



COMMUNITY CARE
OF
B R O O K L Y N

Cultural
Competency and
Health Literacy
Strategy

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I. Executive Summary

Cultural competency and health literacy are fundamental to addressing disparities in access, quality, and cost that have long challenged Brooklyn's healthcare delivery system. Community Care of Brooklyn (CCB) is dedicated to fully re-engineering our delivery system in ways that best promote patient engagement, facilitate wellness self-management, and improve health outcomes.

Governance Structure

CCB's Executive Committee will support our transformation efforts, with the Community Engagement Advisory Committee directly overseeing our Cultural Competency and Health Literacy Strategy ("Strategy"). Their work will be supported by the CCB Central Services Organization (CSO) in conjunction with an array of community partners. Strategy implementation will involve close coordination with the policy initiatives and training efforts conducted by the Care Delivery and Quality and Workforce Committees. CCB's Strategy was developed in collaboration with the Arthur Ashe Institute for Urban Health, the Brooklyn Perinatal Network, the Caribbean Women's Health Association, and CAMBA. These community-based organizations within CCB bring deep expertise in the borough's resources and needs related to health care access and disparities.

Priority Groups Experiencing Health Disparities in Brooklyn

CCB's Cultural Competency and Health Literacy Strategy is responsive to critical disparities and access barriers, especially for the borough's most vulnerable populations whose needs have been documented in the Brooklyn Community Needs Assessment¹ and the Brooklyn Healthcare Improvement Project (B-HIP)². In developing this Strategy, additional organizations serving high need immigrant communities were also interviewed for their input, with the intent of additional interviews moving forward. Some of the salient findings include:

- a large immigrant population speaking over 35 languages;
- more than two-thirds of the population speaking a language other than English at home;
- limited supply and poor connectivity or awareness of primary care resources;
- a younger population with relatively low educational attainment;
- high numbers of uninsured;
- confusion about the health care system;
- low life expectancy and high rates of premature death, especially among minority populations; and
- high rates of new HIV infections in Brooklyn.

¹ New York Academy of Medicine. New York City Healthcare Provider Partnership Brooklyn Community Needs Assessment. (October 2014).

<http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/maimonides_medical_center/3.8_maimonides_cna.pdf>

² Wong, G., Fyfe, D. Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. SUNY Downstate Medical Center. (August 2012). <<http://www.downstate.edu/bhip/pdf/B-HIP-Final-Report.pdf>>

Framework for Cultural Competency and Health Literacy

Our organizing framework is the federal guidance to provide Culturally and Linguistically Appropriate Services (CLAS). This set of standards has as its Principal Standard the “provision of 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.”³ In full alignment with CCB’s goals, the CLAS guidelines address three broad focus areas: (1) Governance, Leadership and Workforce; (2) Communication and Language Assistance; and (3) Engagement, Continuous Improvement, and Accountability. Our Strategy will promote CLAS adherence and health literacy by ensuring that high quality assessment, training, and intervention resources are utilized throughout our DSRIP projects and initiatives. We recognize that CLAS adherence is only possible when care is truly person-centered and relationship-based to meet the individual patient/consumer and family’s needs, preferences, and priorities.

Current State Assessment

Key stakeholder and community input is vital to our approach, so we will initiate our Strategy with an assessment of the current state of cultural competency and health literacy across CCB. This assessment will leverage current initiatives already underway, such as the existing CCB Participant Survey and primary care providers’ transition to Patient-Centered Medical Home (PCMH) recognition, but supplemental stakeholder interviews and expanded assessment steps will be considered. We intend to interview additional key stakeholders who best understand the gaps and barriers that relate to cultural competence and health literacy access (including barriers that are racial, ethnic, linguistic, sociodemographic, disability-related, sexual orientation or age specific, etc.) to further inform our Strategy. Results of the assessments will continually inform the details of our evolving Strategy.

Strategies to Address Cultural Competency and Health Literacy

Our goals will focus on achieving CLAS within CCB’s existing structures, services, activities, and projects delivered by providers throughout our network. Our approach is integrated within existing initiatives and leverages present capacity wherever possible.

Identification of Resources, Tools, and Interventions: Our goal is to fully integrate the most widely accepted and universally agreed best practices across every aspect of our care delivery system— throughout all provider types and at every level of service provision. We will work to promote utilization of the best and most robust and meaningful training material and resources around cultural competency and health literacy in our DSRIP projects and broader network initiatives. We will actively promote evidence based practices relevant to the cultural populations served and encourage models that follow national standards for care.

CCB, working through the Community Engagement Advisory Committee and other key community partners, will supplement our initial inventory of the tools, resources, and interventions related to cultural competency and health literacy (see Appendix), to include additional assessments and tools to

³ HHS. (2015). CLAS and the CLAS Standards. <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>.

assist patients with self-management of conditions (considering cultural, linguistic and literacy factors). We will promote, and where needed, modify or develop CLAS and health literacy resources and information appropriate for consumer use (i.e., translated, as indicated, and via images whenever possible). These resources will be shared across the broad CCB network via an online Resource Library.

System-wide Workforce Training and Staff Development: Training and staff development for cultural competency and health literacy will not be developed and implemented in a silo. The Community Engagement Advisory Committee, working with the Workforce Committee, will be instrumental in selecting and designing appropriate cultural competency training(s) to implement across the entire CCB workforce. The CCB training strategy is presently under development with our partner, 1199 SEIU Training and Upgrading Fund. Utilizing input from our key stakeholder interviews and our Community Engagement Advisory Committee, CCB will incorporate the drivers of health disparities, cultural competency, and health literacy so that this training is received broadly across the CCB network. Our training plan will include standardized, comprehensive curricula to educate stakeholders and staff regarding culturally rooted concepts of health, illness, pain, and healing. Training material will be widely available and recordings will be shared broadly across the network via the online Resource Library, so partners can access the trainings at their convenience.

Staff Recruitment and Hiring: Our goal is to ensure that policies and practices around recruiting, promoting and hiring staff are congruent with our goals for a fully representative and diverse workforce. Our staff development approach will emphasize strategic staffing to recruit and hire a diverse staff reflective of the patient population where possible. We will assess linguistic and communication competencies of staff, including their ability to utilize interpreters and translation services effectively where necessary and to actively match providers to patients and resources based on linguistic and cultural needs. This approach will be integrated into the CCB workforce planning activities.

