Advancing Cultural Competence in the Era of Healthcare Reform

NYAPRS Cultural Competence Committee Webinar Series
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Presenters

Lenora Reid-Rose  
Coordinated Care Services, Inc.  
1099 Jay Street  
Rochester, NY 14611  
Phone: (585) 613 7615  
E-mail: lreid-rose@ccsi.org

Harvey Rosenthal  
Executive Director  
New York Association of Psychiatric Rehabilitation Services (NYAPRS)  
harveyr@nyaprs.org
New York Association of Psychiatric Rehabilitation Services (NYAPRS)

A peer-led statewide coalition of people who use and/or provide community mental health recovery services and peer supports that is dedicated to improving services, social conditions and policies for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and full community inclusion.

harveyr@nyaprs.org   www.nyaprs.org
Very high health, social and criminal justice costs with very low outcomes

Early mortality: cardiovascular, respiratory and infectious diseases, diabetes and hypertension

Highest rates of avoidable readmissions

High rates of violence victimization, incarceration, homelessness and suicide
Impact of a Broken System

- High rates of poverty: unemployment and idleness
- Stigma and discrimination: isolation
- Loss of hope, purpose, dignity
- Magnified exponentially for communities of color and other underserved groups
Elements of a Broken System

- Fragmented, Siloed and Uncoordinated
- Unresponsive: Reactive vs Preventive and Diversionary
- Unaccountable: who can we turn to?
- Wrong Incentives: volume over value
- Illness over Wellness? Wellness over Illness?
- ‘Chronic’ Patienthood over Personhood
The Need for Healthcare Reform
NYS Example

- $60 billion Medicaid program with 5+ million beneficiaries
- 20 percent (1 million beneficiaries) use 80 percent of these dollars
  - Hospital, emergency room, medications, longtime “chronic” services
  - Over 40 percent with behavioral health conditions
- NYS avoidable Medicaid hospital readmissions: $800 million to $1 billion annually
  - 70 percent with behavioral health conditions; 3/5 of these admissions for medical reasons
- Thousands of adult and nursing home residents with psychiatric disabilities who can successfully live in the community with appropriate individualized supports
- 85 percent unemployment, high homelessness, incarceration rates
Fundamental Overhaul: National Healthcare Reform

- Triple Aim: improving outcomes and quality while reducing cost and paying attention to consumers experiences
- Integrating physical and behavioral healthcare
- Emphasis on ‘upstream’ prevention and diversion
Fundamental Overhaul: National Healthcare Reform

- Accountable integrated care
- Coordinated care networks using electronic healthcare records
- Culturally relevant and appropriate person-centered engagement and care
- Increased Medicaid flexibility, waivers
- Value based payment
Care management for all
Integration of physical and behavioral health services
Develop adequate and comprehensive networks
Focus on improved health and recovery outcomes
Tie payment to outcomes
Reinvest savings to improve services for behavioral health populations
NYS Medicaid Waiver

- Health and Recovery Plans
- Health Homes
- Home and Community Based Services
- Delivery System Reform Incentive Payment
  - Performing Provider Systems
- Value Based Payment
- Eliminate racial disparities in healthcare
Medicaid managed care plans that coordinate health and pharmacy benefits for New Yorkers with serious BH conditions are now responsible for integrating and managing their BH services as well.

These include an expanded array of previously non-Medicaid funded HCBS.
Rehabilitation
- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Residential Supports/Supported Housing

Habilitation

Crisis Intervention
- Short-Term Crisis Respite
- Intensive Crisis Intervention
- Mobil Crisis Intervention

Educational Support Services

Support Services
- Family Support and Training
- Non-Medical Transportation

Individual Employment Support Services
- Prevocational
- Transitional Employment Support
- Intensive Supported Employment
- On-going Supported Employment

Peer and Family Supports

Self Directed Services
7 days from inpatient discharge to outpatient appointment
30 days to filled prescription
Depression screening and follow up
HCBS Outcome Measures:
Social Determinants of Care

