

Cultural Competency and Health Literacy Strategy

Prepared by the Albany Medical Center Hospital PPS
PMO & Cultural Competency and Health Literacy
Committee (CCHLC)

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Introduction/Background

The Albany Medical Center Hospital (AMCH) Performing Provider System (PPS) was created in response to the New York State Department of Health's (NYSDOH) Delivery System Reform Incentive Payment (DSRIP) program. Within the PPS structure, the Cultural Competency and Health Literacy Committee (CCHLC) was formed as one of the sub-committees under the Project Advisory Committee (PAC) to:

- Identify cultural competence and health literacy challenges for the AMCH PPS to overcome.
- Build a strategic plan to develop a culturally competent organization and a culturally responsive system of care.
- Pursue initiatives to promote cultural competency and health literacy in participating organizations' mission, structure, and operations.
- Collaborate with community-based organizations (CBOs) to achieve and maintain cultural competence and health literacy.

Purpose of the Cultural Competency and Health Literacy Strategy

The AMCH Cultural Competency and Health Literacy (CC/HL) Strategy provides information to the AMCH PPS providers on: 1) priority groups experiencing health disparities, 2) key factors to improve access to quality primary, behavioral health, and preventive health care, 3) assessments and tools to assist patients with self-management of conditions, and 4) community-based interventions to reduce health disparities and improve outcomes. The CC/HL Strategy also offers a list of actionable items, such as a two-way communication plan with the community in an effort to address identified health disparities. This document is intended to provide guidance and available resources to the AMCH PPS providers who are participating in the DSRIP initiative.

Definitions of Cultural Competency and Health Literacy

Cultural competence is defined as “the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”¹ As the nation becomes increasingly diverse, the U.S. health care system faces the challenge of addressing patient’s unique cultural and linguistic needs. Failing to meet these needs can lead to health disparities, poor health outcomes, and limited health care access, all of which have serious implications on overall population health and rising health care costs. Thus, the AMCH PPS recognizes the significant need to address health disparities with culturally and linguistically competent care in order to achieve the DSRIP’s overall goal of reducing 25% of avoidable hospital uses by 2020.

Health literacy is known to affect patients’ ability to navigate the health care system, share personal information, and engage in self-management. According to the Institute of Medicine, 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.”² Patients with low health literacy often utilize the emergency department as their primary source of care, and lack understanding about self-care and prevention strategies. The AMCH PPS plans to develop solutions to address these health literacy challenges.

¹ Cultural Competence in Health Care: Is it important for people with chronic conditions? (2004). Retrieved from <https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html>.

² Institute of Medicine. (2004). *Health literacy: A prescription to end confusion*. Board on Neuroscience and Behavioral Health, Nielson-Bohman, L., Panzer, A.M., Kindig, D.A., Editors, Institute of Medicine and the National Academies. The National Academies Press: Washington, D.C.

Mission of the Cultural Competency and Health Literacy Committee

This committee will conduct an assessment of the competency of our participating providers' ability to provide culturally and linguistically appropriate services. We will identify where gaps exist, and will create a work plan to identify the steps necessary to close the gaps. This committee will include consumer, provider and community-based organizations (CBO) representation. It will follow national standards and best practices to establish a system-wide approach to ensure culturally and linguistically appropriate services. This will include tools for providers to assess each patient's ability to comprehend health information, as well as developing materials in languages that are appropriate and consistent with patient's ability to comprehend. The committee will develop a comprehensive blue print which will direct the efforts of the PAC and all participating providers in providing information and materials in a manner that is understandable to the patient, and inclusive of all identities. The committee will elect a chair who will serve as its representative on the PAC's Executive Committee.

Operations of the Cultural Competency and Health Literacy Committee

The CCHLC was established in May 2015 with representatives from various health and community-based organizations who serve the Medicaid beneficiaries in Albany, Columbia, Greene, Saratoga, and Warren Counties. These motivated and committed members are instrumental in providing guidance and feedback on the AMCH PPS's effort to improve cultural and linguistic competence of all providers. The CCHLC members meet regularly to ensure successful implementation of the 11 DSRIP projects taking into consideration the needs of AMCH PPS's diverse patient populations.

Over the 5-year DSRIP period, the CCHLC is responsible for accomplishing the following tasks:

- Make recommendations and provide feedback on project implementation progress, specifically related to cultural competency and health literacy.
- Review and implement evidence-based best practices for culturally and linguistically appropriate care.
- Develop strategies to reduce health disparities among various patient groups.
- Provide guidance on successful implementation of strategies identified in the CC/HL Strategy document.
- Engage community members through regularly-held forums to receive feedback on patient education materials.
- Approve of and ensure completion of annual CC/HL assessments with pre and post-tests among participating PPS providers.

AMCH PPS Cultural Competency and Health Literacy Survey Results

In October 2015, the Project Management Office disseminated a survey created and approved by the CCHLC, with input from our Consumer and Community Affairs Committee (CCAC) and various stakeholders in our PPS. The intent of this survey was to identify the current state of cultural competency and health literacy within each organization, and to identify where gaps exist. The graphs below allow us to identify baseline information, as well as where we need improvement.

Graph 1. Organization’s Services are Offered in Specified Languages (multi-selection)
(n=52)

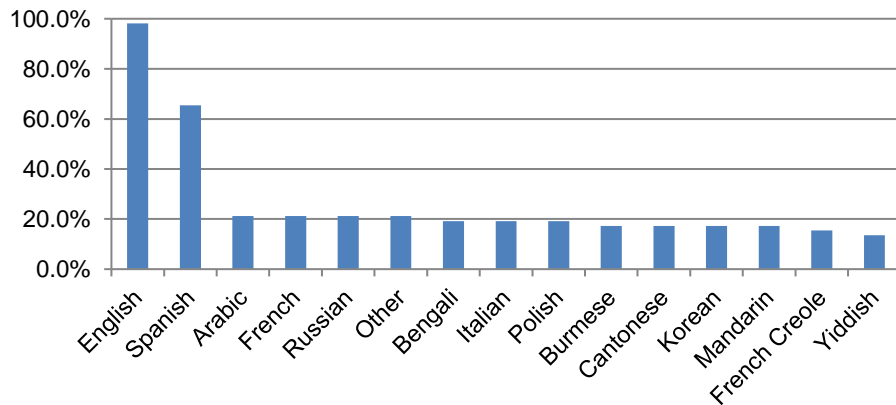


Chart 1. Organization's Mission Statement Incorporates Cultural and Linguistic Competence in Service Delivery (n=52)

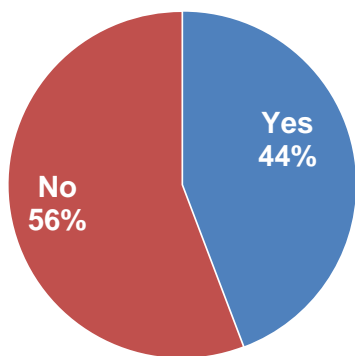
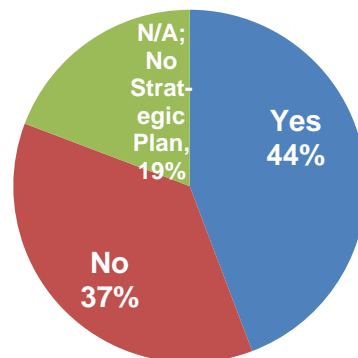


Chart 2. Organization’s Strategic Plan Addresses Cultural Competence, Including a Cultural Competence Development Plan (n=52)



Although there are a high number of organizations who offer services in other languages, 56% of mission statements do not incorporate the need for cultural competent and health literate service delivery ([Chart 1](#)). The CCHLC will work to strengthen the mission of these organizations by including the need for culturally competent care at a literacy level that patients can comprehend.

Chart 3. Organization has a Community Advisory Committee(s) or Similar Structure Representative of the Population and Community Served (n=52)

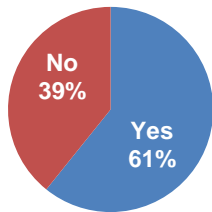


Chart 4. Organization Requests Feedback from Patients Regarding Staff Members' Cultural Competency (n=52)

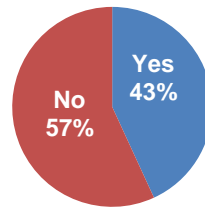


Chart 5. There is a Team or Staff Committee Responsible for Coordinating Cultural Competence Activities/initiatives (n=52)

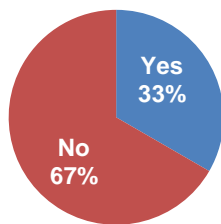


Chart 6. Organization has Funds Allocated for Cultural Competence Activities/initiatives (n=52)

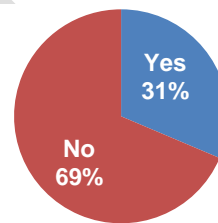


Chart 7. Organization Monitors and Evaluates the Implementation and Results of Cultural Competence Plans/activities/initiatives as Part of Quality Improvement Activities (n=52)

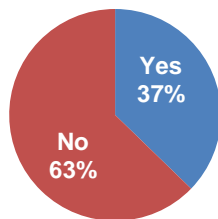


Chart 8. Organization Requires/facilitates Individual Provider Assessments Regarding Cultural Competence (n=52)

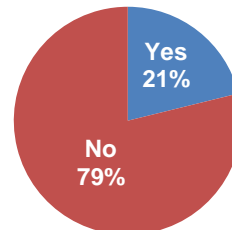
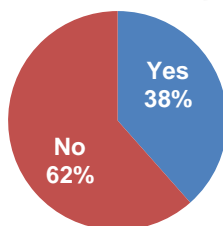


Chart 9. Organization Conducts Training Activities to Improve Staff Competence on Linguistic Issues (e.g., Title VI, CLAS Standards, ADA mandates) (n=52)



Although some organizations actively monitor, evaluate, and improve the cultural competency and linguistic abilities of staff within their organization, approximately 63% do not indicate making this a priority ([Chart 7](#)). This creates an opportunity for improvement for these organizations.

Chart 10. Organization uses Appropriate Language Services (e.g., trained medical interpreters) with Patients who Prefer a Language Other than English (n=52)

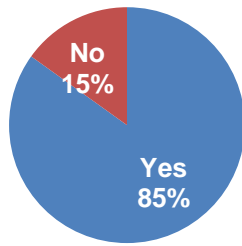


Chart 11. Policies and Procedures are in Place to Ensure that Content Reflects the Different Cultures of Individuals and Families Served (n=52)

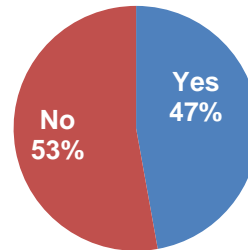


Chart 12. Organization Uses Certified or Trained Medical Interpreters to Provide Interpretation Services (n=52)

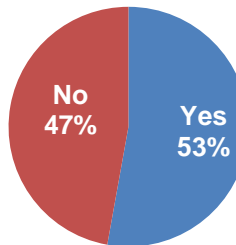


Chart 13. Organization Uses Sign Language Interpreters to Provide Interpretation Services (n=52)

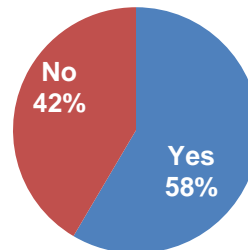


Chart 14. Organization has a policy that Minimizes the Use of Family Members as Interpreters (n=52)

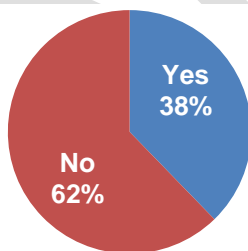
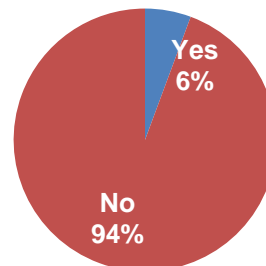


Chart 15. Organization Assesses the Health Literacy of Patients Using a Formal Health Literacy Assessment Tool (n=52)



The above graph indicates that although most (85%) organizations report using appropriate language services ([Chart 10](#)), almost half state that they do not use certified or trained medical interpreters (47%) or sign language interpreters (42%) to provide this care ([Charts 12](#) and [13](#)). Furthermore, only 38% of organizations established a policy to minimize the use of family members as an interpreters, and more than half not have policies and procedures in place to ensure that content reflects the different cultures of individuals and families served ([Charts 11](#) and [14](#)). The use of a formal health literacy assessment tool is low, with only 6% of organizations reporting their use ([Chart 15](#)). Based on these results, it is evident that there is a need for appropriate linguistic services, including materials, forms and other information in languages other than English.

