Cultural Competency/Health Literacy Strategy

December 31, 2015

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Introduction

The Alliance for Better Healthcare, LLC ("Alliance") is committed to significantly enhancing cultural competency and health literacy across its service area through its participation in New York State's Delivery System Reform Incentive Payment (DSRIP) program. Cultural competency and health literacy are foundational elements of delivering high-quality patient-centered care and reducing health disparities that exist for the Medicaid population and uninsured generally, and in the Capital District and surrounding areas specifically. Disparities in care contribute to poorer health among minority populations, based on any number of factors including: race, ethnicity, sexual orientation, disability status and demographic factors, among others. Disparities translate into decreased utilization of preventive services, increased rates of unnecessary emergency room visits and poorer outcomes overall – often due to the way in which a lack of provider cultural competence or patient health literacy affects patients' ability to participate in their own care. The Alliance's goal is to improve self-care and outcomes through increased cultural competence and health literacy through a multi-pronged strategy. This approach will connect patients to services that deliberately incorporate and address key social determinants of health through increased sensitivity to, understanding of and attention to cultural and linguistic factors in health care delivery.

This document will serve as a blueprint for Alliance's administrative, medical, behavioral and community-based networks, in collaboration with its' Cultural Competency and Health Literacy Task Force, to meet and exceed DSRIP goals and requirements to improve cultural competency and health literacy for minority groups across its service area. This dynamic document will be continuously refined as implementation of Cultural and Linguistic Competence strategies and tactics develop with ongoing input from consumers, medical, behavioral and community-based partners and the Task Force. Emerging data that illustrates the impact of cultural and linguistic competence on disparities in health care delivery will also be sought and incorporated.

Governance

The Alliance Performing Provider System (PPS) represents a collaborative network of more than 2,000 providers and community-based organizations. These partners include 3 health systems with group practices, 2 Federally Qualified Health Centers (FQHCs), an independent group practice, and a large and highly diverse group of community-based organizations that Alliance continues to build upon.

The Alliance for Better Health Care is governed by a five member Board including: Ellis Medicine; Samaritan Hospital, which represents St. Peter's Health Partners; St. Mary's Healthcare in Amsterdam; Hometown Health Centers; and Whitney M. Young, Jr. Health Center. Additional governance is provided by a Board of Managers; comprised of two managers from each of the five Alliance members, two managers from Capital Care Physicians, two managers from Community Care Physicians, one manager from each of two identified community practitioners, and one manager representing the Project Advisory Committee (PAC). Graphic 1 illustrates the Alliance governance structure.

Graphic 1: Alliance Organizational Structure
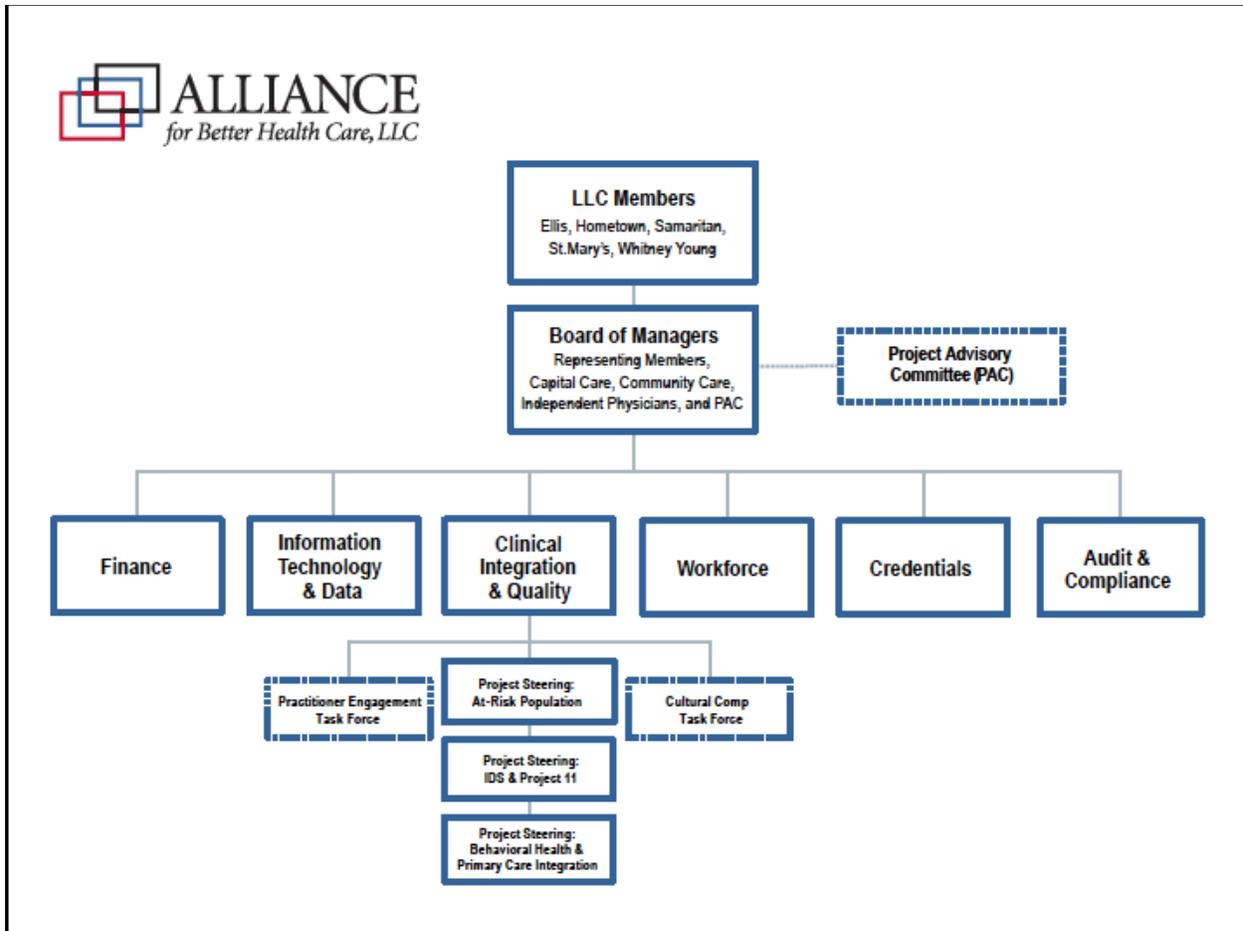
Included within the governance structure, and in accordance with DSRIP requirements, the Alliance has created the Cultural Competency and Health Literacy Task Force. As illustrated in Graphic 1, the task force is an advisory body to the Clinical Integration and Quality Committee. The Task Force will be comprised of representatives from PPS partners and community-based organizations and will represent the various diverse populations served by the PPS including, but not limited to, ethnic, racial and linguistic minorities as well as Lesbian, Gay Bisexual and Transgender individuals and other minority groups.

The ultimate goal of the task force is to enhance consumers' ability to receive care that supports their cultural and linguistic needs and beliefs among others and, to significantly enhance health literacy. Through the delivery of culturally and linguistically competent care, the Alliance seeks to enhance consumers' ability to participate in their health care in a meaningful way as a result of improved provider performance as well as enhanced self-literacy and the ability to perform self-care. The task force goal supports an overall aim of DSRIP, to improve the quality of care delivered to patients, by decreasing measurable disparities in care outcomes among minority populations.

The task force is primarily an advisory body to the PPS and its' partners on matters related to cultural competency and health literacy for DSRIP overall and on project-specific matters. The task force is

further a resource for Alliance staff and PPS partners to utilize on an as needed basis. The task force will convene both in-person and virtually on a regular basis, with input sought as needed.

The proposed Cultural Competency and Health Literacy Task Force charter is below:

The Cultural Competency and Health Literacy Task Force is committed to enhancing cultural competency and health literacy across the Alliance PPS service area. As key providers of both healthcare and community-based supports, the task force will utilize their expertise working with populations with low socio-economic status, racial and ethnic minorities, and other subpopulations who experience health disparities to help target interventions that will reduce health disparities and improve the delivery of culturally and linguistically appropriate services. The task force will guide all Alliance activities that directly relate to cultural competency and health literacy and will also serve as an advisor on training of providers and community health workers, data collection of patient demographics and social needs, assessment of community resources, and patient education and other interventions on Alliance's eleven projects.

PPS Service Area

The Alliance serves an estimated 193,000 diverse Medicaid and uninsured population in six counties (Albany, Fulton, Montgomery, Rensselaer, Saratoga, and Schenectady) in upstate New York. The demographics for the six counties in the Alliance service area are found in Table 1. Comparison to the entire state is also found in Table 2, though it should be noted that New York City likely influenced the outcomes. Notably, the City of Schenectady has a large population of Guyanese, comprising close to 12% of the total city population, many of whom are uninsured. Of all six counties in Alliance's service area, Montgomery County's Hispanic/Latino(a) population comprises the largest percentage of the total population (12.6%). The Black/African American population comprises the largest percentage of the total population in Albany County (13.7%).

Poverty is also a major factor in the PPS service area. According to the U.S. Census, the highest poverty rates in the service area are in Montgomery and Fulton Counties, 18.7% and 16.1%, respectively, which were higher than the state average as well. Although the rates are not as high in the other counties, they are still significant in Rensselaer (13.2%), Albany (13.0%) and Schenectady (12.7%) Counties. Racial/ethnic disparities related to poverty are apparent when the data are stratified. By considering the demographics in each of the six counties, the Alliance will be able to design interventions to ensure priority populations are targeted most effectively to reduce health disparities.

Table 2: State and County Demographics for the Alliance Service Area

County Demographics	Persons Below Poverty Level	Black/ African American	Hispanic or Latino(a)	Foreign Born Persons	Guyanese
Albany	13.0%	13.7%	5.7%	9.1%	NA
Rensselaer	13.2%	7.3%	4.5%	5.1%	NA
Schenectady	12.7%	11.3%	6.6%	8.6%	12%*
Saratoga	6.5%	1.8%	2.9%	4.6%	NA
Fulton	16.1%	2.0%	2.8%	2.3%	NA

Montgomery	18.7%	2.7%	12.6%	3.5%	NA
New York State	15.3%	17.6%	18.6%	22.1%	NA

Data Source: U.S. Census; * UMatter Schenectady Survey 2013

As part of the application for DSRIP, the Alliance conducted a Community Health Needs Assessment (CHNA) to assess health systems' resources and its utilization, and more importantly, the health needs for the general population, Medicaid insured, and uninsured population. Not surprisingly, persons below the poverty level experienced significant health disparities, including a lack of access to and utilization of appropriate healthcare. In addition, significant disparities based on race and ethnicity emerged for Black/African American and Hispanic or Latino individuals. Further, immigrants and refugees experience significant barriers to healthcare from unmet language needs and unfamiliarity with navigating the system.

