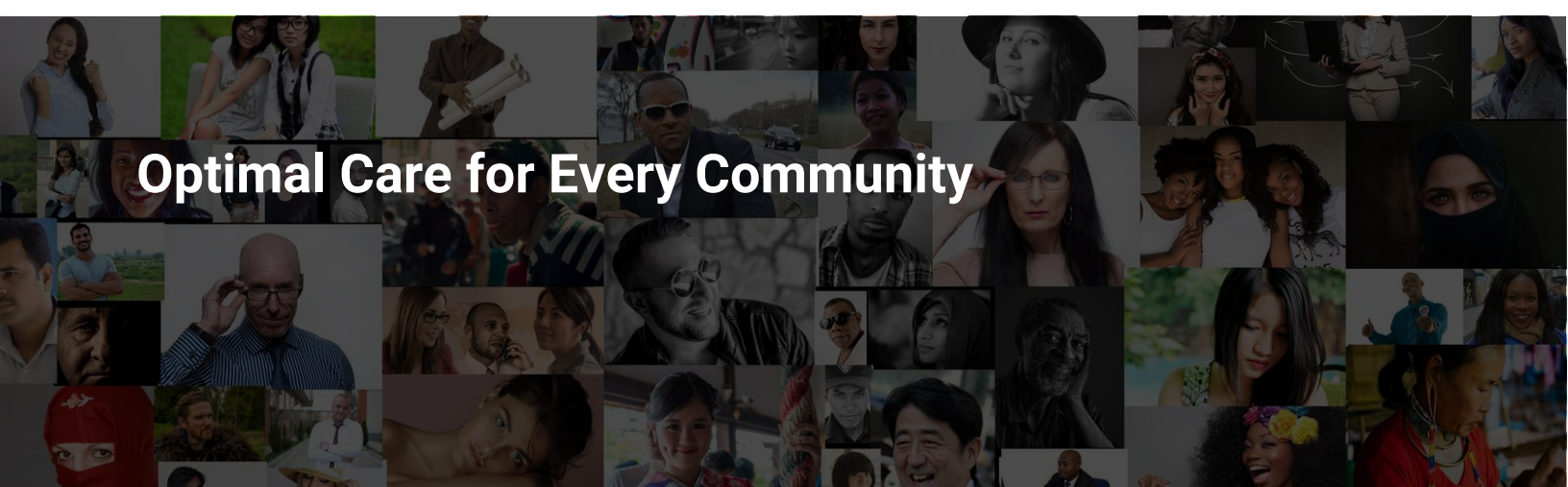




Optimal Care for Every Community



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 main topics included in this training are:

1. **IEHP Member Demographics**
2. **Cultural Competence**
3. **IEHP Member Experience**
4. **Social Needs of IEHP Members**

HOW TO NAVIGATE THIS COURSE



How to Navigate This Course

IEHP MEMBER POPULATION

 IEHP Member Demographics

 IEHP Member Data Policies

 Check Your Understanding

CULTURAL COMPETENCE FOR TEAM MEMEBERS AND PROVIDERS

 Structural and Institutional Racism

 Unconscious Bias

 Health Equity

 Check Your Understanding

IEHP MEMBER EXPERIENCE

 The Effect of Culture on Members

 Impact of Member Experience

 Meeting IEHP Member Cultural Needs

 Check Your Understanding

MEETING IEHP MEMBER SOCIAL NEEDS

 Social Needs of IEHP Members

 Gender-Affirming Care



Language and Literacy Needs



Seniors and Persons With Disabilities (SPD)



Check Your Understanding

CONCLUSION



Summary



Quiz



Course Completion

How to Navigate This Course

This course has been created with a webpage-like design that allows for easy navigation. Please note that for learners who use assistive technologies, some screen readers may read decorative images throughout the course as "unlabeled graphic" versus skipping them depending on the abilities of the screen reader technology.

On the image below, click each of the information buttons to see tips on using the course interface. Once you are ready, click the *CONTINUE* button to move to your first lesson.

4% COMPLETE

≡ How to Navigate This Course

IEHP Member Demographics

Check Your Understanding

▼ CULTURAL COMPETENCE

Check Your Unconscious Biases

≡ Health Equity

≡ Culture & Cultural Competence: Objectives

≡ Culturally Competent Care

≡ Cultural Influences

1

2

CONTINUE

CONTINUE

Diversity, Equity and Inclusion - 2024

4% COMPLETE

HOW TO NAVIGATE THIS COURSE

How to Navigate This Course

IEHP MEMBER POPULATION

IEHP Member Demographics

Check Your Understanding

CULTURAL COMPETENCE

Check Your Unconscious Biases

Health Equity

Culture & Cultural Competence: Objectives

Culturally Competent Care

Cultural Influences

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).

CONTINUE

Overall percent of course completed.

Diversity, Equity and Inclusion - 2024

4% COMPLETE

HOW TO NAVIGATE THIS COURSE

How to Navigate This Course

IEHP MEMBER POPULATION

IEHP Member Demographics

Check Your Understanding

CULTURAL COMPETENCE

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CONTINUE

Click here to collapse or expand the **Table of Contents**.

Diversity, Equity and Inclusion - 2024
4% COMPLETE

▼ HOW TO NAVIGATE THIS COURSE

- How to Navigate This Course ✓

▼ IEHP MEMBER POPULATION

- IEHP Member Demographics** ⓘ
- Check Your Understanding ○

▼ CULTURAL COMPETENCE

- Check Your Unconscious Biases ○
- Health Equity ○
- Culture & Cultural Competence: Objectives ○
- Culturally Competent Care ○
- Cultural Influences ○

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).

CONTINUE

Percent of lesson completed.

Diversity, Equity and Inclusion - 2024
4% COMPLETE

▼ HOW TO NAVIGATE THIS COURSE

- How to Navigate This Course ✓

▼ IEHP MEMBER POPULATION

- IEHP Member Demographics ○
- Check Your Understanding ○

▼ CULTURAL COMPETENCE

- Check Your Unconscious Biases ○
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CONTINUE

Depending on the requirements of the course, navigation may be restricted. This means you must view all lessons in order.

You can always click on an earlier title to revisit completed lessons.

Diversity,
Equity and
Inclusion -
2024

4% COMPLETE

▼ HOW TO NAVIGATE THIS COURSE

How to Navigate This Course ☒

▼ IEHP MEMBER POPULATION

IEHP Member Demographics ☐

Check Your Understanding ☐

▼ CULTURAL COMPETENCE

Check Your Unconscious Biases ☐

Health Equity ☐

Culture & Cultural Competence: Objectives ☐

Culturally Competent Care ☐

Cultural Influences ☐

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CONTINUE 

Click the **Continue** button to move to new sections of the course.

In some cases, the **Continue** button may be locked until all of the activities in the lesson have been completed.

Diversity,
Equity and
Inclusion -
2024

4% COMPLETE

▼ HOW TO NAVIGATE THIS COURSE

How to Navigate This Course ☒

▼ IEHP MEMBER POPULATION

IEHP Member Demographics ☐

Check Your Understanding ☐

▼ CULTURAL COMPETENCE

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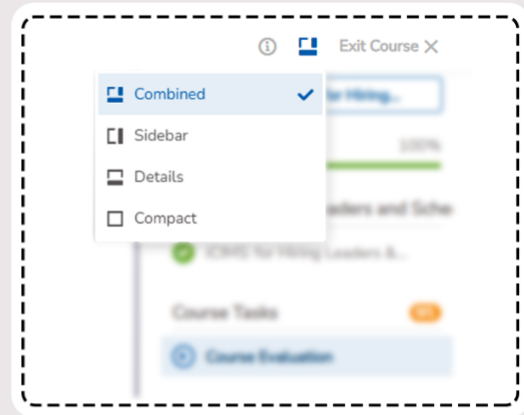

CONTINUE

Scroll to navigate through the course.

LMS VIEW

The default view in the Learning Management System (LMS) works well for many learners, but it may not always provide the most comfortable layout for everyone. You can easily adjust this by clicking the **Choose View** button and selecting a different option.

Each view is designed to hide or minimize certain parts of the LMS interface—such as menus or sidebars—so you can focus on the course itself. Experiment with the available views to find the one that works best for you.



Audio / Video

Some elements in this course may require you to listen to audio and/or watch a video to get portions of the course content. Please be sure that your audio is working properly before proceeding. Video playback controls will be explained where they are utilized in the course. Transcripts and/or closed captioning will be provided for any video content.

The knowledge checks in this course will display if your response was correct or incorrect. A correct response is not required to proceed to the next section, but you are encouraged to review the correct answers that are provided in the feedback to ensure you understand the content.

Retaking a knowledge check is optional and will not impact your completion of the course.



The final quiz requires a passing score to receive a completion for this course.

*To view **SOURCE CITATIONS** for content or images contained in this course download the document below.*

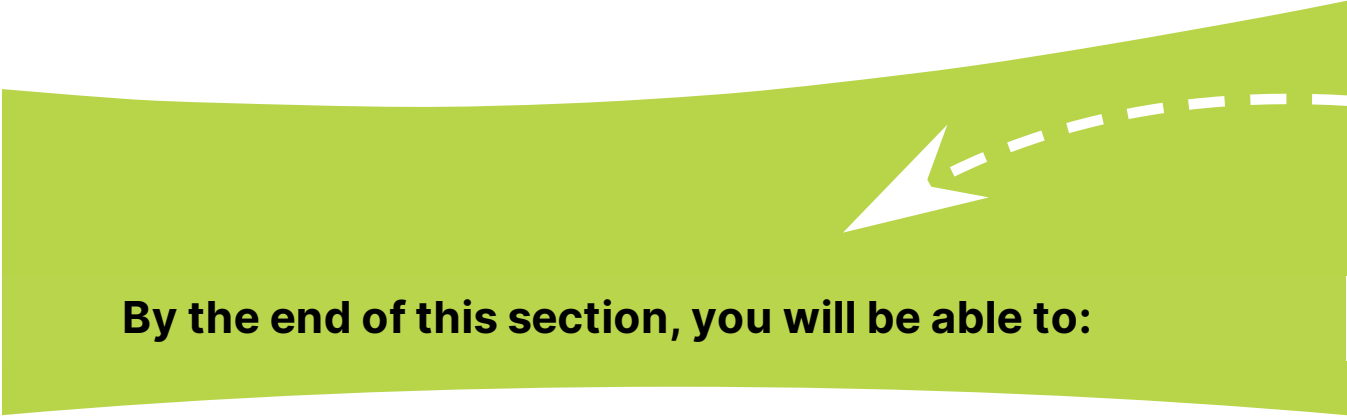


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307.3 KB



CONTINUE

IEHP Member Demographics



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.

CONTINUE

Who are IEHP Members?

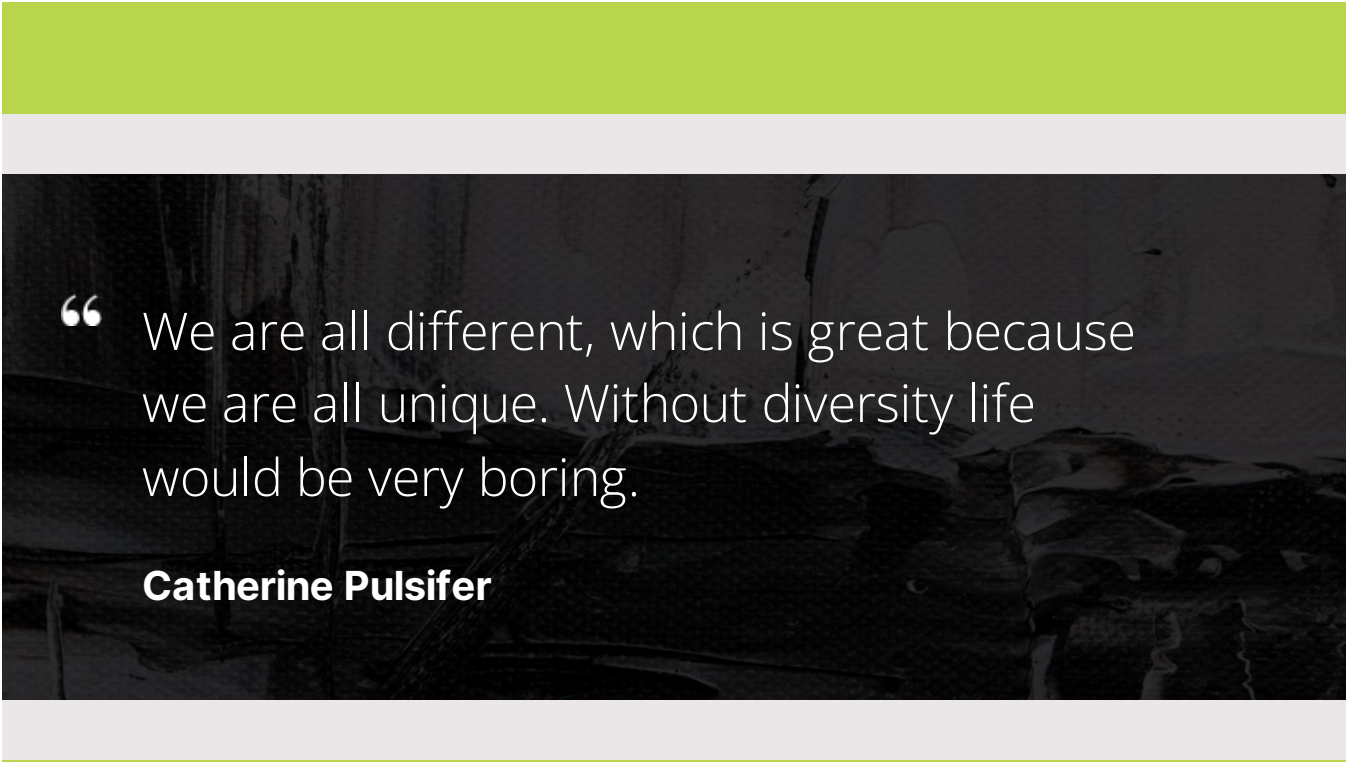


IEHP is committed to delivering health care services that are respectful and responsive to the access and cultural needs of our members and to do this, it is important to understand the population we serve.



**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.

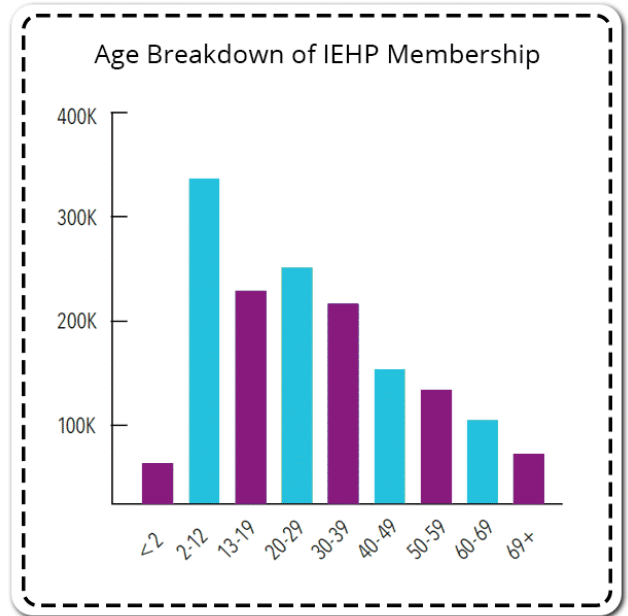
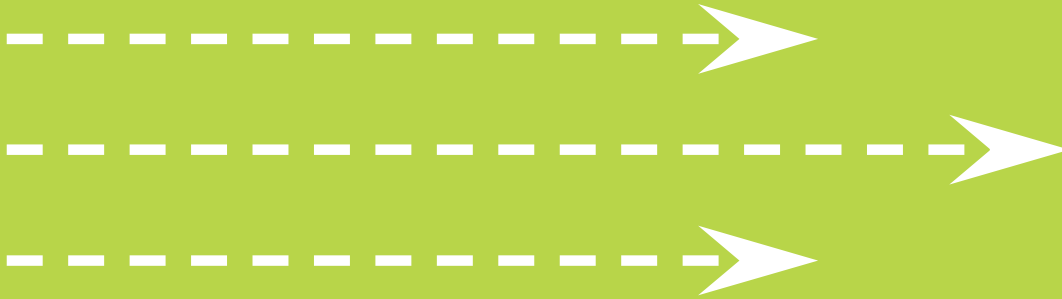
Catherine Pulsifer

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**.

Click the card below to view the age breakdown of IEHP membership.

AGE OF IEHP MEMBERS

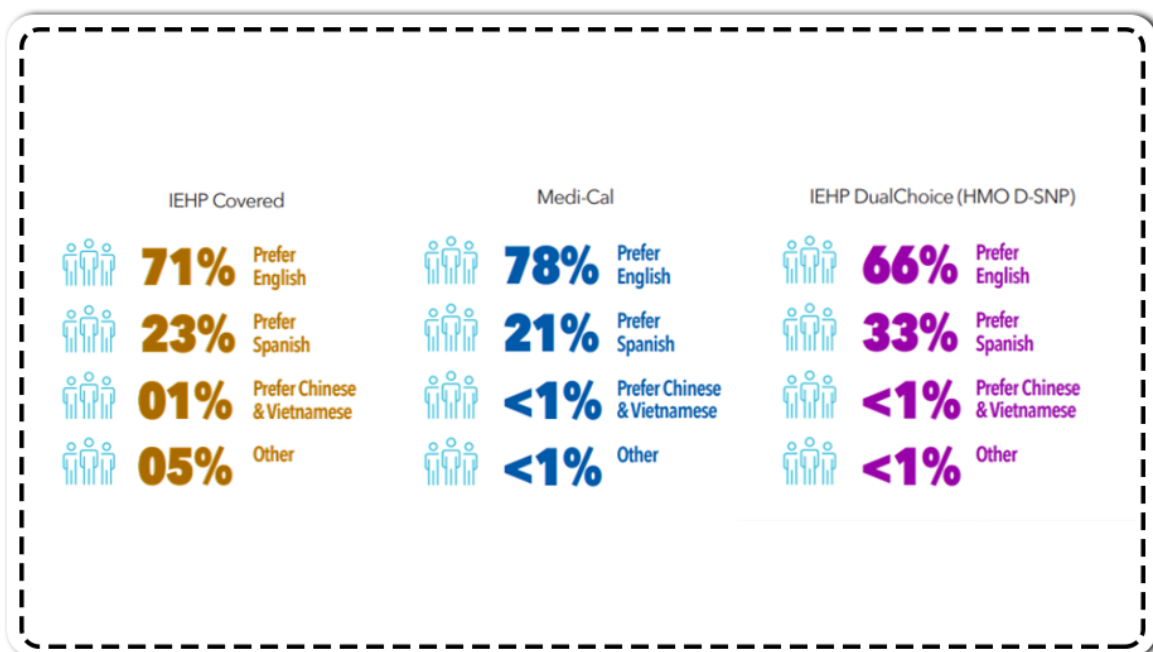


IEHP Member Language

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.

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**.

A close-up photograph of a hand holding a yellow pencil, filling out a form. The form has a blue header with the word "STATUS" in white capital letters. Below the header, there are four options, each with a checkbox: "Single", "Married", "Widowed", and "Divorced". The hand is currently checking the box next to "Married".

STATUS	
☐	Single
☒	Married
☐	Widowed
☐	Divorced

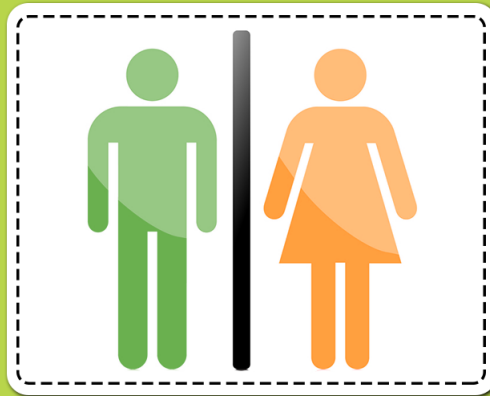
CONTINUE

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



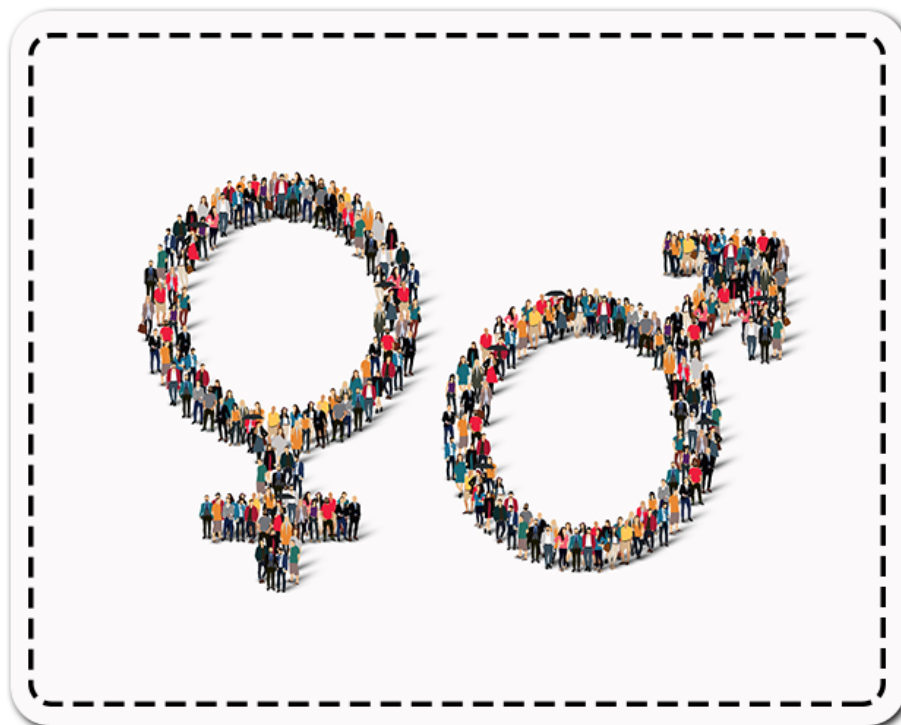
You will learn more about gender and orientation terminology in the section titled *Social Needs of IEHP Members: Gender-Affirming Care*.



