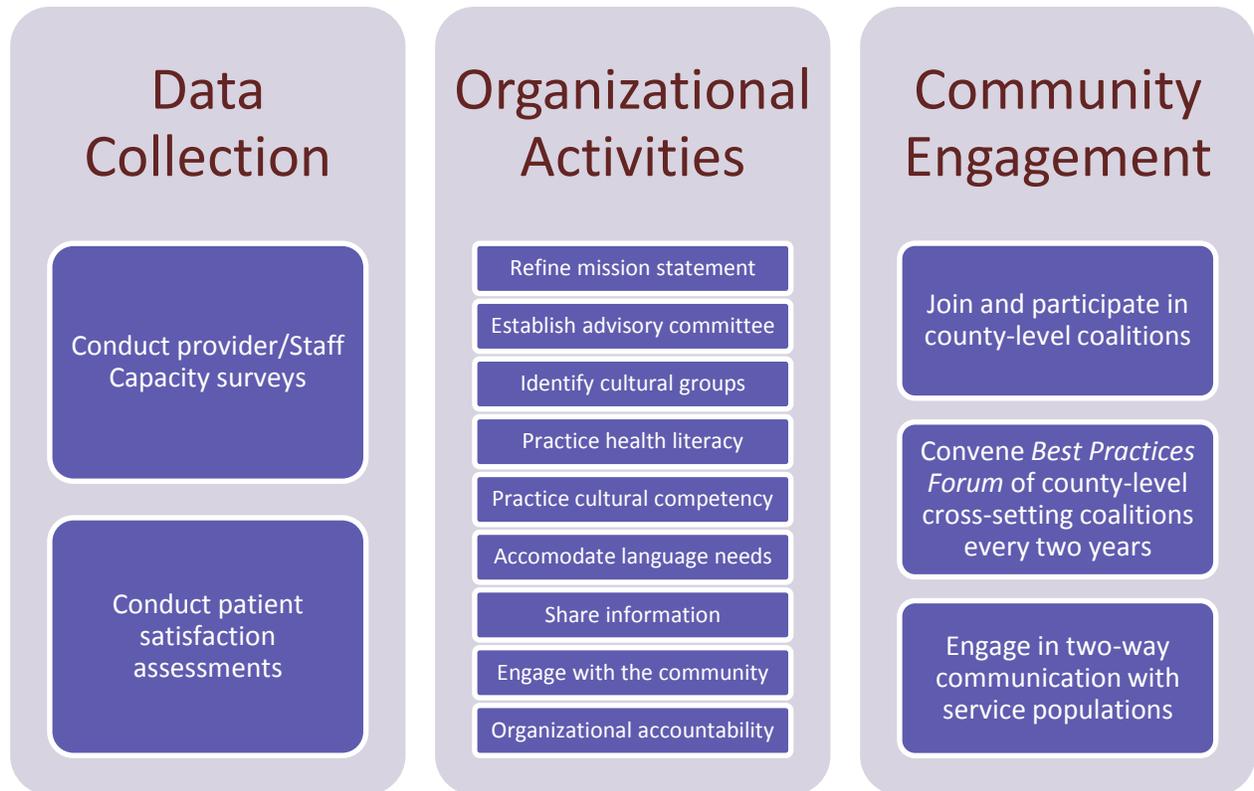
community engagement. Information flow connects provider organizations to the MHVC CC/HL Workgroup and the areas of effort (data collection, organizational activity, and community engagement) push and pull information from all sectors and levels of our PPS, foregrounding the communication of information as a way to emphasize community-defined quality of care.



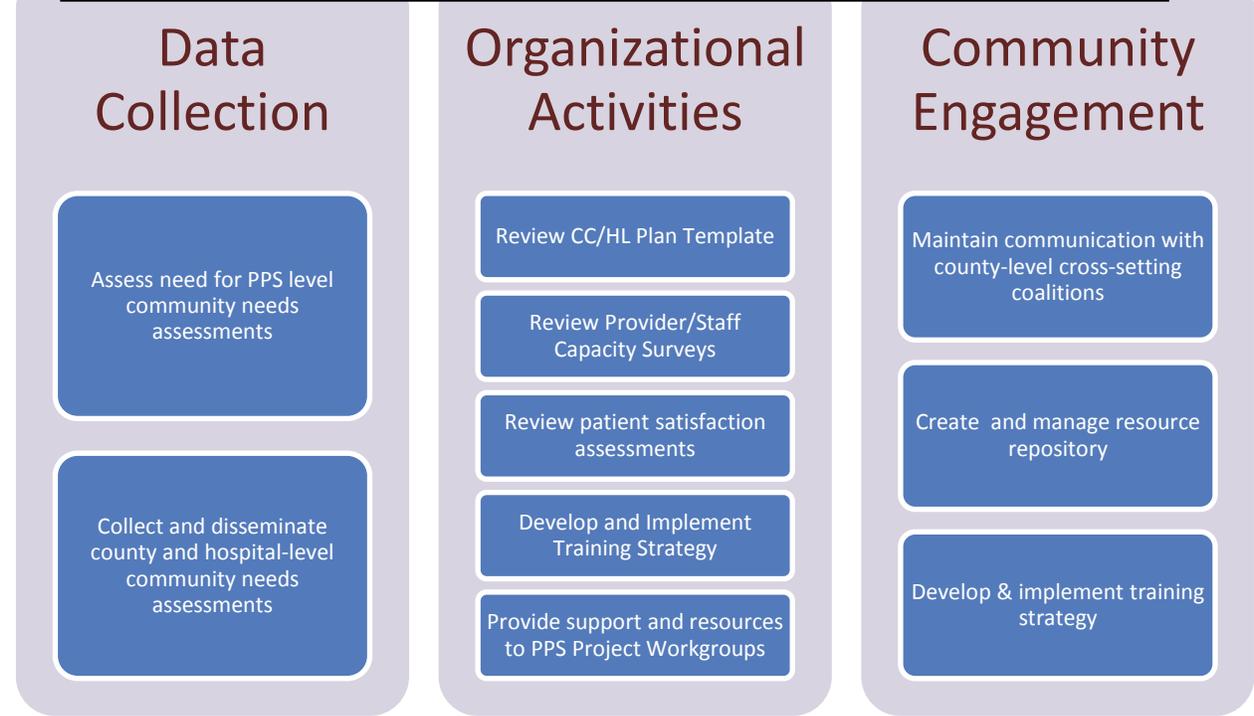
CC/HL Strategy

The CC/HL strategy rests upon tackling/addressing these identified domains such that the needs of our priority groups are met, and appropriate/relevant care can be realized. The next section of this document includes a visual representation of these three areas of effort (data collection, organizational activities and community engagement) encompassing the CC/HL Strategy. Following sections will describe the suggested activities of provider organizations and the MHVC CC/HL Workgroup. The final section of the strategy will lay out the potential flow of information between the MHVC CC/HL Workgroup and the provider organizations.

OVERVIEW OF THE STRATEGY



MHVC Cultural Competency/Health Literacy Workgroup



PROVIDER ORGANIZATIONS

The following section will describe the recommended activities provider organizations should initiate or continue in order to deliver culturally competent and health literate care. The initial activity each provider organization should undergo is to encourage staff (e.g. provider, nurses, patient technicians, clerks, etc.) to complete the Provider and Staff CC/HL Capacity Survey. This will provide a quantified understanding of the organization's ability to provide cultural competent and health literate care. The second activity is to create or update an organization's Cultural Competency and Health Literacy Plan. This plan will be responsive to the findings elicited by the Capabilities Survey. Lastly, provider organizations are encouraged to join, create or maintain membership in community-based cross-setting coalition. These coalitions provide opportunities for provider organizations to immerse themselves in the needs and resources of the community and its population. Furthermore, community providers can either create or strengthen existing resources, referral pathways and connections to care through active membership and participation in these coalitions.

Data Collection

Provider and Staff CC/HL Capacity Survey

Provider organizations are recommended to administer the Provider and Staff CC/HL Capacity Survey every two years. This survey will measure the skills, behaviors and attitudes around cultural competency and health literacy practices and policies of the providers and staff in an organization. By administering the survey every two years, the organization is able to: 1) identify gaps in CC/HL practices and policies, 2) assess the application and effectiveness of CC/HL activities and initiatives, and 3) better understand their internal organizational culture.

The survey has 10 domains: provider/staff demographics, engagement, mental health stigma, alcohol use stigma, opiate use stigma, shared decision-making, trauma-informed care, services and groups served profile, compassion satisfaction, and lastly cultural competency practices. These domains were informed by community-specific information captured in the need domains of the community needs assessment. The survey can be found in the MHVC PPS CC/HL Resource Repository at <website address> and in Appendix III.

➤ *Engagement*

Research strongly supports the association of engagement to patient outcomes. When patients are engaged with their care, response and adherence to treatment significantly increases¹. For marginalized groups (e.g. immigrants, LGBT, non-English speakers), engagement may be a particular challenge as several barriers may exist prohibiting them from receiving and adhering to care. This domain of the survey assesses the ability of providers and staff to connect patients to resources that will facilitate better engagement to their healthcare.

¹ Concannon, T. W., Meissner, P., Grunbaum, J. A., McElwee, N., Guise, J., Santa, J., & ... Leslie, L. K. (2012). A new taxonomy for stakeholder engagement in patient-centered outcomes research. *Journal Of General Internal Medicine*, 27(8), 985-991. doi:10.1007/s11606-012-2037-1

- *Stigma*
Stigma remains one of the largest barriers to care that many patients experience.² It is well documented that patients who feel stigmatized by providers and staff do not return to care and disengage in any care or treatment process³. The survey assesses stigma around mental health, alcohol-use and opiate-use. Understanding the level of stigma held by providers and staff provides an opportunity for growth and education around these conditions. This will benefit both providers/staff and patients in creating stronger trust and therapeutic alliances between healthcare professionals and the patients they serve.
- *Shared Decision-Making (SDM)*
As we move into healthcare delivery that is more patient centered, shared decision-making has become a centerpiece to patient-centered care. SDM is described as “a collaborative process that allows the patients and their provider to make healthcare decisions together, taking into account medical evidence as well as patients’ values and preferences”⁴. This approach to treatment and care has shown great improvements in outcomes for patients such as treatment adherence and retention⁵. This domain of the survey assesses providers on their employment of shared-decision making techniques. Results from this domain can be used to determine if SDM training is needed for some or all clinical staff.
- *Trauma-Informed Care*
Studies have shown almost all patients who suffer from mental illness have experienced trauma in their lifetimes⁶. Trauma-informed care is an integral part in patient-centeredness as trauma can have effects on all aspects of a patient’s healthcare experience. Trauma that is unaddressed or unacknowledged can lead to poor health outcomes such as little retention to services, ineffective adherence to treatment and, most severely, exacerbation of mental and/or physical illness⁷. The survey domain assesses clinical staff on their ability to provide trauma-informed care in both physical and behavioral health settings.
- *Services and Groups-Served Profile*
In this domain of the survey, providers and staff are assessed on their knowledge of common barriers their patients may experience and the types of groups their patients represent. This domain is intended to determine if providers and staff understand the social determinants of health their patients’ experience. Findings of

² Chan, K. K., & Mak, W. W. (2015). The Content and Process of Self-Stigma in People With Mental Illness. *The American journal of orthopsychiatry*.

³ Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies Patrick W. Corrigan, Scott B. Morris, Patrick J. Michaels, Jennifer D. Rafacz, and Nicolas Rüschi *Psychiatric Services* 2012 63:10, 963-973

⁴ Godolphin, W. (2009). Shared decision-making. *Healthc Q*, 12(Spec No Patient), e186-e190.

⁵ Joosten, E. A., DeFuentes-Merillas, L., De Weert, G. H., Sensky, T., Van Der Staak, C. P. F., & de Jong, C. A. (2008). Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status. *Psychotherapy and psychosomatics*, 77(4), 219-226.

⁶ Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of consulting and clinical psychology*, 66(3), 493.

⁷ Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2014). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*.

this domain can inform whether further outreach and engagement is needed for particular patient groups.

- *Cultural Competency and Health Literacy General Practices*
This domain will assess providers and staff on their knowledge and employment of the CC/HL practices and policies of an organization. Findings will be able to advise: 1) additional CC/HL considerations, 2) knowledge and awareness of CC/HL practices and policies to providers and staff and, 3) employment of CC/HL practices.
- *Compassion Satisfaction*
This domain is intended to measure compassion satisfaction of providers. Finding will determine if providers derive pleasure and satisfaction from their work and from their ability to contribute to the greater good of society.

Patient Satisfaction Surveys

In order to have a comprehensive understanding of an organization's CC/HL practices and its effectiveness, we recommend that patients be surveyed routinely to determine their satisfaction with care and other unmet needs. By examining the CC/HL Patient Satisfaction Survey as well as the Provider and Staff CC/HL Capacity Survey, organizations will be able to identify gaps as well as needed improvements in implementation and application of practices/policies. Patient satisfaction surveys will provide the needed perspective to ensure that CC/HL is being systematically and effectively implemented. The Patient Satisfaction Survey is included Appendix IIA and will be found in the MHVC PPS CC/HL Resource Repository.

Organizational Activities

Cultural Competency and Health Literacy (CC/HL) Plan

Each organization is recommended to create or update their CC/HL plan. This plan will capture and coordinate all CC/HL organizational activities. Specifically, the plan should be responsive to the findings of the Provider and Staff Capacity Survey and the Patient Satisfaction Survey.

Providers serving within hot spot communities will be requested to submit their CC/HL plans based on current level of cultural competency and health literacy as determined by the Provider and Staff Capacity Survey. The Workgroup will establish the frequency of which plans are submitted. A template for the CC/HL plan for organizations and single/multi-provider groups can be found in Appendix II. Provider organizations do not need to use the template, as long as the following sections are addressed within the plan.

The plan will consist of 10 sections:

- Mission Statement
- Advisory Committee
- Cultural Group Identification
- Self Management of Illnesses
- Health Literacy Practices
- CC Training Practices
- Language Accommodations
- Information Sharing
- Community Engagement

➤ Organizational Accountability

1. *Mission Statement*

The organization's mission statement should capture the organization's commitment to cultural competency and health literacy and the value of providing such care to their patients. An example, "To improve communication with patients for whom cultural and/or linguistic issues are present, decrease health care disparities, improve staff understanding and sensitivity to cultural diversity, and improve services, care and health outcomes for cultural group members."

2. *CC/HL Advisory Committee*

This group should be multi-disciplinary and include members of the communities the organization serves. The committee's primary charge will be to oversee the implementation of CC/HL activities, as they are described in the organization's CC/HL plan. Furthermore, the committee will be responsible for: 1) disseminating and analyzing provider/staff and patient surveys; 2) identifying gaps in CC/HL practices and policies; 3) revising organization's CC/HL plan; 4) connecting with local county cross-setting coalition and; 5) submitting plan and survey findings to MHVC CC/HL Workgroup.

For Single or Multi-Provider Groups:

Due to the smaller size and possible capacity concerns of Single or Multi-Provider Groups, in lieu of a CC/HL Advisory Committee a staff person can be assigned to be responsible for the activities described above. This person will serve as the CC/HL Champion.

3. *Cultural Group Identification*

Data will be collected and analyzed to identify groups and any disparities that may exist among them. Such disparity metrics should include DSRIP project metrics stratified by cultural groups, as well as preventable emergency room visits, retention in services and adherence to treatment. Findings from this analysis will be used to modify care, improve engagement and advise other clinical and non-clinical practices. The CC/HL Advisory Committee will review these findings and make the appropriate recommendations to the appropriate departments/divisions.

4. *Self Management of Illnesses*

This section is an opportunity for the provider organizations to describe the self-management strategies used for the variety of chronic illness groups they serve. Self management strategies and techniques are expected to be culturally competent and patient-centered. Examples of self management strategies and interventions include:

- Motivational Interviewing
- Stanford Model of Chronic Disease Self-Management
- Patient-Centered Goal Setting
- Brief Action Planning
- "What Matters to Patients?"

5. *Health Literacy Practices*

In this section, the plan should describe how the organization will ensure that the appropriate level of health literacy will be used with each patient. Organizations should also document current and planned accommodations for those with low health literacy and

strategies to educate and expand patients' health literacy. Examples of health literacy strategies include the use of visual aids, the "teach-back" method, and open-ended questions.

6. *CC Training Practices*

We recommend that clinical and non-clinical staff undergo cultural sensitivity and humility training within three months of hire and receive refresher training annually. Furthermore, identified gaps in skills, behaviors and attitudes (e.g. trauma-informed care, stigma, etc.) revealed by the provider and staff survey should be included in this section. The plan should detail which resource(s) is being used and how the training will be administered to staff. Recommended training and resources will be located in the MHVC PPS CC/HL Resource Repository.

7. *Language Accommodations*

This section of the plan should describe how interpreters should be accessed and used, as well as a list of all documents translated in non-English languages. Lastly, the steps to translate a document should also be described in this section.

8. *Information Sharing*

Information about current and new practices and policies as well as health trends in certain patient groups should be easily accessible to all clinical and non-clinical staff. This section should describe way in which the organization and the CC Advisory Committee will communicate information to all staff.

9. *Community Engagement*

Organizations should make concerted efforts to establish reciprocal communication with not only patient groups, but with other community-based agencies and organizations, e.g. substance abuse clinics, food banks, law enforcement, housing, education, etc. Plans should describe mechanisms in which two-way communication with the community can be achieved. A variety and combination of mechanisms can be utilized such as: message boards, town hall meetings, etc. Another mechanism that allows for bidirectional communication with community stakeholders is membership and participation in county level cross-setting coalitions. These coalitions will be described in detail in the following section.

