



**Availability of Practitioners
Cultural Needs and Preferences**

**Analysis and Recommendations
2023**

Presented to the Alliance Quality Improvement Health Equity Committee on 5/17/2024

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**Alameda Alliance for Health
Availability of Practitioners
Member Cultural Needs and Preferences
Analysis and Recommendations**

I. PROGRAM GOAL

Alameda Alliance for Health (Alliance) is a managed care health plan that serves eligible Medi-Cal and Group Care members in Alameda County, California. The goal of the Alliance is to offer a practitioner network that meets the cultural and linguistic needs of its membership in sufficient volume and capabilities. The goal also ensures that all members receive equal access to high quality health care services that are culturally and linguistically appropriate regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

The Alliance has established a Cultural and Linguistic Services program to ensure that all members receive equal access to high quality services. The Alliance:

- Hires, assesses, and monitors bilingual Alliance staff to speak with members in their language
- Provides free telephone, video, and in-person interpretation
- Provides member materials in the Alliance's threshold languages, English, Spanish, Chinese, Vietnamese, and Tagalog. Alternative formats, such as, large print, audio format, Braille, data CD and other auxiliary aids are also available
- Recruits, credentials, and contracts with practitioners who speak languages that reflect members' linguistic needs
- Recruits, credentials, and contracts with practitioners with similar cultural and ethnic background as members
- Provides and requires practitioners to complete cultural competency training courses based on racial/ethnic composition of the member population.

II. REPORT PURPOSE

This report provides an analysis of cultural, racial, ethnic, and linguistic needs and preferences of Alliance members and compares those needs to the composition of the Alliance practitioner network. To better understand the unique cultural and linguistic needs of our members, Alliance performs quarterly and annual assessments of our members as well as evaluates the composition of practitioners that can meet those needs within the current network. The Alliance then uses that data to adjust the practitioner network to meet the needs of the population.

The purpose of this report is to:

1. Identify ethnic, racial and linguistic needs of Alliance members from enrollment data.
2. Conduct research into the cultural needs and preferences based on characteristics of Alliance members.
3. Identify language, race/ethnicity and cultures of practitioners in the network to assess whether they meet members' needs
4. Assess whether members' CLS needs and preferences were met
5. Identify network activities to address members' language needs and cultural preferences.

Alameda Alliance for Health understands its responsibility to provide culturally and linguistically appropriate practitioner networks to our members whenever possible. Members are generally more comfortable with practitioners who speak their language and/or share their cultural/ethnic background. Additionally, members who face obstacles of understanding or access may not seek timely medical or behavioral health care services.

This report demonstrates that Alliance understands the needs of its members and the necessity of meaningful action to tailor our practitioner network towards those needs and preferences.

III. PROCESS AND FREQUENCY REPORTING

This report was created in 2024 based on data collected throughout 2023. The report was compiled by the Lead Interpreter Services Coordinator.

The process for the development of this report is:

1. The Lead Interpreter Services Coordinator is responsible for the collection of data and development of the summary report.
2. The Director of Population Health and Equity and Manager of Cultural and Linguistic Services analyzes the data and drafts the recommendations for submission to the Alliance Cultural and Linguistic Services Subcommittee of the Quality Improvement and Health Equity Committee (QIHEC).
3. The Director of Population Health and Equity presents any significant results, recommendations, and actions to the Alliance QIHEC.

IV. DEFINITIONS

Alliance –Alameda Alliance for Health

Group Care – Commercial plan of Alameda Alliance for Health

Cultural and Linguistic Services Subcommittee (CLSS) is a subcommittee of the QIHEC. It reports demographic changes in the Alliance membership, language services offered, grievances related to discrimination, sensitivity and language services and overall execution of the Alliance’s Cultural and Linguistic Services Program to QIHEC. Its primary role is to ensure members receive culturally and linguistically appropriate health care services regardless of language, ethnicity, gender identity, sexual orientation, age, or disability.

V. DATA SOURCE AND METHODOLOGY

The sources, population and information collected are summarized in Table A – Data Sources and Characteristics below.

Table A. Data Sources and Characteristics

Data Source	Frequency	Population
Alliance Member Enrollment Database Report by Business Line	Quarterly	All Alliance Members active during calendar year
Healthy Alameda County-Alameda County Public Health Department	Annually	Alameda County Residents (Population 5+)
Alliance Practitioner Credentialing Database	Annually	All Alliance Network credentialed during calendar year
Alliance Interpreter Services Report	Quarterly	Alliance Interpreter Services Provided
Alliance Member Satisfaction Survey: Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	Quarterly	Random Sample of Alliance members seen by Primary Care Physician
Alliance Grievances and Appeals Reports	Quarterly	Members who express any form of dissatisfaction of Alliance benefits and services
Pew Research Center Religious Landscape Study	2014 Report	Religious preferences by region.

VI. INDICATORS / METRICS

The specific metrics tracked by the Alliance from the data sources are listed in Table B – Indicators and Metrics below. The Alliance selected these metrics to best understand the cultural and linguistic needs of our membership and determine how those needs are currently being met by the existing practitioner network.

Table B. Indicators and Metrics

Indicators/ Metrics Tracked	
Data Source	Metric
Alliance Member Enrollment Database Report by Business Line	<ul style="list-style-type: none"> Member Language Spoken (% of all members) Member Race/ Ethnicity (% of all members)
Healthy Alameda County-Alameda County Public Health Department	<ul style="list-style-type: none"> Alameda County Languages Spoken at Home (Population Age 5+)
Alliance Practitioner Credentialing Data	<ul style="list-style-type: none"> Providers' Race/Ethnicity and Language Information

Alliance Interpreter Services Report	<ul style="list-style-type: none"> Number of on-demand and scheduled interpreter services provided by language.
Alliance Member Satisfaction Survey: CG-CAHPS	<ul style="list-style-type: none"> Ability to communicate with doctor in preferred language, by Adult and Child Use of Family and Friends as interpreters
Alliance Grievances and Appeals Report	<ul style="list-style-type: none"> Grievances related to cultural and linguistic and discrimination by provider type Grievances related to discrimination/sensitivity by provider type
Pew Religious Landscape Study	<ul style="list-style-type: none"> % of individuals in region who identify with specific religious beliefs.

VII. RESULTS

The Alliance collects and compiles results of surveys, census, enrollment, and practitioner data on an ongoing basis which are then evaluated routinely to determine areas for improvement. The Alliance summarizes the data and compares the member profiles to the network practitioner characteristics to identify opportunities to improve alignment of the practitioner network with member needs and preferences with regards to race/ethnicity and language.

For member cultural preference, the PHM Strategy is a comprehensive report which is conducted by the Population Health Equity (PHE) team every year. The PHM strategy identifies and addresses member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health and supporting enhanced quality of life.

The results of these analyses are then used to focus network development and education efforts for the coming year. The sections below outline and summarize the annual findings for each tracked metric.

1. Assessing Language, Ethnic, and Racial needs of Alliance Members

A. Member Preferred Language

Alliance tracks and examines quarterly the spoken languages of membership and annually the population of Alameda County. See Table C below for threshold languages in 2023 by line of business, Medi-Cal and Group Care.