Community Outreach and Engagement: Ongoing input and full stakeholder engagement is essential to our Strategy's success. The CCB Project Advisory Committee (PAC), which includes representatives from each of the 850+ organizations in the CCB network, will be leveraged to disseminate information and facilitate training access, as well as create an opportunity for feedback from our partners at each meeting. We will build the tenets of cultural competency and health literacy into community engagement activities, including town hall forums, local social marketing efforts, surveys, and public education activities in order to inform and facilitate input from our community based organization partners, cultural and linguistic advisors and providers, and residents and consumers. Town hall forums will further elicit input about issues and challenges consumers encounter in accessing care and cultural or linguistic barriers that are of the most importance to the Brooklyn communities. The CCB Community Engagement Plan, due later this year, will spell out our planned modalities and approach in a more detailed way. We will work to ensure that those who best know "how we're doing" can tell us when our services might better meet their needs. We will make available our CCB Support line for patient concerns related to cultural or linguistic access. We will also engage patients in CCB Governance, including consideration of a Community Council to obtain patient/consumer feedback, since patients are critical to our feedback loop for continuous improvement.

Overview of Potential Roadblocks and Challenges

The scope and scale of transformation is a daunting challenge. Given the borough's great diversity and DSRIP's emphasis on new workflows, projects, and workforce retraining, we will be challenged to maintain our focus on cultural competency and health literacy. To address this challenge, our approach is designed to assess our capacity and then initially leverage our existing network resources and infrastructure to conduct consumer and provider education, outreach, and training. Cultural competency and health literacy will be a priority throughout the planning, implementation, and delivery of our DSRIP projects. Extending this approach, we will integrate cultural competency and health literacy trainings into pre-existing DSRIP provider engagements. Another challenge, competition among the groups and organizations best suited to provide the support and assistance necessary for the success of the Strategy, has led CCB to engage existing community collaboratives in developing this plan, and our initial capacity assessment will inform the development of a resource allocation process to guide sustainable linkages among our community-based organizations and the preventive, primary care, and behavioral health providers in the delivery system.

Plan to Evaluate and Monitor Efforts, Including Identification of Best Practices

Our Strategy will be a living document that is continually updated and revised to fully reflect the input and feedback of our many engaged stakeholders, training evaluations, staff and consumer surveys, and a formal evaluation of the effort itself in achieving our clearly defined and measurable goals. As such, we view this process as iterative, continually evaluated, and informed by feedback from patients, providers, staff and leaders alike. CCB will monitor the implementation of this plan and evaluate our effectiveness in reaching goals for cultural competency, health literacy, and consumer engagement. We will share actionable feedback with providers and partners able to address identified gaps. We will utilize existing data sources (such as CAHPS, REAL, and Medicaid claims data) to evaluate our efforts, and supplement where necessary in order to assess our progress on implementing CLAS across CCB. We will promote our progress via metrics for key indicators with our partners and consider options for incentivizing participation.

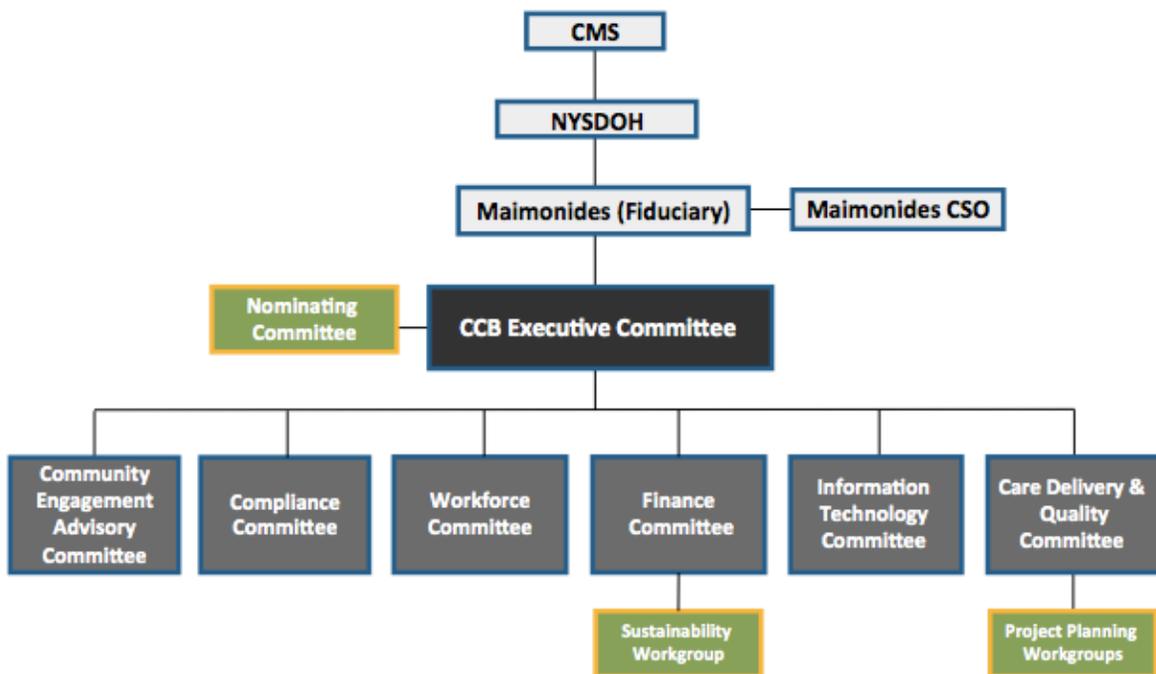
We will identify key factors to improve access to quality primary, behavioral health, and preventive health care. We will receive feedback regarding barriers to or gaps in access to quality health care and will develop solutions that incorporate best practices and suggest or "broker" local resources and relationships, as necessary, to implement the needed support. We will identify and use evidence-based community-based interventions shown to reduce health disparities and improve outcomes. Where evidence does not exist, we will develop and share best practices across our network. Our goal will be to understand the needs, listen to our experts from the community, focus our existing community resources, enhance available services, expand existing initiatives when and as needed, and design new interventions, in partnership with the local providers best able to offer the necessary services. These activities will be carefully managed, tracked, and analyzed for impact via CCB's ongoing evaluation. CCB's Community Engagement Advisory Committee will regularly review reports and make recommendations around areas for improvement in order to result in a truly transformed, person-centered system.

II. Community Care of Brooklyn (CCB) Governance Structure

CCB is comprised of over 850 participant organizations, including 6 hospitals, 8 federally-qualified health centers, and more than 3,700 clinical providers (of which 1,600 are primary care providers). We are responsible for over 448,000 attributed Medicaid lives, making it the largest Performing Provider System (PPS) in Brooklyn and one of the largest PPSs in New York State.

