

New York-Presbyterian/Queens PPS Cultural Competency & Health Literacy Strategy

PLAN OVERVIEW

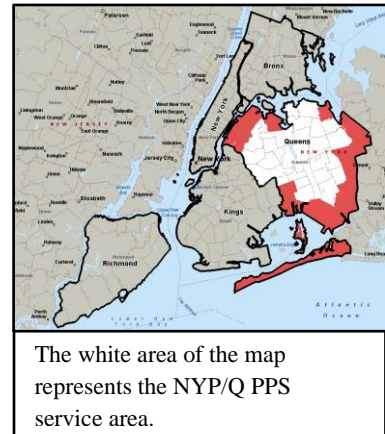
Document Title:	NYP/Q PPS Cultural Competency and Health Literacy Strategy
Version	2.0
Purpose:	To provide a comprehensive overview of the PPS wide strategy for integrating cultural competency & health literacy into the cultures of partner organizations.
Approving Committee:	Executive Committee
Approval Date:	TBD

Table of Contents

OVERVIEW	3
GOVERNANCE	4
DEFINITIONS.....	5
<i>Cultural Competency</i>	5
<i>Health Literacy</i>	5
CULTURAL COMPETENCY & HEALTH LITERACY STRATEGY	5
<i>Identifying factors to improve access to quality primary, behavioral, and preventive care services</i>	5
<i>Surveying partners on current cultural competency and health literacy training/programs..</i>	6
<i>Enhancing communication with the community members on services available and techniques to improve communication during interactions with healthcare providers</i>	6
<i>Deploying assessments/tools to assist patients with compliance on self-management goals</i> .	7
<i>Leveraging community-based interventions to reduce health disparities and improve outcomes</i>	7
TARGET POPULATIONS	8
<i>Macro Approach</i>	8
<i>Micro Approach</i>	9
NEXT STEPS	11
APPENDIX.....	12
<i>NYP/Q PPS Community Needs Assessment</i>	12

OVERVIEW

The NewYork-Presbyterian/Queens PPS is located in the New York City borough of Queens and is comprised of 33 of the 52 zip codes in the County. The PPS is led by the NewYork-Presbyterian/Queens hospital and includes over 134 partner organizations; the PPS partners include skilled nursing facilities, behavioral health providers, hospices, pharmacies, practitioners, substance abuse providers and community based organizations (CBOs). The PPS is located in an immensely culturally and ethnically diverse area of New York City. Based on the community needs assessment (CNA), completed in the fall of 2014 by the NYP/Q PPS, the service area covers a population of 1.6M people and of that population, 629k are Medicaid beneficiaries. This population represents diverse races / ethnicities; approximately 24% Caucasian, 14% Black, 26% Asian, 30% Hispanic, and 4% Other. Additionally, the PPS service area has significant geographic disparity of people living in poverty with the rate ranging from 4.6% (Whitestone zip code 11357) to 23.8% (Jamaica zip code 11433). In addition to the disparities of poverty across the service area, approximately 1 in 4 residents of Queens County are not a U.S. citizen. This diversity within both Queens County, and specifically the NYP/Q PPS service area, drives significant health disparities in the population. The data on health disparities collected during the CNA informed the NYP/Q PPS project selection for DSRIP. The projects selected aim to reduce health disparities and work towards achieving the triple aim of decreasing cost of care, improving the quality of care provided, and improving patient outcomes illustrated by both performance data and an overall reduction in avoidable inpatient and emergency department admissions for the DSRIP population. To achieve these goals, the PPS selected nine projects specific to the Queens County population:



- 2.a.ii Increase certification of primary care practitioners with PCMH certification and/or Advance Primary Care Models
- 2.b.v Care transitions intervention for skilled nursing facility residents
- 2.b.vii Implementing the INTERACT project for SNF