10. *Organizational Accountability*

Organizations should establish policies for identifying and managing staff and patient grievances related to cultural sensitivity and humility. Current policies and procedures may be expanded to include plan for review and resolution of complaints regarding patients, and this information should be made readily available to patients and staff. Organizations may wish to review patient retention data to ensure that patients from certain cultural groups or with certain diagnoses are not experiencing high discharge rates.

Community Engagement

County-Level Cross Setting Coalitions (CCC)

These county-level coalitions will be populated by representatives from organizations situated across care settings. Its focus will be on community engagement and aligning resources, thus creating the possibility of fostering cultural competency *in context*. It can also create clinical and service partnerships and referral pathways across agencies and CBOs. These coalitions have the ability to not only augment the understanding of cultural competency in context of patients' communities, but also physically connect people and resources. Several counties within the PPS have active cross-setting coalitions - such as Orange, Dutchess/Putnam, and Westchester.

There are three specific leadership roles in each coalition:

- *Facilitator*
This entity will facilitate organizing interested parties together and assisting in developing coalition structure. They will connect new coalitions to existing coalitions for guidance.
- *Convener*
The convener is an entity that is exposed to the breadth of the patient population. The convener will host coalition meetings as well as maintain group cohesion. It will also cultivate and maintain coalition purpose based on community-level information and input from coalition members.
- *Cultural Competency/Health Literacy Champion*
The CC Chairperson will maintain the perspective of cultural competency within the identified needs of the service population and coalition. They will be the holder of the CLAS standards; making sure that these recommendations are maintained throughout the conversation, even when the context (i.e. needs and resources landscape) changes.

The frequency of coalition meetings as well as membership make-up will be unique to each coalition as well as county/community needs. Organizations that are interested in being a member or creating a coalition in a county that does not have one will be encouraged to contact the MHVC CC/HL Workgroup to get connected to existing coalitions for guidance and or assistance in assembling other interested parties.

Each coalition will report to the MHVC CC/HL Workgroup twice a year or as needed to discuss the needs and concerns of their respective county coalitions. This information could advise efforts for modified or enhances services in certain communities, elucidate emerging needs, additional materials for the Resource Repository, etc. Based upon capacity each coalitions will determine frequency of reporting to the MHVC CC/HL Workgroup, however we suggest coalitions should communicate with the Workgroup twice a year.

Best Practices Forum

Every two years, all 7 county-level cross-setting coalitions (possibly in collaboration with the MHVC CC/HL Workgroup) could convene for a half-day forum to present and discuss best practices implemented within each county. This will provide an opportunity for stakeholders to exchange ideas,

challenges and solutions that are informed by providers and organizations on the ground and in communities that being served.

Drilling Down: An Example of a Cross-Setting Coalition

The Orange County Coalition is developing a cross-setting coalition, which is called the “Population Health Initiative.” This group was assembled with assistance from IPRO, a national organization providing a full spectrum of healthcare assessment and improvement services. The following are excerpts from transcribed interviews with members of the Orange County Coalition.

On the next three pages, see interviews with three people of central importance to the Orange County Coalition, including Chris Stegel of IPRO, Dan Maughan of St. Luke’s Cornwall, and Nadia Allen of the Mental Health Association of Orange County.

Chris Stegel, Senior Quality Improvement Specialist at IPRO, on her work initiating and facilitating cross-setting community coalitions:

IPRO is a Medicare quality improvement company for NYS. We work under federal contract and focus on fee-for service (FFS) Medicare patients, which include the dually eligible patients. I help to initiate and facilitate cross-setting community coalitions that include both community based organizations (CBOs) and health care providers. We come as the objective participant and our services are free (paid for by the federal government, CMS). Our goal is to create an all-learn, all-share environment. Our projects include all of New York State; the goal of our initiatives is to reduce hospital 30-day readmissions for FFS Medicare beneficiaries.

The part of the contract that I work is focused on care transition initiative, which looks to improve the communication and coordination of care as patients’ transition between the care settings during an exacerbation of their chronic illness. We assist each coalition in performing a community root cause analysis to investigate reasons patients are being readmitted to the hospital and linking the reasons to evidence-based care transition interventions. We have a broad perspective, but each coalition is different in participation and intervention implementation.

Many of our activities have been integrated into the DSRIP programs because our activities and DSRIP are centered on the same activity: to reduce hospital 30-day re-admissions. DSRIP focuses on the Medicaid population. Although our focus is on FFS Medicare patients, we understand that many providers are implementing specific interventions, which we have recommended, for every patient; we understand that this is essentially good patient care.

Dan Maughan, Vice President of Patient Care Operations at St. Luke's Cornwall Hospital, on leading the Orange County Cross-Setting Coalition, which has been named the "Population Health Committee":

Culture is many things and each of the CBO's may be working with a specific culture or multiple cultures, some defining culture by gender, race, age, or other populations, some simply by the majority of the people they serve. CBOs can be very specific in the populations with whom they work. Hospitals have a large cross-cultural census and have to deal with whatever comes our way, but that doesn't mean we are the experts for all the populations we serve.

I think our organizations strongest potential contribution to cultural competence is bringing the different community based organizations (CBO) to the table to discuss what we collectively need to provide to our community based on the rapidly changing healthcare environment and to learn about the ever changing needs of the communities we serve. This is currently done through the Population Health Coalition (PHC). The hospital may have a more global view than some of the CBO's, but the CBO may have the specialty (cultural competence) with a specific population and that's the work the PHC will need to gravitate towards in order to successfully meet the needs of our community. If we are successful, the work of the coalition will translate into policies that come together to create better systems. The coalition is in its infancy, but together we are identifying what this group is, what our unique skill sets are, what we need to succeed, and lastly, what we believe we can collectively provide to have a greater influence on the populations we serve.

Two examples of what this coalition will do that plays into cultural competency are: 1) Aging and 2) Linkage to Services.

(1) Aging- Families and Providers are giving us the same message when it comes to the aging population. The message is; we need more resources for this population and we can't let the situation get to crisis and continue to have a reactive rather than proactive response. The PHC will be working on two programs. The first is; "Aging 101 for Care Givers" and the second "Aging and the Proactive Role of the Healthcare Provider"

(2) Linkage to Services- At each meeting someone usually makes a statement about not knowing that another CBO was providing a service. We recognize that we still do not know what each of us does. As such, we will embark on creating an electronic directory of services in the Hudson Valley that will be updatable and will list the services each of us provides. We will work with established directories and then look to MHVC to assist with bringing the directory to a larger IT database accessible by the masses.

We are starting the two workgroups as defined above and both can be tied to DSRIP projects. I believe that both projects work to improve cultural competency and address issues related to health literacy.

Nadia Allen, Executive Director of the Mental Health Association of Orange County, on her role, as an expert in Cultural Competency and Health Literacy, thus far on the Orange County Coalition / Population Health Committee:

The group is naturally evolving and I attempt to ensure that we are looking through the lens of social justice as decisions are being made.

From my experience, including 30+ years in the field – I believe I can speak with confidence about next steps. This perspective is invaluable because, as well all know, if we are not looking at our charge through the lens of social justice and having a deeper understanding of oppression, we are going to miss key initiatives and concepts around what needs to be done.

Health disparities disproportionately affect groups of people that have systemically experienced greater social and economic obstacles. It's not a level playing field. These obstacles are a result of characteristics historically linked to discrimination and exclusion, such as but not limited to race or ethnicity, mental health, religion, gender, socioeconomic status, sexual orientation, geographic location, cognitive, sensory, or physical disability.

The reality is that today, 30% of direct medical costs for Black, Hispanic, and Asian Americans are directly linked to health disparities. So, we can't talk about population health without talking about and understanding the social determinants of health. People don't like to talk about race, racism, and all the –isms – but, economic and racial inequality - are real and palpable concepts...economic and racial inequality hospitalize and kill more people than cigarettes. The wages we earn, the places we live (overcrowded, unsafe areas), the schools we attend, our access to resources are health issues just as life-threatening as poor diet, smoking and lack of exercise... We can't look at smoking cessation without looking at the racial and economic realities of people who smoke.

The imbalanced distribution of social conditions and their health consequences are not natural or inevitable. They are the consequences of choices that we, as people, as a community, state and nation, have made. And we can make those choices differently. Other countries have, and the people live longer and healthier as a result.

It is my hope that I'm able to be a voice in the group that heightens our sensitivity to the deeper realities faced by the individuals we are attempting to serve and all of us, therefore developing initiatives and projects that are meaningful and relevant.

MHVC CULTURAL COMPETENCY/HEALTH LITERACY WORKGROUP

The Montefiore Hudson Valley Collaborative (MHVC) Cultural Competency and Health Literacy (CC/HL) Workgroup is comprised of a passionate and dedicated group individuals representing our partner organizations across the Hudson Valley. The workgroup, which held its first meeting in December 2015, is committed to having diverse range of members including age, gender, and ethnicity, as well as having provider, peer and patient representation.

This workgroup is an extension of our workforce subcommittee and is a critical part of our CC/HL strategy work. Members of the CC/HL workgroup will help guide the implementation of our CC/HL strategy implementation. Its tasks will include developing and implementing a CC/HL training strategy, providing support and information to our provider organizations, and ensuring that the lenses of Cultural Competency and Health Literacy are present and integrated throughout the work of MHVC.

Our workgroup is co-chaired by Nolly Climes of Rehabilitation Support Services and Kathy Brieger of Hudson River HealthCare with administrative support provided by MHVC staff members. The workgroup will initially meet on a monthly basis with the opportunity to review and revise the frequency as needed. Meetings will be held at rotating locations throughout the region to promote accessibility and sustainment for group members.

As with the provider organizations, the activities of the MHVC Cultural Competency Workgroup are broadly divided into: data collection, organizational activities, and community engagement. This section includes three representations of these activities, beginning with a timeline, followed by a narrative description of that timeline, and ending with a visual representation of how the activities of the MHVC CC/HL Workgroup fit in with the activities of the provider organizations.

We have taken a phase-based approach in which the Workgroup will provide feedback and recommendations on the activities and tasks undertaken by provider organizations. The Workgroup will then guide organizations in improving their organizational cultural competency and health literacy by providing various supports, resources and templates.

Below is a suggested timeline that lists Workgroup activities at the provider organization and community level. Creating a timeline could be an activity that the MHVC CC/HL Workgroup undertakes.

Phase 1 (Now through end of DY2Q4):

- Organizational Activities: Engage targeted organizations, provide feedback to these organizations on their provider survey results, provide support and guidance about completion of self-assessments and organizational CC/HL plans.
- Community Activities: Form connections to existing county cross provider coalitions, help stand up cross provider coalitions where needed (or identify ways to integrate this work into pre-existing groups). Create and begin rolling out training strategy (Milestone 2). Convene community forums and assist with planning of Best Practices Forum.

Phase 2 (DY3Q1 through end of project):

- Organizational Activities: Scope will expand to include additional organizations to be determined by the Workgroup and MHVC and based upon the Community Needs Assessment, project work, and other ongoing assessment and data. Workgroup will request and review organizational CC/HL plans and provide feedback.
- Community Activities: Continue rollout of training strategy. Update resource repository. Review external needs assessments, and assess need for new CNA. Ongoing communication with project workgroups, and provider organizations. Convene community forums.
- Mid-point in Phase 2, the MHVC CC/HL Workgroup will begin an internal capacity assessment to determine how to continue tasks mentioned in the strategy after the duration of the DSRIP program.

	Activities	Phase 1	Phase 2
Data Collection	Collect and disseminate county and hospital-level community needs assessments	—————→	—————→
	Assess the need for PPS-level community needs assessments		—————→ *
Organizational Activities	Review the CC/HL Plan Template	—————→	—————→
	Review Provider/Staff Capacity Surveys		—————→
	Review Patient Satisfaction Assessments		—————→
Community Engagement	Communicate with County-level Cross-Setting Coalitions	—————→	—————→
	Manage the Resource Repository	—————→	—————→
	Internal capacity assessment to continue tasks mentioned in the strategy after the duration of the DSRIP program		—————→

* every two years

Data Collection

County and Hospital-Level Community Needs Assessments

The Workgroup could collect county and hospital-level community needs assessments throughout the year, as the assessments become available. Disseminating these assessments could include posting links or PDFs onto the CC/HL section of the MHVC Website.

PPS-Level Community Needs Assessments

The Workgroup could assess the need for a PPS-level community needs assessment, every two years. Data collection, organizational activities, and community engagement efforts across the PPS can be reviewed and a decision to undergo additional assessments can be made.

Organizational Activities

Cultural Competency/Health Literacy (CC/HL) Plan

The Workgroup will request organizations serving hot spot areas to submit their CC/HL plans for review. The frequency in which organizations will have to submit their plan will be based up on the current level of organizational cultural competency determined by the Provider and Staff Capacity Survey, i.e. organizations that score low may be requested to submit their plans annually.

Provider/Staff Capacity Survey & Patient Satisfaction Assessment

The Workgroup could review the results of the Provider/Staff Capacity Surveys and Patient Satisfaction Assessments from 20 or more randomly selected provider organizations with focus on organizations serving high need populations. These results should be interpreted within the context of information collated from other assessments in order to make the appropriate recommendations.

Develop and Implement Training Strategy

The Workgroup will develop and implement a training strategy designed to support the promotion and enhancement of cultural competency *in context*. This strategy will give priority to organizations working with high need population groups, and will be informed by the needs and gaps indicated by our ongoing assessment and communication with partner organizations, patients and communities. The strategy will aim to build upon current practices and harness the resources, knowledge and expertise present in the community. Curricula and resources that include the social determinants of health, structural competency and an understanding of structural and institutionalized forms of oppression, examination of privilege and unconscious bias, as well as those that incorporate patient and community involvement, will be given the highest consideration.

Training resources and curricula will be shared via our Website Resource Repository and promoted through webinars, email alerts, partner communication, and MHVC newsletters. Some of the trainings we have identified for rollout as part of our strategy include:

- Advancing Cultural Competence in the Public Health and Health Care Workforce, an online certificate program offered through the University at Albany's School of Public Health, http://www.albany.edu/sph/cphce/advancing_cc.shtml
- Community Action Poverty Simulation Training, a live training event designed to provide healthcare and social service providers with an understanding of the day-to-day experience of living in poverty, <http://www.caastlc.org/programs/poverty-simulation.html>

Community Engagement

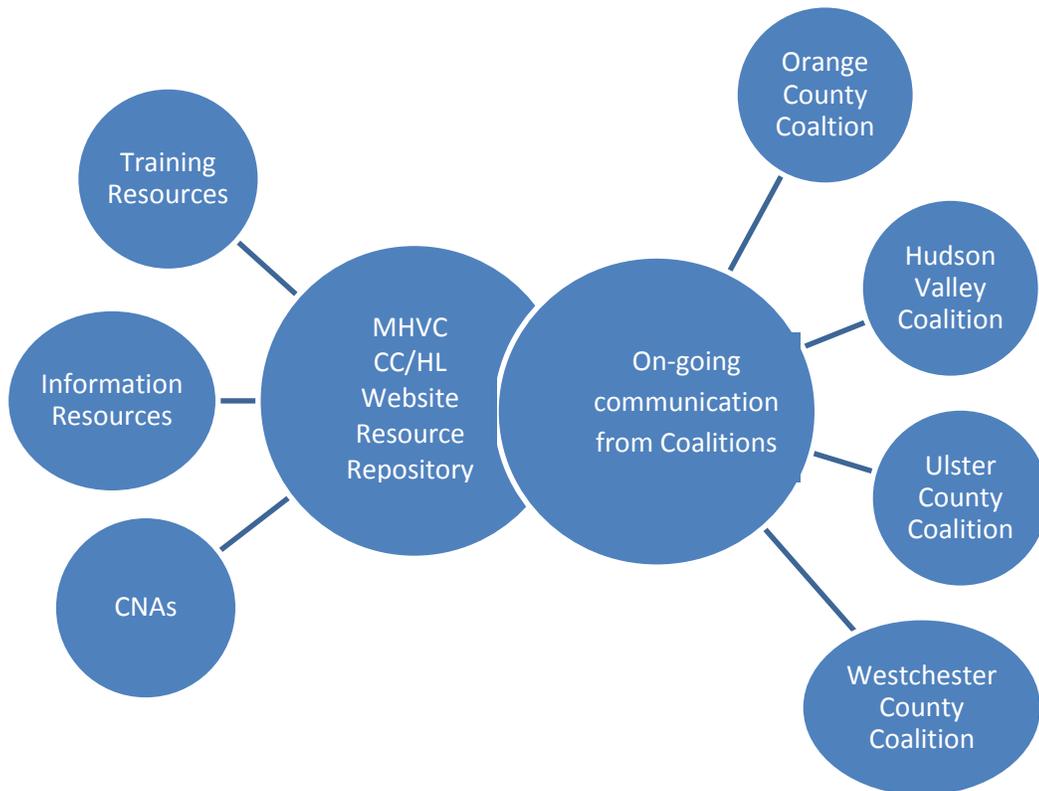
Communication with County-level Cross-setting Coalitions

The Workgroup should maintain consistent communication with each coalition. As aforementioned, this will enable the PPS to assist and facilitate community organizations in better serving their patients, create opportunities for sharing best practices, as well as provide needed resources to communities where needed. Based on capacity of the Workgroup, frequency of communication between all coalitions can be determined.

