<u>Analysis of Culturally Competent Care and Improvement in Health Disparities-2014/2015</u>

<u>Community needs</u>: (identification of priority groups experiencing

Health disparities)

Cultural Competency work stream: Milestone #1 – bullets 1-5 are highlighted throughout document)

A Community Needs Assessment (CNA) [1] was completed in 2014 for Community Partners of WNY PPS and the Millennium Collaborative PPS.   The PPS CNA key observations were as follows: African –Americans are heavily concentrated in the cities of Niagara Falls and Buffalo; Latinos/Hispanics have higher concentrations on Buffalo's west side, Lackawanna, and Niagara Falls, as well as Dunkirk, Jamestown, Orleans County and other rural areas; Non-English speakers are distributed in a more complex pattern across the region. Many live in the West Side of Buffalo, with its heavy refugee populations, or in Lackawanna, where many Yemeni and other Middle Easterners live. There are other clusters of non-English speakers in Jamestown and in Amherst around the University at Buffalo (students/faculty with health insurance).   The CNA identified the following for health disparities: (1) The WNY region has a major problem with adult obesity (30.2% compared to 23.3 % statewide); (2) Prevalence of cigarette smoking among adults is 20.8%, compared to NYS Prevention agenda goal of 16.7%; (3) Although 69.7% of adults age 50-75 who receive a colorectal cancer screening is at or near the NYS Prevention Agenda goal of 71.4% (57% among the lowest income group to 75% among the highest income group, with the uninsured having a screening rate of 41%), the 6 rural counties of Genesee, Wyoming Orleans, Allegany, Cattaraugus, and Chautauqua have rates as low as 51.3%. Colorectal disease is the fourth most common cancer in NYS (excluding skin cancer) and second leading cause of cancer deaths with blacks having a higher incidence and mortality than whites according to "Screening Amenable Cancers in New York State Report (2014)"; (4) With educational attainment recognized as an underlying factor for poverty status and, by extension, health care need, the region's lowest rates of high school completion are concentrated in Buffalo and Niagara Falls and across the Southern Tier counties. Poverty status is perhaps the most important indicator of health need. In the Western New York region, 15% of the population lives below federal poverty level compared to 10% for the State. People at 200% of the Federal poverty level are overwhelmingly concentrated in the cities of Buffalo and Niagara Falls and widely across the Southern Tier counties of Chautauqua, Cattaraugus and Allegany in both small cities and rural areas. These areas also have excessively high rates of children under 18 living in poverty (30% in Chautauqua County). In June 2014 the US Census Bureau ranked the City of Buffalo as the 4th poorest city in the nation, where nearly 27% of the population lives in poverty, nearly two thirds under 200% of the federal poverty level.

 In Chautauqua County, the Women's Christian Association (WCA) Hospital service area is reviewed periodically as part of the organization's Strategic Plan. The review includes market share data of services provided by zip codes along with population and demographic data. Generally, the hospital's primary service area is considered to be the zip codes from which 75% of WCA admissions originate. WCA designs its community service plan around the community's needs. The present plan includes cardiology, cancer

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treatment, general surgery, orthopedic care, women's services, behavioral health, community preventative services, primary and emergency department care. The vast geographic size of the County, coupled with the fact that almost half of its residents live in sparsely populated rural areas, creates challenges in transportation and access to healthcare. Chautauqua County includes two cities, Dunkirk and Jamestown, and is one of the poorest counties in the state: 14.5% of all county residents live below the federal poverty level (U.S. Census Bureau 2007 – 2011). Hispanics are the fastest growing ethnic group in the county and in the nation, currently making up 5.9% of the county's population. Language and cultural differences can create barriers to the provision of health knowledge, health education and service delivery. Among the county's Hispanic population, 57.1% primarily speak Spanish. Other high-need populations served by WCA within the county include migrant families, Native Americans of the Seneca Nation reservations, the Amish and the homeless.

Based on a community needs assessment [2]conducted in 2013 by Catholic Health, Erie County, where a majority of our providers practice, is less racially and ethnically diverse than NYS or the country as a whole. The non-white populations are concentrated in and immediately around the city of Buffalo: 13 % Black and 4.7% Hispanic. The 11 Erie County zip codes with a non-white population of 50% or more are in Buffalo. Within Erie County, poverty is disproportionate across race and ethnicity (14.2%) with the percent of Black and Hispanic families in Erie County with income below the poverty level being far greater than that of their White and Asian Counterparts. Black (31.7%) and Hispanic (39.2%) populations reside primarily in the City of Buffalo (29.9%). The poor, the less-educated, racial minorities and the aged tend to experience disparities in health status compared to other parts of the population. Participants in the community assessment recognized that City of Buffalo neighborhoods are challenged with high rates of poverty, illiteracy (< 60% graduate from high school), crime, and poor access to primary care, compared to suburban neighborhoods.

Based on a Community Needs Assessment [3]conducted in 2013 by Mt St Mary's of Lewiston, the population of Niagara County is 7% African-American and 2% Hispanic. Twelve percent of the population is illiterate. Fifty percent of the population that seeks care in Mt St Mary's resides in the actual City of Niagara Falls

For all three counties, transportation for patients without cars is limited to a bus route or taxi service, although Medicaid does pay for transportation to and from medical appointments in Niagara and Erie Counties. Practices located in the cities of Buffalo and Niagara Falls consist of many clinics that are associated with hospitals or community based organizations. Approximately 50 % of our CPWNY

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[1] Community Needs Assessment jointly conducted by CPWNY PPS and MCC PPS, compiled by Buffalo Region Institute, 2014.
[2] Community Needs Assessment conducted by Catholic Health and accessed on 7/7/14 :
http://www.chsbuffalo.org/AboutUs/Community

[3] Community Needs Assessment conducted by Mount St. Mary's and accessed on 7/7/14:
https://www.msmh.org/community-service-and-health-needs-assessment/

Medicaid population is linked to Catholic Medical Partners (CMP) providers. To meet the needs of patients, CMP has a central policy regarding communication and language needs and provides standard training on cultural diversity and health literacy to care coordinators that work in physician offices.

In 2014, data was obtained through electronic medical record (EMR) downloads from offices aligned with Catholic Medical Partners that have Medent EMR and are partners in CPWNY. The data represents approximately 30% of the practitioners in the network, mostly in the suburbs of Buffalo, and excludes Chautauqua practitioners (at this time) but provides a snapshot of data that can be extracted from a practice electronic medical record. A July 2014 analysis of the CMP patient population (inclusive of Medicaid) broken out by race, ethnicity and language, reports the following:

Race	Count	Percent
American Indian/Alaska Native	77	0.07%
American Indian/Alaska Native, Asian	2	0.00%
American Indian/Alaska Native, Black/African American	8	0.01%
American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander	1	0.00%
American Indian/Alaska Native, White	36	0.03%
Asian	472	0.45%
Asian, Black/African American	1	0.00%
Asian, Native Hawaiian/Other Pacific Islander, White	1	0.00%
Asian, White	27	0.03%
Black/African American	1,886	1.81%
Black/African American, White	34	0.03%
Declined to Specify/Unknown	755	0.72%
Native Hawaiian/Other Pacific Islander	19	0.02%
Native Hawaiian/Other Pacific Islander, White	5	0.00%
Other	881	0.84%
White	100,080	95.97%
TOTAL	104,285	100.00%
Ethnicity	Count	Percent
Not of Spanish/Hispanic Origin	93,631	89.78%
Spanish/Hispanic Origin	1,274	1.22%
Unknown	9,380	8.99%
TOTAL	104,285	100.00%
Language	Count	Percent
Albanian	5	0.0048%
Amharic	1	0.0010%
Arabic	63	0.0604%
Bosnian	4	0.0038%
Bulgarian	6	0.0058%

