Amerigroup Florida, Inc.
2015 Cultural Competency Plan
Florida Healthy Kids
SMMC MMA & LTC

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Introduction

Cultural competence can be defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. A culturally competent system acknowledges and incorporates the following at all levels: valuing diversity; cultural self-assessment; vigilance toward the dynamics that result from cultural differences; expansion of cultural knowledge; and adaptation of services to meet culturally-unique needs.(Cross, et al., 1989) Cultural and language may influence the way individuals view:

- health, healing, and wellness belief systems;
- how illness, disease, and their causes are perceived; both by the patient/consumer and
- the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers;
- as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

Amerigroup of Florida, Inc. (Amerigroup) firmly believes that it must recognize and thoroughly understand the role that age, culture; ability, race, and ethnicity play in the lives of its members to ensure everyone receives equitable and effective health care services and close the disparities gap in health care.

According to the 2010 U.S. Census Bureau statistics (latest statistics available), Florida is represented by a more culturally diverse population than the majority of the states. Amerigroup is committed to eliminating all barriers and to providing access to equitable and quality healthcare services for all populations.

Table 1 demonstrates the diversity of the Amerigroup Membership:

Table 1: Amerigroup Membership Ethnicity vs. Florida and US Ethnicity

Ethnic Group	AGP Staff	AGP Membership	Florida	US
White persons, percent, 2012 (a)	40.7%	26.3%	78.3%	77.9%
Black persons, percent, 2012 (a)	25.8%	21.6%	16.6%	13.1%
American Indian and Alaska Native persons, percent, 2012(a)	0.73%	0.2%	0.5%	1.2%
Asian persons, percent, 2012 (a)	2.2%	1.5%	2.7%	5.1%
Native Hawaiian and Other Pacific Islander, percent, 2012 (a)	Reported with Asian	Reported with Asian	0.1%	0.2%
Persons of Hispanic or Latino origin, percent, 2012 (b)	24.7%	36.3%	23.2%	16.9%

Table 2: Primary Languages for AGP FL Members 2014

1. Primary Languages for AGP FL Members 2014

Language	Members	%Total
English	202619	77.790%
Spanish	35652	13.688%
Multi-Lingual	18878	7.248%
Unspecified	2671	1.025%
Creoles and Pidgins, French-Based (other)	571	0.219%
Vietnamese	23	0.009%
Bosnian	10	0.004%
Tagalog	6	0.002%
Creoles and Pidgins, English-Based (other)	5	0.002%
Otomian Languages	4	0.002%
Hindi	4	0.002%
Russian	4	0.002%
Arabic	3	0.001%
French	3	0.001%
Gujarati	3	0.001%
Italian	2	0.001%
Korean	2	0.001%
Persian	2	0.001%
Philippine (other)	2	0.001%
Serbo-Croatian	2	0.001%
Latin	2	0.001%
Lao	1	0.000%
Haitian; Haitian Creole	1	0.000%

Florida's diverse population poses cultural and linguistic challenges for its health care system. This document serves as the blueprint for Amerigroup cultural competency program. It reflects a comprehensive, organized and methodical approach to the strategic planning, development, implementation, and evaluation of cultural competency. It serves as a guide in the ongoing development process of a multicultural, competent service delivery system. The plan is descriptive, organized around objectives and strategies, and designed to provide a measurable approach to ensuring the cultural competence of Amerigroup as an organization.

In agreement with the U.S. Department of Health and Human Services Office of Minority Health, we believe that:

Principal Standard:

1. Health care organizations should ensure that patients/consumers receive from all staff members' effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce:

2. Health care organizations should advance and sustain organizational governance and leadership that promotes culturally and linguistically appropriate services and health equity through policy, practices, and allocated resources (Objective 1 and 6 below).
3. Health care organizations should implement strategies to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area (Objective 1 and 7 below)
4. Health Care organizations should educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis (Objective 2 below).

Communication and Language Assistance:

5. Health care organizations should offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Objective 4 below).
6. Health care organizations should inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Objective 4 below).
7. Health care organizations should ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Objective 4 below).
8. Health care organizations provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Objective 5 below).

