Culturally and Linguistically Appropriate Services (CLAS) Program Description 2024

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CONTENTS

I. Introduction

Centene Corporation is a diversified, multi-national healthcare enterprise that provides a portfolio of services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. Founded as a single health plan in 1984, Centene Corporation (Centene) has established itself as a national leader in the healthcare field. Today, through a comprehensive portfolio of innovative solutions, we remain deeply committed to delivering results for our stakeholders: state governments, members, providers, uninsured individuals and families, and other healthcare and commercial organizations through a holistic, customized approach to care for our members based on their unique physical, behavioral, pharmaceutical, cultural and social needs.

SilverSummit Healthplan, a Centene Corporation health plan, is contracted to deliver services to Medicaid recipients and is committed to the practical application of strategies and innovated interventions to transform the health of the community, one person at a time.

SilverSummit Healthplan is a quality-driven organization that adopts continuous quality improvement that includes culturally and linguistically sensitive services as a core business strategy for the entire health plan. Guided by the concept of *cultural humility* that acknowledges the complexity of identities and the evolving and dynamic nature of an individual's experience and needs (e.g., social, cultural, linguistic). SilverSummit Healthplan employs a system perspective that values differences and is responsive to diversity at all levels. Cultural humility is community focused, and family oriented, valuing the differences and integration of cultural attitudes, beliefs and practices. These core components are integrated into diagnostic and treatment methods throughout the health care system to support the delivery of culturally relevant and competent care.

The health plan develops, embeds and implements a quality management strategy and a Culturally and Linguistically Appropriate Services (CLAS) Program that is embedded within every staff role and department function. SilverSummit Healthplan, approaches quality assurance, quality management, and quality improvement as a culture, integral to all day-to-day operations to provide services that are accessible and responsive to all members. This manner accounts for diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency (LEP), disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.

A. Purpose

SilverSummit Healthplan endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. Specifically, the Quality Program identifies and addresses clinical areas of health inequity. The health plan ensures communications are culturally sensitive, appropriate, and meet federal and state requirements. SilverSummit Healthplan also promotes the delivery of services through a cultural humility lens to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Population health management initiatives are reviewed to ensure cultural issues and social determinants of health (SDOH) are identified, considered, and addressed. Additionally, the health plan is committed to improving inequities in care as an approach to improving Healthcare Effectiveness Data and information Set (HEDIS) measures, reducing utilization costs, and delivering locally tailored, culturally relevant care.

The purpose of the CLAS Program Description is to ensure the integration of the National CLAS Standards within the organization's operational framework to ensure equitable, culturally, and linguistically

appropriate programs for our diverse population and to advance health equity. The identified goals and objectives are integrated, ensuring services are provided in an accessible and responsive manner to all members.

The health plan implements processes that ensure the health care services provided have the flexibility to meet the unique needs of each member, accounting for the diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency, disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy. Population health management initiatives adhere to the National CLAS Standards and achieve success within the following priority domains:

- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Practitioner Network Cultural Responsiveness
- Data and Infrastructure

B. Program Description

The health plan is guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care developed by the Office of Minority Health. The Principal Standard (Standard 1) of the National CLAS Standards has been made the Principal Standard with the understanding that it frames the essential goal of all the Standards, and if the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.

The National CLAS Standards describes a framework to deliver services that are culturally and linguistically appropriate and respectful, and that respond to the individual's cultural health beliefs, preferences, and communication needs. To achieve the Principal Standard, the CLAS Program Description is organized by priority domains and identifies alignment with the National CLAS Standards. Since the National CLAS Standards are not prescriptive and simply provides a framework, the SilverSummit Healthplan CLAS Program Description identifies and aligns multiple standards across our program domains with the goal of achieving the Principal Standard.

Principal Standard (Standard 1): *Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.*

The CLAS Program is embedded within the Quality Program and utilizes a systematic approach using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members. Whenever possible, the health plan's Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity.

To fulfill its responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following CLAS Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and SilverSummit Healthplan Board of Directors.

C. Monitoring and Evaluation

SilverSummit Healthplan sets goals each year to improve the provision of culturally and linguistically appropriate services and reduction of health care disparities that reflect the identified needs of our population *(Standard 9)*. The CLAS Program priorities and objectives are aligned and driven by the National CLAS Standards and reflects the demographics of the community, known or expected needs of individuals and previously identified opportunities for improvement. To achieve our purpose and mission of better health outcomes at lower costs for our members and the communities we serve, goals are identified, and activities and timelines are documented in an annual workplan to achieve the following:

- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
- To ensure that members and potential enrollees are active participants in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

The CLAS Program goals written in SMART format, are referenced in tables within each of the subsequent priority domains and are also included in the annual work plan. On an annual basis or as needed, data are reported, analyzed, and modified, with the CLAS Workplan, by the Quality Improvement Committee to identify trends, reflect changes in the population, new programs, and services, projects completed, and sets goals to meet the needs of the targeted population within the priority domains.

Workplan

CLAS Work Plan *(Standard 9)*: The annual development of the CLAS Program Description includes a detailed work plan that is informed by the preceding CLAS Program Evaluation. The work plan considers performance in all aspects of the CLAS Program scope to achieve identified objectives and address overall effectiveness. The work plan identifies and documents all CLAS related activities outlining annual objectives, quarterly progress monitoring, associated activities to achieve stated objectives within a designated timeframe, defined roles and responsibilities for each identified activity, and includes a monitoring and evaluation plan to track and assess previously identified issues, and CLAS Program Evaluation.

Quality Improvement leadership, or designee, is responsible for review of data collected and/or reports used to monitor progress against goals, for all measures, throughout the year. The workplan status is monitored and updated through the Quality Improvement Committee quarterly to reflect progress on CLAS activities within the program priorities:

- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement, and Accountability to Improve Health Equity
- Practitioner Network Cultural Responsiveness
- Data Infrastructure

The health plan reviews and updates the CLAS Work plan to reflect changes in the population, new programs and services, projects completed, and sets goals to meet the needs of the targeted population and confirms compliance with the health plan's current needs, accreditation requirements, and current state and/or federal requirements and deliverables related to the Quality Program, as applicable. The CLAS Program Description and work plan are formally approved (or accepted) by the Quality Improvement Committee on an annual basis.

A program evaluation will be conducted annually to evaluate the overall effectiveness of the CLAS Program. Deliverables and activities identified in the work plan will include an evaluation plan that describes how we will monitor and evaluate the program, objectives, and/or activities, where applicable. The evaluation includes indicators and performance measures, data sources, and methods, as well as roles and responsibilities, to meet the program goals.

A systematic method for collecting, analyzing, and using data to examine the effectiveness and efficiency of the program and related activities is employed to support continuous program improvement. The CLAS Program Evaluation provides a description of the completed and ongoing activities of the previous year; trending of measures collected over time to assess performance; and analysis of whether there have been demonstrated improvement; and identification of limitations and barriers to achieving program goals.

