Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation 2023

TITLE: 2023 Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation
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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.

The health plan 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. The 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. The health plan 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 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. Scope

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.

To achieve our mission, SilverSummit Healthplan conducts an annual evaluation on the CLAS activities identified in the program description and work plan, including all delegated functions. The evaluation includes a description of completed and ongoing CLAS activities, a quantitative analysis of year over year data trends to identify opportunities for improvement in the following priority domains:

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

- Data and Infrastructure

In addition to the above scope, SilverSummit Healthplan annual evaluation also includes State requirements related to Behavioral Health pursuant to NRS 422.2734 that includes evaluation of the following areas:

- Identification of disparities in the incidence of behavioral health problems, in access to or usage of behavioral health services and in behavioral health outcomes based on race, color, ancestry, national origin, disability, familial status, sex, sexual orientation, gender identity or expression, immigration status, primary language and income level, to the extent that data is available to identify such disparities;
- Strategies for reducing the disparities identified pursuant to paragraph (a) and the rationale for each strategy;
- Mechanisms and goals to measure the effectiveness of the strategies prescribed pursuant to paragraph (b) and, if applicable, the degree to which the managed care organization has achieved goals set forth in previous plans;
- Strategies for addressing trauma and providing services in a trauma-informed manner; and
- Strategies for soliciting input from persons to whom the managed care organization provides services and other interested persons.

II. Program Evaluation

The health plan is guided by state and/or federal guidelines and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) 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 of the Standards, and if the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.

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 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.

A. 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 evaluates CLAS implementation as a systemic responsibility through endorsement and investment of leadership that promotes CLAS and health equity through policy, practices, and allocated resources to support and/or to provide training for all individuals within an organization.

SilverSummit Healthplan sets goals and analyzes results 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.

Methodology

Member race and ethnicity demographics are obtained from Centene Population Health and Analytics, and findings are reported for health plan members, if enrolled prior to the fourth quarter, annually. Approximately 32 members were excluded from the analysis, due to either missing race and/or ethnicity demographics reported, loss to follow-up, or if the member did not meet the enrollment deadline inclusion criteria. Data are indicated as Unknown/Not provided.

B. Recruiting and Hiring to Support Diversity

Workplace diversity is understanding, accepting, and valuing differences between people of different races, genders, ages, religions, disabilities, and sexual orientations. SilverSummit Healthplan takes pride in being an equal opportunity employer that is committed to diversity and values differences in personalities, skill sets, experiences, and knowledge. SilverSummit Healthplan's vision of success requires a diverse workforce that reflects the communities we serve. Therefore, hiring and recruitment practices for internal and external positions promote diversity by considering which groups might be in the minority or are inadequately represented at all levels of the organization. These practices include promotions, temporary and permanent positions.

To attract, increase diverse talent, and avoid inadequately represented groups in the workforce, job descriptions use gender-neutral language, eliminates the term "requirement" when applicable, and emphasizes the company's commitment to diversity and inclusion. There are policies that appeal to diverse candidates such as a culture of work/life balance, flexible schedules, and work from home. To eliminate the potential for unconscious bias and determine groups that may be marginalized, disenfranchised or disempowered by the recruitment and hiring practices, SilverSummit Healthplan uses a diverse panel-style interview process which ensures an inclusive interview experience and the value of diversity. Lastly, job postings are sent to third party vendors such as LinkedIn and Indeed to reach a larger and more diverse candidate pool.

C. Workforce Demographic Data Collection

To assess if the workforce reflects the diversity of the population served, and identify groups that may be marginalized, disenfranchised or disempowered by recruitment and hiring practices, the health plan compares the diversity of the workforce to the membership. To obtain workforce demographics, SilverSummit Healthplan collects voluntarily self-identified data for race, ethnicity, age, gender and LGBTQIA+ identity when a candidate applies for a role at within the organization, and again if the candidate is hired. Candidates and employees may opt out of providing demographic data, and those numbers are not included in the representation data provided below. To encourage participation, an annual "I Count — Why I Self-Identify" campaign is promoted to encourage employees to voluntarily self-identify their gender, LGBTQ+ identity, or status as a veteran and/or person with disabilities if not completed. Workforce demographic data is collected through Workday, an enterprise software system that our parent company, Centene, uses for recruiting, hiring, and talent performance management. By using a consistent system, Centene ensures accuracy of data reporting throughout the organization.

Employee Feedback: Shaping Centene Pulse Surveys

Shaping Centene is a series of enterprise-wide surveys seeking employee feedback on what is most important to them while measuring employee engagement and sentiment on current initiatives. 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. Shaping Centene surveys are conducted at least two times per year. Overall employee engagement is measured in each survey along with one of the rotating key themes, such as Diversity, Equity & Inclusion (DEI), People Leader Effectiveness (PLE), and Company & Culture (CC). The DEI index measures employee sentiment around the company's commitment to DEI as well as that of their people leader/manager. The People Leader Effectiveness score measures employee perception on how well leaders supports career development, encourage teamwork and lead through change. The Company & Culture index measures an employee's understanding of the company's mission and how leaders embody company values and communicate a clear vision for the future.

The surveys include both quantitative and qualitative measures. Employee engagement, people leader effectiveness, company and culture, and DEI engagement are measured on a 100-point percentage scale, and the surveys includes one question for free-form text responses. Individual responses are kept confidential; all data is reported in aggregate to respect the confidentiality of employees.

A multi-faceted communications campaign is used to ensure that employees are aware of each survey. It begins with announcements on the company's intranet site, and more messages are cascaded through departmental communications, town hall meetings and team huddles, and personalized emails. Each survey period is open for eleven business days, allowing ample time for employees to participate. Results at the corporate level for employee engagement, people leader effectiveness, company and culture, and DEI index are shared on Centene's intranet site. SilverSummit Healthplan results for these data points along with qualitative data are shared with senior leaders at the plan and department levels. In our most recent survey, 91.6 % of health plan staff participated in the survey and 8.4% are excluded from the analysis, as participation in the assessment is voluntary.

SilverSummit Healthplan can review this employee data on-demand through Centene's People Analytics Hub (PAH), a versatile platform available through Workday that provides an expansive overview of demographics throughout the employee lifecycle. In addition to workforce demographics such as race, ethnicity and gender, the platform reports on hiring and turnover rates, succession planning and internal fill rates. The hub also supplies data on employee engagement by including participation rates for Employee Inclusion Group membership and pulse survey scores. Reports are available at both the health plan and departmental levels. This comprehensive, dynamic tool allows SilverSummit Healthplan to conduct profound and insightful analyses.

To drive accountability across the organization, Centene's performance measure for people leaders provides guidance for creating a strong employee experience and inclusive culture, which is key to the development and retention of a diverse workforce. The measure includes targets for business unit employee engagement scores, hiring metrics and retention rates. This measure is included in people leaders' performance goals in Workday, and they are reviewed in conjunction with pulse survey metrics and annually as part of a leader's performance review.

All data is reviewed semi-annually with people leaders and senior leadership throughout the SilverSummit Healthplan to track progress against established goals and develop action plans to address new areas of opportunity for DEI advancement.

Domain: Governance, Leadership, and Workforce
Objective: Assess SMART goals / objectives identified in CLAS Program Description

Domain: Governance, Leadership, and Workforce	
Evaluation Requirement: The health plan identifies and evaluates opportunities to improve diversity, equity, inclusion or cultural humility for staff, leadership, committees and governance bodies, where applicable.	
Objective 1:	By 12/2023, increase health plan Employee Inclusion Group participation from 16% to 20% to improve diversity, equity, inclusion, or cultural humility for health plan staff.
Objective 2:	By 12/2023, encourage participation in "Courageous Conversations" events 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).
Objective 3:	By 12/2023, the Health Equity team will present at the health plan People Leader meetings at least annually to improve diversity, equity, inclusion, or cultural humility for health plan committees and/or governance bodies.
Objective 4:	By 12/2023, create an action plan to improve survey and assess staff feedback on and satisfaction with the organization's promotion of diversity, equity, inclusion and cultural humility and identify opportunities, utilization a 360° collaboration.

Staff:

Results

Table 1. *Member to Workforce Race and Ethnicity Comparison*

	Membership 2022		**Healthplan Workforce 2022**		**Membership 2023**		**Healthplan Workforce 2023**	
	f	**%**	***f***	**%**	***f***	**%**	***f***	**%**
Race								
American Indian and Alaska Native alone, not Hispanic or Latino	2,436	1.55%	1	0.70%	1,967	1.5%	3	2.4%
Asian alone, not Hispanic or Latino	9,988	6.37%	19	13.29%	11,087	8.5%	17	13.5%
Black or African American alone, not Hispanic or Latino	28,516	18.19%	21	14.69%	32,876	25.3%	18	14.3%
Native Hawaiian or Other Pacific Islander alone, not Hispanic or Latino	4,184	2.67%	3	2.10%	26	0.02%	3	2.4%
White alone, not Hispanic or Latino	47,109	30.06%	63	44.06%	34,170	26.2%	62	49.2%
Unknown/Not reported	17,922	11.43%	36	25.17%	50,062	38.5%	6	4.8%
Ethnicity								
Hispanic or Latino	46,551	29.70%	14	9.79%	4	0.003%	17	13.5%
Non-Hispanic or Latino	110,185	70.30%	113	79.02%	21	0.02%	NA	NA
Unknown/Not provided	30	0.02%	16	11.19%	130,163	99.98%	NA	NA

Quantitative Analysis

SilverSummit Healthplan analyzed the results comparing the workforce to membership to determine whether there is an opportunity to improve diversity, equity, inclusion or cultural humility for Staff. Of note, the membership and workforce data include all members in the NV market and all staff that support those members.

26.2% of membership report White as their race, followed by Black or African American (25.3%). 38.5% did not report their race and 99.98% did not report ethnicity.

When the workforce is compared to the membership it is found that the rate of individuals that identify as White and Asian in the Healthplan Workforce is higher than in our Membership and, conversely, the rate of individuals that identify as Black or African American and Hispanic in the Membership is higher than in the Healthplan Workforce. Analysis of the findings identified that the staff is moving towards increased diversity.

