



Cultural Competency and Health Literacy Strategy

Milestone 1:
Community-Based
Interventions to
Reduce Health
Disparities

December 2015



Contents

| | |
|---|----|
| Introduction | 3 |
| <i>Vision</i> | 4 |
| <i>Milestones</i> | 4 |
| Management and Implementation | 4 |
| <i>Approach</i> | 4 |
| Workgroup | 4 |
| Conceptual Framework | 5 |
| Assessment of Health Disparities | 7 |
| Table 1: Population Demographics by Region | 7 |
| Cultural Competency and Health Literacy Strategic Plan | 9 |
| 1: <i>Identify priority groups experiencing health disparities</i> | 9 |
| 2: <i>Identify key factors to improve access to quality primary, behavioral health, and preventive health care</i> . | 10 |
| 3: <i>Define plans for two-way communication with the population and community groups through specific community forums</i> | 11 |
| 4: <i>Identify assessments and tools to assist patients with self-management of conditions</i> | 11 |
| 5: <i>Identify community-based interventions to reduce health disparities and improve outcomes</i> | 11 |
| <i>Interdependencies with other Workstreams</i> | 12 |
| Reporting on Deliverables | 13 |
| <i>Potential Risks and Challenges</i> | 13 |
| Recommendations | 13 |
| Appendix | 14 |
| A. Workgroup Roster | 15 |
| B. Workgroup Timeline | 16 |
| C. National Standards for Culturally and Linguistically Appropriate Services (CLAS) | 17 |
| D. Ten Attributes of Health Literate Health Care Organizations | 18 |
| E. Evidence-Based Strategies for Health Literacy | 19 |



Introduction

The success of New York State's Delivery System Reform Incentive Payment (DSRIP) Program and each Performing Provider System (PPS) hinges on all facets of a PPS achieving cultural competency and improving health literacy. Each PPS must demonstrate cultural competence by successfully engaging Medicaid members from all backgrounds and capabilities in the design and implementation of their health care delivery system transformation. The ability of the Central New York Care Collaborative (CNYCC) to develop solutions to overcome cultural and health literacy challenges is essential in order to successfully address healthcare issues and disparities within our region.

The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Cultural competency is critical to reducing health disparities and improving access to high-quality health care. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research—in an inclusive partnership where the provider and the user of the information meet on common ground.

Health literacy has been defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." Individuals must possess the skills to understand information and services and use them to make appropriate decisions about their healthcare needs and priorities. Health literacy incorporates the ability of the patient population to read, comprehend, and analyze information, weigh risks and benefits, and make decisions and take action in regards to their health care. The concept of health literacy extends to the materials, environments, and challenges specifically associated with disease prevention and health promotion. According to Healthy People 2010, an individual is considered to be "health literate" when he or she possesses the skills to understand information and services and use them to make suitable decisions about health.

The ability of CNYCC to apply cultural competency and health literacy strategies throughout the collaborative is essential in order to successfully engage Medicaid members from all backgrounds and abilities to improve quality of care and health outcomes. Ultimately, these strategies must be infused into all areas impacting care delivery, including staff training, community outreach and education, partnerships with community organizations and organizational policy.

The cultural competency and health literacy strategy is directed at two audiences: 1) groups of people living in CNYCC's service area experiencing health disparities and 2) providers and other members of the workforce involved with the delivery of information and/or provision of care. These two audiences and the related DSRIP Milestones are unified in their focus on addressing healthcare disparities in a manner which reflects the diversity of needs and assets of the communities and providers in our region. Interventions proposed under the first Milestone, the focus of this document, will be designed to support community members' health and well-being outside of the clinical setting, through the use culturally and socially relevant assessments, tools, and community-based interventions.



Vision

The Workgroup's vision is to support:

- A community of consumers who have the skills, motivation and trust to access care and use available health information to engage in self-care and preventive health behaviors to support optimum health.
- A system of care delivery that is responsive to the cultures, language and literacy needs of an increasingly diverse patient population; and also acknowledges the impact of social determinants of health on individuals' abilities to access care and maintain health in their own communities.