Table C. Alliance Membership Threshold Languages, December 2023
By Membership Count and Percent*

Total by Plan	Threshold Languages		
	English	217,727	62.89%

Medi-Cal 346,228	Spanish	70,126	20.25%
	Chinese	30,852	8.91%
	Vietnamese	9,063	2.62%
	Tagalog	2,273	0.66%
Group Care 5,622	English	3,301	58.72%
	Chinese	1,411	25.10%
	Spanish	286	5.09%

Source: Alliance Monthly Health Education Report, December 2023

*Not all members indicate their language preferences

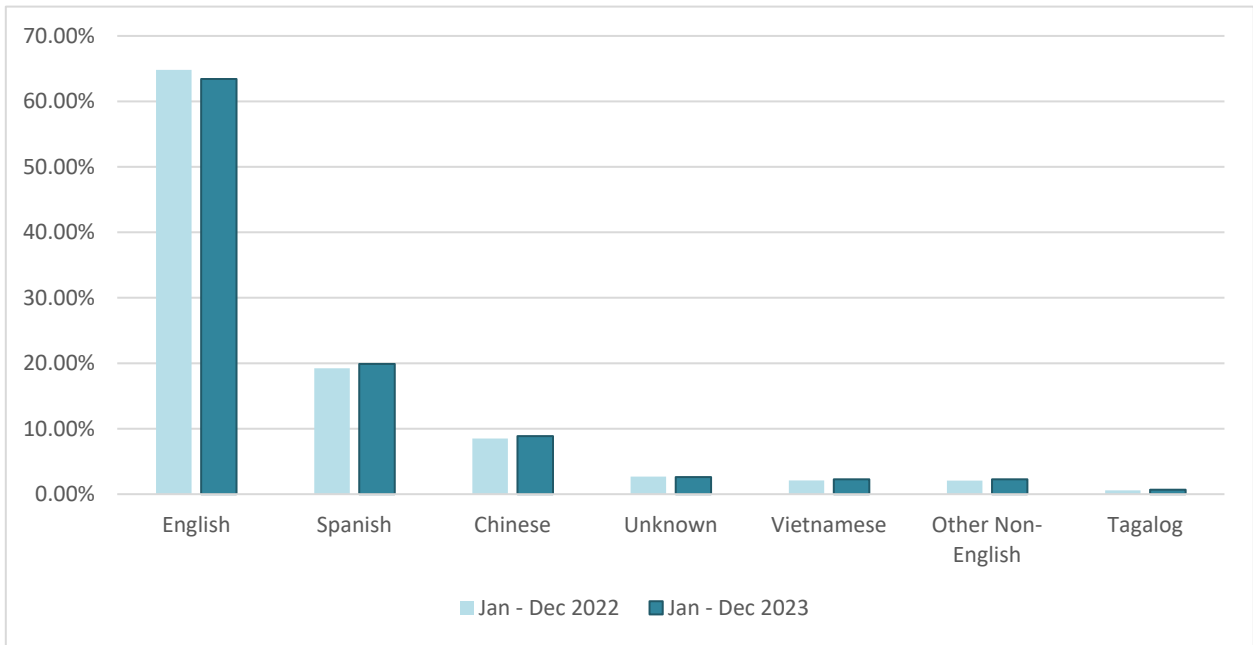
The threshold languages are defined as languages spoken by either 3,000 or 5% of eligible beneficiaries residing in the Alliance’s service area who indicate their primary language as other than English, whichever is less. A more detailed look at languages spoken by the Alliance membership by lines of business, Medi-Cal and Group Care, is provided in Membership by Language Comparison in the tables and figures below.

Table D. Alliance Membership by Language Comparison-Medi-Cal, 2022-2023

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2022	Jan - Dec 2023	% YTD Membership in Jan - Dec 2023 (minus) % of Membership in Jan - Dec 2022	Dec 2023	Dec 2023 %
English	64.81%	63.42%	-1.40%	217,727	62.89%
Spanish	19.24%	19.88%	0.64%	70,126	20.25%
Chinese	8.50%	8.88%	0.38%	30,852	8.91%
Vietnamese	2.68%	2.62%	-0.06%	9,063	2.62%
Unknown	2.09%	2.27%	0.17%	8,150	2.35%
Other non-English	2.08%	2.27%	0.19%	8,037	2.32%
Tagalog	0.59%	0.67%	0.08%	2,273	0.66%
Total Members				346,228	

Source: Alliance Monthly Health Education Report, December 2023

Figure 1. Alliance Membership by Language Comparison-Medi-Cal, 2022-2023



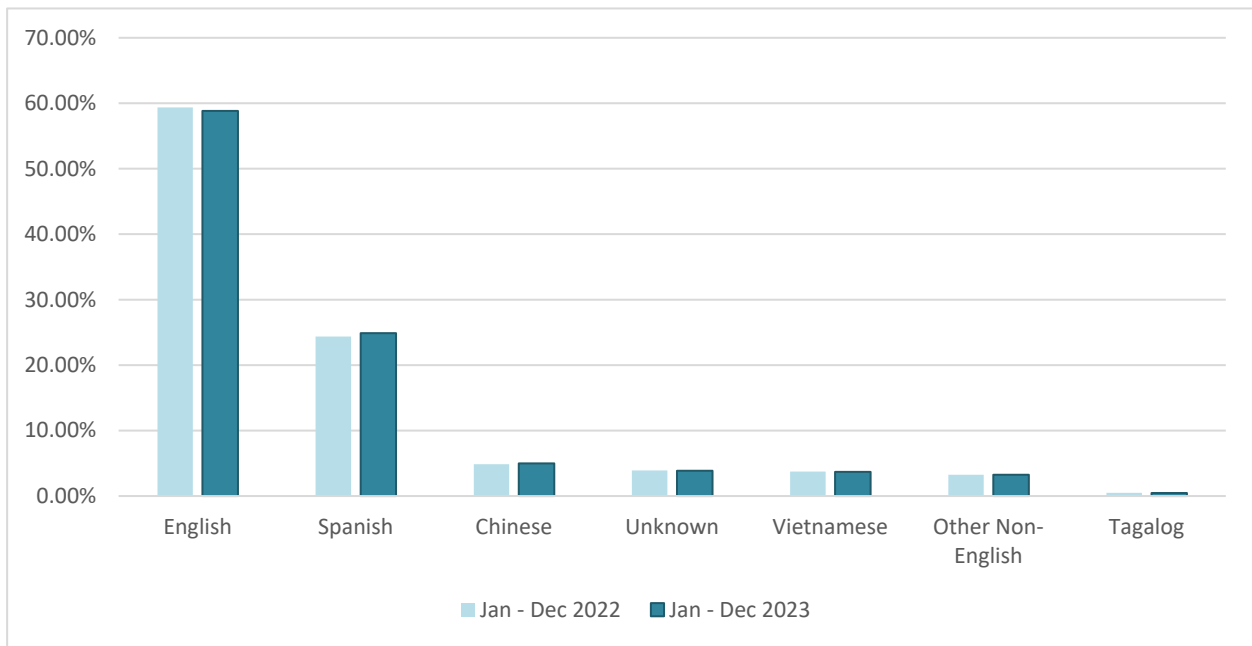
Source: Alliance Monthly Health Education Report, December 2023

Table E. Alliance Membership by Language Comparison-Group Care, 2022–2023

GROUP CARE	Prior Year	YTD	% Change	Current Month	
	Jan – Dec 2022	Jan – Dec 2023	% YTD Membership in Jan – Dec 2023 (minus) % of Membership in Jan – Dec 2022	Dec 2023	Dec 2023 %
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE					
English	59.38%	58.84%	-0.54%	3,301	58.72%
Chinese	24.36%	24.88%	0.52%	1,411	25.10%
Spanish	4.86%	4.99%	0.13%	286	5.09%
Vietnamese	3.90%	3.87%	-0.03%	221	3.93%
Other non-English	3.75%	3.68%	-0.07%	200	3.56%
Unknown	3.25%	3.26%	0.01%	177	3.15%
Tagalog	0.49%	0.47%	-0.02%	26	0.46%
Total Members				5,622	

Source: Alliance Monthly Health Education Report, December 2023

Figure 2. Alliance Membership by Language Comparison-Group Care, 2022-2023



Source: Alliance Monthly Health Education Report, December 2023

Notable Findings:

- Medi-Cal continues to be predominantly English and Spanish speaking with the highest increase for Spanish language.
- Group Care continues to be predominately English and Chinese speaking. The percentages remained the same from 2022 to 2023 with the greatest decrease seen for English language.

