



**Availability of Practitioners to meet the
Cultural Needs and Preferences of Alliance Members**

**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. language, race/ethnicity and cultural backgrounds of Alliance members
- ~~1-2.~~ Conduct research into the cultural needs and preferences based on characteristics of Alliance members.
- ~~2-3.~~ Identify language, race/ethnicity and cultures of practitioners in the network to assess whether they meet members’ needs
- ~~3-4.~~ Assess whether members’ CLS needs and preferences were met

4.5. 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 |
| <u>Pew Research Center Religious Landscape Study</u> | <u>2014 Report</u> | <u>Religious preferences by region.</u> |
| Alliance Population Health Management (PHM) Strategy- Population Assessment | Annually | All Alliance Members and by Subpopulation |

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 |
| <u>Alliance PHM Strategy Population Assessment</u> <u>Pew Religious Landscape Study</u> | <ul style="list-style-type: none"> <u>Assess cultural gaps within subpopulations of the network by examining race/ethnicity and language disparities % of individuals in region who identify with specific religious beliefs.</u> |

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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.

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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. Data Collection: Assessing Cultural, Language, Ethnic/Racial, and Racial needs of Alliance Members

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A. A. Member Preferred Language

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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.

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Table C. Alliance Membership Threshold Languages, December 2023

By Membership Count and Percent*

| Total by Plan | Threshold Languages | | |
|----------------------------|---------------------|---------|--------|
| Medi-Cal 346,228 | English | 217,727 | 62.89% |
| | 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

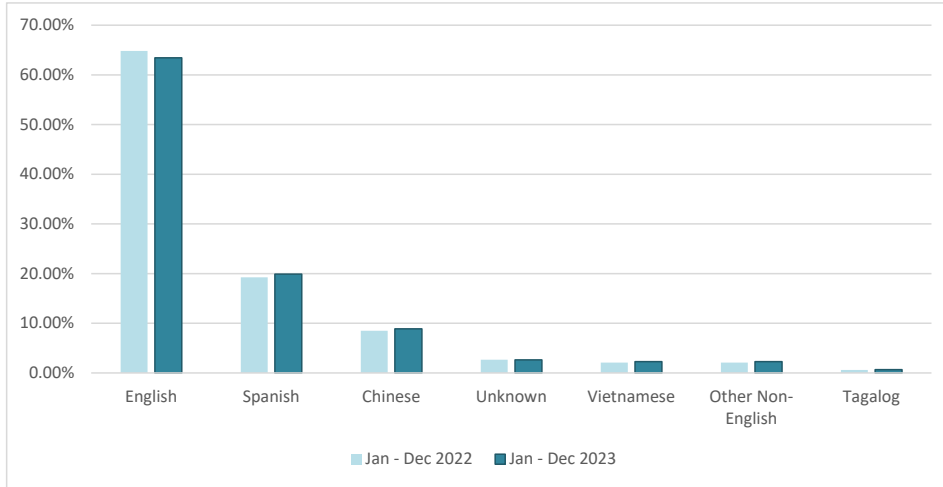
The threshold languages are defined as languages spoken by either 3,000 or 5% of eligible beneficiaries residing in the Alliance’s service area who indicate their primary language as other than English, whichever is less. A more detailed look at languages spoken by the Alliance membership by lines of 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



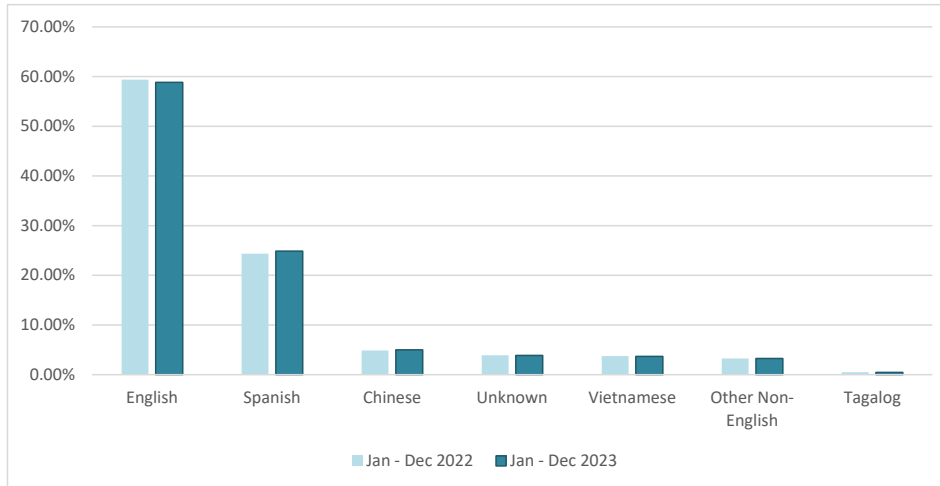
Source: Alliance Monthly Health Education Report, December 2023

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

| GROUP CARE | Prior Year | YTD | % Change | Current Month | | |
|--|----------------------|-------------------|--|---------------|---------------|--------|
| 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 | 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. 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% |

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|---|-------|-------|--------|----------------|-------|
| 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 % |
| Alameda Alliance for Health Membership by Race/Ethnicity | | | | | |
| 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.

