Oregon Health Authority
Transformation Center and Division of Equity & Inclusion

Meaningful Language Access to Culturally Responsive Health Care
Learning Collaborative
June 25, 2021
8:30am – 10:00am

TOPIC: Supporting the Meaningful Language Access Incentive Measure

Maria Elena Castro, from the Oregon Health Authority (OHA) Division of Equity & Inclusion provided an overview of Coordinated Care Organization (CCO) Health Equity Plan Activities to Support the Meaningful Language Access Incentive Measure.

The CCOs have been engaged in work on language access since they were established in 2012; there were language access requirements in the CCO Transformation Plans and the Transformation and Quality Reporting Strategy under the CCO 1.0 contract. However, there were no uniform tools or overall health equity plan required.

Under the CCO 2.0 contract, the CCOs now are required to have comprehensive health equity plans that include ensuring culturally and linguistically appropriate services, and language access reporting. There has been significant progress made by the CCOs, including many having a language access administrator, doing comprehensive reviews to incorporate language access into all policies, procedures, and workflows, and developing materials following accessibility, literacy, and language access standards.

The first year CCO health equity plans included some highlights about how CCOs were addressing language access needs, including training for CCO staff and providers, using pay differentials for language proficiency to increase language diversity, and developing tools for providers to offer information about language access, and how to access language services. There is also increased awareness of the diversity of languages spoken by CCO members, including Meso-American languages (Mayan, Mam), Chinese dialects, and languages spoken by Pacific Islanders from the Freely Associated States under the Compact of Free Association (COFA).

However, the first year CCO health equity plans also identified areas that need improvement, including gaps in language access data collection and analyses, which the CCOs report as administratively burdensome and time-consuming, including manual chart review and scrubbing language services vendor invoices. CCOs noted that their providers have manual and ineffective methods of identifying members with language access needs and that EHRs do not allow automated reports. CCOs also identified challenges in the recruitment and retention of bilingual staff and health care interpreters, and the need for education and support to providers on the importance of requesting certified or qualified health care interpreters.

Some of the goals that CCOs included in their health equity plans include increasing the percentage of in-person language services provided, increasing the number of certified health care interpreters who reside in the CCO service area, providing training on language access, outreach and education of community partners to promote language

access, and enhancing grievance and appeals processes and analyzing data by language.

While there will be no changes to the CCO 2.0 second year requirements for health equity, there will be a new reporting template, due in August 2021. OHA will wait until it has received these second year health equity plans to develop a full analysis and report of the health equity plans.

Kweku Wilson, from the OHA Division of Equity & Inclusion then presented on Documenting and Reporting on the Meaningful Language Access Incentive Measure.

The goal of the meaningful language access to culturally responsive health care CCO incentive measure is to ensure meaningful access to health care services for all CCO members who need spoken and sign language interpreter services; meaningful access is access that is not significantly restricted, delayed, or inferior as compared to programs and activities provided to English proficient individuals.

CCOs should be documenting which CCO members need interpreter services, the timeliness and actual provision of appropriate interpreter services, and that those providing interpreter services have the requisite training and/or language proficiency. Under the CCO 2.0 contract, CCOs are required to complete an annual language access self-assessment, and report quarterly on the utilization of language access services by their members.

The CCO self-assessment can be used as a road map for the CCO to develop a system for documenting and reporting on language access, including documentation of CCO member refusal of interpreter services and eventually, wait times for interpreter services and the modality of interpreter service delivery (e.g., in-person, video, telephonic). For example, CCOs are using “I Speak” language identification cards or posters to identify member language access needs, tracking services provided by contracted telephonic language services vendors, tracking services provided by remote video language services vendors, and tracking services provided by contracted in-person interpreters.

The denominator for the language access measure is the total number of visits by CCO members who have limited English proficiency (LEP) or a disability that requires language access services (such as sign language interpretation for a CCO member who is deaf). The language access needs of CCO members are identified during enrollment and are included in the “834” Medicaid/Oregon Health Plan monthly enrollment reports/files shared by OHA with the CCOs. If there is additional information about a CCO member’s language assistance needs, the CCOs should document and use such additional information.

The numerator for the language access measure is the number of visits by CCO member who require language access services when health care interpreter services are provided, and then further refined by the number of visits when the health care interpreters provided are certified or qualified by OHA.

