CULTURAL COMPETENCY PROGRAM

2010-2011

Florida Medicaid Reform
Florida Medicaid Non-Reform

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CULTURAL COMPETENCY PROGRAM

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CULTURAL COMPETENCY PROGRAM

Purpose

The purpose of the Cultural Competency program is to make certain that the Plan meets the individual, culturally and linguistically diverse needs of all members; to ascertain that the providers of the Plan value diversity within the organization; meet the needs of the members that are in need of linguistic services; and enable members to obtain adequate communication support.

The Plan, by extension as the tenants of the Cultural Competency Plan, will ensure that development of systems, policies, and procedures will reflect the needs of our culturally disparate membership, provider network, and include additional regard for the cultural blend of our staff.

Objectives

The objectives of the Cultural Competency program are to:

- Identify members that have potential cultural or linguistic needs for which alternate communication methods are required;
- Establish a Committee to oversight diversity and cultural competency for all stakeholders;
- Use adequate educational materials that are culturally sensitive to the member's race, ethnicity and primary language spoken;
- Ascertain that the appropriate processes and tools are available to meet the unique communication and language barriers that exist in the population;

- Ensure that providers recognize the culturally diverse needs of the population; and
- Make sure that providers are educated and acknowledge the value of the diverse cultural and linguistic differences in the organization and the populations that they serve.

Goals

The goals of the Cultural Competency Program are to:

- Improve communication to and for members for whom cultural and/or linguistic issues are present.
- Decrease health care disparities in the minority populations we serve;
- Improve employees' understanding and sensitivity to cultural diversity within the Plan and the members served.
- Improve services, care and health outcomes for members (improved understanding leads to better adherence and satisfaction).

The Plan's Cultural Competency program will include the following eight components:

1. Diversity of Health Plan Employees

- The Plan does not discriminate with regards to race, religion or ethnic background when hiring employees.
- The Plan hires diverse talented employees in all levels of management.

- The Plan makes certain that bilingual employees are hired for areas that have direct contact with members to meet the needs identified.
- The Plan ensures there is training for staff to improve understanding of and sensitivity to our culturally diverse population, and increase competency in serving those members.

2. Diversity of Provider Network

- Providers are cataloged for their language knowledge. This information is stored in our provider data system, so that members can select a provider that speaks their language of origin.
- Providers are contracted to ensure a culturally diverse selection of providers to care for the population served.
- Providers will be surveyed regarding their experience with UnitedHealthcare of Florida Inc.'s support, assistance, training and information to meeting the cultural and linguistic needs of their patients. Providers also have the opportunity to list any additional support they may need to meet the cultural, linguistic and other special needs of their patients. This information will be gathered utilizing the additional questions added to the Provider Satisfaction Survey (commencing 2009).

3. Provider Education

- Providers will receive ongoing education regarding the Cultural Competency Program through the Website and the

Provider Manual (Provider Administration Guide), as well as their initial in-service training upon contracting.

- Providers identified as having complaints and grievances in the area of cultural competency will be referred for additional education in serving our diverse membership.

4. Linguistic Services

- Providers will identify members that have potential language issues for which alternative communication methods are needed and contact the Plan to arrange appropriate assistance.
- When necessary, members may receive interpreter services at no cost to access covered services through a provider, as arranged by the Customer Services Department.
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by the Plan's Customer Services Department.
- Written materials are available for members in large print format as well as available for high volume non-English languages of the Plan's service areas.

5. Community – Outreach

- Health Plan staff outreach to community and faith - based organizations which support all minorities and the disabled to be sure that the available resources for members are being maximized to the fullest.

6. Data Analysis

- Routine collection of data on race, ethnicity and language spoken for members; analysis of these data is used to determine the need for changes/additions to verbal and written member services and tools.
- Medicaid and Florida Healthy Kids' state data are utilized to perform a cultural and linguistic assessment for the Plan's service areas as appropriate.
- Data on service areas are used in the analysis of culturally appropriate services; service area data include grievances/appeals, requests for translation services, requests for member information in alternate languages, requests for providers who speak specific languages or who need special services for hearing impaired, etc.

7. Electronic Media

- The Plan ensures the website is easy to navigate for those members with linguistic difficulties.
- Telephone system applications were established to ensure members have access to the TTY/TDD line for hearing impaired services. The Customer Service representatives have

responsibility for any necessary follow-up phone calls to the member.

8. Performance Improvement Program

- Identify opportunities for program improvement;
- Establishing priorities and assignments;
- Implement identified improvements;
- Ongoing monitoring and measurement.

9. Annual Evaluation - 2009

The Cultural Competency Plan is evaluated annually using several qualitative and quantitative indicators, including the annual CAHPS survey performed by the University of Florida- Survey Research Center), the annual "Vital Signs" employee survey, grievance and appeals audits, and other ad hoc sources. The 2009 evaluation includes data from both the 2008 and 2009 calendar year to ensure the most up-to-date information is included upon annual submission of the Cultural Competency Plan to the Agency for Healthcare Administration each year, and includes a reference to the date of the data collection and analysis in the evaluation. Analysis, where possible, is completed for each line of business. However, as most surveys are not line of business specific, an aggregate result is benchmarked, trended, and analyzed where comparison data is available.