C. Member and Provider Cultural Preference

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)

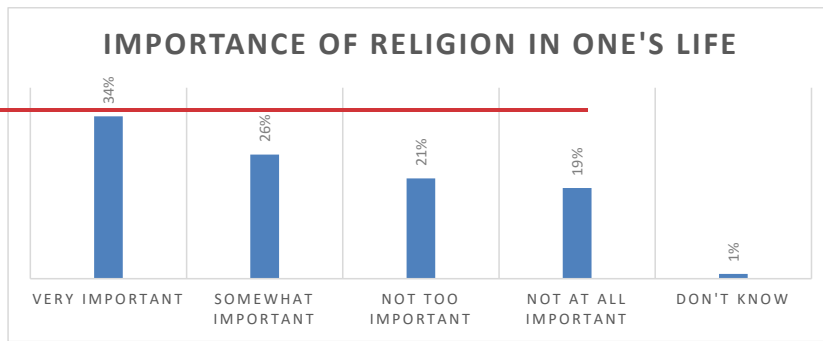
African American: African American adolescent males are affected by physical and emotional stressors that include "adverse experiences such as racism, poverty, incarceration, and the lack of positive emotional attachments". African American males must be engaged in ways that honor how they experience 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)

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 (acmhhsa.org)

Pacific Islander: A study by the Stanford School of Medicine reported that Pacific Islanders are a very



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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 for Alliance members and providers is not available, but this information for the San Francisco metro area shows that religious beliefs should be included in cultural sensitivity training for providers.

Health disparities by race/ethnicity

The Alliance used the Population Assessment based on 2023 data for Medi-Cal and Group Care populations in the 2024 PHM Strategy to assess cultural gaps within subpopulations of the network by examining race/ethnicity/language disparities.

The following gaps and disparities were identified by race/ethnicity:

- American Indian or Alaskan Native Alliance Members
American Indian or Alaskan Native members are 0.2% of Medi-Cal (487 members) and 0.1% of Group Care (7 members). For Group Care the population is too small for comparison.
 - Homelessness: The prevalence of homelessness was 8.0% of American Indian or Alaskan Native Medi-Cal children and 15.7% of Medi-Cal adults.
 - Depression: The prevalence of depression by race/ethnicity was highest for American Indian or Alaskan Native members: 3.6% of Medi-Cal children and 10.4% of Medi-Cal adults.
 - Breast cancer screening: The rate of breast cancer screening for American Indian or Alaskan Native Medi-Cal members was 32.61%, below the MPL of 50.95%.
 - Emergency visits and admissions: The rates of admissions, emergency visits, and high ED use were higher for American Indian or Alaskan Native Medi-Cal adult members. The emergency visit rate was highest among children.
- Asian American and Pacific Islander Alliance Members
Asian American and Pacific Islander members are 24.2% of Medi-Cal (55,478 Asian American and 5,370 Pacific Islander members) and 49.2% of Group Care (2,251 Asian American and 53 Pacific Islander members).
 - Diabetes and hypertension: The prevalence of diabetes, hypertension, and diabetes with hypertension were higher in various Asian American and Pacific Islander groups, which was expected since this is an older population. About a fifth of Other Asian, Filipino, or Pacific Islander members had both diabetes and hypertension. Other Asian

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American groups still had significant numbers of members with both diabetes and hypertension.

- Women's cancer screenings: In Group Care, Other Asian members made up a quarter of the breast cancer and cervical cancer screening HEDIS samples and were below the 50th percentile for both. "Other Asian" is mostly Asian Indian members in the Group Care line of business.
- Transitional Care Services care manager contact: Compared to 17.1% of transitions that had a care manager contact within 7 days, the rate was 7.8% for Asian and 6.9% for Pacific Islander members.
- No PCP visits: While Chinese and Vietnamese groups had lower rates of no PCP Visits, Filipino Medi-Cal members had higher no PCP visit rates for children (53.3%) and adults (65.0%), and Pacific Islander members had higher rates for Medi-Cal children (48.4%) and Group Care (43.4%). Filipino members were below MPL for Well Child Visits in the First 15 Months (W30-6), and Pacific Islander members were below for Child and Adolescent Well-Care Visits (WCV).