CCB has developed a strong, consensus-based governance structure, including participation of a broad range of stakeholders from clinical, social, and community-based organizations. CCB is governed centrally by an Executive Committee and supported by the Maimonides Central Services Organization (CSO). The Executive Committee is responsible for strategic leadership and oversight for CCB and oversees committees responsible for key functions of the Performing Provider System (PPS), including the Community Engagement Advisory Committee, Workforce Committee, Information Technology Committee, and the Care Delivery and Quality Committee.

The following organizational chart represents CCB's current governance structure:



The Community Engagement Advisory Committee, supported by the CSO, will oversee the implementation of our Strategy, working in conjunction with the Workforce and Care Delivery and Quality Committees. The Community Engagement Advisory Committee will conduct a deeper cross-system assessment of our network's present capacity and identify and coordinate community resources and organizations able to inform our plans and support our efforts. To inform this Strategy, CCB has engaged the Arthur Ashe Institute for Urban Health and other community partners, including the Brooklyn Perinatal Network, the Caribbean Women's Health Association, and CAMBA, to craft our

approach. Each of these partners delivers services to Brooklyn's diverse community and is also connected to a network of additional providers whose experience-based insights have informed this Strategy.

Specifically, the Community Engagement Advisory Committee is responsible for:

- Overseeing and advising the Executive Committee on opportunities and strategies to address health disparities;
- Soliciting informal input from participants and community members and providing recommendations on the best methods and venues for communicating with the Brooklyn community.
- Making recommendations about how best to evaluate and identify existing and required resources needed to serve the health needs of the community.
- Serving as the CCB knowledge base for Brooklyn community contacts and resources.

The Community Engagement Advisory Committee will consist of 12 to 15 members appointed annually, taking into account recommendations by the Nominating Committee. The Community Engagement Advisory Committee will use a collaborative, consensus-based decision-process, the actions of which will be submitted to the Executive Committee for review. Members will serve for one-year terms, and mid-term vacancies will be filled by the Executive Committee as needed. The Community Engagement Advisory Committee will hold regular meetings, no less than four times a year, and may schedule more meetings, as needed, to address emerging issues.

III. Overview of Cultural Competency and Health Literacy Strategy Needs

Strategy leadership and decision-making will be informed by a Cultural Competency and Health Literacy Needs Assessment that builds on the existing research regarding health disparities and needs in Brooklyn. Brooklyn is one of the nation's most concentrated and diverse urban centers, with significant populations from multiple racial and ethnic groups, including African American, Latino/Hispanic, Caribbean and Haitian, Chinese, Russian, Polish, South Asian, Orthodox/Jewish, and Arab. The **Brooklyn Community Needs Assessment (CNA)**⁴ found that 65% of the borough's residents are members of minority groups, including the following demographic breakdown:

- 1/3 of Brooklyn residents identify as Black/African American (compared to 25% NYC and 16% NYS)
- 1/5 of Brooklyn residents identify as Hispanic/Latino
- 1/10 of Brooklyn residents identify as Asian
- Foreign born residents comprise 35% of the population (however, since roughly 17% of Brooklyn resident are not U.S. citizens, this is likely an underestimate)
- A large proportion of Brooklyn's residents speak a language other than English at home (17% Spanish or French Creole, 7% Chinese, 5% Russian, 2% French)^{5 6}

Priority Groups Experiencing Health Disparities in Brooklyn

Across Brooklyn, cultural and linguistic lapses contribute to poor access to health care services, as well as mortality, morbidity, and high cost health care. The Brooklyn Community Needs Assessment notes the relationship between avoidable and repeat hospital admissions and the barriers to effective primary care access for the borough's culturally and linguistically diverse immigrant population. A lack of primary care providers able to meet the cultural and linguistic needs of diverse populations, combined with a lack of interpreter assistance and consumer discomfort navigating the healthcare system, create barriers to preventive care and contribute to higher rates of preventable disease, emergency department (ED) utilization, and repeat hospital admissions. The New York City Department of Health and Mental Hygiene Community Health Profiles identify an average life expectancy that differs by as much as six years between Brownsville and Park Slope/Carroll Gardens.⁷ In addition, the percentage of Hispanic and Black individuals with premature deaths in Brooklyn is more than twice that of White individuals, and the rate of new HIV diagnoses among Black/African Americans in the borough is over five times the rate among Whites in the borough (and over 2.5 times for Latinos).⁸

⁴ New York Academy of Medicine. New York City Healthcare Provider Partnership Brooklyn Community Needs Assessment. (October 2014).

<http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/maimonides_medical_center/3.8_maimonides_cna.pdf>

⁵ Ibid.

⁶ MLA Language Map Retrieved 1/27/16 from www.arcmap.mla.org

⁷ NYC Community Health Profiles. Retrieved from www.NYC.gov on 1/27/16.

⁸ Ibid.

In addition to the group-specific access barriers and needs identified in the CNA, this Strategy is responsive to the findings of the **Brooklyn Healthcare Improvement Project (B-HIP)**⁹, a comprehensive 2 ½ year community health planning process that culminated in 2012 and provided recommendations for improving access and quality in the 15 poorest and most medically underserved zip codes of Central and Northern Brooklyn. Three “hotspots” within this region – Brownsville/East New York, Crown Heights North/Bedford Stuyvesant, and Bushwick/Stuyvesant Heights – were prioritized based on high rates of ED utilization, low engagement with primary care, and high rates of unmet need related to limited primary care and behavioral health access. Although these three hotspots represent only 4% of the borough’s population they account for 9% of all potentially preventable ED visits, 6% of all discharges, and 8% of all ambulatory care sensitive condition admissions in Brooklyn.¹⁰

B-HIP found disproportionately high ED utilization and low primary care utilization, both of which were related to a shortage of quality, accessible primary care services throughout much of the study area and challenges to access of the current primary care network. 62% of the non-emergency patients surveyed said they have a primary care practitioner (PCP), but 11% of them do not access those services. Of the remaining individuals, 33% percent said they do not have a PCP, and 5% said they do not know if they have a PCP. Further, managed care enrollees appeared not to have a clear understanding of the managed care system: 17% stated that they did not have a PCP or they did not know if they had a PCP, despite the fact that by regulation, these managed care participants were either required to have chosen a PCP or have had one auto-assigned.

Within this sub-region, a million Brooklyn residents speak over 35 languages (not including dialects) and more than two-thirds of the population speaks a language other than English at home. The report identified significant challenges in care access and coordination that related to limited supply, poor connectivity or awareness of primary care resources, language barriers and health literacy issues. Compounding these issues, the population in this area is younger and

BROOKLYN’S HEALTH DISPARITIES

Findings from CCB’s CNA highlighted the fact that cultural beliefs are a vital factor that providers must recognize and address. For instance, residents of the Chinese community may be discouraged from seeking medical care outside of more familiar Chinese medicine practitioners, and language barriers among many of these individuals limit access to health information. Substance abuse and behavioral health stigma are significant barriers for many whose needs are presently unmet, and a lack of culturally and linguistically competent specialists, multi-specialty centers, and innovative providers of whole-person integrated care are critical gaps that must be filled, particularly for behavioral and mental health services.

