Optimal Care for Every Community

This training is provided to comply with California law, including DHCS APL 24-016. Its purpose is to inform respectful care for all members, including individuals who identify as transgender, gender-diverse, or intersex (TGI). IEHP acknowledges that federal policies may define gender differently; however, as a Medi-Cal managed care plan operating under California law, we are required to provide this training and ensure access to care for all members.

The goal of this training is to educate IEHP health care professionals on how to provide medically necessary and covered services to all members in a culturally and linguistically appropriate manner regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, disability, or gender identity.

The table of contents below identifies the five main sections of the course. Each section contains hyperlinks to the individual topics they contain.

Note: All course content and image citations are contained in a separate document. To request a copy of this document, please email IEHP Learning and Development.

IEHP Member Population

By the end of this section, you will be able to:

1. Describe IEHP's diverse member demographics.
2. Describe IEHP's data policy and procedures for proper gathering, management, and communication of protected health information (PHI).

Note: At this time, IEHP does not collect the following member demographics: ancestry, creed, national origin, color, or genetic information.

IEHP Member Demographics

Who are IEHP Members?

IEHP is committed to delivering health care services that are respectful and responsive to the access and cultural needs of our members and to do this, it is important to understand the population we serve.

IEHP provides health care services to about 1 in 3 residents in the Inland Empire (as of 3/2023).

"We are all different, which is great because we are all unique. Without diversity life would be very boring." - Catherine Pulsifer

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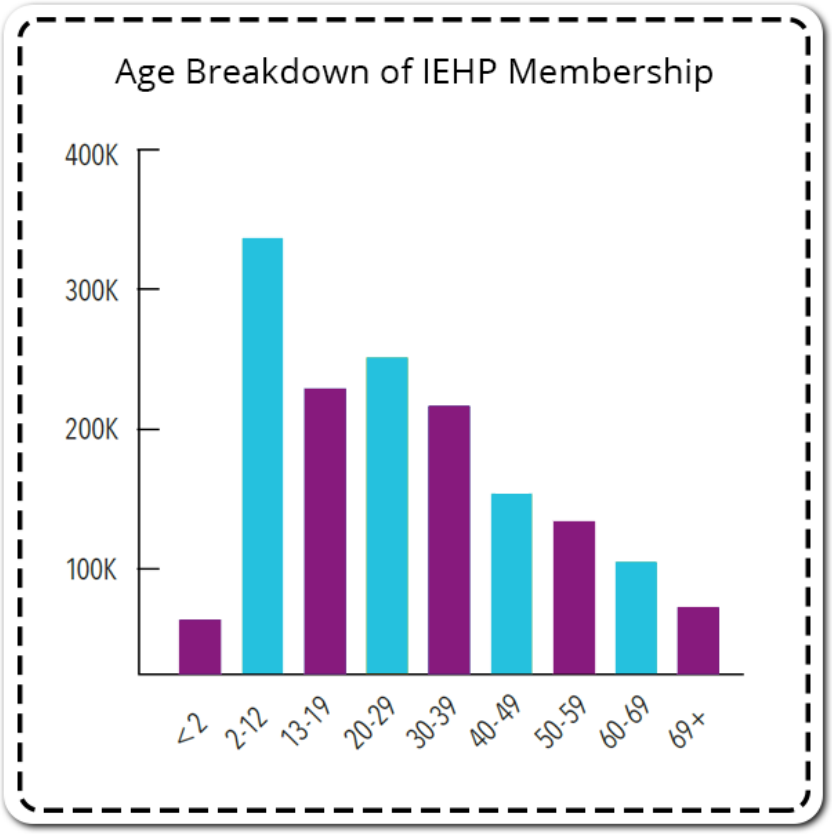
IEHP Member Age

Over 67% of IEHP members are between the ages of 2 to 39 while the majority of D-SNP members are over the age of 60.



IEHP Member Language

Although IEHP serves a large Hispanic population, over 78% of members across all of our product lines, IEHP Covered, Medi-Cal and IEHP DualChoice (also known as HMO Dual Special Needs Plans or D-SNP), use ENGLISH as their language of choice followed second by over 20% of members who use Spanish. This means that most Hispanic members are not first generation.

Some IEHP members prefer threshold languages which are languages other than English spoken by 5% of IEHP's population or by 1,000 eligible individuals, whichever is less.

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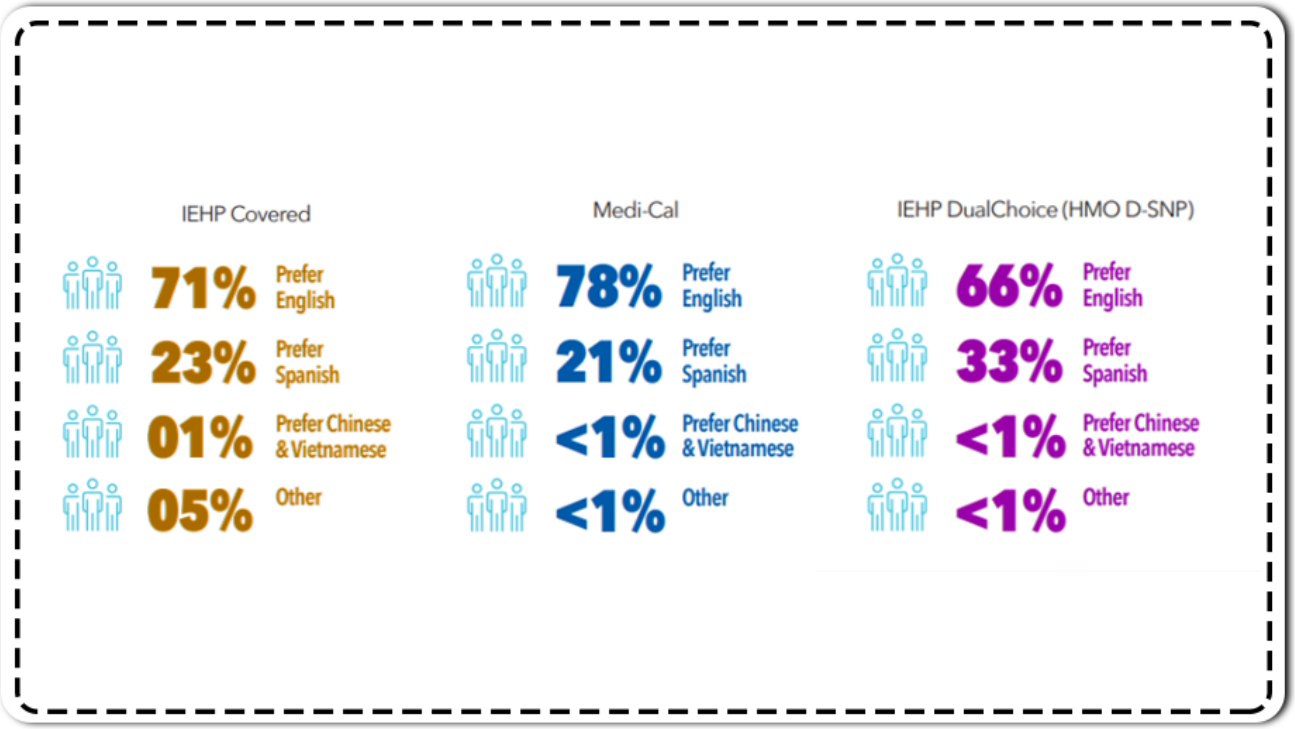
IEHP's threshold languages are Spanish, Chinese and Vietnamese.



IEHP Member Marital Status

When surveyed, only 13% of members reported their marital status. The top three responses in order were single, married, and divorced.

IEHP Member Gender

This training is provided to comply with California law, including DHCS APL 24-016. Its purpose is to inform respectful care for all members, including individuals who identify as transgender, gender-diverse, or intersex (TGI). IEHP acknowledges that federal policies may define gender differently; however, as a Medi-Cal managed care plan operating under California law, we are required to provide this training and ensure access to care for all members.

Gender Diversity: Part of understanding IEHP's member diversity means that we need to understand some additional demographics related to our members' sex assigned at birth, gender identity and sexual orientation.

Sex Assigned At Birth: For the 12% of the IEHP member population that reported their sex assigned at birth across both Riverside and San Bernardino counties, 54% of IEHP members were assigned as female at birth.

Gender Identity: For the 12% of the IEHP member population that reported their gender identity across both Riverside and San Bernardino counties, the majority of IEHP's members identify as:

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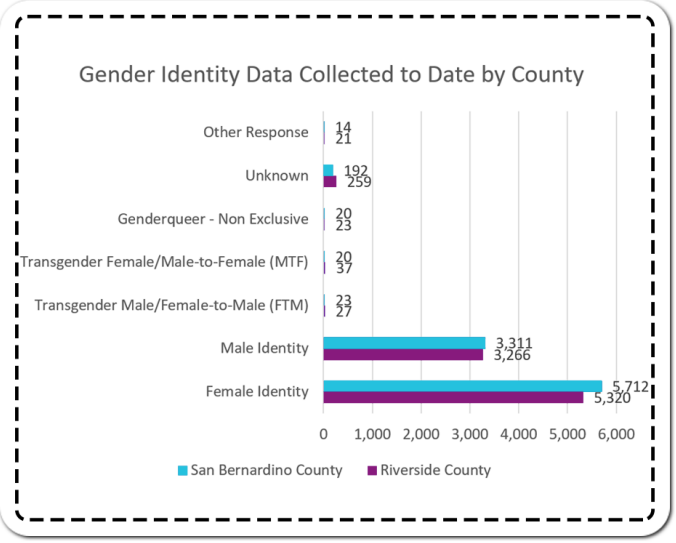
- Female (60%)
- Male (36%)
- Unknown (2%)

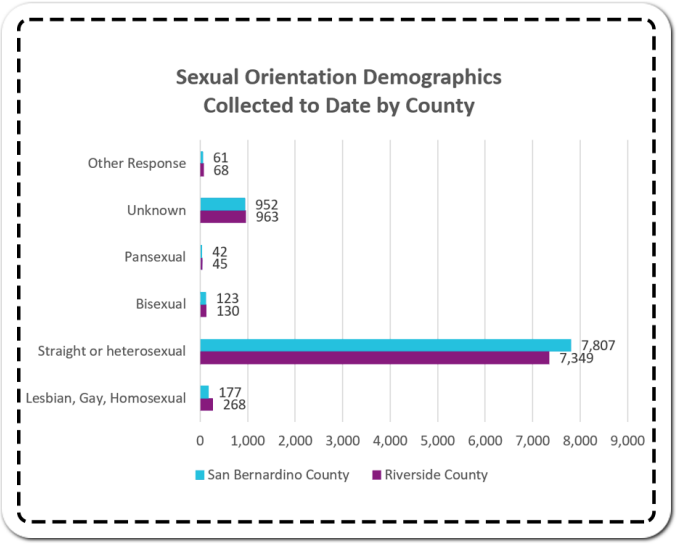
The chart below illustrates a breakdown for each gender identity category by county.



Sexual Orientation: For the 12% of the IEHP member population that reported their sexual orientation across both Riverside and San Bernardino counties, the majority of IEHP's members identify as:

- Straight or Heterosexual (84.2%)
- Unknown (11%)
- Lesbian/Gay (2.4%)

The chart below illustrates a breakdown for each sexual orientation category by county.



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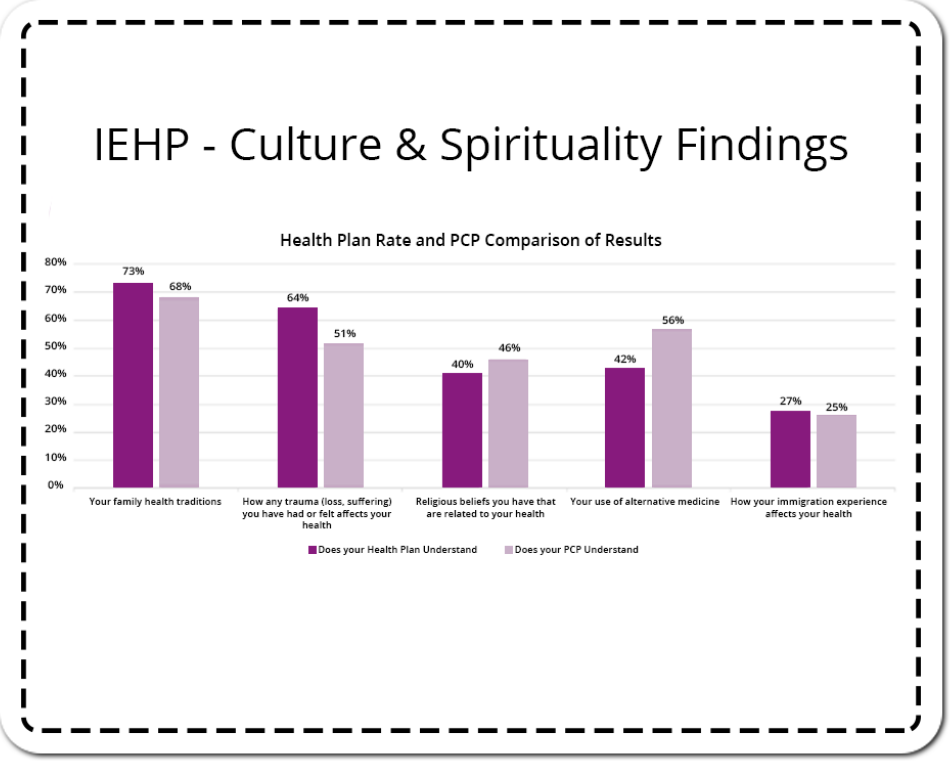
IEHP Member Spirituality and Religion

Religion and spirituality encompass the beliefs, practices and personal networks that are connected to how a person discovers and interprets significance and meaning in their life.

