Oregon Health Authority
Transformation Center and Division of Equity & Inclusion

Meaningful Language Access to Culturally Responsive Health Care Learning Collaborative

May 28, 2021
8:30am – 10:00am
TOPIC: Supporting Provider Training and Documentation about Language Assistance Services

Toc Soneoulay-Gillespe from Health Share of Oregon and Anna Lynch from CareOregon shared the highlights of a training they developed for providers and staff about language assistance services. The training objectives are to recognize the unique and essential role of an interpreter service provider, to explore how power and privilege impacts access to communication and information, and to introduce an interpreting framework that improves access to health care. The training invites participants to explore their own power, privilege, and access. For example, the training notes the vicarious and personal trauma that many interpreters experience as they interpret for individuals and communities that have experienced historical and contemporary trauma. The acronym CIFE is offered as a framework: **C**onfidentiality **- I** use first person **- F**low – and **E**verything heard or said in this space will be interpreted. Finally, participants are challenged to strive to follow the meaning of a Zulu word, sawubona, meaning “I see you, you are important to me, and I value you”.

Charissa Young-White from IHN-CCO introduced Earlean Wilson Huey from Samaritan Health Services to share how a large health system (5 hospitals and over 80 clinics in three counties) is supporting provider training and documentation about language assistance services. Samaritan has an Equity & Inclusion Council and a language access work group, and is working on standardizing interpreter vendors, providing training by department about how to access interpreter services, creating a guide for how to work with vendors, and reinforcing not using children as interpreters. The language access work group is developing bilingual proficiency testing for providers and staff, supporting health care interpreter training, and exploring a bilingual pay differential. There also is a race, ethnicity, language, and disability (REAL-D) work group to move from data collection on paper forms to the electronic health record (EHR)(Epic). Others are working on getting the patient portal MyChart accessible in Spanish. There also are trainings and lunch and learns on broader equity topics and issues.

Debi Farr and Hestian Stoica from Trillium Community Health Plan shared about its Trillium University as an educational platform; has featured Cliff Coleman from Oregon Health & Science University about health literacy and culturally responsive care. The education and trainings emphasize the difference between equality and equity, and why some members need different services such as interpreter services. Trillium’s new providers receive training about language assistance services during orientation, including an overview of interpreter services (on-site telephone, virtual, ASL) and instructions on engaging with and scheduling interpreters. Trillium works with two vendors to provide interpreter services. In addition, Trillium support providers in developing and implementing workflows to identify interpreter needs and provide timely interpreter services. The CCO also encourages bilingual staff to sign up for training and seek OHA certification as a certified or qualified health care interpreter; staff can receive the training during their work hours or get paid for receiving the training off-hours. The CCO also will be sponsoring 10 scholarships for health care interpreter training this July-

September. Trillium has worked with its providers and vendors to develop a monthly dashboard to monitor utilization of interpreter services, including by provider, language needed, and modality. For example, Trillium recognizes that there has been an unfilled need for interpreters for its Karen-speaking members, but there are very few Karen interpreters available. There are still gaps in the data, e.g. some larger providers have their own language services vendors but that data doesn't get to the CCO. For the top 5 languages needed and top 5 providers, there is additional analysis whether the interpreters used are OHA-certified or qualified.

Aleysa Garcia Rivas from PacificSource shared the CCO's guidelines and FAQs for its providers about health care interpreters, which informs providers how to bill for interpreter services (including an administrative add-on fee) and reminds them that members may not be charged for interpreter services. The CCO also has vendors that provide interpreter services that can be accessed by providers. The CCO reminds providers about the difference between non-certified, certified, and qualified health care interpreters, and that "providers should not use untrained bilingual employees or bilingual patient family members for medical interpretation". PacificSource will be surveying its providers about language access issues and has piloted a health equity dashboard, which includes monitoring utilization of interpreter services. PacificSource also has supported health care interpreter training in its regions.

Discussion (including comments and questions from the chat)

Question: Has the add-on fee resulted in increased payment rates to interpreters?

Question: How many providers is Health Share training and how are these providers selected?
Anna Lynch: This is not a required training for our providers so not all providers have had it. We do bring teasers about it to our collaborative meetings and will do it for anyone who asks. Happy to talk more about it, we are also constantly recruiting others to provide it.

Question: When you talk about training providers, do you also train the administrative staff that interacts with the public to work with interpreters?
Debi Farr, Anna Lynch, and Earlean Wilson Huey: Trillium's trainings are available to both clinicians and administrative staff; Care Oregon and Health Share's trainings are available for all staff of the CCOs, clinical partners, and community partners; goal of Samaritan's trainings is for all staff, has started with the CEO and leadership.

Question: Do you test individuals for language proficiency before sending them to health care interpreter training?