- Participation in employment
- Enrollment in vocational rehabilitation services and education/training
- Improved or Stable Housing status
- Access to and use of Peer Support
- Longer Community tenure, Decreased Hospital Readmissions
- Decreased Criminal justice involvement
- Improvements in functional status
- Cultural & Linguistic Competence, Engagement
Health homes provide:

- Care managers who assure that enrollees receive all needed medical, behavioral, and social services from their assembled networks of treatment, housing and social services.
- in accordance with a single care management plan.
- that is shared with all providers via an electronic healthcare record.
New York State Designated Lead Health Home
Administrative Services, Network Management, Health IT Support/Data Exchange

Health Home Care Management Network Partners
(includes former Total Care Management Providers)
Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link Services
(Electronic Care Management Records)

Access to Required Primary and Specialty Services
(Coordinated with MCO)
Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Social Services and Supports

Managed Care Organizations (MCOs)

Medicaid Analytics Performance Portal (MAPP)

Regional Health Information Organizations (RHIOs)
Overarching goal is to reduce avoidable hospital use – ED and inpatient – by 25% over 5+ years of DSRIP.

This will be done by developing integrated delivery systems, removing silos, enhancing primary care and community-based services, and integrating behavioral health and primary care.
Performing Provider Systems are networks of providers that collaborate to implement DSRIP projects.

Each PPS must include providers to form an entire continuum of care:
- Hospitals
- Health Homes
- Skilled Nursing Facilities (SNF)
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Other Key Stakeholders

Community health care needs assessment based on multi-stakeholder input and objective data.

Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.

Meeting and Reporting on DSRIP Project Plan process and outcome milestones.
Each PPS had the opportunity to choose the best projects to support their community based on identified healthcare gaps, however, over and above the projects there is a governance piece that includes Cultural Competence and Health Literacy that every PPS must infuse into the fabric of their work to create an effective, sustainable Integrated Delivery System.

**DSRIP PPS Organizational Application**

“Overall DSRIP and local PPS success hinges on all facets of the PPS achieving cultural competency and improving health literacy. Each PPS must demonstrate cultural competence by successfully engaging Medicaid members from all backgrounds and capabilities in the design and implementation of their health care delivery system transformation. The ability of the PPS to develop solutions to overcome cultural and health literacy challenges is essential in order to successfully address healthcare issues and disparities of the PPS community.”
## Key Mental Health Projects in DSRIP

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>PPSs Involved</th>
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<td>Integration of primary care and behavioral health services</td>
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<td>Behavioral health community crisis stabilization services</td>
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<td>Implementation of Evidence-Based Medication Adherence Program (MAP) in Community Based Sites for Behavioral Health Medication Compliance</td>
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<td>3.a.iv</td>
<td>Development of Withdrawal Management (e.g. ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs</td>
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<td>Behavioral Interventions Paradigm (BIP) in Nursing Homes</td>
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<td>4.a.i</td>
<td>Promote mental, emotional and behavioral (MEB) well-being in communities</td>
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<td>4.a.ii</td>
<td>Prevent Substance Abuse and other Mental Emotional Behavioral Disorders</td>
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<td>4.a.iii</td>
<td>Strengthen Mental Health and Substance Abuse Infrastructure across Systems</td>
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What are Value Based Payments (VBPs)?

An approach to Medicaid reimbursement that rewards value over volume

Incentivizes providers through shared savings and financial risk

Directly ties payment to providers with quality of care and health outcomes

A component of DSRIP that is key to the sustainability of the Program
By DSRIP Year 5 (2019), all Managed Care Organizations must employ value based payment systems that reward value over volume for at least 80 – 90% of their provider payments.

If VBP goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced.
Creating an Expert Group for Achieving Cultural Competence in Incentive Programs

The Subcommittee recommends that the State should convene a group of experts and consumers to create more detailed guidance... for the development of incentive programs.