Religious Affiliations: Catholic, Christian, and Non-Denominational are the top three religious affiliations identified by the 13% of IEHP's members that provided survey data.

143 IEHP members were surveyed on culture and spirituality. 40% felt that IEHP understood their religious beliefs related to their health as compared to 46% that indicated their primary care physician (PCP) understood their religious beliefs related to their health.



IEHP Member Race and Ethnicity

What is the difference between race and ethnicity? Let's look at some definitions:

Race: "A biological categorization of genetically transferred physical characteristics (e.g., skin color, eye color, hair color, bone and jaw structure)."

Ethnicity: "A shared culture and way of life, especially reflected in language, religion, and material culture products...."

Diversity: The presence of "racial/ethnic and linguistic groups that constitute at least 5% of the community or population of individuals served."

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While IEHP serves a diverse population, most IEHP members in both D-SNP and Medi-Cal are Hispanic.

- Hispanic: 58%
- Caucasian: 16%
- Black or African American: 8%
- Asian or Pacific Islander: 4%
- Other Race or Ethnicity: 1%
- Not Reported: 13%

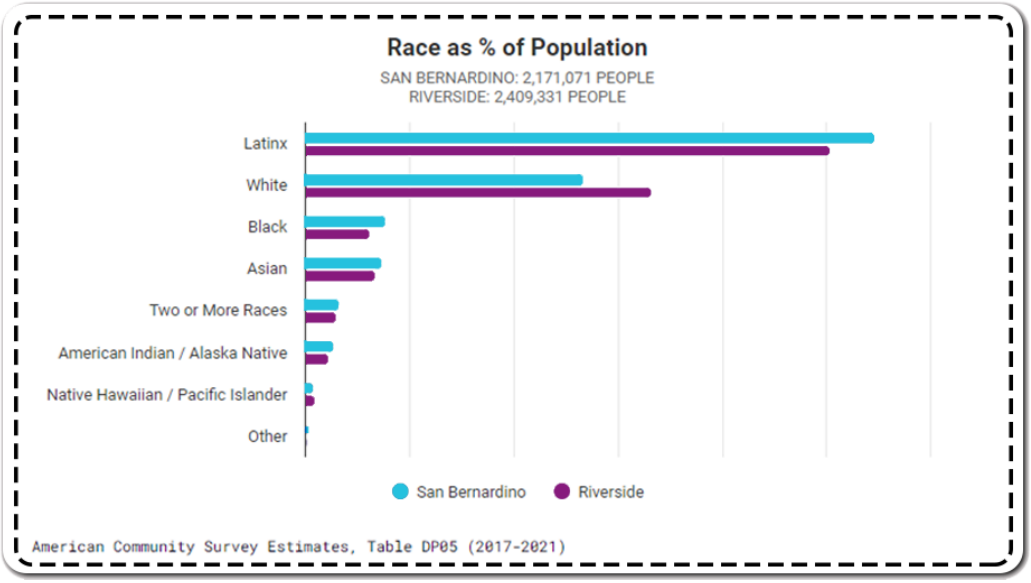
The Inland Empire is one of the most diverse regions in California. Demographic data for the Inland Empire projects an overall population growth of 3.7% by 2027.

The fastest growing ethnic group is multi-racial; the Hispanic/Latino and Black/African American populations will continue to grow at a slightly higher rate than the White population.

The 65+ population will grow by 13%, while the number of children ages 1–17 is projected to decline by 0.7%.

Understanding the cultural groups that make up the Inland Empire and IEHP's diverse population will help to better serve our members and target health disparities. In order of highest population, the predominant cultural groups in the Inland Empire are Latinx, White, Black and Asian.

Latinx is a person of Latin American origin or descent (used by some individuals as a gender-neutral or nonbinary alternative to Latino or Latina).



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IEHP Member Health Status and Medical Conditions

Hypertension is the top chronic condition among IEHP's membership followed by back pain, hyperlipidemia, vitamin D deficiency, and gastroesophageal reflux disease (in no specific order).

Top 10 Medical Diagnoses For Medi-Cal

1. Hypertension
2. Hyperlipidemia
3. Obesity
4. Vitamin D deficiency
5. Other long-term drug therapy
6. Type 2 diabetes mellitus without complications
7. Anxiety disorder
8. Low back pain
9. Gastroesophageal reflux disease without esophagitis
10. Chronic pain

Top 10 Medical Diagnoses For D-SNP

1. Hypertension
2. Hyperlipidemia
3. Type 2 diabetes mellitus without complications
4. Other long-term drug therapy
5. Vitamin D deficiency
6. Gastroesophageal reflux disease without esophagitis
7. Mixed hyperlipidemia
8. Presbyopia
9. Type 2 diabetes mellitus with other specified complications
10. Low back pain

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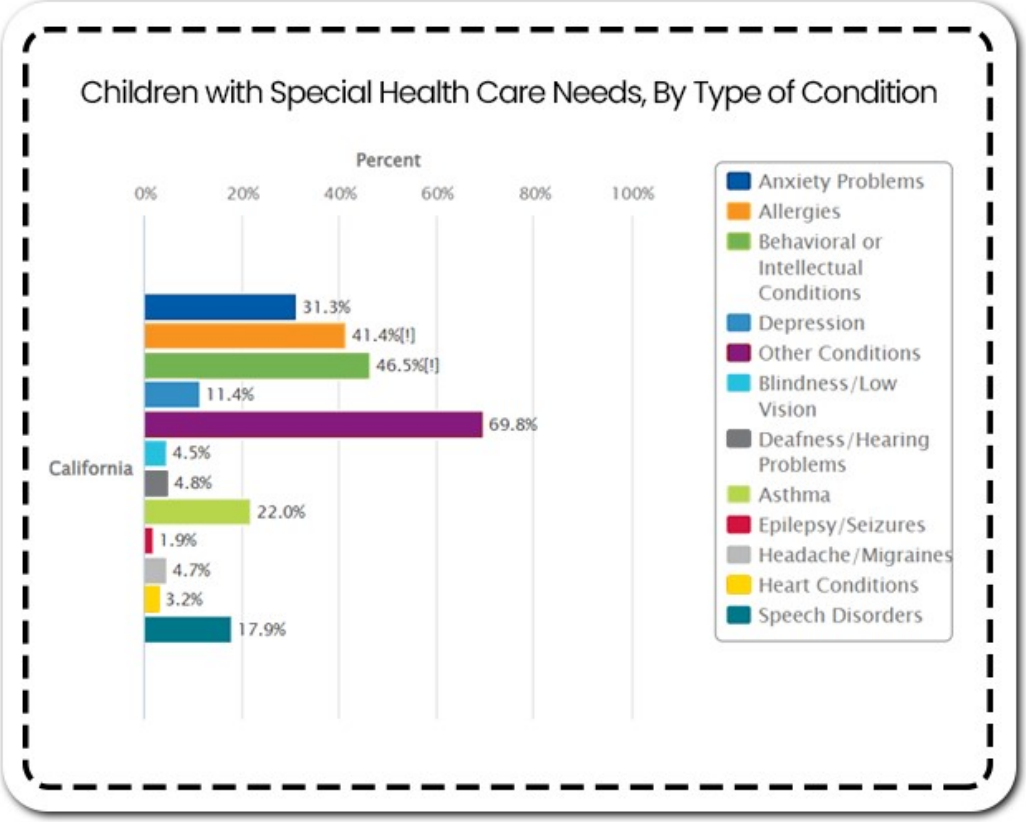
Children with Special Health Care Needs

According to the California Department of Public Health, “children and youth with special health care needs (CYSHCN) include infants, children, and youth from birth to age 21 who have one or more chronic, physical, developmental, behavioral, or emotional conditions, and require special health and support services.”

These conditions include but are not limited to asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders. There is a prevalence of 18% of CYSHCN in San Bernardino County as compared to 15.4% in Riverside County.



Barriers to Care

Statewide and nationally, around 9 in 10 CYSHCN do not receive care in a well-functioning system of services. Barriers to care include a fragmented system of services, limited workforce of pediatric subspecialists, and social factors such as poverty and discrimination influence access to care and health outcomes.

According to the California Department of Public Health, only 12.5% of CYSHCN received care in well-functioning systems in California in 2020-2021.

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Health Disparities

Disparities faced by CYSHCN as compared to peers without special health care needs include but are not limited to:

1. Greater exposures to family poverty and other adversities.
2. Parents are more likely to have difficulties with child care arrangements that require them to change jobs.
3. CYSHCN miss more school days and are more likely to repeat a grade.

Members with Substance Use Disorders (SUDs)

Drug overdose deaths have increased in California from 10.7 per 100,000 in 2011 to 26.6 per 100,000 in 2021. Over the same period, drug overdose death rates increased from 13.2 to 32.4 per 100,000 in the U.S. Opioid overdoses are the primary driver of increases in drug overdoses.

Substance use disorders (SUDs) appear to be equally prevalent among Whites, Latinos, and Blacks (approximately 8%).

Alcohol-related Disorders

Disparities faced by CYSHCN as compared to peers without special health care needs include but are not limited to:

1. More severe alcohol problems among Latinos than among Whites.
2. Higher rates of injuries attributable to alcohol among American Indians.
3. Disproportionately high rates of alcohol-attributable injury and mortality for Blacks and Latinos.

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Barriers to Treatment

Barriers to finding treatment may vary by personal situation but the most common barriers include:

1. Financial/cost
2. Geographic location
3. Stigma
4. Co-occurring disorder availability

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “low barrier care for individuals with SUDs is a critical way to address substance use challenges. Low barrier models focus on availability, flexibility, responsiveness, a collaborative approach to the needs and interests of the individual and promoting a culture of learning and evaluation.”

A low barrier model would include:

1. Flexible scheduling and walk-in services
2. A non-punitive approach to ongoing substance use
3. Decreased stigma about SUD compared to traditional care settings
4. Incorporation of patient goals and choice into medication decisions
5. Telehealth and in-person services availability – this is important for individuals in remote or underserved areas, eliminating transportation barriers

