



# Performing Provider System (PPS)

Westchester Medical Center Health Network

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## **CULTURAL COMPETENCY AND HEALTH LITERACY STRATEGY DOCUMENT**

Submitted January 2016

## **ACKNOWLEDGMENTS**

*The WMCHHealth PPS's Cultural Competency and Health Literacy Strategy is supported by the involvement of our Community Engagement Quality Advisory Committee and Workforce Workgroup members who meet regularly to address the health literacy related burden placed upon individuals receiving health care and to increase the cultural and linguistic appropriateness of care and services delivered to all individuals within our region.*

*In particular we would like to thank our reviewers, Mecca Santana (Vice President Diversity & Community Relations, Westchester Medical Center), Terri Ann Parnell (Principal, Health Literacy Partners) and Nadia Allen (Executive Director, Mental Health Association in Orange County) for their time and thoughtful feedback.*

*Approved by the WMCHHealth PPS Executive Committee on December 15, 2015.*

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## **INTRODUCTION**

The purpose of the WMCHHealth PPS Cultural Competency and Health Literacy Strategy is to enhance culturally and linguistically appropriate awareness, education and inter-professional collaboration of all providers in our network, in an effort to foster an organizational culture that promotes the provision of equitable, person-centered health care and services for all members of our communities.

The NYS Department of Health has placed an unprecedented importance on the cultural competence of the workforce and the need for appropriate health education for Medicaid and underserved populations. Cultural competency and health literacy strategies apply to and influence all NYS DOH DSRIP projects. These strategies have been embedded into all core WMCHHealth PPS organizational components and in our 11 project plans. While the provision of health literate, culturally and linguistically appropriate health care is vital to all individuals, the ability of our PPS to raise awareness of regional health disparities and the diversity of the population is based on our ability to identify socio-economic determinants and neighborhood contextual factors that contribute to preventable differences in health outcomes across the region.

Our Cultural Competency and Health Literacy Strategy Document describes priority groups experiencing health disparities in our region; identifies key factors to improve access to quality primary, behavioral health, and preventive health care; defines plans for two-way communication with our communities; outlines a system of care supported by cultural, linguistic and literacy appropriate assessments and tools to assist patients/clients with self-management; and supports community-based interventions to reduce health disparities and improve outcomes.

The overarching goal of our strategy is to decrease health literacy related complexities and increase the cultural and linguistic responsiveness of care and services delivered to all individuals within our region.

## **HEALTH DISPARITIES**

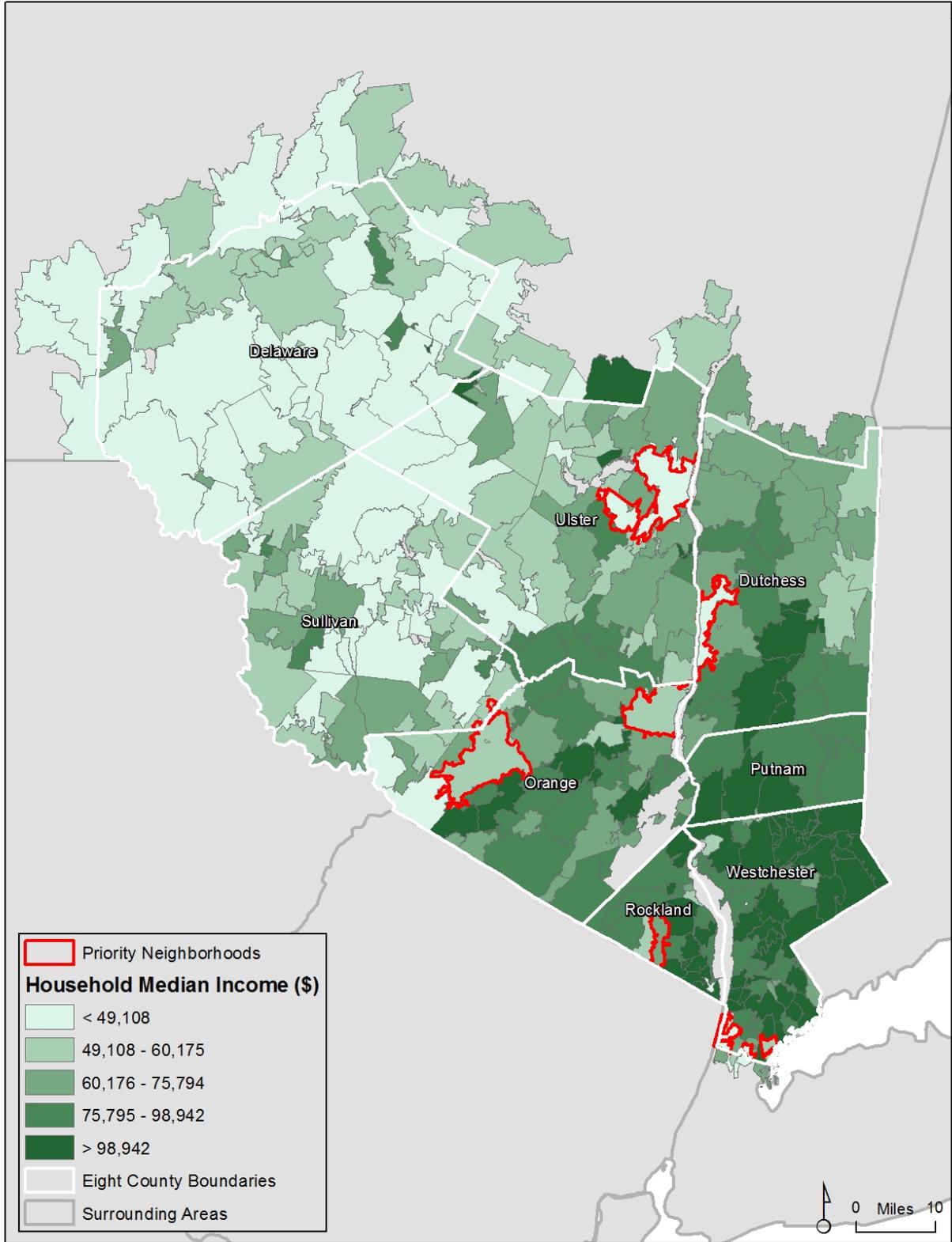
Our eight counties (Westchester, Rockland, Putnam, Orange, Dutchess, Ulster, Sullivan and Delaware) are home to 2.3 million residents, evenly divided by males and females. The region consists of densely populated urban areas contrasted by sparsely populated rural communities with suburban “bedroom” communities in-between; numbers of households per county range from a low of 20,000 to more than 340,000. A microcosm of the U.S., it has pockets of great wealth and pervasive poverty; median household income ranges from \$40-93,000. In cities across the region fully one third of households spend two thirds of their income on housing costs. Childhood poverty ranges from 6% in Putnam to 28% in Sullivan; there are cities within each county where childhood poverty rates exceed the national average. Approximately 46,000 grandparents live with grandchildren under 18 years of age and in over 25% of these households the grandparents have financial responsibility for care of the children.

