Community Health Improvement Plan to Improve the Health Literacy and Health Engagement of Transition Age Youth

Prepared by the

FamilyCare Community Advisory Council

TABLE OF CONTENTS

Acknowledgements

The FamilyCare Community Advisory Council developed this Community Health Improvement Plan to improve the Health Literacy and Health Engagement of Transition Age Youth. Their time, dedication, passion, and efforts are greatly appreciated. The following is a list of those Community Advisory Council members:

Alicia Atalla-Mei, Community Partner, Outside In

Carmen Cordis, Consumer

Amber Fay, Consumer

Kyna Harris, Consumer

Melissa Henderson, Community Partner, Native American Youth and Family Center (NAYA)

Richard Jenkins, Consumer

Candice Jimenez, Consumer, Northwest Portland Area Indian Health Board

Paul Lewis, County Partner, Clackamas County

Barbara Lombard, Consumer

Chris Murphy, County Partner, Multnomah County

Nick Ocon, County Partner, Washington County

Laura O'Neill, Consumer

Eric Owens, Community Partner, Tualatin Hills Parks and Recreation District

Ellene Smith, Community Partner, JOIN

Jan Tesch, Council Chair and Vice Chair of FamilyCare Board of Directors

Katherine Walker, Consumer

Deborah Westfall, Consumer

Duane Westfall, Consumer

Executive Summary

Multiple system barriers at the federal, state, and community level contribute to the problems which transition age youth face in Oregon. For example, these transition age youth are 80% less likely to receive necessary mental health services than any population in Oregon with mental health needs.

Barriers to services include: eligibility guidelines for financial and housing services; differences in "eligible" diagnoses between child and adult mental health providers; conflicting roles among service providers; a lack of age-appropriate community resources; and a youth culture that is often difficult to engage in services.

Because these are difficult issues to resolve, a concerted effort must be made. The State of Oregon pays millions of dollars each year to provide treatment to these youth as children and adolescents, then, at the focal point in their lives when intervention can have a profound impact on their life trajectory and ability to live as independent, productive adults, the existing systems fail to provide adequate services to support them on that path.[1]

The Community Health Improvement Plan (CHIP) intentionally and strategically focuses on transition age youth: FamilyCare members ages 15-25. The Council believes a CHIP focused on improving the health and wellness of these FamilyCare members will fulfill the triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare. Further, the CHIP is intentionally targeted at a strategic population that has been identified as the "hot spotters of the future", since today's population of high-risk youth will quickly age into the most costly, high-utilizing individuals of tomorrow. Because of this, the proposed CHIP is truly prevention-focused, and will allow our community to get ahead of the cost curve of our health system.

The Council advises the analysis and identification of high-utilizers within the transition age youth membership, a process which is known as "hot-spotting". "Hot-spotting" targets specific diagnoses and patient populations with personal interventions that bring together providers and community groups to solve problems.

The Council recommends a focus of interventions on this subset of transition age youth members, which includes youth of color, homeless youth, members with mental health and substance use issues, and members with histories of frequent, high-acuity, and high-cost care.

The Council advises FamilyCare to do things differently than they have in the past, which includes the use of community-driven methods of engaging transition age youth members in their health and wellness. It is strongly advised that the assessment and improvement strategies contained in the CHIP be guided by youth voices. Further, the Council strongly recommends that FamilyCare be proactive in its engagement of youth in their healthcare and wellness, which will require FamilyCare, as an organization, to improve its cultural competency.

The Council believes this upstream approach, a focus on preventive strategies rather than reacting to acute care, begins with health literacy and continues through engaging youth during their transition into adult healthcare. For the CHIP to be successful, it is paramount that its assessment and improvement strategies be guided by the youth population itself.

[1] McMillan, Rita (2009) White Paper: Transition Age Youth in Oregon: Considerations for a Statewide Model of Care State of Oregon Department of Human Services Addiction & Mental Health Division.

The Council acknowledges that the CHIP will take FamilyCare into uncharted territory. Improving the wide transitional gap between child healthcare and adult healthcare has eluded others. However, it is an opportunity to live out FamilyCare's mission, *Create healthy individuals through innovative systems,* and get ahead of the cost curve before these members transition into adult care and become the next population of "high-utilizers". This makes this Community Health Improvement Plan an upstream forward-thinking Approach to improving the health of the community FamilyCare serves.

FamilyCare Community Health Improvement Plan Overview

Vision: All FamilyCare transition age youth members and young adults (15-25 years old) deserve an equitable opportunity to make the choices that lead to good health. To ensure that all FamilyCare transition age youth members have that opportunity, advances are needed: in approaching and collaborating with communities, in healthcare integration, in health literacy, and in care coordination.