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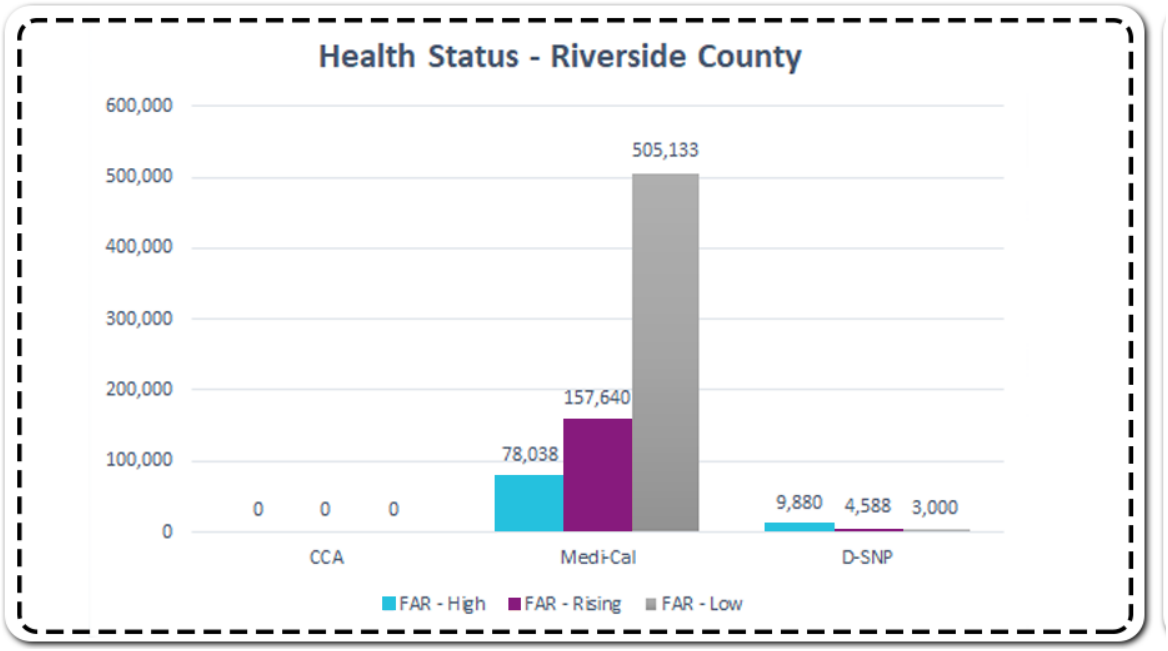
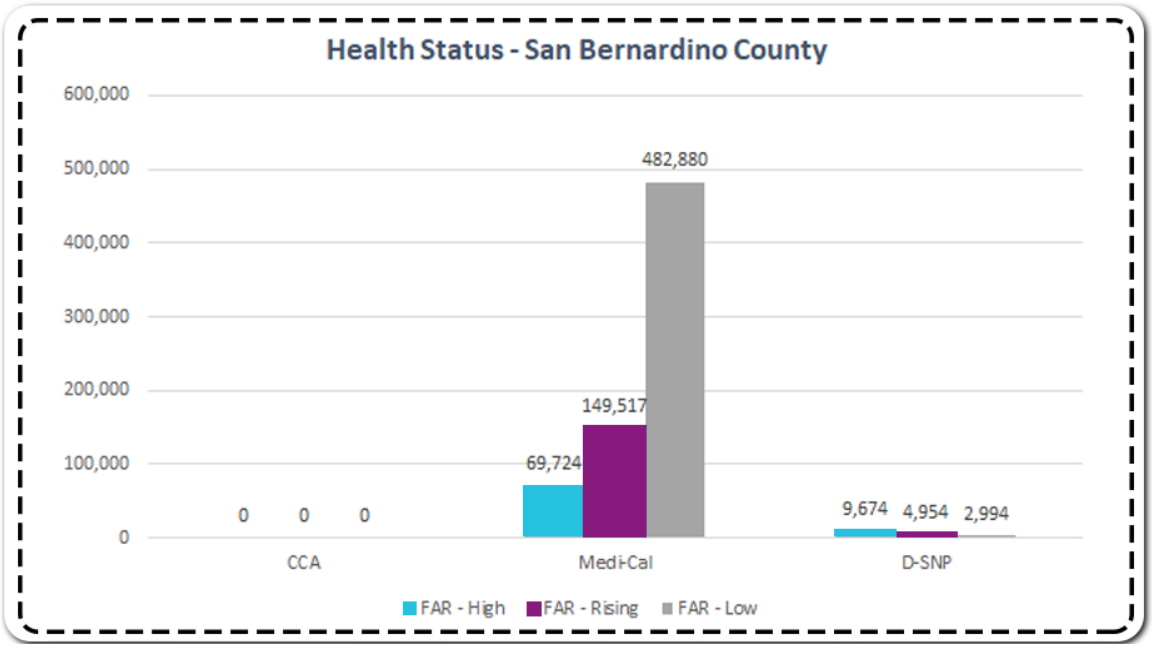
Across Riverside and San Bernardino counties, similar numbers of IEHP members experience low health statuses or are persons with mental and physical disabilities.

Health Status: About 500,000 IEHP Medi-Cal members reported a low health status in both Riverside and San Bernardino County.





*Note: The Finalized Administrative Risk (FAR) score is used as a measure of morbidity.

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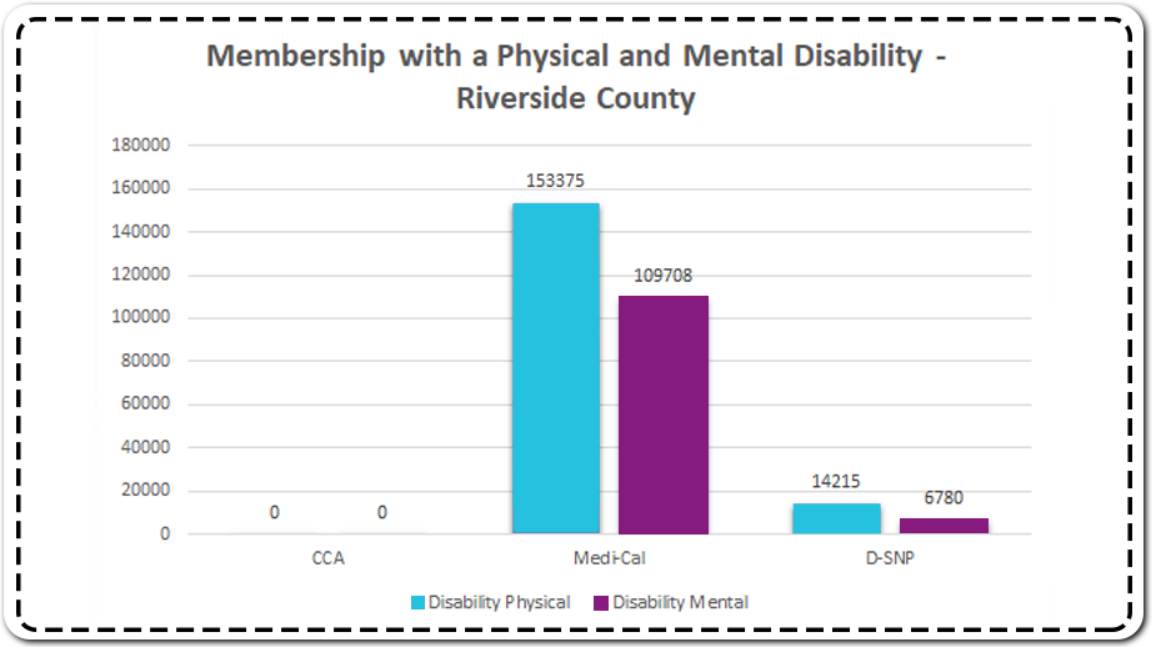
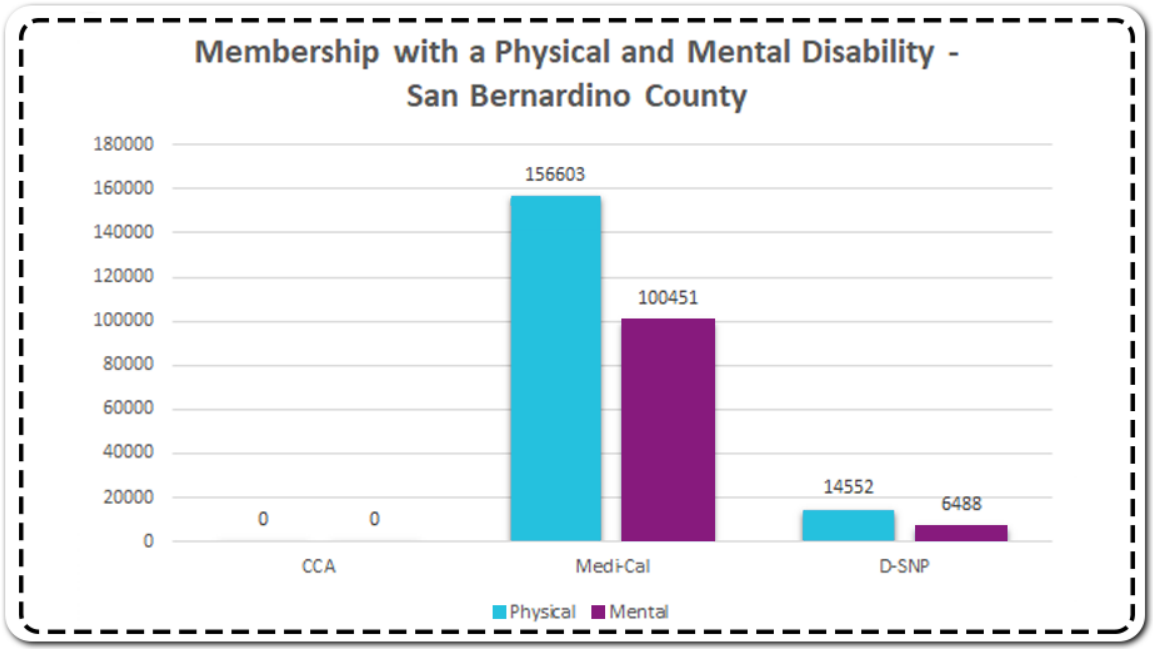
Mental & Physical Disability: As of March 2024, of IEHP's 1.5+ million members, over 160,000 are seniors and persons with disabilities (SPD).





These SPD members require a higher level of care management as they are identified as high risk and represent 4.5% of IEHP's total member population.

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Health Inequities in Riverside and San Bernardino Counties

According to the 2022 Community Needs Assessment, the top four health inequities impacting the Inland Empire as compared to the overall state benchmark are:

1. Mental Health Care Providers: number of mental health care providers per 100,000 people
2. Hypertension Deaths: number of deaths due to hypertensive heart disease per 100,000
3. High Cholesterol: adults 18+ reporting high cholesterol
4. Diagnosed Diabetes: adults 20+ who have been told they have diabetes including gestational

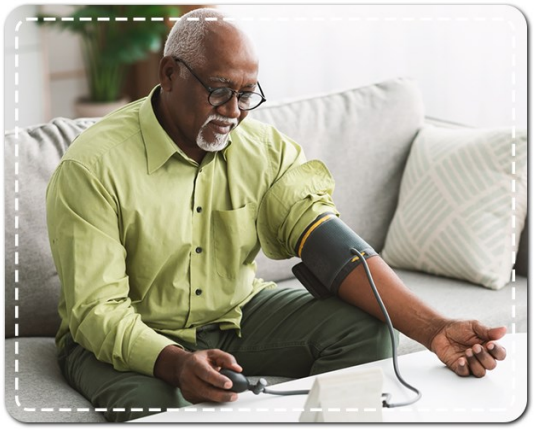
Health Inequities for IEHP Members

All health plans that deliver hospital, medical, or surgical services and/or behavioral health services are required to report on all 13 Health Equity and Quality Measure Sets (HEQMS). Certain measures have been identified in which IEHP ranks below the 50th percentile nationwide.

American Indian and Alaska Natives: American Indian and Alaska Natives have been identified by HEQMS as a disparity group for IEHP for the following quality measures:

1. Breast cancer screenings
2. Child and adolescent well-care visits
3. Immunizations for adolescents-combo 2
4. Well child visits in the first 30 months of life

Black or African Americans: Black or African Americans have been identified by HEQMS as a disparity group for IEHP for the following quality measures:



1. Asthma medication ratio
2. Prenatal and postpartum care
3. Controlling high blood pressure
4. Hemoglobin A1c control for patients with diabetes
5. Childhood immunization status with lead screening-combo 10

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Hispanics: Hispanics have been identified by HEQMS as a disparity group for IEHP for the following quality measure:

1. Hemoglobin A1c control for patients with diabetes – A1C < 8

Asian/Pacific Islanders: Asian/Pacific Islanders have been identified by HEQMS as a disparity group for IEHP for the following quality measure:

1. Cervical Cancer

Mario's Story: A Health Disparity Group Example

Meet Mario: To help gain a better understanding of how health disparities might affect a member from an IEHP disparity group, review Mario's story below.

Mario: Mario, an IEHP member, is a 58-year-old Hispanic/American Indian male with history of uncontrolled type 2 diabetes, high blood pressure and high cholesterol.

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Mario's Family: Mario is part of a low-income, multi-generational household. He lives with his wife, adult daughter who is currently pregnant, and his daughter's three children.

Mario's Grandchildren: One of Mario's grandchildren has a history of childhood obesity and high cholesterol while another was diagnosed with asthma and missed his adolescent immunizations; the youngest has missed child immunizations and well-care visits.

Mario's Wife: Mario's wife does not have health insurance and has a history of missing her breast cancer screenings. Their daughter is often a source of conflict as she is his wife's daughter from a previous relationship.

Effect on Mario's Health: While Mario's wife attempts to cook healthy meals for the family, Mario often chooses to eat the unhealthy food and snacks his daughter and grandchildren continue to bring into the home.

Mario is having a difficult time coping and managing his chronic conditions and their possible outcomes. While he understands how stress and poor nutrition contribute to his declining health, he feels powerless and unable to make changes.

Interventions: How can IEHP help individuals in disparity groups to overcome these health challenges? In Mario's case, possible interventions include:

1. Assigning Mario to enhanced care management
2. Conducting home visits (by a nurse case manager, social services case managers, and health education)
3. Assisting Mario and his daughter with enrolling in Cal-Fresh
4. Assisting Mario's wife with enrolling in Medi-Cal

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IEHP Member Data Policies

How Does IEHP Protect Member Data?

IEHP is committed to protecting member information, which may include sensitive information. Sensitive information includes protected health information (PHI), "...as defined under HIPAA regulations, and other personal, private health information."

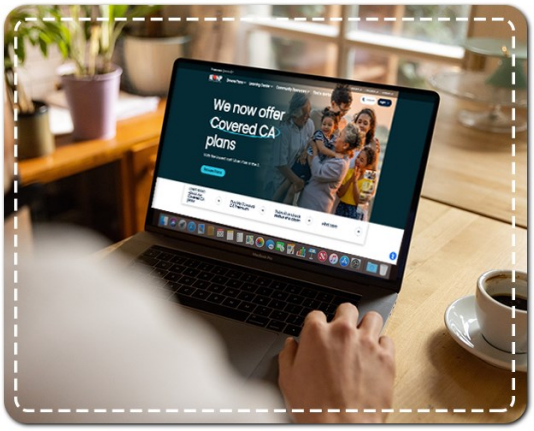
IEHP's Notice of Privacy Practices policy also outlines how the plan protects the privacy and confidentiality of our members' sensitive information.