Click each of the tabs below to learn more. Click images to zoom in/out.

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.

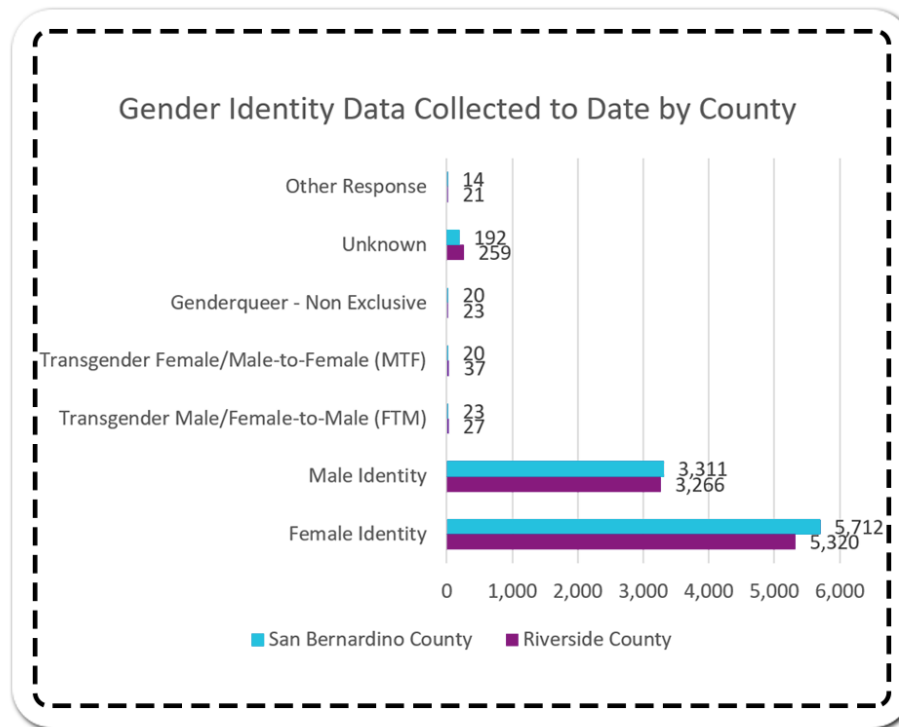


Gender Identity

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:

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

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



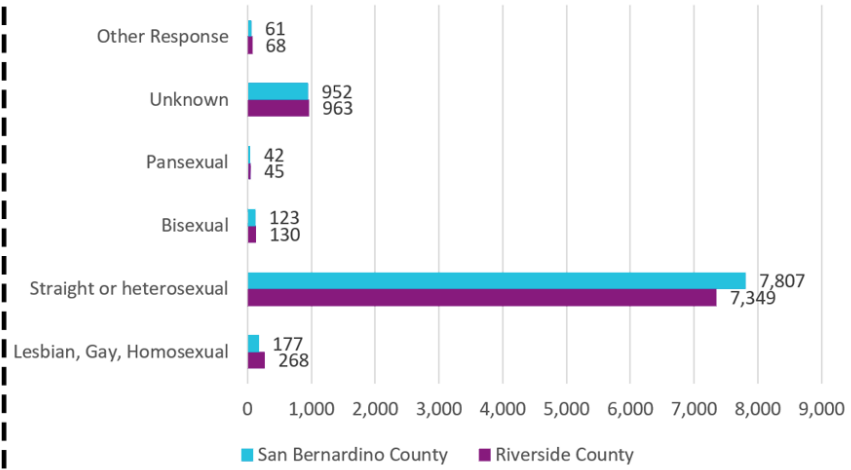
Sexual Orientation —

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.

Sexual Orientation Demographics Collected to Date by County



CONTINUE

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.

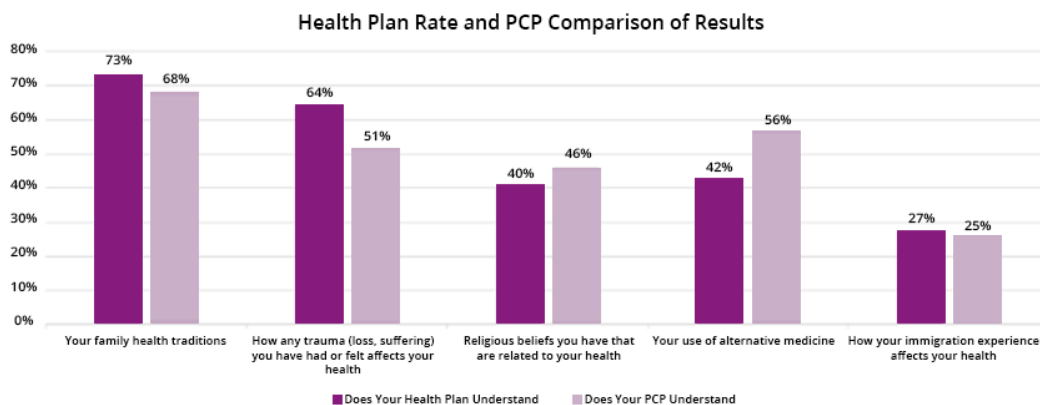


Religious Affiliations

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%** of members that indicated their **primary care physician (PCP)** understood their **religious beliefs** related to their health.

IEHP - Culture & Spirituality Findings



CONTINUE



IEHP Member Race and Ethnicity

What is the difference between race and ethnicity?

To help us understand our members better, let's look at how major health organizations define race and ethnicity:

RACE	ETHNICITY
<p>American Psychological Association</p> <p>"A socially constructed system of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others."</p>	<p>American Psychological Association</p> <p>"A characterization of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry and shared history."</p>
<p>National Committee of Quality Assurance</p> <p>"A biological categorization of genetically transferred physical characteristics (e.g., skin, color, eye color, hair color, bone and jaw structure)."</p>	<p>National Committee of Quality Assurance</p> <p>"A shared culture and way of life, especially reflected in language, religion, and material culture products...."</p>

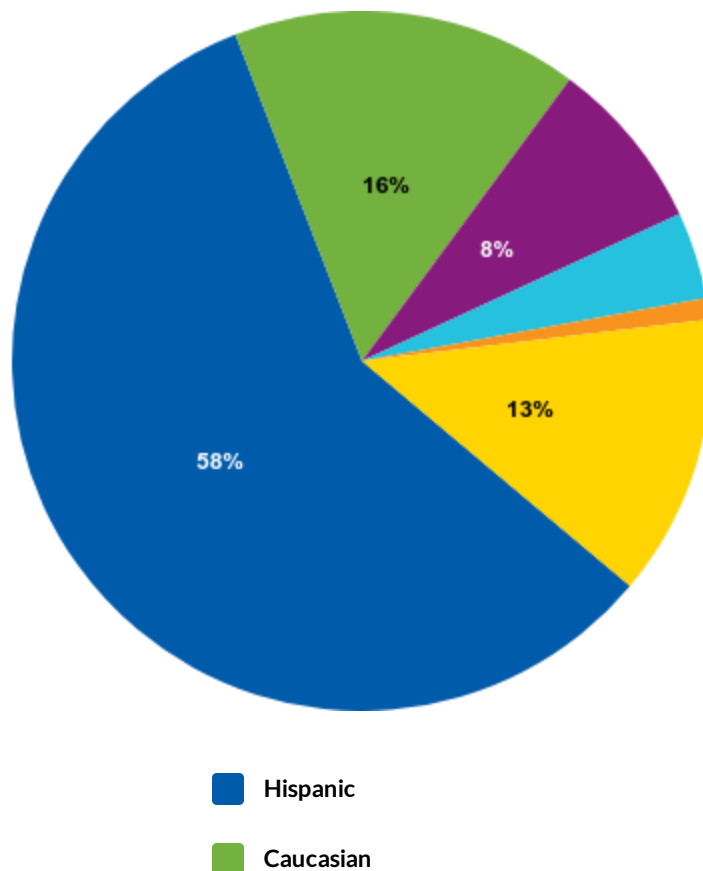
Diversity is the presence of "racial/ethnic and linguistic groups that constitute at least 5% of the community or population of individuals served."

For more information, see the citations document at the end of this lesson.

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

Hover your mouse cursor over the pieces of the pie chart below to view a snapshot of the IEHP member race and ethnic breakdown, or expand the section below the chart to view a list of the race and ethnic breakdown data in text form.

IEHP Member Ethnicity



-  Black or African American
-  Asian or Pacific Islander
-  Other Race or Ethnicity
-  Not Reported

To view a text version of the graph above, click the "+" sign to expand the section below.

IEHP Member Ethnicity (text version) —

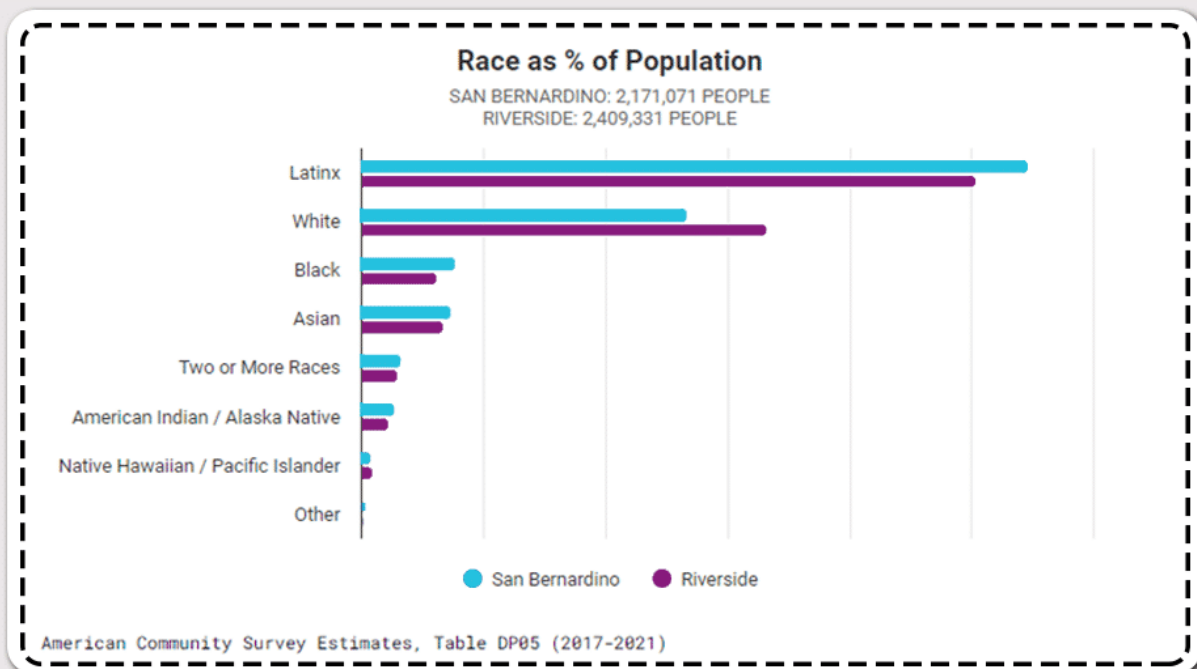
Hispanic: 58%
Caucasian: 16%
Black or African American: 8%
Asian or Pacific Islander: 4%
Other Race or Ethnicity: 1%
Not Reported: 13%



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%.



Click image to zoom in/out.

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).**

For more information about the Inland Empire statistics above, see the citations document at the end of this lesson.

CONTINUE

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

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

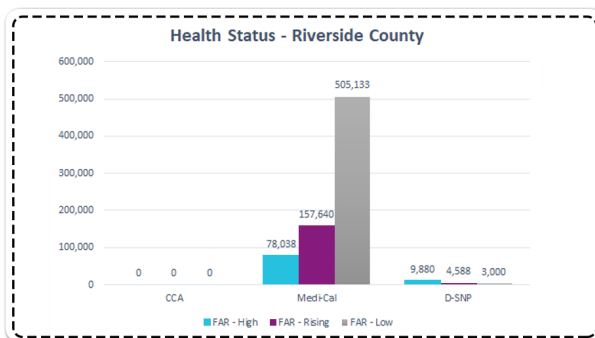
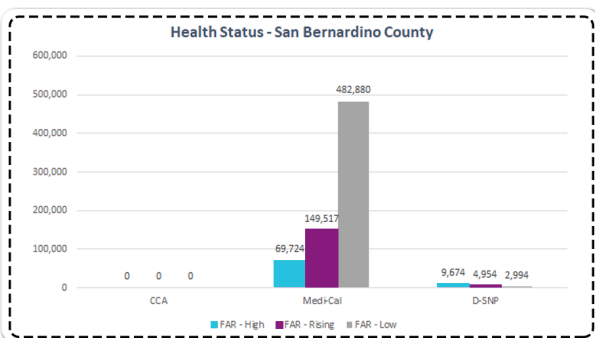
Click each of the tabs below to learn more. Click on images to zoom in/out.

HEALTH STATUS

MENTAL & PHYSICAL DISABILITY

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

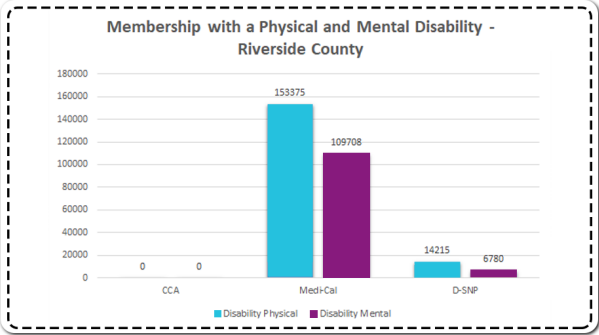
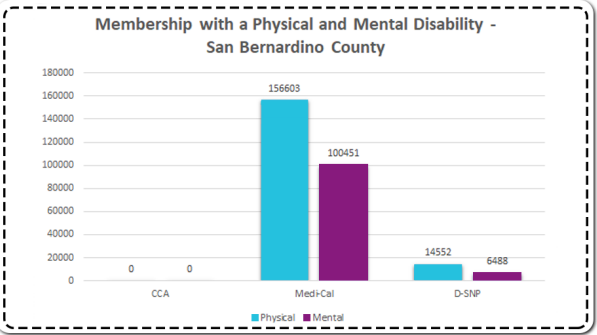
**Note: The Finalized Administrative Risk (FAR) score is used as a measure of morbidity.*



HEALTH STATUS

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.



CONTINUE

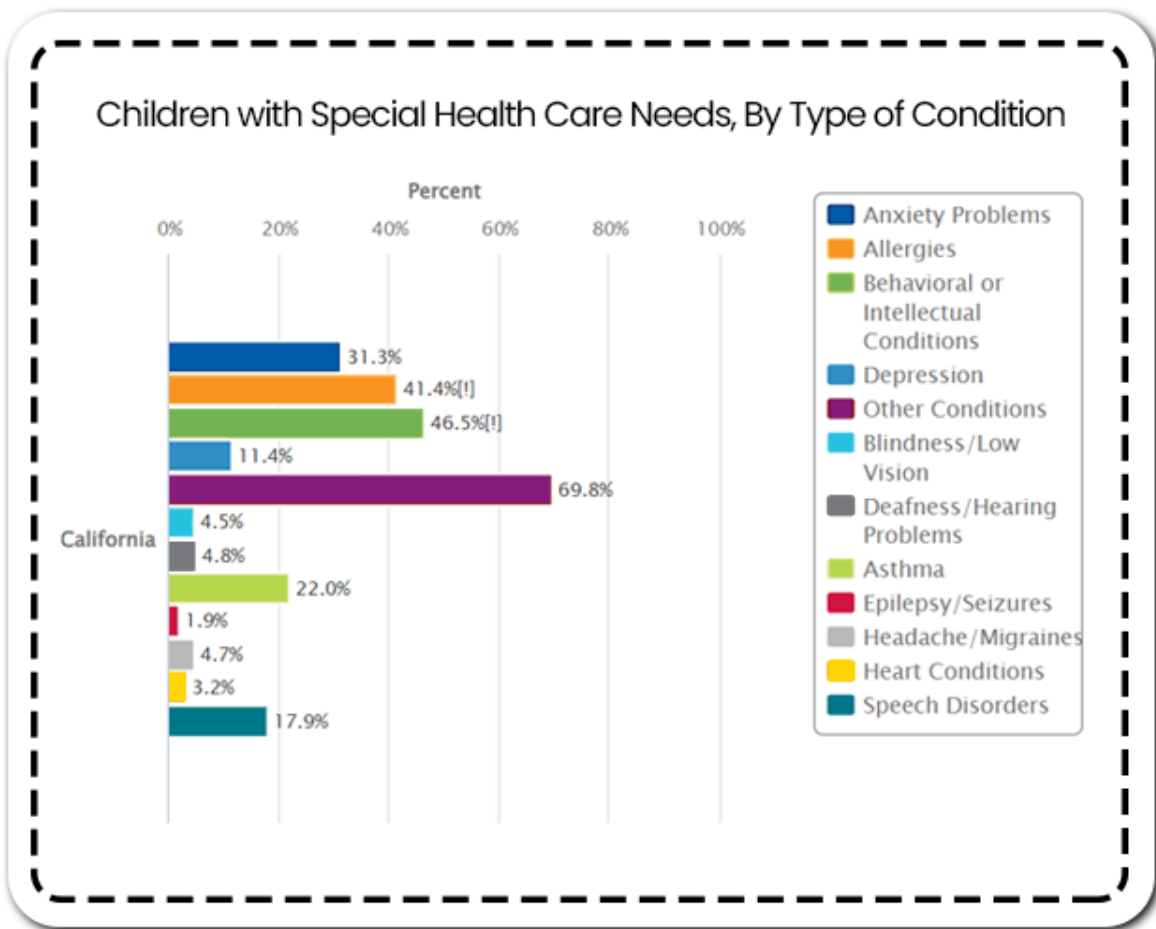
Children with Special Health Care Needs



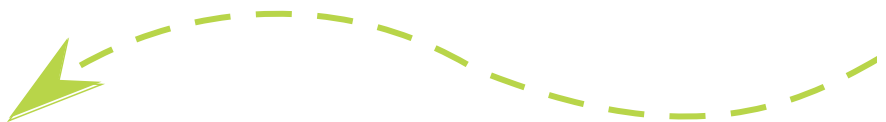
According to the California Department of Public Health, “children and youth with special health care needs (CYSHCN) include infants, children, and youth from birth to age 21 who have one or more chronic, physical, developmental, behavioral, or emotional conditions, and require special health and support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

For more information about the CYSHCN statistics above, see the citations document at the end of this lesson.



The annotation [!] indicates that the margin error for this estimate is greater than 5 percentage points but no greater than 10 percentage points.



Click the "+" on each of the sections below to learn more. Click images to zoom in/out.

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.

Health Disparities —

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

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

For more information, see the citations document at the end of this lesson.

CONTINUE



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%).

FOR MORE INFORMATION

Click the LEARN MORE button.

LEARN MORE

Click each of the tabs below to learn more.

ALCOHOL-RELATED DISORDERS

BARRIERS TO TREATMENT

Alcohol-related disorders display disparities among certain minority groups, such as:

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



ALCOHOL-RELATED DISORDERS

BARRIERS TO TREATMENT

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

- Financial/cost
- Geographic location
- Stigma
- 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:

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

CONTINUE

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)

For more information, see the citations document at the end of this lesson.



Health Inequities for IEHP Members

IEHP uses demographic data such as, but not limited to race, ethnicity, language, sexual orientation, gender identity and geography to identify disparities in member experience and health outcomes.

These insights guide quality improvement efforts focused on culturally and linguistically appropriate care and reducing health inequities. Health outcome measures are prioritized and aligned with regulatory and organizational strategies to increase impactful interventions and advance health equity.

American Indian and Alaska Natives

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

- **Glycemic status assessment for patients with diabetes**
- **Depression screening and follow-up for adolescents and adults**





Black or African Americans

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

- **Controlling blood pressure**
- **Cervical cancer screenings**
- **Glycemic status assessment for patients with diabetes**
- **Depression screening and follow-up for adolescents and adults**
- **Prenatal and postpartum care**
- **Childhood immunization status - combo 10**
- **Immunizations for adolescents - combo 2**
- **Child and adolescent well-care visits**

Hispanics

Hispanics have been identified as a disparity group for the following quality measures:

- **Controlling high blood pressure**
- **Childhood immunization status – combo 10**
- **Depression screening and follow-up for adolescents and adults**
- **Glycemic status assessment for patients with diabetes**
- **Prenatal care**





Asians

Asians have been identified as a disparity group for the following quality measures:

- **Controlling high blood pressure**
- **Cervical cancer screenings**
- **Depression screening and follow-up for adolescents and adults**

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 by clicking the start button below and then use the arrow buttons to move through each of the slides.

1

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.

2

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.

3

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.

4

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.

5

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.

Intervention

To help our members achieve real results, the chart below adds practical behavior-change tools to our health equity training.

By focusing on building member confidence, setting achievable goals, and simplifying the healthcare process, we do more than just complete paperwork—we help people make long-term changes that actually improve their health.

Intervention	Health Equity Outcome	Behavior Change Element (the “How”)
Enrollment in Enhanced Care Management (ECM)	A person-centered care plan resulted in controlled diabetes and improved medication management.	Self-Efficacy & Goal Setting: Collaborative goal-setting empowers Mario to take ownership of his health, increasing his confidence (self-efficacy) to manage chronic conditions independently.
Enrollment in CalFresh	Mario and his wife are now able to afford healthier food choices.	Reducing Friction (Environmental Restructuring): By removing the financial barrier to healthy food, the intervention changes Mario's "choice architecture," making the healthy choice the easiest and most accessible choice.
Mario's Wife's Enrollment in Medi-Cal	Mario's wife became an IEHP member and received her breast cancer screening.	Prompts & Social Norms: Proactive outreach and personalized reminders from the care team serve as "cues to action," overcoming procrastination and addressing medical mistrust through a trusted health partner.
Complex Children & Family Services	Mario's daughter has case management support for her children's medical needs.	Reducing Cognitive Load: Professional case management offloads the complex mental task of navigating systems, preventing "caregiver burnout" and allowing the daughter to focus on consistent health behaviors for her children.