- 2.b.viii Hospital – Home Care Collaboration Solutions
- 3.a.i Integration of primary care and behavioral health services
- 3.b.i Evidence-based strategies for disease management in high risk/affected populations (Cardiovascular Disease – Adults Only)
- 3.d.ii Expansion of asthma home-based self-management program (Pediatric Only)
- 3.g.ii Integration of palliative care into nursing homes
- 4.c.ii Increase early access to, and retention in, HIV care

A key factor to the success of these programs is ensuring a culturally competent staff and a health literate community. This strategy, detailed below, for the NYP/Q PPS provides a high-level plan for what is required to create the cultural shift for incorporating cultural competency and health literacy into everyday patient care. This strategy will continue to grow and reflect the changes in the PPS and patient populations needs.

GOVERNANCE

The PPS formed a cultural competency and health literacy committee, which reports to the PPS Executive Committee, to complete the two milestones assigned to this DSRIP work stream. The committee is led by a chair and vice-chair with expertise in cultural competency and health literacy and has 14 members from representative PPS partner organizations. The committee has for created the overall strategy cultural competency and health literacy and will begin to create the training strategy for the PPS in alignment with the overall goals of the NYP/Q PPS and DSRIP. Additionally, the NYP/Q PPS is collaborating with the workforce committee and the NYP PPS on this work stream to strategic and training plans, streamline resources, and share potential tools / IT solutions across the PPSs and partner networks.

FOUNDATIONAL CONCEPTS

Both the NYP and NYP/Q PPSs will leverage the National Quality Forum’s (NQF)¹ patient-centered approach to cultural competency, known as “A Culture of One”. This framework is built for providers across healthcare entities and will be the basis for the NYP/Q PPS strategy.

¹ : A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency, NQF, April 2009

This patient centered approach of this framework aligns with the PPSs goal of achieving Patient Centered Medical Home (PCMH) status at applicable sites in the PPS. At its core, the strategy for cultural competency and health literacy in the PPS is the patient.

DEFINITIONS

To inform the planning and execution of this strategy, the PPS is utilizing the NQF definition of Cultural Competency and the Department of Health and Human Services definition of Health Literacy²:

- **Cultural Competency** is the ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is patient and family-centered and equitable.
- **Health Literacy** is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

CULTURAL COMPETENCY & HEALTH LITERACY STRATEGY

The goal of the Cultural Competency and Health Literacy strategy is to create a comprehensive PPS wide plan to incorporate these philosophies in to the culture of the PPS and the partner organizations. This strategy focuses on respecting diversity, clear communication with patients and patient’s families, and understanding the health disparities that arise to differences in culture, ethnicity, spoken language, socio-economic status, religion, gender identity, and sexual orientation. To that end, the PPS will focus on:

1. *Identifying factors to improve access to quality primary, behavioral, and preventive care services*
 - a. Through the selected DSRIP projects, the PPS will work to improve access to quality primary, behavioral, and preventative care services at participating partner sites. The NYP/Q service area has a significant shortage of behavioral health

² U.S. Department of Health and Human Services 2000. Healthy People 2010.

providers and the PPS will work with partners to increase the availability of these services.

- b. The NYP/Q PPS will capture data to refine cultural competency and health literacy strategy, including (1) disparity sensitive outcomes, (2) measures associated with cultural competency, and (3) participation in relevant training.
 - c. The success of the integration of cultural competency into the culture of the workforce will be measured on a regular basis; feedback will be provided to network members, through methods such as patient experience surveys to determine the success of the interventions and trainings provided to all participating providers and organizations. These measurements may include employee satisfaction surveys, provider cultural competency pre- and post-training assessments, and patient feedback through forums and/or focus groups to assess cultural competency in care received.
2. *Surveying partners on current cultural competency and health literacy training / programs*
 - a. PPS partners will be surveyed on current training for cultural competency and health literacy, perceived needs for new and/or enhanced training, and community engagement on navigating the healthcare system. The PPS will inventory current training mechanisms and utilize this information to inform an efficient and comprehensive training strategy.
 - b. The PPS will determine, with committee chairs and selected members as needed, any project specific needs related to cultural competency and health literacy.
3. *Enhancing communication with the community members on services available and techniques to improve communication during interactions with healthcare providers*
 - a. PPS partners will provide interpretation services for patients as needed, that includes sensitivity to gender preferences based on religion, domestic abuse status, or personal comfort level. Additionally, PPS community town hall meetings and partners CBOs will be utilized to help inform community members on services, such as interpreters, that are available.

