Health Equity Metric: Meaningful Language Access provider interview analysis

Table of contents

Interview process

Oregon Health Authority staff held interviews with Oregon clinics about meaningful language access in July–August 2024 to better understand providers' needs for technical assistance to improve language access.

Interview questions

1. Could you walk us through what happens when a patient requests interpretation for an appointment? [Note: While this is the question interviewers asked, providers most often answered by clarifying that they were describing their process for setting up an appointment for a patient who is flagged as needing interpretation.]
2. What about providing interpretation services has been working well for your clinic/office?
3. In your experience, how do interpretation services affect patient visits?
4. How do you bill for interpretation services?
5. What other resources for interpretation have you encountered that you would want other providers to know about?

Interviewee demographics

Interviewees represented 18 clinics or clinic systems. Each clinic or clinic system may represent multiple care types, geographic regions and sizes below.

Care type

Primary care	**12**	**Behavioral health**	**6**
Integrated	4	Integrated	4
Pediatric	3	**Specialty**	**3**
School-based	2	Optometry	1
In-home	1	Occupational/physical/speech therapy	1
Mobile	1	OB/GYN	1
Oral health	**6**	**Public health**	**1**
Integrated	3		

Region(s)

Portland metro	7	Central	3
Coast	3	Southern	3
Eastern	1	Gorge	1

Size

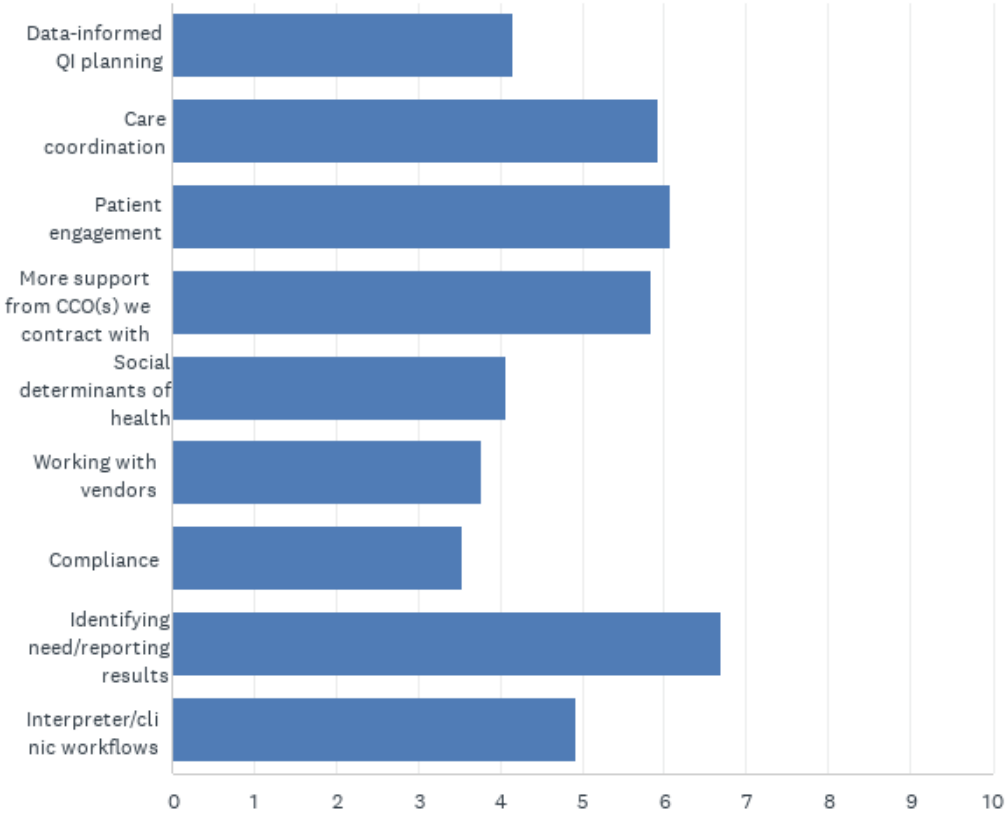
Networks	9	Individual clinics (or just a couple)	9

Poll results (13 responses)

Interviewees were asked to respond to a poll to rank potential technical assistance topics. Limitations include the following:

1. We only asked clinics to rank topics, not whether they wanted assistance.
2. The highest-rated topic is actually two topics related to data: Identifying who needs interpreters and reporting results.

How would you prioritize technical assistance to improve meaningful language access at your clinic or setting?



Emerging themes from interviews

Clinics understand the value of quality interpretation.

On the whole, providers and clinic staff make the connection between high-quality interpretation and better care. However, they express concerns about how low-quality interpretation services and poor technology can interfere with providing good care. One clinic summed up this tension, saying, “One of the [behavioral health] clinicians said, ‘I’ve had a horrible experience, and I actually don’t want to work with interpreter services again.’ We have others that are just fine working with them and it’s a blessing and a great opportunity.”