If you haven't downloaded it yet and want to view the full citations and data links used in this lesson, please download the citation document below.



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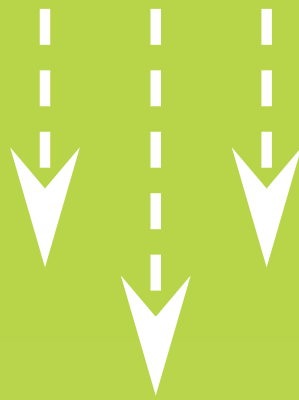
IEHP Member Data Policies



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.

Click each of the tabs below to learn more.

TYPE OF INFORMATION

**DISCLOSURE OF
INFORMATION**

**MEMBER ACCESS TO
INFORMATION**

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

- Name
- Address
- Personal facts
- Medical care given
- Medical history
- Other information such as race/ethnicity, language, gender identity and sexual orientation



TYPE OF INFORMATION	DISCLOSURE OF INFORMATION	MEMBER ACCESS TO INFORMATION
---------------------	------------------------------	---------------------------------

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

- Treatment
- Payment
- Health care operations associated with a particular program for which a member is enrolled



TYPE OF INFORMATION	DISCLOSURE OF INFORMATION	MEMBER ACCESS TO INFORMATION
<p>The Notice of Privacy Practices informs members that when IEHP shares medical health information, members have the right to request a list of:</p> <ul style="list-style-type: none">• With whom IEHP shared the information with• When IEHP shared it• The reasons the data was shared• What information 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 "Privacy Practices" button.

PRIVACY PRACTICES

CONTINUE

Check Your Understanding



CHECK YOUR UNDERSTANDING

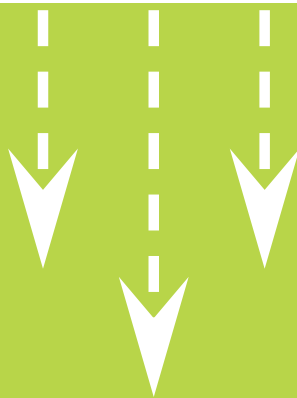


**It's time to check how much you remember. Select
the correct option for the following questions:**

More than 50% of IEHP members are Hispanic. What is the preferred language of most IEHP members?

- ☐ English
- ☐ Spanish
- ☐ Other

SUBMIT

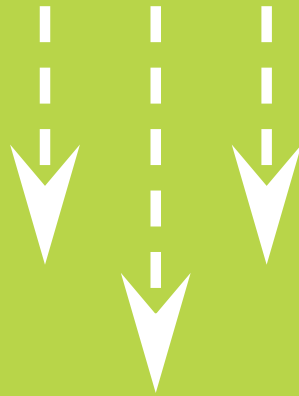


The sex-at-birth and gender identity of most IEHP members is:

☐ Female

☐ Male

SUBMIT



What medical diagnoses are listed in the top 10 for both Medi-Cal and D-SNP members? *select all that apply*

☐ Hypertension

☐ Hyperlipidemia

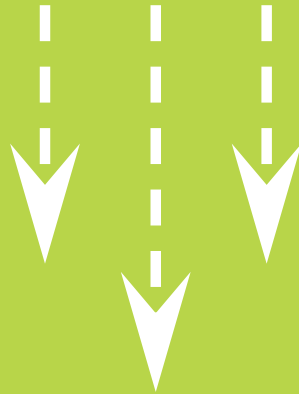
☐

Vitamin D deficiency

☐

Type 2 diabetes mellitus without complications

SUBMIT



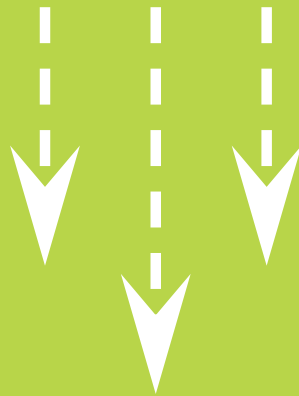
**Black or African Americans have been identified as a disparity group
for which of the following quality measures:**

☐

Breast cancer screenings

- ☐ Vitamin D deficiency
- ☐ Controlling blood pressure

SUBMIT



What is the informing notice that IEHP members receive upon enrollment that outlines how the plan protects the privacy and confidentiality of our members' sensitive information?

- ☐ Health Insurance Portability and Accountability Act (HIPAA)
- ☐ Notice of Privacy Practices

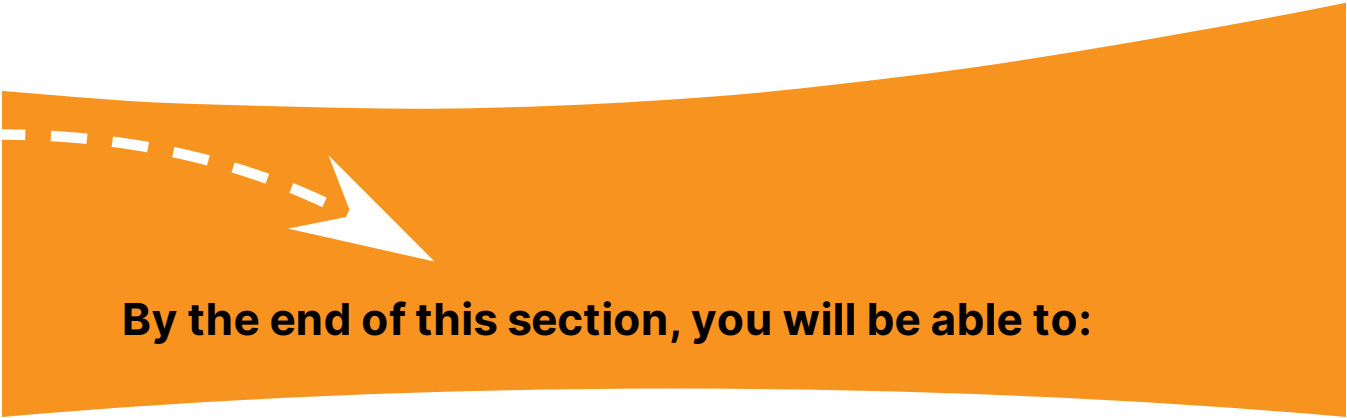


Protected Health Information (PHI)

SUBMIT

CONTINUE

Structural and Institutional Racism



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.

CONTINUE



Structural and 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.



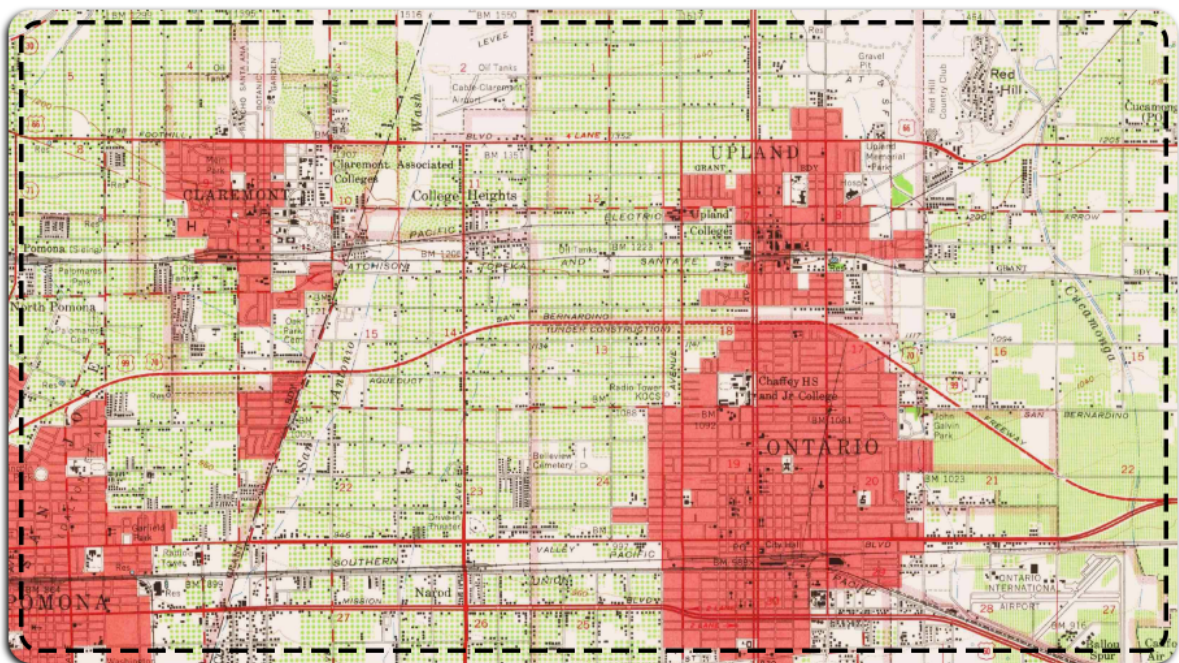
Examples of Structural and Institutional Racism

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 Centers for Disease Control and Prevention (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."

1

Redlining and Discriminatory Lending



During the Great Depression, residential neighborhoods were graded as either low risk or "hazardous" (high risk) based on various factors, including their racial and ethnic makeup. Learn more by clicking the start button below and then use the arrow buttons to move through each of the slides.

1



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.

2



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.

Summary

Redlining negatively impacted both individuals and communities by:

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

For more information, see the citations document at the end of this lesson.

CONTINUE



Racial Residential Discrimination

Jim Crow Laws

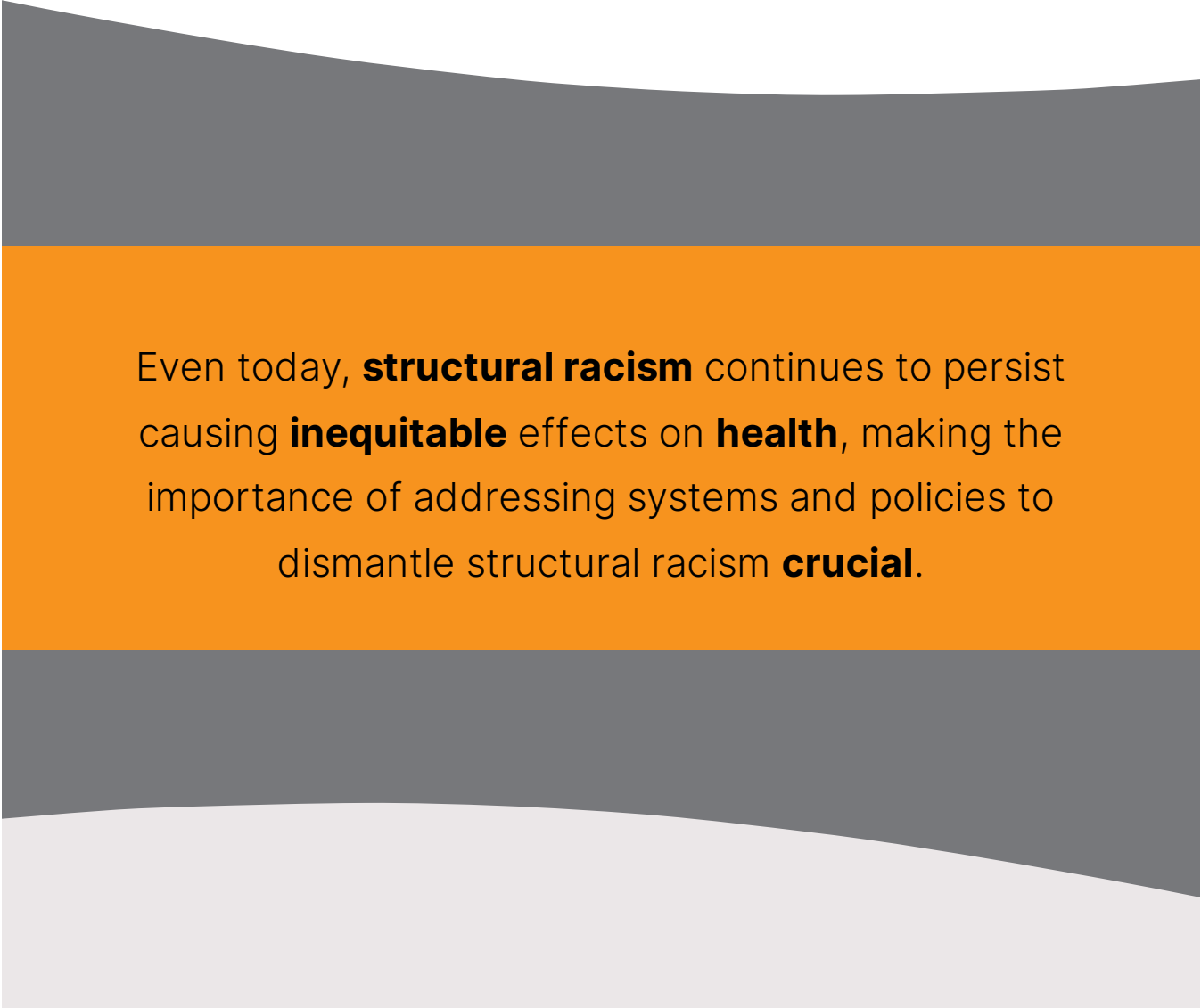
In the late 19th and early 20th centuries state and local laws, known as the Jim Crow laws, enforced racial segregation.

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**.

CONTINUE

Impact of Structural Racism on IEHP Members

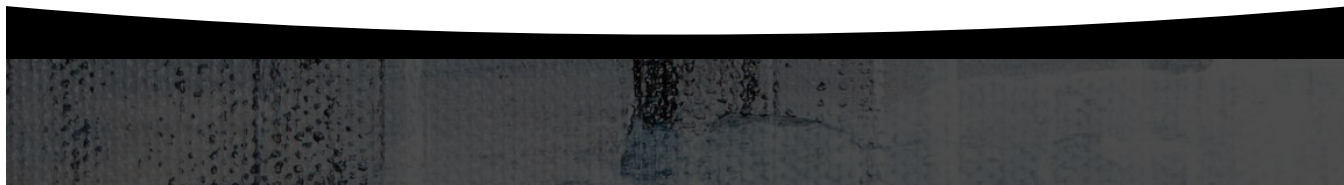
The following example helps demonstrate how structural racism, and the health inequalities it creates, fostered intergenerational illness in an African American family.





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

CONTINUE



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:

- Discrimination
- Prejudice
- Verbal violence
- 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.





CONTINUE

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.

- Shifts the focus from “What’s wrong with you?” to “What happened to you?”
- Allows health care providers to deliver more effective health care services by being sensitive about the importance of understanding a patient’s life experience.
- Provides improved patient and provider engagement, treatment cooperation, and health outcomes.
- 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.

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA's six principles that guide a trauma-informed approach, including:



Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

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- 1. Safety**
- 2. Trustworthiness & transparency**
- 3. Peer support**
- 4. Collaboration & mutuality**

5. **Empowerment voice & choice**

6. **Cultural, historical & gender issues**

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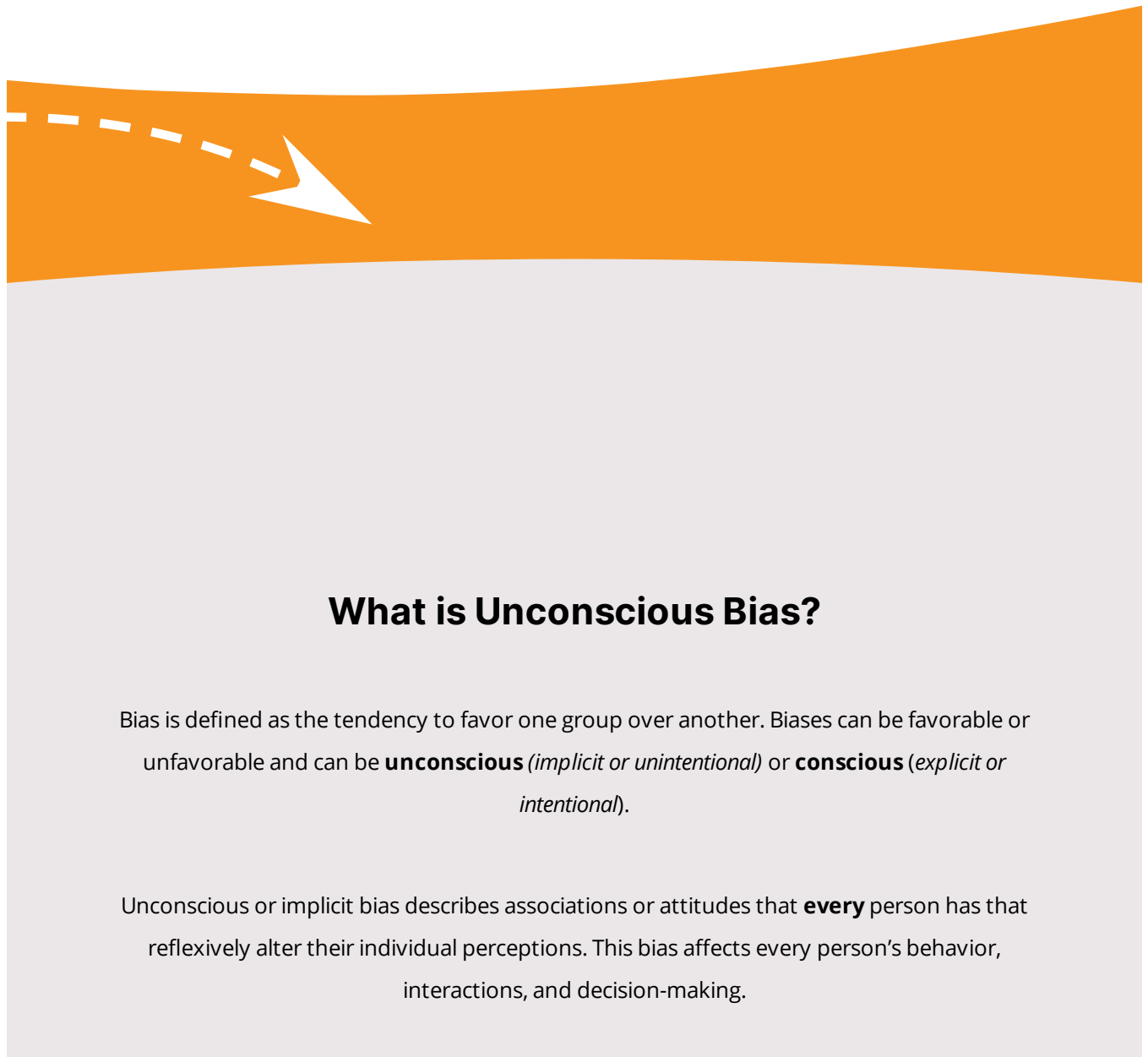


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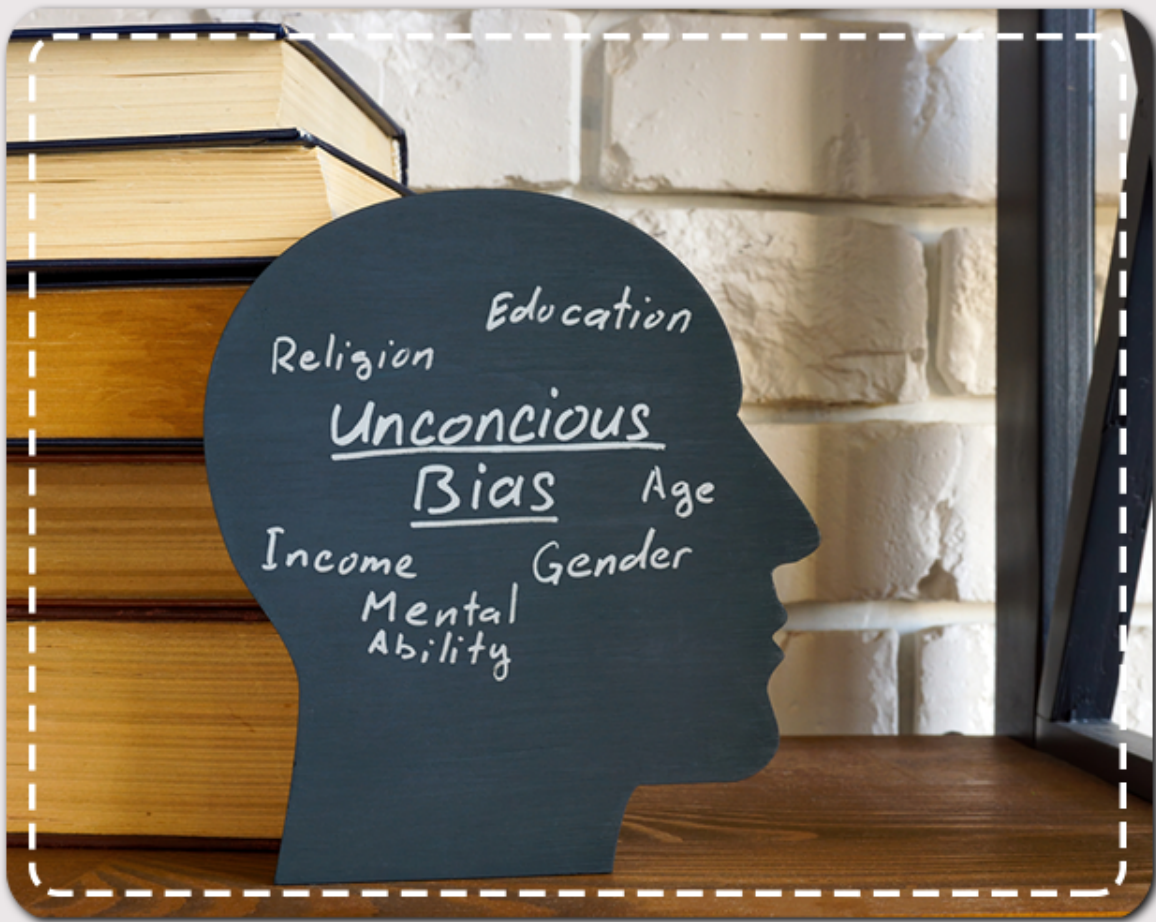
Unconscious Bias



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.



