North Country Initiative Health Literacy and Cultural Competency Strategy

A Living Document – Informed by the DSRIP CNA and Community Forums

MILESTONE: Finalize cultural competency/health literacy strategy.	
Goal 1: Identify priority groups experiencing health disparities (based on PPS CNA and other analysis)	
Objective 1: Identify key characteristics of priority groups.	
Strategy: Conduct community needs assessment of the population in the Tug Hill Seaway region.	**Priority groups experiencing health disparities**: Low socioeconomic is the primary health disparity in the NCI service region as identified in the DSRIP Community Needs Assessment. To a lesser degree there are particular groups that experience health disparities and/or cultural variation in small populations including the (Akwesasne) Native Americans in Northern St. Lawrence County, near Massena Memorial Hospital and the Amish populations throughout the three counties. In addition, particular to the Medicaid population there is a generational variation between the physicians, who are predominantly over the age of 50, and the primary Medicaid population between the ages of 18-40. There are also cultural variations between the physician population which is composed of a significant number of foreign medical graduates and the region's population which is 92% White, 91% English speaking. Individuals living with significant mental illness and/or substance abuse issues also experience health disparities, although it is difficult to isolate this from socioeconomic disparity.
Goal 2: Identify key factors to improve access to quality primary, behavioral health, and preventive health care.	
Strategy 1: Successfully implement the DSRIP project plan with the identified interventions to address to community needs identified in the DSRIP CNA.	Increase access to primary care and behavioral health services through recruitment of professionals. Integrate behavioral health and primary care. Implement PPS wide care management and care coordination at the hospital, primary care, and community levels. Implement nationally recognized clinical practice guidelines to address cardiac and diabetes for high risk populations. Implement systematic referrals for preventive services and clinical decision support utilizing IT infrastructure. Conduct outreach to hotspots utilizing community navigators and community health workers.

Goal 3: Define plans for two-way communication with the population and community groups through specific community forums.	
Strategy I: Publishing an RFP and select a community based organization to conduct community forums in hot spots as identified in the community needs assessment.	Seaway Valley Prevention Council, in collaboration with the North Country Initiative and the Fort Drum Regional Health Planning Organization conducted twelve focus groups in ten out of the twelve hot spots. The CBOs that were utilized were NCPPC, PIVOT, Credo Community Center, Rose Hill, Massena Housing Authority, Mental Health Association of Jefferson County, Governeur Activity and Learning Center, NRCIL, TLS, Step-by-Step, North Country Freedom Homes, and Clifton-Fine Hospital. Each session varied between thirty-five minutes and one hour, depending on the number of participants. Number of participants ranged from three to twelve.
Strategy II: Within the first two years of DSRIP identify a plan to periodically revisit hot spots to maintain communication and evaluate impact.	
Strategy III: The CBOs who hosted the focus groups will be utilized to identify participants for an advisory group which will be used to inform two way communication strategies.	
Goal 4: In collaboration with care management teams, identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors)	
Strategy I: The care management teams and Population Health Improvement Committee will vet communication materials and patient education materials through the health literacy committee and the advisory group ensuring that they meet the CLAS standards.	
Goal 5: In collaboration with Population Health Improvement Committee/workgroups identify community-based interventions to reduce health disparities and improve outcomes.	
Strategy I: The care management teams and Population Health Improvement Committee will vet communication materials and patient education materials through the advisory group ensuring that they meet the CLAS standards.	
Strategy II: The advisory group will also be consulted on the most appropriate communication channels to be utilized for community based interventions.	

Goal 6: Incorporate evaluation plan into CC & HL strategy. Evaluation plan to include CAHPS Health Literacy Measure as identified in DSRIP Measure specification guide and to include target population improvement in outcomes responsive to self-management.	
Strategy I: The HLCC committee will receive and monitor the results of the CAHPS Health Literacy Measure for the clinical measures reported by the PPS for domain 3 and suggest interventions to improve PPS wide performance on the measure.	
Goal 7: Incorporate Health Literacy and Cultural Competency plan into NCI Communication Plan in partnership with Communication Committee.	
Strategy I: The NCI communication plan will include communication related elements of the HLCC strategy as identified.	