Preliminary review and analysis of the first self-assessments and utilization reports from CCOs show that identification of visits by members with interpreter needs is improving but still has data lags. Moreover, when interpreter services are provided, there is low documentation of such services being provided by OHA-certified or qualified health care interpreters. The CCOs remain at different stages of establishing workflows to collect

and report data on the meaningful language access incentive measure, with most reporting some required information but needing continuous improvement on reporting complete data. Most CCOs have not yet reported complete data on interpreter credentials, or whether the interpreter provided is an OHA-certified or qualified interpreter.

After reviewing the CCO self-assessments and first quarter reports, OHA has extended the quarterly reporting deadline to 90 days following the end of each calendar quarter to account for data lags, and has added the option of reporting a bilingual staff provider as the interpreter provided. OHA provided feedback about the self-assessment and reports to the CCOs in March and will be providing additional feedback to the CCOs in July. Former U.S. Surgeon General Regina Benjamin has said, "If our patients don't understand us well enough to make good health care decisions, then we didn't treat them."

Discussion and Questions and Answers

Question: Are the CCO health equity plans and CCO language access self-assessments going to be publicly available?
Maria: Many of the CCOs have posted their health equity plans or summaries of their health equity plans on their websites; especially with the second year health equity plans, we will be talking with the CCOs about what can be posted by OHA
Kweku: We are still analyzing the first quarter reports from the CCO and will provide feedback to the CCOs; we have made the self-assessments available to the Innovator Agents

Question: Will these documents, or summaries, be available in alternate formats and multiple languages for CCO members?
Maria: We have to have something in alternate formats and multiple languages that would be for CCO members; might be OHA's summary of all the health equity plans
Kweku: We haven't discussed this but yes, we should consider what can be available in multiple languages and alternate formats

Comment: For the deaf and hard of hearing, would need audio formats
Answer: As noted in a prior learning collaborative session, some of the CCOs have made their member handbooks available in audio formats; whatever summaries or other information about the health equity plans and language access self-assessments should be available in these alternate formats

Question: Glad that OHA is addressing the claims lag but still issues with the 834 files/flags
Kweku Andy Parker/OHA Health Analytics: OHA is looking both at what is in the 834 files and what additional information CCOs identify about their members; OHA is exploring how that information from CCOs can be incorporated back into the OHA data

Question: if the OHP member is a child but the parent needs interpreter services, how is that flagged? If that parent (or a spouse) uses interpreter services, how should that be documented and reported?
Kweku and Andy Parker: not currently included in the report template but could report such cases and get "credit" for non-flagged visits; and should be documenting whether the interpreter provided is OHA-certified or qualified interpreter

Maria: if the parent is the one providing informed consent, then important to document the interpreter services; there are also adolescent services where parental consent is not required; have to think through these cases
Comment: and in some cases, also issues of health literacy and need to simplify the communication
Comment: at one CCO, do flag when a parent needs an interpreter
Comment: using a whole-person lens, how would we ensure effective communication and understanding for an English-speaking member who cannot speak; it should be no different for a member who speaks another language

Question: How do document and report when there is a bilingual provider or interpretation by a bilingual staff member?
Kweku: the reporting template change about bilingual providers is effective for the next quarterly report; but OHA has not made a decision about crediting visits with bilingual providers because no standards or documentation about language proficiency of those bilingual providers

Other questions and comments:

- I heard from both Maria and Kweku an area of improvement is the retention of health care interpreters and bilingual staff; I believe this is due to the low compensation so does OHA have any plans of making sure compensation is a fair amount?
- If a national vendor becomes an OHA-approved training provider, will they get an OHA number? If yes, would that number apply to their interpreters? Or how should their certified/qualified interpreters be documented?
- At this time in Coos and Curry County we are having an issue getting the qualification certificate for an employee of Advanced Health that took the 80-hour course with All Care 2 years ago and still cannot get her number that she is qualified and listed on the lists of interpreters for the State of Oregon
- Perhaps the question shouldn't be "does the member need an interpretive service" but rather "does an interpretive service need to be provided during this visit in order to ensure high quality of care"?
- If a member was accidentally flagged as needing interpreter services, what is the process of confirming that, and having the flag removed?