Although the majority of the population is White, the region has also seen marked increases in minority populations. Westchester County’s city of Mount Vernon has the highest urban concentration of African American residents in New York (60%). Hispanic and Asian populations are the fastest growing minority populations, with 74% and 64% growth across the region since 2000, respectively. The aging population (≥65) in the region is expected to increase by 28.5% by 2020, outpacing NYS’s projected growth of 22.4%. Foreign born residents represent a quarter of the population of Rockland and Westchester Counties. The major language spoken is English, closely followed by Spanish in most counties and in major cities in the region. French and Spanish Creole, Portuguese and Yiddish are dominant languages in some of our communities with high levels of health needs. Educational achievement varies but on average nearly half of adults have completed high school or college; dropout rates range from 8%-15% of adults 25 years or older.

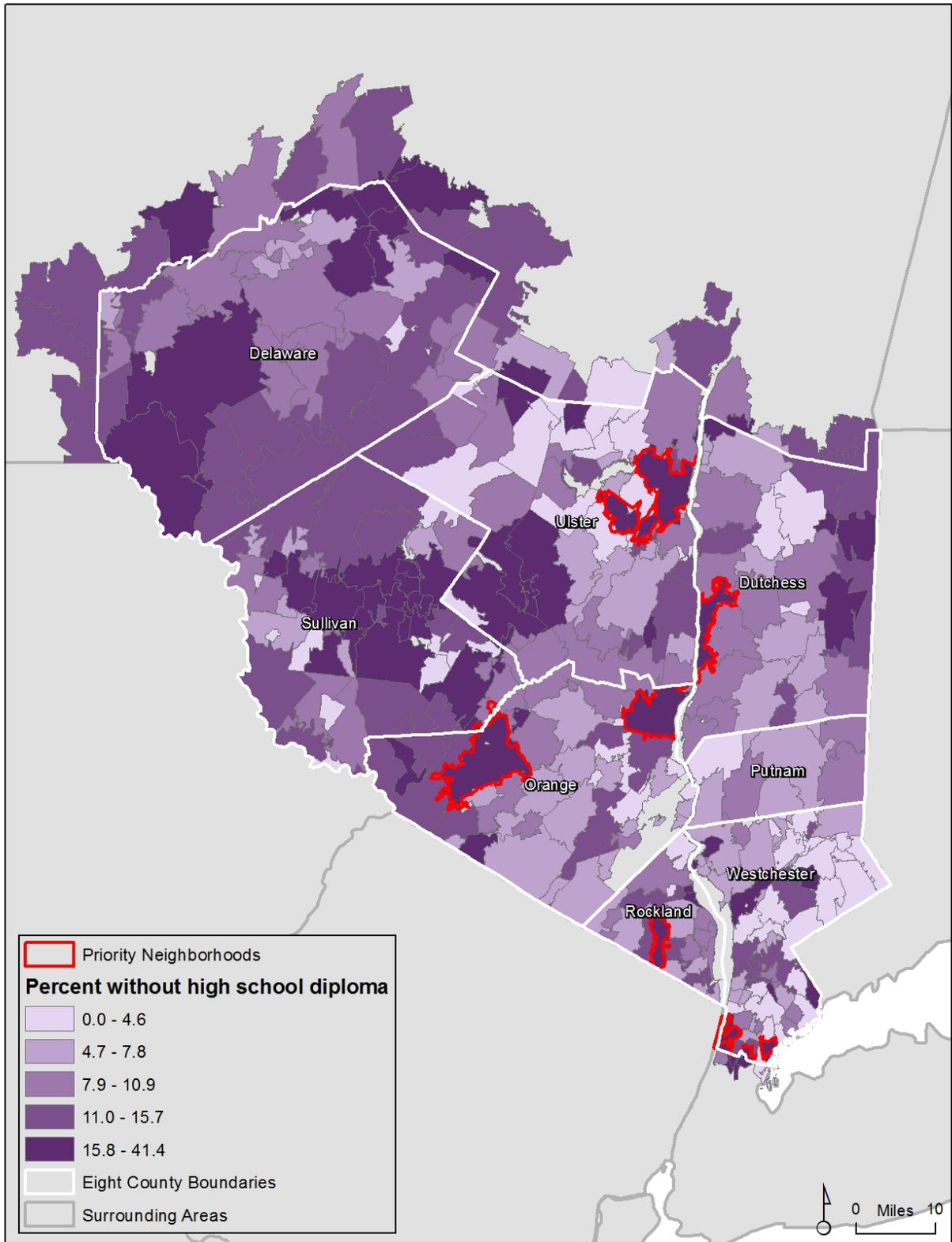
We relied upon surveys, focus groups and community engagement sessions to identify cultural competency challenges faced by providers and patients in the region. Results suggest that providers and staff often do not speak patients’ native languages such as Spanish, Portuguese, French and Spanish Creole, and Yiddish; do not demographically represent the target patient population and may not have a sufficient understanding of the communities in which they are working; and lack awareness of the particular competencies and accommodations needed for special needs patients. Further, there are limited health literacy and cultural competency resources and training/education programs available for providers and staff and it is difficult to measure the effectiveness of existing resources and programs; patients, especially limited - English proficient patients, may be hesitant to access services and wait until an emergency arises to seek care or may not have access to healthcare services during normal working hours. Ethnic communities and their subpopulations each have unique cultural and dietary considerations that may contribute to health challenges.

