Developing Truly Culturally Competent Service Delivery

November 17, 2016

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

NYAPRS Conference

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Agenda

Finger Lakes Performing Provider System

System Transformation

NYS Cultural Competency and Health Literacy Requirements

FLPPS Cultural Competency & Health Literacy Strategy and Training Strategy

Progress-to-Date

Sustainability Plan

Next Steps for FLPPS & Final Takeaway

The Finger Lakes PPS

Our Region Had a Unique Opportunity...

**Rochester Regional Hospital (RRH) & University of Rochester Medicine (URMed)**

- Related missions, deep talent and existing experience collaborating on health care initiatives

13-County Region

- Leverage DSRIP funding to re-design care delivery and improve the health of a large portion of our population (Medicaid & Uninsured)
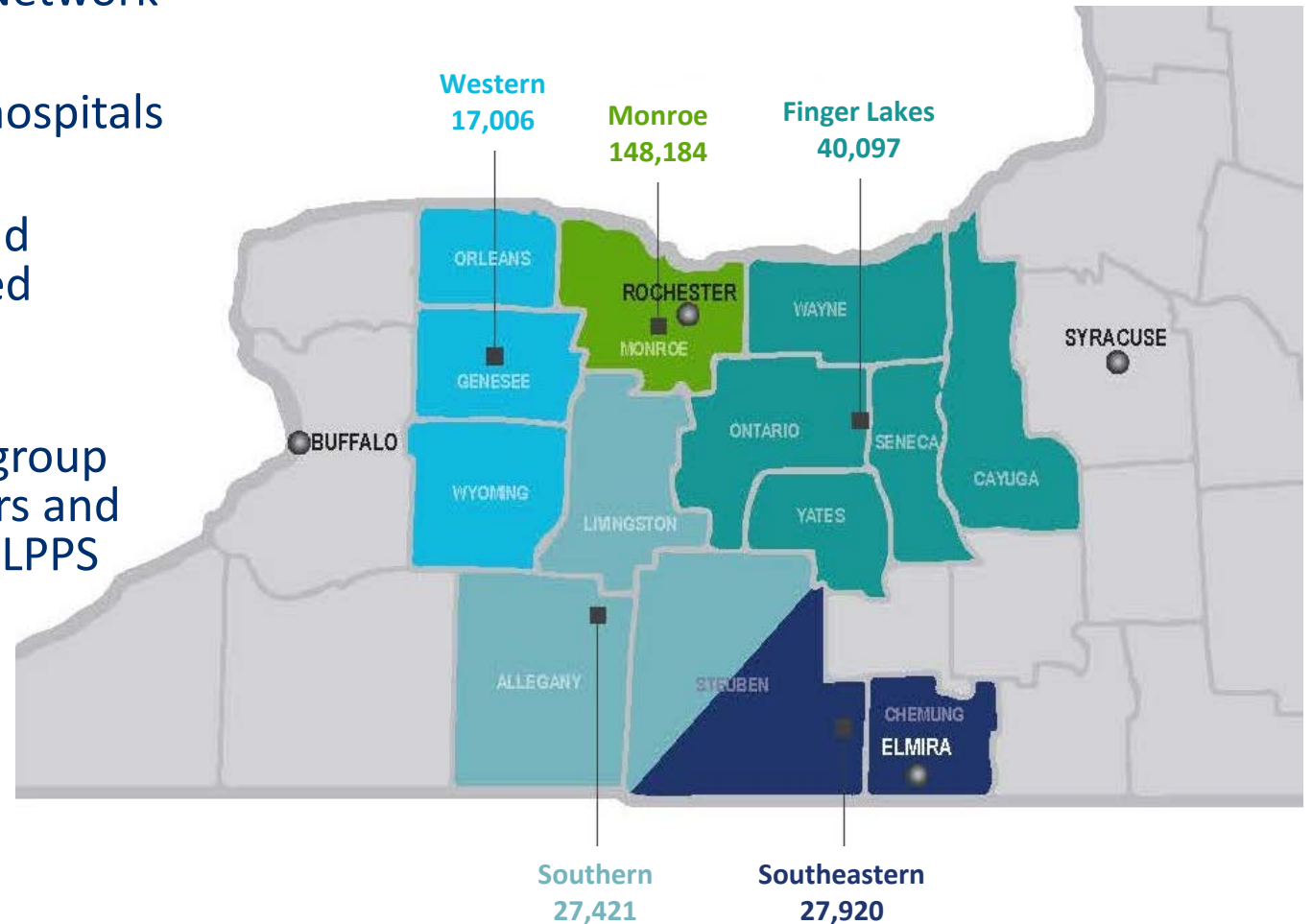
Finger Lakes PPS (FLPPS)