Qualitative Analysis

We leverage our Talent Attraction Team and DEI recruiting strategy to identify specific areas of opportunity; a targeted approach to sourcing supported by data and partnerships is utilized, including the following:

- Utilizing workforce monitoring for potential underrepresentation to support recruitment initiatives.
- Centene uses an integrated, multi-channel methodology when promoting open jobs at the company and its subsidiaries. This includes a dedicated career site (jobs.centene.com), XML job listing feed to more than 100+ job board aggregators (i.e. Indeed, LinkedIn, DirectEmployers etc.), email jobs marketing (i.e. CRM system) and other marketing tactics depending on the needs of the organization.
- Cultivating diverse candidate pools and outreach through our CRM (Candidate Relationship Management system) and career events, and targeted marketing and recruitment campaigns showcasing the diverse experiences and backgrounds of the organization.
- Leveraging national diversity and inclusion partnerships such as the **National Urban League**, The Consortium for Graduate Study in Management, and nursing associations to support our recruiting goals and advancement efforts of underrepresented groups in leadership.
- We support the mission of The Consortium for Graduate Study in Management, an alliance of leading American business schools and some of our country's top corporations who are working to enhance diversity in business education and leadership, by helping reduce the underrepresentation of African Americans, Hispanic Americans, and Native Americans in the member schools' enrollments and the ranks of management.
- We support the mission of this organization by partnering with the Consortium’s undergraduate development program “Competitive Advantage” and offering a robust paid summer intern program with nearly two hundred remote and onsite internship opportunities across the enterprise.
- Centene’s University Relations team partners with educational institutions across the state, including the 10 HBCUs in North Carolina, through targeted advertising of our summer internship experience. Over the last several years, we have successfully hired and placed students from Johnson C. Smith and NC Agriculture & Technical State University. For the 2024 cohort, we have 5 students slated to join us from North Carolina attending University of North Carolina, University of North Carolina – Greensboro, University of North Carolina – Chapel Hill, University of North

Carolina - Charlotte, and Johnson C. Smith. To attract top talent, the University Relations team participated in diversity focused recruitment events including a workshop presented to the University of North Carolina Association of Computer Machinery – Women in Technology student group.

- Engaging with local community leaders, community-based organizations, universities, community colleges, and faith-based organizations
- Piloting a **candidate portal tool** contingent workforce vendor that allows for the self-identification of diversity (gender, sexual orientation, disability, gender identity, race, military/veteran). This capability is the first reporting mechanism for contingent workers in the industry, and it allows us to measure our diversity and inclusion metrics across more segments of our workforce.
- Access Talent Neuron, LinkedIn, Lightcast and other resources for diversity data insights across skill sets and locations.
- Hiring managers are strongly encouraged to diversify their interviewing panels. This can help counteract unconscious bias by bringing a variety of perspectives to the interview process and it demonstrates to potential new hires that our company is inclusive.

Training and Certificating Recruiters in Diversity Strategies. All requisition-carrying team members complete training and achieve certification as Certified Diversity Recruiters through Advanced Internet Recruitment Strategies (AIRS). The team works to activate stakeholder partnerships with nonprofits and academic institutions, including HBCUs, to enhance our ability to recruit and develop diverse talent. In addition to achieving the CDR certifications, team members have earned certifications from the SHRM Foundation Employing Abilities at Work where participants learn how to recruit and retain individuals with disabilities and the SHRM Foundation Veterans at Work for best practices for attracting, hiring and retaining veterans.

Table 2.

Employee Inclusion Group (EIG) Participation Rate	**DEC 2022**	**DEC 2023**
	18.6%	28.0%

The health plan successfully exceeded our Employee Inclusion Group participation goal to improve diversity, equity, inclusion, or cultural humility for health plan staff with a 28% engagement rate. Our Diversity, Equity & Inclusion Council was instrumental in this success. The council encouraged EIG participation regularly and shared EIG volunteer and mentorship opportunities in our all-staff meetings and directly with our people leaders to ensure top-down DEI immersion. We will look to continue to improve on this percentage in 2024.

If performance or results fall short of expectations, the organization **conducts a root cause analysis or barrier analysis** to identify why performance or results were less than expected. Analysis of the findings included Human Resources Business Partner, the Diversity Equity & Inclusion Office and the Health Equity Improvement Committee. The group has experience and is involved with processes that present challenges or barriers to improvement.

Barriers:

- External Influences: External factors such as societal attitudes, economic conditions, and industry trends can also impact the alignment between staff and membership diversity.

- Limited applicant options: Individuals from underrepresented groups may face barriers to accessing education, training, and professional development opportunities, which can hinder their ability to enter and advance within certain industries or organizations. General diversity in the geographical area, market competitiveness and limitation of the hiring pool are also considerations.
- Resource Constraints: Limited financial resources or competing priorities may hinder the health plan's ability to implement diversity initiatives effectively. Securing buy-in from leadership and allocating adequate resources to diversity efforts are essential for overcoming this barrier.

Opportunity identified for Staff:

- Maximize job boards such as Direct Employers, Disability Solutions and Programmatic to ensure job vacancies are widely shared and accessible to a diverse population.
- Retention & Engagement – encourage use of the Employee Inclusion Groups' mentoring and sponsorship programs to nurture internal talent and create opportunities for advancement.

Leadership, Committees and Governance Bodies:

Quantitative Analysis

SilverSummit Healthplan analyzed the results to determine whether there is an opportunity to improve diversity, equity, inclusion or cultural humility for Leadership.

Table 3. *Workforce Demographics – Gender/Race*

	Healthplan Workforce 2022		Healthplan Workforce 2023	
	ƒ	%	*ƒ*	%
Male	28	22%	32	25.4%
Female	101	78%	94	74.6%
White	61	50%	62	49.0%
People of Color (POC)	62	50%	64	50.8%

Table 4. *Leadership Demographics - Gender*

Management Level	Female	Male	Overall%
Vice President (8)	2.3%	2.3%	4.6%
Senior Director (10)	1.5%	0.8%	2.3%
Director (11)	2.3%	0.8%	3.1%
Senior Manager (12)	5.3%	0.0%	5.3%
Manager (13)	1.5%	0.8%	2.3%
Supervisor (14)	2.5%	2.3%	3.8%
Individual Contributor (15)	60.3%	18.3%	78.6%
Total	**74.8%**	**25.2%**	**100.0%**

2022 data for workforce gender and race shows that 78% (101) were female and 22% (28) are male. 50% of the workforce were People of Color (POC) and 50% were White. Current 2023 demographic breakdown of the workforce demographics show that 74.6% (94) are female and 25.4% (32) are male. 50.8% of the workforce are People of Color (POC) and 49.2% were White. It is also notable that 75% of plan Vice Presidents are women, 67% of the Senior Director/Directors are women, and 77% of the Senior Managers/Managers/Supervisors are women. 51.2% of SSHP's employees identify as POC.

Qualitative Analysis

Centene has been acknowledged as a DEI leader in employment by several organizations:

- Best Places to Work for LGBTQ+ Equality, 100% Corporate Equality Index – Human Rights Campaign
- DEI Best Place to Work for Disability Inclusion, 100% Disability Equality Index
- Fortune – The World's Most Admired Companies and Change the World
- Leading Disability Employer -National Organization on Disability
- CEO Action for Diversity & Inclusion
- Top 50 Companies for Diversity, Top Companies for Black Executives, Top Companies for Latino Executives - DiversityInc
- Best of the Best – U.S. Veterans Magazine
- Great Place to Work – Certified USA

The organization reviewed opportunities to improve survey and assessed the staff feedback on and satisfaction with the organization's promotion of diversity, equity, inclusion and cultural humility and identify opportunities. The most recent Pulse Survey results show a significant improvement from the 2023 Winter Pulse Survey results. Staff were surveyed regarding leadership performance around Diversity, Equity and Inclusion. In all areas, SilverSummit scored higher than Centene overall and the Fortune 100 benchmark. Almost 100% of staff not only feel their people leaders treats them with respect (96%), but also that their leader supports diversity, equity and inclusion in the workplace (98%). 90% of employees felt that, regardless of their differences, they are treated fairly and 89% feel there is equal opportunity for people to have a successful career.

	My Hierarchy	Winter 2023	Centene Overall	Fortune 100 Benchmark
My People Leader treats me with respect.	96%	89% (+7)	94% (+2)	92% (+4)
All employees, regardless of their differences, are treated fairly.	90%	82% (+8)	85% (+5)	74% (+16)
There is an equal opportunity for people to have a successful career at the company.	89%	87% (+2)	78% (+11)	78% (+11)
My People Leader supports diversity, equity, and inclusion in the workplace.	98%	89% (+9)	93% (+5)	85% (+13)

The health plan partnered with the Arizona DEI Council to participate in "Courageous Conversations" events throughout 2023 to improve diversity, equity, inclusion, or cultural humility for health plan leadership.

A Courageous Conversation Series that was offered by the AZDEI Council and featured the following topics:

- Privilege
- Bias
- Can African Americans and other People of Color find success in White spaces?
- Self-Compassion: A Tool for Better Listening
- The Basics of Belonging
- The Power of Cute & Mini Moments of Joy

The events were well received, and our Nevada DEI Council facilitated our first one in 2024 extending it to all employees.

The Health Equity team also presented workplan updates at the health plan People Leader meetings. Our disparity zone strategy was presented to our People Leaders, health plan committees and governance bodies to improve diversity, equity, inclusion, and cultural humility. We also shared information on heritage observances each month with all staff during All Hands monthly meetings. The CLAS Program description, program evaluation, and health equity work plan are reviewed and approved by the Quality Improvement Committee and the Board of Directors.

If performance or results fall short of expectations, the organization **conducts a root cause analysis or barrier analysis** to identify why performance or results were less than expected. Analysis of the findings includes Human Resources Business Partner, the Diversity Equity & Inclusion Office and the Health Equity Improvement Committee. Each group has experience and is involved with processes that present challenges or barriers to improvement.

Barriers that may contribute to the misalignment include:

- Limited Accountability: If accountability measures are not clear, leaders may not feel responsible for promoting diversity, equity, and inclusion within leadership, governance bodies and/or committees.
- Limited Resources: Constraints on time or other resources may hinder leaders' ability to dedicate sufficient attention and resources to DEI initiatives.

Opportunity identified for Leadership, Governance bodies and Committees*:*

- Hold leaders accountable for advancing DEI initiatives and tie performance evaluations to progress in this area.
- Support leadership completing awareness-building programs to help leaders recognize and mitigate biases in decision-making processes. Share updates and findings with governance bodies.
- Add to Health Equity Improvement Committee agenda, at least annually, specific informational sessions on diversity, equity, and inclusion, as well as cultural humility and discuss key findings with committee participants. Share updates and findings with governance bodies.

Evaluation Requirement: The health plan provides all employees 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 12/2023, 100% of health plan staff will complete Cultural Humility and Health Equity training and present the results at Quality Improvement Committee.