The CLAS Program Evaluation is presented for approval to the Quality Improvement Committee on an annual basis. The Quality Improvement Committee reviews the evaluation, makes any necessary recommendations to ensure the program goals and objectives are met and utilizes the results in relevant health plan quality improvement projects to improve the delivery of clinical services, quality outcomes, and the members experience when engaging in health care. The Vice President of Quality Improvement is responsible for the final review and approval of the program evaluation and revisions/modifications identified in the quarterly progress monitoring of the work plan. The annual CLAS Program Evaluation, or an executive summary as appropriate, can be used to provide information to a larger audience such as, accrediting agencies, regulators, the member advisory council and /or Representatives, stakeholders, and the Board of Directors.

II. Governance, Leadership, and Workforce

To ensure effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs, SilverSummit Healthplan emphasizes the importance of CLAS implementation as a systemic responsibility that requires the endorsement and investment of leadership that promotes CLAS and health equity through policy, practices, and allocated resources to support and/or training for all individuals within an organization.

Through strengthened data analytics capabilities, we seek to better understand our workforce, the progress of initiatives and opportunities to grow. It is important for SilverSummit Healthplan to ensure that leadership and the workforce at all levels are culturally and linguistically diverse and representative of the diversity of members served as well as the current labor market. To evaluate the effectiveness of our DEI initiatives and develop new programs and resources to meet employee needs, we consistently work to understand the fabric of diverse identities within our workforce.

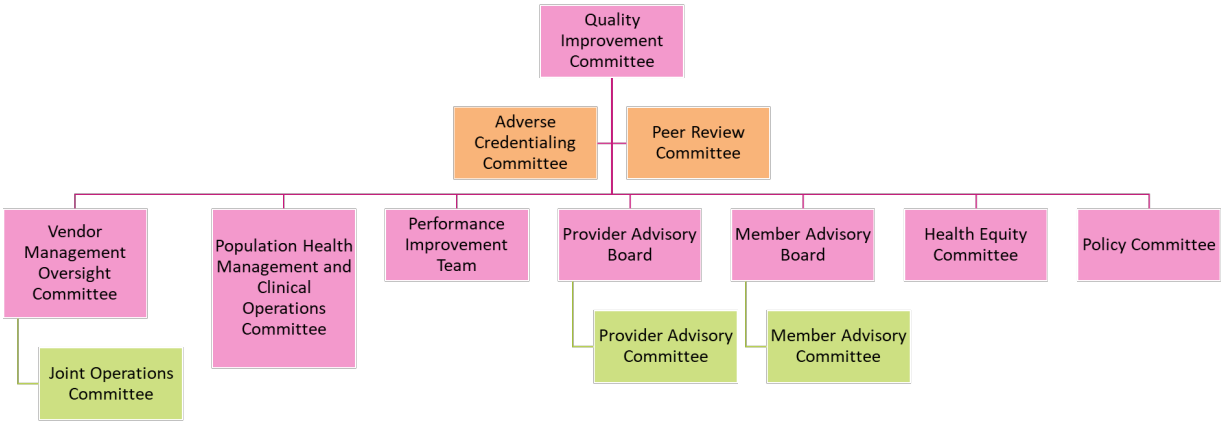
A. Governance and Leadership *(Standard 2)*

Quality is integrated throughout the health plan and demonstrates a strong commitment to culturally and linguistically appropriate assistance services for members. Health plan provides direction, overall support, and oversight across departments in all aspects of language assistance services. Informed by data and feedback from field staff, every department and advisory group contributes and works as a team to promote health equity.

The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality

Program to the Quality Improvement Committee. The Quality Improvement Committee is chaired by the Chief Medical Director (or designee), or the Senior Quality Executive. Reports on CCLAS Program activities, findings, recommendations, actions, and results are presented to the Board of Directors no less than annually. The Quality Improvement Committee serves as the umbrella committee through which all subcommittee activities, including those of the Health Equity Improvement Committee, are reported and approved. The SilverSummit Healthplan's Quality Improvement Committee structure is designed to promote information, reports, and improvement activity results, driven by the CLAS Workplan, throughout the organization and to providers, members, and stakeholders.

SilverSummit Healthplan Committee Structure



The Vice President of Quality Improvement, Senior Manager of Performance Quality Improvement and the Project Manager of Health Equity collaborates with the heads of all functional units to ensure that the CLAS Program is properly executed. SilverSummit Healthplan's leadership promotes CLAS through policy, practices, and the allocation of human and financial resources to ensure:

- Hiring and recruitment practices, and related policies, promote diversity, equity, and inclusion at all levels and reflect the composition of the community served.
- Integration and alignment of CLAS opportunities across the health plan and functional areas (e.g., medical management, customer service, provider services, quality, Information Technology, etc.).
- Cultural Sensitivity/Humility education is required within the organization.
- *Best in CLAS Awareness Week* and/or *Health Equity Learning Circles* are required within the organization.
- Diffusion of information to stakeholders and constituents.

B. Community Engagement

It is important to note SilverSummit Healthplan also establishes a Member Advisory Board (MAB) to ensure members of culturally diverse communities are included in processes to assist in identifying and prioritizing opportunities for improvement. The member advisory board assists with identifying cultural

competency and/or language service-related issues, provides feedback on service needs of the community, and promotes health equity services to community members (*Standard 13, 15)*.

The member advisory board is comprised of a diverse and demographically representative group of participants that reflect the community. As defined by the charter, the member advisory board consists of community members, representatives of community-based organizations (CBOs), providers, and other invested stakeholders, representing ≥ 5% of the geographic, cultural, racial/ethnic, and linguistic diversity of eligible individuals. The member advisory board meets quarterly to share issues and opportunities with the health plan (Appendix B). Meeting minutes and information are shared with plan leadership and incorporated into quality improvement projects to close gaps as appropriate.