arise around creation of written materials. Materials / trainings on health literacy techniques for delivering verbal information, such as the Teach Back and AskMe3 methods, will also be made available.

- f. The NYP/Q PPS will be updated to include a cultural competency and health literacy section. This will include materials, trainings, resources, and assessment tools for PPS members and patient specific tools to assist with self-management of conditions.
- g. A guidance document for PPS partners which outlines best practices for the provision of cultural and linguistically appropriate care will be developed. Partner organizations and providers will attest to utilizing these best practices in their organizations in line with DSRIP requirements and deliverables.

TARGET POPULATIONS

The PPS will employ both a macro and micro approach as it moved towards development of the training strategy and implementation of the overall strategy. The macro approach for the PPS will ensure an overall understanding of cultural competency and health literacy and will help to drive the fundamental culture shifts that will need to occur across PPS partner organizations. The micro approach will utilize data available to the PPS, both quantitative and qualitative, to target specific segments of the population for engagement and training.

Macro Approach

The PPS will work to ensure that cultural competency and health literacy is a foundational function of all of the project and organizational committees. This will be achieved through presentations from the cultural competency and health literacy committee to the project and relevant organizational committees; the goal of these presentations will be to educate the teams on the strategy and training plan and foster an open dialogue about potential risks and perceived needs. This interaction will continue to inform the progress of the cultural competency and health literacy strategy and training plan and will take into account the high-level needs of:

- Partner organizations
- PPS Workforce

- Patient population
- PPS Committees – clinical and organizational

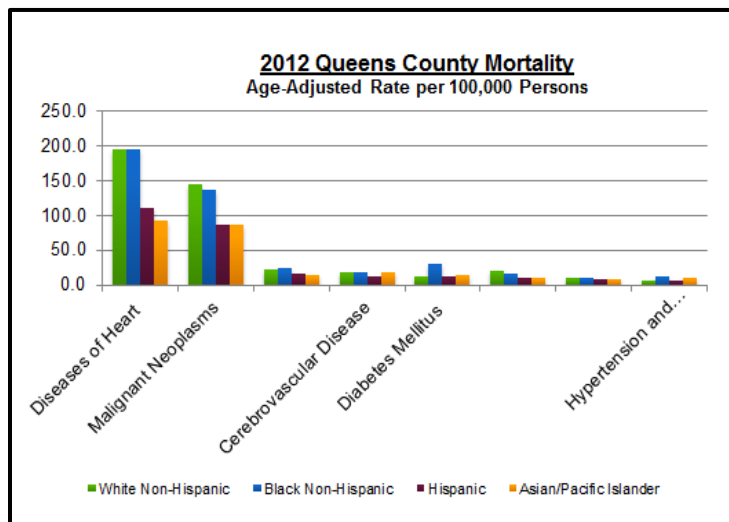
Additionally, the PPS will also present information on cultural competency and health literacy at the ongoing PAC meetings and town hall meetings. These presentations will be conducted on both an annual and adhoc basis to ensure that the committees and stakeholders have an understanding of cultural competency and health literacy and are provided regular updates on changes, successes, and/or lessons learned on the implementation of the strategic and training plan.

This macro strategy for incorporating cultural competency and health literacy will begin to initiate the paradigm shift in culture for the NYP/Q PPS. The goal is for cultural competency and health literacy to become an integral piece of all activities at the PPS level and to expand outward to PPS partners.

