Health Equity Department

2025

Program Description

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Table of Contents

1.0 ORGANIZATIONAL BACKGROUND

Health Net of California is dedicated to providing cultural and linguistic services, promoting health equity, and addressing disparities to a diverse membership across California. The diversity of our membership represents over 150 spoken languages and cultures with 28% of CHPIV membership and 32% of the Health Net membership identifying as limited English proficient. The Health Equity Department supports Health Net, CalViva Health, and Community Health Plan of Imperial Valley in providing culturally competent and responsive member experiences and fostering health equity for all members and their communities.

As of December 2024, Health Net provides services to over 2.7 million individuals, including:

- 507,368 Commercial members (including Individual Family Plan members and Marketplace members)
- 2,149,528 State Health Program members including
    - 1,588,660 Medi-Cal members
    - 431,963 CalViva Health members
    - 96,956 Community Health Plan of Imperial Valley (CHPIV) members
- 109,631 Medicare members

The 2025 Health Equity Program Description demonstrates the commitment of the Health Equity strategy throughout the organization, with our community partners, with our provider groups, and across products. It includes the operational alignment of cultural and linguistic and health equity services for the entire California market, unless otherwise noted.

2.0 HEALTH EQUITY PROGRAM SCOPE

The organization's health equity mission and vision are led by the Chief Health Equity Officer and are implemented through cross-functional collaboration and partnership. The mission and vision are aligned with regulatory requirements and implemented across products and lines of business.

2.1 Vision

To help all the people and communities we serve achieve the highest level of health by advancing equity in health and health care.

This vision aligns with and helps advance Health Net's enterprise-wide purpose – "Transforming the health of the communities we serve, one person at a time."

The organization implements an overarching vision of diversity, equity, and inclusion that works to:

- Eliminate disparities and improve quality of care and health outcomes.
- Eliminate systemic organizational marginalization.
- Promotes inclusion and anti-racist practices, that will be evidenced through our structures, customs, and leadership.
- Driving systemic strategy to ensure all of our members have access to equitable health outcomes.
- Expanding current and develop new community partnerships to elevate the health of the communities we serve.
- Informing policy discussion as well as investments to close the gap in equity.

We recognize that health equity is both a process and an outcome. As such, it requires each of us, as institutional leaders, to:

- **Understand** that health equity is intersectional – that it is shaped by a multi-dimensional overlapping of factors such as race, class, income, education, age, ability, sexual orientation, immigration status, ethnicity, indigeneity, and geography.
- **Elevate and embed** health equity as a shared enterprise-wide goal across all business units.
- **Identify** health disparities and underlying social, institutional, and structural drivers of health inequities among members, providers, and the communities we serve.
- **Invest** in infrastructure **and implement** strategies to reduce identified patterns of health inequity and dismantle structural, social, and institutional drivers of health inequity.

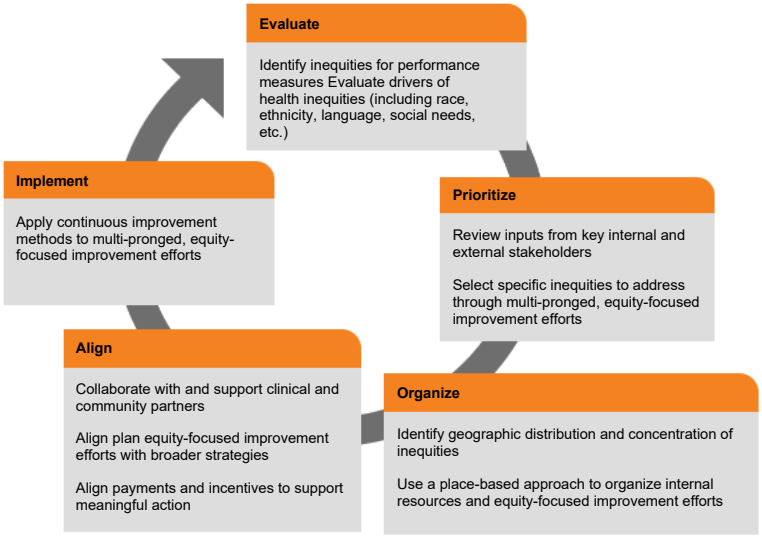
This approach to this work is accomplished through member engagement, provider engagement, community engagement, and workplace/workforce engagement.

2.2 Mission

Our mission is to:

- Improve structural determinants of health equity, by working within and across societal institutions and systems.
- Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities.
- Improve institutional drivers of health equity, by working within our institution, all lines of business, with providers, and with other key stakeholders.
- Improve individual & household-level social needs & networks, by improving access, quality, and value of services for our members.

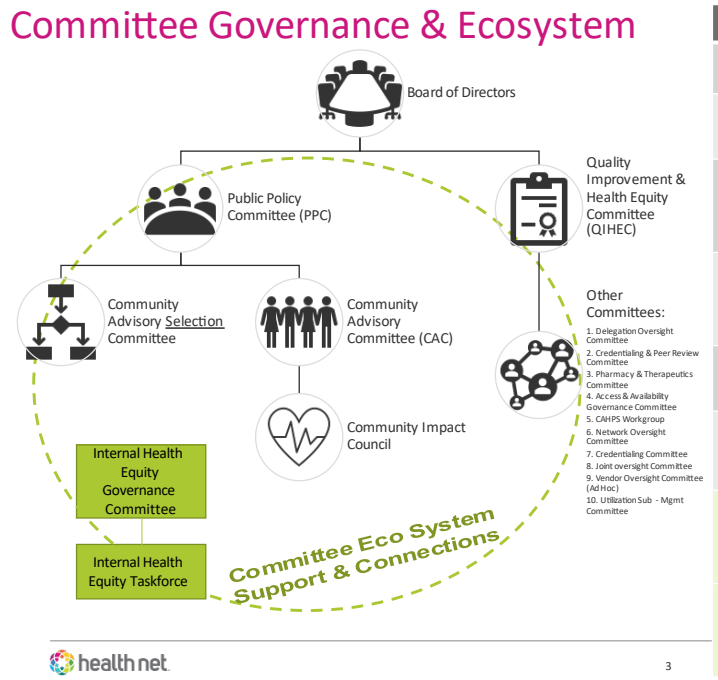
2.3 Basic Approach to Health Equity Strategy



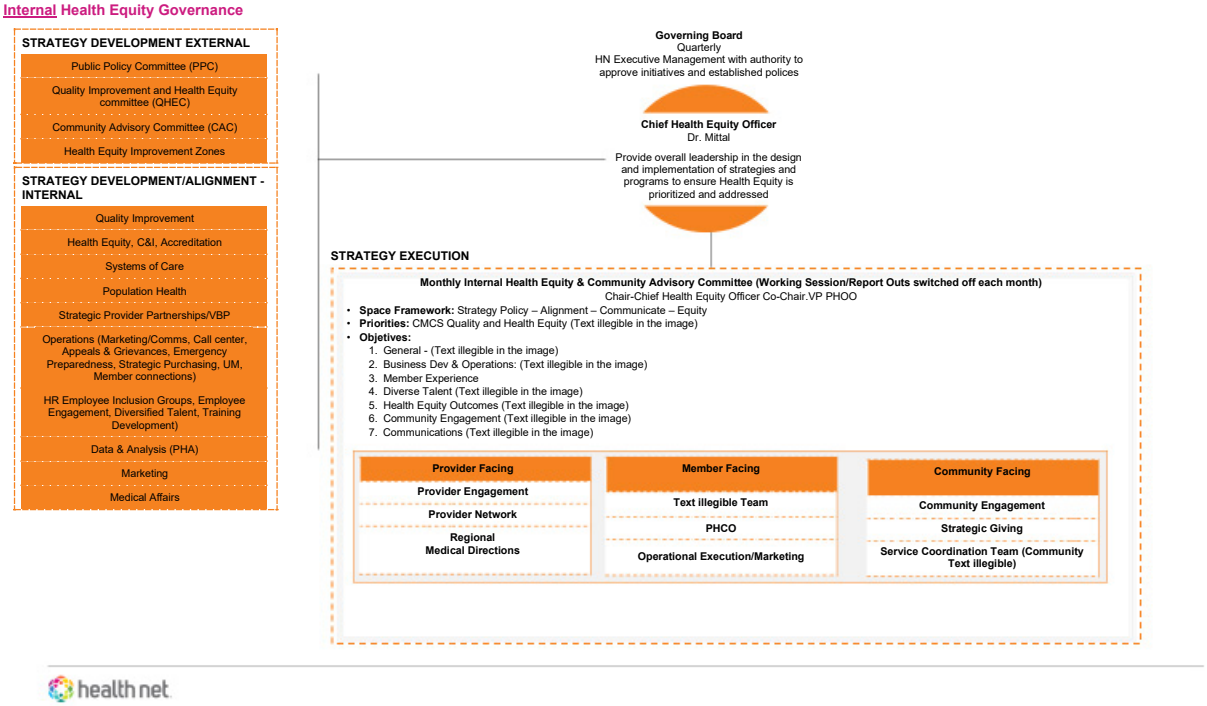
Health Equity Model

The Health Equity strategy includes cross-functional collaboration, to ensure all teams are aligned on the Health Equity goals, ensure coordination of strategies across lines of business and departments, and utilize governance structures focused on advancing health equity, addressing social needs, and mitigating social risks. Please see the chart below. The Health Equity Department scope, within Quality, is aligned with the Health Equity Strategy and supports the implementation of the goals and objectives of the program.