The Cultural Competence/Health Literacy Task Force conducted a number of focus groups to identify and prioritize populations beyond the general Medicaid and uninsured populations. The Task Force leadership presented findings from the CHNA and solicited feedback to identify priority populations. The Task Force discussed for specific cultural competency/health literacy initiatives, as well as identify significant barriers to care and interventions to address them.

Priority populations identified by the Task Force included racial/ethnic groups experiencing significant disparities, persons living in poverty, immigrants and refugees, individuals with behavioral health needs (e.g., patients with only behavioral health diagnoses, as well as those with co-occurring illnesses), and members of the Lesbian Gay, Bi-sexual, Transgender (LGBT) community. There are also large numbers of immigrants in the Cities of Albany and Rensselaer. Clearly, these groups are not mutually exclusive; an individual can be a member of one or more of these sub-populations and needs of sub-populations are evident in all counties in the PPS service area. The needs of all of these populations are described below.

Table 3: Priority Populations Affected and Needs

Thematic Needs	Specific Issues	Priority Populations Affected
Transportation and Navigation Barriers	• Lack of automobile ownership; • Availability and accessibility of transportation and ability to navigate the system	• Racial/ethnic groups experiencing significant health disparities • Immigrants and refugees
	• Decentralized facilities	• Immigrants and refugees
Financial Barriers	• Increased time spent securing basic needs making health care a lower priority	• Persons living in poverty
	• Immigrant status resulting in Medicaid ineligibility	• Racial/ethnic groups experiencing significant health disparities

Barriers to Patient Self-Management	• Medication adherence due to affordability, complexity and side effects	• Individuals with BH diagnoses
	• Impact of low (health) literacy levels on self-management	• Persons living in poverty
Lack of Data on Race/Ethnicity	• Race/ethnicity data is not captured by providers • Lack of ability to track changes in health disparities over time, stratify sub-populations and target interventions	Racial/ethnic groups experiencing significant health disparities
Barriers to Accessing Primary Care	• Difficult to get established with PCP overall • Lack of sufficient access, especially during off-hours and to PCPs with cultural and linguistic competencies. • Fears among providers regarding serving minority populations or those with substance use disorders and/or behavioral health problems • Lack of willingness of individuals with behavioral health conditions to be seen outside of the behavioral health setting in primary care or other medical settings	Racial/ethnic groups experiencing significant health disparities Immigrants and refugees
	• Long wait times to get appointment at facilities closest to downtown with the greatest accessibility to transportation	• Immigrants and refugees
	• LGBT-friendly providers are not easily identified or "promoted"	• LGBT
Additional Barriers to Accessing Behavioral Health Care	• Lack of coordinated outpatient BH services	• Individuals with BH diagnoses
	• Long waits to be seen by outpatient BH providers	• Individuals with BH diagnoses
Provider Cultural Competency	• Lack of provider training about unique medical challenges experienced by these populations	• Immigrants and refugees • LGBT
	• Lack of provider knowledge about the cultural and religious implications on health care decisions	• Racial/ethnic groups experiencing significant health disparities • Immigrants and refugees

	• Providers not asking questions about sexual orientation or gender identity therefore miss screening for health disparities common among this population	• LGBT
	• Lack of provider awareness of community-based BH resources	• Individuals with BH diagnoses
	• Availability of language services	• Racial/ethnic groups experiencing significant health disparities • Immigrants and refugees
Stigma/Discrimination	• Social stigma associated with mental health and substance use disorders	• Individuals with BH diagnoses
	• Discrimination, or fear of it, against LGBT individuals	• LGBT

Despite the initial data provided in the CHNA and from the Census, such data is insufficient to truly understand disparities – and what to do about them. Furthermore, a gap in standardized collection of race, ethnicity, and language preference (REAL) data during patient encounters exists across the PPS service area. This finding is consistent with results from a 2011 study conducted by the Institute for Diversity in Health Management, an affiliate of the AHA, that found only 18% of hospitals were collecting REAL data at the first encounter and using it to assess gaps in care.[1] Improved data collection would enable deeper actionable analyses with targeted interventions designed for priority populations, and sub-populations that might not have been identified within the initial CNA methodology. As such, an approach to address this gap is included in this Cultural Competency/Health Literacy strategy and will be discussed in greater detail in the sections below. Further, interventions to reduce these health disparities are described via the Alliance's 11 projects and the activities of the Task Force broadly.

Cultural Competence /Health Literacy Evidence

Cultural competence is defined as "the ability of health care providers and organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to: 1) value diversity; 2) assess themselves; 3) manage the dynamics of difference; 4) acquire and institutionalize cultural knowledge; and 5) adapt to diversity and the cultural contexts of individuals and communities served." Given the health disparities identified through the CHNA and the stakeholder focus groups, there is a need to improve cultural competence broadly across the PPS in order to provide culturally and

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[1] Equity of Care. "Reducing Health Care Disparities: Collection and Use of Race, Ethnicity, and Language Data." Signature Leadership Series. August 2013. Available at: http://www.hpoe.org/resources/hpoehretaha-guides/1431.

linguistically appropriate services – i.e. health care services that are respectful of and responsive to cultural and language needs.

Health literacy can be defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions."[2]

Providers, patients and their families, and organizations all must have the capacity and skills to engage in the health care system in a manner that maximizes positive health outcomes, including access to and satisfaction with appropriate services. Further, health literacy is necessary in order for patients and their families to, among other things:

- Locate information and health care services
- Communicate their needs and preferences
- Process information they receive and be able to act upon that information, and understand the choices, consequences and context of the information and services

Health literacy enables those who provide information to patients and families (e.g. clinicians, pharmacists, community health workers) to, among others things:

- Communicate information about health and health care services
- Help patients and families locate appropriate health care services
- Process and understand what people are trying to communicate (explicitly and implicitly)
- Understand how to provide useful information and services, and
- Decide which information and services work best for different situations and people so they can act

Health literacy infrastructure is also incredibly important in the context of organizations (healthcare systems, managed care organizations, clinics, community-based organizations and others) in order for the organization to support patients and families and providers, and to remove barriers. The Alliance strategy incorporates many activities and tasks to support partner organizations as they further develop into health literate organizations.

Overview of Strategy

The cultural competency/health literacy strategy developed by the Alliance and the Task Force is built upon the following foundational elements:

- Best practices and resources identified in the literature on these themes;
- An assessment of current community needs in the PPS service area;
- Prioritization of populations for targeting interventions based on community and stakeholder input; and
- Requirements set forth by NYS Department of Health.

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[2] Centers for Disease Control. "Health Literacy." Webpage. Available at: http://www.cdc.gov/healthliteracy/learn/.

Of great importance, is the recognition that a cultural competence strategy relies on understanding the needs of the population served and resources that exist within the community and in the health system. Community-based organizations have knowledge of, and access to, resources that impact the upstream factors of health for patients (i.e. social determinants of health). Simultaneously, information on navigating the healthcare system is a crucial need for patients, and in particular, the priority groups identified. As such, Alliance sees a major role of the Cultural Competency/Health Literacy Task Force to "bridge" gaps between the medical, behavioral, and psycho-social support systems. The Task Force will further work with Alliance and its partners to develop a strategy to provide culturally and linguistically appropriate services to patients across the full continuum of care.

Due to its multi-faceted nature, a strategy to enhance the cultural competency/health literacy requires an approach that targets different levels of stakeholders – the PPS broadly, health systems, provider groups, clinicians, community-based organizations, navigators and community health workers, and patients. The Task Force identified tasks around the following themes: leadership and governing, data and measurement, education, training, and communication. This strategy has been visualized in Graphic 2.

Graphic 2: Visual Representation of Cultural Competency and Health Literacy Strategy by Stakeholders and Themes
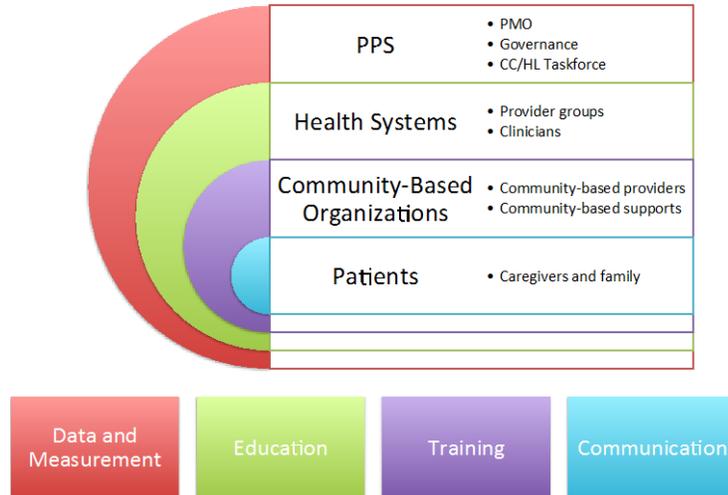
This strategy is also derived from key elements identified in the June 2015 implementation plan. Alliance will meet Milestone deadlines, as agreed upon in the Implementation Plan submitted to the Department of Health. These elements and their corresponding deadlines are summarized in Table 3.

Table 3: Key Elements of Cultural Competency and Health Literacy Strategy

Key Elements	DSRIP Year and Quarter Start/End Dates
1. Cultural competency and health literacy baseline assessments of major partners	DY1Q4/DY2Q1
2. Assessment of CBOs to determine best community-based locations (e.g., faith-based communities) to engage priority populations	DY1Q4
3. Hold community forums and focus groups to assess community needs	DY1Q4/ongoing
4. Conduct gap analysis	DY2Q2
5. Develop organizational plans and dashboards for tracking implementation progress and changes in cultural competency and health literacy outcomes	DY2Q3/DY2Q4
6. Begin implementation	DY3Q1
7. Monitoring and evaluation	DY3Q1/ongoing

Summary of Approach

Leadership and Governance

Organizational commitment to cultural competence and health literacy is critical for successful implementation of interventions to improve the responsiveness of the health care system to the needs and preferences of culturally diverse populations.

Data and Measurement

The development, implementation and evaluation of targeted strategies to improve cultural competence and reduce health disparities are dependent on the capability to capture accurate data across process and outcomes domains, for both planning and monitoring/evaluation purposes.