C. Workforce *(Standard 3)*

Hiring and Recruiting Practices to Build a Diverse Staff

To ensure organizational governance, leadership, and workforce are responsive and representative of our member population, health plan hiring and recruitment practices, and related policies, promote diversity, equity, and inclusion, at all levels and positions, and reflect the composition of the community served. Our Talent Attraction (TA) team, in partnership with hiring leaders and human resources, nurtures a talent pipeline that connects us to a diverse workforce. All our talent advisors receive training to become Certified Diversity Recruiters. And the team works to activate stakeholder partnerships such as those with nonprofits and academic institutions, including Historically Black Colleges and Universities (HBCUs), to enhance our ability to recruit and develop diverse talent, to reflect the diversity of Health plan membership. Recruitment and hiring practices that support diversity include:

- developing and posting online job descriptions emphasizing organizational values on diversity and inclusion,
- targeted job fairs to engage diverse candidates and underrepresented groups,
- engagement with local community leaders, community-based organizations (CBO), universities, community colleges, and faith-based organizations to promote opportunities within the organization,
- provide guides and resources for hiring leaders, such as, the Partnership Guide and Interview Structure Best Practices: Selecting a Diverse Interview Panel to promote diverse hiring,

Promoting and Monitoring Diversity, Equity, and Inclusion in the Workplace

Our commitment to diversity, equity, and inclusion starts at the top of the organization with our board of directors and permeates every layer and level. To help our employees maintain their level of excellence in support of our members, we provide programs, resources, and support tools to ensure employee development and growth. Every individual is a leader, and as such, all staff set goals around and are measured against our Leadership Model. This process enables staff from all backgrounds and cultures to collaborate, contribute, and provides opportunities for development and advancement.

The Diversity, Equity & Inclusion (DEI) efforts of the health plan and the Centene Corporate enterprise include workforce metrics and tracking capabilities to ensure we value diversity, create equity, and embrace inclusion. Centene believes that a diverse workforce and an inclusive workplace fuel improved service, innovation, and performance. We strengthen our workforce by hiring a range of candidates with varying life experiences and professional backgrounds, and we thoughtfully engage them throughout their employee life cycles with dedicated support and leadership development opportunities (Corporate Policy CC.HUMR.12). This includes reporting mechanisms that ensure we have the capability to develop and monitor strategic initiatives that address areas of opportunity for DEI advancement. A new DEI dashboard

for our DEI Councils, HR Business Partners, and Business Unit Leadership provides a way to track ongoing progress of programs and initiatives.

Another monitoring activity involves the deployment of the Shaping Centene enterprise-wide surveys to obtain employee feedback on what is most important to them while measuring employee engagement and sentiment on current DEI initiatives, People Leader Effectives, and Company Culture. The surveys create opportunities for employees to feel valued and heard throughout the year, and the insights gathered serve as an important catalyst in how we further improve our employee experience, and the organizations commitment to DEI.

Additional support of a diverse workforce includes the opportunity to participate in Inclusion Groups. These groups are the Veterans and Military Families Employee Inclusion Group; the Multicultural Employee Inclusion Group; I.N.S.P.I.R.E., the Women's Employee Inclusion Group; ABILITY, the People with Disabilities & Caregivers Employee Inclusion Group; and cPRIDE, the company's LGBTQ+ Employee Inclusion Group. Furthermore, the company maintains an Executive Diversity and Inclusion Council comprised of senior leaders who guide their respective business units in implementing and sustaining successful diversity and inclusion practices across the enterprise.

Training and Development *(Standard 2, 4)*

To ensure organizational governance, leadership, workforce and those external to the organization, but serve on committees, are prepared to meet the needs of our diverse population, we provide a range of learning opportunities in variety of modalities to engage staff and leadership throughout the organization. Understanding and developing a process-oriented approach to cultural humility, though complex, positions our organization to better achieve our mission and reduce health disparities. Selected education and development opportunities that support diversity, equity, inclusion, and cultural humility are included below:

- *Cultural Humility and Health Equity*
- *Cultivating Equity and Inclusion Playlist*
- *Cultural Humility Playlist*
- *DEI: Introduction to Unconscious Bias*
- *DEI: Unconscious Bias Fundamentals*
- *DEI: Inclusive Leadership*
- *Health Equity 101*
- *Health Equity Learning Circle*
- *Language Access*
- *Moving From Cultural Competence to Cultural Humility*
- *Tribal Sovereignty 101*
- *Unnatural Causes: Is Inequality Making Us Sick?*
- *Using Gender Inclusive Language*
- *Writing in Plain Language*

To ensure education and development opportunities are relevant to member needs and barriers to care, the health plan reviews membership demographic profiles and ensures that training topics and consulting services integrate concepts reflective of the diverse membership. Required trainings are provided annually to all staff/ staff from call center operations, utilization management, grievance and appeals, provider relations, and case management on topics such as cultural humility, CLAS, reducing bias, promoting inclusion, and Language Access Programs and resources for members.

Additionally, our health plan engages in the Centene Corporate *Health Equity Learning Circles* that provides an opportunity to engage diverse perspectives with our health plan partners across the nation. The *CLAS Learning Circle* is based on the series "UNNATURAL CAUSES: Is Inequality Making Us Sick?" presented by the Corporation for Public Broadcasting. The associated curriculum developed for the original series was modified to enhance the impact and opportunities within the managed care model and provides employees engage in collaborative learning and discussion while identifying and tackling CLAS related issues impacting the member population. The *Health Equity Learning Circle* comprises an

innovative curriculum that examines the root causes of health inequities through a series of film screenings and dialogue sessions, with the opportunity to culminate in a community health equity initiative. Participating staff explore beliefs around health inequities and establish a common ground for action.

Domain: Governance, Leadership, and Workforce	
Evaluation Requirement: The health plan annually identifies and evaluates opportunities to improve diversity, equity, inclusion or cultural humility for staff, leadership, committees, and governance bodies, where applicable.	
Objective:	By 12/2024, health will implement at least one new health equity activity to improve diversity, equity, inclusion, or cultural humility for health plan staff from 0% to 95% / and sustain a 95% participation rate to support a diverse membership and organization.
Objective:	By 12/2024, health plan will implement at least one new health equity activity to improve diversity, equity, inclusion, or cultural humility for health plan leadership (i.e., individuals with managerial authority and executive roles such as managers, directors, vice presidents or chief officers) from 0% to 95% / and sustain a 95% completion rate to support a diverse membership and organization.
Objective:	By 12/2024, health plan will present health equity, disparities and efforts at least annually to improve diversity, equity, inclusion, or cultural humility for health plan committees from 50% to 75% / by 25% to support a diverse membership and organization.
Objective:	By 12/2024, will present CLAS evaluation, program description, and work plan to improve diversity, equity, inclusion, or cultural humility for governance bodies, such as Board of Directors to support a diverse membership and organization.
Objective:	By 12/2024, conduct an employee survey and assess staff feedback on and satisfaction with the organization's promotion of diversity, equity, inclusion and cultural humility and identify opportunities, if applicable.
Evaluation Requirement: The health plan provides all employees, regardless of position within the organization, with training and educational opportunities at least annually on diversity, equity, inclusion, recognizing and reducing the effects of bias, and cultural humility and evaluates completion rates.	
Objective:	By 12/2024, 100% of health plan staff will complete the Cultural Humility and Health Equity training and present the results at the Quality Improvement Committee.