Health Disparities in the AMCH PPS Region



AMCH PPS covers five counties: Warren and Saratoga Counties in the Northern Hub, Albany County in the Central Hub, and Greene and Columbia Counties in the Southern Hub.

Definition of Health Disparity

Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked to social, economic, and/or environmental disadvantages.”³ There is an increasing amount of research and evidence across the nation that demonstrates how factors, such as race, ethnicity, socioeconomic status, gender, age, disability, sexual orientation and gender identity, and geographic differences can adversely affect a person’s ability to receive quality health care with positive health outcomes.

Disparities Based on Race

There is a significant amount of evidence that demonstrates how racial differences can directly and indirectly affect the health of individuals in our region. According to the NYS Prevention Agenda (PA) Dashboard at the county level, Black non-Hispanics are 1.7-3.2 times more likely to experience premature deaths than White non-Hispanics, and this ratio continues to elevate in Albany and Columbia counties ([Table 1](#)). Similarly, Black non-Hispanics are more likely to experience preventable hospitalizations compared to White non-Hispanics. Although the PA 2017 objective was met in some counties for this measure, all counties, except Saratoga County, had worsened ratios compared to previous years.

In addition, an intricate link between race and poverty appears to play an important role in people’s health outcomes. The NYS Poverty Reports provide some insight about how African Americans and Hispanics/Latinos are far more likely to experience poverty compared to Whites ([Graph 2](#)). The close relationship between poverty and poor health outcomes will be further discussed in a later section ([Disparities Based on Socioeconomic Status](#)).

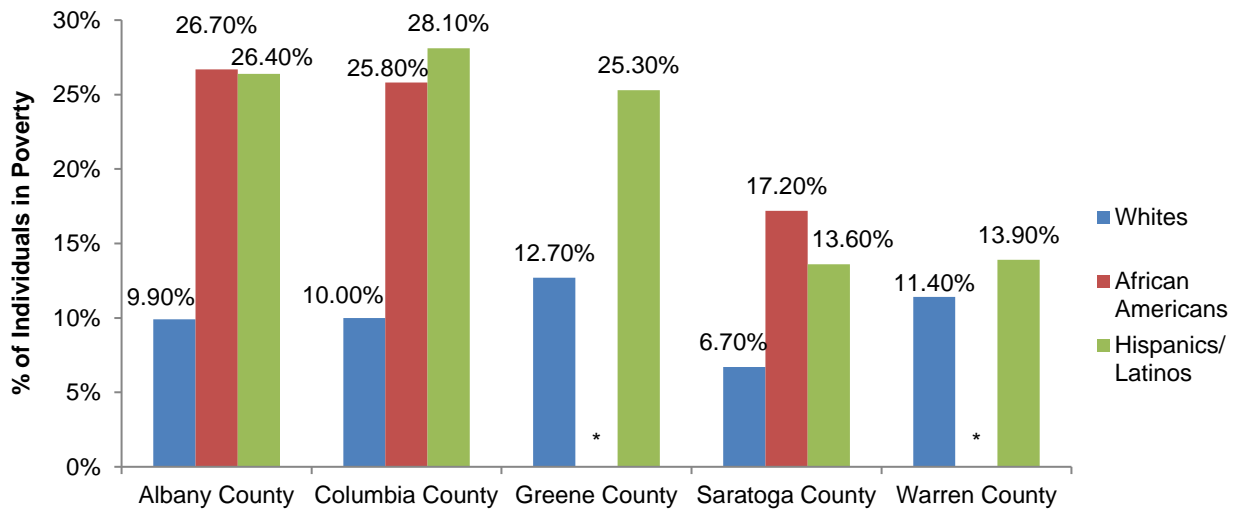
Table 1. NYS Prevention Agenda Dashboard – Health Disparities Based on Race

³ U.S. Department of Health and Human Services. The Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

Prevention Agenda (PA) Indicator	Data Years	PA 2017 Objective	Albany County	Columbia County	Greene County	Saratoga County	Warren County
Ratio of Black non-Hispanics to white non-Hispanics for percentage of premature death (before age 65 years)	2011-2013	1.87	2.66	2.32	2.03	1.68	3.15
Ratio of Black non-Hispanics to White non-Hispanics for age-adjusted rate of preventable hospitalizations – Aged 18+ years	2011-2013	1.85	2.36	2.05	1.6	1.44	1.28

* Green text notates indicators that have shown improvement compared to data year 2010-2012, and red text notates indicators that have worsened compared to data year 2010-2012.

Graph 2. NYS Poverty Reports – Poverty Levels by Race



* Data was unavailable for African Americans in Greene and Warren County.

Disparities Based on Ethnicity

One of the major challenges for assessing disparities based on ethnicity is the lack of disaggregated data. Unfortunately, the majority of data on current health outcomes is not separated by specific ethnicities, which makes it difficult to use data to identify particular ethnic groups experiencing disparities. Limited information about refugee populations in our areas also reduces our ability to fully address their needs.

Evidence does show that cultural and linguistic barriers based on ethnicity may have an enormous impact on people’s ability to access and receive quality health care services. According to the Bureau of Refugee and Immigration Assistance (BRIA) 2014 Population Report, about 7% of refugees in NYS settled in Albany County, and a significant portion of them came from Burma and Bhutan ([Charts 16](#) and [17](#)). Considering the small percentage of providers offering services in Burmese in our PPS ([Graph 1](#)), these refugee populations are likely facing cultural and linguistic barriers to health care access. Furthermore, poor health outcomes, such as premature deaths, were prevalent among individuals with ethnic backgrounds, especially Hispanics, compared to Whites in our communities ([Graph 3](#)).

Chart 16. BRIA 2014 Population Report – Countries of Origin

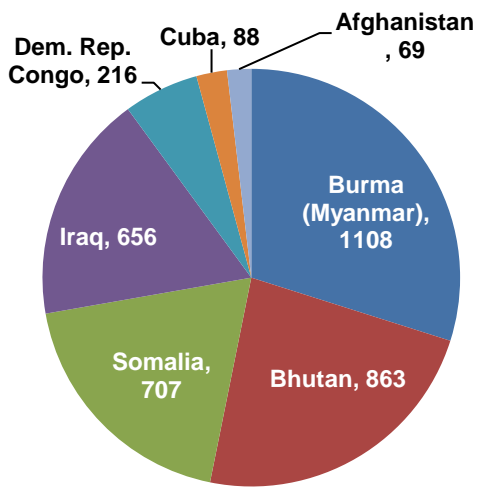
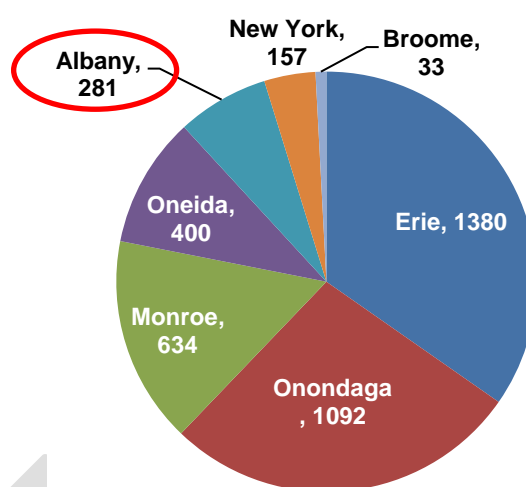
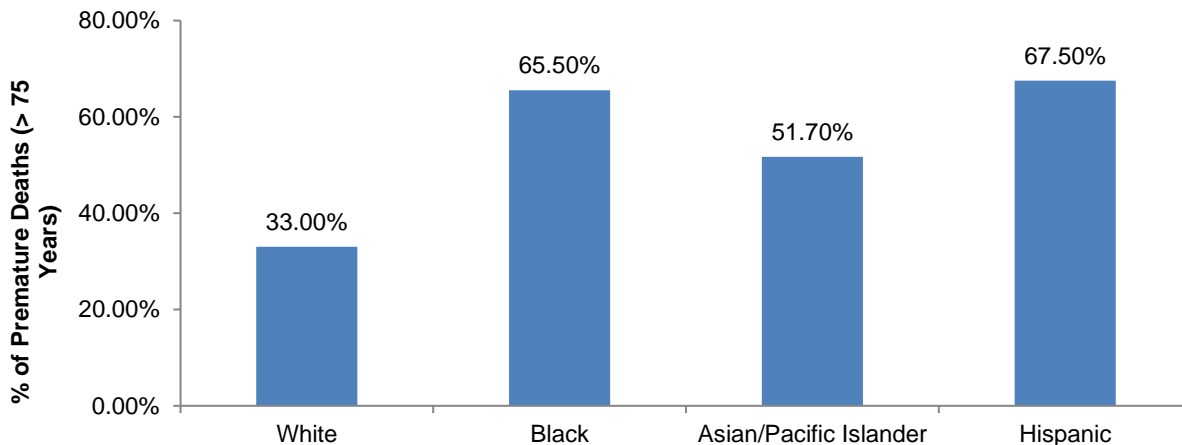


Chart 17. BRIA 2014 Population Report – Counties of New Resettlement



Graph 3. Albany County Health Indicators, 2010-2012-% of Premature Deaths by Race/Ethnicity

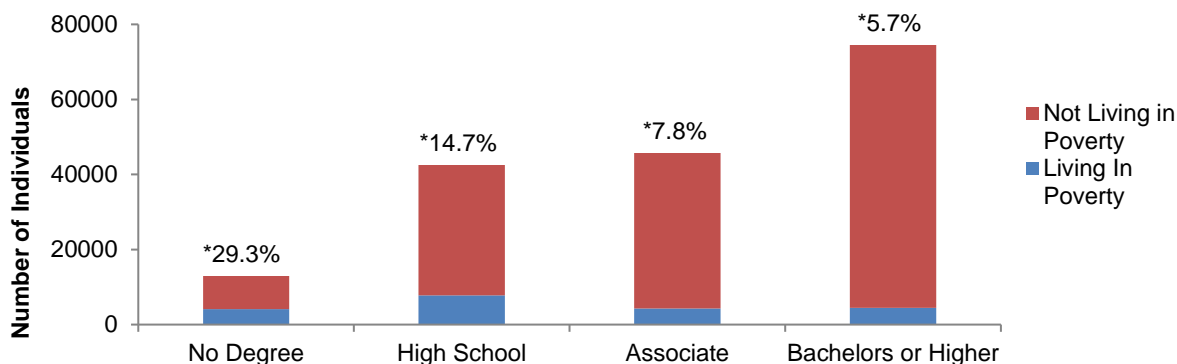


Disparities Based on Socioeconomic Status

As previously mentioned, socioeconomic status (SES) has a significant impact on health outcomes. According to the NYS Poverty Reports, individuals with no educational degrees are more likely to experience poverty compared to those with a bachelor degree or higher. ([Graph 4](#)). Furthermore, an indirect relationship between education and health was demonstrated by the percentage of health insurance coverage based on employment, which is closely linked to educational levels ([Graph 5](#)).

