Cultural & Linguistic Program Description

MCND9002

November 13, 2024

Original Date:

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

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

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Program Purpose

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

Introduction

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

Partnership also works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 21-004.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members, regardless of sex, race, color, national origin, religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964 or Section 1557 of the Affordable Care Act of 2010. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.[3]

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing materials are routinely distributed in all of Partnerships threshold languages, meet the

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[1] National Culturally and Linguistically Appropriate Services Standards
[2] APL 21-004 and Threshold and Concentration Languages
[3] Penal Code 422.56 [4] APL 18-016 Readability and Suitability of Written Health Education Materials

requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[4] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

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

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.[5,6,7,8,9]
- Continually assessing, monitoring, improving and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members

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

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[4] APL 18-016 Readability and Suitability of Written Health Education Materials
[5] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[6] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[7] 42 CFR 438.206(c)(2); 438.10; 438.404
[8] W&I Code 14029.91
[9] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

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

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MCND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 21-004 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals), as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 21-004 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[10] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

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

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

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

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

Partnership distributes a written notice in English and up to 18 languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.[11]. Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery in a culturally sensitive and linguistically appropriate manner. Members are informed when language information is directly collected that their language preferences may be shared.

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

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[12] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

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

[12] DHCS Basic Population Health Management Policy Guide

(CHIP) process. Based on this collaborative work, and input from various stakeholders, Partnership annually reviews and updates its strategies and work streams related to the DHCS goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.[13] Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership members are entitled to interpretation services and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, and Transportation). Members can also call a toll-free number with TTY/TDD.

Language Assistance Taglines, Nondiscrimination Notices, and Member Information

In alignment with APL 21-004[14] and other DHCS requirements, Partnership publishes nondiscrimination notices and language assistance taglines. They are sent with all member correspondences as well. Language assistance taglines are published in a conspicuously visible font size in English and California's top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members of all available language assistance services and how to access them (including written translation and interpretation). These taglines and nondiscrimination notices are in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages and alternative formats (including Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format), and Auxiliary Aids at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. Vital member correspondences include, but are not limited to:

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

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[13] DHCS Comprehensive Quality Strategy

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

- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public

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

a) In a conspicuous place in all physical locations where Partnership interacts with the public;
b) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

In alignment with DHCS requirements, all member facing material and correspondences are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format, and are approved by DHCS before distribution. Health education materials are approved by a Qualified

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

Health educator as defined by APL 18-016.[16] Translation of member facing materials are provided to members at no cost to them.

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

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, at no cost to the member.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS APL 21-004. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see attachment MCND9002 D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 21-004.[12] Per this APL, a translator interpreting for Partnership member must:

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

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

- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Partnership has requirements for their translator certification process, as set forth by ULG Services in MCND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Oral interpreter services are available for any language spoken by the member (see MCND9002 attachment A for criteria and authorization requirements for interpreting services). Key points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Interpreter services are available in all of Partnership's threshold languages, and over 200 additional languages are available upon member request through Partnership's contracted language service provider. Member's preferred language (if other than English) is also prominently noted in their medical record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964[17]. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language.

Partnership has contracted with AMN HealthCare as their language interpretation service provider. Sight translation (oral interpretation) of written information can also be provided upon member request. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also

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

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

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

- Has demonstrated proficiency in speaking and understanding both spoken English and the non-English language in need of interpretation,
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology; and,
- Adheres to generally accepted interpreter ethics principles, including client confidentiality.

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance per the requirements stated in APL 21-004. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes). When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership does not allow for the use of adult friends, family, or minor accompanying a member to interpret. The exceptions to this rule are as follows:

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

Auxiliary Aids and Services

In accordance with APL 21-004 and APL 22-022, Partnership provides the following auxiliary aids and services to members, their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with ("companion") by request or as needed, and at no cost to the member:

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

Please see MCND 9002 attachment B to learn how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 21-004 and APL 22-002, Partnership provides member information to members and potential members in alternate formats to meet the cultural and linguistic needs of members, including Braille, large print text (20 point font or larger), audio, and electronic formats, at no cost. Partnership maintains record of member's linguistic capability upon member enrollment, and as reported thereafter, using data provided by DHCS or reported to Partnership by the member and/or their

AR, or by Subcontractors. Partnership members, their ARs, or someone with whom it is appropriate for Partnership to communicate with ("companion"), are encouraged to call Partnership or report their format preference via the DHCS AFS application system; this information is then passed on to Partnership for incorporation into the member record and implemented as appropriate.