• Black or African American Alliance Member

Black or African American members are 13.6% of Medi-Cal (34,101 members) and 11% of Group Care (514 members).

- Homelessness: The prevalence of homelessness indicators was 10.2% of Medi-Cal children, 17.6% of Medi-Cal adults, and 4.9% of Group Care. By count they were the largest group for Medi-Cal adults and Group Care.
- Well-child visits: Well Child Visits in the First 15 Months (W30-6) and Ages 15 to 30 Months (W30-2) were both below MPL. In addition, they had the highest rate of no PCP visits for children and adolescents at 56.7%.
- Breast cancer screening: Breast cancer screening in Black (African American) members was below the 50th percentile for both Medi-Cal and Group Care.
- Chronic disease: Asthma had both high prevalence and count for Black (African American) members. The prevalence of diabetes and hypertension were similar to the overall population but still had large numbers.
- Emergency visits and admissions: Black (African American) adult Medi-Cal members had the highest rates of admissions, readmissions, emergency, and high ED use. ED use and admissions were also high for Medi-Cal children and Group Care members. One fifth of members used the ED more than primary care.
- Perinatal health: Black (African American) perinatal Medi-Cal members had a higher prevalence of premature birth (1.1% compared to 0.8% overall). For both lines of business about 15% of Black (African American) pregnant members had depression compared to 11.4% for Medi-Cal and 8.9% for Group Care pregnant members.

• Hispanic (Latino) Alliance Members

Hispanic (Latino) members were 30.4% of Medi-Cal (76,356 members) and 4.5% of Group Care (209 members).

- Chronic disease: Although Hispanic (Latino) members had a lower prevalence of chronic diseases, in Medi-Cal they are still the largest group after Other ethnicity.
- Perinatal health: Hispanic (Latino) members are also the largest group after Other ethnicity among perinatal members. They had the highest count (21 members) and rate of prematurity (1.2%).

• White Alliance Members

White members were 7.9% of Medi-Cal (19,742 members) and 2.0% of Group Care (93 members).

- Homelessness: The prevalence of homelessness indicators was highest for White Medi-Cal adults (17.7%) and Group Care (5.2%).
- Primary care: White Medi-Cal adults had a higher rate of no PCP visits (70.4%) and

admissions (10.3 admits/1000). Almost one fifth of members used the ED more than primary care.

- Depression: The prevalence of depression was 9.3% for White Medi-Cal adults and 10.8% for Group Care compared to 6.0% for all Medi-Cal adults and 4.7% for all Group Care members.

Notable Findings:

- The Population Assessment in the PHM Strategy showed that there were many differences seen by racial/ethnic groups.
- All race/ethnicities need culturally concordant education and outreach for preventive care services, transitional care services, and chronic disease management.
- American Indian or Alaskan Native and Black or African American members as well as White adult members also need support with housing and other related basic needs.
- The Alliance has programs and activities to address the areas of member needs described, but programs may have limited capacity or reach compared to the number of members who would be eligible for the programs and services. Chronic disease management programs have been recently expanded, so improved outreach efforts, culturally appropriate approaches, and other program development are still underway. Quality improvement and non-utilizer outreach efforts have had challenges with no responses or no shows.

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

A. DC. Provider Language Capacity 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 HHI. 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.

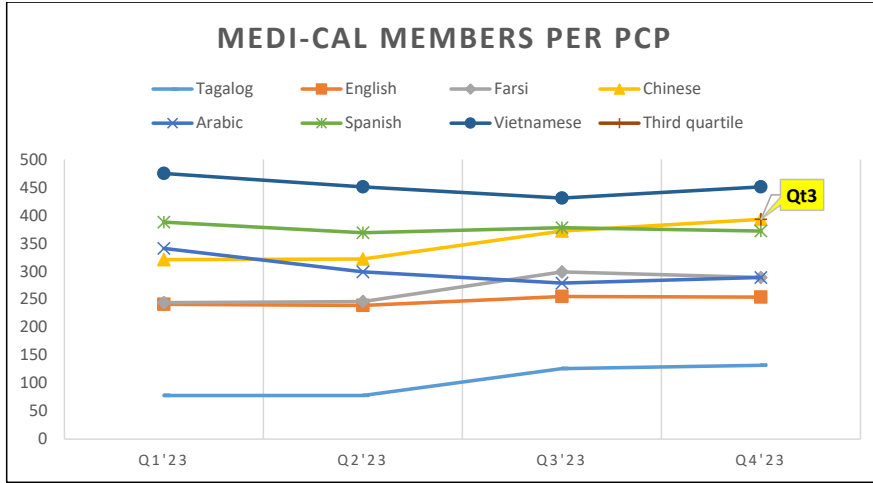
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Figure 354. PCP Language Capacity-Medi-Cal, 2023



