**2023 Culturally and Linguistically Appropriate Services (CLAS) Network Analysis**

## Purpose

CareFirst Community Health Plan Maryland (CareFirst CHPMD) is committed to maintaining a provider network that can meet the cultural and linguistic needs of its member population. To support these efforts, CareFirst CHPMD completes a CLAS Network Analysis annually. This report outlines findings of the 2023 data review and analysis performed. Utilization and performance data from 2022 was leveraged for analysis as part of this assessment.

## Overview of Maryland and CareFirst CHPMD Medicaid Demographics

### State of Maryland Demographics

The United States continues to grow in diversity each year and the same is true for Maryland. According to a U.S. News and World Report, Maryland (2023), Maryland is ranked as the 8th most diverse state in the United States. Maryland has a Diversity Index of 68.69%. The Diversity Index, according to Census.gov shows the probability that two people chosen at random will be from different race and ethnic groups.

|  |  |
| --- | --- |
| Race – Maryland | Percentage |
| Asian | 6.346% |
| Black | 29.83% |
| Other Race | 5.32% |
| Two or More Races | 5.5% |
| White (Non-Hispanic) | 52.67% |
| Native American | 0.28% |
| Native Hawaiian or Pacific Islander | 0.05% |

Source: World Population Review, 2023

|  |  |
| --- | --- |
| Hispanics and Non-Hispanics in Maryland | Population Data |
| Hispanics | 10.58% |
| Non-Hispanic or Latino | 89.42% |

 World Population Review, 2023

Maryland’s Hispanic population in 2022 is 11.5% compared to the national percentage of 19.1% (U.S. Census, 2021). Foreign-born persons living in Maryland constitute 15.4% of the population which is an increase from 2019 of less than one percent. In 2022, 20.7% of Marylanders speak a language other than English at home, compared to 22% for the entire United States (U.S. Census, 2022). In over 50% of the homes where languages other than English is spoken, Spanish is the most commonly spoken language (U.S. Census, 2022).

Disparities in health and access to care adversely impact individuals who are foreign-born and/or who do not speak English. The health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern (HHS, 2016). Children growing up in non-English speaking homes also experience these disparities (Lau et al, 2012). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services and reducing health care disparities (Beach et al, 2004). CareFirst CHPMD strives to meet the needs of its members of all ethnicities to ensure all members receive an equal level of quality care.

Culture plays a huge role in medical interactions. It influences how an individual views an illness or treatment and affects how a physician should address an older patient. Culture influences healthcare at all levels, including communications and interactions with doctors and nurses, health disparities, health care outcomes, and even the illness experience itself. In some Hispanic cultures, it is believed that illness is the will of a higher power, and they may be reluctant to receive health care. Many older Hispanic family members and other relatives are respected and are often consulted on important matters involving health and illness. Non-verbal cultural differences, such as the head of household responsibilities or rules about making eye contact, are also a factor. For example, the oldest male of an Asian-Pacific Islander family is often the decision-maker and spokesperson, so doctors should talk to the eldest male about health care decisions instead of the patient. Some sub-populations of people from India and Pakistan are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married. In Vietnamese culture they do not readily accept Western mental health counseling and interventions as they believe health is viewed as the result of harmonious balance between the poles of hot and cold that govern bodily functions. CareFirst CHPMD has an Asian American population of over six percent of its total membership. In 2023, there were 397,087 Asian Americans residing in Maryland accounting for 6.46% of the total population in the State. Asian Americans are one of the fastest growing groups in North America and includes a diversity of ethnicities and languages including Chinese, Japanese, Korean, Indonesian, Laotian, Philippine, Thai, and Vietnamese ancestry.

People with chronic conditions require more health services which increases their interaction with the health care system. If providers, organizations, and systems are not working together to provide culturally competent care, patients are at a higher risk of experiencing negative health consequences, receiving poor quality care, or being dissatisfied with their care. African Americans and other ethnic minorities including Latinos and Asian Americans indicate lower levels of collaboration with physicians, reduced involvement in medical decision-making, and decreased satisfaction with care. Non-White patients, especially Latinos and Asian-Americans, experience lower quality in their interactions with physicians.