The Alliance strategy for data collection and measurement includes involving the community (through CBO representation), providers, health plans and staff in the design and implementation of data collection activities, and the application of data to program interventions. The Alliance will further leverage Domain 2 and Domain 3 metrics and evaluate the success of cultural and linguistic interventions based on changes in disparities in care delivery over time.

With technical assistance provided by Alliance, partners will be asked to create a demographic profile of the community, patients and staff. These profiles will inform targeted interventions as well as workforce hiring practices and requirements that will be discussed in the following section.

Workforce/Staff Development

A multicultural workforce engaged in ongoing education and training in cultural and linguistic competence is integral to providing appropriate services to patients.

Working through the Workforce Committee with the input of the task force, the Alliance will recommend strategies to diversify the workforce of health systems and provider organizations, and to embed cultural competence throughout their human resources structure. This includes implementing organizational policies and practices, including hiring and retention policies, that foster multiculturalism within all levels of the organization; including cultural competence requirements in recruiting practices, performance, evaluations, and promotion decisions; and promoting the acquisition and application of specialized expertise (such as bilingual and bicultural skills) among staff to ensure services are culturally appropriate.

This strategy will be informed by the demographic profiles discussed in the Data Collection section. For example, the Alliance will seek to encourage partners to hire staff that represent the demographic and ethnic populations they serve. In particular, the PPS and its' partners will seek to hire navigators and peer supports who can truly relate to the population based on shared demographic characteristics and understanding.

Education

Becoming a culturally competent organization requires a thorough understanding of the principles that characterize cultural competence. Achieving buy-in from staff at all levels of the organization is critical, and this requires a solid understanding of, and grounding in, why cultural competence and health literacy are important to the organization and should be important to them. This includes the impact of culture on disparities in access, satisfaction and outcomes.

The Alliance strategy for education has two major components: (1) the development of new, and identification of existing, materials and information to be used to educate PPS, health system, and CBO clinicians and staff about cultural competence generally and the DSRIP Cultural Competence/Health Literacy goals, objectives, and tasks specifically; and (2) the deployment of educational vehicles to their intended audiences.

Training

The Alliance Training Strategy consists of 3 major components: (1) Organizational Assessment of Training Needs; (2) Development of Curricula; and (3) Deployment of Training, and monitoring of effectiveness of Training.

Organizational Assessment of Training Needs: The Alliance will provide Partner Organizations with technical assistance regarding the assessment of staff training needs. This includes guidance on how to perform such assessments, as well as recommendations for appropriate assessment tools that such organizations can use.

Development of Curricula: Training in cultural competence and heath literacy generally takes on one of two forms. The first is training programs focused on specific cultural groups (e.g. racial/ethnic minorities, LGBT). The second is training programs in generic or universal models (e.g. power-sharing, active listening). The Alliance training strategy will include both, depending on the results of each organization's assessment. Alliance will develop and/or identify existing training materials and curricula that will include some or all of the following:

- o Universal skills and themes such as reflective awareness, empathy, active listening techniques, and the cognitive mechanisms contributing to cultural insensitivity or blindness, such as implicit biases or stereotype threats.
- o Group-specific health-related attitudes, values, and beliefs for each priority group. Alliance will work closely with CBOs and the task force to ensure that materials used for this component are sensitive to the risk of perpetuating cultural biases or stereotypes.

Cultural Competence/Health Literacy Training Needs Assessments will be administered in Health Systems and Provider Organizations. The PPS will provide technical assistance as needed. Such assessments will include clinicians and staff at all levels of the organization who are identified as having direct contact with patients/clients, or are in leadership/governance roles.

Deployment of Training: Once the assessment has been completed, the PPS will make recommendations for a training program that is tailored at a high level to the type of organization, staffing needs, and implementation timeframes.

The Alliance believes that that cultural competence is a process that is enhanced in stages by building upon prior knowledge and experience, rather than an outcome. As a result, the Alliance will implement a process to assess training outcomes. Such assessments will address such issues as achieving behavioral changes among trainees and measuring impact on health care delivery and health outcomes (e.g., patient satisfaction).

Alliance is proposing a phased-in approach to training, beginning with pilot self-assessment(s) at one or two selected sites (to be determined). Cultural competence and health literacy training will be based on best practices in the area as well as nationally.

Alliance will look to CBOs to provide input from the community in the development or identification of existing training materials, and will take every opportunity to leverage CBO expertise in the deployment of training throughout the PPS. Specifically, the PPS will look to CBOs to provide in-service training, continuing education and other professional development activities that focus on strengthening skills for collaboration with culturally and linguistically diverse communities.

Communication

Communication includes understanding of different communication needs and styles of the client population, culturally competent oral communication, and culturally competent written /other communication, communication with community and intra-organizational communication.

Alliance will assess the availability and acceptability of existing language services and promote best practices among partner organizations and establish practice and training guidelines for the provision of language services. Alliance will provide support to partner organizations to develop and align patient materials and caregiver tools to populations served as well as literacy levels.

Overall Approach Regarding Key Stakeholders and Their Activities

Each of these four themes include activities for the PPS broadly, providers, and CBOs. A summary of these strategies is in Table 4 below. The activities described in the table are drawn from the June 2015 implementation plan.

Table 4: Summary of Key Activities to be performed by Stakeholders Related to Cultural Competency and Health Literacy

	Leadership and Governance	Data and Measurement	Workforce	Education	Training	Communication
PPS	• Review and update vision, goals and mission to reflect commitment to CC/HL • Foster an environment of cultural competence (i.e. embed leadership on CC/HL into the organization and project workgroups) • Identify committed champions across the PPS and at partner organizations to lead implementation efforts	• Provide support to partner organizations to standardize data fields and collection across the organization to include accurate capture of cultural competence and health literacy-relevant information. • Conduct organizational self-assessments of CC/HL • Develop dashboard for ongoing monitoring of performance improvement strategies. • Work with CBOs to conduct local community focus groups	• Develop staff recruitment, retention and promotion strategies that reflect the populations served. • Partner with CBOs to build a robust network of community health workers.	• Development of educational materials reflecting key themes and messages regarding the importance of CC/HL and those specific to DSRIP program • Assist each health system/provider organization to develop an implementation plan for educational activities within the organization.	• Provide partner organizations technical assistance regarding the assessment of staff training needs and suggested curricula.	• Identify culturally appropriate acceptable communication strategies and technologies for sharing information with priority populations (e.g. creating electronic and interactive resource guides for CHWs to use that consider cultural and linguistic needs)

Health System Partners	• Review and update vision, goals and mission to reflect commitment to CC/HL • Establish a mechanism for community input and involvement to complement the governing boards • Identify a committed staff champion to coordinate CC/HL activities at the organizational level	• Explore incorporating CC/HL item sets on existing CAHPS surveys • Standardize data fields and collection across the organization to include accurate capture of CC/HL-relevant information • Create a demographic profile of their community, their patients, staff and organizational leadership	• Implement staff recruitment, retention and promotion strategies that reflect the populations served	• Adapt and implement educational programs for their clinicians and staff, utilizing the materials and guidance provided by the Alliance	• Assess performance on CC/HL, and baseline training needs of staff, and create training plans and curricula that address CC/HL, at both the organizational and program levels for all priority populations • Train physicians in the PCMH/APC AHRQ Toolkit EMR Prompts and leverage a teach-back method	• Work with the Alliance and with CBOs to standardize and align patient materials and caregiver tools to address the needs of priority populations. • Develop and implement a plan to deploy these materials across the system • Develop targeted outreach strategies to improve access to care with the input of the Task Force and CBOs
CBOs	• Provide input on the PPS activities broadly through PAC meetings • Participate on the CC/HL Task Force • Participate and contribute to the development of the Community Based Services Council • Participate on project workgroups as opportunities are identified • Help identify community members and patients to serve on governance bodies	• Contribute expertise on available community resources for PPS, as well as specific projects' gap analyses • Provide input on the collection of demographic data based on experiences with priority populations • Convene focus groups and community forums on behalf of PPS	• Assist the Alliance with recruiting and hiring CHWs and patient navigators, utilizing CHWs and patient navigators already working in the community	• Provide feedback on tools educational tools to be used across the PPS and with partner organization on CC/HL	• Advise on baseline training needs of staff, including those working with priority populations • Assist with in-service training, continuing education and other professional development activities that focus on strengthening CC/HL skills as feasible • Utilize "Train the Trainer" model whereby the PPS will leverage CBO champions to support training of CHWs	• Provide input on patient materials and caregiver tools to address the needs of the population (e.g., linguistic needs) • Provide input on how to connect patients with community resources and strategies to encourage patient self-management • Guide activities related to empowering patients and families to participate in governance bodies

Project-based approach

As described in the overall strategy, Cultural Competency and Health Literacy are important themes to be incorporated throughout the Alliance's work. In addition to these PPS-wide activities, there are opportunities in each of the 11 projects to incorporate these efforts, whether it be through training for providers or patient navigators, patient-friendly educational materials or integrating social services into patient assessments, care and discharge planning. Activities related to cultural competency and health literacy have been identified for each project and categorized as opportunities for data collection/assessment of community resources, training for providers and/or patient navigators, patient education and additional interventions. In some projects, the submitted implementation plan specifically includes outreach to the Cultural Competency and Health Literacy Task Force. Others do not explicitly state, but an analysis to prepare this strategy has identified a number of potential opportunities for engagement of the Cultural Competency and Health Literacy Task Force or community-based organizations. These activities are summarized in Appendix 2 by project. The Cultural Competency and Health Literacy Task Force will first prioritize activities committed to in the implementation plan, before engaging in additional work. To the extent possible, the Cultural Competency and Health Literacy Task Force will serve in an advisory role to the projects and will also help identify community-based organizations to serve on project workgroups for more extensive collaboration.

Many of these projects also address the needs described above for the priority populations. A summary of how the Alliance and projects will address these needs is found in Table 5.