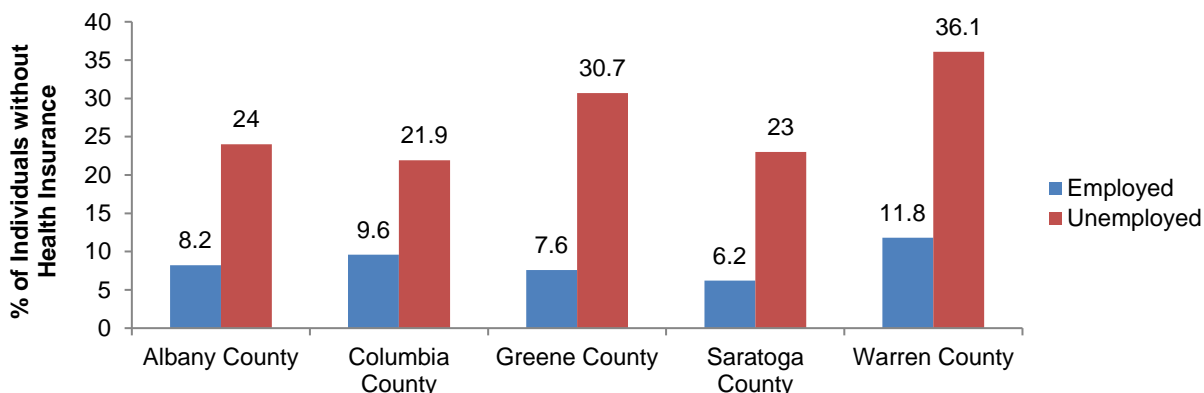
SES influences not only the person’s ability to acquire health care coverage, but also his or her living environment that directly impacts health. According to the NYS Prevention Agenda dashboard, the ratio of low income zip codes to non-low income zip codes on assault-related hospitalization in Albany County was 6.43, which was far higher than the NYS average of 3.22, and has increased over the previous year. Such disparity suggests the importance of addressing people’s living environment and social determinants of health.

Graph 4. NYS Poverty Reports – Education and Poverty in Albany County



* Percentage of individuals in each category who live in poverty

Graph 5. NYS Poverty Reports – Employment and Health Insurance



Disparities Based on Gender

Data suggests that females are likely to experience health disparities mainly due to socioeconomic barriers related to income. In all five counties, women have significantly lower median income compared to men ([Graph 6](#)). The chart below, which displays data from 2009-2013 shows that in all four counties presented, females are more likely to be living in poverty than males. In addition, over 30% of mother-led households in Albany and Greene Counties live in poverty, indicating that gender and socioeconomic status are intricately related ([Table 2](#)).

In addition to gender disparities based on income, data demonstrates significant gender differences in health outcomes. According to the Healthy Capital District Indicator Comparison Report, males in Albany and Saratoga Counties were more likely to have an unintentional injury resulting in death compared to females ([Graph 7](#)). The report also indicates that more females had a case of Chlamydia compared to males in our five counties ([Graph 8](#)). Both statistics suggest the importance of targeting specific gender population for our prevention efforts, such as education, resource dissemination, and referrals.

Graph 6. NYS Poverty Reports – Gender and Income

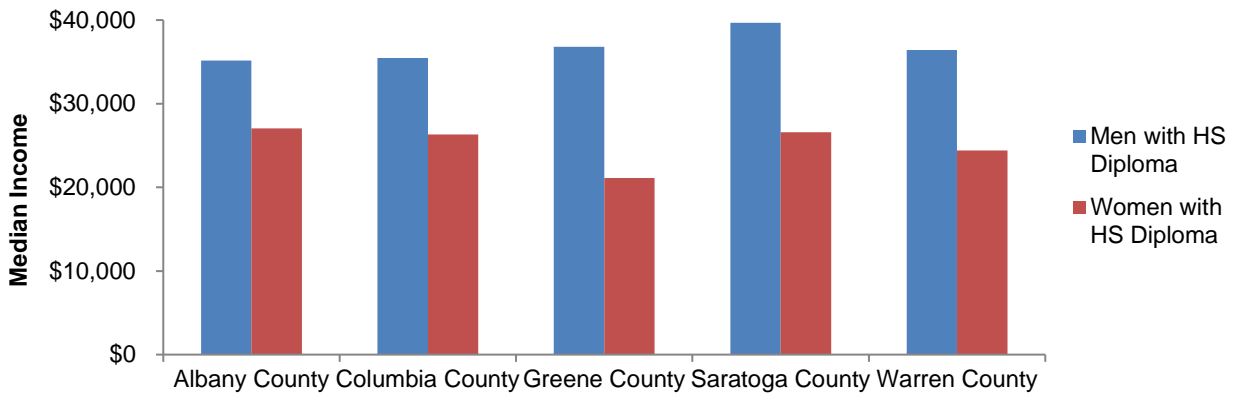
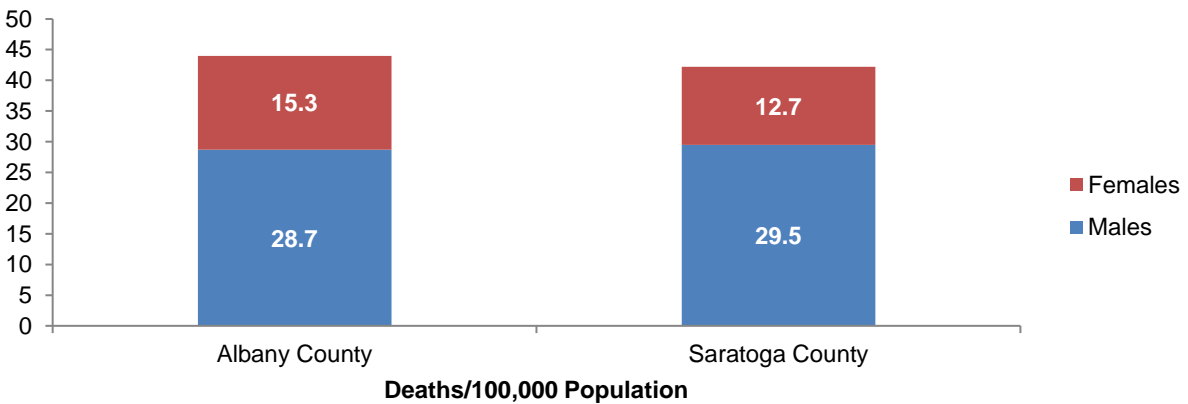


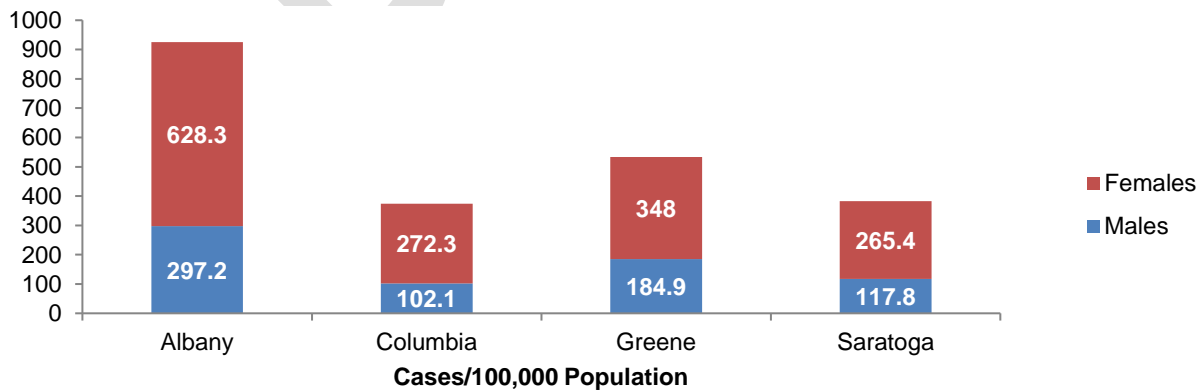
Table 2. NYS Poverty Reports - % of Mother-Led Household Living in Poverty

	Albany County	Columbia County	Greene County	Saratoga County	Warren County
% of Mother-led Household living in Poverty	36.9%	26.0%	47.5%	24.1%	35.6%

Graph 7. Healthy Capital District Indicator Comparison Report (2009-2013) – Death Due to Unintentional Injury by Gender



Graph 8. Healthy Capital District Indicator Comparison Report (2009-2013) – People with Chlamydia by Gender



Disparities Based on Mental Health

There is a strong correlation between mental health and poor health outcomes. Rates of tobacco use, poverty, homelessness, and substance abuse are significantly high among adults with mental illness. The chart below reports mental health service utilization among Medicaid beneficiaries in our five-county regions in 2014. Although Albany County makes up 43% of the total population in our five county regions, it accounts for 62% of the region’s mental health services ([Charts 18 and 19](#)). On the other hand, Saratoga County, which accounts for 32% of the population, provides mental health services to only 12% of our population. When broken down into various types of mental health services, clinic treatment appears to be the most utilized service type in all counties, although the number of service utilizers in Albany County is substantially higher than in other comparing counties ([Graph 9](#)). It is important to take into consideration that this data represents only those who have engaged in care for their mental health needs, and does not represent the high number of people who have mental health needs that go undiagnosed. The NYS Office of Mental Health suggests that 1 out of every 5 persons in NYS has a mental health need.

Chart 18. Population Sizes in All Five Counties

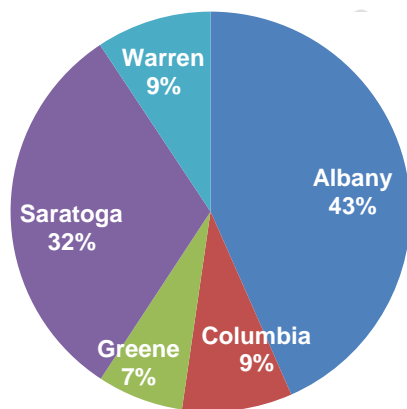
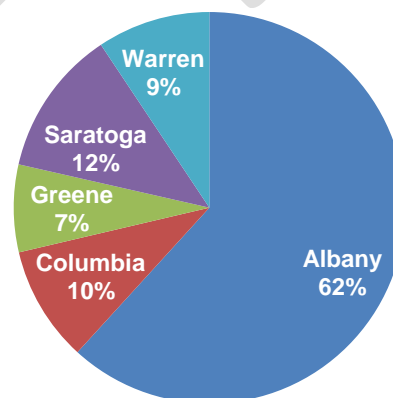
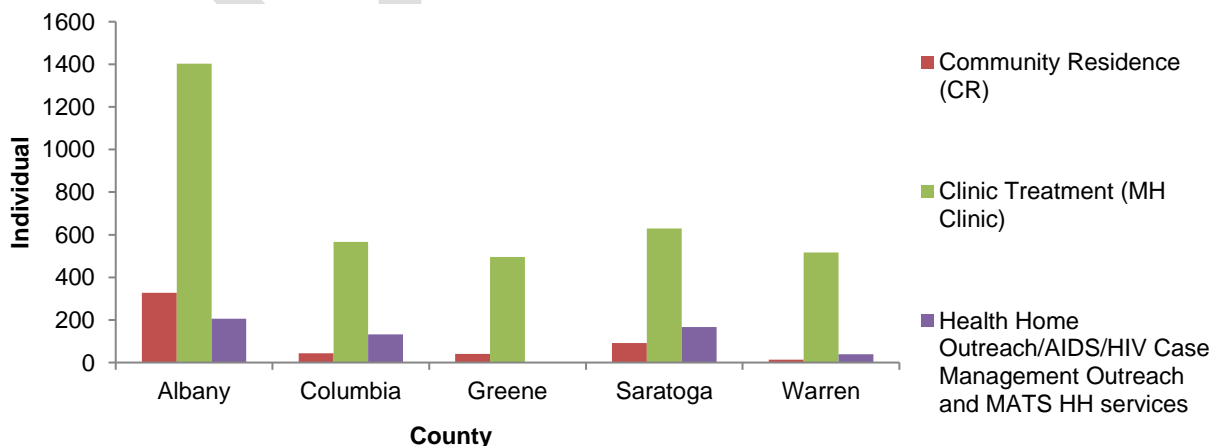


