2023

Population Health Management (PHM) Population Assessment Study

Prepared by Quality Systems

May 2024

INLAND EMPIRE HEALTH PLAN

INTRODUCTION

STUDY BACKGROUND

Annually, IEHP assesses the characteristics of the membership to identify Member needs and to review and update its Population Health Management (PHM) structure, strategy, and resources. IEHP assesses areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI). Furthermore, health disparities among different populations are identified. The needs of Members of different ethnic groups and of those with limited English proficiency (LEP) are also included in this analysis.

STUDY AIM

Based on this assessment, IEHP reviews its PHM structure, activities, and other resources such as Community programs to ensure that Member needs are met. This assessment is conducted annually in accordance with NCQA Standard PHM 2, Elements B and C.

STUDY METHODS

STUDY PERIOD AND POPULATION

Data was extracted from IEHP's claims and encounters systems, IEHP's Medical Management System (MedHOK), HEDIS data and ACG data. All Members who were currently active at the time of the study (January 2024) were included in this analysis. The following individuals participated in this analysis: Vice President of Quality, Sr Director of Quality, Senior Director of Population Health, Healthcare Informatics Director, Clinical Informatics Manager. The results of these analyses are presented to IEHP's Population Health Management Subcommittee annually for review, comment, and approval.

STUDY MEASURES

1.) **Assesses the characteristics and needs, including social determinants of health, of its member population using the following analysis**:
   - Seniors and Persons with Disabilities (SPD) breakdown by line of business
   - Ethnicity
   - Language
   - Age
   - Homeless
   - Transportation Needs
   - Top Diagnosis
     - Overall Chronic conditions
     - Social Determinants of Health Top Diagnoses (All Plan Letter 21-009 'Collecting SDOH Data')

- HEDIS Disparities
    - Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health. (using HEDIS measures) Disparity analysis includes age, gender, ethnicity, language, homelessness indicator and region for measurement year 2022.

2.) Identifies and assesses the needs of relevant member subpopulations using the following analysis:

- Frail and Elderly
- Chronic Condition Count (ACG)
- Direct Vs. Delegated Membership distribution
- IPA Membership
- Risk Categorization (High risk, Rising risk, low risk)

3.) Assesses the needs of child and adolescent members using the following analysis:

- Children with Special Needs
- Age ranges of children enrolled in the BHT Program
- Childhood Depression Stats
- Top Diagnoses – Child / Adolescents (ages 2-19)

4.) Assesses the needs of members with disabilities and serious and persistent mental illness (SPMI).

- Top Diagnoses- SPD
- Top BH Diagnoses
- Top BH Medications Filled by County

5.) Assesses the needs of members of racial and ethnic groups

- Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health (using HEDIS measures).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Disparity analysis for Members of different ethnicities (White, Black, Hispanic, Asian, Native Hawaiian, American Indian) was assessed using the following key measures: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.
- The Medicare CAHPS annual survey was not fielded for MY 2022 due to the sunsetting of IEHP's CalMediConnect product on 12/31/2022. As of 1/1/2023, IEHP launched Medicare benefit coverage under the Duals Special Needs Plan (D-SNP) contract. The next Medicare CAHPS survey will be fielded in 2024 to assess MY 2023 performance. The study will be presented at the Member Experience Subcommittee in 2024.

6.) Assesses the needs of Members with limited English proficiency (LEP)

- Hanna Interpreting Service, a third-party vendor is utilized by IEHP Members when requesting face to face interpreters during the Member's medical appointments.
- Pacific Interpreters, a third-party vendor, submitted data to IEHP for calendar year 2023.
- Disparity Analysis by language (including Spanish, Vietnamese, Mandarin, and Cantonese) for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health.
- CAHPS Member experience survey results are assessed by Primary member language, English and Spanish. Key measures assessed include: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.

RESULTS

MEMBER POPULATION

Table 1 reports Members with an SPD Aid code. These SPD Members require a higher level of care management as they are identified as high-risk and compose of 4.5% of IEHP's total Member population.

Table 1: SPD Breakdown- by Line of Business

Category*	SPD	Non-SPD	All
D-SNP	0	36,604	36,604
MMD	0	124,284	124,284
D-SNP and MMD	0	0	0
Non-DSNP/Non-MMD	82,096	1,586,572	1,668,668
Total	**82,096**	**1,747,460**	**1,829,556**

The majority (56.1%) of the IEHP membership identifies as being Hispanic. Caucasians make up the second highest proportion of the Member population at 16.7%.

Not reported ethnicity makes up 12.4% of the population and 8.5% of the population identified as Black. Asian or Pacific Islanders make up 4.6%, Other Race or Ethnicity 1.5%. Lastly, American Indian or Alaskan Native make up 0.2% of the IEHP Member population.

Table 2: Ethnicity Breakdown

Ethnicity	Member Count	% of Membership
Hispanic	1,026,011	56.1%
Caucasian	305,156	16.7%
Not Reported	226,095	12.4%
Black	156,287	8.5%
Asian or Pacific Islander	83,601	4.6%
Other Race or Ethnicity	28,302	1.5%
American Indian or Alaskan Native	4,104	0.2%
Total Membership	**1,829,556**	**100.0%**

Table 3 displays the language breakdown for the IEHP Membership. Only the top languages are displayed. The data consists of active Members who reported speaking the language (as primary or secondary). The majority of the population reported English and Spanish as their preferred language.

Table 3: Top spoken languages

Language	Member Count	% of Membership
English	1,441,686	78.8%
Spanish	373,126	20.4%

Vietnamese	5,275	0.29%
Chinese (Chinese, Mandarin, Yue)	9,264	0.51%
Other	125	0.007%
Arabic	62	0.003%
Korean	18	0.001%
Total	1,829,556	100%

A large proportion of IEHP's Membership are children between the ages of 2-12 (22.4%). Those aged 13-19 and 20-29 make up 15% and 17% of the Membership in each group. Members aged 30-39 make up 13% of the population, 40-49 years old 8.5%, 50-59 years old 8.7%, 60-69 years old 7.5%, and those over 69, 4.5% of the Member population.