Table 5: Priority Populations and Planned Interventions

Priority Populations	Planned Interventions
Persons living in poverty	- Work with the Schenectady Bridges program to expand Bridges Out of Poverty trainings across the 6 county region (2.d.i.) - Identify Bridges Champions at each partner organization to coordinate and conduct trainings (2.d.i.) - Look into becoming a Bridges to Health pilot site to explore innovative strategies to connect this population to health care (2.d.i.) - Promote trainings on trauma-informed care (4.a.iii.) - Asthma and tobacco projects will bring Community Health Workers into homes to identify, educate about and remediate environmental triggers (3.d.i., 3.g.ii.) - Community Health Workers will promote prescription assistance programs (All PPS) - Identify opportunities to address social determinants of health (All PPS) - Work to change policies related to discharge from practices for missing appointments 9. Ensure educational materials are available at appropriate reading levels (All PPS)
Persons living in poverty	- Work with the Schenectady Bridges program to expand Bridges Out of Poverty trainings across the 6 county region (2.d.i.) - Identify Bridges Champions at each partner organization to coordinate and conduct trainings (2.d.i.) - Look into becoming a Bridges to Health pilot site to explore innovative strategies to connect this population to health care (2.d.i.) - Promote trainings on trauma-informed care (4.a.iii.) - Asthma and tobacco projects will bring Community Health Workers into homes to identify, educate about and remediate environmental triggers (3.d.i., 3.g.ii.) - Community Health Workers will promote prescription assistance programs (All PPS) - Identify opportunities to address social determinants of health (All PPS) - Work to change policies related to discharge from practices for missing appointments - Ensure educational materials are available at appropriate reading levels (All PPS)

Behavioral Health	• Integration of BH into primary care should improve wait times for outpatient services as well as provider awareness (3.a.i.) • Explore expansion of mental health peer program (3.a.i., 4.a.iii.) • 3. Ensure training of providers to employ best practices for working with the BH population and educate on community-based BH resources (3.a.i., 3.a.iv., 4.a.iii.)
LGBT (Lesbian, Gay, Bi-sexual, Transgender)	• Identify and promote LGBT-friendly providers across the 6 county region (All PPS) • Include questions about sexual orientation and gender identity on admission/intake forms (All PPS) • Promote provider education for working with the LGBT population (All PPS) • 4. Explore designation of partner organizations as a "Leader in LGBT Healthcare Equality" by the Human Rights Campaign Foundation (All PPS)

Implementation

Alliance is proposing an ambitious and comprehensive strategy to ensure that all partners have the knowledge, skills, and abilities to deliver services in a culturally competent manner. Success is dependent not only on a well-designed, evidence-based strategy, but also on a sound implementation plan that reflects both the commitment of the State, the PPS and our partners to the goals and objectives of the Cultural Competence/Health Literacy Initiative, but also the very real challenges inherent in such an effort.

What is proposed below represents a high-level approach to implementation, not a detailed work plan. It remains subject to review and modification by the Task Force, with input from our partner organizations (Health Systems, provider organizations, and CBOs). Future iterations of this plan will provide more detailed and definitive information.

Tools and Assessments

Proposed Cultural Competence Guidelines for Health Care Organizations and Clinicians

Cultural Competence guidelines at the Organizational level serve to foster understanding of cultural competence, promote engagement with cultural competence/health literacy initiatives, and impose consistency or alignment in policies and procedures.

Alliance's strategy includes the development or identification of existing Cultural Competence/Health Literacy guidelines, and the adoption of such for the organization. These guidelines will be evidence-based, and will serve as a framework for all CC/HL activities. Alliance will encourage partner organizations to adopt guidelines within their own organizations, but will allow flexibility to allow for tailoring to the unique circumstances of each.

Content:

Guidelines are expected to address the following, at a minimum:

- Awareness of the influences that sociocultural factors have on patients, clinicians, and the clinical relationship
- Acceptance of the responsibility to understand the cultural aspects of health and illness
- Willingness to make all aspects of an organization more reflective of and responsive to culturally diverse populations
- Willingness to make clinical settings more accessible to patients
- Recognition of personal biases against people of different cultures, and
- Respect and tolerance for cultural differences

Proposed Process:

Step 1: Alliance staff will identify guidelines promulgated by select government agencies and professional societies, and evaluate for appropriateness for the organization and partner organizations

Step 2: Alliance staff will, to the extent necessary and appropriate – and in consultation with partner organization CC Champions – develop additional guidelines and/or customize existing guidelines to accurately reflect the needs and priorities of the project.

Step 3: Staff will then submit suggested options to the task force, which will evaluate them and make its recommendation to the Clinical Integration and Quality Committee.

Step 4: The Clinical Integration and Quality Committee will make it's final recommendation to the Board of Managers, which will make the final determination.

Assessments and tools to assist patients with self-management of conditions

The Alliance will assess and provide to its partner organizations information regarding tools that they can use to assist their patients with self-management of chronic conditions**.** The task force will provide input on the selection of these tools, and in particular, the cultural, linguistic and literacy factors that impact their success. The Alliance will draw from the rich evidence on best practices. Several potential tools for selection are described below:

- **The Planned Care Visit:** This resource was created by Improving Chronic Illness Care and include tools on "The Patient Experience," "The Provider Experience," and "The Self-Management Interview." Each of these tools and related videos can help patients and providers prepare for care delivery to make the most of their patient-provider interactions.[3]
- **Partnering in Self-Management Support – A Toolkit for Clinicians**: The Institute for Healthcare Improvement and New Health Partnerships host this toolkit. The toolkit is intended to give busy

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[3] Improving Chronic Illness Care. "Resource Library: Watch a Planned Care Visit." Webpage. Available at: http://www.improvingchroniccare.org/index.php?p=Planned_Care_Videos&s=225. Accessed December 28, 2015.

providers an introduction to a set of activities and changes that support patients and families in the day-to-day management of chronic conditions.[4]

- **Health Coaching Tools:** Resources and curriculum developed by the UCSF Center for Excellence in Primary Care helps patients build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Health coaches, such as community health workers, social workers, or patient navigators can empower patients to engage in self-management activities at home, work, and schools, where they spend most of their lives.[5]

Proposed refinements to data collection tools used at admission/intake

In order to better understand the populations and patients, health systems need to collect standardized data on race, ethnicity, and language to develop strategies to reduce healthcare disparities. Data collection can facilitate analyzing quality-of-care and health outcomes data using patient demographics to identify specific disparities that will then inform chosen interventions. Barriers to collecting and using patient, race, ethnicity, and primary language data include: 1) Lack of standardization of race, ethnicity, and language categories; 2) Lack of staff understanding of why data is collected; 3) Information technology limitations; 4) Staff discomfort about data collection; and 4) Patient privacy concerns.[6] The following strategy will address these barriers and create an approach for the PPS broadly and health systems to follow.
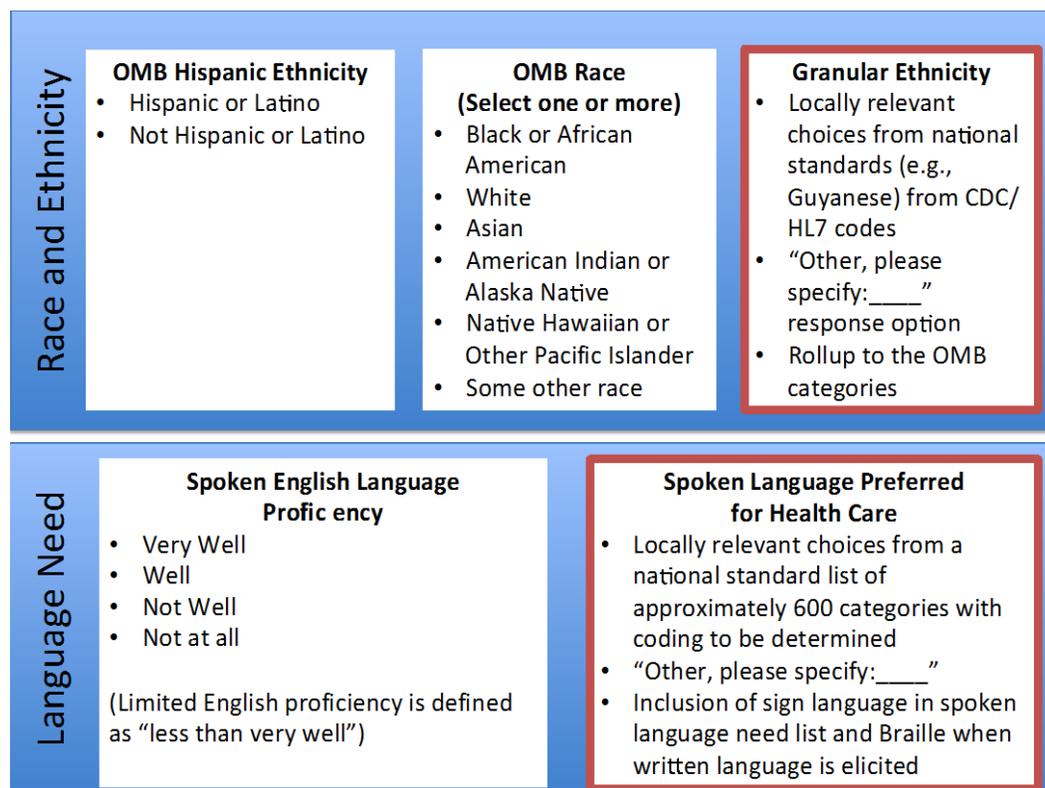
Determine appropriate data categories: The Cultural Competency and Health Literacy Task Force will meet with the Clinical Integration and Quality Workgroup and the Information Technology & Data Workgroup determine appropriate race and ethnicity categories and language need categories. The task force and the Workgroups will rely on the recommendations from the Institute of Medicine on the categories from the federal Office of Management Budget (OMB) that are appropriate. These recommendations include categories to standardize data collection at a national level (e.g., Hispanic Ethnicity, Race and Spoken English Proficiency), as well as adapt to the specific service area with more granular categories provided by the Centers for Disease Control (CDC) and HL7 in the boxes outlined in red in Graphic 3. For the Alliance service area, these granular standards could create specific categories relevant to the Guyanese population or refugees from Burma, Iraq, Bhutan, Afghanistan, Congo and Sudan. The Task Force will help identify which categories are culturally relevant to the PPS service area, the Clinical Integration and Quality Workgroup will provide input on anticipated burden for clinicians, and the Information Technology and Data Workgroup will weigh in on the feasibility of updating the electronic health record infrastructure to accommodate these updated categories.

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[4] Institute for Healthcare Improvement. "Partnering in Self-Management Support: A Toolkit for Clinicians." Website. Available at: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx. Accessed December 28, 2015.

[5] USCF Center for Excellence in Primary Care. "Health Coaches." Webpage. Available at: http://cepc.ucsf.edu/health-coaching. Accessed December 28, 2015.

[6] Health Research and Educational Trust. "Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders." Signature Leadership Series. March 2011. Available at: http://www.hpoe.org/resources/hpoehretaha-guides/1431.