III. Communication and Language Assistance

To ensure that health plan provides equitable care and effective communications to all members and caregivers, language assistance will be provided through use of competent interpreters, contracted to provide interpretation or translation services, or technology and telephonic interpretation services. All work force members are provided notice of the CC.QI.CLAS.29 policy and associated procedures to govern direct contact with people who are Limited English Proficient (LEP), deaf, deaf-blind, or hard of hearing. All staff who may have contact with members in need of such services are trained in effective communication techniques, including the effective use of an interpreter. The health plan conducts regular reviews of the language access needs of the member population.

Language Assistance: Access and Availability *(Standard 5)*

The CLAS Program and CC.QI.CLAS.29 policy addresses the provision of language access services with guidance to departments that interact with members and providers to ensure a continuum of language

services to members and/or caregivers who are LEP, are deaf, deaf-blind, hard of hearing, and/or those who requests language services. Language Services include:

- Over-the-phone (OPI): interpretation that occurs over the telephone.
- On-site Interpretation, otherwise known as in-person or face-to-face interpreting, when a language interpreter is scheduled to meet a member at a defined location.
- Video Remote Interpretation (VRI): available to mitigate communication barriers to individuals who are deaf, deaf-blind, and hard of hearing. All attempts will be made to secure an on-site sign language; however, it is recommended that the VRI device be introduced into the communication process as soon as possible in the case that on-site interpreter cannot be secured.
- TTY/TDD (toll-free number) capability. TTY is presently the preferred term for this technology.
- Written Translation: transposition of a text from one language to another.
- Alternate Format: materials as an alternative to traditional print: audio, Braille, large print, and machine-readable electronic formats.

Member facing staff are trained to receive and effectively access language services requested or required by members at the point of contact with the health plan. OPI services are available on-demand in more than 150 languages and accessed by the health plan at the point-of-contact to ensure that members with LEP have access to plan benefit information. Additionally, Member facing staff are trained on the use of the 711 relay to communicate with members who are deaf and hard of hearing. Members who are deaf and/or hard of hearing will be able to contact the call center using 711 relay operations. Member communications from SilverSummit Healthplan must clearly identify the toll-free number for members who are deaf and/or hard of hearing to provide to the 711-relay operator to reach the call center.

Language Access Services are available at no cost, at all points of contact where a covered benefit or service is accessed. The Language Access Service modality (i.e., OPI, VRI, etc.) requested and/or required for practitioner interactions is evaluated at the point-of-contact with the health plan staff and scheduled on the members behalf through the network of nationally known interpretation vendors (i.e., Cyracom, Language Service Associates, etc.) and/or local resources. Contractors, major subcontractors, and subcontractors are responsible for implementing language services and cultural humility programs as aligned with regulations. The health plan incorporates this requirement through contracting and/or the submission of reports demonstrating compliance.

Access and Availability: Spoken and Sign Language Services (*Standard 7*)

SilverSummit Healthplan has established quality standards for interpreters, translations and alternate formats that are based on the definitions provided in 45 CFR 92 (Section 1557 of the ACA). The health plan ensures the use of competent spoken language and sign language interpreters to facilitate communication accurately and effectively with people who are LEP, deaf, deaf-blind, hard of hearing and hearing impaired. Quality standards for contracted interpreter services are documented in detail in contracts with individual language services vendors.

Bilingual workforce at the health plan may be used for interpreting if the staff member has been assessed for language proficiency and completed the requisite education and training programs in effective communication techniques. Bilingual workforce at the health plan engaging in direct communication with LEP individuals are assessed for language proficiency through bilingual assessments in target languages and can perform their responsibilities either in English or in another language. Evaluation and documentation are maintained in the employee profile with the organization's Human Resource system.

Practitioners and offices who provide bilingual services attest to proficiency during the credentialing process. This information is included in the provider directory. Providers are advised of the quality standards and both providers and members are encouraged and educated on the use of language services that are available from the health plan, in compliance with the federal CLAS standards and Company policy.

Access and Availability: Written Translation Services *(Standard 8)*

The health plan provides easy-to-read, culturally sensitive materials in English and threshold languages. Materials are written in plain language at, or below maximum reading grade level defined by the State of Nevada, and take into consideration language proficiencies, type of disabilities, literacy levels, cultural variation, age-specific targeted learning skills and ability to access and use technology. Plain language is assessed through resources such as the Flesch Reading Ease and Flesch-Kincaid grade level scales, in addition to tools such as Readability Studio and Health Literacy Advisor available through Centene. Training materials on how to write and communicate using plain language are available to all departments that produce member materials. Translation vendors are also required to maintain the reading level of the English version in their translations.

The health plan provides required translated materials in threshold/prevalent languages in accordance with state and federal requirements for mailed materials and materials available electronically. At a minimum, these materials are provided upon request by the member. Written translations are available as required by contract or regulation and ensures that all non-English translations and alternate formats meet the standards of quality required by law, regulatory agency, contract, or oversight agency. The organization uses contracted vendors for all non-English translations and braille. Translation vendors provide an attestation of quality for all materials and adhere to agreed-upon standards for timeliness in producing translations, as documented in contracts.

If available, certified bilingual staff may be utilized for sight translations. Requests for written translation and for sight translation (oral translation) of print materials are managed in accordance with Centene's CC.QI.CLAS.29 policy.

Notification of Language Access Services (*Standard 6*)

Member Notification: Communication and dissemination of the health plan's availability of language assistance services is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. The health plan works to ensure that members are informed on how to access language services at all points of contact (member services, claims, utilization management, disease management, care management, and/or grievances and appeals).

The organization disseminates notice of Language Access Services using Taglines on printed and electronic materials. Taglines are designed to inform individuals with limited English proficiency about the availability of language assistance services. For example, a tagline written in Spanish might say: "If you speak Spanish, language assistance services are available free of charge. Call XXX-XXX-XXXX for assistance." Members also receive written materials informing them of the availability of language services in *threshold languages*. Threshold languages are all languages other than English spoken by 5 percent of the population or by 1,000 individuals, whichever is less. Threshold languages are evaluated at least every three years using census or community-level data.

The notification of language assistance must be provided annually to all individuals as per Section 1557 of the Patient Protection and Affordable Care Act or under state law, whichever provides more robust

guidelines for notification. If the percentage of community individuals speaking any non-English languages reach a 1 percent threshold, or other threshold outlined in federal law, state law, or contractual obligations of SilverSummit Healthplan, certain materials may be required to be provided in a threshold language to individuals with a documented preference for the threshold language.

Written communications (i.e., Member Handbook, Newsletters, etc.,) provide notice of Language Access Services available and written in plain language. A language insert is also sent with new member materials advising members how to request a translation, alternate format or arrange for interpreter support. The language notice and nondiscrimination notice are included with all significant communications and posted in public spaces. To ensure members have unlimited access to information on language services and the plan's nondiscrimination efforts, the health plan's website also contains these materials on both its public and secure member portals. Provider and practice language capabilities are published in provider directory (see policy CC.PRVR.19).

