# Cultural & Linguistic Program Description

MCND9002

**November 2024**

**Original Date:**

Previously Applied to MPLD7001 02/19/14 to 09/09/20

**Revision Dates:** MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23; 11/13/24

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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 also 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 21-004.[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, 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 or Section 1557 of the Affordable Care Act of 2010. 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.[3]

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 materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education

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[1] National Culturally and Linguistically Appropriate Services Standards

[2] APL 21-004 and Threshold and Concentration Languages

[3] Penal Code 422.56 [4] APL 18-016 Readability and Suitability of Written Health Education Materials

Materials,[4] 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.[5,6,7,8,9]
- 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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[4] APL 18-016 Readability and Suitability of Written Health Education Materials
[5] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[6] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[7] 42 CFR 438.206(c)(2); 438.10; 438.404
[8] W&I Code 14029.91
[9] 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 immediate 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 MCND9002 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 21-004 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 21-004 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.[10] 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 will conduct 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, and Spanish, as determined by DHCS. For information on threshold languages as determined by Partnership, please refer to the Community Language Assessment report.

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[10] APL 21-004 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 up to 18 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.[11]. 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 in a culturally sensitive and linguistically appropriate manner. Members are informed when language information is directly collected that their language preferences may be shared.

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 drives 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.[12] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

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[11] APL 22-017 and APL 22-017 MMR Standards

[12] DHCS Basic Population Health Management Policy Guide

(CHIP) process. Based on this collaborative work, and input from various stakeholders, Partnership annually reviews and updates its strategies and work streams related to the DHCS 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.[13] 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 interpretation 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.

### Language Assistance Taglines, Nondiscrimination Notices, and Member Information

In alignment with APL 21-004[14] and other DHCS requirements, Partnership publishes nondiscrimination notices and language assistance taglines. They are sent with all member correspondences as well. Language assistance taglines are published in a conspicuously visible font size in English and California's top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members of all available language assistance services and how to access them (including written translation and interpretation). These taglines and nondiscrimination notices are in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages and alternative formats (including 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. Vital member correspondences include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory

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[13] DHCS Comprehensive Quality Strategy

[14] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

- 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
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public

The nondiscrimination notice and the notice with taglines includes Partnership's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and are posted:[15]

a) In a conspicuous place in all physical locations where Partnership interacts with the public;
b) 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
c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

In alignment with DHCS requirements, all member facing material and correspondences 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, and are approved by DHCS before distribution. Health education materials are approved by a Qualified

[15] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

Health educator as defined by APL 18-016.[16] 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 includes 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-related, 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.

## 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 Threshold or Concentration Standard Languages. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, at no cost to the member.

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 21-004. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see attachment MCND9002 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 21-004.[12] Per this APL, a translator interpreting for Partnership member must:

- Adhere to generally accepted translator ethics principles, including client confidentiality,

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

- 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, terminology, and phraseology.

Partnership has requirements for their translator certification process, as set forth by ULG Services in MCND9002 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. Oral interpreter services are available for any language spoken by the member (see MCND9002 attachment A for criteria and authorization requirements for interpreting services). Key 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. Interpreter services are available in all of Partnership's threshold languages, and over 200 additional languages are available upon member request through Partnership's contracted language service provider. Member's preferred language (if other than English) is also prominently noted in their medical record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964[17]. 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 contracted with AMN HealthCare as their language interpretation service provider. Sight translation (oral interpretation) of written information can also be provided upon member request. 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

[17] Title VI of the Civil Rights Act of 1964

required to provide interpreter services for members, however, workflows vary per delegate.

Partnership uses the definition provided by APL 21-004 in vendor selection and to define a qualified interpreter as an interpreter who:[9]

- Has demonstrated proficiency in speaking and understanding both spoken English and the non-English language in need of interpretation,
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology; and,
- Adheres 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 per the requirements stated in APL 21-004. 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.

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 adult friends, family, or minor accompanying a member to interpret. The exceptions to this rule are as follows:

- In the middle of an emergency where a qualified interpreter is not available, or
- If the member explicitly requests the accompanying person to interpret, the accompanying person agrees to help, and it is appropriate for the situation.

## Auxiliary Aids and Services

In accordance with APL 21-004 and APL 22-022, Partnership provides the following auxiliary aids and services 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 at no cost to the member:

- 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; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones/telephone typewriters (TTYs) or Telecommunication Devices for the Deaf (TDD), 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 MCND 9002 attachment B to learn how Partnership provides auxiliary aids and services for persons with disabilities.

## Alternate Formats

In accordance with APL 21-004 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 font or larger), audio, and electronic formats, at no cost. 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 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.

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, which may make the information more vulnerable to loss or misuse. 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.[18]

## Trainings

In alignment with APL 23-025 Diversity, Equity, And Inclusion Training Program Requirements, Partnership educates and trains all contracted network providers on diversity, equity and inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings), as well as Partnership-specific culturally and linguistically appropriate policies and practices. Providers also separately receive a review of Partnership's policies and procedures for language assistance services and how to access them. Partnership provides trainings for contracted-Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles.[19]

Also in alignment with APL 23-025, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as 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 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 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 themes

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

[19] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements

described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

The training program will be region specific and include consideration of health-related social needs that are specific to Partnership's servicing counties. Practitioners from different regions will receive different course recommendations that are specific to their region. Practitioners will also acknowledge review of their region's respective disparity report during the completion of the training. For more information on this training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Partnership has two mandatory trainings required for Partnership staff. Permanent and temporary staff receive the cultural and linguistic program trainings upon hire. Upon hire and then annually, permanent, temporary, and contracted employees receive a diversity basics training with topics such as diversity, equity, and inclusion.