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.[18]

Trainings

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

Also in alignment with APL 23-025, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 themes

[18] APL 22-002 Alternative Format Selection for Members with Visual Impairments
[19] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements

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

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

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

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

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

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

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of

Partnership's members. Using the results from an annual, self-reported survey of our primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices. Annually, Partnership performs an audit of its contracted translation and linguistic services providers (including employees, contracted staff, and other individuals who provide linguistic service) to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

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

Member-facing Departments include:

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

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees all regulatory requirements related to Cultural & Linguistics services program and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership recently created the Population Needs Assessment Committee to review findings and strategies to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system to address improvements in the quality

of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

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

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

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

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

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

Quality Improvement Health Equity Committee

HEALTH SERVICES TEAM

Chief Health Services Officer

Director(s)

Associate Director

Manager(s)

HEALTH EQUITY

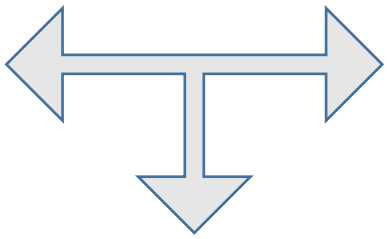
Director/Officer of Health Equity

Tribal Liaison

EXECUTIVE LEADERSHIP

Chief Operations Officer

Chief Medical Officer



REGIONAL ENGAGEMENT

Regional Representatives

Regional Medical Directors

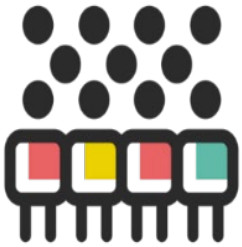
DEPARTMENTAL REPRESENTATION

Quality

Improvement

Health Equity

Human Resources



Provider Relations

Behavioral Health

OpEx/PMO

Transportation Services

Community Engagement

Partnership's Consumer Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community see attachment MCND9002-E CAC Guiding Principles and attachment MCND9002-F FAC Charter for additional details. The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD), persons with chronic conditions, Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

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

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services;
- Health related initiatives;
- Resource allocation; and
- Other community-based initiatives

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of

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

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

Goals and Work Plan

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

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

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L work plan to all stakeholders, constituents, and the general public.

2024-2025 Goals

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

- Goal 1: By December 31, 2024 90% of members requesting an alternate format will receive at least one mailing in their preferred format.
    - This goal was chosen to ensure members are receiving information in a way that they can understand.
- Goal 2: By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.
    - This goal was chosen to strategize and streamline required initiatives to advance Health Equity.
- Goal 3: By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables.
    - This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 4: By December 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen in order to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%.
    - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
    - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.

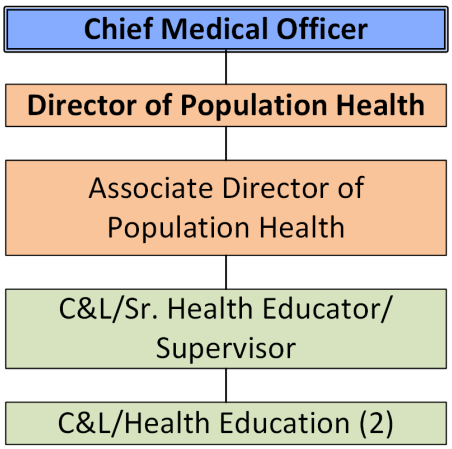
- Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

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

Population Health Department Structure

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

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MCND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts include making referrals to culturally and linguistically appropriate community service programs, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services.



Team Roles and Responsibilities

Chief Medical Officer:

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

Director of Population Health

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

Associate Director of Population Health

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

Supervisor

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound

judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff.

Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

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

Health Educator(s)

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

Criteria and Authorization Requirements for Interpreting Services

Telephonic or Video Remote Interpreter Services

a. Member or patient (non-member) is being seen at a PHC contracted provider site.
b. Member or patient does not have other health coverage (OHC) that covers the requested/required interpreting service.
c. Telephonic or Video Remote Interpreter Services do not require prior authorization through PHC's Member Services.