This includes protected health information (PHI) such as race/ethnicity, language, gender identity and sexual orientation, and how it will be used and disclosed.

"We do the right thing by placing our members at the center of our universe." - IEHP

Notice of Privacy Practices

In accordance with HIPAA, after IEHP provides the Notice of Privacy Practices to new members upon enrollment, they will continue to receive them on an annual basis. Members have the option to receive an electronic or paper copy of the notice and have the right to request a paper copy of the Notice of Privacy Practices at any time.



Members can also find IEHP's Notice of Privacy Practices on our website at: www.iehp.org.

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Type of Information: The Notice of Privacy Practices describe the type of information IEHP may use or share. This includes, but is not limited to member:

1. Name
2. Address
3. Personal facts
4. Medical care given
5. Medical history
6. Other information such as race/ethnicity, language, gender identity and sexual orientation

Disclosure of Information: The Notice of Privacy Practices describe how member medical information may be used and disclosed. Member information may be used or shared by IEHP only for:

1. Treatment
2. Payment
3. Health care operations associated with a particular program for which a member is enrolled

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Member Access to Information: The Notice of Privacy Practices informs members that when IEHP shares medical health information, members have the right to request a list of:

1. With whom IEHP shared the information with
2. When IEHP shared it
3. The reasons the data was shared

If material revisions are made to the Notice of Privacy Practices, IEHP provides members with the revised notice within sixty (60) days of the material revision.

Why does IEHP share member information?

For Treatment: A member may need medical treatment that requires IEHP to approve care in advance. In this instance, IEHP will share information with doctors, hospitals and others in order to get the member the care they need.

For Payment: IEHP reviews, approves, and pays for health care claims sent to us for member medical care. When we do this, we share information with the doctors, clinics, and others who bill IEHP for a member's care and we may forward bills to other health plans or organizations for payment.

For Health Care Operations: IEHP may use information in a member's health record to judge the quality of the health care received. We may also use this information in audits, fraud and abuse investigations, planning, and general administration.

For Public Health Activities: We may disclose a member's protected health information for public health activities, research, reporting purposes, and as required by law.

To read a full copy of the IEHP Notice of Privacy Practices click the following link: Privacy Practices.

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Cultural Competence for Team Members and Providers

By the end of this section, you will be able to:

1. Define structural/institutional racism.
2. Discuss the impact of structural and institutional racism on members, providers and IEHP team members.
3. Identify ways unconscious bias may impact or influence the way information about an individual is processed.
4. Explain the difference between health equity and health equality.

Structural & Institutional Racism

What is it?

The American Medical Association (AMA), states that structural racism "refers to the various ways in which societies cultivate racial discrimination through reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice."

Social and economic inequalities lead to racially discriminated populations being at greater risk for health inequalities, leading to poor health outcomes.

Structural and institutional racism can impact access to multiple social determinants of health (SDOH) including housing, education, wealth, and employment and cause harm to a person's health when racially discriminatory practices create obstacles to economic resources or opportunities.

Examples of Structural and Institutional Racism

One of the major contributors to health inequities across racial and ethnic minorities is lack of access to social and economic benefits, according to the CDC.

The CDC indicates that these groups experience higher rates of "illness and death across a wide range of health conditions including diabetes hypertension, obesity, asthma, and heart disease, when compared to their white counterparts."

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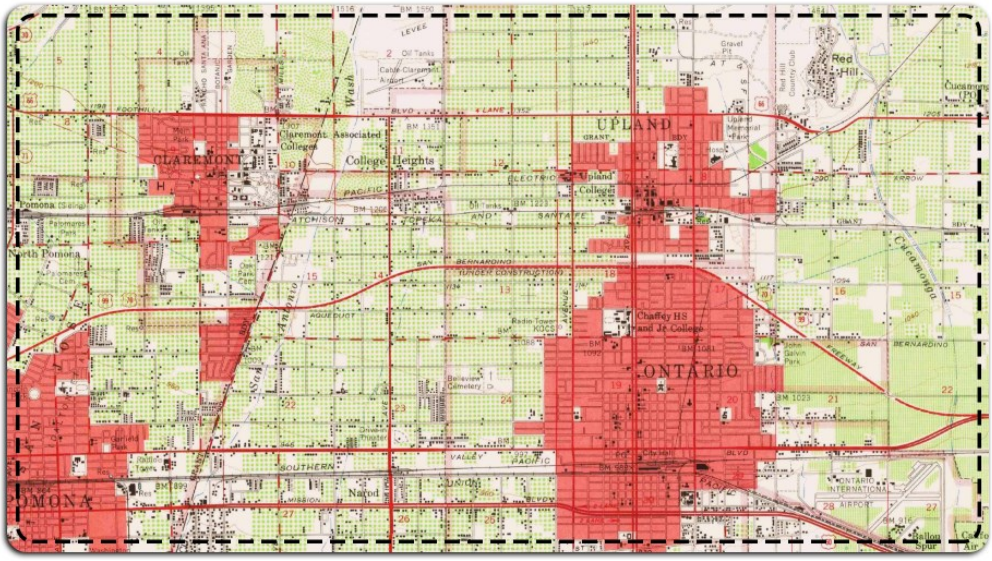
Redlining and Discriminatory Lending: During the Great Depression, residential neighborhoods were graded as low risk or “hazardous” (high risk) based on various factors, including their racial and ethnic makeup.



Neighborhoods with the presence of specific groups of people, (historically "black people or brown people, and/or Jewish people") were graded as red on Home Owners Loan Corporation maps, signifying they were thought to be hazardous or high risk.

The systemic denial of mortgage lending to residents of specific neighborhoods based on their race or ethnicity became known as redlining, and prevented certain groups from being able to own a home, accumulate wealth or finance a college education.

Redlining negatively impacted both individuals and communities by:

1. Reducing generation of property tax revenues for school funding
2. Limiting investment by developers into redlined neighborhoods
3. Reducing access to healthy food
4. Reducing access to adequate health care facilities

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Jim Crow Laws: In the late 19th and early 20th centuries state and local laws, known as the Jim Crow laws, enforced racial segregation.

These laws are thought to be a fundamental cause of inequities that led to predominately Black segregated neighborhoods typically having "fewer resources and opportunities that promote physical and mental health."

Racially segregated neighborhoods have felt the impact of economic disadvantages, including lack of accessible and quality employment and schools, and were often located near businesses known to cause negative health consequences, such as coal plants.

Today, discriminatory policies continue to impact people of color and leave many facing increased health risks. Lack of investment in areas where Black people are more likely to live has implications that lead to increased risks of limited educational and employment opportunities, limited transportation options, and limited access to healthy food. These factors can also make it more difficult to access quality health care and harder to engage in healthy activities.

Even today, structural racism continues to persist causing inequitable effects on health, making the importance of addressing systems and policies to dismantle structural racism crucial.

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Impact of Structural Racism on Members

The following example helps demonstrate how structural racism, and the health inequalities it creates, fostered intergenerational illness in an African American family.

Anna: Anna experiences depressive episodes and PTSD, which are often made worse when current events, like the murder of George Floyd in 2020, remind her of the historical trauma of her own parents Sarah and William.

Anna's Mother: As a child, Sarah was diagnosed and struggled with depression. Sarah's mother never sought treatment for her, as she believed that it was better to handle her daughter's illness on her own. She believed that instead of treating African Americans, psychiatrists would only lock them up in hospitals.

Anna's Father: William relocated to a large, urban city, to ease his mother's fears that he would be in danger after the lynching of Emmett Till in 1955. He was continually denied jobs due to what was said to be a lack of experience.

Anna's Childhood: During Anna's childhood, the family was repeatedly denied apartment rental opportunities, often with no reason for the denial or they were told it was because the neighborhood didn't rent to African Americans.

When Anna was 16, William was arrested and convicted of possession of marijuana and was sentenced to 15 years in prison for what was his first criminal offense. As a result, Anna was bullied at school by White students because of her father's incarceration.

For Anna, her family history of depression and trauma are directly related to her own experience of depression, and the persistence of her depressive symptoms has continued due to a multitude of factors including:

1. Difficulty navigating the health care system
2. Mistreatment by mental health care providers
3. Lack of access to affordable care
4. Lack of access to high-quality treatment

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Impact of Structural Racism on IEHP Health Care Professionals

Given that IEHP serves a diverse population, IEHP health care professionals are likely to be interacting with community members who have experienced racism and are subject to minority stress.

Minority Stress Defined: According to the American Psychological Association, minority stress is the physiological and psychological effects associated with adverse social conditions experienced by ethnic, racial, sexual, and gender minorities, and others who are members of stigmatized social groups. Common sources are:

1. Discrimination
2. Prejudice
3. Verbal violence
4. Physical violence

Minority stress stems from social processes, institutions, and structures beyond the individual events that characterize the stressors.

Lessening the Effects: IEHP team members and providers may not be able to remove the experience of minority stress from the community members they serve but they can lessen the effects on an individual's overall health and wellness.

Research shows that building coping skills and social support can counteract the impact of stress and can lead to better health outcomes.

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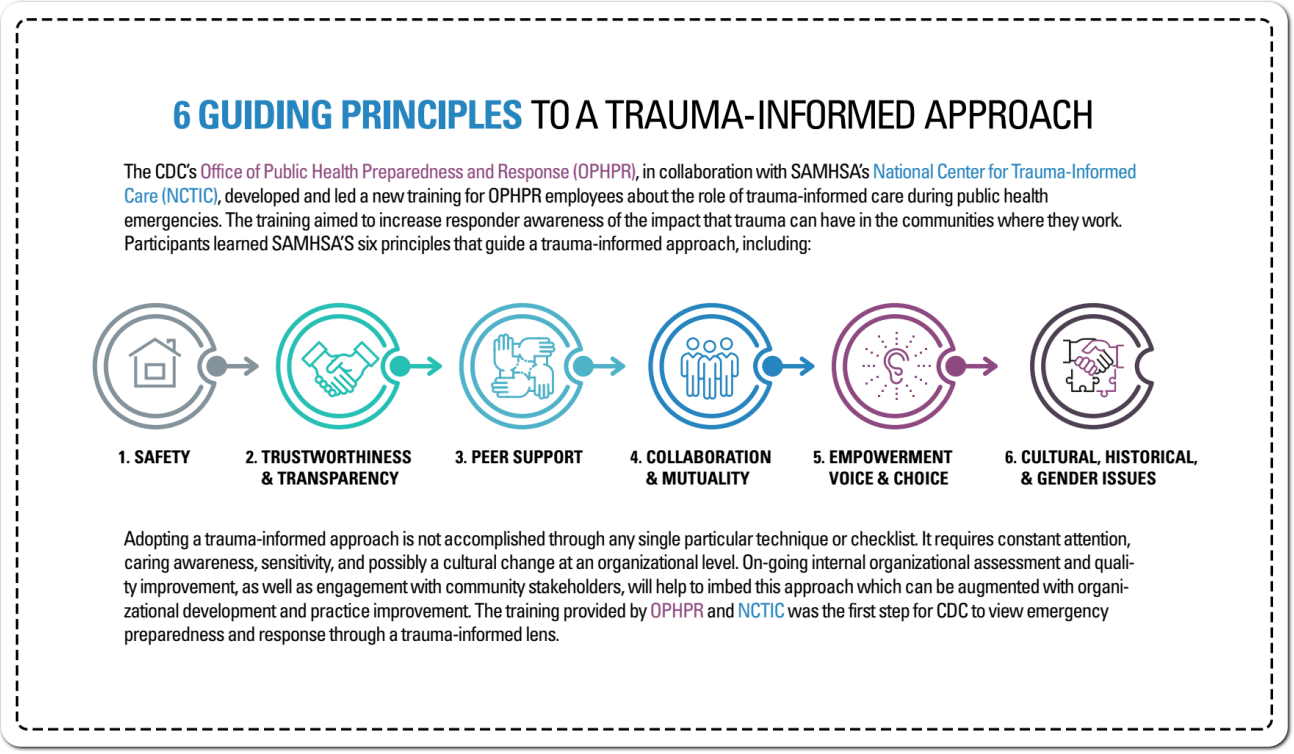
Providing "Trauma-informed" Care

According to the Trauma-Informed Care Implementation Resource Center, racism is an example of a traumatic event that can have long-term effects on a person's mental, physical, social, emotional, and/or spiritual well-being.

1. Shifts the focus from “What’s wrong with you?” to “What happened to you?”
2. Allows health care providers to deliver more effective health care services by being sensitive about the importance of understanding a patient’s life experience.
3. Provides improved patient and provider engagement, treatment cooperation, and health outcomes.
4. Improves health care professional wellness as it can reduce burnout and staff turnover.

Given the systemic roots of inequities, trauma-informed services require culturally responsive involvement across organizations, communities, and service sectors to reduce barriers, overcome stigma, address social adversities, and promote positive ethnic identities.

It is important for health care professionals to understand that historical, racial, and other intergenerational traumas are part of a person’s experience, and being trauma-informed means recognizing this and showing humility about the aspects of a person’s cultural experiences that are different from our own.