Milestones

Under the DSRIP Program, each PPS is required to respond to the following Milestones, also described in the Organizational Section of the CNYCC Implementation (June 2015), which align with the vision as stated above:

1. Finalize a Cultural Competency / Health Literacy Strategy
2. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)

Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities.¹ The Milestones describe a cohesive two-pronged approach.

This report details the first Milestone, which focuses on supporting the community's ability to find and use information, to access the services to which they are entitled and successfully manage their health, as well as community-based interventions to facilitate these efforts.

This will be accomplished by partnering with community-based organizations; particularly those focused on addressing the social determinants of health, who maintain trust with at-risk groups in the CNYCC service area. The second Milestone will address the training of clinicians and other segments of the workforce focused on available evidence-based research addressing health disparities for identified priority groups. This Milestone will be detailed in a subsequent report due in DSRIP Year 2, Q1 (June 2016).

Management and Implementation

Approach

Workgroup

In line with CNYCC's collaborative and inclusive approach, a workgroup consisting of individuals from partner organizations was formed to develop the cultural competency and health literacy strategy. Workgroup participation was first solicited in a session at the [August 4th Project Advisory Committee Meeting in Syracuse, NY](#) and subsequently via newsletter and webinar communications. The first meeting of the Cultural

¹ US Dept of Health and Human Services Health Resources and Services Administration
<http://www.hrsa.gov/culturalcompetence/index.html>



Competency and Health Literacy Workgroup occurred on October 16th at Pioneer Homes in Syracuse, chaired by Kari Burke, the interim Workforce Coordinator for CNYCC. Workgroup participants include representatives from hospitals, regional public health departments, residential programs and community-based organizations in five of the six CNYCC counties. A timeline of Workgroup meetings and list of members can be found in **Appendices A and B**.

Workgroup membership is voluntary and may be subject to change based on the stage of planning or implementation. Yet, at any stage inclusiveness must be balanced against the effectiveness and efficiency of the Workgroup with respect to DSRIP timelines.

Conceptual Framework

In order to establish common understanding and vision, Workgroup members first examined concepts of health disparities and sought to identify definitions and professional guidelines or standards to support implementation and evaluation activities. The following definitions, professional standards and principles were identified through consensus processes by the Workgroup.

Definitions

These definitions were selected following the review of available definitions from federal, national and state-level organizations.

Health Literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Source: U.S. Department of Health and Human Services. 2000. Healthy People 2010. Washington, DC: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In National Library of Medicine Current Bibliographies in Medicine: Health Literacy. Selden CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

Cultural Competency: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. In healthcare, cultural competence is defined as a tenet of professional competence or an integrated aspect of overall competence. As part of culturally competent care, a care provider would consider culture-specific elements of a patient's lifestyle such as emotional expression, familial living arrangements, or recreational activities. Considering these elements facilitates accurate diagnosis and treatment planning that reaches across cultural boundaries and is acceptable to patients and their families.

Source: Cross et al., 1998

Health Disparity: A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual



orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Source: Healthy People 2020, U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020.

Professional Standards

The Workgroup decided on the following standards to underpin future assessment, implementation and evaluation processes. The vision for a culturally competent and health literate system of care delivery is one that upholds the two sets of standards referenced here (Full text of standards available in **Appendices C and D**):

- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
- Ten Attributes of Health Literate Health Care Organizations

Guiding Principles

The Workgroup has adopted guiding principles to establish norms, rules and values to govern actions (decisions or recommendations) within the Cultural Competency and Health Literacy workstream and in related DSRIP projects.