Sign Language Interpreters

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. Appointment is for a service that is covered by PHC.
d. Member has hearing and/or speech impairment.
e. Sign Language Interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.

Face-to-Face Interpreter Services

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. The appointment is for a service that is covered by PHC.
f. Face-to-face interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.
d. Behavioral Health Treatment (BHT) services for members under 21 years of age, such as evaluations and Applied Behavior Analysis, in a therapeutic and/or home setting are a PHC benefit and fall under PHC responsibility to arrange and schedule face-to-face interpreter services.
e. If face-to-face interpreter services are being requested at a hospital, PHC staff contacts the Patient Services department at the hospital for these services. If the hospital refuses to provide these services, PHC arranges the service. The Provider Relations department is notified of the hospital's refusal to provide service.
f. If face-to-face interpreter services are being requested for PHC Medi-Cal covered mental health services, the caller is referred to Carelon Behavioral Health (formerly Beacon Health Options) at (855) 765-9703. Carelon is responsible to provide face-to-face interpreting services. Members are advised to contact Carelon three (3) business days in advance of their appointment to arrange the service.

Providing Auxiliary Aids and Services for Persons with Disabilities

1. Identification and Assessment of Need:
    a. PHC provides notice of the availability of and procedure for requesting auxiliary aids and services through our language assistance taglines and non-discrimination notices.
    b. When a member, their authorized representative (AR), or someone with whom it is appropriate for PHC to communicate (hereafter called "companion") identifies as having a disability affecting the ability to communicate, access, or manipulate written materials, or requests an auxiliary aid or service:
        i. The member/AR/companion can fill out and submit PHC's Auxiliary Aid Request Form
            1. PHC staff will notate this request and reach out to the member/AR/companion to determine what aids or services are necessary to provide effective communication, based on their identified disability.
        ii. The member/AR/companion can tell PHC staff over the phone about their auxiliary aids or services request.
            1. PHC staff will notate this request at time of call.
            2. PHC staff will then work with the member/AR to determine what aids or services are necessary to provide effective communication based on their identified disability.

2. Provision of Auxiliary Aids and Services:
    a. PHC staff will determine and provide the appropriate aid and/or service necessary for members/ARs/companions with impaired sensory, manual, or speaking skills in a timely manner. MCND9002 lists the auxiliary aids and services PHC provides.

Threshold and Concentration Languages

For All Counties as of *July 2021*

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Alameda (5)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N	Y
Alpine (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Amador (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Butte (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Calaveras (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Colusa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Contra Costa (3)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Del Norte (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
El Dorado (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Fresno (3)	N	N	N	N	Y	N	N	Y	N	N	N	N	N	N	Y	N	N	N
Glenn (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Humboldt (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Imperial (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Inyo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Kern (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Kings (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lake (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lassen (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Los Angeles (11)	Y	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N	Y	Y	Y	N	Y
Madera (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Marin (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Mariposa (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Mendocino (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Merced (3)	N	N	N	N	Y	N	N	Y[2]	N	N	N	N	N	N	Y	N	N	N
Modoc (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Mono (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Monterey (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Napa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Nevada (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Orange (7)	Y	N	N	Y	Y	Y	N	N	N	Y	N	N	N	N	Y	N	N	Y
Placer (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y[2]	Y	N	N	N
Plumas (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Riverside (3)	N	N	N	Y[2]	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Sacramento (8)	Y	N	N	Y	Y	Y	N	Y	N	N	N	N	N	Y	Y	N	N	Y
San Benito (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Bernardino (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	Y
San Diego (7)	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	N	Y
San Francisco (6)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y[2]	N	Y
San Joaquin (3)	N	N	N	Y[2]	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Luis Obispo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Mateo (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y[2]	N	N
Santa Barbara (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Santa Clara (5)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N	Y
Santa Cruz (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Shasta (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Sierra (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Siskiyou (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Solano (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	Y[2]	N	N
Sonoma (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Stanislaus (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Sutter (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Tehama (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Trinity (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Tulare (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Tuolumne (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Ventura (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Yolo (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y^2	Y	N	N	N
Yuba (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

Notes:

Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language. Where Chinese has been identified as a threshold or concentration language and the member has requested to receive translated written information in either traditional or simplified Chinese characters, the Medi-Cal Managed Care Health Plan (MCP) must provide written information in the member's preferred characters. However, if the member has not indicated a preference for simplified or traditional Chinese characters, and the MCP does not yet have a process in place to provide written translations in Chinese, the MCP must provide translations in traditional Chinese characters. Only upon member request will the MCP be required to provide translated written information in simplified Chinese characters.*

**Hindi, Japanese, Laotian, Mien, Punjabi, Thai, and Ukrainian are new languages added per APL-21-004. As of July 2021, there is no data available for Ukrainian language.

