Meaningful Language Access to Culturally-Responsive Health Care Services

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Historical Overview

- **Oct 2018:** Health Equity Metric workgroup convened at the request of the Oregon Health Policy Board.
- **Oct 2018 to May 2019:** Health Equity Metric workgroup developed a metric proposal to address community members' desire for improved bilingual services and culturally appropriate care (CCO 2.0 townhall sessions, 2018)
- **May 2019:** Measure presented to Health Plan Quality Metrics Committee (HPQMC) with request to be included on committee's measure menu. HPQMC voted against including the measure. Asked OHA for further development.
- **June 2019:** Reporting requirements for interpreter services added to 2020-2024 contracts.
- **Oct – Dec 2019:** Pilot test the measure with nine CCOs
- **Jan – Feb 2020:** Present pilot test results to Metrics and Scoring Committee and Health Plan Quality Metrics Committee
- **March 2020:** Measure added to HPQMC 2021 Aligned Measure Menu
- **July 2021: Measure selected as a 2021 CCO incentive measure**

Measure Foundations

The measure was developed after a thorough review of the literature, and the information shared by community members during the CCO 2.0 policy development process in focus groups.

- In the United States, 21 million individuals speak English “less than very well” and are thus said to have limited English-proficiency (LEP).
- One million individuals in the United States use American Sign Language (ASL) as their primary language.
- Individuals with LEP have difficulties accessing health services; the same can be said for people that are deaf.

Measure Evidence - Limited English Proficiency (LEP) and Quality Health Care

- LEP is a risk factor for poor health access and outcomes. It can result in challenges obtaining health insurance and completing processes associated with obtaining and maintaining coverage.
- Individuals with LEP are less likely to have a regular source of primary care and receive fewer preventive services for chronic conditions.
- LEP results in increased medical errors in hospital settings. In a meta analysis, LEP patients were shown to be far safer with the presence of a professional medical interpreter. Despite this evidence, other studies in the same meta-analysis pointed to healthcare professionals trying to “get by” without one in non-emergent settings.

MEASURE GOAL -

Meaningful Language Access to Culturally-Responsive Health Care Services

Achieve meaningful access to health care services for all CCO members through quality communication, language access services, and the delivery of culturally responsive care.

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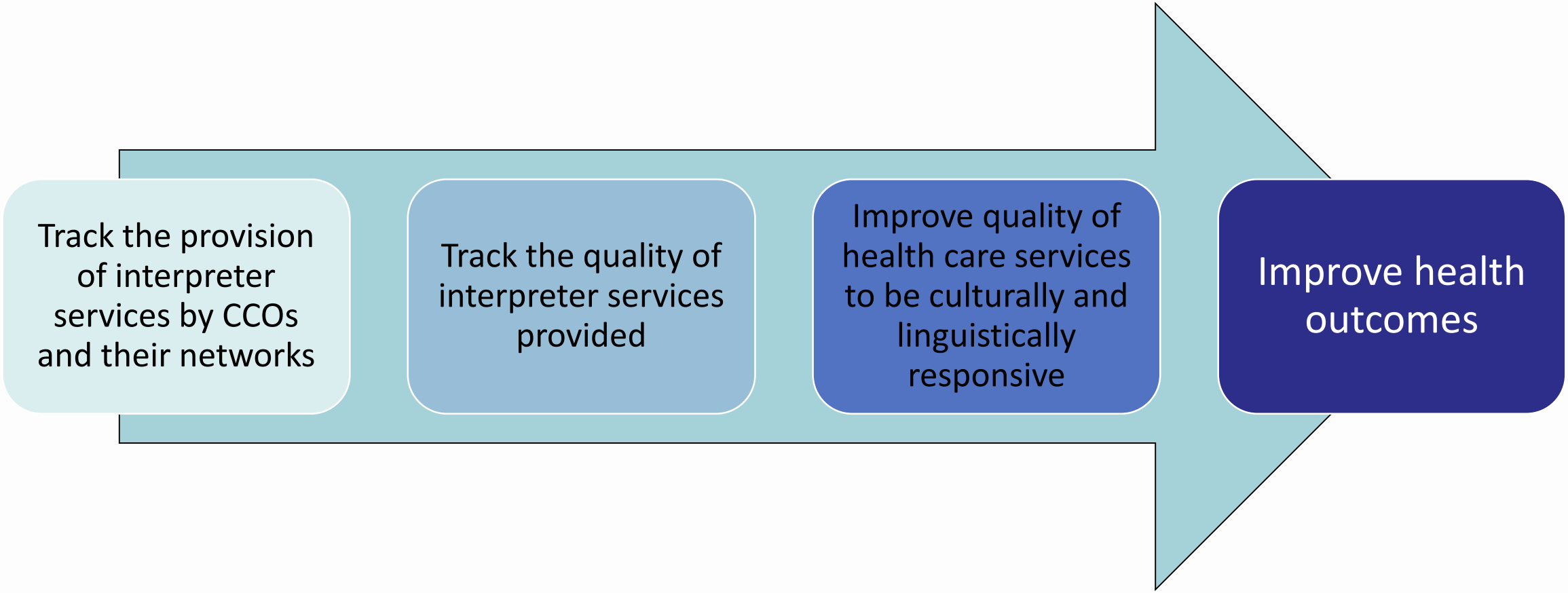
Community-based Evidence Measures

Meaningful Language Access to Culturally-Responsive Health Care Services



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Meaningful Language Access: Summary

A multi-year glide path to build and integrate structures for improving meaningful access to quality health care and reporting on the QUALITY of service delivered.