Graphic 3: Proposed REAL Categories

<table>
<tr><td rowspan="2">Race and Ethnicity</td><td>OMB Hispanic Ethnicity
• Hispanic or Latino
• Not Hispanic or Latino</td><td>OMB Race
(Select one or more)
• Black or African American
• White
• Asian
• American Indian or Alaska Native
• Native Hawaiian or Other Pacific Islander
• Some other race</td><td>Granular Ethnicity
• Locally relevant choices from national standards (e.g., Guyanese) from CDC/HL7 codes
• "Other, please specify:____" response option
• Rollup to the OMB categories</td></tr>
</table>

<table>
<tr><td rowspan="2">Language Need</td><td>Spoken English Language Proficency
• Very Well
• Well
• Not Well
• Not at all

(Limited English proficiency is defined as "less than very well")</td><td>Spoken Language Preferred for Health Care
• Locally relevant choices from a national standard list of approximately 600 categories with coding to be determined
• "Other, please specify:____"
• Inclusion of sign language in spoken language need list and Braille when written language is elicited</td></tr>
</table>

Sources: Institute of Medicine, 2009, "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement"; American Hospital Association, 2013.

Alliance plans to deploy the Single Item Literacy Screen (SILS) to complement the data collected on Spoken English Language Proficiency and the Spoken Language Preferred to Healthcare. This question asks patients about "How often do you need or have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy" with a 5-point Likert scale.[7]

To address disparities for LGBT populations, the Alliance plans to include questions about gender identity and sexual orientation on admission/intake forms. Though data collection efforts are increasing in national surveys, questions regarding gender identity and sexual orientation are not often conducted in healthcare settings. Improved data collection would allow the Alliance to better understand the needs and outcomes of LGBT individuals in order to develop better interventions to reduce health disparities experienced by the LGBT population. Graphic 4 describes the recommended data collection categories for gender identity and sexual orientation. The sexual orientation data collection questions have been

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[7] Morris, N. S., C. D. MacLean, et al. (2006). "The Single Item Literacy Screener: evaluation of a brief instrument to identify limited reading ability." *BMC Family Prac*tice **7**: 21, available athttp://www.biomedcentral.com/1471-2296/7/21,

tested and assessed by the CDC in their National Health Interview Survey.[8] With regards to assessing gender identity, the literature is evolving, though the field is in agreement that a two-step process is needed; first to determine current gender identity and then to determine sex at birth. With regards to current gender identity, the first option (Current Gender Identity (1)) has been successful in allowing transgender individuals to identify as such.[9] However, some researchers believe that the first option is too restrictive for transgender and gender-queer individuals as it does not capture the multifaceted nature of gender (i.e., a person may identify as both female and also transgender) and different interpretations of sex and gender, and thus suggest the second option instead.[10] However, the second option has not been tested as thoroughly as the first option. Thus, the Cultural Competency and Health Literacy Task Force will discuss further and recommend options for current gender identity they should include.

Graphic 4: Proposed Gender Identify and Sexual Orientation Categories

Develop a methodology for data collection: Once the Cultural Competency and Health Literacy Task Force, Clinical Integration and Quality Workgroup and the Information Technology and Data Workgroup

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[8] Dahlhamer, J.M., Galinsky, A.M., Joestl, S.S., Ward, B.W. "Sexual Orientation in 2013 National Health Interview Survey: A Quality Assessment." Centers for Disease Control and Prevention; National Center for Health Statistics. December 2014. DHHS Publication No. 2015-1368. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_169.pdf. Accessed December 26, 2015.

[9] The Williams Institute & the Gender Identity in U.S. Surveillance (GenIUSS) Group. "Best Practices to Identify Transgender and Gender Minority Respondents on Population-Based Surveys." September 2014. Available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/geniuss-report-sep-2014.pdf.

[10] University of California, San Francisco Center of Excellence for Transgender Health. "Recommendations for Inclusive Data Collection of Trans People for HIV Prevention, Care & Services." Webpage. Available at: http://transhealth.ucsf.edu/trans?page=lib-data-collection. Accessed: December 26, 2015.

choose and approve the REAL data categories, SILS, the gender identity and sexual orientation questions, the three bodies will develop a methodology for data collection. The IT Workgroup will build upon its initial assessment of IT capabilities to develop a strategy targeted to each provider's IT infrastructure with work steps to integrate the categories into the respective EHRs. In doing so, the IT Workgroup will identify barriers and brainstorm solutions to address them. Simultaneously, the Clinical Integration Workgroup, in collaboration with the Cultural Competency and Health Literacy Task Force will create a guide introducing the need and importance of standardized data collection to providers, definitions of each category (particularly for the gender identity categories), and instructions on how and when to complete the data (e.g., at the first patient encounter or ask if it had not been completed before). The instructions will also include language for providers to use to explain to patients why they are collecting this data to address any concerns about patient privacy as questions about race, ethnicity, gender identity and sexual orientation can be sensitive topics.

Train staff and members on methodology for data collection: The Cultural Competence and Health Literacy Task Force and the Clinical Integration and Quality Workgroup will collaborate with the Workforce Workgroup to develop a plan and timeline for training clinical providers in collecting the data. The Workforce Workgroup will provide feedback on the instructions created for the data methodology. It is anticipated that training on the data collection efforts will be integrated in the overall cultural competency and health literacy training for providers that will be discussed in further detail in subsequent sections.

Assign accountability and monitor progress of data collection efforts: The Alliance plans to create a dashboard related to monitoring and reporting performance related to cultural competency and health literacy broadly. This dashboard will be described in greater detail in a subsequent section, however it is important to note that this dashboard will track progress on collecting REAL data, SILS, gender identity and sexual orientation on an organization-wide basis. In addition, the Information Technology and Data Workgroups will monitor requests for technical assistance related to data collection and share with the Cultural Competency and Health Literacy Workgroup, Clinical Integration and Quality Workgroup and Workforce Workgroup. If necessary, the Task Force and respective Workgroups will brainstorm potential adaptions to the strategy and training as needed. Furthermore, the task force and respective workgroups will create goals for percent completion of REAL, SILS, gender identity, and sexual orientation data collection, etc. and will highlight success in Alliance communication vehicles (e.g., quarterly PAC meetings and newsletters).

Processes and Procedures

Proposed Process to standardize / align patient materials and caregiver tools

To ensure some level of uniformity and consistency in meeting the needs of culturally diverse groups across all the entire PPS, the Alliance providers will engage in a process to standardize and align, to the extent feasible, patient materials and caregiver tools across systems and providers, taking into account potential differences in priority populations by geographic area and provider. The intent and goal is to develop and disseminate materials and tools that are "effective, equitable, understandable and

respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs."[11]

This includes but is not limited to information to support self-care and self-management of targeted diseases and conditions, wellness information, access and health-system navigation guides, and discharge and after-case instructions.

The Clinical Integration and Quality Committee will meet to identify a set of priority tools and materials based on the needs assessment of the priority populations. Leveraging the Standards for Culturally and Linguistically Appropriate Services (CLAS) standards as a guide, the task force will identify evidence-based best practices for content, design and format for each, ensuring that materials and tools are accurate, accessible, and actionable. With the input of CBOs, the task force will also identify resources, templates, existing materials, etc. that can be leveraged for this purpose. After these efforts, the task force will develop a recommended action plan for approval by the Clinical Integration committee. The plan will include guidelines for materials; an inventory of existing materials/tools; identified resources to support development of additional tools as necessary; a plan and schedule for disseminating materials to providers; and a proposed evaluation plan.

Proposed process to track outcomes for disparate population groups

The capacity to measure and monitor quality of care for various racial/ethnic populations rests across different racial/ethnic groups. The completion of the data refinement process and integration of REAL data into EHRs serves as the basis for tracking outcomes by disparate population groups.

Once integrated into the EHR, REAL data can be used to track outcomes by the identified category, to identify opportunities to reduce disparities by implementing targeted initiatives.

The Alliance will also explore using the cultural competency and health literacy item set in the CAHPS survey assess patient satisfaction with the clear recognition that cultural and linguistic competence is an important element of this measurement activity.

The Alliance approach to tracking outcomes involves 4 key steps: (1) identifying specific diseases, conditions, or other areas of interest for potential improvement; (2) selecting appropriate measures to assess these areas, (3) establishing a baseline of current performance using the selected measures from the EHR and other sources (e.g. CAHPS) and 4) reassessing or monitoring the effect of improvement efforts on measured performance.

Over time, the Alliance intends to include outcome measures in its Performance Dashboard, and will undertake an assessment of the feasibility of doing so.

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[11] Institute for Healthcare Improvement. "Partnering in Self-Management Support: A Toolkit for Clinicians." Website. Available at: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx. Accessed December 28, 2015.

Proposed approach and schedule for 7 key partners to conduct a Cultural Competency, Health Literacy, Engagement, and Self-Assessment to establish baseline current state

Becoming a Culturally Competent and Health Literate organization is a process, not a defined outcome. Regardless of current status performance, there is always the opportunity to improve. However, it is critical that each organization achieve a threshold level of competency. Establishing a baseline current state is critical so interventions can be targeted to areas where there are the greatest opportunities for improvement.

The Alliance will work closely with the 7 key partners to establish the baseline current state for each, as follows:

Identify Assessment Tools: The Task Force, with input from CBOs, will identify organizational assessment tools for cultural competence, health literacy and patient engagement. This will include evaluating existing tools (e.g. the National Center for Cultural Competence's Cultural and Linguistic Competence Policy Assessment), and making recommendations to the Clinical Integration Committee for selection.[12]

It is anticipated that assessments will address the five domains outlined in the Health Research and Services Administration's (HRSA): Organizational Values; Planning and Monitoring/Evaluation; Communication; Staff Development; Organizational Infrastructure; and Services/Interventions.

Although there are benefits to having a single instrument or set of instruments used across the system, the Alliance recognizes that self-assessments must be appropriate and relevant for each organization, and that therefore a one-size fits-all tool may not be feasible. The Alliance will work with its partners to identify he most appropriate instrument(s) for their organization,

Cultural Competence/Health Literacy/Engagement Dashboard

The Alliance plans to utilize a dashboard to assess performance towards cultural competency, health literacy and engagement goals. This Dashboard will combine the different sources of data collection and reporting together in one location. The task force will work closely with the IT Workgroup and Performance Reporting team to create the Dashboard and align these activities with other ongoing initiatives. Specifically, the Performance Reporting team will consult with the task force on the design of the CC/HL dashboard. To maximize synergies, it is anticipated that the CC/HL Dashboard will be one "page or tab" of the entire performance reporting system. Further, the task force will work with the Performance Reporting team to help train providers on how to assess their progress and what interventions and approaches they can use to improve their performance.

