

# Transformation Plan Element #7

## Provider Network and Staff Ability to Meet Culturally Diverse Community Needs

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### **Transformation Plan Guidance and Technical Assistance**

Oregon Health Authority's technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

### **Overview**

Forty percent of Medicaid enrollees statewide are people of color, who along with other culturally and socially diverse groups, continue to experience the most disparities in access, quality and outcomes of care. If we want to achieve the triple aim of improving health, improving care and lowering costs, we must develop a health care system that is responsive and respectful of cultural and social differences. Evidence shows that culturally competent and culturally specific care leads to improved patient-provider interaction, a decrease in high cost inpatient and urgent care visits and overall, improved system savings. In accordance with the objectives and requirements established in HB 3650 (2011) and SB 1580 (2012) Health System Transformation, CCOs will be responsible for integrated and coordinated health care with a focus on improving including culturally appropriate prevention, care, and elimination of health disparities.

### **Background**

Providing health care that addresses members' cultural, health literacy and linguistic needs requires an approach that permeates all aspects of service delivery. This includes the facility and all member interactions whether they are on-line, by phone, or in person – in any phase of the clinical encounter. Culture has been described as everything that is not nature.

#### *RFA Language*

#### **A.3.1. Patient-Centered Primary Care Homes**

**A.3.1.a.** Describe Applicant's plan to support the provider network through the provision of:

- Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.

#### **A.3.3. Access**

Applicant's network of providers will be adequate to serve Members' health care and service needs, meet access to care standards, and allow for appropriate choice for Members, and include non-traditional health care workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

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**A.3.3.a.** Describe the actions taken to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible, are available in non-traditional settings and ensure culturally-appropriate services, including outreach, engagement, and re-engagement of diverse communities and underserved populations (e.g., members with severe and persistent mental illness) and delivery of a service array and mix comparable to the majority population.

**A.3.5.h.** Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

**Comprehensive transitional care:** The Applicant must ensure that Members receive comprehensive transitional care so that Members' experience of care and outcomes are improved. Care coordination and transitional care should be culturally and linguistically appropriate to the Member's need.

**A.3.6.c.** Describe how the Applicant has integrated care and service delivery to address mental health and chemical dependency issues by proactively screening for and identifying Members with them, arranging and facilitating the provision of care, development of crisis intervention plans as appropriate, and coordinating care with related Health Services including DHS Medicaid-funded LTC services and other health services not funded by the Applicant. This includes Members from all cultural, linguistic and social backgrounds at different ages and developmental stages.

**A.3.6.d.** Describe how the Applicant has organized a system of services and supports for mental health and chemical dependency, including:

- Recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models

**A.4.1.** CCOs and their providers are encouraged to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of Members. Describe how the Applicant and its providers will achieve this objective.

#### **Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)**

(a) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

#### **Standard #6 – Integrated Service Array (ISA) for children and adolescents**

(c) Describe how the Applicant's service delivery approach is family-driven, strength-based, culturally sensitive, and enhances community-based service delivery.

### **6.2. Technical Application Evaluation**

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Evaluation of Applicant's Technical Application will be based on criteria included in this RFA and OAR 410-141-3015, including but not limited to the Applicant's demonstrated experience and capacity for:

**6.2.3.** Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the Members and in the CCO's community.

**Attestation B-10.** Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through:

- Addressing diverse patient populations in a culturally competent manner.

**Applicants must describe their demonstrated experience and capacity for:**

- (3) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

#### **Accountability Standards**

**C.1.1.e.** Describe the mechanisms that the Applicant has for sharing performance information in a culturally and linguistically appropriate manner with Members.

#### **Quality Improvement:**

- C.2.1.g.** Describe how the Applicant addresses QI in relation to:
- Customer satisfaction: clinical, facility, cultural appropriateness

#### **Definitions**

**Cross-cultural communication-** The term "cross-cultural" implies interaction with persons of different cultural, ethnic, racial, gender, sexual orientation, religious, age and class backgrounds. "Cross-cultural communication" is a process of exchanging, negotiating, and mediating one's cultural differences through language, non-verbal gestures, and space relationships. It is also the process by which people express their openness to an intercultural experience. (Clarke and Sanchez, 2001)

**Health care interpreter** means a person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency.

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**Non-Traditional Health Care Workers (NTHWs)** are trusted community-based providers who provide a bridge between health care systems and community members. They promote health by serving as a liaison between communities, individuals and coordinated care organizations; providing health and mental health guidance and social assistance to community residents, enhancing community residents' ability to effectively communicate with health care providers by providing culturally and linguistically appropriate health education; advocate for individual and community health conduct home visitations to monitor health needs and reinforce treatment regimens; identify and assist in resolving issues that create barriers to care for specific individuals; provide referral and follow-up services or otherwise coordinate health and social service options; and proactively identify and enroll eligible individuals in federal, state, local, private or nonprofit health and human services programs.

