Cultural & Linguistic Program Description

MPND9002

August 2025

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Program Purpose

To demonstrate the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members.

Introduction

This Cultural and Linguistic (C&L) Program description defines how Partnership uses its resources to achieve the goals and commitments to delivering culturally and linguistically competent health care services to all Partnership members, including members with Limited English Proficiency (LEP) or sensory impairment. This program description also describes how Partnership offers care and services in a way that is effective, health equity-driven, understandable, and respectful and responds to diverse cultural health beliefs and practices and linguistic/communication needs.[1]

Partnership works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 25-005.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members regardless of sex, race, color, national origin (including LEP and primary language), religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964[3] or Section 1557 of the Affordable Care Act of 2010,[4] the Americans with Disabilities Act of 1990,[5] or as specified in APL 25-005. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing

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[1] National Culturally and Linguistically Appropriate Services Standards

[2] All Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services and Threshold and Concentration Languages

[3] Penal Code 422.56

[4] ACA 1557

[5] Americans with Disabilities Act of 1990

materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[6] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

Partnership's C&L Program objectives are accomplished through interdepartmental collaboration and include:

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.[7,8,9,10,11]
- Continually assessing, monitoring, improving, and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services.
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members.

Measurable objectives can be found later in this document and in the joint Quality Improvement Health Equity Transformation Program (QIHETP) and Cultural and Linguistics (C&L) annual work plan.

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[6] APL 18-016 Readability and Suitability of Written Health Education Materials
[7] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[8] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[9] 42 CFR 438.206(c)(2); 438.10; 438.404
[10] W&I Code 14029.91
[11] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

Partnership's C&L programs and services outlined below encompass the services directly provided to members and potential members, as well as the support provided to Partnership staff, providers', and delegates' capacity in understanding the C&L needs of our member population. Partnership will take action to improve its culturally and linguistically appropriate services when deficiencies are noted.

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MPND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 25-005 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals, as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 25-005 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[12] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

In addition to DHCS's language data collection and analysis process for Partnerships' member population, Partnership conducts its own data analysis at the community and/or census level to determine and report out on the languages spoken by five (5) percent or 1,000 individuals, whichever is less, and by 1% of the population or 200 individuals, whichever is less. For more details on this process, please refer to the Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, Spanish, and Punjabi, as determined by DHCS. For information on threshold languages as determined by Partnership using NCQA methodology, please refer to the Community Language Assessment report.

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[12] APL 25-005 and Threshold and Concentration Languages

These practices help to address potential changes to threshold and concentration standard languages, as well as any changes in state and/or federal law. This information is used as part of the assessment of language services for members to improve the Cultural and Linguistics program offerings, and when possible, to guide network development. Partnership will retain a list of the DHCS- provided, and Partnership-determined threshold and concentration standard languages. Adjustments to the list will be based on findings from the Community Language Assessment report and DHCS's triennial timeline.

Partnership distributes a written notice in English and other languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.[13] Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery are in a culturally sensitive and linguistically appropriate manner. Members are informed that their language preferences may be shared when language information is directly collected.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which helps drive the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[14] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

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[13] APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and APL 22-017 MMR Standards

[14] DHCS Basic Population Health Management Policy Guide

(CHIP) process. Based on this collaborative work, and input from various stakeholders, including Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee), Partnership annually reviews, and updates as needed, its strategies and work streams related to the DHCS Bold Goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.[15] Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership members are entitled to timely language assistance services at no cost to them, such as oral interpretation services (including the provision of auxiliary aids and services) and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, and Transportation). Members can also call a toll-free number with TTY/TDD.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services, Nondiscrimination Notices, and Member Information

In alignment with APL 25-005[16] and other DHCS requirements, Partnership provides nondiscrimination notices and Language Assistance Notice of Availability. Nondiscrimination notices are provided and inform Members, Potential Members, and the public about nondiscrimination, protected characteristics, accessibility requirements, and information on how to file a grievance. A Language Assistance Notice of Availability is also provided in a visible font size in English and the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members, potential members, and the public of all available language assistance services at no cost to them as well as how to access them (including written translation and interpretation). To see these two notices in detail please refer to attachment A & B in MCNP9004 Regulatory Required Notices.

