Health Education and Cultural & Linguistic Group Needs Assessment (GNA)

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Prepared for:
California Department of Health Care Services
Medi-Cal Managed Care Division

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I. EXCUTIVE SUMMARY

The 2016 Group Needs Assessment (GNA) Report addresses Medi-Cal members' health risks and practices, chronic health condition incidence, utilization patterns, health education and cultural and linguistic needs. External and internal data sources were used to make comparisons in the different areas.

The Inland Empire Health Plan (IEHP) GNA Member Survey is one internal data source. The sample pool for the Survey consists of all IEHP Medi-Cal members who have been continuously enrolled with IEHP for 6 months with no more than one month gap in enrollment and who had outpatient encounters in 2015. The IEHP GNA Survey was sent to 5,692 randomly selected members in Riverside and San Bernardino Counties. IEHP achieved a 7.41% response rate (422 eligible members).
Survey statistics are as follows:

- 238 adult member responses
- 184 child member responses
- 281 responses in English
- 141 responses in Spanish

The survey asked 23 questions about 4 interest areas, Primary Care Providers (PCP), Medical Interpreters, Health and Using Your Health Plan, and Forms and Health Plan Materials.

In questions related to PCP, the majority surveyed (94.1%) responded that their PCP and/or office staff speaks their language. About half reported that their PCP do not understand or respect the use of alternative medicine and do not understand/respect their religious beliefs.

In questions related to Medical Interpreters about a quarter identified themselves as needing interpreter services and 80% of those were aware that the health plan provides interpreter services to them at no cost.

When asked about Health and Using Your Health Plan about 50% stated that they would like information on who to call at night when they or a family members is sick. Over 40% were also interested in information on how to ask questions related to the health plan and how to choose a doctor. The plan also learned that over a third access the internet to search for health information. About a third communicated that they would like the health plan to assist them to get appointments with a specialist and to get information in their language.

When asked about Forms and Health Plan Materials about 40% reported that sometimes or always have trouble filling out health forms by themselves. Asked if they would prefer to get information from the health plans website or via text message only about 40% affirmed that they would. More than 60% believe that IEHP provides them with information about regular medical checkups and shots and vaccines. About half the respondents access the internet daily.

The demographic and disease prevalence information found that most IEHP Medi-Cal members identified themselves as “Caucasian/Hispanic”
(56%). This is a higher percentage than the 2010 Census data for Riverside County (45.5%) and San Bernardino County (49.2%). The Census data for “Caucasian/Non-Hispanic” in Riverside County is 39.7% and San Bernardino County is 33.3%, compared to IEHP Medi-Cal members at 20%. IEHP Medi-Cal membership reported language preference as 73% English-speaking, 25% Spanish-speaking and 2% Other.

IEHP Medi-Cal members report to have accessed certain preventive health services, though there are opportunities for education. The 2016 IEHP HEDIS rate for Well-Child Visit for Medi-Cal members is 68.06%. This is a lower rate than the 2010 IEHP 74.1% HEDIS rate.

Health condition prevalence varies within the child, adult, and Senior and Person with a Disability (SPD) member populations. The IEHP Disease Management Program identified 5% of members have diabetes and 9% of members have asthma using specific medication and hospitalization criteria. The adult members diabetes rate as identified in the IEHP Disease Management Program is similar to overall 9.9% county data. Morbid obesity rates for Caucasian/Non-Hispanic and Black/African American children was disproportionately higher than other groups. The rates are 11% higher for Caucasian/Non-Hispanic and 6 % higher for Blacks/African Americans and than the total ethnic composition ratio represented by each group. For adults, morbid obesity rates were disproportionately higher for Black/African Americans, Caucasian/Hispanics and Caucasian/Non-Hispanics. Regardless of the rates, obesity is a common health issue that PCPs refer members for interventions. The top 5 most Prevalent Diagnoses for CY 2015 by Diagnostic Group – Individuals with Disabilities (Medi-Cal Only SPDs) are respiratory disease, back problems, hypertension, joint disorders and connective tissue disease.