➢ **13 Counties -** Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates

➢ **1.5M Total Population**

➢ **~400,000 Lives (including 100K uninsured)**

➢ **5 Naturally Occurring Care Networks (NOCNs)**

➢ **~600 Partner Organizations**

➢ **19 Hospitals**

➢ **~6,700 Providers** Primary Care, SNF, Hospice, Specialists, Pharmacies, etc.
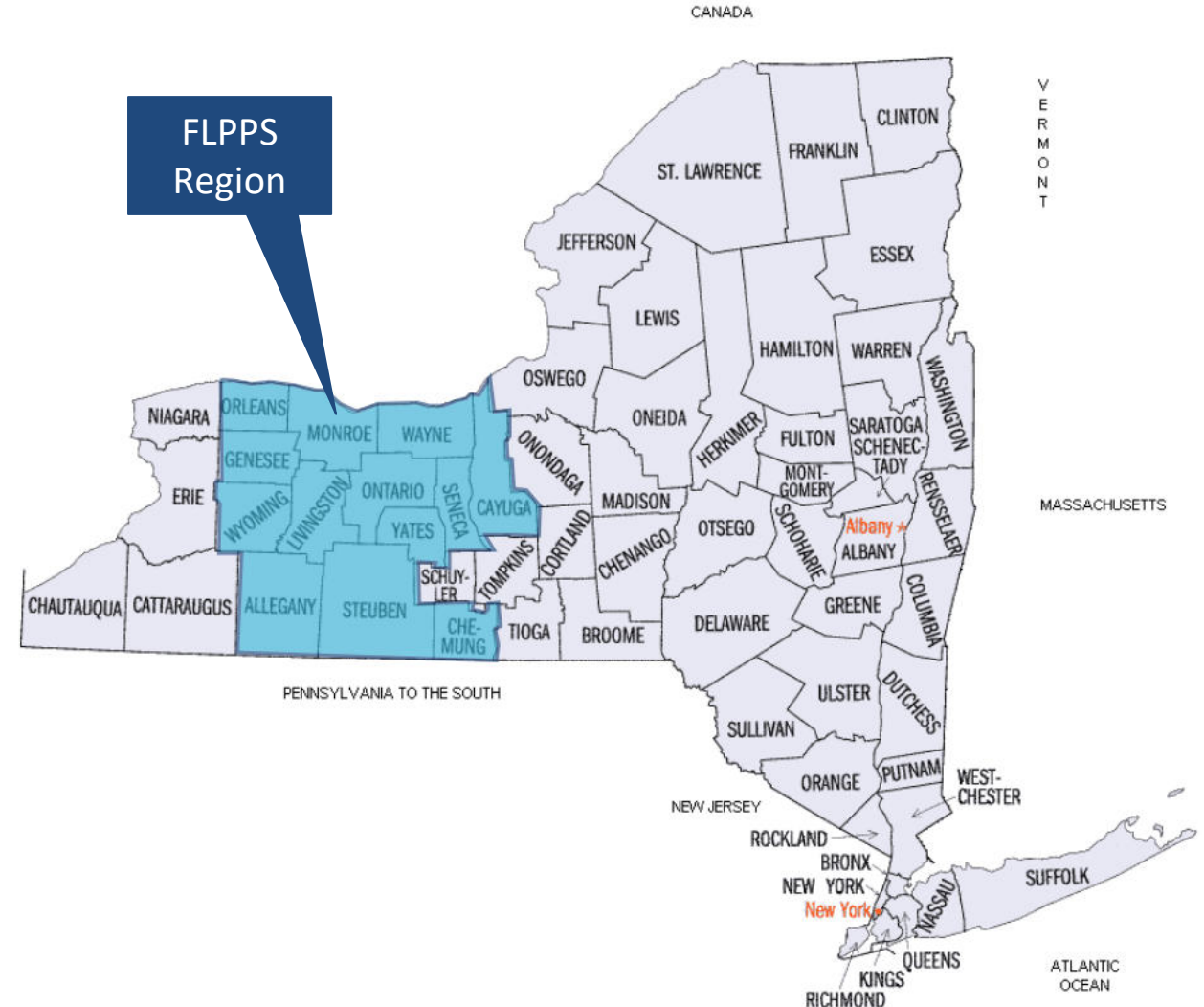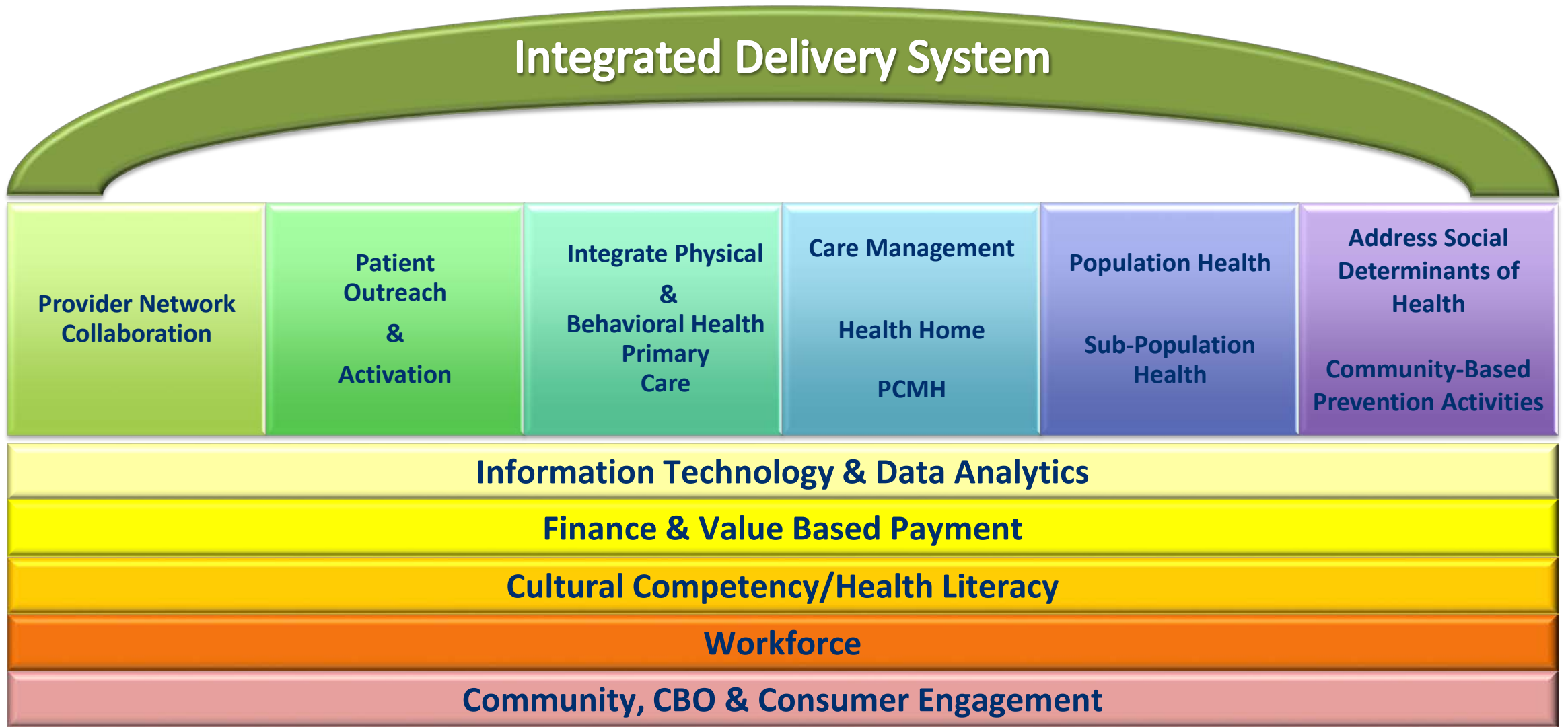

FLPPS Region

Naturally Occurring Care Networks (NOCN)

➢ 5 geographic sub-regions of the FLPPS Network

➢ Based on referral patterns and anchor hospitals

➢ Represent the full continuum of care and organizational leadership within a shared geographic service area

➢ Each NOCN is led by a participant workgroup that represents the health care providers and CBOs in their area and supported by a FLPPS Regional Manager

➢ Workgroups are responsible for organizing local providers by hosting collaborative dialogue and supporting project implementation

Western
17,006

Monroe
148,184

Finger Lakes
40,097

Southern
27,421

Southeastern
27,920

Key Pillars of the IDS

Integrated Delivery System

Provider Network Collaboration	Patient Outreach & Activation	Integrate Physical & Behavioral Health Primary Care	Care Management Health Home PCMH	Population Health Sub-Population Health	Address Social Determinants of Health Community-Based Prevention Activities

Information Technology & Data Analytics

Finance & Value Based Payment

Cultural Competency/Health Literacy

Workforce

Community, CBO & Consumer Engagement

System Transformation

The DSRIP Challenge: Transforming the Delivery System

Reduce Avoidable ER Visits

Reduce Avoidable (re)admissions

Reduce other avoidable complications (diabetes, patients at risk for becoming multi-morbid, crisis stabilization)

Improve patient experience (CAHPS)
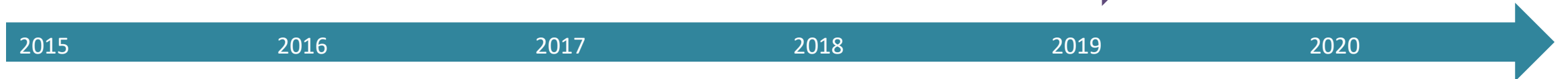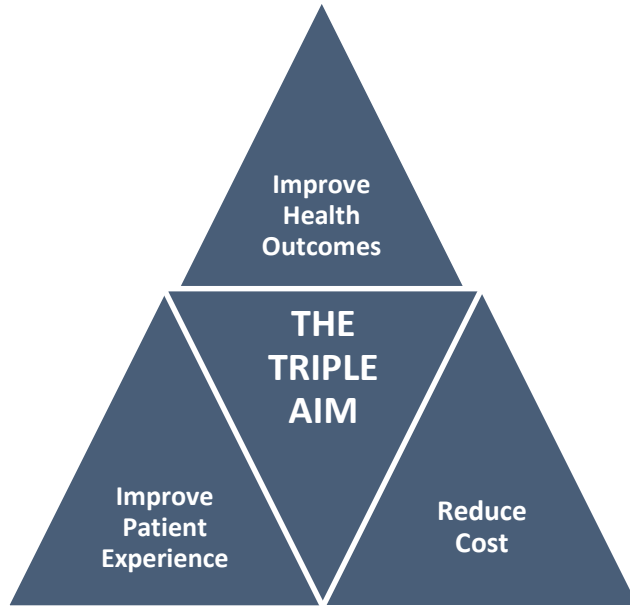
The Path of System Transformation