Table 4: Age Breakdown

Age Range	Count	% of Membership
Children: <2	51,093	2.8%
Children: 2-12	410,634	22.4%
Adolescence: 13-19	277,058	15.1%
20-29	312,633	17.1%
30-39	244,930	13.4%
40-49	155,406	8.5%
50-59	158,285	8.7%
60-69	136,755	7.5%
Over 69	82,762	4.5%
Total	**1,829,556**	**100.0%**

The results in Table 5 show that 6.7% of the population (122,398 Members) were identified as being potentially homeless. For all members, the most recent claims or encounters by date of service within the past 4 months were used. The Member was identified as homeless if:

- The claim had a homeless diagnosis code (e.g., Dx Codes: Z59.0, Z59.1, Z59.2, Z59.3, Z59.4, Z59.5, Z59.6, Z59.7 Z59.8, Z58.9). The list of codes is maintained by the Healthcare Analytics team.
- The member has an address matching a Homeless Address.
- The member has a street address containing a Homeless Keyword (e.g. Homeless, no address).

Table 5: Potentially Homeless counts

Category	Homeless	Non-Homeless	Total	% of Members
D-SNP	434	36,170	36,604	2.0%
MMD	3,975	120,309	124,284	6.8%
Non-DSNP/Non-MMD	117,989	1,550,679	1,668,668	91.2%
Total	122,398	1,707,158	1,829,556	**100%**

Table 6 below reveals that 42,300 unique Members accessed IEHP's transportation benefit during Jan-Dec 2023. Transportation modes are defined as non-emergency medical transportation (NEMT), non-medical transportation (NMT) and/or bus. Members are able to call into the IEHP Member Services department to connect with the Transportation team and schedule transportation services when needed.

Table 6: Transportation Needs

LOB	Member Count
D-SNP	5,877
Medi-Cal	36,423
Medi-Cal - SPD (1)	8,015
Medi-Cal - MMD (2)	7,883
Total	42,300

(1) LOB on Last Elig Month = Medi-Cal and Member was SPD and not MMD
(2) LOB on Last Elig Month = Medi-Cal and Member was MMD and not SPD

Table 7 below lists the top diagnosis codes for both lines of business for the general population. Hypertension is the top diagnosis for both line of business. Back pain, hyperlipidemia, vitamin D deficiency, and gastro-esophageal reflux disease are also diagnoses that appear in both lines of business.

Table 7: Top Diagnoses in the general population - Medi-Cal

	Medi-Cal Member Top 10 Diagnoses	Member Count
1	Essential hypertension	202,037
2	Hyperlipidemia	148,480
3	Obesity	111,159
4	Vitamin D deficiency	110,276
5	Other long term drug therapy	110,105
6	Type 2 diabetes mellitus without complications	103,955
7	Anxiety disorder	87,629
8	Low Back Pain	86,635
9	Gastro-esophageal reflux disease without esophagitis	84,832
10	Chronic Pain	66,111
	D-SNP Member Top 10 Diagnoses	**Member Count**
1	Essential hypertension	24,603
2	Hyperlipidemia	18,278
3	Type 2 diabetes mellitus without complications	13,470
4	Other long term drug therapy	9,612
5	Vitamin D deficiency	8,603
6	Gastro-esophageal reflux disease without esophagitis	8,341
7	Mixed hyperlipidemia	7,904
8	Presbyopia	7,742
9	Type 2 diabetes mellitus with other specified complication	7,584
10	Low Back Pain	7,307

An analysis of the top 20 SDOH was assessed for all IEHP Members. Low income, homelessness, and food insecurity diagnoses codes have the highest member counts.

Table 8: Top 20 SDOH Diagnoses (All Members)

	Diagnosis Name	Member Count
1	Low Income	42,352
2	Homelessness	13,411
3	Food Insecurity	12,109
4	Acculturation	9,231
5	Unemployment	9,072
6	Problems Related to Unwanted Pregnancy	8,178
7	Problem Related to Social Environment	8,042
8	Problem Related to Unspecified Psychosocial Circumstances	7,746
9	Other Stressful Life Events Affecting Family and Household	7,376
10	Other Specified Problems Related to Psychosocial Circumstances	6,554
11	Problems related to housing	5,041
12	Problem Related to Housing and Economic Circumstances	4,139
13	Disappearance And Death of Family Member	2,954
14	Problems Related to Living Alone	2,928
15	Child In Welfare Custody	2,861
16	Underachievement In School	2,767
17	Other Specified Problems Related to Primary Support Group	2,711
18	Disruption Of Family by Separation and Divorce	2,462
19	Problems In Relationship with Spouse Or Partner	2,435
20	Other Problems Related To Education And Literacy	2,150

MEMBER SUBPOPULATIONS

Table 9 shows that 8.3% of Members have a frailty flag. The frailty flag indicator was taken from IEHP's Johns Hopkins' ACG tool. Members with the frailty flag had an incidence of at least one of the following during 2023: malnutrition, dementia, severe vision impairment, decubitus ulcer, major problems of urine retention or control, loss of weight, absence of fecal control, social support needs, difficulty in walking, or falling. (Some Members may be listed as frail or not frail at different points throughout the year).

Table 9: Frail and Elderly

Frailty Flag	Member Count	Percent
No	1,677,771	91.7%
Yes	150,910	**8.3%**
Total	**1,828,681**	100%

The Johns Hopkins' ACG Tool was used to run the total Medi-Cal and D-SNP population data and are indicated in accordance with chronic condition counts. The counts include all active Members with ACG data for profile date 12/01/2023.

- A chronic condition is defined as disease which are: 1) likely to last longer than 12 months with or without medical treatment, and (2) likely to have a negative impact on health or functional status.
- Expanded Diagnosis Clusters (EDCs) are used to identify chronic conditions within the ACG System.
- 3.7% of the overall population was identified as being within the Complex category and having 10+ Chronic Condition Counts (depicted in table 10 below). The Extended Chronic Condition category measured at 4.1%.
- Most of the Member population (82.7%) has a chronic condition count of 0 or 1-3 for "Low" and "Basic" respectively.

Table 10: Chronic condition count

Chronic Condition Category	Number of Chronic Conditions	Number of Members	Percent of Members
Low	0	840,064	51.8%
Basic	1-3	501,051	30.9%
Intermediate	4-6	152,964	9.4%
Extended	7-9	66,607	4.1%
Complex	10+	60,480	3.7%
Total		1,621,166	100.0%

Table 11 shows that 44.5% of the IEHP Membership is assigned to a delegated Independent Physician Association (IPA). Many Members' Care Management Services and Care Coordination services are delegated to an IPA and IEHP has developed Delegation Oversight (DO) processes to ensure that regulatory requirements and IEHP Guidelines/Standards are met. The IEHP DO staff monitors and supports various delegated activities through case reviews and delegation oversight audits.