⁹ Wong, G., Fyfe, D. Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. SUNY Downstate Medical Center. (August 2012). < <http://www.downstate.edu/bhip/pdf/B-HIP-Final-Report.pdf>>

¹⁰ Ibid.

has relatively low educational attainment: 25% was under the age of 18 (13% higher than the state average) and more than 23% over the age of 25 had not graduated from high school (44% higher than the state average). Additional stressors include poverty, racism, sexism, heterosexism, and other forms of oppression often experienced through daily micro- and macro-aggressions, which profoundly affect physical and mental wellbeing, and exacerbate mistrust in health and social services providers.

Based on these disparities, B-HIP study's authors recommended:

- Funding to train local provider staff on culturally relevant customer service and to make facility/equipment upgrades
- Increasing recruitment and retention of culturally and linguistically competent and representative practitioners
- Supporting and strengthening continuity of provider-patient relationships
- Delivering high quality care and presenting health information in a way that is easily understood, while ensuring courteous customer service.

In addition, the B-HIP study noted that any intervention in the target region will need to develop locally tailored approaches that address two distinct but fundamentally linked focus areas: (1) necessary changes to the healthcare delivery system, and (2) a means of improving patient and community engagement/empowerment in their own healthcare and the healthcare system. Equally as important, the community, which includes patients, their families and social networks, must be involved in the design of the new systems of care and care models.

Findings from Initial Key Informant Interviews

The Brooklyn CNA and B-HIP report described above are two extensive efforts to capture and define the needs related to Brooklyn's health disparities that we can leverage to inform the CCB Cultural Competency and Health Literacy Strategy. However, we recognize that there is more work to be done, including a deeper analysis of the needs of different sub-populations within the borough and on-going assessment to identify changing needs and available resources over time. To begin this work and develop this Strategy, we sought additional input from the groups whose health disparities were underscored by the needs assessment. An initial series of key informant interviews was conducted with stakeholders who work with a diverse array of sub-populations experiencing health disparities: Arab American Family Center (AAFC), Haitian American Community Coalition (HCC), Mixteca Organization, Inc., and OHEL Children's Home and Family Services, with the intent of additional interviews moving forward.

We asked each stakeholder to speak to us about their perception of the following topics relative to the community/ies and subgroups with whom they engage:

1. Issues and needs faced by the unique subpopulations that they served in terms of healthcare access, quality, and effectiveness;
2. Barriers to care that are cultural, linguistic, religious, or may relate to values, attitudes, or beliefs;
3. Challenges that are faced by their clients seeking care for medical, mental health or substance abuse needs that may relate to not understanding the doctor, nurse, or therapist's advice or treatment recommendations;
4. Issues of those served by their agency that relate to doctors or therapists not understanding patient needs due to a lack of understanding the cultural or language being spoken;
5. Efforts their organization has taken to reduce these barriers;
6. Recommendations for systemic solutions to the problem; and
7. Available formal and/or informal resources, tools, or interventions to facilitate access to care or improve the quality of care provided.

These discussions yielded the following key findings and anecdotes, which further elucidate the great diversity and need to address cultural competency and health literacy across Brooklyn:

Linguistic, cultural, and religious beliefs and attitudes must be understood in order to provide effective access and care. Informants cited an array of factors in patient access and activation. For instance, many elderly Brooklynites who are Orthodox Jewish and hail from Russia do not take advantage of available community supports like Access-A-Ride, which could help them reach necessary services, due to a lack of Russian speaking staff. Doulas are culturally accepted providers for Latinas who are pregnant, especially for Mexican women. Increased awareness about the availability of this service would be a programming draw within this community. Among conservative Jewish families, there is a stigma associated with families who undergo a divorce or experience mental illness; therefore, individuals experiencing marriage difficulties or having mental health problems are less likely to seek needed behavioral health and support services outside of their community. Consideration of these issues could be valuable in promoting access to confidential services.

Community outreach and health education efforts are more likely to achieve greater success when aligned with or endorsed by a local Pastor, Rabbi, spiritual leader, or other trusted community liaison. Many groups who are fundamentally connected to faith will take their cues from pastors and faith leaders. Members of the Haitian community, who are often more recent immigrants, remain attached to their culture of origin and religion where, for many, illness is often accepted as God's will. Preventive care or personal health is not given a high priority, unless a child's health is involved, in which case adults can be engaged. In these situations, connections brokered via children's health or through a few churches can have deep impact on patient engagement. For engagement of many Orthodox Jewish individuals in care, Rabbi support was noted as crucial.

Many cultural “groups” have distinct and unique subgroups within them. The Arab American community in Brooklyn consists of individuals from 22 different countries. Residents from each country bring with them a slightly different cultural background and language (i.e., words and actions are often interpreted differently among them). Brooklyn’s Latino community is comprised of immigrants from many countries and cultures and the age at which they immigrated is another factor that affects access to care. Further, there are thousands of Jewish individuals across Brooklyn, many of whom subscribe to different faith-based and cultural beliefs that vary quite significantly. Effective providers must be aware of these differences and approach their patients with these considerations in mind.

Cultural biases make access for some even more restrictive. Within the Afro-Caribbean communities, most notably Haitian communities, significant homophobia is an additional barrier to care for those who are LGBTQ and face the same language and cultural barriers as others within the immigrant community. For those who are Jewish, there is a spectrum of conservative-liberal beliefs that vary by individual and subgroup. For example, Hasidic individuals do not utilize the internet in their everyday lives, while others who are members of less conservative sects do use the internet. Outreach efforts to different sub-groups within the Jewish communities must be tailored to these beliefs. Cultural and religious concerns preclude Arab American individuals from accessing necessary care, especially for substance abuse and behavioral health, which are of particular concern in this population due to cultural stigma.

Although there are many effective initiatives being conducted to improve health disparities, coordination is critical and a focus on sustaining and expanding efforts is warranted. Many of the organizations who are reaching and serving culturally-based groups experiencing significant health disparities are small not-for-profits with minimal resources. One organization mentioned developing anti-stigma videos related to behavioral health that were incredibly well received and effective in helping people access care, but noted that these types of efforts are limited in reach and virtually unfunded. Several stakeholders mentioned the feeling of “chasing” grant funding in order to keep their doors open, and a few brought up the fact that the contracts through which they do receive grant funds restrict them from tailoring services to meet unique individual needs. One organization mentioned that although they see improvements in consumers’ connection to care as a result of their services, their present size does not enable them to meet the need that exists within the community. As well, organizations that must compete against each other for grant funding face *de facto* barriers to collaboration. Several mentioned that their deep understanding of community needs is not often leveraged by larger organizations working in the community, although opportunities for improved engagement will enhance service delivery.