NYS DSRIP Program → **Integrated Delivery System** → **Value-Based Payment**

Improve Health Outcomes

THE TRIPLE AIM

Improve Patient Experience

Reduce Cost

Transformed Thinking

2015   2016   2017   2018   2019   2020

The Path of System Transformation

➢Care and Services:

✓*Equitable*

✓*Address the Social Determinants of Health*

✓*Culturally and Linguistically Relevant and Appropriate*

✓*Address Health Literacy*

✓*Community Engagement*

Delivery System Transformation
Equitable Healthcare

Delivery System Transformation
Social Factors Contributing to Health Outcomes
Contributing Factors to Premature Death
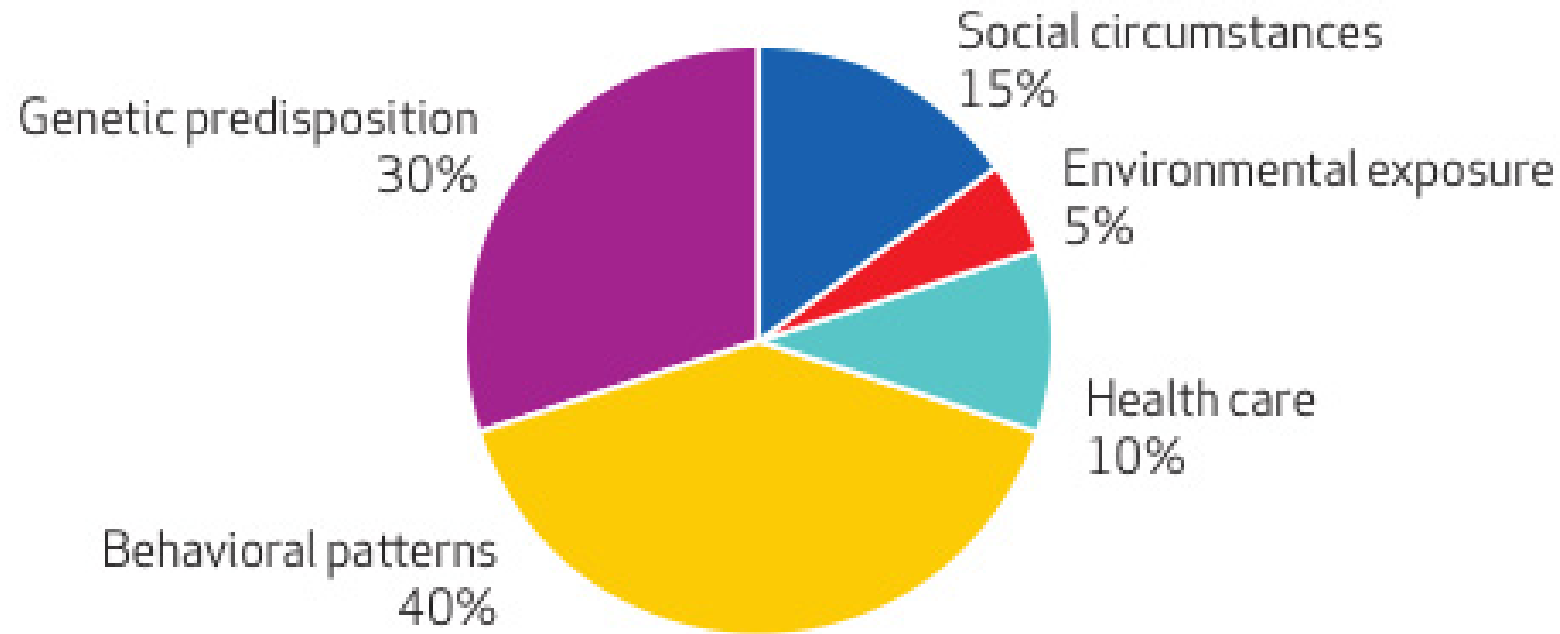
Pie chart: Social circumstances 15%, Environmental exposure 5%, Health care 10%, Behavioral patterns 40%, Genetic predisposition 30%

FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM

Social Determinants of Health

Delivery System Transformation
Culturally Competent Care

Reducing Health Disparities through CC/HL Implementation

Diverse Populations

- Linguistically
- Ethically
- Culturally

Cultural Competency

- Effective techniques
- Sound implementation

Appropriate Services for Diverse Groups

- Preventive
- Screening
- Diagnostic
- Treatment

Improved Outcomes for Diverse Groups

- Health status
- Functioning
- Satisfaction

Reduction of Health Disparities
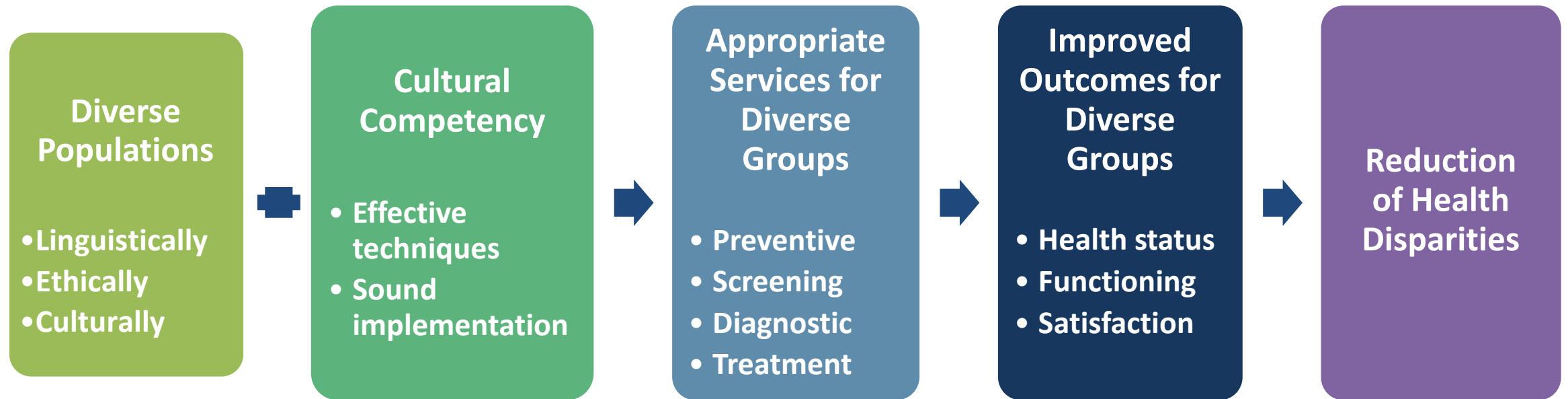
Source: Brach and Fraser, Cultural Competency, 2000

Delivery System Transformation
Culturally Competent Care

Benefits of Becoming a Culturally Competent Practice/Organization

Social Benefits	Health Benefits	Business Benefits
▪ Increases mutual respect and understanding between patient and organization	▪ Improves patient data collection	▪ Incorporates different perspectives, ideas, and strategies into the decision-making process
▪ Increases trust	▪ Increases preventive care by patients	▪ Decreases barriers that slow progress
▪ Promotes inclusion of all community members	▪ Reduces care disparities in the patient population	▪ Moves toward meeting legal and regulatory guidelines
▪ Increases community participation and involvement in health issues	▪ Increases cost savings from a reduction in medical errors, number of treatments, and legal costs	▪ Improves efficiency of care services
▪ Assists patients and families in their care	▪ Reduces the number of missed medical visits	▪ Increases the market share of the organization
▪ Promotes patient and family responsibilities for health	▪ Promotes patient and family responsibilities for health	▪ Promotes patient and family responsibilities for health