Table 11: Direct total vs. Delegated Total

Line of business	Direct Membership	Delegated Membership
Medi-Cal	877,572	714,354
D-SNP	24,543	9,720
Total	**902,115 (55.5%)**	**724,074 (44.5%)**

Table 12 displays the Membership breakdowns between IPAs for each LOB. For the Medi-Cal and D-SNP LOB, the largest percentage of Membership is currently assigned to IEHP Direct (55.5%), followed by Optum Care-Inland Faculty Medical Group (12.9 %). Only IEHP Direct and Dignity Health Medical Network services both lines of business.

Table 12: Breakdown of IPA Membership

IPA Name	Medi-Cal	D-SNP	Total Members	% of Members
IEHP Direct	877,572	24,543	902,115	55.5%
Optum Care Network - Inland Faculty MG	210,186	0	210,186	12.9%

Kaiser - Fontana & Riverside	158,797	1	158,798	9.8%
IEHP Health Plan	86,480	0	86,480	5.3%
Alpha Care Medical Group	81,224	0	81,224	5.0%
LaSalle Medical Associates	74,879	0	74,879	4.6%
Physicians Health Network	67,896	0	67,896	4.2%
Horizon Valley Medical Group	22,644	0	22,644	1.4%
Dignity Health Medical Network	11,487	452	11,939	0.7%
Heritage Medical	0	2,529	2,529	0.2%
Primecare Medical Network	0	3,692	3,692	0.2%
Epic Health Plan	0	1,839	1,839	0.1%
CPN - Horizon Valley Medical Group	0	543	543	0.0%
Riverside Medical Clinic	0	497	497	0.0%

IEHP's population health risk stratification algorithm uses all available data sources and a variety of risk models to identify Members who are at higher risk of poor health outcomes. The objective of the risk stratification is to segment IEHP members into a system that provides data-driven support for the allocation of population-based disease management resources.

The stratification algorithm utilizes the following sources to stratify Members into low, rising, and high categories: IEHP utilization data, ACG coordination risk scores, ACG diagnosis-based markers social determinant of health tools (i.e. Healthy Places Index, Social Vulnerability Index, Area of Deprivation Index), Supplemental data (i.e. Health Information Form, IHSS, MSSP, IRC, CCS, and BHT)
The current risk categorization for 1,636,559 Members is summarized in the table below. Currently, 10% of the IEHP membership is categorized as High risk utilizing this PHM risk stratification methodology.

Table 13: PHM Risk Stratification of Members

Risk Categorization	Count of Members
High	163,184
Rising	331,659
Low	1,141,716
Total Members	1,636,559

Active membership with a risk categorization as of 11/06/23

CHILDREN AND ADOLESCENT POPULATION

The California Children Services (CCS) Program and IEHP's Behavioral Health Treatment (BHT) Program provide services for children with special needs. Table 14 shows that 9,403 Members are enrolled in BHT and 31,354 Members are enrolled in CCS. CCS is a carve-out benefit that provides and pays for diagnostic, treatment, and rehabilitation services to children under the age of 21. A small population (1,268 Members) receive both BHT and CCS. IEHP Plan Based Integrated Care Team works together to coordinate Members care between both BHT and CCS.

Table 14: Children with Special Needs

Program	Total Members
Behavioral Health Treatment (BHT)	9,403
California Children Services (CCS)	31,354
Both	1,268
Total	42,025

Members enrolled in the BHT Program are eligible to receive treatment, functional behavior assessment, speech therapy, occupational therapy, and/or physical therapy. The table 15 below illustrates most children are between the ages of 6 and 12 years old. Furthermore, about 83% of members enrolled in IEHP's BHT Program are children 12 years old and younger.

Table 15: Children utilizing BHT Services by age

Age range	Total Members
<5 years	3,993
6-12	4,866
13-17	1,370
18-21	442
Total Members	10,671

Table 16 indicates the total count of children under 21 with a diagnosis of depression and/or suicidal ideation. The "NAL" column is a count of Members who reported depression self-harm when calling the Nurse Advice line (NAL). The NAL dispositions criteria reported 24 child Members with a disposition of depression and/or suicide. The NAL is available 24/7 and nurses can offer medical advice over the phone or guide Members to get the care they need.

Table 16: Childhood Depression

Line of Business	Total Members	NAL*
Medi-Cal	34,917	33
Medi-Cal - SPD	1,767	2
Medi-Cal - MMD	13	
Total	36,697	35

**using Nurse Advice Line (NAL) dispositions criteria*

Table 17 lists top diagnoses in children ages 2-19. The most common diagnoses for children are disorders of refraction, vasomotor/allergic rhinitis, and overweight/obesity. Asthma and anxiety are also listed in the top 10.

Table 17: Top Diagnoses in Children aged 2-19

	Top Diagnoses list for Members under 19 years	Member Count
1	Disorders of refraction and accommodation	95,927
2	Vasomotor and allergic rhinitis	54,978
3	Overweight and obesity	51,164

4	Asthma	44,562
5	Symptoms and signs involving the circulatory and respiratory system	41,184
6	Unspecified soft tissue disorders	34,570
7	Joint disorder	33,129
8	Specific developmental disorders of speech and language	25,904
9	Anxiety disorders	24,985
10	Functional intestinal disorders	22,182

MEMBERS WITH DISABILTIES AND SPMI

Table 18 displays the top diagnoses for the SPD population. The most common conditions among this population are hypertension, lipidemia and diabetes. Table 18 shows SPD Members who are also covered under Medicare (MMD Members)

Table 18: Top Diagnoses- SPD Members

	SPD Members Top Diagnoses	Member Count
1	Essential hypertension	43,934
2	Disorders of lipoprotein metabolism and other lipidemia	38,891
3	BMI/Overweight/Obesity	34,677
4	Type 2 diabetes mellitus	29,269
5	Long term (current) drug therapy	25,168
6	Unspecified soft tissue disorders	20,504
7	Dorsalgia	19,814
8	Other joint disorder	19,690
9	Gastro-esophageal reflux disease	16,626
10	Chronic kidney disease (CKD)	15,282

IEHP members who meet Title 9 “specialty mental health criteria” receive their Behavioral Health services from the county Mental Health plan and not the Medi-Cal managed care plan. These members meet the criteria for the NCQA “SPMI Population” and since IEHP is not financially responsible for this group of members’ care, data is limited and therefore excluded from the Medi-Cal data presented.

For the Medi-Cal members that IEHP does serve, depressive disorder, anxiety, and nicotine dependance accounts for the top 3 diagnoses for both lines of business. This was also the noted trend in 2022. Alcohol related disorders also fall within the top 10 diagnoses. Due to the nature of mental health and substance use, both have a propensity to go hand in hand making secondary diagnoses equally as significant as the primary.