Interviewees believe that providing interpreters is a high value for patients, increasing understanding of their care with better follow-up.

- “Staff get to see the rewards of what it truly means for someone to understand their treatment and how to stay healthy long term.”

Only way to give effective services is to provide language they need.

- “If there’s someone there to help, it’s a way better experience for patients. They’re a lot more relaxed. They get their questions answered. It’s the care team working together with the patient, and that’s my goal. I’m a firm believer in informed consent.”
- “The highest quality care that we provide is for our Spanish-speaking patients who are with our Spanish-speaking providers, but there aren’t enough Spanish-speaking providers.”
- “It’s actually dangerous if they don't really understand what they need to do for their health and puts them at risk for increased hospitalizations, emergency room visits. So it’s pretty critical to make sure we have good communication and no barriers.”
- “When we have a good visit and the patient is understanding, the providers will notice there are more questions… and engagement from the patient.”
- “We allow family members to translate, but the best experience for all parties has been with a certified interpreter.”
- “Depending on the interpreter, some visits can run longer than expected. Having a certified interpreter often runs the smoothest and gives us the most confidence that real, effective communication is happening.”

Low-quality interpreter, mismatched dialect, or poor technology impedes care.

- Patients might not tell provider everything if a stranger (interpreter) is in the visit. Clinic tries to keep the same in-person interpreters with patients so they can feel more comfortable and develop a relationship (not possible with phone interpreters).
- Affects clients negatively if interpreter doesn’t show up, is late, or if they don’t connect (behavioral health).
- “If the provider feels like the patient doesn’t understand… and we’re not being efficient in explaining the treatment plan and it’s going to cause more harm, then we will stop the visit and reschedule them for a different date and then have resources ready.”
- “If it is a bad connection [on tablet], we don’t get as many questions. We want to make sure [patients] understand how to take the medication or be administering the medication to their kids, and sometimes with the tablet and not being able to hear clearly, it creates a little bit of hindrance. Sometimes we need to take siblings out of the room to make it quieter and improve experience.”

Clinics believe using bilingual staff and staff interpreters is the best strategy for providing interpretation services.

- Using bilingual staff and staff interpreters builds relationships and can move through appointments more quickly.
- Having in-house interpreter or in-language care is critical for clinic volume (availability and cost).
- Leaning into bilingual care teams and native speaker option for getting proficiency tested to reduce reliance on vendors.
- Any issue with interpretation vendor for one appointment throws of the schedule for the day.
- "We're really doing an employer-based effort to get as many of our folks proficiency tested as we can, as well as to actively assess who of our current rank and file employees would meet the definition of native speaker."

Clinics describe administrative burden of scheduling, billing and reporting.

Many interpretation vendors don't meet Oregon requirements for certification or reporting. Some clinics stick with those vendors because they meet the clinic's needs for scheduling and availability. Each CCO contracts with different interpretation vendors, which is administratively burdensome for clinics to navigate if they work with multiple CCOs (scheduling, invoicing, etc.). Clinics experience the requirements from the state or from CCOs as too burdensome.

Needing to provide a certified or qualified interpreter makes appointment scheduling more challenging.

Appointments using interpretation services add more variables to clinic workflows.

- Interpreter arrives late or is a no-show.
- Patient or provider running late, and interpreter needs to leave.
- Difficult getting interpreter for last-minute appointments.
- Sometimes interpreter won't stay for siblings scheduled back-to-back.

Sometimes it's difficult to identify whether patients need interpreters or, if so, for what language.

- Not knowing patient needs interpreter in advance (family member interpreter doesn't show up; patient doesn't initially think they need interpreter and

changes their mind; or English-speaking family member scheduled the appointment)
- Info from OHA usually is for parents, not the child. Need for interpreter depends on which caregiver needs one and which attends appointment.
- Once patient is 18 or of age of consent, still flagged by OHA as needing interpreter, but by that age most don't need interpreter.
- Patient's primary language was Mam dialect, secondary was Spanish (but didn't read or write Spanish well). Some Farsi and Dari are difficult to figure out dialects. Clinic doesn't know what to ask to help figure it out.

Clinics experience other scheduling challenges.

- Each CCO works with different interpreter service, and it is administratively burdensome to make sure clinic is scheduling with correct one for each patient.
- Can't get the same interpreter for weekly behavioral health appointments, so new person is hearing about traumatic experiences every week is (uncomfortable).
- Not all the scheduling happens in the office (part of larger dental system), and scheduler doesn't always order an interpreter.
- Provider faxes request for interpreter, and supposedly interpreter is scheduled, but there's no way to confirm if they're coming or have the right dialect.
- Some interpreters refuse to give any identifiers (name or identifier number) and hang up on schedulers. Vendors said it's interpreters outside of Oregon.

Clinics encounter difficulties with billing because of confusing processes and inconsistencies across payers.

DMAP[1]/Open Card: Interviewees had mixed experiences with and knowledge about billing DMAP for interpretation services.