2.4 Health Equity Organizational Chart



Committee Name	Brief Description: Purpose, Frequency & Reporting
Board of Directors (BOD)	• **Purpose:** HN Executive Mgmt with authority to approve initiatives & establish policies • **Mtg Frequency:** Quarterly
Quality Improvement & Health Equity Committee (QIHEC)	• **Purpose:** Develop and execute overarching strategy to deliver whole person-centered highquality care. • **Mtg Frequency:** Quarterly • **Reports to:** BOD
Public Policy Committee (PPC)	• **Purpose:** Statewide convening with external stakeholders to solicit input to inform public policy operations, and programming to address community needs • **Mtg Frequency:** Quarterly • **Reports to:** (1) QIHEC (2) BOD (3) Internal Health Equity Governance Workgroup as necessary
Community Advisory Committee (CAC)	• **Purpose:** County or regional convenings with external stakeholders intended to provide local presence to engage and collaborate with lo community partners and resources to ensure community needs are met. • **Mtg Frequency:** Quarterly in each County/Region • **Reports to:** (1) PPC (2) QIHEC
CAC Selection Committee	• **Purpose:** Identifies and selects committee representatives to the CAC and/or PPC • **Mtg Frequency:** Annually • **Reports to:** N/A
Community Impact Council	• **Purpose:** Community lead interventions supported and funded by HN (Community partners lead convenings) • **Mtg Frequency:** As needed, progress reporting is TBD • **Reports to:** Community Advisory Committee & HE Taskforce for Internal Health Equity Committee consideration
Health Equity Taskforce *(Prep to enable decision making)*	• **Purpose:** Internal only, intended to prepare and drive the agenda/materials for Internal Health Equity Governance Committee t support a focused and meaningful discussion, and decision making as needed. • **Mtg Frequency:** Monthly • **Reports to:** Internal Health Equity Governance Committee
Internal Health Equity Governance Committee *(Decision making committee)*	• **Purpose:** Internal only, intended to be the connection to the committee ecosystem where recommendations and insights from other committees and external stakeholders are raised for discussion and decisions on how to proceed. • **Mtg Frequency:** Bi-Monthly • **Reports to:** N/A



Quality Improvement & Health Equity Committee (QIHEC)

Purpose:	Ensure members receive the highest level of quality, safe and equitable care in accordance with applicable NCQA, statutory, regulatory and contractual standard J — Bas through community health improvements (i.e., social drivers of health and health condition intervention) and improving quality and health equity metrics **Objectives:** 1. Review, analyze, evaluate and act on the results of QI and Health Equity activities to ensure appropriate follow-up of performance deficiencies and gaps in care. 2. Gather cross-functional internal feedback (Quality Improvement, Health Equity, Utilization Management, and several other operational areas) and external physician feedback to drive priorities, initiatives, and assist in identifying areas of opportunity. 3. Through QIHEC, ensure connectedness to the findings, recommendations and actions from the Internal Health Equity Governance Committee, Community Advisory Committees (CACs) and Public Policy Committee (PPC), and other required subcommittees to drive universal decisions and programming. 4. Institute actions to address performance deficiencies, including policy recommendations. 5. Ensure follow-up of identified performance deficiencies or gaps in care. 6. Present formal recommendations to the Board of Directors to advance the QIHEC priorities and needed interventions.
Lead (Chair)	Dr. Ramiro Zuniga, Vice President, Medical Director, Medi -Cal Dr. Pooja Mittal, Chief Health Equity Officer (CHEO)
Key Participants	Representation from: 1. Vice President, Medical Director, Medi-Cal 2. Chief Health Equity Officer 3. External Network Physicians 4. Regional Medical Directors 5. BH Medical Director 6. VP Quality Management 7. VPs from different business units
Mtg Frequency	Quarterly
Reports to	HNCS Board of Directors

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15

Internal Health Equity Taskforce

Purpose:	A working group that will consolidate the data & recommendations received from QIHEC, CAC, PPCs and the PHM annual assessment and **create materials that will inspire actionable recommendations and discussions during the Internal Health Equity Committee.** **"Prep-Mtg" Objectives:** • Agenda, materials, discussion topics, identification of decision points for discussion during the Internal Health Equi ty Committee • Governance eco-system monitoring • Informs PPC & CAC Agenda topics as needed • Ensure a health equity lens and Member voice is embedded into all operations • Supporting equitable care • Inform Community Impact Councils, such as engaging with social & community partners and/or assign work • Implement and evaluate local partners, for example Community Impact Councils and targeted projects or pilots
Lead	Chief Health Equity Officer (CH EO)
Key Participants	1. Dr. Mittal - CHEO 2. Dr. Zuniga - QIHEC owner 3. Laetitia - QIHEC owner 4. Dipa 5. Maya Marmo - Analytics; Dashboards and overlays of data 6. Anush Schoepf - Health Equity Specialist 7. Alissa Ko - Strategic giving connections 8. Sydney Turner & Ayleen Dimailig - PPC/CAC owners and Health Equity Task Force admin support (interim until Dr. Mittal hires)
Mtg Frequency	Monthly / 90 min: 60 min decision making & 30 min "spotlight" awareness/brainstorming
Reports to	Internal Health Equity Governance Committee

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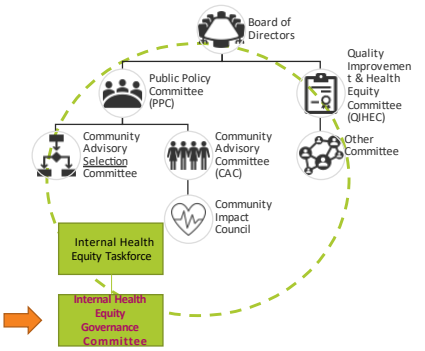
Internal Health Equity Governance Committee



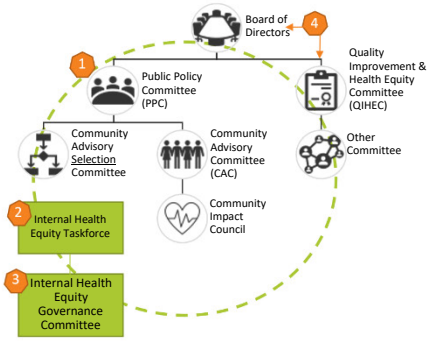
Purpose: • Strategy Policy • Alignment • Communicate • Equity	**Priorities:** DHCS Quality and Health Equity Strategy/Roadmap (i.e., Maternal Health, EPSTD-Core, COL, CBP, CDC, Behavioral Health (BH)), PNA Assessment **Objectives:** 1.General: Drives connectedness across internal functional teams and external committees (PPC, QIHEC, CAC) to inform and address community insights/gaps/ recommendations, to drive execution of long -term programming 2.Business Dev & Operations: Iterate health policy, structure, supplier/vendor diversity 3.Member Experience 4.Health Equity Diverse Talent (recruitment, retention, advocacy and training) 5.Outcomes (quality/HEDIS, provider operations, SDoH) 6.Community Engagement (align staff volunteerism, strategic giving, academic and/or other anchor partnerships and institutions), Local Government/County Agencies 7.Communications (Marketing, web, brand development)
Lead (Chair)	Chief Health Equity Officer (CHEO)
Key Participants	Representation from: 1. Provider, Member, and Community facing 2. Health Equity, C&L, and Accreditation 3. Social Determinants of Health 4. Population Health 5. Operations 6. Strategic Provider Partnerships 7. HR 8. Data and Analytics 9. Marketing 10. Medical Affairs
Mtg Frequency	Bi-monthly: 90 min: 60 min decision making & 30 min "spotlight" awareness/brainstorming
Reports to	N/A

Committee Governance & Flow of Information

How does a recommendation from the CAC or PPC fit into internal governance?

- Example: During the Q3 PPC, DSNP discussion inspired committee members to ask question as to how external case mgrs. would be made a ware DSNP HRA was conducted and who the assigned Care Mgr is?

* PPC Recommendation: Include flags or notice in provider portal



Recommendation approval (or approval for further vetting) or denial process:

1. If the recommendation is **approved** or approved for further vetting by the Internal Health Equity Committee
2. Ownership assignment to operationalize recommendation
3. Recommendation is captured and shared with BOD, QIHEC through PPC and CAC reporting mechanisms.
4. Internal Health Equity Committee, QIHEC and PPC will continue to receive updates on the progress, in writing or verbally as needed.

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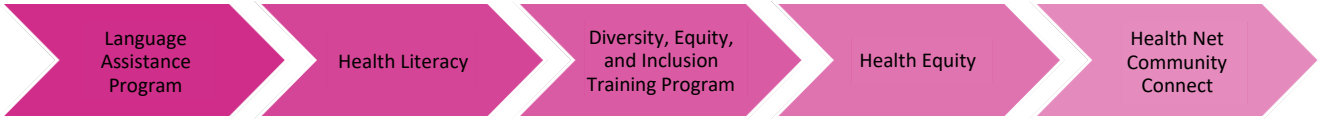
1. If the recommendation is **denied** by the Internal Health Equity Committee
2. Reason for rejection is documented
3. Recommendation rejection and reasoning will be communicated back to the PPC and documented in the minutes/agenda.

3.0 HEALTH EQUITY DEPARTMENT PROGRAM STRUCTURE

The Health Equity Department provides oversight, implementation, and operational support to the Health Equity strategy. The Health Equity Department supports departments throughout the organization and manages 5 core areas. These core areas are further defined in Sections 6.0 through 10.0.

Core Areas of Oversight



The Health Equity Department adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represent 15 different standards that serve as the foundation for the development of the Health Equity Department strategic plans. CLAS standards are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States." (Think Cultural Health)

CLAS Standards ensure that services comply with the Office of Civil Rights Guidelines and Section 1557 of the Affordable Care Act (ACA) for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act), which cover three major areas: 1) Culturally Competent Care; 2) Language Access Services; and 3) Organizational Supports. In addition to CLAS, Health Net, Inc. ensures implementation activities and compliance with National Council on Quality Assurance (NCQA) Health Equity (HE) and Health Equity Plus Accreditation guidelines and multiple state and federal requirements, including 2 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights) of our contract with the State of California, and DHCS APL 21-004.

Health Net's overall aim is to provide equitable, high-quality care services to its culturally and linguistically diverse population no matter the individual's personal characteristics. The purpose of the organization's HE and HE Plus programs is to reduce health care inequities and disparities by implementing interventions for identified individuals who are likely to experience or are experiencing obstacles to health care services due to their race/ethnicity, language preference, gender identity, and/or sexual orientation. By working to eliminate bias and discrimination within communities and the healthcare industry, the ultimate goal is to improve care.

The Health Equity Department supports departments throughout the organization to enable social risk and social need analyses. As the owner of the findhelp platform relationship, the Health Equity Department serves a vital role in monitoring the social needs assessment data and providing insights to the departments about prioritizations for outreach efforts. The Health Equity Department also supports findhelp to add partners to the platform as needs are revealed at the plan level. These external organization partnerships, including but not limited to the organizations through findhelp, are within the Health Equity Department scope, and reporting up to the Health Equity Charter.

3.1 Staff Roles and Responsibilities

The Health Equity Department is unique in its cross-functional support structure, includes representation in throughout the state to align with our membership locations to align with our membership and is

staffed by a Vice President of Quality Management, a Manager of Health Equity Department, one Program Manager III, five Senior Health Equity Specialists, two Health Equity Specialists, and one supplemental staff. Staff cover all services related to the California Market.

The organization has a strong governance structure to oversee and provide support to the health equity program and accompanying cultural and linguistic services. This includes reporting to Health Net Community Solutions Quality Improvement and Health Equity Committee (HNCS QIHEC), and Commercial and Medicare reporting to Health Net Quality Improvement Committee (HNQIC). For detailed staff roles and responsibilities description, please see Appendix 4.4.

The Chief Health Equity Officer and Medical Director, under the Chief Medical Officer, are responsible for providing leadership in Health Equity efforts across the organization. Under the Chief Health Equity Officer, the Health Equity department contributes to planning program structure for Health Net. The Chief Health Equity Officer ensures the plan's health equity structure is aligned with Corporate and other state plans, as appropriate.

The Chief Health Equity Officer:

- Hosts monthly Social Determinant of Health Strategy sessions to convene departments across the enterprise.
- Leads the Health Equity Charter. See Section 3.4.
- Develops and implements policies and procedures aimed at improving Health Equity and reducing Health Disparities.
- Engages and collaborates with staff, subcontractors, downstream subcontractors, providers, entities including but not limited to local community-based organizations, local health department, behavioral health and social services, child welfare systems and members in Health Equity efforts and initiatives.
- Implements strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers.
- Ensures all staff, subcontractor, and providers receive mandatory diversity, equity and inclusion training annually.