Practitioner Notification: Communication and dissemination of the health plan's availability of language assistance services to practitioners is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. To facilitate language access services, information about the language patterns of the community or service area are provided and individual member level data is available through the Provider Portal to prepare the practitioner for interaction and educates contracted practitioners on how members can get access to no-cost interpreter services and oral translation services.

The organization disseminates information and resources on Language Access Services to Practitioners to assist in the provision of services. Practitioners receive information on the availability of language assistance services contracted through the health plan, language composition of the service area and/or state, and how to access services. Information is disseminated through the Provider Manual, Provider Portal, and online provider newsletter. Additionally, materials and resources are available for practitioners to deploy at their locations to educate members about language services. Resource and materials include:

- ***I speak* Cards**: these cards are cards to help identify what language an individual speaks, and to identify what language an interpreter will need to speak to communicate effectively with that individual. "I speak" cards are also called language identification cards and contain the text "I speak" in a variety of languages. They are intended to help an individual point to a language they understand.
- Practitioners are offered training on the provision of language services
- Practitioners are offered cultural humility training demonstrating the impact that culture and language has on health care outcomes and patient decisions.

Domain: Communication and Language Assistance	
Evaluation Requirement: On an annual basis, the health plan collects the language characteristics of our member population to gain a greater understanding of the demographic characteristics and identify any emerging needs. Evaluation includes preferred languages identified in the member demographics profile and language services requests.	
Objective:	On an annual basis, the health plan collects the language characteristics of our member population to gain a greater understanding of the demographic characteristics and identify any

	emerging needs. Evaluation includes preferred languages identified in the member demographics profile and language services requests.
Objective:	By 12/2024, will report and disclose language needs findings to members, providers, and practitioners in network to improve language service offering.
Evaluation Requirement: On an annual basis, the health plan evaluates state-level census data to determine the languages spoken in its service area and determine threshold languages for translation. The language assessment identifies languages spoken by 1 percent of the population or 200 individuals, whichever is less, up to a maximum of 15 languages to ensure the health plan provides a *Notification of Language services* (e.g., taglines) in the identified threshold languages.	
Objective:	By 12/2024, health plan will assess member demographic data for REL from public data such as the American Community Survey or the MLA Language Map Data Center, or other data source.
Objective:	By 12/2024, health plan will conduct a threshold languages analysis of the 1%, 5%, and Top 15 non-English languages spoken in the community to identify any emerging trends within the community.
Objective:	By 12/2024, notification of language assistance in the HHS Office of Civil Rights list of Top 15 languages will be provided to all members per section 1557 of the Patient Protection and Affordable Care Act.
Evaluation Requirement: On an annual basis, the health plan evaluates member/enrollee grievances related to the delivery of language access services.	
Objective:	By 12/2024, will have a documented process for collecting qualitative and/or quantitative data related to member experiences with language access services.
Objective:	By 12/2024, health plan will monitor and evaluate grievance data to identify any emerging trends, annually.
Evaluation Requirement: On an annual basis, the health plan evaluates the provision of language services to assess utilization of languages services for organizational functions, individual experiences with language services for organizational functions, staff experiences with obtaining and utilizing language services, and individual experience with language services during health care encounters.	
Objective:	By 12/2024, will have a documented process for collecting qualitative and quantitative data related to member experiences with language access services, for organizational functions and during health care encounters.
Objective:	By 12/2024, will have a documented process for collecting data related to the number of practitioners that have worked with an interpreter during health care encounters.
Objective:	By 12/2024, health plan will evaluate data to identify trends and barriers, annually.

IV. Practitioner Network Cultural Responsiveness

Recognizing that a strong relationship between the individual/caregiver, physician, and care team enhances care coordination and is the key to improving the health and care experience for our members, we evaluate our practitioner network annually against the cultural, ethnic, racial, and linguistic needs and/or preferences of our member population.

To support this effort, demographic data is collected from practitioners and practice. Race, ethnicity, and language proficiency is obtained through the credentialing and enrollment process as outlined in the CC.PRVR.47 policy. Self-reported, practitioner demographic information is available upon request for

member access preferences. Through data, we can expose and analyze deficiencies in our practitioner network and adjust the network as appropriate. The annual report describes our assessment, methodology, monitoring, results, and analysis for each data source, and actions initiated to improve the network adequacy. The health plan is committed to ensuring that its policies and infrastructure are attuned to the diverse needs of all members, thereby taking active steps to reduce known healthcare disparities that stem from cultural and linguistic issues.

Education and Development *(Standard 4)*

The health plan supports contracted practitioners in their efforts to provide culturally responsive and linguistically appropriate care and covered services to members. Contracted providers are advised on how to access language services in the provider operations manual, through routine provider updates, and via online newsletter articles. The services offered to contracted providers are intended to:

- Promote cultural responsiveness and awareness.
- Support access to and coordination of language services (i.e., interpretation and translation)
- Offer tips for effective communication using interpreters.

Providers may request cultural competency training tailored to the needs of their practice. Customized training may include specific strategies to address the cultural barriers to health care prevalent in the service area. The health plan may provide the training in person, as a webinar, or in computer-based training modules. Providers are also encouraged to take the online cultural competency trainings offered by the Office of Minority Health on its website. These training modules encourage providers to focus on local population cultural needs and includes:

- Information on the cultural expectations for health care.
- Information on traditional or alternative health care.
- Tips and suggestions on how to address cultural issues.
- Patient-centered care and effective communication techniques.

Additional training courses offer specialized information for nurses, psychiatrists, psychologists, behavioral health professionals, maternal health providers, oral health professionals, and more. Providers are reminded annually of their responsibility to take cultural competency training through an annual provider newsletter or an annual provider update and in the provider manual. Providers may also call the health plan's toll-free Provider Relations number with any questions about cultural or linguistic issues they may have.

Domain: Practitioner Network Cultural Responsiveness
Evaluation Requirement: To ensure the health plan supports health equity goals and takes actions toward reducing bias and improving diversity, equity, and inclusion, the practitioner network is annually evaluated to ensure the availability of primary care, behavioral healthcare, and specialty care practitioners meet the cultural, ethnic, racial, and linguistic needs of our diverse member population.
Evaluation Requirement: On an annual basis, the health plan collects information about languages in which a practitioner is fluent when communicating about medical care, language services available through the practitioner practice, and collects practitioner race/ethnicity data.