- DMAP paying only ~$40 instead of $60.
- DMAP recently started paying for interpreter.
- Have tried to bill with DMAP, but not sure if it worked because so few patients.

CCOs generally pay or reimburse for interpretation, unless it's part of capitation. Interviewees have issues with CCOs only paying if interpreter is from a vendor the CCO is contracted with. Experience varies by CCO.

[1] DMAP refers to the Division of Medical Assistance Programs, a previous name for what is now roughly Oregon Health Authority's Medicaid Division. Many clinic offices use DMAP as an umbrella term for fee-for-service Medicaid business processes in Oregon.

- One CCO pays for two units instead of one.
- Don't bill CCO — part of our capitation.
- Some interpreter companies bill CCO, some bill clinic.
- We currently bill for in-house interpretation (done by an employee) with cpt: D9990, $60.
- Each CCO contracts with different interpreter companies, which is administratively burdensome for clinics.
    - "We have three CCOs, and they all contract with different companies, and that is not patient centered. Then we have to [figure out] what insurance do they have, which company can we use, and then we call and [the vendor] doesn't have a certified interpreter in that language. And then we're getting four different invoices for four different companies and four different ways. I literally had to create a position. The cost of interpretation is not just the cost of us covering uninsured, commercially insured and Medicaid insured who we can't find a certified interpreter for at a contracted company, it's also the cost of the administrative burden."
- Linguava often bills clinic directly instead of CCO, so they might be double-dipping and getting paid by both. No way to reconcile this.

Commercial insurance isn't paying for interpretation.
Other

- See an obligation for Oregon Educators Benefit Board and Public Employees Benefit Board (OEBB and PEBB) as well.
- "Don't know if we bill Idaho Medicaid."
- Rural clinic has encounter rate and finally split out interpreter payment.

Providers aren't happy about the documentation required outside of clinical care (Race Ethnicity Language and Disability (REALD), chaperone, interpreter, etc.).

Large administrative burden to document everything and report to CCOs in the right way.

- "There's so much detail that's required that absolutely means nothing to anyone, and it's frustrating to me to have to spend hours and hours providing detailed information when I don't know why you can't trust us that we're doing that correctly. For example, why didn't they want an interpreter? Well, that's a silly question. We document they declined an interpreter. That should be enough. I think a lot of the rules were set not understanding the type of volume [of patients needing interpretive services] we have here. I wouldn't have a problem with an audit."

"We [are] still now exploring other vendors to have some backup options, but for a confluence of reasons, whether it's cost per incident, cost by type of incident, willingness or ability to provide the data we need, or viability of adequate certified qualified, we've eliminated a lot of those additional potential vendors. The biggest showstopper is the inability and or unwillingness to provide the data we need."

- Clinic can't have each interpreter name and number in a reportable field (might have 50 interpreters). Clinic needs to open every chart to get interpreter name and number, which is unrealistic burden. Clinic collects it but can't pull it from a report. Clinic does have yes/no for telephone interpreter and if provider passed qualification tests so can report on those.
- "It's a huge process to document a specific interpreter with a specific interpreter number and whether they are qualified or certified. We need to rely on the vendor. Ideally, we would require the vendors to upload a file to OHA which then would be fed into our EHR. The focus on certified or qualified makes it really difficult because our number one goal is to make sure that interpreter services are available for the client and it's a huge administrative burden. We do at least put agency, whether interpreter was provided, and reasons for declination."

When patients don't need an interpreter, clinics have a hard time updating the information, which they receive from CCOs.

- Patients get upset that they need to fill out waiver every time. They don't understand they need to call the CCO to get off the list.
- Electronic health record (E.H.R.) workflows are cumbersome, so providers haven't fully adopted them.
- "We've added suffix codes that help us track what occurred in the visit. It's become an inextricable tool to enable us to even fulfill the reporting obligations and track by visit, by doctor, by interpreter case. We're still working to get all of our providers to use it."

Clinics struggle with added expenses because of longer visits, un-reimbursable expenses.

Clinics are often paying for interpretation services (not reimbursed by insurance).

- Clinic isn't charging CCO for interpretation if using staff who aren't in the database.
- Providers are paid on salary and VBP so don't bill for interpretation services.
- Clinic takes the financial hit if in-person interpreter is a no-show.
- If not a CCO patient, clinic pays the interpretation vendors.

- If it's not a covered benefit or we request it from a company not contracted with the CCO, clinic "scholarships" it and pays.
- Can't bill for interpretation by dental assistants who passed interpreter certification because their role is wrapped into capitation rate.
- If it's a third party (remote interpreter), clinic doesn't bill and uses a non-billable code: TX0145. Clinic hopes Cyracom will get their staff fully certified so will be qualified to bill. Still working through the process.
- It's the clinic investing the time of employees doing interpretation.
- Behavioral health clinicians are paid per service/time (not salaried), so if interpreter is consistently late, then shorter sessions and smaller paycheck.
- "We don't get paid for Open Card interpretation because its somehow in our reimbursement (even though it doesn't cover the cost). We're about to trial on-site staff interpreter, but it wouldn't be in capitation rate because it wasn't scoped."
- CCO refuses to pay for in-house certified/qualified interpreter because they aren't in the database (they don't want to be contacted outside clinic system).
- CCOs wouldn't pay for our qualified staff interpreters (Health Share, YCCO, CareOregon, OHSU).
- No reimbursement from commercial payers so clinic must pay.
- Moda said they would [reimburse], but clinic needs to follow up.