Table 19: Behavioral Health Top Diagnoses by LOB

	BH Top 10 Diagnoses – Medi-Cal Members	Member Count
1	Major depressive disorder	151,009
2	Other anxiety disorders	138,582

3	Nicotine dependence	66,435
4	Severe stress/adjustment disorders	51,046
5	Attention-deficit hyperactivity disorders	30,462
6	Disorders of speech and language	28,098
7	Pervasive developmental disorders	26,411
8	Alcohol related disorders	25,810
9	Cannabis related disorders	23,596
10	Bipolar disorder	22,286
	BH Top 10 Diagnoses – Medicare Members	Member Count
1	Major depressive disorder	12,658
2	Anxiety disorders	7,169
3	Nicotine dependence	5,245
4	Opioid related disorders	2,823
9	Schizophrenia	2,717
5	Bipolar disorder	2,332
6	Alcohol related disorders	2,018
7	Severe stress/adjustment disorders	1,904
8	Unspecified dementia	1,769
10	Sleep Disorders	1,252

Table 20 illustrates the unique Member fills for each medication type in the categories of Anti-Alcoholic Preparations, Psychoactive Drugs, and Opioid Analgesics.

- The count of fills is based on 87,000 unique IEHP Members. The largest volume of medications are in the Opioid Drug Class.
- The proportion of unique Members with a county medication fill is larger for the SPD population (23.8%) than in the Non-SPD population (3.9%).

Table 20: Count of top fills of BH Meds

Medication Type	Medi-Cal Non-SPD	SPD	Total
Total Unique Members	67,475	19,525	87,000
o Anti-Alcoholic Preparations	1,255	97	1,352
o Psychoactive Drugs	29,568	13,631	43,199
o Opioid Analgesics	42,410	7,940	50,350
Total Membership	1,747,460	82,096	1,829,556
Proportion of unique Members with a county fill	3.9%	23.8%	

MEMBERS OF RACIAL AND ETHNIC GROUPS

An assessment of health disparities using HEDIS measures was assessed using HEDIS 2020 2021, and 2022 data. Table 3 below describes disparities identified among the Hispanic, White, Black, American Indian or Alaskan Native, and Asian and Pacific Islander ethnicities. The conditions where disparities were noted were in the Child Preventative measures, Women's Health, Disease Management, Behavioral Health measures, and Cancer Screening measures.

Table 21: Assessment of needs of Members by racial or ethnic groups - Medi-Cal

Race/Ethnic Group	HEDIS 2020-2022 Measure Disparities for Medi-Cal Members 3-year trends are summarized (i.e. Members with the disparity identified during measurement years 2020, 2021, 2022)
Hispanic	• **Diabetes A1C Control of less <8** was identified as a disparity for the Hispanic group. The compliance rate of 49.64% is lower than the total IEHP population compliance rate of 51.37%. (Lower rate signifies poorer health). • **Diabetes Control of greater than >9** (measurement of poor health) was identified as a disparity for the Hispanic group. The rate of 40.67% is higher than the total IEHP Population rate of 39.59%. (Higher rate signifies poorer health).
White	• **Immunizations for adolescents** was identified as a disparity for the White race/ethnic group. The compliance rate of 23.38% is lower than the total IEHP population compliance rate of 34.41%. • **Breast Cancer screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 47.92%. is lower than the total IEHP population compliance rate of 58.73%. • **Cervical Cancer Screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 47.96% is lower than the total IEHP population compliance rate of 55.18% • **Chlamydia screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 59.35% is lower than the total IEHP population compliance rate of 64.88%. • **Prenatal Care** was identified as a disparity for the White race/ethnic group. The compliance rate of 81.27% is lower than the total IEHP population compliance rate of 82.57%. • **Post-Partum Care** was identified as a disparity for the White race/ethnic group. The compliance rate of 71.13% is lower than the total IEHP population rate of 74.21%. • **Well child Visits** was identified as a disparity for the White race/ethnic group. The compliance rate of 38.48% is lower than the total IEHP population compliance rate of 46.78%. • **Colorectal Screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 36.49% is lower than the total IEHP population rate of 40.36% • **Kidney Health Evaluation for patients with Diabetes** was identified as a HEDIS disparity for the White race/ethnic ethnic group. The compliance rate of 40.74% is lower than the total IEHP population rate of 45.47%. • **Prenatal Immunization Status** was identified as a HEDIS disparity for the White race/ethnic group. The compliance rate of 10.67% is lower than the total IEHP population rate of 14.48%. • **Risk of continued opioid use** was identified as a HEDIS disparity for the White race/ethnic group. The rate of 9.80% is higher than the total IEHP population rate of 6.76% (higher rate signifies higher risk) • **Lead screening** was identified as a HEDIS disparity for the White race/ethnic group. The compliance rate of 43.75% is lower than the total

	IEHP population rate of 50.26%.
Black	• **Childhood immunization-10** was identified as a disparity for the Black race/ethnic group. The rate of 9.89% is lower than the total IEHP population compliance rate of 22.94%. • **Well child visits** was identified as a disparity for the Black race/ethnic group. The rate of 39.55% is lower than the total IEHP population compliance rate of 46.78%. • **Well Child visits in the first 30 months** was identified as a disparity for the Black race/ethnic group. The rate of 49.47% is lower than the total IEHP population compliance rate of 62.93%. • **Well Child visits in the first 15 months** was identified as a disparity for the Black race/ethnic group. The rate of 40.05% is lower than the total IEHP population compliance rate of 55.79% • **Immunizations for adolescents** was identified as a disparity for the Black race/ethnic group. The compliance rate of 21.73% is lower than the total IEHP compliance rate of 34.41%. • **Prenatal Care** was identified as a disparity for the Black race/ethnic group. The compliance rate of 78.41% is lower than the total IEHP population compliance rate of 82.57%. • **Post-Partum Care** was identified as a disparity for the Black race/ethnic group. The compliance rate of 64.25% is lower than the total IEHP population compliance rate of 74.21%. • **Controlling Blood Pressure** was identified as a disparity for the Black race/ethnic group. The compliance rate of 45.55% is lower than the total IEHP population rate of 50.97%. • **Antidepressant Medication management** was identified as a HEDIS disparity for the Black race/ethnic group. The compliance rate of 56.86% is lower than the total IEHP population rate of 63.39%. • **Lead screening** was identified as a HEDIS disparity for the Black race/ethnic group. The compliance rate of 39.49% is lower than the total IEHP population rate of 50.26%. • **Kidney Health Evaluation for patients with Diabetes** was identified as a HEDIS disparity for the Black race/ethnic group. The compliance rate of 38.94% is lower than the total IEHP population rate of 45.47%. • **Prenatal Immunization Status** was identified as a HEDIS disparity for the Black race/ethnic group. The compliance rate of 9.44% is lower than the total IEHP population rate of 14.48%. • **Risk of continued opioid use** was identified as a HEDIS disparity for the Black race/ethnic group. The rate of 8.88% is higher than the total IEHP population rate of 6.76% (higher rate signifies higher risk)
American Indian or Alaskan Native	• **Well Child Visits** was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 32.80% is lower than the total IEHP population compliance rate of 46.78%. • **Cervical Cancer Screening** was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 42.95% is lower than the total IEHP population compliance rate of 55.18%. • **Diabetes A1C Control of less <8** was identified as a disparity for the American Indian or Alaskan Native. The compliance rate of 32.85% is lower than the total IEHP population compliance rate of 51.37%.