Programs need to incorporate respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors (e.g. race, ethnicity, language, urban/rural, LGBT). .
NYAPRS Advocacy on Value Based Payment Work Groups

- Recovery outcomes (beyond HEDIS): improvements in functioning, quality of life, social determinants.
- Parity for community providers with hospitals; e.g. the State should join PPSs and MCOs in offering TA, Infrastructure Dollars for Community Recovery Providers
- Attribution of beneficiaries to provider with greatest contact and connection
- Include non-Medicaid costs in benchmarking calculations
- Culturally competent incentives for beneficiaries
- Statewide education campaign
DSRIP Governance

DSRIP PPS Organizational Application

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**Culture:** A way of life of a group of people that encompasses behaviors, values, and symbols that are accepted and passed along, by communication from one generation to the next.

**Culture is:**
- Dynamic – influenced by time, place and circumstances
- Determines the way we think, feel, act, perceive and respond to situations etc.
- Consists of attitudes, beliefs, values and rules of conduct
- Is shaped by factors as proximity, education, gender, age and sexual preference
- Learned – it is not innate or biological
- Is a group phenomenon – it must be shared
- Reflects tradition, having been passed from one generation to another
Cultural Competence Definitions:

- Cultural Competence in an individual or organization implies having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. *Cross et al*

- The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural and linguistic needs. *(HRET)*

- The ability of an individual or organization to accommodate the needs presented by consumers and communities with diverse languages, modes of communication, customs, beliefs, and values. *(Cancer Action Network)*

- Leads to better communication, medication adherence, improved health status, and fewer emergency visits and hospitalization.

- The **integration and transformation of knowledge, behaviors, attitudes and policies** that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations.

- A developmental process that evolves over an extended period of time.
Health Literacy is defined in the Institute of Medicine report, as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."
Health Literacy in a Cultural Context

- Recognizing that culture plays an important role in communication helps us better understand health literacy. For people from different cultural backgrounds, health literacy is affected by belief systems, communication styles, and understanding and response to health information. Even though culture is only one part of health literacy, it is a very important piece of the complicated topic of health literacy. The United States Department of Health and Human Services (HHS) recognizes that "culture affects how people communicate, understand and respond to health information."
Cultural Competence and Health Literacy

Diversity of the New York State Population

- The rational for the promotion of cultural competence in health care reform in NYS is clear. NYS is an increasingly multicultural state. According to the 2010 Census, the NYS population is comprised of:
  - 18% Hispanic/Latino
  - 16% African American
  - 7% Asian American
  - 11% other than non-White, non-Hispanic race or two or more races

The above groups comprise 52% of the state's population
Milestone 1 - Due December 2015:
- Finalize Cultural Competence / Health Literacy Strategic Plan

Milestone 2 – Due June 2016:
- Develop a training strategy focused on addressing the drivers of Health Disparities (beyond the availability of language appropriate material)
Approach To Achieving Cultural Competence & Health Literacy

☐ Finalize Cultural Competency/Health Literacy Strategy

☐ Identify Priority Groups Experiencing Health And Health Care Disparities (Based On Your Community Needs Assessment - CNA And Other Analysis)

☐ Identify Key Factors To Improve Access To Quality Primary, Behavioral Health, And Preventative Health Care. Key Factors To Define Access Must Be Culturally Driven. Definitions Will Consider Cultural, Linguistic, Geographic Health Literacy And Illiteracy. Key Factors Relating To Social Determinants Must Be Accounted For In This Analysis
Approach to achieving Cultural Competence & Health Literacy

- Define plans for two-way communication with the population and community groups through specific community forums
- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistics and literacy levels)
- Identify community-based interventions to reduce health disparities and improve outcomes
- Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)
Cultural competency is critical to reducing health disparities and improving access to high-quality health care.

As a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of individuals accessing health information and health care.

- **Competency 1:** Describe the identified and/or known cultural competency challenges which the PPS must address to ensure success.

