Advocate Community Providers (ACP)
Health Literacy and Cultural Competency Strategic Plan

ACP Mission

ACP's mission is to convene safety-net providers, partners and other stakeholders to create a patient-centered, comprehensive and coordinated service care model to meet the needs of Medicaid members.

We are committed to transforming the public health system to a sustainable and integrated continuous care delivery system.

No more sitting in the emergency room: together, we will change healthcare for the better.

ACP Vision

ACP's network of physicians, specialists, community-based organizations and other providers delivers high-quality, patient-centered care in a comprehensive, coordinated, and accessible manner to individuals and families participating in the Medicaid program.

ACP physicians and clinical teams are from these communities. We speak the language and understand the culture.

We are here to work with all family members – and health care providers – to practice preventative, total care that's integrated. From infancy to elder care, we are here for every Medicaid member.

Purpose of Plan

The National Institutes of Health and the New York State Department of Health have provided evidence that organizational cultural competency and efforts to promote health literacy have a positive impact on health outcomes. The purpose of this plan is to provide a framework for:

- Cultural competency, or the ability to tailor the delivery of care to meet patients' social, cultural, communications and linguistic needs.
- Health literacy, or the degree to which individuals have the capacity to obtain, process, communicate and understand basic health information and services in order to make appropriate health decisions.

ACP's mission and vision will help guide its cultural competency and health literacy efforts to establish a culturally responsive care system, promote and maintain health literacy and meet workstream milestones and deliverables.

CCHL Advisory Committee

As part of its implementation plan, ACP formed the Cultural Competency and Health Literacy (CCHL) Advisory Committee, comprised of key PPS stakeholders and partners. The task of this committee is to provide feedback on the completion of the two milestones related to the CCHL work stream:

- Milestone 1: Finalize a cultural competency/health literacy strategy (December 31, 2015)
- Milestone 2: Develop a training strategy focused on addressing the drivers of health disparities (June 30, 2016)

Important Elements of Plan

1. *Community Engagement*: ACP will use the neighborhood medical practice as the organizing principle for community engagement. ACP medical providers are located throughout the four boroughs and specifically in neighborhoods where there are large concentrations of Medicaid recipients, thus representing a significant opportunity for impact. Additionally, the CCHL Strategic Plan will integrate with ACP's *Community Engagement Plan* in order to align CCHL initiatives with a multipronged strategy for engaging CBOs, schools, faith-based organizations, community health workers and community members.

2. *Health Advisory Committees*: ACP will convene Health Advisory Committees comprised of patients, families, caregivers and community members across the four boroughs we serve. These committees will serve to increase awareness of local health issues affecting communities, advocate for increased health education and access to resources and services, and liaise between neighborhood medical practices, community-based organizations and community residents to address health disparities. As a starting point, ACP will recruit community members within a "hotspot" area to pilot the model (i.e., build the team, develop the committee structure, prepare members for their role, empower the team to develop a clear scope of work). Building on the experience of the pilot model, ACP will determine the speed and scale of implementation.

3. *Alignment of Strategy with Patient Centered Medical Home (PCMH) Requirements*: The goal of PCMH certification is to improve the quality, effectiveness and efficiency of primary care to better meet the needs of patients. The core features of PCMH standards integrate and are compatible with the concepts of cultural competency and health literacy. This represents

an opportunity for alignment with regard to incentives, tracking and reporting, as an estimated 400 PCP medical offices within the ACP network transform their practices into high-value health care systems that provide whole-person care. As part of this initiative, ACP will contract with vendors that will oversee the PCMH certification process. The CCHL Workgroup will work closely with PCMH vendors to ensure inclusion of requirements related to cultural competency/health literacy into a standardized certification process, but the final list of PCMH elements and factors that will be tracked for reporting purposes will hinge on negotiations with these vendors. Additionally, the actual number of PCP medical offices that will undergo PCMH transformation has yet to be determined.

Objectives

1. Identify priority groups experiencing health disparities.
2. Identify key factors to improve access to quality primary, behavioral health and preventive health care.
3. Define plans for two-way communication with the population and community groups through specific community forums.
4. Identify assessment and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors).
5. Identify community-based interventions to reduce health disparities and improve outcomes.

Implementation Plan

Objective 1: Identify priority groups experiencing health disparities.

