



# 2010 Cultural & Linguistic Services Survey Report

*July 1, 2009 – September 30, 2010*

Managed Risk Medical Insurance Board

Revised 4/18/2012

# Managed Risk Medical Insurance Board

## Healthy Families Program

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*MRMIB provides and promotes access to affordable coverage  
for comprehensive, high quality, cost effective health care  
services to improve the health of Californians.*

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# Executive Summary

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## Introduction

Since the inception of the program in 1998, the Managed Risk Medical Insurance Board (MRMIB) has required all plans participating in the Healthy Families Program (HFP) to report annually on the services they provide to meet the cultural and linguistic needs of their subscribers. The 2010 Cultural and Linguistic Services Survey Report presents information on the services provided during the period of July 1, 2009 through September 30, 2010 by the 31 health, dental and vision plans participating in the program.

California has long been known as a state of great diversity and this is evident in the cultural and ethnic diversity of the children in HFP. In September 2010, nearly half (49.8%) of children enrolled in HFP were Latino. Asian/Pacific Islanders comprised nearly 10 percent (9.8%). Caucasians represented about ten percent (9.4%), while African Americans represented about two percent (1.9%). Because of this diversity, it is crucial that the HFP plans provide language assistance service and culturally competent care to their Limited-English Proficient (LEP) subscribers.

## Key Findings from the 2010 Cultural and Linguistic Services Survey

Analysis of the 2010 Cultural and Linguistic Services Survey (Appendix A) indicate several key findings which are highlighted below.

### *Threshold Languages*

- Plans are required to translate written materials in Spanish and any other language that is the preferred mode of communication for either five percent (5%) of enrollment or more than 3,000 subscribers, referred to as a threshold language. Chinese was identified as a threshold language for 11 of the 31 plans, Vietnamese was a threshold language for 8 of the 31 plans and Korean was a threshold language for 3 of the 31 plans.

### *Interpreter Services*

- All plans have more than one option to make interpretation services available to LEP subscribers. Most plans use a combination of telephone language lines or outside vendors/contractors and their own plan staff to provide interpreting services.
- For those plans that were able to provide cost information, the average annual cost of interpretation services was \$13,863 for HFP subscribers, while the average annual cost for translation services was \$7,221.

- Most plans reported using one or more method to ensure the proficiency of their interpreters and translators, including the use of certified interpreters and translators or requiring a certificate of attestation.

### *Providers*

- The majority of plans allow providers to self-report their proficiency in a language. Half of plans rely on various other methods to ensure language proficiency, including secret shopper calls and monitoring subscriber complaints and grievances. A few plans allow bilingual staff to provide interpreter services for customer service functions only and use face-to-face interpreter services or a language line for all other requests.
- The HFP enrollment application is the primary source used by the plan to identify a HFP subscribers' language preference.
- The majority of plans inform their contracted providers of the language preference of their assigned subscribers and most use more than one method, including monthly eligibility reports (21 of the 31 plans), new enrollee notification (15 of the 31 plans) and through their secure website (12 of the 31 plans). Seventeen of the plans indicated that they use other methods such as printing the language preference on the subscriber identification card.
- All plans indicated they require providers to document the language needs of subscribers for reference when interacting with the subscriber. This is accomplished through contracts, communications, training, or service representatives. Almost all plans instruct providers to document any requests or refusals for interpreter services in the medical record. Twenty-seven (27) of the 30 plans (90%) reported that they conduct periodic audits.

### *Internal Systems to Monitor Needs of LEP Subscribers*

- Plans are required by the HFP contract to develop internal systems to meet the needs of their subscribers. In order to develop internal systems to meet the needs of their LEP subscribers almost all plans evaluate the satisfaction of subscribers, staff members, and/or providers. Many of the plans maintain an information system capable of identifying ethnicity and language preference information about their subscribers. Plans also distribute communication tools to their staff that provide information on cultural competency issues. Additionally, plans develop recruitment and retention initiatives for organization-wide staffing that reflects and responds to the cultural and linguistic (C&L) needs of the community.

## Training

- MRMIB validated that training was provided by the plans to plan staff, providers and provider staff. This validation was accomplished through a review of lists of training sessions, dates, number of attendees, attendance type and the goals for each session. Training topics included how to access and use interpreter services, resources, policies and procedures, sensitivity to specific cultures surrounding health beliefs and practices, and Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) Language Assistance Program requirements.

## Key Findings from the Other Quality Monitoring Activities

The Cultural and Linguistics Services Survey is just one of the tools used by MRMIB to monitor the services provided to HFP subscribers. Other activities undertaken by MRMIB to monitor services provided to LEP members include:

- Consumer satisfaction surveys;
- Monitoring complaint information;
- Analyzing grievance data by ethnicity and language; and
- Analyzing utilization and quality of care data by demographic variables such as ethnicity and language to identify disparities in care.

In 2011, MRMIB administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and a Dental CAHPS (D-CAHPS) survey, to assess the satisfaction and quality of care provided to the children in HFP. The surveys were sent in five languages – English, Spanish, Chinese, Korean and Vietnamese – based on the families preferred written language, as indicated on the HFP application. A total of 21,000 families were randomly selected to receive the CAHPS survey and 11,767 useable surveys were returned for a response rate of 58%. A total of 5,400 families were randomly selected to receive the D-CAHPS survey and 2,052 useable surveys were returned for a response rate of 44%.

The CAHPS survey included four questions that assess whether the parent and the child were able to understand the doctor and whether the parent or child needed interpreter services. Key findings from the 2011 CAHPS surveys are:

- Six percent (6%) of CAHPS survey respondents indicated they usually or always had a hard time understanding their child's doctor;
- Thirteen percent (13%) of parents needed an interpreter; and
- Seventy-seven percent (77%) of those that needed an interpreter usually or always got one. Only three percent (3%) indicated they never got an interpreter when they needed one.

The D-CAHPS survey included four questions that assess whether the parent and the child were able to understand the dentist and whether the parent or child needed interpreter services. Key findings from the 2011 D-CAHPS survey are:

- Twenty-eight percent (28%) of D-CAHPS respondents indicated they needed an interpreter to speak to their child's dentist. This is more than twice the rate of those that needed an interpreter to speak to their child's doctor; and
- Similar to the CAHPS survey results, seventy-nine percent (79%) of those that needed an interpreter usually or always got one.