Reimbursement rate doesn't cover the true cost of interpretation.

- "For clinics like ours using interpreters all day every day, would be nice to have cost covered more."
- "We put a lot of time into making sure patients with language barriers have access to interpretation services to better their care outcome. Our staff and providers often need to put a lot more time and effort into setting up interpreters and making interpretation accessible."
- Dental Care Organizations (DCOs) aren't paying for interpretation.
- Two told clinic no; one said yes but only reimbursed $45 instead of $60.

One clinic reported paying for interpretation when they refer a patient to a specialist who refuses to provide interpretative services.
Reimbursement rate doesn't cover the full cost of interpretation.

- Clinics provide the service, but there's not always reimbursement for it.
- Clinics want to provide high quality health care, which requires patients to understand. Cost also includes staff time for documentation, contracts, navigation.
- No model of care to have longer appointments when an interpreter is involved, which would make it more financially sustainable.
- "Appointment times often run longer when interpretation is needed. The time adds up to cost, and the costs are putting pressure on our very small clinic.

We would like to provide quality services and more robust access, but we are stretched thin."

At least some CCOs are only paying for interpreters scheduled with their contracted interpretation vendors.
Reimbursement rate is too low to make interpreters want to stay and wait if provider or patient are late; minimums would be supportive.

Clinics have issues with certification, qualification and proficiency

Interviewees often use the terms *staff* and *providers* interchangeably. They also use *certified*, *qualified* and *proficient* interchangeably, making it difficult to discern whether they understand there are different requirements for staff and providers and that certified, qualified, and proficient mean different things. This shows up in several of the providers' questions and requests from our interviews (see Appendix).

Clinics have difficulty finding certified/qualified interpreters or helping staff and providers demonstrate they meet certification/qualification or proficiency requirements.

- "We've had a lot of providers say, well, do I have to? I've been speaking Spanish with my patients for 22 years here. Are we going to have to take them off the floor? They're not going to see two to three patients that day and then we're gonna pay for them to go through this. We have a grant, but other organizations could really struggle with that. The impact is larger than meaningful language access. READL is another really big example. Or cultural competency training… chaperone training. Every time we add those requirements on providers, we are taking time away from patients. We start getting into 6, 7, 8, 10, 12, 15 hours a year. And then we start looking around our state at the access issues that patients are having, and the workforce issues post pandemic. And we're like, wow, this is really having a huge impact when we multiply 12 hours a year times 100 providers. We're basically paying two full-time providers to just do trainings and competencies."
- One clinic described a provider's negative experience with the proficiency test, which they reported asked no medical questions, which dissuaded other providers from completing proficiency testing. The provider is a native Spanish speaker. They characterized it as a "humiliating experience and waste of my time."

Clinics find that some members do not want interpreters

Some patients decline an interpreter and prefer to use a family member.

- "Some families prefer that bilingual clinic staff interpret, even if they're not certified, rather than get a stranger from the database."
- "Our families don't like remote interpretation, and neither do our providers. If it's not an interpreter that works here in our clinic, our families don't really understand them and they don't like them because they don't speak, for lack of a better term, 'Woodburn Spanish' and our staff does. Even the folks that maybe needed a dialect because they're from Central America, they prefer to work with our in-house interpreters and they get what they need from that."

Patients declining interpreter

- Strategies: Follow up with community health worker to try to figure out why; try different vendor company, interpreter gender, etc. (persistence and revisiting conversations).
- When offered an interpreter, some patients decline and use family member (usually a child, although this is prohibited by law).
- A lot of patients who are declining are teens who speak English well. They are marked as needing an interpreter because their parents needed one when the child was younger. Clinics are unable to update the interpretation need in the child's record with the CCO or OHA.
- If a parent wants their child to interpret for them, clinic fills out the waiver and explains the interpreter is for them to understand the visit. But about 50% still want child to interpret. "I think it comes from not wanting a stranger in the visit."
- Challenging to have an interpreter come in just for patient to sign a form to decline interpretation services.
- Patients might not tell provider everything if a stranger (interpreter) is in the visit. Clinic tries to keep the same in-person interpreters with patients so they can feel more comfortable and develop a relationship. This is not possible with phone interpreters.

Additional lessons from interviews

Note: References to staff versus providers may not be meaningful. These terms are often used interchangeably. However, there are different standards for having staff provide interpretation services than for having clinicians provide in-language care. This points to an area for additional follow up.

Potential best practices (offered for verification, not OHA endorsement)

Based on what interviewees described working in their clinics, the following may be helpful for other clinics to explore implementing.