The Language Assistance Notice of Availability and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold

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[15] DHCS Comprehensive Quality Strategy

[16] APL 25-005

Languages/Concentration Standard Languages and in an ADA-compliant, accessible format. Alternative formats available to members includes Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format, and Auxiliary Aids at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. Although quick response codes, otherwise known as QR code may be used alongside the nondiscrimination notice and notice of availability, they are not to be replaced by the use of QR codes.

Nondiscrimination notices and the Notice of Availability of Language Assistance Services are also sent with all member correspondences, which include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- Notices of Organization and Coverage Determinations
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public
- Other written communications and/or informational notices for members, Potential Members, and the public as applicable.

In alignment with APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats, the nondiscrimination notice and the Notice of Availability includes Partnership’s toll-free and/or Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services. The nondiscrimination notice also includes information on how to file a discrimination

grievance directly with Partnership, DHCS' OCR, and HHS' OCR. The regulatory notices are posted in the following places in a clear and prominent manner:[17]

a) In the Member Handbook/EOC and other electronic and written communications,
b) In all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking heath programs or activities would be able to read or hear the notice;
c) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
d) In all Member information and other informational notices, in accordance with federal and state law and this APL.

In alignment with DHCS requirements, all member facing material and correspondences (member informing and health education) are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format; member informing materials are approved by DHCS before distribution, while health education materials are approved by a Qualified Health educator as defined by APL 18-016.[18] Translation of member facing materials are provided to members at no cost to them.

Partnership also provides members with requested information in their preferred format in a timely fashion. Preferred formats include Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon member request. Partnership maintains a library of all member facing materials in all Partnership threshold languages, including the major correspondence, health education materials, and other benefit-relate member informing materials. Any mailed correspondence is sent according to the member's preferred threshold language or format. Other documents, such as letters or utilization review determinations are translated within 2 business days. Members may also request translation of other documents. Translated materials are completed within 2 business days of the request and members receive their fully translated materials in a timely manner.

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[17] APL 25-005

[18] APL 18-016 Readability and Suitability of Written Health Education Materials

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Partnership's Threshold or Concentration Standard Languages. Partnership translates all member facing materials into its designed threshold and concentration standard languages or other languages as requested. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, or other languages as necessary, at no cost to the member from a qualified translator. If a member has requested to receive translated written information in either traditional or simplified Chinese characters, Partnership must provide written information in the member's preferred characters. If member does not indicate a preference, Partnership will provide translations in Traditional Chinese characters. Only upon member request, Partnership is required to provide translated written information in Simplified Chinese characters.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS APL 25-005. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see MPND9002 attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 25-005.[19] Per this APL, a translator interpreting for Partnership member must:

- Adhere to generally accepted translator ethics principles, including client confidentiality,
- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original written statement.

[19] APL 25-005

Partnership has requirements for their translator certification process, as set forth by ULG Translations in MPND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Oral interpreter services are available for any language spoken by the member (see MPND9002 attachment A for criteria and authorization requirements for interpreting services). Interpreter services are available in all of Partnership's threshold languages, and over 140 additional languages are available upon member request through Partnership's contracted language service provider. The member's preferred language (if other than English) is also prominently noted in their medical record, as well as their request or refusal of language/interpretation services (including refusal of interpreter services from members with disabilities) in accordance with APL 25-005.[20] As described in the translation services section above, Partnership offers written translation services of member facing materials in its threshold and concentration languages and upon member request; however, sight translation (oral interpretation) of written information can also be provided upon member request.

Partnership will not require Members with LEP or members with a disability to provide their own interpreters or pay for the cost of their own interpreter or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language. Partnership has also contracted with AMN HealthCare as their language interpretation service provider. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate.

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[20] APL 25-005

Partnership uses the definition provided by APL 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:

- Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);
- Be able to interpret effectively, accurately, and impartially to and from such language and English, (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and
- Adhere to generally accepted interpreter ethics principles, including client confidentiality.

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance in alignment with the requirements stated in APL 25-005. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology without changes, omissions, or additions while preserving the tone, sentiment, and emotional level of the original statement; and
- Has demonstrated proficiency in communicating in and understanding English and a non-English language (including American Sign Language) or another communication modality such as cued-language transliterators or oral transliterators.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular

pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership does not allow for the use of unqualified interpreters, adult friends, family, or minor accompanying a member to provide interpreting services or facilitate communication except:

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the Member or the public and a qualified interpreter is not immediately available; or,
- If the LEP Member or member with a disability specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement is documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

Prior to using a family member, friend, or in an emergency only, a minor child, for interpretation services, the MCP will inform the Member they have the right to free interpreter services and ensure that the use of an interpreter will not compromise the effectiveness of services or violate the individual’s confidentiality. Partnership will ensure that the refusal of free interpreter services and the member’s request to use a family member, friend or minor child as an interpreter is documented in the medical record.