The results of the 2011 CAHPS and D-CAHPS survey indicated that nearly eight out of ten survey respondents got an interpreter when they needed one. Further research is needed to understand where the gaps are in obtaining needed interpreter services for the remaining families to ensure that the need for interpreter services is not a barrier to care.

## Conclusion

The 2010 Cultural and Linguistic Services Survey provided MRMIB the opportunity to evaluate plan methods to meet the needs of their LEP subscribers. While most HFP plans are providing subscribers with interpreter and translation services, there were several challenges related to the plan's ability to track and report some of the data. For example, less than half of the plans were able to provide cost information for interpretation services because either the information was only tracked at the provider level and not reported to the plan or the plan did not specifically track the cost for HFP. This was also the first year that MRMIB asked the plans to report the number of requests for interpretation services by language and how the services were provided. Most of the plans were unable to provide complete data and had challenges providing information specific to HFP.

While MRMIB would like to see improvement in the plans ability to track and report on how they are meeting the needs of their LEP subscribers, MRMIB is also looking into other ways to capture this information. Over the next year, MRMIB will look into other means of assessing if LEP subscribers understand how to access services and what the barriers are to receiving language assistance services and culturally-competent care.

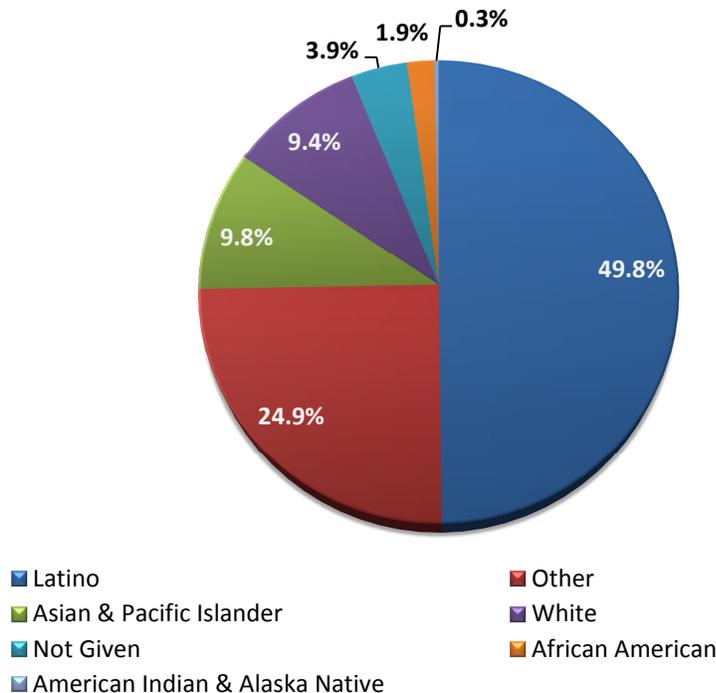
# Introduction

The Healthy Families Program (HFP) provides low cost health, dental and vision insurance to children in families with incomes between 100 percent to 250 percent of federal poverty level. MRMIB contracted with thirty-one (31) insurance plans in 2009-10 to provide health, dental and vision services to children enrolled in the HFP. Twenty-two (22) health plans provided comprehensive health coverage through Health Maintenance Organizations (HMO) and Exclusive Provider Organizations (EPO). Six (6) dental plans provided preventive and restorative dental services. Three (3) vision plans provided routine eye care. As of September 30, 2010, there were 868,306 children enrolled in HFP.

## Ethnicity of the HFP Subscribers

The HFP population is ethnically diverse (Figure 1). Latino subscribers represent almost half (49.8%) of the HFP enrolled population. Asian/Pacific Islanders and Whites make up nearly ten percent (9.8% and 9.4% respectively) of the HFP population. African-Americans comprise two percent (1.9%) of the HFP subscribers. All other groups, including those not disclosing their ethnicity, make up the remaining thirty percent (30%).

**Figure 1. Ethnicity of Subscribers in HFP**

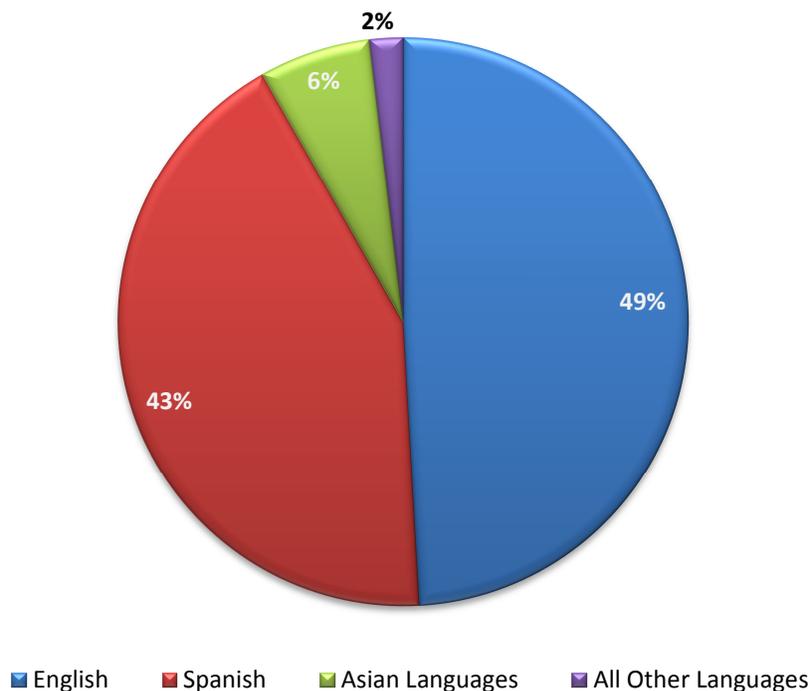


Source: September 2010 Enrollment Data

## Languages Spoken by HFP Families

In addition to being ethnically diverse, the families in HFP also speak a variety of languages (Figure 2). While the majority (49%) of HFP applicants speak English, nearly half (43%) speak Spanish. A little over five percent (5%) speak an Asian language, including Cantonese, Mandarin, Korean and Vietnamese. Information about preferred written and spoken language is provided on the HFP application. Language preference is transmitted to the plans to assist them in meeting the needs of their LEP subscribers.