We identified priority neighborhoods using data available through Open Health NY and categorized by: Diabetes, Congestive Heart Failure, Coronary Atherosclerosis, Hypertension, Asthma, Chronic Obstructive Pulmonary Disease and Bronchiectasis, HIV Disease, Bi-Polar Disorder, Bi-Polar Disorder – Severe, Depression, Depressive and Other Psychoses, Depressive Psychosis – Severe, Schizophrenia, Chronic Alcohol Abuse, and Opioid Abuse. For each category we identified the top 10 high density areas (ZIP codes). We then combined all categories; there were 9 ZIP codes more frequently represented than all others (ZIP codes in position 1 through 9 appear between 18-20 times on the list whereas the ZIP code in position 10 only appears 6 times). They are Mt. Vernon (10550), Yonkers (10701 and 10705 appear 20 and 18 times, respectively), Kingston (12401), Newburgh (12550), Middletown (10940), Poughkeepsie (12601), New Rochelle (10801), and Spring Valley (10977).

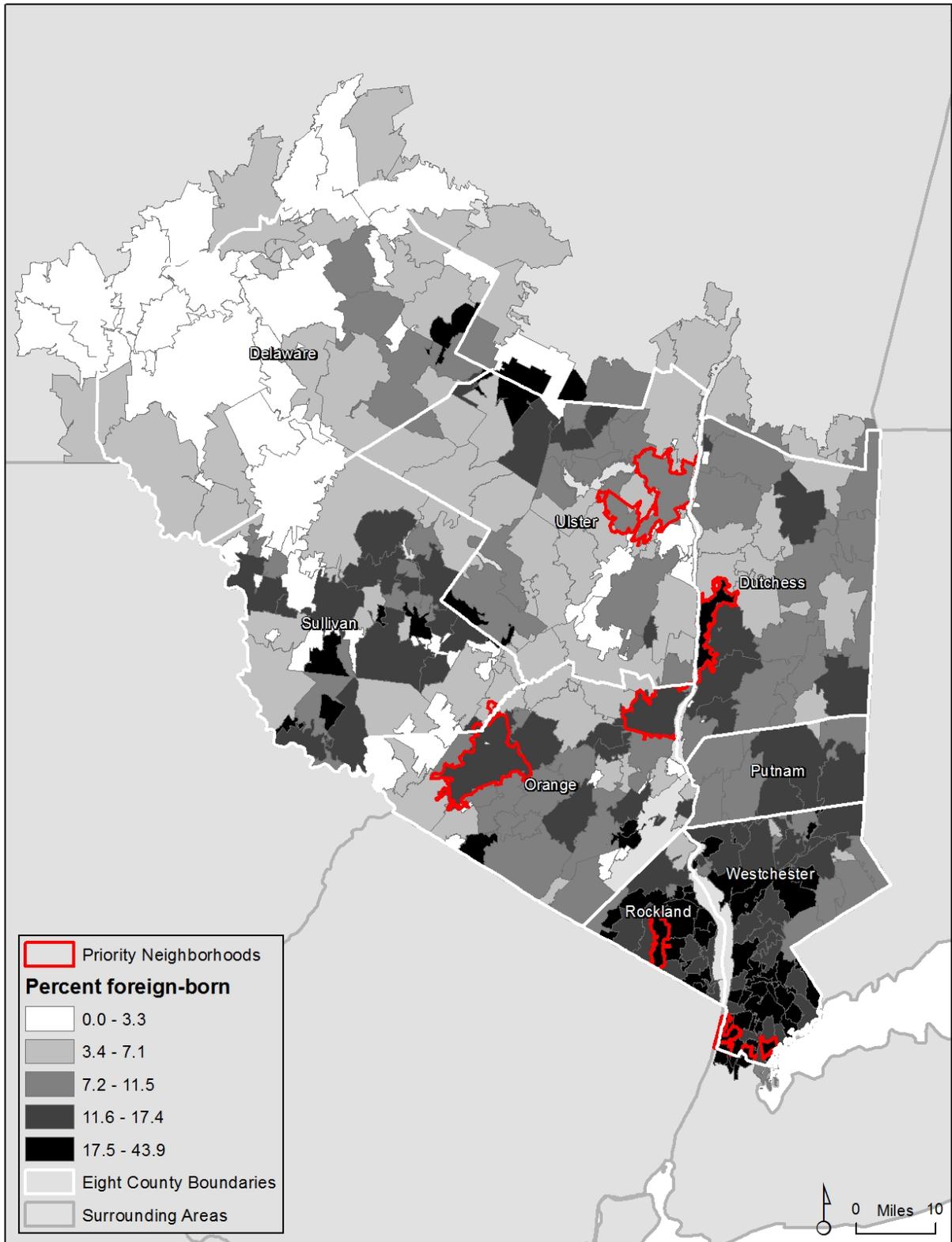
We prepared detailed county level and priority neighborhood level profiles that present information on social determinants of health, including income, education, employment, housing, and other social and economic determinant of health and wellness. We have provided visualizations by mapping these determinants (Maps 1-4 below are some examples). Having a clear understanding of social determinants of health for these neighborhoods will influence how we coordinate local health care and provide services and support in our DSRIP projects. Following the lead of Dr. Jeffrey Brenner of the Camden Coalition we posted our profiles and maps on our website so that community members and providers, who know their cities so well, can *“begin to take the data and tell stories with the data. And that’s an incredibly powerful tool for making change”* (Dr. Brenner).