The Medical Director:

- Leads Health Net Community Solutions Quality Improvement and Health Equity Committee and Health Net Quality Improvement Committee
- Ensures that medical and other health services decisions are rendered by qualified medical personnel and not influenced by fiscal or administrative management considerations.
- Ensures that medical and other health care provided meets acceptable standards of care.
- Ensures that providers follow medical protocols and rules of conduct.
- Develops and implements policies consistent with applicable standards of care.
- Participates in the implementation of Quality Improvement and Health Equity activities.
- Participates in the execution of Grievance and Appeal procedures.

The Health Equity program structures are organized to meet program goals and objectives through formal processes that objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and services to meet the needs of multicultural populations, reduce social risks in the community, and address social needs of individuals. The program's multidimensional approach enables the organization to focus on opportunities for improving operational

processes, services, health outcomes, experiences, and community partnerships. The HE and HE Plus programs are formulated and operated based on foundational structures that include the program description, an annual work plan, and an annual evaluation. Programming focus and initiative development is based on assessment of the population and individuals' personal characteristics (race/ethnicity, preferred languages, gender identity, sexual orientation, age, socio-economic status, geographic location), social risks, and social needs through community-level and individual-level data collection to determine high volume, high risk, and problem-prone clinical and service bias and discrimination issues leading to uneven care outcomes. Performance goals and thresholds are established for all measures and are trended over time. At a minimum, the HE and HE Plus programs monitor and evaluate CLAS, individual demographic/personal characteristic data, network responsiveness, individual experience, practitioner experience, staff feedback, service performance, stratified clinical performance measures (i.e., HEDIS), and stratified individual experience measure (i.e., CAHPS). A comprehensive summary of measures and the specific objectives describing areas selected for focused improvement is in the Health Equity work plan.

A description of how the HE and HE Plus programs are related operationally and with regard to oversight, and how the programs collaborate on activities is below.

- Operationally the two programs are combined into one program where the organization builds on its CLAS program in its HE Plus Accreditation by also addressing social risks and social needs.
    - The Health Equity Department monitors and evaluates the Social Needs and Social Risks goals
    - Activities in support of the goals are within the Health Equity Department, Care Management, System of Care, Population Health Management, Quality Improvement, and additional departments.
- The Health Equity Department is responsible for oversight of the two programs.
    - The organization chart below shows the reporting relationship between program staff roles. See Section 3.3.

3.2 Program Oversight

At Health Net, there are three established quality improvement committees that conduct regular oversight of the HE and HE Plus program and provide reports to the governing body. These committees have delegated responsibility from the Health Net Community Solutions Board of Directors:

- Health Net Quality Improvement Committee
- Health Net Community Solutions Quality Improvement/Health Equity Committee (HNCS QIHEC)

The Governing Body reviews progress through the Committees on HE and HE Plus activities and initiatives at least annually.

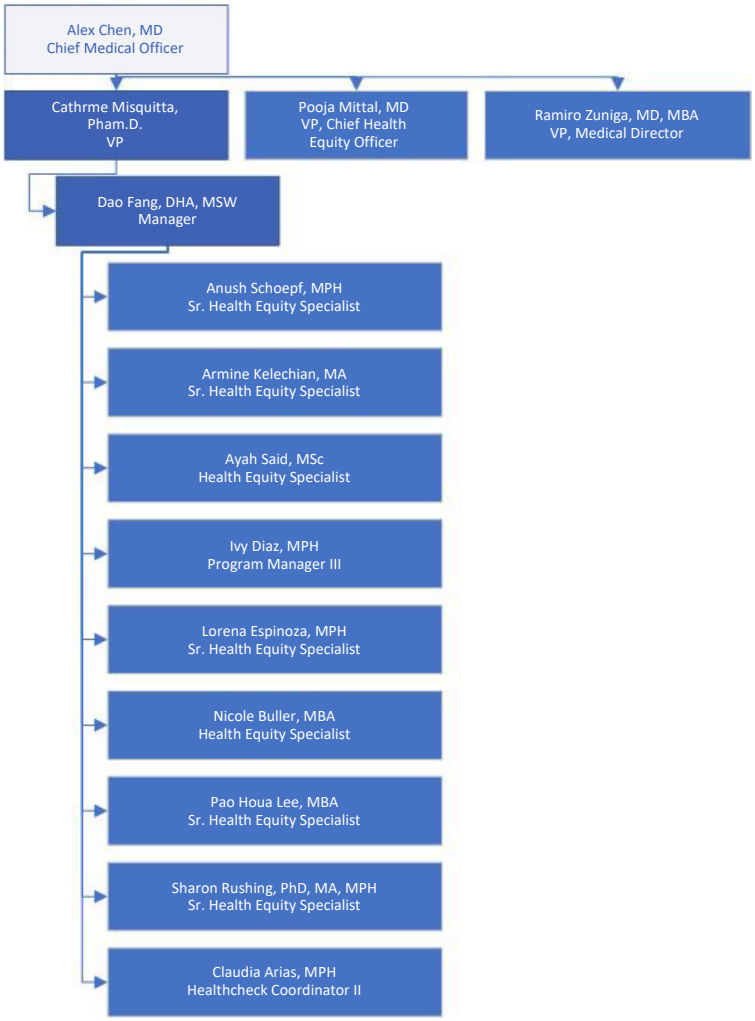
Committee responsibilities include:

- Review and approve the annual Health Equity documents:
    - Program Description
    - Work Plan
    - Work Plan Evaluations (Mid-Year and End of Year)
    - Health Equity End of Year Report
- Provide feedback and approval for program outcomes.
- Review program goals and semi-annual progress.

- Receive/review/analyze status reports from core areas.
- Submit reports to the governing body (Board of Directors)
- Health Equity Oversight, including:
    - Monitors, approves, supports, and evaluates the activities for this program, and makes recommendations for improvement.
    - Conducts an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).
    - Addresses identified health disparities, social risk, social determinants of health (SDoH), and community needs and makes ongoing recommendations to improve individuals and community outcomes.

3.3 Department Organization Chart

The Health Equity Department organizational structure begins with the Chief Medical Officer (CMO). The Vice President of Health Equity reports directly to the CMO. The Health Equity Department reports up to the Vice President of Quality Management, who also reports directly to the CMO.



3.4 Health Equity Charter

As part of an Internal Advisory Committee the Chief Health Equity Officer has established a Health Equity Charter. This charter is part of the overall Health Equity Strategy. The high-level goal is to Partner with Health Begins (HB) to design and endorse an enterprise-wide strategic plan to embed, align and advance health equity goals and investments for the next 1-3 years.

4.0 HEALTH EQUITY DEPARTMENT CORE AREAS AND WORK PLAN OVERVIEW

The Health Equity Department goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities. The work plan objectives and activities reflect the Office of Minority Health's CLAS standards and directly address regulatory requirements for California and Federal guidelines.

The Health Equity Department has conducted an initial and ongoing organizational assessment of CLAS related activities. This assessment is used to identify areas for improvement and departments that may need increased support or attention to maintain the CLAS standards. As a result of the self-assessment, we can identify and prioritize activities that can help improve the language assistance program such as member satisfaction surveys, internal audits, or oversight efforts.

The work plan is structured around 6 core areas to ensure that our department goals (Section 4.1 below) are met and CLAS standards are achieved.

- Core Areas Subject Matter Experts

1. Language Assistance Program
2. Health Literacy
3. Diversity, Equity, and Inclusion Training Program
4. Health Equity
5. Health Net Community Connect
6. General Compliance Activities

4.1 Goals

1. Ensure language services meet regulatory requirements and achieve metric goals.
2. Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
3. Complete staff and provider trainings for required topics.
4. Address health disparities through targeted cross-collaborative projects.
5. Implement social needs assistance strategies with integrated approaches for mitigating social risks. Ensure seamless access to Community Connect Program/findhelp for members, providers, and staff.

4.2 Work Plan Overview

The Health Equity Department's work plan activities are evaluated by quality monitoring committees. The mid-year review (June/July) monitors the progress of each activity and assesses if it is the established objective. The end-of-year evaluation assesses if the activity has met the objective, its successes, identifies the challenges and barriers encountered and how they were addressed, and is also an assessment for the future direction of C&L and health equity services. This work plan review and approval process assures that a standard of excellence is maintained in the delivery of C&L and health equity services.

Our HE and HE Plus work plan outlines the program's scope, program goals, yearly objectives, and calendar of events. The Health Equity Department also oversees goals specific to Health Net Community Connect. The work plan's calendar of events lists objectives and planned activities to achieve meeting goals. Objectives and planned activities list the time frame for completion, responsible staff member title/role, program partners, resources, monitoring method and frequency, and timeline for monitoring progress against the program's measurable goals through the annual program evaluations for HE (CLAS) and HE Plus programs. Work plan activities address the following: language services, practitioner network cultural responsiveness, and utilization on Health Net Community Connect.

5.0 SUBJECT MATTER EXPERTS

The Health Equity Department has a breadth of knowledge as it relates to the integration of C&L services within the health plan and across core areas of cultural competency, health literacy, language assistance services, health equity, Health Net Community Connect, and compliance.

The Health Equity Department supports the interactions between staff and members by providing consulting services to answer C&L questions that may arise and supporting to develop and implement strategic interventions to decrease health disparities. The Health Equity Department also provides a demographic snapshot of Medicaid, Commercial and Medicare members to various departments that include the Customer Contact Center, Provider Relations, Quality Improvement and Health Education. The demographic snapshot provides information about member language preferences, race, ethnicity, age, and gender distribution via the Language Assistance Program End of Year reports.

6.0 LANGUAGE ASSISTANCE PROGRAM

Established in 1996, The Health Equity Department collaborated across departments to develop the Language Assistance Program (LAP) in response to CA SB853 (Escutia, 2007). The LAP establishes quality standards that encompass how we communicate with members and contracted providers. Although the regulation only affects CA Commercial lines of business, we demonstrated our commitment to health equity for all members by implementing LAP services across all lines of business.

The LAP is fully compliant with the fifteen national standards for culturally and linguistically appropriate services (CLAS) in health care developed by the Office of Minority Health. Health Net's LAP P&P's include provisions in support of all fifteen CLAS standards. The mandated standards (4, 5, 6 and 7) provide the basis for language support services for our Medi-Cal, Medicare, and D-SNP members. These standards are also the basis of the language assistance program regulations implemented in California for Commercial members in 2006.

6.1 LAP Governance

The Health Equity Department provides direction, overall support, and oversight in all aspects of language assistance services. The LAP P&P (CA.CLAS.03) ensures processes are in place throughout the enterprise to support the main elements of the LAP. We have two established quality improvement committees that review and make suggestions to improve the language assistance program (HNCS QIHEC and HNQIC). These committees have delegated responsibility from the Health Net Community Solutions Board of Directors. Health Equity's departmental activities and LAP summaries are submitted for review and comment in addition to the program description, work plan and end of year report.

