STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916) 654-8076

April 2, 1999

MMCD Policy Letter 99-02

TO:
[X] County Organized Health Systems Plans
[X] Geographic Managed Care Plans
[ ] Prepaid Health Plans
[ ] Primary Care Case Management Plans
[X] Two-Plan Model Plans

SUBJECT: HEALTH EDUCATION AND CULTURAL AND LINGUISTIC GROUP NEEDS ASSESSMENT

PURPOSE

The purpose of this policy letter is to clarify the contract responsibilities of Medi-Cal managed care plans' (hereafter referred to as Plans) in conducting the Health Education and Cultural and Linguistic Group Needs Assessment.

GOALS

1. To identify health education and cultural and linguistic needs of members which will facilitate the development and implementation of effective health education programs and cultural and linguistic services.
2. To identify community health education and health promotion resources which will assist the Plan in the development and implementation of culturally competent and linguistically appropriate programs and services.

POLICY

Some plans have contract requirements to conduct a group needs assessment for their health education and cultural and linguistic programs.

1. Oversight and Administration of the Group Needs Assessment

The Plan must maintain administrative oversight of this program requirement by a qualified full-time health education director with a master's degree in community or public health education. The Plan must develop and implement procedures to assure involvement by appropriate cultural and linguistic services staff.

2. Data Sources and Methodology

The Plan must use multiple, reliable data sources, methodologies, techniques, and tools to implement the group needs assessment. (See Appendix A for suggested data sources.) The Plan's Health Education Department is encouraged to work in close collaboration with other plan departments and policy level committees, as well as local public health departments and community based organizations in implementing the group needs assessment.

3. Consumer Input

The Community Advisory Committee, which includes representatives of targeted groups of plan members, must be included in a formal process to provide input, review, and make recommendations based on group needs assessment findings. Plans are encouraged to solicit input from other community advisory groups and organizations.

4. Timeline

Plans must complete the group needs assessment within one year of release of this policy letter, and every three years thereafter for the duration of the contract. Plans are encouraged to update the group needs assessment annually and utilize findings on an ongoing basis for continuous development of its health education and cultural and linguistic services program.

5. Group Needs Assessment Work Plan

Within three months of release of this policy letter, the Plan must submit to the Department of Health Services (DHS) its work plan for conducting the Health Education and Cultural and Linguistic Group Needs Assessment. This work plan must demonstrate that the group needs assessment will be successfully conducted, achieve the desired purpose, incorporate the required elements, and be completed

within the required timeline. The work plan must include the implementation activities, timeline with milestones, responsible individuals, and the individual with overall responsibility.

6. Summary Report

A. Within one year of release of this policy letter, Plans must submit a Summary Report to DHS. The Summary Report must include the following: Objectives, Methodology, Literature Review, Existing Data Sources, Survey Instruments (if applicable), Findings, Conclusions, Program and Policy Implications, and References.

B. The Group Needs Assessment Summary Report must identify the following for health plan members:

1) Risks for diseases, health problems, and conditions.
2) Health-related behaviors and practices, including:
   a. knowledge, attitudes, and cultural and religious beliefs and practices relating to risk for disease, injury, health problems, or medical conditions.
   b. Knowledge, attitudes, and cultural beliefs and practices relating to access and utilization of preventive and primary health care, including perceived barriers and/or satisfaction.
3) Perceived health care and health education needs including expectations regarding communication with health care providers.
4) Cultural beliefs and practices relating to use of alternative preventive and therapeutic health methods, and traditional practitioners and healers.
5) Perceived learning needs and preferred methods of learning.
6) Literacy level.
7) Culturally competent and linguistically appropriate community health education, health promotion, and other health related resources.

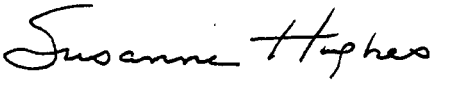
The Program and Policy Implications Section of the Summary Report must illustrate that relevant group needs assessment findings are being used to guide the development and implementation of contractually required health education and cultural and linguistic programs.

DISCUSSION

Despite overall health improvements for the general population as a result of increasing emphasis on health promoting behaviors and preventive health care, the Medi-Cal population continues to be burdened by preventable illness, injury and disability, and are at high risk for almost all major disease categories. Health benefits can be realized by placing increased priority on supporting behaviors which promote optimum health, reduce risk for disease, injury and disability, and promote adherence to self-care and treatment regimens.

Health education needs are inextricably linked to culture, language, customs and beliefs regarding health and disease, and must be viewed within this cultural context. Health education principles and practices, including population based assessment, have been successfully utilized to design, develop, and deliver health programs and services for California's culturally diverse and at risk populations. Partnership with community health, education, and social service agencies will assist Plans in identifying health care consumer needs, providing relevant health education, health promotion programs and services, as well as language translation and interpreter services.

If you have any questions regarding this policy letter, please contact your contract manager.



Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

Appendix A - Suggested Group Needs Assessment Data Sources:

a. Data from national, state, and local agencies including prevalence, incidence and risk-reduction data from CDC, DHS, and local health departments.
b. Risk prevalence data applied by age, sex, ethnic group, and other significant demographic variables to adjust for membership and state population differences.
c. Local health department data regarding communicable diseases, immunization rates, birth data, maternal and infant morbidity and mortality, and general mortality information.
d. Consumer survey data assessing member health practices, perception of health needs, knowledge and use of available health care services, expectations of health plan, and nature and extent of interest in learning how to improve/protect health.
e. Community advisory committee input regarding health education and cultural linguistic needs.
f. Survey data of ongoing programs and activities within the plan, including input from clinic staff, managers, and supervisors.
g. Survey data of community health, education, and social service agencies that provide a range of services to the member population and community.
h. Health Status and Behavioral Risk Data.
i. Demographic information including age distribution, family composition, geographic distribution/location, and cultural, ethnic, and language characteristics.
j. Focus Group Data representative of plan members including those identified by age, risk, gender, ethnicity, language, and groups with special needs.
k. Satisfaction Survey Data including criteria addressing member/patient education and counseling, and cultural linguistic services.
l. Data from national, state, and local agencies identifying knowledge, attitudes, values/beliefs, behaviors and practices related to specific diseases, health problems or medical conditions.
m. Data from national, state, and local agencies identifying knowledge, attitudes, values/beliefs and practices related to access and utilization of preventive and primary health care services.
n. Data from health care plans/HMOs, community and public health clinics, and providers identifying member/patient satisfaction, health care expectations, perceived/encountered barriers to access and utilization of preventive and primary health care services.
o. Data from health care plans/HMOs, community and public health clinics regarding language capability of providers.
p. Data from tumor registries and voluntary health agencies.
q. Administrative Data on utilization by type of provider, site, purpose, initiator of encounter, and hospital admission rates by disease and demographic grouping; sampling of medical records, grievance, and disenrollment records.
r. Survey data from state and local agencies identifying health care provider knowledge and practices related to clinical preventive services including education and testing.
s. Systems analysis data including patient process flow and new members enrollment information.