B. Member Race/Ethnicity

Table F. Membership by Race/Ethnicity Comparison-Medi-Cal, 2022-2023

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
Alameda Alliance for Health Membership by Race/Ethnicity	Jan – Dec 2022	Jan – Dec 2023	% YTD Membership in Jan – Dec 2023 (minus) % of Membership in Jan – Dec 2022	Dec 2023	Dec 2023 %
Hispanic (Latinx)	28.75%	28.56%	-0.19%	99,239	28.66%
Other *	24.43%	24.38%	-0.05%	82,837	23.93%
Black (African American)	14.56%	14.04%	-0.52%	48,395	13.98%
Chinese	9.79%	10.04%	0.24%	34,595	9.99%
White	8.76%	8.82%	0.06%	29,883	8.63%
Vietnamese	3.59%	3.43%	-0.16%	11,757	3.40%
Asian Indian	3.11%	3.11%	0.01%	10,772	3.11%
Filipino	2.82%	2.91%	0.09%	9,830	2.84%

Asian or Pacific Islander	1.98%	2.07%	0.10%	7,361	2.13%
Unknown	0.49%	0.89%	0.41%	5,535	1.60%
Korean	0.45%	0.50%	0.05%	1,722	0.50%
Cambodian	0.48%	0.46%	-0.02%	1,589	0.46%
American Indian or Indian Alaskan Nativ	0.21%	0.20%	-0.00%	718	0.21%
Samoan	0.18%	0.17%	-0.01%	620	0.18%
Japanese	0.14%	0.15%	0.01%	494	0.14%
Laotian	0.14%	0.14%	-0.01%	461	0.13%
Hawaiian	0.08%	0.08%	-0.00%	264	0.08%
Guamanian	0.05%	0.05%	-0.00%	156	0.05%
Total Members				346,228	

**The "Other" category is self-reported by members as ethnicity "other" and is not a combination of other ethnicity categories.*

Source: Alliance Monthly Health Education Report, December 2023

Table G. Membership by Race/Ethnicity Comparison-Group Care, 2022-2023

GROUP CARE	Prior Year	YTD	% Change	Current Month	
	Jan – Dec 2022	Jan – Dec 2023	% YTD Membership in Jan – Dec 2023 (minus) % of Membership in Jan – Dec 2022	Dec 2023	Dec 2023 %
Asian Indian	27.15%	29.45%	2.29%	1,692	30.10%
Unknown	25.03%	23.68%	-1.35%	1,272	22.63%
Chinese	14.42%	14.47%	0.06%	833	14.82%
Black (African American)	11.43%	10.91%	-0.52%	601	10.69%
Other*	8.64%	8.18%	-0.45%	479	8.52%
Hispanic (Latinx)	3.97%	3.95%	-0.02%	229	4.07%
Vietnamese	3.14%	3.07%	-0.07%	172	3.06%
White	2.06%	2.06%	-0.01%	112	1.99%
Filipino	1.15%	1.17%	0.02%	67	1.19%
Asian or Pacific Islander	1.15%	1.20%	0.05%	63	1.12%
Cambodian	0.96%	0.91%	-0.05%	48	0.85%
Korean	0.52%	0.52%	0.00%	31	0.55%
Amerasian	0.10%	0.14%	0.04%	8	0.14%
American Indian or Alaskan Native	0.10%	0.14%	0.04%	8	0.14%

Laotian	0.16%	0.13%	-0.03%	6	0.11%
Samoan	0.03%	0.02%	-0.01%	1	0.02%
Total Members				5,622	

*The “Other” category is self-reported by members as ethnicity “other” and is not a combination of other ethnicity categories.

Source: Alliance Monthly Health Education Report, December 2023

Notable Findings:

- Medi-Cal member ethnicities have had fluctuations of less than 1 percentage point. The “Hispanic/Latinx” and “Other” categories represent half of the membership.
- For Group Care members, the percentage of ethnicity for “Unknown” continues to decline, while the percentage of “Asian Indian” members continues to rise (+2.29 percentage points). Furthermore, “Other” Group Care ethnicities show only slight fluctuations.

2. Identify Language, Race, Ethnicity and Culture of Practitioners in the Network to Assess Whether They Meet Member Cultural and Linguistic Needs

A. Meeting Member Language Needs

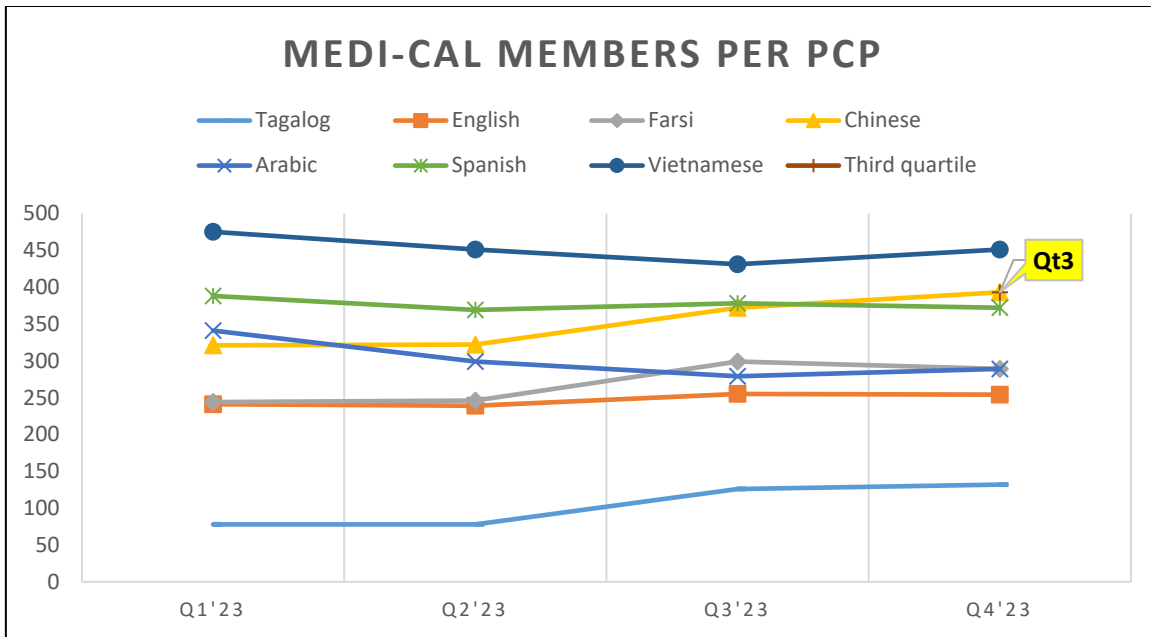
The Alliance monitors Provider Language Capacity quarterly to ensure that our provider network meets the language needs of our membership. The following compares provider language capacity for 2022-2023 by PCP, and point in time 2023 for Specialists and Behavioral Health (BH) providers. We also analyze provider availability for two (2) of the most common languages beyond our threshold languages, Arabic and Farsi, as these languages make up most of our “Other Non-English” speaking members.