Objective:	By 12/2024, completed an assessment or survey of all non-English languages spoken by practitioners from self-reported data or enrollment applications to calculate concordance with member needs. Goal is full concordance.
Objective:	By 12/2024, completed an assessment or survey of language services available through the practitioner practice from self-reported data or enrollment applications to assess the network's language capacity. Goal is the language services available meet membership's reported preferred language.
Objective:	By 12/2024, completed an assessment or survey of practitioner race and ethnicity from self-reported data or enrollment applications to calculate concordance with member needs. Goal is full concordance.
Evaluation Requirement: On an annual basis, the health plan analyzes the capacity of its network to meet the language needs of members, provide culturally appropriate care, identify and prioritize opportunities, and implements interventions to address gaps, if applicable.	
Objective:	By 12/2024, will have a documented process for collecting qualitative and quantitative data related to network practitioners completing annual cultural humility or cultural competency training to assess the network's cultural responsiveness.
Objective:	By 12/2024, increase participation in cultural sensitivity/humility training of SilverSummit Healthplan's network practitioners by 5%

V. Data and Infrastructure

The health plan has the technology infrastructure and data analytics capabilities to support goals for cultural competency and linguistic assistance services. Health plan's health information systems collect, analyze, integrate, and report encounter data and other types of data to support demographic analysis, disparity outcomes and analysis, utilization of language services, and other CLAS activities. The IT infrastructure integrates REL data for monitoring, analysis, evaluation, and improvement of the delivery, quality and appropriateness of health care furnished to all members, including those with special health care needs.

IT systems and informatics tools support advanced assessment and improvement of cultural competency and linguistic assistance services, including collection of performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, and retrieve data from internal, subcontractor, and external sources for effective use through a suite of data informatics and reporting solutions.

Demographic Data (*Standard 11*)

Self-identification of member demographic data is the gold standard and is always preferred to indirect imputation methods. Direct methods of data collection include methods for which a member, or a parent, guardian or caregiver on behalf of a member, self-reports race, ethnicity, preferred language, alternate format through survey or enrollment data. Direct member demographic data is initially collected and maintained from third-party sources for Medicaid and Marketplace lines of business (e.g., state or local agencies, CMS enrollment data, health information exchange (HIE), electronic health records (EHR) data) to capture race, ethnicity, and preferred language.

Post enrollment, the health plan employs additional direct collection methods to enhance member demographic data at various points of interaction. When a member engages with member services, staff are provided a script and trained to review contact information, as well as race/ethnicity, and language at

each point of contact. Members can self-report gender identity to member services and staff will notate their file in the appropriate remarks/notes section within Omni.

- ***Member Services***: Member race, ethnicity, and preferred language collection and updates are completed through the Centene Corporate, Member Services call center system. When a member contacts Member Services, and a member's demographics are not populated, a customer service representatives requests (directly or through an interpreter) language, race, and ethnicity information. The customer service representative utilizes a standard script to communicate intent:

  "We show your member preferences are not updated, which consists of race, ethnicity and written/spoken language. Would you like to update your preferences today? This information helps us understand your culture and provide higher quality healthcare. "

  If the member provides information, the customer service representative must inform the member:

  "Race, Ethnicity and Language data is protected health information. As such, we have strict policies on how your information can and cannot be used. For example, we may share your information with doctors to help them in your treatment. We may not use your information to make decisions on benefits. For detailed information on how your information can and cannot be used, please go to our website and view the Notice of Privacy Practices."

  If the member has previously provided the information, Opted Out during enrollment, or the member has declined to answer, the member record is coded as "Declined to State" in REL fields and they will no longer be asked for REL preference.

Direct data collection for race/ethnicity are mapped according to U.S. Office of Management and Budget (OMB) guidelines. OMB requires that race data be collected for a minimum of five groups: American Indian or Alaska Native, Asian, Black/African American, Caucasian/White, and Native Hawaiian or other Pacific Islander. OMB permits the Census Bureau to also use a sixth category – Some Other Race. In alignment with the OMB, the health plan defines ethnicity within two minimum categories, Hispanic or Latino and Not Hispanic or Latino, and considers race and Hispanic origin to be two separate and distinct concepts. If direct race/ethnicity data is not available for a minimum of 80% of the member population, the health plan utilizes indirect data sources that have been evaluated for reliability and validity for the population to which it will be applied (e.g., age group, geography, product line).

Indirect race/ethnicity estimations and local data sources aid in creating a demographic profile when member reported data is not sufficient. SilverSummit Healthplan utilizes the analytics and artificial intelligence services of Ethnic Technologies to predict a person's ethnicity based on first name, surname, and nine-digit zip code. The analysis is applied to all members and results are available in membership tables in Centene databases. Indirect data are also mapped according to U.S. Office of Management and Budget (OMB) guidelines.

Data Stratification and Analysis (*Standard 11, 12*)
Annually, the health plan uses a reporting and analytics platform to stratify the entire enrolled membership into meaningful subsets. The annual assessment drives the Population Health planning and strategy and uses the information to evaluate current programs and services for impact and the

development new interventions and programs to meet needs of our members based on their clinical and sociodemographic factors. IT systems and informatics tools support advanced assessment and improvement of culturally and linguistically appropriate assistance services, including collection of performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, and retrieve data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.
The Health Plan and its parent company, Centene, is committed to health equity and population health, and values proven outcomes across departments. As such, the plan annually assesses its quality improvement program to identify targeted Healthcare Effectiveness Data and Information Set (HEDIS) measures, utilization outcomes, and opportunities for member experience improvements to identify disparities.

Engagement, Continuous Improvement, and Accountability to Improve Health Equity

The health plan is committed to the provision of a well-designed and well-implemented CLAS Program. The health plan's culture, systems, and processes are structured around the purpose and mission to improve the health of all enrolled members which includes a focus on health outcomes as well as healthcare process measures, and member and provider experience.

The CLAS Program is embedded with the Quality Program and utilizes a systematic approach using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members. Whenever possible, the health plan's Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity.

The health plan conducts a comprehensive Population Health and Disparity Assessment to identify the needs of our members. By assessing the characteristics and needs of the entire member population we can better understand, appropriately segment, and address the needs of our member populations.

Annually, the health plan uses Centene's reporting and analytics platform to stratify the entire enrolled membership into meaningful subsets. The annual assessment drives the PHM planning and strategy and uses the information to evaluate current PHM programs and services for impact and the development new interventions and programs to meet needs of our members based on their clinical and sociodemographic factors. Data for the annual assessment is supplied through analytic and reporting applications.

Analysis of the data is reviewed by the Population Health Management and Clinical Operations Committee, Health Equity Improvement Committee, and the Quality Improvement Committee and is used to determine if changes are required to PHM programs, activities, or resources to evaluate the extent to which the programs facilitate access and connection to community resources that address member needs outside the scope of health plan benefits to reduce disparities. Through the NEST Model's predictive analytics, the health plan develops partnerships and programs to support members.

A review of community resources for integration into program offerings to support member needs is completed to facilitate access and connection as additional support to the membership. Updating activities or resources to address health care disparities will be conducted and modifications to the PHM strategy, program design and resources are made based on these findings (*Standard 12*).