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 expected to become a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored. Partnership staff training records are maintained by Human Resources while the Provider training records are maintained by Provider Relations.

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 Health Equity Accreditation workforce analyses:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

# Assessment and Evaluation

## 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 contracted translation and linguistic services providers (including employees, contracted staff, and other individuals who provide linguistic service) 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 bilingual staff members 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:

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

# 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 all regulatory requirements related to Cultural & Linguistics services program and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership recently created the Population Needs Assessment Committee to review findings and strategies to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 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.

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system 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. The Partnership 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

As part of the QIHETP, and in accordance with MCND9001, the Quality Improvement Health Equity Committee (QIHEC) is comprised of various stakeholders including community based organizations, academic institutions, clinical staff, and Partnership members. The Partnership QIHEC serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. This is done by engaging with a member and using a family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership, with oversight and participation of the governing Board of Commissioners and the QIHEC.
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews.
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism, and health inequities on members, staff, subcontractors, and downstream subcontractors per DHCS's published DEI training All Provider Letters (APLs).

This committee meets quarterly 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). As described in MCEP6002, the 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 committees. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002).

QIHEC also makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our 24 counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.

## Quality Improvement Health Equity Committee

**HEALTH SERVICES TEAM**

Chief Health Services Officer

Director(s)

Associate Director

Manager(s)

**HEALTH EQUITY**

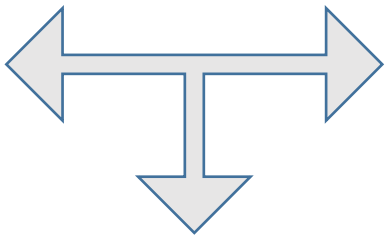
Director/Officer of Health Equity

Tribal Liaison

**EXECUTIVE LEADERSHIP**

Chief Operations Officer

Chief Medical Officer



**REGIONAL ENGAGEMENT**

Regional Representatives

Regional Medical Directors

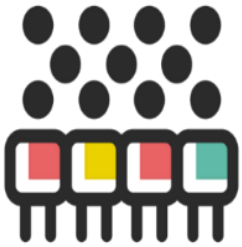
**DEPARTMENTAL REPRESENTATION**

Quality

Improvement

Health Equity

Human Resources



Provider Relations

Behavioral Health

OpEx/PMO

Transportation Services

## Community Engagement

Partnership's Consumer Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community see attachment MCND9002-E CAC Guiding Principles and attachment MCND9002-F FAC Charter for additional details. 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), persons with chronic conditions, Limited English Proficient (LEP) Members, 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;
- Health related initiatives;
- Resource allocation; and
- Other community-based initiatives

## 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 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 QIHEC/C&L Work Plan. Partnership has an annual work plan that described 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), and
- 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 work plan to all stakeholders, constituents, and the general public.

## 2024-2025 Goals

Partnership identified multiple goals for 2024-2025. Goals 1-5 will carry over from 2024; goals 6-10 are new goals. These goals are listed below. Additional goal details can found in the C&L/QIHETP Work Plan:

- Goal 1: By December 31, 2024 90% of members requesting an alternate format will receive at least one mailing in their preferred format.
    - This goal was chosen to ensure members are receiving information in a way that they can understand.
- Goal 2: By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.
    - This goal was chosen to strategize and streamline required initiatives to advance Health Equity.
- Goal 3: By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables.
    - 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 4: By December 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen in order to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%.
    - 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 prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months 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 in at least 1.25% in at least one region.

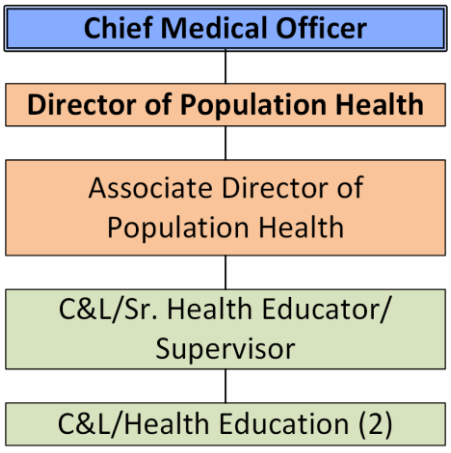
- Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

Partnership will continue to monitor these goals through the annual C&L Work Plan to ensure the goals are met. Progress toward this goal 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 (MCND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts 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 and NCQA requirements. In order 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

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 the Manager 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 trainings for contracted providers, internal Partnership staff, Partnership members, and community members as appropriate and 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, 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

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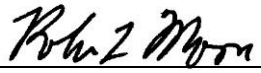
|  | **10/09/2024** |

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

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|  | **11/13/2024** |

*Steve Gwiazdowski, MD, FAAP* *Date Approved*
*Physician Advisory Committee Chairperson*

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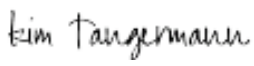
|  | **12/04/2024** |

*Kim Tangermann* *Date Approved*
*Board of Commissioners Chairperson*