1) Threshold Standard Languages (Y) ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county.

2) Concentration Standard Languages (Y^2) ≥1,000 per zip code or ≥1,500 per two contiguous – **Hmong** in Merced County, **Tagalog** in San Francisco, San Mateo, and Solano counties, **Russian** in Placer and Yolo counties, & **Chinese** in Riverside and San Joaquin counties.

UNITED LANGUAGE GROUP®

United Language Group: Quality and Culturally and Linguistically Appropriate Translation Services

September 27, 2023

UNITED LANGUAGE GROUP

ULG: Written Translation Quality Processes and Overview

United Language Group has nearly four decades of experience providing qualified written translation and localization services for the U.S. healthcare, health insurance and medical industries in over 235 languages. We approach language access with evidence-based solutions, proactive measures and culturally-sensitive communication to ensure equitable, meaningful access for all diverse communities and populations

From health education and vital documents to member outreach and enrollment materials, ULG delivers high service standards with every translation project, delivering language translation with quality, service and speed. Our ISO-certified quality assurance processes, rigorous linguist assessment and qualification requirements, and metric-driven reporting ensure that all translated materials meet the high level of accuracy that is required while still resonating on a cultural level.

1. Translator Qualifications and Language Proficiency Assessments

ULG has adopted a rigorous screening and training process to assess, evaluate, and qualify our healthcare translators. All translators must be native speakers of the language into which they translate, and most average ten or more years of experience in most languages, hold language certification and/or advanced degrees, and all must pass a variety of tests and questionnaires to measure each applicant's language skill and proficiency in source and target languages, as well as healthcare terminology and cultural appropriateness. The results, combined with the applicant's background and experience, indicate whether a linguist is skilled and proficient enough to work with ULG. We further continue this with training, rating, and assigning the most appropriate translators to work on any given project. Please see below for requirements for our translators in our linguist qualification policy:

- Must pass a rigorous translation test for accuracy and regional nuance.
- Most hold a verifiable language certification and at least one advanced degree from a recognized university. Additional degree(s) in industry subject matter are preferred and prioritized
- Must be a native and primary speaker of their target language(s).
- Must have >5 years of professional translations experience. >10 years is preferred and prioritized.
- Must provide 3+ contactable references from clients and samples of previous work to be assessed.
- Ongoing assessment: In addition to these entry criteria, ULG linguists are continuously assessed at the project level as part of the QA step.

Additionally, ULG looks to ensure the following:

- ATA Accreditation: Many of our translators are certified by the American Translators Association (ATA). However, ATA certification is not available in many of the language pairs of the U.S. LEP populations. Due to our high standards of linguist proficiency requirements, we rely on our multi-step qualification process and translator's background, assessment results, education and references to determine their skill level.
- Technical capabilities: We require translators have appropriate electronic tools, working

knowledge of translation memory, automated term lists and other software programs.

- Onboarding: Once a translator is qualified and approved through the recruitment and qualification process mentioned above, an on-boarding process is in place that includes contract signing, confidentiality agreements, portal training and customer-specific training as well as process and policy review.
- Ongoing monitoring: Work completed by our active translators undergoes our internal quality assessment audits on a regular sample of translation projects. All linguists must maintain high quality scores on these audits to continue working with us.