(Source: American Hospital Association, 2013)

Community Engagement

PHYSICAL

BEHAVIORAL

SOCIAL

FLPPS IDS

Health

Government

Education

Economic Development
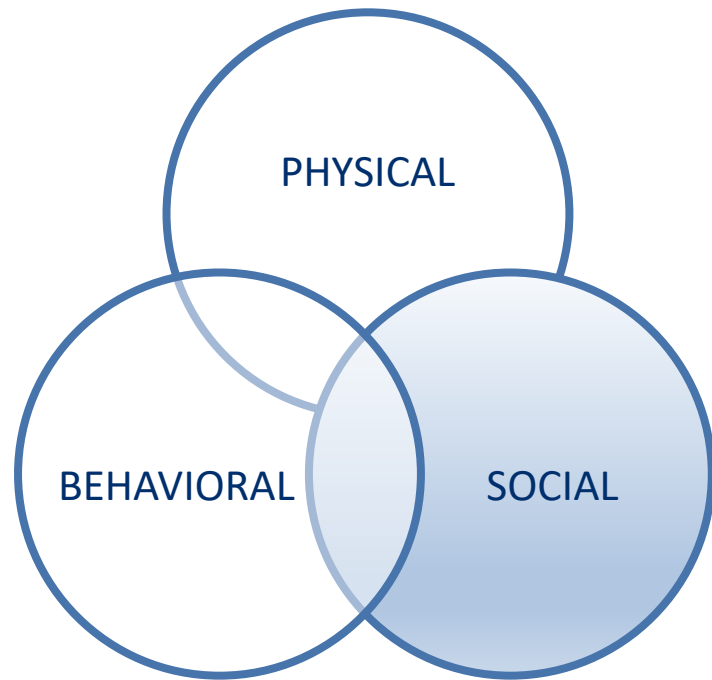
Social Services
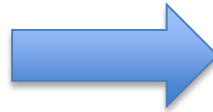
NYS Requirements for Cultural Competency & Health Literacy

Milestone 1 & 2

NYSDOH DSRIP Milestones

Milestone 1
(Achieved January 2016)

- *Finalize Cultural Competence / Health Literacy Strategic Plan*

Milestone 2
(Achieved July 2016)

- *Develop a training strategy focused on addressing the drivers of Health Disparities (beyond the availability of language appropriate material)*

Cultural Competency & Health Literacy Strategy

Milestone 1

NYS MILESTONE 1

Finalize Cultural Competency/Health Literacy Strategy
DOH Minimum Standard Requirements:

- Identifies Priority Groups Experiencing Health Disparities

- Defines Plans for Two-Way Communication with the Population and Community Groups through Specific Community Forums

- Identifies Assessments and Tools to Assist Patients with Self-Management of Conditions

- Identifies Key Factors to Improve Access to Quality Primary Health, Behavioral Health and Preventive Health Care

- Identifies Community-Based Interventions to Reduce Health Disparities and Improve Outcomes

FLPPS CCHL Strategy: ❖5 Strategic Initiatives ❖18 Goals

Key Stakeholder Input

FLPPS CNA, Project and Workstream Objectives

FLPPS CC/HL Committee Members

Patients/Consumers and Community Members

FLPPS Partners

FLPPS Board, Leadership and Staff

FLPPS CC/HL Strategy

FLPPS CC/HL Training Strategy
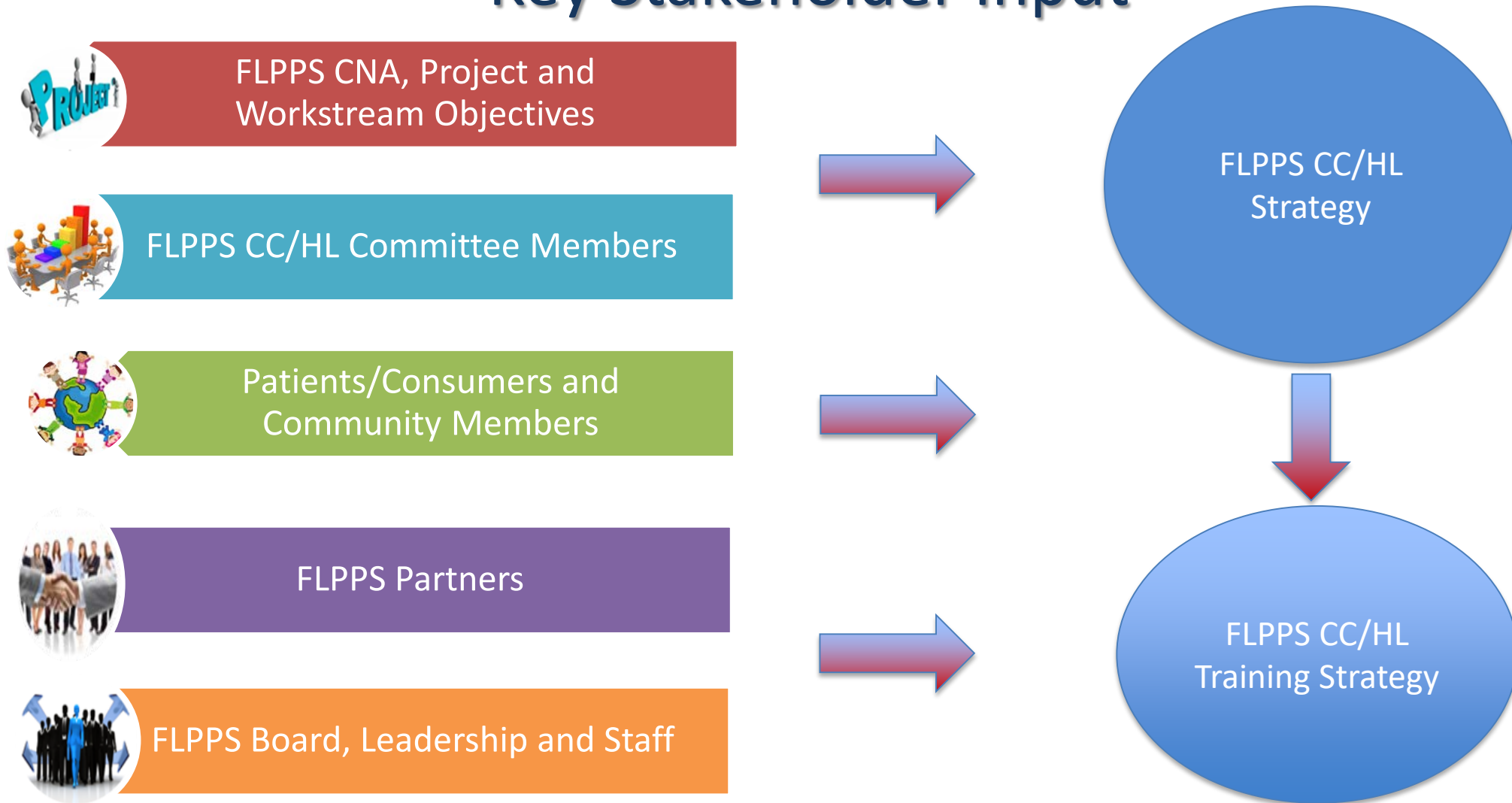
CC/HL Strategic Plan Overarching Goal

To Promote **Patient Voice…**

- Patients' wishes, preferences and values being respected

- Highlights the need to seek patient feedback when it comes to their care and in the Medicaid redesign process