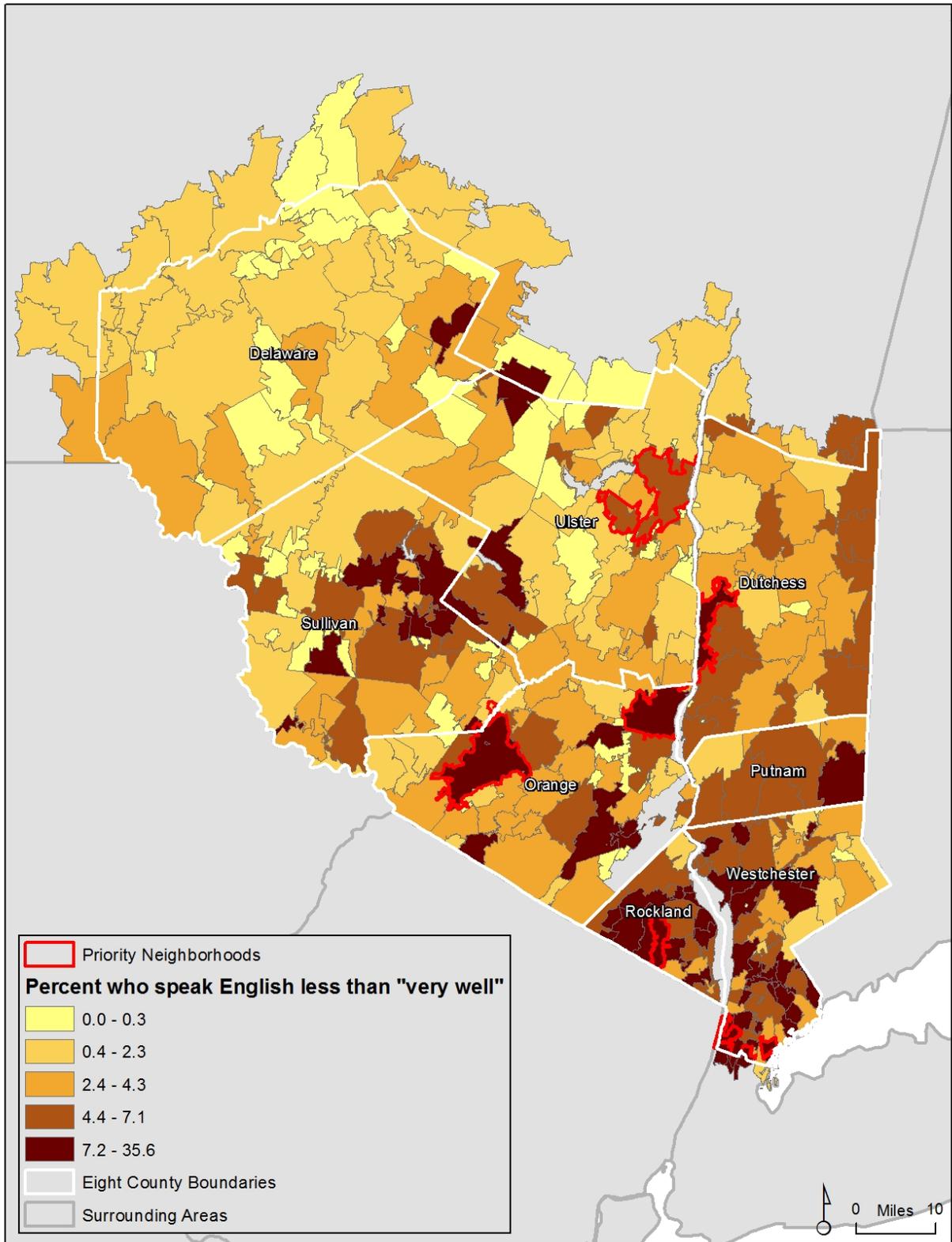
**Map 1.**



**Map 2.**



**Map 3.**



**Map 4.**

## **NEIGHBORHOOD CONTEXTUAL FACTORS AND ACCESS**

Causes for gaps in care encompass broader social determinants including higher poverty rates, lower levels of education, and high unemployment. These determinants when considered at a ZIP code level help us to characterize a neighborhood's risk. We utilized the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage based on 17 U.S. census indicators; four counties in our region have an ADI higher than the State. Our priority neighborhoods all have higher ADIs compared to their county averages and experience higher levels of depression and mood disorders. Discussions with community stakeholders and focus group participants indicate that households are disproportionately stressed due to long waits for care; limited transportation options; and interaction with providers who are often insensitive to their language, cultural and disability-related challenges and needs.

These risk factors may also impact acceptability by community members and perceived quality of services. In a series of facilitated discussions with Medicaid, uninsured and insured consumers, Medicaid