Guiding Cultural Competency Principle: This work will be ever evolving, improving upon itself year by year, and becoming the cultural norm of the organization to influence its partners, vendors, and providers. FamilyCare members will know they are valued via the culturally-competent and equitable care they receive as members of this insurer.

The Community Advisory Council Finds the Following Community Health Needs for Transition Age Youth at Ages 15-25:

a. Access to and engagement in care, specifically around mental health and substance use treatment.

b. A culturally-competent healthcare system that has understanding of the transition age youth population, and operationalizes best practices in serving them.

c. Support in transitioning patients from child to adult healthcare systems, especially in the area of mental health services, and for youth exiting the foster care system.

The Community Advisory Council Envisions:

a. Increase of health literacy and wellness knowledge for 15-25-year-old FamilyCare members (knowledge gain).
b. Increase of engagement in health and healthcare for 15-25-year-old FamilyCare members (behavior change).
c. Improved cultural competency of FamilyCare Health Systems for 15-25-year-old members.
d. Above improvement strategies will be guided by the voices of 15-25-year-old members.

The Community Advisory Council Advises the Following Measurable Objectives:

a. From baseline to post-intervention evaluation, achieve a 10% increase in measured health literacy among Transition Age Youth.

b. From baseline to post-intervention evaluation, achieve a 10% increase in measured engagement in health and healthcare among Transition Age Youth.

c. From baseline to post-intervention evaluation of FamilyCare Health Systems, will facilitate at least one listening session in each county served by FamilyCare. And implement at least two projects—informed by the listening sessions—that will improve FamilyCare's ability to effectively serve transition age youth.

Community Health Needs Assessment

In June 2013, FamilyCare joined a regional health assessment partnership, the Healthy Columbia Willamette Collaborative. The Healthy Columbia Willamette Collaborative covers Clackamas, Multnomah, and Washington Counties in Oregon, and Clark County, in Washington. The Collaborative includes representatives from 15 hospitals, the four county health departments, and the two CCOs (FamilyCare and Health Share) that operate in this region.

The FamilyCare Community Advisory Council has used both data from The Healthy Columbia Willamette Collaborative, and internal FamilyCare membership data to inform the direction of its Community Health Improvement Plan.

The information below offers a snapshot of FamilyCare's Transition Age Youth membership, ages 15-25, as of **April 10, 2014**. This is the information FamilyCare was able to report on the population at that time, only three months, after open enrollment. It should be noted that processing claims data can create a lag of up to three months for health indicators and member activation data.

Although these numbers have and will continue to change as membership fluctuates, the data provides a basic overview of the population on which the improvement plan is focused, and has given the council a member profile on which to map its planned interventions.

The Community Health Improvement Plan will utilize the widely-used and well-respected Health Effectiveness Data Information Set (HEDIS), which has been tailored for Oregon's Coordinated Care Organizations. The baseline data for the CHIP will be collected at the end of June and then reassessed very six months thereafter.

Finally, the data for the 15-25 age groups has been split in between ages 15-18 and 19-25. The Council elected this approach to analyze the differences in data between the two data sets but also recognizing the two groups will likely need different interventions for improving their health. A main concern of the Council is the transition of youth from children healthcare to adult healthcare.

FamilyCare Member Profile (Ages 15-25) ***Data as of 4/10/14***

- 15,340 FamilyCare members are aged 15-25 range, which represents 16 per cent of the total 93,947 members served.
- 55 percent women, 45 percent men.
- 49 percent live in Multnomah County, and the remaining 51 percent are split between Washington and Clackamas County.

<u>Race Description</u>

An individual self-identifies their race when applying for health insurance. The table 1, which can be found below, describes how FamilyCare members aged 15-25 identified their race description. The breakdown of the ages appears to indicate that the younger transition age youth (ages 15-18) are more stratified by racial description. This is significant especially considering the small difference in ages.

However, please note that in the 19-25 Unknown columns there are 2,148 members. This is because Cover Oregon has not yet provided the race/ ethnicity or primary language information of new enrollees who applied through the paper application process.

Race Description	**Members 15-25**	**%**	**15-18**	**%**	**19-25**	**%**
White	7,250	47	3,394	47	3,856	53
Hispanic	3,402	22	1,764	52	1,638	48
Unknown*	2,835	18	687	24	2,148	76
Black	1,055	7	452	43	603	57
Asian	643	4	340	53	303	47
Native American	151	1	66	44	85	56
Other	2	0	2	100	0	0

The table also reinforces the demographic shift of Oregon noted in the most recent census as more of FamilyCare members are identifying themselves as Hispanic.