Table H. PCP Language Capacity Comparison-Medi-Cal, 2022-2023

Language	Q4 2022			Q4 2023			Change			
	PCPs	Members	Ratio PCPs: Members	PCPs	Members	Ratio PCPs: Members	# PCPs	% PCPs	# Members	% Members
English	679	162,956	1:239	719	186,084	1:258	40	6%	23,128	14%
Spanish	167	61,723	1:369	183	60,804	1:332	16	10%	-919	-1%
Chinese	77	24,812	1:322	75	26,424	1:352	-2	-3%	1,612	6%
Vietnamese	20	8,168	1:408	19	7,829	1:412	-1	-5%	-339	-4%
Arabic	8	2,392	1:299	10	2,036	1:203	2	25%	-356	-15%
Tagalog	22	1,733	1:78	21	1,845	1:87	-1	-4%	112	6%
Farsi	7	1,722	1:246	9	2,383	1:264	2	28%	661	38%
Total	1,188	272,796		1,246	296,280					

Source: Provider Language Access Report, 2022-2023. A number of PCPs do not have a primary language designated in the data we receive. Multilingual providers are counted for each language they speak. Kaiser members are not included.

Figure 3. PCP Language Capacity-Medi-Cal, 2023



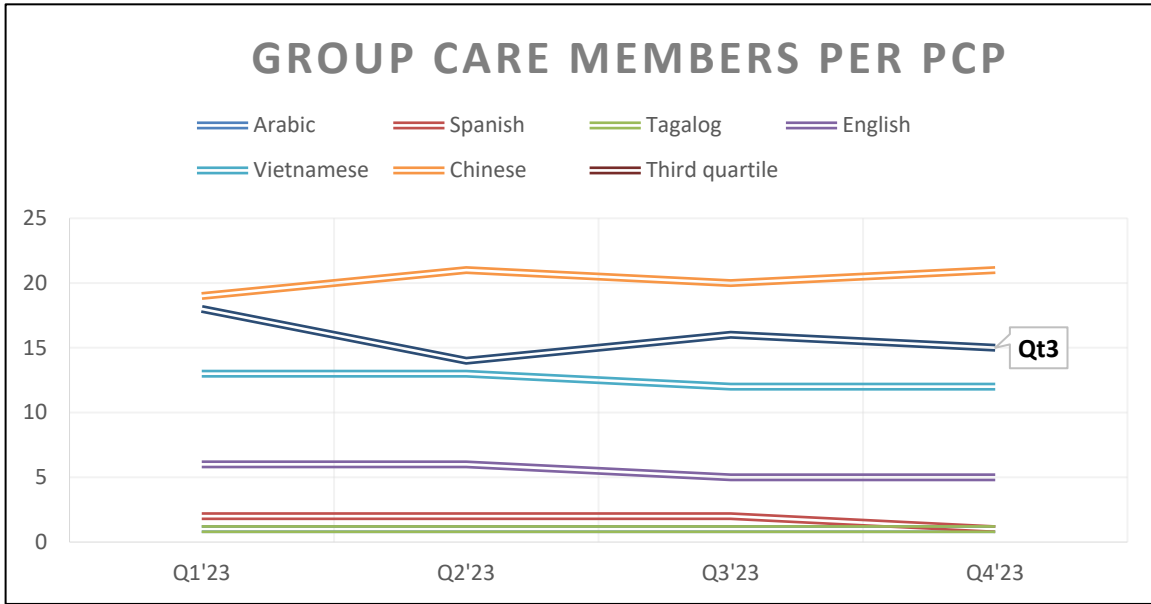
Source: Provider Language Access Report, 2023

Table I. PCP Language Capacity Comparison-Group Care, 2022-2023

Language	Q4 2022			Q4 2023			Change			
	PCPs	Members	Ratio PCPs: Members	PCPs	Members	Ratio PCPs: Members	# PCPs	% PCPs	# Members	% Members
English	560	3,376	1:6	588	3,324	1:5	28	5%	-52	-2%
Spanish	138	290	1:2	152	284	1:1	14	10%	-6	-2%
Chinese	68	1,438	1:21	64	1,396	1:21	-4	-6%	-42	-3%
Vietnamese	18	226	1:12	16	221	1:13	-2	-11%	-5	-2%
Arabic	8	6	1:0	10	7	1:0	2	25%	1	17%
Tagalog	21	27	1:1	20	26	1:1	-1	-5%	-1	-4%
Farsi	6	86	1:14	8	84	1:10	2	33%	-2	-2%
Total	993	5,777		1,034	5,622					

Source: Provider Language Access Report, 2022-2023. A number of PCPs do not have a primary language designated in the data we receive. Multilingual providers are counted for each language they speak. Kaiser members are not included.

Figure 4. PCP Language Capacity-Group Care, 2023



Source: Provider Language Access Report, 2023

Table J. Specialists Language Capacity Comparison-Medi-Cal, Q4 2023

Language	Q4 2023		
	Specialists	Members	Ratio Specialists: Members
English	8,236	244,411	1:29
Spanish	900	95,695	1:106
Chinese	426	29,432	1:69
Vietnamese	77	8,336	1:108
Unknown	799	7,887	1:9
Other Non-English	1,202	3,419	1:2
Farsi	90	2,785	1:30
Arabic	62	2,552	1:41
Tagalog	78	2,120	1:27
Total	11,870	396,637	

Source: Provider Language Access Report, Q4 2023

Table K. Specialists Language Capacity Comparison-Group Care, Q4 2023

	Q4 2023		
Language	Specialists	Members	Ratio Specialists: Members
English	8,100	3,309	1:0
Chinese	422	1,396	1:3
Spanish	885	289	1:0
Vietnamese	77	222	1:2
Unknown	778	175	1:0
Other Non-English	1,189	104	1:0
Farsi	89	82	1:0
Tagalog	76	24	1:0
Arabic	61	6	1:0
Total	11,677	5,607	

Source: Provider Language Access Report, Q4 2023

Table L. Behavioral Health Providers Language Capacity Comparison-Medi-Cal, Q4 2023

	Q4 2023		
Language	Behavioral Health Providers	Members	Ratio BH: Members
English	872	244,411	1:280
Spanish	130	95,695	1:736
Chinese	18	29,432	1:1,635
Vietnamese	7	8,336	1:1,190
Unknown	14	7,887	1:563
Other Non-English	144	3,419	1:23
Farsi	14	2,785	1:198
Arabic	7	2,552	1:364
Tagalog	4	2,120	1:530

Total	1,210	396,637
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Source: Provider Language Access Report, Q4 2023

Table M. Behavioral Health Providers Language Capacity Comparison-Group Care, Q4 2023

	Q4 2023		
Language	Behavioral Health Providers	Members	Ratio BH: Members
English	856	3,309	1:3
Chinese	18	1,396	1:77
Spanish	130	289	1:2
Vietnamese	7	222	1:31
Unknown	14	175	1:12
Other Non-English	144	104	1:0
Farsi	14	82	1:5
Tagalog	4	24	1:6
Arabic	7	6	1:0
Total	1,194	5,607	

Source: Provider Language Access Report, Q4 2023

Notable Findings:

- For PCP, the Medi-Cal member population increased for the listed languages except for Spanish, Vietnamese, and Arabic. In Group Care, the member population decreased for all listed languages except for Arabic.
- Overall, members per PCP is higher for Vietnamese and Chinese languages for both lines of business.
- The number of PCPs increased for the listed languages except for Chinese, Vietnamese, and Tagalog for both lines of business.
- For Specialists in Medi-Cal, Spanish and Vietnamese languages have the highest ratio per member. In Group Care, Chinese and Vietnamese have the highest ratio per member.
- For BH providers in Medi-Cal, Chinese and Vietnamese languages have the highest ratio per member. In Group Care, this remains the same.