	• **WCC- Physical Activity, Nutrition, BMI** was identified as a disparity for the American Indian or Alaskan Native ethnic group. The compliance rate of 53.66% is lower than the total IEHP population compliance rate of 72.81%. • **Diabetes Control of greater than >9** (measurement of poor health) was identified as a disparity for the American Indian or Alaskan Native ethnic group. The rate of 60.65% is higher than the total IEHP Population rate of 39.59%. (Higher rate means poorer health).
Asian or Pacific Islander	• **Cervical Cancer Screening** was identified as a disparity for the Asian or Pacific Islander ethnic group. The compliance rate of 52.76% is lower than the total IEHP population compliance rate of 55.18%. • **Chlamydia Screening** was identified as a disparity for the Asian or Pacific Islander ethnic group. The compliance rate of 60.23% is lower than the total IEHP population compliance rate of 64.88%.

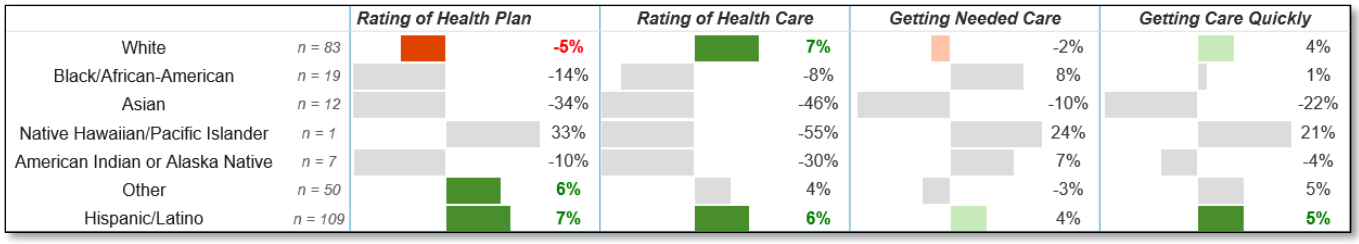
Table 22: Assessment of needs of Members by racial or ethnic groups - Medicare

Ethnicity	**HEDIS 2020-2022 Measure Disparities for Medicare Members** 3-year trends are summarized (i.e. Members with the disparity identified during measurement years 2020, 2021, 2022)
White race/ethnic group	**Colorectal Cancer screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 57.01% is lower than the total IEHP population compliance rate of 61.74%. **Breast Cancer Screening** was identified as a disparity for the White race/ethnic group. The compliance rate of 57.71% is lower than the total IEHP population compliance rate of 66.70%. **Eye exams for patients with Diabetes** was identified as a disparity for the White race/ethnic group. The compliance rate of 60.78% is lower than the total IEHP population compliance rate of 67.06%. **Use of High-Risk Medications in Older Adults** was identified as a disparity for the White race/ethnic group. The rate of 26.94% is higher than the total IEHP Population rate of 21.40% (higher rate signifies higher risk). **Risk of continued opioid use** was identified as a disparity for the White race/ethnic group. The rate of 19.42% is higher than the total IEHP Population rate of 14.17% (higher rate signifies higher risk).

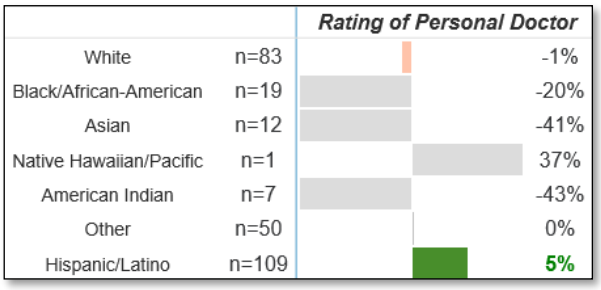
The graphs below are taken from the MY 2022 Annual CAHPS Medicaid survey results. For Overall Ratings by ethnicity, Members of White race/ethnic group reported low Member experience rates in ‘Rating of Health Plan’, ‘Rating of Personal Doctor’, and ‘Rating of Specialist’ as well as ‘Getting Care Quickly’ Composite. In contrast, Hispanic Members reported high Member experience rates in all Overall rating questions as well as ‘Getting Needed Care’ and ‘Getting Care Quickly’ composites. Summary rates are scores for ‘9’, or ‘10’, and ‘Usually’ or ‘Always’.

Graphs 1-3 Assessment of Needs of Members by racial or ethnic groups – Member Experience Results

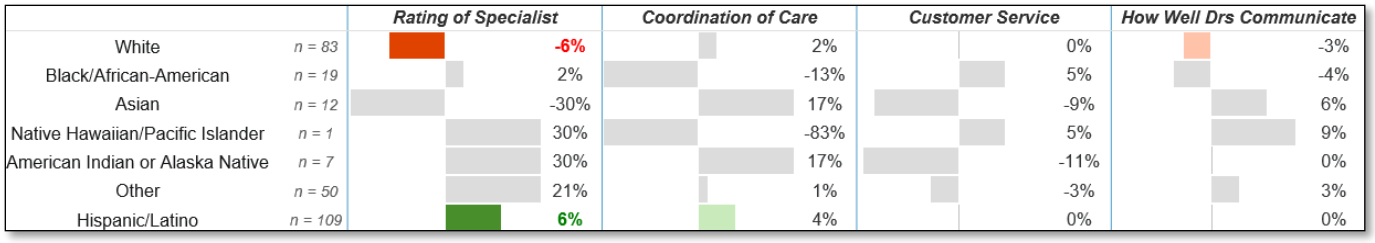
Graph 1

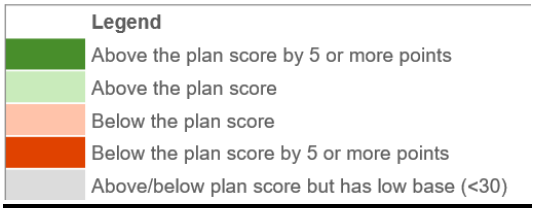


Graph 2



Graph 3





Members With Limited English Proficiency (LEP)

IEHP ensures that services (clinical and non-clinical) are provided in a culturally competent manner and are accessible to all IEHP Members. All Network Providers must offer services to Members with limited English proficiency in the Member's primary language. Both Providers and Members may call IEHP Member Services department and request a face-to-face interpreter prior to a medical appointment.