Burmese	1	0.0010%
Chinese	16	0.0153%
Croatian	7	0.0067%
Dutch	3	0.0029%
Dzongkha	1	0.0010%
English	102,264	98.0620%
Farsi/Persian	4	0.0038%
Filipino	2	0.0019%
French	12	0.0115%
Fulah	1	0.0010%
German	8	0.0077%
Greek	4	0.0038%
Gujarati	2	0.0019%
Hindi	9	0.0086%
Hungarian	3	0.0029%
Icelandic	1	0.0010%
Italian	48	0.0460%
Japanese	1	0.0010%
Kirundi/Rundi	2	0.0019%
Korean	3	0.0029%
Lao	5	0.0048%
Lithuanian	2	0.0019%
Nepali	2	0.0019%
No Linguistic Content/Not Applicable	3	0.0029%
Patient Declined/Unknown	1,566	1.5017%
Polish	40	0.0384%
Portuguese	9	0.0086%
Romanian	1	0.0010%
Russian	18	0.0173%
Serbian	3	0.0029%
Slovak	1	0.0010%
Spanish	111	0.1064%
Tamil	2	0.0019%
Telugu	1	0.0010%
Thai	1	0.0010%
Tigrinya	1	0.0010%
Turkish	2	0.0019%
Ukrainian	5	0.0048%
Urdu	3	0.0029%
Vietnamese	38	0.0364%
TOTAL	104,285	100.0000%

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In September 2015, CPWNY, conducted an online Culturally and Linguistically Appropriate Services (CLAS) survey of providers, organizations, and community based organizations, regarding:

1. Demographic makeup (including Chautauqua county practitioners)
2. Ability of the partners to meet the needs of the population they serve
3. Attitude about working with people from different cultures
4. Ability to determine language or cultural barriers to patient engagement based on communication and education
5. Whether the partners needed additional education and in what areas.

Outcome of the CPWNY CLAS survey of Partners w/r/t cultural competency and health literacy

A CLAS Cultural Competency survey, administered in collaboration with P2 Collaborative and Millennium Collaborative PPS in September 2015, yielded a total response for CPWNY of 137 out of 436 CBO's and Primary Care practices surveyed (28%)

Based on the results of the survey the following information is obtained:

1. Respondents represented in the survey were 29% PCP, 17.5% specialty, 27% community based organizations, 29% behavioral health, and 27% other
2. Counties representative of CPWNY PPS partner distribution: 49.6% Erie, 30% Niagara, and 26% Chautauqua.
3. Regarding data collection in knowing the demographics of the population with respect to culture, language, ethnicity, preferences: 80% collect information on race, 79% on ethnicity, 81% on preferred language and 33% collect information on cultural preferences.
4. Minority populations served: 76% American Indian, 76% Asian American, 92.6%, Black/African American, 86% Hispanic, 42.1% Hawaiian Native/Pacific Islander, 48.8% Immigrant, 33.1% Refugee, 19% Other.
5. Primary languages served by the respondents: 95% English, 58.7% Spanish, 15.7% Arabic, 15.7% Burmese, 12.4% Russian, 9.1% Italian, 9.1% Karen, 9.1% Somali, 9.1 % Vietnamese, 8.3% Nepali , 5.8% Kirundi, 5% Polish and 5% Urdu. Between 2.6% and 4.1%: Bengali, French, and Thai. 2.5% and less: Albanian, German, Kurdish, Lao, Serbo-Croatian. Other: 9.9%
6. Languages spoken by staff: 47.5 % Spanish, 10% Arabic, 9.2% French, 5% Burmese, 8.3% Italian, 6.7% Polish, 5% Russian, 5% Burmese, German 4.2%
7. Regarding training: majority of respondents indicated that they have no training at orientation, most training occurred in 2014 and 2015 with none reported before 2013, no training on an ongoing basis: 53.5 % have no training on cultural competency and 70% have no training on health literacy. The rest of the respondents have annual training, the length of the trainings are 1 to 4 hours. The majority of practitioners have not attended training on cultural competency and health literacy approaches.

8. When asked if the organization is ready to meet cultural, racial and ethnic needs and preferences of their population 85% of respondents "agreed" or "strongly agreed" they are ready.

9. When asked if the staff feel comfortable in discussing a plan with clients taking into consideration cultural preferences, health literacy and lifestyle, 73.5 % of respondents stated they agreed and strongly agreed.

10. In regards to language assistance, the majority responded family or support person (though this is attributed to community based organization utilizing family or support persons for interpretation). 46. 2% used certified translators, and 43.4% used language lines. The rest of the responses were varied in methods of language assistance such as signage, translated educational items and computer translation. Phone lines were utilized by 43% and phone apps are now being utilized by 9.4%.

11. When asked the level of participation in becoming culturally competent and addressing health literacy, the areas indicating a need for improvement were: "the expressed lack of a cultural competency champion from within our staff to monitor activities and advancement in cultural competency", and "the lack of consistent cultural competency training and implementation as factors in staff evaluations."

In summary, those surveyed are interested in improving their approach to becoming culturally competent and addressing health literacy. There is a need to appoint champions in the partner organizations who will bring attention to addressing the needs of the population served. Training will need to occur and implemented with train the trainers to insure sustainability. Also, we want to insure everyone conducts surveys of the population as well as be able to pull data from their electronic systems in order to analyze for disparities.

Outcome of Patient Experience Survey w/r/t disparities

A. CMP CGCAHPS 2013 for all patients including Medicaid population (ATTACHMENT A)

Disparities exist amongst the population of Caucasian, Black, Asian, Native American and Other so that no single item was impacted. At times there was a statistical difference in that the ethnicity was statistically better than the Caucasian responses (Asian population had more time spent on explanations of medications which is indicative of the need by some patients and that need being met). The Black/African–American patients scored significantly lower for wait time for urgent care, discussing prescription medications, had difficulty getting an appointment for routine care and getting an answer calling the office during office hours, and rating of provider. The Black, Pacific Islander, and Other responded that they did not know what to do to be healthy compared to White population. Asians rated getting routine and urgent care less than for Whites. Urgent care stands out as an issue. CMP has provided education on disparities to care coordinators and providers, and incorporated the topic into the training of care coordinators at their offices since 2008. There is a missing educational link with the rest of the office, including the provider.

Outcome of Clinical Performance data w/r/t disparities   (ATTACHMENT B)

A. EMR Downloads, (includes all lines of insurance business and uninsured)

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Measures were analyzed by race and language. Ethnicity from the data was not robust enough to support any conclusions. Data was evaluated and reported where at least 50 patients are statistically lower than the average for any of the performance measures. The outliers identified were breast cancer screening, colorectal screening, diabetes LDL and blood pressure. According to the National Quality Forum Consensus paper on healthcare disparities, *Disparities Report*[4], for most core quality measures, Blacks, Hispanics, and the economically depressed received lower quality care than their reference groups. Disparities were increasing and more prevalent in the area of chronic disease management. The groups at CMP, representative of Erie and Niagara counties, demonstrating disparity are Blacks/African American and Asian:

- Breast Cancer Screening - Race – Asian, Black and American Indian were statistically lower than the average; Language --Chinese, Spanish, Vietnamese were statistically lower than average.
- Colorectal Cancer Screening – Race – Black and Other are statistically lower than average; Language – Chinese was statistically lower than average.
- Diabetes LDL<100 – Race – Black was statistically lower than average
- Diabetes BP < 140/90 – Race – Black were statistically lower than average

This disparity breakdown coincides with the CPWNY CNA and the Susan B Komen WNY Quantitative data, 2015 report[5] that demonstrates an opportunity to improve breast cancer screening exists. For Chautauqua County, the Community Needs Assessment indicates that disparities exist regarding premature (before 65 years of age) deaths for the Hispanic population along with cancer screening, which is in line with the NYS Prevention Agenda. CPWNY, in collaboration with P2 Collaborative of WNY (Population Health Improvement Program grant recipient) will undertake initiatives to increase screening rates for breast cancer, cardiovascular disease, and diabetes, cervical and colorectal cancers, especially among populations experiencing health disparities.