Analyses for possible health disparities using health plan data sources showed that relationships exist among race, language, culture, and health conditions. In the Medi-Cal population, members that identified as being African American/Black had a 26% chronic disease prevalence while White had a 23% prevalence and Hispanic had a 16% prevalence. SPD members comprised just over 5% of the IEHP membership (varying by month of enrollment). Data shows that these members have a higher incidence of multiple and/or complex health conditions.

Key recommendations to improve health status among Medi-Cal members includes increasing relevant resources, continued preventive health services and positive lifestyle change education for adult members and parents of child members. IEHP continues to provide variation in program time, language, and venue in order to maximize access. Preventative health services and healthy lifestyle choices are foundational to Medi-Cal members’ health and wellness.

II. INTRODUCTION

The 2016 Health Education and Cultural and Linguistic Group Needs Assessment was conducted in accordance with the Department of Health Care Services – Medi-Cal Managed Care policy. This GNA specifically addresses areas of health risks and practices, incidence of chronic health conditions, utilization patterns, and health education and cultural and linguistic needs for the Medi-Cal membership.

Goal: The goal of the GNA is to identify Medi-Cal members' health risks and health care needs, prioritize health education, cultural and linguistic services, quality improvement programs and resources.

Objectives: The GNA assesses the IEHP Medi-Cal members in the following areas:

1) Demographic profiles

2) Preventive health services access practices

3) Urgent care services, 24-Hour Nurse Advice Line and emergency room services access practices

4) Linguistic needs and access to interpreter services

5) Health beliefs

6) Chronic health condition incidence

7) Preferred learning methods

8) Health disparities

IV. DATA SOURCES AND METHODS

The 2016 Medi-Cal GNA Report comprised of data collected from internal and external sources. External data sources include:

- Census data for state and county,
- California Health Interview Survey (CHIS),
- Centers for Disease Control (CDC) Data
- Healthy People 2020 measures.

Health plan data sources include data from HEDIS, enrollment, claims, encounter, administrative and IEHP GNA Member Surveys. IEHP data is pulled from Medi-Cal members who were active during 01/01/2015 and 12/31/2015.

The IEHP GNA Member Survey uses a randomization methodology to select Members to receive the survey. The sample pool consists of currently active IEHP Medi-Cal members who have been continuously enrolled with IEHP for the past 6 months. A 6,000 member sample was generated and sent to a vender who conducted the surveys until they reached 422 completed surveys.

Data analysis includes significance testing to show changes between population years. This report intends to present a snap shot of the Medi-Cal membership in areas such as health condition prevalence, service gaps, cultural and linguistic needs and health education needs. In addition, the report attempts to determine variables that may impact health outcomes and possible relationships between variables. It is crucial to understand underlying causes for outcomes in order to effectively develop solutions to the problems.

V. MEDI-CAL MANAGED CARE MEMBER DEMOGRAPHICS

According to the 2010 Census data, California has a population of 37,253,956. Riverside County and San Bernardino County each has approximately 6% of the state's population. In California, 25% of the population is under the age of 18. San Bernardino County reports 29.2% and Riverside County reports 28.3% are under the age of 18. Females comprised of 49.9% and males 50.1% in California, which is similar in both Riverside and San Bernardino Counties. IEHP membership reports 53.7% females and 46.3% males. The average age is 14.8 years. The race distribution for the state and the two target counties is outlined in Table 3.

Overall Medi-Cal representation increased in both counties for Caucasian/Non-Hispanic, Pacific Islanders, American Indian/Alaskan Native, Asian, and Mutli-Racial ethnic groups and decreased slightly for Black or African American and Caucasian/Hispanic groups (Table 3).

The top five cities with the highest IEHP membership concentration by county were as follows (From largest to smallest):

1. Riverside County: Riverside, Moreno Valley, Corona, Hemet, and Perris.
2. San Bernardino County: San Bernardino, Fontana, Victorville, Ontario, and Rialto.