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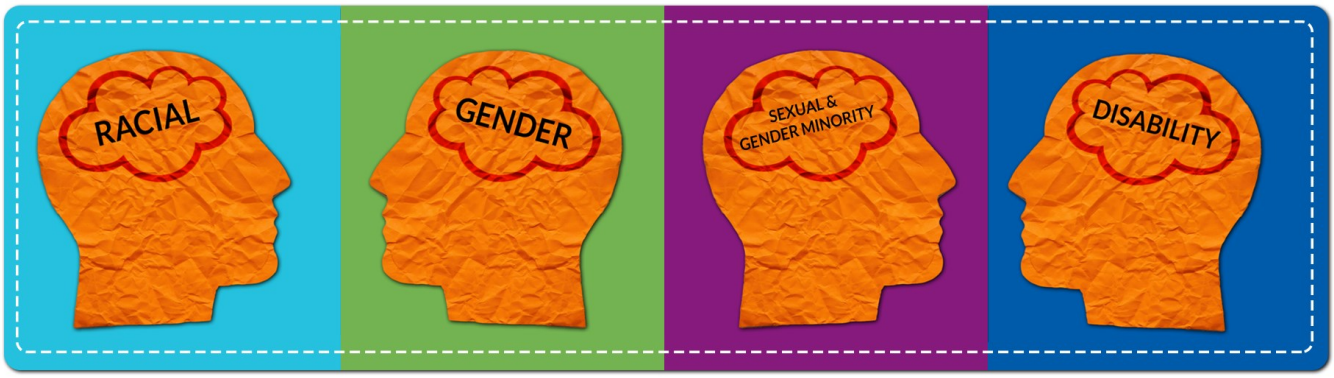
Unconscious Bias

What is Unconscious Bias?

Bias is defined as the tendency to favor one group over another. Biases can be favorable or unfavorable and can be unconscious (implicit or unintentional) or conscious (explicit or intentional).

Unconscious or implicit bias describes associations or attitudes that every person has that reflexively alter their individual perceptions. This bias affects every person's behavior, interactions, and decision-making.

These associations are made in the unconscious state of mind, meaning that we likely are not aware of our own biased associations.



Impact of Unconscious Bias

Bias may unconsciously influence the way information about an individual is processed, leading to unintended disparities that have real consequences.

Types of Bias: There are many different types of unconscious bias, which are often defined as stereotypes, prejudices or deeply held beliefs. The four most common biases are:

1. Racial
2. Gender
3. Sexual and Gender Minority
4. Disability

While these four are the most common, biases may exist toward any social group. One's age, gender, gender identity, physical abilities, faith or religion, sexual orientation, weight, education, socioeconomic status, language and many other characteristics are all subject to bias.

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Evaluate how your own experiences and identities influence your day-to-day interactions.

Remember to consider the perspective of the individual who is being interacted with and the potential impact of your unconscious biases on that individual.

Overcoming Unconscious Bias

IEHP: A Culture of Inclusion: IEHP believes in a culture of inclusion. Inclusion means having "intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes."

Inclusion refers to the way groups demonstrate their appreciation for individuals as valued and respected members of the group, team, organization, or community.

Inclusion means that all people, regardless of their abilities, disabilities, or health care needs, have the right to be respected and treated as valuable. It is important to become more self-aware of our own unconscious bias before it affects encounters with IEHP members and other health care professionals.

Tips for Overcoming Unconscious Bias: Unconscious biases are not permanent. In fact, steps can be taken to limit their impact on our thoughts and behaviors.

1. Recognize that you have biases
    - Accept that we all have unconscious biases - It's part of being human.

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2. Identify what those biases are
    - Before you can work on overcoming your biases, you first have to understand them.
    - Many online sites offer assessments that help identify your implicit bias, since because it is unconscious, it can be difficult to do on your own.
    - One example is Project Implicit which allows you to test your own biases by taking assessments in a range of categories such as age, race, gender, sexuality, and disability. The tool is completely free to use and doesn't collect any personally identifying information.

3. Ask others to hold you accountable
    - You aren't in this alone. An outside perspective may help in identifying where your unconscious bias is affecting your interactions.
    - Ask for feedback and support from someone you trust and who will help keep you accountable in a positive and constructive way.
    - Remember that the goal is to help each other overcome biases, not to belittle or tear someone down because they have them. Encouraging one another to talk about where our unconscious bias comes from can help identify ways to counteract and change it.

4. Counter stereotypical imaging
    - Your unconscious biases exist because your brain formed associations based on your world view, upbringing, culture, and a multitude of other factors. This means that you can train it to form new associations too.
    - Intentionally give yourself opportunities to make new pairings for things that you've held certain biases against.
    - As an example, if you had a bias against a certain race or gender being in management, then intentionally watch movies or read books which positively feature that race or gender in management roles to make associations that negate existing stereotypes.

5. Widen your social circle
    - Spend time with other people from different cultural and academic backgrounds, social groups, etc.
    - Don't sit with the same people every day; make a point to move around. This will build your cultural competence and lead to better understanding.

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6. Practice perspective-talking
    - Perspective-talking involves imagining what it would be like to be in the other person's situation.
    - If needed, use role-playing, simulations and other interactive exercises to help you take the perspective of another person.
    - Treat others the way they would want to be treated.

It takes ongoing practice. Recognizing that you are not immune to having your own unconscious bias will help you to begin identifying areas in which your own personal associations or attitudes may be affecting how you interact with others. Recognizing your bias is the first step towards learning new ways to interact with others to ensure every IEHP member receives the best service possible.

Health Equity

Equality vs. Equity - What's the Difference?

Equality is giving everyone the same bike. Equity is giving everyone a bike tailored to their individual needs.

Now let's define equity and inequity.

Equity: "Developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create equitable opportunity for all individuals. Equity and "equitable" are distinct from equality or "equal," which refers to everyone having the same treatment but does not account for different needs or circumstances. Equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups."

Inequity: "Systematic differences in health and health outcomes, or in the distribution of health resources between different population groups, arising from avoidable, unnecessary, unfair and unjust social conditions in which people are born, grow, live, work and age."

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It is important to understand health equity, but it is also important to understand how this relates to the health disparities IEHP members may encounter.

The goal is to provide equitable health care and services to all IEHP members.

Who is affected by health inequities?

1. Racial and ethnic minority groups
2. Seniors and persons with disabilities (physical, intellectual, developmental)
3. Women
4. LGBTQIA+
5. Limited English Proficiency (LEP) groups
6. Refugees and immigrants
7. Persons of lower socioeconomic status
8. Persons with certain religious preferences
9. Persons with substance use disorders
10. Persons with a history of incarceration
11. Other communities who have been historically marginalized

Social drivers, the “conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” are the contributing factors to health inequities.

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IEHP Member Experience

By the end of this section, you will be able to:

1. Explain how a member's culture impacts their health beliefs and related behaviors.
2. Discuss the member experience related to perceived discrimination and how this impacts their interactions with IEHP, our team members and our providers.
3. Explain how the cultural needs of IEHP members are being met during interactions with IEHP and the IEHP provider network.

The Effect of Culture on Members

This training is provided to comply with California law, including DMHC APL 24-016 and SB 923. Its purpose is to inform respectful care for all members, including individuals who identify as transgender, gender-diverse, or intersex (TGI). IEHP acknowledges that federal policies may define gender differently; however, as a Medi-Cal managed care plan operating under California law, we are required to provide this training and ensure access to care for all members.

What is Culture?

According to the National Committee for Quality Assurance (NCQA) 2024 health equity standards, culture is defined as "the shared values, ideals and beliefs of a group of people."

Due to IEHP's diverse populations, IEHP is committed to delivering respectful, responsive and equitable health care services to address the access and cultural needs of our members.

Cultural Factors: Cultural factors include but are not limited to: geography, age, socioeconomic status, education, politics, race, ethnicity, language, religion, gender, sexual orientation, gender identity, and disability.

Cultural Competence: Cultural competence is the capability of understanding, appreciating, and interacting with people from different cultures.

It is having a set of aligned behaviors, attitudes, and policies that come together in a system, agency or among professionals to enable them to work effectively in cross-cultural situations.

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Cultural Humility: Cultural humility is defined as "the ability of organizations, systems and health care professionals to... value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services."

Strategies for practicing cultural humility

Practice Self-Reflection: Practice cultural humility by "practicing self-reflection, including awareness of your beliefs, values, and implicit biases."

Recognize What You Don't Know: Practice cultural humility by "recognizing what you don't know and being open to learning as much as you can."

Be Open to Other Identities and Experiences: Practice cultural humility by "being open to other people's identities and empathizing with their life experiences."

Acknowledge the Patient's Authority: Practice cultural humility by "acknowledging that the patient is their own best authority, not you."

Learn From Different Beliefs and Worldviews: Practice cultural humility by "learning and growing from people whose beliefs, values, and worldviews differ from yours."

Cultural Beliefs and Behaviors

Culture impacts every health care encounter!

"...Doctors need to understand that when you see a patient, you're seeing their culture, their family, the stressors placed upon them. You're seeing the total patient."
Carla Coutin-Foster, MD, MS

Culture informs on:

1. Concepts of health and healing
2. How illness, disease, and their causes are perceived
3. The behaviors of patients seeking health care
4. Attitudes toward health care providers

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Culture also defines health care expectations.

Who Provides Treatment: Culture defines who provides treatment, including male versus female doctors or the use of a doctor versus family, friends or a healer.

What is Considered a Health Problem: Culture defines what is considered an illness or disease as this often varies from culture to culture.

What Type of Treatment: Culture defines the use of home remedies versus traditional medicine.

Home remedies are simple measures of symptom management for minor health complaints. Examples can include teas, herbal products, homemade compresses, topical products, and baths.

The World Health Organization (WHO) describes "traditional medicine as the sum of total knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness." Examples of traditional remedies include acupuncture, naturopathy, herbal medicine, chiropractic medicine and traditional Chinese medicine.

Where Care is Sought: Culture defines whether care is sought through conventional health care facilities or instead through traditional medicine and practitioners.

How Symptoms Are Expressed: "Culture can account for minor variations in how people communicate their symptoms and which symptoms they report."

For example, being nervous is frequently used by Hispanic individuals to express anxiety. In other cultures, anxiety and depression might not even be expressed in words but instead as physical symptoms such as headaches, backaches or stomach discomfort.

How Rights and Protections Are Understood: Culture defines how rights and protections are understood because of language and cultural beliefs and misconceptions.

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An individual's culture affects their beliefs on illness and health. Understanding racial and ethnic differences may assist you in providing care for members of diverse backgrounds.

Multiple Doctors: Many patients may become dissuaded by the requirements set by visiting multiple doctors. Explain to members why they have to be seen by another doctor and stress the need for follow-up care and medication adherence.

Provider Gender: Members may also be uncomfortable with a provider or interpreter of a different sex or gender. Team members can accommodate with a doctor or interpreter of the same sex or gender.

Clinical Assessment: People who have lived in poverty, or come from places where medical treatment is difficult to get, will often go to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

Traditional Medicine: Some treatments and medicines that are considered folk medicine or herbal medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about “alternative,” “traditional,” “folk,” or “herbal” medicine.

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Refugees and Immigrants

Refugees and immigrants can face challenges in accessing health care for multiple reasons including their legal status, language barriers and discrimination.

1. Refugees and immigrants may not be familiar with the U.S. health care system.
2. Refugees and immigrants may experience illness related to life changes.
3. Refugees and immigrants may practice spiritual and botanic healing or treatments before seeking U.S. medical advice.

Use of Traditional Medicine

Some treatments and medicines that are considered folk medicine or herbal medications in the United States are part of standard medical care in other countries. Traditional medicine is applied with different methods including:

1. Acupuncture
2. Homeopathy
3. Mesotherapy
4. Massage
5. Aromatherapy
6. Yoga

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According to the WHO, the demand for traditional medicine is growing, with patients seeking greater ownership of their health and well-being, and seeking more compassionate and personalized health care.

Traditional medicine is particularly prevalent and used as the first choice for health and well-being in remote and rural areas. However, data noted that almost half the population in many industrialized countries now regularly use some form of traditional and complementary medicine (United States, 42%; Australia, 48%; France, 49%; Canada, 70%).

“People in Asian countries like Bangladesh, India, Iran, and Pakistan use a number of plant-based remedies, including a warm mixture of ginger, cloves, coriander, black cumin seeds, and honey, fruits high in Vitamin C, garlic, turmeric, cinnamon, black pepper, Ayurveda and Chinese chaste tree powder, while others drink herbal teas. Ginger is used to treat common health problems such as pain, nausea, and vomiting.”

Incorporation Into Member Treatment

Establish Healthy Communication: It is important to establish healthy communication and consider the views of patients while making health care decisions to develop trust and increase patient satisfaction.

Ask About Alternative Medicines: Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about “alternative,” “traditional,” “folk,” or “herbal” medicine.

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Remember:

1. Some members may adhere to traditional health beliefs along with “western” beliefs.
2. Some members may already have their own ideas about what caused their illness.
3. Some members may not comply with a treatment because it conflicts with their beliefs or traditional practices.