Chart 19. Unduplicated Individuals Receiving Any Mental Health Services



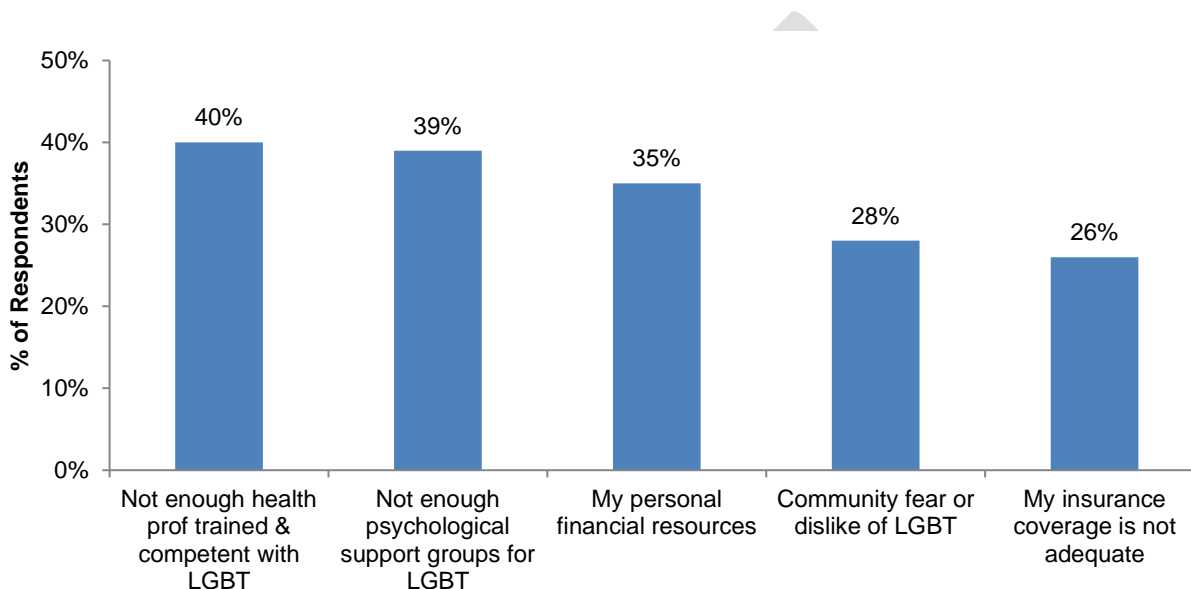
Graph 9. Medicaid Mental Health Service Utilization Pattern



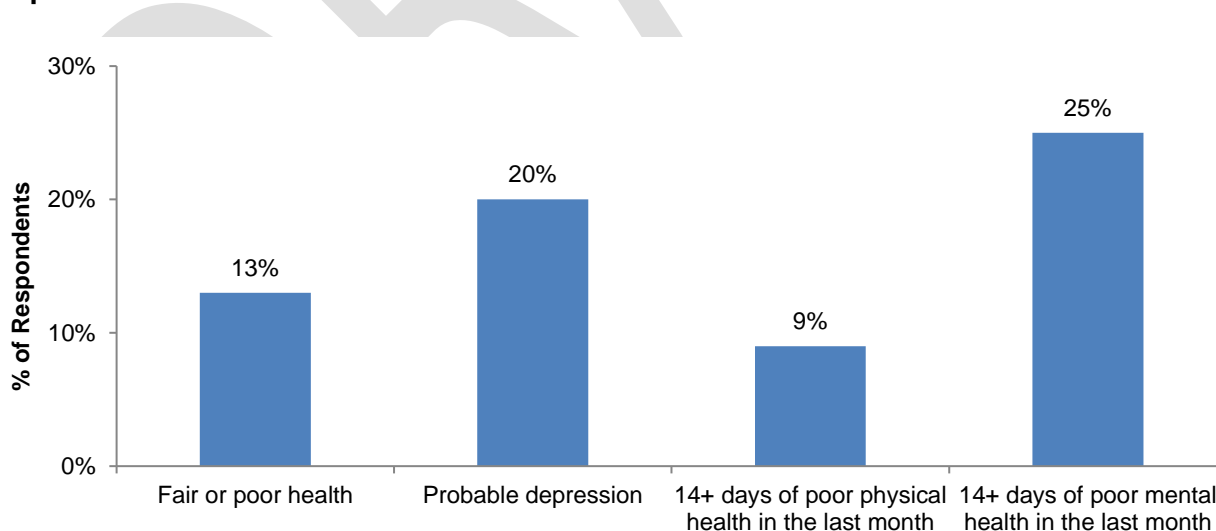
Disparities Based on Sexual Orientation and Gender Identities

Deep societal stigma and discrimination highly influence the health of Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals in our communities. According to the 2015 NYS LGBT Health and Human Services Needs Assessment, LGBT individuals in the Northeastern New York region face barriers to care related to unprepared health professionals, stigma, and financial obstacles ([Graph 10](#)). Furthermore, their current health status should call for immediate attention since ~25% of respondents reported have frequent mental distress ([Graph 11](#)).

Graph 10. 2015 NYS LGBT Needs Assessment – Barriers to Care



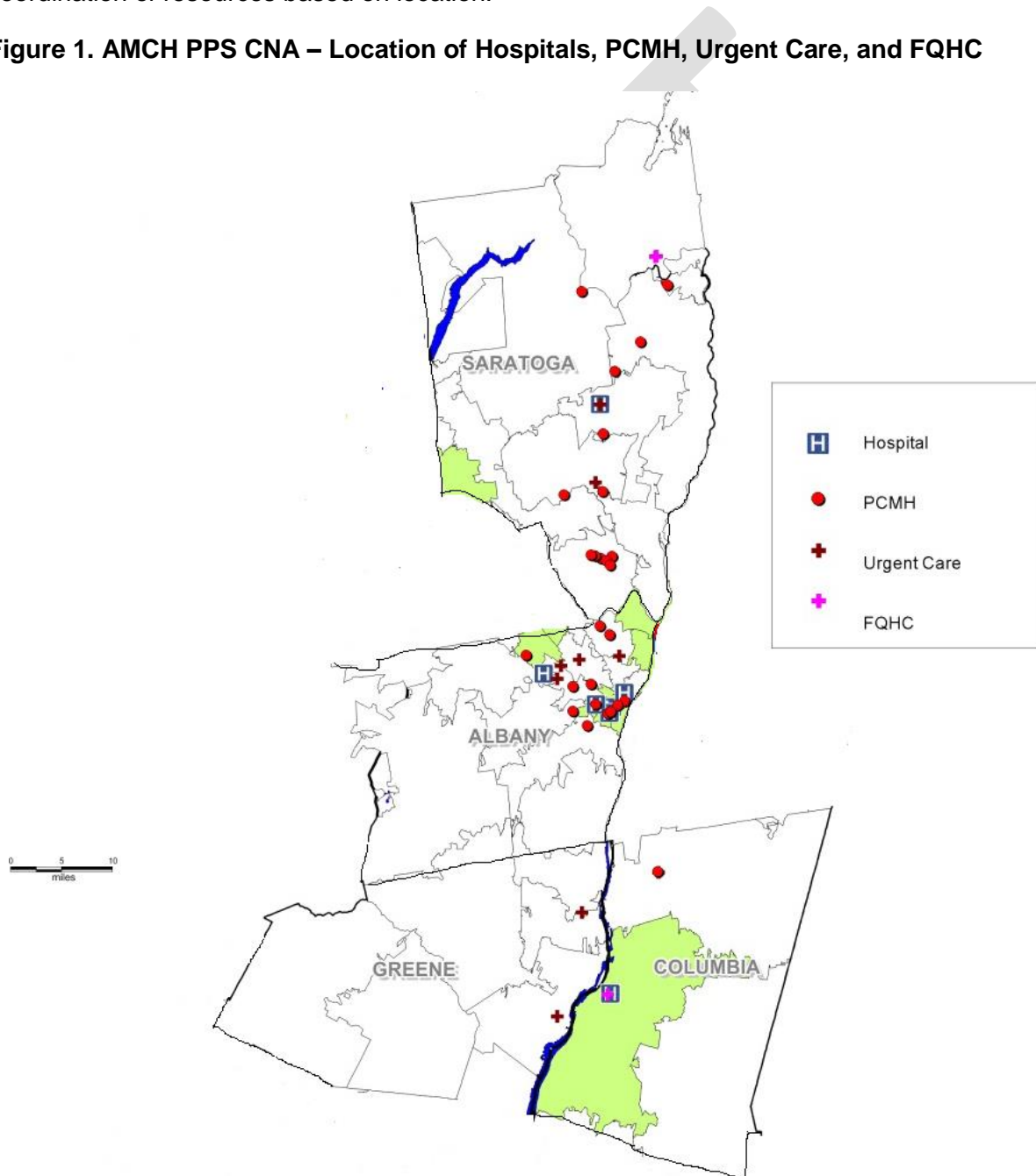
Graph 11. 2015 NYS LGBT Needs Assessment – Current Health Status



Disparities Based on Geography

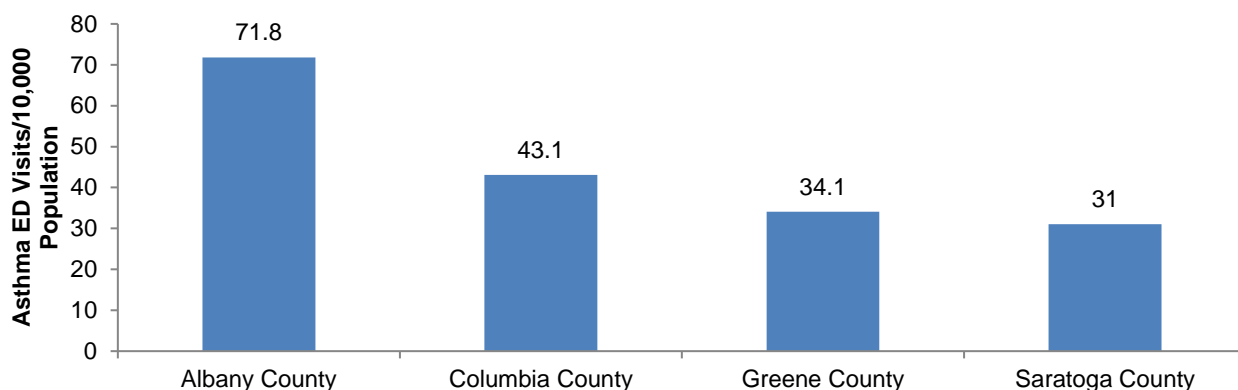
There are substantial differences among the five counties in terms of density of healthcare providers and disease burdens. A map of hospitals, Patient-Centered Medical Homes (PCMHs), urgent care centers, and Federally-Qualified Health Centers (FQHCs) in our Community Needs Assessment (CNA) allowed us to see the major challenge of the staggering differences between counties ([Figure 1](#)). The assessment also demonstrates significant disparities based on geography for particular diseases such as asthma ([Graph 12](#)). Thus, the AMCH PPS recognizes the need to address the transportation barriers and the importance of allocation and coordination of resources based on location.