Methodology

SilverSummit Healthplan staff, at all levels of employment, are assigned to take Cultural Humility and Health Equity training. Health Equity Operations (HE Ops) collaborates with the People Business Solutions Digital Learning team to assign training on an annual basis. To ensure an accurate staffing list is provided to the Learning team, HE Ops contacts each health plan to confirm participation prior to the assignment list being provided. Training is assigned, via email notification, each September with 30 days to complete, and reporting is available in October showing the completion rate. Exclusions include contingent workers and those on Leave of Absence (LOA). This assignment dynamically un-enrolls employees based on their

LOA status in Workday. Upon return to work, the training is automatically reassigned, and the employee is allotted the full duration to complete.

Results

Table 5.

	2022		2023		Variance
	f	%	*f*	%	%
Completion Rate by Staffing Level					
Executive Leadership (C-suite/President/VP) and Medical Directors (all levels)	7/7	100%	6/7	83%	-17%
Mid-level Leaders (manager/director/supervisor)	14/14	100%	19/19	100%	0%
Independent Contributor staff	77/77	100%	98/100	98%	-2%
Overall Completion Rate					
All Staff	98/98	100%	123/126	98%	-2%

Analysis

The training objective is to provide education and guidance regarding culturally and linguistically appropriate practices, reducing bias and promoting diversity and inclusion for all health plan staff to improve the awareness of cultural differences and sensitivities that need to be taken into consideration when helping members.

In 2023, SilverSummit Healthplan assigned the 2023 Centene: Cultural Humility and Health Equity training to 126 staff.

A total of 123 staff completed training for a rate of 98%, missing the goal of 100% by only 2% points. Compared to 2022 data, the overall completion rate declined by 2% percentage points. When found performance falls short of goals, the health plan conducts a root cause analysis to identify the reason.

The root cause analysis of the 2023 findings included the Health Equity Improvement Committee and Quality Improvement Committee. The group has experience and is involved with processes that present barriers to achieving the training completion goal. The goal was not met due to one executive level staff and 2 individual contributor staff not completing the training.

Barriers:

- Limited Resources: Constraints on time or other resources may have hinder staffs' ability to dedicate sufficient attention to completion of this training. Staff may have been on leave during the completion due date.

Opportunity identified:

- Health Equity Improvement Committee will collaborate with the People Business Solutions Digital Learning team to assign training on an annual basis and work with Leadership to remind their teams and that completion of this training is required and encourage all staff to complete timely.

D. 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.MBRS.02 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.

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.

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.

Domain: Communication and Language Assistance
Objective: Assess SMART goals / objectives identified in CLAS Program Description

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.

To proactively meet member needs for language service requests, as well as to identify emerging needs based on community demographics, the health plan collects the language characteristics of the member population on an annual basis. The two tables below show the languages reported and the top languages for which an interpreter is requested.

Table 6. *Top 10 Languages Reported by Membership*

	Membership 2022		**Membership 2023**	
	f	**%**	***f***	**%**
English	121,573	87.82%	113,395	87.18%
Spanish	16,208	11.71%	16,100	12.38%
Chinese	224	0.16%	194	0.15%
Lao	147	0.11%	125	0.10%
Vietnamese	100	0.07%	94	0.07%
Tagalog	57	0.04%	53	0.04%
Russian	46	0.03%	45	0.03%
French	35	0.03%	36	0.03%

	f	%	*f*	%
Portuguese	24	0.02%	25	0.02%
Central Khmer	4	0.00%	4	0.00%

Table 7. *Top 15 Languages for Interpreter Requests*

	Requests 2022		Requests 2023	
	f	%	*f*	%
Spanish	7,295	94.2%	7,613	92.4%
Mandarin	171	2.2%	183	2.2%
Arabic	78	1.0%	92	1.1%
Farsi (Persian)	28	0.4%	76	0.9%
Amharic	8	0.1%	38	0.5%
Russian	9	0.1%	29	0.4%
Armenian	17	0.2%	22	0.3%
Vietnamese	22	0.3%	19	0.2%
Cantonese	11	0.1%	17	0.2%
Korean	7	0.1%	14	0.2%
Pashto (Afghanistan)	6	0.1%	13	0.2%
Sudanese Arabic	28	0.4%	12	0.1%
Haitian Creole	0	0.0%	10	0.1%
Lao	0	0.0%	9	0.1%
Serbian	7	0.1%	9	0.1%

Analysis

Overall, the data indicate the vast majority of the membership speak English (87.18%) followed by Spanish (12.38%) and those whose preferred language is Spanish utilize the interpreter services the most (92.4%).

By using quality language services, SilverSummit Healthplan can facilitate effective and accurate communication between health plan staff, providers, and members regardless of language proficiency level. 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.

Language access services are available at no cost, at all points of contact where a covered benefit or service is accessed. Members and practitioners are informed of availability and how to access services upon enrollment, or joining the network and each Spring, annually.

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 12/2023, 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 12/2023, 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.

In order to ensure SilverSummit Healthplan has the services available for potential members and identifies threshold languages, the below summarizes the language composition of the state population.

Table 8. *Household Language Census Data*

Nevada	***f***	**%**
English only	2,107,939	70.48%
Spanish	620,424	20.74%
Portuguese	93,337	3.12%
Greek	66,066	2.21%
French, Haitian, or Cajun	11,778	0.39%
Japanese	10,270	0.34%
Haitian	8,234	0.28%
Chinese (incl. Mandarin, Cantonese)	7,990	0.27%
Hindi	6,985	0.23%
Polish	6,514	0.22%
German or other West Germanic languages	5,495	0.18%
Other Indo-European languages	5,493	0.18%
Italian	5,061	0.17%
Russian	3,320	0.11%
Yiddish, Pennsylvania Dutch or other West Germanic languages	2,739	0.09%
Armenian	2,277	0.08%
Yoruba, Twi, Igbo, or other languages of Western Africa	2,229	0.07%
Punjabi	2,196	0.07%
Ilocano, Samoan, Hawaiian, or other Austronesian languages	2,061	0.07%
Ukrainian or other Slavic languages	2,014	0.07%
Nepali, Marathi, or other Indic languages	1,840	0.06%
Korean	1,827	0.06%
Hmong	1,801	0.06%
Persian (incl. Farsi, Dari)	1,619	0.05%
Tamil	1,378	0.05%
Serbo-Croatian	1,186	0.04%
Telugu	1,109	0.04%

Nevada	*f*	%
Bengali	1,037	0.03%
Navajo	1,022	0.03%
Arabic	971	0.03%
Hebrew	731	0.02%
Gujarati	693	0.02%
Urdu	660	0.02%
Other and unspecified languages	577	0.02%
Other languages of Asia	324	0.01%
Tagalog (incl. Filipino)	322	0.01%
Malayalam, Kannada, or other Dravidian languages	303	0.01%
Vietnamese	292	0.01%
Swahili or other languages of Central, Eastern, and Southern Africa	255	0.01%
Thai, Lao, or other Tai-Kadai languages	217	0.01%
Amharic, Somali, or other Afro-Asiatic languages	137	0.00%
Khmer	86	0.00%
Other Native languages of North America	71	0.00%
Grand Total	**2,990,880**	**100%**

Source: U.S. Census Bureau, American Community Survey 2021; https://api.census.gov/data/2021/acs/acs1

The threshold languages analysis assesses languages spoken by 5% (1,000 or less) and 1% (200 or less) of residents. Data show fourteen languages are spoken by 1,000 residents or less with three, Afro-Asiatic (137 people), Khmer (86 people), and Other Native Languages of North America (71 people), spoken by 200 residents or less. At the time of assessment, SilverSummit Healthplan does have members that speak these languages and language services will be obtained to support communication needs.

The census data align with the Resource for Entities Covered by Section 1557 of the Affordable Care Act Estimates for Nevada of the top 15 languages spoken by individuals with LEP used to determine threshold languages for translation.

Rank	Language	Estimate
1	Spanish	229,155
2	Tagalog	21,723
3	Chinese	16,103
4	Korean	6,342
5	Vietnamese	5,068
6	Amharic	3,915
7	Thai	3,348
8	Japanese	2,445
9	Arabic	1,945
10	Russian	1,757
11	French	1,734
12	Persian	1,344
13	Samoan	1,315

Rank	Language	Estimate
14	German	1,156
15	Ilocano	795

SilverSummit Healthplan uses this information to implement the tagline requirement at § 92.8(d)(1)-(2) of the Section 1557 rule (45 C.F.R. pt. 92) for threshold languages. Notification of language assistance in the HHS Office of Civil Rights list of Top 15 languages is provided upon enrollment and each Spring 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 12/2023, will have a documented process for collecting qualitative and/or quantitative data related to member experiences with cultural and linguistic services and report and disclose to the Quality Improvement Committee.

Methodology

The health plan assesses member complaints related to linguistic needs and/or concerns. The health plan evaluated all member complaints for 2022 and 2023. The health plan's goal is to have less than three complaints per 1,000 members.

Results

Table 9. *CLAS Related Grievances of Member Population, per category within the measurement year*

Grievance Type	**2022: N = 135,930**	Goal Met? (<3)	**2023: N = 130,188**	Goal Met? (<3)
	f		***f***	
Quality of Care				
Cultural Need	0	Yes	0	Yes
Discrimination	2	Yes	0	Yes
Total	2	Yes	0	Yes
Access				
Cultural Need	0	Yes	0	Yes
Discrimination	0	Yes	0	Yes
Total	0	Yes	0	Yes
Attitude and Service				
Cultural Need	1	Yes	0	Yes
Discrimination	1	Yes	2	Yes
Total	2	Yes	2	Yes
Billing and Financial				
Cultural Need	0	Yes	0	Yes
Discrimination	1	Yes	0	Yes
Total	1	Yes	0	Yes
Quality of Practitioner Office Site				
Cultural Need	0	Yes	0	Yes
Discrimination	0	Yes	0	Yes
Total	0	Yes	0	Yes

Analysis

Year over year trends show a reduction in member complaints related to linguistic needs and/or concerns. The 2023 results show that the goal of less than 3 complaints per 1000 was met.

If performance falls short of goals, the organization conducts a root cause analysis or barrier analysis to identify why goals were not achieved. Analysis of the findings included Senior Manager of Grievances & Appeals and the Appeals and Grievances Committee. All cases are reviewed on a quarterly bases with the respective departments and as part of the Appeals and Grievances committee. Root cause and outliers are assessed and each respective department reviews the full information of the cases to complete their own deep dives and process improvements. The Plan also has huddles with respective departments on a monthly basis to review any trends or potential process improvements.