and uninsured respondents felt there was a "bias against them" exhibited by doctors who do not accept them into their practice; and when they are, the staff is often rude or they feel their wait times are longer. Some respondents indicated that when given a choice among household expenses, "Food comes first." Most respondents did not have an advocate who could help them navigate the system. Urgent Care centers and emergency rooms become preferred options due to long waits for appointments, and multiple appointments at disparate sites are a challenge due to transportation issues.

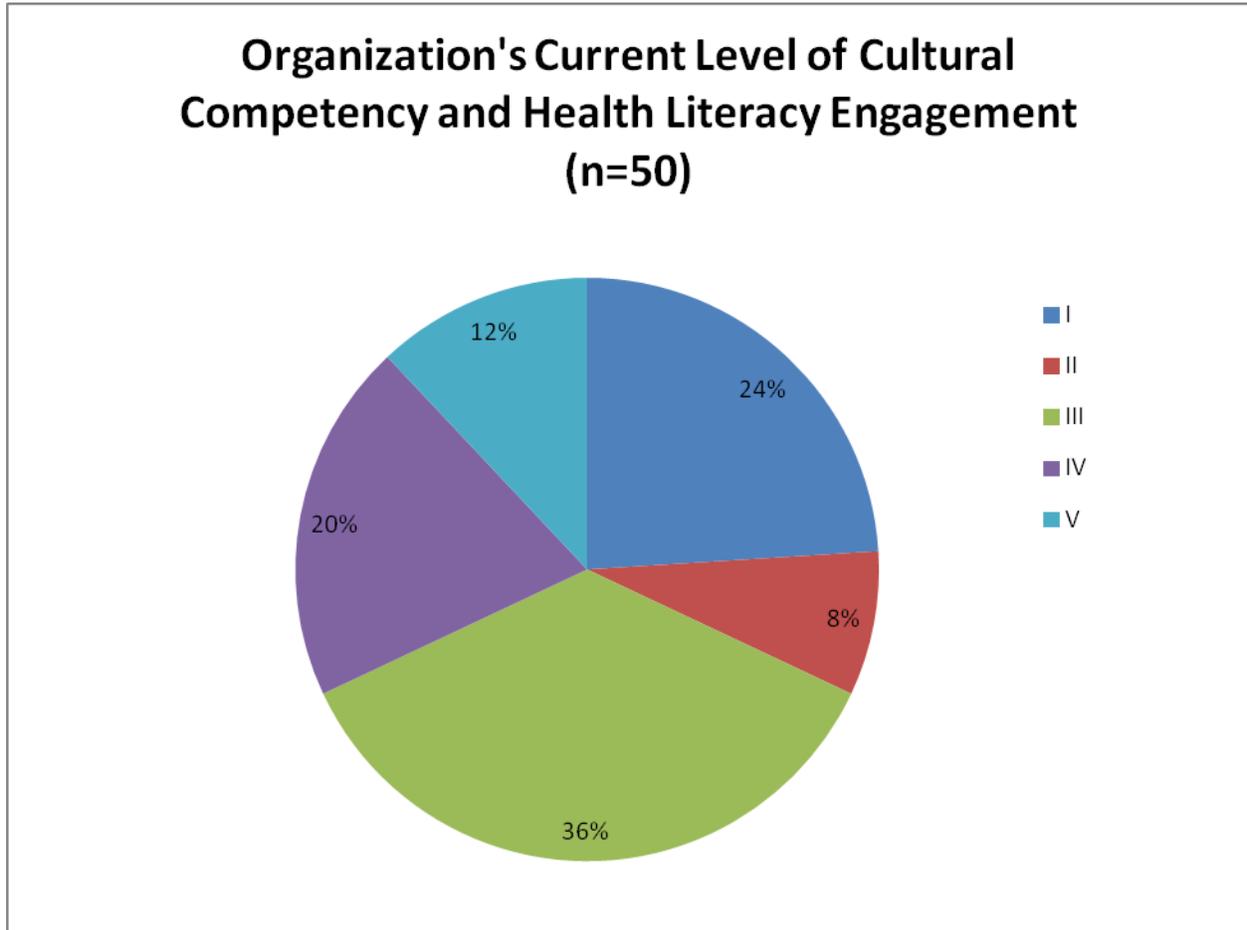
Survey responses corroborated the feedback from these discussions. Among Medicaid and uninsured respondents, who represent 31% and 10% respectively of our total (4,952), Medicaid respondents were almost twice as likely and uninsured respondents were 1.2 times as likely to have been to the ED in the past twelve months for care. Among reasons indicated for the visit, 33% of both groups indicated that their doctor's office was not open or their provider instructed them to go to the ED for care; almost 13% of uninsured respondents indicated that there was "no other place to go."