Opportunities for Improvement

Cooper and Rowe (2004) [6] conducted a Commonwealth Fund supported study that reviewed previously conducted studies on impact of race, language and culture on patient satisfaction and provider relationships and concluded the following:

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[4]. National Voluntary Consensus Standards for Ambulatory Care Measuring Healthcare Disparities, pp.1-62, March 2008, accessed 10/1/2014 at http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency. aspx

[5] Susan B. Komen Western New York Quantitative Data: Measuring Breast Cancer Impact in Local Communities, 2015 analysis, page 22-23.

[6] Cooper L.A, Powe NR, John Hopkins University, "Disparities in Patient Experiences , Health Care Processes, and Outcomes: The Role of the Patient – Provider Racial, Ethnic, and Language Concordance:"pp 1-24, 2004, Accessed 10/1/2014 at http://www.commonwealthfund.org/programs/minority/cooper_raceconcordance_753.pdf

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- Patients in race–concordant relationships rate their physicians as more participatory (patient participation in medical decision is strongly or significantly related to satisfaction across all racial groups)
- Minorities are less likely than whites to have racial concordance with their regular physician who is not of the same race.
- Patients in race–concordant relationships have longer visits with more positive patient effect
- Patients who need an interpreter report less understanding of their disease and treatment
- Patients receiving interpreter services increase use of preventive services
- Language concordance with providers and professional interpreter services are associated with patient satisfaction.

Recommendations from the aforementioned study:

- Delivery of services needs to be optimized to allow adequate time and appropriate scheduling of follow up visits for patients; incentives for providers to deliver high quality care to ethnic minority patients; and professional interpreter services to reduce medical errors, improve quality of preventive care, and improve patient ratings of care and health status.

CPWNY Opportunities for Improvement

Based upon the aforementioned analysis, the partner responses to the cultural competence survey, results of the patient experience survey and Catholic Medical Partners performance measures by race, language and culture, CPWNY has decided that improving access and patient understanding of office appointments, as well as improving provider sensitivity to literacy and cultural diversity, must be undertaken by CPWNY for all our clinical partners. Practices will need to evaluate their level of cultural competence if they are to realize improvements in both patient experience and performance measures. Partners will also need to utilize the "universal approach "to health literacy, tackling literacy issues first. Focus groups, to include Amish and Hispanic populations in Chautauqua County as indicated in the Community Needs Assessment, will expand our knowledge on health disparities in that county, along with approaches of engagement.

Plan to Address Gaps and Health Disparities

CPWNY must first meet a basic need of organizations and clinical practices:

1. Provide information and resources on our website for the providers and the office manager regarding cultural needs of patients. CPWNY will promote its central policies on Communication Needs and Cultural Competency Health Literacy (Attachment D) and will also provide resources to the providers for interpretation services via our CPWNY newsletter.
2. Instruct organizations on how to dissect their registries to determine impact of language and cultural barriers upon clinical quality and patient satisfaction surveys to expand knowledge on health care disparities. Insure that guidelines are incorporated into the electronic medical record

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so that there is an immediate reminder of patient treatment needs utilizing clinical decision support. The use of the electronic health system will bring new guidelines to the point of care, thereby mitigating racial disparities. [7] (Identifies priority groups experiencing health disparities)

3. Insure that the organizations share information on language, cultural belief preference for patients regarding office appointments, how to get urgent care, and shared decision making. One of the first actions may be to explain how to receive care at the office and how information is to be relayed in person and on a clinical summary, in various languages as needed, in easy to understand explanations. The adoption of self-management tools will be a growing and ever changing process. Population focus teams will be in place for each county to assist with ease of use and understanding of self-management tools. Community forums are held and will continue to be held for input and training on patient engagement tools.
(Identify assessments and tools to assist patients with self-management of conditions)

4. Work with P2 collaborative (PHIP grant recipient) and Millennium Collaborative Care PPS for broad based solutions to reduce disparities ** (see Strategy Blueprint for Success). This program is designed to address access to quality primary, behavioral and preventive health care. (Defines plans for 2-way communication with the population and community groups though specific community forums and Identifies community-based interventions to reduce health disparities and improve outcomes.)

5. Department of Health (county) to conduct community needs assessment surveys of communities served by hospital systems January thru March 2016 in languages of Spanish, Arabic, Somali and Karen. In April 2016 results will be shared with the providers. There will be focus group meetings of patients served by that hospital to ascertain opportunities for improvement. Strategic initiatives will focus on NYS Prevention Agenda, Opioid Addiction babies and Substance Abuse.

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[7] Hirsch, Marla Durben, "Racial Disparities Reduced through EMR Use", web accessed 12/14/15: http://www.fierceemr.com/story/racial-disparities-reduced-through-ehr-use/2012-01-11.

2015-2020 Strategy to Improve Health Literacy and Access to Culturally Competent Care

Goal	Intervention
Culturally Competent Care: 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 common needs	• Staff members are knowledgeable regarding cultural health beliefs and practices and preferred languages and recommend a "go to" person who takes accountability in meeting healthcare beliefs of patients. • Ongoing education and training as part of the workforce workstream in culturally and linguistically appropriate service delivery as well as addressing social stigmas and determinants of care. • Newsletter "spotlight" on providers who use creativity in reaching out to the population, thereby engaging patients in their healthcare. • Instruct partner organizations on how to dissect their registries to determine impact of language and cultural barriers upon clinical quality and patient satisfaction surveys. • Promote use of a standardized cultural and linguistic assessment tool for organizations to use in comprehending deficiencies in cultural competency. • Provide information and resources on the CPWNY website for partner organizations regarding cultural needs of patients. • Address "stigma" and "stereotyping", inclusive of behavioral health and substance abuse through education, dissemination of information, and use of community forums. One such method is to ask patients their healthcare preference and make no assumptions. The CPWNY PAC will serve as the source of two way communication with the public sector and community based organizations(Defines plans for two way communication with the population and community groups through specific community forums) • Engage our CBOs in assisting our mission and vision for the health disparities population, for example, with involvement in training, follow through, information, referrals. Focus on training of Community Health Outreach workers on resources for health screenings to provide to the Medicaid member.(Identifies community based interventions to reduce health disparities and improve outcomes) • Insure incorporation of cultural diversity and health literacy, along with

	awareness of social stigmas and determinants of health, into each project and workstream. A quality meeting, minimally quarterly, will occur for each project to ascertain incorporation of CC/HL workstream into the projects and other workstreams, especially Workforce.
	RESOURCE:
	https://www.thinkculturalhealth.hhs.gov/content/clas.asp
	http://ethnomed.org/
	https://hclsig.thinkculturalhealth.hhs.gov/
	http://www.diversityrx.org/
	http://dhmh.maryland.gov/mhhd/CCHLP/Documents/Cover.pdf
	http://www.albany.edu/sph/cphce/advancing_cc.shtml
	http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf
Language Access Services: Provide easy to understand print and multimedia materials and signage in the language commonly used by the population	• Inform all individuals of availability of language assistance services • Document if patient refuses language assistance services RESOURCE: http://www.diversityrx.org/topic-areas/language-access https://www.thinkculturalhealth.hhs.gov/Content/communication_tools.asp http://www.lgbtcultcomp.org/
Instilling cultural competence and health literacy universal approach	www.advancingcc.org. http://www.improvingchroniccare.org/downloads/health_literacy_universal_precautions_toolkit.pdf