The Website Resource Repository

The Workgroup will create and maintain a Resource Repository on the CC/HL section of the MHVC Website. This Resource Repository will include resources directly aligned with sections from the Provider/Staff Capacity Survey. The application and effectiveness of these resources could be measured by the Capacity Survey. These resources and its connection to the Capacity Survey are described in a table located in Appendix I as well as the Resource Repository on the MHVC website. Other resources and documents related to CC/HL as well as needed information for the community can be located in the Resource Repository.

Below, please see a visual representation of the connections between *potential* MHVC Cultural Competency Workgroup efforts around data collection, organizational activities, and community engagement. As a note, the coalitions listed are known to exist because they are facilitated by IPRO. Coalitions may also exist in other counties, but these counties do not currently house IPRO-facilitated coalitions.

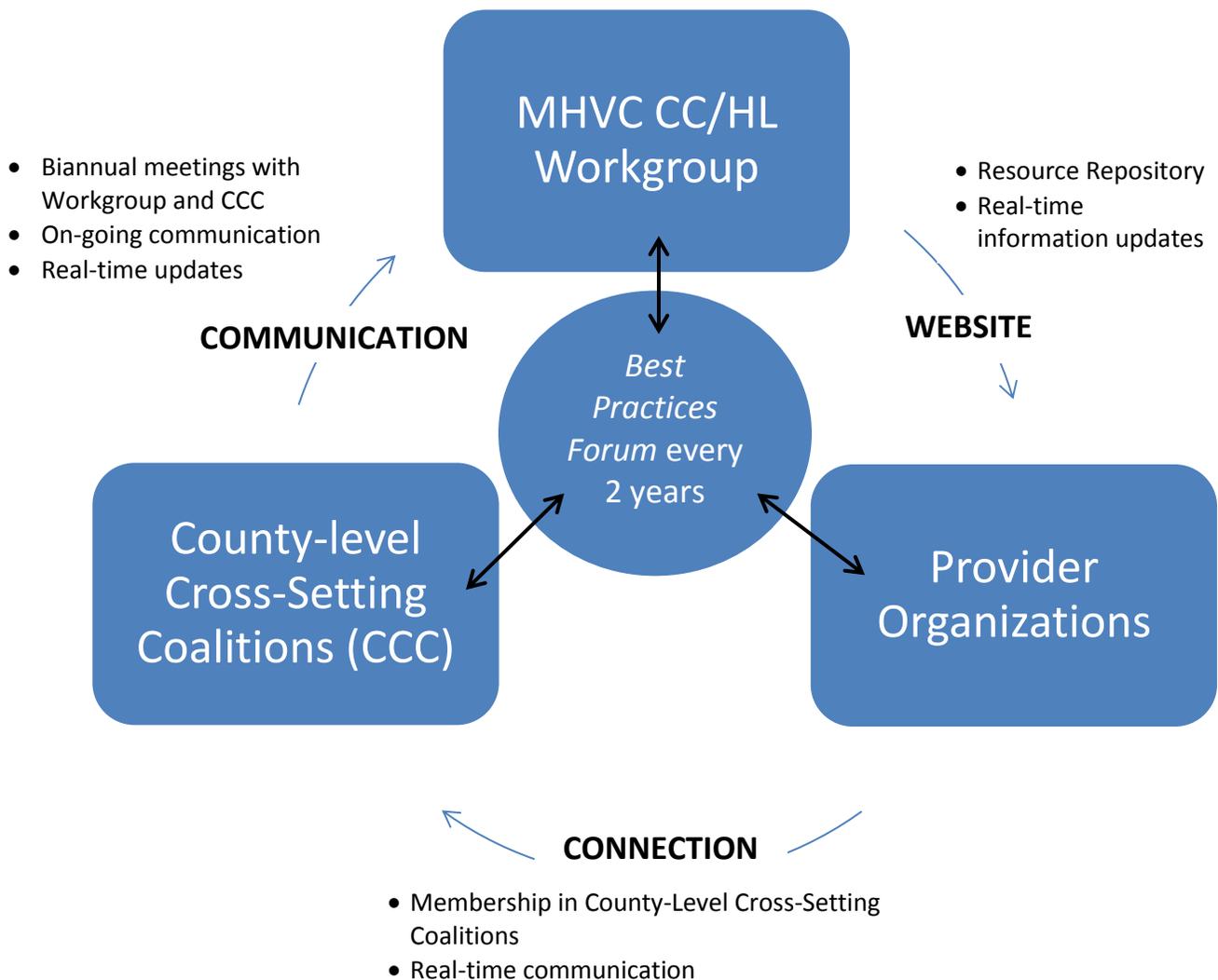


MHVC Cultural Competency Workgroup

- Collect and disseminate county and hospital-level community needs assessments
- Create and manage resource repository
 - Information resources
 - Training resources
- Review CC/HL Plans
- Review Provider/Staff Capacity Surveys
- Review patient satisfaction assessments
- Provide support and resources to PPS Project Committees

WORKING TOGETHER: FLOW OF INFORMATION AND RESOURCES

Creating a feedback loop for information to be shared among the community, provider organizations and the MHVC CC/HL Workgroup is paramount to maintaining quality care within the context of patients' communities. We recommend provider organizations either participating or communicating with the CCC to convey current practices, community needs, gaps in services, etc. The CCC will then collate and communicate the needs and concerns of the provider organizations in their respective county to the MHVC CC/HL Workgroup. In response to the needs of the county, the MHVC CC/HL Workgroup will add, modify and update its repository. This will make needed information accessible to all providers across the PPS. Furthermore, **information** will be **specific** to the identified needs of the county and **responsive** to challenges, barriers and concerns at the **community-level**. The Workgroup will also provide feedback, support and resources to the MHVC.



APPENDIX I: THE RESOURCE REPOSITORY

Competencies	Survey Section	Resource
Engagement	EQ 1-9	<ul style="list-style-type: none"> • Outreach to High-Need, High-Cost Individuals: Best Practices for New York Health Homes • Brief Report: Spirituality Matters: Creating a Time and Place for Hope • Original Paper: Blacks And Hispanics Are Less Likely Than Whites To Complete Addiction Treatment, Largely Due to Socioeconomic Factors
Stigma	SMH 1-27, SAU 1-12, SOU 1-8	<ul style="list-style-type: none"> • A Toolkit for Evaluating Programs Meant to Erase the Stigma of Mental Illness • The Stigma Scale: development of a standardized measure of the stigma of mental illness • The “Backbone” of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness • Original Article: Conceptualizing Stigma • Original Article: Measuring Mental Illness Stigma • Original Article: Mental Health Treatment Seeking Among Older Adults with Depression: The Impact of Stigma and Race • ANTI-STIGMA TOOLKIT: A Guide to Reducing Addiction-Related Stigma
Shared Decision Making	SDM 1-15	<ul style="list-style-type: none"> • Shared Decision-Making in Mental Health Care
Trauma-Informed Care	TIC 1-11	<ul style="list-style-type: none"> • A Treatment Improvement Protocol- Trauma-Informed Care in Behavioral Health Services • National Council for Community Behavioral Healthcare Presentation: Is Your Organization Trauma-Informed? • Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services
Motivational Interviewing	SDM 11-15	<ul style="list-style-type: none"> • Motivational Interviewing for Better Health Outcomes
Cultural Awareness	CC 1-13	<ul style="list-style-type: none"> • A Checklist to Facilitate Cultural Awareness and Sensitivity • Cultural Competency Assessment Scale: Organizational Level • Organizational Cultural Competence: A Review of Assessment Protocols
Health Literacy	CC 14-20	<ul style="list-style-type: none"> • Quick Guide to Health Literacy

		<ul style="list-style-type: none"> • Toolkit for Making Written Material Clear and Effective
CLAS	CC 14-20	<ul style="list-style-type: none"> • A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Joint Commission Hospital Accreditation Standards • A Cultural Competency Standards Crosswalk: A tool to examine the relationship between OMH CLAS Standards and Joint Commission/URAC/NCQA Accreditation Standards • Implementing CLAS Standards and Improving Cultural Competency and Language Access • National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care • National Standards for Culturally and Linguistically Appropriate Services in Health Care FINAL REPORT
Cultural Humility and Sensitivity Training		<ul style="list-style-type: none"> • Cultural Competence Education for Practicing Physicians: Lessons in Cultural Humility, Nonjudgmental Behaviors, and Health Beliefs Elicitation • Bridging the Gap: A Curriculum to Teach Residents Cultural Humility
Other Resources		<ul style="list-style-type: none"> • Original Article- Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence • Commentary- A Mental Health Clinician’s View of Cultural Competence Training • Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence • Recovery through the Lens of Cultural Diversity • Program Level Cultural Competency Assessment Scale • Examining the Structural Determinants of Poverty, <i>an Annotated Bibliography</i> • Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services • Cultural Formulation Interview • Patient Satisfaction Survey

APPENDIX IIA: PATIENT SATISFACTION SURVEY TEMPLATE

PATIENT SATISFACTION SURVEY

ORGANIZATION NAME: _____

PROVIDER NAME: _____

Dear Patient: According to our records, you recently visited **the provider named above**. Please tell us your opinion about the service you received **from this provider**. Your responses will be kept strictly confidential. Thanks for your help.

PLEASE RATE THE FOLLOWING:

A.	YOUR APPOINTMENT:	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
1.	Ease of making appointments by phone	5	4	3	2	1	N/A
2.	Availability of an interpreter when making appointment by phone	5	4	3	2	1	N/A
3.	Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
4.	Getting care for illness/injury as soon as you wanted it	5	4	3	2	1	N/A
5.	Getting after-hours care when you needed it	5	4	3	2	1	N/A
6.	The efficiency of the check-in process	5	4	3	2	1	N/A
7.	Waiting time in the reception area	5	4	3	2	1	N/A
8.	Waiting time in the exam room	5	4	3	2	1	N/A
9.	Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
10.	Ease of getting a referral when you needed one	5	4	3	2	1	N/A

B.	OUR STAFF:						
1.	The courtesy of the person who took your call	5	4	3	2	1	N/A
2.	The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3.	The caring concern of our nurses/medical assistants	5	4	3	2	1	N/A
4.	The helpfulness of the people who assisted you with billing or insurance	5	4	3	2	1	N/A
5.	The professionalism of our lab or x-ray staff	5	4	3	2	1	N/A

C.	OUR COMMUNICATION WITH YOU:						
1.	Your phone calls answered promptly	5	4	3	2	1	N/A
2.	Getting advice or help when needed during office hours	5	4	3	2	1	N/A
3.	Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
4.	Explanation of your procedure in your preferred language (if applicable)	5	4	3	2	1	N/A
5.	Your test results reported in a reasonable	5	4	3	2	1	N/A

SOME INFORMATION ABOUT YOU:

I SELF-IDENTIFY AS:

Male 1
Female 2

AGE GROUP:

<30 1
30-40 2
40-50 3
50-60 4
>60 5

RACE/ETHNICITY:

Black/African American 1
White/Caucasian 2
Hispanic 3
Asian 4
Pacific Islander 5
Native American/Alaskan Native 6

ARE YOU:

A new patient 1
A returning Patient 2

APPENDIX II: PROVIDER ORGANIZATION CC/HL PLAN TEMPLATE

Cultural Competency & Health Literacy Plan Template

Preparatory work:

The first step in the development of a *cultural competency and health literacy plan* is a self-assessment. It is recommended to conduct the NKI Organizational Cultural Competency Assessment Scale as well as the Provider and Staff Capacity Survey.

The template provided below gives guidelines for items that should be included in the plan. Each provider setting is expected to have site-specific approaches that are anticipated to work best for the cultural populations served, the particular service areas covered, and the operations of the organization.

I. Mission Statement

- a) Please provide your *mission statement*.

II. CC/HL Advisory Committee

- a) Please provide membership of *CC/HL Advisory Committee* and describe their organizational job title/function.

(For Single or Multi-Provider Groups - Please list staff and job title/role of the person who will serve as the CC/HL Champion.)

III. Cultural Group Identification

- a) Describe how data will be collected and analyzed to identify groups and any disparities that may exist among them.

IV. Self Management of Illnesses

- a) Describe the self management strategies and techniques recommended for the chronic illness groups you serve, e.g. dementia, diabetes, HIV, etc.

V. Health Literacy Practices

- a) Describe how the organization will ensure that the appropriate level of health literacy will be used for each patient.
- b) Describe strategies to educate and expand patients' health literacy.

VI. CC Training Practices

- a) How often does your clinical and non-clinical staff undergo cultural sensitivity and humility training?
- b) How long is the training?
- c) Please specify which resource is being used for CC Training and how training is administered to staff.

VII. Language Accommodations

- a) Describe procedure to be used to assess and use interpreters.
- b) Describe how staff are trained in the use of interpreters.
- c) Please list all documents that are translated in to non-English languages.
- d) Describe process by which a document is translated in to non-English languages.

VIII. Information Sharing

- a) Indicate how the organization and the CC Advisory Committee will share communicate information learned/gained to staff

IX. Community Engagement

- a) Describe mechanism by which two-way communication with the community can be achieved. Specifically describe venue and timelines.
- b) List community-based agencies and organizations where deliberate efforts are made to establish reciprocal communication with.

X. Organizational Accountability

- a) Describe your strategy for managing patient grievances pertaining to cultural competency.
- b) Describe your strategy for managing staff grievances pertaining to cultural competency.

APPENDIX III: PROVIDER/STAFF CAPACITY SURVEY

DEMOGRAPHICAL INFORMATION (everyone)

Please select your answer by circling the corresponding number.

1. What organization are you affiliated with? (drop-down)

List of organizations needed

2. I self-identify as a:

- 1 Male
- 2 Female
- 3 Transgender Male (Female-to-Male)
- 4 Transgender Female (Male-to-Female)
- 5 Genderqueer, neither exclusively male nor female
- 6 Additional gender category or Other, please specify _____

3. Age Group:

- 1 < 30
- 2 30 – 40
- 3 40 – 50
- 4 50 – 60
- 5 > 60

4. My primary role in my organization is :

- 1 MD/DO
- 2 Nurse Practitioner (NP)
- 3 Nurse (RN)
- 4 Psychologist
- 5 LMSW
- 6 LCSW
- 7 Case/Care Manager
- 8 Clerical/Intake/Front-desk
- 9 Patient Navigator/Advocate
- 10 Other: _____

5. What type of services do you provide? (Choose all that apply)

- 1 Primary care
- 2 Specialty medical care: _____
- 3 Mental healthcare
- 4 Substance abuse treatment
- 5 Administration (e.g. intake, billing, medical record, benefits)

- 6 Advocacy
- 7 Counseling
- 8 Other: _____

6. What is your role in the organization?

- 1 Senior Management
- 2 Middle Management
- 3 Non-Management

Location

7. In which county(ies) do you see patients? (Choose all that apply)

- 1 Dutchess
- 2 Orange
- 3 Putnam
- 4 Rockland
- 5 Sullivan
- 6 Ulster
- 7 Westchester
- 8 Bronx and NYC

8. In which county(ies) do your patients live? (Choose all that apply)

- 1 Delaware
- 2 Dutchess
- 3 Orange
- 4 Putnam
- 5 Rockland
- 6 Sullivan
- 7 Ulster

- 8 Westchester
- 9 Bronx and NYC
- 10 Other New York State
- 11 Outside of New York State

ENGAGEMENT (everyone)

Please circle 1 if you AGREE or 0 if you DO NOT AGREE to each of the following statements.

At any given time...	Agree	Do Not Agree	N/A
9. I am responsible for having conversations with patients regarding their social and economic barriers to care and how to overcome them.	1	0	11
10. I am willing to talk with patients about their social and economic barriers to care.	1	0	11
11. I have time to talk with patients about their social and economic barriers to care.	1	0	11
12. I am responsible for connecting patients to other resources outside the clinic/healthcare facility.	1	0	11
13. I know how to connect patients to other resources outside the clinic/healthcare facility.	1	0	11
14. I am supported, by other clinical staff and colleagues, in connecting patients to other resources outside the clinic/healthcare facility.	1	0	11
15. I connect patients to needed resources outside the clinic/healthcare facility (e.g. transportation services).	1	0	11
16. I connect patients to community-based organizations for additional services (e.g. faith-based and civic organizations).	1	0	11
17. I share relevant information, including language preferences and cultural group affiliations when I refer patients to other providers.	1	0	11

Source: NKI

STIGMA (MH) (everyone)

Please circle the number that corresponds to how much you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
18. One of the main causes of mental illness is a lack of self-discipline and willpower.	1	2	3	4	5
19. There is something about people with mental illness that makes it easy to tell them from normal people.	1	2	3	4	5
20. As soon as a person shows signs of mental disturbance, he should be hospitalized.	1	2	3	4	5
21. Mental illness is an illness like any other.	1	2	3	4	5
22. Less emphasis should be placed on protecting the public from people with mental illness.	1	2	3	4	5
23. Mental hospitals are an outdated means of treating people with mental illness.	1	2	3	4	5
24. Virtually anyone can become mentally ill.	1	2	3	4	5
25. People with mental illness have for too long been the subject of ridicule.	1	2	3	4	5
26. We need to adopt a far more tolerant attitude toward people with mental illness in our society.	1	2	3	4	5
27. We have a responsibility to provide the best possible care for people with mental illness.	1	2	3	4	5
28. People with mental illness don't deserve our sympathy.	1	2	3	4	5
29. People with mental illness are	1	2	3	4	5

a burden on society.