I. *2010 CAHPS Survey*

The 2010 CAHPS survey was completed by the University of Florida-Survey Research Center in the Spring of 2010. This survey

included questions to determine the gender, age, education, race, health status for the surveyed population. At this time the gender and race for the adults surveyed is not available. However, data was requested from the Florida Center for Health Statistics, and is expected in October 2010. Data will be used as baseline data for next year's evaluation.

The 2010 CAHPS Survey information, the questions and results, are listed below. There is no separate survey for reform and non-reform populations, therefore combined results are provided.

Adult								
Q28-In general, how would you rate your overall		Excellent	Very Good	Good	Fair	Poor	Did not Know/Respond	
	2010	12	19	28	27	13	1	
	2009	13	19	24	24	17	3	
Q33- Age of member?	2010	18-29	30-39	40-49	50+			No Response
	2009	24	20	18	37			<1
	2008	18-25	26-35	36-45	46-55	56-65	66-88	No Response
		18	15	17	22	19	9	1
Q35-What is the highest grade or level of school completed?		8th	Some HS	HS/GED	Some College/ 2 yr degree	4-yr degree	More than 4 yr degree	Did not Know/Respond
	2010	7	24	35	24	5	2	3
	2009	10	22	32	22	6	2	4
Q36- Are you of Hispanic or Latino origin or decent?		Yes	No	Did not Know/ Respond				
	2010							
	2009	27	70	3				
Q37 What is your race? (More than one could be selected)		White	Black/AA	Asian	Native Hawaiian/P acific Islander	American Indian	Other	Did not Know/Refused
	2010							
	2009	60	24	1	<1	<.01	15	1
Child Medicaid Responses								
Q31-In general, how would you rate your overall		Excellent	Very Good	Good	Fair	Poor	Did not Know/Respond	
	2010	51	30	13	6	0	N/A	
	2009	45	27	22	6	0	N/A	
Q32- Age of child?		0-5	6-10	11-15	16-17	No Response		
	2010							
	2009	42	25	22	10	<1		
Q33-is your child male or female?		Male	Female	Did not know				
	2010	49	51	0				
	2009	54	46	0.5				
Q34- Is your child of Hispanic or Latino origin or decent?		Yes	No	Did not Know/ Respond				
	2010							
	2009	34	64	2				
Q35 What is your child's race?		White	Black/AA	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Other	Did not Know/Refused
	2010							
	2009	53	29	9	1	1	17	<1

II. *2009 Vital Signs Survey*

The annual employee Vital Signs Survey collects input from health plan employees on factors that influence satisfaction at work, and includes measurement of employee ratings of the diversity of workforces and leadership, and other measures that would affect the ability to provide staff, and as an extension membership, with culturally sensitive and appropriate services. The survey is on employees and therefore is not different for reform and non-reform.

The 2009 survey data showed that on average, 95% of employees surveyed felt the Plan had a diverse workforce which was one point lower than the 2008 Vital Signs Survey, which is not a statistically significant change.

The previous survey reviewed had a 78% response rate, but the 2009 Vital Signs Survey had a significant increase with a response rate of 95%. The results of the Vital Signs survey have been shared with the Quality Management Committee; however, to ensure actionable, system-wide improvement activities are developed, a Healthcare Disparities Committee was formed. The first Committee meeting is planned for Sept 30, 2010.

III. *2009 Grievance & Appeals*

Reform

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An analysis was completed of grievances and appeals, including all quality of care and service concerns. Of all received issues, there were no allegations or concerns related to inequitable care or services on the basis of race, gender, religion, language, speech or hearing limitations, or other cultural factors.

Additionally, there were no complaints from AHCA with allegations or concerns related to inequitable care or services due to cultural reasons.

Non-reform

An analysis was completed of grievances and appeals, including all quality of care and service concerns. Of all received issues, there was only one concern related to language translation services available at the provider office. The provider refused to offer or coordinate translation services for the member. UnitedHealthcare of Florida educated the provider group and required they have translation services available for members. On recheck of provider, the provider agreed to facilitate translation services, and had a mechanism to request such services as needed. The provider was reminded that facilitating such a need was a requirement of their provider contract. There were no other concerns on services on the basis of race, gender, religion, language, speech or hearing limitations, or other cultural factors, and no trends that could be gleaned with only 1 issue reported.

Additionally, there were no complaints from AHCA with allegations or concerns related to inequitable care or services due to cultural reasons.

However, as AHCA reported a general potential industry concern regarding services for hearing impaired members, our providers were reminded via Provider Newsletter that they are required to provide services to assist members who are hearing and/or vision impaired, as well as other culturally sensitive services as needed.