Auxiliary Aids and Services

In accordance with APL 25-005 and APL 22-022, Partnership provides the following auxiliary aids and services in an accessible format, in a timely manner, and at no cost to the member, including qualified interpreters and written materials in alternative formats, to members their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with (“companion”) by request or as needed, and in a way to preserve member privacy. This is done in a way to protect the Member’s privacy and to ensure that Members with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities. Auxiliary aids and services include

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Please see MPND9002 attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 25-005 and APL 22-002, Partnership provides member information to members and potential members in alternate formats to meet the cultural and linguistic needs of members, including Braille, large print text (20 point or larger), audio, and accessible electronic formats (such as data cd), at no cost to the member and with primary consideration of the individuals request for specific auxiliary aids or service. Partnership maintains record of member's linguistic capability upon member enrollment, and as reported thereafter, using data provided by DHCS or reported to Partnership by the member and/or their AR, or by Subcontractors. Partnership also collects and stores the alternative format selections of members. Partnership members, their ARs, or someone with whom it is appropriate for Partnership to communicate with ("companion"), are encouraged to call Partnership or report their format preference via the DHCS AFS application system; this information is then passed on to Partnership for incorporation into the member record and implemented as appropriate. This information is also shared with Partnership subcontractors and network providers as appropriate.

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an

electronic format that is not password protected. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.[21]

Trainings

In alignment with APL 24-016, Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. Contracted network providers, contractors, and subcontractors are eligible to submit their own diversity, equity, and inclusion training for review and approval by Partnership's Director of Health Equity in consideration of DHCS regulatory requirements. Separately, Partnership educates contracted network providers, contractors, subcontractors, and staff on Partnership-specific policies, practices, and guidelines for Partnership-specific cultural and language assistance services.

Partnership provides trainings for contracted practitioners of Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles. The training program for providers will be region specific and include consideration of health-related social needs and disparities that are specific to Partnership's servicing counties and demographics. Practitioners from different regions will receive different course recommendations that are unique to their region. Practitioners are required to acknowledge review of their region's respective disparity report during the completion of the training. For more information on the provider training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Partnership staff will receive the staff-specific DEI training on an annual basis. Partnership staff training records are managed by Human Resources while the Provider training records are managed by Provider Relations and Health Equity Department.

Also in alignment with APL 24-016, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as digital training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 three major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical

[21] APL 22-002 Alternative Format Selection for Members with Visual Impairments

disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 three themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

The Cultural and Linguistic unit audits DHCS-identified delegates' annual trainings to ensure that they are in compliance with required elements.

Partnership's State Hearing Representative is working towards becoming a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored.

Beyond offering training to promote Cultural and Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the annual Health Equity Accreditation workforce analyses:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

On an annual basis, Partnership writes an evaluation report detailing the Cultural and Linguistic (C&L) program structure and interventions performed in accordance with PHM and other Partnership efforts of the given year. This report is drafted using elements and findings from this program description and the annual C&L/QIHETP workplan. Key elements in this annual evaluation include program structure/processes, goals for completed activities, review of the Community Advisory Committee (CAC) feedback, overall program effectiveness, and opportunities for improvement.

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of Partnership's members. Using the results from an annual, self-reported survey of our

primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices.

Annually, Partnership performs an audit of its delegated cultural and linguistic services providers to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

In accordance with Partnership's Policy HR509 Bilingual Standards, Partnership assesses the linguistic capabilities of its bilingual staff from member-facing departments to ensure they meet the necessary linguistic requirements to serve as qualified interpreters. Partnership's Human Resources Department maintains a record of staff members deemed as qualified interpreters, and their evaluation results.