30. Increased spending on mental health services is a waste of money.	1	2	3	4	5
--	---	---	---	---	---

31. There are sufficient existing services for people with mental illness.	1	2	3	4	5
---	---	---	---	---	---

32. People with mental illness should not be given any responsibility	1	2	3	4	5
--	---	---	---	---	---

33. A person would be foolish to marry someone who suffered from mental illness, even though they seem fully recovered.	1	2	3	4	5
--	---	---	---	---	---

34. I would not want to live next door to someone who has been mentally ill.	1	2	3	4	5
---	---	---	---	---	---

35. Anyone with a history of mental problems should be excluded from taking public office.	1	2	3	4	5
---	---	---	---	---	---

36. No one has the right to exclude people with mental illness from their neighborhood.	1	2	3	4	5
--	---	---	---	---	---

37. People with mental illness are far less of a danger than most people suppose.	1	2	3	4	5
--	---	---	---	---	---

38. Most people who were once patients in a mental hospital can be trusted as babysitters.	1	2	3	4	5
---	---	---	---	---	---

39. The best therapy for many people with mental illness is to be part of a normal community.	1	2	3	4	5
--	---	---	---	---	---

40. As far as possible, mental	1	2	3	4	5
---------------------------------------	---	---	---	---	---

health services should be provided through community-based facilities.

41. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.

1	2	3	4	5
---	---	---	---	---

42. It is frightening to think of people with mental problems living in residential neighborhoods.

1	2	3	4	5
---	---	---	---	---

43. Locating mental health facilities in a residential area downgrades the neighborhood.

1	2	3	4	5
---	---	---	---	---

44. People with mental health problems should have the same rights to a job as anyone else.

1	2	3	4	5
---	---	---	---	---

STIGMA (AU) (everyone)

Please circle the number that corresponds to how much you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
45. Most people would willingly accept a former alcoholic as a close friend.	1	2	3	4	5
46. Most people believe that a person who has had alcohol treatment is just as intelligent as the average person.	1	2	3	4	5
47. Most people believe that a former alcoholic is just as trustworthy as the average person.	1	2	3	4	5
48. Most people would accept a fully recovered former alcoholic as a teacher of young children in a public school.	1	2	3	4	5
49. Most people feel that entering alcohol treatment is a sign of personal failure.	1	2	3	4	5
50. Most people would not hire a former alcoholic to take care of their children, even if he or she had been sober for some time.	1	2	3	4	5
51. Most people think less of a person who has been in alcohol treatment.	1	2	3	4	5
52. Most employers will hire a former alcoholic if he or she is qualified for the job.	1	2	3	4	5
53. Most employers will pass over the application of a former alcoholic in favor of another applicant.	1	2	3	4	5
54. Most people in my community would treat a former alcoholic just as they would treat anyone else.	1	2	3	4	5
55. Most young women would be reluctant to date a man who has been hospitalized for	1	2	3	4	5

alcoholism.

56. Once they know a person was in alcohol treatment, most people will take his or her opinion less seriously.	1	2	3	4	5
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Source: Glass, Kristjansson, and Bucholz, "Perceived alcohol stigma: factor structure and construct validation"

STIGMA (OUD) (everyone)

Please circle the number that corresponds to how much you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
57. Most people would willingly accept someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) as a close friend.	1	2	3	4
58. Most people believe that someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) is just as trustworthy as the average citizen.	1	2	3	4
59. Most people would accept someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) as a teacher of young children in a public school.	1	2	3	4
60. Most people would hire someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) to take care of their children.	1	2	3	4
61. Most people think less of a person who has been in treatment for non-prescribed opiate use (e.g. Vicodin, Oxycontin).	1	2	3	4
62. Most employers will hire someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) if he or she is qualified for the job.	1	2	3	4

63. Most employers will pass over the application of someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin) in favor of another applicant.

1

2

3

4

64. Most people would be willing to date someone who has been treated for non-prescribed opiate use (e.g. Vicodin, Oxycontin).

1

2

3

4

Source: Perceived Stigma of Substance Abuse Scale (PSAS) <http://www.portlandpsychotherapyclinic.com/training/publications>

SHARED DECISION MAKING (SDM) (clinical staff)

Please circle the number that corresponds to how often you utilize the following skills.

	Never	Sometimes	Often
65. I identify the partners in treatment decisions (myself and the patient) as equals.	1	2	3
66. I provide balanced information about treatment options (i.e., information about both the positive and the negative features of the options.)	1	2	3
67. I explore how my patient understands the treatment options and what my patient expects.	1	2	3
68. I identify my patient's preferences regarding treatment.	1	2	3
69. I negotiate treatment options with my patient.	1	2	3
70. I use plain language, consumer stories and/or testimonials, as well as scientific information, when discussing treatment options.	1	2	3
71. I share in the decision about treatment with my patient.	1	2	3
72. I arrange follow-up conversations to evaluate the outcomes of our shared decisions.	1	2	3
73. I work proactively to evoke client's own reasons for change and ideas about how change should happen.	1	2	3
74. I foster and encourage power sharing in the interaction in such a way that client's ideas substantially influence the nature of the session.	1	2	3
75. I add to the feeling and meaning of client's expression of autonomy, in such a way as to markedly expand client's experience of own control and choice.	1	2	3
76. Ask-tell-ask scale items			

Source: "Shared Decision Making in Mental Health Care," SAMHSA <http://store.samhsa.gov/shin/content//SMA09-4371/SMA09-4371.pdf>

75. Choose the responses that best describes your approach to the patient scenario.

A 60 year old man with multiple cardiovascular risk factors expresses to you that he is not interested in quitting smoking.

- I would emphasize the risks of smoking (cancer, heart attack, stroke, cost). **Non MI adherent**
- I would ask him about what he knows about the risks associated with smoking. **(MI adherent)**
- Sharing information will help me move him toward changing his unhealthy behavior **Non MI adherent**
- I would respect the fact that he is not interested in quitting and ask his permission to address again during a future visit. **(MI adherent)**

76. For each of the following pairs, choose the response that best describes your approach when giving patients' information and advice.

- a. I am the expert and it is my responsibility to share what I know with my patients. (Non MI adherent)
- b. I have some expertise, and people are experts on themselves (MI Adherent)

- a. I find out what information people want and need (MI Adherent)
- b. I collect information about problems (Non MI adherent)

- a. I rectify gaps in knowledge (Non MI adherent)
- a. I match information to people's needs and strengths. (MI spirit)

- a. Providing frightening information is helpful. (Non MI adherent)
- b. People can tell me what kind of information would be helpful. (MI adherent)

- a. Advice that promotes people's needs and autonomy can be helpful (MI adherent)
- b. I need to tell people clearly what to do. (Non MI adherent)

TRAUMA (clinical staff)*Please circle the number that corresponds to how often you utilize the following skills.*

Counseling Skills	Never	Seldom	Half the Time	Usually	Always
77. I incorporate client-directed choice and demonstrate a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship.	1	2	3	4	5
78. I maintain clarity of roles and boundaries in the clinical relationship.	1	2	3	4	5
79. I am competent in screening and assessment of trauma history (within the bounds of my licensing and scope of practice), including knowledge of and practice with specific screening tools.	1	2	3	4	5
80. I am competent in screening and assessment of substance use disorders (within the bounds of my licensing and scope of practice), including knowledge of and practice with specific screening tools.	1	2	3	4	5
81. I know how to identify clients' strengths, coping resources, and resilience.	1	2	3	4	5
82. I facilitate collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them.	1	2	3	4	5
83. I respect clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world.	1	2	3	4	5
84. I am skilled in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences and cognitive-behavioral tools that focus on both anxiety reduction and distress tolerance.	1	2	3	4	5
85. I am skilled in general trauma-informed counseling strategies, including, but not limited to stress management and relaxation tools that reduce hyperarousal.					
86. I identify signs of secondary traumatic stress (STS)	1	2	3	4	5

reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

87. I recognize when the needs of my clients are beyond my scope of practice and I make appropriate referrals to other behavioral health professionals.	1	2	3	4	5
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Source: Trauma-Informed Counselor Competencies Checklist, "Building a Trauma-Informed Workforce," SAMHSA

SERVICES AND GROUPS SERVED PROFILE (SGSP) (everyone)

Access to Services Profile	Forget to go	Transportation	Limited English Proficiency	Cost of care	Lack of Family Support	Childcare	Flexible hours/scheduling	Lack of information about service	Stigma	Housing Instability	Other	N/A
88. Given your knowledge of available outpatient care, what are some common barriers your patients experience in trying to access this service?	1	2	3	4	5	6	7	8	9	10	TEXT	11
89. Given your knowledge of available preventative care (e.g. annual physicals) services, what are some common barriers your patients experience in trying to access this service?	1	2	3	4	5	6	7	8	9	10	TEXT	11
90. Given your knowledge of available mobile crisis outreach	1	2	3	4	5	6	7	8	9	10	TEXT	11

services, what are some common barriers your patients experience in trying to access this service?

91. Given your knowledge of available peer support services, in the community, what are some common barriers your patients experience in trying to access this service?

1 2 3 4 5 6 7 8 9 10 TEXT 11

92. Given your knowledge of available nutrition and weight loss services, what are some common barriers your patients experience in trying to access this service?

1 2 3 4 5 6 7 8 9 10 TEXT 11

93. Given your knowledge of available diabetes testing services, what are some

1 2 3 4 5 6 7 8 9 10 TEXT 11

**common barriers
your patients
experience in trying
to access this
service?**

94. **Given your
knowledge of
available smoking
cessation services,
what are some
common barriers
your patients
experience in trying
to access this
service?**

1	2	3	4	5	6	7	8	9	10	TEXT	11
---	---	---	---	---	---	---	---	---	----	------	----

95. **Given your
knowledge of
available cancer
screening services
(e.g. mammography,
colon cancer
screening), what are
some common
barriers your
patients experience
in trying to access
this service?**

1	2	3	4	5	6	7	8	9	10	TEXT	11
---	---	---	---	---	---	---	---	---	----	------	----

96. **Given your
knowledge of
available supported
housing services,
what are some**

1	2	3	4	5	6	7	8	9	10	TEXT	11
---	---	---	---	---	---	---	---	---	----	------	----

**common barriers
your patients
experience in trying
to access this
service?**

**97. Given your
knowledge of
available
prenatal/maternal
health care services,
what are some
common barriers
your patients
experience in trying
to access this
service?**

1

2

3

4

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6

7

8

9

10

TEXT

11

Please select your best estimate of the populations that you serve. **(everyone)**

Priority Groups: Percentage of Groups Served	0%	≤5%	5-10%	10-30%	30-50%	≥50%
98. African American/Black	1	2	3	4	5	6
99. Latino/Hispanic	1	2	3	4	5	6
100. Asian/Pacific Islander	1	2	3	4	5	6
101. Caucasian/White	1	2	3	4	5	6
102. Native American	1	2	3	4	5	6
103. Other (text)	1	2	3	4	5	6
104. Low-income	1	2	3	4	5	6
105. Uninsured/Low-Utilizing Groups	1	2	3	4	5	6
106. Chronic Disease Sufferers	1	2	3	4	5	6
107. Non-English Speaking	1	2	3	4	5	6
108. Homeless	1	2	3	4	5	6
109. People with a Mental Health Diagnosis	1	2	3	4	5	6

CULTURAL COMPETENCY (CC) (everyone)

For the following questions please use this definition of culture:

Culture is the way of life of a group of people. It encompasses behaviors, beliefs, values, and symbols that are accepted and passed along, by communication and imitation, from one generation to the next. Culture can be shaped by the society in which one lives. Large societies often encompass cultural variations which differentiate some members from the larger group. These can be based on domains such as age, race, ethnicity, class, gender, political affiliation, religion, geographic location, and/or sexual orientation, among other factors.

	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
85. My organization has procedures for accessing interpreters for patients/families with limited English proficiency (LEP).	1	2	3	4	5
86. My organization has procedures for accessing persons who sign in American Sign Language for patients who are Deaf.	1	2	3	4	5
87. In my organization, clinicians have received training in the use of interpreters.	1	2	3	4	5
88. My organization has bilingual staff or uses the language line to serve as interpreters for the most prevalent cultural group with Limited English Proficiency (LEP).	1	2	3	4	5
89. My organization has procedures to identify and address patient complaints of mistreatment based on cultural group affiliation.	1	2	3	4	5
90. My organization hires peers (e.g., people with lived experience of	1	2	3	4	5

illness).

91. My organization documents engagement of family members (e.g., records in case-notes/charts when communicating with family members).	1	2	3	4	5
--	---	---	---	---	---

92. My organization provides family members with educational materials.	1	2	3	4	5
--	---	---	---	---	---

93. Satisfaction surveys routinely conducted by my organization include information on:					
race/ethnicity	1	2	3	4	5
gender identity	1	2	3	4	5
sexual orientation	1	2	3	4	5
religion	1	2	3	4	5

94. My organization uses information collected through feedback mechanisms to refine services/resources for groups served.	1	2	3	4	5
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95. My organization collects data or arranges access to service data that identifies specific cultural group:					
race/ethnicity	1	2	3	4	5
gender identity	1	2	3	4	5
sexual orientation	1	2	3	4	5
religion	1	2	3	4	5

96. My organization defines benchmarks for service measures of engagement and retention.	1	2	3	4	5
97. My organization uses outcome data to tailor services to groups served.	1	2	3	4	5
98. Materials describing providers and services are available in easy-to-understand language and in the client's native language.	1	2	3	4	5
99. My organization prepares our workforce to be health literate and monitors progress.	1	2	3	4	5
100. My organization provides access to health information, especially during care transitions and communication about medicines	1	2	3	4	5
101. My organization creates and distributes audiovisual content that is easy to understand and act on.	1	2	3	4	5
102. My organization creates and distributes social media content that is easy to understand and act on.	1	2	3	4	5
103. As a part of my organization's procedure, a staff person clearly communicates to patients about what health plans cover and what individuals will have to pay for.	1	2	3	4	5

Compassion Satisfaction (CS)

When you provide care for people you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences as a care provider. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	Never	Rarely	Sometimes	Often	Very Often
1. I get satisfaction from being able to care for people.	1	2	3	4	5
2. I feel invigorated after working with those I care for.	1	2	3	4	5
3. I like my work as a care provider.	1	2	3	4	5
4. I am pleased with how I am able to keep up with care giving techniques and protocols.	1	2	3	4	5
5. My work makes me feel satisfied.	1	2	3	4	5
6. I have happy thoughts and feelings about those I provide care for and how I could help them.	1	2	3	4	5
7. I believe I can make a difference through my work.	1	2	3	4	5
8. I am proud of what I can do to help.	1	2	3	4	5
9. I have thoughts that I am a "success" as a care provider.	1	2	3	4	5
10. I am happy that I chose to do this work.	1	2	3	4	5
11. I get satisfaction from being able to care for people.	1	2	3	4	5

APPENDIX IV: FOCUS GROUPS AND IN-DEPTH INTERVIEWS

Focus Groups/Community Forums <i>n=2</i>	JMHCA Meeting- Newburgh
	Family Ties of Westchester- Parent Support Group for New Immigrant Parents
Client Interviews <i>n=39</i>	HOPE House (Human Development Services of Westchester)
	Emergency Department at St. Luke's Hospital Newburgh
Key Informant Interviews <i>n=10</i>	Orange County Health Department
	St. Luke's Cornwall Hospital
	Access: Supports for Living
	The Greater Hudson Valley Family Health Center
	The Alzheimer's Association
	I PRO
	The HOPE Center at St. John's Riverside Hospital
Mental Health Association of Orange County	