- Supporting bilingual staff to complete interpreter certification training (beyond proficiency test for native speakers)
- For systems large enough, creating a full-time language access specialist position (qualified interpreter who can also help find resources for other languages)
- Using color coding on schedule for who needs an interpreter.
- For pediatric visits, asking family if need an interpreter every visit – multiple people are involved in child's care, and some might need interpreter and some might not.
- Creating suffix codes in EHR for tracking interpreter use by visit, clinic and provider.
- Paying differential to staff who passed proficiency test.
- Using REALD questions in MyChart to help identify who needs an interpreter. [Note: While CCOs have REALD data from OHA, it is unclear whether they consistently share the data with individual clinics.]
- Include Spanish line in phone tree to connect directly with Spanish-speaking schedulers.
- Implementing closed counter validation in Epic; if "yes", provider must document if interpreter used.
- Assigning the same in-person interpreters to patients so they can feel more comfortable and develop a relationship with the interpreter.
- Using in-house interpreters; having multiple clinic staff get certified
    - "We are training our medical system and dental assistant teams to get that certification. There's a sort of a shared lived experience there that adds to the comfort level. We've been in the community for a long time and I think patients know they can come here and get care in the language that they are most comfortable in."
    - Advanced Health has in-person interpreter that goes to clinics, but often is booked.
    - Dental assistants passed interpreter certification test; works well because they sit with provider entire time.
    - CCOs sponsoring staff to get certification training (PacificSource, CareOregon).
    - Clinic leaders support staff to take proficiency exam or certification training.
- Providing in-language services by bilingual staff who have taken proficiency tests
- In-person interpretation is working well at some clinics.
- For some clinics, working with vendors for remote interpretation is going well.
    - Vendor is accountable and transparent (Passport to Languages)

    - AMN Healthcare vendor – no issues
    - Can get last-minute remote interpreter scheduled.
    - Interpretation services work well as long as they're planned in advance.
- Some clinics have made workflow/documentation improvements that have helped.
    - Use color coding on schedule for who needs an interpreter.
    - Created suffix codes in EHR for tracking interpreter use by visit, clinic and provider.
    - Use Spanish line in phone tree to connect with Spanish-speaking schedulers.
    - Implemented closed counter validation in Epic; if "yes", provider must document if interpreter used.
    - Using the Epic flag for who needs interpreter.
- Other
    - Dedicated operational group.
    - Owners invested in putting phones in each exam room.
    - For some clinics, interpretation is part of CCO capitation so don't have admin burden of billing.

Challenges

Challenges: Compliance

Specialists are telling patients they need to bring their own interpreter, especially for language of lesser diffusion.

- "It is not uncommon for us to have a specialist tell us 'We will only see them if you provide the interpreter.' Or [the specialist] will tell the patient they have to provide the interpreter, which is illegal. Sometimes I will give permission for one of my referral coordinators to go ahead and schedule an interpreter, because if they don't see this specialist, it will be really bad. We can't bill the CCO for an interpreter that was used by the specialist, so we just eat the cost."

Challenges: Availability

Clinics don't have access to enough certified/qualified interpreters.

- Not enough certified/qualified interpreters in Oregon, which makes it difficult to follow OHA guidelines.
- No sign language interpreter on registry in region so use video or non-qualified in-person interpreter.
- Not enough interpreters for Spanish population (nearly every appointment needs Spanish).
- Vendors don't all have Oregon certified/qualified interpreters.
- Current vendors struggle with number of requests. Finding vendors that work with CareOregon has been an issue.

In-person interpreters aren't available in region or on the timeline needed.

- Can't get in-person interpreters to travel to small towns.
- Can't get in-person interpreter last-minute; most pediatric visits are booked within 24 hours.
- If in-person interpreter and qualified staff aren't available, prefer to use non-qualified bilingual staff to interpret more than telephone interpreter.
- If can't get in-person interpreter, must reschedule (phone/video difficult with pediatric physical/speech/occupational therapies).

It's difficult finding interpreters for specific dialects or languages of lesser diffusion, even remote interpretation (examples: Karen, Akateco, Mixtec, Zapotec, Mam, Farsi and Dari dialects)

- CCO's interpretation vendor doesn't have the language needed, so the clinic must schedule with a different service.
- "A family… had a very, very hard dialect to get. We couldn't even get someone on the phone to interpret for us. We ended up using Google Translate. I think there are three grievances on me (there were three kids in the family) because I didn't get an interpreter. I don't know what more to do. Somehow they got on the plan, so I know there's an interpreter out there."
- Often only one or two interpreters for certain dialects. If OCIN doesn't have enough interpreters, must call interpreters in Mexico.
- Large population of indigenous languages, especially in reproductive clinic. Often requires two interpreters — indigenous to Spanish, and then Spanish to English. Difficult to get credit for and document because one might not be certified.
- For indigenous languages, need to have a matching meeting first to get right dialect. Minimum of two hours to translate. Least expensive is $450 and up to $1500 per 20-minute appointment. Can't provide MLA to people in these language groups. Get dinged in metric because they aren't certified/qualified.