**Figure 2. Languages Spoken by HFP Families**



Source: September 2010 Enrollment

## Federal Requirements for Federally Funded Programs

Title VI of the federal Civil Rights Act of 1964 prohibits recipients of federal funding from discriminating against persons based on race, color, or national origin. Title VI sets out standards for equal access and participation in federally funded programs for LEP individuals. MRMIB receives federal funding for the HFP through the Children's Health Insurance Program (CHIP); therefore the standards of Title VI apply to all HFP participating plans.

In addition to complying with Title VI of the Civil Rights Act, contracts between MRMIB and HFP plans require plans to conduct specific C&L activities during the contract year including:

- Assessing subscribers cultural and linguistic needs in a Group Needs Assessment (GNA) every four years;
- Providing interpretation services;
- Assigning primary care providers to LEP subscribers;
- Translating written materials such as evidence of coverage booklets and health education materials;
- Providing alternative formats of written materials;
- Training staff and providers;
- Monitoring language assistance services; and
- Improving internal C&L systems.

In addition to the contract requirements above, MRMIB monitors the services provided to LEP subscribers in several ways, including:

- Consumer satisfaction surveys;
- Monitoring complaint information;
- Analyzing grievance data by ethnicity and language; and
- Analyzing utilization and quality of care data by demographic variables such as ethnicity and language to identify disparities in care.

In 2011, MRMIB administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and a Dental CAHPS (D-CAHPS) survey, to assess the satisfaction and quality of care provided to the children in HFP. The surveys were sent in five languages – English, Spanish, Chinese, Korean and Vietnamese – based on the families preferred written language, as indicated on the HFP application. A total of 21,000 families were randomly selected to receive the CAHPS survey and 11,767 useable surveys were returned for a response rate of 58%. A total of 5,400 families were randomly selected to receive the D-CAHPS survey and 2,052 useable surveys were returned for a response rate of 44%.

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## State Requirements for Language Assistance Programs

SB 853, Chapter 713, Statutes of 2003 required the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to adopt Language Assistance Program (LAP) regulations for health, dental and vision plans. The regulations were adopted in 2007 and required plans to implement the LAP regulations on January 1, 2009. HFP regulations require contracted health, dental and vision plans to comply with DMHC law and regulations. As a result, HFP plans are required to comply with both the HFP C&L contractual requirements and the LAP regulations.

# Cultural & Linguistic Services Survey

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Since the inception of the program in 1998, MRMIB has required all HFP participating plans to report annually on services provided to meet the cultural and linguistic needs of their subscribers. The Cultural and Linguistic Services Survey is intended to assist MRMIB in monitoring plan compliance with language assistance requirements and assessing the progress plans are making in implementing cultural and linguistic activities for their HFP subscribers. These activities should also be based upon the implementation plan developed as a result of each plan’s Group Needs Assessment. Results from the survey will inform policymakers, advocates and other stakeholders about how plans meet the needs of their LEP subscribers.

In 2009, Monica Hau Le, MD reviewed the 2007-08 survey results at the request of the Board. Based on the recommendations of Dr. Le, MRMIB staff redesigned the 2009-10 survey template. Dr. Le’s recommendations can be viewed on the MRMIB website at [http://mrmib.ca.gov/MRMIB/HFP/2007-08\\_Cultural\\_Linguistic\\_Services\\_Survey.pdf](http://mrmib.ca.gov/MRMIB/HFP/2007-08_Cultural_Linguistic_Services_Survey.pdf) .

The redesign included the following new components:

- Word count was limited for qualitative responses;
- Plans were required to report on the utilization of interpreter services (e.g.; 24 hour translation line or face-to-face interpreter requests, number of interpreter services requested); and

- Plans were required to report the number of requests for interpreter services by language and the number of requests that were actually provided.

The 2009-10 C&L survey also contains questions about the following plan activities to meet the C&L needs of their HFP subscribers:

- Interpreter Services;
- Communication with Providers;
- Proficiency of Interpreters and Translators;
- Internal Systems; and
- Quality Improvement.

The survey instrument is attached as Appendix A.

## Group Needs Assessment

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HFP contracted plans are also required to complete a Cultural and Linguistic Group Needs Assessment (GNA) of their subscribers every four years. The GNA serves as a foundation for the plans' C&L activities and includes:

- A demographic profile of the plan's subscribers by ethnicity and language. The development of the profile includes examining the language preference of the plan subscribers as well as other data related to the health risks and cultural beliefs and practices of the plan subscribers;
- An assessment of the plan's internal systems to address the C&L needs of its subscribers. This includes evaluating the plan's capacity to provide linguistically appropriate services; and
- A review of internal data as it relates to C&L competency including:
  - Complaints and grievances;
  - Subscriber survey results;
  - Plan staff diversity and language ability;
  - Policies and procedures;
  - Staff and provider training; and
  - Utilization and outcome data analyzed by race, ethnicity, and primary language, if feasible.

The plans are required to compare their internal data to external data benchmarks and trends. The plans are also required to provide subscriber representatives the opportunity to provide input on the C&L GNA.

Plans also must develop a plan that outlines the proposed services to be improved or implemented as a result of the assessment findings, including addressing any cultural and linguistic barriers they have identified and describing how they will work toward

reducing racial, ethnic, and language disparities. Plans update the result of these activities annually in the C&L report.

MRMIB received the 2011 GNA reports from all plans on September 30, 2011. HFP Plans are contractually required to submit an update to the 2011 GNA by September 30, 2012. MRMIB staff will review the plan submission of these updates to assess their progress made in addressing identified disparities.

## Identification of Threshold Languages

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HFP plans are required to translate written plan materials in Spanish and any other language that is the preferred mode of communication for either five percent (5%) of enrollment or 3,000 total subscribers. Languages that meet either of these criteria are referred to as “threshold languages.” In addition to Spanish, 11 of the 31 plans reported Chinese as a threshold language. Vietnamese was a threshold language for 8 of the 31 plans and Korean was a threshold language for 3 of the 31 plans. Plans are encouraged, but not required to translate written material into additional Medi-Cal threshold languages.