Opportunity identified:

- Health Equity Improvement Committee will partner with the Appeals and Grievances Committee to review any member complaints related to linguistic needs and/or concerns to identify barriers and opportunities to improving member experience related to linguistic needs and/or concerns. A representative will report on root cause and resolution in the HEI Committee.

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 12/2023, 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 12/2023, will have a documented process for collecting data related to the number of practitioners that have worked with an interpreter during health care encounters.

Staff Experience Survey

Quality Compliance Requirement: The minimum standards of quality and health equity as outlined by the National Committee for Quality Assurance (NCQA) requires organizations seeking Health Equity Accreditation to assess and monitor Language Access Services on an annual basis in compliance with the following standards:

- HEA:6C; F3: Staff experience with language services for organization functions.

Scope: Survey of front-line staff to assess their experience with language access services to support organizational functions (i.e.., Member Services, Population health management, Case management, Complaints, grievances and appeals, etc.) for the following services: over-the-phone interpretation (OPI) for spoken language, face-to-face (F2F) interpretation requests for spoken language and sign language, written translation, Teletypewriters (TTY) /Telecommunications Device for the Deaf (TDD), and alternate format requests.

Language Access Services: Staff Experience Survey

To evaluate the effectiveness of our contracted language service vendors, SilverSummit Healthplan and its parent company, Centene Corporation conducted an annual survey of front-line staff to assess their experience with language access services to support organizational functions (i.e.., Member Services,

Population health management, Case management, Complaints, grievances and appeals, Claims and Utilization Management.) for the following services: over-the-phone interpretation (OPI) for spoken language, face-to-face (F2F) interpretation requests for spoken language and sign language, written translation, Teletypewriters (TTY) /Telecommunications Device for the Deaf (TDD), and alternate format requests.

Note: The *2023 Language Access Services: Staff Experience Survey* was expanded from four questions that focused on OPI to a comprehensive 39 question survey assessing experience and training of front-line with all language access services. Recognizing that staff encounter(s) with the varied language access service types (i.e., OPI, F2F, written translation, TTY/TDD, VRI, and alternate format) are highly variable, the survey logic was designed with conditional branching logic to allow survey participants to skip questions if certain predefined conditions were met. Also known branch logic, the survey design allowed a customized pathway through which the respondent could proceed based on their answers.

Methodology

Centene Corporation utilizes a shared services model for National Products (Medicare and Marketplace) with state/market specific assignment(s) for Medicaid products to ensure front-line staff are able to address the complexities of the state benefits and coverage. In the shared model, front-line are trained utilizing a standard core curriculum with function specific education.

Centene Corporation conducted a survey of front-line staff to evaluate their experience with language access services during member interactions within a 12-month period prior to the survey. The population was identified and extracted by the Centene, Human Resource Data Management department from selected *job family* categories (ie., clinical, customer service, etc,.) that include direct member contact as a standard function of the position. Supervisors and above were excluded from the survey resulting in 65 job profiles (26,047 eligible employees at the time of data extraction).

Our objective was to achieve a ±5% margin of error using a confidence level of 95%. The stratified sample was drawn from each *job family* to achieve representation with a total sample population of 6, 840 (4,340 customer service and 2,500 clinical/behavorial front-line staff). From the total population, 26,047 (19,196 customer service, 6,851 clinical/behavorial front-line staff) surveys were completed with a response rate of 10 percent, which gives us a margin of error of 4%.

The sample population were provided with information on the purpose of the survey, the scope of services/activites the comprise langauge access services, the anonymity of the collected data and the voluntary nature of their participation. The survey questions utilized a binary response scale (yes / no) to support respondent segmentation and identify distinct opportunities. The survey was disseminated via email and data was collected through an online survey platform (Qualtrics©) to increase the response rate and facilitate the collection of large amounts of data efficiently within the designated survey period. The survey was deployed on 09/26/2023 with collection occurring for a 14-day period. Two reminders (day five and day ten) were sent via email to the survey population to increase the response rate. All collected data were analyzed.

Recognizing that staff encounter(s) with the varied language access service types (i.e., OPI, F2F, written translation, TTY/TDD, VRI, and alternate format) are highly variable, the survey logic was designed with conditional branching logic to allow survey participants to skip questions if certain predefined conditions were met. Also known branch logic, the survey design allowed a customized pathway through which the respondent could proceed based on their answers.

Monitoring and Evaluation
The Quality Improvement Committee monitor data on an annual basis. This document summarizes the results and analysis.

Results
Tables are formatted for ease of analysis. The tally or frequency count is denoted by the symbol (f). Data is for the measurement year (MY) is compared against prior year (PY) data. Survey questions with no responses and/or fields left blank were removed from the results for analysis.

The 2023 Language Access Experience Survey administered to front-line staff *(e.g., behavioral care management, clinical, and customer service)* yielded 684 participants. Of those participants, 31 percent indicated they are in a customer service role, and 58 percent of staff respondents indicated they primarily work with the Medicaid Line of Business ***(Table: 10)***.

Table 10. *Survey Results from Front-line Staff Experience with Language Services*

Characteristics	**2023: N = 684**	
Function	***f***	**%**
Behavioral: Care Management or Care Coordination	212	30.99%
Clinical	155	22.66%
Customer Service	214	31.29%
Other	103	15.06%
Line of Business	***f***	**%**
Medicaid	401	58.63%
Medicare	114	16.67%
Marketplace	55	8.04%
Multiple LOB's	114	16.67

The majority of front-line staff participating in the survey (77.6 percent) indicated they had been provided training on how to access Over-the- Phone Interpretation (OPI). Less than 30 percent of respondents indicated they had received training on how to access Face-To-Face interpretation (F2F), Written Translation, Teletypewriters/Telecommunications Device for the Deaf (TTY/TDD), and Alternate format. Less than 11 percent, or 70 front-line staff indicated receiving training on how to access Video Remote Interpreting (VRI). This is shown in ***Table 11.*** *Responses left blank or unanswered for each question were removed from the results, and therefore the total response tally or frequency (f) may be less than the number of survey participants (n=684).*

Table 11. Training: *Survey Participants Receiving Training on Accessing Language Services*

	2023	
	Yes	**No**
Q1.1 (OPI)	*506 (77.6%)*	*146 (22.4%)*
Q1.2 (F2F)	*179 (27.6%)*	*469 (72.4%)*
Q1.3 (Written Translation)	*132 (20.4%)*	*515 (79.6%)*
Q1.4 (TTY/TDD)	*105 (16.2%)*	*545 (83.8%)*
Q1.5 (VRI)	*70 (10.8%)*	*581 (89.2%)*
Q1.6 (Alternate Format) *n*	*137 (21.1%)*	*512 (78.9%)*

Within the last 12-months survey participants indicated accessing over the phone interpretation (OPI) with the highest frequency (72.8 percent), followed by Face-to-Face interpretation (12.4 percent). Video Remote Interpretation was accessed the least (2.8 percent). This is depicted in ***Table 12.*** *Responses left*

blank or unanswered for each question were removed from the results, and therefore the total response tally or frequency (f) may be less than the total number of survey participants (n=684).

Table 12. Utilization: *Survey Participants Utilizing or Accessing Language Services*

	2023	
	Yes	**No**
Q2.1 (OPI)	*470 (72.8%)*	*176 (27.2%)*
Q2.2 (F2F)	80 *(12.4%)*	565 *(87.6%)*
Q2.3 (Written Translation)	67 *(10.4%)*	576 *(89.6%)*
Q2.4 (TTY/TDD)	41 *(06.4%)*	604 *(93.6%)*
Q2.5 (VRI)	18 *(02.8%)*	628 *(97.2%)*
Q2.6 (Alternate Format)	51 *(07.9%)*	595 *(92.1%)*

Table 13. OPI Experience: *Survey Results from Front-line Staff, n = 469*

	2023	
	Yes	**No**
Q2.1.1 During the most recent encounter, was the wait to be connected to the appropriate spoken language interpreter as expected?	*422 (90.0%)*	*47 (10.0%)*
Q2.1.2 Is the process to access interpreter services for spoken languages easy?	*424 (90.4%)*	*45 (09.6%)*
Q2.1.3 Have you experienced challenges accessing interpreter services for spoken languages other than Spanish?	*146 (31.1%)*	*323 (68.9%)*
Q2.1.4 Did the spoken language interpreter help you better communicate with the member?	*440 (93.8%)*	*29 (06.2%)*
Q2.1.5 Were you satisfied with the interpreter service for spoken languages?	*422 (90.0%)*	*47 (10.0%)*

Table 14. F2F Experience: *Survey Results from Front-line Staff, n = 80*

	2023	
	Yes	**No**
Q2.2.1 During your most recent encounter, was the wait to be connected to the language service vendor to schedule a face-to-face encounter as expected?	*59 (73.8%)*	*21 (26.3%)*
Q2.2.2 Is the process to schedule face-to-face interpreter services easy?	*62 (77.5%)*	*18 (22.5%)*
Q2.2.3 Have you experienced challenges scheduling face-to-face encounters for clinical encounters?	*27 (33.8%)*	*53 (66.3%)*
	2023	**2023**
	Yes	**Yes**
Q2.2.4 Were you satisfied with the services when scheduling face-to-face encounters for clinical encounters?	*62 (77.5%)*	*18 (22.5%)*

Table 15. *Written Translation Experience Results from Front-line Staff, n = 67*

	2023	
	Yes	**No**
Q2.3.1 Do you know the process for requesting a written translation?	*37 (55.2%)*	*30 (44.8%)*
Q2.3.2 Is the process to request written translations easy?	*35 (52.2%)*	*32 (47.8%)*
Q2.3.3 Did you receive the written translations timely?	*35 (52.2%)*	*32 (47.8%)*
Q2.3.4 Were you satisfied with the services when using written translations?	*43 (64.2%)*	*24 (35.8%)*

Table 16. TTY/TTD Experience: Survey Results from Front-line Staff, n = 40

	2023	
	Yes	**No**
Q2.4.1	*34 (85.0%)*	*6 (15.0%)*

Table 17. *VRI Experience Results from Front-line Staff, n = 17*

	2023	
	Yes	**No**
Q2.5.1 Do you know the process for requesting video remote interpreting services?	*8 (47.1%)*	*9 (52.9%)*
Q2.5.2 Is the process to schedule video remote interpreting services easy?	*10 (58.8%)*	*7 (41.2%)*
Q2.5.3 Have you experienced challenges scheduling video remote interpreting services for clinical encounters?	*1 (05.9%)*	*16 (94.1%)*
Q2.5.4 Were you satisfied with the services when scheduling video remote interpreting services for clinical encounters?	*12 (70.6%)*	*5 (29.4%)*