Strategy Blueprint for Success in Reducing Health Disparities and Outcomes

Population Health Improvement Program (PHIP) Strategies as put forth by P2 Collaborative, Buffalo , NY coinciding and collaborating with the CPWNY Delivery System Redesign Incentive Payment (DSRIP) Program Strategies and the NYS Department of Health Prevention Agenda Western New York Community Priorities (ATTACHMENT C)

(Identify key factors to improve access to quality primary , behavioral health, and preventive health care)

(Identify community based interventions to reduce health disparities and improve outcomes)

(Defines plans for 2-way communication with the population and community groups through specific community forums)

(Identifies assessments and tools to assist patients with self management of conditions (considering cultural, linguistic and literacy factors)

GOAL: Increase screening rates for cardiovascular disease, diabetes, and breast, cervical, and colorectal cancers, behavioral health especially among disparate populations

Desired Long Term Outcomes/Measures	Outputs: What we will use as evidence that we have succeeded
Decrease Mortality	NYS mortality rates as related to indicators, i.e. SPARCS data; CDC Wonder Page; HEDIS and QARR measures as outlined in DSRIP Measurement manual.
Increased culture of self-management	Ongoing screening- people going year after year; patient level detail from HMO and State.
Reduction of avoidable hospital use	
Desired Short Term Outcomes/Measures/Interventions	Outputs: What we will use as evidence that we have succeeded
Early Cancer Screening, breast, colorectal :	
Increased early detection breast and colorectal cancer screening for health disparities populations where there is highest need. Use of a matrix to ascertain current screenings and interventions	Look at high needs (risk stratification) – data currently used; Look at number of early detection screenings, specifically for breast and colorectal cancers.

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used in past that were or were not successful. Engagement of CBOs (2 way communication) to occur at this point for brainstorming and improvements as well as patient focus groups to address barriers. Training of Community Health Outreach workers on preventive screenings and where people can go to obtain.	
Population education on importance of early breast cancer and colorectal screening with emphasis on patient beliefs and values. Involvement of health homes and community outreach workers. One on One, patient navigation to improve access to primary and preventive health care Increase patient engagement in health homes	HEDIS / QARR measures
Blood Pressure Screening:	
Increased Awareness of blood pressure monitoring – providing educational self-care information related to hypertension and impact on health.	Meeting schedule template/posters/self-management tools utilized.
Increased blood pressure screening – use of self-management tools that are easy to use, reviewed by community forums and in languages prevalent in the population. Convene community stakeholders in collaborative learning sessions to identify opportunities to replicate best practices focusing on primarily on geographical areas and communities of people with the greatest need. Involvement of health homes and community outreach workers to improve access to primary care for BP monitoring. Utilize care management advisors to teach and work with practices to reduce barriers to self-care as well as community forums.	Early detection HTN and blood pressure control (HEDIS) Meeting and training templates. Increase in patient engagement in health homes thereby increasing primary care access and BP monitoring.
Behavioral Health Screening: (PHQ2,9 /SBIRT)	
Obtain understanding from diverse communities related to accessibility, resources, educational needs, stigma, and cultural competence w/r/t depression, suicide, and substance abuse. Early detection of behavioral health disorders through understanding of barriers, promotion of 2-1-1 services. Behavioral health integration with primary care.	Patient Experience surveys
Increased access to trained professionals – Care Management advisors to promote the engagement of Health Homes and PCMH offices	Increased assistance of Health Homes and social workers for linkages – DSRIP measure – Health Home assigned/ referred members in outreach or engagement.
Increase in PHQ2, 9/SBIRT screenings - Clinical Transformation specialists to work with each practice documentation system that can be	HEDIS measure – screening for clinical depression and follow up; 2-1-1 usage, patient engagement data

queried, Meaningful Use compliance, incorporation into Clinical Integration Plan Resources (2-1-1) will be promoted by the Care Management team and Territory leads.	
Follow up on positive screenings	HEDIS measure – screening for clinical depression and follow up

Reviewed and Approved:

CGC: November 12, 2015

EGB: December 9, 2015

ATTACHMENT A

Based on their responses to the "PCMH-A: Race" question, how respondents answered the following questions.

	White		Black or African-American		Asian		Native Hawaiian or other Pacific Islander		American Indian or Alaska Native		Other	
	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size
PCMH-A: Able to get after hours care	43.9	1,646	48.8	82	50.0u	24	100.0u	1	47.1u	17	16.0u	25
PCMH-A: Clerks/receptionists courtesy/respect	84.3	14,112	83.2	357	77.6	116	86.7u	15	87.3	71	77.8	126
PCMH-A: Clerks/receptionists helpful	70.7	14,106	66.6	356	63.8	116	60.0u	15	71.8	71	61.6	125
PCMH-A: Days had to wait for urgent care	50.9	5,667	40.5	163	40.0	65	75.0u	4	50.0	34	41.5	65
PCMH-A: Discussed non-medical problem	32.4	14,019	33.5	358	36.5	115	20.0u	15	41.4	70	37.4	123
PCMH-A: Discussed patient's worry/stress	47.1	13,999	45.9	357	41.4	116	40.0u	15	52.9	70	54.8	124
PCMH-A: Discussed prescription meds	86.5	12,847	82.2	320	84.5	97	100.0u	13	86.2	65	90.1	111
PCMH-A: Discussed problems with monitoring health	34.5	13,853	37.2	349	29.5	112	33.3p	15	34.3	70	44.4	124
PCMH-A: Easy to understand instructions about concerns	82.2	11,226	78.7	296	83.3	96	90.9u	11	81.3	64	82.6	109
PCMH-A: Got answer calling after office hrs in past year	66.5	890	54.1	37	77.8u	18	100.0u	1	42.9u	7	38.5u	13
PCMH-A: Got info about after-hours care	70.3	5,581	63.2	136	78.8	52	60.0u	5	66.7	39	65.7	67
PCMH-A: Got routine care appt when needed in past year	73.2	13,709	75.3	344	80.5	113	73.3p	15	76.8	69	78.2	124
PCMH-A: Got urgent care appt when needed in past year	78.6	12,015	70.8	288	62.5	104	81.8p	11	76.6	64	64.9	111
PCMH-A: Office asked about leadings of depression	77.5	5,867	72.7	172	64.1	64	75.0u	4	69.4	36	70.1	67
PCMH-A: Office followed up with results	50.7	13,999	47.7	354	42.2	116	53.3p	15	53.6	69	55.3	123
PCMH-A: Office helped set goals for managing health	61.8	12,147	61.5	304	55.3	103	76.9u	13	67.7	65	53.0	115
PCMH-A: Provider asked about patient's opinion of meds	62.2	13,956	66.2	349	51.3	113	66.7u	15	77.1	70	68.3	126
PCMH-A: Provider discussed reasons not to take meds	80.2	6,653	76.1	180	89.2	65	100.0u	5	79.1	43	80.6	67
PCMH-A: Provider explained things understandably	44.8	6,629	48.9	102	56.3	64	80.0p	5	42.9	62	54.5	66
PCMH-A: Provider informed about specialist care	64.6	6,707	62.6	179	64.1	64	80.0u	5	65.1	43	72.3	65
PCMH-A: Provider knew medical history	83.6	14,056	82.6	357	81.2	117	73.3p	15	78.9	71	78.6	126
PCMH-A: Provider listened carefully	63.7	9,391	67.0	221	55.9	59	87.5u	8	62.3	53	66.7	69
PCMH-A: Provider seen w/in 15 min of appt time in past year	78.3	14,005	78.8	353	78.3	115	86.7p	15	73.2	71	73.6	125
PCMH-A: Provider sent reminders between visits	84.8	14,055	83.4	356	87.1	116	86.7u	15	80.3	71	83.1	125
PCMH-A: Provider showed respect for what patient said	31.0	14,023	27.8	352	34.5	116	46.7u	15	38.0	71	30.4	125
PCMH-A: Provider spent enough time with patient	66.4	13,929	70.9	351	63.4	114	66.7u	15	75.7	70	74.8	127
PCMH-A: Rate provider	89.8	14,058	86.7	354	88.8	116	86.7u	15	81.7	71	83.6	125
PCMH-A: Would recommend provider	82.7	14,047	79.7	355	77.8	117	89.0u	15	80.3	71	78.4	125
PMCH-A: Get care when needed	95.0	14,074	93.4	350	95.7	117	86.7u	15	92.9	70	93.6	125
PMCH-A: Know what to do to be healthy	95.1	14,080	89.5	352	94.9	117	80.0u	15	91.5	71	88.2	127