Plan	Deliverables	Interdependencies	Metrics/Evaluation
Identify and map the "hotspots" in the service area as it pertains to health disparities.	"Understanding Our Health Disparity Hotspots" report, a living document that analyzes the zip codes and neighborhoods with the most pressing health needs among ACP's targeted Medicaid population. Evaluate demographic trends and prevalence rates throughout the ACP network in order to develop a plan to address health disparities that incorporates	Finalized network list of ACP medical providers, categorized and mapped according to provider type (IT Systems). ACP Medicaid beneficiaries prevalence data on progressive chronic diseases, severe mental illnesses, behavioral health	Ongoing annual hot-spotting as new demographic, medical utilization and prevalence data becomes available.

	outreach, education, communications and engagement.	disorders, cardiovascular diseases, diabetes, asthma, tobacco; as well as rates for hospital admissions and chronic disease screening (Project Management). Develop series of media hits regarding healthcare disparities, challenges, opportunities and needs throughout Manhattan, Bronx, Brooklyn and Queens (Communications).	
Integration of CCHL to PCMH certification.	Through close collaboration with PCMH vendors, standardize factors of PCMH 3, Element A: Patient Information/Electronic Health Records (EHRs): • Factor 3: Race • Factor 4: Ethnicity • Factor 5: Preferred Language	Develop "mini-lessons" – elaborated with input from CBO partners – for medical providers and their staff on the importance of accurately capturing information on: • Race, Ethnicity and Preferred Language. • Communication needs (hearing, vision and cognition). Reinforce lessons through visits to providers, as well as through ACP website and/or providers' portal (Physician Engagement and Communications).	Track the following factors on PCMH Reporting Checklist: • PCMH 3, Element A: Factors 3,4,5

Objective 2: Identify key factors to improve access to quality primary, behavioral health and preventive health care.

Plan	Deliverables	Interdependencies	Metrics/Evaluation
Launch fact-finding campaign to gauge the needs of ACP medical providers on issues related to cultural competency and health literacy.	Physician focus groups on patient education materials and other issues related to CCHL to gauge provider needs, and collect and share best practices within the ACP network.	Hold meetings with key physicians and stakeholder organizations coordinated through PAC leadership council and/or CCHL Advisory Committee.	Ongoing review of provider needs and CCHL best practices.
Complete compilation of CCHL best practices for improving patients' health outcomes.	"Best Practices in Health Literacy and Culturally Responsive Care" report, a living document that highlights evidence-based best practices that can be put into action to train staff, educate patients and improve health outcomes. The document will guide the elaboration of the training strategy to address the drivers of health disparities (CCHL Milestone 2).	Convey CCHL best practices through ongoing appointments with medical providers and regular newsletters (Physician Engagement and Communications).	
Identify key CBOs and partner organizations that can deploy resources within the PPS to increase cultural competency and health literacy.	"Health-related CBOs in NYC" report, a modifiable list of nonprofits that could potentially serve as strategic partners, informing ACP's community-based health promotion and population health management efforts, in addition to assisting in the deployment of resources within the PPS.	Integrate compiled list of CBOs related to ACP clinical improvement and population-wide projects (Project Management).	Ongoing review of compatibility and feasibility of CBOs and ACP work scopes.
Establish inventory of online resources that can be deployed and accessed to increase cultural competency and health literacy across the network.	"Inventory of Online Resources Related to CCHL" report, a modifiable list that includes survey and assessment tools, organizational action plans, patient education materials and online training programs. List to be posted onto ACP website.	Integrate online resources onto ACP website and/or providers' portal (Communications).	Ongoing review of CCHL online resources.

Conduct Health Literacy Assessment to review CCHL efforts in the PPS and determine gaps in best practices, as well as which best practices to leverage as a network strategy.	Analyze Health Literacy Assessment data, evaluate service gaps in the ACP network and identify the areas with the largest opportunities for improvement.	Schedule appointments with providers for walking interviews (Physician Engagement).	Number and percentage of medical practices assessed. Tabulation of assessment results and compilation of individual provider written reports.
Integration of CCHL to PCMH certification.	Through close collaboration with PCMH vendors, standardize the following factor of PCMH 5, Element B: Referral Tracking and Follow-Up (**MUST PASS**): • Factor 6: Include relevant demographic information in referrals (i.e., communication needs, primary language, and cultural/ethnic background).	Develop "mini-lessons" for medical providers and their staff on documenting and imparting information on: • Race, Ethnicity and Preferred Language. • Communication needs (hearing, vision and cognition). (Physician Engagement)	Track the following factors on PCMH Reporting Checklist: • PCMH 5, Element B: Factor 6 (**MUST PASS**)

Objective 3: Define plans for two-way communication with the population and community groups through specific community forums.