Table 18. *Alternate Format* Experience Results from *Front-line Staff, n = 49*

	2023	
	Yes	**No**
Q2.6.1 Do you know the process for requesting an alternate format?	*40 (81.6%)*	*9 (18.4%)*
Q2.6.2 Is the process to request alternate formats easy?	*39 (79.6%)*	*10 (20.4%)*
Q2.6.3 Are you notified when your alternate format request is complete?	*26 (53.1%)*	*23 (46.9%)*

Table 19. *Front-line Staff Experience with Language Access Service Vendors*

	2023	
	Yes	**No**
Q2.7.1 Do you know the vendors utilized for language access services requests? n=473	*344 (72.7%)*	*129 (27.3%)*
Q2.7.2 Have you experienced challenges with any of the listed vendors below? n= 684	--	--
Language Line (VRI)	*45 (06.6%)*	*N/A*
LSA (Onsite)	*1 (00.1%)*	*N/A*
LSA(Onsite), Translation Station (Onsite)	*1 (00.1%)*	*N/A*
Voiance (VRI)	*78 (11.4%)*	*N/A*
Multiple Vendor Options	*35 (05.1%)*	*N/A*
No Response	*524 (76.6%)*	*N/A*
Q2.7.3 Were you satisfied with the process of working with the vendor(s)? n= 473	410 *(86.7%)*	63 *(13.3%)*

Analysis & Discussion

The results of this survey indicate that the majority of front-line staff, have been trained on and are utilizing over the phone interpretation language services more frequently when compared to other language access services *(e.g. F2F, written translation, TTY/TDD, VRI, and alternate format)*. Additionally, the majority of front-line staff who had experience accessing or requesting F2F interpretation, written translations TTY/TDD, or alternate format reported understanding how to request these services, indicated they received translation or interpreter services in a timely matter, and overall reported they were satisfied with language services. The majority of front-line staff who reported having an experience with VRI, however indicated they did not know the process for how to request VRI.

Based on the findings of this survey, there are also areas of opportunity to improve. The first area of consideration is training provided to front-line staff on language access services other than Over-the-

Phone Interpretation (OPI). Face-to Face interpretation (12 percent) was reported as the second most frequently utilized language service by front-line staff, however the majority of respondents (72 percent) indicated they had not received training on how to access this service. Additionally, despite a small number of staff who reported utilization of VRI, the majority of identified staff also indicated they did not know the process of how to access the service. As such, it would also be beneficial to increase staff trainings related to VRI.

Another area of opportunity is further exploration of the frequency in which front-line staff are utilizing or requesting language access services other than OPI. This could be done by collecting data from front-line staff on their utilization of language service types more frequently *(e.g., weekly, monthly, or quarterly)*. This would not only serve to capture how often front-line staff are interacting with these services, but I would also serve to reduce the impact of recall bias over a 12-month time frame regarding their experiences with language access services. This information could also be examined concurrently with an assessment of health plan members awareness of language services, and whether they "would" use other interpreter or translation services if aware/offered.

It is also unclear if certain language services with low reporting of utilization (e.g., VRI, TTY/TDD, alternate format) by front-line staff is correlated with lack of awareness by the member (and therefore fewer requests for certain language services other than OPI), or if there are unmet member needs for language services being requested due to gaps in knowledge among front line staff about how to access these services due to lack of training. Further assessment on the correlation between member awareness of language service offerings, member requests for language services, and front-line staff awareness/understanding of how to access language services other than OPI could provide clarity on additional communication opportunities to members. It could also provide additional guidance on which language services trainings to prioritize and enhance for front-line staff.

Limitations

Several limitations should be considered in interpreting these findings. First, the response rate is less than the 60 percent benchmark. This may, in part, be attributed to inaccuracies in email addresses provided, and/or the email notification regarding the survey being filtered to the spam folder. Additionally, position turnover or transition of front-line staff identified by Human Resources may have occurred between the time the sample distribution list was provided by Human Resources and the deployment of the survey. This may have impacted the delivery of the Language Access Services Survey to the intended recipient and therefore decreased opportunities for front-line staff to participate in the survey.

Another limitation of the reported findings is the reliance on quantitative self-reported data which subjects the results to recall bias about the experiences of front-line staff with various language services over a 12-month time frame. Recall bias can be reduced in future efforts to obtain this information by increasing the frequency in which staff are surveyed about their experiences with language services. Ideally this should be done immediately following point of contact/interaction with language services.

Lastly, expanding the quantitative survey to also include qualitative methods *(e.g., open-ended survey questions, focus groups with front-line staff)* may provide additional context and understanding about the degree to which front-line staff are satisfied with language services. It can also serve to provide further insights about the types of challenges front-line staff may experience when accessing language services, and specific opportunities to improve by developing solutions to resolve identified challenges.

This feedback is valuable to SilverSummit Healthplan and our partners and will be shared with call center leaders and the vendor management team for possible use in improving language access vendor services. Additionally, SilverSummit Healthplan encourages staff to file an interpreter complaint when they suspect an interpreter quality issue, so that the call can be investigated, and proper resolution reached.

SilverSummit Healthplan will continue to monitor the provision and quality of language services and take necessary steps for effective delivery of these services to ensure positive health outcomes for our diverse members. Robust Culturally and Linguistically Appropriate Services (CLAS) policies that govern quality standards, processes, compliance monitoring and oversight and various training opportunities help meet this goal.

Language Access Services: Member Experience Survey

To evaluate the effectiveness of our contracted language service vendors, SilverSummit Healthplan conducts an annual survey of eligible members to assess their experience with language access services to support organizational functions (i.e.., Member Services, Population health management, Case management, Complaints, grievances and appeals, etc.) and experience in healthcare encounter.

To facilitate survey deployment and expedite market-level evaluations, surveys were translated in the top four non-English member-preferred languages across the Centene member population, as determined by enterprise ACA Section 1557 compliance analyses, Korean, Spanish, Traditional Chinese, and Vietnamese.

Utilization data for over-the-phone interpretation (OPI) for spoken language and face-to-face (F2F) interpretation requests for spoken language and sign language show the top three languages were for Spanish, Vietnamese, and Brazilian Portuguese.

Methodology

SilverSummit Healthplan conducts an annual survey of members that utilized language access services within a 3-month period prior to the survey. The member population is identified and extracted by the Centene, Microstrategy Platform which is linked to member data in the electronic data warehouse.

Members who utilized language access services in interactions with organization functions, or who received support from an on-site interpreter at a clinical interaction, were identified through MicroStrategy of all logged interpreter requests and fulfillments. Members who have not opted-in to receive email communications were excluded from the survey.

Our objective was to achieve a ±5% margin of error using a confidence level of 95%. A pull from the MicroStrategy platform of members with email addresses who indicated a language preference of Spanish, Korean, Traditional Chinese, and Vietnamese on record provided a total sample population of 168,323 (155,657 Spanish, 1,784 Korean, 5 Traditional Chinese, and 10,877 Vietnamese). From the total population, 1,598 (2,384 Spanish, 72 Korean, 0 Traditional Chinese, 167 Vietnamese, and 50 English/English-Spanish) surveys were completed with a response rate of 2 percent, which gives us a margin of error of 2%. Of this sample, 18 members from SilverSummit Healthplan responded.

The sample population were provided with information on the purpose of the survey, the anonymity of the collected data and the voluntary nature of their participation. The survey questions utilized a binary response scale (yes / no) to support respondent segmentation, a five-point (1-5) Likert scale to assess satisfaction, multiple choice selection, and open-end questions to allow respondents to provide additional detail.

The survey was disseminated via email and data was collected through an online survey platform (Qualtrics©) to increase the response rate and facilitate the collection of large amounts of data efficiently within the designated survey period. The survey was deployed on 09/26/2023 with collection occurring for a 10-day period. Two (2) reminders (day five [5] and day ten [10]) were sent via email to the survey population to increase the response rate. All collected data were analyzed.

Results

Tables are formatted for ease of analysis. The tally or frequency count is denoted by the symbol *(f).* Percentages for each response are based on the number of responses to that question. A breakdown of the findings are displayed by the survey respondents spoken language. Responses to Likert-scale questions regarding member level of satisfaction are reported as "satisfied," "unsatisfied" or "neither." A response of "extremely satisfied," or "somewhat satisfied" were aggregated by count or frequency *(f)* and percent (%) and reported as "satisfied." A response of "extremely dissatisfied" or "somewhat dissatisfied" were aggregated by count or frequency *(f)* and percent *(%)* and reported as a grouped category of "unsatisfied." The same is true for reporting of responses for Likert-scale responses corresponding to level of difficulty (e.g., easy, or hard). Responses of neutrality are reported as "neither." For this report, responses to open-ended questions have been translated into English.

Of the 119 survey participants, 37 (32 percent) indicated that they had not used telephone interpreter services to talk with their health plan in the last 3 month. For members indicating this response, the survey ended and therefore no additional responses are reported for subsequent survey questions. As such, the reported sample population by question may be less than 119 due to "no response," or the member was no longer eligible to participate in survey questions regarding their experience and level of satisfaction with interpreter services. Additionally, there were no (0) completed surveys for members who speak Korean, English/Spanish or Traditional Chinese and therefore, are not displayed in the following results tables.