6.2 Interpreter Services

Interpreter Services range from ensuring contracted vendors are in place, monitoring the provision of services and annual communication with members or potential members and providers on how to access these services. Interpreter services meet the national quality standards for interpreter support and are guided by the P&Ps: Interpreter Services (CA.CLAS.06); Assessment of Bilingual Staff (CA.CLAS.04), and LAP (CA.CLAS.03). Interpreter services facilitate communication between members or potential members with limited English proficiency (LEP), the health plan and/or its contracted providers. We use bilingual staff and contracted telephone interpreter services vendors to assist individuals with LEP. Interpreters are available during business hours for the Medicare line of business and 24/7 for Medicaid and California Commercial lines of business. Interpretation services may be delivered telephonically, face-to-face, video remote interpreting, closed caption services or American Sign Language (ASL), depending on the nature of the appointment and need. To support additional modalities in patient care delivery, Health Net provides direct access to telephone interpreters for pre-scheduled interpreter requests and video remote interpreting services are available on-demand for same day appointments (advanced set-up with the health center may be required for direct access). Interpreter services also include oral translation services of print documents upon request from a member, which may be provided by either bilingual staff or contracted interpreter vendor, depending on the document content. Quality standards for contracted interpreter services include being versed in health care and medical terminology as demonstrated by documentation of interpreter skills, familiarity with interpreter ethics, and verification process for basic interpreter skills such as sight translation, listening and memory skills, commitment, confidentiality, and punctuality. Interpreter quality standards are fully compliant with the interpreter quality definitions from the federal requirements in Section 1557 of the ACA and with CA SB 223, Language Assistance Services.

The Health Equity Department supports provider groups and individual providers' efforts to supply interpreter services for members or potential members with LEP. Providers may call member services toll free number and request interpreter assistance. Updates on the Health Equity language services available to contracted providers are sent regularly to all contracted providers.

6.3 Translation Services

Translation services are guided by the Translation of Written Member Informing Materials P&P (CA.CLAS.02) and are based on industry translation standards. Our Translation services include quality standards for translators, a style guide to promote consistent translation quality, a glossary of common terms in threshold languages, provision of materials in Alternate Formats (e.g., large print, Braille, remediation), a review process to prepare English documents for translation, and a process to monitor translations for quality, timely delivery and accuracy. Translation services include monitoring the language distribution of members to identify threshold languages as required by federal regulations. Translation services ensure that required documents are translated into the threshold languages and that a notice of language assistance (NOLA) is included in member mailings when necessary. The Translation Program includes oversight of the use of Non-Discrimination Notices and taglines with English or translated documents as required by state and federal rules (DHCS All Plan Letter 21-004 or any superseding APL and Section 1557, 45 CFR 155.205).

6.3.1 Alternate Formats

We provide alternate formats of member informing documents as required by regulation, law, and upon member request. Alternate formats are available to members in all lines of business. Alternate formats include, but are not limited to: Braille, large print, audio, accessible PDF documents, and CD. The quality of the documents and the time to fulfill member requests for these documents are monitored by the Health

Equity Department to assure timely access of benefit information to our members. Medi-Cal members receive their member informing materials in the alternate format preference the member provided. The provision of alternate formats is compliant with Section 1557 of the ACA and DHCS APLs 21-004 or any superseding APL, 22-002, and 22-011.

6.4 LAP Communication

The Health Equity Department is directly responsible for assuring routine delivery of member or potential member and provider communications promoting the LAP. The department advises members annually of no-cost language services (inclusive of interpreter and translation support) that are available to them. Methods for member communication are inclusive of CACs, community-based organizations, customer service representatives, member newsletters and mailings, call center script and provider relations representatives.

Providers receive an annual reminder of the language assistance services that are available to them in support of members which includes how to access the LAP at no-cost. Methods for communication are inclusive of Provider Operations Manual, Provider Updates, Newsletters, faxed or emailed bulletins, Provider Web portal and mailings.

6.5 Oversight of Contracted Specialty Plans and Health Care Service Vendors

The Health Equity Department is responsible for monitoring LAP, including plan partners, specialty plans and delegated health care service vendors, and to make modifications as necessary to ensure full compliance. Oversight is guided by our P&P Compliance Monitoring for Specialty Plans and Ancillary CA.CLAS.12.

Language assistance services are not delegated to commercial specialty plans or health care services vendors. Language assistance activities are part of the routine provision of delegated utilization management and case management services.

The Health Equity Department maintains audit readiness for the LAP through routine oversight of the specialty plans and health care service vendors that are delegated for utilization management or case management. To ensure that all language assistance regulations are adhered to for members at all points of contact, Health Equity requests an annual report from each specialty plan or health care service vendor. The report includes the following information/data:

- Attesting that there are policies in place for the provision of language support services.
- Monitoring utilization of language support services provided by Health Net to members that were accessing the services of specialty plans.
- Tracking bilingual staff assessment.
- Attestation that translations were provided for required documents in the required languages.
- Monitoring and tracking cultural and linguistic related grievances to assure member satisfaction with the LAP.
- Evaluating the arrangements and resources for providing language assistance services to determine if they are adequate to meet the needs of enrollees.

6.6 LAP Demographic Data Collection for Member/Enrollee

The Health Equity Department is responsible for implementing standards for direct enrollee assessment of race, ethnicity, sexual orientation, gender identity, pronouns, alternate format, spoken and written language needs. Methods consist of informing enrollees of the need to collect information, requesting

information from enrollees, capturing the information accurately in membership databases and monitoring the information collected. Members are informed of the need to collect this information via annual newsletters and website registration. Our call centers use a contact script that advises members of the need and uses of race, ethnicity, and language information. The Call Center can record a member's gender identity and preferred pronouns and name for all lines of business. Providers may request the information collected for lawful purposes.

Member individual-level data is collected either directly or indirectly by multiple sources within the organization. Protected electronic data system databases enable collected member race, ethnicity, sexual orientation, gender identity, pronouns, and social needs data to be received, stored, and retrieved. When collecting data directly from patients or members, the organization employs a direct data collection framework that includes when data will be collected, where data will be collected, how and by whom data will be collected, and what questions will be used to collect data as well as response options that include option to "decline" or "choose not to answer". A more comprehensive description of the Program Information Systems and Analytic Resources is in Section 11.

6.7 Vital Documents

The Health Equity Department maintains a list of vital documents sent to Commercial, Exchange and Medicare, members that are produced by various departments. This list is updated annually. Quarterly meetings and biannual e-mail reminders are sent to all departments that produce vital documents or adverse benefit determination notices. The Health Equity Department monitors that the translation of standard vital documents follows regulatory guidance and that non-standard vital documents are translated within the required 21 days when requested by a member. In close collaboration with the Compliance and Legal Departments, the Health Equity Department ensures that vital documents are sent to members along with the Non-Discrimination Notice and taglines translated in different languages, as required by state and federal requirements.

6.8 Health Net Staff Training on LAP

The Health Equity Department is responsible for developing, implementing, and evaluating LAP training for staff. All staff who have direct routine contact with members or potential members with LEP and whose duties may include elements of our language services must be trained on the LAP and on the P&Ps specific to their business units and their duties. Training is conducted annually and is done either live and/or via on-demand online learning.

6.9 Monitoring for LAP Quality

The quality of the LAP is assured through quarterly monitoring of the utilization of language services such as interpreter requests by language and line of business, telephone interpreter utilization by language and by line of business, and the number of member requested translations. All translation vendors are provided with a translation and alternate format style guide and a glossary of preferred terms in each of the threshold languages. The quality of Spanish, Chinese, Hmong, Armenian and Arabic translations are additionally monitored by doing ad hoc review of translated documents. Translated documents are not required to go through an internal translation review process per APL 21-004. The provision of language support services is monitored through review of complaints or grievances about the availability or quality of service and oversight of contracted specialty plans and health care vendors (See Section 6.9.1).

Under the LAP, the Health Equity Department oversees and monitors the delegation of LAP services with our specialty plans and ancillary vendors that provide language services to members. The Health Equity Department in collaboration with other departments ensures LAP services are available to all members at

all points of contact and that the specialty plans and ancillary vendors have processes in place to adhere to the regulations and monitoring reports are submitted in a timely manner. The Health Equity Department also provides consultation services to these plans and vendors as necessary.

6.9.1 Grievances

The Health Equity Department is responsible for investigating cultural, linguistic, and perceived discrimination grievances and ensures all case correspondence are documented. Discrimination allegations that are part of the "protected classes" include national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information. The Health Equity Department maintains a log of all cultural or linguistic-related grievances or complaints received by Health Net. The logs for culture or language-related grievances and complaints are analyzed to determine if members' cultural and communication needs are being met and/or addressed by contracted providers and Health Net. Information from the Appeals and Grievances Department, in conjunction with information from the community demographic profile, helps to identify cultural and/or linguistic issues that may act as barriers to accessing health care. Should a communication need be identified, the Health Equity Department develops a provider or member education program to meet that need.

Grievances are tracked for all lines of business including Health Net Community Solutions Medi-Cal, Health Net of CA IFP & group, CA Medicare Advantage & Supplemental, Health Net Behavioral Health (HNBH), Community Health Plan of Imperial Valley (CHPIV), CalViva Health (CVH), and Liberty Dental.

6.9.2 Grievance Reporting

The Health Equity Department has a comprehensive training, response, tracking and monitoring procedure. All cultural or linguistic-related grievances are responded to in real-time with the A&G representative. Grievance information is reported biannually within the LAP Reports and discussed at the respective quality committees. The Health Equity Department conducts an annual qualitative narrative analysis across all lines of business that looks at individual grievances as well as trend information to identify regional or systemic issues that impact the effectiveness of language services for the member or provider. Health Equity will work with respective stakeholders to identify and implement solutions and/or corrective actions if any notable trends or systemic issues are identified based on the trending. The Health Equity Department and A&G Department meet on a monthly basis to conduct a Cultural and Linguistic Case Report Review. Health Equity provides feedback and comments on cases that need to be reclassified, any cases that Health Equity has not received, or any other pertinent feedback.

6.10 LAP Utilization Report

The Health Equity Department summarizes LAP Utilization data by line of business, the non-English call volume to the member service call center, interpreter vendor (telephone, face-to-face, ASL, and video) utilization per language, and requests for oral and written translations from members. Language call volume and identified language preferences are tracked to identify developing trends and possible future member language needs.

Health Net produces a LAP report biannually that summarizes LAP data and assesses utilization and usage trends. The end of the year LAP Utilization report compares current usage by language and line of business to the previous year's data to allow Health Net to project future language trends. Any notable trends are reported to the Health Net Quality Improvement Committees throughout the year.

7.0 DIVERSITY, EQUITY AND INCLUSION TRAINING PROGRAM

The Health Equity Department provides support to integrate culturally competent best practices across the organization. This is accomplished across our network through a provider and staff training program. The training program includes training content, training presentations and evaluations. The training program also offers topic specific education and consultation as needed by internal departments and contracted providers. The cultural competency training program covers non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. A listing of the available language services and resources for Health Net members and providers is presented in Appendix 14.3.