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2. Metrics and KPI's For Consistent Service Delivery

ULG's Quality/Information Security Management System (QMS/ISMS) guides our policies, principles, processes and procedures which describe how ULG manages organizational goals, meets applicable customer and regulatory requirements and complies with our ISO certifications (see attached)

Our quality process enables us to optimize our services and deliver consistent quality, and timely language services. This approach also facilitates achieving consistent results by measuring KPI's such as turnaround time, accuracy and more, thereby helping to ensure timely, accurate and reliable translations that meet client requirements. Metrics and KPIs tracked include:

- On-time deliveries: ULG maintains a 99% on-time delivery (OTD) rating. On-time delivery is automatically tracked through our secure portal and Translation Management System. ULG translation services and timelines are aligned to meet customer-specific or product-specific timelines, such as rapid-turn Grievance and Appeals, annual enrollment materials, and more.
- Translation Quality: Measuring translation quality is vital to understanding and evaluating final deliverables. Regular quality-level audits help to identify any potential issues with processes/resources and allow us to identify trends that require immediate corrective action.
- Customer Satisfaction: Gathering feedback directly from our clients allows us to identify potential issues which are not visible/identifiable from other reports/KPIs. As well, it indicates where improvements and innovations may be needed.
- TM leveraging analysis: By analyzing TM (translation memory) we identify content trends and savings to maximize the TM leveraging.
- Utilization: Comparing translation volumes against utilization numbers is a great way to identify ULG's capacity for scalability planning for account growth and managing volume projects.

3. Language Quality Control and Quality Assessment Process

Language quality control is at the heart of ULG's ability to help ensure accurate, effective and culturally appropriate translations. Our documented quality-driven policies, procedures, evaluation

standards, and multi-step translation processes, help ensure consistently high quality for every translation in every language.

ULG knows the importance of ensuring linguistic accuracy, readability, and cultural appropriateness in written translations. Our teams take special care to ensure cultural nuance and appropriate literacy levels are applied to each delivery. We also follow industry-leading best practices from healthcare-focused institutes such as Centers for Medicare & Medicaid Services, Department of Health and Human Services, American Medical Association and more. Some examples include:

- Utilizing qualified, subject-matter professional translators who have the appropriate cultural knowledge, translation and writing skills needed to for high-quality, culturally appropriate translations.
- A requirement for using multiple, separate and qualified professionals listed above for every translation.
- Providing linguists with training, reference/ background information, target audience insight, and any specific requirements to better result in a translation that resonates with the intended recipient.
- Ensuring translations preserve the content and meaning of the original text, easy to understand, and translated with cultural and linguistic sensitivity as needed.
- Multiple QA steps to ensure translated text is reviewed for accuracy, cultural and linguistic appropriateness, and literacy level consistency.

Quality Control is measured across the process. Separate, experienced, native-speaking linguists translate, edit and proofread each translation as well as perform an auto check to ensure content matches any approved term lists/glossaries. Separate, qualified proofreaders are utilized with every language pair and service we offer. Proofreaders check for any errors in the grammar, syntax, punctuation, sentence structure and more. They also can check to ensure that the translated text is contextually correct and culturally appropriate. Translated and formatted documents can also go through an additional multi-step Third-Party Quality Assurance (QA) process that includes tasks such as checking sizing and placement of text or headers/footers, text and graphic formatting, function of hyperlinks, updating/ formatting of tables of contents and indices, formatting/placement of bullets and margins and column and page breaks. Quality e assurance representative sign off on the process once complete and is saved for tracking purposes.

Leslie Iburg

Leslie Iburg
Director of Healthcare Accounts
United Language Group,
September 27, 2023

Certificate of Registration

This certifies that the Information Security Management System of

United Language Group, Inc.

1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

has been assessed by NSF-ISR and found to be in conformance to the following standard(s):

ISO 27001:2013

Scope of Certification:

The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020

Statement of Applicability (SOA): January 27, 2020 V 7.0

Sameer Vachani
Senior Director, NSF-ISR

Certificate Number:	C0748976-IM3
Certificate Decision Date:	17-MAR-2023
Certificate Issue Date:	24-MAR-2023
Cycle Effective Date:	11-APR-2023
Certificate Expiration Date*:	10-APR-2026

Issued by:
NSF International Strategic Registrations (NSF-ISR)
789 N. Dixboro Road, Ann Arbor, MI 48105 USA

Authorized Certification and/or Accreditation Marks. This certificate is property of NSF-ISR and must be returned upon request.