Among all five (5) languages spoken by survey respondents, the majority indicated being "satisfied" with the interpreter service received (83.33% percent). Members who speak Spanish reported being "satisfied" the most (82.35 percent). Of the languages spoken, members who speak Spanish also reported being "dissatisfied" the most (17.65 percent) when compared to the other spoken languages. This is shown in

Table 1A. *Reported Member Satisfaction with interpreter Service, N= 18*

Q2. Overall, how satisfied (happy) or dissatisfied (unhappy) are you with the interpreter service?	**Spanish n=17**		**Spanish (Spain) n=1**		**Total**	**Total**
	f	**%**	***f***	**%**	***f***	**%**
Satisfied	14	82.35%	1	100%	**15**	**83.33%**
Unsatisfied	3	17.65%	0	0%	3	16.67%
Neither	0	0%	0	0%	0	0%

Table 1B. *Reported Member Satisfaction Accessing an Interpreter, N= 17*

Q3. How easy or hard was it to get an interpreter?	**Spanish n=17**		**Spanish (Spain) n=1**		**Total**	**Total**
	f	**%**	***f***	**%**	***f***	**%**
Satisfied	13	81.25%	1	100%	**14**	**82.35%**
Unsatisfied	1	6.25%	0	0%	1	5.88%
Neither	2	12.50%	0	0%	2	11.76%

Table 2. *Member Reported Barriers to Satisfaction, N= 1*

Q4. What made the process of getting an interpreter hard? - Selected Choice	Spanish n=1		Spanish (Spain) n=0		Total	Total
	f	%	*f*	%	*f*	%
After asking for an interpreter, it took too long to get one	0	0%	NA	NA	**0**	**0%**
The interpreter did not speak the right language	0	0%	NA	NA	**0**	**0%**
We got disconnected (hung up) and I had to call again	1	100%	NA	NA	**1**	**100%**
Other: Please give us details	0	0%	NA	NA	**0**	**0%**
Multiple Selected	0	0%	NA	NA	**0**	**0%**

Table 2A. *Open-ended Member Reported Details*

Comment	No responses

Table 3. *Member Reported Experiences about their Interaction with the Interpreter*

Q5.1-4. Please tell us how much you agree or don't agree with the following:	Spanish N=14		Spanish (Spain) N=0		Total	Total
	f	%	*f*	%	*f*	%
Q5.1: The interpreter said everything right						
Agree	12	85.71%	NA	NA	**12**	**85.71%**
Disagree	1	7.14%	NA	NA	**1**	**7.14%**
Q5.2 The interpreter was easy to understand						
Agree	12	85.71%	NA	NA	**12**	**85.71%**
Disagree	2	14.29%	NA	NA	**2**	**14.29%**
Q5.3 The interpreter was professional						
Agree	12	85.71%	NA	NA	**12**	**85.71%**
Disagree	1	7.14%	NA	NA	**1**	**7.14%**
Q5.4 The interpreter service was helpful						
Agree	12	85.71%	NA	NA	**12**	**85.71%**
Disagree	1	7.14%	NA	NA	**1**	**7.14%**

Table 4A. *Member Reported Difficulties Understanding the Interpreter*

Q6. What made the interpreter hard to understand?, N=2	Spanish n=2		Spanish (Spain) n=0		Total	Total
	f	%	*f*	%	*f*	%
Background noise made it hard to hear	0	0%	NA	NA	**0**	**0%**
Bad phone connection (such as static)	0	0%	NA	NA	**0**	**0%**
I don't think the interpreter was right	1	50%	NA	NA	**1**	**50%**
The dialect of the interpreter did not match my language	0	0%	NA	NA	**0**	**0%**
The interpreter talked too fast	1	50%	NA	NA	**1**	**50%**
Other: Please give us details	0	0%	NA	NA	**0**	**0%**
Multiple Selected	0	0%	NA	NA	**0**	**0%**

Table 4B. *Members Open-ended Feedback Indicating Difficulty Understanding the Interpreter in Q5.2, n=0*

Q6. What made the interpreter hard to understand?, Other: Please give us details	No responses

Discussion

The results of this survey indicate that overall, survey participants are satisfied with interpreter services.

Based on the findings of this survey, there are also areas of opportunity to improve.

- The first area of consideration is to improve response rate in general and specifically among members that are non-Spanish speaking.
- A second area of opportunity is to increase the frequency in which members are surveyed about their experiences with language services to increase accuracy of response.
- Lastly, expanding the survey to also include assessing all types of language access services available to members *(e.g., F2F, written translation, TTY/TDD, VRI, and alternate format)* would provide further insight regarding the types of challenges members may experience when accessing language services, and specific opportunities to improve by developing solutions to resolve identified challenges. It may also provide additional context and understanding regarding the degree in which members are satisfied with language services.

Limitations

Several limitations should be considered in interpreting these findings. The results may not be generalized to the full Limited English Proficiency (LEP) member population. Additionally, there may have been inaccuracies in self-reported email addresses, and/or the email notification regarding the survey was filtered to their spam folder. This may have impacted the delivery of the Language Access Services Survey to the intended recipient and therefore decreased opportunities for members to participate in the survey.

Additionally, these results reported are solely the over-the-phone interpreter (OPI) language access service available to members. This survey did not include an assessment of all other language access services available to members (e.g., Face-to-face interpretation, Video Remote Interpretation, TTY/TDD, written translation and alternate format). As such, the responses received cannot be extrapolated to represent the experiences or level of satisfaction for members towards all language access services offered.

Lastly, limitation of the reported findings is the reliance on quantitative self-reported data which subjects the results to recall bias about the experiences of members with language services over a 12-month time frame. Recall bias can be reduced in future efforts to obtain this information by increasing the frequency in which members are surveyed about their experiences with language services. Ideally, this should be done immediately following point of contact/interaction with language services.

Opportunities and Action Plan

Based on the results of measurement language services, SilverSummit Healthplan has identified and prioritized opportunities to improve CLAS in the table below. From the opportunities identified actions and interventions are determined with a plan for evaluation of the results.

Opportunities

Improve CLAS	
Opportunity 1:	Explore additional staff training on how to request video remote interpretation (VRI) and face-to-face (F2F) interpretation services for members
Target Population:	Frontline staff who may have an opportunity to schedule language services for members
Priority for Impact:	Medium
Assessment:	**Selected**. Ensuring frontline staff who speak directly with members are familiar with all the language services available to members and are at ease with correctly scheduling those services for members, may result in more members being satisfactorily connected to vital language services. This may also help with the opportunity noted from the member survey, whereby a potential lack of awareness by the member of the full range of language services available may be resulting in fewer requests for certain language services other than other-the-phone interpretation.
Opportunity 2:	Survey members specifically about their experience with interpreters during health care encounters
Target Population:	Members who indicate a preference for a non-English language and/or who have accessed language services
Priority for Impact:	High
Assessment:	**Selected**. Asking about members' experience with interactions that take place in the clinical setting, specifically and separately from all other language service experiences, may point toward specific opportunities to improve the in-person service for our members, regardless of whether we have arranged the interpreter. Knowing how the experience is for members, particularly if it is unsatisfactory, can point us in the way of opportunities to improve it, whether by better preparing members, offering training for providers and office staff, advocating for better services, and more. Similarly, expanding the survey to also include a clear interest in feedback about experiences with all types of language access services available to members (e.g., F2F, written translation, TTY/TDD, VRI, and alternate format) would provide further insight regarding the types of challenges members may experience when accessing language services, and specific opportunities to improve by developing solutions to resolve identified challenges.
Opportunity 3:	Expanding the quantitative staff survey to also include qualitative methods (e.g., open-ended survey questions, focus groups)
Target Population:	Frontline staff
Priority for Impact:	Low
Assessment:	**Not selected** for current year. May provide additional context and understanding about the degree to which front-line staff are satisfied with language services, and what challenges exist. However, there is a compelling interest in keeping the survey design and questions consistent for another year. Will explore possibilities for implementing qualitative methods of obtaining staff feedback in 2025.

Opportunity 4	Survey members at the point of contact, or immediately following the over-the-phone interpreter (OPI) call
Target Population:	Members who indicate a preference for a non-English language and/or who have accessed language services
Priority for Impact:	High
Assessment:	**Selected**. While this is not an easy opportunity to implement, particularly in the short term, as it involves multiple corporate teams, vendors, and perhaps an additional cost to the company, it represents a strong process and member experience improvement. Taking an experience survey immediately after the completion of a phone call is a practice that consumers are accustomed to. Furthermore, it should increase survey participation rates, reduce recall bias on the part of survey participants, support improved service from our vendors, and allow us to survey members in additional languages.
Opportunity 5	Adjust timeframe for experience being surveyed
Target Population:	Both members and staff being surveyed
Priority for Impact	Low
Assessment	**Selected.** This low-effort improvement to the survey may mitigate some effects of recall bias present when the survey asked respondents to recall their experiences withing a smaller window. For the staff survey, we propose asking for responses looking back to a smaller window of time than 12 months, and for the member survey, we would like to hear about experiences in a longer window than just three months.

Action and Evaluation Plan

Intervention – Improve CLAS	
Selected Opportunity:	Additional staff resources for support of language services use by members
Target Population:	Frontline staff
Priority for Impact:	Increased staff awareness and comfort with processes to recommend and procure language services for members provides an improved member experience, and supports improved member interaction with, acceptance of, and adherence to healthcare recommendations
Implemented:	See implementation plan below
Action and Evaluation Plan	
Action:	Identify or support creation of additional staff training materials on how to request video remote interpretation (VRI) and face-to-face (F2F) interpretation services for members.
Measure:	Number of available training materials, staff self-reported knowledge around request processes
Method:	Evidence of training materials, staff survey responses
Data Source:	2024 and 2025 frontline staff language experience survey findings
Evaluation:	7/1/2025
Responsibility:	eQPI Health Equity, shared services call center training leadership
Status:	*Pending*
Action:	Survey members specifically about their experience with interpreters during health care encounters
Measure:	Positive and negative experiences with language services in the clinical setting
Method:	Survey
Data Source:	2024 member language experience survey
Evaluation:	10/2024
Responsibility:	eQPI Health Equity
Status:	Survey administered in July

E. 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 enrollment process as outlined in the CC.PRVR.47 policy. Self-reported, practitioner demographic information is published in the provider directory 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.

Domain: Practitioner Network Cultural Responsiveness
Objective: Assess SMART goals / objectives identified in CLAS Program Description

Domain: Practitioner Network Cultural Responsiveness	
Evaluation Requirement: On an annual basis, the health 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 12/2023, 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.
Objective:	By 12/2023, has established an electronic and/or printed directory of practitioners sharing race, ethnicity and/or language demographics for members.

Methodology

The purpose of this assessment is to evaluate SilverSummit Healthplan's provider/practitioner network 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. A variety of both direct and indirect data sources were used to obtain member and practitioner race, ethnicity, and language of the local and state population. Data sources include: U.S. Census Data, Ethnic Technologies (E-Tech) & State 834 Files, Cyracom, Portico, the Association of American Medical Colleges, and Prime 2.0.