7.1 Services in support of Staff

Cultural Competency trainings and services for our Health Net staff are designed to help support staff in meeting our diverse members' needs in a culturally sensitive, empathic and efficacious manner. Support services focus on resources, such as, trainings, in-services, scripts, and language access services available through SharePoint, on demand trainings and by request.

7.1.1 Staff Training

Health Equity Department services in support of staff include workshops, trainings, in-services, and cultural awareness events. Cultural awareness in-services are provided upon hire to all Member Services staff. In addition, the Health Equity Department collaborates with internal departments such as Provider Engagement, Provider Network Administration, Health Education, and Quality Management to provide in-service of C&L/health equity services and/or cultural competency workshops. As needed, Health Equity also provides in-services to case managers to assist in building trust with patients who are recently arrived immigrants. The goal of these in-services is to provide information to staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L and health equity resources and Health Net and CH&W member diversity.

The Health Equity Department takes the lead to annually host “Best in CLAS Month” for staff as the main cultural competency training activity. Staff engage in training, interactive learning and events related to cultural competency. Cultural competency training courses include content on access to care needs for all members regardless of their gender, sexual orientation, or gender identity. CLAS Month events also highlight the current and emerging needs of our members across populations most impacted by health inequities as well as special health care needs populations. The event demonstrates Health Net's commitment to being a culturally competent organization by providing a forum for staff to learn about diverse cultures, which increases their understanding of the diverse cultures represented in our membership. This understanding also serves to build sensitivities that promote a non-discrimination environment within the enterprise.

7.1.2 Cultural and Linguistic Consulting Services

Each Health Equity staff member has a cultural subject matter area of expertise that includes; cultural issues that impact seniors and persons with disabilities, cultural issues that impede health care access for LGBTQ+ populations, cultural disconnects that may result in perceived discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information and the cultural issues that impede accessing health care services for recent arrivals to the United States and many other specialized areas including:

- Case managers to assist in building trust with patients who are recently arrived immigrants and refugees.
- Quality improvement coordinators to help identify cultural issues that may impede cancer screening.
- Grievance coordinators and provider relations staff to address perceived discrimination including but not limited to those due to members' gender, gender preference or gender identity.
- Care coordinators trying to obtain medical information for patients hospitalized outside of the U.S.

7.2 Cultural Competency Education for Providers

The Health Equity Department supports contracted providers in their efforts to provide culturally responsive care to members. The services offered to contracted providers are intended to:

- Encourage cultural responsiveness and awareness.
- Provide strategies that can easily be implemented into clinical practice.
- Foster improved communication and health outcomes for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, gender, gender preference or gender identity.
- Foster non-discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Trainings for providers and their office staff include the following:

- Advancing Health Equity: Cultural Humility, Diversity and Equity in Healthcare
- Language Assistance Program/Services and Health Literacy
- Gender Inclusive/Affirming Care
- Community Connect Program- Social Needs Support
- By request trainings on specialty topics

To identify the cultural needs of providers, the Health Equity Department collects information from providers using a variety of methods, including the annual Health Net provider survey that is conducted by the Quality Improvement Department.

Cultural competency services are also promoted to providers with the Provider Communication Department through our website, the Health Industry Collaboration Effort (HICE) provider toolkit, "Better Communication, Better Care" and tailored cultural competency workshops. Many topic areas for presentations on cultural aspects of health care, provider group in-services on interpreter services, cultural and linguistic requirements and working with Specialty Healthcare Needs populations are available to providers upon request. Cultural Competency training for Medi-Cal providers is documented in the provider directory.

Additionally, the Health Equity Department has developed materials for use in Health Net provider offices that specifically address cultural background and clinical issues. Health Net recognizes that diverse backgrounds include culture, ethnicity, religion, age, residential area, disability, gender, gender preference and gender identity. Because diversity is complex and an important component for individuals as they access and utilize services, Health Net has placed emphasis on developing materials that are researched and field-tested to assure quality and cultural appropriateness. Health Net providers may access the materials by emailing the Health Equity Department Group Inbox Cultural.and.Linguistic.Services@healthnet.com or calling the Health Equity Department toll free number

during business hours at (800) 977-6750. For a detailed list of Health Net materials, please see Appendix 4.1.

7.3 Collaborations

The Health Equity Department has been an active participant in the Health Industry Collaboration Effort (HICE) as a co-leader for over fifteen years. Participation in this collaboration has provided cost-saving suggestions to implement new cultural or linguistic legislation. It has also provided a forum to discuss LAP and health equity challenges faced by provider groups and other health plans that result in a more consistent experience for consumers with LEP. Additional workgroup participation through HICE continues to develop, including the Health Equity Accreditation Workgroup, and State (DHCS, DMHC) issued training requirements.

8.0 HEALTH LITERACY

The Health Equity Department continues to make strides in the promotion of health literacy through the implementation of the health literacy initiative, *Clear and Simple.* The department operates from the Health Literacy best practice of universal precautions. Health Literacy universal precautions dictate that member health information should be understandable across all levels. As such, Health Equity follows practices to promote the delivery of member health information at a 6th grade reading level.

The Clear and Simple Initiative involves:

1. Plain Language and Readability Studio online training.
2. Plain language tip sheets.
3. Support writing documents at appropriate grade level.
4. Organization-wide access to plain language readability software.
5. Content and Layout review checklists for materials production.
6. A review process that streamlines the English Material Review (EMRs).
7. Organization-wide deployment of participation in National Health Literacy Month.
8. Provider training on motivational interviewing/reflective listening and plain language resources.

8.1 Readability Software

To sustain the Clear and Simple principles across the enterprise, Health Equity launched Readability Studio. Readability Studio is software that is available to staff at no charge to their departments. The software supports staff in editing written materials so that they are easily understandable for members.

In addition, the Health Equity Department has developed and implemented Readability Studio training so that staff have the support to effectively navigate the software and produce effective member materials. The training uses adult learning theory and provides hands-on experiential learning in operating the software and editing written materials to a 6th grade reading level.

All staff who produce written materials for members are required to submit reading grade level scores from Readability Studio as part of the English Material Review process. More detail on the EMR process is in Section 8.3.

8.2 *Clear and Simple* Education

Our training, “Plain Language 101: A primer on writing in plain language”, provides staff with a basic understanding of health literacy and its impact on health care access. It also goes over useful tips on how to write in plain language such as avoiding jargon, using simple words, and giving examples to explain

difficult concepts. This ensures that letters and materials sent to members and information Health Net posts on websites are clear and easy to understand.

Health Literacy Toolkit: The Health Equity Department produces a Health Literacy Toolkit that consists of

- Clear and Simple Plain Language Guide
- Readability Studio Tips and Tricks
- Content and Layout Review Checklists
- Health Equity Review Grid
- Many other resources

The guide is provided during training and is available on the Health Literacy SharePoint site.

8.3 English Materials Review (EMRs)

The Health Equity Department conducts English material reviews through Workfront. EMRs are conducted on all member informing materials to ensure that the information received by members is culturally and linguistically appropriate and supports stigma reduction. Readability levels are assessed on the original document and revised accordingly to ensure they comply with required reading grade levels as mandated by regulatory agencies. The review process ensures that document layouts are clean, easy-to-read, well organized, and that images are appropriate and culturally relevant and prepares vital documents to be "translation ready". Content and Layout Review checklists are required to be submitted with all EMR requests.

8.4 National Health Literacy Month

Every October, National Health Literacy Month is celebrated company wide. NHLM is an opportunity for staff to participate in various contests to exemplify how they are using the Clear and Simple principles in their everyday work. Health Net's plain language efforts have been recognized externally by America's Health Insurance Plans (AHIP) in a publication that summarizes the health literacy activities of 27 health plans across the nation.

9.0 HEALTH EQUITY

Health Net is committed to supporting the health of our members and promoting the reduction of health disparities across our membership. To accomplish this, Health Equity collaborates across departments and with external partners to analyze, design, implement and evaluate healthy disparity interventions.

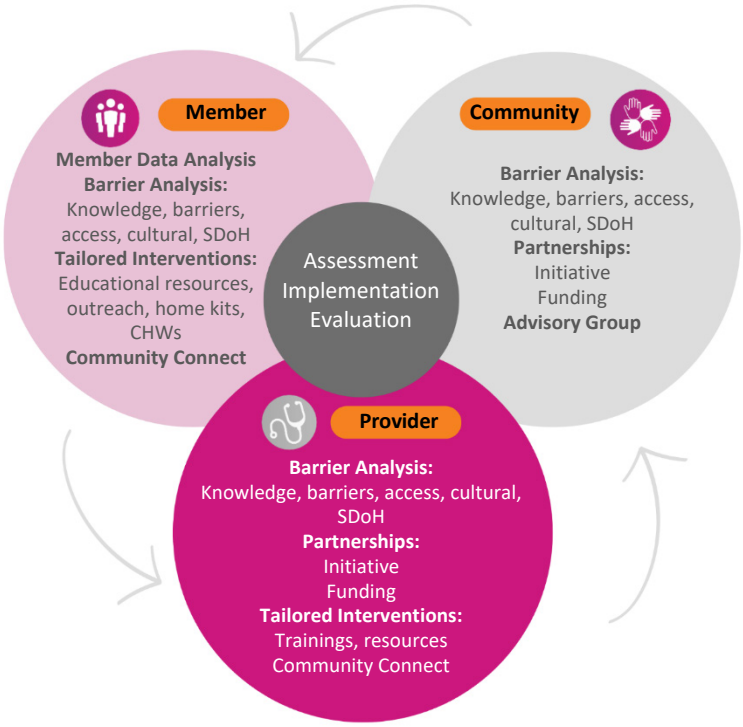
9.1 Health Equity Interventions

The Health Equity Department coordinates organization-wide strategies to support the reduction of health disparities. The department facilitates the Health Equity workgroups, which are responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures. The workgroups look systematically and deliberately at resources and the development of strategies to reduce targeted health disparities. The workgroups are aligned with requirements to address health disparities from NCQA Health Equity Accreditation, the state, internal directives, and DHCS Performance Improvement Project (PIP). Disparity reduction efforts are implemented through a model that integrates departments across Quality Improvement, Provider Engagement, Health Equity, Community Engagement, Health Education, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach and media, provider interventions and member level initiatives. The following highlights the core components of the disparity reduction model:

- Assessment inclusive of member data analysis and member, community, and provider barrier analyses. These include literature reviews, key informant interviews, and focus groups.
- Implementation of efforts is targeted at one or more of three core levels:
  1.) Community: Partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions.
  2.) Provider: Interventions targeting high volume low performing groups and providers who have disparate outcomes.
  3.) Member: Internal programs to improve disparities in identification, engagement and outcomes in Case Management and Disease Management.
- Evaluation and improvement of health disparity reduction efforts.
- Social needs and social risks all play into determining appropriate partners, selecting, engaging and initiatives with partners.

9.2 Health Equity Model

Our disparity work follows a model that utilizes a multidimensional approach to improving quality and delivery of care inclusive of community, provider and member interventions and system level initiatives. The Health Disparity model gives us a unique ability to understand target populations and implement tailored disparity reductions efforts to improve health care quality. Race, ethnicity, language, gender, and geographic location are analyzed to develop targets for disparity reduction efforts and specific interventions to address the associated disparities and barriers.