B. Meeting Member Ethnic/Racial Needs

The Alliance monitors the Provider race/ethnicity using data collected during the credentialing process. This data is self-reported. Alliance Providers are broken down below by categories of PCP, BH and Specialists and race/ethnicity.

Table N. Provider by Race/Ethnicity, 2023

Provider by Race/Ethnicity	% PCP	% BH	%Specialists
Hispanic (Latinx)	8%	18%	2%
Asian *	48%	20%	43%
Black (African American)	8%	10%	5%
White	29%	50%	43%
Asian Indian	5%	0%	4%
Pacific Islander **	1%	1%	1%
American Indian or Alaskan Native	0%	1%	1%
Other ***	1%	0%	1%
Unknown	0%	0%	0%
Total	100%	100%	100%

Source: Provider Race/Ethnicity and Language Report, 2023

* Includes Chinese, Vietnamese, Korean, Cambodian, Japanese, Filipino and Laotian

** Includes Hawaiian

*** Includes Samoan, Guamanian, and Amerasian

Table O. Provider by Race/Ethnicity Comparison-Medi-Cal and Group Care Members, 2023

Race/Ethnicity	% Members	% PCP	% BH	% Specialists
Hispanic (Latinx)	34%	8%	18%	2%
Asian *	12%	48%	20%	43%
Black (African American)	13%	8%	10%	5%
White	8%	29%	50%	43%
Asian Indian	3%	5%	0%	4%
Pacific Islander **	2%	1%	1%	1%
American Indian or Alaskan Native	0.20%	0%	1%	1%
Other ***	20%	1%	0%	1%
Unknown	4%	0%	0%	0%

Source: Provider Race/Ethnicity and Language Report, 2023 and Alliance Monthly Health Education Report, December 2023

* Includes Chinese, Vietnamese, Korean, Cambodian, Japanese, Filipino and Laotian

** Includes Hawaiian

*** Includes Samoan, Guamanian, and Amerasian

Notable Findings:

- For provider race/ethnicity data that was disclosed, Asian (48%) made the largest percentage for PCP followed by White (29%), Hispanic/Latino (8%), Black or African American (8%), and Asian Indian (5%).
- BH providers by race/ethnicity is predominantly White (50%) followed by Asian (20%), Hispanic (Latinx) (18%) and Black (African American) (10%).
- Specialists by race/ethnicity is predominately both Asian (43%) and White (43%) followed by Asian Indian Black (African American) (5%), Asian Indian (4%), and Hispanic (Latinx) (2%).

- The greatest difference in member compared to provider race/ethnicity was for Hispanic (Latinx) members in PCPs and Specialists, which showed lower percentages.
- Other race/ethnicity comparisons between member and PCP, BH providers and Specialists were either above or comparable in percentages.

C. Meeting Member Cultural Needs

Cultural Traits for Ethnic Groups

External studies completed in Alameda County were used to assess the cultural traits of the top four (4) ethnic groups identified, which are Hispanic, African American, Chinese and Pacific Islander. The following is a summary of the cultural traits of the identified groups.

Hispanic: The value placed on human life is paramount in the Hispanic culture. Research shows that especially the elder generation, prefer seeing a male physician because male doctors are considered more knowledgeable than that of their female counterparts. Practitioners are respected and viewed as authority figures. Additionally, Hispanic women are generally very shy when it comes to discussing medical information with providers. Hispanics also want a personal relationship with practitioners. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

Source: [San Francisco Bay Area Hispanic Chamber of Commerce - Home \(sfbayhcc.com\)](http://sfbayhcc.com)

African American: African American adolescent males are affected by physical and emotional stressors that include “adverse experiences such as racism, poverty, incarceration, and the lack of positive emotional attachments”. African American males must be engaged in ways that honor how they experience life as an African American. In Alameda County, one in three African American residents live in a high poverty neighborhood compared to one in fifteen white residents.

Source: [African American Adolescent Males: Living Stressfully in Alameda County - Policy Forum at Mills College \(millspolicyforum.com\)](http://millspolicyforum.com)

Chinese: The concept of “saving face” is deep in Chinese culture. It means maintaining dignity and a good reputation. Family plays a huge role in the Chinese culture. The Chinese practice both Western medicines, as well as traditional folk medicine. The elderly may find it very hard to ask for help from individuals or agencies, such as case management. Language barriers may prevent access to health care information.

Sources: [Elaine Peng - Mental Health Services Act - Alameda County Behavioral Health Care Services \(acmhsa.org\)](http://acmhsa.org)

Pacific Islander: A study by the Stanford School of Medicine reported that Pacific Islanders are a very diverse group and that it is important to avoid stereotyping. The study showed that for the clinical interaction to be meaningful, Pacific Islanders need to develop a sense of trust with their healthcare providers. Pacific Islanders have the second highest infant death rate and some of the overall worst health outcomes in Alameda County, yet their vulnerability is too often overlooked. The pandemic heavily affected Pacific Islander communities. Life in multigenerational households, common among communities of Pacific Islanders, complicates the challenge to maintain distance. Not only did coronavirus threaten the health of the Pacific Islanders, but it also impacted their customs.

Source: ['The disease is ripping through': why coronavirus is devastating California's Pacific Islanders | California | The Guardian](https://www.theguardian.com/us-news/2020/apr/07/california-pacific-islanders-coronavirus)

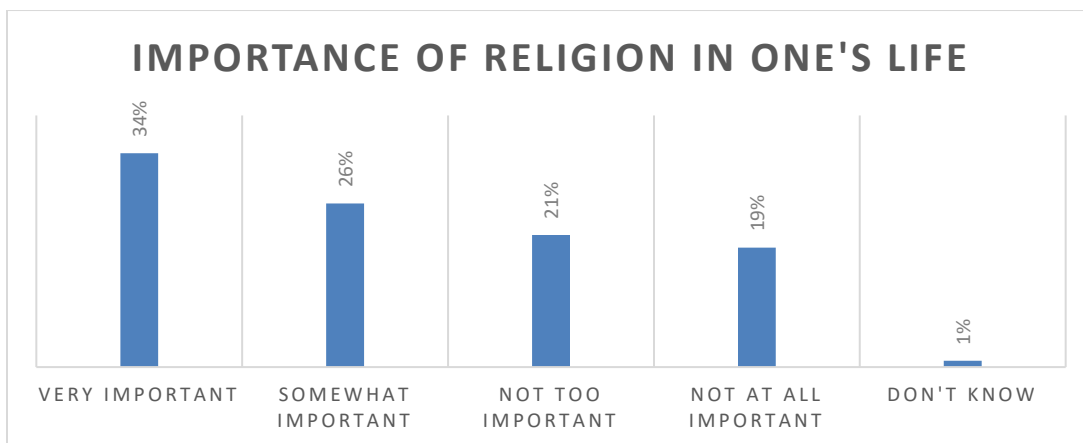
Religion

The Pew Research Center Religious Landscape Study from 2014 was used to understand the religious beliefs of adults in the San Francisco metro area.

Table P. Religious composition of adults in the San Francisco metro area, 2014

Religion	Percent
Christian	48%
Evangelical Protestant	10%
Mainline Protestant	6%
Historically Black Protestant	4%
Catholic	25%
Mormon	1%
Orthodox Christian	1%
Jehovah's Witness	<1%
Other Christian	1%
Non-Christian Faiths	15%
Jewish	3%
Muslim	1%
Buddhist	2%
Hindu	5%
Other World Religions	1%
Other Faiths	3%
Unaffiliated	35%
Atheist	5%
Agnostic	10%
Nothing in particular	20%
Don't know	2%

Figure 5. Importance of religion in one's life among adults in the San Francisco metro area, 2014



Notable Findings:

- Almost two-thirds (63%) of adults in the San Francisco metro area were affiliated with a Christian (48%) or non-Christian (15%) religion in 2014.