- To support and empower individuals who are most at-risk, it is critical to involve community members representing the diversity of the service area in the planning, design, implementation and evaluation of materials, services, and practices.
- Healthcare is a complex and rapidly changing field and effective communication is not widely practiced among healthcare organizations and providers. Therefore, a universal precautions approach is preferred to one that focuses on responding to stereotypical characteristics of a specific group of people.
- Interventions involving the community are most effective when there is a trusting relationship among individuals and groups interacting with the organization presenting the intervention. Whenever possible, CC and HL interventions in communities will be implemented through collaboration with organizations who are already trusted and known advocates in the community.
- CC and HL interventions in healthcare settings will be implemented to enhance, rather than supplant, organizational efforts currently in place. The goal is to support more effective care delivery without taxing existing systems.



Assessment of Health Disparities

The definition of culture is broad and extends beyond race, ethnicity and language. It is important to emphasize Cultural Competency and Health Literacy is not directed only at individuals and groups of different races, ethnic cultures and languages, as is often the assumption attached to the charge of “cultural competency.”

Literacy, and health literacy in particular, is often cited as a stronger predictor of poor health than ethnicity, socioeconomic status and education level.² It has been identified as a social determinant of health and connected to access to care, adherence to treatment plans, management of chronic conditions, and overall health outcomes, as well as reliance on emergency services, longer hospital stays and higher healthcare costs.² Thus, low health literacy itself is a source of health disparity.

Workgroup members appreciate the many determinants of health, which contribute to disparities among more racially and ethnically homogeneous populations. In early meetings, it was clear members were not limiting discussion of at-risk groups based upon race, ethnicity and language (REAL), but additional demographics such as age, geographic location, socioeconomic status, and disability status, among others.

A review of the demographics of the CNYCC service area further supports this approach. Compared to New York State as a whole, the six CNYCC counties have less racial and ethnic diversity (**Table 1**) outside of the sizeable immigrant and refugee populations in the urban centers of Syracuse and Utica. Limited health literacy, both not being aware of what services are available, as well as not understanding how to utilize them were also identified as contributors to unnecessary ED visits and higher in-patient rates. Five of the six counties exceed the Upstate rate for population with less than a high school education. Additionally, most counties have experienced an aging of the population over the past decade, as the loss of industry has led younger people seeking economic opportunities elsewhere, leaving the older and poorer residents behind. Regardless of ethnicity and language, these demographics are disproportionately represented among those with low health literacy levels, and thus poorer health care access, health management and health outcomes.

Table 1: Population Demographics by Region

| Region | Population | % White | % Black | % Asian | % Hispanic/ Latino | % Foreign Born |
|------------------|------------|---------|---------|---------|-----------------------|-------------------|
| NY State | 19,398,125 | 66.0 | 15.7 | 7.5 | 17.7 | 22.0 |
| CNYCC Counties | 1,002,605 | 86.9 | 7.0 | 2.4 | 3.6 | 5.6 |
| City of Syracuse | 144,669 | 56.0 | 29.5 | 5.5 | 8.3 | 11.1 |
| City of Utica | 61,808 | 69.0 | 15.3 | 7.4 | 10.5 | 17.6 |

As there is no standard methodology for identifying and framing priority groups, the Workgroup proceeded in a methodical and thoughtful process in order to best capture the region’s healthcare concerns as reflected by available data. The Workgroup identified overarching groups--or categories--that represent the biggest health

² Agency for Healthcare Research and Quality Improving Cultural Competence to Reduce Health Disparities for Priority Populations (2014) <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1934&pageaction=displayproduct>



challenges in all six counties and then focused on the geographical hotspots and most affected population groups within each general category as reflected by the data.