Figure 1. AMCH PPS CNA – Location of Hospitals, PCMH, Urgent Care, and FQHC



* Warren County was not included in this analysis.

Graph 12. AMCH PPS CNA – Asthma ED Visits in the PPS area, Based on County of Residence



* Warren County was not included in this analysis.

Identified Hotspots

With the consideration of the above factors contributing to health disparities, the AMCH PMO and the CCHLC identified hotspot areas within our five counties using the Community Needs Assessment (CNA), gathered in November 2014, and the American Community Survey (ACS) census data from 2013. Eight factors used in this analysis were selected based on the previous discussions of health disparities being linked to race, ethnicity, SES, and gender.

Table 2. Analysis of Hotspot Areas

Location	Population	Non-White	Mother-led Household	Graduation Rate****	Vacant Homes	Median Income	Limited English Proficiency	Uninsured
Albany County	305,279	60,920 (20.0%)	14,606 (11.9%)	92%	14,883 (10.8%)	\$59,394	3.9%	21,126 (7%)
South End (12202)	9,628	6,867 (71.3%)	1,207 (27.9%)	82.9%	885 (17%)	\$26,466	4.6%	961 (10.7%)
Arbor Hill (12210)	10,158	5,877 (58.9%)	930 (18%)	90.3%	1,072 (17%)	\$22,916	2%	222 (13.2%)
West Hill (12206)	16,395	10,651 (65%)	1,591 (23%)	78.2%	1,394 (17%)	\$24,471	6.6%	475 (14.47%)
Columbia County	62,674	4,307 (6.9%)	2,826 (11.2%)	87.2%	7,428 (22.7%)	\$57,336	1.7%	5,354 (8.8%)
Hudson (12534)	17,867	3,835 (21%)	1,008 (14%)	79.6%	1,287 (15%)	\$46,261	2.2%	1,465 (8%)
Greene County	48,928	3,869 (7.9%)	1,879 (10.2%)	86.4%	10,809 (37.1%)	\$49,655	2.6%	4,157 (9.1%)
Coxsackie (12051)	7,070	2,116 (30%)	220 (12%)	74.17%	289 (14%)	\$46,373	5.8%	306 (4%)
Catskill (12414)	10,510	1,379 (13%)	601 (13%)	86.7%	929 (17%)	\$41,842	2.2%	1,012 (9%)
Prattsville (12468)	1,036	19 (2%)	43 (10%)	83.9%	403** (47%)	\$39,063	9%	214 (21%)
Earlton (12058)	1,445	47 (2%)	39 (6%)	77.3%	125 (18%)	\$49,479	8.5%	271 (19%)
Saratoga County	221,169	9,255 (4.2%)	7,342 (8.3%)	93.4%	10,835 (10.9%)	\$69,826	1.8%	13,928 (6.4%)
South Glens Falls (12803)	7,983	192 (2.4%)	372 (11.6%)	92.0%	208 (6.1%)	\$58,083	0.6%	655 (8.2%)

Location	Population	Non-White	Mother-led Household	Graduation Rate****	Vacant Homes	Median Income	Limited English Proficiency	Uninsured
Mechanicville (12118)	14,204	577 (4.1%)	672 (11.5%)	90.7%	314 (5.1%)	\$61,389	1.5%	1273 (9.0%)
Hadley (12835)	2,381	35 (1.5%)	27 (2.6%)	86.8%	1,838 (63.9%)	\$50,662	0.5%	247 (10.4%)
Milton (12020)	18,677	363 (1.9%)	675 (9.2%)	93.6%	560 (7.1%)	\$62,681	100 (0.6%)	1,752 (9.7%)
Warren County	65,584	1,768 (2.7%)	3,161 (11.3%)	90.8%	10,665 (27.5%)	\$55,804	1.3%	6,351 (9.8%)
Glens Falls (12801)	14,707	1,027 (7%)	944 (14%)	89.6%	673 (9.26%)	\$45,538	1.1%	53 (1.9%)
North Creek (12853)	1,770	38 (2%)	65 (9%)	81.8%	538*** (48.2%)	\$41,563	0.3%	242 (18%)

* Red text highlights indicators demonstrating significant health disparities compared to their respective county averages.

**Many of the homes were destroyed by hurricane Irene in 2011.

*** Ski resort vacation homes may have led to an increased number of vacant homes.

****Graduation rate is a collective percentage of both public and private schools.

In addition to the eight factors listed in [Table 2](#), the number of healthcare providers, particularly in the behavioral health field, is far below the Upstate average in Columbia, Greene, and Warren Counties.⁴ Such shortage of providers may increase the risk of limited access to quality behavioral health services.

Albany County

Three neighborhoods in Albany County were identified as hotspots: South End (12202), Arbor Hill (12210), and West Hill (12206). Racial and ethnic disparities were present in all three neighborhoods where non-White populations were predominant. Furthermore, these neighborhoods had a high percentage of mother-led households, which may translate to emotional and financial strains impacting the health of individuals in these households. The median incomes of these neighborhoods were far lower than the County average (\$59,394) or the New York State average (\$58,003). In addition, the high percentages of uninsured population in these communities indicate that they may experience a disproportionate burden when accessing health care services.

Columbia County

Hudson (12534) is identified as a hot spot in Columbia County. Hudson had a median income of \$46,260, lower than the County average of \$57,336, and a graduation rate of 79.60%, which is significantly lower than the County average of 87.20%. According to the Healthy People 2020 definition of health disparity, Hudson's higher percentage of non-White people (21%) compared to the County average (6.9%) may also contribute to the community members' poor health outcomes, justifying the need for the AMCH PPS to target this neighborhood.

⁴ Jobin-Davis, K. (2014). Capital Region, Mohawk and Hudson Valley DSRIP Community Needs Assessment.

Greene County

Four towns in Greene County were selected as hotspots: Coxsackie (12051), Prattsville (12468), Earlton (12058), and Catskill (12414). The median incomes in all of these areas were below the County average (\$49,655), and all but Catskill had a high percentage of people with limited English proficiency. Coxsackie and Prattsville had high percentages of non-White populations and mother-led households, both of which are known risk factors for health disparities. Low high school graduation rates and high uninsured rates in some of these areas indicate that individuals in these communities are likely to benefit from improved access to culturally and linguistically appropriate services.

Saratoga County

The AMCH PPS identified four towns in Saratoga County as hotspots: South Glens Falls (12803), Mechanicville (12118), Hadley (12835), and Milton (12020). All of these areas had a high percentage of uninsured people, and some had a high percentage of mother-led households, which may contribute to increased risk for health disparities. Therefore, people in these areas will be targeted services focused on the uninsured population.

Warren County

Two areas were selected as hotspots in Warren County, Glens Falls (12801) and North Creek (12853). Both communities had lower median household incomes than the County average of \$55,804. Furthermore, while over 20% of the County population, Glens Falls had a large non-White population (1,027 or 7%) that encompassed nearly 60% of the County's total non-White population (1,768 or 2.7%). An uninsured population of 18% in North Creek was high compared to the County average of 9.8%. In order to address these risk factors for health disparities, the AMCH PPS will strive to provide community-based interventions and increased access to culturally and linguistically appropriate services in these areas.

Factors to Improve Health Care Access

Patients frequently face social, language, and cultural barriers that prevent them from accessing quality primary care, behavioral health care, and preventive services. Strategies and best practices to identify and reduce barriers and help patients manage their own health are discussed below.

- Patient education via patient navigators
 - Patient navigators are invaluable resources for people with low health literacy. They not only spend time to ensure patient understanding of physicians' medical instructions, but also help address some of the social challenges, such as transportation issues. By coordinating care and addressing barriers, patient navigators have shown success in improving access and reducing health disparities for patients in other areas.
- Address patients' social barriers to care
 - Social determinants of health, such as location, socioeconomic status, education, racism, stigma, and oppression, all contribute to poor access to quality care. Addressing factors, such as transportation, limited food options, lack of childcare services, and neighborhood violence, requires extensive collaboration across sectors. Working closely with community-based organizations and social service agencies is necessary to improve the health of our Medicaid population.
- Help patients build relationships with their primary care physicians (PCPs)
 - Research shows that a stable relationship between the patient and PCP is an important indicator for patients' timely receipt of preventive services.⁵ As part of the Patient Centered Medical Home (PCMH) certification, primary care practices are required to build a patient panel for each provider who will take the responsibility of providing integrated care and preventive services to designated patients. Linking patients to PCMH-certified primary care practices can be an effective strategy to addressing some of their social barriers.
- Help overcome communication barriers with translation and interpretation services
 - Patients with low English proficiency (LEP) are at a disadvantage when accessing quality primary, behavioral health, and preventive services. Research indicates that interpretation services are effective in helping LEP patients make more outpatient visits, fill more prescriptions, and have higher satisfaction.⁶

⁵ Xu, K. T. (2002). Usual source of care in preventive service use: a regular doctor versus a regular site. *Health services research, 37*(6), 1509-1529.

⁶ Jacobs, E. A., Lauderdale, D. S., Meltzer, D., Shorey, J. M., Levinson, W., & Thisted, R. A. (2001). Impact of Interpreter Services on Delivery of Health Care to Limited-English-proficient Patients. *Journal of General Internal Medicine, 16*(7), 468-474.

- Identify organizational limitations in providing accessible health care services
 - Medicaid patients with multiple diagnoses often require services from multiple providers, such as primary care, behavioral health, and specialty care providers. Without appropriate care management and coordination, these patients easily fall into the cracks of poorly organized care. In order to promote their medication adherence and self-management, health and social service agencies, as well as health care providers, should communicate and coordinate effectively.
 - Self-assessments, developed by the [National Center for Cultural Competence](#), allow organizations and individual providers to identify barriers to achieve cultural and linguistic competence. These assessments measure the levels of awareness, knowledge, and skill related to cultural competency in order to help patients overcome cultural and linguistic challenges in health care settings. Organizations participating in the AMCH PPS will continue to conduct these self-assessments as a step toward achieving cultural and linguistic competence.
- Maximize the use of health information technology
 - Electronic health records (EHRs) and health information exchanges (HIEs) are fast-growing technologies that are crucial in innovative delivery models. Maximizing the use of health technology will help create an integrated delivery system and accelerate the implementation of alternative delivery models, such as telemedicine. These technology solutions will greatly increase access, particularly for those in areas with limited transportation.
 - Population health platforms on EHRs are important in managing disease registries and creating reminders for patients with various levels of needs. This technology is likely to increase efficiency in identifying high-risk patients and managing their ongoing care plans.
- Assist uninsured with health insurance coverage and community resources
 - The Affordable Care Act (ACA) has greatly contributed to increasing access to health insurance by expanding Medicaid eligibility and creating the Health Insurance Marketplace for low-income individuals. Nonetheless, millions of residents in NYS remain uninsured due to limited knowledge about available assistance and ineligibility criteria. Increasing outreach and enrollment assistance, as well as providing information and community resources, are likely to help improve uninsured individuals' access to necessary health care service.

- Increase access during off-hours
 - Medicaid patients often struggle to find providers who offer services outside of normal business hours. Taking time away from work for medical appointments is especially difficult for the working poor. Expanded hours of operation and increased access to urgent care centers have been beneficial in accommodating their circumstances and redirecting frequent ED users.⁷

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⁷ Merritt et al, 2000. The Influence of an Urgent Care Center on the Frequency of ED Visits in an Urban Hospital Setting. *Am J. of Emerg Med.* Mar; 18 (2):123-5.