Engagement, Continuous Improvement, and Accountability:

9. Health Care organizations should establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
10. Health care organizations should conduct ongoing assessments of the organizations CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities (Objective 8 below).
    - In 2009 - 2010, Amerigroup conducted an external survey of providers to determine if they were aware of the cultural issues and diverse groups in their communities. The survey was made up of 51 questions and the results were presented in the 2010 Cultural Competency Program Evaluation.
    - Annually, Amerigroup conducts ongoing self-assessments by reviewing the membership make up, provider make up, associate make up and training materials to ensure we are monitoring the diversity in the service area and changes that occur.
    - Amerigroup also reviews member satisfaction surveys to identify concerns or areas of improvement related to cultural diversity.
11. Health care organizations should collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS and health equity and outcomes and to inform services delivery (Evaluation Process below).
12. Health care organizations should collect regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area (Objective 8 below).
13. Health care organizations should collaborate with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Objective #6 Below)

14. Health care organizations should create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints (Objective 9 below).
15. Health care organization should communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public (Authority, Structure… section below).

Guiding Principles

The Guiding Principles for cultural competency are the character and nature of Amerigroup. They are the filters through which Amerigroup makes its decisions. Their meaning, and sometimes expression, are expected to evolve as staff reflect and talk about the principles and as the principles are utilized to guide decisions and actions. It is the expectation that everyone will follow and reinforce the principles with each other regardless of position or level.

1. *We acknowledge that a person's culture is relevant to their health care recovery and the services they receive.*
2. *We believe that cultural, racial, ethnic, religious, linguistic, and sexual orientation diversity enhances the personal and professional experiences of all stakeholders.*
3. *We are committed to developing culturally sensitive practices that can help reduce barriers to effective care.*
4. *We are committed to broadening access for multi-cultural participation within* Amerigroup *and its provider and community relations network.*
5. *We are committed to educating our staff, provider network, client organizations and their members, and the community in cultural competency as a right.*
6. *We are committed to promoting models of communication giving voice to all cultures.*
7. *We are committed to ensuring all organizational and individual activities are culturally competent.*

Philosophy

Within the context of guiding principles is Amerigroup's philosophy regarding cultural competency. Amerigroup believes that compliance with service plans, preventive and restorative health behaviors and lifestyle choices are more likely to occur when systems, services and providers are culturally competent. This includes developing awareness, attitudes and utilizing knowledge and skills reflecting a cultural competence compatible with the backgrounds of the person served, their families and communities. Within this philosophy, Amerigroup has developed the following definitions based on recommendations of U.S. Department of Health and Human Services, Office of Minority Health (http://minorityhealth.hhs.gov).

Cultural and linguistic competence in health – a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an

organization within the context of the cultural beliefs, behaviors and needs presented by the consumers and their communities.

Culturally and linguistically appropriate services **-** health care services that are respectful of and responsive to cultural and linguistic needs

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer/member. By striving to overcome cultural, language, and communications barriers; providing an environment where the patient/consumer/member feels comfortable discussing cultural health beliefs and practices in order to be part of the treatment planning; encouraging patients/consumers/members to express their spiritual beliefs and cultural practices; and being aware of different traditional healing systems and beliefs and integrating this into the treatment plans of patients/consumers/members leads to effective care. Effective care results in "positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001)

Health care organizations – any public or private institution involved in any aspect of delivering health care services

Limited-English proficiency - persons who have difficulty speaking, reading, writing, or understanding the English language because they are individuals who:

- were not born in the United States or whose native language is a language other than English; or
- come from environments where a language other than English is dominant; or
- are American Indian and Alaskan Natives and who come from environments where a language other than English has had a significant impact on their level of English language proficiency; and
- by reason, thereof, are denied the opportunity to learn successfully in classrooms where the language of instruction is English or to participate fully in our society (Adapted from A Study of Programs and Demographics for Students of Limited English Proficiency in Delaware Schools 1995-1996 School Year, Delaware Department of Education, 1996).

Patients/consumers - individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Staff - individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Individual Cultural Competency: "the ability to use knowledge and interactive skills to work effectively with people of different cultures, ages and abilities."

Individual cultural competence at a provider level also includes the acknowledgment and incorporation of the acceptance of various abilities, behaviors, beliefs, and values in determining the persons' served physical and mental wellness/illness and incorporating those variables into the assessment and treatment of the person (See Objective 2 below).