At the community level, we engage with community-based organizations and stakeholders to identify community level needs while at the same time leveraging the same community connections to support our members and the community. At the member level, we aim to identify member level disparities and

assess and address member level barriers. At the provider level, we look for a solid partnership with providers to identify challenges and support providers in addressing those challenges.

9.3 Consultation

The Health Equity Department collaborates across departments to provide consultative services for cultural competency and linguistic perspectives to improve health disparities. Examples of consultations include partnership in QI PODS, QI intervention development, and support of care management programs.

10.0 SOCIAL RISKS & SOCIAL NEEDS

10.1 Defining Social Risks and Social Needs

Social risk factors are specific adverse social conditions (e.g. social isolation, housing instability, poverty) associated with poor health outcomes. Health Net uses the following data/sources to assess for social risks in the community:

- Membership database on member addresses and claims data. A member is categorized as housing insecure if they meet at least one of the following situations:
  1) currently registered with the address of homeless shelter, place of worship, hospital, transitional housing, public office or an address containing a keyword synonymous with "homelessness", "General Delivery", or "Friend's Couch".
  2) From January 1st of prior year to the end of the current measurement year, the member had any claims/encounter data with ICD-10-CM Code Z59.X.
- Healthy Place Index (HPI) Quartiles. Quartiles of HPI composite score, which indicates the relationship between community social, economic, environmental, and educational conditions and health outcome (life expectancy at birth). The higher the quartiles, the less healthy the community is.
- Health Net Community Connect (findhelp). Perform quarterly analysis of the top ten searched social programs on findhelp to assess for social risks that members and community might have. More information is in Section 10.2.2.
- Community health assessment by a local public health agency.
- American Community Survey Census data

The Health Net process to identify the social needs of targeted individuals served includes:

- Social needs assessment (SNA) conducted through findhelp. SNA details are provided below.
- Case management assessment to identify social needs.
- Community-level searches for social need categories through findhelp.
- Member Connections (population health management) department uses a mini-screener tool to identify social determinants of health, including social needs like food, transportation, housing, utilities, and safety.

Health Net uses community and individual social needs and risk data to determine partnerships with community partners. Health Net's selects cross-sector partners to address social risks and social needs of the community and individuals that the organizations mutually serve as part of its HE and HE Plus programs. Engaging with partner organizations that share the same goal to reduce the negative effects of social risks and improve outcomes for individuals within communities provides more effective ways to address social needs. Cross-collaboration is mutually beneficial and enables partners to support each other in providing resources and interventions.

Health Net Community Connect, powered by findhelp, utilizes a social needs assessment (SNA) to gather and assess data on members' unmet social needs. The questions that are asked on the SNA assesses for safety, transportation, housing, food, finances, and more. Resource gaps exist because member social needs are out-of-scope for Health Net and we are unable to directly fulfil those needs, such as food resources or housing support. This data can be collected from any Health Net member across all lines of business and products. Data is collected via phone or in person by case managers, providers, Quality Improvement, Health Education, and members can self-input their answers. This data can be collected at any point and can be collected multiple times to meet the member's evolving needs. For staff and providers to know how to utilize the SNA, the Health Equity department provides regularly scheduled training on how to complete the survey to internal staff, community partners, and providers. Health Net also developed a findhelp guide to support staff with a walkthrough on how to utilize the assessment. The Health Equity Department collects the social needs assessment data monthly to assess the needs that are most important to members. The SNA results are used to identify and prioritize social needs and service interventions to support our members and the community. Additional domains that the SNA assesses for are access to the internet, issues applying to public benefits, access to a working phone, childcare, and more. It is important to collect this additional information as it could impact members' access to being able to get core social needs such as transportation, food, and housing.

10.2 Community Engagement and Collaborations

10.2.1 Community-Based Organizations

To support the reduction of health disparities, the Health Equity Department interacts with community-based organizations (CBOs) to identify C&L-related concerns, obtain feedback on C&L service needs of the community and promote C&L services to community members. The Health Equity Department actively participates in local community workgroups, collaboratives, and other CBO activities. Creating and maintaining a community network allows for input and guidance on member services and programs and assures that the Health Equity Department work reflects the needs of Health Net members. Social needs and social risks information contributes to determining appropriate partners, selecting, and engaging in initiatives with community-based organizations.

10.2.2 Community Referrals

To support and foster engagement with community resources, Health Net has partnered with findhelp to establish the Health Net Community Connect (HNCC). Culturally and linguistically appropriate referrals support Health Net members' clinical, social, and economic needs that may arise as part of members' efforts to maintain a healthy lifestyle. Health Net will provide a culturally and linguistically service referral to 2-1-1 Resource and referral and/or other culturally competent referral sources such as findhelp for Health Net members at no cost.

Findhelp supports direct referrals to programs through the platform. Health Net staff or members can search for a program that meets the member's needs, then make a direct referral when there is a "Refer" button within that program's page, or "program card". This tool enables Health Net staff to review and update the status of a referral to give a full picture of how they are navigating the social system through these closed loop referrals.

10.2.3 Cross-Sector Partners

In support of the Systems of Care Department, the Health Equity Department shares the relationship with the findhelp platform and social needs assessment. The multi-county, cross-sector Enhanced Care Management (ECM) and Community Support (CS) providers are added to the findhelp platform if they do not already have an active account, to have a streamlined referral process. Once on the platform, ECM and CS providers can support members across all lines of business.

Selection of these cross-sector partners occurs through the Community Engagement and Regional Teams. They use community-level insight and triangulate based on findhelp social needs assessment data to determine engagement with partners. Once engaged, the Systems of Care team executes a thorough Community Supports certification application review process to ensure the partner meets satisfactory evidence of requirements as laid out in a Model of Care.

11.0 PROGRAM INFORMATION SYSTEMS AND ANALYTIC RESOURCES

Member individual-level data is collected either directly or indirectly by multiple sources within the organization. Our Member Orchestration & Digital Engagement (MODE) program focuses on understanding who our members are, how they prefer to engage with Health Net, and how best we can support them through their health care journey. It begins when the individual onboards and becomes a new member of Health Net. We ingest and validate 834 enrollment and membership data in our MIS, through systems such as our Member Enrollment System and our Customer Relationship Management (CRM) Platform. In CRM, we create an integrated member data profile where we store an ongoing history of interactions and touchpoints with our members from day one throughout their entire enrollment with us. This insight helps identify opportunities to improve their healthcare experience and enhance continued delivery of equitable healthcare.

Our Customer Services Advocates (CSAs) have visibility into all recent interactions with a member (e.g., the member used the Member Portal, received a mailer, or has placed a call to the call center or care management team). MODE allows CSAs to support the member with any inquiry they have, while having additional context on what a member may be calling about. The MODE program drives an omni-channel experience so that we can honor a member's engagement preference – such as email, text, or phone – while optimizing messaging through all appropriate channels to consistently engage members.

The tables below illustrate the variety of protected data sources accessed and utilized by program staff through the organization's electronic data systems and work applications.

11.1 Data Sources

Individual Level Direct Data Sources

	race/ethnicity	preferred language	social needs	gender identity	sexual orientation
Call Center service records	✓	✓	✓	✓	✓
Case management intake forms	✓	✓	✓		
Disease management intake forms	✓	✓	✓		
Enrollment or registration forms	✓	✓			
Health assessments			✓		
Language services data (translation and interpreter requests)		✓			
Organization's website/member portal	✓	✓	✓	✓	✓
Population Health Management social needs screener			✓		
Social Needs Assessment			✓		

Individual-Level Indirect Data Resources

	race/ethnicity	preferred language	social needs
CMS	✓	✓	
State or local agency	✓	✓	
Health information exchange	✓	✓	✓
Electronic health records	✓	✓	
Medical records data	✓	✓	✓
Care management systems	✓	✓	✓
Employers	✓	✓	✓

Provider Engagement and Provider Network Management assist program staff with obtaining data on network practitioner race/ethnicity and languages spoken other than English by practitioners. Health Net does not delegate language services to provider-level practices. The table below illustrates data resources utilized and types of data collected that the HE and HE Plus program uses to assess the practitioner network racial/ethnic make-up and languages spoken other than English. This data is used to evaluate needs and improve the practitioner network cultural responsiveness (Section 11.1.2 Geo Access Report).

Practitioner Data Resources	
✓ Practitioner contracting demographic data: languages spoken other than English by provider or certified provider office staff	✓ Practitioner directory data: languages spoken other than English by provider or certified provider office staff
✓ Credentialing verification data: certified provider office staff	✓ Provider network data: languages spoken other than English by provider or certified provider office staff

12.0 OVERSIGHT AND MONITORING

12.1 Reports

The Health Equity Department produces numerous key reports in a calendar year. The reports provide analyses of Health Equity services and assist in monitoring and evaluating the impact of various activities. The reports are an integral part of the regulatory and compliance requirements and are used to help identify areas where modifications and corrective measures may be needed. The key reports include the following:

12.1.1 Population Needs Assessment

The Population Health Management and Health Equity Departments conduct a Population Needs Assessment (PNA) every three years to improve health outcomes for members. The PNA is conducted through an analysis of CAHPS survey data and follows the DHCS guidance provided in APL 23-021. Participants in Health Net's Community Advisory Committee provide input and advice to the PNA and review the PNA results, discuss and provide input into opportunities to improve performance with an emphasis on Health Equity and Social Drivers of Health on an annual basis.

The results of the PNA are used to identify C&L/health equity program strategies to improve health outcomes and to reduce health disparities. The Health Equity work plan is adjusted annually to include all strategies that have been identified to improve health outcomes and reduce health disparities for members. The Health Equity work plan serves as the PNA action plan that is submitted to DHCS on an annual basis.

12.1.2 Geo Access Report

The Health Equity Department prepares a report to identify the need for linguistic services for all product lines using a spatial analysis software program. The purpose of the Geo Access report is to determine if members have access to provider locations where either the provider or office staff speak their preferred language. The Provider Network Management Department assists Health Equity program staff with obtaining data on network practitioner race/ethnicity, languages spoken other than English by practitioners, and languages spoken other than English by office staff. This data is used to evaluate needs and improve the practitioner network cultural responsiveness.

This analysis is conducted for both PCP offices and Specialist offices. The locations of members and providers are compared across language preference. Using predetermined time and distance parameters, the software measures the time and distance for each member to each provider office by language by county. Time and distance standards vary by type of place: urban, suburban, and rural. The language capabilities of the provider network are compared to the language needs of members by product line and county. The availability of linguistic services by contracted providers for members with LEP is analyzed and recommendations made for provider network development. The Geo Access report is submitted to the Quality Improvement committee every two years for review and comment.