Patient Self-Management Support

Self-management support is a crucial function in chronic disease care management. Ensuring patient understanding of clinical instructions and medications can influence their health outcomes. Below are examples of some tools and assessments that are recognized as effective in assessing patients' health literacy levels and with helping patients manage their health.

- Formal health literacy assessments and Plain Language Thesaurus
 - Health literacy, as defined in Page 3, is the patient's ability to understand health information including self-management resources. Patients with low health literacy, which is common among the Medicaid population, often do not comprehend medical jargon and instructions provided by their physicians. In order to recognize patients' varying health literacy levels, formal health literacy assessments are available. These are simple and effective tools that can easily measure health literacy levels without compromising patients' dignity, and they should be used with the consideration of patient's cultural background.
 - **Rapid Estimate of Adult Literacy in Medicine-Short Form (REALM-SF)** is a 7-item word recognition test that has been validated and field tested.⁸
 - **Short Test of Functional Health Literacy in Adults (S-TOHFLA)** measures both numeracy and reading comprehension using actual health-related materials such as prescription bottles and appointment slips.⁹
 - **The Newest Vital Sign (NVS)** is a 6-item assessment measuring reading and comprehension of a nutrition label.¹⁰
 - The Plain Language Thesaurus ([PDF](#)), written by the Centers for Disease Control and Prevention (CDC), is an informative document for providers to look up layman's terms that are equivalent to complex medical terms.
- Resources for patient engagement and educational materials in multiple languages
 - Written materials for patients who speak a language other than English need to be appropriately translated and readily available. Several online resources are available for providers to obtain linguistically appropriate and easy-to-read patient education materials in multiple languages.
 - **Health Information Translation** ([website](#)) contains quality health education resources in multiple languages for health care providers to use in their communities.

⁸ Health Literacy Measurement Tools (Revised). November 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html>

⁹ Baker, D. W., Williams, M. V., Parker, R. M., Gazmararian, J. A., & Nurss, J. (1999). Development of a brief test to measure functional health literacy. *Patient education and counseling*, 38(1), 33-42.

¹⁰ Hubbard, R. (2011). The Newest Vital Sign. Retrieved from https://www.pfizer.com/files/health/nvs_flipbook_english_final.pdf.

- **Health Reach** ([website](#)) is a national collaborative partnership that has created a resource of quality multilingual, multicultural public health information.
 - **EthnoMed** ([website](#)) has medical and cultural information about various immigrant and refugee groups.
 - **MedlinePlus** ([website](#)) is the National Institutes of Health's website for patients to access information in languages they can understand.
- Care coordination and navigation services
 - To ensure effective doctor's visits and successful self-management of chronic diseases, patients need to obtain and maintain their health insurance. Unfortunately, getting health insurance and keeping the coverage are often cumbersome and confusing tasks. **Community Health Advocates** from [Healthy Capital District Initiative \(HCDI\)](#) are free resources for these patients who need help with various insurance-related issues, such as medical bills, discounted prescription assistance, and filing appeals.
 - [Alliance for Positive Health](#) provides care coordination services at numerous locations for people with chronic diseases including HIV/AIDS, diabetes, hypertension, serious mental illness, and asthma.
 - Community Health Workers at [Albany County Department of Health](#) assist families in getting basic needs for healthy living, such as medical care, food, clothing, and shelter.
 - Teach-back methods ([website](#))
 - The Teach-back method is a tool health care providers can use to ensure patient understanding of clinical instructions and medications. Asking patients to explain what they need to know and do in their own words can improve patient-provider communication and health outcomes.
 - Motivational interviewing
 - Motivational interviewing¹¹ is a proven technique that promotes patients' positive behavioral adoptions. In order to manage chronic diseases, patients often need to make long-term behavioral changes that are difficult to achieve. With the use of motivational interviewing techniques, many providers have found success with taking the patients preferences and readiness for change into consideration.¹²
 - [This Youtube Channel](#) provides a series of videos on motivational interviewing.

¹¹ Rollnick, S., & Miller, W. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press.

¹² Elwyn, G., Dehlendorf, C., Epstein, R. M., Marrin, K., White, J., & Frosch, D. L. (2014). Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *The Annals of Family Medicine*, 12(3), 270-275.

- Stanford Self-Management Model and provider recognition programs
 - Stanford self-management program is a workshop series designed to provide disease-specific education and skill building exercises for patients with chronic health problems.
 - [Center for Excellence in Aging and Community Wellness](#) offers 6-session workshop based on the Stanford model.
 - **Community Health Care Association of New York State** ([website](#)) conducts train-the-trainer sessions at Federally Qualified Health Centers (FQHCs) on Chronic Disease Self-Management Program.
 - The National Committee for Quality Assurance (NCQA) has voluntary recognition programs for providers who are interested in gaining tools to better support patients with chronic diseases. These recognitions also fulfill some of the PCMH accreditation requirements.
 - **Diabetes Recognition Program (DRP)** ([website](#)) is developed to recognize providers who use evidence-based measures and practices to care for patients with diabetes.
 - **Heart/Stroke Recognition Program (HSRP)** ([website](#)) is for providers who use evidence-based measures and follow national guidelines to serve patients with cardiovascular disease or who have had a stroke.
- Online patient self-management tools
 - Several websites provide worksheets and tools that providers can utilize to engage patients in self-management. These instruments should be used with the consideration of patient's cultural background.
 - **My Action Plans** ([website](#)) is a simple worksheet to help patients set reasonable goals for their behavioral changes.
 - **Diabetes Self-Management Tools** ([website](#)) include handouts and worksheets for patients with diabetes to track their medications and health status.
 - **Million Hearts** ([website](#)) has several self-management tools and educational materials, such as Heart 360 and Heart Attack Risk Calculator, for patients with hypertension.
 - **Asthma Action Plan** ([PDF](#)) is a template for personalized management plan, developed by the National Heart, Lung, and Blood Institute, for patients with asthma.
- Linkages to community resources
 - Many community-based organizations assist Medicaid patients with fulfilling everyday needs, such as child care, employment, food, and shelter. These basic needs should be met in order for patients to successfully manage their health. Please refer to [Attachment A](#), or the Service Directory on our PPS website, to find the list of community-based organizations in the five-county area.

Community-Based Interventions to Reduce Health Disparities

In order to reduce health disparities, collaborations between social service programs and health care providers are crucial. Within our five-county region, many community-based organizations have already established connections with the Medicaid and uninsured populations. Maximizing utilization of their services will help the AMCH PPS reach the communities in need and successfully reduce health disparities among various patient groups. Below are some examples of existing resources. For a more extensive list, please see the [Attachment A](#), or the Service Directory on our PPS website.

- Free screening services
 - Several programs target uninsured and underinsured patients by providing free screening services.
 - [In Our Own Voices, Inc.](#) provides free Hepatitis C and HIV screening.
 - **New York State Cancer Services Program** ([website](#)) provides free breast, cervical, and colon cancer screenings for uninsured patients in all counties of New York State.
 - [Whitney Young](#) **Community Prevention & Treatment Services** offers free HIV screening.

- Self-management support
 - Patients can greatly benefit from community-based tools and education that focus on disease management and behavioral change support.
 - **CapitalCare Nutrition and Diabetes Education Center** ([website](#)) provides self-management education and nutrition therapy to patients with diabetes.
 - **Columbia Memorial Hospital** ([website](#)) holds diabetes self-management classes and support groups.
 - **Cornell Cooperative Extension** ([Albany website](#), [Columbia-Greene website](#), [Saratoga website](#), [Warren website](#)) brings research-based solutions for issues regarding social determinants of health by implementing programs, such as nutrition classes, lead prevention, and youth development programs.
 - **NYS Smokers' Quitline** ([website](#)) is a valuable resource for anyone trying to quit smoking.
 - **Select ShopRite, Price Chopper and Hannaford Stores** provide the free services of an in-store dietitian to help customers make healthy food choices.

- Food and housing services
 - Inadequate healthy food resources and poor housing situations are significant risk factors leading to poor health outcomes. In order to address these needs, several community-based organizations dedicate their efforts to offer proper food access and housing support to those in need.
 - **Capital City Rescue Mission** ([website](#)) provides services to the homeless and needy population, including food, shelter, clothing, transitional living programs, education through the Mission's Learning Center, and employment readiness training.
 - **Catholic Charities** is a large social service agency in the region, and serves poor and vulnerable populations through a wide variety of services, including food and shelter.
 - **Food Pantries of the Capital District** is a coalition of 53 food pantries in Albany, Rensselaer, and Saratoga Counties. Services provided include distribution of grocery store gift cards, milk cards, holiday meals, emergency food funding, and infant needs, such as diapers and formula.
 - **Homeless and Travelers Aid Society (HATAS)** offers shelter, food and clothes for those with immediate needs, as well as assistance with finding long-term affordable housing. Additional services include 24-hour emergency shelter, rapid rehousing, veteran housing, backpacks for hungry students, and code blue shelter.
 - **In Our Own Voices, Inc.** offers rental and utilities assistance, food and clothes for LGBTQ individuals with immediate needs, as well as assistance with finding long-term affordable housing and 12-hour support line.
 - **Interfaith Partnership for the Homeless** empowers and provides skills and tools to individuals and families who are homeless or facing homelessness. Services include emergency shelter, transitional and permanent housing, meals, showers, laundry facilities, case management, and life skills groups.
 - **Regional Food Bank of Northeastern NY** ([website](#)) has a mission to alleviate hunger and prevent food waste, and serves our PPS's entire five-county region.
 - **Office for the Aging** in each county ([Albany](#), [Columbia](#), [Greene](#), [Saratoga](#), [Warren](#)) provides home delivered meals, nutrition education and counselling to seniors.
- Children and youth programs
 - Children and youth development programs are critical in improving the overall health of our future communities. Several afterschool programs offered by community-based organizations in our five-county region aim to enhance children's literacy skills and help them adopt healthy life choices in a safe environment. These programs include enrichment and educational exercises, social skills building projects, and recreational/ healthy living activities.

- **Albany PAL** (Police Athletic League) ([website](#)) provides recreation and educational crime prevention programs in Albany County. Services include afterschool homework club, PAL mentoring, and Youth Leadership Council.
 - **Girls Inc.** offers free after school programs to girls in the capital region, with a mission to inspire all girls to be strong, smart and bold. Programs include economic, media and computer literacy, healthy snacking, and conflict resolution.
 - **NYS Museum Afterschool Program** ([website](#)) provides afternoon programs with educational activities to Albany's underserved neighborhoods through their Museum Club and Discover Squad programs.
 - **South End Children's Café** serves children in grades K-6 by offering afterschool tutoring, art, and exercise programs followed by healthy dinners for their family.
- Advocacy and support
 - Several organizations are committed to empowering specific patient groups by making their voices heard. Such efforts are extremely important in addressing various issues of health disparity.
 - **American Heart Association** ([website](#)) offers CPR education training, science-based treatment guidelines for providers and advocacy support for individuals with heart disease and stroke.
 - **Asthma Coalition of the Capital Region** provides services in Albany County, with a mission to coordinate sustainable initiatives that will reduce the burden of asthma in our region.
 - **Capital District Tobacco-Free Coalition** assists employers and property owners to promote smoke-free worksites and housing.
 - **In Our Own Voices, Inc.** provides services to the LGBTQ community, with a focus on people of color. Services include a domestic and sexual violence hotline, information and referral, individual advocacy, support groups, individual, family, and couples counseling, HIV/Hepatitis C testing, community events, training, and technical assistance.
 - **New York StateWide Senior Action Council, Inc.** assists older persons and family members with hospital discharge problems, patients' rights issues, insurance and prescription coverage issues.
 - **Northern Rivers Family of Services** is a parent company of two agencies, [Northeast Parent & Child Society](#) and [Parsons Child & Family Center](#), both of which provides various behavioral health, case management, early childhood, residential care, and family preservation support services, such as [Capital Region Child and Adolescent Mobile Crisis Team](#) and [Healthy Families Albany County](#).
 - **NY Connects** ([website](#)) offers a wide range of long term services and supports, such as in-home services, crisis intervention, and service coordination, to older individuals and those with disabilities.