In accordance with this philosophy, Amerigroup has developed a Statement of Diversity:

> "Managing diversity is the key to Amerigroup's competitive edge. On behalf of our members and associates, we create and maintain an inclusive, respectful and equitable environment through effective leadership, policies and practices."

Overall, this philosophy includes the expectation that management, staff and providers will attain the knowledge, attitudes and skills to provide effective care and, in concert with the voices of our members, services to people of different cultures and to work within that person's values.

Cultural Competency Strategic Plan

Amerigroup believes cultural competence influences every aspect of care and service. From the broadest of operational perspectives, the strategic plan provides Senior Management the direction for Corporate, Health Plan and network processes, policies and procedures, clinical as well as administrative, to ensure their cultural relevance.

The plan also provides for the structured training of management, staff and providers in a common framework of cultural competency to assist in the integration of the knowledge, attitudes and skills reflective of a culturally competent organization. Therefore, the identified cultural competency objectives and strategies address the total organization and network. The Plan is accessible to the providers at no cost via the website or upon request.

Objective 1 - Provide a high-performance organizational culture of social awareness, values, cultural sensitivity and customer service that supports, attracts and retains a diverse staff.

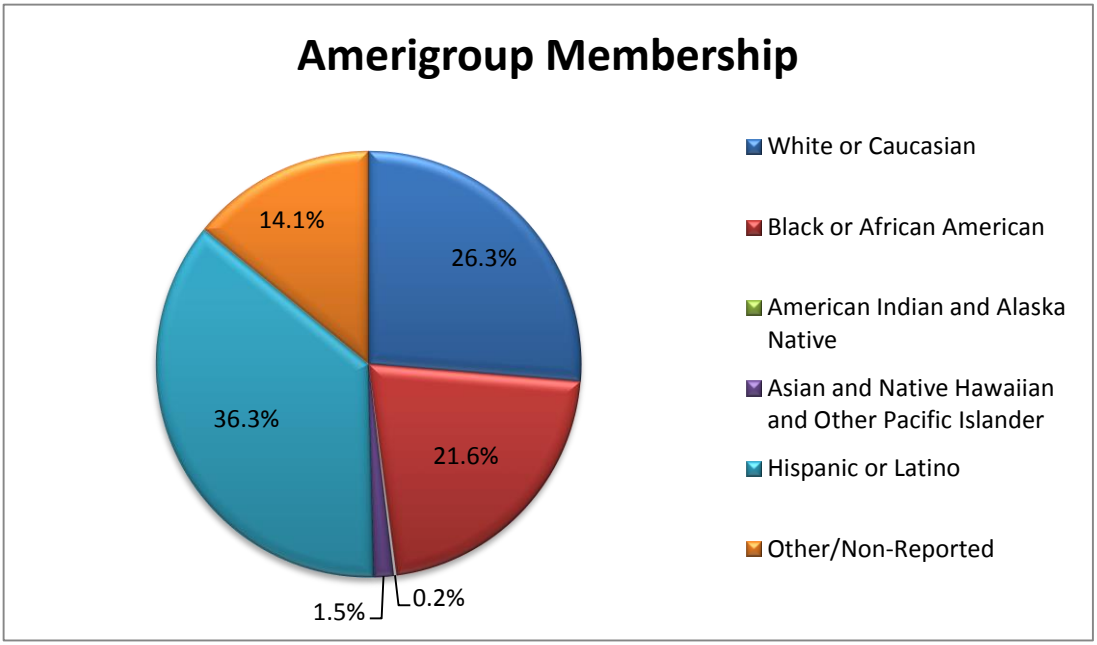
Key Strategy

Recruit and retain a culturally diverse and culturally competent workforce that is representative of the demographic characteristics of the population serviced (Please see paragraph at the bottom of Objective 1).

Amerigroup strives to hire associates from cultural backgrounds similar to those of our members (Please see paragraph at the bottom of Objective 1).

This gives our associates a greater understanding of members' cultural norms, languages and folk beliefs, which enables them to work with members on treatment options resulting in more positive health outcomes. We also strive to hire associates who speak languages similar to the languages spoken and understood by the members that we serve, so that we can minimize the need for outside interpretation and increase member engagement (Please see paragraph at the bottom of Objective 1).