- **Competency 2:** Describe the strategic plan and ongoing processes the PPS will implement to develop a culturally competent organization and a culturally responsive system of care. Particularly address how the PPS will engage and train frontline healthcare workers in order to improve patient outcomes by overcoming cultural competency challenges.

- **Competency 3:** Describe how the PPS will contract with community based organizations to achieve and maintain cultural competence throughout the DSRIP Program.
How an upstate PPS is operationalizing this – Finger Lakes Provider Performing System (FLPPS)

To transform the way health care is delivered to more than 300,000 Medicaid beneficiaries in the Finger Lakes region through:

- Improved Access To Quality Primary, Behavioral Health, And Preventative Health Care
- Reduction In Unavoidable Emergency Room Visits
- Addressing And Eliminating Health Disparities
FLPPS Operationalizing CC and HL

FLPPS Cultural Competency and Health Literacy at the Executive Level of the organization

- Creation of Cultural Competence and Health Literacy Committee.
- An in-house FTE was charged with CC and HL budget management.
- Ensuring the CC and HL strategic plan is fully operationalized.
- Contracting with the CCHL vendor brings a CCHL richness to the overall project.
- Managing internal and external CCHL initiatives as well as being the liaison with a CCHL vendor.
- Assemble Project Team.
Activities to achieve Milestone 1 and Milestone 2

- Identify Priority Groups/Vulnerable Populations
- Conduct CC and HL Assessment of the PPS Provider Network
- Establish Meaningful Performance Metrics and Outline Strategy for Assessing Progress
  - Encourage and work with providers to implement a continuous quality improvement (CQI) process that addresses the identified disparities and publicly report on progress
  - Identify community-based interventions to eliminate disparities and improve outcomes
- Develop Two-Way Community Communication / Engagement Strategy
- Identify and Assemble Tools and Resources to Support CLC and HL Priorities
- Develop CLC/HL Training Strategy
Activities to achieve Milestone 1 and Milestone 2

- **Identify Priority Groups/Vulnerable Populations using**
  - FLPPS DSRIP Community Needs Assessment
  - County-Level Community Needs Assessment
  - NYS Prevention agenda
  - NYS Medicaid Redesign Health Disparities Team – workgroup report
  - Regional Data Reports
  - Census/Public Databases
  - Salient Databases
Activities to achieve Milestone 1 and Milestone 2

Vulnerable Populations

- Individuals with Behavioral Health Conditions
- Individuals with Developmental Disabilities
- Homeless
- Individuals Living in Poverty
- Maternal & Child Health
- African Americans
- Hispanics/Latinos
- American Indians/Alaska Natives
- Migrant and Seasonal Farmworkers
- Lesbian, Gay, Bisexual, Transgender & Questioning/Queer (LGBTQ)
- Deaf and Hard of Hearing
Activities to achieve Milestone 1 and Milestone 2 contd.

Conduct CC and HL Assessment of the PPS Provider Network

CC and HL Assessment Designed to:

- Serve as a Self-Assessment: Guide and an Evaluation of Cultural Competence and Health Literacy Within Your Organization
- Provide Essential Information Concerning The Organization’s Structure and Function
- Serve as a Data Collection Tool Which Will Allow Database Development
- Provide Organizations With a Series of Questions That Can Help Continue the Performance Improvement and Management Journey
- Serve as a Roadmap for Organizations to Improve the Organization’s Cultural Competency and Health Literacy
- Serve as a Process Document to develop a Cultural Competence Strategic Plan – Short, Medium, and Long Term Goals
Activities to achieve Milestone 1 and Milestone 2 contd.

CC and HL Organizational Self-Assessment Tool

COMPONENT PARTS OF THE TOOL ARE:
- General Information
- Organizational Profile
- Cultural Competency Information
  - Needs Assessment
  - Information Exchange
  - Services
  - Human Resources
  - Organizational Policies and Plan
  - Outcomes Regarding Cultural Competency
- Health Literacy Information
THE FINDINGS CAN BE USED TO:

- Establish baseline measure, current state
- Inform Cultural Competence and Health Literacy training interventions and staff development activities
- Recognize and promote best clinical and administrative practices
- Identify hidden cross-cultural resources and talents that currently exist within a given workforce
- Identify strengths and assets of an organization
- Identify areas for improvement
Activities to achieve Milestone 1 and Milestone 2 contd.