Other availability challenges

- No candidates for bilingual staff position. Hiring in general is difficult; hiring bilingual is even more difficult.
- Interpretation service does not always have real-time availability for phone calls with new patients. Clinic often relies on calling back with an interpreter, but the patient doesn't pick up or call back.

Challenges: Remote interpretation

Providers prefer in-person interpreters. However, they hear patients sometimes prefer remote interpretation because it feels less invasive.

- Can't see body language.

- Example of in-person interpreter identifying case of child abuse because provider was focused on documenting.
- More difficult with ASL than spoken language.

Difficult to use in pediatrics – kids running around, hyperactive, noise, crying
Takes more time

- "There's a two to five minute delay in the connection time when it's a commonly used language. When it is a language other than Spanish, it can take as much as 20 to 30 minutes to get an interpreter on the line, which has a huge impact on patient care clinic schedule."

Technology issues (hard to hear; dropped connections)

- Don't have phones in exam rooms, so provider or MA needs to use their cell phone.
- A lot of troubleshooting with tablet to be able to hear interpreters. Different speakers, sustaining connection (calls were getting dropped between rooms).
- "Outfitting every clinic room to pick up those individual voices in a way that makes sense within a busy clinic space… no one ever made a commitment to make that be a thing. No one's available to get pulled into the room troubleshoot the mic problems."

Quality of care

- "Sometime the interpreters that we get on the phone are not really good. Sometimes the provider… can just tell that they're not really interpreting exactly what was said or we can't hear them adequately or understand them. I always assumed if they were working for a service they were at least qualified, and then I found out that that's not the case. If you know the phone interpreter just isn't working, and if one of our qualified interpreters isn't available, then the next thing is really to use a bilingual staff member, and sometimes we just have to do that because that is in the best interest of the family. That's better than the phone."
- "Even when you have someone on the phone versus in person, it is providing less ideal care. Because there is something more beneficial about having someone physically present to be able to pick up on social cues and body language and look at medication jars with you."

Challenges: Interpretation quality

- Interpreters who don't translate exactly what was said.
- Not all interpreters create a comfortable environment in a visit (for example, interpreter gender different than patient).
- Not all interpreters are good at relaying uncomfortable conversations, especially around reproductive health for some cultural groups.

Challenges: Other

Translating forms

- Expensive; not enough resources.
- Need to re-translate documents already translated in Spanish by OHA (needs to be simpler).
- "We rely on Google translate for our forms and other communications, which is not ideal."

Staffing

- Bilingual staff have other jobs so they aren't always available or need to change schedules.
- Hiring in general is difficult; hiring bilingual is even more difficult.
- Staff awareness of interpretation services; need to continue educating.

Meeting needs of specific populations

- For less common languages, communities are small and they know each other. Sometimes families or caregivers are uncomfortable because they know the interpreters and don't want them knowing all their health information.
- "One woman comes from a really patriarchal sort of system in her home country, and having a male interpreter is somewhat problematic because of that."
- Patients who are deaf but didn't learn sign language or learn to read or write.
- Patients might not be literate in their primary language, so even if after-visit summary is translated, it might not be understandable.

Interpretation makes visits longer, but clinics are still using standard appointment times. Rushing can impact quality of appointment.

Recommended resources from interviewees

- Book: Healthcare Interpreting in Small Bites by Cindy Roat (https://cindyroat.com/healthcare-interpreting-in-small-bites)
- Take advantage of certification training through PacificSource if clinic works with them.
  - One clinic also described a very negative experience with this training.
- Encourage other CCOs to offer interpreter training like PacificSource does; otherwise certification cost is prohibitive.
- Maximize in-language services (bilingual staff).
- Hire more bicultural staff. Huge game changer. Shared lived experience adds to the comfort level. Hiring standalone interpreters doesn't work as well.

- Discovering mixteco.org was helpful, but expensive option and no certification for Mixteco.
- Medical Center Eye Clinic is open to sharing their workflows.

Improvements clinics have made

Increased number of staff who complete proficiency test or certification training.

- Used grant funds to evaluated approved proficiency test, but learned the clinic's own test was better and got it approved (Alta). Others weren't medically focused. Contracted with Alta to do language screening for bilingual providers. Got TA funds from one of the counties and using that to get bilingual providers through training.
- Working on job description for dedicated in-house interpreter. Still run into how to bill for that.
- 90% of clinical team completed proficiency test through Lopez Translation, and clinic has been working with OHA to get Lopez added as qualified for proficiency testing.
- Encouraging staff who have completed their proficiency test to go on and complete the course to become qualified health care interpreters. "That really solidifies that we have those qualified people within the clinic. I just always have those that have taken the course realize there's a lot more to the interpreting than a simple test. And I like that they come back and they share it with their coworkers and use it as a teaching tool."
- Clinic used to have a dedicated interpreter at each site, but it didn't work very well — either over or under demand. The shifted to 12 medical and dental assistants certified with OHA try to ensure the float MA is a certified interpreter.
- 100% of clinic's direct service positions are bilingual preferred (some are bilingual required), with pay differential. Two differentials — one for certified/qualified; one for bilingual staff who aren't interpreters.