Table 1: Age Distribution for California, Riverside County, San Bernardino County and IEHP

Age	California*	Riverside County*	San Bernardino County*	IEHP Medi-Cal Membership (Average for both counties) 2015	IEHP SPD Membership 2015
Under 18	25.0%	28.3%	29.2%	46.6%	13.7%
>18	75.1%	71.7%	70.8%	53.5%	86.3%

*2010 U. S. Census Data

Table 2: Gender Distribution for California, Riverside County, San Bernardino County and IEHP

Gender	California*	Riverside County*	San Bernardino County*	2010		2015	
				IEHP Medi-Cal Membership (Average for both counties) 2010	% of IEHP SPD Membership 2010	IEHP Medi-Cal Membership (Average for both counties)	IEHP SPD Membership
Female	49.9%	49.8%	50.3%	55.8%	51.7%	53.7%	53.5%
Male	50.1%	50.2%	49.7%	44.2%	48.3%	46.3%	46.5%

*2010 U. S. Census Data

Table 3: Race Distribution for California, Riverside County, San Bernardino County and IEHP

Race	California*	Riverside County*	San Bernardino County*	2010		2015	
				IEHP Medi-Cal Membership (Average for both counties)	IEHP SPD Membership	IEHP Medi-Cal Membership (Average for both counties)	IEHP SPD Membership
Black or African-American	6.2%	6.0%	8.4%	12.4%	17.4%	9.7%	13.4%
Caucasian/Hispanic	37.6%	45.5%	49.2%	62.4%	33.3%	55.8%	34.3%
Caucasian/Non-Hispanic	40.1%	39.7%	33.3%	17.9%	27.1%	20.1%	25.0%
Pacific Islander	0.4%	0.3%	0.3%	7.3%	22.2%	14.4%	27.3%
American Indian/Alaska Native	1.0%	0.5%	0.4%				
Asian	13.0%	5.8%	6.1%				
Multi-racial	1.7%	2.2%	2.3%				

*2010 U. S. Census Data

Table 4: Language Distribution for California, Riverside County, San Bernardino County and IEHP

Language	California*	Riverside County*	San Bernardino County*	2010		2015	
				IEHP Medi-Cal Membership (Average for both counties)	IEHP SPD Membership	IEHP Medi-Cal Membership (Average for both counties)	IEHP SPD Membership
English	57.80%	61.50%	60.40%	70.30%	72.40%	73.1%	66.6%
Spanish	28.20%	32.50%	33.00%	27.50%	14.90%	24.5%	21.6%
Asian & Pacific Islander Languages	8.90%	3.50%	4.10%				
Other	5.10%	2.50%	2.50%	2.20%	12.70%	2.3%	11.8%

*2010 U. S. Census Data

VI. Plan-Specific Medi-Cal Managed Care Member Health Status, Disease Prevalence, and Gap Analysis

Health Education

IEHP's Health Education Department offers classes in both English and Spanish to meet the needs of the people in the two counties served. IEHP offers a wide variety of health and wellness resources to Members through instructor-lead courses and at home programs(Table 5). The three top courses attended by Spanish speaking Members are, Car Seat, Diabetes and Asthma classes.

In addition to health education programs IEHP offers interactive self-help tools in the following areas; Eating Healthy, Depression, Healthy Weight, Managing Stress, Physical Activity, Smoking Cessation and At-risk Drinking.

Table 5: Distribution of Languages in Health Education Classes Offered

Class	Language Offered	
	English	Spanish
Asthma Classes	70.60%	29.40%
Car Seat Classes	57.10%	42.90%
Diabetes Classes	68.00%	32.00%
Healthy Babies Program	77.90%	22.10%
Stop Smoking Program	93.90%	6.10%

Cultural and Linguistic Study (Source: Inland Empire Health Plan -Cultural & Linguistics Study- 2015)

The Healthy people 2020 measure RD-6 seeks to increase formal patient education for individuals living with asthma. In 2013 the rate was 12.8%. Data shows that 16.4% of Hispanic or Latinos and 11.4% of White individuals have received formal asthma education. IEHP offers the Breathe Program to all members with Asthma.