Potential Structure, Process and Outcome Measures

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[12] The University of Iowa: Hardin Library for the Health Sciences. "Cultural Competency Resources: Assessment Tools." Webpage. Available at: guides.lib.uiowa.edu/c.php?g=131924&p=864758.

Structure Measures:

- Cultural Competency/Health Literacy champions identified at each partner site (Completed/In process/Not started)
- Organizational self-assessment performed at each provider site (Completed/In process/Not started)
- Update and revision of vision/mission at each provider site (Completed/In process/Not started)
- Update to workforce recruitment practices (Completed/In process/Not started)

Process Measures:

- Number of trainings completed by staff at each site by provider type (clinician, patient navigator, CHW, etc.)
- Completion rate for demographic data (REAL, SILS, gender identity, sexual orientation)
- Engagement of CBOs, patients and families in governance boards

Outcomes Measures:

- Health outcomes stratified by demographics to assess health disparities
- Results of HCAHPS survey from the cultural competency and health literacy item set
- Tracking of deployment of patient education tools
- Tracking of referrals to community services

Staffing and Timeline

It is anticipated that staff at each provider site that are responsible for performance reporting broadly will be engaged also in the Cultural Competency/Health Literacy Dashboard. These staff persons should work closely with the provider site champion to ensure the accuracy of the data. The timeline for completing these reports will align with other performance reporting efforts. Integration of HCAHPS data will depend on the survey schedule and availability of data.

Training

Training for Health Systems and Providers

Training is an essential element to building greater cultural competency among healthcare organizations. Staff training ensures buy-in on why the changes to the status quo described in this strategy are needed. Training also builds staff capacity to successfully implement the quality improvement projects chosen by the Alliance and will also carry-over into the quality of care delivered more broadly. Training should be viewed as an opportunity to give providers the resources and skills to provide better patient-centered care, particularly for priority populations.

The Cultural Competency and Health Literacy Task Force will meet with the Workforce Workgroup to look over all of the different training needs for clinicians and other segments of the workforce related to cultural competency and health literacy. Leveraging the Standards for Culturally and Linguistically

Appropriate Services (CLAS) as a guide, the Task Force will coordinate with the Workforce Workgroup to design training goals, curriculum, target audience, methods, system for tracking completion, training schedule, and evaluation plan to prepare staff to be culturally and linguistically competent. The Task Force and the Workforce workgroup will identify current training across the PPS on these themes. In addition, the Task Force will conduct a review of best practices identified from the literature on best practices for training staff about cultural and linguistic sensitive behavior for working with ethnic minorities, persons in poverty, LGBTQ, disabilities, substance abuse. After these efforts, the Task Force will create training plans and curricula that address cultural competence, including health literacy strategies, at both the organizational and program levels for all priority populations. Partner organizations will evaluate staff performance on cultural competence using the self-assessments described above.

It is anticipated that training will center on the following activities:

- Data collection: How providers can feel more comfortable asking patients about race, ethnicity, sexual orientation and health literacy.
- Provider-provider interactions and shared decision-making: How providers can provide patient-centered care that is culturally and linguistically appropriate.
- Referrals and connections to community based services: How providers can ask patients about their non-healthcare needs and provide referrals to community resources to address the social determinants of health.

The training curricula will also integrate CBOs into the training, education and other professional development activities that focus on strengthening these skills. Specifically, the Alliance will partner with Schenectady Bridges to expand Bridges Out of Poverty trainings across the 6 county service area.

The Task Force and the Workforce workgroup will develop a schedule and roll-out for implementation of the cultural competency and health literacy guidelines with an established schedule for trainings at each of the partner sites.

Appendix 1: Activities Related to Cultural Competency and Health Literacy by Project

Cultural Competency and Health Literacy are important themes to be incorporated throughout the Alliance's work. More specifically, there are opportunities in each of the 11 projects to incorporate these efforts, whether it be through training for providers or patient navigators, patient-friendly educational materials or integrating social services into patient assessments, care and discharge planning. Activities related to cultural competency and health literacy have been identified for each project and categorized as opportunities for data collection/assessment of community resources, training for providers and/or patient navigators, patient education and additional interventions. In some projects, the submitted implementation plan specifically includes outreach to the Cultural Competency and Health Literacy Taskforce. Others do not explicitly state, but an analysis to prepare this strategy has identified a number of potential opportunities for engagement of the Cultural Competency and Health Literacy Taskforce or community-based organizations. These activities are summarized in Appendix 2 by project. The Cultural Competency and Health Literacy Taskforce will first prioritize activities committed to in the implementation plan, before engaging in additional work. To the extent possible, the Cultural Competency and Health Literacy will serve in an advisory role to the projects and will also help identify community-based organizations to serve on project workgroups for more extensive collaboration.

Project:	2.a.i. Integrated Delivery System Development
Objective	Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminates service fragmentation and increases opportunity to align provider incentives.
Governance	All PPS providers must be included in the Integrated Delivery System (i.e., all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network). Additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy. Engage Medicaid members to participate as ad hoc advisors in the planning and development of programs, processes, and tools to transform healthcare delivery and address health disparities across cultures. In addition, Cultural Competency Taskforce will be utilized to ensure appropriate cultural and linguistic supports throughout the PPS.
Data Collection and Assessing Community Resources	Leveraging information from the CHNA and DSRIP Project Plan, 1) Conduct a drill-down assessment of the specific services provided by each stakeholder organization and how many clients/patients may be added to the their current case load with existing resources; 2) identify other populations that could benefit from the program in their native language using language interpretation platforms; and 3) establish methods to stratify outcomes to quantify disparities, identify target areas and evaluate interventions.
Input on Project Structure Broadly	Primary areas of input: 1) Cultural Competency / Health Literacy committee to decide where and how advisors will be used throughout the PPS; 2) Develop a training program for patients and families to serve in advisor roles in the PPS; and 3) Recruitment, training and retention of community health workers.
Training and Workforce (Clinical Providers)	The Cultural Competency and Health Literacy Taskforce will provide input to the Workforce workgroup on training and technical assistance related to PCMH requirements for the CLAS standards (culturally & linguistically appropriate services).
Training and Workforce (CHWs, patient navigators, social workers, and others)	In conjunction with the Workforce Workgroup, the Cultural Competency Taskforce will establish roles, expectations, selection process, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. The Taskforce will also help develop protocols for engagement broadly, as well as in relation to specific projects.
Communication	Any materials that are produced for patients and families for this project should be reviewed by the Cultural Competency and Health Literacy Taskforce.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Project	2.d.i. Patient Activation
Objective	Increase patient activation related to health care paired with increased resources that can help the uninsured (UI), non-utilizing (NU) and low utilizing (LU) populations gain access to and utilize the benefits associated with DSRIP PPS projects, particularly primary and preventative services.
Governance	Partner with multiple levels of community stakeholders throughout the project as workgroup members or contractors for specific portions of the project. **Community-based organizations:** Partner with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation. **Beneficiaries:** Include beneficiaries in development team to promote preventative care. **Government officials:** Collaborate with officials regarding legal aspects of healthcare reform and assistance for illegal immigrants and populations/cultures that are not networked into mainstream society. **Convening:** In addition to project workgroup meetings, the PPS will arrange for Project 11 retreat to assemble key stakeholders and Workforce Committee to review current hot spot data and determine if there are outlying gaps in the PPS region.
Data Collection and Assessing Community Resources	**Using existing data (CHNA and Healthy Capital District Initiative):** Perform hot-spotting analyses to create poster maps that also include contracted partners and CBOs. **Gather additional data:** 1) Additional level of information from CBOs on current involvement; 2) Survey the targeted population about healthcare needs in the PPS' region. Community engagement forums and other information-gathering mechanisms established and performed; 3) Create survey/questionnaire for participation in project that is culturally, intellectually and linguistically suitable for participants to complete.
Input on Project Structure Broadly	Primary areas of input: 1) Cultural Competency Taskforce will serve as a resource in understanding community resources and partners; 2) Taskforce and Project Workgroup will review hotspot data and identify outlying gaps for specific sub-cultures (e.g., Amish, Burmese, and Guyanese); 3) The Taskforce, in conjunction with the Project Workgroup will develop pathways for community navigators and providers to administer PAM, as well as additional supports as needed; and 4) The Taskforce will discuss processes to ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.

Training and Workforce (Clinical Providers)	Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. PPS will elicit volunteers from partners to assign PAM "train the trainer" champions. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
Training and Workforce (CHWs, patient navigators, social workers, and others)	PPS will elicit volunteers from d CBOs to assign PAM "train the trainer" champions. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. The PPS Cultural Competency Taskforce will collaborate with Iroquois Healthcare Alliance to develop curriculum and training programs that will address patient activation techniques. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.
Communication	Several communication/patient education vehicles will be developed and deployed: 1) Educational materials regarding insurance coverage, language resources, and availability of primary and preventive care services for use by patients and families; 2) Tool to be used by community navigators to assess cultural, linguistic and other needs that will enable placement with the most appropriate provider; and a 3) training program for patients and families to serve in advisor roles in the PPS.
Additional Interventions	Explore streamlining of resource directories into an existing platform(s), such as 2-1-1, to be used by community navigators

Project	2.b.iv. Care Transitions Model to Reduce 30-Day Readmissions
Objective	Provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.
Governance	The project will engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources.
Data Collection and Assessing Community Resources	With input from the Cultural Competency Taskforce and other engaged CBOs, the project will identify trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to add or enhance services that are absent or deficient by linking with project roadmap. In addition, the project will conduct an assessment of the ability of PPS's local Meals on Wheels (MOW), regional food banks and food delivery companies to provide medically tailored meals to members identified through the care transitions planning process. Finally, the project will complete an assessment of participating providers, LTC and CBOs of targeted high risk diagnosis (Core Measure, developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting.
Input on Project Structure Broadly	Primary areas for input: 1) Develop model for the Care Transitions Intervention and standardized protocols for implementation (e.g., appropriate follow-up and connections following discharge, including social services need); 2) Engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources.
Training and Workforce (Clinical Providers)	Provider trainings to adopt the Coleman-like model of care transition staff will be needed. This training will include how each provider will work with intensive care coaches in the proposed model and how social needs are considered in this process.