** Cover Oregon has not yet provided the race/ ethnicity or primary language information of new enrollees who applied through the paper application process.*

Selected Health-Related Indicators of Transition Age Youth

- When this data was collected on April 10, 2014 four percent (4%) of transition age youth FamilyCare members were pregnant.
- 24 members aged 15-18 were receiving support for abuse of opiates through prescribed abatement, while 143 members aged 19-25 were prescribed an opiate abatement.
- Between January 1- April 10, 274 FamilyCare members aged 15-18 had already received care in the emergency room. During this same period, 609 FamilyCare members aged 19-25 received care in the emergency room.

Prescribed an Opiate Abatement	**15-18**	**%**	**19-25**	**%**
Members	24	0	143	1

ER Visits 1/1/ to 4/10/2014	**15-18**	**%**	**19-25**	**%**
Members	274	2	609	4

Member Activation

The Council does not believe that engagement in health can solely be measured by the number of an individual's doctor visits. However, data regarding how many FamilyCare members have primary care providers is a valuable metric, and a great starting place for us to begin to measure patient engagement within the healthcare system.

FamilyCare members aged 15-18 had a significantly higher percentage primary care visits since August 1, 2013 compared to those members aged 19-25. There might be a variety of reasons for this difference including the implementation of the Healthy Kids program or the poor transition of child care into adult care.

	PCP Visits Since 8/1/2013	**No PCP Visit Since 8/1/2013**	**% w/ PCP Visit Since 8/1/2013**	**% w/o PCP Visit Since 8/1/2013**
15-18	4,083	2,623	61	29
19-25	3,115	5,519	36	64

This data set, although only for the first three months of the year, might indicate that newly eligible members aged 19-25 are now connecting with a primary care provider.

	PCP Visits Since 12/31/2013 to 4/10/2014	**No PCP Visit Since 12/31/2013 to 4/10/2014**	**% w/ PCP Visit Since 12/31/2013 to 4/10/2014**	**% w/o PCP Visit Since 12/31/2013 to 4/10/2014**
15-18	1,585	5,120	24	76
19-25	1,427	7,206	20	80

Member Type

At the time the data was collected (April 10, 2014), 89 percent of FamilyCare members aged 15-18 were categorized as *Children at Ages 6-18 Who Qualify for Medicaid based on Poverty Level.* There are also 487 members (7 percent) categorized as *Foster Children* and 226, 3 percent categorized as *Blind and/or Disabled with No Medicare*.

FamilyCare members aged 19-25 were more varied by member type. The majority of members (53 percent) were categorized as *OHP without Children.* However, there also 16 percent of these members categorized as *Children at Ages 6-18 Who Qualify for Medicaid based on Poverty Level* and 14 percent categorized as Temporary Assistance to Needy Families (TANF).

Measurable Objectives: Measurable Objectives are set to achieve the triple aim: better health, lower costs, and higher patient satisfaction more needs to be done besides merely going to the doctor. An upstream approach to improving and sustaining health and wellness must include an increase in health literacy, an increase in engagement of individuals in their health and health care, and health care delivered in a culturally competent manner. Measurable objectives can be found as the last table of each Health Priority.

Health Priority #1: Community Assessment of Engagement of TAY in Their Health and Healthcare	
Community Health Improvement Plan Outcomes	Identify barriers which impact the engagement of Transition Age Youth (TAY) in their health and healthcare, and develop strategies for increasing engagement.
Health Equity Focus	Subpopulation focus of Transition Age Youth will include (based on data used from HCWC): • Youth of color, • Youth experiencing homelessness, • High-risk/high-need youth (i.e. those with mental health and/or substance use issues), • "High-utilizer" TAY with histories of frequent, high-acuity, and high-cost care.
Measureable Objectives	1. Identify barriers which impact the engagement of Transition Age Youth (TAY) in their health and healthcare. 2. Identify strategies for increasing engagement among TAY. 3. Form strong relationships with the community organizations that serve TAY.

Community Health Improvement Plan Strategies for Health Priority #1			
Improvement Strategies	**Performance Measures**	**Target by July 2016**	**Responsible Parties**
1. Identify TAY leaders to participate on a TAY sub-committee of The Council. a. Pay stipend to TAY leaders.	• Creation of sub-committee that makes recommendations to The Council.	• Sub-committee is meeting on a regular basis, and providing guidance and recommendations to The Council.	• The Council work group • TAY Council members
1. Identify community organizations that work with TAY, and distribute listening grants to support their partnership in conducting the assessments. 2. Work with community partners to conduct assessments in several different capacities, which could include surveys, focus groups, and interviews.	• Contract with __ community-based organizations to conduct assessments.	• __ completed TAY assessments on the barriers to engagement in health and healthcare.	• FamilyCare • Selected community-based organizations • The Council

Health Priority #1: Community Assessment of Engagement of Transition Age Youth in Their Health and Healthcare

Measurable Objectives

All measurable objectives will be community-driven, guided by the voices of transition age youth FamilyCare members and the community, toward the goals of increasing health literacy and improving health and wellness.