Domain: Data and Infrastructure	
Evaluation Requirement: On an annual basis, the health plan evaluates the percentage of direct data on member race/ethnicity to identify opportunities to improve collection. If direct race/ethnicity data is not available for ≥ 80% of the member population, the health plan utilizes indirect data sources that have been evaluated for reliability and validity for the population to which it will be applied (e.g., age group, geography, product line).	
Objective:	By 12/2024, member facing staff have a script and have been trained how to obtain REL member data during member calls to increase the percentage of direct data.
Objective:	By 12/2024, health plan has a documented process for obtaining REL member data to be absorbed into the electronic data system, if not meeting a threshold of 80 percent.
Objective:	By 12/2024, health plan has a documented process for validating e-tech data, to estimate race/ethnicity when indirect data collection methodology is used.
Evaluation Requirement: Annually evaluates the collection of direct member race and ethnicity data to identify opportunities to improve collection, if not meeting a threshold of 80 percent.	
Objective:	Annually evaluates electronic data system is able to receive, store and retrieve individual-level data on race, ethnicity and language.
Objective:	By 12/2024, HealthPlan will maintain 90% or greater in collection of direct members REL data.

Commitment to Health Equity

Centene is committed to Health Equity through focusing clinical, network, and operational processes and resources towards improving the health of its diverse population. As such, the health plan has developed a health equity approach that identifies disparities in member demographics such as race, ethnicity, language, and geography, prioritizes opportunities at the neighborhood and health plan level, and collaborates across the community to reduce disparities by targeting member, provider, and community interventions. Core components of our health equity approach include:

- Enhance and sustain organizational structure for promoting health equity including training and advocacy on cultural sensitivity, promoting diversity in recruiting and hiring, enhancing the demographic data collection, internal and external governance structure, and incorporation of our health equity improvement model across the organization.
- Empowering members and their caregivers in their health care choices through plain language and language services innovation
- Deliberately addressing health inequities through a data-driven 4 step approach including analysis of inequities, identification of health equity opportunities in HEDIS, obtaining stakeholder (member driven) feedback and partnership and implementing strategies across member, provider, and community systems
- Improving understanding and sensitivity to cultural diversity among staff and network providers
- Improving health outcomes by instilling cultural sensitivity into all parts of the organization, such as member services, network development, population health, utilization and care management, and quality improvement.
- Monitors all grievances and aggregates by type and category to identify the underlying reason for member grievances, including perceptions of ethnic, racial, cultural, or linguistic bias in access and deficiencies in organizational processes were interpreted to identify barriers to improvement and/or impacting our ability to achieve our member experience goals. To facilitate the analysis

and aggregation of data, perceptions of ethnic, racial, cultural, or linguistic bias are grouped into two primary CLAS sub-categories of cultural needs and discrimination. (*Standard 14*).

VI. Governance Approval

To fulfill its responsibility to members, providers, the community and regulatory and accreditation agencies, the health plan has adopted the following Culturally and Linguistically Appropriate Services (CLAS) Program Description and work plan. The program description and work plan are reviewed and approved at least annually by the Quality Improvement Committee and the SilverSummit Healthplan Board of Directors. The primary objective of the CLAS Program is to establish an equitable, culturally, and linguistically appropriate program for our diverse population.

Approvals	
Oversight Body	**APPROVAL DATE**
SilverSummit Healthplan Board of Directors	03/19/2024
Quality Improvement Committee	03/13/2024
Health Equity Improvement Committee	05/01/2024

Appendices

Appendix A: National CLAS Standards

NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Appendix B: Member Advisory Board

Member Advisory Board (MAB)
Charter Statement: The Member Advisory Board (MAB) is a group of members, parents, legal representative/guardian, and SilverSummit Healthplan (SSHP) staff as appropriate, that reviews and reports on a variety of quality improvement issues, initiatives, and activities. **Purpose:** The primary purpose is to keep members informed of quality initiatives and results; review Member Satisfaction results, improve service quality and member experience in the program. **Objectives of the Committee and Relationship to Strategic Objectives:** Solicit member input into the quality improvement program, quality initiatives and member experience with the quality improvement program.
Committee Structure and Operation: **Frequency:** Quarterly. **Committee Chair:** VP/Director of Quality **Committee Recorder**: MAB designee. **Reports To:** QIC **Committee Composition:** • Manager Legislative & Government Affairs • Manager, Quality Improvement • Manager, Justice Systems • Population Health Management designee • Healthy Equity designee • Behavioral Health designee • Designee(s) from each applicable functional area: Operations, Quality, Member Experience and potentially Case Management • Enrollees*/Representatives (Parents/foster parents/guardians/representatives) - may volunteer or be suggested by staff **At a minimum, the committee involves twelve members and individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of eligible individuals* **Scheduling:** MAB Chair **Agenda:** MAB Chair will develop Agenda items for the next meeting in collaboration with relevant member input. Agenda and presentation will need to go to Compliance and the State for approval before sharing with committee members. **Minutes:** Draft minutes are completed no later than within 15 days of the meeting. Meeting minutes are provided to the State within thirty calendar days of the meeting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. **Attendance Requirement:** Members may not be standing members of the committee. Therefore, there is no minimum meeting attendance requirement

Quorum: At minimum, (12) SSHP members in attendance.
Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format. **Decision Authority**: The MAB is a non-voting committee to solicit feedback from SilverSummit membership perspective. This committee reports to the QIC and meeting minutes forwarded to DHCFP. **Evaluation:** The Committee will review the charter annually. **Confidentiality:** Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information is managed in a specific manner.

Appendix C: Community Advisory Workgroup under the Provider Advisory Board

Provider Advisory Board (PAB)

Charter Statement: The Provider Advisory Board (PAB) serves as a consulting resource to SilverSummit Healthplan (SSHP) in policy and operational matters, and further strengthen the bridge between SSHP and the provider community.

Purpose: The PAB is responsible to represent the interest and viewpoint of the provider population to ensure that providers have a direct voice in developing and monitoring clinical policies and operational issues in addition to quality and safety of clinical care, quality of services, and access standards. The Committee is comprised of external providers and Plan representation.

Objectives of the Committee and Relationship to Strategic Objectives:

- Provider input on QIC activities, program monitoring, and evaluation
- Establish and review process for responding to provider concerns
- Provide review and comment on quality and access standards
- Provide review and comment on Grievance and Appeals Process
- Providing review and comment on Provider Manual
- Providing review and comment on provider education materials
- Providing review and comment on policies that affect providers
- Providing review and comment on Provider Incentive programs

Sub-Committees:

- Community Advisory Workgroup: This group identifies key issues related to programs that may affect specific community groups and provide community input on potential service improvements. They offer effective approaches from reaching or communicating with members or other issues related to the member population. They are responsible for making recommendations regarding health plan performance from a community-based perspective.