The chart below details the ethnic diversity of staff supporting the Amerigroup Florida membership:



In addition to our Cultural Competency training, this diversity enables our associates to educate each other on cultural difference, which can positively influence our members. In our Florida Plan, we intend to recruit and hire staff representing the various cultures including Hispanic associates in areas of the highest concentration, as well as persons with disabilities.
Amerigroup Corporation is an equal employment opportunity employer. It is the policy of the company to prohibit discrimination of any type and to afford equal employment opportunities to associates and applicants, without regard to race, color, sex, age, religion, national origin, disability, veteran status, sexual orientation or other protected classifications. Amerigroup complies with applicable state and local laws governing non-discrimination in employment in every location in which the company has facilities.

The policy of equal employment opportunity and anti-discrimination applies to all aspects of the relationship between the Company and its associates, including, but not limited to, recruitment and selection, promotion, transfer, compensation, employee benefits, company-sponsored training programs, privileges of employment, working conditions, lay-offs and termination.

Amerigroup FL has offices in Miami Lakes, Plantation, Orlando, Tallahassee, and Tampa Florida. For all positions, Amerigroup recruits from the communities in which we serve but sometimes have to go outside the area if we do not have qualified candidates. By having offices in many of the communities we serve, Amerigroup is able to recruit individuals such as case managers, provider relations staff and customer service representatives from these areas with similar cultural backgrounds to those of the members.

Objective 2 - Develop and maintain a comprehensive training curriculum for cultural competency.

Key Strategy

1. All associates receive education and training in appropriate service delivery to address diversity of culture and language (For 2015, Amerigroup does not anticipate any demographic changes. However, if Amerigroup was to move into counties or regions within FL that may have a significant different make up of members than we currently serve, Amerigroup would adjust the cultural competency training to reflect the new cultures as necessary). Training is designed to meeting the following goals:

    a) To respond to current and projected demographic changes in the United States for 2015, Amerigroup does not anticipate and demographic changes. However, if Amerigroup was to move into counties or regions within FL that may have a significant different make up of members than we currently serve, Amerigroup would adjust the cultural competency training to reflect the new cultures as necessary.
    b) To understand the specific demographics of the populations to be served in Florida.
    c) To meet legislative, regulatory and accreditation mandates
    d) To coincide with Amerigroup's diversity initiatives

3. Amerigroup of Florida, Inc. requires all associates to take Cultural Competency training during their first 30 days of service. Supervisors are required to document the date the training occurred on the associate's' 90 day evaluations.

Learning objectives include the ability to:

a) Describe laws and regulations concerning cultural competence.
b) Identify the cultural groups served by Amerigroup, including those with disabilities and advanced age.
c) Assess cultural beliefs that impact a member's world view and how these beliefs impact patient care procedures
d) Explore innovative approaches to better serve our culturally diverse members
e) Identify how culture influences members' approaches to health care and social services
f) Identify how culture influences member attitudes towards aging, disability and illness
g) Define approaches that promote self-awareness
h) Identify actions taken to accommodate our diverse members and their families including those in geographically rural areas and/or with disabilities.
i) Describe techniques to overcome language barrier

The training is designed to allow for regular review of items covered throughout the training course. At the end of the session, associates take a final exam that requires a passing score of 90%. Associates who do not achieve a 90% score are given the opportunity to review the course and re-take the exam until they are able to achieve 90%.

In addition, Amerigroup Florida associates, at all levels and across all disciplines, are encouraged to review the cultural training annually and obtain additional trainings from The Office of Minority Health (http://minorityhealth.hhs.gov).

Amerigroup associates are provided an online tool called ATLAS. This online tool allows associates to look up instructions on how to access the Language Interpretation line as well as what to do when providers call to request a copy of the Cultural Competency Plan.

3. Providers are given training on cultural competency at the time of orientation with the plan. In addition, providers are encouraged to complete ongoing cultural competency training and are provided with The Office of Minority Health website at http://minorityhealth.hhs.gov, the location for continued education. Amerigroup reviews complaints and grievances against providers as identifying providers who may need additional training related to cultural competency.