Provider surveys administered within our network as part of our Current State Assessment also provide insights regarding potential access barriers. Although the majority of our partners have staff fluent in languages other than English, 12% do not and almost 25% indicated that they currently do not have an organized approach to address cross cultural and health literacy competencies within their organizations (Figure 1). We introduced at our PAC-wide annual summit on November 5, 2015 resources and training plans that we believe will meet the needs and concerns they have expressed. Our speaker, Terri Ann Parnell of Health Literacy Partners, shared a presentation integrating the concepts of health literacy, cultural awareness and patient-centered care into core organizational activities, including training, hiring, safety, communication, and development of patient/ client interventions. Dr. Parnell will also be creating and advising on our training strategy which will focus on addressing the drivers

of health disparities beyond the availability of language-appropriate resources. Our first PAC wide training module will be available by the end of DY1.

Our PPS is also partnering with HealthlinkNY to sponsor a “Walk In My Shoes” poverty simulation experience for healthcare practitioners in the Hudson Valley during DY2. This simulation experience requires participants to assume the roles of 26 different families facing poverty. The program has been implemented nationally in diverse organizations including United Way and the American Bar Association and through faith-based and school groups. Our PPS will provide as part of this experience a presentation on diversity across the region with emphasis on the needs of our priority neighborhoods and groups.

**Figure 1.**



**Legend:**

*I - There is no organized approach or conscious intent to address cross cultural and health literacy competencies. – 24%*

*II - There are committees that address cross cultural and health literacy competencies for patients/clients and staff but initiatives tend to be adhoc and funding is limited. – 8%*

*III - There are formalized efforts in cross cultural and health literacy competencies; internalized action on cultural diversity is centered on training sessions and seminars. – 36%*

*IV - There are formalized efforts in cross cultural and health literacy competencies both within the organization and/or services to diverse populations and communities; plans have been developed and actions taken to advance diversity re: staffing/management and patient/client issues. – 20%*

*V - There are formalized efforts in cross cultural and health literacy competencies and cultural diversity is part of orientation and training for staff; diversity activities are an integral part of the organization and diverse communities are incorporated into planning and decision making at all levels; external training to communities encourages feedback to the organization. – 12%*

## **COMMUNITY ENGAGEMENT AND COMMUNICATION**

The WMCHHealth PPS commitment to community engagement began with the formation of our PPS in 2014. We undertook an extensive CNA that recognized the integral role of our community stakeholders, e.g. community based organizations, consumers, and local county departments. The needs and opinions represented by these stakeholders were gathered in a systematic way that included a series of meetings with county department leadership; focus groups; and a consumer survey that garnered close to 5000 responses. We have 68 community based organizations in our network. As we began project implementation this past April, we reconvened with the county health, mental health and social services leadership in addition to many of our behavioral health partners so that they could share their insights on our project strategies.

We also established with the other two PPSs in the region (Montefiore Medical Center and Refuah Health Center) a Hudson Region DSRIP Public Health Council (HRDPHC). The HRDPHC's first initiative involves Project 4.b.i, Tobacco Cessation. We formed a private group on the MIX that includes more than 25 local county health departments, providers and community based organizations who meet regularly.

The HRDPHC determined that the rates of youth use of e-cigarettes, hookah sticks, and vape pens have begun to surpass the use of cigarettes in some communities. In addition, recent research has shown that e-cigarettes are a gateway substance for regular tobacco use by youth. Working through county-wide organizations, we began a series of media campaigns scheduled for November 2015, April 2016 and November 2016. We plan to evaluate the impact on youth tobacco use from baseline and one year follow-up using data from the OASAS Youth Development Survey.

One part of the print campaign (Figure 2) will target the approximately 116,860 students attending the 137 public high schools in the eight county region which includes Delaware, Dutchess, Orange, Putnam, Rockland, Ulster, Sullivan, Westchester counties. The other part will target their parents. Each campaign is geared toward reducing the risk factors that impact youth vaping, e-cig, hookah, and tobacco use: perception of risk, perception of parental disapproval, and perception of peer disapproval. Our county-wide distribution is being facilitated by Student Assistive Services Corporation in Westchester in cooperation with other local agencies.

**Figure 2. Sample from Print Campaign**



# Phony

You think you're getting the full smoking experience without the lung cancer. What you're really getting is a nicotine addiction. The more you smoke, the more you crave. The more you crave, the more you smoke. Why do you think they call it chain smoking?