IEHP annually conducts a study to identify the linguistic and ethnic diversity of IEHP's Primary Care Physician (PCP) and Member populations. The study assesses the cultural, ethnic, racial and linguistics needs of its members. The results of the 2015 study are below:

Table 6: Distribution of Languages Spoken by PCPs and Members

Language	2010					2015				
	PCPs	%	Members	%	PCPs per 2,000 Members*	PCPs	%	Members	%	PCPs Per 2,000 Members*
English	1,448	100%	694,050	72.24%	**4.17**	1,550	100%	796,812	72.57%	**3.89**
Spanish	812	56.07%	245,583	25.56%	**6.61**	1,096	70.71%	274,783	25.03%	**7.98**
Other	576	39.78%	21,153	2.20%	54.46	680	43.87%	26,421	2.41%	51.47
Total	1,448	100%	960,786	100%	3.01	1,550	100%	1,098,016	100%	2.82

In 2015, the top two spoken languages for IEHP Members were English at 72.57% and Spanish at 25.03%. This accounts for approximately 98% of IEHP's total member population.

Results in Table 6 show that 100% of PCPs identified themselves as English speaking. There were 3.89 English speaking PCPs per 2,000 members in 2015. This is a decrease from the 4.17 English Speaking PCPs per 2,000 members in 2014. The difference between 2014 and 2015 results was statistically significant ($p<0.05$). The results show that the ratio of English Speaking PCPs to members exceeded the standard rate of at least 1 PCP per 2,000 members.

Table 6 results also show that 70.71% of PCPs identified themselves as Spanish speaking PCPs. There were 7.98 PCPs per 2,000 members in 2015. This is a decrease from the 6.61 Spanish Speaking PCPs per 2,000 members in 2014. The difference between 2014 and 2015 rates was statistically significant ($p<0.05$). The results show that the ratio of Spanish Speaking PCPs met the standard rate of at least 1 PCP per 2,000 Members

Race/Ethnicity:

Table 7: Distribution of PCP and Member Race/Ethnicity

Race/ Ethnicity	2014					2015				
	PCPs	%	Members	%	PCPs Per 2,000 Members	PCPs	%	Members	%	PCPs Per 2,000 Members
Hispanic	99	6.84%	539,869	56.19%	**0.37**	125	8.06%	613,329	55.86%	**0.41**
White	112	7.73%	186,440	19.40%	**1.20**	146	9.42%	216,416	19.71%	**1.35**
Black	24	1.66%	94,454	9.83%	**0.51**	2	0.13%	104,370	9.51%	**0.04**
Other	1,213	83.7%	140,023	14.57%	17.33	1,277	82.39%	163,901	14.93%	15.58
Total	1,448	100%	960,786	100%	3.01	1,550	100%	1,098,016	100%	2.82

The top three reported races/ethnicities for IEHP members was Hispanic, White, and Black, accounting for approximately 85% of IEHP's total member population in 2015 (Table 4).

A total of 55.86% of members identified themselves as Hispanic. There were 0.41 Hispanic PCPs per 2,000 Hispanic Members in 2015. This is an increase from 0.37

PCPs in 2014 and the difference in rate between 2014 and 2015 was not statistically significant (p>0.05). The results show the ratio of Hispanic identified PCPs did not meet the IEHP standard of 1 PCP for every 2,000 Members.

A total of 19.71% of members identified themselves as White. There were 1.35 White PCPs per 2,000 White Members in 2015, this was an increase from 1.20 in 2014 and the difference in rate between 2014 and 2015 was not statistically significant (p>0.05). The results show the ratio of White-identified PCPs to members met the IEHP standard of 1 PCP for every 2,000 members.

A total of 9.51% of members identified themselves as Black. There were 0.04 Black PCPs per 2,000 Black Members in 2015, this was a decrease from 0.51 in 2014 and the difference in rate between 2014 and 2015 was statistically significant (p<0.05). The results show the ratio of Black-identified PCPs to members did not meet the IEHP standard of 1 PCP for every 2,000 members.

Table 8: HEDIS Results

Measure	HEDIS 2015 Results	HEDIS 2016 Results
BMI Percentile Documentation	78.01%	79.63%
Counseling for Nutrition	76.39%	80.09%
Counseling for Phys. Activity	65.05%	65.74%
Prenatal Care	86.38%	83.68%
Postpartum Care	61.03%	59.67%
Well Child Visit 3-6	71.06%	68.06%

Between 2015 and 2016 IEHP did not identify any significant changes in HEDIS measures as outlined in Table 8. The plan however did notice a decrease in compliance in three categories averaging about a 3% variation in Prenatal Care, Postpartum Care and Well Child Visits (Children 3-6 years old).