Company is audited for conformance at regular intervals. To verify certification call (888) NSF-9000 or visit our web site at www.nsf-isr.org

ANAB ANSI National Accreditation Board ACCREDITED ISO/IEC 17021-1 MANAGEMENT SYSTEMS CERTIFICATION BODY

MEMBER OF MULTILATERAL RECOGNITION ARRANGEMENT IAF

Certificate of Registration

ANNEX PAGE FOR CERTIFICATE NUMBER: C0748976-IM3

This Annex is only Valid in connection with the above-mentioned certificate issued by NSF-ISR

CERTIFICATE ISSUE DATE:
24-MAR-2023
CERTIFICATE EXPIRATION DATE:
10-APR-2026

United Language Group, Inc.
1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

Location:	Scope:
United Language Group, Inc. - 67852 Unit 27 Glenrock Business Park Ballybane, Galway, H91 AE12, Ireland	The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020
Location:	**Scope:**
United Language Group, Inc.- C0359514 Office No. 713- 714, Neelkanth Corporate IT Park Neelkanth Corporate IT Park Kirol Road, Vidyavihar (West) Mumbai, 400086, India	The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020

Issued by:
NSF International Strategic Registrations (NSF-ISR)
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MEMBER OF MULTILATERAL RECOGNITION ARRANGEMENT
IAF

Consumer Advisory Committee Guiding Principles

I. Purpose & Overview

The purpose of the Consumer Advisory Committee (CAC) is to act as a liaison between Partnership HealthPlan of California (Partnership) and our members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership's CAC is primarily composed of members, advocates, and stakeholders. The CAC may also include participation from select providers within the service area. Partnership values the input received through the CAC and considers the feedback during annual reviews and policy/procedural updates that affect quality and Health Equity. Additionally, Partnership provides relevant updates to the CAC on how their input is incorporated.

The CAC also advocates for Partnership members by ensuring that the health plan is responsive to the diversity of health care needs of all members. Partnership will make a good faith effort to ensure that CAC members feel supported in their role and may provide resources to help educate CAC members so they can effectively participate in CAC meetings.

The CAC is responsible for and shall carry out the duties listed below:

- Identifying and advocating for preventative care practices utilized by Partnership
- Participate in the development and updating of cultural and linguistic policy and procedure decisions related to quality improvement, member education, and operational and cultural competency issues that may affect groups who speak a primary language other than English
- Provide input on necessary member/provider targeted services, programs, and trainings
- Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services
- Review Population Needs Assessment findings and discuss improvement opportunities related to Health Equity and Social Drivers of Health
- Identify member concerns that may influence Partnership policies and practices
- Ensure that the concerns of members of all cultures are respected and addressed, including members that speak a primary language other than English
- Serve as advocates for members of Partnership, promote self-advocacy, and cultural competency, thereby improving health outcomes
- Review and provide input regarding Member Rights and Responsibilities and other member materials
- Annually review grievance and appeal data

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- Review and make recommendations regarding Member Services' Quality Improvement activities, including but not limited to the Member Satisfaction Survey results
- Provide feedback and input on Partnership's health education and community focused activities

To manage the operations of this committee, Partnership has a designated CAC Facilitator and Coordinator. The CAC Coordinator, in partnership with the Facilitator is responsible for managing the operations of the CAC. Together, they ensure compliance with all statutory, rule, and DHCS contractual requirements.

These Guiding Principles, may be updated or amended as needed to comply with regulatory or accreditation body requirements, or as proposed by CAC members and/or Partnership staff.

II. Membership

Member Selection

All Partnership members are eligible to become a CAC member if seats are available by completing a CAC application and meeting the requirements below:

- They are an eligible Partnership member, legal parent of a minor (under age 18), or a legal guardian or conservator of an eligible Partnership member
- Will regularly attend and actively participate in meetings

Partnership's CAC Selection Committee is tasked with selecting and appointing all CAC members. The purpose of the CAC Selection Committee is to ensure that the committee is composed of representatives that bring different perspectives, ideas, and views to the committee. These representatives may reflect Partnership's population and serve the following:

- Members of hard-to-reach populations
- Members of diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, physical disabilities, age backgrounds (including parents/caregivers of adolescents/foster youth), IHS Provider representatives)
- Limited English Proficient (LEP) Members

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Partnership conducts an annual review to ensure that CAC membership is representative of its membership base. Partnership may modify the CAC membership base to reflect changes in member demographics.

Each county within Partnership's service area is allocated a set amount of CAC seats available to members. To determine this allocation, Partnership established a ratio based on the number of Partnership Board of Commissioner seats that each county holds. The ratio selected for each county is defined as 1.5 times the number of Partnership Board of Commissioner seats per county.