Smoking. Vaping. E-Cigarettes. Hookahs.  
**Blow them all off.**

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Learn more at [www.hrdphc.org](http://www.hrdphc.org)

A program of the Hudson Region Delivery System Reform Incentive Payment Public Health Council.  
For more information about the Public Health Council or local services go to [www.hrdphc.org](http://www.hrdphc.org)

Print campaign and website: [www.hrdphc.org](http://www.hrdphc.org)

Local deployment councils (LDCs) are an important component of our community engagement as we implement projects across our eight counties. We will rely upon our LDCs to assure appropriate outreach and effective communication takes place between local community groups and the PPS project management teams. Although the involvement of community stakeholders will vary by project, they will be critical towards our PPS achieving success with several cross-cutting work streams, including the implementation of our cultural competency and health literacy strategy. For this reason, we are conducting additional community engagement sessions, coordinated through the LDCs and CBOs during DY1 in our priority neighborhoods to help determine key access factors and effective communication pathways that will acknowledge and embrace cultural and linguistic differences and health literacy competencies from a community perspective. We recently completed two sessions with groups in Mt. Vernon in Westchester County.

We realize the challenge of reaching out to uninsured populations in addition to some of our most vulnerable, including those with behavioral health issues and those who are homeless. We will provide training for our community based partners to help us with outreach and patient activation as part of Project 2.d.i, Implementation of Patient Activation Measures.

We have also prepared and shared evidence based research for tobacco, asthma and overall health for special populations including behavioral health, intellectual and developmental disabilities (IDD), and formerly incarcerated. We are currently conducting key informant interviews with directors of organizations who provide care and services to the IDD population.

We also maintain a community facing website that contains all of the CNA work we have undertaken as well as links to information and resources to support cultural competency and health literacy awareness and training. We have optimized access to our website by major search engines such as Google and Bing which has resulted in over 12,000 visits from users representing over 100 cities worldwide.

Our PPS is becoming increasingly involved with the Westchester Medical Center Health Network in other community engagement activities. These include wellness fairs, cancer screenings, conferences (ACLAIMH Direct Service Workers), Smart Scholars Early College Program (Charles E. Gorton High School's Academy of Medical Professionals, Yonkers), and citizenship educational seminars for the Westchester Medical Center workforce. We are also establishing new relationships with organizations, including One Hundred Black Men, Inc of New York.

## **PATIENT/CLIENT SELF MANAGEMENT**

As previously described, our PPS conducted focus groups, community engagement sessions and surveys of consumers, providers and community-based organizations to identify health literacy challenges and innovative programs that address them. Among the challenges identified: inability of providers and staff to communicate in patients' native languages; reliance and emphasis on written care documentation (vs. verbal or picture-based instruction); and lack of education/health literacy courses available to providers and staff.

As a result of the extensive inventory of provider and community resources identified in the CNA, our PPS is positioned to address the above challenges and accommodate the cultural competence, language and health literacy needs of patients/clients in all of its DSRIP projects. First, we will integrate our strategy into DSRIP implementation efforts and evaluation measures, underscoring the importance of participation through our contracting process.

Second, our PPS will pursue a series of initiatives to promote cultural competency and health literacy and raise awareness about the impact of unconscious bias, including but not limited to: educating providers on use of plain language and incorporating teach back; recruitment of qualified, bilingual health educators, medical interpreters, and staff to fill identified gaps; development of health literate care plans and other patient and caregiver-facing materials, translated into prevalent beneficiary languages (i.e., Spanish, Portuguese, Yiddish, and French and Spanish Creole); partnership with community-based organizations serving limited-English proficient or low literacy populations to increase awareness of available health care services and promote general wellness and prevention strategies; identification and integration of effective communication and health literacy programs and leading patient-engagement practices into our PPS participants' policies and protocols; and identification and use of bilingual peers to act as champions and trusted "go to" resources in their communities. Our overall workforce training strategy will also be informed by the Cultural Competency and Health Literacy Workforce Workgroup who report to the PPS Workforce Committee.

Third, our PPS will adopt a set of common organizational values and evaluation measures that place the patient at the center of the care model. This framework will be coordinated to the extent possible with the other PPSs in our region to create organizations and systems that will enable everyone to access and benefit from all health care services across the region.

Finally, our PPS is in the process of identifying local champions or cultural brokers to support our strategy. We believe that community-based organizations are best positioned to promote health literacy and cultural competency among their peers and clients and foster changes in organizational culture that will be sustaining. Our Community Engagement Quality Advisory Committee is comprised of such

organizations and informs and guides the development of the WMCHHealth PPS's cultural competency and health literacy strategy and coordinates these efforts with the PPS's patient engagement strategies as these relate to Project 2.d.i.- Patient Activation. Patient Activation efforts focus on the Uninsured as well as Low-utilizing and Non-utilizing Medicaid populations. We are currently leveraging the expertise of organizations that work with identified Medicaid populations and the uninsured to develop the core capability to coordinate, train, and conduct patient activation activities across the region.

**Figure 3. Building Cultural Competence & Improving Health Literacy: Successful Patient/Client Engagement**



## **COMMUNITY-BASED INTERVENTIONS**

During our CNA we inventoried available community resources across the region including, but not limited to: housing services, food banks, employment support services, religious service organizations, family support and training, local governmental social service programs, and transportation services. The CNA proved that the distribution of these and other resources vary widely across the region and many services are not available or accessible within our priority communities.