- About one-third (35%) were unaffiliated and 2% didn't know.
- Of the Christian faiths, the most common were Catholic, Evangelical Protestant, and Mainline Protestant. Of the non-Christian faiths, the most common were Hindu and Jewish.
- Over half (60%) of adults said religion was very or somewhat important, and 40% said it was not too important, not at all important, or they didn't know.
- Data on religion on Alliance members and providers is not available, but this information for the San Francisco metro area shows that religious beliefs are an important cultural consideration for members and providers.

3. Analysis of Member Language Services, Survey Feedback and Member Grievance Data

A. Language Services Provided

To support culturally competent care at all points of services, the Alliance supplements internal bilingual capacity as well as provider bilingual capacity with at no cost telephonic, in-person, and video interpreter services. The following services were offered in 2022-2023.

Table Q. Telephonic Interpreter Services-All Lines of Business, 2022-2023

Language	2022	2023	% Change
Cantonese (Threshold Language)	12848	12890	0.33%
Spanish (Threshold Language)	5648	10744	47.43%
Vietnamese (Threshold Language)	7345	8249	10.96%
Mandarin (Threshold Language)	3248	3744	13.25%
Mam	442	1607	72.50%
Arabic	1091	1465	25.53%
Dari	544	848	35.85%
Mien	213	810	73.70%
Khmer	918	786	-16.79%
Korean	690	771	10.51%
Farsi	464	675	31.26%
Punjabi	311	579	46.29%
Russian	179	415	56.87%
Mongolian	669	405	-65.19%
Tigrinya	166	387	57.11%
Pashto	274	302	9.27%
Tagalog (Threshold Language)	244	277	11.91%
Burmese	157	264	40.53%
Hindi	215	257	16.34%
Taishanese	139	162	14.20%
Amharic	104	156	33.33%
Nepali	34	102	66.67%
French	39	95	58.95%
Urdu	58	95	38.95%
Portuguese	39	90	56.67%
Karen	54	63	14.29%

Tamil	39	62	37.10%
Lao	52	58	10.34%
Ukrainian	7	44	84.09%
Telugu	21	38	44.74%
Thai	56	36	-55.56%
Igbo	53	34	-55.88%
Japanese	38	33	-15.15%
Tongan	12	33	63.64%
Hmong	8	29	72.41%
Gujarati	13	26	50.00%
Haitian	22	23	4.35%
Turkish	8	18	55.56%
Indonesian	2	13	84.62%
Bengali	22	12	-83.33%
Swahili	2	12	83.33%
Romanian	3	10	70.00%
Tibetan	6	10	40.00%
Other languages of lesser diffusion	88	136	35.29%

Source: Interpretive Services Summaries (Power BI), 2022-2023

Table R. In-Person Interpreter Services-All Lines of Business, 2022-2023

Language	2022	2023	% Change
Cantonese (Threshold Language)	1901	2504	24.08%
Spanish (Threshold Language)	1077	2261	52.37%
Vietnamese (Threshold Language)	1503	1554	3.28%
Mandarin (Threshold Language)	663	930	28.71%
American Sign Language	434	416	-4.33%
Arabic	290	275	-5.45%
Russian	132	213	38.03%
Dari	186	207	10.14%
Punjabi	143	132	-8.33%
Burmese	34	98	65.31%
Korean	55	92	40.22%
Farsi	78	91	14.29%
Tigrinya	74	77	3.90%
Hindi	52	67	22.39%
Mam	32	61	47.54%
Taishanese	70	54	-29.63%
Pashto	31	44	29.55%
Khmer	50	39	-28.21%
Mien	12	24	50.00%
Amharic	26	20	-30.00%
Tagalog (Threshold Language)	31	18	-72.22%

Mongolian	23	16	-43.75%
Thai	3	10	70.00%
Other languages of lesser diffusion	36	53	32.08%

Source: Interpretive Services Summaries (Power BI), 2022-2023

Table S. Video Interpreter Services-All Lines of Business, 2022-2023

Language	2022	2023	% Change
Cantonese (Threshold Language)	670	537	-24.77%
Spanish (Threshold Language)	298	475	37.26%
Vietnamese (Threshold Language)	178	130	-36.92%
Mandarin (Threshold Language)	122	103	-18.45%
Arabic	24	39	38.46%
American Sign Language	27	34	20.59%
Farsi	6	25	76.00%
Dari	8	23	65.22%
Korean	19	18	-5.56%
Portuguese	23	17	-35.29%
Russian	4	17	76.47%
Khmer	12	12	0.00%
Taishanese	5	11	54.55%
Urdu	0	11	100.00%
Mam	2	10	80.00%
Punjabi	2	10	80.00%
Other languages of lesser diffusion	66	60	-10.00%

Source: Interpretive Services Summaries (Power BI), 2022-2023

Notable Findings:

- Telephonic interpreter services increased in 2023 for all threshold languages, with Spanish and Mandarin languages having the highest increase.
- There was a decrease in utilization for video interpreter services for all threshold languages from 2022-2023, except for Spanish, due to clinics re-opening to in-person visits after the Covid-19 pandemic.
- For in-person interpreter services, Spanish language utilization doubled in 2023.
- Overall, utilization for all interpreter services modalities increased in 2023.

B. Member Satisfaction Survey

Alameda Alliance for Health conducts a member satisfaction survey with the CG-CAHPS survey tool once per quarter. The goal of the survey is to better understand our member’s level of satisfaction with our Plan and our Plan’s providers. Members are asked about five (5) topics for an individual provider encounter. One of the topics is language services. We asked adults and parents of children who needed language services, “Were you able to communicate with your child’s doctor and clinic staff in your preferred language?” Response options included:

- No
- Yes, my health plan provided one for me.
- Yes, my doctor’s office gave me an interpreter or spoke my language.
- Yes, I used family or a friend as my interpreter.

A favorable answer was either “Yes, my health plan provided one for me” or “Yes, my doctor’s office gave me an interpreter or spoke my language”. These results are evaluated for disparities found between languages, and adult versus child and over time.

Table T. Member Satisfaction Survey-CG-CAHPS-Adult, 2022-2023

ADULT: Able to communicate with doctor and clinic staff in preferred language?	Favorable % 2022	Favorable % 2023	Family and Friends % 2022	Family and Friends % 2023	No % 2022	No % 2023
Total	81.6%	85.20%	15.39%	12.19%	3.00%	2.60%
Chinese	89.25%	87.59%	9.44%	10.86%	1.30%	1.53%
Spanish	86.87%	91.46%	6.71%	6.71%	2.81%	1.81%
Vietnamese	85.56%	85.71%	9.95%	9.82%	3.48%	4.46%
English	57.14%	61.84%	34.69%	29.60%	8.16%	8.55%
Tagalog (2023 n= 15)	45.45%	40.00%	48.48%	60%	6.06%	0.00%
Other Languages	58.77%	63.80%	36.84%	32.38%	4.38%	3.80%

Source: CG-CAHPS-Adult, 2022-2023

¹ Eligible response excludes any skipped or not answered responses

² Favorable response is based on question category -

*** Either doctor's office or health plan provided interpreter or spoke my language

Table U. Member Satisfaction Survey-CG-CAHPS-Child, 2022-2023

CHILD: Able to communicate with doctor and clinic staff in preferred language?	Favorable % 2022	Favorable % 2023	Family and Friends % 2022	Family and Friends % 2023	No % 2022	No % 2023
Total	92.30%	95.40%	5.01%	3.04%	2.69%	1.59%
Chinese	94.01%	98.36%	4.70%	0.40%	1.28%	1.22%
Spanish	93.82%	95.58%	4.49%	3.01%	1.68%	1.40%
Vietnamese	70.00%	100%	10.00%	0.00%	20.00%	0.00%
English	80.76%	90.41%	7.69%	8.77%	11.53%	1.36%
Tagalog (2023 n= 0)	100%	0.00%	0.00%	0.00%	0.00%	0.00%