12.2 Community Advisory Committee

The Public Policy Department, with support from Health Equity department, facilitates Community Advisory Committee (CACs) meetings in each region that maintain a Medi-Cal contract to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care and to establish and maintain community linkages. In compliance with DHCS guidelines, for each county or region of the Plan's service area, a County or Regionally Focused CAC will empower members to ensure the Plan is actively driving interventions and solutions to build more equitable care by:

- Obtaining local level feedback, insights, and perspectives to inform and address our quality and health equity strategy,
- Providing the Plan with the community's perspective on health equity and disparities, population health, children's services, and relevant plan operations and programs, and
- Informing the Plan's cultural and linguistic services program.

Information provided by the CAC participants is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for Health Net to understand that perception, experience, and satisfaction of services.

Health Net developed and implemented a CAC member selection process to recruit a culturally diverse group of community members, consumers, and individuals (See Section 12.2.1). As part of their involvement, the group's focus is to serve meaningful community and consumer advisory functions that includes taking part in identifying and prioritizing opportunities for improvement, as well as identifying and prioritizing social risks and needs of individuals for Health Net to address.

12.2.1 Selection, Recruitment and Engagement

The Public Policy department under the Government Programs Officer leads the development and programming of the CACs. Further details and guidance are in the Public Policy P&P CA.GOVP.02 CAC & CAC Selection Committee. The following is an excerpt from CA.GOVP.02:

Selection Committee Role & Responsibility

1. *Ensure the CAC membership reflects the general Medi-Cal Member population in the Plan's Service Area(s), including representatives from IHS Providers, and adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that the Plan's communities are represented and engaged;*
2. *The CAC Selection Committee will review, at least annually, demographic data, including data on racial, ethnic, and linguistic composition, of residents and members living in a Service Area to ensure CAC recruitment efforts and membership aligns with and reflects the racial, ethnic and linguistic diversity of their respective Service Area.*
3. *Make a good faith effort to include representatives from diverse and hard- to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience health disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation and physical disabilities.*

A. Committee Composition

The Plan will work to engage the below types of stakeholders to participate in the quarterly and local Community Advisory Committee (CAC). The Plan is committed, and will make every effort, to have the committee composition be comprised primarily of Medi-Cal Members or consumers from the communities we serve. The plan will ensure no less than 33% of the committee are Medi-Cal Members or consumers.

1. *Medi-Cal Members, including:*
    a. *Seniors and Persons with Disabilities (SPDs)*
    b. *Individuals with chronic conditions (e.g., asthma, diabetes, congestive heart failure)*
    c. *Individuals with Limited English Proficiency (LEP)*
    d. *Individuals from diverse cultural and ethnic backgrounds or their representatives*
    e. *Adolescents and/or parents and/or caregivers of children, including foster youth*

2. *Community Based Organizations (CBOs)*
3. *Community Advocates*
4. *Health Care Service Providers including those representing the Safety Net, e.g., Federally Qualified Health Centers (FQHCs), behavioral health, regional centers, local education authorities, Dental Providers, Indian Health Service (IHS) Facilities, and home and community-based service Providers*
5. *County Partners and Local Government Agencies*
6. *The Plan's CAC management team*
    a. *Public Policy Director*
    b. *Health Equity Officer*
    c. *Regional Medical Director(s) as needed*
    d. *Regional Medi-Cal Lead*
    e. *Strategic Giving Director or designee as needed*
    f. *Quality Improvement and Cultural & Linguistic Team Members*

B. Objectives

1. *Obtain local level feedback, insights and perspectives to inform and address the Plan's quality and health equity strategy;*
2. *Maintain a stable local presence and forum to engage and collaborate with local community partners and resources to ensure community needs are met;*
3. *Provide perspectives on health equity and disparities, population health, children's services, and relevant plan operations and programs;*
4. *Inform the Plan's cultural and linguistic services program;*
5. *Maximize member participation and involvement to solicit meaningful insights and perspectives to improve how the Plan delivers services through an intentional onboarding and ongoing training as well as effective meeting facilitation;*
6. *Inform and advise the Plan on how to utilize Health Equity Improvement zones based on identified health disparities to ensure talent, resources and partnerships are aligned to improve health equity performance outcomes for members and residents of the County or Region;*
7. *Provide a forum for bidirectional communication between committee members and the Plan's leadership to inform use of community reinvestment funds; and*
8. *Assess the need for and establish Community Impact Councils using data, insights, and considering community and the Plan's priorities, who will collaborate with diverse community stakeholders to further drive community impact and create sustainable forums for continued work.*

C. Frequency

1. *The first regular CAC meeting will be held promptly after all initial CAC members have been selected by the CAC selection committee, and quarterly thereafter. The Plan will make the regularly scheduled CAC meetings open to the public by posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.*

D. Length of Appointment

1. *Committee members may serve for 2 years with the opportunity to serve additional terms as approved by the CAC Selection Committee.*
    a. *The CAC Selection Committee may revise the length of appointment based on an annual review of CAC composition.*

2. *Should a CAC member resign, be asked to resign, or otherwise unable to serve on the CAC, the Plan will exercise best efforts to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.*

The CAC membership is reflective of the State Health Program population in the respective regions, comprising community stakeholders, State health Program members, consumer advocates, community organizations, community-based organizations, providers, community members, parent groups and safety net providers. Community stakeholders serve all members across our lines of business.

- Health Net will leverage Member race, ethnicity, language, SOGI, and Social Determinants of health information to identify potential candidates for CAC participation to ensure the demographic characteristics and populations served are represented, including:
    - Seniors and Persons with Disabilities (SPD),
    - Persons with chronic conditions (such as asthma, diabetes, congestive heart failure),
    - Members with Limited English Proficiency (LEP), and
    - Members from diverse cultural and ethnic backgrounds or their representatives
- The Member demographic information noted above will inform the types of providers and organizations for potential candidates for CAC participation.
- In the future, Health Net intends to create a public-facing webpage where CAC materials can be shared. Here we will create an opportunity for community members to directly outreach to the Medi-Cal Public Policy team for consideration.
- Health Net has created an internal position to support committee member recruitment and engagement – Program Manager, Community Advisory Committees.
- Among other written job description responsibilities, the Program Manager will:
    - Maintain committee membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC.
    - Ensure that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings.
    - Ensure compliance with all CAC reporting and public posting requirement.

12.2.2 Forum

The CAC meetings are held online via a virtual meeting platform. There are online participants, although calling in via telephone only is also an option to accommodate participants that may not have consistent access to a device to connect online.

12.2.3 Advisory Functions

The CACs are charged with the responsibility of providing input and advice, including, but not limited to, the following:

1. Identify and advocate for preventive care practices;
2. Gather feedback, develop, and update cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting groups who speak a primary language other than English;
3. Advise on necessary Member or Provider targeted services, programs, and training;
4. Make recommendations to the Plan regarding the cultural appropriateness of communications, partnerships, program design and services;

5. Review Population Needs Assessment (PNA) results, discuss and provide input into opportunities to improve performance with an emphasis on Health Equity and Social Drivers of Health.
6. Provide input on the selection of targeted health education, cultural and linguistic, and QI strategies;
7. Ensure findings, recommendations and actions to/from the Quality Improvement and Health Equity Committee (QIHEC) and Public Policy Committee (PPC) connect to holistic decisions and programming;
8. Recommend strategies to effectively engage members, including but not limited to consumer listening sessions, focus groups, and/or surveys; and
9. Provide input and advice, including, but not limited to, the following:
    a. Culturally appropriate service or program design;
    b. Priorities for health education and outreach program;
    c. Member satisfaction survey results;
    d. Findings of the Populations Needs Assessment (PNA);
    e. Plan marketing materials and campaigns.
    f. Communication of needs for Network development and assessment;
    g. Community resources and information;
    h. Population Health Management;
    i. Quality;
    j. Health Delivery Systems Reforms to improve health outcomes;
    k. Carved Out Services;
    l. Coordination of Care;
    m. Health Equity; and
    n. Accessibility of Services
10. The Plan will ensure that CAC meetings are accessible to CAC members and that CAC feedback is meaningfully incorporated in Plan's operations and governance; and
11. Review and approve meeting minutes from previous session.

12.3 Community Impact Council

Building on efforts to improve health equity and address individual social needs and community-level social determinants of health, Health Net is building, designing, or joining Community Impact Councils (CICs). A CIC is a collaborative assembly of community and civic leaders representing a broad spectrum of stakeholders including local social service agencies, advocacy groups, faith-based organizations, and service providers. The CIC will be designed to identify social issues at a community level using key data in order to identify ways to improve. CICs are strongly rooted in local communities and membership and typically includes individuals who have strong connections and are willing to take ownership of community projects.

The CICs will be created in key geographies that have a disproportionate share of identified health inequities in priority performance measures. In 2024, Health Net launched a Los Angeles CIC that is focusing on reducing the disparities seen in the Black Pediatric Population of South Los Angeles. In 2025, Health Net's regional teams will prioritize partnering with local health jurisdictions or other existing coalitions to establish CICs in San Joaquin/Stanislaus, and Tulare Counties. The CICs will help advance Health Net's health equity work and strengthen existing community-provider partnerships.

12.4 Member Advisory Committee

Health Net hosts a Commercial Member Advisory Committee (MAC) to empower members to bring their voices to the table to ensure Health Net is actively driving interventions and solutions to build more equitable care. The MAC advocates for Health Net members by ensuring that Health Net is responsive to their diverse health care needs. MAC members provide knowledgeable feedback based on their experiences navigating the healthcare system and benefits.

12.5 Data Collection

The Health Equity Department monitors the demographic composition of the Medi-Cal, Medicare, and Commercial California HMO and PPO members. Demographic information is used to assess the language needs of members; to identify possible cultural and socio-economic background barriers to accessing health care; and to understand the range of diversity within the communities that we serve. Collected and analyzed on a regular basis, data is based on existing member language needs, race, and ethnicity. Health Net protects the privacy of members and does not use individual REL, SOGI, and social needs data for underwriting and denial of service, coverage, and benefits. At a minimum, communication about Health Net privacy policies is made at the time of direct data collection. The Health Equity Department maintains the list of all races, ethnicity and language codes and categories used by all data systems. Health Equity collaborates with IT to assure that all new databases and modified databases can share member race, ethnicity, and language information. The list of data collected and monitored by Health Equity is listed at Appendix 14.2.

Member individual-level data is collected either directly or indirectly by multiple sources within the organization. Protected electronic data system databases enable collected member race, ethnicity, sexual orientation, gender identity, and social needs data to be received, stored, and retrieved. When collecting data directly from patients or members, the organization employs a direct data collection framework that includes when data will be collected, where data will be collected, how and by whom data will be collected, and what questions will be used to collect data as well as response options that include option to “decline” or “choose not to answer”. For more detail, see Section 11 Program Information Systems and Analytic Resources.

12.6 Health Equity End of Year Report

The Health Equity Department prepares the end of year Health Equity report to evaluate and provide an overview of the C&L/health equity activities, main achievements, and barriers for the year. The report is structured around CLAS standards to ensure our department goals and activities are aligned with the standards. This report is reviewed and approved by the HNCS QIHEC and HNQIC committees.