Member-facing Departments include:

- Care Coordination
- Grievance & Appeals
- Member Services
- Population Health Management
- Transportation
- Utilization Management

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees regulatory requirements related to Cultural & Linguistics programs and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership also created the Population Needs Assessment Committee to review findings and strategies, as needed, to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MPND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

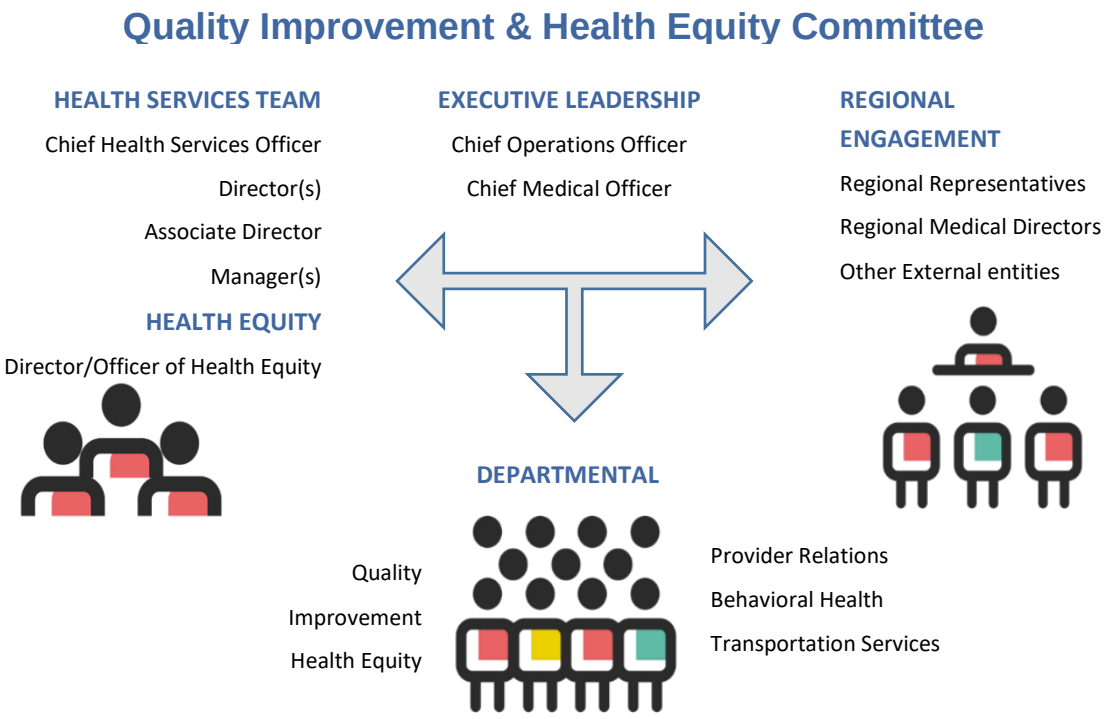
Partnership also houses the Quality Improvement Health Equity Transformation Program (QIHETP). The QIHETP is designed to develop, implement, monitor, and

maintain a health equity transformation system. The goal of this system is to address improvements in the quality of care delivered by all of its providers in any setting and take appropriate action to improve upon the health equity and health care delivered to members. Partnership's QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

For more information on QIHETP, refer to MCED6001 QIHETP Program description.

As part of the QIHETP, in accordance with MPND9001 and MCEP6002, the Quality Improvement Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership specific committee. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. Furthermore, the QIHEC meets bi-monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on the QIHEC, refer to MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).



Community Engagement

Partnership's Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment MPND9002-E CAC Guiding Principles and Policy MCCP2024 for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD) (including representatives who receive LTSS and/or individuals representing LTSS recipients), persons with chronic conditions, Limited English Proficient (LEP) Members, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

One role of the CAC and FAC is to advise Partnership on the development and implementation of its C&L services program. The CAC and FAC also work to identify and help prioritize opportunities for improvement. The CAC can also provide input and advice, including, but not limited to, the following:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;

- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services; Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and Health Equity and the Population Needs Assessment;
- Health related initiatives; Reforms to improve health outcomes, accessibility, and coordination of care for Members; and
- Inform the development of the MCP's Provider Manual.
- Resource allocation; and
- Other community-based initiatives

To learn more about the CAC, please refer to MPND9002 attachment E CAC Guiding Principles.