1) Annual language self-assessment – attestation for meeting services and data collection requirements
2) Annual report for the proportion of spoken and sign language interpreter needs fulfilled by certified and qualified interpreters. Mirrors the quarterly contract reporting structure
    - Denominator: Total counts of visits from members who need interpreter services.
    - Numerator: Total counts of denominator visits when spoken and sign language interpreter services were provided:
        - By certified interpreters
        - By qualified interpreters
        - By interpreters NOT certified or qualified

This measure incentivizes improvement on proportion of services by certified or qualified interpreters.

Measure aligns with OHAs Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability**, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

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Pilot test: Lessons learned (Oct – Dec 2019)

Objectives

- Identify data collection and reporting concerns
- Assess accuracy of self-identified interpreter needs data from OHA member enrollment
- Assess accuracy and quality of data for members who received interpreter services provided by a CCO
- Identify gaps between claims-based qualifying visits and actual visits CCOs can track with interpreter services
- Learn from CCOs about how the information is collected for different modes of interpreter services
- Assess the feasibility of reporting in monthly increments
- Assess the feasibility of submitting quarterly reports to OHA
- Gain understanding of the time burden and workload on CCOs and/or clinics

What we learned: there are some challenges

- Reporting turnaround time
  - Claims data lag 90-120 days
  - Invoice data lag from vendors
- Matching records between data systems (administrative burden)
  - Invoices from vendors do not include member level data
  - Invoices from vendors do not include interpreter qualification
- Workflows not in place to capture services by provider networks
  - Language services contract with provider networks
  - Bilingual staff and bilingual providers
- Not all CCOs have the ability to identify additional members needing interpreter services apart from intake data

What we learned: there are successful practices

- Investment in language access services
  - Dedicated staff person assigned to tracking
  - Clinic and provider education and training
- Provider education and frequent communication of the importance of reporting
- Matching patient with bilingual providers (some assumptions to this process)
- Workflow in place for tracking certified and qualified providers
- Established data processes with clinics and providers to use non-billable code (T1013) for tracking purposes only

What we learned from the self assessments

There are gaps in workflow, service delivery, and compliance with statutes

- CCOs are at different stages of providing meaningful access to language services.
- CCOs are at different stages of establishing workflows across provider network.
- CCOs that scored higher on their self-assessment had invested in workflows to:
  - Identify and provide meaningful language access to members
  - Collect data and measure performance
  - Train staff and keep track of the credentials of HCIs who provide services
- The development of structures and workflows across provider network would take some time.
- Based on the results of the pilot and self-assessments, the measure was revised to include a glide path for CCOs to build internal structures for providing quality and reliable language services.

Measure details – Year 1 (MY2021)

Component 1 – Language Access Self-Assessment

- CCO begins to establish data collection systems and attests to system development progress and capability.
- CCO submits the self-assessment mid-January 2022.
- Minimum points required = 46 (of 89)

Measure details – Year 2 (MY2022)

Component 1 – Language Access Self-Assessment

- CCO continues to establish data collection systems and attests to collecting additional data components. Submission by mid-January 2023. Minimum points required = 56 (of 89)

Component 2 – Sampled Hybrid Quantitative Report

- OHA to sample CCO members who are identified with interpreter needs as of December 31, 2022 and have at least one visit in the year confirmed by claims data.
  - Sample size TBD, suggests 30% or up to 411 members who have interpreter needs
- Members are identified based on MMIS with low English proficiency (LEP; IND_INTERPRETER = Y) or with sign language needs (IND_SL_INTERPRETER = Y).
- OHA provides sample member list by mid-January 2023. CCO may request to adjust the sample member list based on additional information available to CCO.
- CCO to submit hybrid data by early April, 2023 (same deadline as other hybrid measures) using the report template.
- CCO must submit data to meet component 2. No benchmark or improvement target for year 2.

Measure details – Year 3 (MY2023)

Component 1 – Language Access Self-Assessment

- CCO continues to refine data collection systems and attests to collecting additional data components. Submission by mid-January 2024. Minimum points required = 77 (of 89)

Component 2 – Standardized Quantitative Interpreter Services Report

- CCO reports all members with interpreter needs and all visits from these members.
  - OHA may develop additional process with CCOs to reconcile eligible members against MMIS.
- Use reporting template and report all stratifications, including:
  - Incentivized services by certified or qualified interpreters (with credential records)
  - Care setting of the visit (outpatient, inpatient, ED, etc.)
  - Modality in which the interpreter service is provided (in-person interpreter, telephonic, video report, etc.)
- CCO submits standard reporting data by early April, 2024 (same deadline as other hybrid measures) using the report template.
- CCO must achieve benchmark or improvement target to meet component 2.
  - Benchmark TBD by M&SC, based on MY2022 sampled reporting results.

Using the Self-Assessment as a road map for system development

Example 1 - Domain 1: Identification and assessment for communication needs:

- Beginning Year 1, must attest to have utilized at least 5 of 7 available data sources to identify members with language access needs (Q1).
- Beginning Year 2, must be able to identify and document the following which helps to identify MMIS data issues (Q10).
    - member refusal of interpreter services
    - Did not need interpreter services
    - Needed interpreter services but were not identified as such
- Beginning Year 3, must collect data on wait times for members who need appointments with interpreter services (Q11) and report average wait times (Q12).

Using the Self-Assessment as a road map for system development

Example 2 - Domain 2: Provision of Language Assistance Services:

- Beginning Year 1, must track 3 out of 4 basic language services data components such as the language provided, modality of the service delivery (Q18).
- Beginning Year 2, requires tracking advanced data components from invoice information (Q26).
- Beginning Year 3, requires tracking credentialing of contracted interpreters, bilingual staff, etc. (Q27) and in different care settings (Q29).

Needs Assessment & Discussion

To request a summary from the needs assessment calls, please email: adrienne.p.mullock@dhsoha.state.or.us