Micro Approach

In addition to employing an overall strategy for incorporating cultural competency and health literacy into the philosophy of the NYP/Q PPS, the PPS will also utilize a tactical approach for engaging specific segments of the PPS and population in cultural competency and health literacy. Utilizing the CNA results (quantitative data and qualitative focus groups), the committee has identified several specific areas of the workforce and population to target for cultural competency and health literacy education and training to reduce specific health disparities:

- Racial / Ethnic Specific Patient Populations
 - The PPS will work with CBOs to gain an in depth knowledge of the populations identified in the CNA as having the highest rates of health disparities, such as the Black population (hypertension), Asian population (cerebrovascular disease), and the Guyanese population (behavioral health).



- Sexual Identity
 - The PPS will work to engage both patients and providers in education surrounding the sensitivity of providing care to the LGBT population, especially in regards to behavioral health and HIV/AIDS.
- Pediatric population
 - The pediatric population has unique needs due to consent laws, parental oversight, and access to care. The PPS aims to provide training and education to providers, patients, and guardians, in management of pediatric asthma as a chronic disease.
- Behavioral Health
 - The PPS will work to ensure training for both providers and the community on the necessity for behavioral health, the sensitivity of care in this field, the potential barriers to access, and resources available.

In addition to these groups identified in the CNA, the PPS will be training segments of the workforce on providing culturally competent care:

- Leadership
 - PPS will provide training to leadership of partner organizations on the importance of cultural competency and how it can be integrated into the organization at every level. The PPS will also discuss what health literacy is and how to encourage the patient population to become health literate.
- Clinical providers
 - Cultural competency will be embedded into the annual competency training for all providers across the PPS. The PPS is looking at various mechanisms, including e-based learning modules, to roll out to partners.
- Front line staff
 - Similar to clinical providers, front line staff will be engaged in annual competency training and provided resources for patients who may have specific cultural or health literacy needs during their healthcare encounter.

The workforce training for cultural competency and health literacy will provide the workforce both an introductory level understanding of what cultural competency and health literacy means and how it affects both their patients and their roles in each practice / organization. Additionally, the PPS aims to provide in depth training, in collaboration with partner CBOs and partners that

have expertise in the areas, on specific health disparities, cultural needs of various communities, and how to engage the patients in health literacy.

NEXT STEPS


The NYP/Q PPS will utilize this strategy to inform the detailed cultural competency and health literacy training strategy. The training strategy will be developed in collaboration with the workforce committee to ensure alignment of plans for engagement of the workforce across the PPS. Additionally, the PPS will continue to collaborate with PPS partners and the NYP PPS to develop a robust implementation plan. The training strategy will guide the PPS in training both the workforce across partner organizations and community engagement in understanding health literacy and ensuring they are receiving culturally competency care through tools like TeachBack and AskMe3. The strategy presented for cultural competency and health literacy is intended to be both a guide to the PPS and a philosophy that can continue to grow as the PPS experiences both successes and lessons learned in implementation and amasses new data, both quantitative and qualitative, on the population and provider network.

APPENDIX



NYP/Q PPS Community Needs Assessment

The executive summary of the CNA has been included for reference (NYP/Q PPS was formally the NYHQ PPS). The full CNA including the executive summary, quantitative analysis, and qualitative information can be found under the documents tab on the PPS website:


<http://www.nyhq.org/dsrippps>




Summary and Conclusions - Quantitative






- ▶ The NYHQ service area is home to a large, incredibly diverse, population base that is growing rapidly.
- ▶ Poverty is an issue of concern for this population – particularly the disparity in poverty rates across the service area. Some portions of the service area see as much as ¼ of the population living in poverty.
- ▶ Approximately 1.6M persons in the service area are Medicaid beneficiaries. This is 43% of population.
- ▶ Despite the significant presence of poverty in the service area, mortality rates are relatively low. This may be attributable to several factors, including but not limited to, the following:
 - ▶ Health risk factor data shows that the service area population does not engage in risky behaviors to the extent that populations in comparative geographies engage in these behaviors.
 - ▶ A large percentage of the service area population is Asian (more than 500k Asian residents). Asians are much healthier, as defined by mortality rates, than any other racial/ethnic group.
 - ▶ There are some excellent health care and community resources available to the population base.
- ▶ Two causes of mortality do rank higher in the service area than in other geographies. These are cerebrovascular disease (stroke) and intentional self harm (suicide).
- ▶ The most significant areas of concern from a morbidity, or disease prevalence, perspective are cardiovascular disease and behavioral health. These two diseases result in almost 300k admissions and another 300k ED visits annually in Queens County.


2
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Summary and Conclusions - Quantitative

- ▶ The service area has a high rate of preventable readmissions, suggesting that there may be difficulty with coordination and transitions of care across providers, and from acute to post acute.
- ▶ Provider demand for the DSRIP population exceeds the supply of safety net providers in the area. Perhaps most concerning are the areas in the west and northwest of the service area that have little to no safety net providers, yet have a high concentration of Medicaid beneficiaries.
- ▶ Geographic disparity in the availability of resources (both health care resources and community resources) is significant. Roll out of new strategies should not be concentrated in the areas with current providers, but should focus on pockets of the service area that are underserved.
- ▶ Demand ratios indicate that the area is not over-bedded as it relates to acute care or SNF beds. Low bed rates and high occupancy may be appropriate as the focus shifts to outpatient and home care.
- ▶ There are not enough behavioral health resources to meet demand.
 - ▶ Fewer than 150 behavioral health beds in area hospitals, yet ~150k behavioral health admissions in the County. Hospitals are forced to admit behavioral health patients to med/surg beds.
 - ▶ More than 200k behavioral health ED visits suggest that outpatient resources are inadequate.
- ▶ Community resources are available, but perhaps not at a level to meet demand, particularly with housing and food. In addition, the area has not seized opportunities to create healthier places.

3
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Summary and Conclusions - Qualitative



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- ▶ Patrons have a strong interest in community based services that address the needs of residents holistically in order to prevent hospitalization and promote good health.
- ▶ Recommendations were made to include community residents when making decisions.
- ▶ Physical health issues such as diabetes, hypertension, heart disease, cancer, and HIV are of the largest concern.
- ▶ The perception of services include general concerns that providers are more interested in profit than taking care of their health.
- ▶ There is a general avoidance of doctors unless something serious, a preference for food as medicine, and an interest in alternative medicine and healing.
- ▶ The need for affordable and quality dental care as well as primary care and specialty care doctors in immigrant communities is present (linguistically & culturally competent).
- ▶ Mental health is an urgent priority as well as the need to overcome the social stigma of mental illness, particularly in immigrant communities.
- ▶ Suicide is considered a major issue with the 2014 CDC report indicating suicidal ideation among Latina adolescents in Queens up from 11% to 20%, and attempts up from 9% to 15%.

4

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Summary and Conclusions - Qualitative



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- ▶ There are concerns with tobacco and casino industries targeting Asian Americans.
- ▶ Stigmas and the lack of culturally and linguistically services are considered challenges in addressing mental health issues.
- ▶ An overwhelming concern is the reduction in the availability of community based mental health services.
- ▶ The community supports the concept of Community Health Workers, Care Coordinators / Case Managers, and Health Education.
- ▶ Community resources of concern are; access to healthy & affordable food, the need for physical activity with few recreational areas and lack of time, and the fear of public parks due to violence.
- ▶ Affordable housing is a concern and transportation is considered inadequate for the growth of the population.
- ▶ Special populations outlined in the community include; older adults with multiple chronic conditions, individuals who are hearing impaired, Long Term Care residents who have limited medical options, homeless who have a high utilization of healthcare resources, immigrants, LGBT individuals, and undocumented community members.

5

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