- Establish Meaningful Performance Metrics and Outline Strategy for Assessing Progress
  - Encourage and work with providers to implement a continuous quality improvement (CQI) process that addresses the identified disparities and publicly report on progress
  - Identify community-based interventions to eliminate disparities and improve outcomes
Data

Activities

Outcomes

Demographics

Social determinants of health

Trauma

Community influence

Co-occurring conditions, SUDs, chronic conditions

Provider understanding and awareness of community

Have a PCP

Access to PCP

Engage patient

Engage patient

Effective screening tool

Complete screen

Depression screening and follow up measure

NYS Goals: Improve Outcomes

Reduce avoidable ER visits

Patient participation in treatment

Patient denies care

Adherence to antidepressant medication measure

Outcomes

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**NYS Goals:**
- Improve Outcomes
- Reduce avoidable ER visits

**Data**
- Demographics
- Social determinants of health
  - Co-occurring conditions, SUDs, chronic conditions
  - Provider understanding and awareness of community

**Activities**
- Have a PCP
- Engage patient
- Effective screening tool
- Complete screen
- Engagement in treatment
- Present treatment alternatives
- Patient participation in treatment
- Patient denies care

**Outcomes**
- Depression screening
- Adherence to antidepressant medication measure

**Social determinants of health**
- Trauma
- Community influence

**Provider understanding and awareness of community**
- Health literacy
- Low reading ability
- Language
- Format
- Choice
- Administration and presentation
Data
Activities
Outcomes

- Demographics
- Social determinants of health
- Co-occurring conditions, SUDs, chronic conditions
- Provider understanding and awareness of community

- Trauma
- Community influence

- Have a PCP
- Access to PCP

- Engage patient

- Effective screening tool
- Complete screen
- Depression screening
- and follow up measure

- Patient participation in treatment
- Patient denies care
- Adherence to antidepressant medication measure

NYS Goals:
- Improve Outcomes
- Reduce avoidable ER visits

- Engage patient
- Present treatment alternatives

- Have a PCP

- Patient participation in treatment
- Patient denies care
- Adherence to antidepressant medication measure

- Validated for this culture
- Follow up assessment
- Other questions, methods, formats
Data

Activities

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and follow up measure

NYS Goals:

• Improve Outcomes
• Reduce avoidable ER visits

Patient participation in treatment

Patient denies care

Adherence to antidepressant medication measure

Presentation at intake

• Include important others
• Trust

Engage patient

Present treatment alternatives
-**Data**

-**Activities**
  - Have a PCP
  - Engage patient
  - Effective screening tool
  - Access to PCP
  - Complete screen

-**Outcomes**
  - Depression screening
  - NYS Goals: Improve Outcomes
  - Reduce avoidable ER visits

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- Social determinants of health
  - Trauma
  - Community influence

- Co-occurring conditions, SUDs, chronic conditions
  - Provider understanding and awareness of community

- Demographics

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- Patient participation in treatment
  - Adherence to antidepressant medication measure

- Patient denies care

- Present treatment alternatives

- NYS Goals: Improve Outcomes

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- Engage patient

- Have a PCP

- Engage patient

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- Effective screening tool

- Complete screen

- Adherence to antidepressant medication measure

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- Patient participation in treatment

- Present treatment alternatives

- Patient denies care

---

- Effective screening tool

- Complete screen

- Engage patient

- Have a PCP

---

- Depression screening

- NYS Goals: Reduce avoidable ER visits
- Want a PCP?
- History with health care system
- Distrust, suspicion
- Preference for providers from similar cultural groups