Objective 3 - Assessments and care plans reflect relevant cultural issues.

Key Strategies

1. Assessments clearly identify relevant cultural issues of the member.
2. Language preference is identified at the time of enrollment and is verified during member assessment.
3. Member assessment form contains questions related to primary language preference and cultural expectations. Case managers document primary language in their case notes as a part of their assessment.
4. Care plans are individualized and reflect appropriate integration and utilization of the member's culture (to include age, disability, race, and ethnicity, as appropriate).
5. Care Plans are shared with the member's primary care provider.

The initial assessment examines a broad range of domains to determine the member's individual situation and risk of adverse outcomes. These domains include physical and mental health, social, economic and emotional status, capability for self-care, the members' goals, and the current service plan. Assessments are completed via phone or home visits to collect and assess information from the members and/or their representatives. Service coordinators also obtain information from the members during Welcome Calls.

All of this information is used to determine need for care coordination/case management and to guide, develop and implement the care plan. Care plans are individualized using the industry-recognized Case Management Society of America approach. Working closely with the member and/or their representatives, case managers and care coordinators develop plans with the members that include long and short-term goals, the scope, duration, and frequency of services, authorizations, and schedule for re-evaluation of service recommendations. Members' needs for social, educational, therapeutic, and other non-medical services are a key component of the plan. By working closely with members and/or their representatives, Care Managers ensure that members' cultural needs are met in the development of their individualized service plans.

Objective 4 - Provide language assistance services, at no cost, to members with limited English proficiency, hard of hearing, or visual difficulty at all points of contact.

Key Strategy

1. Amerigroup and providers assure the availability of interpreter services through either bilingual staff or qualified interpreters.

Amerigroup's policies are designed to ensure members with low English proficiency or hearing or visual impairments have meaningful access to health care services, assisting them in overcoming barriers, which allows them to fully utilize services/benefits. Language assistance options are available at no cost to the member. Oral interpretive services are available either in-office or telephonically. Members can contact our National Contact Center to arrange for services by calling 1-800-600-4441. Members who are hard of hearing can contact TDD/TTY for telephonic interpretation at 1-800-855-2880. Members can also contact the National Contact Center to arrange for in-office sign language assistance at the provider's office. Members that have low acuity vision can receive information on how to obtain interpretation services in the Member Handbook as well as through calls to the National Contact Center. Providers are able to obtain interpreter services for telephonic contact and in-office visits by calling the National Contact Center at 1-800-454-3730. Information on how to obtain these services is documented in the Provider Manual and through other means such as the Provider Newsletter and Assist website.

Amerigroup intends to continue employing associates who are fluent in Spanish, Creole, French and Vietnamese. In addition, associates receive training on how to assist members with language difficulties, and how to access our in-house bilingual staff as well as contracted interpreters, the Language Line and Merkafon International Services. Associates also receive training on how to access local interpreters and the TDD/TTY 1-800 number. Associates are trained to offer interpretation services whenever they encounter a member who would benefit from such services and to educate members about the availability of services.

Objective 5 - Easily understood and culturally sensitive member-related materials are available.

Key Strategies

1. Vital documents (all written materials) are printed in both English and Spanish. Additional languages and formats are available to members in the member's language of preference as requested. Documents are available for members in a variety of formats upon request, i.e. large print and audio.
2. Written materials, such as member Handbooks and member notices will be available in English and Spanish. Large print and audio versions are available upon request with a 14-day turn-around. Written member materials are available in other languages upon request. All member materials are written at or near a 4th grade reading level according to the Flesch-Kincaid Grade Level scale or comparable rating system. Information on our website is available in both English and Spanish.
3. Amerigroup holds Health Education Advisory Committee meetings at least quarterly. This is an organized forum where community-based organizations, Amerigroup staff and Amerigroup members provide feedback on the appropriateness of our programs and activities for all cultural and ethnic groups. The committee leader solicits input on the effectiveness of current health promotion efforts, identifies additional member health education needs and recommends additional health education program development. This enables us to make every effort to provide materials and

programs that are understandable to members, to address their health education needs, and to meet cultural competency requirements.