In 2023 IEHP received a total of 32,178 face-to-face interpreter requests. This is an increase from the 25,152 face-to-face interpreter requests received in 2022. Members may request interpreter services prior to routine medical appointments or emergency medical appointments. The top requested languages in 2023 were Spanish, American Sign Language (ASL), Arabic, and Mandarin. Spanish and ASL interpreter requests make up 83% of total requests.

Table 23: Face to Face interpreter requests (Top languages)

Language	2023 total requests	% of total requests
Spanish	22810	70.9%
ASL	4006	12.4%
Arabic	2323	7.2%
Mandarin	1473	4.6%
Vietnamese	583	1.8%
Yue Chinese (Cantonese)	125	0.4%
Other	**858**	2.7%
Total	32,178	**100%**

In addition to medical appointment interpreters, IEHP offers telephonic interpreter services within the Member Services call center based on the linguistic needs of Members. IEHP contracts with a third-party interpreter language line to offer interpreter services for over 200 languages. During normal business hours, the Member Services Representative (MSR) facilitates access which involves a three-way conversation between the MSR, the non-English speaking Member/caller and the contracted interpreter Agent.

In 2023, a total of 60,372 telephone interpreter requests were received by IEHP staff. This is an increase from the 59,171 requests in 2022.

The top requested languages were Spanish, Mandarin, Arabic, and Vietnamese. Spanish interpreter requests make up the largest volume of requests at 76.9%. Cantonese is an IEHP threshold language but not a top requested language. There were only 376 requests for Cantonese interpretation in 2023.

Table 24: Telephone Language Interpreter requests (Top 4 languages)

Top languages	2023 Total Calls	% of total requests
Spanish	46,436	76.9%
Mandarin/Chinese	4,272	7.1%
Arabic	2,609	4.3%
Vietnamese	2,274	3.8%
Other	4,781	7.9%
Total	**60,372**	**100%**

HEDIS disparities identified for MY 2021 (using HEDIS 2022 results) are depicted in the tables below. Chinese, Vietnamese, Mandarin and Cantonese are new threshold languages included in this report. Disparities identified for the new threshold languages were only identified during MY 2021, versus English and Spanish which identified disparities in both MY 2020 and MY 2021. The majority of HEDIS disparities was identified with English speaking

Members, followed by Vietnamese speaking Members. There were no disparities identified for the Spanish speaking population using the selected HEDIS measures.

Table 25: Assessment of needs of Members by primary language – Medi-Cal

Language	HEDIS 2022 Measure Disparities for Medi-Cal Members 2-year trends are summarized (i.e., members with the disparity identified during measurement years 2021 and 2022)
English	• **Immunizations of adolescents** was identified as a disparity for the English-speaking group. The compliance rate of 30.92% is lower than the IEHP population compliance rate of 34.41% • **Well Child Assessment for BMI** was identified as a disparity for the English-speaking group. The compliance rate of 70.57% is lower than the IEHP population compliance rate of 72.81%. • **Developmental Screening in the First Three Years of life** was identified as a disparity for the English-speaking group. The compliance rate of 39.69% is lower than the IEHP population compliance rate of 40.69%. • **Hemoglobin A1C control for Patients with Diabetes A1C<8** was identified as a disparity for the English-speaking group. The compliance rate of 50.14% is lower than the IEHP population compliance rate of 51.37%. • **Lead Screening** was identified as a disparity for the English-speaking group. The compliance rate of 48.14 is lower than the IEHP population compliance rate of 50.26%.
Spanish	• **Appropriate Testing for Pharyngitis** was identified as a disparity for the Spanish-speaking group. The compliance rate of 14.43% is lower than the IEHP population compliance rate of 18.34%.
Vietnamese	• **Well Child Assessment for BMI*** was identified as a disparity for the Vietnamese-speaking group. The compliance rate of 55.05% is lower than the IEHP population compliance rate of 72.81%. • **Well Child Assessment for Nutrition*** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 52.26% is lower than the IEHP population compliance rate of 70.76%. • **Well Child Assessment for Physical Exercise*** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 51.22% is lower than the IEHP population compliance rate of 69.40%. • **Child and Adolescent Well Care Visits** was identified as a disparity for the Vietnamese -speaking group. The compliance rate of 39.75% is lower than the IEHP population compliance rate of 46.78%. •
Mandarin	• **Kidney Health Evaluation for patients with Diabetes*** was identified as a disparity for the Mandarin -speaking group. The compliance rate of 32.18% is lower than the IEHP population compliance rate of 45.47%.

*include disparity data for 3 years, 2020,2021,2022

An assessment of language disparities using the same HEDIS measures as the table above, reveals disparities were identified with the English-speaking Members (Breast Cancer Screening and

Colonoscopy measures), and Spanish speaking Members (Statin Adherence). No Disparities were found with Vietnamese, Chinese, Mandarin, or Cantonese speaking languages.

Table 26: Assessment of needs of Members by Primary language- Medicare

Language	HEDIS 2022 Measure Disparities for Medicare Members 2-year trends are summarized (i.e., members with the disparity identified during both MY 2020, 2021, 2022)
English	• **Statin Therapy for Patients with Diabetes** was identified as a disparity for the English-speaking group. The compliance rate of 75.96% is lower than the total IEHP population compliance rate of 79.05%.

The graphs below are taken from the MY 2022 Annual CAHPS Medicaid survey results. Member rates were assessed using surveys completed by English speaking Members and surveys completed by Spanish speaking Members. Summary rates are calculated using member scoring the question with a '9', or '10', or 'Usually' or 'Always'. In general, English-speaking Members scored below plan score for all measures listed in the table below. Rating of Health Plan score had the largest difference when compared to the plan score (10.2 points below the plan score)

In contrast, Spanish Speaking Members rated 3 of the questions higher than the plan score. Additionally, the 'Rating of Health Plan' question revealed positive performance, rating 19.9 points above the plan score.