Translation and interpretation services for many groups are severely under-resourced within Brooklyn. Health service providers experience a severe shortage of bilingual staff that speak the variety of languages required for the Brooklyn community. There is a paucity of written materials that are linguistically appropriate and understandable. Community members typically obtain information through word of mouth, visual aids, and the few community health workers that are accepted within the community. Because of cultural sensitivities and language barriers, many members of certain sub-populations will only seek services at certain doctors or hospital centers, resulting in long waiting lists among specialty providers or cutting off access all together for some services.

A focus on and awareness of literacy rates can improve care. The National Center for Education Statistics estimates that 37% of the population of Brooklyn lack basic prose literacy in the English language.¹¹ In addition, for non-native English speakers, written comprehension typically lags behind oral comprehension, and low-literacy versions of patient education material are not always available. It is not only the patient who may have comprehension issues; many caregivers, both family members and paid caregivers, are not Native English speakers. This creates a challenge when communicating health information and treatment plans, as caregivers may have trouble understanding and complying with complex treatment plans. Front-line staff responsible for patient engagement needs materials that reflect both the language and literacy needs of their clients.

In addition to translation services, outreach and educational materials that include visuals are paramount to reaching many Brooklyn residents. All interviewees noted the importance of translating health-related information and educational materials into the multiple languages spoken by the communities served, but several spoke about the importance of including visuals as well as text. Nearly every organization that we interviewed mentioned serving specific segments of their communities that have low literacy rates (both in English *and* their native languages).

Tapping into existing groups/individuals trusted by the targeted sub-groups is critical for effective outreach. Within many cultural/ethnic minority communities, there is an inherent mistrust associated with seeking services outside of the community. Most of the community outreach is done through word of mouth (i.e., extended family members referring newly immigrated individuals), via cultural organizations and groups, or via religious and/or spiritual forums. Within the Afro-Caribbean and Haitian communities, as well as many different Jewish groups, critical linkages to religious leaders can improve screening and adherence. Engaging community based organizations and other community institutions, religious or otherwise, offers opportunities to build interventions to activate patients. For example, difficulty attracting men to healthcare screening services has led to outreach in community barbershops, which has already met with success in some of Brooklyn's neighborhoods.¹²

Additional Populations of Focus

The Cultural Competency and Health Literacy Strategy, as articulated here, has largely been informed by the data obtained through the CNA, B-HIP, and key informant interviews. Acknowledging that general perceptions/interpretations of cultural competency focus primarily on diversity in race, ethnicity, cultural values, norms, and languages, a deeper review of the experiences and needs of special populations will be conducted. This will help ensure that the Strategy can be effectively implemented to meet the needs of all groups including, but not limited to, older adults, individuals living with disabilities, those who identify as LGBTQ, persons re-entering the community from prison, etc.

¹¹ National Center for Education Statistics. (2003). Kings County, NY. <https://nces.ed.gov/naal/estimates/StateEstimates.aspx>.

¹² Wilson, T. "Barbershop Talk With Brothers: Using Community-Based Participatory Research To Develop and Pilot Test a Program to Reduce HIV Risk Among Black Heterosexual Men." *International Society for AIDS Education* (2015).

IV. Cultural Competency and Health Literacy Framework

CCB's network of health and social services agencies will collaborate to enhance the delivery of coordinated and culturally responsive services to the diverse communities of Brooklyn with the overarching goal of decreasing health disparities throughout the region.

We recognize that the provision of culturally responsive health care has evolved from specific understanding about groups (e.g., providing health care to an individual who is an African American, Latino/a, or Jehovah's Witness, etc.), to a more universal focus on rapport-building, clear empathic communication, and negotiated treatment planning that embraces and respects each patient's world view and health decisions. The culturally responsive practitioner must engage in self-reflective work on his or her own biases, stereotypes and blind spots (the awareness/attitudinal component). On the other hand, we believe that it is important for practitioners to be able to build some hypotheses about patient care preferences to guide their clinical work.

The key to achieving cultural competency hinges upon **person-centered care**, which is defined by the Agency for Healthcare Research and Quality (AHRQ) as "relationship-based primary care that meets the individual patient and family's needs, preferences, and priorities."¹³ Person-centered care demands that providers find ways to engage with individuals based on their specific needs, informed by an understanding of -- or an openness to learning about -- their unique values, attitudes, and beliefs, which are intricately influenced by a variety of variables such as culture, race, ethnicity, disability, religion, sexual orientation, neighborhood, when a person immigrated to the country and immigration status, as well as incarceration history, etc. The list is numerous and every "group" that can be named is comprised of individuals whose affiliations and influences cross and overlap with other groups. So, while learning the kinds of population norms and trends described for those of specific immigrant communities, religious groups, or racial/ethnic populations can provide a useful starting place for understanding an individual or planning for a group, it is by no means sufficient, and the risk of unintended stereotyping and bias is inherent.

The U.S. Department of Health and Human Services, Office of Minority Health (OMH) defines **cultural competence** as: A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals which enables that system, agency or those professionals to work effectively in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by health care recipients and their communities.

The Health Resources and Services Administration (HRSA) defines **health literacy** as: The degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.

¹³ <https://pcmh.ahrq.gov/page/patient-centered-care>

Person-centered care requires that providers seek opportunities in conversation, practice workflows and operational infrastructure to assess and deliver services that respond to individual cultural, language, educational, religious, sexual, social, and other characteristics. Providers who are open to these connections are more likely to successfully build trust and engage and activate patients as well as others who are in each patient's social support circle, facilitating high quality community based care.

Developed by the Office for Minority Health, and updated in 2010, the National **Cultural and Linguistically Appropriate Services** (CLAS) Standards¹⁴ provide a rich framework and foundation for constructing our training strategy for broad community-wide multi-level network change efforts. These federally-recommended guidelines are comprised of 15 standards, which include a Principal Standard and three broad focus areas as follows:

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 (i.e., family members) 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.

¹⁴ HHS. (2015). CLAS and the CLAS Standards. <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

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.

Additionally, we will focus on achieving CLAS within CCB's existing structures, services, activities, and the projects delivered by providers throughout our network. CCB does not view Cultural Competency/Health Literacy efforts as distinct work—separate from the projects, achieving targets/milestones, etc.—but instead, views cultural competency and health literacy as integral to all trainings and interactions. Foundational to our Strategy, these factors will not be viewed as “add-on” activities, but as essential aspects of the larger transformational effort.