While many titles have been applied to NTHWs, in Oregon, Community Health Workers, Peer Wellness Specialists, Personal Health Navigators and Doulas were named in the legislation to firmly establish these workers as providers in Oregon:

- Community Health Workers: promote health or nutrition within their community by serving as a liaison between communities, individuals and coordinated care organizations
- Peer Support Specialists: provide peer services in the field of behavioral health and addictions recovery to individuals or families with similar life experiences
- Peer Wellness Specialists: provide peer services in the field of behavioral health and addictions recovery with an expanded role encompassing physical health promotion, and disease prevention and intervention activities
- Personal Health Navigators: provide information, assistance, tools and support to enable patients to make the best health care decisions in the context of their particular circumstances
- Doulas: provide personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience

**Cultural Competence** (Please note: This definition was recently adopted and recommended by the Oregon Health Authority's Cultural Competence Continuing Education Committee): A life-long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider<sup>1</sup>-patient interactions and preserves the dignity of individuals, families and communities.

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<sup>1</sup> For simplification, the term "provider" is used throughout this document and it intends to represent the broadest spectrum of roles in health care, including but not limited to physician, social worker, medical technician, community health worker or "promotor/a," etc.

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This process is applicable to all patients<sup>2</sup>; assumptions will not be made on the basis of a person's expressed or perceived race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, and gender transition, level of formal education, physical or mental disability, medical condition or any other consideration under federal, state and local law. The term "cultural" is used here in its broadest sense as "the totality of a person's or a group's accumulated experience", and the term "competency" is defined as the "ability to do something well." Based on this document's definition of cultural competency, it would mean to adequately engage in the lifelong process of self-examination, inclusivity, awareness and respect in health care practice in accordance to the principles and standards below.

### References/Resources

#### *Resources on NTHWs:*

- "The Role of Non-Traditional Health Workers in Oregon's Health Care System" <http://www.oregon.gov/oha/oei/docs/nthw-report-120106.pdf>
- "Utilizing Doulas to Improve Birth Outcomes for Underserved Women in Oregon" - <http://www.oregon.gov/oha/legactivity/2012/hb3311report-doulas.pdf>
- "Paving a Path to Advance the CHW Workforce in New York State: A New Summary Report and Recommendations" <http://nyshealthfoundation.org/uploads/resources/paving-path-advance-community-health-worker-october-2011.pdf>
- "CHWs Then and Now: An Overview of National Studies Aimed at Defining the Field" [http://159.36.1.66/phs/healthdisparities/pdf/wklyUpdate/110720/Attachment3\\_CHWsThenAndNowJACM.pdf](http://159.36.1.66/phs/healthdisparities/pdf/wklyUpdate/110720/Attachment3_CHWsThenAndNowJACM.pdf)
- "CHWs: A Front Line for Primary Care?" [http://www.nhpf.org/library/issue-briefs/IB846\\_CHW\\_09-17-12.pdf](http://www.nhpf.org/library/issue-briefs/IB846_CHW_09-17-12.pdf)
- "CHW Insights on Their Training and Certification" - <http://www.oregon.gov/oha/oei/docs/nthw-report-120106.pdf>
- CDC course: "Promoting Policy and Systems Change to Expand Employment of CHWs" [http://www.cdc.gov/dhdsp/pubs/chw\\_elearning.htm](http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm)
- Toolkit for Developing a CHW program: <http://www.raconline.org/communityhealth/chw>
- Substance Abuse and Mental Health Services Administration. Consumer-Operated Services: The Evidence. HHS Pub. No. SMA-11-4633, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.
- The SAMHA-HRSA Center for Integrated Health Solutions new peer support curriculum, Whole Health Action Management (WHAM), guidance to promote whole health self-management and strengthen the peer workforce's role in integrated healthcare delivery. [www.integration.samhsa.gov/health-wellness/wham](http://www.integration.samhsa.gov/health-wellness/wham)

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<sup>2</sup> For simplification, the term "patient" is used throughout this document and it intends to represent the broadest spectrum of roles in health care, including but not limited to patient representative, client, resident, consumer, patient's family and community, etc.