Training and Workforce (CHWs, patient navigators, social workers, and others)	Collaborate with the Workforce Committee to create a PPS-wide strategy to redeploy/recruit the necessary professionals to support care transitions services and from the assessment of the vulnerable populations to expand capacity and competence to include "intensive care transitions coaches." The care transitions coach will perform interventions during the home visit with the family: medication reconciliation, develop personal health record and create questions to be discussed at post acute PCP visit, provide, utilizing the teach –back method, disease and medication education, provide GREEN-YELLOW-RED symptom/self management guide sheets, establish 3 additional follow up calls/visits that surround significant health care events to provide support and establish any additional community support needs for the patient to avoid unnecessary ED visit or hospital readmission.
Communication	Utilize, develop and standardize education and training materials that are sensitive to cognitive competency, and culturally and linguistically tailored to the populations the PPS serves (for example Easy To Read [ETR] materials).
Additional Interventions	Identify with trusted social service agencies and PPS stakeholders to add or enhance services that are absent or deficient by linking with project roadmap.

Project	2.b.iii. Emergency Department Triage for At-Risk Populations
Objective	Develop an evidence-based care coordination and transition care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding self-management of personal health condition(s), improve provider to provider communication, and provide supportive assistance to transitioning members to the least restrictive environment.
Governance	The project will identify and engage community stakeholders (law enforcement, transportation, housing, community services and public organizations) to participate on project teams. **Convening:** Monthly meetings with project lead and teams from sites, and additional stakeholder meetings.
Data Collection and Assessing Community Resources	With input from the Cultural Competency Taskforce and other engaged CBOs, the project will assess community support resources and maintain current listing of these resources that will be used to connect target patients to appropriate services.
Input on Project Structure Broadly	Members of the Project Workgroup, with potentially input from the Cultural Competency Taskforce, will define future state for ED patient navigator model to include a social triage for at-risk populations' needs (e.g., transportation barriers, food, housing, etc.). The PPS will also develop processes for warm hand-offs and connections with community primary care providers and community service organizations.
Training and Workforce (Clinical Providers)	Members of the Project Workgroup, with potentially input from the Cultural Competency Taskforce, will develop a standardized protocol and training for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient admission to discharge.
Training and Workforce (CHWs, patient navigators, social workers, and others)	Members of the Project Workgroup, with potentially input from the Cultural Competency Taskforce, will develop process to select, hire, retrain, redeploy patient navigators to work on this project and create training curricula that includes information on cultural competency and health literacy needs of the target population.
Communication	Members of the Project Workgroup, with potentially input from the Cultural Competency Taskforce, will design scripting to be used by navigator staff when interfacing with patients that includes cultural competency and health literacy.
Additional Interventions	Potential additional intervention to address transportation barriers with the goal of increasing medication adherence and preventing ED recidivism.

Project	2.b.viii. Hospital Homecare Collaboration
Objective	Integration of mental health and substance abuse with primary care services to ensure coordination of care.
Governance	The main stakeholders to be engaged in this project are healthcare facilities and home care providers. The project requirements do not explicitly mention CBOs but it is understood that this project will be closely aligned with the activities of the Project 2 b iv which does significantly engage CBOs and social service organizations in the workgroup and intervention development.
Data Collection and Assessing Community Resources	The project workgroup will complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement.
Input on Project Structure Broadly	Primary areas of input: 1) How to integrate behavioral health concerns into processes, including screening and appropriate referrals; 2) Provide feedback on training for home care staff on the knowledge and skills to assess patient risks for readmissions and support evidence-based preventive medicine and chronic disease management.
Training and Workforce (Clinical Providers)	Training needs: 1) Education for home care staff on needs of special populations, including intellectually and developmentally disabled members; 2) Advance care planning, MOLST, and palliative care (subject matter experts such as Hospice Teams will assist).
Training and Workforce (CHWs, patient navigators, social workers, and others)	NA
Communication	This project will develop several tools and materials for patients and their families on Advance Care planning with communication guide, tracking tool, comfort order set, and educational materials for patient and families. The project workgroup will coordinate with Cultural Competency and Health Literacy Taskforce on the inclusion of age appropriate, culturally sensitive care planning tools, as well as how they are delivered (e.g. videos, tablets to address principles of adult education). The project workgroup will also establish a patient and family-oriented teach back program for early identification of adverse effects of medication.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Project	3.a.i. Integration of PC and BH
Objective	Integrate mental health and substance abuse with primary care services to ensure coordination of care.
Governance	The project workgroup will convene community, facility and PPS governance representatives to review PPS program structure, MOUs, financial plan and regulatory requirements for the Behavioral Health Site model structure. The project workgroup will also strategize with the Clinical Leadership Council, Clinical Integration Committee, CBOs and other relevant stakeholders to collaborate and include internal and external stakeholders in leveraging BH and SUD providers to participate in co-location.
Data Collection and Assessing Community Resources	The Cultural Competency and Health Literacy taskforce can serve as a resource for discussing barriers to accessing behavioral healthcare as well as community resources available.
Input on Project Structure Broadly	Primary areas of input: 1) Develop collaborative evidence-based standards of care including medication management and care engagement process with input from different levels of stakeholders; 2) Input on program design, particularly warm hand off processes; 3) Input on training for providers about behavioral health needs.
Training and Workforce (Clinical Providers)	Project workgroup will collaborate with the workforce team to strategize on recruitment, training, and involvement of behavioral health providers to ensure adequate services are available in the integration sites. The project workgroup will track and monitor workforce enhancements on a regular basis and adjust as needed to ensure success. They will also develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in primary care.
Training and Workforce (CHWs, patient navigators, social workers, and others)	NA
Communication	Any materials that are produced for patients and families for this project should be reviewed by the Cultural Competency and Health Literacy Taskforce.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Project	3.a.iv. Ambulatory Detoxification
Objective	Develop withdrawal management services for substance use disorders (SUD) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services and provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use.
Governance	The project workgroup will include OASAS, social service providers, criminal justice, public health, health centers, urgent care centers, intervention hotlines, housing representatives and other representatives.
Data Collection and Assessing Community Resources	The project workgroup will identify any geographical gaps in services within community-based programs. They will also identify community support resources, including transportation, childcare, housing and employment training to care managers to use as resources.
Input on Project Structure Broadly	Primary area of input: 1) Develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.
Training and Workforce (Clinical Providers)	Project team and project medical director to make recommendations to workforce committee regarding workforce and training needs specific to the delivery of ambulatory withdrawal management, including care coordination and connection to treatment programs, and potentially other community resources. The Cultural Competency Taskforce can provide feedback on the cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health.
Training and Workforce (CHWs, patient navigators, social workers, and others)	NA
Communication	Any materials that are produced for patients and families for this project should be reviewed by the Cultural Competency and Health Literacy Taskforce.
Additional Interventions	Opportunities to explore: 1) How to provide clients with 24 hour access to services; either through hotline or other forms of communication; and 2) Transportation services in area to bolster transitions between levels of care and from community to program sites and develop transportation plan

Project	3.d.ii. Asthma Self-Management
Objective	Ensure implementation of asthma self-management skills including home environmental trigger reduction, self-monitoring, medication use and medical follow-up to reduce avoidable emergency department and hospital care. A special focus will be on children for whom asthma is a major driver of avoidable hospital use.
Governance	The Project Workgroup will engaged and also contract social service organization and other members of the asthma care coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, and housing.
Data Collection and Assessing Community Resources	Using CNA results and population health tools, the project workgroup will conduct a hot spot analysis on asthma diagnoses in the covered 6 county regions. The workgroup will identify those provider and/or sites, including PCPs, home care providers, health homes, pharmacies, school health and hospital that support the activities of the Asthma self-management program. The project workgroup will then assess providers to determine current service provision and then identify entities & agencies that will be implementing home based medical and social services, including current providers.
Input on Project Structure Broadly	Primary areas of input: 1) Develop strategy to partner with community resources, such as pest control and housing to link clients with resources available for reducing environmental asthma triggers; and 2) Provide feedback on the self-management education for the appropriate control of asthma.
Training and Workforce (Clinical Providers)	The project workgroup will develop a strategy with workforce team to identify gaps in needed community providers, monitor progress of filling gaps & identifying training opportunities to minimize shortages.
Training and Workforce (CHWs, patient navigators, social workers, and others)	The project workgroup will collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients. The workgroup will implement training and asthma self-management education services for CBOs and social service agencies, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. The workgroup will also educate school-based programs on project goals and their roles (e.g.- American Academy of Pediatrics use and feedback, school referrals to home-based self-management, etc.). The Cultural

	Competency and Health Literacy Taskforce could provide feedback on all of these activities.
Communication	The project workgroup will collaborate with the Cultural Competency and Health Literacy Taskforce to establish age appropriate, culturally sensitive interventions to engage clients. Consider creating tool for patient/family that can be used at the ED visit or post discharge from hospital as part of asthma action plan.
Additional Interventions	The project workgroup plans to partner with community resources, such as the Asthma Coalition, to create a resource directory for clients (not limited to mold, mites, dust, roaches, pets, etc.). They are also considering piloting a Community Emergency Management Services (EMS) program to conduct home visits for education, self-management support to improve asthma home management. Include information from EMS in home/environmental assessments.