The CAC Selection Committee will ensure that all CAC members are selected by June 29, 2024.

Member Responsibilities

- Regularly attend scheduled meetings
- Arrive in a timely manner
- Participate in CAC meetings
- Provide opinions and feedback to improve Partnership services
- Provide updated contact information to the CAC Facilitator and/or Coordinator for the purpose of meeting notices
- Notify the CAC Facilitator and/or Coordinator in advance if you cannot attend a meeting

Membership Term

CAC members may serve for a term of up to four (4) years. At the end of the four (4) year term, CAC members may continue their role as long as there is not a replacement CAC member available.

A CAC member who is absent for three (3) consecutive CAC meetings shall lose voting privileges at the subsequent meeting and will forfeit their membership. The individual may reapply for a seat on the CAC.

CAC members may lose their membership seat and privileges by a quorum of the CAC. CAC members may terminate their position at any time by resigning. The member may resign by calling, emailing, or sending a letter to the CAC Facilitator and/or Coordinator. The CAC Selection Committee

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will make a good faith effort to replace any vacant seats due to member resignation (voluntary or involuntary) within 60 calendar days.

Compensation

A CAC member may receive a stipend for travel and childcare expenses that allows them to attend CAC meetings during their membership term. No CAC member shall receive any profit from the operations of Partnership. This provision shall not prevent reasonable compensation to a CAC member for services performed for Partnership, if such compensation is not in conflict with Partnership policies or procedures, is permitted by these Guiding Principles, and is approved by the Chief Executive Officer of Partnership.

Member Demographic Report

Partnership prepares an annual Member Demographic Report that highlights the composition of the CAC. The Member Demographic Report is submitted to DHCS no later than April 1 of each calendar year. Partnership strives to ensure that the CAC is representative of Partnerships' member demographic. The CAC Member Demographic Report will also identify the following:

- Description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies
- Barriers/challenges in meeting or increasing alignment between CAC's membership with the demographics of the members within Partnership's service area
- Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the members within Partnership's service area

Board of Commissioners

The CAC reports directly to Partnership's Board of Commissioners. A consumer representative from Partnership's Northern and Southern Regions will be selected every two years to represent the CAC on the Board of Commissioners. Selection will then rotate from region to region within the larger region.

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Department of Healthcare Services (DHCS) Statewide Consumer Advisory Committee
The CAC shall select and appoint one member of the CAC, or another Partnership member, to serve as the Partnership representative to the DHCS' Statewide Consumer Advisory Committee. Partnership shall compensate the representative for time and participation within the Statewide CAC, including transportation expenses to appear in-person.

Non-Liability of Members
CAC members shall not be personally liable for the debts, liabilities, or other obligations of Partnership.

III. Committee Meetings

Meeting Schedule
CAC meetings are held four times a year (quarterly) and at times and in formats, that foster and facilitate CAC member participation. The CAC meeting schedule is published at the beginning of each year and posted on Partnership's website. Partnership may conduct additional CAC meetings to discuss and take action on matters of urgency.

The principal offices of Partnership's CAC for the transactions of its business for all regions are located at the following meeting locations:

Address	County
4665 Business Center Drive, Fairfield, CA 94534	Solano
495 Tesconi Circle, Santa Rosa, CA 95401	Sonoma
3688 Avtech Parkway, Redding, CA 96002	Shasta
1036 5th St., Suite E, Eureka, CA 95501	Humboldt

CAC meetings are open to the public and we welcome and encourage attendance. Meetings may also be held at additional sites, which will be listed on the meeting notice. Meeting notices are posted in a centralized location on Partnership's website up to 30 days, and no later than 72 hours prior to the meeting. Video conferencing equipment is used when members from multiple locations participate.

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Facilitation of Meetings

CAC meetings are conducted in compliance with the Ralph M. Brown Act. The CAC Facilitator(s) is responsible for the facilitation of all CAC meetings. The CAC Coordinator acts as secretary or may appoint a member/designee to act as secretary of the meeting, for the purpose of taking meeting minutes. Meeting minutes are posted on Partnership's website and distributed to members before the next quarterly meeting. Partnership will also submit meeting minutes to DHCS within 45 calendar days.