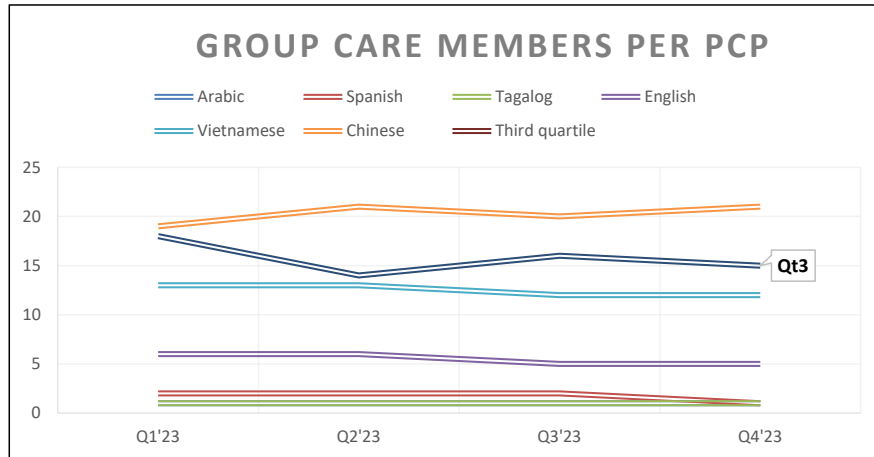
Source: Provider Language Access Report, 2023

Table 14. 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 465. PCP Language Capacity-Group Care, 2023



Source: Provider Language Access Report, 2023

Table 464. 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 KKL. 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 LML. 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 |
|--------------|--------------|----------------|

Source: Provider Language Access Report, Q4 2023

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

| Language | Q4 2023 | | |
|-------------------|-----------------------------|--------------|-------------------|
| | 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. ED. Provider Race/Ethnicity Assessment 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.

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Table [NON](#). 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 Alaska 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 [OPO](#). 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 Alaska 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. E. 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)

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)

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)

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

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Religion

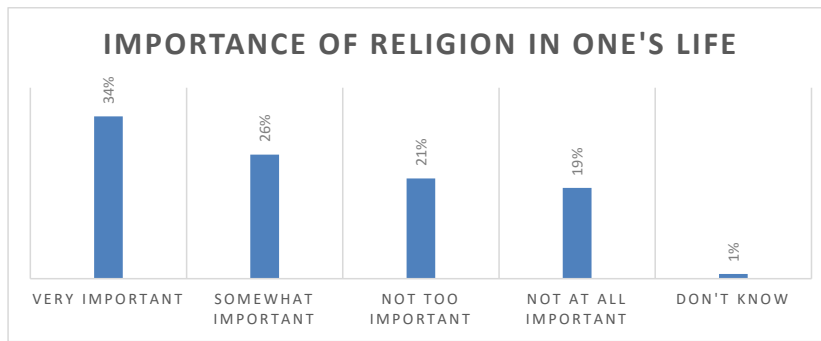
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The Pew Research Center Religious Landscape Study from 2014 was used to understand the religious beliefs of adults in the San Francisco metro area.

Table PH. 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 53. 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. Assess Whether Members' Language Needs and Preferences Were Met- Analysis of Member Language Services, Survey Feedback and Member Grievance Data.

3. A. FE- 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 QR. 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% |

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| | | | |
|-------------------------------------|----|-----|---------|
| 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 RQ. 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 SR. 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. ~~GF~~ 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.

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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 15. 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 16. 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% |

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. H. 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.

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Table VU. 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 [preferences-influences by race/ethnicity/language-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

4- 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.

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- ~~• 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.~~
- ~~• 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.~~
- **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.

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- 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.
- 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.
- 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.
- 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.
- Continue to offer the Cultural Sensitivity Training to staff and practitioners, 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.
- 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.
- 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.

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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.

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- **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.
- ~~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.
- **Provider eEducation** - 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.
- ~~Ensure that our contracted health care providers, subcontractors, and downstream subcontractors are compliant with all standards related to the Alliance's Cultural and Linguistic Services Program, including participation in Cultural Sensitivity Training that covers the availability of interpreter services, best practices for working with interpreters, and how to access interpreters for patients.~~
- ~~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.
- **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.
- ~~Collect and maintain information on provider race/ethnicity and make available to Alliance staff to assist in matching providers to member preferences.~~
- **Targeted Provider Outreach** - Identify and conduct targeted outreach to provider offices that are 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

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recruitment of culturally concordant providers.

~~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.~~

3. C. 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.

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