CAC Envisions CHIP Outcome:	Measurable Objective	Evaluation Strategies	FamilyCare's Responsibilities	Council Responsibilities
1. Increase health literacy among TAY FamilyCare members ages 15-25. (knowledge gain)	From baseline to post-intervention evaluation, achieve a **10% increase** in measured health literacy among TAY.	a. FamilyCare will establish evidence-based metric **baseline data** for members at ages 15-25 who have been FamilyCare members for over 6 months. b. Slice data based on utilization and diagnosis. c. Post-intervention evaluation will consist of analyzing change from baseline. Note: Data should be broken into subpopulations including race, ethnicity, and primary language.	• Collect baseline data. • Analyze data. • Re-measure data at 6-month intervals.	• Review data analysis. • Identify and elevate areas of concern in analysis. • Assist in defining the next actionable steps.

Health Priority #2: Increased Care Coordination and Engagement in Health and Healthcare for the Transition Age Youth (TAY) Population Served by FamilyCare	
Community Health Improvement Plan Outcomes	1. Increased engagement among TAY (ages 15-25) in their health and healthcare 2. Increased health literacy and knowledge about health and healthcare resources among TAY 3. Improved care coordination for TAY 4. Strong relationships with community organizations serving the TAY population
Health Equity Focus	Population focus on TAY will include emphasis on: • Youth of color, • Youth experiencing homelessness, • High-risk/high-need youth (i.e. those with mental health and/or substance use issues), • "High-utilizer" TAY with histories of frequent, high-acuity, and high-cost care.
Measureable Objectives	1. Decrease emergency room visits. 2. Decrease urgent care visits. 3. Increase Primary Care Provider (PCP) visits. 4. Transition members into suitable care based on acuity. 5. Improve transition of members from child care services to adult care services. 6. Increase number of adolescent well-child visits. 7. Increase number of members with PCPs.

Community Health Improvement Plan Strategies for Health Priority #2			
Improvement Strategies	**Performance Measures**	**Target by July 2016**	**Responsible Parties**
1. Identify TAY leaders to participate on a TAY sub-committee of The Council.	• Creation of sub-committee that makes recommendations to The Council.	• TAY sub-committee is meeting on a regular basis, and providing guidance and recommendation to The Council.	• The Council work group • TAY Council members • FamilyCare staff
2. Identify and partner with community organizations and providers to employ Traditional Health Workers—including Community Health Workers, Health/Patient Navigators, and Peer Advocates— to engage TAY.	• The number of project planning meetings with community-based organizations • The number of hired Traditional Health Workers.	• Employed __ Traditional Health Workers.	• The Council work group • FamilyCare staff

Improvement Strategies	**Performance Measures**	**Target by July 2016**	**Responsible Parties**
3. Traditional Health Workers will use best practices to increase knowledge and health literacy among TAY.	• Identify and formalize best practices for Traditional Health Workers. • Traditional Health Workers triaging.	• Traditional Health Workers engaging in community preventive measures and conducting health trainings in their communities.	• FamilyCare staff
4. Employ evidence-based, innovative communication strategies for engaging TAY.	• Utilization of TAY-identified communication channels to engage X number of TAY.	• All TAY members are contacted 3 times throughout the year.	• FamilyCare staff
5. Connect members to TAY services and programs (e.g. Lifeworks NW, Catholic Charities and El Programo Hispano, New Avenues for Youth, etc.)	• TAY members are offered the opportunity to connect to TAY programs.	• Navigation Services offer opportunity to connect with TAY programs upon enrollment.	• FamilyCare staff • The Council work group • TAY Council members
6. FamilyCare-hosted ”healthy lifestyle” trainings at community-based organizations that serve TAY members (e.g. nutrition courses).	• FamilyCare works with TAY Council members to develop three healthy lifestyle trainings and host nine events. • _ number of TAY participate in healthy lifestyle events.	• Measured change in TAY health literacy and knowledge around healthy lifestyle behaviors.	• FamilyCare Staff • TAY Council members
7. Link TAY members with healthy lifestyle options (seek partnerships with community-based organizations to offer healthy behavioral opportunities).	• Establish partnerships with Friendly House to offer TAY members gym memberships. • Extend Tualatin Hills Parks and Recreation Department passes to TAY members.	• FamilyCare TAY members utilize partnerships for healthy behavioral opportunities.	• FamilyCare staff • TAY Council members

Health Priority #2: Increased Care Coordination and Engagement in Health and Healthcare for the Transition Age Youth (TAY) Population Served by FamilyCare

Measurable Objectives

All measurable objectives will be community-driven, guided by the voices of TAY FamilyCare members and the community, toward the goals of increasing health literacy and improving health and wellness.