Low health literacy also affects access to appropriate health care for many in the U.S. In 2016, the Centers for Disease Control and Prevention commissioned A Health Literacy Report: Analysis of 2016 Behavioral Risk Factor Surveillance System (BRFSS) Health Literacy Data (NAAL, 2003 and Kutner et al, 2006). Key findings revealed the following:



Only 12% of the adult population are proficiently health literate [(Milken Institute)](https://milkeninstitute.org/sites/default/files/2022-05/Health_Literacy_United_States_Final_Report.pdf). Adults with lower health literacy are more likely to return incomplete medical forms and/or assessment tools, miss appointments with providers, and not attend follow-up appointments for required medical procedures. Adults with low health literacy have difficulty explaining the purpose of preventive, diagnostic, and therapeutic procedures, and with just reading the names and labels of prescribed medications. These same adults also tend to postpone communications with health providers and have difficulty maintaining consistent medical histories. The elderly typically has lower levels of literacy and have had less access to formal education than younger populations. Racial and ethnic minorities are also more likely to have lower levels of literacy, often due to cultural and language barriers and differing educational opportunities. Adults identifying as Hispanic demonstrate the lowest health literacy of all groups examined. White and Asian/Pacific Islander adults have higher average health literacy levels than other racial/ethnic groups. Women are slightly more health literate than men overall (12 percent compared to 16 percent below basic competency). The study also found that Americans with employment-based, military, or private insurance have higher health literacy on average than adults covered by Medicaid or Medicare or without health insurance coverage. Those with low literacy skills typically use more health services which results in increased health care costs.

The COVID-19 global health pandemic highlighted greater disparities in health care related needs of minorities in Maryland, across the United States, and the world. From risk of exposure to COVID to poorer outcomes from COVID have been observed and reported on by the CDC, Johns Hopkins researchers and the media. Multiple factors contribute including neighborhood(s) and physical environment, housing, occupation(s), education, and income. The graphic below shows a breakdown of COVID cases, hospitalizations, deaths, and population in Maryland which demonstrates that as the pandemic progressed, White Marylanders died at much higher rates than black, Hispanic, and Asian-Americans in 2022, despite a larger percentage of full-vaccinated Marylanders.

### CareFirst CHPMD Medicaid Member Demographics

Each year, CareFirst CHPMD completes a [Community Health Plan Maryland Medicaid Population Assessment](https://carefirst-my.sharepoint.com/%3Aw%3A/r/personal/aad8832_carefirst_com/Documents/Quality/Population%20Assessment/2023/v3.2023%20Population%20Assessment_final.docx?d=w7580806be6f14ffdaf3f7c830c010f15&csf=1&web=1&e=GXfv7W). This report details demographic data for the CareFirst CHPMD’s Medicaid population to include:

* Geographic distribution of Members
* Race and Ethnicity of Member population
* Category of aid
* Membership by age
* Membership by gender
* Membership by languages spoken
* Membership based on special needs
* Top diagnoses
* Social determinants of health factors impacting members
* Education
* Member health needs specific to:
	+ Children
	+ Behavioral health needs
	+ Chronic conditions
	+ Pregnant and postpartum members

The data as well as the summary outlined in 2023 Community Health Plan Maryland Medicaid Population Assessment was reviewed and utilized during this analysis to ensure the network could support the specific needs of the member population. Upon evaluation of this data, it was noted that the CareFirst CHPMD continues to experience significant membership growth since the 2022 service area expansion. Despite the growth, member demographics remained largely.

## Analysis

### Activity Selection and Methodology

CareFirst CHPMD tracks the following metrics to ensure the provider network adequately mirrors the make-up of our membership, including those with disabilities. This information is reported at least annually to the QIC. On an ongoing basis, the Provider Relations Department reviews the CLAS Network Analysis to ensure members are getting culturally competent care; if a member needs care from a specific ethnic provider, the Provider Relations team will either recruit that specific provider to join the network or engage in a single-case agreement so that member can be seen.