Impact of Member Experience

Member Experience with IEHP

106 grievances were received in 2023 from members on their perceived discrimination from IEHP.

791 grievances were also received from members on perceived discrimination from providers, hospitals, independent physician associations (IPAs), pharmacies, and urgent cares. 40 additional grievances were filed by members on perceived discrimination from IEHP vendors.

DEI Focus Groups

To gain more insight, community input was obtained via focus groups on discrimination within the IEHP's service area.

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Riverside County: From the 2024 DEI focus groups, Riverside County community members reported experiencing perceived discrimination based on their:

1. Language - a member felt discriminated against when they did not speak Spanish after a vendor approached and assumed that they were Spanish-speaking.
2. Racial Profile – a member was pulled over due to racial profiling and type of vehicle they drove.
3. Disability – the member felt their employer's attitude changed during an interview when they saw that he used a wheelchair.

San Bernardino County: From the 2024 DEI focus groups, San Bernardino County community members reported experiencing perceived discrimination based on their:

1. Racial Profile – the member was followed at a retail store due to racial profiling.

Member Experience with IEHP Network Providers

"I just want to add that IEHP are really good for sending something in the mail like for an appointment or something, and there's always something attached in English and Spanish that says that if you've been discriminated against, contact us. So IEHP is good with that."

- IEHP member

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Additional community input was obtained from members to identify perceived discrimination from IEHP network providers within IEHP's service area.

Riverside County

1. Weight: The member reported their provider immediately assumed the member's knee issues were due to being overweight without completing other testing or questions.
2. Racial Profile: The member reported they have been on a waitlist for knee surgery for the past 2 years and feels that it is due to their race.

San Bernardino County

1. Ethnicity and Language: The member reported their provider did not take the time to listen to her concerns and felt the provider was dismissive due to her ethnicity and language. The member reported feeling that she has a longer wait time to receive care at a provider's office when she asks for an interpreter.

The DEI focus groups provided a platform for members to share about their communities and provide feedback on issues they believed needed to be addressed. These focus groups highlighted the importance of community engagements to gain insight on solutions for the region.

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Meeting IEHP Member Cultural Needs

Culturally and Linguistically Appropriate Practices

It is important that all IEHP team members and network providers meet the cultural needs of IEHP members by using culturally and linguistically appropriate practices.

Culturally and linguistically appropriate practices "seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001)."

When Members Interact with Providers

Member engagement has been identified as a key factor to ensure the health care system functions in a way that improves access and quality of care.

1. Members as Partners
    - It is important that we look at members as partners in their health care management and we incorporate a multicultural approach when discussing strategies for engaging members.

2. Cultural Competence
    - Cultural competence is an essential strategy to increase patient engagement in a way that empowers the individual and their families to make better informed decisions and ways to manage their health and health care.

3. Personal Relationships
    - Personal relationships and attention to life experiences are key factors to ensuring that communities of color experience true member engagement across the health care system.

4. Member Interaction
    - Members interact with providers during medical appointments or over the phone to address questions or challenges.

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Kleinman's 8 Questions

Psychiatrist and anthropologist Arthur Kleinman proposed that health care service providers ask their members questions to gain insight into each individual's worldview, culture, social context, and spirituality.

By building a trusting relationship, it helps to gain insight into what is most important for a member in terms of their health, illness, and care.

Kleinman's model is a set of eight questions that may be asked when speaking to members instead of only asking, "Where does it hurt?"

When asking questions, focus on eliciting the member's answers to: "Why," "When," "How," and "What Next?"

Kleinman's 8 Questions are:

1. What do you call your problem? What name does it have?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the illness does? How does it work?
5. How severe is the illness? Will it have a short or long course?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?
7. What are the main problems that the illness has caused?
8. What do you fear most about the illness?

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HOPE and FICA Assessment Tools

Spiritual assessment tools, such as HOPE and FICA assessment tools, provide efficient means of eliciting member thoughts on spirituality and beliefs.

HOPE and FICA: The use of spiritual assessment tools allow health care professionals to support members by promoting empathetic listening, documenting preferences for future visits, and incorporating preferred traditions into treatment.

The HOPE assessment tool uses questions like:

1. H: Sources of hope
    - What are your sources of hope, strength, comfort, and peace?
    - What do you hold on to during difficult times?

2. O: Organized religion
    - Are you part of a religious or spiritual community?
    - If so, does it help you? How?

3. P: Personal spirituality and practices
    - Do you have personal spiritual beliefs?
    - What aspects of your spirituality or spiritual practices do you find most helpful?

4. E: Effects in medical care and end-of-life concerns
    - Does your current situation affect your ability to do the things that usually help you spiritually?
    - As a health care professional, is there anything I can do to help you access the resources that normally help you?
    - Are there any specific practices or restrictions I should know about in providing your medical care?
    - For chronic or terminal illness: How do your beliefs affect the kind of medical care you would like me to provide over the next few days (or weeks, or months)?

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The FICA assessment tool uses questions like:

1. F: Faith and Belief
    - Do you consider yourself spiritual or religious?
    - Do you have spiritual beliefs that help you cope with stress?
    - What gives your life meaning?

2. I: Importance
    - What importance does your faith or belief have in your life?
    - Have your beliefs influenced you in how you handle stress?
    - Do you have specific beliefs that might influence your health care decisions?

3. C: Community
    - Are you part of a spiritual or religious community?
    - If so, is this helpful and supportive to you? How?
    - Is there a group of people you really love or who are important to you?

4. A: Address in Care
    - How should health care providers address these issues in your health care?

IEHP encourages our team members and providers to use HOPE and FICA assessment tools in their work and practice.

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For an additional resource on sample questions for HOPE and FICA assessment tools, visit Equity, Diversity, Inclusion & Access (EDIA).

When Members Contact IEHP

IEHP addresses culturally and linguistically appropriate services by implementing a multi-prong approach to deliver health care services that meet members' social, cultural, and linguistic needs in the following ways:

1. IEHP provides cultural competence and humility training to our health care professionals.
2. IEHP implements policies to reduce administrative and linguistic barriers to member care.
3. IEHP recruits and retains a culturally and linguistically diverse governance that represents the community served by IEHP.

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Meeting IEHP Member Social Needs

By the end of this section, you will be able to:

1. Explain the health-related social needs of IEHP members.
2. Explain the importance of gender-affirming care.
3. Identify ways that gender-affirming care may be provided to IEHP members.
4. Identify the language and literacy needs of IEHP members.
5. Provide appropriate communication services for members, including linguistic services or alternative format transcription services.
6. Describe appropriate methods to remove barriers that prevent access to care for the seniors and persons with disabilities (SPD) population.

Social Needs of IEHP Members

In addition to meeting the cultural needs of our members, IEHP also strives to meet the social needs of our members. What are social needs?

Social needs are the "non-clinical needs individuals identify as essential to their well-being which are related to the social risks they experience and their intersectional identities or characteristics, such as race, ethnicity, preferred language, gender identity, sexual orientation and aspects of disability."

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Understanding the social needs of IEHP members is essential for health care professionals. The Health Equity Operations (HEO) team at IEHP obtained input from members throughout the Inland Empire regarding issues and barriers they have experienced.

Riverside County

From 2024 DEI focus groups, Riverside County community members reported the following issues and barriers:

1. Language barriers (The elder population does not obtain primary care or complete health screenings possibly due to language barrier and/or lack of education.)
2. Quality and availability of interpretation services
3. Low appointment availability
4. Lack of privacy and respect
5. Transportation route design
6. Lack of affordable housing

San Bernardino County

From 2024 DEI focus groups, San Bernardino County community members reported the following issues and barriers:

1. Increased criminal activity
2. Theft
3. Vandalism
4. Homelessness
5. Panhandling
6. Lack of affordable housing
7. Traffic
8. Lack of weed abatement
9. Community input before making big decisions, relocations, etc.
10. Food insecurity
11. Lack of transportation resources

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Gender-Affirming Care

This training is provided to comply with California law, including DHCS APL 24-016. Its purpose is to inform respectful care for all members, including individuals who identify as transgender, gender-diverse, or intersex (TGI). IEHP acknowledges that federal policies may define gender differently; however, as a Medi-Cal managed care plan operating under California law, we are required to provide this training and ensure access to care for all members.

Understanding LGBTQIA+ terminology

Everyone relies on health care services, but not everybody has the same access to medical advice and treatment. As a result, certain populations suffer poorer health outcomes, which are known as health disparities.

In 2016, The National Institute on Minority Health and Health Disparities identified the LGBTQIA+ population as a health disparity population.

In 2017 a national survey of LGBTQIA+ people conducted by the Center for American Progress found:

1. Almost 1 in 10 LGBTQIA+ people reported that a health care professional refused to see them during the previous year because of their perceived or actual sexual orientation.
2. 3 in 10 transgender people reported that they were unable to be seen by providers because of their gender identity.

To understand what gender identity is and is not, we need to understand a variety of terms.

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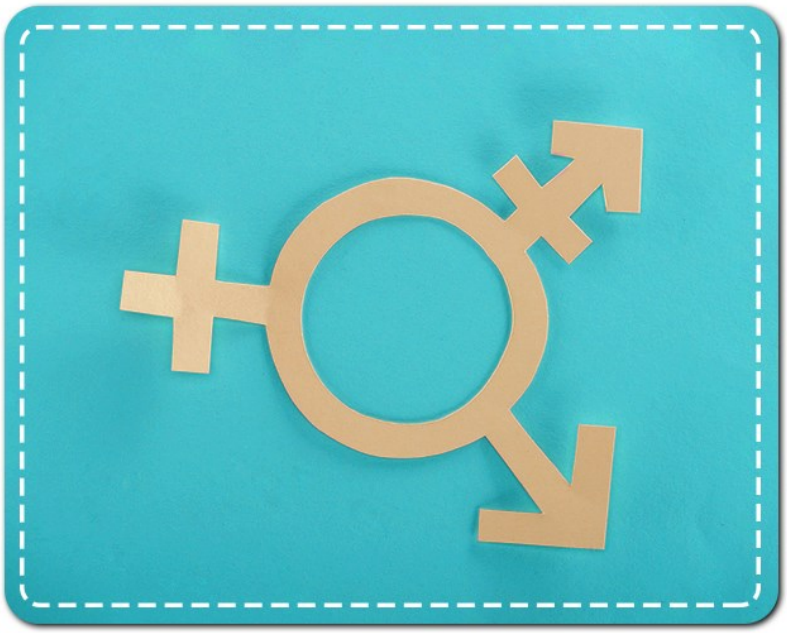
Heteronormative: adjective | het·er·o·nor·ma·tive | hedərōˈnôrmədiv : of, relating to, or based on the attitude that heterosexuality is the only normal and natural expression of sexuality

Heteronormative assumptions can dissuade members who are lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) from seeking future care. We must anticipate that all members are not heterosexual and avoid making assumptions about family members or relationships.

Gender-affirming care includes:

1. Using 'partner' instead of 'boy/girlfriend' or 'spouse'
2. Replacing 'marital status' with 'relationship status'
3. Remembering that coming out to health care providers can add a layer of anxiety and fear



Gender Identity: noun | gen·der iden·ti·ty | jen-dər ī-ˈden-tə-tē : An individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.

Gender and gender identity are often thought to be understood by everyone, but most people don't fully understand them. Gender isn't binary. It's not either/or. In many cases it's both/and. A bit of this, a dash of that. Gender identity isn't something you can determine by a person's name, how they dress, or how they speak.

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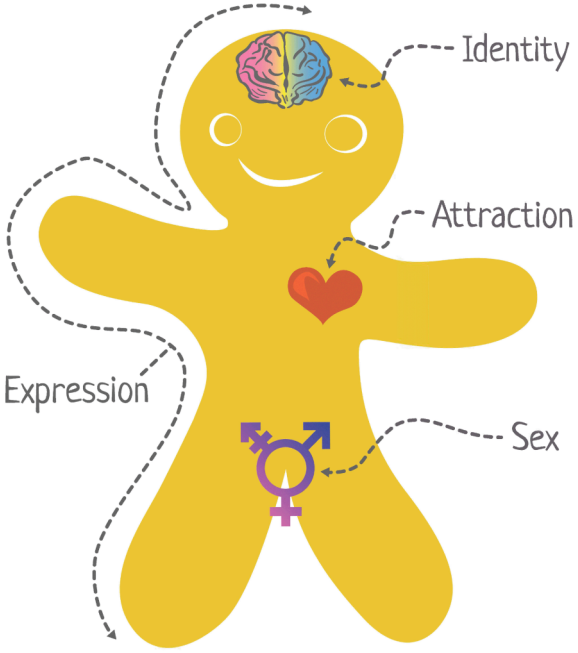
Gender-affirming care includes:

1. Listening to how members refer to themselves and loved ones (pronouns, names)
2. Using the same language members use
3. Asking relevant and appropriate questions when you are not sure



The Genderbread Person

The Genderbread Person model will help us better understand the social construction of gender and its associated terminology.