Results

Table 20. *Member Reported Language to Practitioner Language Composition Comparison by Practitioner Type*

Language	Member		Primary Care		Specialist		Behavioral		All Practitioners		Ratio
	f	%	*f*	%	*f*	%	*f*	%	*f*	%	(:)
English	163409	88.6%									
Spanish	20286	11.0%	263	14.1%	258	13.6%	96	8.6%	513	13.0%	39.54
Chinese	300	0.2%	11	0.6%	7	0.4%	1	0.1%	16	0.4%	18.75
Vietnamese	128	0.1%	15	0.8%	9	0.5%	0	0.0%	18	0.5%	7.11
Lao	121	0.07%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.00
Tagalog	78	0.04%	97	5.2%	45	2.4%	8	0.7%	111	2.8%	0.70
Russian	55	0.03%	15	0.8%	13	0.7%	6	0.5%	30	0.8%	1.83
French	55	0.03%	28	1.5%	14	0.7%	8	0.7%	41	1.0%	1.34
Portuguese	28	0.02%	4	0.2%	6	0.3%	5	0.5%	13	0.3%	0.00
Central Khmer	6	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.00
Japanese	6	0.00%	4	0.2%	4	0.2%	3	0.3%	9	0.2%	0.00
Korean	2	0.00%	10	0.5%	10	0.5%	0	0.0%	14	0.4%	0.14
Dari (Afghanistan)	1	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.00
Arabic	1	0.00%	22	1.2%	24	1.3%	5	0.5%	33	0.8%	0.03
Turkish	1	0.00%	0	0.0%	2	0.1%	0	0.0%	2	0.1%	0.50

Sources: 834 file & Portico
* Portico reports practitioner additional fluent languages and does not report practitioner primary languages, thus the English language for practitioners is marked N/A.
Ratio: All practitioners to member reported language

Analysis

Table 20 presents a comparison of language composition between SilverSummit Healthplan members and practitioners. The table provides information on the languages reported by members and the corresponding language proficiency of primary care providers, specialists, behavioral practitioners, and all practitioners combined. The data includes both the absolute number of individuals and the percentage representation for each language category. Additionally, the table includes a ratio column that highlights the disparity between member-reported languages and the language proficiency of practitioners. In general, ratios under 1 are favorable.

The analysis compared the proportion of member's reported language against practitioner types (Primary Care, Specialist, and Behavioral Health) and analyzed the practitioner to member ratio for language concordance for all practitioner types. The proportion of member reported language for Spanish, Chinese, Vietnamese, Russian, and French was not proportionate to practitioner language capabilities within the network, indicating the goal of full concordance was not met.

Table 21. *Member to Practitioner Race and Ethnicity Comparison*

	Member		Practitioner	
	f	**%**	***f***	**%**
Race				
American Indian and Alaska Native	1,967	1.5%	0	0.00%
Asian	11,087	8.5%	137	3.75%
Black or African American	32,876	25.3%	82	2.25%
Native Hawaiian or Other Pacific Islander	26	0.0%	0	0.00%
White	34,170	26.2%	10	0.27%
Unknown/Not provided	50,062	38.5%	3418	93.67%
Ethnicity				
Hispanic or Latino	4	0.0%	2	0.05%
Non-Hispanic or Latino	21	0.0%	246	6.74%
Unknown/Not provided	130,163	100.0%	3401	93.20%

Sources: State 834 File; provider demographic records

Analysis

To determine concordance, a comparison of self-reported member and practitioner race and ethnicity data was analyzed. The majority of the membership, 26.2%, report White as their race, followed by Black or African American (25.3%). 0% of the membership name Hispanic or Latino as their ethnicity. 38.5% did not report their race or ethnicity. The self-reported practitioner data show the largest racial composition of practitioners to be Asian (3.75%) followed by Black or African American (2.25%) and White (0.27%). The proportion of our practitioner network with missing (i.e., unknown) race data accounted for 93.67% of the participating practitioner population; ethnicity data are absent for 93.20%. The self-reported practitioner data may not fully demonstrate the composition of the practitioner network because it is voluntary to provide this information. These results are different from the self-reported member population data. The self-reported ethnicity data from the enrollment credentialing process showed 0.05% of practitioners are Hispanic or Latino. The results show the race and ethnic composition of our member to practitioner populations are not proportionate, indicating the goal of full concordance was not met.

Upon comparison of data collected and analysis conducted to assess the cultural, ethnic, racial, and linguistic needs of its membership and network cultural responsiveness, the health plan believes the

practitioner network is able to meet the cultural needs and preferences of the membership. The health plan has an appropriate number of practitioners who speak languages other than English, with Spanish being the highest surveyed language spoken by members and practitioners. The health plan also provides interpretation services, which members are accessing, for languages other than English. The minimal number of grievances related to cultural and linguistic issues shows that overall, members were satisfied with the availability of practitioners to meet their cultural, ethnic, racial, and linguistic needs and preferences.

Cultural and linguistic availability of services is an important characteristic of the resources the health plan provides to its membership. The health plan is committed to continuous monitoring, tracking, and trending of all available data sources to regularly assess the needs of the population against the network's ability to support member needs and determine if the current practitioner network is meeting those needs adequately.

In 2023, a group consisting of the Grievance & Appeals Sr. Manager, Vice President of Population Health Management, Provider Relations Sr. Manager, Network Development & Maintenance Director, Vice President of Network Development & Contracting, and a member experience Specialist, Sr. Manager and Sr. Director of Quality Improvement completed the analysis utilizing the quality data included in this report. The group assessed and prioritized the opportunities for feasibility and impact.

Barriers:

- The self-reported practitioner data may not fully demonstrate the composition of the practitioner network because it is an optional application question. Due to the limited self-reported practitioner race and ethnicity data, it is difficult to provide an accurate comparison between the self-reported practitioner data and the member population data.

Opportunities:

- To improve the internal data limitations, SilverSummit Healthplan will encourage practitioners and members to self-report their race, ethnicity, and language.
- SilverSummit Healthplan will continue to recruit/credential all non-par practitioners in its service area, as well as those new practitioners that relocate to the service area, to ensure the practitioner network represents a diverse group of practitioners.
- The health plan will also continue to support practitioners in their efforts to provide culturally responsive and linguistically appropriate care and covered services to members by providing annual cultural humility training.

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 12/2023, increase cultural sensitivity/humility training of SilverSummit Healthplan network practitioners by 5% from the previous year rate of 26%.

Methodology

To ensure the network maintains a high level of awareness to culturally sensitive topics or situations, SilverSummit Healthplan supports practitioners in their efforts to provide culturally responsive and linguistically appropriate care and covered services to members. Providers are reminded annually of their responsibility to take cultural humility training through an annual provider newsletter or update.

Practitioners may also call the toll-free Provider Relations number with any questions about cultural or linguistic issues.

Results

Table 22. *Practitioner Cultural Humility and/or Language service training*

	2022		2023	
	f	%	*f*	%
Cultural training	21	22%	42	23%

Analysis

SilverSummit Healthplan received attestations from practitioners who completed cultural humility, cultural competency, or other such training, to assess the practitioner network's ability to deliver culturally appropriate care to members. Evaluation of the data demonstrate that providers are not engaged in enhancing their cultural competence and that there is an opportunity for the health plan to provide a deeper understanding of cultural humility, its significance in healthcare, and strategies for promoting cultural inclusivity. The results show the rate of completion did not meet the goal of increasing cultural sensitivity/humility training of network practitioners by 5%.

When performance falls short of goals, the organization **conducts a root cause analysis or barrier analysis** to identify why goals were not achieved. Analysis of the findings included Grievance & Appeals Sr. Manager, Vice President of Population Health Management, Provider Relations Sr. Manager, Network Development & Maintenance Director, Vice President of Network Development & Contracting, and a member experience Specialist, Sr. Manager, Sr. Director of Quality Improvement, and the Provider Advisory Board. The group has experience and is involved with processes that present barriers to improvement. It was determined the goal was not met due to poor completion rate of the trainings and barriers related to self-attestation.

Barriers:

- Limited practitioner participation in completing the self-reported attestation for the State required Cultural Humility and Language Services Training.

Opportunity identified:

- Improve participation and attest that practitioners will respectfully treat our members with cultural humility and provide language services options offered by the Plan. By 12/2024, the Network Development and Contracting department will launch a campaign to encourage network practitioners to participate in the annual Cultural Humility and Language Services training course and/or attest to completing a course(s).

F. 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 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 analyze data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.

Domain: Data and Infrastructure
Objective: Assess SMART goals / objectives identified in CLAS Program Description

Domain: Data and Infrastructure	
Evaluation Requirement: On an annual basis, the health plan evaluates the percentage of direct data on 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 12/2023, member services will have a script and has been trained how to obtain REL member data during member calls to increase the percentage of direct data.
Objective:	By 12/2023, health plan has a documented process for utilizing 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:	CAHPS results from MY-2023, improve the survey response rate of members who identify as Hispanic or Latino.

Methodology

Member race and ethnicity demographics are obtained, and findings are reported for health plan members, if enrolled prior to the fourth quarter, annually. Approximately 32 members were excluded from the analysis, due to either missing race and/or ethnicity demographics reported, loss to follow-up, or if the member did not meet the enrollment deadline inclusion criteria. Data are indicated as Unknown/Not provided.

Results

Table 23. *Direct Member Race and Ethnicity Data*

	Membership 2022		**Membership 2023**	
	f	**%**	***f***	**%**
Race				
American Indian and Alaska Native alone, not Hispanic or Latino	2,069	1.5%	1,887	1.5%
Asian alone, not Hispanic or Latino	12,040	8.7%	7,519	5.9%
Black or African American alone, not Hispanic or Latino	34,935	25.2%	31,893	25.1%
Native Hawaiian or Other Pacific Islander alone, not Hispanic or Latino	0	0.0%	3,198	2.5%
White alone, not Hispanic or Latino	34,500	24.9%	33,222	26.2%
Other			11,662	9.2%
Unknown/Not reported	54,923	39.7%	32	0.0%

	f	%	*f*	%
Ethnicity				
Hispanic or Latino	4	0.0%	37,427	29.5%
Non-Hispanic or Latino	31	0.0%	89,362	70.5%
Unknown/Not provided	138,432	100.0%	32	0.0%

When less than 80% of direct member data are available, indirect data are evaluated.

	Membership 2022		Membership 2023	
	f	%	*f*	%
Race				
American Indian and Alaska Native	197	0.3%	173	0.1%
Asian	4,255	5.8%	3,396	2.6%
Black or African American	9,545	13.0%	7,880	6.1%
Native Hawaiian or Other Pacific Islander	497	0.7%	393	0.3%
White	34,752	47.3%	28,666	22.0%
Unknown/Not provided	24,148	32.9%	89,680	68.9%
Ethnicity				
Hispanic or Latino	22,985	31.3%	18,588	14.3%
Non-Hispanic or Latino	49,246	67.1%	40,508	31.1%
Unknown/Not provided	1,163	1.6%	71,092	54.6%

Quantitative Analysis
Year over year membership trends show a slight decrease in the percentage of members who identify as Asian and increase in percentage of Native Hawaiian or Other Pacific Islander, an increase in members who identify as Hispanic, and an increase in member's who chose to identify as Other. The unknown/not reported group decreased 39.7% sense 2022.