CAC Envisions CHIP Outcome:	**Measurable Objective**	• **Evaluation Strategies**	• **FamilyCare's Responsibilities**	**Council Responsibilities**
1. Increase health and healthcare engagement among TAY FamilyCare members at ages 15-25. (behavior change)	From baseline to post-intervention evaluation, achieve a **10% increase** in measured engagement in health and healthcare.	• With professional assistance, FamilyCare will develop **Health Engagement Surveys**. • FamilyCare will conduct pre- and post-intervention surveys to establish baseline and change from baseline. • Hold listening sessions (number TBD) so as to learn how TAY want to engage in their health. Note: Outreach will include all identified subpopulations and all three counties. Note: Grants will support listening sessions. Note: Intervention will consist of employing **Traditional Health Workers** in TAY communities as a pilot project; FamilyCare will partner with organizations to employ Traditional	• Develop TAY-specific surveys to measure engagement in health and healthcare. • Implement surveys. • Conduct listening sessions. • Collect and summarize results.	Review the survey before implementation • Review the results of the surveys. • Assist in defining the next actionable steps. • Assist in identifying community-based organizations with whom to conduct listening sessions. • Assist in defining the next actionable steps.

		Health Workers within organizations that serve TAY community. Traditional Health Workers will reflect the subpopulations listed.		

Health Priority #3: Improved Organizational Cultural Competency of FamilyCare Health Systems	
Community Health Improvement Plan Outcomes	Improved organizational cultural competency of FamilyCare Health Systems
Health Equity Focus	Organizational Assessment of Cultural Competence
Measureable Objectives	1. From baseline to post-intervention systematic evaluation of FamilyCare Health Systems, will facilitate at least one listening session in each county served by FamilyCare. And implement at least two projects—informed by the listening sessions—that will improve FamilyCare's ability to effectively serve transition age youth. **Note:** Evaluation will be conducted by external experts.

Community Health Improvement Plan Strategies for Health Priority #3			
Improvement Strategies	**Performance Measures**	**Target by July 2016**	**Responsible Parties**
a. Partner with Office of Equity and Inclusion (OEI) to assess FamilyCare's cultural competency as a system both internally and externally.	• A partnership to assess FamilyCare's cultural competency is established.	• FamilyCare has conducted an assess in 2015 and is annually assessing progress	• FamilyCare
b. Pre- and post-assessment following implementation of institutional changes to address lack of cultural competency	• Pre- and post-assessment are implemented.	• Measurements are created and tracked.	• FamilyCare
c. Cultural Competency Training for the Board of Directors, Committees, and other FamilyCare internal groups.	• Training program is established.	• Training program is offered to Board of Directors, Committees, and any other FamilyCare internal groups.	• FamilyCare

Health Priority #3: Improved Organizational Cultural Competency of FamilyCare Health Systems

Measurable Objectives

All measurable objectives will be community-driven, guided by the voices of TAY FamilyCare members and the community, toward the goals of increasing health literacy and improvingement health and wellness.

CAC Envisions CHIP Outcome:	**Measurable Objective**	**Evaluation Strategies**	**FamilyCare's Responsibilities**	**Council Responsibilities**
1. Improved cultural competency of FamilyCare Health Systems	From baseline to post-intervention systematic evaluation of FamilyCare Health Systems, will facilitate at least one listening session in each county served by FamilyCare. And implement at least two projects—informed by the listening sessions—that will improve FamilyCare's ability to effectively serve transition age youth. Note: Evaluation will be conducted by external experts.	1. Partner with Office of Equity and Inclusion (OEI) to assess FamilyCare's cultural competency as a system both internally and externally. 2. Pre- and post-assessment following implementation of institutional changes to address lack of cultural competency.	-Reach out to OEI and partner to assess cultural competency of FamilyCare Health Systems. -Implement improvement strategies in accordance with OEI recommendations.	- Review feedback from OEI. - Assist in defining the next actionable steps.

Health Literacy and Health Engagement Assessment

There are not yet well-established measurement tools for assessment in the fields of health literacy and health engagement. Although the FamilyCare Community Advisory Council conducted a rigorous literature review for measurement tools that could be implemented to assess its CHIP, the search uncovered limited resources. So, the council reached out to local experts in the field, and conducted in-depth interviews regarding evidence-based models for assessing health literacy and health engagement among transition age youth.

Ultimately, it was determined that the one evidence-based assessment model for measuring health literacy is the Rapid Estimate of Adult Literacy in Medicine (REALM). A tool to measure engagement was not identified. The council recommends that FamilyCare work with local experts in these fields to develop a tool for measuring health literacy and engagement among transition age youth. The council also requests that they be involved in the development of the assessment tool, and would like to review the draft questionnaires that would be administered to assess the CHIP's impact.