### Quantifiable Measures

1. [Utilization of translation services by language requested](#_Utilization_of_Translation)
2. [Number of interpreter visits during a healthcare encounter with providers by language, broken down by unique membership](#_Number_of_Interpreter)
3. [Number of complaints about access to care or language barrier with provider](#_Number_of_Complaints)
4. [Languages spoken by providers against membership](#_Languages_Spoken_by)
5. [Race/Ethnicity of providers compared to membership](#_Race/Ethnicity_of_Providers)
6. [CAHPS scores stratified by specific demographics including race and ethnicity](#_CAHPS_Scores_Stratified)
7. [Analyzing Practitioner Network Cultural Responsiveness](#_Analyzing_Practitioner_Network)

### Data Sources and Methodologies

Data for measure 1 and 2 is collected from CareFirst CHPMDs telephonic translation vendors, CQ Fluency and Language Line, and interpreter utilization respectively, as tracked and reported directly from our vendors. This information is collected and tracked quarterly and analyzed yearly by the Quality Improvement Committee.

Data for measure 3 is collected from CareFirst CHPMD’s Appeals & Grievances system, OnBase. CareFirst CHPMD has a distinct list of categories within which grievances are tracked to trend data and to identify potential gaps. This information is tracked quarterly and presented to the Member Experience Committee, then to QIC.

Provider language data is collected during the credentialing process and captured in the Enterprise Data Warehouse. As providers are credentialed, information regarding “other languages spoken” is captured in this system, as is their specialty.

Provider race and ethnicity is captured during the credentialling process as well as through data collected by the Health Resources and Services Administration’s Area Health Resource Files. Data on the race of Maryland medical school graduates is provided by the Maryland Department of Health (MDH).

Additionally, CareFirst CHPMD collects race and ethnicity data on members as it is provided by the State on enrollment. Historically, members were asked to self-identify as either Black, White, Hispanic, Asian, or Pacific Islander. In 2022, MDH is making the race and ethnicity fields on the Medicaid applications required fields. As this information is provided, it is captured in the enrollment/claims and care management systems. If a specific language preference is identified, this is also captured. Limitations still exist as members will continue to be given an option to not report on this data, which means not all members are reporting, and the language information is not always transferred from the State to the MCOs effectively, but information that is provided, is utilized by CareFirst CHPMD. Because of these limitations CareFirst CHPMD also utilizes race and ethnicity data of its CAHPS respondents who are less likely to omit their race on the survey.

The CAHPS report is reviewed by the Member Experience Committee, a subcommittee of the QIC. Outcomes from the survey are chosen for action plans to address issues and then presented to the QIC and tracked in the QIWP. An annual CAHPS survey analysis breaks down member satisfaction by the race and ethnicity of the respondent.

The Maryland Department of Health contracts with a CAHPS vendor, CSS, who conduct annual CAHPS surveys for all MCOs. While CSS uses the same CAHPS methodology, since their contract with MDH began in 2018, CareFirst CHPMD has consistently received a minimum of three N/A scores (less than 100 responses) for both adult and child surveys which has impacted our CAHPS rates in 2021 and 2022.

## Data/Results

### Utilization of Translation Services by Requested Language

During 2022, CareFirst CHPMD utilized two telephonic translation service vendors, which included, CQ Fluency and Language Line. The chart below outlines the utilization of translation services by requested language:

|  |  |  |
| --- | --- | --- |
| Language | Total Calls 2022 | Percent of Total 2022 |
| Total all Languages | 5,279 | 100% |
| Spanish | 3,060 | 57.96% |
| Arabic | 24 | 0.45% |
| Chinese | 63 | 1.19% |
| Haitian creole | 158 | 2.99% |
| Amharic | 59 | 1.11% |
| French | 43 | 0.81% |
| Nepali | 33 | 0.63% |
| Other Languages | 1,839 | 34.84% |

The usage with Language Line totaled 434 calls. The largest volume is with CQ Fluency with a total of 4,845 calls in 2022. Translation calls increased in 2022 compared to the previous year over 1,000 calls which is in line with the increase in membership. Additionally, Spanish continues to be the largest requested language for telephonic translation services.