And **Patient Choice…**

- The action of informed decision making

- Requires an innate understanding on the part of the patient/consumer

While Ensuring **High Value Equitable Care.**

- *High Value Care* refers to care that is based on the impact on both cost and quality of life, and the patient's perceptions of value

- *Equity* speaks to the elimination of health disparities, that resources are responsive to the needs and culture of the patients

FLPPS' Priority Populations

African American/Black

American Indian/Alaska Native

Amish/Mennonite Communities

Deaf and Hard of Hearing Individuals

Hispanic/Latino

Homeless Individuals

Those Living in Poverty

Migrant and Seasonal Farm Workers

Mothers, Infants and Children

Individual that Identify as Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)

Refugee

Individuals Diagnosed with:

- An Intellectual or Developmental Disability

- A Mental, Emotional or Behavioral Health Disorder (MEB Disorder)

Cultural Competency & Health Literacy Strategy

CC/HL Strategic Initiatives and Goals

Strategic Initiative #1
Improve Health Outcomes Among Priority Populations in the FLPPS Region

- **Goal # 1:** Identify priority groups experiencing health care disparities

- **Goal # 2:** Establish a process to continually identify and refine our understanding of priority groups experiencing disparities

- **Goal # 3:** Identify existing and/or additional performance metrics that support the monitoring of health care disparities among priority groups.

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

- **Goal # 5:** Educate FLPPS Partners about the importance of patient cultural activation.

Strategic Initiative #2
Promote Patients' Ability To Self-Manage Conditions

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

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

- **Goal # 8:** Assemble tools and resources to support CC/HL principles.

Strategic Initiative #3

IMPROVE ACCESS TO QUALITY PRIMARY HEALTH, BEHAVIORAL HEALTH AND PREVENTIVE HEALTH CARE

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

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

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

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

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

Strategic Initiative #4

UTILIZE COMMUNITY-BASED INTERVENTIONS TO REDUCE HEALTH DISPARITIES AND IMPROVE OUTCOMES

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

- Goal # 15: Work with partners to implement and utilize high-value community-based programs that address heath disparities among priority populations.

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

Strategic Initiative #5

PARTNER WITH POPULATION OF FOCUS AND OTHER COMMUNITY GROUPS TO IMPROVE HEALTH OUTCOMES AMONG PRIORITY GROUPS EXPERIENCING HEALTH CARE DISPARITIES

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

- Goal # 18: Facilitate partner collaboration with community-based organizations.

Cultural Competency & Health Literacy Strategy

FOUNDATIONAL GOALS

Foundational Goals:

➢ *Goal # 1: Ensure that CC/HL is woven throughout FLPPS Central.*

➢ *Goal # 2: Ensure that CC/HL is woven throughout the FLPPS Partnership.*

➢ *Goal # 3: Ensure FLPPS Information Technology (IT) ecosystem incorporates CCHL principles into the data collection, data analysis and data management processes.*

➢ *Goal # 4: Integrate CC/HL into contracting and reporting payment processes.*

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

➢ *Goal # 6: Ensure Corporate Compliance reporting mechanisms include CC/HL strategies.*

Cultural Competency and Health Literacy Training Strategy

Milestone 2

NYS Milestone 2

Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)

- *Training plans for clinicians, focused on **available evidenced-based research addressing health disparities** for particular groups identified in your cultural competency strategy*

- *Training plans for other segments of your workforce (and others as appropriate) **regarding specific population needs** and **effective patient engagement approaches***
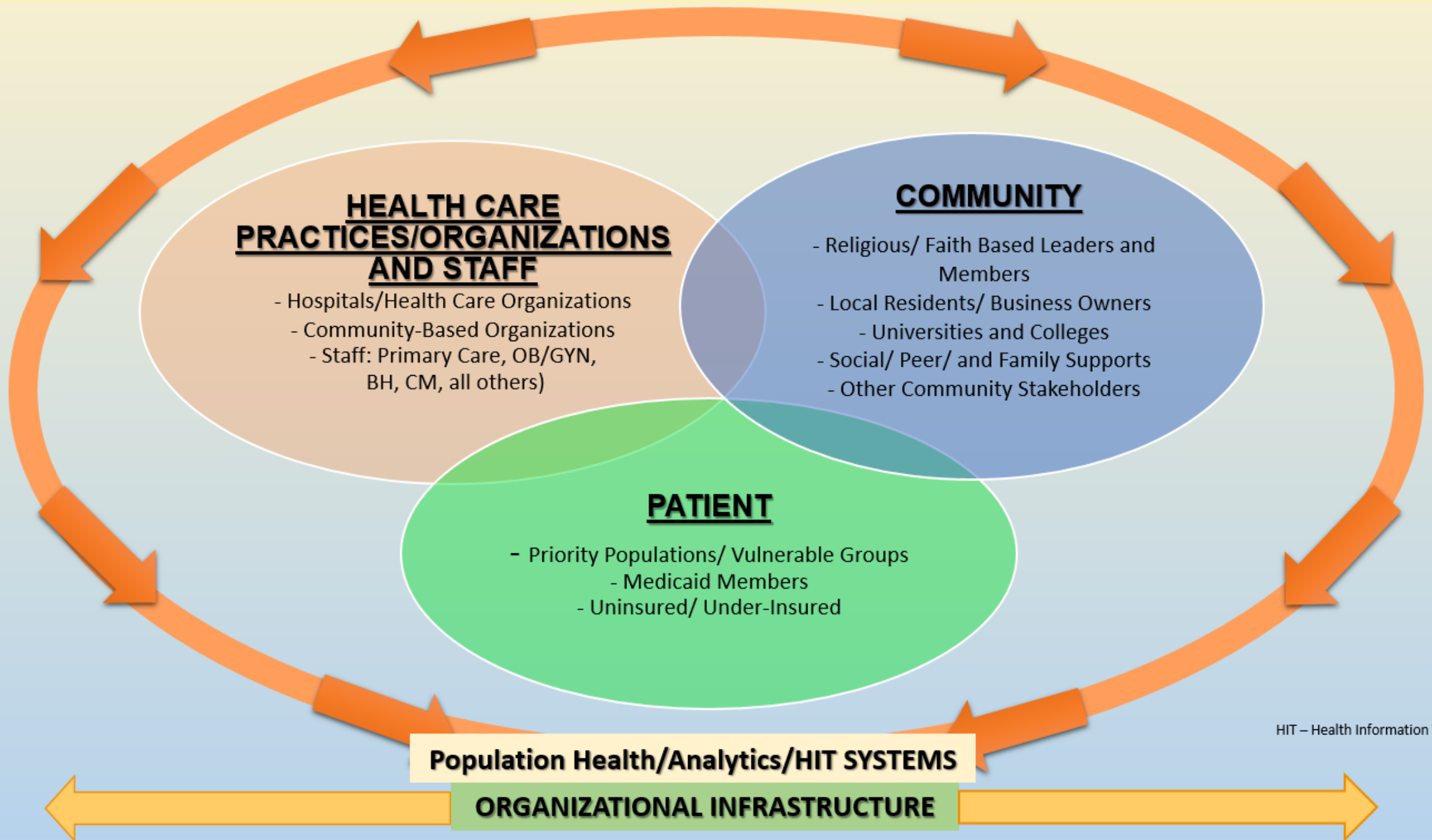
Training Strategy – Conceptual Framework**

Training Audience	Training Approach	Training Methods	Foundational Support	Organizational Support