Troubleshooting with interpretation vendors

- Clinic that works with several language companies piloted to see if better success with one or the other. Trialed giving more notice to better understand barriers to getting in-person interpreter.
- Clinic tracks client, agency, reason why interpreter not secured, then reaches out to interpretation vendors to see if anything can be done to make it better for clients.

Improved identification and tracking of who needs an interpreter

- Clinic focuses on training teams to ask if patient prefers to have interpreter. Some patients who speak some English might be comfortable scheduling or

have blood draw in English, but not full provider visit without interpreter. It can be challenging for staff to understand what the preference is, or maybe patient is uncomfortable saying they need one.
- Clinic has gotten better identifying who needs interpreter with READLD questions. Clinic gets better response through MyChart than when asking verbally. “I don’t think we’re always getting the correct answer, unfortunately, because usually we’re asking in English.”

Electronic health record improvements

- Clinic set up a tracking code system. “Trying to marry interpreter vendor invoice data to offices to providers, to patients trying to capture it even out of an EHR… absent the codes, it’s a nightmare from a data management prospect. Even with the tools we've got, it's still a sizable lift to collate all these disparate data sources together into one synthesized OHA reporting template. So that was one means by which we were able to get unique identifiers that help stitch together something in an in a more empirical manner.”
- Clinic worked with OCHIN on how to document in EHR to pull out interpretation information, but the providers aren’t happy with all the documentation needed (READLD, chaperone, HRSA, CMS etc. — everything outside clinical care). “Every click is an extra few seconds or minutes of our time. You know, at some point, the amount of data that we’re being asked to collect to inform, ironically, equity, it is actually creating a burden for the same patient.”

Technology improvements

- Troubleshooting with tablet (Linguava) to be able to hear interpreters (different speakers, sustaining connection).
- Before iPad, clinic used phone system but didn’t have the equipment to run phone lines to every room. The video works well.
- Clinic invested in speaker phones for all exam rooms so don’t need to pass a phone back and forth.
- Clinic system is creating video interpretation rooms in administration building to see if they can do video interpretation internally (for same-day and interpreter no-shows). This would help alleviate issues when interpreter needs to leave before the post-appointment steps (patient needs to go to internal pharmacy and schedule follow-up) requiring clinic to get a second interpreter.

Other improvements

- Created an interpretation services program manager position, which saved money by better tracking interpretation payments. They’re also an advocate who knows the laws.

    - Our first step has been to make sure all documents are available in multiple languages. We used to only have Spanish but have expanded to Russian and Vietnamese. For Spanish speakers we have been pushing the use of our Patient Portal because it has some automatic translation features.
    - We would like to make more improvements, but our clinic is small and our resources are extremely limited.

Relationship with CCO

While the interviewers did not ask about the clinics' relationships with CCOs, some of them offered insights into how they interact with CCOs about providing language access.

- Advanced Health has in-person interpreter that goes to clinics; CCO arranges it but often interpreter is booked.
- PacificSource created their own interpreter certification program and pays for clinic staff to get training. Clinics found it very easy to participate. One provider had very negative feedback about the experience being humiliating and the content not being relevant to daily communication with patients.
- CareOregon did a presentation to clinics about how to use interpretation services that was helpful.
- Finding vendors that work with CareOregon has been an issue. Current contracted vendors struggle with capacity to meet needs.

Feedback on specific language service vendors

The following comments represent provider experience with vendors. OHA has not fact checked the comments.

- Proprio – On demand, instant access, affordable, reliable; some but not all interpreters are Oregon certified; "refused to meet Oregon compliance needs."
- Passport to Languages – Two minutes or less to get someone on the phone; promises all interpreters are Oregon certified; Oregon-based company; proactive in tracking the rules and transparent on process. Good customer service to resolve issues. Still issues with languages of lesser diffusion. No longer contracted with CareOregon. Bills CCO directly.
- AMN Healthcare – Immediate access; don't need to schedule in advance for remote; great success with in-person and telephone; no issues with availability; all their interpreters are certified and meet everything required; don't think they're local.
- Linguava – Pretty good about providing someone (video) right away. Haven't found good Somalian interpreter.