Additionally, CareFirst CHPMD makes many of its member written materials available in non-English languages based on its AD.EA.06 Language Services policy. While all materials are available in Spanish upon request, CareFirst CHPMD provides member materials in other languages on an as needed basis.

CareFirst CHPMD recognized a gap in surveying members related to satisfaction when utilizing telephonic translation services. CareFirst CHPMD future actions will focus on developing a mechanism to track and survey members who have utilized telephonic translation services in order to better understand their experience with the services.

CareFirst CHPMD conducted an internal survey of all member-facing staff who have utilized translation services to communicate with a member(s) in 2023. A total of 50 staff members from Member Services, Quality, A&G, and Care Management were requested to take part in the survey. We received a total of 29 completed surveys for a response rate of 58%. There was a total of eight survey questions; five questions used a Likert scale of 1 to 5 (1 being the worst and five being the best) responses, two questions used responses of Always, Sometimes, Usually, Never responses, and one question asked how frequently the staff used the translation services vendor to communicate with members.

The table below demonstrates the survey results. Overall, 32% of staff rated CareFirst CHPMDs translation services vendor a five (5) on a scale of 1 to 5 with five being the best.

|  |  |  |
| --- | --- | --- |
| Survey Questions | Repsonses | Rates |
| How frequently do you use the language services provided by our vendor in your weekly work? | 1-2x/week - 103-4x/week - 15 or more - 11 | 20%2%22% |
| Are the language services from our vendor easy to access and use in your daily tasks? | Always - 12Most of the time - 16Sometimes - 2 | 24%32%4% |
| Do you feel that the quality of interpretation and translation services from our vendor meets your expectations? | Always - 12Usually - 14Sometimes - 3 | 24%28%6% |
| On a scale of 1 to 5, how satisfied are you with the time it took to connect to an interpreter? | 2 - 13 - 54 - 95 - 14 | 2%10%18%28% |
| On a scale of 1 to 5, did the interpreter help you better communicate with the member? | 2 - 13 - 44 - 125 - 10 | 2%8%24%20% |
| On a scale of 1 to 5, how satisfied were you with how the interpreter communicated on your behalf? | 2 - 13 - 44 - 135 - 10 | 2%8%26%20% |
| On a scale of 1 to 5, how satisfied were you with how the interpreter communicated on behalf of the member? | 2 - 13 - 44 - 145 - 10 | 2%8%28%20% |
| On a scale of 1 to 5, overall, how satisfied were you with the language services received? | 3 - 44 - 95 - 16 | 8%18%32% |

Several A&G staff members indicated that they have not utilized translation services in CY 2023 to communicate with members. The plan for next year’s survey will be ask the frequency of use of a translation vendor first and if the response is zero, the survey will end. CareFirst CHPMD’s Member Services and Operations management team will work with our telephone vendor to ensure that all telephonic translation calls are identifiable to allow for survey calls to be conducted in real time.

### Number of Interpreter Visits During a Healthcare Encounter with Providers by Language

CareFirst CHPMD also provides onsite interpreter services during a healthcare encounter to members as needed/requested. In 2023, CareFirst CHPMD changed to a new vendor, TransPerfect, to provide this service. The table below shows the total utilization of interpreters utilized during a healthcare encounter by members in 2022.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Language | 2021 Totals | 2021 Unique Members | 2022 Totals | 2022 Unique Members |
| Arabic | 2 | 1 | 0 | 0 |
| Farsi | 3 | 1 | 0 | 0 |
| Portuguese | 13 | 1 | 8 | 2 |
| Spanish | 0 | 0 | 5 | 1 |
| Amharic | 2 | 1 | 3 | 2 |
| Dari | 3 | 1 | 1 | 1 |
| Haitian Creole | 5 | 1 | 1 | 1 |
| ASL | 11 | 4 | 2 | 2 |
| Mandarin | 2 | 2 | 1 | 1 |
| Total | 41 | 12 | 21 | 10 |