Table 27: Assessment of Needs of Members by language – Member Experience

	English			Spanish		
Measures	n=	rate	points above/below plan score	n=	rate	points above/below plan score
Rating of Health Care	80	50.0%	-5.1	27	70.4%	*Less than 30 respondents*
Rating of Personal Doctor	89	55.1%	-8.2	39	82.1%	18.8
Rating of Specialist +	58	65.5%	-4.4	25	80.0%	*Less than 30 respondents*
Rating of Health Plan	118	56.8%	-10.2	61	86.9%	19.9
Getting Needed Care	71	73.9%	-2.0	26	80.7%	*Less than 30 respondents*
Getting Care Quickly	61	76.8%	-2.0	30	82.7%	3.9
How Well Doctors Communicate +	64	89.9%	-1.5	28	94.7%	*Less than 30 respondents*
Customer Service +	49	93.9%	-0.8	27	96.3%	*Less than 30 respondents*
Coordination of Care +	41	80.5%	-2.3	17	88.2%	*Less than 30 respondents*

NEEDS ASSESSMENT

Population	Summary of key findings
General Population	• The largest ethnicity is the Hispanic Group which makes up 56.1% of the membership. • Children under 19 make up 40% of the population, while adults ages 20-49 make up 39% of the population. • English and Spanish are the primary languages. • 6.7% of the population was identified as homeless. • The top diagnoses in the general population are Hypertension, Hyperlipidemia, type 2 diabetes.
Sub Populations	• About half of the IEHP Membership is delegated to an IPA • 8.3% of the population was identified as frail. • Most of the Member population (82.7%) has a chronic condition count of 0 or 1-3, while 7.8% of the Members have 7+ chronic conditions.
Children and Adolescents	• 42,025 children were identified as special needs. • The top diagnoses for children ages 2-19 are Disorders of refraction allergic rhinitis, and obesity. • Asthma in children is a top chronic condition.
SPD Members	• 4.5% of the Membership are Members and persons with disabilities. • The top diagnoses of SPD Members are hypertension, lipidemia, obesity, and diabetes.
Members with SPMI	• For BH related top diagnoses, anxiety, depression, and nicotine disorder are the most common. • 23.8% of SPD Members fill prescriptions for Anti-Alcoholic, Psychoactive, or Opioid medications through the county. • Alcohol related disorders is a top diagnosis for both lines of business
Ethnic Groups	• 56.1% of the total IEHP population is Hispanic • For Pediatric Preventative Care, Black Ethnicity disparity across all measures was identified. • For Cancer Prevention, the White race/ethnic group had a disparity in Breast Cancer, Cervical Cancer and Colorectal cancer screening for 3 consecutive years. • Hemoglobin A1C control was identified as a disparity for the Hispanic and American Indian/Alaskan Native Ethnicity • Risk of Opioid use was identified as a disparity for the White and Black Ethnicity Group • Controlling Blood Pressure and Antidepressant medication management was identified as a disparity for Black Ethnicity. • For Member Experience, Members of White ethnicity reported low Member experience rates in ‘Rating of Health Plan’, ‘Rating of

	Personal Doctor', and 'Rating of Specialist' as well as 'Getting Care Quickly' Composite.
Members with LEP	• Of the Members that call into IEHP requiring translator services, 76.9% are Spanish speaking. • For face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator. Followed by 12.4% requiring American Sign Language. • Well Child Assessments and Well Child visits was identified as a disparity for Vietnamese speaking Members for 3 consecutive years. • Kidney Health Evaluation for patients with Diabetes was identified as a disparity for the Mandarin speaking Members. • Members who speak 'English' reported lower rates in CAHPS questions than Members who's primary language is Spanish.

ACTIVITIES AND RESOURCES

The results of the Population assessment were used to review and update activities, resources, and community resources.

REVIEW AND UPDATE ACTIVITIES TO ADDRESS MEMBER NEEDS

Hypertension is the most common diagnosis for the general population and for the SPD population.

- Activity: Controlling Blood Pressure measure is included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

- Activity: IEHP's Enhanced Care Management (ECM) team to engage high risk and complex care Members to participate in self-monitoring blood pressure to achieve improved blood pressure control in support of the 'Controlling Blood Pressure' (CBP) HEDIS measure.

- Activity: Blood Pressure control of 140/90 is a Value Based Payment metric to incentivize quality performance in ECM providers.

- Activity: Targeted fax outreach by IEHP's Pharmacy department to Providers with Members eligible for and noncompliant with HEDIS CBP. The MTM program outreaches to Members (Medicare LOB) for medication optimization for those with Diabetes/Hypertension.

- Activity: Targeted telephonic outreach by IEHP's pharmacy department to Members newly diagnosed with hypertension to provide medication education.

Special needs children: About 42,000 children are identified as special needs and about 2.3% of the total IEHP Member population is under the age of 2 years old.

- Activity: Development Screening in Children is a measure included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

- Activity: Developmental Screening education during Provider office visits is part of the Regional Quality Community Model (RQCM). Offices are provided with Quality Coding resources and education on the developmental screening billing code, 96100.

- Activity: Key Pediatric Preventative Care Measures will consist of targeted efforts utilizing a community-based approach to support care coordination in WIC Program offices leveraging new CHW-led care coordination and support resources.

Members with Diabetes is a top condition for the general population and the SPD population. Activities to support diabetes care include:

- Activity: Targeted outreach (fax) to Providers with Members eligible for and noncompliant with HEDIS CDC. The MTM program outreaches to Members (Medicare LOB) for medication optimization for those with Diabetes/Hypertension.

- Activity: TMR program outreaches to Members for medication education for those who are newly diagnosed and with history of Diabetes/Hypertension.

- Activity: The Global Quality P4P Program provides financial incentives to PCPs and IPAs for improving measure performance on Diabetes related measures.

Depression was identified as a top diagnosis for the SPMI population. Activities to support Depression screening include:

- Activity: Screening for Clinical Depression is a measure included in the Global Quality P4P PCP and IPA Programs which provide a financial incentive to PCPs and IPAs for improved measure performance.

- Activity: Screen Members for depression with PHQ-9 within first 90 days of enrollment and improve follow-up screening with Members identified for moderate/severe risk.

- Activity: Depression Screening with PHQ9 is a Value Based Payment metric to incentivize quality performance in ECM providers.