## Subscriber Requests for Interpretation

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This was the first year HFP plans were asked to provide detailed information on the total number of interpretation services requested, number requested by service type and a breakdown of those requests by language. Methods used by the plans to gather this information include in-person requests, language lines, plan staff requests, and provider requests. However, only four of the thirty-one plans were able to provide the number of interpretation requests made by HFP subscribers and the specific languages for each. The four plans were Health Net Dental, Health Net EPO & HMO, Kaiser Foundation Health Plan and Safeguard Dental.

The plans sighted several challenges to reporting this information, including:

- Requests made by plan or provider staff was not tracked;
- Requests for interpretation services are tracked across all lines of business and could not be reported separately for HFP;
- Many provider offices are designated as Spanish-speaking offices and do not track interpretation services provided by office staff; and
- Primary Care Physicians (PCPs) provide interpretation services and it would be a heavy administrative requirement to have them track and report this information to the plan.

# Type and Cost of Interpreter Services

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## Interpreter Services Used

Plans provide interpreter services in a variety of ways to meet the needs of their subscribers, including the following:

- Twenty-seven of the thirty-one plans use a language line;
- Twenty-seven of the thirty-one plans use a vendor or contractor;
- Twenty-three of the thirty-one plans use bilingual providers and their staff;
- Twenty-two of the thirty-one plans use plan staff ;
- Five of the thirty-one plans use a community based organization (CBO); and
- Five of the thirty-one plans sighted other services.

One innovative approach to providing interpreter services was from Kaiser Foundation Health Plan, who uses a remote video operated by plan staff to provide interpreter services.

## Annual Cost for Interpretation and/or Translation Services

HFP plans were asked to provide the annual cost for all interpretation and translation services provided in the 2009-10 benefit year. Only 13 of the 31 plans were able to provide costs for interpretation services. The average annual cost for interpretation services was \$13,863. Fourteen plans were able to provide costs for translation services. The average annual cost for translation services was \$7,221.

The most common reasons plans stated they were unable to report annual costs for interpretation services was that the data was collected for their entire line of business and they could not report specific cost for HFP or that the amount that they paid for interpretation and translation services was proprietary and part of their provider agreements.

# Quality & Compliance of Plans

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## Proficiency of Interpreters & Translators

All plans reported that they ensure the proficiency of interpreters and translators using one or more of the following methods or certification:

- Twenty-six of the thirty-one plans use certified translators & interpreters;
- Twenty of the thirty-one plans require a Certificate of Attestation;
- Nine of the thirty-one plans rely on the interpreters reputation; and

- Fourteen of plans listed other methods of ensuring proficiency, such as:
  - Berlitz Bilingual Proficiency Test;
  - California Healthcare Interpreting Association;
  - National Council on Interpreting in Health Care (NCIHC);
  - Community Based Organizations;
  - Internal Translation and Interpretation Assessments;
  - Complaints and Grievances by Subscribers; and
  - Industry Collaborative Effort (ICE) uses volunteers from health care industry stakeholders to develop educational and “best practice” materials designed to streamline, simplify, and standardize all regulatory policies and procedures that govern the provision of health care services that particularly require the collaboration between health plans and their provider partners.

## 6th Grade Readability Level

The HFP contract requires plans to translate certain written documents that are sent to subscribers. The contract also requires that documents to be at a 6<sup>th</sup> grade reading level.

The majority of plans (24 of 31) use internal staff to verify a 6<sup>th</sup> grade reading level as well as one or more of the following:

- SMOG Readability Formula;
- FRY Readability Formula; and
- Flesch-Kincaid Tests.

## Quality Assurance for Interpretation from Third Party Vendors

Most plans reported using one or more methods to ensure the quality of interpretation services provided by third party vendors:

- Twenty-one of the thirty-one plans require interpreters be certified;
- Twenty-one of the thirty-one plans rely on their vendor to enforce quality provisions specifically related to interpretation services;
- Sixteen of the thirty-one plans have contracts with their third party vendors that require them to follow the National Standards of Practice for Interpreters in Health Care;
- Twelve of the thirty-one plans request the methods used for quality assurance during the vendor solicitation process; and
- Fifteen of the plans reported “other” quality assurance methods which include monitoring and investigating grievances and complaints.

## Subcontracted Providers and/or Vendors

Plans sometimes use a subcontracted provider and/or vendor to provide services for the plan. The HFP contract requires plans to ensure that subcontracted providers and/or

vendors comply with cultural and linguistic requirements. Most of the plans (24 of 31) include language in their contracts with subcontracted providers and/or vendors regarding compliance with C&L requirements and most (23 of 31) include the C&L requirements in their subcontractor policies and procedures. Nineteen plans reported other methods for complying with the HFP C&L requirements, such as:

- Training;
- Provider website information;
- Provider bulletins;
- Provider manuals;
- Annual audits;
- Written and/or oral assessments;
- Subscriber grievances; and
- Subscriber surveys.

## Verifying Proficiency of Bilingual Providers

The majority of plans reported that providers self-report language proficiencies. Other methods used to verify proficiency were:

- Provider staff proficiency is assessed at the providers' offices and certifications are verified;
- Plan surveys of provider offices to identify and obtain language capability;
- Industry Collaborative Effort (ICE) Proficiency Assessment;
- Deficiencies identified as a result of plan staff interaction with provider staff;
- Bilingual assessments to ensure office staff have adequate bilingual proficiency;
- Audits of provider offices to confirm language proficiency;
- Language Concordance Program (LCP) used to identify physician language and voluntarily assesses language proficiency;
- Monitoring complaints and grievances;
- Bilingual staff limited to interpreting customer service functions. Requests for other interpreter services are handled through language line or face-to-face interpreter services; and
- Secret Shopper Calls.