Further, as advised in *Health Priority #1: Community Assessment of Engagement of transition age youth in their Health and Healthcare,* the Community Advisory Council recommends specific strategies for partnering with the community to assess engagement among the target population. These strategies are as follows:

a. Identify community organizations that work with transition age youth, and distribute listening grants to support their partnership in assessing the engagement of transition age youth in their health and healthcare.

b. Work with community partners to assess this issue using several different capacities, which could include surveys, focus groups, and interviews.

As previously described, the council advises FamilyCare that the development of the assessment tools used to measure its CHIP be guided by the voice of 15-25 year-old FamilyCare members. Although the council is not stipulating the use of a particular assessment tool or model at this time, it is committed to the use of a Community-Based Participatory Research approach, in which measurement of this project will be conducted through researchers working "side by side" with community members, rather than "acting upon" them. This will require that community members participate in defining the questions and methods used to assess the project, implementing the research, and in disseminating the findings. (CCPH CBPR Curriculum, 2006)

Community Based Participatory Research- "A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has t e aim of combining knowledge with action and achieving social change". (W.K. Kellogg Community Health Scholars Program)

Source:
http://static.squarespace.com/static/52b20be1e4b09f7904dfa46f/t/52d88cabe4b04290350979ba/1389923499506/Intro_to_CBPR.pdf

Appendix A

Glossary of Definitions and Terms

Health literacy, engagement in health and health care and cultural competency are highly valued but often hard to define. Consequently, individuals' definition might greatly vary making its measurement a difficult task without establishing definitions and baselines.

Further, health literacy and engagement in health and health care can easily be mistaken, and arguably so, as the same concepts. The Community Health Improvement Plan defines these two concepts differently but acknowledges that to the two purposefully complement each other.

In order to realize the envision outcomes of the Community Health Improvement Plan and to measure FamilyCare's success in improvements the following definitions and baselines need to be created. Below are national definitions; however, it is expected that these definitions might evolve depending upon the views of Council and FamilyCare members.

Health Literacy: Health literacy is defined 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. (http://HRSA.gov)

Patient Engagement in Health and Health Care: The Center for Advancing Health defines engagement as "actions individuals must take to obtain the greatest benefit from the health services available to them." This definition focuses on behaviors of individuals relative to their health care that are critical and proximal to health outcomes, rather than the actions of professionals or policies of institutions. (http://www.cfah.org/engagement/)

The CAC work group has suggested the following definition, "Identifying and understanding health conditions, navigating the health care system; and self-advocacy and management in health care which includes mental health and dental health.

Target Populations: The Community Health Improvement Plan is aimed to increase the literacy and engagement of FamilyCare members aged 15-25. However, there will be a particular focus on a sub-populations that consists of youth of color, homeless youth, high-risk/ high-need youth (i.e. those with mental health and/or substance use issues), "High-utilizer" youth with histories of frequent high-acuity and high-cost care (i.e. youth transitioning from foster care).

Improvement Targets: OHA set improvement targets using a method developed by the Minnesota Department of Health's Quality Incentive Payment System. This method requires participants to have had at least a 10 percent reduction in the gap between its baseline and the benchmark.

For example: a CCO's baseline for the timeliness of prenatal care measure may be 50 percent and Oregon has set the benchmark at 69.4 percent. The difference between the CCO's baseline and the benchmark is 19.4 percent. The CCO must reduce the gap by 10 percent to meet the improvement target: therefore, the CCO must improve their rate on the timeliness of prenatal care measure by 1.9 percent, bringing their total rate to 51.9 percent to meet the improvement target.

Cultural Competency – "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. '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 consumers and their communities". (Minority health hhs)

Cultural competency is important because it is" one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes".

Culture and language may influence:

- health, healing, and wellness belief systems;
- how illness, disease, and their causes are perceived; both by the patient/consumer and
- the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers;
- as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures. (Minority health hhs) – See more at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11#sthash.nLBy5APC.dpuf

Microaggressions – Common verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicates hostile or negative slights to marginalized groups. Perpetrators of microaggressions are often unaware that they engage in such interactions when they interact with minorities. (Fordham University) http://www.fordham.edu/academics/office_of_research/research_centers__in/center_for_teaching_/the_art_of_teaching/microaggressions_89343.asp

Social Determinants of Health – The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources as global, national and local levels. (World Health Organization)