- Activity: The Community BH department identify at risk Members via depression screening (PHQ-2) and either refer to the ‘in-house’ clinician or to a Provider referral, when appropriate.

Asthma is a top diagnosis in children and adolescents.

- Activity: The Community Supports Asthma Remediation Program addresses environmental triggers in the Members home.

- Activity: The Asthma Medication Ratio (AMR) HEDIS Measure is a measure on the PCP and IPA Global Quality P4P Program.

- Activity: Pharmacy Fax Blast targeted to providers not meeting AMR measure.

- Activity: Pharmacy Call Campaign targeted to Members not meeting AMR measure.

- Activity: Health Equity Operations department aim to increase referrals to asthma program and asthma classes as identified in the community.

REVIEW AND UPDATE RESOURCES TO ADDRESS MEMBER NEEDS

Depression diagnosis ranks as the #1 diagnosis related to Behavioral Health. It is also found in the child population.

- Resource: Health Education Department to disseminate education materials to Providers with focus on preventive education; including depression screening.

Diabetes is a top diagnosis in the general population and SPD population.

- Resource: Diabetes Self-Management Workshops is a 6 week class for people with type 2 diabetes and their relatives that need information on diabetes self-management.
- Resource: The Health Education and Marketing departments develop educational brochures and booklets to help stay healthy with Diabetes. Material is available on the website and available in different languages when requested.

Members with LEP that call into IEHP requiring translator services are Spanish speaking 76.9% of the time. For face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator.

- Resource: The Health Equity Operations department will lead activities such as language assessments for Member Service Representatives, develop and support Member educational materials in English, Spanish, Vietnamese, Mandarin, and Cantonese.
- Resource: Educate new Network Providers in Cultural & Linguistics training. The CLAS program description was updated and approved by the PHM Subcommittee in 2023 to align with regulatory requirements.

ADDRESS HEALTH CARE DISPARITIES FOR AT LEAST ONE IDENTIFIED POPULATION

Well Child visits in the first 15 months was identified as a disparity for the Black ethnic group. The rate of 40.05% is lower than the total IEHP population compliance rate of 55.79%. Well Child visits in the first 30 months was identified as a disparity for the Black ethnic group. The rate of 49.47% is lower than the total IEHP population compliance rate of 62.93%. Improving Well Child Visits within the first 30 months of life in Black infants will be implemented to improve compliance rates.

- IEHP will be assigning a CHW to our community services team that will aid in providing additional support to Members who are referred to Black Infant Health. In addition, our community services team will offer a referral option for fathers of the children in Black Infant Health to Project Fatherhood, an initiative that engages fathers in the care and upbringing of their children.

REVIEW COMMUNITY RESOURCES FOR INTEGRATION INTO PROGRAMS

Asthma is also a leading chronic condition in children**.**

- Community Resource: IEHP Health Navigators provide individual asthma education to Members as needed.

- Community Resource: IEHP Community Health Team connect Members to the "Breathe IE" community asthma program.

- Community Resource: Health Education classes on Asthma are available to Members. Informational Member brochures on Controlling asthma are available on the IEHP Website.

Depression was identified as a top diagnosis for the SPMI population.

- Community Resource: The Community BH department identify at risk Members via depression screening (PHQ-2) and either refer to the 'in-house' clinician or to a Provider referral, when appropriate.

Homelessness was identified in approximately 122,398 of Members. Homelessness was identified as the #2 ranking SDOH, after 'low income'.

- Community Resource: The Community supports Program assists with Housing Navigation Services, Housing Sustaining Services, and Housing Deposits.

Chronic diseases such as Hypertension, Hyperlipemia, Diabetes, and Obesity are the most common chronic conditions of the IEHP population:

- Community Resources: Heath Educators host health coaching sessions on the Healthy Heart Topic. Healthy Heart classes include Blood pressure control and Cholesterol control.

- Community Resource: Community Health Workers (CHW) Heart Disease Curriculum for Targeted populations. 1.) 'Healthy Heart, Healthy Family' for the Filipino Community 2.) 'Your Heart, Your Life' for the Hispanic Community 3.) 'With Every Heartbeat is Life' for the African American Community 4.) 'Your Choice for Change' for the American Indian Community.

- Community Resource: The Community Supports Benefit assists Members with Medically Supportive Food, Meals, and Medically Tailored Meals. To support better health outcomes among members with Chronic conditions.

CONCLUSION

Based on medical claims and behavioral health claims data, the top diagnoses in the general population are Hypertension, hyperlipidemia and obesity. For the SPD population, the most common diagnoses are hypertension, hyperlipidemia, and type 2 diabetes. For children and adolescents, the top diagnoses are disorders of refraction, allergic rhinitis obesity and asthma (chronic condition). For BH Members, the top diagnoses are anxiety and depression. The SDOH top diagnoses are Low income, homelessness, and food insecurity.

When assessing language, English and Spanish are the primary languages, followed by Vietnamese and Chinese. Members with limited English proficiency had a primary language of Spanish. Of the Members that call into IEHP requiring translator services, 76.9% are Spanish speaking and of the Members that require face-to-face interpreter requests during doctor visits, 70.9% require a Spanish translator.

An assessment of needs of Members that do not speak English as their primary language also revealed disparities in preventative care measures. For the Vietnamese speaking group, disparities were identified in the well-child visits and adolescent well care visits for 2 consecutive years.

An analysis across all ethnic groups revealed for pediatric preventative care, Black Ethnicity disparity across the Well child visits measures and immunization measures. Prenatal and Post-Partum care was also identified as a disparity for the Black ethnic group. For Chronic disease, Controlling Blood Pressure and Antidepressant Medication management was identified as a disparity.

For women's health, White race/ethnic group had a disparity in the following: Prenatal and Postpartum Care, Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening.

The findings in the annual population assessment report are used to review and update activities, resources and community resources to better support and meet the needs of the

Member population. The activities and resources will address the needs of Members with chronic conditions such as diabetes, hypertension, depression, and asthma.

Activities to address health care disparities will be focused on Improving Well Child Visits within the first 30 months of life in Black infants. The Black ethnicity was identified as a disparate group for well child visits during the first 30 months of life. The Community Health Workers will aid in providing additional support to Members who are referred to Black Infant Health.

Lastly, IEHP's 3 Community Wellness Centers (CWC) are available to Members in the Riverside and San Bernardino County Communities. CWC offer free exercise classes and health workshops. The CWC also consists of multilingual Team Members to assists with Members with limited English proficiency. In addition to fitness and Wellness support, the CWC also assist with Benefits assistance and Plan enrollment.