# Informing Subscribers

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## Informing Subscribers of Interpreter Services and Rights

The HFP plans are contractually required to provide information to subscribers on interpreter services. Overall most plans comply with the requirements listed below:

- Thirty of the thirty-one plans inform subscribers of the right to request an interpreter during medical discussions with providers;
- Thirty of the thirty-one plans inform subscribers of their right to file a complaint or grievance if linguistic needs are not met;
- Twenty-nine of the thirty-one plans inform subscribers of the right not to use family members, or friends as interpreters;
- Twenty-eight of the thirty-one plans inform subscribers of the availability of no-cost interpreter services;
- Twenty-eight of the thirty-one plans inform subscribers that using minors for interpretation is prohibited and strongly discouraged, except in the most extraordinary circumstances; and
- Twenty-eight of the thirty-one plans inform subscribers of their right to receive plan materials in Spanish and any other plan threshold language.

Several plans listed innovative approaches to informing subscribers of interpreter services such as:

- CalOptima Kids informs subscribers of interpreter services by publishing standing articles in its member newsletter which is published twice a year; and
- Kaiser Foundation Health Plan publishes interpreter service information in its Evidence of Coverage (EOC), Member Guidebook, and its e-newsletter (Partners in Health). In addition, signage is posted in multi-languages throughout medical center areas at all key points of subscriber contact.

## Methods Used to Inform Subscribers of Ban on Using Minors as Interpreters

All plans, except one, use the EOC or new subscriber materials to inform subscribers that minors are not to be used as interpreters, except in the most extraordinary circumstances. Most plans inform subscribers that minors are not to be used as interpreters through member newsletters, welcome calls or they train their providers to inform subscribers during visits.

# Informing Providers

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## Methods Used to Inform Providers of Ban on Using Minors as Interpreters

The most common means of informing providers not to use minors as interpreters, except in the most extraordinary circumstances, is through provider newsletters. Twenty-eight of the thirty-one plans use newsletters and/or bulletins to inform providers while nineteen of the thirty-one plans have language in their provider contracts. Nineteen of the thirty-one plans also post information on their website. The plans reported numerous “other” methods used to inform providers, including:

- Provide trainings, including web-based training, for providers and their staff;
- Provider manuals;
- Workshops;
- Seminars; and
- Orientations.

## Methods Used to Inform Providers of Subscriber's Language Preference

HFP uses the enrollment application to collect subscriber language preferences. The language preference information is transmitted to the selected plan after the subscriber is enrolled. The method of transmittal from the plans to providers varies by plan and many use several methods to ensure providers are made aware of a subscriber's language preference:

- Twenty-one of the thirty-one plans use the monthly eligibility report to inform providers;
- Fifteen plans include the information when they transmit information on new enrollees;
- Twelve plans make the information available to providers through a secure website; and
- Several plans reported other methods such as printing the language preference on the subscriber ID card or provider's contacting the plan to obtain the information.

Only one plan, Ventura County Health Plan, reported that they do not make providers aware of subscriber language preference but that subscribers have the right to self-refer to providers without notification to the plan.

# Provider Documentation

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## Plan Methods to Instruct Providers on Documentation of Subscribers Language Needs

The HFP plan contracts require providers to note the language preference of subscribers in the medical record. Notification of a subscriber's language need is often communicated to the provider from the plan but also is communicated to the provider at the time of the subscriber's first visit to the office. Methods of communicating this requirement to providers include the following:

- Twenty-five of the thirty-one plans instruct providers to document language needs in the medical record through provider newsletter or bulletins;
- Twenty-three of the plans use provider trainings to communicate this requirement;

- Twenty-two plans use provider service representatives to train and inform providers of the contract requirements;
- Sixteen plans include this requirement in their provider contracts; and
- Examples of other ways the plans communicate this requirement are through facility site reviews, audit processes, web based training, annual provider meetings, and provider manuals to instruct providers to note language preference in the medical record.

## Documentation by Providers of Requests and/or Refusals for Interpretation

The HFP contract instructs plans to ensure that the request or refusal of language or interpreter services is documented in the medical records of network providers. Almost all plans instruct providers to document requests and/or refusals of language interpreter services in the medical record. One plan, Safeguard Dental, reported they do not instruct providers to document interpretation request or refusals.

Nearly all of the plans reported that they undertake activities to ensure providers comply with documenting any requests or refusals of interpretation requests, including training, supplying request/refusal forms, chart labels, conducting reviews and incentive programs. Other activities reported by the plan included the following:

- Annual audits to assess training needs;
- Flags in electronic medical record to remind staff to document the use and refusal of language assistance which is monitored through audits and data analysis;
- Provider bulletins/newsletters; and
- Subscriber issues/formal grievances.

# Internal Systems

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## Steps in Developing Internal Systems

Plans were asked to identify activities they have undertaken in developing internal systems to meet the cultural and linguistic needs of subscribers from the list below.

- Evaluate and determine the need for special incentives related to cultural competency (Special Incentives);
- Designate staff to coordinate and facilitate the integration of cultural and linguistic specific patient data (Staff Coordination);
- Maintain an information system capable of identifying cultural and linguistic specific patient data (Information System);
- Evaluate program effectiveness in improving the health status of culturally-defined populations (Evaluate Effectiveness);

- Evaluate satisfaction based on feedback from subscribers, staff member(s) and/or providers (Evaluate Satisfaction);
- Evaluate encounter/claims data to identify disparities (Evaluate Encounter Data);
- Evaluate input from subscriber advisory committees (Evaluate Committee Input);
- Incorporate cultural competency into the plan's mission (Mission Incorporation);
- Develop recruitment and retention initiatives for organization-wide staffing that reflects and is responsive to the needs of the community (Recruitment and Retention);
- Assess the cultural competency of plan providers on a regular basis (Assess Providers);
- Distribute communication tools to staff related to cultural competency issues (Communication Tools); and
- Involve government, community and educational institutions in matters related to best practices in cultural competency (External Involvement).

All plans indicated that they had engaged in one or more of the activities listed in the survey. In addition, plans identified the following activities they have undertaken to develop internal systems to meet the C&L needs of subscribers:

- Work closely with local community based organizations that focus on the needs of specific populations;
- Encourage providers to take cultural competency trainings;
- Use membership data to evaluate language and ethnicity information;
- Use the HFP GNA demographic profile to evaluate the need for special initiatives related to cultural competency;
- Incorporate cultural information into quality improvement projects, health education projects, and community outreach efforts; and
- Ongoing site visits and facility audits.