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: Chief Medical Director

Committee Recorder: PAB designee or VP/Director of Contracting and Network Management.

Reports To: QIC

Committee Composition:

- Chief Medical Officer
- VP/Director of Quality Improvement
- VP/Director of Network Contracting & Development
- VP/Director of Population Health
- Medical Director
- Designee(s) from each applicable functional area-Operations, Quality, Human Resources, Compliance, Network, Case Management
- Network practitioners as prescribed by the State of Nevada

Scheduling: PAB designee.

Agenda: PAB Chair or designee will develop Agenda items for the next meeting.

Meeting Packets: Meeting packets will be distributed at the meeting.

Minutes: Draft minutes are completed no later than within ten calendar days of the meeting and provided to the DHCFP within thirty calendar days of meeting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Attendance Requirement: 75% of scheduled meetings

Quorum: A minimum of (1) PCP serving children & adolescents, (1) PCP serving adults, (1) OB/GYN, (1) psychiatrist, (1) licensed behavioral healthcare clinical professional, (1) substance abuse professional, (1) community-based care coordinator or community case manager serving a Network Provider, and (1) peer support specialist from all recommendations from this committee will be presented to the operational areas within the Healthplan. Both the majority and minority opinions will be documented.

Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow Silver Summit's standard format.

Decision Authority: The PAB is a non-voting committee to solicit feedback from the local provider network. This Committee reports to the QIC.

Evaluation: The Committee will review the PAB charter annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. Members must agree to and sign a committee confidentiality statement on an annual basis.

Appendix D: Meeting Minutes

[Committee Name] ***Meeting Minutes***
[Meeting Date/Time]

Internal Attendance Record (Quorum, if applicable = *[# needed or NA]*
(X = phone conference, P = in person attendance)

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Name	Title
Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Designee Attendee Name**	**Title**

External Attendance Record
(X = phone conference, P = in person attendance)

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Name	Title
Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Ad Hoc Attendee Name**	**Title**

[Committee Name] ***Meeting Minutes***
[Meeting Date/Time]

Agenda Item	Discussion	Decision (Approved or Denied)	Follow-up Action Needed (Date)	Responsible Party
I. Call to Order				
II. Announcements +				
III. Review/Approval of the Minutes *	Example: Dr. Blue presented the meeting minutes of 12/6/2016 for discussion and approval.	Example: Dr. Kale made a motion to approve the minutes as presented Motion seconded by Dr. Smith **Motion: Approved**		
IV. Old Business +				
V. New Business ***Example:*** ***A. QI Program Description YEAR **** ***Insert documents in table*** Example QI program description	Example: Dr. Blue, presented the health plan QI Program Description for 2017. Dr. Blue explained the purpose of the QI Program structure and the systems that support the assessment and improvement of member health. The Committee discussed several components of the program including the methodology on measuring program effectiveness. Dr. Smith suggested that additional information be included in the program description on how the effectiveness of the population health management program would be evaluated.	Example: Dr. Smith made a motion to pend approval of the 2017 QI Program Description information for an update to include a description of Population Health Management effectiveness measurement methodology. Motion seconded by Dr. Kale **Motion: Approved**	Follow Up: The 2017 Program Description will be revised to include a description of Population Health Management Return to Committee by 4/21/2017	Director, Quality Improvement
VI. ***[add rows for other business]***				
VII. Next Meeting Date +				
VIII. Adjournment *				

Appendix E: Annual Workplan

[Attachment B CLAS Work Plan]

Appendix F: Staff Roles and Responsibilities

Chief Medical Director Medical Director(s)	The health plan's Chief Medical Director and supporting Medical Directors (including a behavioral health Medical Director) have an active unencumbered license in accordance with the health plan's state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members and the Quality Program, the Population Health and Clinical Operations (PHCO) Programs, and the Grievance System..
Quality Improvement VP/Director	The VP/Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the health plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Director, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.
Quality Improvement Manager	The Quality Improvement Manager holds a bachelor's degree in nursing or a related field or has equivalent managed care experience. The Quality Improvement Manager is responsible for management and oversight of quality department functions and performance monitoring. The responsibilities include working with multiple departments to: establish objectives, policies and strategies; assure quality initiatives focused on improving operational and program efficiencies: focus on initiatives to improve member outcomes; develop systematic processes and structures that will assure quality and the commitment to enabling quality improvements. The Quality Improvement Manager is also responsible for maintaining departmental documentation to support state contract requirements and accreditation standards including, but not limited to, applicable policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, access and availability analysis, member experience analysis, continuity and coordination of care, and annual evaluation of effectiveness of the Quality Program. Additionally, the Quality Improvement Manager coordinates the documentation, collection and reporting of HEDIS measures to both National Committee for Quality Assurance (NCQA) and the State as required.

Accreditation Specialist	The Accreditation Specialist reports to and supports the Quality Improvement Manager in the achievement of as well as the ongoing maintenance of health plan NCQA Accreditation, Health Equity Accreditation and HEDIS reporting processes and requirements. The incumbent implements objectives, policies, and strategies to maintain a continual state of accreditation readiness and to achieve successful accreditation status for the health plan. The Accreditation Specialist supports the document prep and submission for the accreditation survey and serves as the Subject Matter Expert for accreditation for the health plan. Additionally, the Accreditation Specialist is responsible for implementing the health plan's Health Equity/Cultural Competency Program, including its Health Equity Plan focused on Culturally and Linguistically Appropriate Services (CLAS) and leading its health disparities efforts such as: developing, implementing and providing oversight for Health Equity programs, ensuring the integration of cultural competency into operational programs and coordinating workforce staff development in cultural competency.
Quality Improvement Coordinator/Specialist	Quality Coordinators/Specialists are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management. At least one of the health plan's Quality Coordinators/Specialists is a registered nurse. Quality Coordinators/Specialists scope of work may include medical record audits; data collection for various quality improvement studies and activities; data analysis and implementation of improvement activities; review, investigation, and resolution of quality-of-care issues; and complaint response with follow up review of risk management and sentinel/adverse event issues. A Quality Coordinator/Specialist may specialize in one area of the quality process or may be cross trained across several areas. The Quality Coordinator/Specialist collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through health plan's quality improvement activities and quality of care reviews.
Program Coordinator	The Program Coordinator is a highly motivated and engaging member of the Quality Team that conducts outreach to members to educate, coordinate and support quality of care initiatives. The Program Coordinator facilitates ongoing engagement and collaboration with members and is a direct connection from the Quality Team to health plan members. The Program Coordinator will also review member experience survey results to drive initiatives targeted at CAHPS or other related member surveys and is responsible for coordinating participation in member boards.
Quality Improvement Additional Staff	Program Manager Member Risk Adjustment Coordinator Data Analyst

HEDIS Additional Staff	HEDIS Coordinator Provider Quality Liaison Quality Practice Advisor