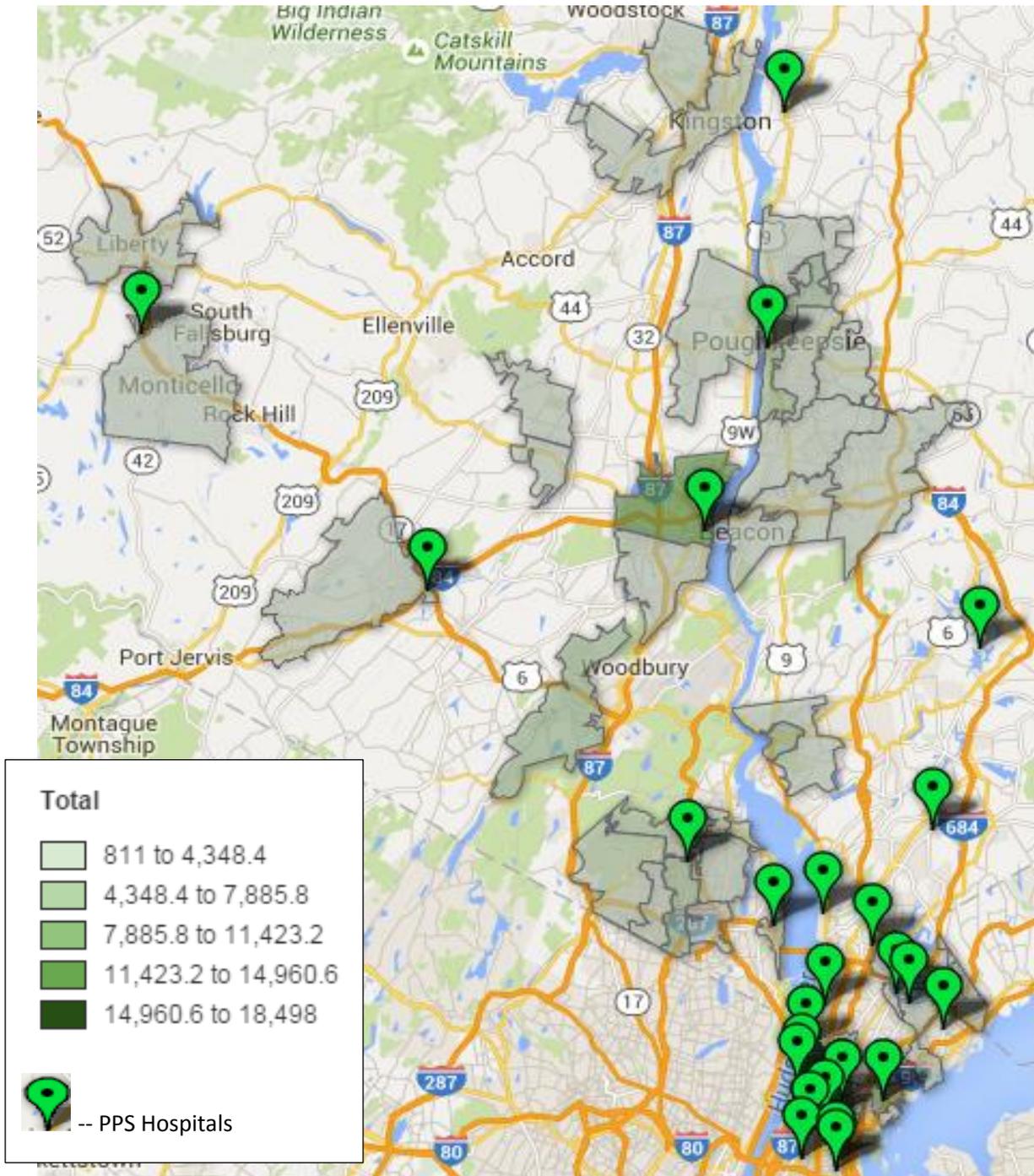
CHARTS SECTION: MHVC MEMBERSHIP BY ZIP CODE

Prepared by L. Perez, Strategic Planning

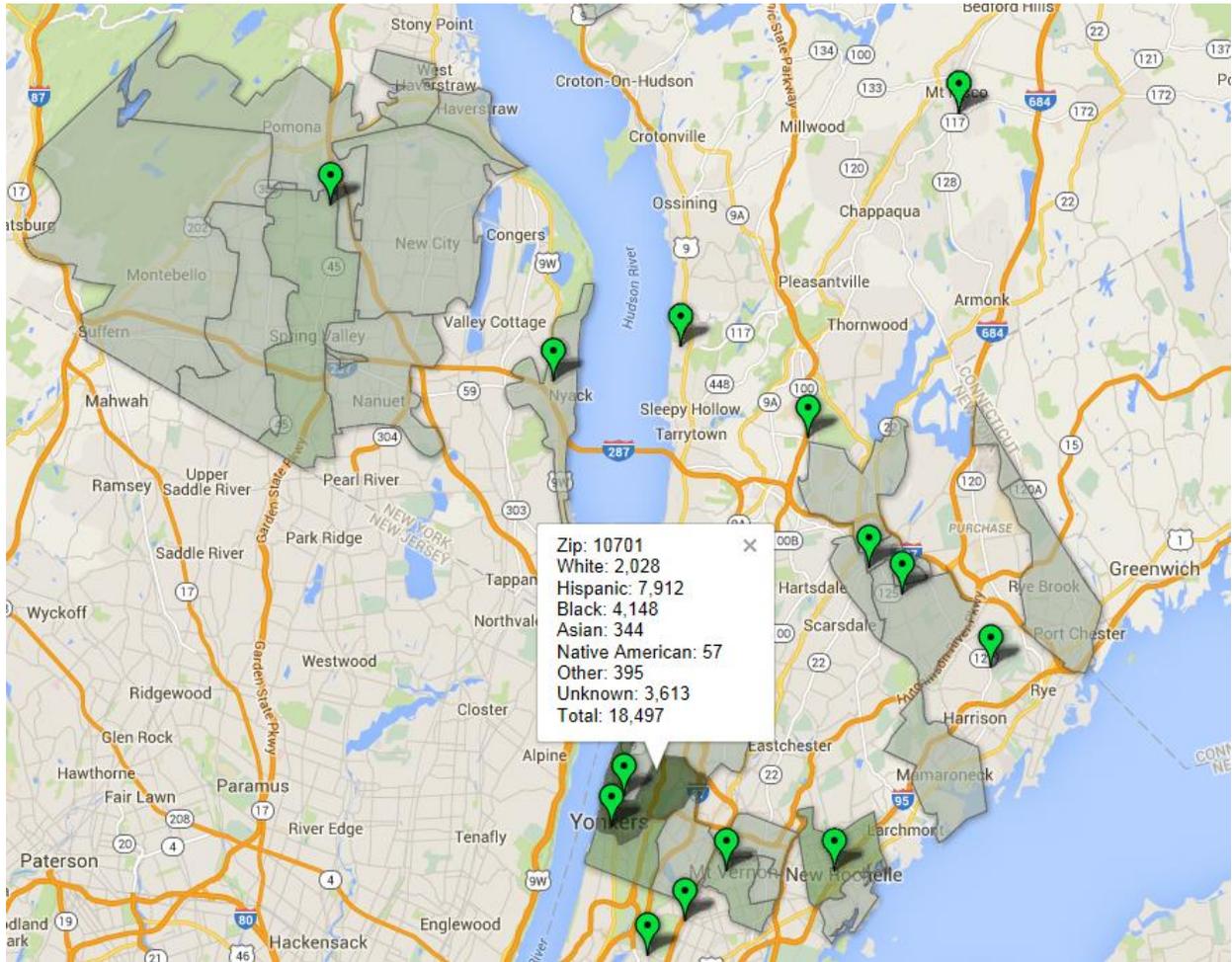
As of 15-12-22

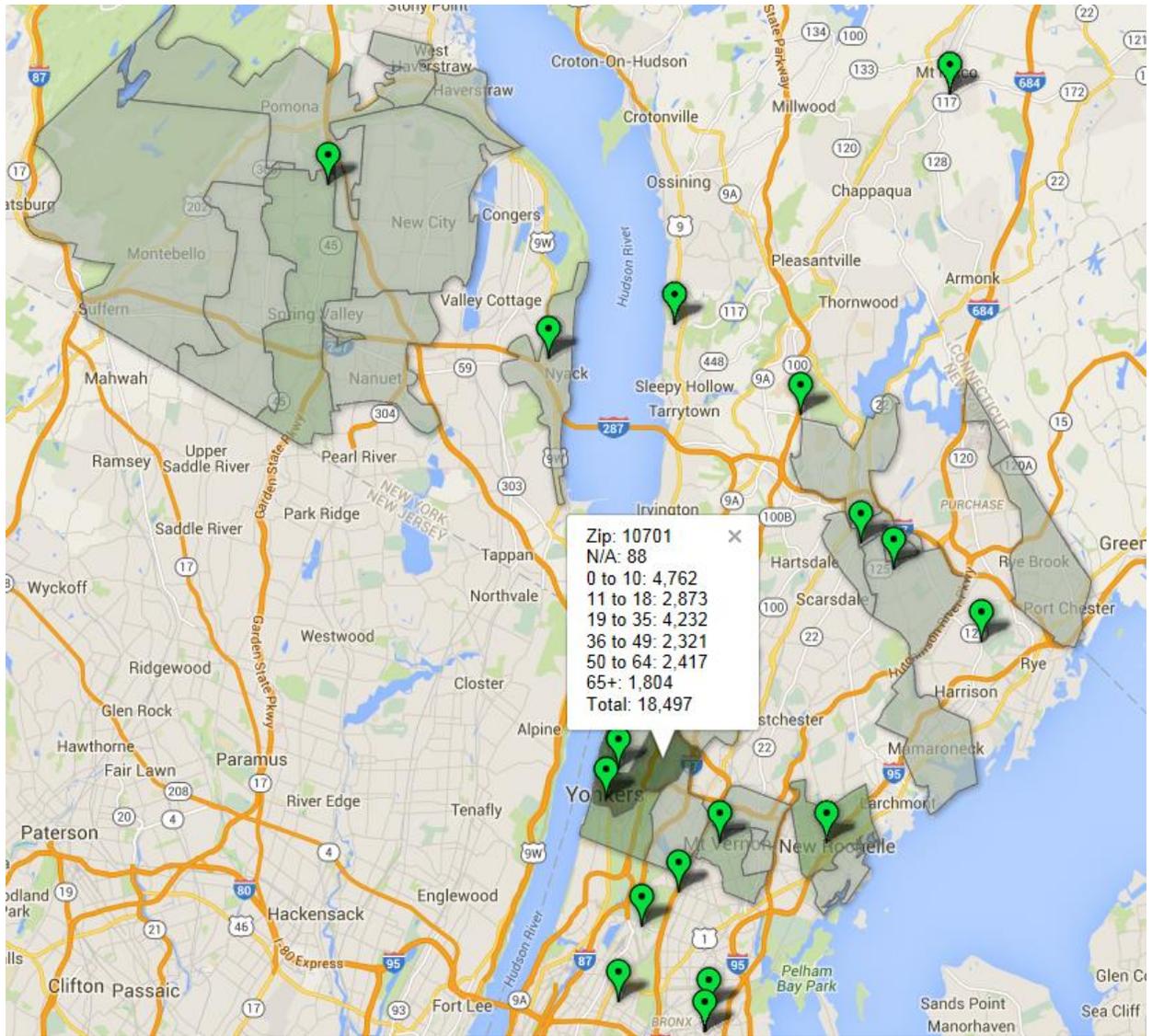
Sources: NYSDOH Member roster data

Notes: This map only includes zip codes with more than 800 members.

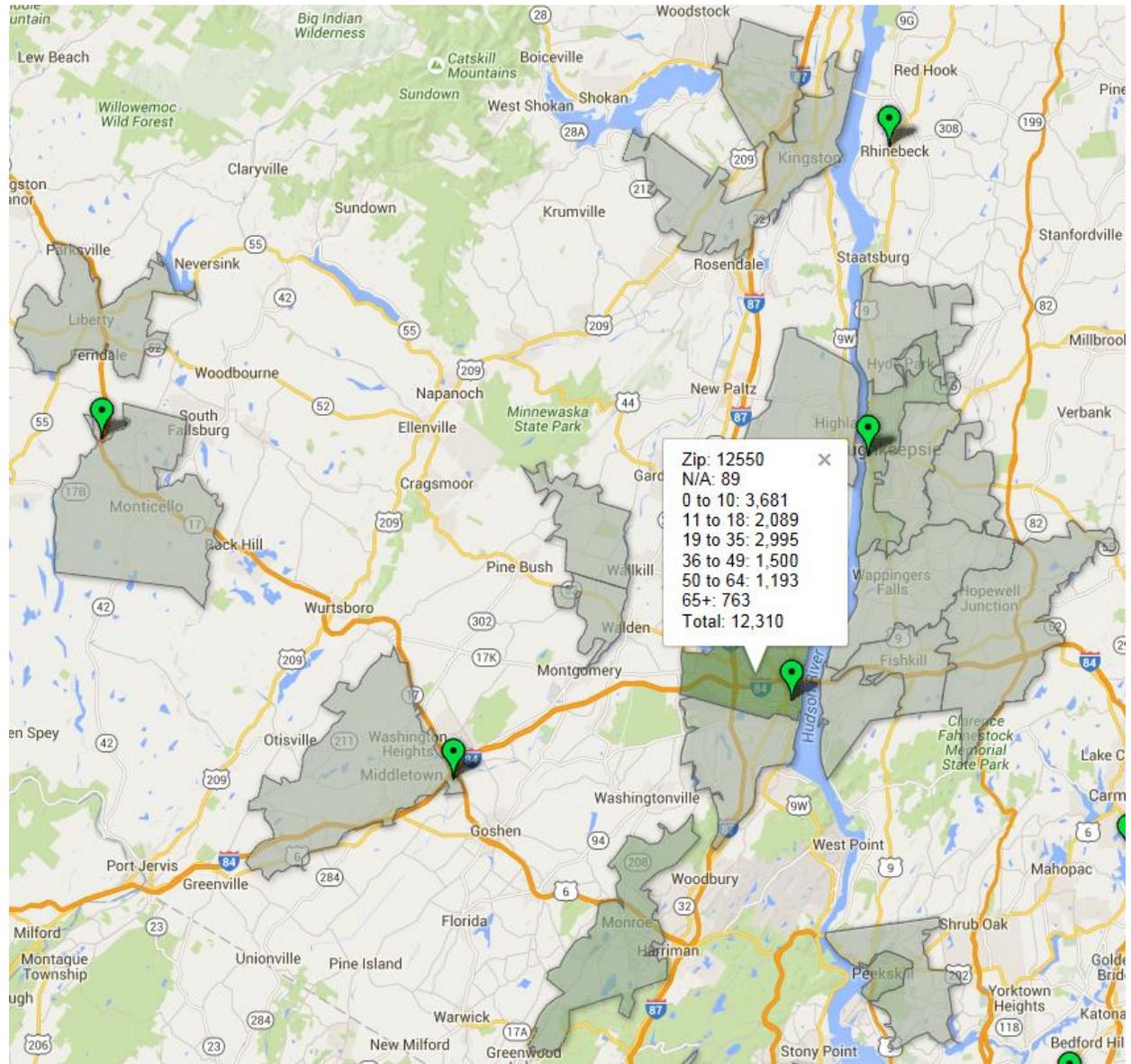


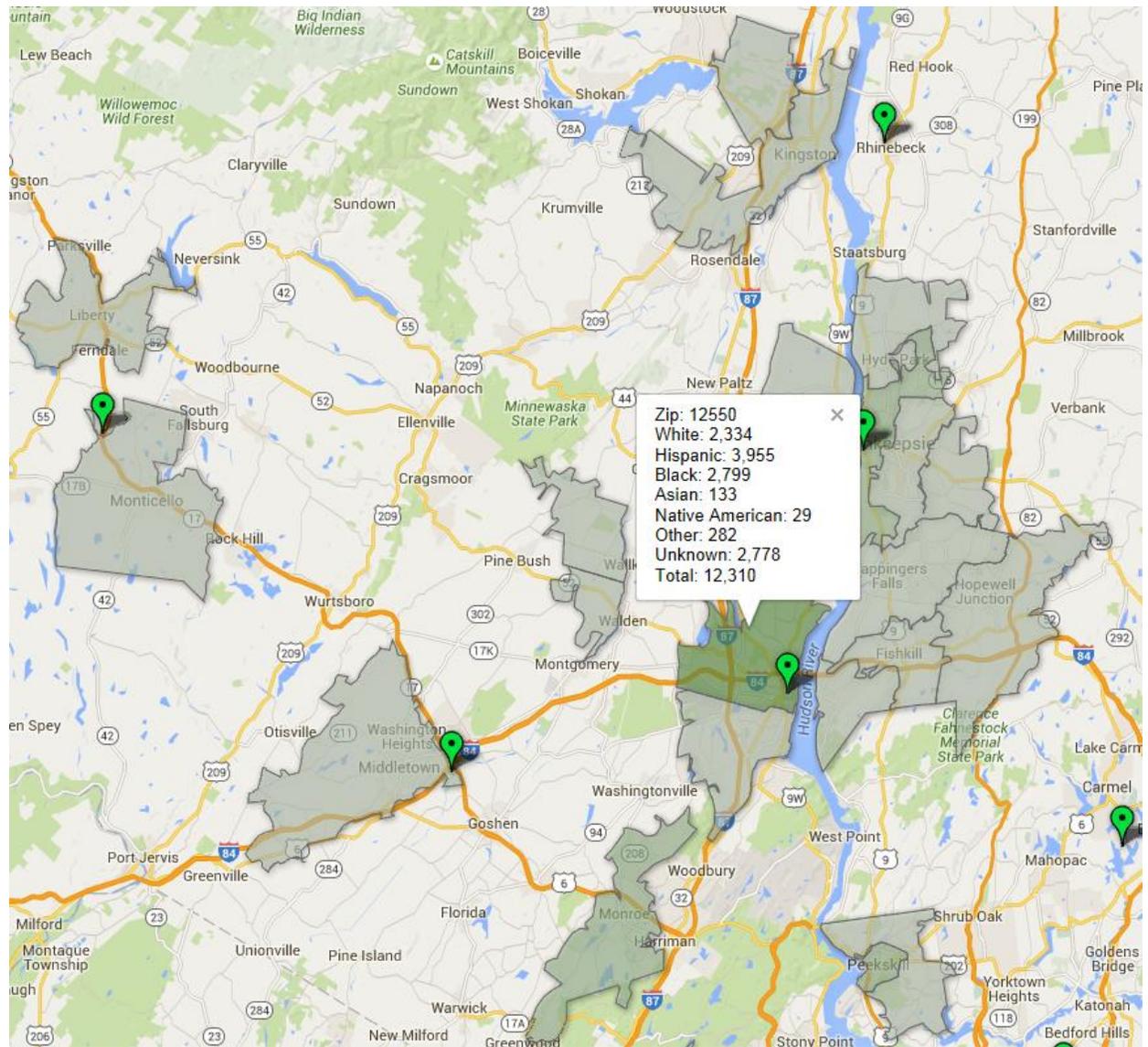
MHVC Membership by Zip code – Yonkers zoomed in