## Quality Improvement

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### Ethnicity and Language Data

As part of each plan's quality improvement efforts, plans were asked how they use ethnicity and language data to evaluate C&L services and to examine the outcomes of C&L activities. Only one plan, EyeMed Vision, indicated that they do not use ethnicity and language data.

Most of the plans use ethnicity and language data to evaluate C&L activities in the following areas:

- Complaints and grievances (29 plans);

- Satisfaction surveys (26 plans);
- Utilization or other clinical data (17 plans); and
- Chart reviews (8 plans).

Seven plans identified several other ways in which they use ethnicity and language data:

- Outreach activities including telephone calls, and subscriber educational mailings;
- Use of ethnicity in Healthcare Effectiveness Data and Information Set (HEDIS) results in order to identify trends;
- Provider feedback through trainings and provider satisfaction tools;
- GNA survey and findings; and
- GeoAccess program to map and compare the language needs of HFP subscribers to the languages offered by provider offices.

## Disparities Identified within the Plans

When asked if they had identified any health care disparities in the HFP population based on language or ethnicity, six plans identified the following disparities:

- GenCal Health has identified Hispanic, Spanish-speaking youth at a higher risk for obesity and pre-diabetes;
- Community Health Group, through an arrangement with an endocrinologist, has identified children of color at a higher risk for morbid obesity and pre-diabetes;
- Contra Costa Health Plan has identified disparities in the rate of obesity among Hispanic children. In response, they have developed a quality improvement project and have developed health education materials;
- Kern Family Health Plan identified obesity and diabetes as the top two health conditions for their members. The majority of health referrals for these conditions were for Hispanic members, followed by Caucasian and African-American members;
- In Molina's 2007 GNA, Hispanic and African-American children in HFP were identified as being at a higher risk for pediatric obesity. Both national and regional data since that time show a continuing increase in the prevalence of obesity in these ethnic groups; and
- San Francisco Health Plan has used their HEDIS data to identify the following disparities:
  - African American, Filipino and Samoan groups have the lowest rates across children's access measures;
  - Chinese speakers had the best results for pediatric prevention measures including well checks and childhood immunizations measures; and
  - Chinese and Tagalog speakers had the lowest for pediatric overuse measures (pharyngitis and URI.)

## Specific Strategies to Identify Disparities

Plans were also asked to explain any specific strategies and/or programs that each plan has used to address identified disparities. Plans highlighted the following strategies:

- Use of CBOs;
- Culturally relevant diabetic diet instructions;
- Interventions for ethnic groups that do not use preventive services (e.g. immunizations);
- Educational materials in subscriber's language;
- Obesity and diabetes education and interventions with local schools;
- Applying plain language guidelines in the development of written materials that are targeted at certain ethnic groups;
- Various cultural foods and food preparation methods incorporated into teaching curriculums and educational materials;
- Development of multicultural DVD in English and Spanish that addressed healthy eating and exercise;
- Spanish consumer website;
- Vision risks for ethnic groups identified in educational materials; and
- Dental education classes in underserved areas to educate parents and children on proper oral hygiene habits and the importance of a healthy diet.

## Number of C&L Staff

The average number of full-time equivalent (FTE) staff dedicated to cultural and linguistic services for the plans is identified below:

- Health plans – 2.6;
- Dental plans – 4;
- Vision plans – 1; and
- All plans – 2.7.

## Training

In order for MRMIB to verify the training provided to plan staff members and network providers, plans were asked to provide a list of training sessions, dates, number of attendees, type of attendee and goal for each session. Nineteen (19) plans were identified as providing some type of training for both plan staff and providers. It is not clear that every provider or staff member in the plan is required to take the training. However, some plans reported that employees are exposed to cultural and linguistic education and sensitivity during new employee orientation. Refresher classes for employees and providers are also available. Topics for training classes include the following:

- Access and use of interpreter services and resources;
- Plan policies and procedures for C&L Services;

- Available services and awareness of C&L tools for subscribers;
- Sensitivity to specific cultures around health beliefs and practices;
- Specific disparities within cultures;
- DMHC and CDI Language Assistance Program Law and Regulations;
- Plan translation of documents; and
- Plan grievance system.

Methods used to conduct training included newsletters, videos, classroom training, seminars, e-learning, webinars and toolkits specific to C&L services.

## Conclusion

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This report summarizes the cultural and linguistic services provided to HFP subscribers from July 1, 2009 through September 30, 2010. The survey results and information obtained from the other quality monitoring activities, such as the CAHPS and D-CAHPS surveys, indicate that overall the cultural and linguistic needs of LEP subscribers are being met. However, there were several challenges in collecting accurate data on the number of subscribers that needed interpreter services and how these needs were met.

Over the next year, MRMIB will work with the plans on their ability to track and report on how they are meeting the needs of their LEP subscribers. MRMIB will also look at other ways to capture this information and other options for understanding the barriers to receiving language assistance services and culturally-competent care.

# Appendix A. 2010 Cultural and Linguistic Services Survey

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## Managed Risk Medical Insurance Board Healthy Families Program

### Instructions for Completing the Cultural and Linguistic Services Survey For Services Provided in Benefit Year 2009-2010<sup>1</sup>

This document will take you step by step through the template. Please do not submit attachments unless specifically requested to do so. If any part of this survey is unclear or you see several ways to interpret a question, please contact [sswaney@mrmib.ca.gov](mailto:sswaney@mrmib.ca.gov) or (916) 323-0514.

**Plan Name:** Please input the name of the plan. Please specify whether it is an EPO or HMO.

**Name of Contact Person:** Please input the name of the person who should be contacted if MRMIB has questions about the data provided.

**Phone Number:** Please input the phone number of the contact person above.

**E-mail:** Please give the email address of the contact person listed above.

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#### 1. What are the plan's threshold languages? Check all that apply:

Threshold languages are defined as non-English languages spoken by the lessor of five percent or 3,000 members in a Plan.

If there is a threshold language that is not listed, please check the fifth box and identify the other threshold language(s).