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of auxiliary aids and services in a culturally and linguistically appropriate way. A formal agreement is maintained and inclusive of all delegate functions. Partnership's Health Education unit conducts an audit no less than annually on these delegated bodies. This audit helps to ensure that delegates have appropriate policies and procedures in place to meet compliance with state and federal language and communication assistance requirements as well as civil rights laws requiring access to members with disabilities and other C&L service requirements. The annual audits also help to ensure Subcontractors and Downstream Subcontractors deliver culturally and linguistically competent care, including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. Any unmet requirements result in the delegate receiving preliminary CAPs. Any preliminary CAPs that were not closed within the timeframe given by the Audit team are deemed final CAPs. Any final CAPs will go to Delegation Oversight Review Sub-committee

(DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

Partnership acknowledges the type of relationship described above is known to the National Committee for Quality Assurance (NCQA) as a vendor relationship. Partnership has no known entities acting upon its behalf that would constitute a delegate as defined by the NCQA Health Equity Accreditation standards.

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the C&L/QIHETP Work Plan. This annual work plan describes the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC)
- The Internal Quality Improvement (IQI) Committee
- The Quality Utilization Advisory Committee (Q/UAC)
- The Physician's Advisory Committee (PAC) as final approval

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L/QIHETP Work Plan to all stakeholders, and constituents as appropriate.

2025 Goals

Partnership identified multiple goals for 2025. Several goals will carry over from 2024 to track trends from year to year; goals 1-2 and 6-8 are new goals. Goals carried over from 2024 were modified based on findings of the Cultural and Linguistic Program Evaluation. These goals are listed below. Additional goal details can found in the C&L/QIHETP Work Plan:

- Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.
    - This goal was chosen to strategize and streamline the required initiatives to advance Health Equity.
- Goal 2: By December 31, 2025 Distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.

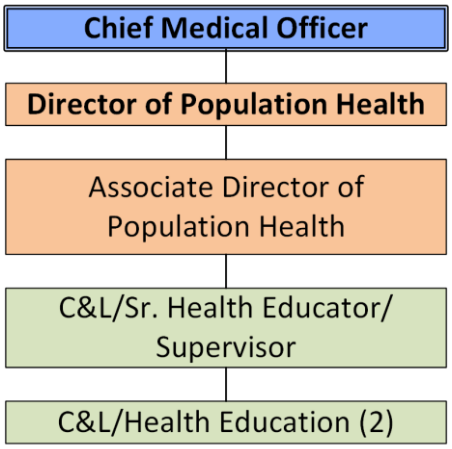
    - This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 3: By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.
    - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 4: By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.
    - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
    - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or at least 1.25% in at least one region.
    - Goals 7 and 8 were chosen due to the recognized disparities in each goal’s respective clinical measure and population of focus.

Partnership will continue to monitor these goals through the annual C&L/QIHETP Work Plan to ensure the goals are met. Progress toward these goals will be reviewed on a quarterly basis. Progress toward this goal will be also be reviewed no less than annually by the committees described above.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to Partnership members.

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MPND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts are also supported by other Partnership departments, and include making referrals to culturally and linguistically appropriate community service programs and aligning organizational and community efforts to meet these needs, in accordance with DHCS, NCQA, and CMS requirements. To accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services.



Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of

services. This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

The Director of Population Health Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members. Reports to the Chief Medical Officer. Works with the Senior Director of Quality and Performance Improvement and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. This professional must have training in Public Health and Population Health processes. This role also requires at least five (5) years of experience in a leadership/management role.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables. This professional must have a Bachelor's degree, an RN license is preferred, with a minimum of five (5) years health care operations experience and three (3) years in a management role.

Supervisor

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff.

Supports and assists Population Health Management leadership and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education

includes a Bachelor’s degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

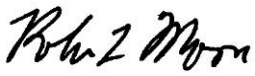
Senior Health Educator

A public health masters-prepared (or MCHES-certified) professional who ensures the delivery of approved health education and member informing resources for both members and primary care providers. Develops materials for Partnership members, and community members as appropriate to promote cultural competency, health equity, and member wellness. Monitors and oversees all regulatory requirements related to Health Education, Cultural & Linguistics programs. The Senior Health Educator may also perform supervisor responsibilities.

Health Educator(s)

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on specific member education projects, and monitors health education materials, and evaluates member grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a Bachelor's Degree in Health Education, Public Health, Community Health or related field; experience in Public Health Education. A minimum two (2) years of health education experience is preferred.

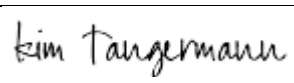
Cultural & Linguistic Program Description Approval

	06/18/2025

Robert Moore, MD, MPH, MBA — *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	08/13/25

Angela Brennan, DO — *Date Approved*
Physician Advisory Committee Chairperson

	08/27/2025

Kim Tangermann — *Date Approved*
Board of Commissioners Chairperson