4. Written materials will be developed to support the unique cultural health issues for the membership. In evaluating our population, we determined that while the Amerigroup membership is strongly Hispanic (36% of Amerigroup members), 77.8% report primary language as English and only 13.7% report primary language as Spanish. Amerigroup is committed to developing culturally sensitive interventions and educational materials versus translating generically cultured materials into Spanish.

Objective 6 - Develop collaborative relationships with communities.

Key Strategies

1. Offer educational programs and other special events to communities that address health beliefs and the needs of ethnic/cultural populations.
2. Amerigroup's committee structure includes members of diverse cultural backgrounds and encourages participating from members as well as providers.

A. Quality Management Committee (QMC) (health plan)

a) Purpose:
   1) To establish quality as a cornerstone of AMERIGROUP Culture;
   2) To be an instrument of change through improvement of care and service;
   3) To provide a mechanism and forum for interdepartmental participation in the Quality Management Program;
   4) To integrate and coordinate quality improvement in care and service throughout Amerigroup including all lines of business (SMMC-LTC, MMA, FHK, Medicare, and Medicaid);
   5) To demonstrate quantifiable improvement in care and service;
   6) Ensure linkages between departments and committees.
   7) To have representation from each sub-committee at the QMC to ensure flow of subcommittee information

b) Responsibilities
   1) Establish strategic direction - monitor and support implementation of the Quality Management Program;
   2) Establish processes and structure that ensures accreditation compliance;
   3) Review and accept Corporate and Local QM Policies and Procedures, as appropriate;
   4) Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical/service quality improvement studies;
   5) Coordinate communication of quality management activities throughout the Work Plan;
   6) Review and analyze HEDIS® and CAHPS® data and action plans for improvement;
   7) Review, monitor, and evaluate program compliance against Anthem GBD, State, Federal and accreditation standards;
   8) Develop and implement a written QM Plan, which incorporates the strategic direction provided by the governing body;

9) Review and approve the annual quality management program description and work plan; determines and describes the program's overall effectiveness; considers the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QM program and determines whether to restructure or change the QM program for the subsequent year based on its findings;
10) Provide oversight and ensure compliance of delegated services;
11) Assure inter-departmental collaboration, coordination and communication of quality improvement activities;
12) Measure compliance to medical and behavioral health practice guidelines;
13) Monitor continuity of care between medical and behavioral health services;
14) Monitor accessibility and availability with cultural assessment;
15) Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety;
16) Make information available about our QI program to members and practitioners;
17) Assure the availability of Quality Management program minutes to the appropriate state regulatory agency, as applicable; and
18) Assure practitioner involvement through direct input from our Medical Advisory Committee or other mechanisms that allow practitioner involvement.

c) Membership
1) Plan Chief Executive Officer, Chair and or designee;
2) Plan RVP and Chief Medical Director, Co-Chair;
3) Director, Health Care Management Services (Utilization Manager or designee);
4) Director, Provider Solutions (Provider Services Leader or designee);
5) Director, Quality Management;
6) Director, Medicaid Compliance;
7) Manager, Quality Management (Plan Health Promotion Leader);
8) RVP and Chief Operating Officer;
9) Director, Human Resource (or designee);
10) Manager, Quality Management (Appeals/ Grievance, Complaints);
11) Risk Manager;
12) Director, Customer Care (or designee);
13) Director, Long Term Support Services (or designee);
14) Director, Finance;
15) Director, Medicaid Field Operations (Credentialing);
16) LTC Medical Director (Geriatrician);
17) Behavioral Health Medical Director;
18) Non-voting members as necessary.

B. Medical Advisory Committee/Peer Review (MAC)

a) Purpose:
1) To assess levels and quality of care provided to members and recommend, evaluate, and monitor minimum standards of care for members;
2) To provide applicable advice and input to the corporate committee with oversight over the development and updating of clinical practice guidelines (CPGs); identify opportunities to improve services and clinical performance by establishing, reviewing/updating clinical practice guidelines based on

review of demographic and epidemiologic information to target high volume, high cost, high risk, problem prone conditions;
3) To conduct a peer review process that provides a systematic approach for monitoring of quality and appropriateness of care;
4) To conduct a systematic process for network maintenance through the credentialing/recredentialing process;
5) To give advice to the health plan administration in any aspect of the health plan policy or operation affecting network providers or members;
6) To provide oversight of the peer review process and drug utilization reviews;
7) To provide guidance and feedback regarding technology assessment.