• Clinicians
• Other Workforce Sectors
• Patients/Consumers
• Community Stakeholders
• Community-Based Organizations
• Social Service Agencies
• Hospitals/Health Care Systems
	• Concept
	• Knowledge-Based Training
	• Skills-Based Training
	• Attitudes-Based Training
	• Training Objectives/Outcomes
	• Evaluation – Measuring Success
	• Communication Plan
		• Train-the-Trainer
		• Modified Learning Collaborative
		• Training Modules
		• E-Learning
		  • Cohort-Based Webinars
		  • CC/HL Training/Educational Resource Repository
		• Community Stakeholder Forums/Community Meetings
		• Community Advisory Councils
		• Cultural Brokers
			• Cultural Competence & Health Literacy Champion
			• Health Information Technology (HIT) & Data Management
			• Workforce Development – Supporting Career Ladders & Strategies for Engaging Colleges and Universities
			• Strategy for Engaging Religious/Spiritual Leaders
			• Strategy for Engaging Community-Based Organizations (CBOs)
				• Organization Infrastructure Support Needed to Achieve Cultural Competence & Health Literacy

**Adapted from Horvat, L., Horey, D., & Kis-Rigo, J, 2014.

TRAINING AUDIENCE

HEALTH CARE PRACTICES/ORGANIZATIONS AND STAFF
- Hospitals/Health Care Organizations
- Community-Based Organizations
- Staff: Primary Care, OB/GYN, BH, CM, all others)

COMMUNITY
- Religious/ Faith Based Leaders and Members
- Local Residents/ Business Owners
- Universities and Colleges
- Social/ Peer/ and Family Supports
- Other Community Stakeholders

PATIENT
- Priority Populations/ Vulnerable Groups
- Medicaid Members
- Uninsured/ Under-Insured

HIT – Health Information Technology

Population Health/Analytics/HIT SYSTEMS

ORGANIZATIONAL INFRASTRUCTURE

FLPPS CC/HL Curriculum

Association of American Medical Colleges (AAMC) Tool for Assessing Cultural Competence Training (TACCT) (AAMC, 2005) – Modified to Develop the FLPPS CC/HL Curriculum.

➢ Curriculum Design:

❑ Knowledge-Based Training

❑ Attitudes Based Training

❑ Skill-Based Training

➢ These core competency training areas will be required for all training audiences, groups and sectors.

Training Methods:

➢ Train -the-Trainer Approach

➢ Modified Learning Collaborative(s)

➢ E-Learning

➢ Cultural Brokers – "influencers"

➢ Patient/Consumer Educational Workshops

➢ Community Stakeholder Forums/Meetings

➢ Consumer Advisory Councils

CC/HL Training: Evaluation – Measuring Success

- Success will be measured by instruments created to identify answers to the following questions:
  - How and to what extent has FLPPS successfully delivered on the proposed CC/HL Training Strategy Outcomes?
  - How have participants/audiences/ groups/sectors responded to CC/HL Training [Pre-Test/Post-Test]?
  - According to training audiences, their supervisors and their patients/ consumers, how and to what extent have the knowledge, attitudes and practices changed for those involved in CC/HL training [Pre-Test/Post-Test]?

Cultural Competency and Health Literacy Training Strategy

The Mental, Emotional, and BH Project:

M.E.B. CC/HL Training Goal and Objectives

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M.E.B. CC/HL Training Goal

FLPPS Contracted Partners and Other Stakeholder Groups Will Demonstrate a Higher Level of MEB Cultural Competency and Health Literacy When Working with Patients/Consumers and other Partners.

M.E.B. CC/HL Objectives

➤ Identified Target Audience: MEB and Allied Professionals, Patients/Consumers, Family and Community Stakeholders

➤ Learning Collaborative(s) That Offer Holistic/Interdisciplinary Training that Includes Practitioners and Staff of All Disciplines.

➤ MEB CC/HL Training Curriculum to Address:

- Misconceptions of MH, the Biases/Prejudices of Providers and Others
- the Promotion and Use of Inclusive Language that is Person-Centered
- Motivational Interviewing Techniques:
  - Promote Consistency in Patient/Consumer Interviews: Consistent Method of Interviewing/Questioning Patients/Consumers
  - Build Meaningful Conversation: Best Practices/Approaches When Meeting and Speaking with Patients/Consumers
- Self-Care and Mindfulness to Educate MEB Practitioners/Staff and Organizational Leaders on the Benefits of Self-Care
- Education for Practitioners/Staff on Community Resources:
  - Practitioners/Staff have an understanding of community resources available to patients/consumers
- The Benefits of Offering a Welcoming Environment:
  - Establish and Maintain Welcoming Environments/Atmospheres for Patients/Consumers

Cultural Competency and Health Literacy

Outcomes & Evaluation Measures

CC/HL: Achievement Outcome Indicators

Patients/Consumers

Achievement Outcome Indicators
- Patients/Consumers are recruited and have committed to participate in the Patient/Consumer Advisory Council.
- Community Stakeholder Forums conducted annually.
- A CC/HL resource repository will be housed on the FLPPS website.
- All patients/consumers and partner organizations will have access to the FLPPS standard brochure for patients/consumers available on the FLPPS website and at partner locations.
- FLPPS will establish social marketing methods to provide information and education on healthcare and health promotion to patient/consumer and the community.
- Shared Decision-Making training and information will be available via training workshops and the CC/HL resource repository on the FLPPS website.

Community

Achievement Outcome Indicators
- Key community stakeholders engaged in developing and implementing educational opportunities and communication strategies to address drivers of healthcare disparities (beyond language).
- Community Stakeholder Forums conducted.
- FLPPS will conduct community training.

CC/HL Training: Achievement Outcome Indicators

Workforce

Achievement Outcome Indicators:
- Contracted clinicians and other workforce Individuals will receive and have access to cultural competence and health literacy training plans.

Organizations

Achievement Outcome Indicators:
- **FLPPS Contracted hospitals, healthcare practices and other partner organizations will complete the Organizational CC/HL Self-Assessment Tool.**
- **FLPPS Contracted hospitals, healthcare practices and other partner organizations will complete the CC/HL Readiness Questionnaire.**
- **FLPPS Contracted hospitals, healthcare practices and other partner organizations will establish cultural competence and health literacy policies and procedures.**
- **FLPPS Contracted hospitals, healthcare practices and other partner organizations will have a CC/HL Strategic Plan in place with an associated budget and individual responsible for carrying out the CC/HL related activities.**

CC/HL Performance Measures Dashboard

CC/HL Performance Measures
DSRIP Clinical Outcomes (focused on health disparities experienced by FLPPS Priority Populations)
Patient Experience
Health Literacy

CC/HL Dashboard: Selected Performance Measures

FLPPS CC/HL Performance Measures	Domain Measures	Reportable for DSRIP Project
Age-adjusted preventable hospitalizations rate per 10,000	Domain 4 – Population-Wide	4.a.iii.; 4.b.ii
Potentially avoidable Emergency Room Visits	Domain 2 – System Transformation	2.a.i.; 2.b.iii.; 2.b.iv; 2.b.vi
Follow-up after hospitalization for mental illness - within 7 days & within 30 days (composite of 2 measures)	Domain 3 Clinical Improvement	3.a.i.; 3.a.ii; 3.a.v.
Controlling High Blood Pressure	Domain 3 Clinical Improvement	Recommended by CC/HL committee due to high prevalence and impact on vulnerable populations
Comprehensive Diabetes care/screening – All four tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor; composite of 2 measures)	Domain 3 Clinical Improvement	Recommended by CC/HL committee due to high prevalence and impact on vulnerable populations
Screening for Clinical Depression and follow up	Domain 3 Clinical Improvement	3.a.i.; 3.a.ii; 3.a.v.
Well Care Visits in the first 15 months (5 or more visits)	Domain 3 Clinical Improvement	3.f.i
Initiation of Alcohol and Other Drug Dependence Treatment (initiation and 2 visits within 44 days; composite pf 2 measures)	Domain 3 Clinical Improvement	3.a.i.; 3.a.ii; 3.a.v.
Adult access to Preventive or Ambulatory Care 20 to 65 and older (composite of 3 measures)	Domain 4 – Population-Wide	2.a.i; 2.b.iii; 2.b.iv; 2.b.vi
Patient experience survey (composite measure)	All Domains	Relevant to all, specific composite components reported to 2.d.i
Health Literacy (QHL13, 14 and 16)	Domain 3 Clinical Improvement	Recommended by CC/HL committee due to high impact on vulnerable populations