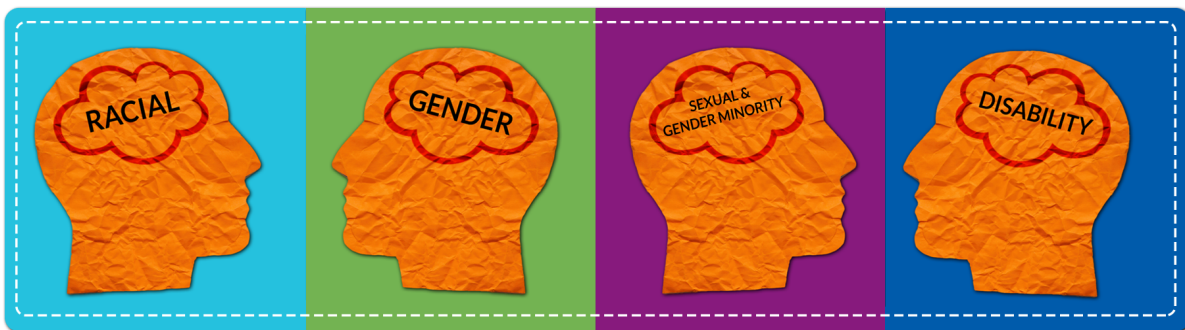
These associations are made in the unconscious state of mind, meaning that we likely are not aware of our own biased associations.



CONTINUE

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, type of insurance, language and many other characteristics are all subject to bias.

CONTINUE



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.

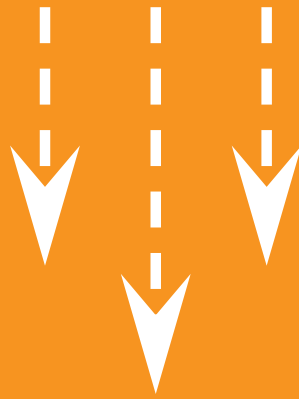
1

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

2

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

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.

Click on each of the sections below to learn ways that unconscious biases may be minimized and changed.

Recognize That You Have Biases —

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

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.

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.

Counter Stereotypical Imaging —

Your unconscious biases exist because your brain formed associations based on your worldview, 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.

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.

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.

CONTINUE

Health Equity

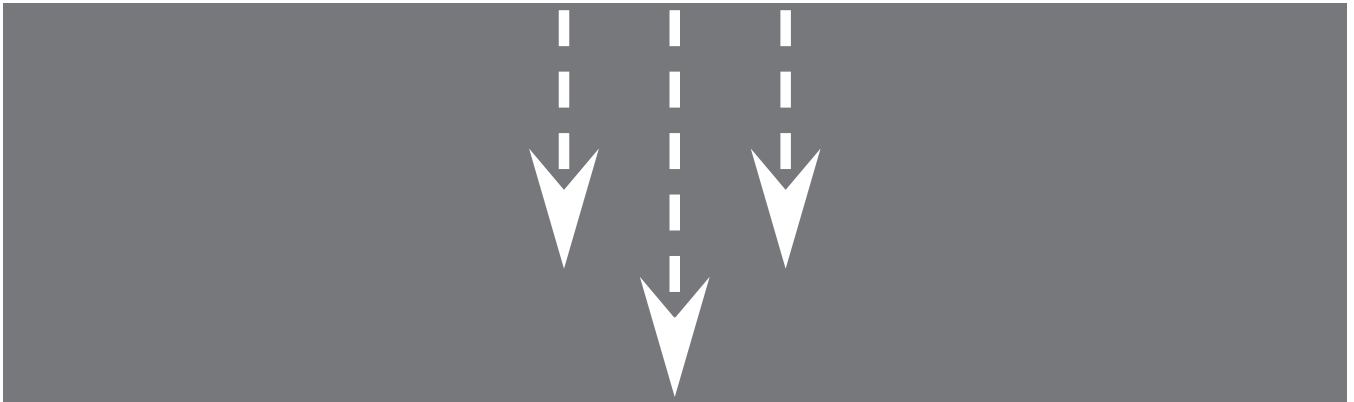


Equality vs. Equity

What's the difference?



Equality is giving everyone the same bike.



Equity is giving everyone access to a bike tailored to their individual needs.

CONTINUE



Now let's define **equity** and **inequity**.

EQUITY

INEQUITY

"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."



E Q U I T Y

EQUITY

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."



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.

“ Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.”

World Health Organization

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

CONTINUE



Who is affected by health inequities?



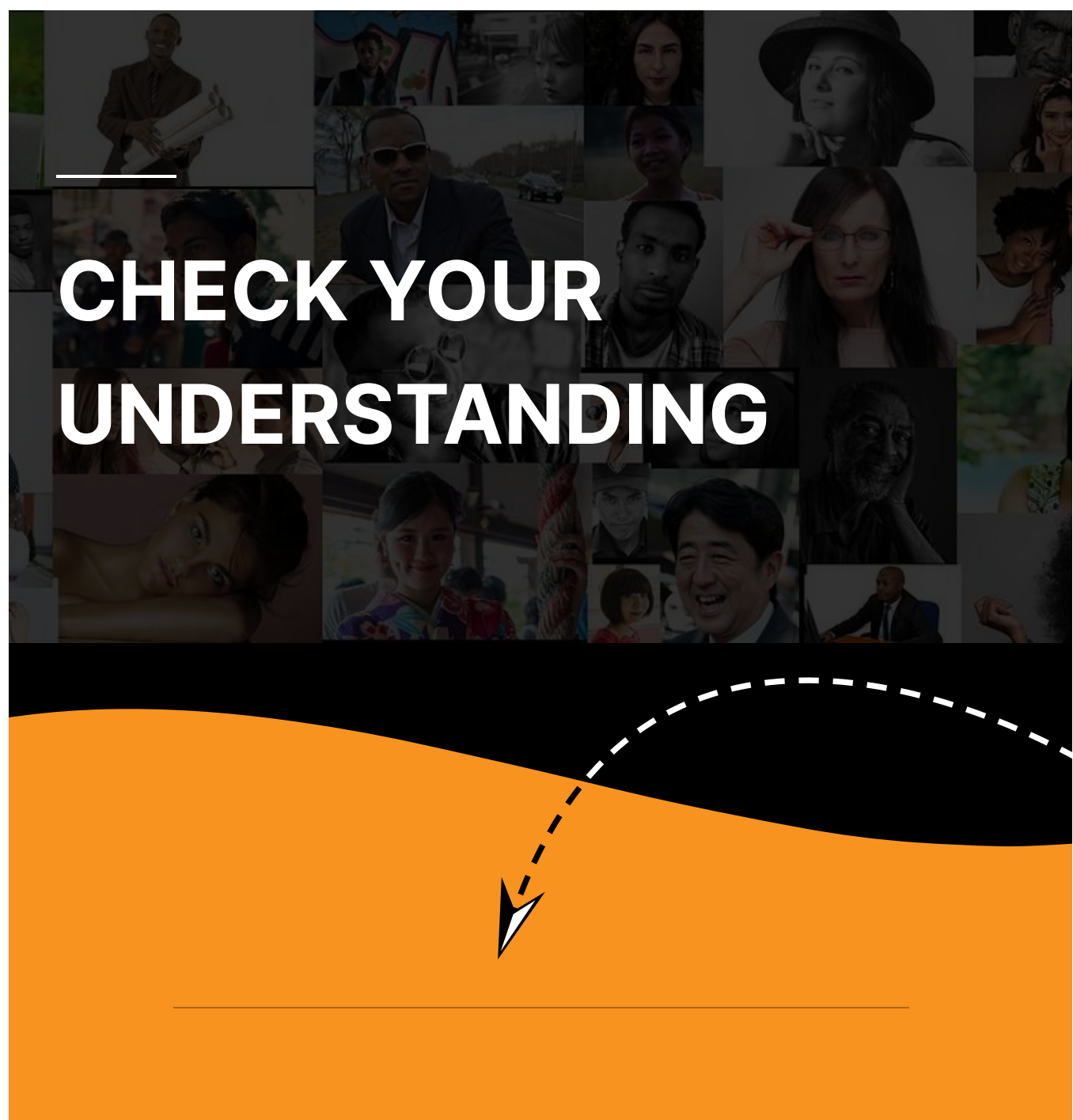
Racial and ethnic minority groups

- Racial and ethnic minority groups
- Seniors and persons with disabilities (physical, intellectual, developmental)
- Women
- LGBTQIA+
- Limited English Proficiency (LEP) groups
- Refugees and immigrants
- Persons of lower socioeconomic status
- Persons with certain religious preferences
- Persons with substance use disorders
- Persons with a history of incarceration
- 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**.

CONTINUE

Check Your Understanding

A collage of various people's faces, including men and women of different ages and ethnicities, arranged in a grid-like pattern. The text "CHECK YOUR UNDERSTANDING" is overlaid in large, white, bold, sans-serif capital letters. Below the collage, a dashed white arrow curves from the right side of the collage down to a horizontal line on a solid orange background.

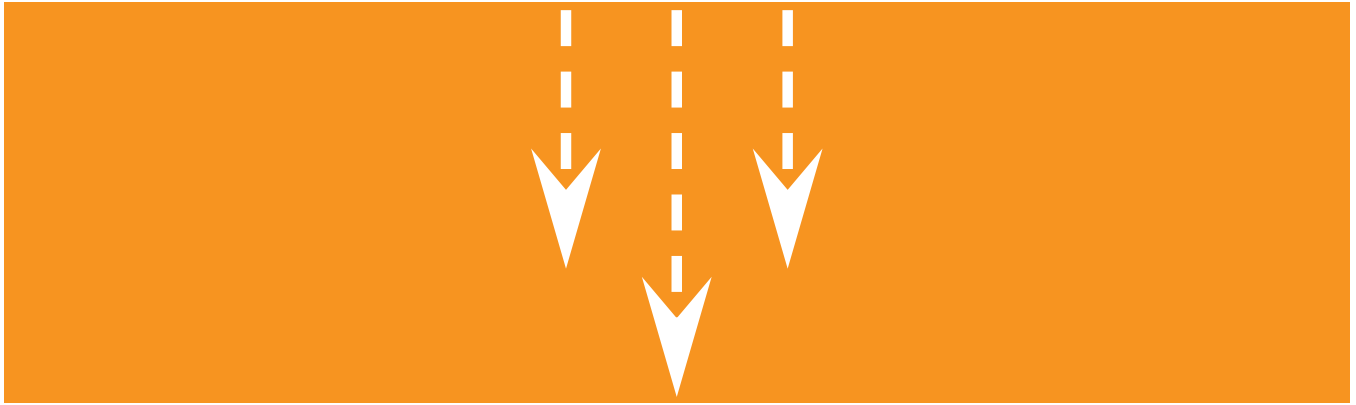
**CHECK YOUR
UNDERSTANDING**

It's time to check how much you remember. Select the correct option for the following questions:

According to the American Medical Association (AMA), structural racism is defined as:

- ☐ The various ways in which societies cultivate racial discrimination through reinforcing personal bias or prejudice held by an individual against a particular racial group.
- ☐ 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.

SUBMIT



Structural racism contributes to racial and ethnic minorities experiencing *LOWER* rates of illness and death across a wide range of health conditions.

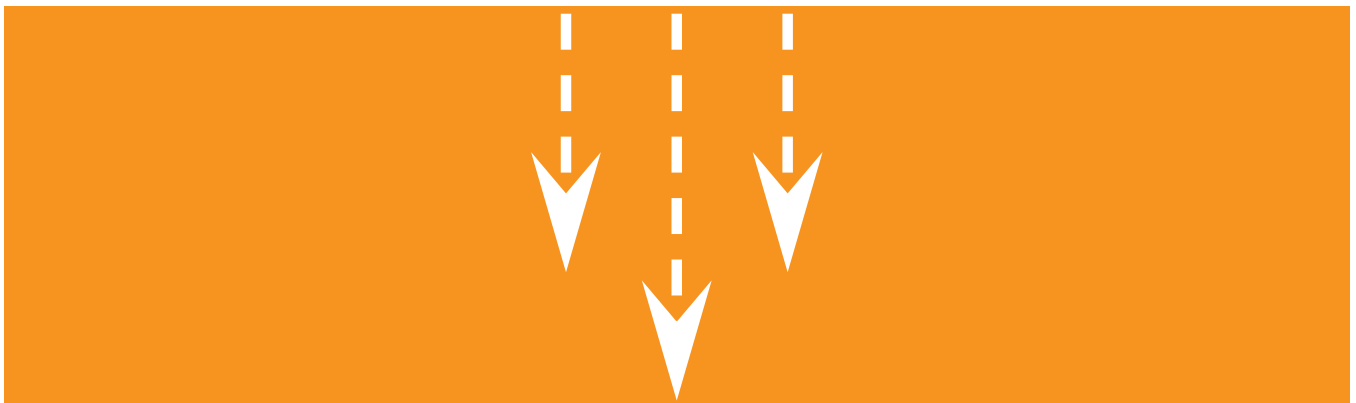
☐

True

☐

False

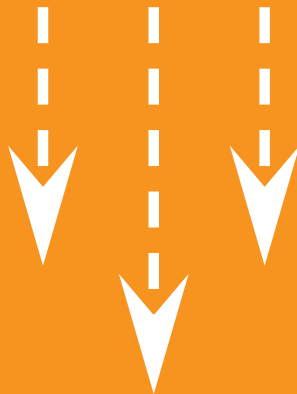
SUBMIT



When health care professionals show humility about the aspects of a person's cultural experiences that are different from their own, this is called:

- ☐ Racism Awareness Approach
- ☐ Bias-free Care Method
- ☐ Trauma-informed Care

SUBMIT



Unconscious bias influences the way information about an individual is processed. Which of the following are types of unconscious bias that can alter our individual perceptions?

select all that apply

☐

Racial

☐

Gender

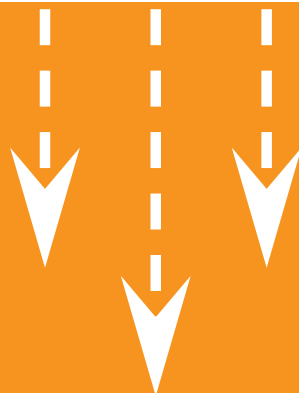
☐

Sexual and Gender Minority

☐

Disability

SUBMIT



Considering our role as health care professionals, when providing health care services we should strive for which of the following?

☐ Equality

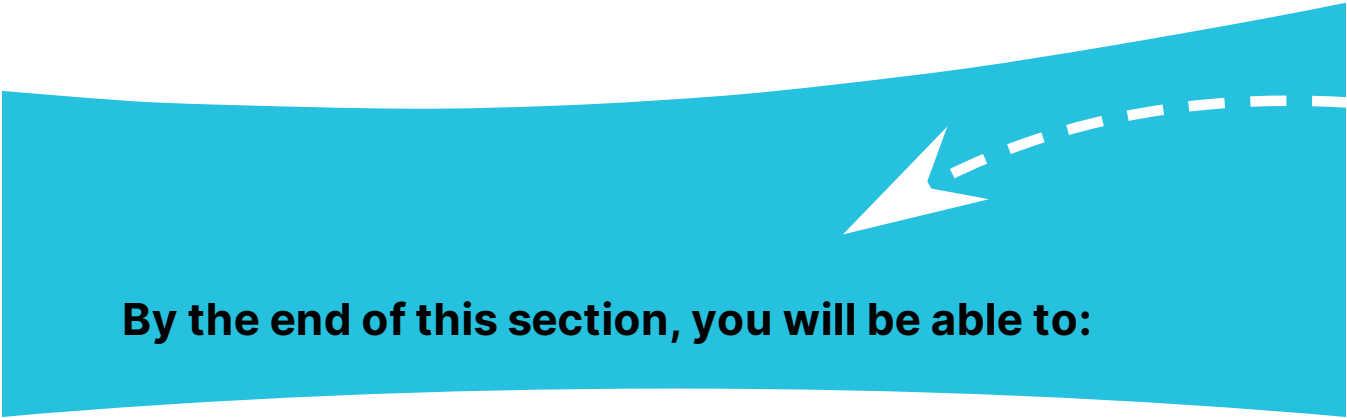
☐ Equity

☐ Inequity

SUBMIT

CONTINUE

The Effect of Culture on Members



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.

CONTINUE

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.

CONTINUE



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.



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.



Cultural competence is an active learning process... a process of a person recognizing their own cultural beliefs and values, and how they may differ from someone else's. This promotes cultural engagement and allows them to effectively use a combination of knowledge, attitude, and skills.



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."

Click through each section below to learn more about strategies to practice 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."

CONTINUE



Cultural Beliefs and Behaviors

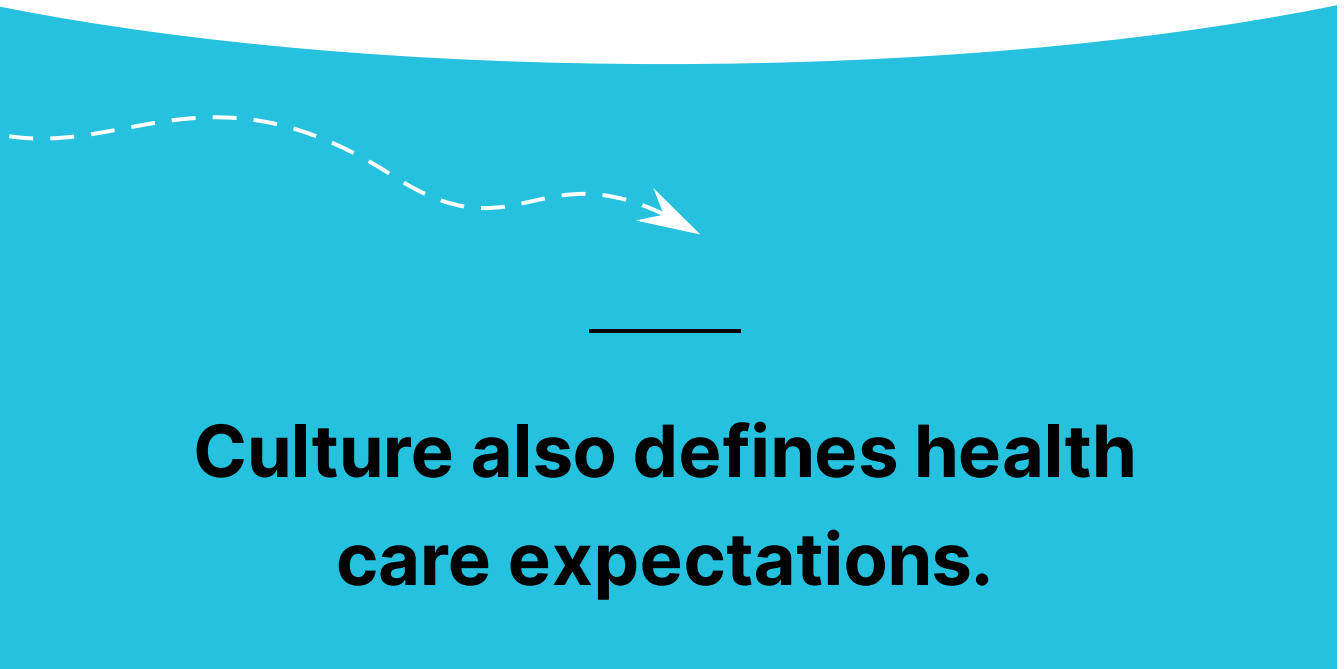
Culture impacts **every** health care encounter!

“ ...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.



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



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.

CONTINUE

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**



**Provider
Gender**

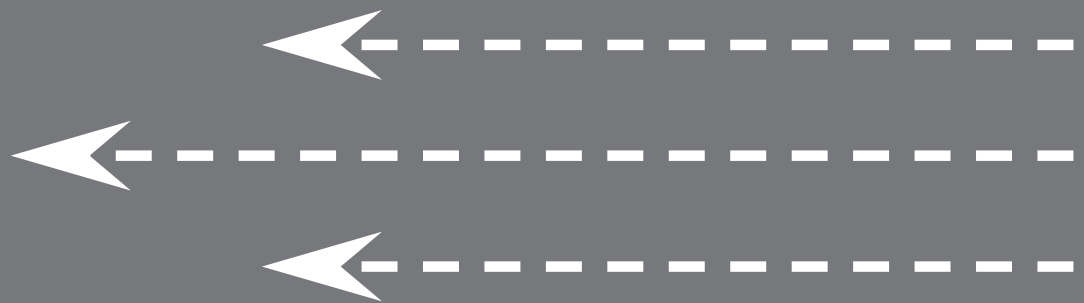


**Clinical
Assessment**



**Traditional
Medicine**

- 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.
- Members may also be uncomfortable with a provider or interpreter of a different sex or gender. Team members can assist with accommodations with a doctor or interpreter of the same sex or gender.
- 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.
- 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.



Refugees and Immigrants



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

Click each of the images below to learn more.



Refugees and immigrants may not be familiar with the U.S. health care system.



Refugees and immigrants may experience illness related to life changes.



Refugees and immigrants may practice spiritual and botanic healing or treatments before seeking U.S. medical advice.

Use of Traditional Medicine

Click each of the buttons below to learn more. Use the scroll bar on each card to read the full text.





#1

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:

- acupuncture
- homeopathy
- mesotherapy
- massage
- aromatherapy
- yoga



#2

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%).



#3

"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.