- [Pride Center of the Capital Region](#) provides services to the LGBTQ community in the Capital Region. Services provided include resources and referrals, counselling, education, peer support groups, recovery groups, youth groups, and programs for seniors.
 - [VNA Home Health](#) provides skilled nursing care, rehabilitative services, and medical social work to individuals with acute or chronic conditions in the comfort of their homes.
- Transportation services
 - Free and low-cost transportation services enable Medicaid beneficiaries to fulfill necessary medical and non-medical needs.
 - **CDTA ACCESS Transit Services, Inc.** ([website](#)) is a transportation services for Medicaid recipients to access non-emergency medical appointments, pharmacy, grocery shopping, and adult day programs. Call 518-437-5161 at least 2 business days in advance for arrangement.
 - **CDTA STAR (Special Transit Available by Request) Program** ([website](#)) provides transportation services to individuals with disability or impairment that prevents them from using the regular fixed route buses.
 - **Medical Answering Services, LLC.** ([website](#)) offers transportation services, covered by Medicaid, to and from medical appointments for eligible Medicaid recipients. Prior authorization is necessary for reimbursement.

Implementation Strategies

AMCH PPS plans to implement several strategies over the 5-year DSRIP period to address cultural and linguistic barriers and health literacy issues. The following is a list of strategies that will be utilized to improve the cultural competency and health literacy skills of all PPS providers.

Organizational Focus on Cultural Competency and Health Literacy

Commitment from organizations' leadership is crucial in making a sustainable change. Creating policies and procedures related to cultural competency and health literacy is one of the major strategies of the AMCH PPS. Specific actions steps include:

- Assist organizations to incorporate cultural competency and health literacy in their mission and strategic plans, and to prioritize cultural competency/health literacy initiatives
- Assist organizations to create policies regarding diverse workforce recruitment and retention
- Assist organizations to engage community representatives in their organizational decision-making processes
- Assist organizations to consistently collect data regarding patients' race, ethnicity, sex, sexual orientation, primary language, and disability status

Provider Trainings

In order to enhance providers' cultural competency and sensitivity to patients' varying health literacy levels, the AMCH PPS will offer training opportunities to all participating providers. Specific action steps include:

- Contract with a training vendor to provide customized training on cultural competency and health literacy, with a focus on high need areas
- Contract with a training vendor to provide, conduct, and evaluate ongoing assessments
- Implement the use of formal health literacy assessment tools that are listed on Page 12
- Train providers on teach-back methods, Patient Activation Measurement Tool (PAM) survey and motivational interviewing techniques

Communications

Effective and open communications with consumers and PPS providers are vital for successful implementation of our strategies. Several efforts will be dedicated to keep communication channels easily accessible for the public and participating providers. Specific action steps include:

- Communicate with PPS providers and the general public through AMCH PPS website (<http://albanymedpps.org/>), which contains PPS provider portal and DSRIP information
- Maintain Project Management Office representation in the Albany CORESTAT meetings
 - CORESTAT is a tool for measuring indicators of distress at the neighborhood-level
- Maintain a master calendar, created by the Consumer and Community Affairs Committee (CCAC), that includes dates for community forums
- Hold regular consumer meetings to receive feedback on patient materials prior to dissemination
- Continue communication with PPS providers and community groups through regular meetings of Project Advisory Committee and seven supporting committees

- Create a population health management roadmap, in collaboration with the HCDI and the CCAC, to develop long-term strategies for reducing health disparities

Patient Navigators/Care Coordinators

The AMCH PPS plans to utilize patient navigators to address the challenges around navigating the health care system and coordinating/following up on services. Specific actions steps include:

- Identification of organizations in need of patient navigators by conducting current state assessments
- Placement and utilization of patient navigators to assist patients with health literacy challenges and/or other needs to help improve care coordination and self-management

Patient Education

The AMCH PPS will dedicate efforts to educate patients on the importance of self-care and the appropriate use of health care services. Specific actions steps include:

- Identify and disseminate patient education materials in multiple languages and appropriate reading level related to the following topics (not limited to):
 - Chronic disease management (Project 2.a.iii)
 - The appropriate use of ED services (Project 2.b.iii)
 - The benefits of primary care services (Project 2.b.iii)
 - The importance of medication adherence and lifestyle changes (Project 3.b.i)
 - How to navigate screening services (Project 4.b.ii)
- Compile a list of community resources for patients from various ethnic groups

Language Services

The AMCH PPS will ensure that all participating providers offer appropriate language services to help patients with limited English proficiency. Specific actions steps include:

- Identify gaps in interpretation and translation services by systematically collecting patients' language preferences
- Train staff on the use of language access services (i.e. telephonic interpreting) and create accountability to set up the service for patients with limited English proficiency
- Educate staff on the federal mandates related to language access (i.e. Title VI of the 1964 Civil Rights Act, Executive Order 13166, Americans with Disabilities Act)
- Assist organizations to create policy to minimize the use of family members as interpreters
- Assist organizations to create policies regarding interpretation, translation and validation of printed materials, as well as the appropriate usage of these materials

Metrics

Tracking progress and celebrating success are important for sustainable change. In order to create goals and incentives for providers, the following steps will be taken:

- Identify patient satisfaction metrics (i.e. CAHPS) to measure progress on cultural competency/health literacy initiatives
- Identify process and outcome metrics to measure the level of AMCH PPS's success in implementing listed strategies

Potential Challenges to Implementation and Mitigation Strategies

Although there are several expected challenges to implementation, the AMCH PPS is confident that these challenges can be mitigated with effective strategies. Here are a few potential challenges:

Change is difficult. The AMCH PPS expects resistance from some providers who are uncomfortable with change. With ongoing changes in the industry, health care providers are challenged with several competing priorities, and sometimes have limited resources to commit efforts to health literacy- and cultural competency-related initiatives.

Cultural competency and health literacy are not easy concepts. Not all providers understand these definitions and/or how competency can be measured or accomplished.

Some providers believe they are already culturally and linguistically competent. Without effective feedback and concrete metrics, providers often have difficulty understanding their current cultural competency levels. Their misperceptions may challenge us when trying to discuss the importance of ongoing cultural competency and health literacy trainings.

Despite these challenges, the AMCH PPS will continue to move forward with the implementation strategies by embracing the following mitigation tactics:

Change in organizational culture and workforce training will bring a sustainable impact. Focusing on the commitment of organizational leaderships and quality training opportunities will likely address some of the identified challenges. The AMCH PPS will create a norm to prioritize cultural competency and health literacy within each organization in order to make long-term changes.

DSRIP offers incentives to accelerate providers' behavioral changes. The AMCH PPS will leverage the resources created by DSRIP to incentivize providers who adopt cultural competency and health literacy activities.

After all, it is about our patients, and also benefits providers. Health care movement towards value-based purchasing will likely benefit providers themselves, not only patients, for engaging in culturally competent care. Educating and incentivizing providers will create the motivation for providers who are hesitant to change.

Cultural Competency and Health Literacy Committee Members

1. Wilma Alvarado-Little, Principal and Founder, AlvaradoLittle Consulting, LLC
2. Shirley Belotte, Provider Relations Field Representative, Xerox State Healthcare, LLC
3. Michael Burgess, Consultant, Community Care Givers
4. Benna Eldridge, Director of the Family and Neighborhood Resource Center, Trinity Alliance
5. Elizabeth Glassanos, Volunteer, New York Statewide Senior Action Council, Inc.
6. Jennifer Guerra, Senior DSRIP Project Coordinator, Albany Medical Center Hospital
7. Marcus Harazin, Coordinator, New York Statewide Senior Action Council, Inc.
8. Micky Jimenez, Regional Director of the Capital District, Camino Nuevo/ Promesa
9. Mingie Kang, DSRIP Project Coordinator, Albany Medical Center Hospital
10. Tandra LaGrone, Executive Director, In Our Own Voices – *Committee Chair*
11. Mary Jo Laposta, Senior Vice President of Patient Care Services, Saratoga Hospital
12. Diane Mickle Gotebiowski, Chronic Care Coordinator, Eddy Visiting Nurse Association
13. Dennis Mosley, Program Director of Peer Support Program, Mental Health Empowerment Project, Inc.
14. Kelly Owens, Interim Center Director, Adirondack Health Institute - Hudson Mohawk Area Health Education Center
15. Phillis Wang, Interim Director, Hudson Mohawk Area Health Education Center
16. Leza Wood, Executive Director, Hudson Mohawk Area Health Education Center

Appendix A. Community-Based Organizations in the AMCH PPS Area

Accent Health Care Services, Inc.

Home health services

<http://www.accenthealthcareservices.com/>

518-237-2700

Albany Community Action Partnership

Child care, early childhood education, and food pantry

<http://www.albanycap.org/>

518-463-3175

Albany County Department of Health – Community Health Worker Program

Assistance for medical care, food, clothing, and shelter for families

518-447-4684

Albany County Rural Housing Alliance, Inc.

Grant and loan programs for first-time home buyers

<http://www.acrha.org/>

518-765-2425

Albany Damien Center

HIV/AIDS support services

<http://www.albanydamiencenter.org/>

518-449-7119

Alliance for Positive Health

HIV/AIDS support services/ chronic disease

<http://www.allianceforpositivehealth.org/>

518-434-4686

Any-Time Home Care, Inc.

Home health services

<http://www.anytimehomecare.com/>

845-353-8280

Asthma Coalition of the Capital Region

Asthma initiatives

<http://www.capitalregionasthma.org/>

518-591-4563

Belvedere Addictions Center

Addiction outpatient and day programs

www.belvedereaddictionscenter.com

518-694-9400

Berkshire Farm Center & Services for Youth

Community-, home-, and school-based programs for youth

<http://www.berkshirefarm.org/>

518-781-4567

Big Brothers Big Sisters of the Capital Region

Youth mentoring programs

<http://www.bbbscr.org/>

518-862-1250

BirthNet

Maternity care education

<http://www.birthnewyork.org/birthnet/>

518-482-2504

Breastfeeding USA – Capital Region (NY) Chapter

Breastfeeding education

<https://breastfeedingusa.org/>

anne.o@breastfeedingusa.org

Camphill Hudson

Residential and recreational programs for individuals with developmental disabilities

<http://www.camphillhudson.org/>

518-828-3431

Cancer Services Program of Albany County

Free breast, cervical, and colon cancer screenings

<http://www.cspofalbandren.com/>

518-525-8680

Capital District Center for Independence, Inc.