Quorum

For the purpose of the CAC, a quorum is defined as the minimum number of members in attendance required to conduct the business of the committee. The CAC quorum shall consist of at least ½ (one half) of the CAC membership seats held. Every act or decision done or made by a quorum is an act of the CAC as a whole.

CAC Records

Partnership shall maintain CAC records, for no less than 10 years. CAC records shall include the following:

- Minutes of all meetings of the CAC, indicating the time and place of holding such meetings, whether regular or special, and the names of those present
- A copy of the Guiding Principles and any modifications to date, which shall be open to inspection

Partnership HealthPlan of California's Whole Child Model Family Advisory Committee (FAC) Charter

Purpose:

The Whole Child Model FAC is a Member Advisory Group to the Chief Executive Officer (CEO) and staff of Partnership HealthPlan of California (Partnership), providing input, review and recommendations on policies and issues that affect children and their families served through the Whole Child Model (WCM) program.

The WCM FAC is intended to promote open communication between families with children who have special health care needs, health plan leadership, California Children's Services (CCS) agencies, and local family support providers. It serves as a mutual learning forum for committee members and health plan staff to make a positive difference in the care the health plan provides to CCS beneficiaries.

Authority and Responsibility:

SB 586 (Hernandez, 2016) established a WCM program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties would provide CCS services to Medi-Cal eligible CCS children and youth. This legislation also required each Medi-Cal managed care plan participating in the WCM program to establish a family advisory group for CCS families (WIC 14094.17(b)(1)).

The WCM FAC may make recommendations to the CEO, based on member and community input and feedback.

As this is an Advisory Committee to the CEO, the Brown Act does not apply.

Membership:

Membership status is reviewed and approved by a committee of Partnership leadership.

Membership includes:

- WCM CCS Member and/or family member – Family representatives from each PHC county (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba). Equal representation (two representatives) from each county is sought but not required.[1]
- Local Consumer Advocate – maximum of one (1) local consumer advocate representing CCS families.
- Local Providers - maximum of one (1) representative from each Partnership region, including CCS County staff, Parent Advocacy groups or CCS paneled

[1] Please note, if there are not enough CCS family members to fill both positions on the WCM FAC, Partnership will allow a county representative from that county to fill that position.

providers. This provider must be serving Partnership Members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, or Yuba County.

Committee Staff

- Partnership employees will serve as support staff to the WCM FAC.

Terms:
WCM CCS Member and/or family member will be appointed to a two-year term. At the end of the term the member may be reappointed to a subsequent two-year term.

Local Consumer Advocate will be appointed to a two -year term. At the end of the term this position will be open to other applicants in the region. If there is no other applicant the advocate may be reappointed to a subsequent term.

Local CCS County Representative will be appointed to a two -year term. At the end of the term, this position will be open to other applicants from other counties in the region. If there is no other applicant the county representative may be reappointed to a subsequent term.

FAC Chair and Vice Chair:

The FAC shall select a Chair and Vice Chair. The Chair and Vice Chair shall be a CCS Member or family representative selected by the voting members of the FAC.

The role of the Chair is to provide meeting facilitation and direct the meeting process through the agenda. The Chair will guide and lead discussion to ensure all participants are provided equal opportunity for participation.

The role of the Vice Chair is to preside at the meetings of the FAC in the absence of the Chair.
If both Chair and Vice Chair are absent, the WCM FAC members present will select one member to act as Chair for the meeting.

The FAC shall elect a Chair and Vice Chair for a two-year term.

Meetings:

The WCM FAC shall meet four (4) times per year (i.e., quarterly).

These meetings will be on the 3rd Tuesday of every third month. This time can be changed at any time by a vote of the Committee.

These meetings will be located at Partnership offices, and remotely. Partnership will provide technical support for remote meeting access. When feasible, meetings could be held at alternative locations with prior approval by the organizers.

Meeting Compensation:

Appointed Members are eligible to receive a stipend for meeting attendance.

Agendas, Minutes, Reports:

Partnership staff will work in collaboration with the Committee, to develop the agenda for each meeting.

Partnership staff are responsible for agenda and meeting material production and distribution.

Partnership staff will record minutes of meetings which will be approved by the FAC members at each subsequent meeting.

Review of Charter:

The FAC shall review this charter as needed. Any proposed changes shall be submitted to the CEO for approval.