Remember:

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



CONTINUE

Impact of Member Experience

Member Experience with IEHP

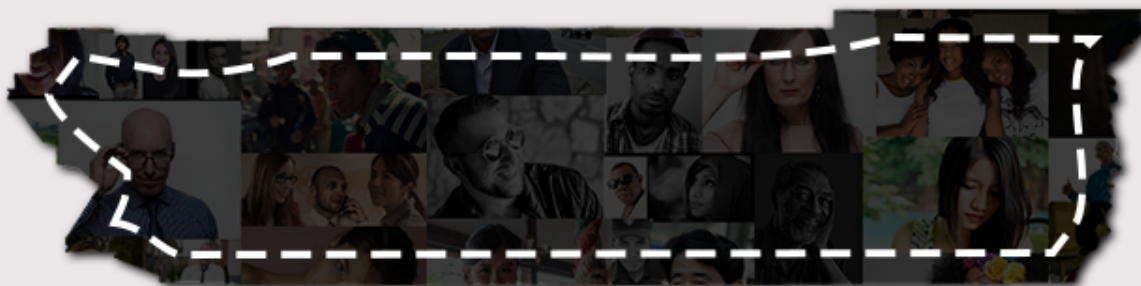


64 grievances were received in **2025** from members on their **perceived discrimination** from IEHP.

647 grievances were also received from members on perceived discrimination from providers, specialists, independent physician associations (IPAs), pharmacies and urgent cares.

DEI Focus Groups

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



Riverside County

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

- **Language** - a member felt discriminated against when they did not speak Spanish after a vendor approached and assumed that they were Spanish-speaking.
- **Racial Profile** – a member was pulled over due to racial profiling and type of vehicle they drove.
- **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:

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



CONTINUE

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.”

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

Click each tab below to learn more about the perceived discrimination members reported experiencing from IEHP network providers:

RIVERSIDE COUNTY

SAN BERNARDINO COUNTY

Weight

The member reported their provider immediately assumed the member's knee issues were due to being overweight without completing other testing or questions.

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.

RIVERSIDE COUNTY

SAN BERNARDINO COUNTY

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.

CONTINUE

Meeting IEHP Member Cultural Needs



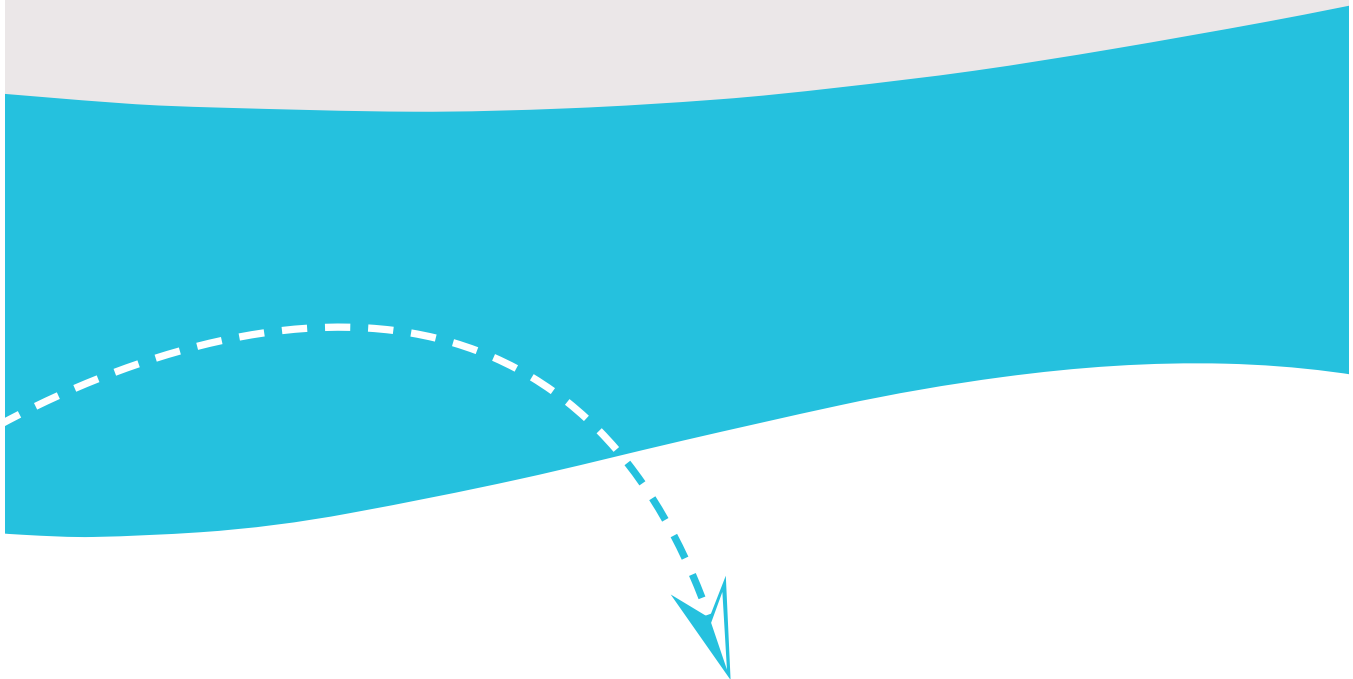
It is **important** that **all** IEHP team members and network providers **meet** the **cultural** needs of IEHP **members** by using **culturally** and **linguistically** appropriate practices.

Click the card below to learn more.

**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,

CONTINUE



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**.



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.

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.

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.

Member Interaction

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

CONTINUE

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

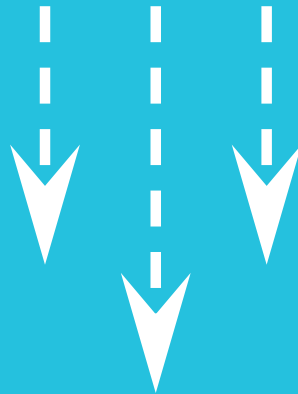
What are the main problems that the illness has caused?

8

What do you fear most about the illness?



To save and keep a Quick Reference Guide of Kleinman's 8 Questions, click on the PDF below.



Kleinmans8Questions_2024.pdf
244 KB



CONTINUE

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. Learn more by clicking the start button below and then use the arrow buttons to move through each of the slides.

HOPE

The HOPE assessment tool uses questions like:

H: Sources of hope

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

O: Organized religion

- Are you part of a religious or spiritual community?
- If so, does it help you? How?

P: Personal spirituality and practices

- Do you have personal spiritual beliefs?
- What aspects of your spirituality or spiritual practices do you find most helpful?

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)?

FICA

The FICA assessment tool uses questions like:

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?

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?

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?

A: Address in Care

- How should health care providers address these issues in your health care?

Summary

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

HOPE and FICA Assessment Tool Resource

For an additional resource on sample questions for HOPE and FICA assessment tools, click the "visit" button to view a PDF from Equity, Diversity, Inclusion & Access (EDIA).

VISIT

CONTINUE



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.**

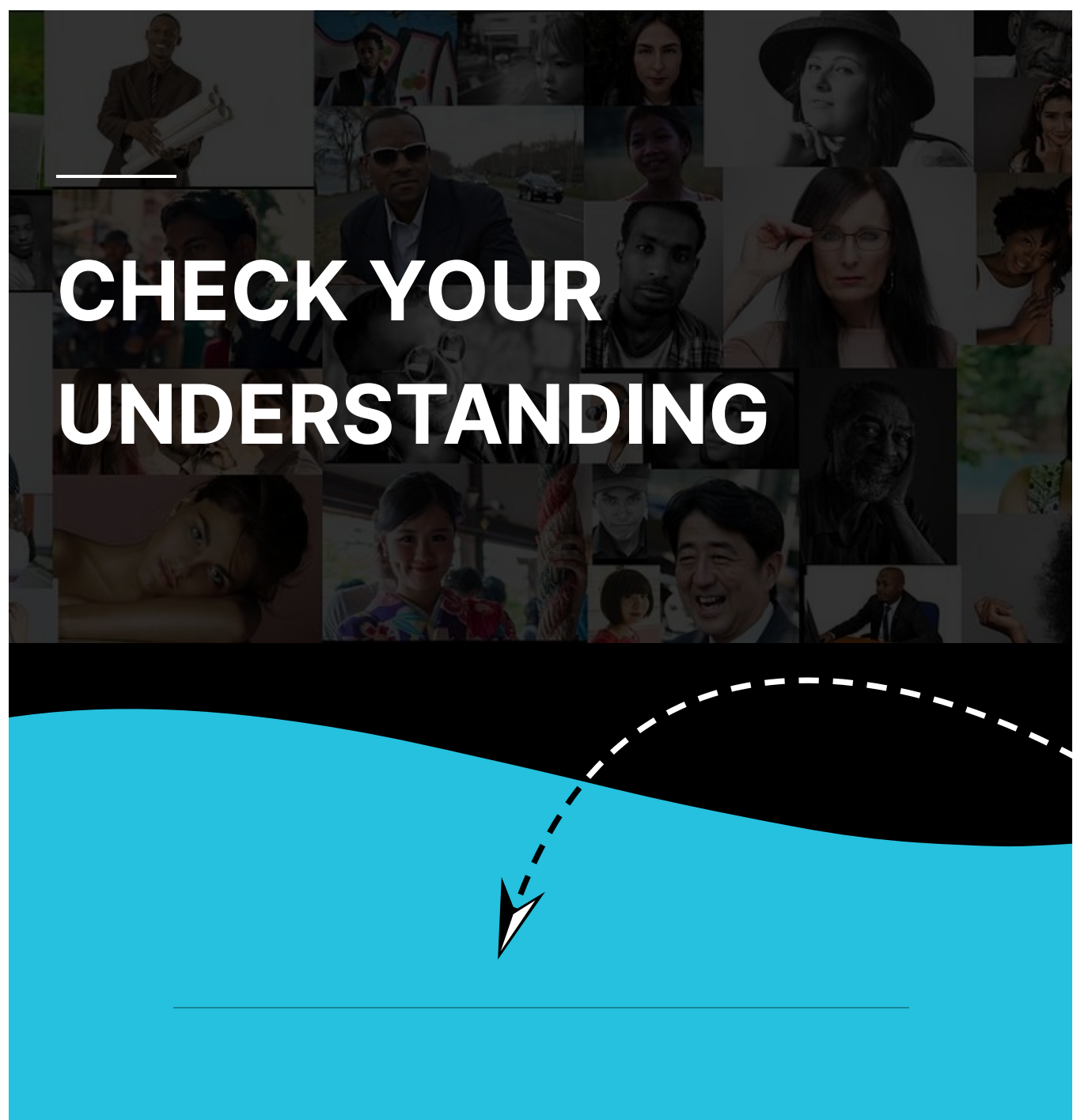
3. IEHP recruits and retains a culturally and linguistically diverse governance that represents the community served by IEHP.



Learn more about the specific culturally and linguistically appropriate services that IEHP provides to our members in the section called "Literacy Needs."

CONTINUE

Check Your Understanding

A collage of diverse people's faces and a stylized graphic of a dashed line with an arrow pointing down into a blue area.

**CHECK YOUR
UNDERSTANDING**

It's time to check how much you remember. Select the correct option for the following questions:

Culture informs on a member's:

select all that apply

☐

Concepts of health and healing

☐

How illness, disease, and their causes are perceived

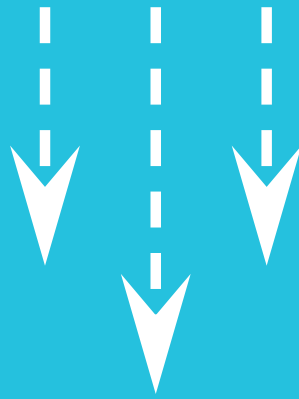
☐

The behaviors of patients seeking health care

☐

Attitudes toward health care providers

SUBMIT



Based on data received from IEHP members during focus groups, members in both Riverside and San Bernardino counties expressed perceived discrimination in which of the following areas?

- ☐ Racial Profile
- ☐ Weight
- ☐ Disability

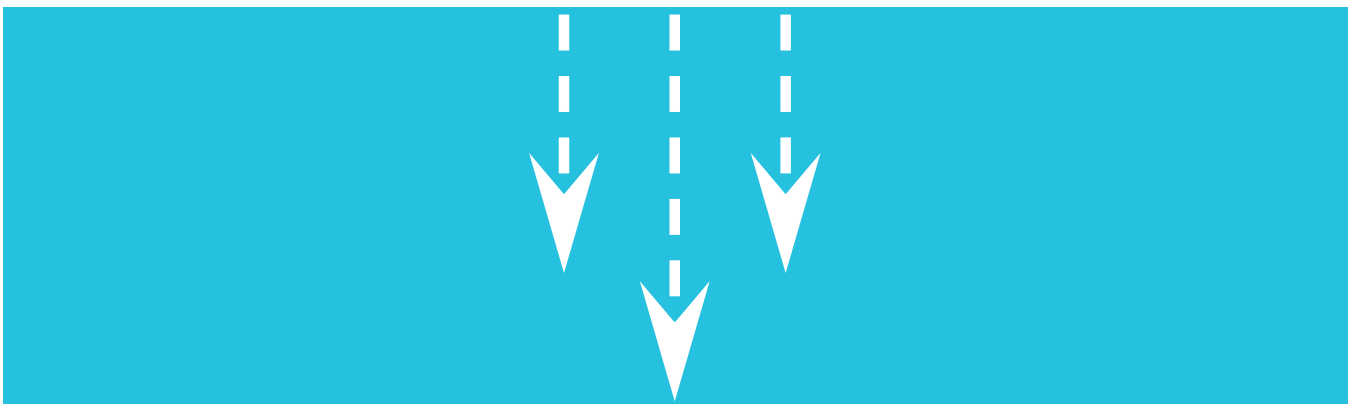
SUBMIT



**It is important that all IEHP team members and network providers
meet the cultural needs of IEHP members by using:**

- ☐ Social determinants of health
- ☐ Culturally and linguistically appropriate practices
- ☐ Member focus groups

SUBMIT



Kleinman's Model is a set of eight questions that may be asked when speaking to IEHP members. Which question is NOT one of the eight questions?

- ☐ What do you think has caused the problem?
- ☐ What do you call your problem?
- ☐ Where does it hurt?
- ☐ What kind of treatment do you think you should receive?

SUBMIT



When interacting with members, HOPE and FICA are what types of assessment tools that health care professionals can use?

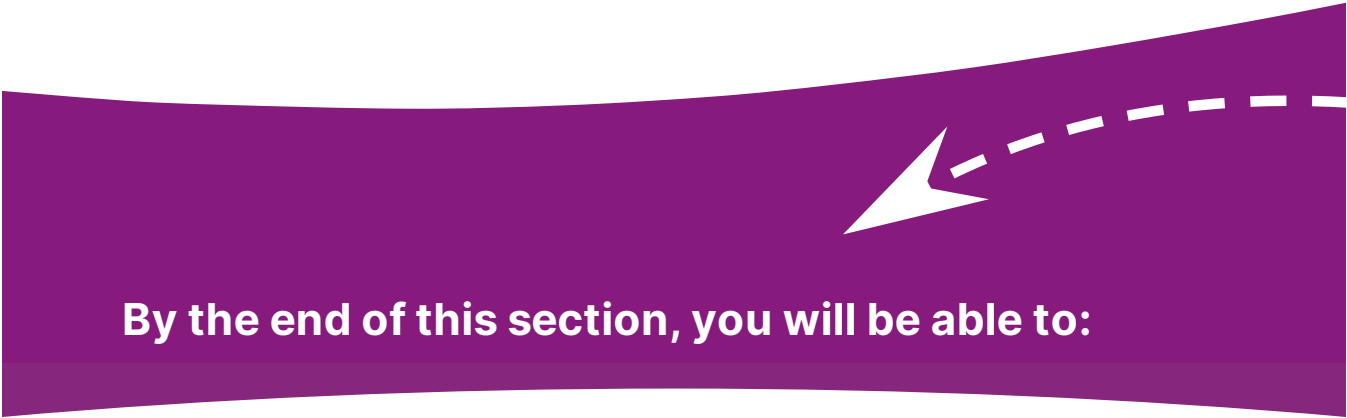
- ☐ Community support assessments
- ☐ Demographic assessments
- ☐ Spirituality assessments

SUBMIT



CONTINUE

Social Needs of IEHP Members



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.

CONTINUE

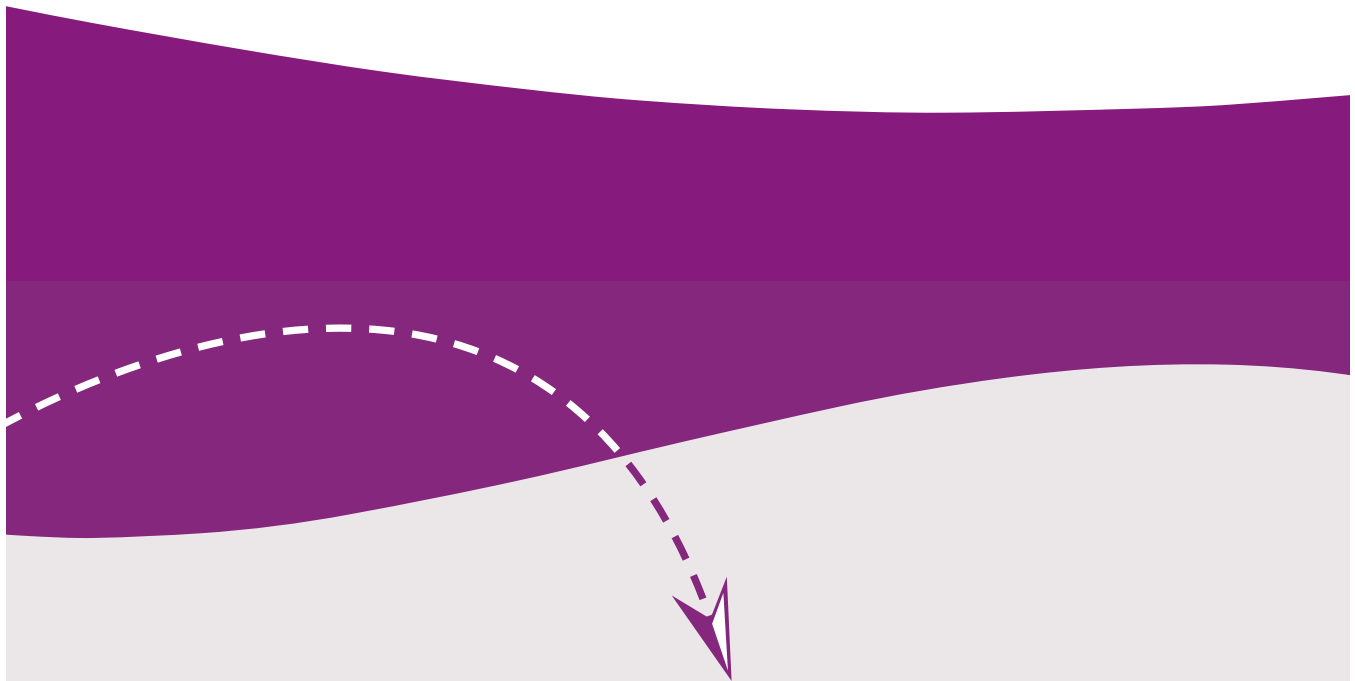
Social Needs of IEHP Members

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

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."



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.

Click each of the tabs below to learn more.

RIVERSIDE COUNTY

SAN BERNARDINO COUNTY

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

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

RIVERSIDE COUNTY

SAN BERNARDINO COUNTY

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

- Increased criminal activity
- Theft
- Vandalism
- Homelessness
- Panhandling
- Lack of affordable housing
- Traffic
- Lack of weed abatement
- Community input before making big decisions, relocations, etc.
- Food insecurity
- Lack of transportation resources

CONTINUE

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.

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:

- 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.
- 3 in 10 transgender people reported that they were unable to be seen by providers because of their gender identity.



FOR MORE INFORMATION

Click the LEARN MORE button.

[LEARN MORE](#)

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

Click each of the images below to learn more.