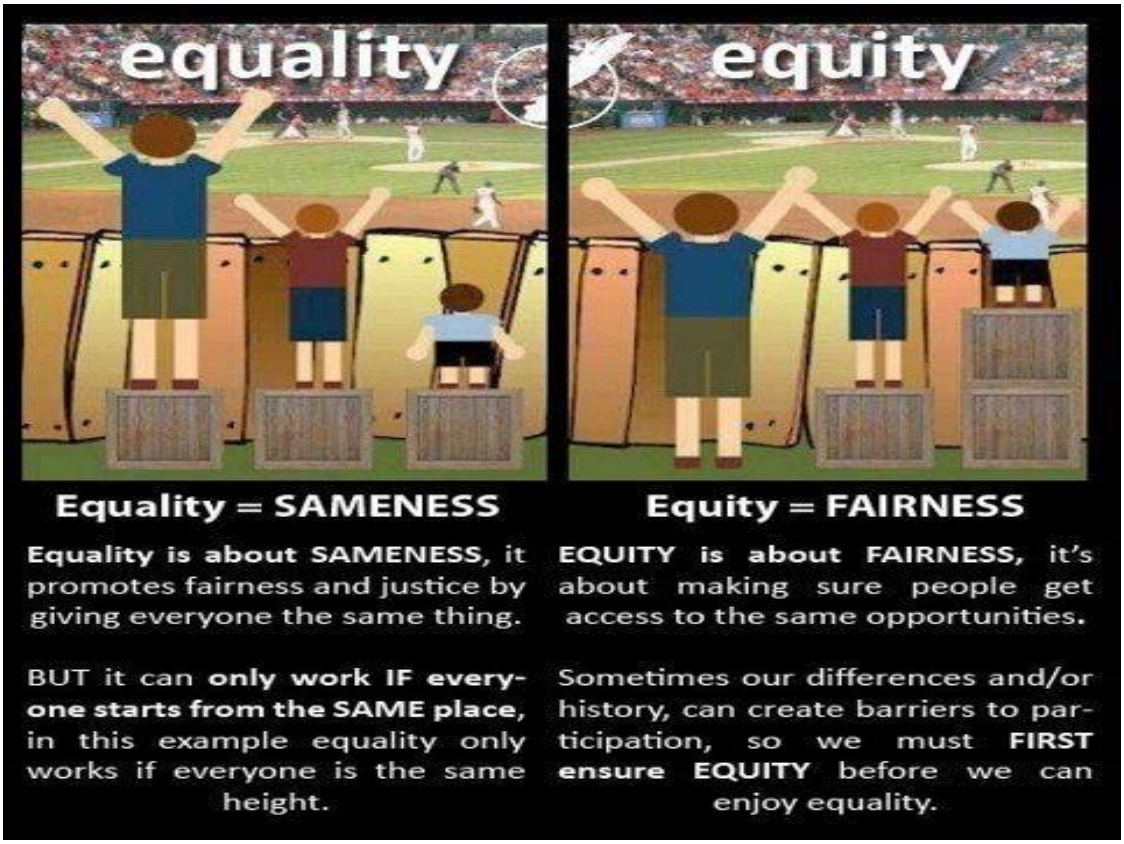
Unintentional Bias– Unconscious racism that is especially invisible to those who perpetrate it. Ex. A white woman eyes an African-American male a half a block away she moves her purse to the opposite side of which the man is walking.

Diversity –the inclusion of different types of people (as people of different races or cultures) in a group or organization (Merriam Dictionary).

An organization can become diverse but without the proactive action of ***inclusion*** the individual(s) may not feel welcome and a part of the organization. Note: diversity and inclusion is NOT tolerance of differences.

Tolerate – 1. allow the existence, occurrence, or practice of (something that one does not necessarily like or agree with) without interference. 2. accept or endure (someone or something unpleasant or disliked) with forbearance. *As you can see by the definition using this word this is offensive to many cultures.*

Equity vs. Equality -



Structural Racism – The interplay of policies, practices and programs of differing institutions which leads to adverse outcomes and conditions for communities of color compared to white communities that occurs within the context of racial historical and cultural conditions.
(Racial & Social Justice Initiative)

Institutional Racism – Policies, practice, and procedures that work to the benefit of white people and the detriment of people of color, usually unintentionally or inadvertently.
(Racial & Social Justice Initiative)

Individual/Interpersonal Racism – Pre-judgment, bias, stereotypes or generalizations about an individual or group based on race. The impacts of racism on individuals – white people and people of color (internalized privilege and oppression). Individual racism can result in illegal discrimination.
(Racial & Social Justice Initiative)

Paternalism - When a government or authority acts like it's your daddy, that's *paternalism*. This is usually an unwelcome kindness, as it comes with complete control and a lot of condescending statements like "it's for your own good."
The root word "paternal," meaning "like a father," is the clue to the word *paternalism*. The *ism* suffix turns the word into a noun. If you conquer a country and then look down on people for not speaking your language, then decide to stick around and help them out by making them do all the work while you make a lot of money, that would be one version of *paternalism*. (Vocabulary.com)

Appendix B

Organizational Assessment of Cultural Competence

The work of Organizational Assessment of Cultural Competence will be ever evolving, improving upon itself year by year, and becoming the cultural norm of the organization to influence its partners, vendors, and providers. FamilyCare members will know they are valued via the culturally-competent and equitable care they receive as members of this insurer.