⬆ Indicates "White" score is significantly higher
➡ Indicates "White" score is significantly lower

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
5	**Based on their responses to the "PCMH-A: Race" question, how respondents answered the following questions.**															
56	PCMH-A: Got answer calling during office hrs in past year	63.2	136	78.8	52	80.0u	5	66.7	39					65.7	67	
57	PCMH-A: Got info about after-hours care	75.3	344	80.5	113	73.3u	15	76.8	69					78.2	124	
58	PCMH-A: Got routine care appt when needed in past year	70.8	288	62.5	104	81.8u	11	76.6	64					64.9	111	
59	PCMH-A: Got urgent care appt when needed in past year	72.7	177	64.1	64	75.0u	4	69.4	36					70.1	67	
60	PCMH-A: Office asked about feelings of depression	47.7	354	42.2	116	53.3u	15	53.6	69					55.3	123	
61	PCMH-A: Office followed up with results	61.5	304	55.3	103	76.9u	13	67.7	65					53.0	115	
62	PCMH-A: Office helped set goals for managing health	66.2	349	51.3	113	66.7u	15	77.1	70					68.3	126	
63	PCMH-A: Provider asked about patient's opinion of meds	76.1	180	89.2	65	100.0u	5	79.1	43					80.6	67	
64	PCMH-A: Provider discussed reasons not to take meds	48.9	182	56.3	64	80.0u	5	42.9	42					54.5	66	
65	PCMH-A: Provider explained things understandably	62.6	179	64.1	64	80.0u	5	65.1	43					72.3	65	
66	PCMH-A: Provider informed about specialist care	82.6	357	81.2	117	73.3u	15	78.9	71					78.6	126	
67	PCMH-A: Provider knew medical history	67.0	221	55.9	59	87.5u	8	62.3	53					66.7	69	
68	PCMH-A: Provider listened carefully	79.9	353	78.3	115	86.7u	15	73.2	71					73.6	125	
69	PCMH-A: Provider seen w/ in 15 min of appt time in past year	83.4	356	87.1	116	86.7u	15	80.3	71					83.1	124	
70	PCMH-A: Provider sent reminders between visits	27.8	352	34.5	116	46.7u	15	30.0	71					30.4	125	
71	PCMH-A: Provider showed respect for what patient said	70.9	351	68.4	114	66.7u	15	75.7	70					74.8	127	
72	PCMH-A: Provider spent enough time with patient	86.7	354	88.8	117	86.7u	15	81.7	71					85.6	125	
73	PCMH-A: Rate provider	79.7	355	77.8	117	80.0u	15	80.3	71					78.4	125	
74	PCMH-A: Would recommend provider	76.1	355	77.2	114	80.0u	15	77.1	70					75.0	124	
75	PMCH-A: Get care when needed	78.8	354	77.6	116	86.7u	15	80.3	71					77.4	124	
76	PMCH-A: Know what to do to be healthy	93.4	359	95.7	117	86.7u	15	92.9	70					93.6	125	
77	⬆ Indicates "Black or African-American" score is significantly higher															
78	⬇ Indicates "Black or African-American" score is significantly lower															
79		89.5	352	94.9	117	80.0u	15	91.5	71					88.2	127	

	C	Asian		Native Hawaiian or other Pacific Islander		American Indian or Alaska Native		Other	
81		Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size
83	PCMH-A: Able to get after hours care	50.0u	24	100.0u	1	47.1u	17	16.0u	25
84	PCMH-A: Clerks/receptionists courteous/respect	77.6	116	86.7u	15	87.3	71	77.8	126
85	PCMH-A: Clerks/receptionists helpful	63.8	116	60.0u	15	71.8	71	61.6	125
86	PCMH-A: Days had to wait for urgent care	40.0	65	75.0u	4	50.0	34	41.5	65
87	PCMH-A: Discussed non-medical problem	36.5	115	20.0u	15	41.4	70	37.4	123
88	PCMH-A: Discussed patient's worry/distress	41.4	116	40.0u	15	52.9	70	54.8	124
89	PCMH-A: Discussed prescription meds	84.5	97	100.0u	13	66.2	65	90.1	111
90	PCMH-A: Discussed problems with monitoring health	29.5	112	33.3u	15	34.3	70	44.4	124
91	PCMH-A: Easy to understand instructions about concerns	83.3	96	90.9u	11	81.3	64	82.6	109
92	PCMH-A: Got answer calling after office hrs in past year	77.0u	13	60.0u	5	42.9u	7	38.5u	13
93	PCMH-A: Got answer calling during office hrs in past year	78.8	52	60.0u	5	66.7	39	65.7	67
94	PCMH-A: Got info about after-hours care	80.5	113	73.3u	15	76.8	69	78.2	124
95	PCMH-A: Got routine care appt when needed in past year	62.5	104	81.8u	11	76.6	64	64.9	111
96	PCMH-A: Got urgent care appt when needed in past year	64.1	64	75.0u	4	69.4	36	70.1	67
97	PCMH-A: Office asked about feelings of depression	42.2	116	53.3u	15	53.6	69	55.3	123
98	PCMH-A: Office followed up with results	55.3	103	76.9u	13	67.7	65	53.0	115
99	PCMH-A: Office helped set goals for managing health	51.3	113	66.7u	15	77.1	70	68.3	126
100	PCMH-A: Provider asked about patient's opinion of meds	89.2	65	100.0u	5	79.1	43	80.6	67
101	PCMH-A: Provider discussed reasons not to take meds	56.3	64	80.0u	5	42.9	42	54.5	66
102	PCMH-A: Provider discussed reasons to take meds	64.1	64	80.0u	5	65.1	43	72.3	65
103	PCMH-A: Provider explained things understandably	81.2	117	73.3u	15	78.9	71	78.6	126
104	PCMH-A: Provider informed about specialist care	55.9	59	87.5u	8	62.3	53	66.7	69
105	PCMH-A: Provider knew medical history	78.3	115	86.7u	15	73.2	71	73.6	125
106	PCMH-A: Provider listened carefully	87.1	116	86.7u	15	80.3	71	83.1	124
107	PCMH-A: Provider seen w/ in 15 min of appt time in past year	34.5	116	46.7u	15	30.0	71	30.4	125

Based on their responses to the "PCMH-A: Race " question, how respondents answered the following questions.