Cultural Competency and Health Literacy Strategy

Progress-to-Date

CC/HL Progress-to-Date

10/2014
- ✓ Established CC/HL Committee

7/2015
- ✓ CC/HL Sessions with FLPPS Project Managers

8/2015
- ✓ Secured Experienced CC/HL Vendor (CCSI) to Support Strategy and Implementation
- ✓ Identified Priority Populations
- ✓ Engage Patient Stakeholders

10/2015
- ✓ FLPPS Staff Participate in CC/HL Training

12/2015
- ✓ FLPPS CC/HL Introduction to Network Partners Webinar
- ✓ 36 Partners Complete Organizational CC/HL Assessment (Phase 1)

1/2016
- ✓ 103 Partners Complete CC/HL Readiness Questionnaire

CC/HL Progress-to-Date

2/2016
- ✓ FLPPS Community Forums

3/2016
- ✓ Draft of CC Policy and HL Policy for FLPPS Central
- ✓ NOCN Regional Summits CC/HL Training

6/2016
- ✓ MEB FLOWER Group CC/HL & MEB Training

7/2016
- ✓ Identification of CC/HL Champions in Partner Organizations – 151 Partners

8/2016
- ✓ Established Internal CC/HL Workgroup for FLPPS Central
- ✓ MEB Project - MEB CC/HL Curriculum Workgroup Established

9/2016
- ✓ Inventory of CC/HL and Patient Self Management Tools and Resources on Website
- ✓ Begin Priority Population Educational Presentations

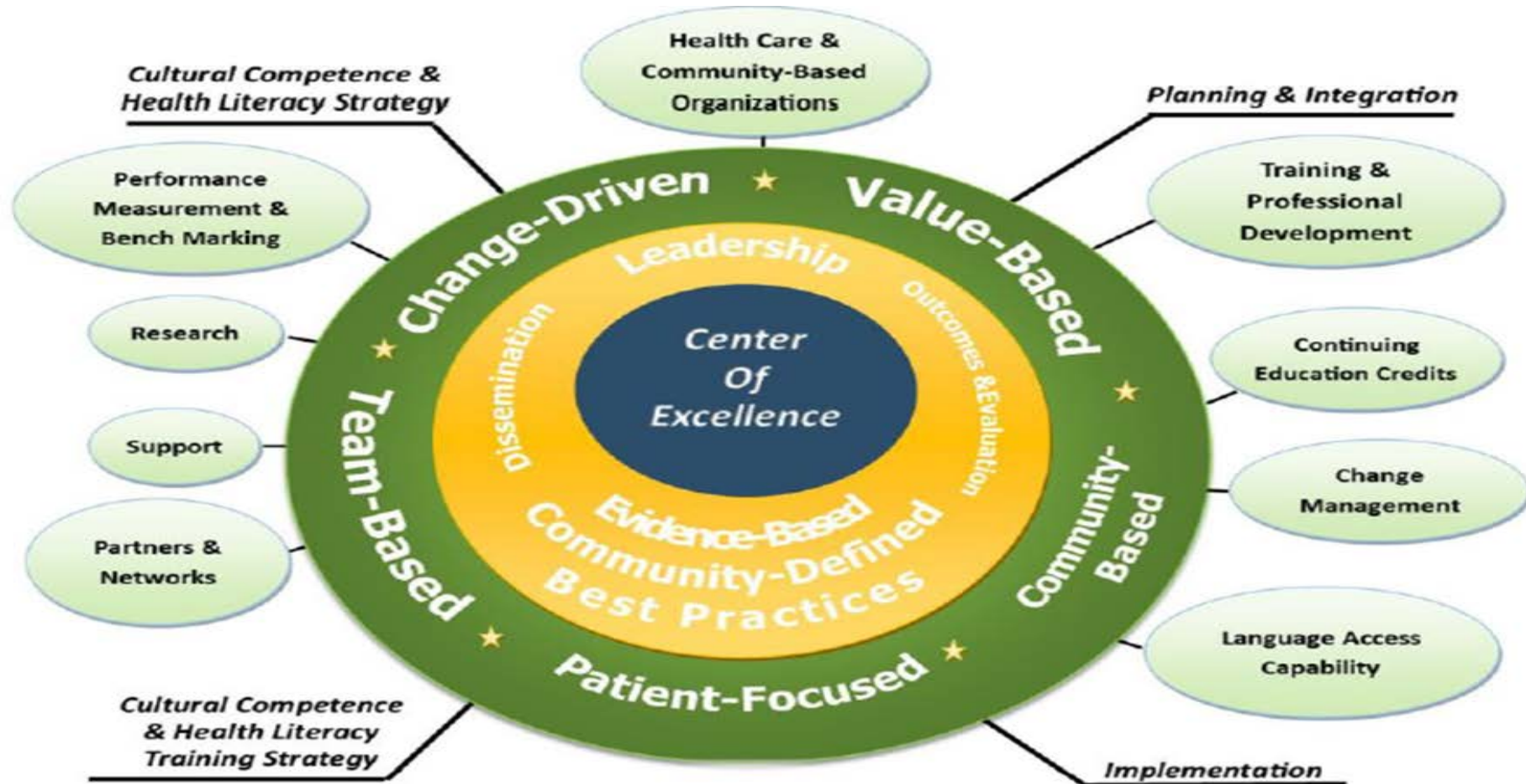# Cultural Competency and Health Literacy Strategy