Other Languages	87.50%	76.92%	9.37%	12.82%	3.12%	10.25%
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Source: CG-CAHPS-Child, 2022-2023

¹ Eligible response excludes any skipped or not answered responses

² Favorable response is based on question category -

*** Either doctor's office or health plan provided interpreter or spoke my language

Notable Findings:

- In 2023, the percentage of people who needed an interpreter and received one through their doctor's office or health plan (a favorable response) was 85.2% for adults and 95.40% for children. Both adult and child showed significant increases for a favorable response from 2022.
- In 2023, use of family or friends to communicate with their doctor was slightly higher for adult for both Chinese and Tagalog languages when compared to 2022. Spanish, Vietnamese, English and Other Languages either showed slight decreases or remained the same. This may be attributed to cultural preferences for family to interpret.
- Overall, we saw an increase in total responses from 2022 to 2023 in both adult, (N=1,429) to 2023 (N=1,993) and child, (N=1,077) to (N=1,315).

C. Cultural & Linguistic Related Grievances

Alliance tracks and examines the number of member Cultural and Linguistic Grievances and Exempt Grievances which cover both lack of language accessibility and discrimination/sensitivity.

Table V. Cultural and Linguistic Grievances and Exempt Grievances
Medi-Cal and Group Care Combined, 2023

Grievance Type	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Grand Total
Access to Care	69	72	94	62	297
Language Assistance Plan	10	7	20	12	49
Language Assistance Provider	59	65	74	50	248
Quality of Service	26	30	37	20	186
Discrimination	23	30	32	16	169
Disability Discrimination	3	0	5	4	17
Grand Total	95	102	131	82	483

Source: CLS Grievances Report, 2023

There was a total of 186 quality of service grievances related to **discrimination** that were resolved during 2023, and all 186 cases were forwarded to the Alliance Compliance Department for further investigation and Alliance Grievance and Appeals team for a follow-up/resolution.

There was a total of 297 access to care grievance cases related to language assistance resolved in 2023. Most common grievances were requests to change PCP to a provider who spoke their language (even though education about language assistance services were made available), provider not scheduling interpreting services, and quality issues with interpreter services at the time of appointment.

Tracking and trending: Grievances filed against our Delegates/Interpreter Service Vendors are reported/reviewed during each of our quarterly Interpreter Service Vendor Joint Operation Meetings and Cultural and Linguistic Services Subcommittee meetings. All grievances are tracked and providers or vendors with two (2) or more grievances within two (2) consecutive quarters are further analyzed for a potential corrective action plan. In 2023, no formal corrective action plans were implemented, however all grievances were addressed with provider and/or interpreter service vendor, and member education was provided, as needed.

Notable Findings:

- No significant patterns of concern for individual providers or interpreter service vendors regarding language services access were identified in 2023.
- Overall, there were significant increases for language assistance grievances from 2022 to 2023 by 53% and for discrimination by 154%.

VIII. ASSESSMENT

The data included in this report is presented to the Alliance’s Cultural and Linguistics Services Subcommittee, which reports to the Quality Improvement Health Equity Committee of the Alliance Board of Governors. Participants include management and director level staff from the Health Care Services division, including the following departments: Quality Improvement, Member Services, Health Equity, Compliance, Provider Services, and Communications and Outreach. When deficiencies are identified, the committee members recommend a course of action to address the concerns and identify areas of opportunity to collaborate to improve services.

Assessment by Language:

No barriers were identified in the number of members per PCP for threshold languages for both Medical and Group Care lines of business. The number of PCPs increased for both English and Spanish, while the other threshold languages remained the same for both lines of business.

For Specialists and BH providers, English is the primary spoken language for both lines of business, which is consistent with the primary spoken language by members. Furthermore, in both of lines of business, while Spanish is the tertiary spoken language, and includes other Alliance threshold languages, there is a large number of “Other Non-English” language in both lines of business for Specialists and BH providers.

Due to lack of availability of provider language data broken down by Specialists and BH providers for Q1-Q3 2023, this made it challenging to be able to conduct a comparison and identify if there were any changes for both lines of business.

Overall, ratios of members to PCP, Specialists and BH by language remained favorable for all languages.

Assessment by Race/Ethnicity

For provider network by race/ethnicity, we found that the self-reported data for “Asian” is a broad category, which made it challenging to identify and compare with our membership for both lines of business. Although our provider network diversity reflects our membership, the proportions are not parallel. The area that warrants monitoring is the high percent of our membership who are Hispanic (Latinx), 34%, compared to the relatively low percent of providers, 6.6%. Although our clinical provider network has less Latinx representation, we observe that many provider offices have non-clinical Hispanic (Latinx) staff who function as links for Alliance members to their non-Hispanic (Latinx) providers. As well, in the Alliance Network, we have safety net providers who specialize in service our varied populations, including Tiburcio Vasquez Health Center and La Clinica who offer specialized services for our Hispanic

(Latinx) members, Native American health Center, who serves many of our Native American members and Asian Health Services, who serves a high number of our Asian members.

Assessment by Culture

The ability to communicate effectively across barriers of culture has a direct impact on the overall healthcare experience in many ways. The Alliance recognizes the diverse population in our membership and the need to include cultural influences and religion in provider education to continue to improve health care experiences and outcomes. The Alliance will continue to use the PHM Strategy Population Assessment and Evaluation to identify and address the overall member needs with the aim of improving health and supporting enhanced quality of life, and our provider diversity, equity, and inclusion trainings that the importance of cultural sensitivity when providing care to our diverse membership.

Intersection of Language/Race-Ethnicity and Culture

Although it is important to consider all dimensions of culturally and linguistically appropriate services, these do not exist in silos. For example, utilization of language services may be impacted by cultural influences. In the CG-CAHPS member satisfaction survey, we saw that members continue to rely on family and friends for both adult and child, although provider access to no cost interpreter services through the Alliance are made readily available and both member and provider education are provided. The greatest use of family and friends were seen in the “English” and “Other Languages” speaking population for child and the “Chinese” and “Tagalog” speaking population for adult, showing the need for interpreter services for both threshold and non-threshold languages and member education regarding their rights to an interpreter. In our ongoing conversations with clinics, we learned that some of this can be attributed to cultural preferences to have trusted family, or friends interpret, while for others changes in clinic practices may be needed to ensure access to quality bilingual practitioners or interpreters. We will continue to monitor and provide targeted education to providers where deficiencies are found.

Grievances regarding language access and discrimination increased significantly from 2022 to 2023. Our current internal workflows include addressing each grievance that involves a potential quality issue with tailored provider and member education. We continue to track patterns throughout the year and work closely with the Provider Services team to address network deficiencies. We also work closely with other provider-facing teams to educate providers on available language access services.

Assessment Conclusions

Overall, the Alliance continues to provide a culturally and linguistically appropriate practitioner network for its members. At this time, no adjustments are needed to the network, however, Alliance will continue to educate the practitioners in the network on the cultural preferences and beliefs of the membership they serve through our annual Cultural Sensitivity Training. Our county has a growing number of residents who speak non-threshold languages, and we continue to see a high need for Arabic, Farsi, Mam, Hindi, Khmer, and Tigrinya interpreters. Practitioners who speak these languages are often difficult to recruit and retain. While the Alliance may wish to provide a culturally and linguistically appropriate practitioner network, the overriding need to meet geographic network access requirements often necessitates that the Alliance accepts the best practitioners into our network regardless of their ability to help fill a cultural or linguistic network gap.