	Positive	n Size	Positive	n Size			Positive	n Size			Positive	n Size
PCMH-A: Provider sent reminders between visits	68.4	114	66.7u	15			75.7	25			74.8	127
PCMH-A: Provider showed respect for what patient said	88.8	116	86.7u	15			81.7				85.6	125
PCMH-A: Provider spent enough time with patient	77.8	117	80.0u	17			80.3				78.4	125
PCMH-A: Rate provider	77.2	114	60.0u	15			77.1				75.0	124
PCMH-A: Would recommend provider	77.6	116	86.7u	15			80.3				77.4	124
PMCH-A: Got care when needed	95.7	117	86.7u	15			92.9				93.6	125
PMCH-A: Know what to do to be healthy	94.9	117	80.0u	15			91.5				88.2	127

⬆ Indicates "Asian" score is significantly higher
⬇ Indicates "Asian" score is significantly lower

	Hawaiian or other Pacific Islander		American Indian or Alaska Native		Other	
	Positive	n Size	Positive	n Size	Positive	n Size
PCMH-A: Able to get after hours care	100.0u	1	47.1u	17	16.0u	25
PCMH-A: Clerks/receptionists courtesy/respect	86.7u	15	87.3	71	77.8	126
PCMH-A: Clerks/receptionists helpful	60.0u	15	71.8	71	61.6	125
PCMH-A: Days had to wait for urgent care	75.0u	4	59.0	34	41.5	65
PCMH-A: Discussed non-medical problem	20.0u	15	41.4	70	37.4	123
PCMH-A: Discussed patient's worry/stress	40.0u	15	52.9	70	54.8	124
PCMH-A: Discussed prescription meds	100.0u	13	86.2	65	90.1	111
PCMH-A: Discussed problems with monitoring health	33.3u	13	34.3	70	44.4	124
PCMH-A: Easy to understand instructions about concerns	90.9u	11	81.3	64	82.6	109
PCMH-A: Got answer calling after office hrs in past year	100.0u	1	42.9u	7	38.5u	13
PCMH-A: Got answer calling during office hrs in past year	60.0u	5	66.7	39	65.7	67
PCMH-A: Got info about after-hours care	73.3u	15	74.8	69	78.2	124
PCMH-A: Got routine care appt when needed in past year	81.8u	11	76.6	64	64.9	111
PCMH-A: Got urgent care appt when needed in past year	75.0u	4	69.4	36	70.1	67
PCMH-A: Office asked about feelings of depression	53.3u	15	53.6	60	55.3	123
PCMH-A: Office followed up with results	76.9u	13	67.7	65	53.0	116
PCMH-A: Office helped set goals for managing health	66.7u	15	77.1	70	68.3	126
PCMH-A: Provider asked about patient's opinion of meds	100.0u	5	79.1	43	80.6	67
PCMH-A: Provider discussed reasons not to take meds	80.0u	5	42.2	42	54.5	66
PCMH-A: Provider discussed reasons to take meds	80.0u	5	65.1	43	72.3	65
PCMH-A: Provider explained things understandably	73.3u	15	78.9	71	78.6	126
PCMH-A: Provider informed about specialist care	87.5u	8	62.3	53	66.7	69
PCMH-A: Provider know medical history	86.7u	15	73.2	71	73.6	125
PCMH-A: Provider listened carefully	86.7u	15	80.3	71	83.1	124
PCMH-A: Provider seen w/in 15 min of appt time in past year	46.7u	15	36.0	71	30.4	125
PCMH-A: Provider sent reminders between visits	66.7u	15	75.7	70	74.8	127
PCMH-A: Provider showed respect for what patient said	66.7u	15	81.7	71	85.6	125
PCMH-A: Provider spent enough time with patient	66.7u	15	80.3	71	78.4	125
PCMH-A: Rate provider	80.0u	15	77.1	70	75.0	124
PCMH-A: Would recommend provider	80.0u	15	80.3	71	77.4	124
PMCH-A: Got care when needed	86.7u	15	92.9	70	93.6	125
PMCH-A: Know what to do to be healthy	80.0u	15	91.5	71	88.2	127

⬆ Indicates "Native Hawaiian or other Pacific Islander" score is significantly higher
⬇ Indicates "Native Hawaiian or other Pacific Islander" score is significantly lower

	American Indian or Alaska Native		Other	
	Positive	n Size	Positive	n Size
PCMH-A: Able to get after hours care	47.1u	17	16.0u	25
PCMH-A: Clerks/receptionists courtesy/respect	87.3	71	77.8	126
PCMH-A: Clerks/receptionists helpful	71.8	71	61.6	125

	C	D	E	F	G	H	I
5	**Based on their responses to the "PCMH-A: Race" question, how respondents answered the following questions.**						
160	PCMH-A: Days had to wait for urgent care			50.0	34	41.5	65
161	PCMH-A: Discussed non-medical problem			41.4	70	37.4	123
162	PCMH-A: Discussed patient's worry/stress			52.9	70	54.8	124
163	PCMH-A: Discussed prescription meds			86.2	65	90.1	111
164	PCMH-A: Discussed problems with monitoring health			34.3	70	44.4	124
165	PCMH-A: Easy to understand instructions about concerns			81.3	64	82.6	109
166	PCMH-A: Got answer calling after office hrs in past year			42.9u	7	38.5u	13
167	PCMH-A: Got answer calling during office hrs in past year			66.7	39	65.7	67
168	PCMH-A: Got info about after-hours care			76.8	69	78.2	124
169	PCMH-A: Got routine care appt when needed in past year			76.6	64	64.9	111
170	PCMH-A: Got urgent care appt when needed in past year			69.4	36	70.1	67
171	PCMH-A: Office asked about feelings of depression			53.6	69	55.3	123
172	PCMH-A: Office followed up with results			67.7	65	53.0	115
173	PCMH-A: Office helped set goals for managing health			77.1	70	68.3	126
174	PCMH-A: Provider asked about patient's opinion of meds			79.1	43	80.6	67
175	PCMH-A: Provider discussed reasons not to take meds			42.9	42	54.5	66
176	PCMH-A: Provider discussed reasons to take meds			65.1	43	72.3	65
177	PCMH-A: Provider explained things understandably			78.9	71	78.6	126
178	PCMH-A: Provider informed about specialist care			62.3	53	66.7	99
179	PCMH-A: Provider knew medical history			73.2	71	73.6	125
180	PCMH-A: Provider listened carefully			80.3	71	83.1	124
181	PCMH-A: Provider seen w/in 15 min of appt time in past year			38.6	71	30.4	125
182	PCMH-A: Provider sent reminders between visits			75.7	70	74.8	127
183	PCMH-A: Provider showed respect for what patient said			81.7	71	85.6	125
184	PCMH-A: Provider spent enough time with patient			80.3	71	73.4	125
185	PCMH-A: Rate provider			77.1	70	75.0	124
186	PCMH-A: Would recommend provider			80.3	71	77.4	124
187	PMCH-A: Got care when needed			92.9	70	93.6	125
188	PMCH-A: Know what to do to be healthy			91.5	71	88.2	127
189	⬆ - Indicates "White" score is significantly higher						
190	⬇ Indicates "White" score is significantly lower						

Catalyst Cross Tab by Questions - *Jan 2013 to Dec 2013 - Catholic Medical Partners PCMH Adult*

Based on their responses to the "*PCMH-A: Of Hispanic/Latino origin/descent*" question, how respondents answered the following questions.