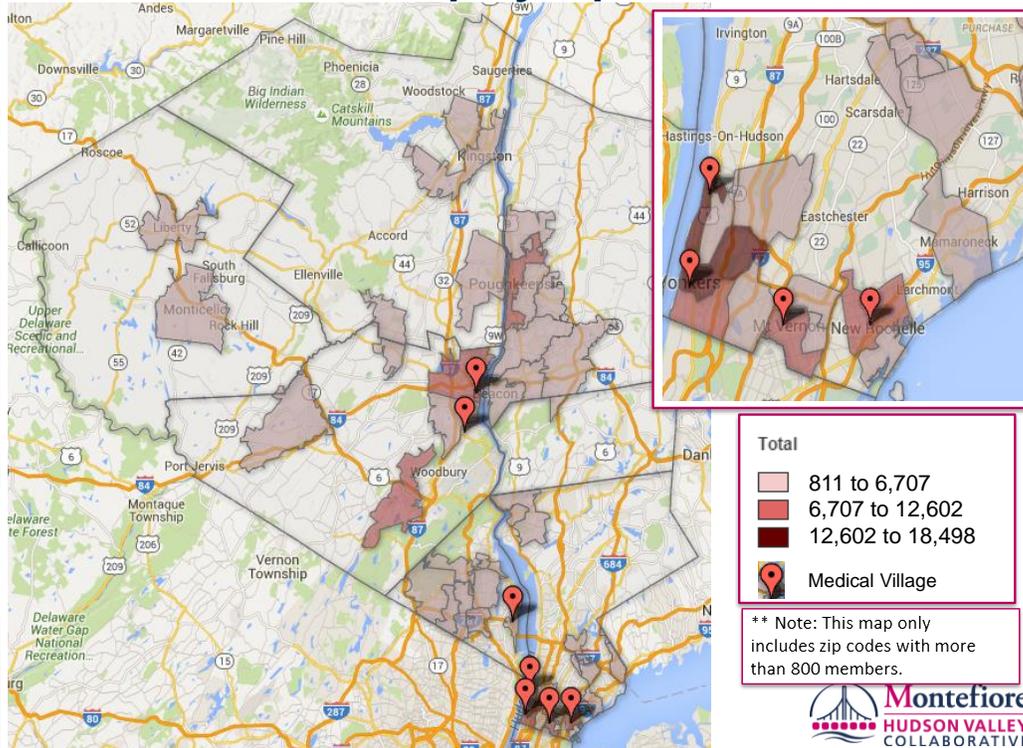


MHVC Membership by Zip code – Newburgh Zoomed





MHVC Membership by Zip Code

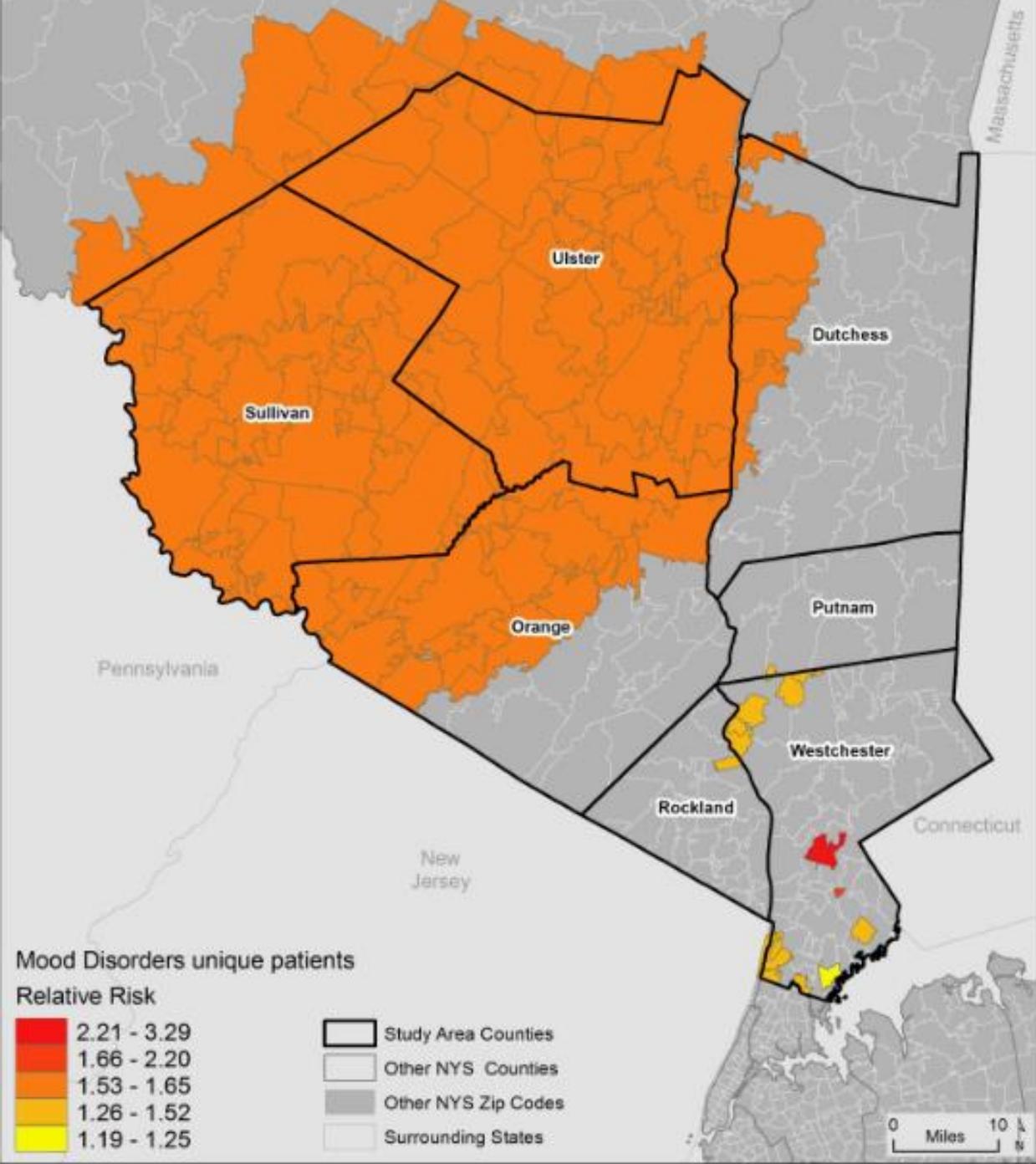


MHVC Membership by Age and Race & Ethnicity

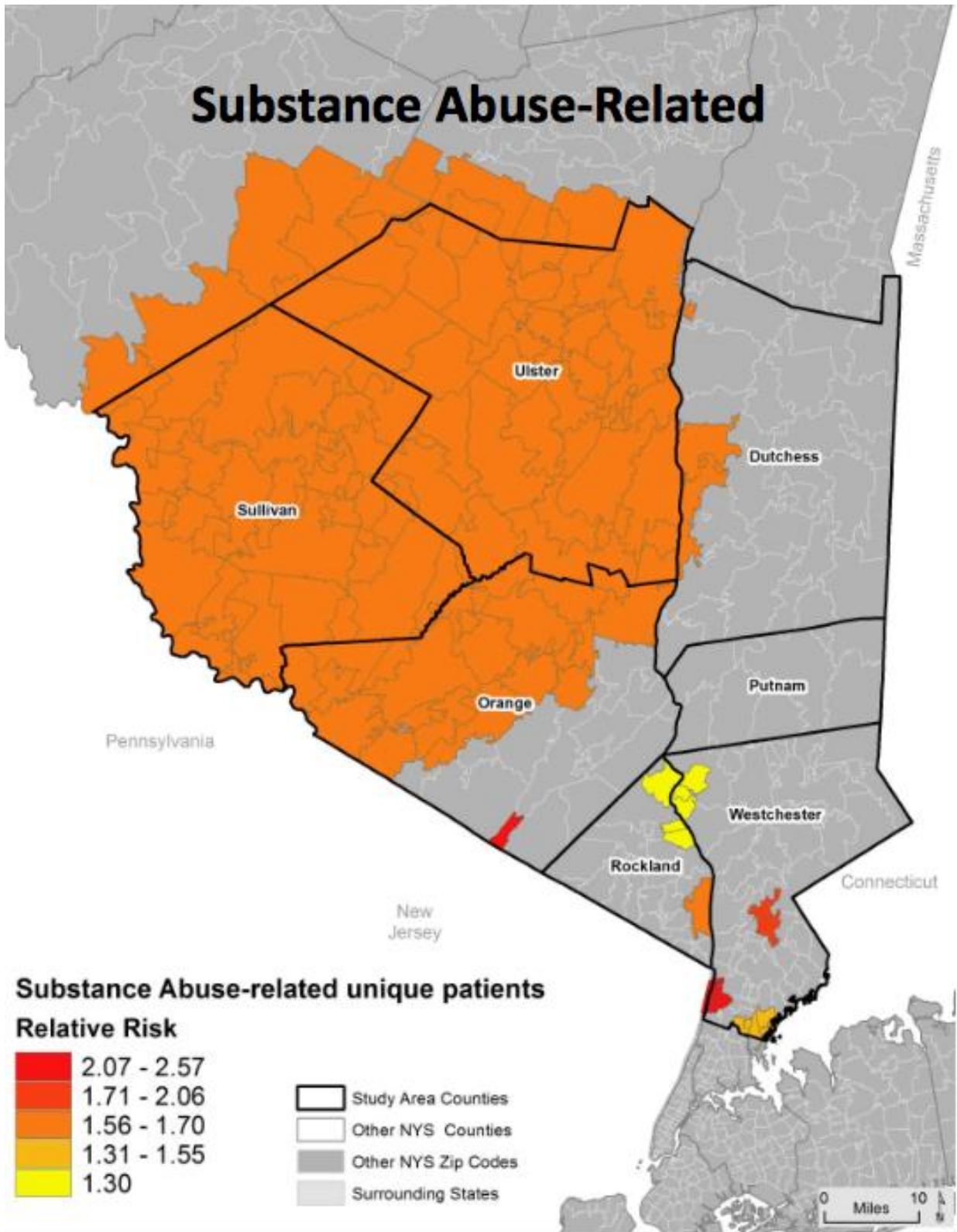
Age Category	Count	%	Race & Ethnicity	Count	%
0 to 10	42,747	22%	White	63,047	33%
11 to 18	25,511	13%	Hispanic	49,671	26%
19 to 35	47,699	25%	Black	31,297	16%
36 to 49	26,879	14%	Asian	4,506	2%
50 to 64	26,438	14%	Native American	854	0%
65+	22,064	11%	Other	3,986	2%
Unknown	1,111	1%	Unknown	39,088	20%
Total	192,449	100%	Total	192,449	100%

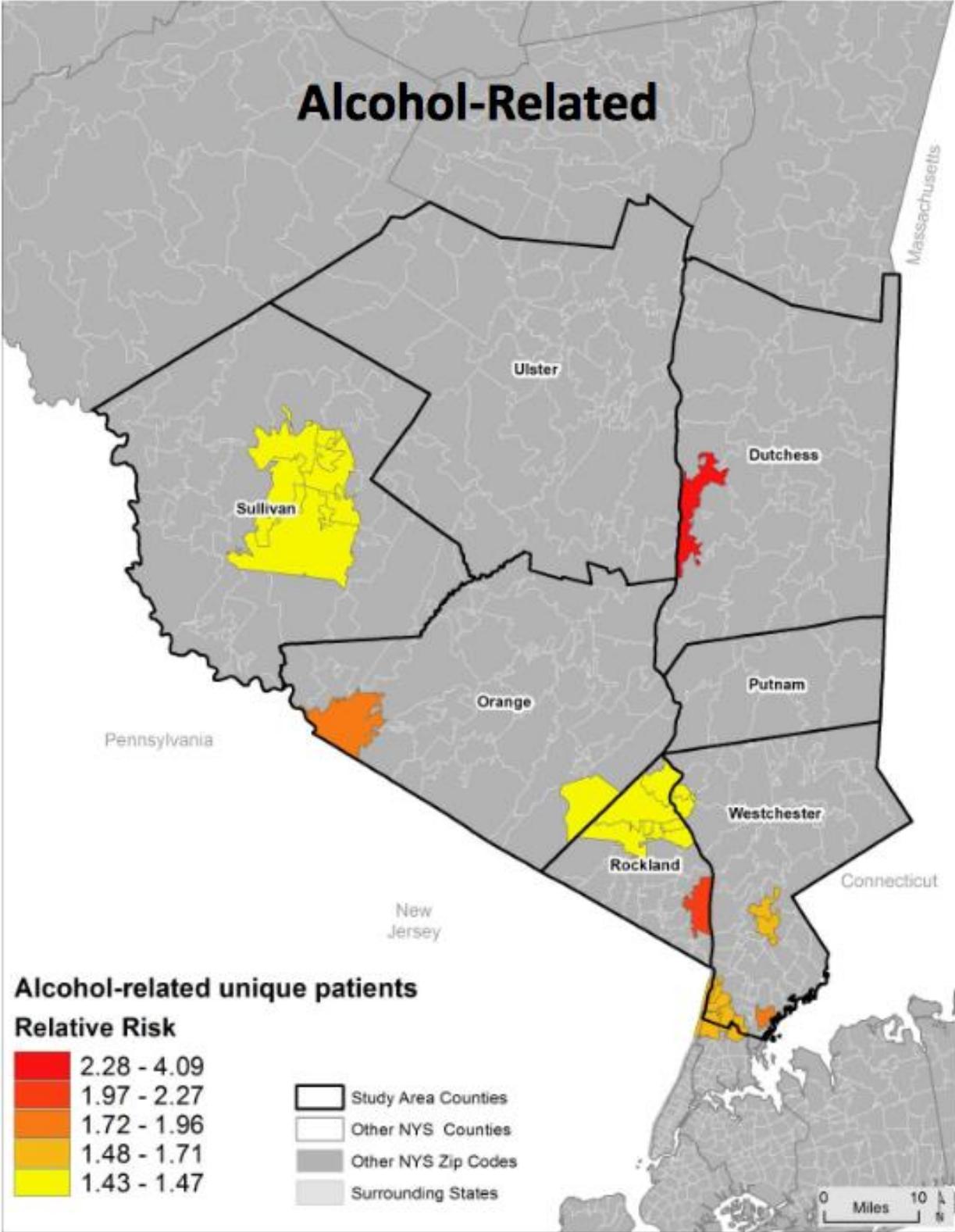
- Yonkers has the highest number of MHVC members – 19% of the total MHVC membership. Newburgh has the second highest – 6%.
- Majority of MHVC membership are either White or Hispanic.
- 31% of MHVC’s Hispanic population lives in Yonkers. New Rochelle has the second highest number of Hispanic population.