Data

Activities

Outcomes

- Effective screening tool

- Trauma

- Access to PCP

- Community influence

- Engage patient

- Complete screen

- Depresssion screening

- Present treatment alternatives

- Patient participation in treatment

- Patient denies care

- NYS Goals: Improve Outcomes

- Reduce avoidable ER visits

- Adherence to antidepressant medication measure

Demographics

Social determinants of health

Co-occurring conditions, SUDs, chronic conditions

Provider understanding and awareness of community

Have a PCP

Engage patient

Effective screening tool
Data

Activities

Outcomes

- Cultural identity
- Health seeking behaviors
- Privacy
- Perceived resiliency
- Stigma

Demographics

Social determinants of health

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Community influence

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Provider understanding and awareness of community

Engage patient

Present treatment alternatives

Patient participation in treatment

Patient denies care

Adherence to antidepressant medication measure

Complete screen

Depression screening and follow up measure

NYS Goals:
- Improve Outcomes
- Reduce avoidable ER visits

Reduce avoidable ER visits

Engage patient under understanding and awareness of community

Patient participation in treatment

Complete screen

Depression screening and follow up measure

NYS Goals:
- Improve Outcomes
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Present treatment alternatives

Patient participation in treatment

Patient denies care

NYS Goals:

Improve Outcomes

Reduce avoidable ER visits

Adherence to antidepressant medication measure

Follow up check in

Ongoing conversation

What does denial mean?

Connect to cultural brokers, faith healers, family members, peer supports, social networks of others with shared experiences

Respect patient’s decision
Data

Activities

Outcomes

- Data
- Activities
- Outcomes

Social determinants of health

Demographics

Co-occurring conditions, SUDs, chronic conditions

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NYS Goals:
- Improve Outcomes
- Reduce avoidable ER visits

Who answers questions?
Who makes treatment decisions?

Provider understanding and awareness of community

Adherence to antidepressant medication measure

Have a PCP

Engage patient

Effective screening tool

Patient participation in treatment

Patient denies care

Present treatment alternatives

Depression screening and follow up measure

Access to PCP

Provider understanding and awareness of community

Engage patient

Complete screen

NYS Goals:
- Improve Outcomes
- Reduce avoidable ER visits

Who answers questions?
Who makes treatment decisions?
Data Activities Outcomes

Demographics Social determinants of health

Trauma Community influence

Have a PCP Access to PCP

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NYS Goals: Improve Outcomes Reduce avoidable ER visits

Co-occurring conditions, SUDs, chronic conditions Provider understanding and awareness of community

Engage patient Present treatment alternatives

Patient participation in treatment

Patient denies care

Adherence to antidepressant medication measure

Sensitive to health literacy

SUDs = Substance Use Disorders

NYS = New York State

ER = Emergency Room
Data

Activities

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NYS Goals:

Improve Outcomes

Reduce avoidable ER visits

Patient participation in treatment

Patient denies care

Adherence to antidepressant medication measure

Provider understanding and awareness of community

Include important others

Culturally appropriate assessment

Presentation of diagnosis and treatment

Engage patient

Outcomes

Have a PCP

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Effective screening tool

Complete screen

Depression screening

NYS Goals:

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Depression screening
Patient participation in treatment
Patient denies care
Adherence to antidepressant medication measure
Needs assessment
Cultural nuances
Culture as stressor/barrier

NYS Goals:
Improve Outcomes
Reduce avoidable ER visits

Provider understanding and awareness of community
Engage patient
Present treatment alternatives
Access to PCP
Trauma
Effective screening tool
Co-occurring conditions, SUDs, chronic conditions
Community influence
Have a PCP
Engage patient
Activities to achieve Milestone 1 and Milestone 2 contd.

Develop two-way communication/Engagement Strategy

- Will be hosting a series of community engagement forums
- Forums will be held both in urban and rural settings
It is much more important to know what sort of a patient has a disease, than what sort of disease a patient has.

William Osler