ATTACHMENT A

	Yes Hispanic or Latino		No, not Hispanic or Latino		
	Positive	n Size	Positive	n Size	
PCMH-A: Able to get after hours care	44.4p	27	43.5	1,711	
PCMH-A: Clerks/receptionists courtesy/respect	79.6	147	84.2	14,241	
PCMH-A: Clerks/receptionists helpful	66.7	147	70.5	14,234	
PCMH-A: Days had to wait for urgent care	54.4	68	50.3	5,759	
PCMH-A: Discussed non-medical problem	33.3	147	32.4	14,157	
PCMH-A: Discussed patient's worry/stress	49.3	148	47.1	14,141	
PCMH-A: Discussed prescription meds	87.9	132	86.5	12,956	
PCMH-A: Discussed problems with monitoring health	42.9	147	34.4	13,992	⬆
PCMH-A: Easy to understand instructions about concerns	79.2	120	82.1	11,368	
PCMH-A: Got answer calling after office hrs in past year	66.7p	12	65.9	916	
PCMH-A: Got answer calling during office hrs in past year	63.9	61	70.1	5,654	
PCMH-A: Got info about after-hours care	75.2	145	73.0	13,852	
PCMH-A: Got routine care appt when needed in past year	60.7	122	78.3	12,130	➡
PCMH-A: Got urgent care appt when needed in past year	73.9	69	77.1	5,958	
PCMH-A: Office followed up with results	61.2	147	50.6	14,138	⬆
PCMH-A: Office helped set goals for managing health	56.0	125	61.6	12,272	⬆
PCMH-A: Provider asked about patient's opinion of meds	72.1	147	62.2	14,097	⬆
PCMH-A: Provider discussed reasons not to take meds	80.8	78	80.1	6,739	
PCMH-A: Provider discussed reasons to take meds	44.2	77	44.8	6,712	
PCMH-A: Provider explained things understandably	55.8	77	64.7	6,787	
PCMH-A: Provider informed about specialist care	79.5	146	83.6	14,184	
PCMH-A: Provider knew medical history	64.5	93	63.5	9,458	
PCMH-A: Provider listened carefully	73.5	147	78.3	14,135	
PCMH-A: Provider seen w/ in 15 min of appt time in past year	87.7	146	84.6	14,181	
PCMH-A: Provider sent reminders between visits	25.9	145	30.8	14,154	⬆
PCMH-A: Provider showed respect for what patient said	73.5	147	66.4	14,063	
PCMH-A: Provider spent enough time with patient	90.3	145	88.7	14,182	
PCMH-A: Rate provider	76.7	146	82.6	14,168	➡
PCMH-A: Would recommend provider	78.1	146	79.5	14,166	
PMCH-A: Get care when needed	77.6	143	81.3	14,169	
PMCH-A: Know what to do to be healthy	91.2	147	94.9	14,206	➡
	89.7	145	95.0	14,211	➡

⬆ Indicates "Yes, Hispanic or Latino" score is significantly higher
➡ Indicates "Yes, Hispanic or Latino" score is significantly lower

	A	B	C	D	E	F
1	Colorectal Cancer Screening					Attachment B
2	Ethnicity	Numerator	Denominator	Percent		
3	Not of Spanish/Hispanic Origin	26,776	39,508	67.77%		
4	Spanish/Hispanic Origin	216	333	64.86%		
5	Unknown	3,360	5,168	65.02%		
6	TOTAL	30,352	45,009	67.44%		
7						
8	Race	Numerator	Denominator	Percent		
9	American Indian/Alaska Native	44	61	72.13%		Statistically lower than average
10	American Indian/Alaska Native, Black/African American	3	4	75.00%		
11	American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander	1	1	100.00%		
12	American Indian/Alaska Native, White	10	10	100.00%		
13	Asian	162	259	62.55%		
14	Asian, Black/African American	0	1	0.00%		
15	Asian, White	5	5	100.00%		
16	Black/African American	601	941	63.87%		
17	Black/African American, White	5	9	55.56%		
18	Declined to Specify/Unknown	178	425	41.88%		
19	Native Hawaiian/Other Pacific Islander	6	9	66.67%		
20	Native Hawaiian/Other Pacific Islander, White	1	1	100.00%		
21	Other	171	277	61.73%		
22	White	29,165	43,006	67.82%		
23	TOTAL	30,352	45,009	67.44%		
24						
25	Language	Numerator	Denominator	Percent		
26	Arabic	23	40	57.50%		
27	Bulgarian	1	1	100.00%		
28	Chinese	34	56	60.71%		
29	Croatian	2	2	100.00%		
30	Dutch	1	1	100.00%		
31	Dzongkha	2	2	100.00%		
32	English	29,984	44,186	67.86%		
33	Filipino	1	1	100.00%		
34	French	3	4	75.00%		
35	German	3	5	60.00%		
36	Greek	1	2	50.00%		
37	Gujarati	1	1	100.00%		
38	Hindi	3	4	75.00%		
39	Hungarian	2	3	66.67%		
40	Italian	27	33	81.82%		
41	Japanese	1	2	50.00%		
42	Korean	4	4	100.00%		
43	Lao	3	4	75.00%		
44	Patient Declined/Unknown	176	545	32.29%		
45	Polish	16	21	76.19%		
46	Portuguese	1	3	33.33%		
47	Romanian	0	1	0.00%		
48	Russian	1	4	25.00%		
49	Serbian	1	2	50.00%		
50	Spanish	30	39	76.92%		
51	Urdu	0	1	0.00%		
52	Vietnamese	31	42	73.81%		
53	TOTAL	30,352	45,009	67.44%		

	A	B	C	D	E	F
1	Diabetes Blood Pressure <140/90					ATTACHMENT B
2	Ethnicity	Numerator	Denominator	Percent		
3	Not of Spanish/Hispanic Origin	11,299	14,735	76.68%		
4	Spanish/Hispanic Origin	165	214	77.10%		
5	Unknown	3,312	4,192	79.01%		
6	TOTAL	14,776	19,141	77.20%		
7						
8	Race	Numerator	Denominator	Percent		
9	American Indian/Alaska Native	42	52	80.77%		
10	American Indian/Alaska Native, Black/African American	3	3	100.00%		statistically lower than average
11	American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander	1	1	100.00%		
12	American Indian/Alaska Native, White	8	9	88.89%		
13	Asian	98	110	89.09%		
14	Asian, White	4	4	100.00%		
15	Black/African American	487	719	67.73%		
16	Black/African American, White	5	5	100.00%		
17	Declined to Specify/Unknown	1,990	2,459	80.93%		
18	Native Hawaiian/Other Pacific Islander	6	8	75.00%		
19	Native Hawaiian/Other Pacific Islander, White	2	2	100.00%		
20	Other	148	180	82.22%		
21	White	11,982	15,589	76.86%		
22	TOTAL	14,776	19,141	77.20%		
23						
24	Language	Numerator	Denominator	Percent		
25	Arabic	31	39	79.49%		
26	Chinese	15	16	93.75%		
27	Croatian	1	1	100.00%		
28	Dzongkha	1	1	100.00%		
29	English	12,689	16,556	76.64%		
30	Farsi/Persian	1	1	100.00%		
31	Filipino	2	2	100.00%		
32	German	0	1	0.00%		
33	Greek	3	3	100.00%		
34	Hungarian	1	1	100.00%		
35	Icelandic	1	1	100.00%		
36	Italian	8	14	57.14%		
37	Korean	1	1	100.00%		
38	Pashto	1	1	100.00%		
39	Patient Declined/Unknown	1,987	2,461	80.74%		
40	Polish	5	5	100.00%		
41	Russian	0	1	0.00%		
42	Serbian	1	1	100.00%		
43	Spanish	14	20	70.00%		
44	Tamil	2	2	100.00%		
45	Ukrainian	1	1	100.00%		
46	Urdu	1	1	100.00%		
47	Vietnamese	10	11	90.91%		
48	TOTAL	14,776	19,141	77.20%		