b) Responsibilities:
1) Utilize ongoing peer review system to assess levels of care and quality of care provided;
2) Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities;
3) Review and provide input, based upon the characteristics of the local delivery system; approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization;
4) Review clinical study design and results;
5) Develop and approve action plans/recommendations regarding clinical quality improvement studies;
6) Consider/act in regard to physician sanctions;
7) Review, and provide input, to credentialing / re-credentialing policies and procedures; and clinically oriented Quality Management policies and procedures, Utilization Management policies and procedures; Disease/Case management policies and procedures;
8) Review and provide feedback regarding new technologies;
9) Oversee compliance of delegated services.

c) Membership:
1) Plan Medical Director - Chair, non-voting.
2) When the Committee is functioning as an appeal board, the Chairmanship is assigned to a committee member;
3) Plan Behavioral Health Medical Director;
4) Plan Medical Management Leader – non-voting;
5) Plan Quality Management Leader - non-voting;
6) Six to ten fully credentialed, actively participating providers reflecting the provider network and member base with representation from primary care, major specialty services, and delegated entity representation.
7) Exceptions to membership other than as described above would include providers in good standing from the local medical community (i.e. physician executives, providers with specialties not represented in the contracted network, etc.) who bring valuable experience and perspective to the committee – Non-voting

C. Health Education Advisory Committee (HEAC) meetings to identify and evaluate involvement of community resources.

Amerigroup has developed close relationships with community-based organizations across all business lines including Medicaid, SMMC MMA, SMMC LTC and Florida Healthy Kids. Amerigroup works collaboratively to improve health and services outcomes for members and the community at large. We will continue to establish relationships with community-based organizations, religious organizations, advocacy groups and industry partners to provide the broad range of services that members may require outside of the scope of the managed care program. Amerigroup provides AMERITIPS to community-based organizations in need of linguistically appropriate health information. We also use educational materials developed by community organizations when they are of benefit to our members. Amerigroup works closely with local minority health coalitions and sponsor educational seminars on aging, minority and disability-related topics. Educational programs highlight areas of concern for members to raise awareness of members regarding their risk factors.

a) Purpose of the Health Education Advisory Committee:
    1) Provide advice to the Plan regarding health education and outreach program development;
    2) To ensure that materials and programs meet cultural competency requirements, are understandable to the membership, and address the health education needs of the membership;
    3) Assist in the review, development, implementation and evaluation of member health education tools for the outreach program;
    4) Review the health education plan and make recommendations on health education strategies; and
    5) To provide a forum for consumers to provide guidance and recommendations to the Plan.

b) Responsibilities:
    1) Assist the Plan in decision making in the areas of member grievances, marketing, member services, case management, outreach, health needs, and cultural competency;
    2) Identify health education needs of the membership based on review of demographic and epidemiologic data;
    3) Provide input into the annual review of policies and procedures, the QM program results and outcomes, and future program goals and interventions;
    4) Identify cultural values and beliefs that must be considered in developing a culturally competent health education program;
    5) Assist in the review, development, implementation and evaluation of member health education tools for the outreach program; and
    6) Review the health education plan and make recommendations on health education strategies.

c) Membership:
    1) Health Promotion Leader, Chair;
    2) Member Advocate;
    3) Participating Providers (ad hoc);
    4) Advocacy Group(s);
    5) Community Health Educators;
    6) Health Plan Members from the major cultural groups served by the Plan (ad hoc).

Objective 7 - Ensure culturally competent care and service is available to all members.

Key Strategy

1. Recruit providers with backgrounds similar to members in order to offer members care that is compatible with their cultural health beliefs and in their preferred language whenever possible.
2. Provide practitioners with educational materials about cultural competency.
3. Make cultural competency materials available to providers via the Amerigroup Provider Website.
4. Continue to recruit providers speaking Creole throughout the provider network but specifically in the counties with no providers.