Visits were halved in 2022 compared to 2021 (41) with 21 interpreter visits which represented 10 unique CareFirst CHPMD members. Upon analysis of this, several factors were evaluated: This included:

* 12 members used this service in 2021 compared to 10 members in 2022. It also appears members utilizing this service had more frequent office visits in 2021 vs 2022
* While the number of Portuguese members utilizing the service increased from 1 member in 2021 to 2 members in 2022, the member who utilized services in both 2021 and 2022 had a significant reduction in office visits, resulting in decreased utilization of services
* The number of members requesting ASL services during a healthcare encounter decreased by 50% between 2021 and 2022 (4 members vs 2 members)
* Utilization for Haitian Creole services decreased from 5 encounters in 2021 to 1 encounter in 2022. CareFirst CHPMD also added Haitian Creole speaking providers to the network in 2022 which may have resulted in decrease utilization of the need for translation services during a health care encounter for this language
* While the membership had grown considerably in 2022, this was related to an expanded service area. The demographics of the newer service areas was noted to be much less diverse than other geographical areas within the service area, hence CareFirst CHPMD did not expect it to significantly increase utilization of this service

The Quality Department conducted telephonic surveys with the members who utilized on-site translation services at a healthcare encounter. The survey consisted of three questions that used a Likert scale of 1 to 5 (1 being the worst, and five being the best): How satisfied were you with the time it took the interpreter to arrive at your healthcare appointment; Did the interpreter help you better communicate with the healthcare provider; Overall, how satisfied were you with the language services you received. Multiple outreach attempts were made to all ten members who utilized on-site translation services at a healthcare encounter, and they successfully reached three members. All three members rated each question with a 5 indicating they were very happy with the services they received.

Based on this analysis and translation service survey results, no gaps or opportunities were identified related to interpreter visits during a healthcare encounter with providers by language.

### Number of Complaints About Access to Care or Language Barrier with Provider

CareFirst CHPMD reviewed grievances for 2022 (and compared data to 2021) to evaluate Member complaints related to provider access and provider communication. The table below outlines the grievance data reviewed as part of this analysis.

|  |  |  |
| --- | --- | --- |
|  | **Measurement Year 2021** | **Measurement Year 2022** |
| **Category** | Grievances Total | Grievances per 1,000 Members (CY Total: 61,123) | Grievances Total | Grievances per 1,000 Members (CY Total:83,655) |
| Quality of Care | 14 | 0.23 | 21 | 0.25 |
| Access | 49 | 0.80 | 83 | 1.00 |
| Attitude/Service | 44 | 0.72 | 27 | 0.32 |
| Billing/Financial | 37 | 0.60 | 9 | 0.11 |
| Quality of Practitioner Office Site | 0 | 0 | 1 | 0.01 |
| Other Grievances | 0 | 0 | 19 | .23 |
|  | 147 | 2.40 | 160 | 1.93 |

In 2022, the grievance rate decreased compared to 2021. The table above indicates that while the total number of grievances increased on 2022, the membership also increased resulting in a lower rate per 1,000 members.

The largest category of grievances in 2022 was Access for the third year in a row followed by Attitude/Service. There was one quality of care related complaint in 2022 which was resolved timely. CareFirst CHPMD’s Member Experience Committee reviews its grievance categories on an annual basis to ensure they adequately capture member complaints that pertain to race, ethnicity, language, or other cultural grievances. In 2022, it was determined that the grievance categories were appropriate, and the committee voted to unanimously keep the current grievance categories.

For CY 2022, grievances in the Access category continued to be the largest category followed by Attitude/Service. Access-related grievances increased in 2022 by 34 to 83 (1.00 per/k), however, CareFirst CHPMD was able to achieve its internal goal of having less than 5.00 grievances in a calendar year at 1.93 per 1,000 members. No CLAS gaps or opportunities were identified during the evaluation of the grievances.