HETERONORMATIVE

GENDER IDENTITY

adjective | het·er·o·nor·ma·tive | hedərō 'nōrmədīv

: 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:

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



HETERONORMATIVE

GENDER IDENTITY

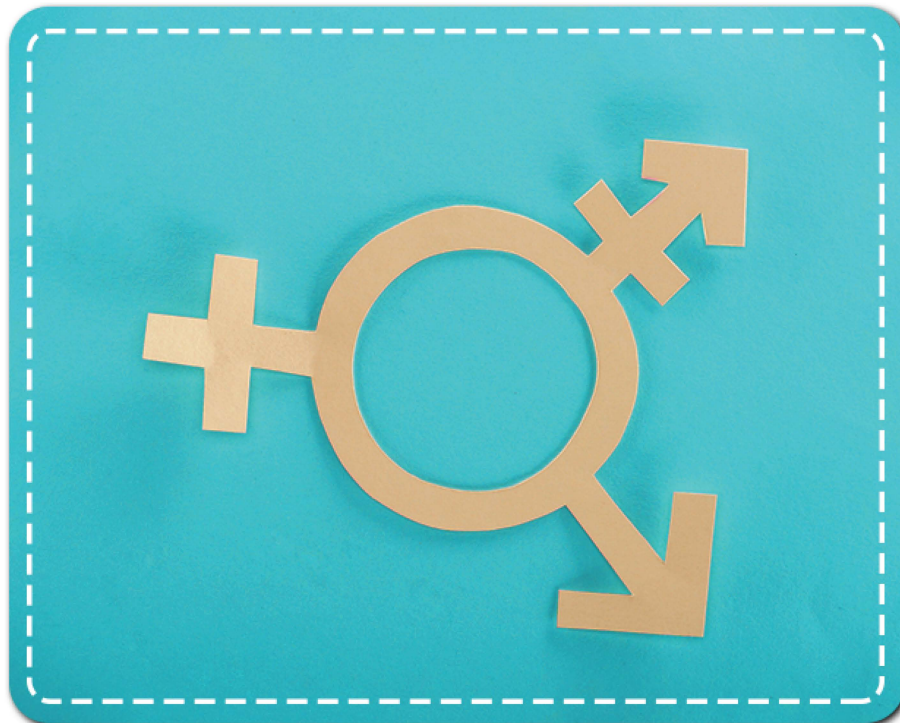
noun | gen·der iden·ti·ty | jen-dər ī-'den-tə-tē

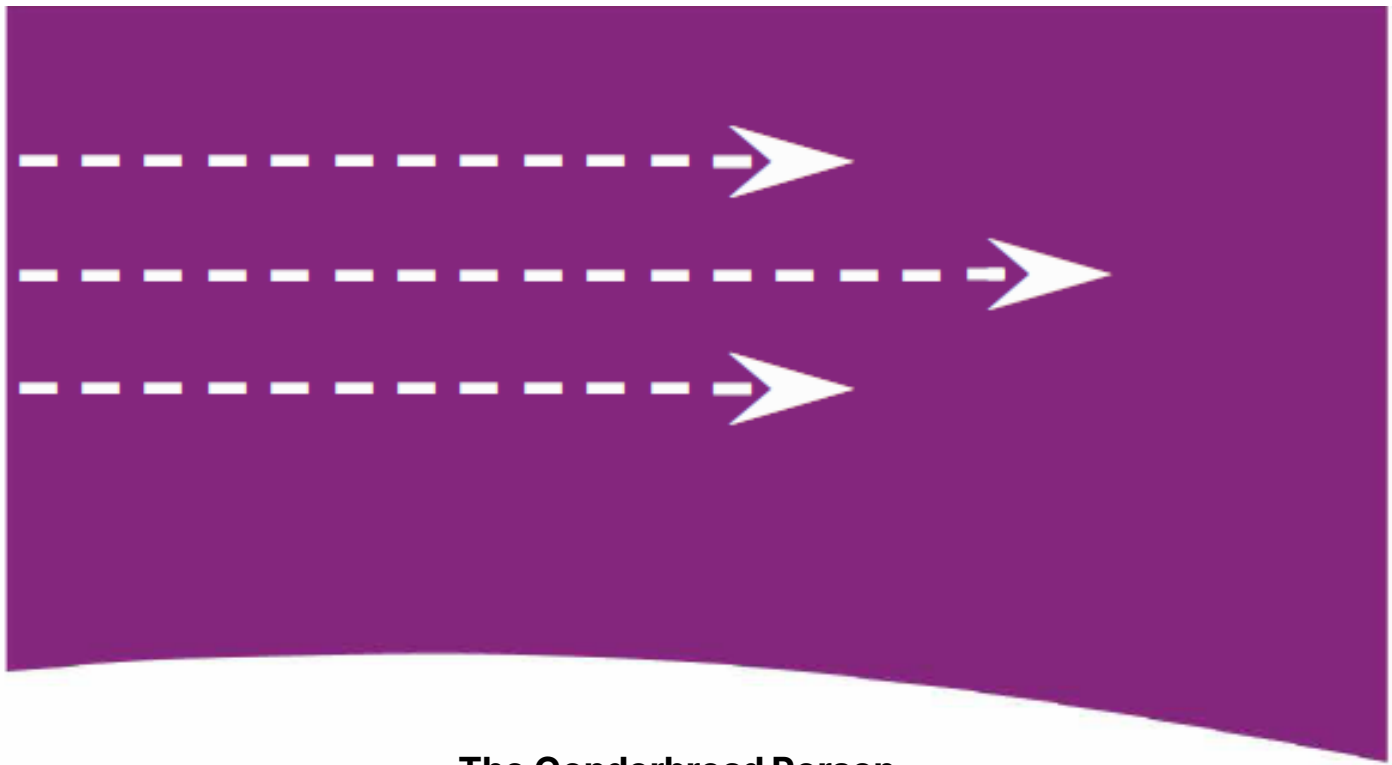
: An individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.

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.

Gender-affirming care includes:

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

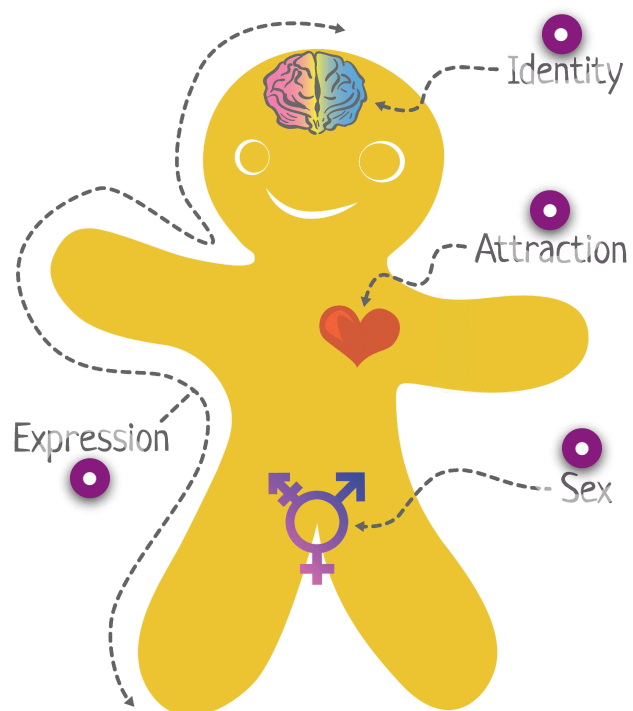


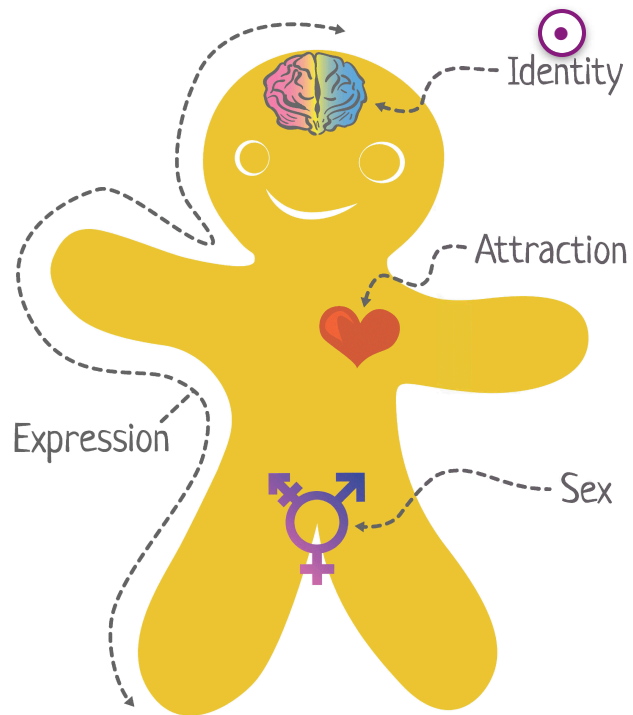


The Genderbread Person

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

Click each of the buttons below to learn more.

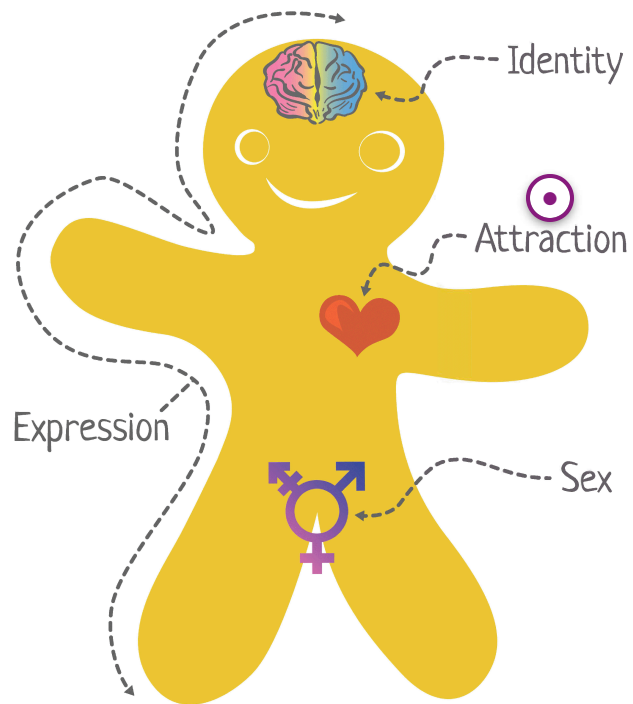




Identity



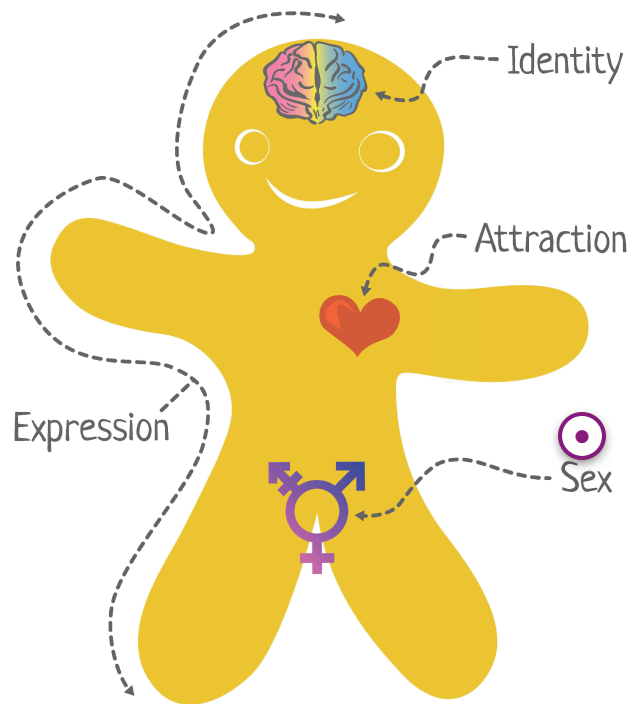
Identity is how you, in your head, experience and define your gender, based on how much you align (or don't align) with what you understand the options for gender to be.



Attraction



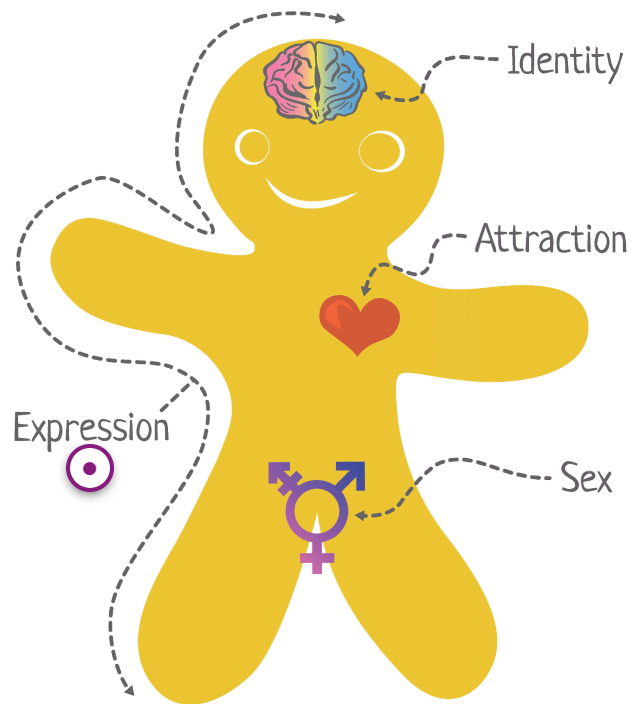
Attraction is how you find yourself feeling drawn (or not drawn) to some other people, in sexual, romantic, and/or other ways (often categorized within gender).



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.



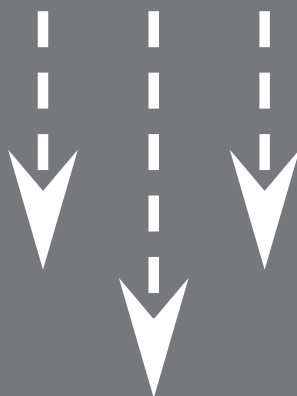
To save and keep a quick reference guide of The Genderbread Person, click on the PDF below.



Genderbread Person v4.pdf
350.5 KB

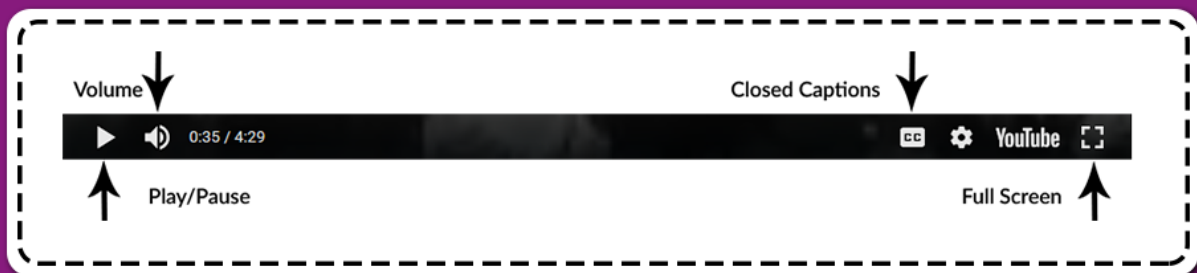


CONTINUE



Still not sure how to explain gender vs. gender identity?
Watch the video below from Onlea.org for more information.

When watching the video, use the bar on the bottom of the video to play or pause the video, adjust the volume, turn on closed captions, or expand the video to full screen.



Click the middle of the image below to open the video in YouTube.



For a quick reference guide on gender inclusive language, click on the PDF below.



GenderInclusiveLanguage_2024.pdf
488.2 KB



CONTINUE

Orientation Terminology

Review the terms listed below to familiarize yourself with common orientation terminology by clicking on the "+" for each section.

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:

- 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."
- 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."

Note: MtF and FtM may be offensive to some people. Language that can be used in place would be transgender woman and transgender man.

National LGBTQIA+ Health Education Center

For additional information on terms relevant to the health care and identities of LGBTQIA+ people, click the "VISIT" button to view the lgbtqiahealtheeducation.org website.

VISIT

CONTINUE



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.



Click each of the tabs below to view examples of gender-affirming care.

SOCIAL

PSYCHOLOGICAL

LEGAL

MEDICAL

- Preferred pronouns
- Names
- Gender expression

SOCIAL

PSYCHOLOGICAL

LEGAL

MEDICAL

- Gender-affirming mental health care

SOCIAL

PSYCHOLOGICAL

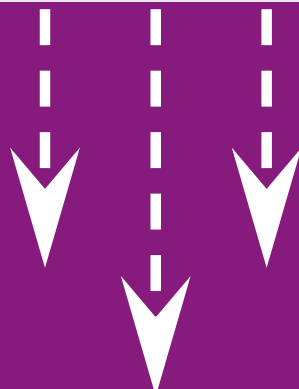
LEGAL

MEDICAL

- Name changes
- Gender recognitions
- Anti-transgender discrimination laws

SOCIAL	PSYCHOLOGICAL	LEGAL	MEDICAL
<ul style="list-style-type: none">• 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:

- Sexually Transmitted Infections
- Substance and Alcohol Abuse
- Mental Health Conditions and Suicide
- Obesity and Body Image Disorders
- Heart Disease
- 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.

CONTINUE

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).

Click each of the images below to learn more.



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



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.



A safe and affirming health care environment is critical in fostering better outcomes for transgender, nonbinary, and other gender expansive people.

CONTINUE

"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.



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. Click the start button below and then use the arrow buttons to move through each of the slides.

Step 1



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."

Step 2



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.

Step 3



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.

Step 4



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.

Summary



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

- A negative patient experience.
- The missed opportunity to address preventive care assessments.
- 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

If you haven't downloaded it yet and want to view the full citations and data links used in this lesson, please download the citation document below.



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308 KB



CONTINUE

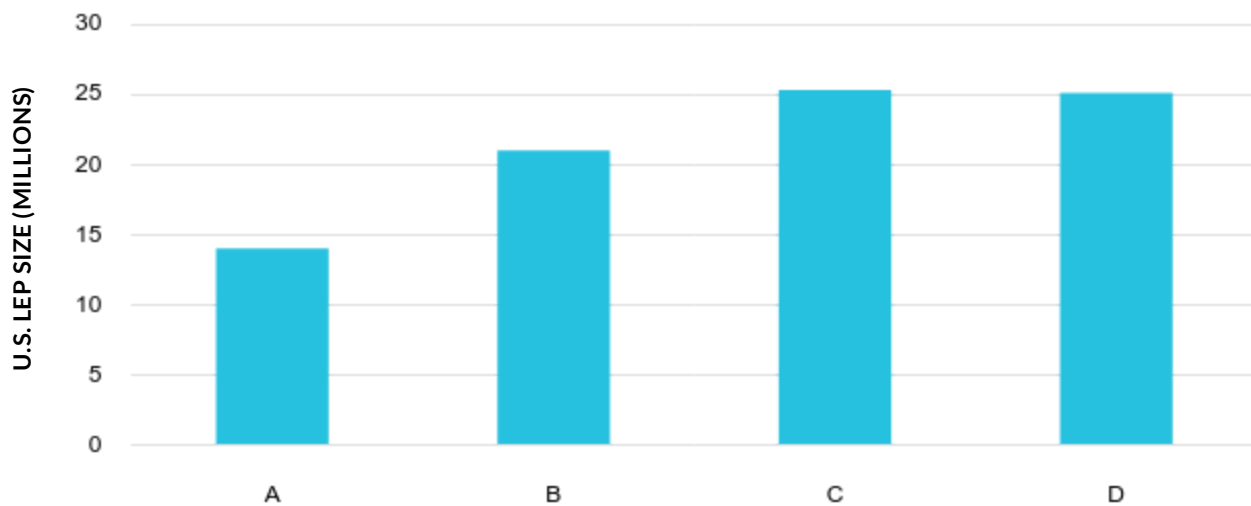
Language and Literacy Needs



Limited English Proficiency (LEP)

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%.



YEAR

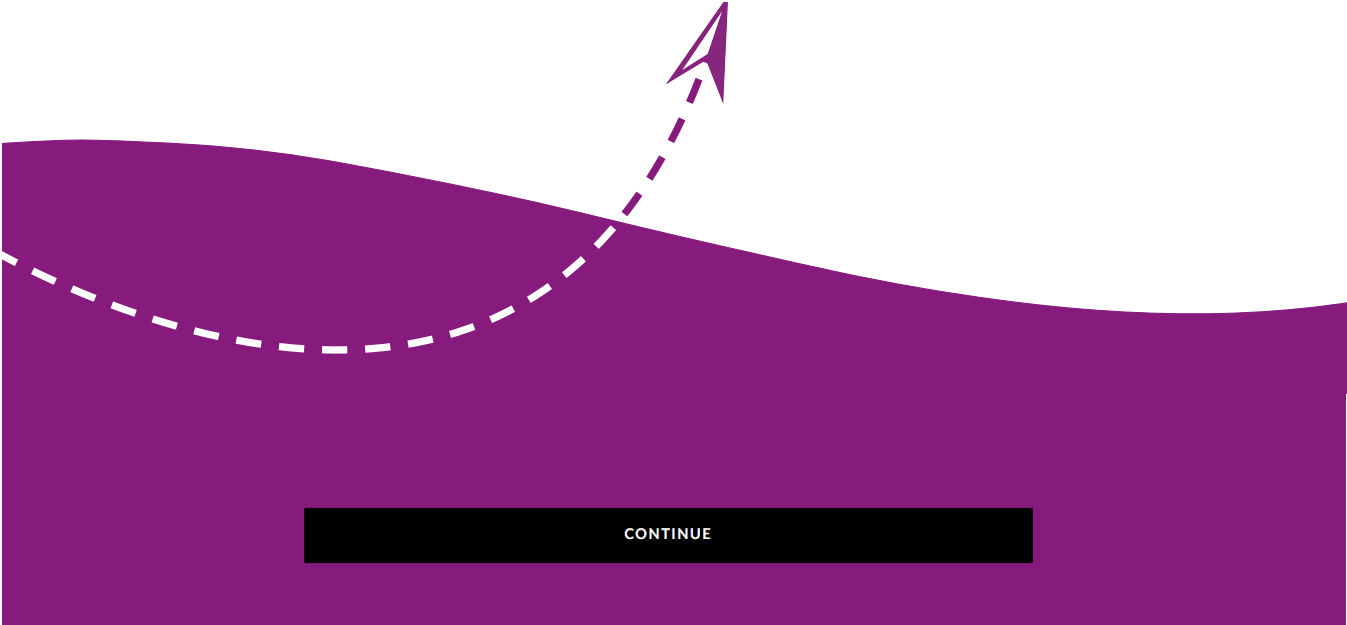
- A. 1990 | 14
- B. 2000 | 21
- C. 2010 | 25.3
- D. 2013 | 25.1

LEP Population Increase (text version)

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

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

For more information about the CYSHCN statistics above, see the citations document at the end of this lesson.



CONTINUE

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

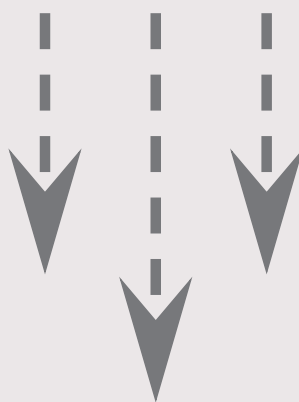
- Vietnamese speakers have been identified by HEQMS as a disparity group for blood pressure control for patients with diabetes.

- 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.

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."



Language and Interpretation Services



**Face-to-Face and
Telephonic Interpretation
Services**



**Video Remote Interpreting
(VRI)**



**Spanish-speaking Member
Services Representatives**



**Provider Office Auditing
Services**

- IEHP provides face-to-face and telephonic interpretation services at medical appointments and when communicating with members.

Click each of the tabs below to learn more.

TELEPHONE INTERPRETATION

FACE-TO-FACE 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.



TELEPHONE INTERPRETATION

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.



- IEHP offers video remote interpreting (VRI) services for American Sign Language (ASL) at urgent care centers.
- IEHP assigns Spanish-speaking members to member service representatives who speak Spanish.
- IEHP also audits provider offices for language capabilities.