The Council suggests reviewing the two tools below for organizational assessment of cultural competence.

http://erc.msh.org/provider/andrulis.pdf

http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/diabetes_events_meetings/oip_equity_and_empowerment_l.pdf

The Council poses the question to FamilyCare, "How does FamilyCare begin to disrupt and dismantle inequities both perceived and real within the organization, amongst its providers and access to quality equitable care of its members?"

The Council has recommended FamilyCare review The Urban Leagues Diversity and Inclusion Strategy Guide, which includes the nine steps below.

1. Cultural competence assessment of the organization - internally and with community stakeholders and insurance members.

2. Identify and address barriers within the organizational system.

3. Create a workforce diversity and inclusion framework with purpose, vision, and value statements.

4. Organizational development strategies ensuring leadership is committed to implement and sustain diversity and inclusion strategies. Establish a management or staff team to head this up.

5. Establish a minority vendor program.

6. Implement a system to track staff career goals within organization.

7. Build a diverse workforce that flows through the entire organization from staff, supervisory, managerial, and executive. Review and modify the recruitment process.

8. Build a diverse board that reflects the communities FamilyCare serves. This is not recruiting a (1) board position to represent a race, etc. This will create tokenism, which is akin to tolerance, and is not

diversity and inclusion. One person cannot represent a whole race or group of people – this would be another example of subtle microaggression or biases.

9. Encourage and influence providers to go beyond "checking the box" of meeting federal guidelines of healthcare civil rights.

Recommended Consultants (CHIP & Family Care) from Ty Schwoeffermann at the Urban League of Portland:

- **Dr. Fabiana Wallis**, http://www.fwallisconsulting.com/ focus on Cultural competency and trauma informed care

- **Lillian Tsai,** http://www.tsaicomms.com/bio.html focus on diversity and inclusion, cross-cultural competency, team building, presentation skills, and intercultural communications

Appendix C

Cultural Competence in Healthcare Settings for Adolescents

Below are some materials that can be used in a literature review for cultural competence in healthcare settings for adolescents.

Source: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/cultural-competence.html

- National Standards on Culturally and Linguistically Appropriate Services (HHS, Office on Minority Health)

- Cultural Stereotypes and Reproductive Health (HHS, Office of Adolescent Health); May, 2013

- Promoting Health Equity in Your Community: Utilizing the Working with Diverse Communities (WDC) Strategies Guided by Best Practice (HHS, Office of Adolescent Health); May, 2013

- Cultural Proficiency in Program Implementation (HHS, Office of Adolescent Health); March, 2012

- Culture Matters: Reaching New Heights in Cultural Proficiency (HHS, Office of Adolescent Health); November, 2011

- Cultural Awareness in Action: Examining Real Life Scenarios (HHS, Office of Adolescent Health); November, 2011

- Doing Right By Your Youth: Using Data to Make Evidence-Based Programs Culturally Responsive (HHS, Office of Adolescent Health); November, 2011

- Implementing Teen Pregnancy Prevention Programs It's What You Say and How You Say It: Cultural Awareness (HHS, Office of Adolescent Health); November, 2011

- Planning, Implementing and Evaluating Culturally Competent Prevention Programs: 25 Years of Lessons Learned (HHS, Office of Adolescent Health); November, 2011

- Community-Based Participatory Evaluation (HHS, Centers for Disease Control and Prevention); September, 2011

- A Physician's Practical Guide to Culturally Competent Care (HHS, Office of Minority Health)

- Culturally Competent Nursing Care: A Cornerstone of Caring (HHS, Office of Minority Health)

- Effective Communication Tools for Healthcare Professionals (HHS, Health Resources Services Administration)

- Health Literacy for Public Health Professionals (HHS, Centers for Disease Control and Prevention)

- Culturally and Linguistically Appropriate Services in Health Care (HHS, Office of Adolescent Health); November, 2011

- A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations (HHS, Office of Minority Health); September, 2005

- Resources to Implement Cross-Cultural Clinical Practice Guidelines For Medicaid Practitioners (HHS, Office of Minority Health); March, 2004

- Quality Health Services for Hispanics: The Cultural Competency Component (HRSA, Office of Minority Health); 2001