Kweku Wilson/OHA Division of Equity & Inclusion: It's important to note that there are a number of other OHA-approved healthcare interpreter trainings:
https://www.oregon.gov/oha/OEI/Pages/HCI-training.aspx

Comment: Have been supporting training as health care interpreters for Pacific Islanders from the Federated States of Micronesia, Republic of Palau, and Republic of Marshall Islands [Freely Associated States under the Compact of Free Association (COFA)]; it is challenging to recruit participants, and then there is no guarantee of a job as an interpreter. And have seen poor translations; communities are asked to translate or re-

translate materials without compensation; why doesn't OHA and CCOs contract with local community resources for translations in the first place?

Comment: A very high percentage of translations have to be redone. Going for lowest cost can be expensive in this area.
Edna Nyamu/OHA Division of Equity & Inclusion: Errors can happen when using "machine translation"; that should not be used at all. For example, a machine translates "tablet" as an "iPad", that is a major error.

Comment: Thank you for using Zoom for these videoconferences, which is a more accessible videoconference platform; say "working with interpreters" rather than "using interpreters" (we don't "use" doctors or nurses); thanks for acknowledging what is not known/needed to ensure language access; important to provide information to members and the community about the right to health care interpreters; certified and qualified interpreters need continuing education and CCOs could provide updates about the changes in health care that they are making; how can health care interpreters receive living wages? include health care interpreters and limited English proficient individuals as subject matter experts

Question: Do the CCOs pay for the continuing education of their qualified and certified interpreters so they can maintain the credential? This should be treated the same way that continuing education is dealt with for doctors and nurses.

Comment: In regards to contracts with interpreting services, it is essential for providers to contract at minimum, with two ASL-only interpreter agencies, and at minimum, with two spoken-language interpreter agencies. There is an ASL-only interpreter agency that pushes an exclusive contract, which needs to be avoided. Meanwhile, many spoken-language interpreter agencies do not have a formal screening process to determine the qualification of an ASL interpreter, and thus the client/patient suffers. "Effective communication" is required in order to meet the federal legal standard for interpreter services. According to the National Consortium of Interpreter Education Centers (NCIEC), 82% of interpreter agencies do not conduct a qualification screening of their interpreters.
Question: Do providers audit the vendors for what percentage of the interpreters they send are on the OHA list? Just asking for a sign in and checking against the OHA list would do the trick.
Comment: Providers should also be able to contract directly with individual interpreters. Exclusive contracts should not be reasonable.
Hestian Stoica: Opening up to providers contracting with many independent interpreters will make it very difficult for CCOs to monitor the quality and other appointment details of the provided appointments.
Comment: It is common for providers in Southern Oregon to have individual contracts with individual ASL interpreters because interpreter agencies up north in Oregon do not cover southern Oregon very well. There's no ASL-only interpreter agency in southern Oregon.

Comment: I would love to know the various ways people are working with their electronic health records (EHRs) to track provision of interpreting resources during the appointment. The records aren't really designed to do this for us and so I'm sure many health providers are using various work-arounds. Our EHR is OCHIN EPIC. I'm struggling to delineate how we've actually provided services for reporting since we use contracted vendors, staff interpreters, and phone/video services as well as bilingual

clinical staff. We can't rely on billing codes since so few interactions meet criteria for billing within a team-based care setting. Our challenge is that right now we attach a resource schedule to scheduled visits (telehealth and in clinic) to indicate an interpreter (whether it is a contracted service or staff interpreter) but just have to memorize which providers speak which languages with fluency for advanced scheduling of interpretation.
Comment: Know that vendors in Washington state do provide more information
Comment: Has there been coordinated conversations with EHR vendors? With the OHA Office of Health Information Technology?

Question: Does the analysis of interpreter service utilization include the days and times people need language access help the most often?
Comment: There are some clinics that try to schedule patients speaking the same language and needing interpreter services together (same day) so there is more efficient use of interpreters.

Kweku Wilson/OHA Office of Equity & Inclusion: the essence of the meaningful language access measure is quality, defined as working with OHA-certified and qualified health care interpreters; do expect CCOs to identify

Edna Nyamu/OHA Division of Equity & Inclusion: important to have health care interpreter perspectives; there are close to 800 OHA-certified and qualified health care interpreters in the registry; yes, there are shortages of interpreters for languages of lesser diffusion but then CCOs should support training opportunities

Comment: many issues with administrative staff who expect health care interpreters to do sight translation of many-page forms that take a long time, or to explain diagnoses such as diabetes

Comment: in ideal world, want to increase both quality and access but in reality, there are tensions and hard to do both at the same time
Comment: yes, cost is the other part of the Triple Aim

Other questions and comments from the chat:

Question: Is there a way to certify providers to apply in-language services without an interpreter towards the metric?

Comment: Interpreters have to get internet with super solid bandwidth to provide remote services: ethernet connection to internet, and at least 60 Mbps of upload and download speed. Also, using noise cancelling headsets with boom mikes, plugged into the computer with USB. These are best practices that could be applied by anyone communicating online.

Comment: There is a challenge with local specialty offices and behavioral health offices being unfamiliar with interpreter benefits for Medicaid members and how to ensure patients are getting that access at the visit, especially if interpretation is being provided over the phone.