13.0 COMMITMENT TO SUPPORT DEI AND CULTURAL HUMILITY

13.1 Accreditations

The NCQA's Health Equity Accreditation Plus program evaluates how well an organization complies with standards specific to the following areas:

- Organizational readiness: building a diverse staff and promoting diversity, equity, and inclusion among staff.
- Collection of race/ethnicity, language, gender identity, and sexual orientation data.
- Access and availability of language service.
- Practitioner network cultural responsiveness.
- Quality improvement of culturally and linguistically appropriate services.

- Reduction of health care disparities.
- Collection, acquisition and analysis of community and individual data.
- Cross-sector partnerships and engagement.
- Data management and interoperability.
- Program to mitigate social risks and address social needs.
- Referrals, outcomes, and impact.

In January 2012, Health Net demonstrated our commitment to our mission and to meeting the CLAS principal standard through becoming the first health plan in the country to earn the NCQA's Multicultural Health Care (MHC) Distinction for Commercial, Medicare and Medicaid lines of business. In January 2012, Health Net became the first health plan in the country to earn the NCQA MHC Distinction for the PPO product and for both Medicaid and Commercial products combined. Health Net has successfully renewed MHC distinction for California Medi-Cal, Commercial and Medicare in 2015, 2017, 2019, and 2021. The MHC distinction was renewed for another two-year period in 2021 valid through December 2023. In 2022, NCQA announced they were transitioning the MHC Distinction program to two new accreditation programs: Health Equity and Health Equity Plus accreditation. Health Net elected to become one of the organizations participating in NCQA's Health Equity Plus pilot program. Health Net was awarded the Health Equity Accreditation Plus in September of 2022. In 2024, Health Net became the only health plan in the United States to earn HEA Plus across all lines of business – Medicaid, Medicare, Commercial, and Exchange.

The Health Equity Accreditation Plus recognizes Health Net's robust Health Equity Services and acknowledges our ongoing efforts and commitment to improve culturally and linguistically appropriate services to reduce health care disparities and provide high-quality health care services.

13.2 Organizational Diversity, Equity, and Inclusion

Health Net is committed to support diversity, equity, inclusion, and cultural humility and eliminating health inequities and disparities by working to break down the barriers that prevent access to high-quality health care services. Through its HEA and HEA Plus programs and services, the organization is committed to finding solutions and providing appropriate resources and interventions to diverse individuals within its population and community. Finally, the organization is committed to CLAS and addressing social risks and needs by:

- Establishment of the Executive DEI Council
    - Composed of senior leaders from our business divisions, focuses on strategic accountability across DEI core pillars.
    - Widespread distribution and presentation of the Diversity, Equity, and Inclusion (DEI) Annual Report, which reflects our commitment to DEI at Centene and demonstrates Centene's tangible steps to achieving a more inclusive workplace.
    - Ensuring policies and practices drive sustainable DEI results throughout the enterprise.
    - Advocating for systemic change that embodies social justice, public policy, equity, and inclusion.
    - Historically, the council has taken action to focus on the following priorities:
        - leadership development and accountability,
        - pay equity,
        - cultural inclusivity,
        - local business unit DEI council development, and
        - enterprise access to DEI resources.

- Embracing diversity without bias or discrimination.
- Supporting and strengthening equitable care through fair distribution in procedures, resources, systems, and mechanisms.
- Actively including, sharing, and engaging diverse individuals, groups, teams, partner organizations, and community members by providing on-going opportunities and pathways for participation in decision-making processes.
- Exhibiting respect for and value of diverse cultural health beliefs, behaviors, and needs of individuals and the community through responses and interactions when providing services to others.
- Partnership with findhelp to support social needs assessment and community social risk identification.
- Strategic Giving through Quality Improvement Department
    - Historical funding for health equity and disparity reduction projects were the top focus, with over 132 funded projects at over $1.5 million investment (2018-2024).
    - From January to November, there were 48 Health Equity projects or initiatives. Total invested was $431,766 in funds for these projects.
    - In 2024, 663 Quality EDGE funding requests were approved across all line of business totaling $4,402,101 for PPGs, PCPs tailored to address specific barriers for quality measures, office staff support, and member incentives.
    - Of the funding approved, $452,556 was pending payout as of 12/31/2024.

14.0 APPENDICES

14.1 Materials Available to Health Net Contracted Providers

1. Health Net Interpreter Service Flyer
2. Language Identification Poster
3. Tool Kit: *Better Communication, Better Care: Provider Tools to Care for Diverse Populations*. Health Net
4. Adverse Childhood Experiences Tips to Help You Support Inclusivity and Equity
5. Achieve Health Equity Through Culturally Competent Care for BIPOC Patients
6. Childhood Immunizations Cultural Approaches to Support Parents who are Vaccine Hesitant
7. Enhance Patient Care Through Better Cultural Awareness
8. Improve Diabetes Management Cultural Recommendations
9. How to Provide Culturally Competent Care for Patients with Disabilities
10. Improve Quality and Inclusive Care for LGBTQ+ Patients
11. Improve Postpartum Care a Cultural Approach
12. Findhelp How-to Guide
13. Findhelp Provider Flyer
14. Health Literacy Resource Guide-Improve Patient-Provider Communication

14.2 Data Collected & Monitored by the Health Equity Department

The following is a list of the data that is collected and monitored by the Health Equity Department.

1. Enrollment counts for all lines of business
2. Membership language preferences by county for all lines of business
3. Member alternate format preferences for all lines of business.
4. Race, ethnicity, and language data by county for all lines of business
5. Age and gender distribution by county for Medi-Cal
6. Interpreter services utilization (telephonic, face-to-face, sign language, video remote) for all lines of business
7. Member services non-English call volume for all lines of business
8. Requests for oral and written translations from members for all lines of business
9. Requests for alternate format from members
10. Annual Census data by county
11. C&L-related grievances
12. Other relevant SHP and commercial data from multiple sources

14.3 Language Services Provided by Health Equity Department

The Health Equity Department provides comprehensive language services in support of members and contracted providers. Language services include:

1. Training for staff to ensure members have access to quality interpreters.
2. Contracts with trained medical interpreters in 250+ languages to assure quality of interpretation services.
3. Monitoring interpreter services to assure that a high quality of interpreter assistance is available for members.
4. Review of English member materials for literacy and cultural appropriateness.
5. Coordination of non-marketing member material for translation.
6. Listing of bilingual staff that are qualified to review translations.
7. Internal review of translated materials to ensure high quality, cultural appropriateness, and accurate literacy are provided in translated materials.

8. Literacy and linguistic workshops and in-services for contracted providers and staff.
9. Listing of community-based interpreter services, including sign language assistance.
10. Listing of interpreter services.
11. Availability of braille documents, large font, and other alternative formats.
12. Coordination and support of bilingual assessment process.
13. Support and documentation for contracted provider/provider staff in evaluating bilingual staff proficiency.
14. Coordination and provision of subject matter expertise in new language assistance regulations to meet DMHC, CDI and CMS compliance.
15. On-demand training on the Language Assistance Program for educating staff who have contact with members or potential members with LEP in California.
16. Monitoring for compliance to program elements of the Language Assistance Program, such as ensuring departments have Policies and Procedures, up-to-date tracking of LAP program components, ensuring Appeals and Grievances and the Customer Contact Center have procedures to process C&L-related complaints, and dissemination of informational materials to contracted providers and networks.

14.4 Health Equity Department

Staff Roles and Responsibilities

The Health Equity Department is unique in its cross-functional support structure. The Department's function is to fulfill all health equity, cultural and linguistic contractual and regulatory requirements and serve as a resource and support for all C&L/health equity services. The Health Equity Department has representation throughout the State with the Manager being responsible for the overall operations and management of the Department. The Manager reports to the Vice President of Quality Improvement and establishes the direction, resources, and priorities based on member and provider needs, and approves the yearly Health Equity Department's work plan.

Vice President of Quality Management

Vice President of Quality Management is responsible for the overall operations of the Health Equity Department. This individual reports directly to the Chief Medical Officer (CMO), and is responsible for the overall direction and management of the QI Program, including:

- Organization-wide quality improvement outcomes and compliance with regulatory and accreditation bodies.
- Successful accreditation outcomes for all applicable regions and product lines.
- Oversight of delegation to ensure performance meets established standards for quality and cost-effective delivery of healthcare services.
- Overall HEDIS® operations and performance.
- Credentialing and Peer Review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.
- Wellness, Health Education, and Health Equity programs and services are developed and implemented for all members.

Health Equity Manager

The Health Equity Manager has a Doctoral degree in Health Administration and a Master's degree in Social Work. The Health Equity Manager reports to Health Net's VP of Quality Management and leads the planning and administration of health equity and cultural and linguistic programs/services and NCQA

Health Equity Accreditation Plus program for all lines of business. Responsibilities for C&L/health equity include the following: planning and administration of C&L/health equity services and mandated requirements statewide; designing policies, establishing standards and ensuring implementation and compliance for Health Net to meet Department of Health Services, Centers for Medicare and Medicaid, National Committee on Quality Assurance, and C&L/Health Equity contractual/accreditation requirements; providing leadership and management for Health Equity staff; and representing the health plan at external regulator and accreditation meetings and taskforces. The Health Equity Manager also educates department leads on proposed and/or newly enacted legislation, oversees the delivery of culturally and linguistically appropriate services at all plan member points of contact, and ensures that regulatory and accreditation requirements are met.

Program Manager II or III

Program Managers have bachelors, master or PHD degrees in Public Health, Social Work, cultural anthropology, managed care, and business along with a combination of academic education, professional training or work experience which demonstrates the ability to perform the duties of the position. Program Managers are responsible for the development, planning, organizing, monitoring and overseeing C&L/Health Equity new services and programs. Responsibilities also include: providing consultation and guidance to the Health Equity Department on regulations and accreditation; working with compliance and program accreditation to ensure C&L inclusion and representation on new and modified legislation; updating policy and procedures; updating the compliance grid to ensure that all C&L and health equity requirements are incorporated into documentation and audit readiness maintained; and taking lead in implementing new regulatory requirements and responding to RFPs.

Health Equity Specialists

Health Equity Specialists have bachelors, master or PHD degrees in Public Health, Social Work, cultural anthropology, managed care, and business along with a combination of academic education, professional training or work experience which demonstrates the ability to perform the duties of the position. To maintain professional standards, the Health Equity Department's staff represents academic disciplines that focus on human groups, language, and diversity such as medical anthropology, global health, and sociology. Each Health Equity Specialist is responsible for the development, planning, implementation, and administration of the wide range of cultural and linguistic services throughout the state of California. Responsibilities include: ensuring that culturally and linguistically appropriate services are provided to members; providing trainings to staff and providers to reduce barriers to care; representing the organization on national, regional and multi-plan initiatives; assessing operations for gaps compared to new standards and making recommendations to senior management; and managing programs in compliance with contracts and regulations and monitoring ongoing program performance to maintain compliance.

The Health Equity Specialists are located throughout California to ensure regional representation and community support. Currently there are 7 Health Equity Specialists in the department, 5 staff are in Southern California, covering Los Angeles County, Imperial County, and the Inland Empire; one is based in Fresno covering the Central Valley; and 1 in the Bay Area covering the Sacramento area and Northern California.