### Languages Spoken by Practitioners Compared to Membership

On an annual basis, CareFirst CHPMD’s Provider Relations Department assist the Quality team by providing a breakdown of languages spoken by its network providers and their office staff. Below is a breakdown of the top non-English languages requested and their percentage of total call volume. This is compared to the number of providers who speak that language.

|  |  |  |  |
| --- | --- | --- | --- |
| **Language** | **Member Calls 2022** | **% Member Calls 2022** | **Provider Speaking Language (2022)** |
| Spanish | 3,060 | 63.16% | 496 |
| Arabic | 24 | 0.49% | 88 |
| Chinese | 63 | 1.19% | 72 |
| HaitianCreole | 77 | 1.59% | 2 |
| Amharic | 158 | 2.99% | 21 |
| French | 43 | 0.81% | 169 |

In 2022, CareFirst CHPMD expanded its service area to include all 24 Maryland counties, and therefore expanded its provider network to ensure adequate coverage for all members including increasing the number of providers speaking languages other than English to better serve its members.

As part of this analysis, CareFirst CHPMD concluded the network has adequate composition of providers to support the language needs of the member population.

### Race/Ethnicity of Providers Compared to Membership

CareFirst CHPMD evaluated the race and ethnicity of providers compared to that of their overall membership to ensure adequate composition of the network to meet the member population’s overall cultural and linguistic needs.

CareFirst CHPMD utilized CHPMD member race/ethnicity data provided both from the State as well as CAHPS responses. Physician race/ethnicity data used in the analysis was leveraged from data collected by the Association of American Medical Colleges (AAMC). Below is a chart comparing CareFirst CHPMD’s 2022 CareFirst CHPMD member race/ethnicity demographics to the race/ethnicity demographics of Maryland physicians.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Race | CareFirst CHPMD Members (State) | CareFirst CHPMD Members (CAHPS) | MD Provider Population (HRSA) | MD Medical School Graduates (AAMC) |
| Black | 38.52% | 51.4% | 12.05% | 7.55% |
| White/Caucasian | 21.54% | 57.6% | 56.89% | 45.98% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ethnicity | CareFirst CHPMD Members (State) | CareFirst CHPMD Members (CAHPS) | MD Provider Population (HRSA) | MD Medical School Graduates (AAMC) |
| Non-Hispanic | 98.07% | 53.2% | 68.94% | 96.01% |
| Hispanic | 1.93% | 53.3% | 4.97% | 3.98% |

Analysis of this data indicates, in 2022 CareFirst CHPMD provides members with access to a network of providers with diverse cultural backgrounds. No gaps were identified upon review of this data.

### CAHPS Scores Stratified by Specific Demographics Including Race and Ethnicity

The Maryland Department of Health (MDH) contracts with certified CAHPS vendor, CSS, to conduct CAHPS surveys for all Maryland MCOs, including, CareFirst CHPMD on an annual basis using the CAHPS Survey and methodology. Responses to all questions are segmented by the race of the respondent. Below CareFirst CHPMD has selected three measures that we believe indicate opportunities for improvement

*Rating of Health Plan -- % of members rating CareFirst CHPMD with an 8, 9 or 10*

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2021 | 2022 | YOY Change |
| White | 54.1% | 57.6% | 3.5 |
| Black | 56.5% | 51.4% | (5.1) |
| Other | 38.5% | 33.3% | (5.2) |
| Hispanic/Latino | 46.7% | 53.3% | 6.6 |
| Non-Hispanic/Latino | 55.6% | 53.2% | (2.4) |

*Rating of Health Care -- % of members rating CareFirst CHPMD with an 8, 9 or 10*

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2021 | 2022 | YOYChange |
| White | 51.0% |  39.8% | (11.2) |
| Black | 31.6% | 45.8% | 14.2 |
| Other | 13.3% | 12.1% | (1.2) |
| Hispanic/Latino | 4.08% | 10.8% | 6.72 |
| Non-Hispanic/Latino | 88.8% | 87.9% | (0.9) |

*Rating of Personal Doctor -- % of members rating personal doctor with an 8, 9 or 10*