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- The National Empowerment Center, <http://www.power2u.org/>
- Engaging Women in Trauma-Informed Peer Support: A Guidebook, <http://www.nasmhpd.org/EngagingWomen.cfm>
- Pillars of Peer Support, <http://www.pillarsofpeersupport.org/>
- Chinman MJ, Rosenheck R, Lam JA, Davidson L “Comparing Consumer and Nonconsumer Provided Case Management Services for Homeless Persons with Serious Mental Illness” *Journal of Nervous and Mental Disease* 2000; 188(7): 446-453
- Chinman MJ, Young AS, Hassell J, Davidson L “Toward the Implementation of Mental Health Consumer Provider Services” *Journal of Behavioral Health Services & Research* 2006; 33(2): 176-195

#### *Cultural Competency*

- [Cultural Competence and Limited English Proficiency Frequently Asked Questions](#)
- [Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices](#)
- [Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals](#)
- [Developing Cultural Competence in a Multicultural World](#)
- [Expanding Perspectives: Improving Cultural Competency in Children's Health Care](#)
- [Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services](#)
- [Cultural Competency: Selected Resources for Instruction](#)
- [Be Safe: A Cultural Competency Model for African Americans](#)
- [Quality Health Services for Hispanics: The Cultural Competency Component](#)
- [Cultural Competence Education for Students in Medicine and Public Health](#)
- Cultural Competency Implementation Survey Guidance Document Version 1.7 (see attached PDF)
- Cultural Competency Implementation Survey Version 1.7 (see attached PDF)
- [Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services \(CLAS\)](#)
- [Policy for DHS & OHA Divisions for Collecting Race, Ethnicity, and Language Data](#)

#### **Components**

- 1. Continuing education of CCO staff and contracted providers/staff**
- 2. Human resources plan for recruitment and retention of diverse staff**
- 3. Plan to ensure person-centered primary or emergency care for members who travel/migrate**

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- 1. Continuing education of CCO staff and contracted providers/staff**

#### **OHA Expectations**

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- One approach for addressing continuing education of CCO staff and contracted providers could include a policy requiring continuing education of CCO staff and contracted providers/staff, including the # of training hours required annually per clinical and non-clinical staff person focused on topics that advance the CCOs understanding of health equity, including but not limited to developing cultural competence, cross-cultural communication, collection and analysis of race, ethnicity and language data, health norms and beliefs of diverse communities in CCO service area, working effectively with health care interpreters, inclusion of nontraditional health care workers on clinical teams, etc.
  - A designation of a CCO point person could fulfill a need to ensure accountability for coordinating, tracking staff participation in, and evaluating the quality and impact of health equity training

#### **Measurement Methodology**

##### **Examples of information to track might include:**

- # of training hours and # of topics available
- % of staff receiving training and frequency
- % of patients with improved satisfaction after 1 year of training
- % of improved patient outcomes after 1 year of training
- % of trainings conducted by community-based organizations, community leaders, community elders, and/or other key informants, representing the population being served.
- # of health equity, diversity and inclusion policies/programs implemented in the organization after 1 year of training
- # of performance improvement assessments conducted

#### **Baseline Measure**

##### **Current:**

- # of training hours and # of topics available
- % of staff receiving training and frequency (by job class type, i.e. MD, RN, MSW, etc.)
- % of trainings conducted by community-based organizations, community leaders, community elders, and/or other key informants, representing diverse populations being served.
- # of health equity, diversity and inclusion policies/programs informed by patient outcome data and patient satisfaction data by race, ethnicity and language

**Transformative Activity** The following activities reflect transformative approaches that might be used to improve cultural competence:

- The CCO might identify standards for provider CE specific to attitudes (values/beliefs competencies), knowledge (cognitive competencies), educational approaches for knowledge acquisition, and skills (practice competencies). Trainings could be tied to the specific populations within the CCO's client base. CCO trainings should be done in partnership with community based organizations, community leaders, community elders, and/or other key informants, representing the communities served by the CCO.
- Annual analysis and evaluation of the quality of continuing education options for staff could be conducted to ensure alignment with improved patient outcomes. Patient

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satisfaction surveys should be collected by race, ethnicity, and language. Together with patient outcomes data, this can inform the effectiveness of cultural competency trainings on an individual and organizational level. For providers who are not experiencing improved outcomes and satisfaction from their clients, either on a broad scale, or among a specific population (i.e. racial, ethnic, linguistic, etc.), the provider could be given a specific technical assistance plan for ensuring improvement. CCOs should have an action plan to address lack of progress. If there is no improvement in eliminating disparities and advancing health equity at an organizational level, the CCO will need to identify and implement specific policies and programs to improve health equity (i.e. staff diversity pipeline program, partner to create a culturally-specific program with a community based organization/partner, strengthen the role of Non-Traditional Health Workers (NTHWs), ensure the presence of a certified/qualified health care interpreter, etc.)

#### **Improvement Metric**

CCO should see improved patient satisfaction and outcomes for individual providers and at an organizational level.

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## **2. Human resources plan for recruitment and retention of diverse staff**

### **OHA Expectations**

OHA would expect CCOs to describe how they will collect data on their provider networks to identify whether they meet established contract requirements. An example of how CCOs might meet this requirement is to provide a detailed human resources plan for recruitment and retention of diverse staff at all levels of the CCO and partner organizations

### **Measurement Methodology**

In order to evaluate progress, CCOs will need to produce data on race/ethnicity of staff at all levels. CCOs may provide data on continuing education delivered and completed by staff, disaggregated by position. CCOs should track client requests for non-traditional health workers and health care interpreters.

### **Baseline**

# of completed documents assessing client needs  
# of referrals to support systems based on client assessments  
Ratio of clients to assigned NTHWs

### **Transformative Activity**

OHA would expect CCOs to describe how they will meet established contract requirements for a culturally diverse workforce that is responsive to the needs of its members. Examples of how CCOs might meet this requirement include, but are not limited to:

- Including a plan for recruitment, retention, and continuing education of non-traditional workforce (community health workers, peer wellness specialists, doulas, and personal health navigators) from communities impacted by health inequities

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- Including a plan for recruitment, retention, qualification/certification, and continuing education for health care interpreters, translators, and bilingual/bicultural staff.
- Including a plan for networking with area mental health providers, including culturally diverse, culturally specific, and culturally competent mental health service providers, and most importantly those providers not contracted currently
- Including a plan for completing geographic analysis of how members are seeking services and provider engagement out of the CCO's immediate area e.g. southeastern Washington, western Idaho, Bend, northern California

#### **Improvement Metric**

In order to assess progress, CCOs might provide the following metrics:

# of NTHWs hired by CCO or subcontracted organizations

# of clients enrolled in plan by NTHWs

# of clients connected to PCPCH by NTHWs

# patient activation/engagement activities conducted by NTHWs

# of clients adhering to treatment plans

Increased patient satisfaction measure

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### **3. Plan to ensure person-centered primary or emergency care for members who travel/migrate**

#### **OHA Expectations**

Detailed plan to ensure person-centered primary or emergency care for members who travel out of state or migrate within the state as part of their work, ensuring the CCO has a process for processing and paying, as appropriate claims from providers that are not contracted (pay on a FFS basis) including CCO's process for responding to requests by providers, including out of area mental health service providers, to contract or enroll with them as a provider.

#### **Measurement Methodology**

The CCO should explain how they will define, operationalize and report their baseline and improvement metrics (benchmarks and milestones) to ensure that the transformation activities are effective.

#### **Baseline Measure**

The CCO should carry down information from the measurement methodology section, and take the additional step of explaining how/when they will report their baseline measure.

#### **Transformative Activities**

The CCO should explain, in detail, the activities they will engage in to improve the baseline measure.

#### **Improvement Metrics**

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The CCO should explain how they will know that the baseline measure is improving – longitudinal measures that show the change over time. This discussion includes milestones (progress reports) and benchmarks (the ultimate goal value the CCO plans to achieve).