#### 2.a. Please list the total number of HFP subscriber requests for interpretation services and the method by which each interpreter service was provided to HFP subscribers in benefit year 2009-2010.

- a. **What is the total number of services that were requested?** The number in this box should equal the sum of the next five boxes.
- b. **In Person (face to face)** - The total requests that were met by bringing an interpreter to a facility or an office.

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<sup>1</sup> Reference: HFP Contract 2010-2011, Exhibit A, Section III.C.3.b

- c. **Language Line** – The total number of requests met as a result of using an interpreter through a language line.
- d. **Plan Staff** – The total number of requests that were met by plan staff member(s) performing the interpretation. The plan staff member(s) does not include a Plan contractor or a member of the provider’s staff.
- e. **Provider Staff** – The total number of requests that were met by provider staff member(s) performing the interpretation. Provider staff member(s) can include physicians, office staff, hospital staff, and clinic staff members. It does not include contract staff or plan staff members.
- f. **Services Requested but not Provided** – This number would include times when no one from the plan or provider staff was available to interpret.

**2.b. Out of the total services requested in Question 2.a. (above), please list the number of requests or interpretation services by language and the number of interpretation services provided (met) in the appropriate column.**

- a. If the language requested is not listed, please put information for columns two and three in the category “all other”.
- b. In the second column please list the number of interpreter services that were requested for each language.
- c. In the third column please enter the total number of services that were provided for each language. A request may only be fulfilled once.

**3. Which of the following does the plan use for interpreter services? Check all that apply.**

- a. **Community based organizations (CBOs)** – A community based organization can include a nonprofit organization paid for their services or volunteer certified interpreter. It can also include a nonprofit organization with which the plan contracts to provide interpreter services. It should not include a private for-profit vendor with whom there is a contract.
- b. **Outside vendor or independent contractor** – An outside vendor or independent contractor is a private vendor with whom the plan contracts and is also paid by the plan for interpretation services. The vendor can be an organization or an independent contractor. This category is separate from a community based organization.
- c. **Contracted Language Line** – Two examples are the Language Line Services and the AT&T Language Line.
- d. **Plan Staff** – Plan staff member(s) is defined as employees of the plan who provide interpreting services. Plan staff member(s) does not include vendors or individuals contracted by the plan or provider staff members.
- e. **Bilingual providers/staff** – Bilingual providers/staff members are defined as either the provider or someone employed by the provider who is able to provide competent interpreter services.
- f. **Other (please explain less in less than 20 words):** Do not submit an attachment.

**4. Please indicate the annual cost for all interpretation and/or translation services provided to HFP members for the 2009-2010 benefit year.**

- a. **Interpretation Cost** - Indicate the total cost for interpretation services for HFP members only.
- b. **Translation Cost** – Indicate the total cost for translation services. Include the cost for all forms, educational materials and any information that is translated into different languages for HFP members.
- c. **Unable to Report (mark with an X)** – Mark only if the plan is unable to report information for the cost of interpretation and/or translation of materials.

**5. If unable to respond to Question #4, explain why (in 50 words or less):**

Explain why information is unavailable for either the cost of interpreting services or translation costs. Do not submit an attachment.

**6. If the plan uses a third-party vendor for interpretation services, how does the plan ensure the quality of interpretation services? Check all that apply.**

A third party vendor is defined as a business with whom the plan has a contract. This includes independent contractors, a language line, or a CBO.

- a. **The Plan contracts with independent contractors, language line or CBO require interpreters to follow National Standards of Practice for Interpreters in Health Care** - The National Standards of Practice for Interpreters in Health Care can be found at this address:  
[http://www.mchb.hrsa.gov/training/documents/pdf\\_library/National\\_Standards\\_of\\_Practice\\_for\\_Interpreters\\_in\\_Health\\_Care%20%2812-05%29.pdf](http://www.mchb.hrsa.gov/training/documents/pdf_library/National_Standards_of_Practice_for_Interpreters_in_Health_Care%20%2812-05%29.pdf)
- b. **The Plan contracts with independent contractors, language line or CBO require certification of interpreters** –There are several certifying organizations. The question does not specify a certifying organization.
- c. **The Plan contracts with independent contractors, language line or CBO include quality provisions** –The quality provision (s) are specific to interpretation services.
- d. **The Request for Proposal (RFP) requests information about the organization’s methods for assuring competence of interpreters** – Information was requested and given by the chosen contractor during the RFP process.
- e. **Other (please explain in less than 50 words):** Do not submit an attachment.

**7. What information does the plan provide to HFP subscribers regarding interpretation services? Check all that apply.**

- a. **Availability of interpreter services to enrollees at no charge.**
- b. **Using minors as interpreters is prohibited or strongly discouraged.**
- c. **The right not to use family enrollees or friends as interpreters.**

- d. The right to request an interpreter during discussion of medical information.
- e. The process to obtain an interpreter through the plan.
- f. The right to file a complaint or grievance if linguistic needs are not met.
- g. Other (please explain in less than 100 words): Do not submit an attachment.

**8. How does the plan inform members that minors are not to be used as interpreters? Check all that apply.**

- a. EOC and/or new member material.
- b. Bilingual staff and/or contracted interpreter services.
- c. Plan website.
- d. Other (please explain below in less than 20 words): An example is a letter sent to members that is not part of the EOC or new member materials. Do not submit an attachment.

**9. How does the plan inform providers that minors are not to be used as interpreters? Check all that apply.**

- a. Provider contract language.
- b. Provider newsletters and/or bulletins.
- c. Plan website.
- d. Other (please explain below in less than 20 words): An example is plan visits with providers. Do not submit an attachment.

**10. How does the plan make providers aware of subscribers' language preferences? Check all that apply.**

- a. Monthly subscriber eligibility reports.
- b. New enrollee notification includes language preference.
- c. Plan's secure website.
- d. Plan does not make providers aware of subscriber language preference.
- e. Other (please explain below in less than 20 words): Do not submit an attachment.

**11. How does the plan ensure subcontracted providers and/or vendors meet HFP cultural and linguistic services contractual requirements? Check all that apply.**

- a. Contract language with vendors and subcontractors consistent with HFP C&L requirements.
- b. Plan's policies and procedures explain C&L requirements and are provided to subcontracted providers and vendors.
- c. Other (please explain below in less than 50 words): Do not submit an attachment.