V. Assessing the Current State of the Network

Our Strategy development process underscored the value of having a comprehensive understanding of population specific needs, gaps, and available resources. As well, we recognize that the process of self-assessment is vital to raising awareness. Accordingly, we will assess the network's strengths and progress as well as its gaps and needs, leveraging activities that are already underway. To accomplish this, we will use a multi-pronged and concurrent approach to assess the current state of CLAS across our network: 1) understand our partners and their services through the CCB Participant Survey and Workforce Survey, 2) utilize or build upon assessments and efforts related to primary care transformation, 3) continue key informant interviews, and 4) target additional needs assessments to address identified gaps. This assessment of "where we are" as a network will be used as a benchmark for measuring progress, as well as for tracking trends among populations, identifying hotspots within geographic areas, and recognizing gaps in care experienced at the provider level.

Participant Surveys

First, in September 2015, CCB launched a comprehensive **Participant Survey** for all of its partner organizations. The information requested in the Survey provides an important baseline understanding of our participant network for project planning, resource identification, and capacity limitations. Relevant to this Strategy, the CCB Participant Survey included the following questions:

- 1) Services provided at each site;
- 2) Languages spoken at each site;
- 3) Use of interpretation services;
- 4) Training related to cultural competency/health literacy;
- 5) Measurement of patient satisfaction/experience of care;
- 6) Organizational capacity; and
- 7) Workforce, including use of community health workers/peers

Additionally, as part of the required DSRIP workforce deliverables, we have issued a more detailed **Workforce Survey** to our partners in collaboration with three other PPSs. We continue to receive responses to the Participant Survey and Workforce Survey which will help to inform and revise this Strategy. However, we recognize that these surveys alone are insufficient to understand the need and target areas for intervention related to cultural competency and health literacy.

Leveraging the PCMH Transition Process

Secondly, CCB is required to assist all primary care practices in achieving **NCQA Patient-Centered Medical Home (PCMH) recognition** under the 2014 standards by March 31, 2018. CCB has already initiated a PCMH assessment with our primary care practices and will evaluate whether different/additional assessments are necessary within these practices to create a baseline of CLAS and health literacy efforts and needs across our primary care providers.

Many of the PCMH standards relate to CLAS, for example:

- Element 2C includes assessing diversity of population, assessing language needs, providing interpretation services and printed materials in correct language.
- Elements 3A and 3C require the provider’s Electronic Health Record (EHR) to collect each individual’s race, ethnicity, and preferred language, and assess health literacy status and family, social, and cultural characteristics.
- Element 6C requires providers to obtain feedback from patients and families on their experiences with the practice and their care at least on an annual basis.

Key Informant Interviews

At the same time, we will continue to conduct additional **key informant interviews** that were initiated to inform this Strategy to supplement the Survey and PCMH assessments to better identify the needs, barriers, and resources within our system. This input is valuable to identify gaps and barriers that relate to cultural and health literacy, and might be specific within certain priority groups within Brooklyn.

Additional Targeted Assessments

Lastly, based on the above steps, we will identify gaps—either in provider types or data collected—to **supplement or expand our assessments as needed** to cover specific providers or organizations in our network. We will assess our network capacity and resources for culturally competent and linguistically appropriate care and identify the interventions and programs that are available for replication, expansion, and enhancement. Taken together, these assessments will inform efforts to immediately close gaps that may hinder the success of our projects (e.g., targeted training, assertive recruitment and task-shifting, coordination with identified programs to support project goals, etc.) as well as continually inform our development of the training, resources, and technical assistance that comprise our Strategy.

VI. Cultural Competency and Health Literacy Strategy

Our goals will focus on achieving CLAS within CCB's existing structures, services, activities, and projects delivered by providers throughout our network. As discussed above, our approach is integrated within existing initiatives and leverages present capacity wherever possible. In addition, we aim to coordinate with other PPSs within our region to share resources, trainings, and best practices wherever possible. Our planned activities are intended to change leadership dynamics resulting in adoption of the CLAS standards, including promotion of diverse and inclusive hiring, CLAS orientation and training for staff and consumers, and coordinated interventions to improve community outreach, education, and accommodations. Our Strategy involves making the implementation of culturally and linguistically patient-centered care as streamlined as possible through extensive training and via immediately accessible, user-friendly resources. Resources and technical assistance to support CLAS adherence will be provided to support policy and practice refinements, especially related to hiring, consumer input, and ongoing quality improvement to address disparities and remediate barriers to care related to issues of culture and language.

Our Strategy acknowledges three critical steps necessary to gain cultural competence, which will be built into each of our actions:

1. *Unlearning*: identifying and correcting learned biases and stereotypes that impact care;
2. *Learning*: gaining new information, knowledge and wisdom to improve care; and
3. *Diversification*: increased collective capacity of organizations to respond to the needs of clients and communities.

Identification of Resources, Tools, and Interventions

Our goal is to fully integrate the most widely accepted and universally agreed best practices across every aspect of our care delivery system—throughout all provider types and at every level of service provision. We will ensure that the best and most robust training material and resources around cultural competency and health literacy are widely utilized and fully integrated into our DSRIP projects and broader network initiatives. We will actively promote evidence based practices relevant to the cultural populations served and encourage models that follow national standards for care.

There is an abundance of resources and programs to help our network build knowledge of general cultural norms among key groups of patients seen by our PPS. There are many comprehensive toolkits and interventions for adopting and implementing CLAS standards and improving cultural competency as well as staff development and training resources. In addition, there are many websites, such as www.ethnomed.org and www.belief.net that are helpful resources when additional knowledge is needed. We have performed an **initial inventory of tools and resources** for adopting person-centered, culturally competent care that providers can consider as they work toward CLAS adherence, which is included in the Appendix and contains an initial inventory of assessments and tools to assist patients with self-management of conditions.

We will continuously add to this initial inventory of the tools and share these resources across the broad CCB network via an online **Resource Library**, so that all of our partners have access to needed resources in one place. Patient education materials in multiple formats, including low-literacy and pictorial formats will be posted and shared among network partners. Based on the baseline assessments and the identified gaps and barriers, CCB (working through the Community Engagement Advisory Committee and other key community partners), will promote resource sharing, and where needed, modify or develop CLAS and health literacy resources and information appropriate for consumer use (i.e., translated, as indicated, and via images whenever possible).