IV. *2009 Performance Improvement Project (PIP) on Addressing Disparities in the Management of Diabetes Mellitus (HbA1c testing) between English Speaking and Spanish Speaking (Hispanic) Members*

A performance improvement project (PIP) was created and submitted to the Agency for approval in 2008. This was created to meet the Medicaid contract cultural diversity PIP requirement. Baseline data was collected in 2008 and re-measured in 2009 and 2010 for the reform population, but data was available for previous years as part of HEDIS performance measurement for the non-reform population.

Reform

Prior to applying this PIP for the Reform population, the HEDIS results were analyzed and were found to have lower HEDIS rates for Spanish-speaking members for diabetes preventive and chronic care management than English-speaking members, specifically for HbA1c. On initial measurement, the

Reform population data mimicked Non-reform. However, for baseline PIP measurement and re-measurement 1, results for the reform population showed a higher HEDIS rate for Spanish-speaking members (100% for HEDIS 2009, 74.49% for HEDIS 2008) than for English-speaking members (81.82% for HEDIS 2009, 68.54% for HEDIS 2008). The population of Spanish-speaking members as a proportion of the total population in this group is currently and historically low (4 members for HEDIS 2009). Because of the small population, it cannot be clearly gleaned if a diversity deficit exists with a high degree of certainty.

Non-reform

Results from HEDIS 2009 showed an overall increase in HbA1c rates (48.48% HEDIS 2006, 55.44% HEDIS 2007, 65.14% HEDIS 2008, 80.49% HEDIS 2009). Rates for Spanish-speaking members were statistically significantly lower than English-speaking members in 2006 and 2007, as per the below table. After interventions were instituted in 2008, differences in rates between languages were not statistically significant, and for HEDIS 2009, rates for Spanish-speakers exceeded rates for English-speakers. However, relatively small population size could have had a small affect of the rate.

In analyzing the results, it was determined that disparity in management of diabetes does not currently exist in this

population, and therefore no new interventions will be initiated.

Re-measurement 2 to Re-

The HbA1c rates reported in re-measurement 3 are displayed in the table below:

HbA1c Testing	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	Numerator	Denominator	**HEDIS 2009**	Goal	Benchmark
Indicator 1: All Eligible Members	48.48%	55.44%	65.14%	854	1061	**80.49%**	84.30% (- 3.81%)	84.30% (- 3.81%)
Indicator 2: English-Speaking Members	52.67%	52.69%	65.19%	776	975	**79.51%**	84.30% (- 4.79%)	84.30% (- 4.79%)
Indicator 3: Spanish-Speaking Members	34.74%	46.50%	64.80%	78	85	**91.76%**	84.30% (+ 7.46%)	84.30% (+ 7.46%)

V. *Member Services Summary*

The information for September 2009 to September 2010 (referred to in chart below as “2009”) related to total calls received by the Member Services Department and the details of the calls were not separable by lines of business (Reform vs. Non-reform).

After English, the top 5 call languages by volume in 2008 and 2009 were Spanish, Creole, Russian, Vietnamese, and Mandarin Chinese. However, only Spanish and English were of significant volume, with all other languages, as in the below chart, under 100 calls (total each language). Although Spanish is the second highest call volume, a statistically significant decrease in calls

from Spanish-speaking members occurred in 2009. This was offset by a similar percent *increase* in English-speaking members. Statistically significant increases or decreases were found for the other top 4 languages, but due to small numbers, that proportional change is not considered significant.

There were no reported problems with language assistance. Of the Spanish calls, 72.4% were handled in-house by bilingual staff, with the remainder by AT&T Language Line (used for all other languages when there is no in-house trained/certified resource).

There were no reported delays in service due to language assistance, nor were there any reported problems with service delivery.

Although no action other than observation is needed, additional routine staff training is being considered for all Member Service Staff to ensure culturally sensitive service delivery.

LANGUAGE	Total Calls-2009	% of Overall Calls 2009	2008	Trend
English	235459	88.4513%	84.1064%	↑
SPANISH	30485	11.4518%	15.8493%	↓
HAITIAN CREOLE	80*	0.0301%	0.0120%	↑
RUSSIAN	26*	0.0098%	0.0055%	↑
VIETNAMESE	26*	0.0098%	0.0046%	↑
MANDARIN	23*	0.0086%	0.0092%	↓

*Small popultion

VI. *Provider Satisfaction Survey*

The Provider Satisfaction Survey is completed each year for network providers, but is not done separately for reform and non-reform providers.

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Two questions (see below) were added to the survey for the 2009 survey administration related to cultural competency, but due to low response rate for those questions, results will not be used as a baseline. The question was repeated for the 2010 survey, which is currently being administered to a sample of primary care providers. Results will be used as a baseline and reported in future evaluations.

Questions added:

23. Support, assistance, training, and information to meet the cultural and linguistic needs of your patients. ❑1 ❑2 ❑3 ❑4 ❑5 ❑0
24. What additional support is needed to meet the cultural, linguistic, and other special needs of your patients? _________