The Workgroup reviewed the CNYCC Community Needs Assessment and combined the key findings with their professional experience within these communities. Members shared suggestions for the priority groups experiencing health disparities, which were then compiled into a chart and reviewed by the Workgroup. Through discussion and review of additional data sources and each member submitting feedback on priorities via survey, the Workgroup selected four categories best supported by available data to guide the identification and refinement of priority group(s) in each of the six counties:

- Heart Disease
- Depression
- Diabetes
- Substance Abuse

The Workgroup is now engaged in examining available data in these categories using GIS mapping technology to identify geographic hotspots layered with demographic information. The Workgroup will consult with Local Government Units, CNYCC Project Implementation Collaborative (PICs) and canvass community-based organizations (CBOs) in each county to verify information and confer on needs and assets related to the priority groups disproportionately affected by these conditions. Engagement with these priority groups and local CBOs will drive the identification and implementation of culturally and socially relevant assessments, tools and interventions.

Cultural Competency and Health Literacy Strategic Plan

| 1: Identify priority groups experiencing health disparities (based on CNA/other analyses) | | |
|--|--|--|
| Steps | Inputs/Data Sources | Results/Findings |
| a) Poll CC/HL Workgroup members for initial consideration of priority groups | <ul style="list-style-type: none"> • CC/HL Workgroup | <ul style="list-style-type: none"> • Homeless • People with behavioral health challenges • Refugees/Immigrants • Low socioeconomic status • Disabled • Elderly • LGBT • Rural poor |
| b) Establish framework for identifying priority groups | <ul style="list-style-type: none"> • CC/HL Workgroup | <ul style="list-style-type: none"> • Identification of priority groups within each county based on selected health conditions |
| c) Review data to identify conditions driving premature death and hospital utilization | <ul style="list-style-type: none"> • CNYCC Community Needs Assessment (JSI) <ul style="list-style-type: none"> ○ Prevention Quality Indicators ○ Leading causes of premature death | <ul style="list-style-type: none"> • Heart Disease • Diabetes • Depression • Substance Abuse |
| d) Identify areas within counties with higher rates using zip code analyses and GIS mapping | <ul style="list-style-type: none"> • CNYCC Community Needs Assessment Data Maps • U.S. Census/American Community Survey | <ul style="list-style-type: none"> • Geographic and demographic information for at-risk populations in each county • Identification of prospective priority group |
| e) Contact Local Government Units (LGUs) to verify at-risk populations and identify available resources/prospective partners | <ul style="list-style-type: none"> • Health • Mental Health • Community Services | <ul style="list-style-type: none"> • Priority group(s) within each county • Geographic and demographic information for priority group(s) • Identification of CBOs serving priority groups |
| f) Disseminate data and information regarding priority groups to CNYCC partners | <ul style="list-style-type: none"> • Project Implementation Collaboratives and/or Regional Project Advisory Committees • CNYCC Communications: Website, Webinar, Newsletter, and others as appropriate | <ul style="list-style-type: none"> • Knowledge of priority groups, including process and inputs for identification • Confirm/identify CBOs serving priority groups |

Cultural Competency and Health Literacy Strategic Plan

| 2: Identify key factors to improve access to quality primary, behavioral health, and preventive health care | | |
|--|---|---|
| Steps | Inputs/Data Sources | Results/Findings |
| a) Review available evidence for key factors (barriers/facilitators) related to accessing care | <ul style="list-style-type: none"> • Research literature • CNYCC Community Needs Assessment (JSI) • CNYCC Consumer Focus Groups (EMA/JSI) | <ul style="list-style-type: none"> • Mental health • Health literacy • Language barriers • Poverty • Transportation • Institutional racism, cultural insensitivity and stigma • Stress, fear • Lack of understanding of health system or health-related needs/preventive care • Lack of supportive resources • Physical and behavioral factors associated with disabilities • Lack of engagement with health system • Low health literacy |
| b) Identify/confirm key factors affecting access specific to locality/priority group(s) | <ul style="list-style-type: none"> • Local Government Units <ul style="list-style-type: none"> ○ Health ○ Mental Health ○ Community Services • Regional Project Advisory Committees | <ul style="list-style-type: none"> • Key factors identified for each locality/priority group |
| c) Conduct series of community forums in collaboration with other DSRIP projects and CBOs to elicit feedback on key factors, including communication | <ul style="list-style-type: none"> • Project 2.d.i Patient Activation – CNYCC staff and partners • CBOs | <ul style="list-style-type: none"> • Key factors identified for each locality/priority group • Potential communication strategies identified |
| d) Map factors using Action Priority Matrix | <ul style="list-style-type: none"> • Community forums • Local Government Units • Regional Project Advisory Committees and/or Project Implementation Collaboratives | <ul style="list-style-type: none"> • Identify potential activities based on Action Priority Matrix <ul style="list-style-type: none"> ○ High Impact / Low Effort ○ High Impact / High Effort |