Mood Disorders

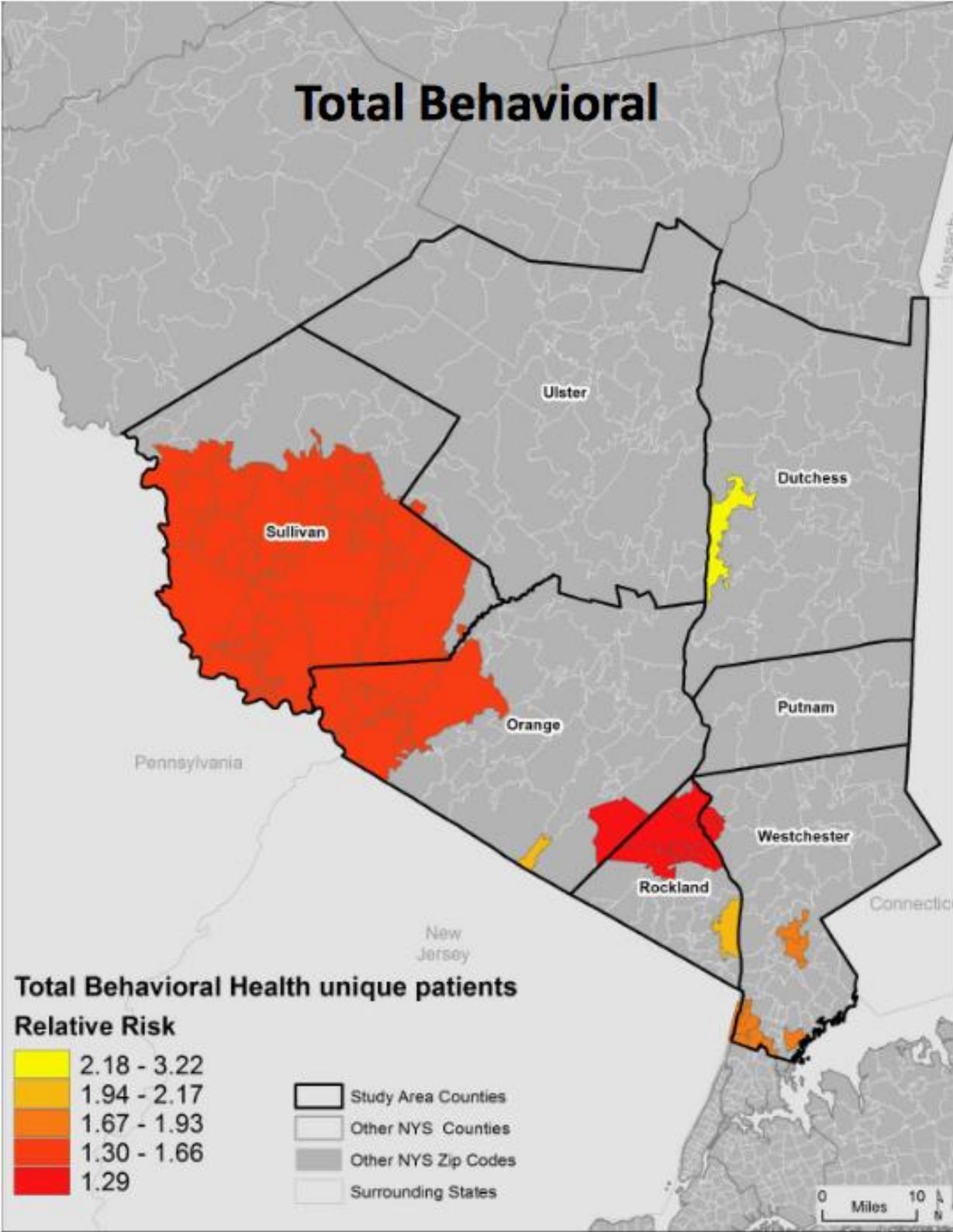


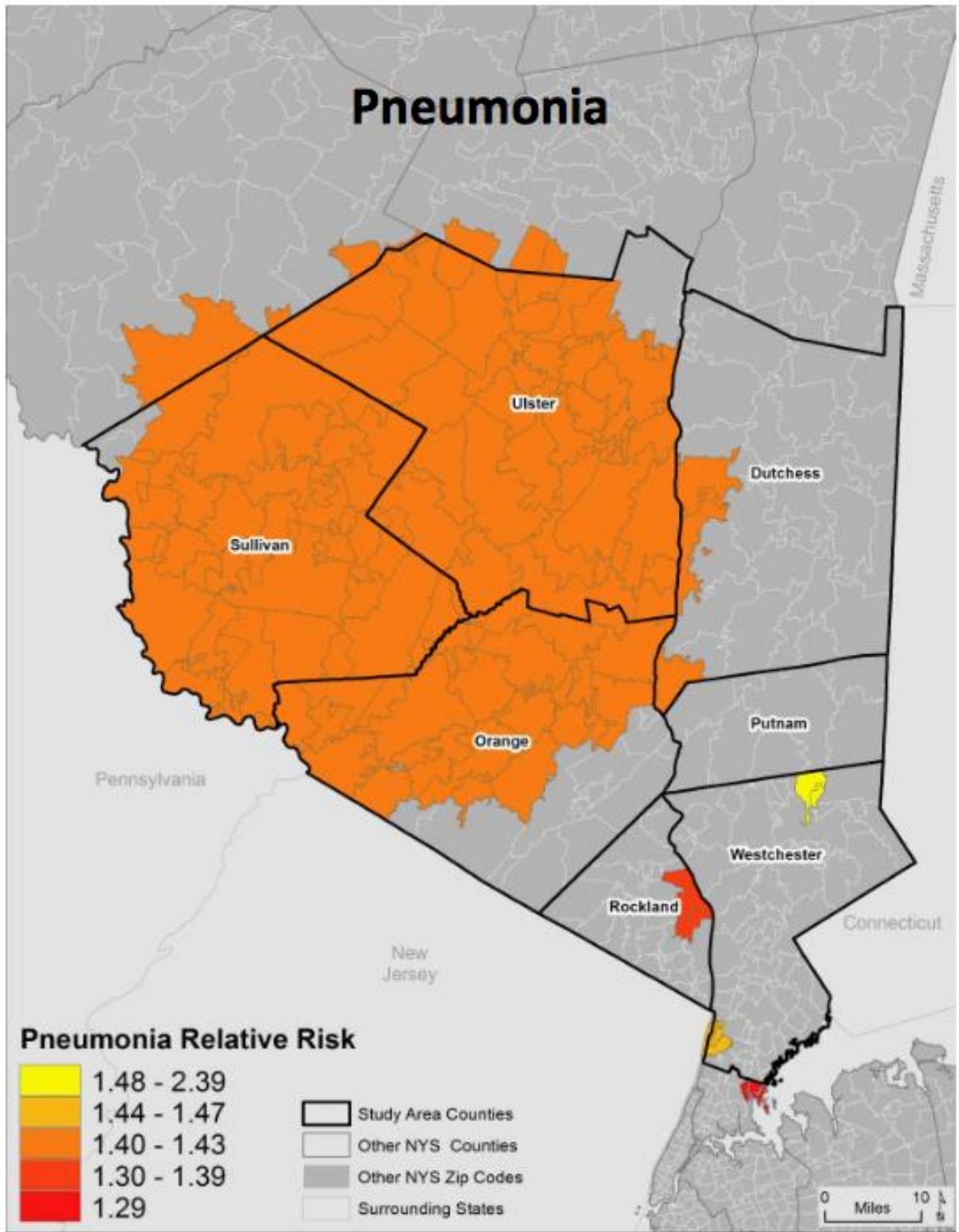
Substance Abuse-Related



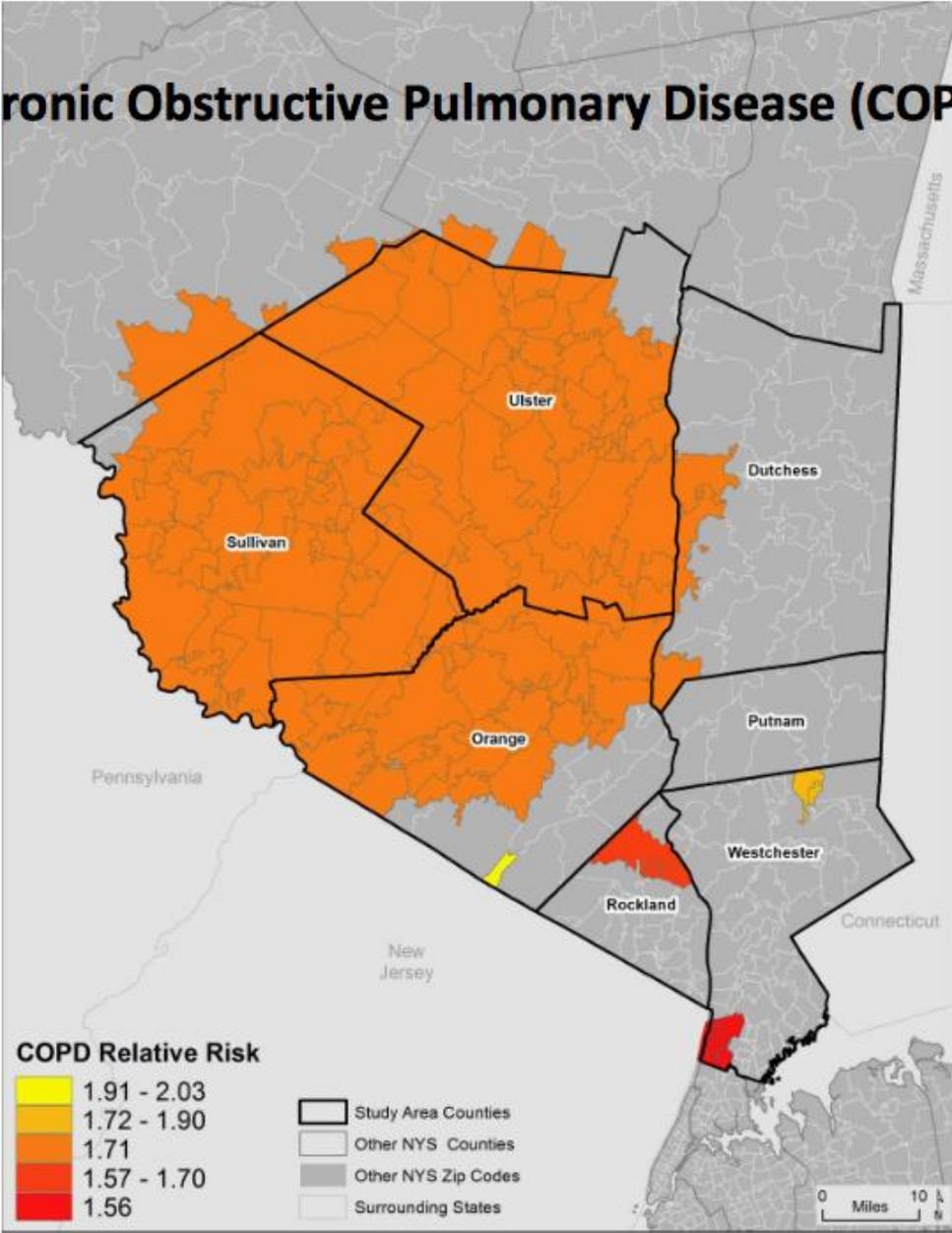


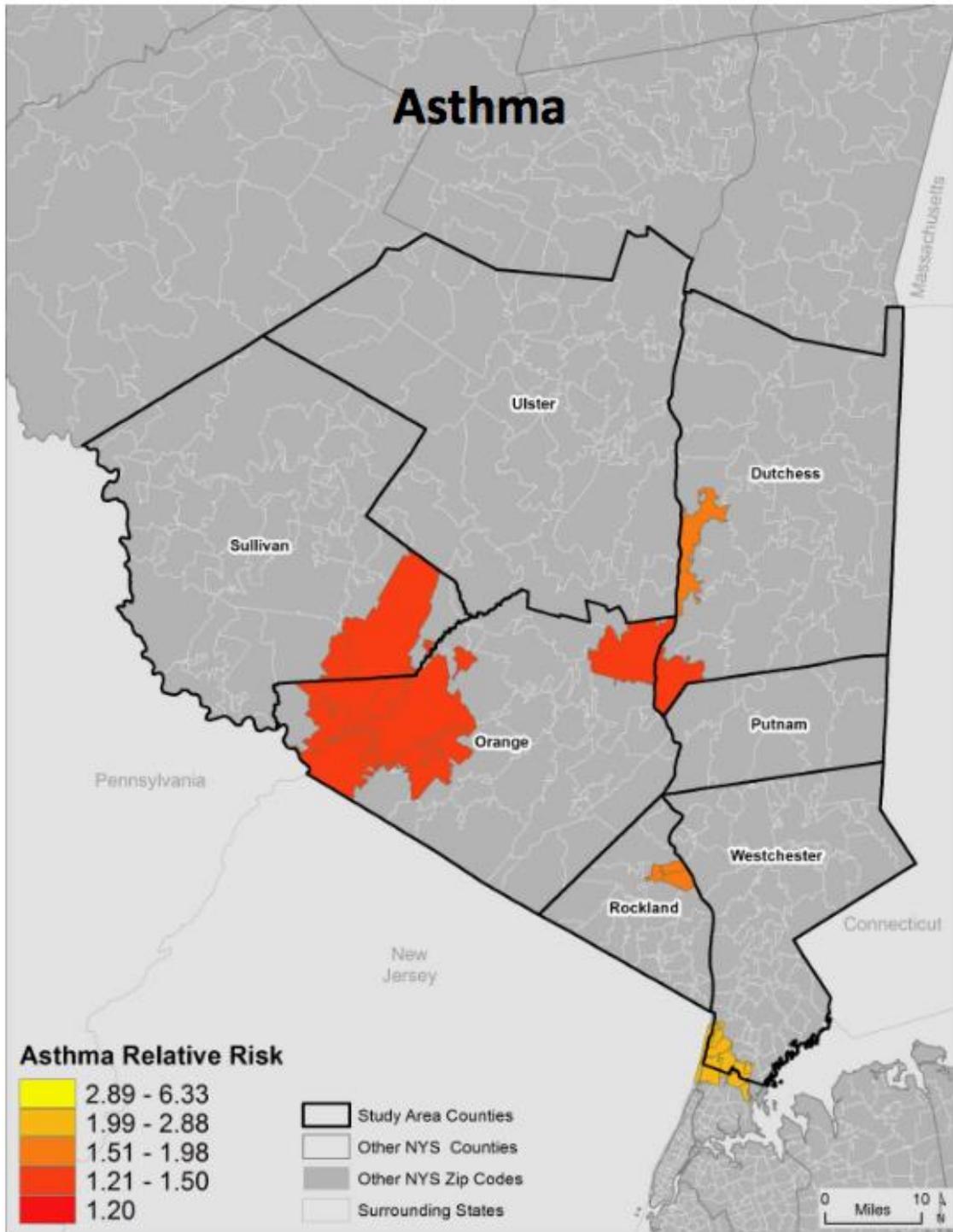
Total Behavioral

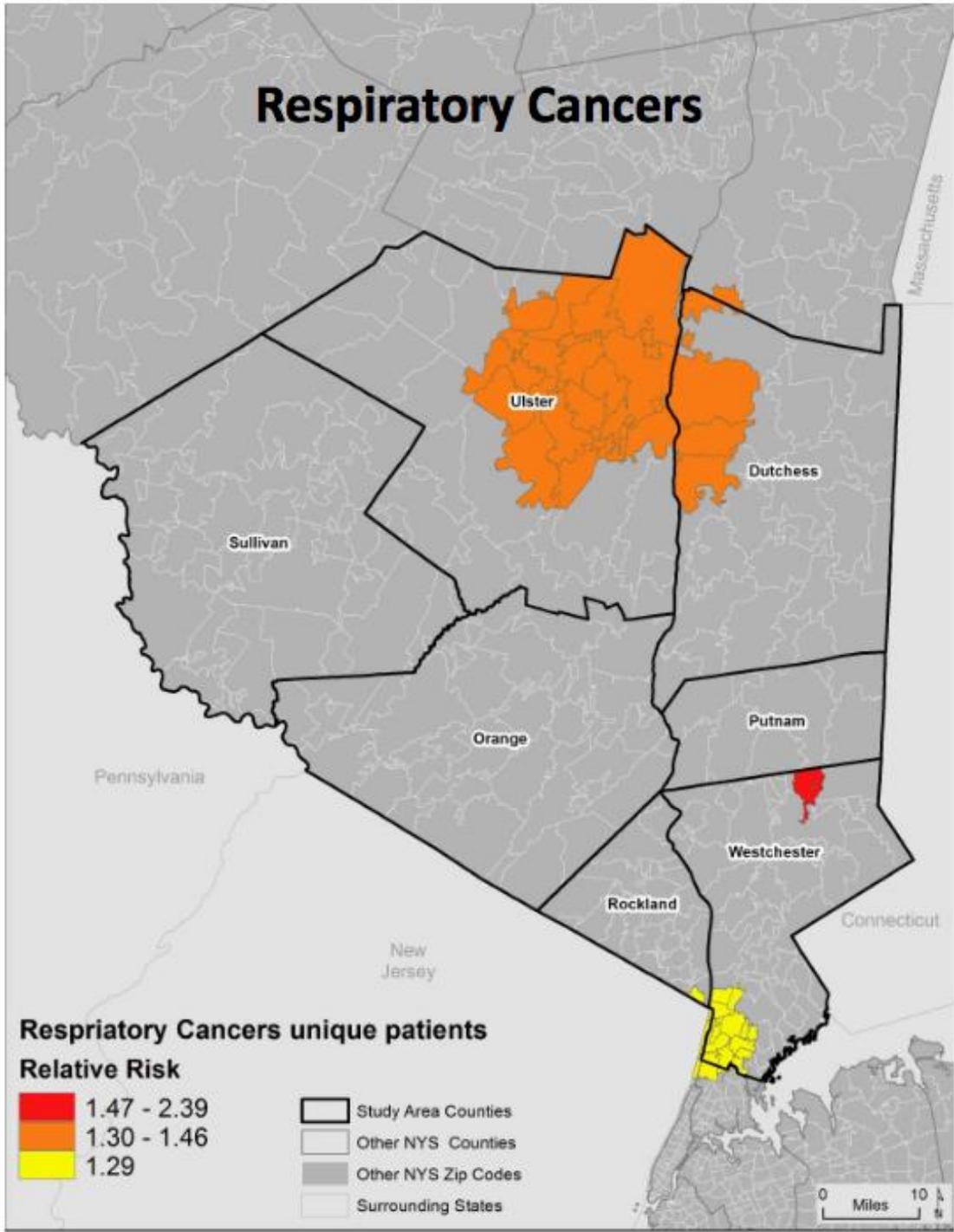


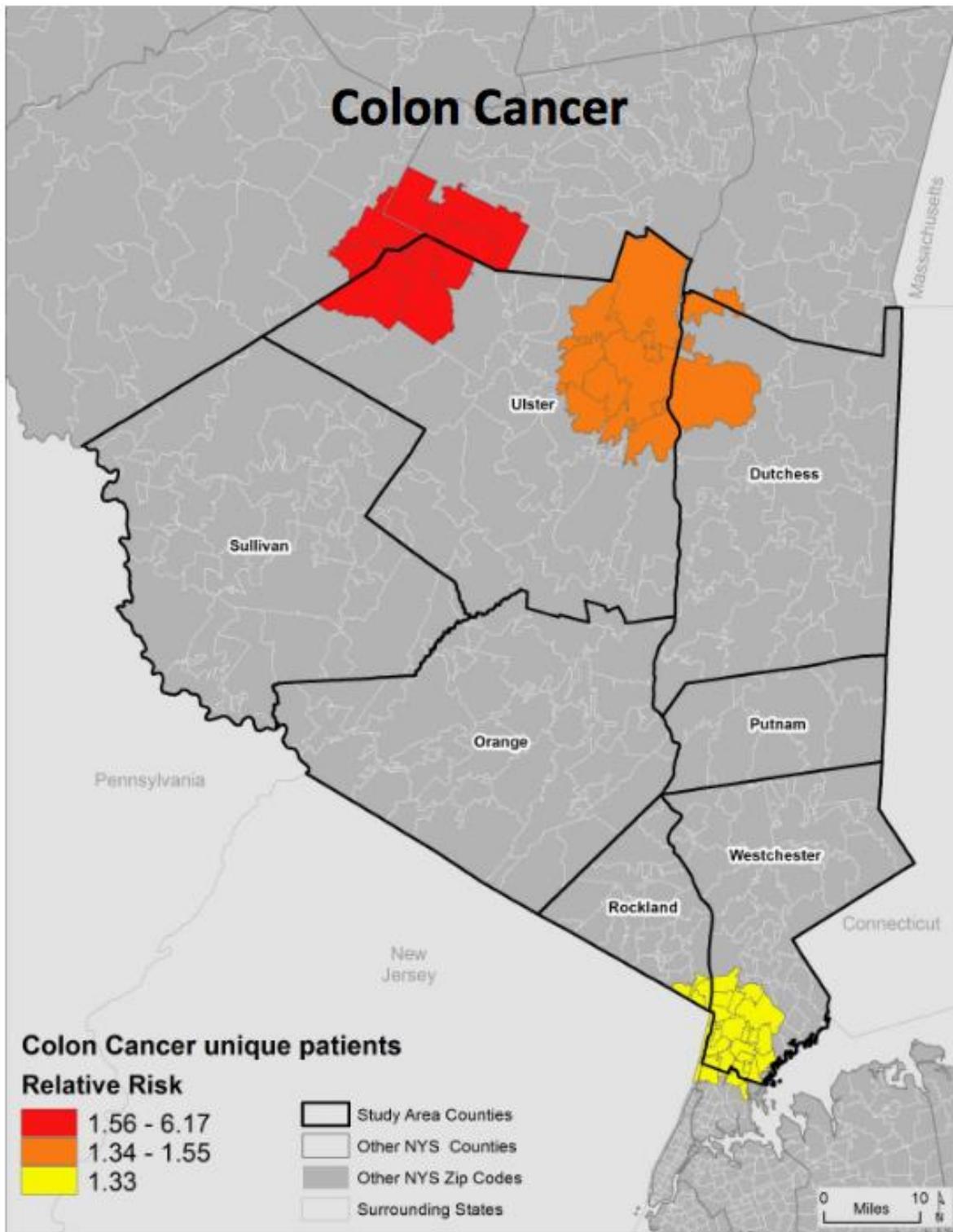