Plan	Deliverables	Interdependencies	Metrics/Evaluation
Work closely with neighborhood medical practices to develop a clearly defined health communication strategy aimed at enhancing the waiting room experience.	Develop and disseminate community health information that is accurate, accessible, and culturally and linguistically appropriate (based on Community Health Profiles reports developed The New York City Department of Health and Mental Hygiene); promote changes in our providers to improve health information, communication and informed decision-making.	Work with CBO partners and Health Advisory Committees to bring forward specific health issues affecting local communities. Develop and design content of educational materials (Communications). Monitor and oversee distribution and uptake of community health information (Physician Engagement).	Track the number of medical practices displaying Community Health Profiles information. Ongoing communications with medical providers to gauge effectiveness of plan in prompting informed discussion.
Integration of CCHL to PCMH certification.	Through close collaboration with PCMH vendors, standardize factors of PCMH 1, Element C: Electronic Access: • Factor 5: Establish two-way communication with patients through website, patient portal or email. • Factor 1: Provide patients with online access to their health information. • Factor 2: Allow patients to download health information and/or transmit it to a third party. Standardize the following factor of PCMH 6, Element C: Measure Patient/Family Experience:	Full integration of PCP medical practices within EHRs (IT Systems). Elaborate patient satisfaction survey template following CAHPS specifications and translate into various languages (Physician Engagement).	Track the following factors on PCMH Reporting Checklist: • PCMH 1, Element C: Factors 5,1,2 • PCMH 6, Element C: Factor 1

	• Factor 1: Conduct survey to evaluate patient/family experiences related to access, communication, coordination of care, and whole-person care/self-management support.		

Objective 4: Identify assessment and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors)

Plan	Deliverables	Interdependencies	Metrics/Evaluation
Integration of CCHL to PCMH certification.	Through close collaboration with PCMH vendors, standardize factors of PCMH 4, Element B: Care Planning and Self-Care Support (**MUST PASS**): • Factor 4: Work with patients to develop a self-management, or individualized care plan. • Factor 1: Incorporate patient preferences and functional/lifestyle goals to individualized care plans. • Factor 3: Work with patients to assess and address barriers to achieving functional/lifestyle goals. • Factor 5: Provide individualized care plan in writing considering health literacy and language. Standardize the following factors of PCMH 2, Element B: Medical Home Responsibilities: • Factor 4: Provide educational resources regarding specific health issues. • Factor 7: Provide information (i.e. brochures, point of contact information) to patients about potential sources of insurance coverage. Standardize the following factor of PCMH 2, Element C: Culturally and Linguistically Appropriate Services: • Factor 4: Provide printed materials in the languages of patient population.	Elaborate individualized care plan templates for clinical improvement projects (Project Management). Establish organizational process for assessing content and readability of educational materials (Project Management and Communications). Distribute and foster use of the AHRQ Universal Precautions Toolkit (Physician Engagement and IT Systems). Convey healthy literacy best practices such as **Teach-back** and **Ask Me 3** through ongoing appointments with medical providers and regular newsletters (Physician Engagement and Communications).	Track the following factors on PCMH Reporting Checklist: • PCMH 4, Element B: Factors 4,1,3,5 (**MUST PASS**) • PCMH 2, Element B: Factors 4,7 • PCMH 2, Element C: Factor 4 • PCMH 3, Element C: Factor 10

	Standardize the following factor of PCMH 3, Element C: Comprehensive Health Assessment: • Factor 10: Assess health literacy levels; apply health literacy principles utilizing the AHRQ Universal Precautions Toolkit.		

Objective 5: Identify community-based interventions to reduce health disparities and improve outcomes.

Plan	Deliverables	Interdependencies	Metrics/Evaluation
Establish a base of community support for ACP projects and activities through Community Based Organizations Partnership Program (CBOPP).	Develop and sign partnership agreements with CBOs within ACP target area through a process initiated by a request for information (RFI). Involvement of CBOs in a range of community engagement activities, including: • Health promotion and education • Cultural competency • Disease management education • Navigation of healthcare system • Advocacy and event planning	Coordination of community forums related clinical improvement and population-wide projects (Project Management).	Ongoing communications with community members and groups to track identified CCHL needs and evaluate if they are being addressed.
Integration of CCHL to PCMH certification.	Through close collaboration with PCMH vendors, standardize the following factor of PCMH 6, Element D: Implement Continuous Quality Improvement (**MUST PASS**): • Factor 7: Set goals and address at least one identified disparity in care/service for vulnerable populations.	Work closely with medical practices – with input from CBO partners and Health Advisory Committees – to address barriers to quality care/service for vulnerable populations (IT Systems and Physician Engagement).	Track the following factor on PCMH Reporting Checklist: • PCMH 6, Element D: Factor 7 (**MUST PASS**)