- Cyracom – Great experience; better connection, sound quality, language availability and interpreter quality than Linguava. For anything outside of Spanish, it takes longer to get someone on the call. One clinic didn't think they met certified/qualified requirements, but one clinic said they were willing to go through Oregon's certification process.
- Language Line Solutions – Told clinic Oregon certification process wasn't on their radar. [Note: The chair of the Health Care Interpreter Council is from Language Line Solutions and is well aware of the Oregon certification process.]
- Other vendors mentioned: Immigrant and Refugee Community Organization, Oregon Certified Interpreter Network, Global Interpreters, Stratus, Stars

Other

- "I think the real challenge is it's a very novel approach that Oregon's taking. We're still in the infancy of this work, which may sound wrong, but I think you know the sea change that this portended. I don't think anybody had really viewed the interpreter function as part of the system to the degree it is now in Oregon, and then figuring out how to scale all this because it's not just Medicaid, it's any patient where public dollars are paid. So we see a fair amount of obligation in OEBB and PEBB as well."

Appendix: Questions and requests received during meaningful language access provider interviews

Certification and proficiency tests	Does a dentist whose primary language is Spanish still need to be certified?
	Is there a deadline for needing to have passed an OHA proficiency test?
	Are there resources within Oregon that offer the qualified interpreter classes or the proficiency courses? We use Lopez Translation in Idaho, but are there any within Oregon we could contract with that are already on OHA's list?
Billing	Do interpretation vendors need to verify insurance of the patients on their end (prior to billing, if they were not given at the time of booking)?
	Can we bill for in-house video interpretation? We're creating video interpretation rooms in administration building to see if we can do video interpretation internally (for same-day and interpreter no-shows).
	Can/how do we bill for interpretation if a patient has Open card or DMAP?
	How/where do we bill for interpretation in Basic Health Plan?
	Is commercial insurance required to cover interpretation? Is it in fee schedule or individual contracts?
Compliance	Can we use an interpreter from anywhere in the country?
	What is the expectation that we make sure our contracted partners are compliant for interpretation? What do you do if the company your CCO is contracted with is sending a non-certified/qualified interpreter? Is trying to meet the intent of the law to the best of our ability sufficient? Examples: 1. Nurse triage line (not our providers) – All the nurses are licensed in Oregon, but they use a telephone interpretation company the clinic doesn't have a relationship with. 2. Telehealth based in another state.

Other	Is there a place to get forms translated that is not super expensive?
Changes to OHA policy, guidance, and resources	Resource/support for translating documents
	Require all insurers to pay for interpretation.
	Reconsider what needs to be documented/reported, specifically: 1. Interpreter name and number – Unrealistic burden on clinic; we collect it but can't pull it from a report (too many interpreters to include in a dropdown). 2. Whether interpretation is in-person/phone/video – Is this used and important?
	I google interpreter rules in Oregon ten times a week because I have so many questions and can't find answers. Even finding basic stuff can be difficult to find.
	Reconsider compensation for language services, especially for in-language providers and certified indigenous interpreters.
	EHR support or coding changes 1. When requirements change, do work up front with OCHIN before getting rolled out to reduce some of the churn. All health centers in Oregon are using OCHIN. 2. Add a bundled sibling code for interpretation (families bring multiple children and go back-to-back). 3. Add a language code to ensure the correct dialect.
	Guidance: 1. Letter from the state to specialists (and that clinics can point specialists to) – Reminder that if they receive any state funding for the services, they are required to provide the interpreter. 2. Billing for in-house interpretation 3. An interactive FAQ page (What is a CCO rule, what is a state rule, what is a fed rule, do they crosswalk, how do we know if we are complying?)

	Metric or policy changes: 1. Option for staff to renew qualification with continuing education instead of becoming certified. 2. Don't penalize clinics on incentives when there aren't enough certified/qualified interpreters to meet the requirement. 3. Reconsider excluding the folks from the denominator because we provided services from the provider who is not certified/qualified. Not being certified/qualified shouldn't prevent provider from giving in-language care.
	Require interpretation vendors to use MMIS to see who has what insurance to decrease risk of two payers for same thing or cost burden falling on clinics. Currently no way for clinic to reconcile and no oversight.
	Have state verify that 4–6 interpretation vendors meet minimum requirements and require CCOs to pay for them so clinics can use any of them and get reimbursed. Currently all CCOs contract with different companies.
	Could we double-check what we heard about which vendors meet Oregon requirements? Does the HCI program keep a list?

Acronym/abbreviation	Definition
CCO	Coordinated care organization
CMS	Centers for Medicare & Medicaid Services
DCO	Dental care organization
DMAP	Division of Medical Assistance Programs (precursor to current Medicaid Division)
EHR	Electronic Medical Record
FAQ	Frequently Asked Questions
HCI	Health Care Interpreter Program

HRSN	Health Related Social Needs
MA	Medical Assistant
MLA	Meaningful Language Access
OEBB	Oregon Educators Benefits Board
OCHIN	Oregon Community Health Information Network
REALD	Race, Ethnicity, Language and Disability Data
TA	Technical Assistance

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Transformation Center at Transformation.Center@odhsoha.oregon.gov or 503-793-1920. We accept all relay calls.

Health Policy and Analytics
Transformation Center
421 SW Oak Street, Suite 775
Portland, OR 97205
503-793-1920
https://www.oregon.gov/oha/hpa/dsi-tc/Pages/index.aspx