**12. How does the plan instruct providers in its network to document the language needs of its HFP subscribers? Check all that apply.**

- a. **Provider contracts.**
- b. **Provider communications (newsletters/bulletins).**
- c. **Provider trainings.**
- d. **Provider services representatives** - A provider service representative is a plan employee who interfaces with providers in order to train, inform, assist and serve.
- e. **Other (please explain below in less than 20 words): Do not submit an attachment.**

**13.a. Does the plan instruct providers to document in the medical record the Requests and/or Refusals of language interpreter services?**

Check only yes or no, not both.

**13b. How does the plan ensure providers comply with the requirements to document the Requests/Refusals of language interpreter services? Check all that apply.**

- a. **Trains providers on the need to document a request or refusal of interpreter services.**
- b. **Supplies providers and their staff with Request/Refusal forms for interpreter services.**
- c. **Supplies providers and their staff with chart labels identifying enrollee language needs.**
- d. **Offers an incentive program to reward provider offices that affirmatively attempt to identify language needs of Limited English Proficient (LEP) enrollees and record those on the medical charts. Please do not submit an attachment.**
- e. **Conducts reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services.**
- f. **Other (please explain below in less than 20 words): Do not submit an attachment.**

**14. How does the plan verify the proficiency of providers who indicate they are bilingual? Check all that apply.**

- a. **Plan does not verify providers' proficiency** - If this box is checked, no additional boxes should be checked.
- b. **Providers self report proficiency** – Plan does not verify proficiency.
- c. **Plan requires Certificates of Attestation or other written documentation.**
- d. **Other (please explain below in less than 50 words): Do not submit an attachment.**

**15. How does the plan ensure the proficiency of interpreters and translators?  
Check all that apply.**

- a. **Plan does not ensure proficiency of interpreters/translators** - If this box is checked, no additional boxes should be checked.
- b. **Plan uses only professional and/or certified interpreters and translators** – If the plan uses a combination of methods to ensure proficiency of interpreters and translators, do not check this box.
- c. **Plan requires Certificates of Attestation or other written documentation.**
- d. **Plan relies on contracted interpreter service reputation.**
- e. **Other (please explain below in less than 20 words):** Do not submit an attachment.

**16. How does the plan ensure a sixth grade readability level for subscriber documents (including translated documents)? Check all that apply.**

- a. **Plan does not ensure a 6<sup>th</sup> grade readability level.**
- b. **SMOG, FRY and/or Flesch-Kincaid Tests.**
- c. **Certified or accredited translation vendor .**
- d. **Internal staff check readability.**
- e. **Other (please explain below in less than 20 words):** Do not submit an attachment.

**17. Which of the following activities does the plan undertake in developing its internal systems to meet the cultural and linguistic needs of subscribers? Check all that apply. Do not submit attachments.**

- a. **Evaluate and determine the need for special incentives related to cultural competency.**
- b. **Designate staff to coordinate and facilitate the integration of cultural and linguistic specific patient data.**
- c. **Maintain an information system capable of identifying cultural and linguistic specific patient data.**
- d. **Evaluate program effectiveness in improving the health status of culturally-defined populations.**
- e. **Evaluate satisfaction based on feedback from subscribers, staff and/or providers.**
- f. **Evaluate encounter/claims data to identify disparities.**
- g. **Evaluate input from subscriber advisory committees.**
- h. **Incorporate cultural competency into the plan's mission.**
- i. **Develop recruitment and retention initiatives for organization-wide staffing that reflects and is responsive to the needs of the community.**
- j. **Assess the cultural competency of plan providers on a regular basis.**
- k. **Distribute communication tools to staff related to cultural competency issues.**

- l. **Involve government, community and educational institutions in matters related to best practices in cultural competency.**
- m. **Other (please explain below in less than 50 words): Do not submit an attachment.**

**18. As part of the plan's quality improvement efforts, how does the plan use race, ethnicity, and language data to evaluate cultural and linguistic services and examine the outcome of C&L activities? Check all that apply.**

- a. **Plan does not use race, ethnicity, and language data to evaluate C&L services.**
- b. **Subscriber complaints and grievances.**
- c. **Results of consumer satisfaction surveys (i.e. Consumer Assessment of Healthcare Providers and Systems (CAHPS), Young Adult Health Care Survey (YAHCS), Dental Consumer Assessment of Healthcare Providers and Systems (D-CAHPS).**
- d. **Utilization or other clinical data.**
- e. **Chart review.**
- f. **Other (please explain in 20 words or less): Do not submit an attachment.**

**19a. Has the plan identified health care disparities in the HFP population based on language, race or ethnicity?**

Check only yes or no, not both.

**19.b. If so, please briefly describe the health care disparities identified in the HFP population (100 words or less): Do not submit an attachment.**

**20. Please explain the specific strategies and/or programs, including any innovative processes or services, the plan has utilized to address any identified disparities. (Please explain in 100 words or less): Do not submit an attachment.**

**21. How many FTE plan staff are dedicated to cultural and linguistic (C&L) services? - FTE stands for full time equivalent. A number should be entered below this question. If one person spends half of their time on C&L services, the number entered would be 0.5 FTE.**

**22. Please attach a list of the training sessions provided to plan staff and to network providers for the 2009-2010 benefit year (include title of training session(s), date(s), categories and number of attendees (e.g., plan staff member(s), physicians, provider office staff Member(s), etc) and goal for each session).**

Please submit an attachment that shows the information requested above. There is no word limit. Please be as descriptive as possible when answering this question.

1. After completion, please save the file with the following name:  
**2009-2010 <<INSERT PLAN NAME>>HFP Cultural and Linguistic Survey.**
2. E-mail the completed survey by 5:00 p.m., April 4, 2011 to:  
[HFPContract11@mrmib.ca.gov](mailto:HFPContract11@mrmib.ca.gov)
3. Mail 1 (one) paper copy by April 4, 2011 to:  
Sarah Swaney  
Managed Risk Medical Insurance Board  
1000 G Street, Suite 450  
Sacramento, CA 95814