Amerigroup strives to recruit and contract with providers who understand and appreciate the socio-economic and cultural challenges that our members face in addition to their abilities and complex healthcare needs. Amerigroup achieves this by recruiting providers in or near the neighborhoods where our members reside. In addition, Amerigroup ask providers to voluntarily report race/ethnicity and languages spoken on the credentialing application. Amerigroup then publishes the languages spoken so members can choose providers who are able to communicate in the members preferred language. Initial credentialing includes an on-site visit to primary care and obstetrician/gynecologist providers to determine compliance with Amerigroup standards for physical accessibility. Provider Directories contain information on the languages that are spoken in provider offices, so that members can make informed decisions when selecting providers. Providers receive information from Amerigroup on how to access interpreters for members via provider orientation, the Provider Manual or by contacting our National Contact Center at 1-800-454-3730.

Amerigroup makes available, as part of the Cultural Competency Plan, education materials for providers. These materials may be located at (http://minorityhealth.hhs.gov) under the cultural competency tab, training tools for physicians and others.

Objective 8 - Performance Measures

Key Strategies:

1. Analyze performance measures, not meeting goal, by race, ethnicity and linguistic aspects.
2. Where differences are noted between cultural groups, identify root cause and develop member interventions based on cultural needs and identified root cause analysis.

Amerigroup believes each cultural group chooses to access medical and behavioral health services by different means based on cultural beliefs. As such, Amerigroup analyzes performance measures based on race, ethnicity and linguistic aspects. Where differences are identified, interventions are developed that will encourage a given cultural group to obtain necessary services.

Objective 9 - Complaint and Grievance Process

Key Strategies:

1. Facilitate open and transparent two-way communication and feedback mechanism between members and Amerigroup.
2. Anticipate, identify and respond to cross-cultural needs.
3. Meet federal and/or state level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures.

Amerigroup has a complaints and grievance process to facilitate open and transparent communication with members. Members may contact the grievance coordinator by calling member services at 1-800-600-4441 (TTY 1-800-855-2880) to file a complaint or grievance. Amerigroup also has an ombudsman line for members to contact if they would like to file a complaint. Members may reach the Amerigroup ombudsman line by calling member services at 1-800-600-4441 and asking for extension 34925, or visit www.myamerigroup.com.

Evaluation Process

Annually, Amerigroup conducts an evaluation of the Cultural Competency plan and submits the evaluation and the updated plan to the Agency of Health Care Administration by June 1st for approval for implementation by September 1st of each contract year.

Amerigroup uses member grievances and appeals, the CAHPS survey, member, provider and associate demographic information, associate recruitment results, audits of case management files, audits of the usage of the language line, requests for documents in other languages, and input from community groups to evaluate the effectiveness of the Cultural Competency program. Amerigroup looks for areas of concern by tracking and trending of this data, and conducting analyses of available reports. This permits issue identification. Root cause analyses are completed and interventions are developed and implemented as necessary throughout the year to improve the provision of services. When deficiencies are noted, they are added to the Cultural Competency Plan as an objective either for the New Year, or for a sub element of one of the current objectives.

Authority, Structure and Responsibilities for the Oversight of the Implementation of the Cultural Competency Strategic Plan

The cornerstone of the foundation for Amerigroup's cultural competency program begins with the commitment and support of Senior Management. Annually, the Quality Management Committee, Medical Advisory Committee, and the Florida Board of Directors approve the Cultural Competency Plan.

In Florida, the Chief Medical Officer oversees and monitors the implementation of the strategic plan to ensure that the provision of health education and outreach services to members and potential members meets the community's cultural, linguistic and social needs. All associates are required to take cultural competency training at the time of new hire and annual refresher course. Provider Relation staff ensure providers are recruited from within the community they are serving in order to have the same cultural backgrounds and sensitivity to their patients.

Conclusion

Florida as a continually growing diverse population stresses the need to recognize and respond to disparities in the provision of health services and care. This requires health care professionals to have a deeper understanding and appreciation of the socio-cultural background of their members and the environments in which they live. Amerigroup is committed to educating and training management, staff and providers to eliminate all barriers and to provide access to equitable and quality healthcare services for all populations.

Copies of the Cultural Competency Plan are available to providers on the Amerigroup Provider Website or are available in hard copy at no cost to providers. Providers can contact their provider representative to request a copy of this plan.