System-wide Workforce Training and Staff Development

Health literacy requires helping individuals understand their health care choices and make effective decisions that reflect their personal values and goals. CCB providers will be trained to clearly understand that the information they encounter about certain cultural, gender, sexual orientation, and/or spiritual/religious groups cannot be generalized to all patients of a certain background but should merely be interpreted as an on-ramp to a deeper discussion with every patient about his or her needs and preferences for health care.

The Community Engagement Advisory Committee, working closely with the Workforce Committee, will be instrumental in selecting and designing cultural competency training(s) that are responsive to the needs of the Brooklyn community for implementation across the entire CCB workforce. A comprehensive curriculum in culturally responsive care must be targeted to every member of the health care team and must emphasize enhancing patient and practitioner satisfaction with care delivery that is respectful, appropriate and useful. We are currently working with 1199 SEIU Training and Upgrading Fund to develop our **workforce training program**. Utilizing input from our key stakeholder interviews and our Community Engagement Advisory Committee, our overall workforce training will incorporate cultural competency and health literacy along with the social determinants of health and the drivers of health disparities. We will facilitate resource sharing, promote infrastructure development, and consider CCB support to providers for their efforts to address the challenges identified by their self-assessment and internal data analysis or reported by patients/consumers. Feedback from key informant interviews and focus groups composed of representatives from within the sponsor organizations, trainers, and recipients of care will serve to identify gaps for enhanced staff and leadership training needs. Based on identified gaps, we will host interactive workshops, lectures, and discussions; host live and recorded webinars; and promote opportunities to join learning collaboratives and receive technical assistance.

Additionally, our practitioners will be trained regarding when and how to **work effectively with interpreters**, in order to communicate with each client in the context of his/her health literacy levels, negotiating treatment plans in the spirit of patient-centered culturally responsive care. Shared decision making, patient engagement and Motivational Interviewing will also be included as cornerstones of the

curricula, as industry research has demonstrated that Motivational Interviewing¹⁵ is a valuable tool for engaging individuals into any kind of dialogue around behavioral change and connection to treatment.

Additionally, for **project-specific trainings**, we intend to integrate concepts of cultural competence and health literacy wherever appropriate. As we work with practices to achieve PCMH recognition, we will build in tenets of CLAS, and the Community Engagement Advisory Committee will ensure that cultural competency and health literacy training material is available as stand-alone training and as integrated material, consistently woven into other training in order to consistently reinforce the critical importance of cultural competency and health literacy as well as to avoid silos, duplication, and inconsistency. Where possible, we will consider our local grassroots community-based providers as a potential training resource.

It is essential that organizational leaders develop the awareness necessary to sustain a commitment to the goal of achieving CLAS adherence and a capacity to articulate a strong rationale for pursuing culturally responsive care. These leaders can then champion the work necessary to ensure functional services that reach those who need them and appropriately meet their diverse needs. To ensure leadership buy-in across all levels, promote “unlearning” of biases, and facilitate the awareness necessary for success, our **CCB Governance Committees**, as well as **Central Services Organization** staff, will be the initial targets for thorough training to ensure that achievement of cultural competence and health literacy is foundational throughout our operational planning, as well as provide feedback on the training program.

Additional training and training materials will be available online to staff at all levels via the **Resource Library** so that training materials can be accessed conveniently. CCB will host the Resource Library and track engagement of the trainings by participant using our customer relationship management solution, Salesforce. Every training event, whether live or recorded, will be evaluated to ensure that participants find it to be meaningful and effective. We will update our training materials to ensure that they include recent, relevant data, speak to our local needs and issues, and reflect the most up-to-date standards for care. More details will be provided in our training plan to address health disparities, due June 2016.

Staff Recruitment and Hiring

As highlighted in the CNA and in our key informant interviews, there are gaps and challenges related to diverse leadership representation within the health care sector as well as access to culturally and linguistically representative providers in Brooklyn. Throughout upcoming DSRIP Workforce deliverables, such as defining our target workforce state and developing a workforce communication and engagement plan, the Community Engagement Advisory Committee will work hand in hand with the Workforce Committee to incorporate and encourage the standards of CLAS for building a **culturally and linguistically diverse workforce**.

Our Strategy will explore assertive **recruitment strategies** to promote diverse hiring and opportunities to support the integration of culturally diverse staff into targeted health care operations (e.g., tuition

¹⁵ Burke, B., Arkowitz, H., and Menchola, M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials." Journal of consulting and clinical psychology, (2003).

reimbursement). We will also assess linguistic and communication competencies of staff, including their ability to utilize interpreters (verbal)/translation (written) services effectively where necessary and to actively match employees to patients based on linguistic and cultural needs.

Community Engagement and Outreach

Patient and stakeholder education, engagement, and input are essential to our Strategy's success, and as a result, we plan for multiple opportunities for two-way communication with our patients, community groups, and network at large. Our community engagement plan, due later this year, will incorporate our efforts related to CLAS and will define our planned modalities and approach in a more detailed way. However, we intend to address community engagement and outreach as it relates to cultural competency and health literacy via: 1) all partner meetings, 2) other community-based forums or conferences, 3) consumer education initiatives and help lines, and 4) consumer involvement in CCB Governance.

The **CCB Project Advisory Committee (PAC)**, which includes representatives from each of the 850+ partner organizations in the CCB network, will be leveraged to disseminate information, as well as create an opportunity for community feedback at each meeting. We will also explore utilizing this meeting to provide CLAS training.

In order to supplement our understanding of the community need and potential opportunities for improving access to quality primary, behavioral health, and preventive health care, we will host **Town Hall Forums**, local social marketing efforts, surveys, and/or public education activities to discuss DSRIP goals in general, elicit input about issues and challenges community members encounter in accessing care, identify key messages for the Brooklyn community, and further inform community members regarding their right to receive CLAS. We will share feedback (e.g., online, during training, or other methods) with our partners and use the input to inform our Strategy. In addition, we will explore the option of hosting a **Conference on Achieving CLAS** for our partners, depending on the need and results of our assessments.

To facilitate patient engagement, we will incorporate **borough-wide patient and consumer education** into the broader community engagement plan to ensure that individuals are aware of their right to receive CLAS adherent care within our system. We will also consider utilizing posters and materials in provider waiting rooms, public service announcements, and widely distributed literature, based on feedback from our stakeholders. In addition, a well-publicized consumer and provider complaint process will be established. A **CCB Support warm line** will be promoted and utilized to more thoroughly monitor barriers and track resolution over time for patient/consumer concerns, which may include issues related to CLAS.

We will also **engage patients in CCB Governance** and implementation, including consideration of a Community Council of patients in order to actively elicit stakeholder input into the design of our training program and the resources and materials we develop.