MILESTONE: Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	
Goal 1: Increase knowledge of health literacy among health providers in both the primary care and ED setting by providing continuing education opportunities.	
Objective I: Provide training opportunities to primary care providers that promotes patient involvement and health literacy among the target population.	
Strategy I: Provide training to primary care providers in hot spots to increase their understanding of health disparities of the population served.	Utilizing various modalities of trainings as identified by the workforce group.
Strategy II: Provide education to primary care providers that promotes frequent and comprehensive communication between the provider and patient regarding health concerns, treatment, and follow-up.	As part of PCMH implementation providers will receive education and must provide evidence of strategy ii to receive certification.
Objective II: Provide training opportunities to emergency department (ED) health professionals that promotes patient involvement and health literacy among the target population.	
Strategy I: Provide training to emergency department (ED) health professionals that promotes patient involvement and health literacy in order to provide a more comprehensive visit.	Utilizing various modalities of trainings as identified by the workforce committees.
Objective III: Provide training opportunities to primary care and ED ancillary staff	
Strategy I: Provide training to ancillary staff at the ED and primary care facilities that promotes frequent and comprehensive communication between providers and patients regarding health concerns, treatment and follow-up.	Utilizing various modalities of trainings as identified by the workforce committees.
Goal 2: Increase awareness of available services amongst the Medicaid eligible target population.	
Objective I: Promote awareness and increase utilization of community supportive services.	
Strategy I: Identify a means to keep referring PPS providers and partners up to date on access points.	*Note: Refers back to Milestone 1 – Tasks 4 and 5.*
Strategy II: Identify a means to keep consumers up to date on access points.	*Note: Refers back to Milestone 1 – Tasks 4 and 5.*

Objective II: Promote awareness and increase utilization of clinical preventive services.	
Strategy I: Identify a means to keep referring PPS providers and partners up to date on access points.	*Note: Refers back to Milestone 1 – Tasks 4 and 5.*
Strategy II: Identify a means to keep consumers up to date on access points.	*Note: Refers back to Milestone 1 – Tasks 4 and 5.*
Goal 3: Provide intervention at primary care level to increase health literacy with primary care providers and patients.	
Objective I: In collaboration with care transition committee ensure that patient records transfer from participating ED to the primary care physician to assist the patient in communicating with their primary care provider.	
Strategy I: In collaboration with care transition committee ensure that patient records transfer from participating ED to the primary care physician to assist the patient in communicating with their primary care provider.	
Strategy II: Increase utilization of patient portals.	
Strategy III: Identify and provide access to self-directed patient engagement tools for consumers to access prior to appointments.	
Strategy IV: Identify and provide access to patient engagement tools for PPS partners and providers.	

List of Resources for Providers		
Name of Evidence-Based Practice	Description	Website
'NVS' Health Literacy Assessment	A health assessment tool designed to measure health literacy in the primary care setting. The first tool made available in both English and Spanish.	http://www.pfizer.com/files/health/nvs_flipbook_english_final.pdf
'Ask Me 3'	A patient education program designed to improve communication between patients and health care providers, encourage patients to become active in their health care, and promote improved health outcomes.	http://www.npsf.org/?page=askme3
Choosing Wisely	Helps to promote communication between the patient and physicians. Asks providers to 'choose wisely' by identifying tests or procedures commonly used that should be questioned and discussed.	http://www.choosingwisely.org/about-us/
Literacy of Northern New York	Trains volunteers to work one-to-one with adults who need help with reading, writing or English as a second language in Jefferson, Lewis, and St. Lawrence.	http://www.proliteracynny.org/index.html
Bridges to Health and Healthcare Program/ Bridges Out of Poverty	Strategies for professionals and the communities that includes a DVD training series, webinars, a hospital integration program, and in-person trainings.	http://www.ahaprocess.com/store/bridges-out-of-poverty-book/