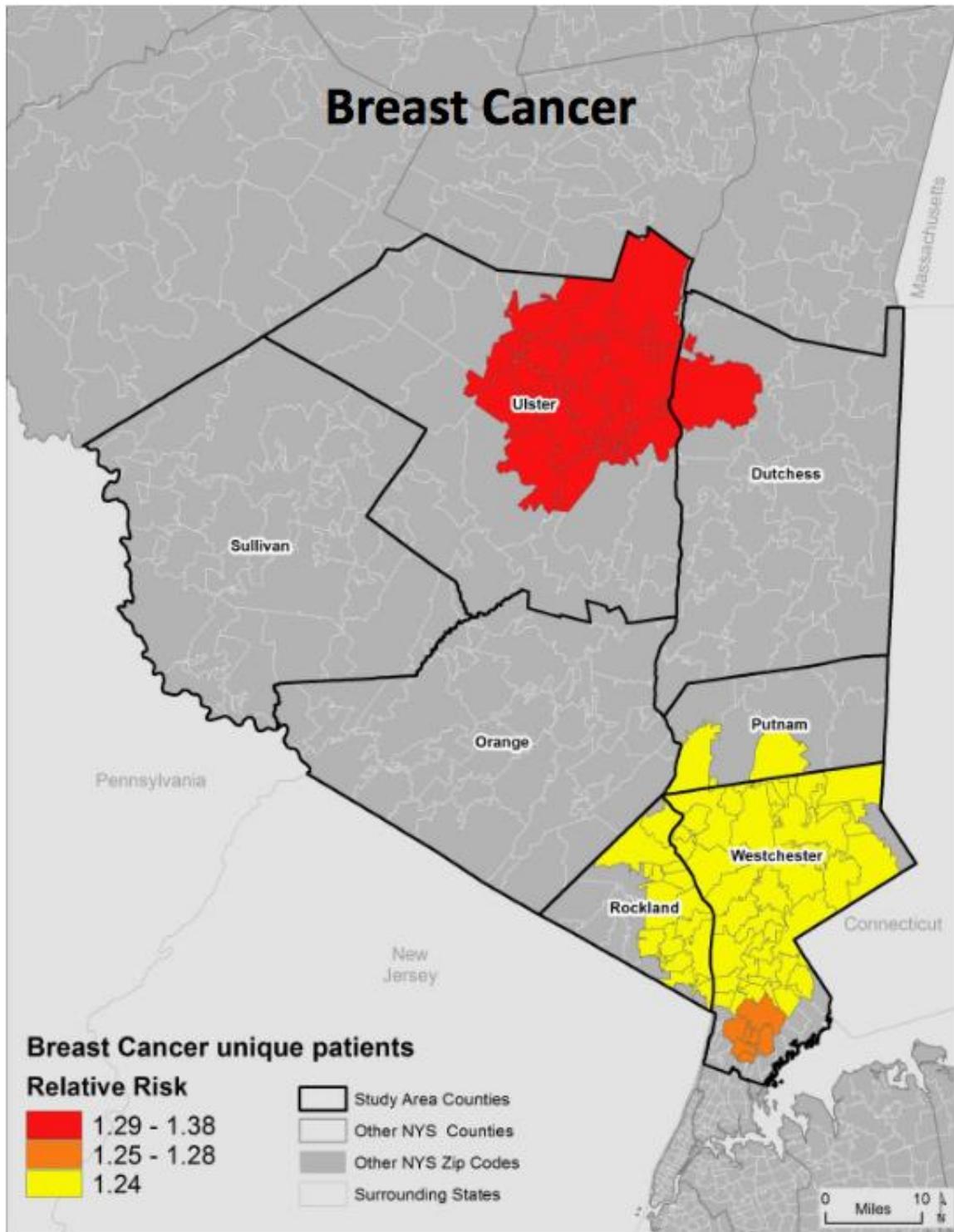
Chronic Obstructive Pulmonary Disease (COPD)



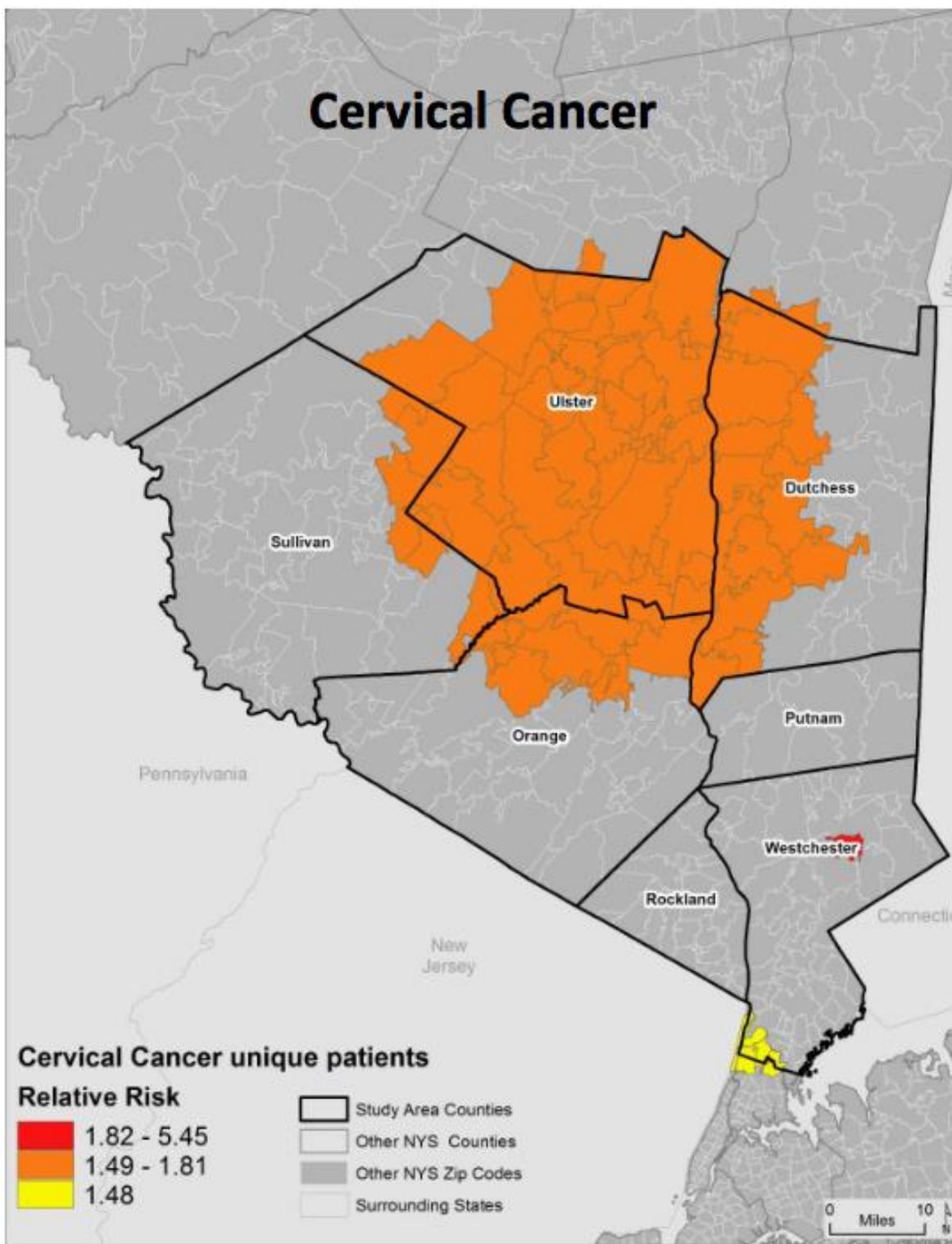


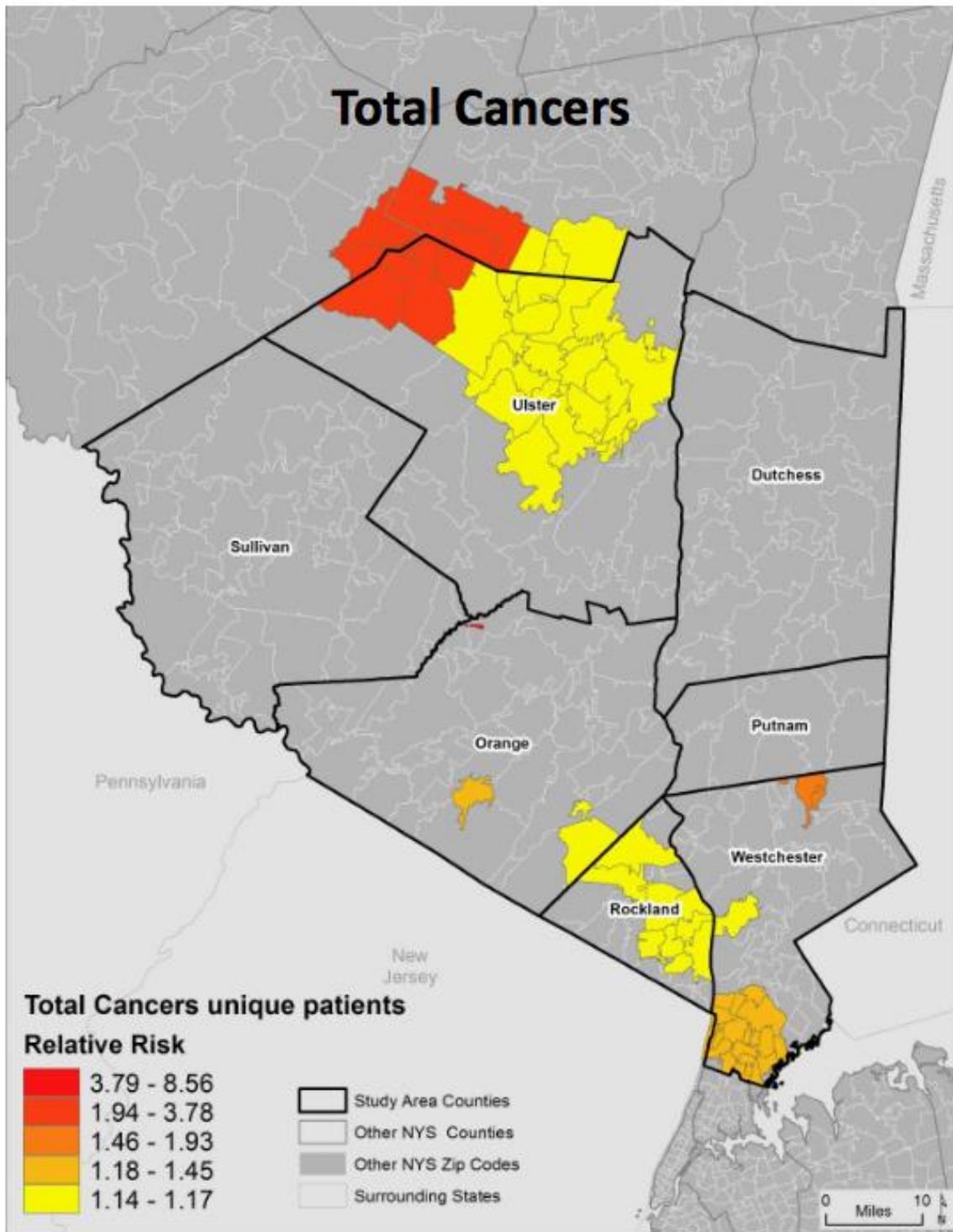




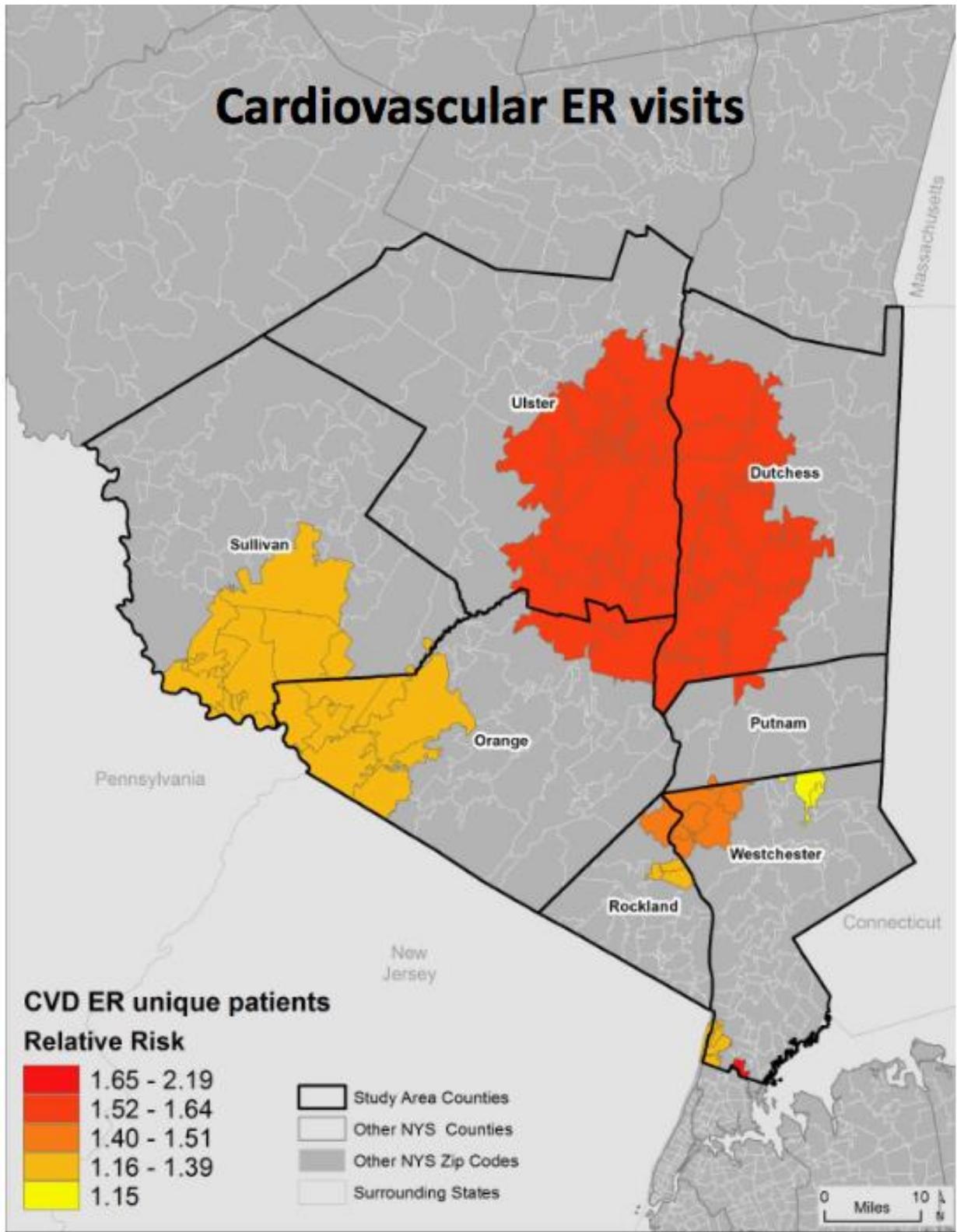


Cervical Cancer





Cardiovascular ER visits



Cardiovascular inpatient