As part of our PPS's vision to provide our partners with innovative tools to address disparities locally, we are contracting with Healthify (<https://www.healthify.us/>), an online resource platform, to make available to our providers and community based organizations a tool that allows referral tracking for patients/clients and their families in need of community resources, social services, and government benefits. It is well established as evidenced within peer reviewed research that an individual's medical and non-medical needs must be met in order to achieve optimal health outcomes. One of the challenges has been how to connect these two spheres of needs through effective communication and tracking methods to ensure that the services are available, locally, and are appropriate. Tools such as Healthify can help resolve this challenge. For example, a patient navigator can assess a client's social needs and instantaneously search for the appropriate services available locally. Healthify will also pilot a new initiative with our PPS to track referrals via texting to communicate with members about resource information and to seek their feedback on received services. This will allow our PPS to track progress in addressing social determinants via screening and analytics, thereby supporting DSRIP initiatives.

When our PPS completes its Current State Assessment and community engagement sessions, we will be able to use the information we have collected to conduct a gap assessment of capabilities of our providers; identify key access factors and effective communication pathways that acknowledge cultural differences, language, and health literacy competencies from a community perspective; and coordinate with our 11 project advisory quality committees through our local champions to provide targeted community-based interventions that address the social and economic determinants of health and reduce disparities across the region. Selected interventions and strategies will be supported with appropriate training and retraining of our workforce and will be incorporated into our workforce and provider communication plans.

## **SUMMARY**

The overarching goal of our cultural competency and health literacy strategy is to decrease the health literacy related burden placed upon individuals receiving health care while increasing the cultural and linguistic appropriateness of care and services delivered to all individuals within our region. This will be accomplished by increasing the capacity of the WMCHHealth PPS network to design, implement and evaluate a culturally and linguistically equitable system of care. This goal is no small undertaking and our strategy to accomplish this will need to evolve over time. Incredibly, and with the input of so many of our partners and community stakeholders, we have begun to institutionalize a process within our 11 projects to achieve equity and eliminate preventable differences in health outcomes (Figure 4).

We hope that this strategy document fosters a dialogue towards a richer development of our PPS organizational philosophy; supports the further acquisition of knowledge of the diversity inherent within our communities; establishes linkages to culturally and linguistically appropriate resources, including communication technologies; informs our cultural competency and health literacy training programs; and most importantly, engages our diverse communities in community-based interventions to reduce health disparities and improve health outcomes.

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Figure 4.

### Behavioral Health: One Approach for Reducing Health Disparities and Improving Outcomes

3.a.i Model 1: Behavioral Health Integration in Primary Care at 30* sites in 7 Counties	
Bon Secours: Rockland Pulmonary & Medical Associates	Suffern, West Nyack
Community Medical & Dental	Monsey, Spring Valley
Crystal Run Health Care	Middletown, Newburgh, Nyack, Rock Hill
Greater Hudson Valley Family Health Center	Newburgh
Haverstraw Pediatrics	Haverstraw
Institute for Family Health	Hyde Park, Ellenville, Port Ewen, Kingston, New Paltz
Middletown Community Health Center	Middletown, Port Jervis, Washingtonville, Pine Bush
Mount Vernon Neighborhood Health Center	Mount Vernon, Greenburgh, Yonkers
Open Door Family Medical Center	Ossining, Port Chester, Sleepy Hollow, Mount Kisco, Brewster
Westchester Medical Center	Vallhalla

\*Application Goal: 22 sites; recruiting additional sites particularly in Sullivan and Delaware Counties .

Integrating Behavioral Health into Eleven Projects		
	2ai Integrated Delivery System*	An integrated delivery system will build the analytical and care management infrastructure for Population Health Management.
	2.a.iii Health Home At Risk*	An integrated Care Plan alerts BH providers to medical concerns; helps primary care to incorporate patient centered goals.
	2.a.iv Medical Village*	Co-located Medical, behavioral and social services will create opportunities for training workforce in integrated care delivery.
	2.b.iv Hosp Transitions*	Adapt evidence based practices like Medication Reconciliation to address medical re-admissions following BH discharges.
	2.d.i Patient Activation*	Connect patients to regular source of care and to options for insurance coverage; provide links to social services.
	3.a.i BH/PC Integration*	BH professional services at PC site, "warm transfer" of patients who screen positive or need BH services, BH notes in PC record.
	3.a.ii BH Crisis Stabilization*	Improve BH crisis stabilization services throughout seven counties in the PPS service area.
	3.c.i Diabetes*	BH medications exacerbate diabetes; protocols adapted to different practice settings support disease management for all.
	3.d.iii Asthma*	Asthma medications can precipitate anxiety attacks; training BH & HH on asthma treatment to reduce anxiety related ED visits.
	4bi Tobacco Cessation*	A focus of the tobacco cessation work is the BH population including development of training for BH staff.
	4bii Cancer Screening*	BH patients often fail to get routine medical preventive care. Population Health Management tools will help patients, families and BH and primary care to be aware of gaps in care.

\*includes TRAINING for partner staff and/or development of new positions

*Working with providers and organizations in priority communities; integrating best practices for provision of care and identifying staff training needs; and linking patients/clients and their families to social service and community-based groups who support our cultural competency and health literacy strategy.*