VII. Overview of Potential Roadblocks and Challenges

As we develop and implement our Strategy, we anticipate an array of roadblocks and challenges. Chief among these is the overwhelming array of **cultural, linguistic, and socioeconomic diversity** throughout the borough. As discussed earlier, Brooklyn is one of the nation's most concentrated and diverse urban centers, with significant populations from multiple racial and ethnic groups, including African American, Latino/Hispanic, Caribbean and Haitian, Chinese, Russian, Polish, South Asian, Orthodox/Jewish, and Arab. However, CCB is fortunate to have the support of many stakeholders and resources in Brooklyn and will seek and utilize the expertise of the many community-based organizations to reach these diverse populations of patients.

Additionally, DSRIP requires an overwhelming focus on projects, workforce re-training, new collaborations, protocols, and workflows. A potential risk is that our Strategy's efforts related to cultural competency and health literacy are overshadowed by the other DSRIP requirements and the milestones each PPS is held to achieving. Our plan is, therefore, **rooted in our centralized administrative infrastructure and leverages our existing models for consumer and provider education, outreach, and staff training**. We will integrate cultural competency and health literacy strategies throughout planning and implementation across all of CCB's projects, so that rather than being a discrete effort, CCB's Cultural Competency and Health Literacy Strategy will permeate the entirety of its system redesign plan. It will be similarly incorporated within our evaluation and rapid cycle change efforts.

Related to the magnitude of work to be done, we recognize that network providers are being asked to attend multiple meetings and trainings related to these efforts. Adding yet another training effort related to cultural competency and health literacy runs the risk of falling into the trap of "training overload." In response, we will largely **integrate cultural competency and health literacy trainings into pre-existing engagements**, such as regular implementation meetings or other trainings.

Our network is quite large, consisting of over 850 partner organizations that vary in size, complexity, and capacity. They each bring unique strengths, as well as gaps and needs related to culturally competent care delivery. An additional potential roadblock relates to **historic competition among the groups and organizations** best suited to provide the support and assistance necessary for the success of the Strategy. In response, CCB has engaged existing community collaboratives in developing this plan. Our initial capacity assessment will inform the development of a resource allocation process to determine the best methodology to implement sustainable linkages among our community-based organizations and the preventive, primary care, and behavioral health providers in the delivery system. We will further utilize this capacity assessment process to begin to address the wide variation that exists among providers within CCB's PPS network. On-going resource sharing and collaboration will be facilitated by our planned stakeholder engagement process as well as input from our Community Engagement Advisory Committee.

VIII. Plan to Evaluate and Monitor Efforts, Including Identification of Best Practices

To ensure the success of our Strategy, we will continually assess cultural competency and share actionable feedback with providers and partners able to address identified gaps. Our Strategy will be a **living document** that is updated and revised to fully reflect the input and feedback of our many engaged stakeholders, evaluation from training, surveys of staff and consumers, and a formal evaluation of the effort itself in achieving our clearly defined and measurable goals. As such, we view this process as iterative, continually evaluated, and informed by feedback from patients, providers, staff and leaders alike. CCB will monitor the implementation of this plan and evaluate our effectiveness in reaching goals for cultural competency, health literacy, and consumer engagement.

CCB will **create internal benchmarks** for each of the major activities of this plan, including meetings, trainings, use of assessments by providers, and meetings held with community leaders. We will monitor our progress on these benchmarks and include as part of DSRIP quarterly reporting requirements. By monitoring the roll-out of our efforts and providing that data to our Governance committees, community partners and providers, we will hold ourselves accountable for progress.

We will also **monitor the use of health care services by subpopulations** and build reports from Medicaid claims data and our GSI Health care coordination platform (the “Dashboard”) to analyze the quality of care and volume of visits (e.g., primary care, behavioral health care, emergency department, and inpatient services) in order to compare utilization rates and care by subpopulation. We will also monitor DSRIP quality metrics such as rates of primary care utilization, smoking cessation counseling, etc. This quantitative data will supplement the qualitative data collected through partner assessments, stakeholder interviews, and community feedback. The experiences of subgroups will be addressed by our review, focusing on those shown to be least engaged in the delivery system at baseline.

Similar to our approach in other areas of the Strategy, we will maximize the use of **existing data sources and processes** to the extent possible. The collection of REAL standards (race, ethnicity, and language) are mandated data fields for PCMH recognition, allowing for the assessment of cross system and individual agency disparities among groups. We will utilize patient satisfaction data (e.g., CAHPS survey) to monitor consumer input on the accessibility and effectiveness of our practices. The review of population data and assessment of quality performance measures will identify needs experienced by specific cultural groups and will help calibrate application of appropriate and targeted interventions, including use of community health workers, collaboration with community gatekeepers, utilization of interpreters and cultural brokers, and accommodation of special needs related to culture, age, religion, socioeconomic factors, disability, sexual orientation/gender identity, etc.

Utilizing the resources and strategies presented above, we will simultaneously engage our existing network systems in a continual analysis of the pathways to appropriate care to **identify key factors to improve access** to quality primary, behavioral health, and preventive health care. We will receive feedback regarding barriers to or gaps in access to quality health care via local or population-specific advisors, patient surveys/focus groups, outreach to local residents or consumers, etc. Based on the identified gaps, we will identify/develop interventions that incorporate best practices and/or identify

“brokers” to assist in promoting local resources and relationships, as necessary, to implement the needed support. We will identify and use evidence-based **community-based interventions shown to reduce health disparities and improve outcomes** (an initial list is included in the Appendix) and, where possible, use that information to inform the development of effective community based interventions, with input from our community-based advisors. Establishing linkages with community advisors, local leaders, faith leaders, cultural groups, etc. will help our providers customize engagement strategies/intervention approaches for specific groups or populations. Where evidence does not exist, we will develop and share best practices across our network. As access barriers are identified which may relate to cultural and linguistic gaps or health literacy needs, our Strategy involves analysis and establishes the infrastructure necessary for localized, customized resolution that fully engages the system of care and the community residents themselves. Our goal will be to understand the needs, listen to our experts from the community, focus our existing community resources, enhance available services, expand existing initiatives when and as needed, and design new interventions, in partnership with the local providers best able to offer the necessary services. These activities will be carefully managed, tracked, and analyzed for impact via CCB’s ongoing evaluation.

Finally, we will **continue our current surveys and consider follow-ups to measure progress** transitioning to and adhering to CLAS standards. For example, we will consider integrating cultural competency and health literacy into planned consumer surveys to explore patient and community opinion regarding the acceptability of CCB, satisfaction with services received as part of CCB, and any barriers to care. Surveys will be conducted in a manner that is consistent with CLAS standards, including consideration with language, health literacy, etc.