IX. ACTIONS

The monitoring and analysis of member characteristics and preferences indicated slight changes in the mix of characteristics from the previous year, but no radical changes. The Alliance network is already diverse and positioned to meet the cultural and linguistic needs of our population, thus there were no significant changes in the characteristics of the network during 2023. However, as the total

membership at the Alliance increases, we will build our provider network to meet that need, and continuously recruit practitioners who meet the language and cultural needs of our membership to support alignment between member's needs and preferences and our provider network.

Based upon the analysis of data received from this annual assessment, the Alliance Manager Cultural and Linguistic Services, Director of Population Health and Equity, Senior Director of Quality Improvement, Senior Director of Members Services, and Director of Provider Services will continue to collaborate on an action plan that may include, but not be limited to:

1. Member - Cultural and linguistic Services Program

The Alliance has a Culture and Linguistic Services Program with components that address the language race/ethnicity, cultural needs of our membership. Included in this program are the following efforts that support members.

- **CBO Partnerships** - Partner with community organizations with cultural and linguistic capacity, and whose personnel reflect the racial/ethnic diversity of our membership for wellness and prevention and care management services.
- **Cultural Sensitivity Training** - Continue to offer the Cultural Sensitivity Training to providers, staff, and vendors, in which we discuss culturally relevant services for our most common cultural groups served. The training was updated in 2023 to include information on diversity, inclusion, and equity, and types of biases. We also added additional resources and links on these newly added topics.
- **Culturally and Linguistically Appropriate Materials** - Translate plan materials into our five (5) threshold languages (English, Spanish, Chinese, Vietnamese, and Tagalog), review for cultural appropriateness and relevance, consider respect for religion and other cultural preferences, and ensure images reflect the racial and ethnic diversity of our members. Also, continue to offer plan materials translation into other foreign languages and alternative formats upon request.
- **Diversity in Staffing** - Hire staff with language and cultural backgrounds reflective of the Alliance membership. In 2024, we anticipate expansion of staffing in the areas of quality improvement engagement, care management, member services, and transitional care services.
- **Monitor Grievances** - Respond to member grievances against our interpreter service vendors through increased monitoring, communication, and addressed process improvement during monthly and/or quarterly interpreter service meetings. This includes, addressing exempt grievances, focusing on one-on-one provider education/coaching about availability/accessing interpreter services, provider language access responsibilities, and how the Alliance can support providers in meeting their patient's linguistic needs.
- **Network Diversity Monitoring** - Monitor member preferences and the provider network, in order to implement procedures that will match our members' cultural and/or language preferences within the contracted provider network and identify and act upon opportunities for improvement.
- **Non-Clinical Cultural Liaisons** - Expand member services and programs offered by non-clinical practitioners with lived experience and that are culturally and linguistically aligned with our members, including services such as community health workers and doula services.
- **Population Assessments** - Through our Population Health Management Program, monitor member health status, preventative services and program engagement data for inequities

based on language, race/ethnicity, and other cultural factors.

- **Provider Assignment** - Continue to use the provider directory to assign providers that meet member language and cultural preferences and assist members whose provider is not meeting their language, race/ethnicity preferences or cultural needs in switching to a provider that does.
- **Vendor Oversight** - Schedule monthly meetings with our interpreter service vendors to address enhancements and/or process improvements to the current workflow as well as address any unfulfilled language trends and need to increase of availability of interpreters and/or by geographic area.

2. Practitioners - Cultural and Linguistic Services Program

- **Cultural Sensitivity Training** - Ensure that our contracted health care providers, subcontractors, and downstream subcontractors participate in Cultural Sensitivity Training that covers the language access, including availability of interpreter services, best practices for working with interpreters, and how to access interpreters for patients, as well as information on working with the diverse cultures represented in the Alliance membership.
- **Data Sharing** - Make available to providers up-to-date information on the language needs of members through PCP member roster available on the Provider Portal and Alliance Provider Website.
- **Interpreter Services Monitoring** - Continue to contract with and monitor interpretation and translation services that assist us in meeting the cultural and linguistic needs of our membership and conduct provider outreach and education when patterns of concern are identified. In particular, the Alliance addresses any instances of providers relying on family or friends as interpreters and providers who are not offering members interpreter services.
- **Network Recruitment** - Make efforts to recruit, credential, and contract with a diverse network of providers whose cultures, race/ethnicity, and languages spoken reflect our membership. Alliance will focus specifically on Spanish, Chinese, Vietnamese, Tagalog, Arabic and Farsi speaking practitioners or speaking providers or staff who are qualified to interpret in communities with higher concentrations of members speaking these languages, as well as practitioners whose race/ethnicity reflects the Alliance membership, such as Hispanic (Latinx) providers.
- **Provider Assignment** - Collect and maintain information on provider race/ethnicity and make available to Alliance staff to assist in matching providers to member preferences.
- **Provider Education** - Regularly inform providers of Alliance interpreter services and the importance of culturally competent services through regular updates in various Alliance provider communication, such as the New Provider Orientation, Provider Quarterly Packets, Provider Manual, provider information on the Alliance website, and the Alliance Interpreter Services Guide for Providers, which describes access to on-demand telephonic interpreters, and the Interpreter Services Request Form for requesting prescheduled interpreters.
- **Provider Language Monitoring** - Maintain information on provider language capacity and update regularly in both online and printed provider directory. Verify and correct when needed the provider language listing.
- **Provider Race/Ethnicity Data Collection** - Improve the self-reported categories for providers by race/ethnicity for "Asian" to ensure granular data is captured and be able to conduct a comparison with our membership by race/ethnicity.

- **Targeted Provider Outreach** - Identify and conduct targeted outreach to provider offices that demonstrate a pattern of potential quality issues related to quality of language to better understand their linguistic needs.
- **Targeted Provider Recruitment** - Continue to monitor the availability of Hispanic (Latinx) providers and explore the use of provider network development incentive funds to support recruitment of culturally concordant providers.

3. Ongoing Monitoring and Continuous Improvement

The Alliance monitors and continuously improves Alliance activities aimed at achieving cultural competence and reducing health care disparities.

- Require practitioners to complete cultural competency courses based on content that reflects the racial/ethnic composition of the Alliance membership population discussed in this report. Further develop this course as needed.
- Conduct regular monitoring of CLS programs, including but not limited to language services usage and access, and reporting to the QIHEC and/or the Board of Governors.
- Conduct facility site reviews for compliance with Cultural and Linguistic services requirements including: 24-hour interpreter services and capacity and training of bilingual medical and interpreter staff.
- Create quarterly reports on CLS for review by QIHEC. Including, but not limited to the following:
 - Monitoring of grievances and appeals and potential quality issues related to quality of language, and cultural and linguistic services to identify areas of improvement as well as report on trends/data to appropriate department(s).
 - Monitoring requests for language services and language services fulfillment metrics. Identifying language trends that show a need for language access improvement.
 - Monitoring of the provider network's language capacity and race/ethnic diversity.
- Monitor contracts with interpreter service vendors for the service level and monitor quality of bilingual staff language skills through yearly review of certifications. Including, addressing unfulfillment rates for all foreign languages and American Sign Language (ASL).
- Present results of all monitoring activities of the CLS program to the CLSS, QIHEC, and Community Advisory Committee (CAC) for input and opportunities for areas of improvements.
- Monitor and investigate, including timely acknowledgment and resolution of discrimination and language assistance grievances.
- Leverage opportunities to educate providers on available language assistance services and culturally effective communication through existing provider and Alliance meetings as well as community-based organization collaborations.