The diabetes prevalence in IEHP counties was within 1% of the State prevalence ratio, identified by the CDC in 2014 as 9.9%. Caucasian/Non-Hispanic adults represent 25.18% of IEHP members and represent 31.6% of IEHP total adults with diabetes.

Cardiovascular conditions among Caucasian/Non-Hispanic children and adults were disproportionately higher in comparison to the total membership composition of Caucasian/Non-Hispanic, children at 11% higher and adults at 15%.

In looking at morbid obesity rates, three ethnic groups had higher rates in comparison to their distribution ratio in the health plan both in the children and adult groups. Black or African-American children and adults had a higher rate at 6%, Caucasian/Hispanic adults with a higher rate at 16% and Caucasian/Non-Hispanic children at 11% and adults 8%.

HEDIS results for Antidepressant Medication Management Acute Phase Treatment, and Medi-Cal for Antidepressant Medication Management Continuation Phase Treatment, and Follow-Up Care for Children Prescribed ADHD Medication – Maintenance Phase are listed in table 9. Adherence to a routine has improved within the past year.

Table 9: HEDIS Behavioral Health Data

Measure	HEDIS 2015 Rate %	HEDIS 2016 Rate %
ADD - Initiation	24.78%	26.11%
ADD Maintenance	22.81%	29.62%
Antidepressant Med Acute	48.42%	55.29%
Antidepressant Med Cont.	33.06%	40.51%

VII. UNDERSTANDING THE CULTURAL AND LINGUISTIC SERVICES AND HEALTH EDUCATION NEEDS FROM THE MEDI-CAL MEMBER'S PERSPECTIVE

The GNA survey asked 23 questions about 4 interest areas, Primary Care Providers (PCP), Medical Interpreters, Health and Using Your Health Plan, and Forms and Health Plan Materials.

In questions related to PCP, the majority surveyed (94.1%) responded that their PCP and/or office staff speaks their language. About half reported that their PCP do not understand or respect the use of alternative medicine and do not understand/respect their religious beliefs. A slightly higher amount at almost 60% reported that their PCP respects their family traditions and practices. About 55% do not believe their PCP understands or respects their immigration experience effects on health. About 80% feel that their PCP explains things in a way that is easy for them to understand.

In questions related to Medical Interpreters about a quarter identified themselves as needing interpreter services and 80% of those were aware that the health plan provides interpreter services to them at no cost. About 87% feel comfortable asking for medical interpreters. Most feel comfortable with having the interpreter within the exam room while about 11% would prefer the interpreter provide services over the phone. About half prefer to have a family member or a friend interpret for them and most have never been told by their doctor that they need to bring a friend or family member to interpret.

When asked about Health and Using Your Health Plan about 50% stated that they would like information on who to call at night when they or a family member is sick. Over 40% were also interested in information on how to ask questions related to the health plan and how to choose a doctor. The plan learned that over a third access the internet to search for health information. About a third communicated that they would like the health plan to assist them to get appointments with a specialist and to get information in their language. In the last six months 8% reported participation in a health related class while nearly 50% had spoken to a health professional within the same timeframe. Almost 20% accessed the internet or YouTube to see a video about health.

When asked about Forms and Health Plan Materials about 40% reported that sometimes or always have trouble filling out health forms by themselves. Asked if they would prefer to get information from the health plans website or via text message only about 40% affirmed that they would. About a third would like to receive information from the health plan via email. About 10% would like to receive information through social media platforms and about 20% would like to receive it through a DVD. About a quarter of respondents demonstrated interest in receiving materials in large print, which is currently offered through the health plan as an alternate form to members at no cost and happens to be the most popular alternate format request. More than 60% believe that IEHP provides them with information about regular medical checkups and

shots and vaccines. About a quarter would like information on diabetes and cancer screenings. About half the respondents access the internet daily and about 30% access the internet less frequently but more than a few times a year.