Identity: Identity is how you, in your head, experience and define your gender, based on how much you align (or don't align) with what you understand the options for gender to be.

Attraction: Attraction is how you find yourself feeling drawn (or not drawn) to some other people, in sexual, romantic, and/or other ways (often categorized within gender).

Sex: Sex is the physical traits you're born with or develop that we think of as "sex characteristics," as well as the sex you are assigned at birth.

Expression: Expression is how you present gender (through your actions, clothing, and demeanor, to name a few), and how those presentations are viewed based on social expectations.

Still not sure how to explain gender vs. gender identity? Watch a video from Onlea.org.

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Orientation Terminology

Asexual: "Describes a person who experiences little or no sexual attraction to others."

Bisexual: "One whose sexual or romantic attractions and behaviors are directed towards both sexes to a significant degree. Bisexuality is a distinct sexual orientation."

Gay: "A sexual orientation describing people who are primarily emotionally and physically attracted to people of the same gender identity as themselves."

Genderqueer: Describes people who see themselves as outside the usually binary man/woman definitions. Having elements of many genders, being androgynous or having no gender. Also Gender Non-Conforming (GNC).

Intersex: "Describes a range of variations in primary and secondary sex characteristics that do not fit into binary notions of female or male bodies. Variations may involve sex chromosomes, external genitalia, gonads, hormone production, hormone responsiveness, and/or internal reproductive organs, and may be identified prenatally, at birth, during puberty, or later in life."

Lesbian: "A sexual orientation describing a woman or non-binary person who is primarily emotionally and physically attracted to women."

Sexual Orientation: "Separate from gender identity, defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or non-attraction to individuals of the same and/or other genders."

Transgender: "Describe people whose gender identity and/or expression is different from that typically associated with their assigned sex at birth." Additional terms related to individuals who identify as transgender are:

1. MtF (male-to-female) - "A person who was assigned the male sex at birth but identifies and lives as a female. Also trans woman or trans female. MtF persons will still need to have prostate exams according to standard guidelines."
2. FtM (female-to-male) - "A person who was assigned the female sex at birth but identifies and lives as a male. Also trans man or trans male. FtM persons will need to have breast exams and Pap tests according to standard guidelines."
3. Note: MtF and FtM may be offensive to some people. Language that can be used in place would be transgender woman and transgender man.

For additional information on terms relevant to the health care and identities of LGBTQIA+ people, visit the National LGBTQIA+ Health Education Center.

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The Need For Gender-Affirming Care

Gender-affirming health care, as defined by WHO, includes any single or combination of a number of social, psychological, behavioral or medical interventions designed to support and affirm an individual's gender identity.

Examples of gender-affirming care:

1. Social
    - Preferred pronouns
    - Names
    - Gender expression
2. Psychological
    - Gender-affirming mental health care
3. Legal
    - Name changes
    - Gender recognitions
    - Anti-transgender discrimination laws

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4. Medical
    - Hormonal treatment
    - Facial hair removal
    - Surgeries such as vaginoplasty, masculinizing phalloplasty, etc.
    - Reproductive options
    - Voice modification

Gender-affirming care means not only being aware of appropriate terminology, but also being able to use those terms appropriately to provide respectful and quality care to all of our members.

Stigma comes in many forms, such as discrimination, family disapproval, social rejection, and violence. This puts the LGBTQIA+ community at increased risk for certain negative health outcomes such as:

1. Sexually Transmitted Infections
2. Substance and Alcohol Abuse
3. Mental Health Conditions and Suicide
4. Obesity and Body Image Disorders
5. Heart Disease
6. Access to Care

According to the Department of Health and Human Services – Office of Population Affairs, gender-affirming health care practices have been demonstrated to have lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse individuals.

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Gender Diverse Adolescents

Due to the lack of access to gender-affirming services, gender diverse adolescents face significant health disparities compared to peers whose internal sense of gender corresponds with the sex they were assigned at birth (cisgender).

Transgender and gender nonbinary adolescents are at increased risk for mental health issues, substance use, and suicide.

1. According to a 2021 LGBTQ Youth Mental Health Nation Survey conducted by The Trevor Project, 52% of LGBTQ youth seriously considered attempting suicide in the past year.
2. A safe and affirming health care environment is critical in fostering better outcomes for transgender, nonbinary, and other gender expansive people.

Gender Incongruence

"Gender Incongruence: characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex at birth."
World Health Organization

A study by researchers Richard Branstrom, Ph.D., and John E. Pachankis, Ph.D. published in the American Psychiatric Association found that "compared with the general population, transgender individuals with a gender incongruence" were:

1. About six times as likely to have had a mood or anxiety disorder health care visit.
2. More than three times as likely to have received prescriptions for antidepressants and anti-anxiety medication.
3. More than six times as likely to have been hospitalized after a suicide attempt.

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Jamie's Story

To better understand how the lack of gender-affirming care can negatively impact our members, review Jamie's story. Jamie is a transgender male patient. He made an appointment at the women's health clinic as he was experiencing pain when urinating.

Upon arrival at the clinic, Jamie checked-in with the nurse at the registration desk who was unable to find Jamie's information in their system. When looking up his phone number, the nurse found a record with the name "Katelyn L."

Jamie uncomfortably reassured the nurse that they are the same person, but shared that he preferred the name Jamie. When the nurse asked for Jamie's license for verification, his license had the name Jamie H. instead of Katelyn L., and the nurse requested to see Jamie's real license.

Jamie insisted that this was his license. After discussing the situation with the nursing supervisor, the nurse ultimately accepted Jamie's identification but did not make any notes or addendums in his patient record.

After being in the medical exam room for some time, the doctor arrived. The doctor did not introduce herself and quickly took a history of present illness (HPI) and listened to Jamie's heart and lungs.

The doctor did not ask for a menstrual history or sexual history, did not offer to do a genital exam or speculum exam, and even though Jamie had not received a Pap smear in the past six years was also not offered that diagnostic. Jamie had also never undergone a mammogram and was not offered one.

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Jamie was prescribed three days of antibiotics and was instructed to return to the clinic if his symptoms worsened. Five days later, Jamie continued to have pain while urinating but did not return to the clinic, hoping that it would “resolve itself.”

For Jamie, the lack of gender-affirming care led to:

1. A negative patient experience.
2. The missed opportunity to address preventive care assessments.
3. A poor health outcome.

Health care professionals have the opportunity to positively impact patient experiences through gender -affirming care by providing:

1. Gender-neutral language
2. Explicit use of personal pronouns
3. Sensitive physical exams
4. Validating and affirming patients

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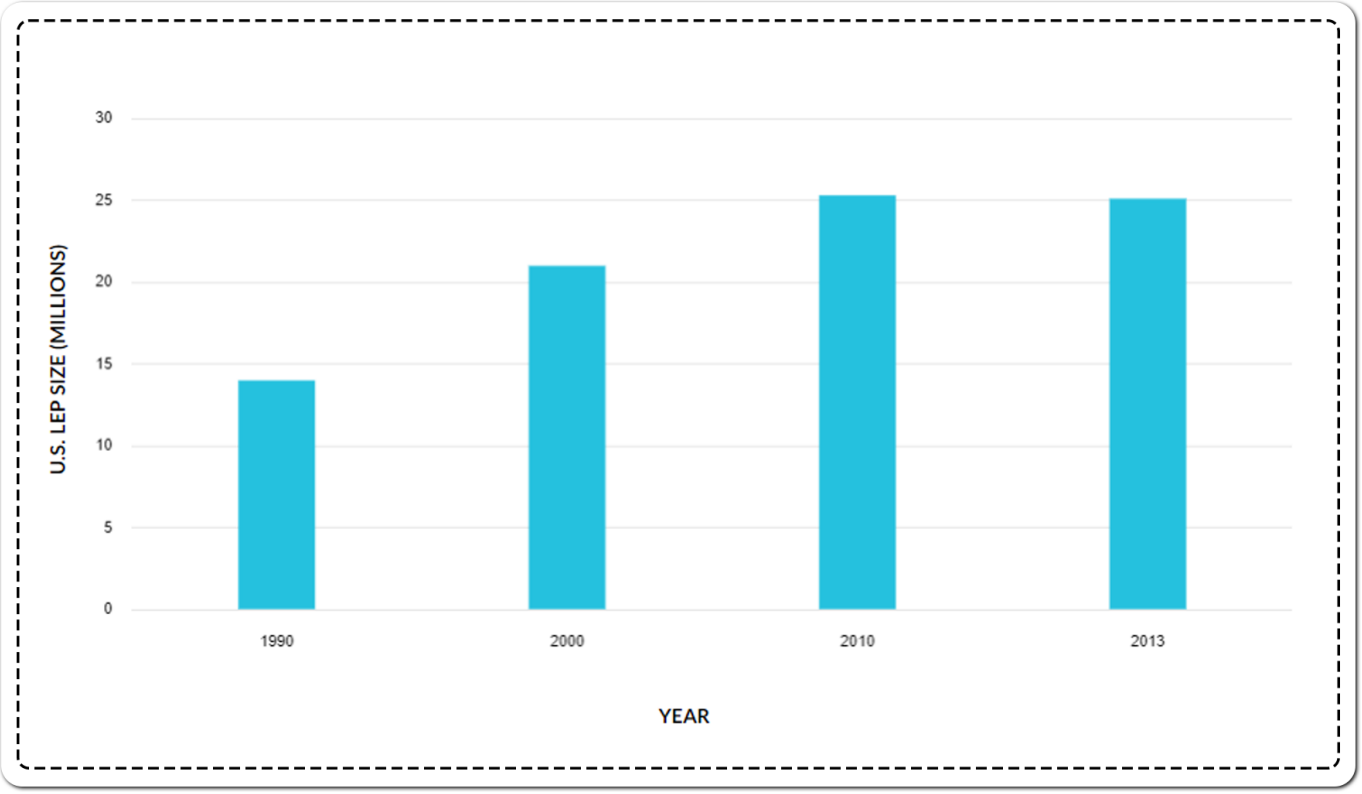
Language and Literacy Needs

Limited English Proficiency

Members with Limited English Proficiency (LEP) experience language and literacy needs as they have a limited ability to read, speak, write or understand English.

Currently, 8% of the total U.S. population is LEP. Between 1990 and 2013 alone, the U.S. LEP population increased by 80%.



Number of U.S. LEP size (millions) by year:

- 1990: 14 million
- 2000: 21 million
- 2010: 25.3 million
- 2013: 25.1 million

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Dangers of Having LEP

Members with LEP are at higher risk for adverse situations that can put their health and quality of life at risk. These include:

1. Receiving lower quality health care.
2. Poorer compliance with medical recommendations.
3. Higher risk of medical errors.
4. Difficulties understanding their diagnosis or why they receive particular types of care.
5. Disproportionately high rates of infectious disease and infant mortality.
6. Inconsistent communication resulting in both lower patient and clinician satisfaction.

Language Disparities for IEHP Members

Vietnamese speakers have been identified by HEQMS as a disparity group for blood pressure control for patients with diabetes.

Mandarin/Chinese speakers have been identified by HEQMS as a disparity group for eye exam patients with diabetes.

When a member is able to effectively communicate, it allows them to more fully participate in their care. When they understand what is being said about their services, care or treatment, they are more likely to follow through.

Language and Interpretation Services

IEHP monitors and meets the linguistic needs of our members by providing a variety of language services, including "bilingual services, oral interpretation and written translation."

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1. Telephone Interpretation
    - Providers and IEHP team members may access telephone interpreter services through Pacific Interpreters.
    - IEHP team members can call Pacific Interpreters directly at 1-866-749-4906.
    - During regular business hours interpretation services are available by calling IEHP Member Services.
    - After hours interpretation services are available by calling the Nurse Advice Line at 1-888-244-4347.

2. Face-to-Face Interpretation
    - Face-to-face interpretation services are also available. Arrangements must be made by calling IEHP Member Services at least 5 working days before the routine appointment.

3. Video Remote Interpreting (VRI)
    - IEHP offers video remote interpreting (VRI) services for American Sign Language (ASL) at urgent care centers.

4. Spanish-speaking Member Services Representatives
    - IEHP assigns Spanish-speaking members to member service representatives who speak Spanish.

5. Provider Office Auditing
    - IEHP also audits provider offices for language capabilities.

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Tips To Remember

To ensure a smooth conversation with a member requesting interpretation services, remember the following tips:

1. Hold a brief introductory discussion. Provide your name, organization, and nature of the call/visit.
2. Inform the interpreter of specific patient needs.
3. Allow enough time for the interpreter sessions.
4. Speak in the first person.
5. Speak in a normal voice; try not to speak fast or too loudly.
6. Speak in short sentences to make it easier for the interpreter to translate.
7. Avoid acronyms, slang, medical jargon, and technical terms.
8. Face and talk to the patient directly instead of speaking to the interpreter.
9. Be aware of body language in the cultural context.
10. Avoid interrupting during interpretation.
11. Reassure the member about confidentiality.

Member Rights

Family: Members have the right to not use family members or friends as interpreters.

Minors: Minors should not act as interpreters unless it's a medical emergency.

No Cost: Members have the right to request an interpreter at no cost for discussions of medical information.

