BRONX HEALTH ACCESS

BHA PPS Cultural Competency/Health Literacy Strategy

Vision

The Bronx Health Access (BHA) PPS's strategic vision for delivering culturally competent care will consider the context of culture and its influence when interacting with patients and their families so as to provide care that results in optimal health outcomes. Culture may include ethnic, religious, or linguistic needs, but also address other types of culture such as LGBTQ, new immigrants, poverty and other group. The vision for health literacy is that professionals and institutions will communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote their health.

Definitions

Cultural Competency

"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." -Office of Minority Health

Health Literacy

"Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness." –Healthy People 2010

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Cultural Competence & Health Literacy Strategic Plan

The BHA PPS LLC Cultural Competency & Health Literacy (CCHL) workgroup strategies and guidelines for the delivery of culturally competent care, and to help all staff and patients achieve a comfortable level of health literacy are as follows:

- PPS Network will provide reading materials in multiple languages and at no higher than a 6th grade reading level in order to meet health literacy best practices.

- PPS Network will coordinate the provision of care for special needs groups such as patients with mental health and developmental delay issues or LGBTQ.

- PPS Network Providers will assess and incorporate into the provision of care the social determinants of care, i.e. housing issues, language, and other social determinants as outlined in this document.

- PPS Network will utilize the Training and Employment Fund a as a clearinghouse for training resources and incorporate CCHL staff training for new and existing employees.

- PPS Network will conduct organizational assessments for cultural competency and health literacy, and it is recommended that all levels of staff, including administrative, clinical, professional and support services participate in the organizational assessment.

- Each project workgroup will work with the Stakeholder Engagement workgroup to ensure outreach that is convenient and accessible to consumers and considers the issues of cultural competency and health literacy. This may include outreach methods such as flyers, websites, and social media.

- Cultural Competency & Health Literacy Committee will also focus on Priority Groups & Key factors to improve access to care as follows:

The rich diversity of the PPS community presents many challenges to providing culturally competent healthcare services. Culture extends well beyond country and language of origin and includes economic status, disability, religion, gender identity, sexual orientation, immigration status and age. According to the NIH “these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services.” The BHA PPS has identified its priority groups based on the diseases and conditions associated with the projects it selected to participate in. These include

Medicaid recipients and uninsured that have Behavioral Health (Mental Health and Substance Abuse) issues, Asthma and respiratory conditions, Diabetes, HIV/AIDS, and Maternal/child health issues. The focus is specifically on Medicaid and Medicaid eligible users with these diagnoses rather than develop broad interventions because we felt that in doing so we could leverage the expertise and resources of members of our project teams in order to best serve our patient population.

Although these priority groups are based on specific diagnostic conditions, The PPS recognizes and is not overlooking other groups in the Bronx also experiencing health care disparities. These include, but are not limited to those born outside of the United State who are without insurance, homeless or inadequately housed individuals, those with ambulatory or other mobility difficulties, older adults, and incarcerated and recently-released individuals.

In order to ensure optimum levels of recruitment, retention and positive health outcomes, the project workgroups have identified the following mitigation strategies:

- Increase the current number of behavioral and mental health providers, especially those who are multi-lingual
- Improve present methods of collaboration with partner organizations and other CBOs
- Increase use of the practice of having a warm hand-off to ensure the likelihood that patients will seek behavioral health services
- Provide support and skill building trainings for PPS providers to adopt evidence based practices by creating a partnership with TEF to offer training on evidence-based guidelines and education on trauma informed care
- Ensure that care coordination staff meet the requirements for the provision of care by creating an accurate job description for care managers, care coordinators and supervisors as well as increasing hiring of multi-lingual care managers
- Provide culturally competent and health literate patient education on the importance of self-management skills
- Identify services with the PPS and develop workflows that create linkages through coordinated referral services.
- Continue to provide education to patients and staff in order to increase awareness and to dispel the myths and stigmas surrounding an HIV/AIDS diagnosis and provide decentralized access to care

- Create a Two-way communication plan -The BHA PPS communication strategy was created and developed by the Stakeholder Engagement Workgroup with input from the PPS project workgroups to ensure two-way communication between the PPS Network and its key stakeholders within the community. See attachments A & B for more information.

- Use standardized Assessments and tools -There is a wealth of information available covering culturally competent and health literate care. The PPS wants to ensure that each partner utilizes standardized cultural competency and health literacy guidelines for developing new materials or evaluating existing materials. It is anticipated that if outreach materials, educational materials, and self-management tools meet CCHL standards then consumers will be more likely to utilize the tools thereby resulting in improved health outcomes.

The following are some of the existing standardized resources available:

1. Administration for Children's Services
    a. http://www1.nyc.gov/site/acs/index.page
2. CLAS standards
    a. https://www.thinkculturalhealth.hhs.gov/content/clas.asp
3. Office of Minority Health (minorityhealth.hhs.gov)
    a. Cultural and Linguistic competency - http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6
4. AHRQ (www.ahrq.gov)
    a. Cultural competency - http://www.ahrq.gov/health-care-information/topics/topic-cultural-competence.html
    b. Health literacy - http://www.ahrq.gov/health-care-information/topics/topic-health-literacy.html
5. Attribute of Health Literate Health Care Organizations
    a. http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf

- Utilize Community based interventions resources-The PPS has identified several community based interventions that are available to its network of partners and patients. The following are examples of interventions that include programs specializing in health literacy, programs linking patients to vocational and employment training, culturally sensitive care needs programs, and many others:

Community Healthcare Network

Health Literacy Program

CHN launched its health literacy initiative in 2011 after identifying a need to improve patient outcomes through organizational health literacy. Activities to advance organizational health literacy include:

- Policies that mandate the sole use of health literate materials; CHN's health literacy team has reviewed and/or created over 1000 patient materials since 2011
- Mandatory health literacy training for all staff (including providers, nurses, social workers, billing staff, human resources, facilities) within 3 months of start date
- Ongoing staff trainings and activities at monthly center meetings and department meetings
- Staff health literacy committee consisting of 13 staff from various departments and centers who act as health literacy leaders at each of CHN's 11 health centers

CHN has provided health literacy trainings or technical assistance on material creation to: Mount Sinai Roosevelt Hospital HIV Rounds, Woodhull Medical Center, NYC HHC, NYU Hospital for Joint Diseases, Albert Einstein School of Medicine, CHCANYS, Planned Parenthood of NYC, Public Health Solutions, Family Planning Advocates of New York state, NYSDOH AIDS Institute, and more.

Other community based interventions at CHN:

- Teens PACT: adolescent pregnancy prevention program operating in Harlem, Washington Heights, Lower East Side, and Brooklyn
- Diabetes Management Group: operating at various sites
- Various LGBTQ services that aim to increase access to care

BOOM! Health

BOOM! Health has delivered the following evidence-based interventions (EBIs) aimed at HIV prevention: Many Men Many Voices (3MV), STREET SMART, Personalized Cognitive Counseling- young and adult MSM; Safety Counts, Safe in the City-People who Inject Drugs. "Homegrown" prevention interventions supported by funders include: CODE RED(Community Organizing Development and Education to Reduce and Eliminate Disease) for young MSM; Inside Out - to build resiliency among marginalized adolescent girls; POWERT, (Positive Outstanding Women Empowered to Reduce Transmission) – Black/Latina women; Health Starts with Me-newly diagnosed HIV positive individuals and TBO or Tool Box – wellness for adult MSM.

STRIVE

For many of our graduates, employment through STRIVE will be the first experience of working in a structured, demanding environment. Our program is designed to train and place participants quickly, in as little as one month. But some clients need intensive support to prepare them to succeed in the rigorous work world. To accommodate diverse personal needs and situations, STRIVE provides Support Services, mentoring participants to overcome the barriers that can prevent a successful transition to employment.

Each STRIVE participant is assigned to a Case Manager who works closely with the participant to address specific needs while they are enrolled in STRIVE programs. The goal of these services is to remove obstacles that could prevent a client from finding or retaining a job.

STRIVE sites provides a broad array of support services, including referrals for child care, legal assistance, one-on-one and group mentoring sessions, housing placement, substance abuse treatment, medical and mental health services, domestic violence counseling, parenting skills and referrals to others services as needed.

Bronx Lebanon Hospital Center

Community Physician Liaison Program

Bronx-Lebanon initiated its Community Physician Liaison Program with the goal of strengthening Bronx-Lebanon's partnership with community physicians and community-based organizations to improve the effectiveness and efficiency of health care delivery in the south and central Bronx. The program established a direct line of communication (one main phone number) between community providers and Bronx-Lebanon. The Community Physician Liaison Program has led to three major initiatives to better meet the needs of community providers: 1) In-Direct Admissions Program, which connects community-based primary care physicians to Bronx-Lebanon emergency department providers when a patient has an emergent health issue; 2) Community Physician Liaison-ED Discharge Program, which connects community-based primary care physicians to Bronx-Lebanon emergency department providers when a patient is discharged from the emergency department; and 3) Community Physician Referrals Program, through which physicians can request expedited specialty care appointments.

West African Population/Diaspora Care: Culturally Sensitive Care Needs

The Diaspora care clinic provides culturally appropriate care with the goal of assuring access to comprehensive primary and specialty health care in a culturally sensitive setting targeted to the large population of West African residents of the service area • Based on the needs of this population, the clinic focuses on health education, prevention, maternal/child health care, chronic disease, dental care and HIV counseling • Partnered with large number of religious organizations in community: mosques and churches to identify needs, issues • Provides culturally sensitive services for example, providing a prayer space • Worked with Health First, and held open houses for 22 religious organizations

Bronx Lebanon & CCNP Health Home

Our Bronx Health Home Model utilizes a multi-disciplinary team, to provide care management, clinical care, and social support services to all enrollees. The Health Home team includes care coordinators, primary care physicians, behavioral health providers, LCSWs, clinicians, and social service supporters (i.e.

outreach workers, health educators). This team works with an integrated model of service that includes BLHC as the primary medical institution for enrollees. Several other local medical, behavioral health, and social service community-based organizations also work to support members of the program. All enrollees are evaluated by a Care Coordinator, under the appropriate supervision, who conducts a comprehensive needs and resources assessment to identify medical, mental, chemical dependency, and social service needs. The Care Coordinator, with the help of his/her team, then develops a plan of care that addresses the identified needs by referring and linking members to community-based networks, providing instruction, and other effective methods. All referrals are actively tracked and managed by the care coordinator per the level of need of the individual member.

Cultural Competency & Health Literacy Review, Update & Monitoring

The CCHL workgroup will review this strategy at least twice a year and more if needed as requested by the Workforce Committee in order to monitor, review, and update the strategy and recommendations on cultural competent and health literate care as new patient groups become part of the PPS.