Sustainability Plan

CC/HL - Ongoing Learning Process

➤ CC & HL is an Ongoing Learning Process

➤ In Addition to Clinical Professionals; Other Workforce Groups, Patients and Community Stakeholders Must be Viewed as an Integral Part of the Ongoing CC/HL Learning Process
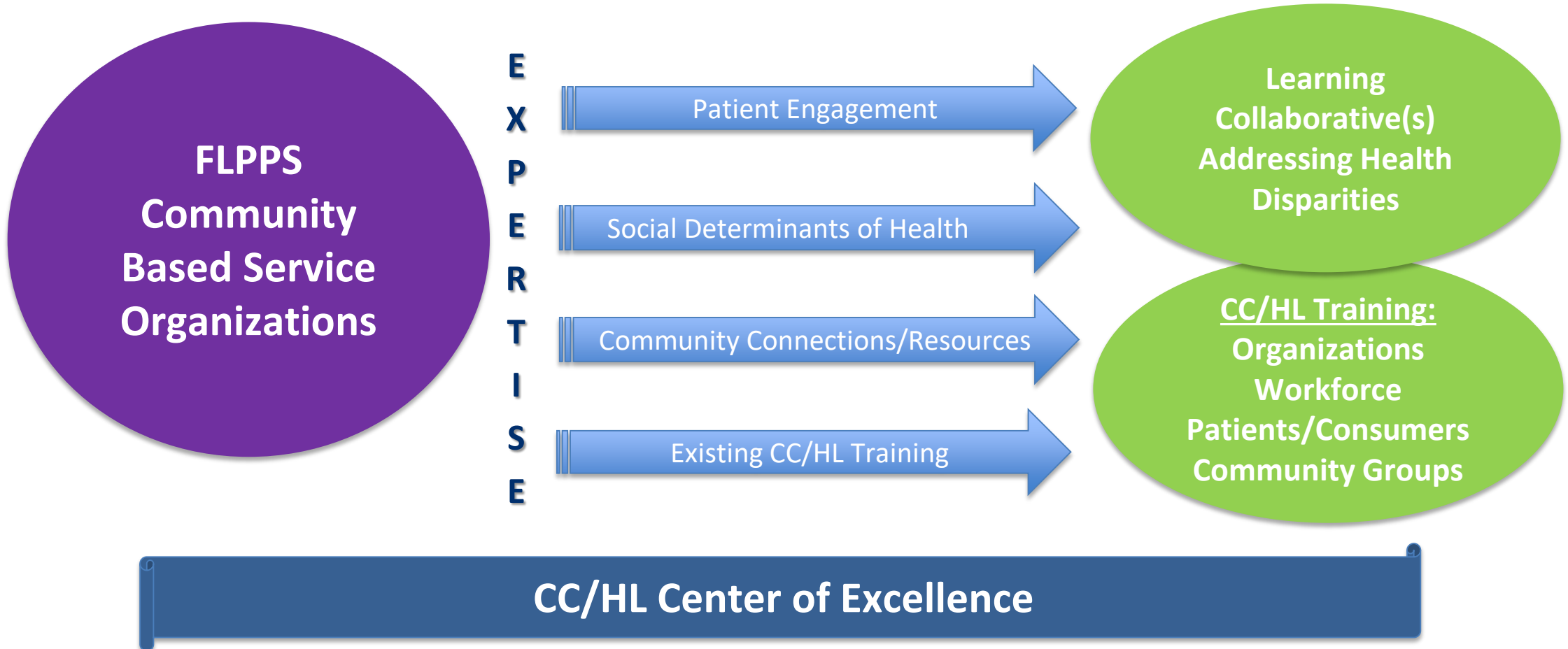
Future State: The CC/HL Center of Excellence

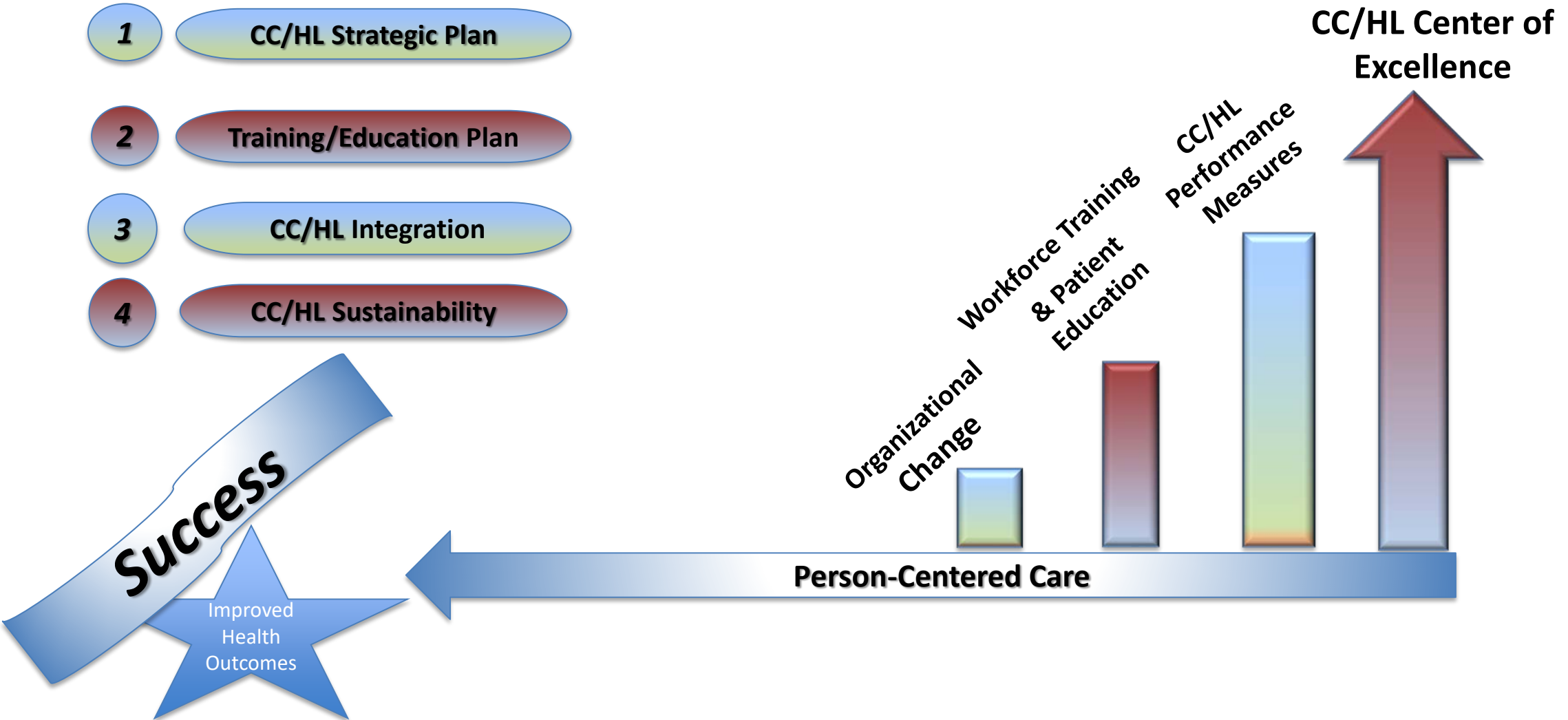Center of Excellence for Cultural Competence & Health Literacy
FLPPS & Its Partners

Critical Partners to the CC/HL Strategy

Community Based Service Organizations Role

FLPPS Community Based Service Organizations

E X P E R T I S E

Patient Engagement →

Social Determinants of Health →

Community Connections/Resources →

Existing CC/HL Training →

Learning Collaborative(s) Addressing Health Disparities

CC/HL Training: Organizations Workforce Patients/Consumers Community Groups

CC/HL Center of Excellence

CC/HL Road Map to Success

1. CC/HL Strategic Plan
2. Training/Education Plan
3. CC/HL Integration
4. CC/HL Sustainability

Organizational Change

Workforce Training & Patient Education

CC/HL Performance Measures

CC/HL Center of Excellence

Person-Centered Care

Success

Improved Health Outcomes

Cultural Competency and Health Literacy Strategy

Next Steps & Final Takeaway

Next Steps for FLPPS

	FLPPS Central	FLPPS Partnership
CC/HL Strategy	- Develop work plan to operationalize CC/HL strategy within the FLPPS Partnership and FLPPS Organization - Incentivized CC/HL Contracting and Reporting Metrics	- Select organizations to begin work to develop CC/HL strategies for their organizations - Work with CC/HL Champions and Organizational Leaders
CC/HL Training Plan	- Role out RFI seeking CC/HL Training Organizations - FLPPS Vendor Selections for CC/HL Training Strategy - Selected Vendors to Receive Training to Promote Consistency with the Training Approach	- CC/HL Trainings Offered to the FLPPS Partner Workforce, Patients/Consumers and the Community - CC/HL Trainings & Tools Accessible via the FLPPS Website

FINAL Takeaway - DSRIP

System Transformation will Benefit **Patients**

➢ The right care at the right time by the right provider

➢ In an integrated, coordinated, culturally competent manner

➢ Improve outcomes

➢ Improve patient experience

➢ Reduce costs

The Triple Aim

Contact Information

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Questions