	A	B	C	D	E	F	G
1	Diabetes HbA1c <8					ATTACHMENT B	
2	Ethnicity	Numerator	Denominator	Percent			
3	Not of Spanish/Hispanic Origin	10,469	14,735	71.05%			
4	Spanish/Hispanic Origin	131	214	61.21%			
5	Unknown	2,703	4,192	64.48%			
6	TOTAL	13,303	19,141	69.50%			
7							
8	Race	Numerator	Denominator	Percent		Statistically lower than average	
9	American Indian/Alaska Native	32	52	61.54%			
10	American Indian/Alaska Native, Black/African American	2	3	66.67%			
11	American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander	0	1	0.00%			
12	American Indian/Alaska Native, White	6	9	66.67%			
13	Asian	73	110	66.36%			
14	Asian, White	2	4	50.00%			
15	Black/African American	451	719	62.73%			
16	Black/African American, White	3	5	60.00%			
17	Declined to Specify/Unknown	1,499	2,459	60.96%			
18	Native Hawaiian/Other Pacific Islander	7	8	87.50%			
19	Native Hawaiian/Other Pacific Islander, White	2	2	100.00%			
20	Other	125	180	69.44%			
21	White	11,101	15,589	71.21%			
22	TOTAL	13,303	19,141	69.50%			
23							
24	Language	Numerator	Denominator	Percent			
25	Arabic	19	39	48.72%			
26	Chinese	12	16	75.00%			
27	Croatian	1	1	100.00%			
28	Dzongkha	1	1	100.00%			
29	English	11,732	16,556	70.86%			
30	Farsi/Persian	0	1	0.00%			
31	Filipino	2	2	100.00%			
32	German	1	1	100.00%			
33	Greek	2	3	66.67%			
34	Hungarian	1	1	100.00%			
35	Icelandic	1	1	100.00%			
36	Italian	10	14	71.43%			
37	Korean	1	1	100.00%			
38	Pashto	1	1	100.00%			
39	Patient Declined/Unknown	1,492	2,461	60.63%			
40	Polish	3	5	60.00%			
41	Russian	1	1	100.00%			
42	Serbian	1	1	100.00%			
43	Spanish	11	20	55.00%			
44	Tamil	1	2	50.00%			
45	Ukrainian	1	1	100.00%			
46	Urdu	1	1	100.00%			
47	Vietnamese	8	11	72.73%			
48	TOTAL	13,303	19,141	69.50%			

	A	B	C	D	E	F
1	Diabetes LDL <100					ATTACHMENT B
2	Ethnicity	Numerator	Denominator	Percent		
3	Not of Spanish/Hispanic Origin	8,230	14,735	55.85%		
4	Spanish/Hispanic Origin	122	214	57.01%		
5	Unknown	2,271	4,192	54.17%		
6	TOTAL	10,623	19,141	55.50%		
7						
8	Race	Numerator	Denominator	Percent		
9	American Indian/Alaska Native	30	52	57.69%		Statistically lower than average
10	American Indian/Alaska Native, Black/African American	2	3	66.67%		
11	American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander	0	1	0.00%		
12	American Indian/Alaska Native, White	6	9	66.67%		
13	Asian	65	110	59.09%		
14	Asian, White	1	4	25.00%		
15	Black/African American	362	719	50.35%		
16	Black/African American, White	1	5	20.00%		
17	Declined to Specify/Unknown	1,313	2,459	53.40%		
18	Native Hawaiian/Other Pacific Islander	4	8	50.00%		
19	Native Hawaiian/Other Pacific Islander, White	2	2	100.00%		
20	Other	97	180	53.89%		
21	White	8,740	15,589	56.07%		
22	TOTAL	10,623	19,141	55.50%		
23						
24	Language	Numerator	Denominator	Percent		
25	Arabic	15	39	38.46%		
26	Chinese	9	16	56.25%		
27	Croatian	1	1	100.00%		
28	Dzongkha	1	1	100.00%		
29	English	9,241	16,556	55.82%		
30	Farsi/Persian	0	1	0.00%		
31	Filipino	2	2	100.00%		
32	German	0	1	0.00%		
33	Greek	2	3	66.67%		
34	Hungarian	1	1	100.00%		
35	Icelandic	0	1	0.00%		
36	Italian	11	14	78.57%		
37	Korean	0	1	0.00%		
38	Pashto	0	1	0.00%		
39	Patient Declined/Unknown	1,314	2,461	53.39%		
40	Polish	2	5	40.00%		
41	Russian	1	1	100.00%		
42	Serbian	0	1	0.00%		
43	Spanish	13	20	65.00%		
44	Tamil	1	2	50.00%		
45	Ukrainian	1	1	100.00%		
46	Urdu	1	1	100.00%		
47	Vietnamese	7	11	63.64%		
48	TOTAL	10,623	19,141	55.50%		

New York State Department of Health Prevention Agenda
Western New York Community Priorities

The Prevention Agenda is a 5-year effort to make New York the healthiest state. Developed in collaboration with 140 organizations, the plan identifies New York's most urgent health concerns, and suggests ways local health departments, hospitals and partners from health, business, education and community organizations can work together to solve them.

Prevent Chronic Disease
Increase screening rates for breast, colorectal and lung cancers, especially among disparate populations where there is the greatest need.
- Formulate a matrix of current WNY screening services in order to identify best practices in the community (those that should be replicated) and focus on areas of the WNY region where best practices may not be implemented.
- Organizations engaged in same/comparable best practices are invited to collaborative learning sessions in order to refine and add to their programs for increased success.
- Convene community stakeholders in collaborative learning sessions to identify opportunities of replication of best practices focusing primarily on geographical areas and communities of people where there is greatest need.

Create community environments that promote and support healthy food and beverage choices and physical activity.
- Implement a region-wide, multi-sector healthy food and physical activity coalition to address and develop strategies to engage the population in healthy behaviors.
- The coalition will be tasked with identifying replication opportunities of existing best practices and develop themes around healthy eating and physical activity.
- Based on chosen themes, formal and informal policies will be developed for schools, businesses and the community to guide activities and interventions of coalition partners.
- Engage primary care providers to identify and/or develop tools, resources and messaging to be utilized by primary care and community-based organizations.

Promote Mental Health and Prevent Substance Abuse
Strengthen infrastructure for MEB (mental and emotional well-being) health promotion and MEB disorder prevention enabling promotion of mental, emotional and behavioral well-being in communities.
- Organize a community forum to contribute to the discussion and priority setting of MEB. This forum will serve as a venue to solicit opinions from diverse communities related to MEB topics such as: accessibility; resources; educational needs; stigma; and cultural competence.
- Convene community MEB educators and community-based organizations to implement community-wide mental health education program and campaign to reduce the stigma of mental health.
- Develop capacity building plan for 2-1-1 WNY and utilize to effectively refer and link individuals to MEB services in WNY.

For more information about the Population Health Improvement Program, contact Karen Hall at 716.923.6576 or khall@p2wny.org