For important tips to remember when using interpretation services, click the "+" sign to expand the section below.

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

Click each of the cards below to learn about member rights related to interpretation services.

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.

CONTINUE



Literacy Services

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

To learn more, click the arrows to move forward or backward through the images below.



Members may contact Member Services to read member informing materials including clinical medical information.



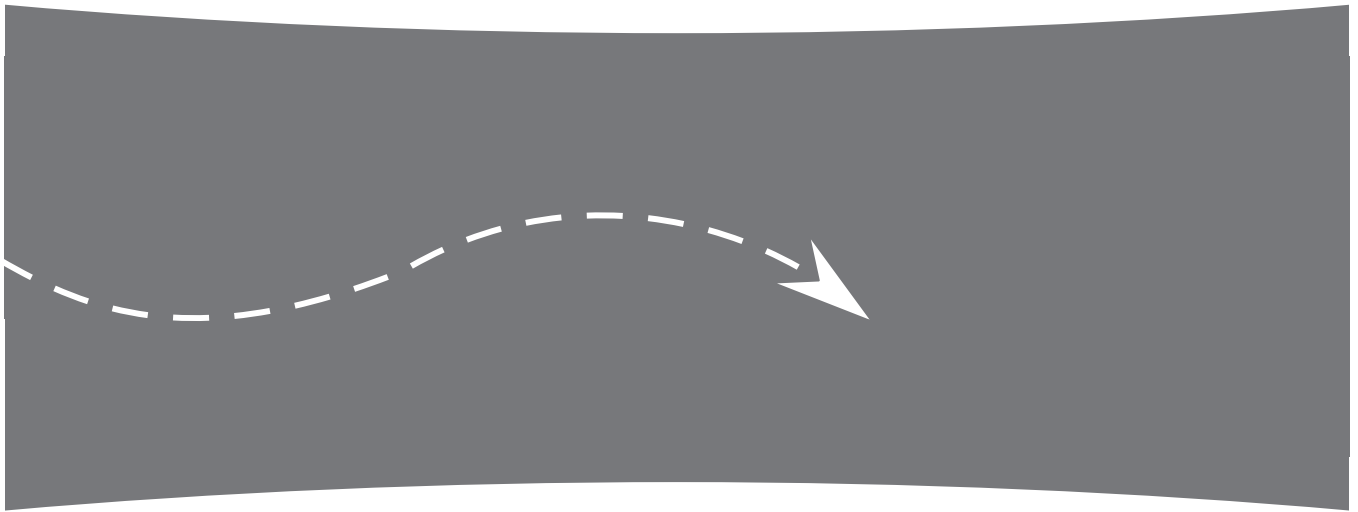
Interpreters can be dispatched to providers offices to read forms.



Qualified office personnel can support members with completing forms.



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.

CONTINUE

Seniors and Persons With Disabilities (SPD)

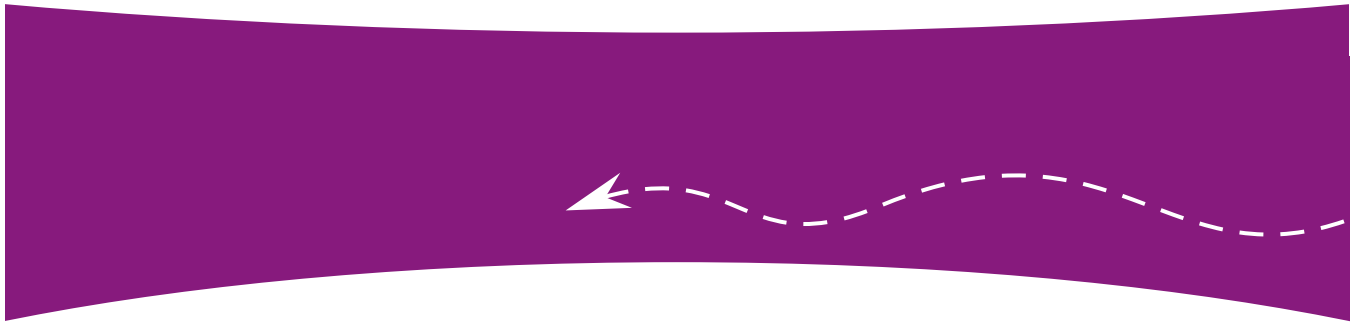




SPD stands for seniors and persons with disabilities. As of 2023, the Medi-Cal program covered more than **13 million** Californians many of whom are **SPD**.



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



Seniors

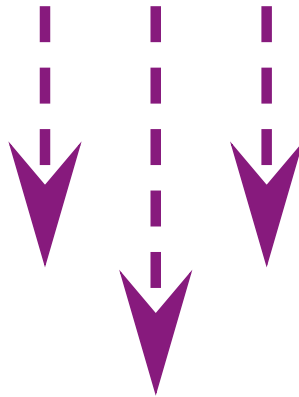
20% of California's population are older adults age 60+.

- Seniors may be individuals at risk to improve or maintain choice, independence, and quality of life.

- Seniors have the right to age in place in the least restrictive environment.



People have a higher risk of developing chronic health problems as they get older. Older adults with physical disabilities may have an even higher risk of health problems, including limited mobility and barriers to health care.



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.

CONTINUE



Persons With Disabilities

26% or 1 in 4 Americans have a disability.

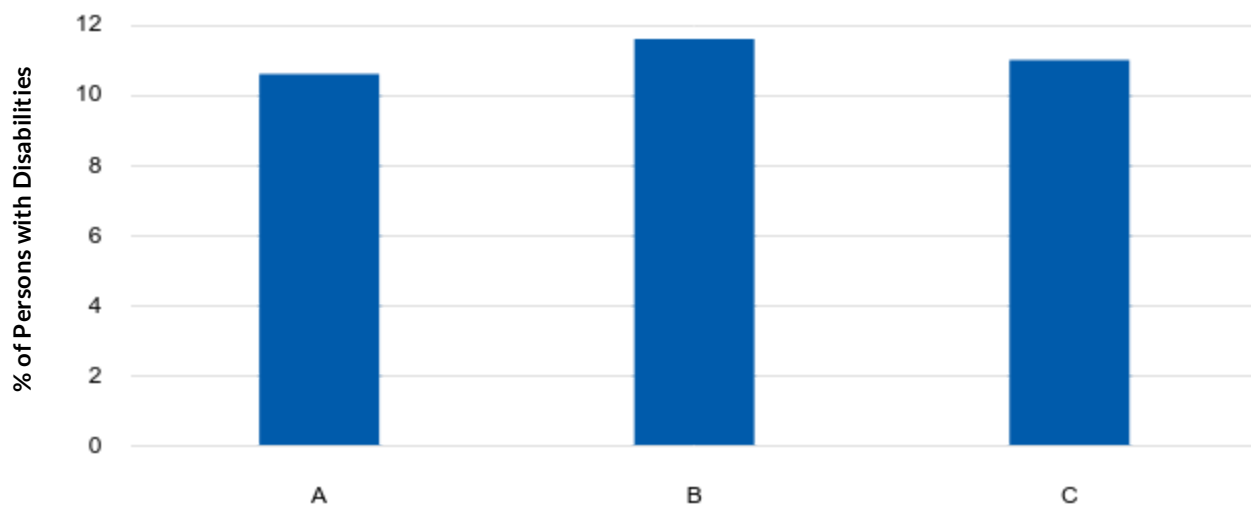
- A disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.
- Not all disabilities are visible or apparent, and not everyone with a disability identifies as having a disability.





Percentage of Persons with Disabilities in California and the Inland Empire (Riverside and San Bernardino Counties)

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.



- A. California | 10.6
- B. Riverside County | 11.6
- C. San Bernardino County | 11

To view a text version of the graph above, click the "+" sign to expand the section below.

Percentage of Persons with Disabilities (text version)

Percentage of Persons with Disabilities in California and the Inland Empire:

- California at 10.6%
- Riverside County at 11.6%
- San Bernardino County at 11%

FOR MORE INFORMATION

Click the LEARN MORE button.

LEARN MORE

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

CONTINUE

IEHP Provides Access to Care

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



**Inaccessibility
of a physical
environment**



**Inadequacies
in assistive
technology**



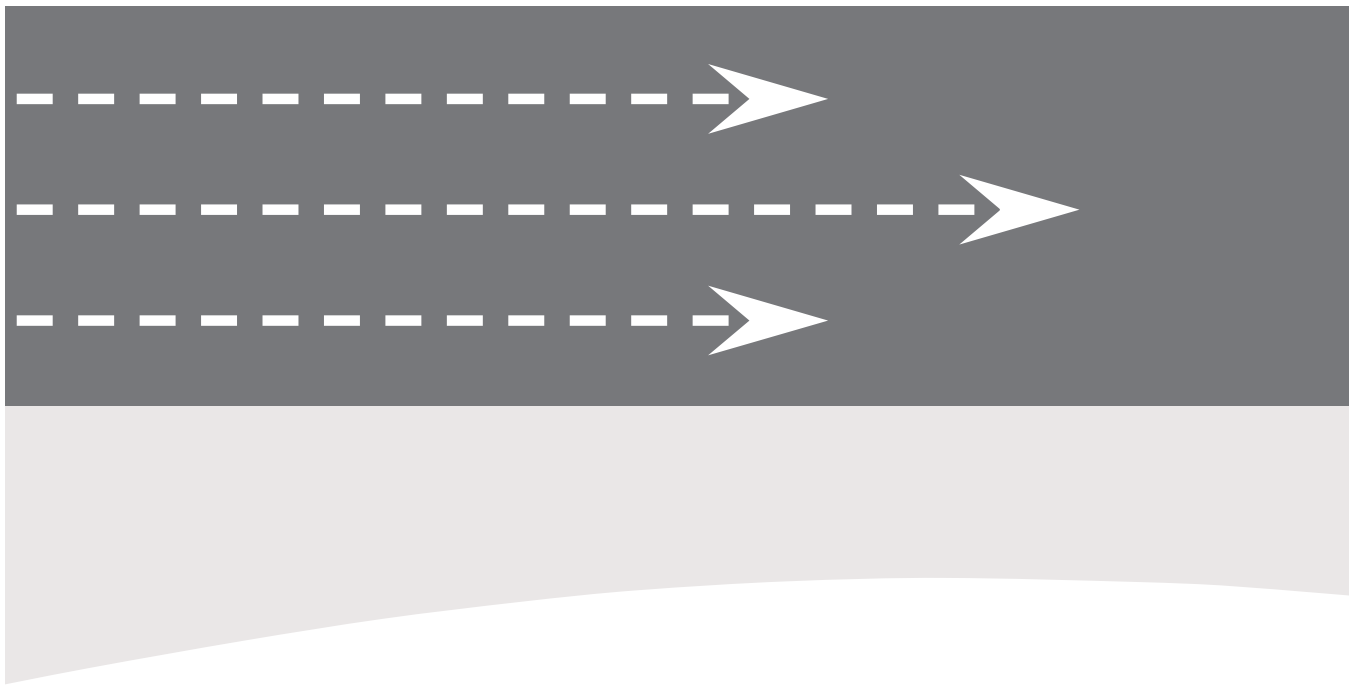
**Negative
attitudes of
people
towards
disability**



**Systems and
policies**

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:

1. Attitudinal barriers
2. Communication and language access barriers
3. Physical and programmatic access barriers



Attitudinal Barriers

Click each of the tabs below to learn more.

STEREOTYPING

STIGMA AND DISCRIMINATION

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



STEREOTYPING

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.



Disability Awareness

Disability awareness means educating people regarding disabilities. It means giving people the knowledge to better help someone with a disability so that they can communicate and work together more effectively.

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.

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 hearing impaired, say a person who is hard of hearing..
- Or instead of saying wheelchair bound, say a person who uses a wheelchair.

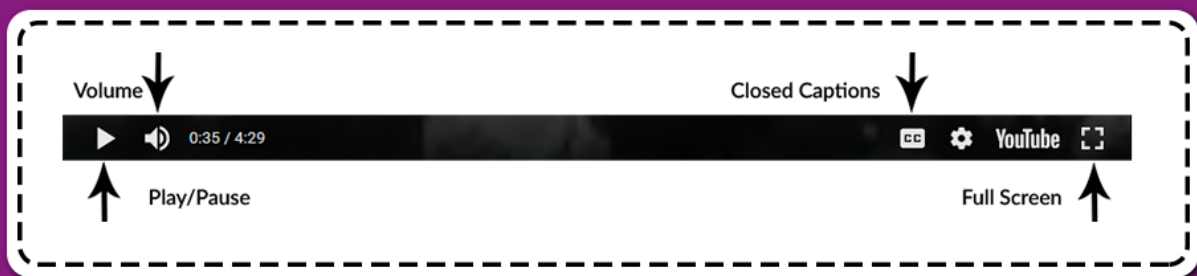


We approach this training with 'linguistic humility.' While we focus on people-first language today, we acknowledge that language is dynamic and individual preferences—especially within disability and marginalized communities—are the ultimate guide.



Watch the video below from the DC Office of Disability Rights (ODR). Follow the protagonist, Bob, as he learns how to interact with people with disabilities.

Use the bar on the bottom of the video to play or pause the video, adjust the volume, turn on closed captions, or expand the video to full screen. Click on the video to view it in YouTube.





To view a transcript of the video, click the "+" sign to expand the section below.

Video Transcript

Good morning, Bob. Morning there... big man.

Morning, Alice!

(There's no need to be awkward). Poor Bob... like so many of us he just doesn't know how to interact with people with disabilities.

It's pretty easy, really. People with disabilities are people first. We need the same things that every person needs, like respect.

Good morning, everyone. (Attention!). Uhhh, okay. Maybe we need to be more specific.

The easiest way to show respect is to focus on the person not the disability. It's okay, you'll get the hang of it.

(Interpreter voice over) One easy way to focus on the person is to watch the person signing and not their interpreter - or their companion.

It's really cool that you'd like to help, but do us both a favor and please ask me first. What you think might be helping...

I got you -...wait... wait.. ahh! ... might actually not.

If you'd like to offer me, help let me hold on to your elbow. Don't take mine.

Hey would you like to take my arm?

Sure. Assistive devices help us to live our lives. They're really important and really personal.

Grabbing them only makes it weird for everyone.

What?

Please only touch our devices and service animals if we've given you permission and don't take it personally if I ask you not to.

Remember that my service animal helps me all the time. Neither of us would like it if we were separated.

Remember, we make our own decisions. We send documents, vote, volunteer, work, and pay taxes. We get married!

So don't underestimate me just because I have a great smile.

Just because I'm blind... (shouting) May I help you?! ... does not mean I'm deaf.

Just because I'm deaf doesn't mean I'm blind.

And just because I use a wheelchair doesn't mean that I can't sweep you off your feet.

So take a deep breath, relax, we don't bite... unless we're really hungry.

Hi there ladies, how are you?

And if you're not sure what to do just ask. Hi would you still like to see a menu?

Uh, no thanks but can you please read it to me?

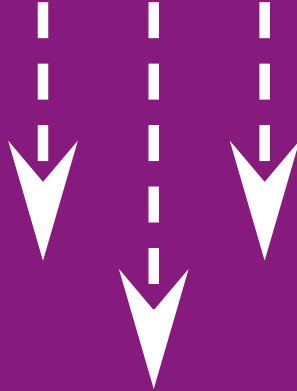
Sure definitely!

Just treat us the way you would want to be treated and we'll all be okay.

Good morning.
Good morning, Alice.
Morning.

Awkward no more, nice job Bob!

Go forth and be human. There's no need to be awkward.



**For a Quick Reference Guide on disability awareness and being
"Awkward No More," click on the PDF below.**



AwkwardNoMore_2024.pdf
446.3 KB

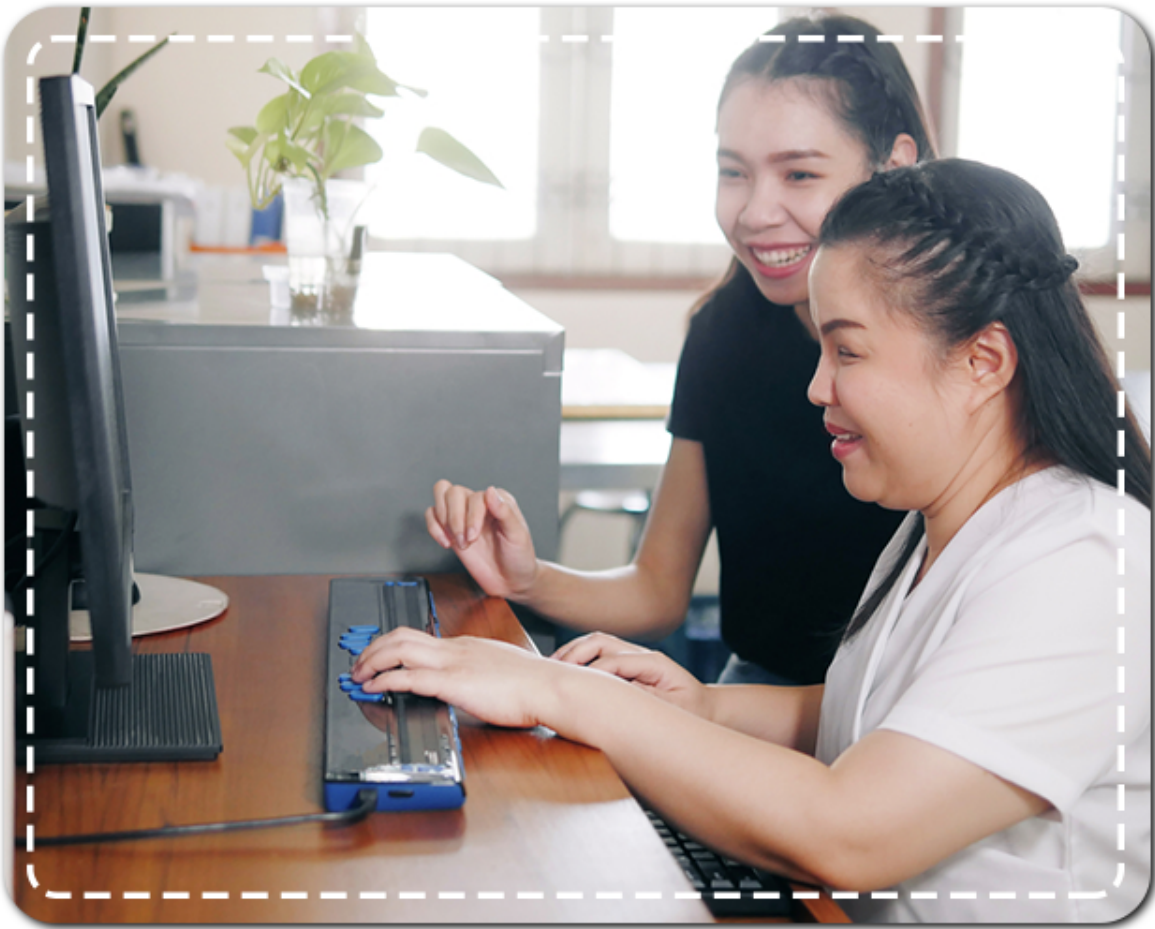


CONTINUE



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:

IEHP Medi-Cal Member Services	IEHP DualChoice Member Services	IEHP Covered Member Services
Tel. 1-800-440-4347	1-877-273-IEHP (4347)	1-855-433-IEHP (4347)
TTY 1-800-718-4347	TTY: 1-800-718-IEHP (4347)	TTY: 711

Member Services

Email Member Services by clicking the "EMAIL" button.

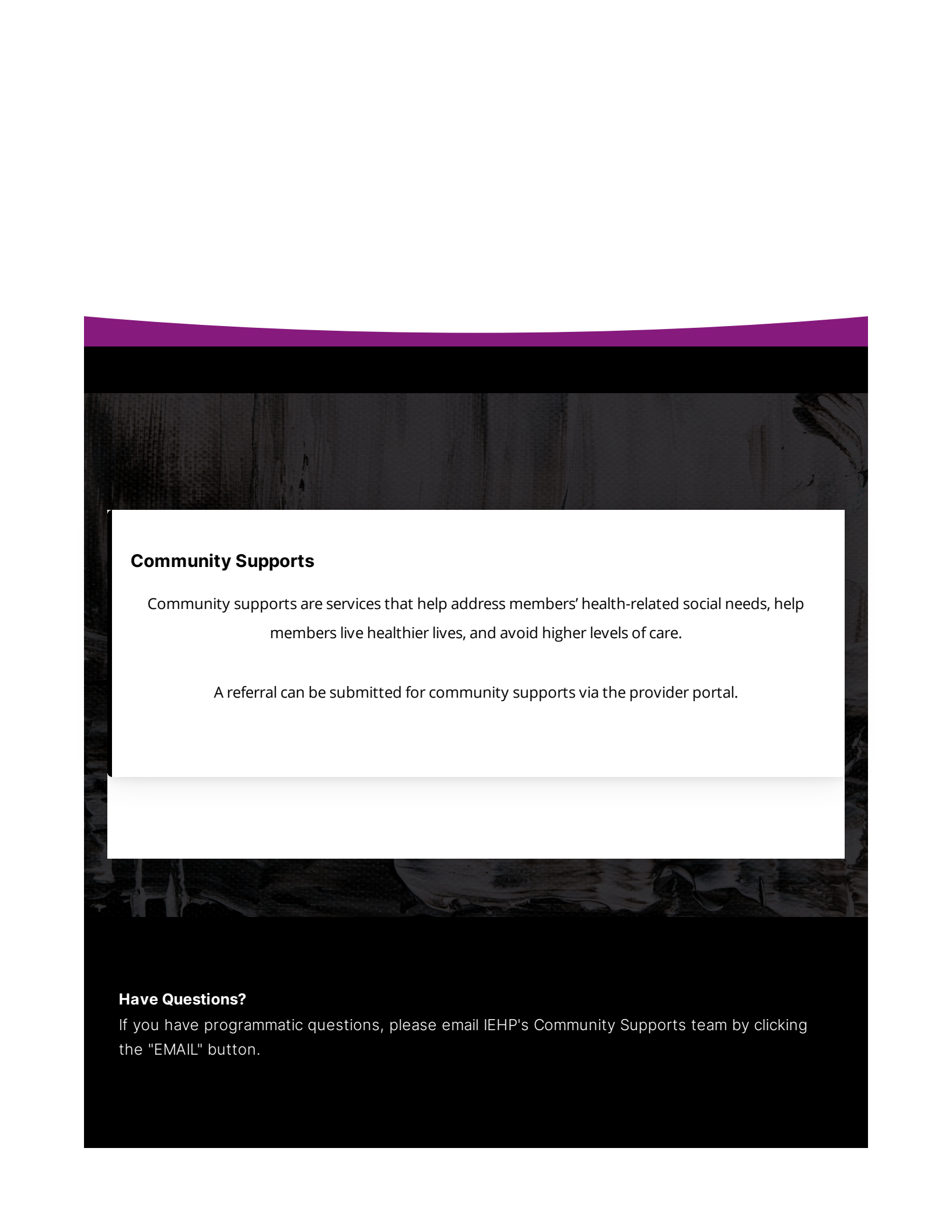
EMAIL

CONTINUE



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.