Cultural Competency and Health Literacy Strategic Plan

| 3: Define plans for two-way communication with the population and community groups through specific community forums | | |
|---|--|---|
| Steps | Inputs/Data Sources | Results/Findings |
| a) Identify existing forums, venues or means of communication with priority groups | <ul style="list-style-type: none"> • Regional Project Advisory Committees and/or Project Implementation Collaboratives • Local Government Units • CBOs • Community leaders | <ul style="list-style-type: none"> • Communication opportunities identified for each locality/priority group |
| b) Collaborate with CBOs and other stakeholders to establish communications where none currently exist | <ul style="list-style-type: none"> • Priority groups and Community leaders • Regional Project Advisory Committees and/or Project Implementation Collaboratives • Local Government Units • CBOs | <ul style="list-style-type: none"> • Communication strategies established for each locality/priority group |

| 4: Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors) | | |
|--|---|---|
| 5: Identify community-based interventions to reduce health disparities and improve outcomes | | |
| Steps | Inputs/Data Sources | Results/Findings |
| a) Review available evidence-based strategies (see Appendix E for Health Literacy Strategies) | <ul style="list-style-type: none"> • Research literature • Workgroup members professional experience • CNYCC partners best practices | <ul style="list-style-type: none"> • English for Health • Staying Healthy: An English Learner’s Guide to Health Care and Healthy Living • Latino Network: A Natural Fit in a Community-Driven Model Westchester County Community Network • Health Empowerment Theory as a Guide for Practice • National Center for Cultural Competence Georgetown University Bridging the Cultural Divide in Health Care Settings The Essential Role of Cultural Broker Programs • Time to Talk Cardio • Chronic Disease Self-Management Program |

Cultural Competency and Health Literacy Strategic Plan

| | | |
|--|---|---|
| b) Utilize community forums to integrate knowledge and action for mutual benefit, engaging in cyclical and iterative processes | <ul style="list-style-type: none">• Community Based Participatory Research Principles• Plan-Do-Study-Act (PDSA) cycles | <ul style="list-style-type: none">• Development/selection and implementation of socially and culturally relevant:<ul style="list-style-type: none">○ Self-management assessments and tools• Improved trust and communication |
|--|---|---|

Interdependencies with other Workstreams

Workgroup efforts will link to the CNYCC Workforce and Practitioner Engagement workstreams.



Reporting on Deliverables

- ☑ Steps a-c of the first deliverable (1: *Identify priority groups experiencing health disparities*)
- ☑ Step a of second deliverable (2: *Identify key factors to improve access to quality primary, behavioral health, and preventive health care*)

Potential Risks and Challenges

Our priority groups may also be identified as hard-to-reach populations and meaningful engagement of the community takes time. To mitigate this, it will be critical to partner with trusted CBOs in order to reach out to the priority population, although challenges may persist.

Cultural competency and health literacy may be perceived as yet another activity for CNYCC partners to undertake with limited resources. Therefore, it will be incumbent upon the Workgroup to seek opportunities to integrate cultural competency and health literacy into DSRIP projects, widely disseminate resources and best practices, as well as identifying strategies to incentivize partner engagement in these areas.

The field of research for cultural competency and health literacy is growing, but presently there is limited research on evidence-based interventions or their impact on health outcomes. As such, greater emphasis needs to be placed on consumer involvement and input to identify key factors to improve access to care, facilitate two-way communication, and identify socially and culturally relevant assessments, tools, and interventions.