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2021 | 2022 | YOYChange |
| White | 43.8% |  15.4% | (28.4) |
| Black | 35.3% | 10.7% | (24.6) |
| Other | 18.0% |  6.0% | (12) |
| Hispanic/Latino | 4.0% |  3.9% | - |
| Non-Hispanic/Latino | 88.3% |  34.2% | (54.1) |

CareFirst CHPMD should be receiving updated CAHPS data from MDH within the next month. While CareFirst CHPMDs 2022 CAHPS survey results have steadily decreased since 2019, analysis also indicates Member response rates decreased for the third year in a row with 2022s response rate at 12.55% which was a 2.25 percentage point drop compared to 2021s response rate. Due to participation rates of CAHPS, CareFirst CHPMD is unable to be certain this data accurately reflects the overall member experience for these 3 measures. Additional action steps will be taken in 2023 and 2024 to develop focus groups and/or pulse surveys to gain additional insight into member experience based on race and ethnicity.

### Analyzing Practitioner Network Cultural Responsiveness

CareFirst CHPMD recognizes how important providing culturally competent care is to our member population. CareFirst CHPMD leveraged demographic profiles of members and providers to identify potential unmet needs and the network’s ability to deliver culturally competent care. As a result, of our analysis, CareFirst CHPMD aimed to provide additional cultural competency training to providers in 2022.

Through CareFirst CHPMD’s Learning and Engagement Center for Providers, three additional cultural competency training courses were added in 2022. These trainings focused on promoting health equity for all CareFirst CHPMD members. In 2022, 3,000 practitioners completed the health equity trainings.

Additional courses are also available to providers including National CLAS Standards from the U.S. Department of Health & Human Services; Behavioral Health Implementation Guide for National CLAS Standards from the U.S. Department of Health and Human Services Office of Minority Health; Resources for Integrated Care Cultural Competence in LTSS and a Resource Compendium for LGBT individuals with LTSS; and finally, a link to the Maryland Department of Health’s Office of Minority Health and Health Disparities where there are an additional 19 training modules available for providers, many with available CEUs.

In 2021, the BlueCross Blue Shield Association (BCBSA) announced a national equity strategy to address the nation’s crisis in racial health disparities. Aligned with BCBSAs multi-year commitment to address the racial inequities in quality of life, care access and health outcomes, CareFirst BlueCross BlueShield (CareFirst) is working throughout the State and the Mid-Atlantic region to establish meaningful collaboration with and advocate for communities that have been historically marginalized. CareFirst’s goals focus on priorities around reducing racial disparities, identifying drivers of inequities, and implementing data-driven strategies to advance the health of all our communities.

CareFirst continued its mission to improve empathy and understanding of its employee’s and the community’s cultural differences through its annual Week of Equity and Action. Through this week of trainings, work groups, and a day devoted to community-based volunteer activities, this week-long event empowers employees to foster a sense of belonging, seek understanding and demand equity at work and in the communities we serve. [View our 2022 Mission in Action Report.](https://individual.carefirst.com/carefirst-resources/pdf/transformation/2022-our-mission-in-action-423.pdf)

## Summary

Based on the analysis outlined above, CareFirst CHPMD has determined that its provider network is able to meet the language needs and provide culturally appropriate care to all members of the plan. No gaps were identified. Several opportunities to enhance our future CLAS Assessments of the CareFirst CHPMD provider network were identified through this analysis that will help with future evaluations.

These include:

* Surveying members related to satisfaction when utilizing telephonic translation services. CareFirst CHPMD future actions will focus on working with current vendors to develop a mechanism to track and survey members who have utilized telephonic translation services to better understand their experience with the services
* Develop focus groups or pulse surveys to gain additional insight into member experience stratified by race and ethnicity (due to participation rates of CAHPS, CareFirst CHPMD was unable to be certain this data accurately reflects the overall member experience for the 3 CAHPS measures)

CareFirst CHPMD will continue to analyze data annually to ensure our network continues to meet the cultural and linguistic needs of our member populations, especially considering the continued growth we typically see each year.