Advocacy, skills training, and housing

<http://www.cdciweb.com/>

518-459-6422

Capital District Child Care Council

Child care provider education programs

<http://www.cdcccc.org/>

518-426-7181

Capital District Educational Opportunity Center

Workforce development and employment assistance
<https://www.hvcc.edu/eoc/>
518-273-1900

Capital District Tobacco-Free Coalition

Tobacco-free advocacy and support
<http://smokefreecapital.org/>
518-459-2388

Capital District Women’s Employment & Resource Center (WERC)

Career services for women
<https://www.hvcc.edu/eoc/>
518-462-7600 ext. 184

Capital District YMCA

Diabetes prevention program, child care, and youth programs
<http://cdymca.org/>
518-869-3500

Capital Region BOCES – CAPIT Program

Youth intervention and staff training for violence prevention
<http://www.capitalregionboces.org/Calendar/CAPIT/Index.cfm>
518-464-3944

Capital Region Child & Adolescent Mobile Crisis Response Team

Youth crisis services
<http://www.parsonscenter.org/program/capital-region-child-and-adolescent-mobile-crisis-team/>
518-549-6500

Capital Region Family Life Institute

Family mentoring services
<http://www.crflm.org/howitworks.htm>
518-365-0741

Capital Region Theological Center

Clergy and non-clergy education
<https://crtc.org/>
518-462-2470

Capital Region Workforce Investment Board (One Stop Career Center)

Job training programs
<http://capreg.org/>
518-462-7600

Capital Roots

Community gardens
<http://www.capitalroots.org/>
518-274-8685

Catholic Charities AIDS Services

HIV/AIDS services
<http://ccaidsalbany.org/>
518-449-3581

Catholic Charities Camp Scully

Youth summer camp programs
<https://campscully.squarespace.com/>
518-512-3577

Catholic Charities Community Maternity Services

Adoption, foster care, residential services, and respite care programs
<http://www.cccms.org/>
518-482-8836

Catholic Charities of Columbia and Greene Counties

WIC, nutrition, and emergency assistance programs
<http://www.catholiccharitiescg.org/>
518-828-8660

Catholic Charities of the Diocese of Albany

Disability, care coordination, and auto loan programs
<http://www.ccrda.org/>
518-453-6792

Catholic Charities Housing Office

Housing support services
<http://www.cchoalbany.org/>
518-459-0183

Catskill Hudson Area Health Education Center (AHEC)

Education programs for health professions students
<http://www.chahec.org/>
845-883-7260

Center for Excellence in Aging & Community Wellness

Chronic disease self-management
<https://www.ceacw.org/>
518-442-5530

Child Find of America

Missing children search and child abduction prevention programs
<http://www.childfindofamerica.org/>
845-883-6614

ClearPoint Credit Counselling Solutions

Budget and credit counselling
<http://www.clearpointcreditcounselingsolutions.org/>
518-438-3710

CloverPatch Early Childhood Services

Diagnostic & evaluation, and early intervention for children with special needs
<http://www.cloverpatchprograms.org/>
518-437-5524

Colonie Senior Service Centers, Inc.

Adult day services, meal, and transportation programs for seniors
<http://www.colonieseniors.org/>
518-459-2857 Ext. 303

Commission on Economic Opportunity (CEO)

Family support services, early childhood education, and employment support
<http://www.ceoempowers.org/>
518-272-6012

Community Caregivers

Free, non-medical services such as meal prep, transportation, and chores
<http://www.communitycaregivers.org/>
518-456-2898

The Community Hospice

Hospice and palliative care
<http://www.communityhospice.org/>
518-724-0242

Compeer, Inc.

Mentoring and supportive friendship program
<http://compeer.org/>
518-462-1094 Ext. 274

Concepts of Independent Choices

Consumer Directed Personal Assistance Program (CDPAP) provider
<http://www.coiny.org/>
518-459-6422

Consumer Directed Choices

Consumer Directed Personal Assistance Program (CDPAP) provider
<https://cdchoices.org/>
518-464-0810

DePaul Housing Management

Low-income senior housing services
<http://www.depaulhousing.com/>
518-459-0183

The Doula Network of the Capital-Saratoga Region

Pregnancy, birth, and postpartum support
<http://thedoulanetwork.org/>
tisha@birthnewyork.org

Easter Seals New York

Support programs for children and adults with disabilities and special needs
<http://www.easterseals.com/newyork/>
518-456-0828

Equinox, Inc.

Addiction, domestic violence, and youth support programs
<http://www.equinoxinc.org/>
518-434-6135

Family & Child Service of Schenectady

Respite care and skill building programs for individuals with developmental disabilities
<http://www.familyandchildservice.com/>
518-393-1369

The Family Life Center of Albany

Childbirth support
<http://www.albanyfamilylifecenter.org/>
518-465-0241

Fidelis Care

Free or low-cost health insurance
<http://www.fideliscare.org/>
518-427-0481

The Food Pantries for the Capital District

Food funding and holiday meals
<http://www.thefoodpantries.org/>
518-458-1167

Girls Inc. of the Greater Capital Region

Youth development programs for girls
<http://girlsinccapitalregion.org/>
518-463-1211

Grand Street Community Arts

Youth FX film/video and urban gardening programs
<http://grandarts.org/>
518-463-2222

Greene County Family Planning

Sliding fee scale for reproductive health services
<http://greenegovernment.com/departments/family-planning/>
518-719-3580

Greene County Rural Health Network

Grant programs for health-related initiatives
<http://www.greenehealthnetwork.com/>
518-943-5072

Healthy Capital District Initiative

Free or low-cost health insurance and community health advocates
<http://www.hcdiny.org/>
518-462-7040

Healthy Families Albany County

Home visiting program for families with newborn
<http://www.parsonscenter.org/program/healthy-families-albany-county/>
518-447-7054

Home Helpers

in-home health care agency
<http://local.homehelpershomecare.com/albany/home/>
518-459-4663

Homeless and Travelers Aid Society

Mobile crisis, homeless emergency service, and housing support
<http://hatas.org/>
518-463-2124

Hope House, Inc.

Residential recovery program for adults and teens with special needs and outpatient clinic
<http://www.hopehouseinc.org/>
518-482-4673

The House of the Good Shepherd

Residential, treatment, and education programs for children
<http://www.hgs-utica.com/>
315-235-7600

Hudson Mohawk Area Health Education Center (AHEC)

Education programs for health professions students
<http://www.gohealthcareer.org/>
518-480-2432

International Caesarean Awareness Network of the Capital District

Support group for women and families with Caesarean birth experience
<http://www.ican-online.org/capitaldistrict/>
1-800-686-4226 Ext. 164

In Our Own Voices, Inc.

Domestic & Sexual Violence Hotline, advocacy, support groups, counseling, HIV/Hepatitis C testing, social events and training & technical assistance.
<http://www.inourownvoices.org/>
518-432-4188

Interfaith Partnership for the Homeless

Shelter, health and youth programs
<http://www.interfaithpartnership.com/>
518-434-8021

Kee to Independent Growth, Inc.

Service coordination services for individuals with disabilities
<http://www.keetoindependentgrowth.com/>
518-309-3557

LaSalle School

Residential treatment, day education, and outpatient counselling for youth
<http://www.lasalle-school.org/>
518-242-4731

The Legal Project

Free and low-cost legal services
<http://www.legalproject.org/>
518-435-1770

Lifesong, Inc.

Employment and skill training programs for individuals with developmental disabilities
<http://www.lifesonginc.org/> 518-406-5157

Lighthouse Guild

Rehabilitation, education, and adult day health care for blind and visually impaired
<http://www.lighthouseguild.org/>
518-436-1520

Literacy New York Greater Capital Region

Literacy and tutoring services
<http://literacynycap.org/>
518-452-3381

Living Resources Certified Home Health Care Agency, Inc.

Home care services
<http://www.livingresources.org/>
518-867-8800

MAMI Interpreters

Interpreting and translations services in health and legal settings
<http://mamiinterpreters.org/>
518-426-1626

Mental Health Empowerment Project, Inc.

Peer support and self-help programs
<http://www.mhepinc.org/>
518-434-1393

Mohawk Opportunities, Inc.

Supportive housing and skill training programs for individuals with mental illness
<http://www.mohawkopportunities.org/>
518-374-8424

Never Alone, Inc.

Drug and alcohol rehabilitation center
845-339-4272

New York StateWide Senior Action Council

Patients' rights helpline and assistance for health and prescription drug coverage issues
<http://www.nysenior.org/>
800-333-4374

Northeast Career Planning's Individual Services

Employment support programs for individuals with mental illness and disabilities
<http://www.northeastcareer.org/>
518-465-5201

Northeast Parent & Child Society

Family preservation programs and residential care for youths
www.neparentchild.org
518-346-1284

Northeast Psychological Associates

Outpatient behavioral health counselling
<http://www.nepsych.com/>
518-456-2060

Northern Rivers Family of Services

Behavioral health, care coordination, education, and residential programs
www.northernrivers.org
518-426-2600

Occupational & Environmental Health Center (OHEC)

Occupational health clinical center
<http://occmedgroup.emblemhealth.com/>
518-690-4420

Parsons Child & Family Center

Behavioral health centers, early childhood programs, and family support programs
<http://www.parsonscenter.org/>
518-426-2600

Postpartum Resource Center of New York

Perinatal mood & anxiety disorder support
<http://postpartumny.org/>
1-855-631-0001

Pride Center of the Capital Region

Advocacy for Lesbian, Gay, Bisexual, Transgender, and Queer individuals
<http://www.capitalpridecenter.org/>
518-462-6138

Refugee and Immigrant Support Services of Emmaus

ESL and employment support services
<http://risse-albany.weebly.com/>
518-621-1041

The Salvation Army Empire State Division

Hunger relief, housing, and emergency assistance
<http://empire.salvationarmy.org/>
518-463-6678

Senior Services of Albany

Adult day and senior support programs
<http://seniorservicesofalbany.com/>
518-465-3322

Sexual Assault and Crime Victims Services of Planned Parenthood Mohawk Hudson, Inc.

Crisis counselling for domestic violence and sexual assault victims in Warren County
<https://www.plannedparenthood.org/ppmh>
1-866-307-4086

Shades of Light

Postpartum support for new mothers
<http://shadesoflightps.org/>
518-955-6770

South End Children's Café

Youth tutoring and meal support
<http://www.southendchildrenscafe.com/>
518-275-8890

St. Paul's Center

Emergency housing and transitional support
<http://stpaulscenter.com/>
518-434-2910

Sudden Infant & Child Death Resource Center

Education and grievance support for families affected by SIDS
<http://www.stonybrookmedicalcenter.org/sids/helpforgrievingfamilies>
518-262-5918

Taxpayer Advocate Service

Free assistance for IRS problems
<https://www.irs.gov/Advocate>
518-292-3001

ToLife!, Inc.

Support group for patients with breast cancer
<http://www.tolife.org/>
518-439-5975

Trinity Alliance of the Capital Region

Food, addiction, literacy, and transitional housing programs
<http://www.trinityalliancealbany.org/>
518-449-5155

United Way 2-1-1 Northeast Region

Food, shelter, referral service, workforce and youth development programs
www.unitedwaygcr.org
518-456-2200

Unity House of Troy, Inc.

Domestic violence services, housing, food and babies pantries
<http://www.unityhousesny.org/>
518-274-2607

Upper Hudson Planned Parenthood

Free or low-cost reproductive services
<https://www.plannedparenthood.org/planned-parenthood-upper-hudson>
518-434-5678

VNA Home Health

Certified home health care agency
<http://vnaalbany.org/>
518-489-2681

Washington Irving Adult & Continuing Education Center

Free ESL and GED classes
http://www.schenectady.k12.ny.us/Washington_Irving_Adult_and_Continuing_Education_Center/
518-370-8220

Whitney M. Young, Jr. Health Services

Affordable medical, dental, and addiction services and WIC program
<http://www.wmyhealth.org/>
518-465-4771

Wildwood Programs, Inc.
Education, residential, and service
coordination programs for individuals with
disabilities
<https://www.wildwood.edu>
518-640-3356

**Women's Health Center of Albany
Medical College WIC Program**
Free nutrition program for women and
children
[https://www.amc.edu/Patient/services/obgyn
/wic_program/](https://www.amc.edu/Patient/services/obgyn/wic_program/)
518-432-4033

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