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Literacy Services

IEHP members have a variety of literary services available to assist in meeting their literacy needs.

1. Members may contact Member Services to read member informing materials including clinical medical information.
2. Interpreters can be dispatched to providers offices to read forms.
3. Qualified office personnel can support members with completing forms.
4. Members may request written informing materials in alternative formats.

Alternative Formats

IEHP members can receive member informing/specific materials in a variety of alternative formats such as audio CD, braille (English or Spanish only), electronic, large print, text to American Sign Language (ASL), and threshold languages.

The Disability Program can assist departments with providing alternative format transcription services in the following available alternative formats: large print, e-text, DAISY.

1. In addition to braille and large print formats, transcription services also can provide electronic text or e-text documents which allow members to access materials digitally to either enlarge them or have them read aloud.
2. DAISY, the Digital Accessible Information System, uses a specialized player to provide document navigation as text, audio or both.
3. In some instances, members may also obtain narrated audio recordings of materials being read aloud.

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Seniors and Persons With Disabilities (SPDs)

Who are SPDs?

SPD stands for seniors and persons with disabilities. As of 2023, the Medi-Cal program covered more than 13 million Californians many of whom are SPD.

Who is a senior? Who is considered a person with a disability? To help you better understand, the following information highlights some of the main things you need to know about the SPD population.

Seniors

1. 20% of California's population are older adults age 60+.
2. Seniors may be individuals at risk to improve or maintain choice, independence, and quality of life.
3. Seniors have the right to age in place in the least restrictive environment.

When interacting with seniors, remember the following tips:

1. Speak at your normal volume. Only talk louder when you are asked.
2. If you are a "fast-talker," slow down a bit.
3. Address the person formally (use "Mr." or "Ms.") and do not use things like "dear," "sweetie," or "sweetheart."
4. Always ask before helping. Offer your arm for balance, if needed, but never grab the person's arm.
5. Treat the person with respect and avoid being condescending or talking "down" to them.

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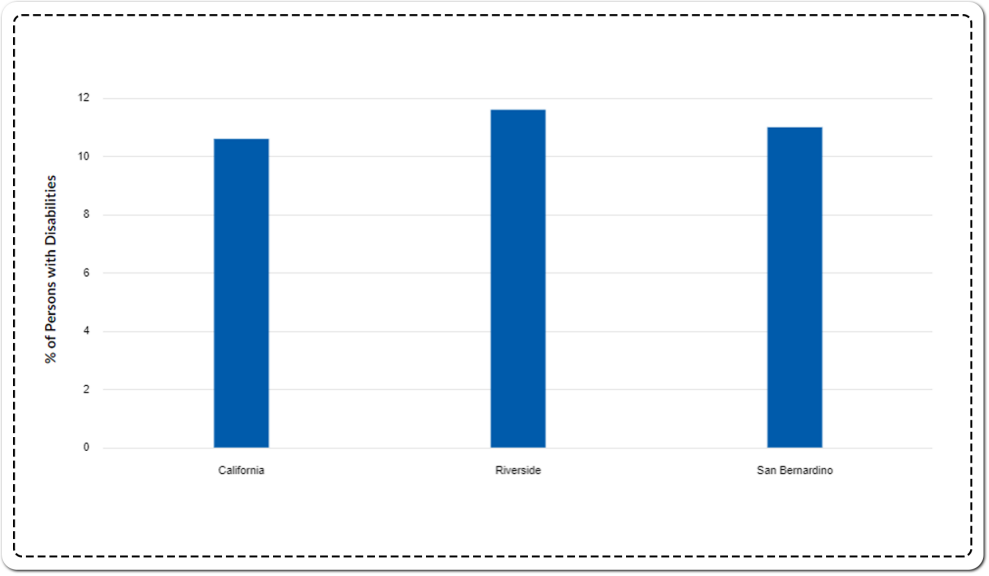
Persons with Disabilities

1. 26% or 1 in 4 Americans have a disability.
2. A disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.
3. Not all disabilities are visible or apparent, and not everyone with a disability identifies as having a disability.

Percentage of Persons with Disabilities in California and the Inland Empire

The following graph shows the percentage of the population that has a disability in the state of California as well as in Riverside and San Bernardino counties specifically.



California at 10.6%

Riverside at 11.6%

San Bernardino at 11%

When interacting with a member who is a SPD, always ask how we can better assist them in achieving their health care goals.

IEHP Provides Access to Care:

IEHP provides access to care for the SPD population by removing barriers. These include aspects such as:

1. The inaccessibility of a physical environment
2. Inadequacies in assistive technology
3. Negative attitudes of people towards disability
4. Systems and policies

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According to the World Health Organization (WHO), barriers are factors in a person's environment that, through their absence or presence, limit functioning and create disability. There are different kinds of barriers, including:

Attitudinal barriers

1. Stereotyping
    - People sometimes assume that people with disabilities have poor quality of life or that they are unhealthy because of their impairments.

2. Stigma and Discrimination
    - People may see disability as a personal tragedy, as something that needs to be cured or prevented, or as an indication of the lack of ability.

3. Disability Awareness
    - It is important that people with disabilities are treated with respect and that people focus on the person and not the disability.
    - The most important thing to know when interacting with people with disabilities is that they are people. And just like all people, one person is different than the next, including being different in how they perceive or handle their own disability.

4. People-First Language
    - A disability is not a negative thing, and it is important to use positive and people-first language to describe the individual not their disability.
    - Person-first language focuses on putting the person first. Instead of saying deaf or blind person, say a person who has a hearing or visual impairment.
    - Or instead of saying wheelchair bound, say a person who uses a wheelchair.

To learn more, watch a video about a protagonist named Bob as he learns how to interact with people with disabilities by visiting DC Office of Disability Rights (ODR).

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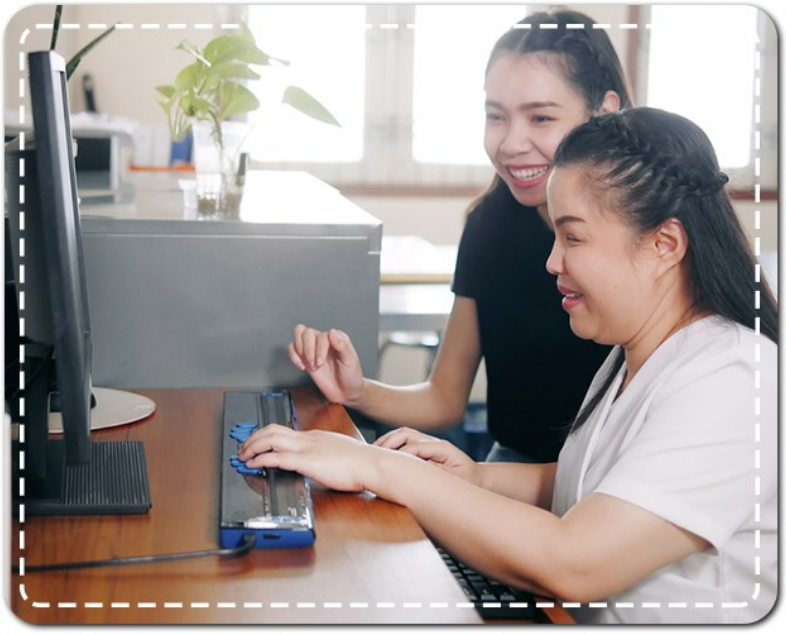
Communication and language access barriers

Communication barriers are experienced by people who have disabilities that affect hearing, speaking, reading, writing, and/or understanding.

Accommodations in communication (oral, written, visual), physical access and health care policy may be appropriate and necessary to achieve health goals.



To request ADA-related accommodations or free language access services, call IEHP Member Services:

1. IEHP Medi-Cal Member Services
    - Tel. 1-800-440-4347
    - TTY 1-800-718-4347
2. IEHP DualChoice Member Services
    - 1-877-273-IEHP (4347)
    - TTY: 1-800-718-IEHP (4347)
3. IEHP Covered Member Services
    - 1-855-433-IEHP (4347)
    - TTY: 711
4. Or email Member Services at MemberServices@iehp.org

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Physical and programmatic access barriers

Physical barriers are structural obstacles in environments that prevent or block mobility or access. IEHP provides access to care for the SPD population by removing barriers. IEHP offers community supports and transportation services.

1. Community Supports
    - Community Supports are services that help address members' health-related social needs, help members live healthier lives, and avoid higher levels of care.
    - A referral can be submitted for Community Supports via the provider portal.
    - If you have programmatic questions, please email IEHP's Community Supports team DGCommunitySupportTeam@iehp.org.
    - For more information on Community Supports, learn more by visiting Provider Services.

2. Transportation Services
    - Transportation provides both non-medical transportation (NMT) and non-emergency medical transportation (NEMT) services for all prior authorized IEHP services and Medi-Cal covered services, which include but are not limited to medical, mental health, substance use, dental, pharmacy and many other benefits covered under Medi-Cal Fee For Services (FFS).

    - Transportation services include door-to-door and curb-to-curb services, as well as ride shares.
    - For more information on transportation services, please call IEHP Medi-Cal Member Services at 1-800-440-IEHP (4347), TTY: 1-800-718-IEHP (4347).

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Summary

By the end of this section, you will be able to:

1. Summarize the benefits of providing culturally competent care.

Encouraging Behavioral Change

Encouragement of behavior change starts with clear communication and adequately conveying information between IEHP members and health care professionals.

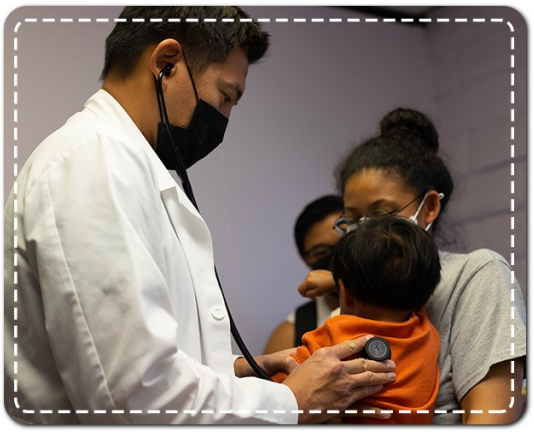
Tailored Services

Instead of providing a one-size-fits-all approach, it is important that all IEHP health care professionals tailor their services to fit members' individual characteristics including: sexual orientation, gender identity, ethnicity, cultural beliefs, language, disability, and age.

To effectively tailor services and help lead IEHP members to an increased likelihood of behavior change, health care professionals are encouraged to:

1. Implement a person-centered care approach.
2. Ask open-ended questions in a nonjudgmental way to initiate important conversations about the member's experiences, views, expectations, and beliefs about their health and behavior.

Health care professionals are encouraged to work collaboratively with members and other health care professionals to achieve optimal care and vibrant health.



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According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), health care professionals can use different strategies to support patients getting started with behavior change efforts.

Shared Decision-Making: Shared decision-making allows patients to be active participants in their care and make informed choices - allowing the patients' values and preferences to play an important role.

Motivational Interviewing: Motivational interviewing is a conversation about change using patient-centered counseling style to strengthen motivation and commitment to change.

Learning Styles: NIDDK noted that, as barriers and challenges arise during behavior change efforts, it is important to use different communication skills. It is important to determine the appropriate content and learning styles for different groups and remember that a patient may prefer to learn via two or more styles of learning.

The styles of learning are:

1. Visual – these patients learn best through what they see such as diagrams, illustrations, pictures, and graphs.
2. Auditory – these patients prefer to learn through what is heard or spoken such as through discussion, groups, and speaking.
3. Read or Write – these patients prefer to have the information to be learned displayed in written words.
4. Kinesthetic or Active Learners – these patients use their body and sense of touch to enhance learning while engaged in physical activity such as playing games, role-playing, or exercising.

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The use of incentive programs is another strategy that targets a variety of health behaviors.

1. In health care, this includes attending preventive visits, receiving immunizations, and completing health risk assessments.
2. In complex health behaviors, this includes behaviors such as smoking cessation, diabetes management, and weight loss.
3. Incentive programs encourage health behaviors by awarding incentives such as gift cards and prizes.

According to Madhu Vulimiri, MPO, evidence suggests that higher value incentives are associated with greater behavior change but further research is needed to understand what amount or duration sustain behavior change.

Key Takeaways

1. IEHP believes in a culture of inclusion - interacting with all members in a culturally and linguistically appropriate manner regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, disability, abilities, or gender identity.
2. IEHP is committed to delivering health care services that are respectful and responsive to the access and cultural needs of its members.
3. IEHP encourages health care professionals to assess the social and cultural factors impacting members' health beliefs and behaviors and be able to assess how these factors affect the member and their families.
4. IEHP monitors and meets the linguistic needs of its members by providing interpretation services and materials in alternative formats.
5. IEHP continuously seeks to remove barriers that prevent access to care for all of its members.

Cultural competence... means a respect for differences and a willingness to accept the idea that there are many ways of viewing the world."
B. Rodriguez

Have Questions?

If you still have questions about what cultural competence means, or need assistance in providing the right support to a member, reach out to IEHP Health Equity Operations.

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