Project	3.g.i. Integration of Palliative Care into PCMH Model
Objective	Increase access to palliative care programs in Patient-Centered Medical Homes (PCMHs).
Governance	In conjunction with Project 2 b iv and 2 b viii, the project workgroup will engage hospice, home care agencies and CBOs to capacitate and strengthen palliative home care for use in all disease-related discharges from the hospitals and nursing homes.
Data Collection and Assessing Community Resources	The PPS PCMH Project Team will inventory partnering PCP practices, hospice providers, palliative care providers that will participate with integrating palliative care services into their practice model.
Input on Project Structure Broadly	Primary areas of input: 1) incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural competency and health literacy aspects.
Training and Workforce (Clinical Providers)	In concert with the Clinical Integration Committee, the Palliative Care Project Implementation Team will propose and train on best practice modalities to integrate Palliative Care Services and Primary Care (i.e.: Advance care plan using Respecting Choices), pain & symptom management, addressing psychosocial & spiritual concerns, establishing goals of care and coordination of care. The Project Team will also provide training on Medical Orders for Life Sustaining Treatment (MOLST) form. The Cultural Competency and Health Literacy Taskforce can provide feedback on these efforts.
Training and Workforce (CHWs, patient navigators, social workers, and others)	The Project Team will use a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions. They will also provide education to key clinical integration team members embedded in Projects 2.b.iv and 2.b.viii to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions.
Communication	The Project Team plans to collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways are culturally and linguistically appropriate and consider the religious and cultural beliefs about the end of life for both patients/families and caregivers.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Project	4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure
Objective	Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery and strengthen infrastructure for MEB health promotion and MEB disorder prevention.
Governance	This project will create MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. The project will engage multi-levels of community agencies and established taskforces to become members of the MEB taskforce to create a trauma informed culture for care, to encourage MEB health promotion (by local government units, public health, prevention specialist/educators, etc.).
Data Collection and Assessing Community Resources	The project workgroup will engage partnering providers to utilize the Adverse Childhood Experiences (ACE) tool to assess member's risk factors of illness and death and improve our efforts towards prevention and recovery. The project workgroup will also target populations into segments for achievement: community-settings on regional basis focusing on low income hotspots and on areas with highest behavioral health morbidity.
Input on Project Structure Broadly	Primary areas of input: 1) prioritize needs related to data, training, technical assistance and evidence-based protocols necessary to support MEB health promotion; and 2) Develop strategies to address these needs at multiple stakeholder levels.
Training and Workforce (Clinical Providers)	The project will create a MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. This training will include cultural and linguistic training competencies as developed by the Cultural Competency and Health Literacy Taskforce, in conjunction with their focus on culture of poverty as it relates to trauma exposure and social living circumstances.
Training and Workforce (CHWs, patient navigators, social workers, and others)	The project workgroup will recruit multi-levels of stakeholders (e.g., local government units, public health, prevention specialist/educators, etc.) to become involved in MEB promotion and will provide training on how to create a trauma-informed culture for care and encourage MEB promotion. The Cultural Competency Taskforce can provide feedback on these efforts.

Communication	Through identified hot spots in our regional community needs assessment, the project workgroup will develop outreach screening forums to community settings linked to low income populations and homelessness. The workgroup also plans to provide prevention/education via trauma informed care approach to members according to risk. The educational programs will also be gender and culturally specific. The Cultural Competency Taskforce can provide feedback on these efforts.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Project	4.b.i. Tobacco Use Cessation
Objective	Decrease the prevalence of cigarette smoking by adults 18 and older and increase the use of tobacco cessation services including NYS Smokers' Quitline and nicotine replacement products.
Governance	The PPS will collaborate with partners and community leaders to revise tobacco free policies to include E-cigarettes and discuss additional strategies to address in-door, smoke-free housing where applicable. The Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects.
Data Collection and Assessing Community Resources	The Tobacco Project Team will identify partnering sites within the PPS communities, Advancing Tobacco Free Community contractors and with cross-county *independent PPS* organizations, that have existing tobacco free grounds.
Input on Project Structure Broadly	Primary areas of input: 1) Collaboration with partners and community leaders to revise tobacco free policies to include E-cigarettes; 2) Develop specific strategies to increase benefit use rate by population segments that underutilize services, including those with behavioral health needs.
Training and Workforce (Clinical Providers)	The Tobacco Project Team will provide 5 A training to our PPS healthcare providers that includes adherence with USPHS clinical guidelines through counseling, prescription and over the counter treatment options, and referrals to cessation services. In addition, the Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects. Further, the training will include information on the current state of coverage that beneficiaries do have for smoking cessation treatment counseling and products. The Cultural Competency and Health Literacy Taskforce can provide feedback on this effort.
Training and Workforce (CHWs, patient navigators, social workers, and others)	The project workgroup will collaborate with, cross-county independent PPS organizations, disability advocacy groups, community support organizations and associations to create a systemic approach in planning, educating and promoting healthy behaviors that is culturally and linguistically appropriate for the populations served. The Cultural Competency and Health Literacy Taskforce can provide feedback on this effort.

Communication	The Tobacco Project team will promote cessation counseling among all smokers, including people with disabilities. To do so, they will develop a Health Promotion and Wellness program targeting individuals with psychiatric illnesses to live a pro-health, positive image lifestyle. In addition, they plan to develop self-help materials that are tailored to specific audiences that are culturally & linguistically appropriate to enhance smoker's acceptance of treatment. The Cultural Competency and Health Literacy Taskforce can provide feedback on this effort.
Additional Interventions	No additional interventions identified in the project implementation plan to date.

Appendix 2: Timeline of Communication and Engagement Activities by Stakeholder Type

Target Audience	Targeted Content Themes & Timing					
	Year 1		Year 2		Year 3	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
	DSRIP orientation and project orientation; project design/ development	Project implementation	Project implementation	Project evaluation and refinement	Refined project implementation	Project evaluation and dissemination
PCPs, Specialists	DSRIP Introduction PCMH Introduction Project planning updates; opportunities to provide feedback	Project implementation updates Learning collaborative: PCMH Implementation experience Focus on provider champions Opportunities for stakeholder feedback	Project implementation updates Learning collaborative: PCMH Implementation experience Focus on provider champions Case studies by project/lessons learned; opportunities for stakeholder feedback	Share initial implementation findings (including PPS engagement/participation across projects) Assess best practices in project development and implementation	Share any relevant project revisions and implementation updates Additional case studies by project/lessons learned Opportunities for stakeholder feedback	Share implementation findings; establish and share best practices in project implementation Outcome measures that demonstrate impact on improved health/reduced costs: population health and management of specific chronic and behavioral health states
Integrated BH and Primary Care	DSRIP Introduction Alliance Project Introduction to care	Project implementation training	Implementation timelines and deliverables	Share initial implementation findings and outcomes (including PPS	Share any relevant data-driven project revisions and	Outcome measures that demonstrate impact on

	integration: Focus on differences in BH and primary care culture and orientation DSRIP Metrics including definitions of actively engaged ("cheat sheet") Project planning updates; opportunities to provide feedback and be involved in process	Best Practices BH Integration Champion activity Population impact of care integration on individuals with co-morbid disease Focus on care transformation	Reporting requirements Metrics with opportunities to improve based on initial results Population impact of care integration on individuals with co-morbid disease Focus on care transformation Important dates and deliverables	engagement/participation across projects) Project revisions based on data analysis assess best practices in project development and implementation	implementation updates Additional case studies by project/lessons learned Opportunities for stakeholder feedback	improved health/reduced costs: population health and management and avoidance of transitions from SNF to the acute care setting
CBOs/Health & Social Service Orgs	DSRIP Introduction Alliance Project Introduction to CBO roles and opportunities PAM/Outreach DSRIP Metrics including definitions of actively engaged ("cheat sheet") for all relevant projects Project planning updates Opportunities to provide feedback	Project implementation training Best Practices in CBO involvement and person-centered care Cultural competence, linguistic appropriateness and self-care supports CBO Champion activity	Implementation timelines and deliverables Reporting requirements Metrics with opportunities to improve based on initial results Population impact of care integration on individuals with co-morbid disease Focus on care transformation	Share initial implementation findings and outcomes (including PPS engagement/ participation across projects) Project revisions based on data analysis Assess best practices in project development and implementation	Share any relevant data-driven project revisions and implementation updates Additional case studies by project/lessons learned Opportunities for stakeholder feedback	Share implementation findings; establish and share best practices in project implementation Outcome measures that demonstrate impact on improved health/reduced costs: population health and management and avoidance of transitions from

and be involved in process	Population impact of CBOs on individuals with complex needs Focus on care transformation					SNF to the acute care setting
Hospital-Based Staff/Health care workers (Transitions in Care; co-located ED services; overall avoidable hospitalization and use of CBOs)	DSRIP Introduction Alliance Project Introduction with a focus on Transitions of Care, avoidable hospital use and co-located ED including CBO and navigator/ community health worker roles and responsibilities DSRIP Metrics including definitions of actively engaged ("cheat sheet") Project planning updates for all relevant projects;	Project implementation updates Case studies by project/lessons learned Opportunities for stakeholder feedback Cultural competence, linguistic appropriateness and self-care supports CBO Champion activity	Implementation timelines and deliverables Reporting requirements Metrics with opportunities to improve based on initial results Population impact of care integration on individuals with co-morbid disease Focus on care transformation	Share initial implementation findings and outcomes (including PPS engagement/ participation across projects) Project revisions based on data analysis Assess best practices in project development and implementation	Share any relevant project revisions and implementation updates Additional case studies by project/lessons learned Opportunities for stakeholder feedback	Share implementation findings; establish and share best practices in project implementation Outcome measures that demonstrate impact on improved health/reduced costs: population health and management of specific chronic and behavioral health states

	opportunities to provide feedback and be involved in process	Population impact of CBOs on individuals with complex needs Focus on care transformation	Project implementation updates Case studies by project/lessons learned Opportunities for stakeholder feedback			
Consumers	Population Health introduction re: availability of new services Cultural and Linguistic competence tools/self-care focus with an emphasis on strategies to increase health literacy How to use the health care system effectively Health literacy	Project outreach and education re: availability of new services Cultural and Linguistic competence tools/self-care focus with an emphasis on strategies to increase health literacy How to use the health care system effectively Health literacy	Project outreach and education re: availability of new services Cultural and Linguistic competence tools/self-care focus with an emphasis on strategies to increase health literacy How to use the health care system effectively Health literacy	Call for consumer feedback to projects; opportunities to share stories and lessons learned Feature consumer champions Cultural and Linguistic competence and self-care focus with an emphasis on strategies to increase health literacy How to use the health care system effectively Health literacy	Project outreach and education re: availability of new or revised services (consumer engagement and satisfaction) Feature consumer champions Cultural and Linguistic competence and self-care focus with an emphasis on strategies to increase health literacy	Call for consumer feedback to projects; opportunities to share stories and lessons learned Outcome measures that demonstrate consumer health literacy, project engagement and satisfaction Outcome measures that demonstrate impact on improved health/reduced costs: population

					How to use the health care system effectively Health literacy	health and management of specific chronic and behavioral health states
Physician organizations	DSRIP Introduction Alliance Project Introduction DSRIP Metrics including definitions of actively engaged ("cheat sheet"); Project planning updates; opportunities to provide feedback and be involved in process	Project implementation updates; case studies by project/lessons learned; opportunities for stakeholder feedback	Project implementation updates; case studies by project/lessons learned; opportunities for stakeholder feedback	Share initial implementation findings (including PPS engagement/ participation across projects) Assess best practices in project development and implementation	Share any relevant project revisions and implementation updates Additional case studies by project/lessons learned Opportunities for stakeholder feedback	Share implementation findings; establish and share best practices in project implementation Outcome measures that demonstrate impact on improved health/reduced costs: population health and management of specific chronic and behavioral health states