VIII. KEY RECOMMENDATIONS, PLANNED ACTIONS AND CONCLUSION

GNA Respondents

Due to the indication that only about 40% of GNA Survey respondents would like to receive health plan information electronically or via text, the Health Plan will focus on communicating the benefits of electronic information dissemination. The Health Plan will highlight the positive impact of electronic reception in regards to Member's ease of access, linguistic needs, and timeliness. Members may relocate, and through electronic information sharing missed information and/or miscommunication may be greatly reduced. Through electronic dissemination of health information any changes to the Member's information can be communicated quickly and efficiently.

Over a third of GNA Survey respondents indicated searching the internet for health information. This response indicates a reliance on the internet for health education and information. The Health Plan will focus on being a primary online source of health information and education for Members. This will ensure that Members receive correct information and will support outreach efforts ensuring Members will rely on the Health Plan for accurate healthcare information.

A quarter of GNA Survey respondents indicated that their health beliefs sometimes or always clash with their PCPs advice. The Health Plan will focus on culture and linguistics training for providers. Half of Members perceive that their PCPs do not understand/respect the use of alternative medication or religious beliefs related to health. The Health Plan will also focus on educating Members about how to discuss and negotiate alternative medications, treatments and ethno-cultural beliefs and practices.

Child Members

IEHP will continue to stress the importance of preventative care for children by promoting the Well Child visit to both parents and providers. Preventative care can be a tough sell for parents or care takers who are often occupied with many emergent responsibilities. When a child is perceived to be healthy it can be easy to put off screenings and preventative check-ups. IEHP will continue to leverage the quarterly member newsletter, provider incentive program, web and social media platforms to increase the awareness of child preventative services.

Adult Members

Obesity still appears to be one of the common health issues that PCPs refer members for interventions. For adults morbid obesity rates were disproportionately higher for Black or African Americans, Caucasian/Hispanics and Caucasian/Non-Hispanics. Given that these three groups represent 60% of the adult member population, a review of the current intervention program will be conducted to explore opportunities for improved participation, outreach and program completion.

SPD Members

SPD members comprise just about 5% of the health plans member population however, utilization of services by this population is at about 88%. The top five conditions for this group are respiratory disease, back problems, hypertension, joint disorders, connective tissue disease. The health plan understands the need for adequate and available care management and resource and referral assistance for this population.

Identified Issue	Recommended Action	Expected Completion
1. Members prefer not to receive health plan information electronically.	Establish a campaign to communicate the benefits of electronic communication. Provide members with resources to low cost technology access and internet services.	Quarter 3 2017
2. Over a third of members use the internet for health information.	Strengthen the health plan's health and education site by including information on conditions encountered at higher rates by IEHP members. Provide access to less common health condition information through a reliable source of information through a more comprehensive validated third party website.	Quarter 3 2017
3. A quarter of GNA Survey respondents indicated that their health beliefs sometimes or always clash with their PCPs advice.	Include cultural competency articles in IEHP's provider newsletter Scrub Talk and member newsletters to promote dialogue between providers and members in the area of cultural and linguistic competency.	Every Quarter Beginning Quarter 1 2017
4. HEDIS Well Child rate decrease.	Strengthen communication with providers and parents of the importance of the Well Child Visit/HEDIS measure. Continue to fund Well Child provider incentive program.	Ongoing
5. Increase availability and promotion of nutrition and weight loss programs.	Review current nutrition and weight loss program access, location and schedules. Evaluate outreach campaign and its effectiveness in increasing member participation. Develop online tools to increase education access for members.	Ongoing
6. SPD members utilize healthcare services at a higher rate than any other group in the health plan, have more complex needs and in many cases need ongoing care management services.	Continue the Living Well with a Disability program across both counties and review training site locations to provide better access to SPD members who have lower access to transportation resources when compared to other groups. Increase awareness of behavioral health services for this group as multiple and complex physical health conditions often have secondary behavioral health impacts.	Ongoing

IX. REFERENCES

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X. ATTACHMENTS

Attachment I – IEHP 2016 GNA Survey Responses