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.

Have Questions?

If you have programmatic questions, please email IEHP's Community Supports team by clicking the "EMAIL" button.

EMAIL

More Information

For more information on Community Supports, learn more by clicking the "VISIT" button.

VISIT



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:

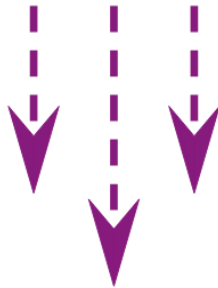
- Medical
- Mental health
- Substance use
- Dental
- Pharmacy

- 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).



*If you haven't downloaded it yet and want to view the full citations and data links used in this lesson,
please download the citation document below.*

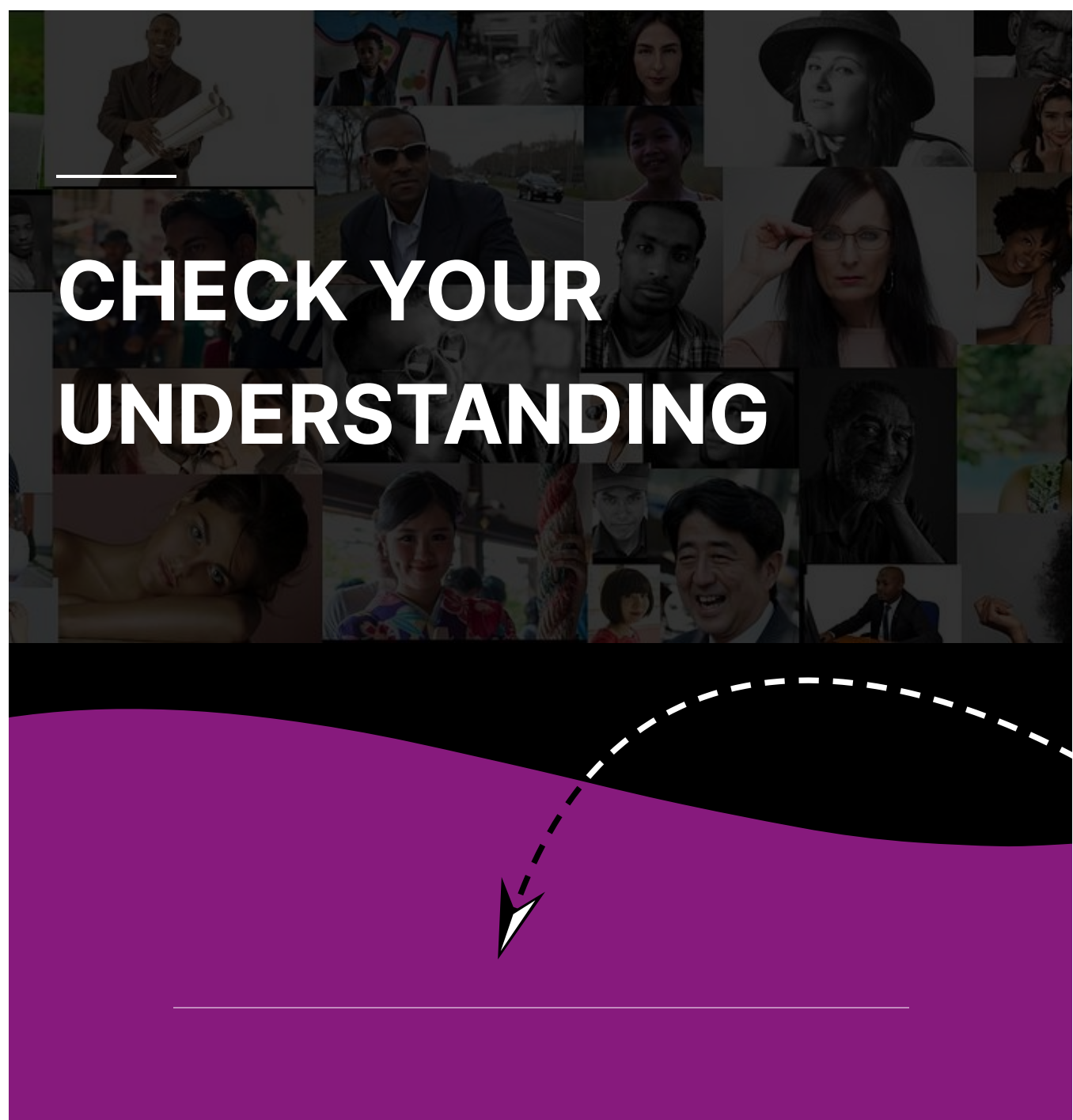


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CONTINUE

Check Your Understanding

A collage of various people's faces and scenes, including a man with a briefcase, a woman in a hat, and a man with glasses. The text "CHECK YOUR UNDERSTANDING" is overlaid in large white letters. Below the collage is a black area with a dashed white arrow pointing down to a purple area.

**CHECK YOUR
UNDERSTANDING**

It's time to check how much you remember. Select the correct option for the following questions:

Social needs are the "non-clinical needs individuals identify as essential to their well-being which are related to the social risks they experience." This includes which of the following identities or characteristics?

select all that apply

☐

Race and ethnicity

☐

Preferred language

☐

Gender identity

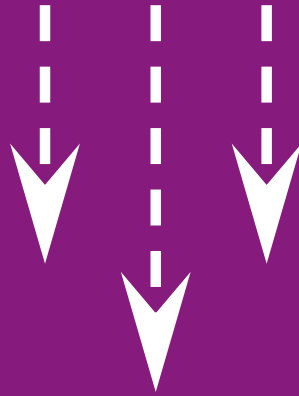
☐

Sexual orientation

☐

Aspects of disability

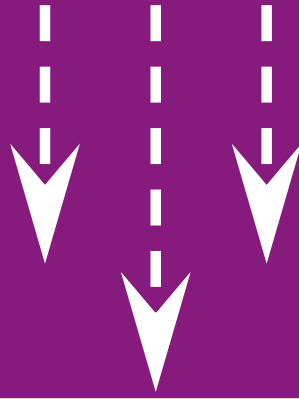
SUBMIT



Gender-affirming care does NOT include which of the following?

- ☐ Making heteronormative assumptions
- ☐ Listening to how members refer to themselves and loved ones (pronouns, names)
- ☐ Using the same language members use
- ☐ Asking relevant and appropriate questions when you are not sure

SUBMIT



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.

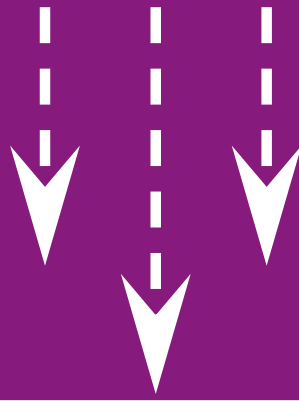
☐

True

☐

False

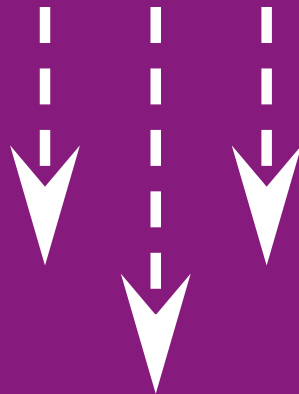
SUBMIT



Due to the lack of access to gender-affirming services, which gender diverse adolescents are at increased risk for mental health issues, substance use, and suicide?

- ☐ Cisgender and asexual
- ☐ Transgender and nonbinary
- ☐ Gay and lesbian

SUBMIT

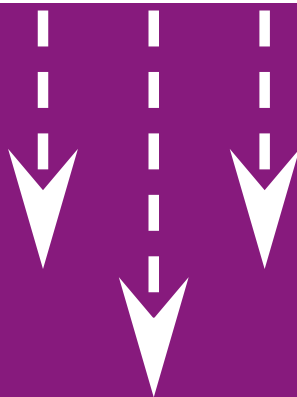


Members with Limited English Proficiency (LEP) are at higher risk for adverse situations. Poorer compliance with medical recommendations is a danger of members having LEP.

☐ True

☐ False

SUBMIT



Which of the following are ways IEHP is meeting the linguistic needs of our members?

select all that apply

☐

Face-to-face and telephonic interpretation services

☐

Video remote interpreting (VRI)

☐

Spanish-speaking member services representatives

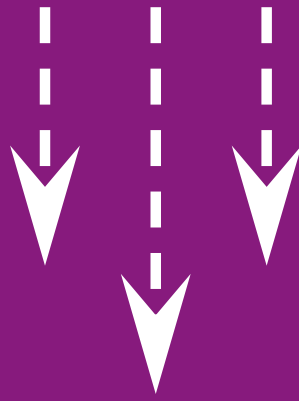
☐

Provider office auditing

☐

Alternative formats, such as audio CD, braille (English or Spanish only), electronic, large print, text to American Sign Language (ASL), and threshold languages

SUBMIT



Which of the following is a way that IEHP strives to remove the *attitudinal barriers* that prevent access to care for the seniors and persons with disabilities (SPD) population?

- ☐ Accommodations in communication
- ☐ Community supports and transportation services
- ☐ Disability awareness and people-first language practices

SUBMIT

CONTINUE

Summary



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

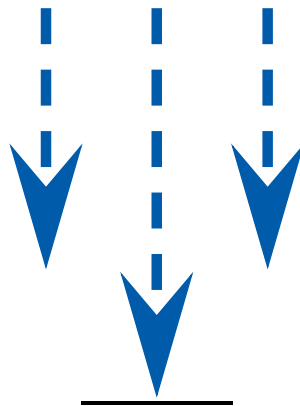
Implement a person-centered care approach.

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**.

CONTINUE



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.

Click each of the tabs below to learn more.

SHARED DECISION-MAKING

**MOTIVATIONAL
INTERVIEWING**

LEARNING STYLES

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.



SHARED DECISION-MAKING

**MOTIVATIONAL
INTERVIEWING**

LEARNING STYLES

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



SHARED DECISION-MAKING

MOTIVATIONAL INTERVIEWING

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:

- **Visual** – these patients learn best through what they see such as diagrams, illustrations, pictures, and graphs.
- **Auditory** – these patients prefer to learn through what is heard or spoken such as through discussion, groups, and speaking.
- **Read or Write** – these patients prefer to have the information to be learned displayed in written words.
- **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.



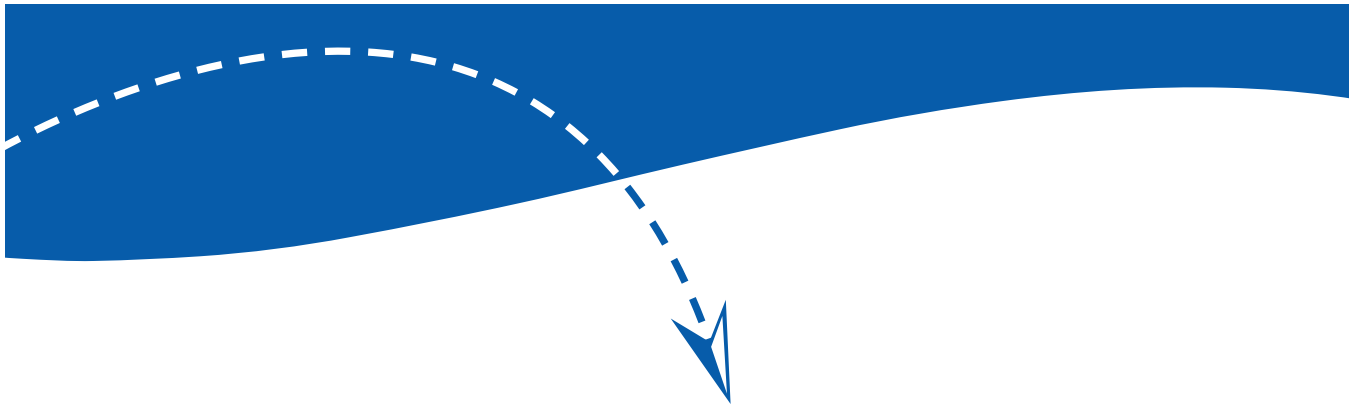
The use of incentive programs is another strategy that targets a variety of health behaviors.

- In health care, this includes attending preventive visits, receiving immunizations, and completing health risk assessments.
- In complex health behaviors, this includes behaviors such as smoking cessation, diabetes management, and weight loss.
- 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.

CONTINUE



Key Takeaways



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.

- IEHP is committed to delivering health care services that are respectful and responsive to the access and cultural needs of its members.

- 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.
- IEHP monitors and meets the linguistic needs of its members by providing interpretation services and materials in alternative formats.
- 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.

Click the "EMAIL" button to email the IEHP Health Equity Operations team.

EMAIL

Thank you for completing this portion of the course!
Click continue to proceed to take the course quiz.

CONTINUE

Quiz

To test your knowledge of the information you received as part of this diversity, equity and inclusion training, complete the following quiz. To pass you must score a 80% or better. You may retake the quiz if you do not successfully pass it the first time. Good luck!

Question

01/10

More than 50% of IEHP members are Hispanic. What is the preferred language of most IEHP members?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Other

Feedback

Any Response 

Although most IEHP members are Hispanic, English is the preferred language of most IEHP members.

Question

02/10

Which of the following best reflects the most common sex-at-birth and gender identity among Medi-Cal and D-SNP members?

- ☐ Male, identifies as male
- ☐ Female, identifies as female
- ☐ Male, identifies as female
- ☐ Female, identifies as male

Feedback

Any Response ▼

Most IEHP members were assigned female at birth and identify as female.

Question

03/10

Which of the following is listed in the top 10 medical diagnoses for both Medi-Cal and D-SNP members?

- ☐ Seasonal allergies
- ☐ Appendicitis
- ☐ Kidney infection
- ☐ Hypertension

Feedback

Any Response ▾

Hypertension is listed in the top 10 medical diagnoses for both Medi-Cal and D-SNP members.

According to the American Medical Association (AMA), structural racism is defined as “the various ways in which societies cultivate racial discrimination through reinforcing systems of...”

- ☐ individual beliefs, values, attitudes, and personal biases.
- ☐ cultural norms, community expectations, and shared social practices.
- ☐ housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.
- ☐ interpersonal interactions, communication patterns, social relationships, and daily experiences.

Feedback

Any Response ▾

Structural racism is defined as 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. Rather than being an individual-level issue, structural racism is a systemic problem that is perpetuated through institutions and policies.

Unconscious bias influences the way information about an individual is processed. Which of the following includes the four most common types of unconscious bias?

- ☐ Racial, Gender, Sexual and Gender Minority, Disability
- ☐ Age, Education, Language, Background
- ☐ Religion, Marital Status, Residency, Insurance Status
- ☐ Occupation, Income, Affiliation, Parental Status

Racial, gender, sexual and gender minority, and disability are the four most common types of unconscious bias. Biases may exist toward any social group.

Question

06/10

Considering our role as health care professionals, when providing health care services we should strive for which of the following?

- ☐ Equality
- ☐ Inequality
- ☐ Equity
- ☐ Inequity

Feedback

Any Response 

Equity involves providing personalized treatment that takes into account individual differences, whereas equality involves providing the same treatment regardless of differences.

Question

07/10

When interacting with members, HOPE and FICA are what types of assessment tools that health care professionals can use?

- ☐ Community support assessments
- ☐ Spirituality assessments
- ☐ Demographic assessments
- ☐ Cognitive assessments

Feedback

Any Response ▾

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

Due to the lack of access to gender-affirming services, which gender diverse adolescents are at increased risk for mental health issues, substance use and suicide?

- ☐ Cisgender and asexual
- ☐ Transgender and nonbinary
- ☐ Gay and lesbian
- ☐ Heterosexual and cisgender

Feedback

Any Response ▾

Transgender and gender nonbinary adolescents are at increased risk for mental health issues, substance use, and suicide. Due to the lack of access to gender-affirming services, gender diverse adolescents face significant health disparities compared to their cisgender peers.

Members with Limited English Proficiency (LEP) are at higher risk for adverse situations. What is a danger associated with having LEP?

- ☐ Poorer compliance with medical recommendations
- ☐ Increased likelihood of choosing providers based on proximity
- ☐ Requesting more frequent second opinions than other members
- ☐ Scheduling early follow-up appointments

Poorer compliance with medical recommendations is a danger of members having LEP, in addition to other adverse situations that can put their health and quality of life at risk.

Which of the following is a way that IEHP strives to remove the ATTITUDINAL BARRIERS that prevent access to care for the seniors and persons with disabilities (SPD) population?

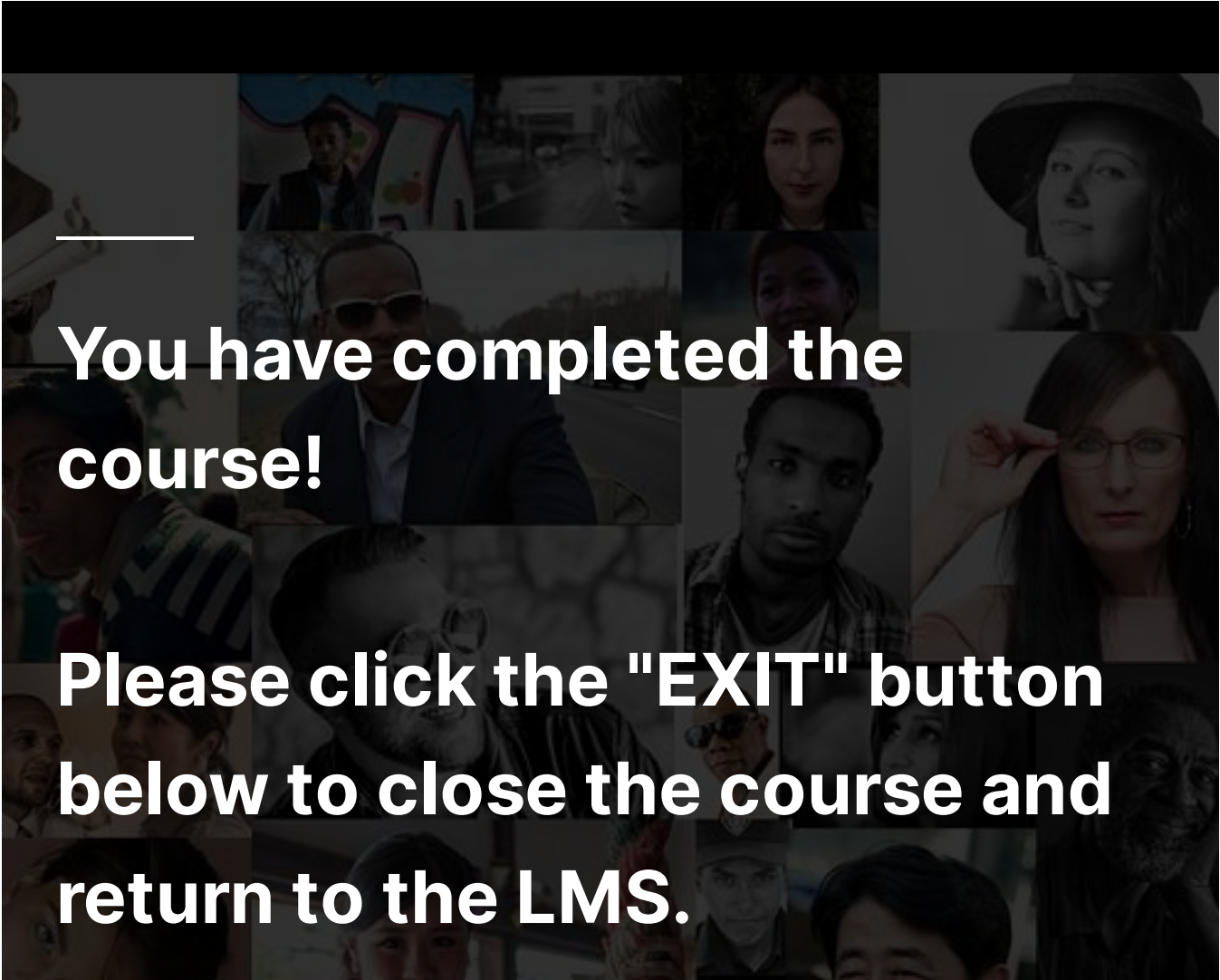
- ☐ Community supports and transportation services
- ☐ Accommodations in communication
- ☐ Disability awareness and people-first language practices
- ☐ Expanded in-home support services

Feedback

Any Response ▾

IEHP helps to remove barriers that prevent access to care for the seniors and persons with disabilities (SPD) population by instructing health care professionals to practice disability awareness. This includes using people-first language to remove attitudinal barriers, providing a variety of alternate format accommodations to remove communication and language barriers, and offering community supports and transportation services to remove physical and programmatic access barriers.

Course Completion



You have completed the course!

Please click the "EXIT" button below to close the course and return to the LMS.



EXIT