Limited funding and other resources to implement effective CC/HL strategies is an ever-present challenge. CC/HL strategies are much needed for the provision of quality services, effective communication, and educational programs, but are not always included in organizational financial planning. Thus, it may be necessary to explore non-traditional resources and funding opportunities.

Recommendations

The CC/HL guiding principles and strategies must be infused into DSRIP projects wherever possible, particularly patient engagement or community outreach activities. In order to provide guidance on including best practices into the goals and activities of relevant projects, members of the CC/HL Workgroup will participate in planning meetings. These projects include 2.d.i., Patient Activation, 3.a.ii, Behavioral Health Crisis Stabilization, 3.b.i, Evidence-Based Strategies for CVD, and 4.d.i, Reducing Preterm Births.

The CC/HL activities as described in this report are those that fulfill the first CC/HL Milestone in the DSRIP Implementation Plan. While this first Milestone is focused on community-based interventions, the second Milestone to be addressed in DY2, Q4 will involve training of providers and other members of the workforce on available evidence-based research addressing health disparities. The second Milestone will require close collaboration with the activities of the CNYCC Workforce Workgroup, which is charged with assessing training needs, developing an inventory of available training resource, and developing a training strategy for CNYCC.



Appendix

- A. Workgroup Roster
- B. Workgroup Timeline
- C. Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)
- D. Ten Attributes of Health Literate Health Care Organizations
- E. Evidence-Based Strategies for Health Literacy



A. Workgroup Roster

| Member | Organization |
|-------------------|---|
| Sharyn Adam | Northwoods Center Rehabilitation and Nursing Center |
| Michelle Brown | St. Joseph's Health |
| Mary Costigan | Michaud Residential |
| Dianne DiMeo | Regional Primary Care Network |
| Constance Gregory | Upstate University Hospital |
| Bruce Hathaway | HealthConnections |
| Beth Hurny | Prevention Network |
| Penny Ingham | Lewis County Public Health |
| Debra Juidiciani | Community Health & Behavioral Services (Upstate Cerebral Palsy) |
| Stacey Keefe | St. Joseph's Health |
| Rachel Kramer | HealthConnections |
| Ellen Owens | Crouse Hospital Library |
| Diane Schenck | Cayuga Centers |
| Darlene Sovey | Community Health & Behavioral Services (Upstate Cerebral Palsy) |
| Mary Stronach | MAMI Interpreters |
| Jill Tibbett | Central New York Field Office- Office of Mental Health |
| Lisa Volo | Regional Primary Care Network |

| Staff/Consultants | Organization |
|-----------------------|------------------------------------|
| Wilma Alvarado-Little | Alvarado Little Consulting, LLC |
| BJ Adigun | CNY Care Collaborative |
| Kari Burke | CNY Care Collaborative |
| Alec McKinney | Senior Consultant/Project Director |
| Julie McKinney | Independent Consultant, Boston, MA |



B. Workgroup Timeline

| Work Plan | | | | | | |
|--|--------------------------|--------------------------|---------------------------|----------------------------|---------------------------|---------------------------|
| CNY CARE COLLABORATIVE | | | | | | |
| CULTURAL COMPETENCY/HEALTH LITERACY WORK GROUP | | | | | | |
| Activity | Friday, October 30, 2015 | Friday, November 6, 2015 | Friday, November 13, 2015 | November 17 or November 18 | Monday, November 23, 2015 | Tuesday, December 1, 2015 |
| Webinar meeting | | | | | | |
| All-State In-Person | | | | | | |
| CC/HL In-Person meeting | | | | | | |
| Webinar meeting | | | | | | |
| In-Person meeting <i>if needed</i> | | | | | | |
| FYI Board meeting | | | | | | |



C. National Standards for Culturally and Linguistically Appropriate Services (CLAS)

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide 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.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.