Year over year membership trends in the indirect data show decrease in Asian, Black or African American, White, Hispanic and Non-Hispanic members. Unknown/not provided rates in both race and ethnicity increased.

Overall, the above results show SilverSummit Healthplan has been successful increasing the percentage in collection of direct member data.

Qualitative Analysis
The health plan collects and maintains member demographic data including race, ethnicity, and language received from various sources such as state or federal electronic file feeds (primary source). The 834 Enrollment forms are used to capture member reported demographic data including race, ethnicity, preferred language, alternate format preferences (audio, Braille, large print, and machine-readable electronic formats), and disability status. Post enrollment, direct methods are available to obtain the member's race, ethnicity, and language (REL) data. Additionally, Centene utilizes the analytics and artificial intelligence services of Ethnic Technologies (E-Tech), which acquires race and ethnicity data from external sources, to predict a person's ethnicity based on first name, surname, and nine-digit zip code. When member reported data is not sufficient, the health plan uses Census data, indirect race and ethnicity estimations, and local data sources to aid in creating a demographic profile and understanding of their needs and preferences.

If performance falls short of goals, the organization **conducts a root cause analysis or barrier analysis** to identify why goals were not achieved. Analysis of the findings included the Health Equity Improvement Committee and Quality Improvement Committee. The group has experience and is involved with processes that present barriers to improvement.

There are limitations to capturing member race and ethnicity data because race and ethnicity are optional questions on Enrollment forms members complete and is housed in the 834 file. Post enrollment, direct methods are available to obtain the member's race, ethnicity, and language (REL) data; however, members are not required to disclose this information. Recognizing that individuals may be reluctant to share personal information for many reasons (i.e., fear of discrimination and/or not identifying with the options provided), Centene utilizes supplemental data sources from E-Tech to predict a person's race and ethnicity to aid in creating a more robust demographic profile when needed.

Barriers:

- Race and ethnicity are optional questions on Enrollment forms members complete and is housed in the 834 file. Post enrollment, direct methods are available to obtain the member's race, ethnicity, and language (REL) data; however, members are not required to disclose this information.

Opportunity Identified:

- By 12/2024, HealthPlan will maintain 90% or greater in collection of direct members REL data.

G. State Requirements Related to Behavioral Health (NRS 422.2734)

<table>
<tr><td colspan="2">Evaluation Requirement: On an annual basis, the health plan evaluates the
▪ Identification of disparities in the incidence of behavioral health problems, in access to or usage of behavioral health services and in behavioral health outcomes based on race, color, ancestry, national origin, disability, familial status, sex, sexual orientation, gender identity or expression, immigration status, primary language and income level, to the extent that data is available to identify such disparities;
▪ Strategies for reducing the disparities identified pursuant to paragraph (a) and the rationale for each strategy;
▪ Mechanisms and goals to measure the effectiveness of the strategies prescribed pursuant to paragraph (b) and, if applicable, the degree to which the managed care organization has achieved goals set forth in previous plans;
▪ Strategies for addressing trauma and providing services in a trauma-informed manner; and
▪ Strategies for soliciting input from persons to whom the managed care organization provides services and other interested persons.</td></tr>
<tr><td>Objective:</td><td>By 12/2023, will have a documented process for soliciting input from persons to whom the managed care organization provides services and other interested persons.</td></tr>
<tr><td>Objective:</td><td>By 12/2023, will Improve Cultural Competency program staffing infrastructure to meet the needs of diverse community.</td></tr>
<tr><td>Objective:</td><td>By 12/2023, will develop and recruit members for the Cultural Competence BH Disparities Committee.</td></tr>
</table>

SilverSummit Healthplan analyzed prior years CLAS materials to determine whether there is an opportunity to improve diversity, equity, inclusion or cultural humility reporting in the utilization of behavioral health services.

Prior data for behavioral health penetration rates show 4.3% of membership population had at least 1 BH claim during the prior year. However, there is no current demographic breakdown for race, gender or other demographic fields to identify disparities within the utilization population. Director of Behavioral Health and Special Programs was hired in November 2023 to assist with the identification of behavioral health disparities and capturing appropriate data to develop those strategies.

In December 2023, the behavioral health disparity committee was created and notice of upcoming meetings added to the healthplan website and dispersed during the member advisory council to illicit community partnership.

H. Barrier Analysis

In Q2 2024, the Health Equity Improvement Committee, consisting of leadership from Quality, Population Health, Community Solutions, Operations, and Network Development & Contracting completed the analysis utilizing the quality data included in this report. The group assessed and prioritized the opportunities for feasibility and impact.

Domain: Governance, Leadership, and Workforce	
Barrier:	Constraints on time or other resources may hinder leaders' ability to dedicate sufficient attention and resources to DEI initiatives.
Priority:	Medium
Assessment:	Selected: To improve leaderships understanding/implementation of diversity, equity, inclusion or cultural humility in the workplace.
Intervention:	By 12/2024, utilize the Health Equity Improvement Committee to share specific informational sessions developed in partnership with the NV DEI Council on diversity, equity, and inclusion, as well as cultural humility and discuss key findings with committee participants. Share updates and findings from the committee discussion with all leadership and/or governance bodies.
Measure:	Response rates for DEI metrics in the Centene Pulse Surveys
Method:	Trends in response rates year over year.
Data Source:	DEI metrics in the Pulse Surveys
Evaluation:	12/2024
Responsibility:	Nevada DEI Council Members and Health Equity Improvement Committee
Advisory Committee:	Quality Improvement Committee
Status:	*In progress*

Domain: Communication and Language Assistance	
Barrier:	Training on how to request video remote interpretation (VRI) and face-to-face (F2F) interpretation services for members.
Priority:	Medium
Assessment:	Selected
Intervention:	Ensuring frontline staff who speak directly with members are familiar with all the language services available to members and are at ease with correctly scheduling those services for members, may result in more members being satisfactorily connected to vital language services. This may also help with the opportunity noted from the member survey, whereby a potential lack of awareness by the member of the full range of language services available may be resulting in fewer requests for certain language services other than other-the-phone interpretation.
Measure:	Interpretation services used
Method:	Fewer requests for certain language services other than other-the-phone interpretation.
Data Source:	Survey results
Evaluation:	12/2024
Responsibility:	Quality Accreditation
Advisory Committee:	Quality Improvement Committee
Status:	Pending

Domain: Practitioner Network Cultural Responsiveness	
Barrier:	Limited practitioner participation in completing the self-reported attestation for the State required Cultural Humility and Language Services Training.
Priority:	Medium
Assessment:	Selected: to improve the practitioner completion rate of the cultural humility and language services training as evidence by self-reported attestation.
Intervention:	By 12/2024, increase participation in cultural sensitivity/humility training of SilverSummit Healthplan's network practitioners by 5% through the following interventions: communications with providers during, new provider orientations, quarterly JOC's, monthly meetings, web notifications and Quarterly newsletters.
Measure:	Collection of attestation form.
Method:	Number of attestations/total number of practitioners
Data Source:	Attestation forms
Evaluation:	12/2024
Responsibility:	Provider Relations
Advisory Committee:	Provider Advisory Board
Status:	In progress

Domain: Data and Infrastructure	
Barrier:	Race and ethnicity are optional questions on Enrollment forms members complete and is housed in the 834 file. Post enrollment, direct methods are available to obtain the member's race, ethnicity, and language (REL) data; however, members are not required to disclose this information.
Priority:	Low
Assessment:	Selected: to maintain 90% or greater in collection of direct members REL data.
Intervention:	By 12/2024, HealthPlan will maintain 90% or greater in collection of direct members REL data.
Measure:	Collection of member demographic data within 834 files.
Method:	% of members with REL data listed/total # of members
Data Source:	834 files
Evaluation:	12/2024
Responsibility:	Enrollment team
Advisory Committee:	Member Advisory Committee; Health Equity Improvement Committee
Status:	In progress

I. Overall Effectiveness

The Cultural and Linguistic Assistance Services Program Description, and CLAS Work Plan, and policy and procedures provided an effective framework for identifying the diverse cultural, language, and service needs of health plan's membership, analyzing results of race, ethnicity, language, disability, and disparity data, prioritizing opportunities for improvement, implementing interventions, and evaluating the effectiveness of actions taken. Health Plan leadership, along with Quality, and the QIC, which includes practitioner participation, provided effective oversight of the CLAS activities in 2023.

In addition, the CLAS Program Evaluation has substantive input and participation from the member community to ensure the needs of the population are identified and met. The Member Advisory Council 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 Committee is comprised of a diverse and demographically representative group of participants that reflect the community. As defined by the charter, the Member Advisory Committee 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 Community Advisory Workgroup reports at Provider Advisor Board meetings and the Population Health Management Committee. They meet quarterly to share issues and opportunities with the health plan. Meeting minutes and information are shared with plan leadership and incorporated into quality improvement projects to close gaps as appropriate. Community representatives offered valuable insights to help guide the CLAS program forward. SilverSummit Healthplan continues to be an organization completely devoted to cultural awareness and acknowledging and appreciating differences to advance health equity, improve quality and outcomes, and deliver the best care and service available. SilverSummit Healthplan will continue to evaluate the effectiveness of its CLAS Program in supporting the organization's mission and vision as processes continue to be improved, streamlined, and implemented. As appropriate, the CLAS Program will continue to adopt new efficiencies,

improved strategies, and in this way continue to ensure SilverSummit Healthplan delivers on its commitments to its members by evaluating the priority domains:

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

2024 goals will be developed using prior year (2023) outcomes as a baseline measure for future improvement opportunities. SilverSummit Healthplan has determined that our program is meeting the CLAS standards and restructure or changes are not indicated at this time.

SilverSummit Healthplan has reviewed the resources, program structure, participation of practitioners, community representatives, and leadership involvement in the program. Recommendations have been identified which outline our areas of opportunity and will be used to evaluate continued effectiveness.

III. Committee Reporting

To fulfill its responsibility to members, providers, the community and regulatory and accreditation agencies, the health plan has adopted the following Cultural Competence and Linguistic Assistance Services Program Description. The program description is 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. CLAS Program Evaluation was reported to the following QI committees:

Committee Name	MEETING DATE	COMMITTEE ACTIONS / RECOMMENDATIONS
Member Advisory Board	06/25/2024	

IV. 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. The program description is 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. CLAS Program Evaluation has been reviewed and approved as follows:

Approvals	
Oversight Body	**APPROVAL DATE**
Quality Improvement Committee	06/26/2024
Board of Directors	06/18/2024