D. Ten Attributes of Health Literate Health Care Organizations

A health literate health care organization:

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

From *Ten Attributes of Health Literate Health Care Organizations*

http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf

E. Evidence-Based Strategies for Health Literacy

| Goal | Target Population | Programmatic Objectives | Community Activities | Evaluative Metrics | Community Partners |
|--|---|--|--|--|---|
| Ensure access to linguistically appropriate materials | <ul style="list-style-type: none"> • CBOs who serve: <ul style="list-style-type: none"> ○ LEP ○ Deaf and Hard of Hearing ○ Immigrants ○ Refugees | <ul style="list-style-type: none"> • Create system for ensuring that all CBOs [and healthcare providers?] have educational and outreach materials available in languages represented in community | <ul style="list-style-type: none"> • Connect CBOs to translation sources • Train CBOs and health care providers in legal requirements and CC awareness • Create compendium of multilingual health education materials • Educate CBO's and providers of the role of the interpreter and translator within the healthcare setting. | <ul style="list-style-type: none"> • Pre and post assessment of language access capacity | <ul style="list-style-type: none"> • CBOs in hotspots working with immigrants/refugees • Public librarians |
| Ensure access to plain language materials | <ul style="list-style-type: none"> • <138% poverty level • parents in rural school districts • Students in adult literacy and GED programs • Behavioral health service clients | <ul style="list-style-type: none"> • Create system for ensuring that all CBOs [and healthcare providers?] have educational and outreach materials available in easy-to-read text, plain language design and alternative formats | <ul style="list-style-type: none"> • Train CBOs in legal requirements and HL awareness • Train materials developers in plain language design • Create compendium of plain language health education materials | <ul style="list-style-type: none"> • Pre and post tests for trainings /education programs | <ul style="list-style-type: none"> • WIC programs • Public Housing • School districts • Public librarians |
| Support improved health literacy among community members | <ul style="list-style-type: none"> • <138% poverty level • parents in rural school districts • Students in adult literacy and GED programs • Behavioral health service clients | <ul style="list-style-type: none"> • Teach community members how to access services appropriately (use primary care, when to go to urgent care vs. ED, how to communicate with providers, self-advocacy, how to find and evaluate health information, etc.) | <ul style="list-style-type: none"> • Health literacy classes <ul style="list-style-type: none"> ▪ English for Health, ▪ Staying Healthy, etc. | <ul style="list-style-type: none"> • Pre and post tests for trainings/education programs | <ul style="list-style-type: none"> • Adult education programs • Public libraries • School districts • CBO's, faith-based orgs, etc. |

| | | | | | |
|--|--|--|--|---|--|
| | | | | | <ul style="list-style-type: none"> • WIC programs • Public Housing • Health centers |
| Support improved chronic disease management among community members | <ul style="list-style-type: none"> • People with chronic conditions | <ul style="list-style-type: none"> • Ensure that education programs are using curricula that are culturally competent and health literate, and have been designed for and tested with relevant target audiences | <ul style="list-style-type: none"> • Assess current curricula being used and adapt to be more culturally competent and health literate • Teach self management using curriculum designed for and tested with relevant target audiences | <ul style="list-style-type: none"> • Pre and post tests for trainings/education programs | <ul style="list-style-type: none"> • Health centers • Disease-specific support and advocacy groups |
| Ensure awareness of Language Access services among Community members | <ul style="list-style-type: none"> • Limited English speakers, deaf and hard of hearing | <ul style="list-style-type: none"> • Ensure community members whose preferred language is one other than English of their right to language access services | <ul style="list-style-type: none"> • Provide community workshops on legal requirements • Identify community contacts within organizations to provide services • Inform the community members of the role of the interpreter | <ul style="list-style-type: none"> • Data on usage of language access services? | <ul style="list-style-type: none"> • Health centers • Social Service agencies • School districts • CBO's, faith based orgs, etc. |