CareOregon

Health equity measure: meaningful access to health care services for persons with limited English proficiency

OHA technical specifications[1]

2022 state benchmark

Component 1: CCO-level language access self-assessment: minimum points required = 77

Component 2: Must report with 80% interpreter service data collection rate; 2023 is hybrid quantitative report on sample of eligible population.

Who: All members – regardless of age – who self-identify with the OHA as having interpretation needs (documented within MMIS file at the time of OHP application), spoken or signed language, and had a health care visit in the measurement year.

Members in this population are identified with interpreter needs as of December 31 of the previous calendar year. There are no continuous enrollment criteria for this measure.

Why: Increasing access to spoken and sign language services are critical tools for advancing equity and meaningful access to health care services.

What: There are two components to this measure. A CCO language access self-assessment survey and a quantitative language access report.

Component 1: CCO language access self-assessment survey – The CCO must (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum total points required for each measurement year. This self-assessment is to be completed at the CCO-level.

Component 2: Quantitative language access report – This component reports the percentage of member visits with interpretation need in which interpreter services were provided.

- **Denominator:** Number of physical, mental, or dental health visits for members in the eligible population.
- **Numerator:** Number of those visits in which interpretation service was provided by an OHA-certified/qualified interpreter.

How: To help members have meaningful language access:

- Ask member's their preferred spoken language and record this in their permanent record.
- Have a clear process and train staff to offer certified interpretation services to members. Interpretation is an essential service that requires advance planning. Have a process for scheduling interpreters as soon as members make their appointment.
- Have a process for documenting the provision of interpreter services in the EHR as structured data (not as a note). Documentation should include what language, the modality (In-person, telephone, video), who provided the interpretation, whether they are certified or qualified, or if the member declines interpretation services.

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- Interpreters can be clinic staff who are certified, or through a contracted interpretation vendor. The measure will be incentivized based on an increasing proportion of interpretation services provided by OHA-certified/qualified providers.
- CareOregon contracts with four language service agencies. To arrange for an interpreter to be present during an appointment, follow instructions explained on the CareOregon website at CareOregon - Language services for providers.
- Only visits during a member's enrollment span with a CCO are required to be reported.

Exclusions

- Only members who refuse interpreter services for the reasons of:
  - in-language visit is provided (for example by provider) **or**
  - member confirms interpreter needs flag in MMIS is inaccurate. This data must be documented.
- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.

  Exceptions: Members who decline to be screened (Patient Declined 1: 2.16.840.1.113883.3.526.3.1582) or members with medical reasons preventing screening (Medical Reason 1: 2.16.840.1.113883.3.526.3.1007) are considered exceptions and may be removed from the screening denominator (rate 1).

Data reporting

- Component 1:
  - The CCO is responsible for completing the language access self-assessment survey, but relies on the clinic network to help support specific domains of the component.
- Component 2:
  - Eligible population is identified by having an interpretation need documented in MMIS. A member will not enter the measure if they have not informed the OHA that they have an interpretation need.
  - Denominator: Visits are identified by claims submitted to the CCO.
  - Numerator: Any information the CCO has available on interpretation service provision can be used for reporting: invoice from interpretation vendor, chart documentation, EHR data report, claims, etc.

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Frequently asked questions

Q: What are clinics responsible for?

A: Clinics are responsible for documenting languages needs, refusal and services in a member's EHR. CareOregon will work with clinics on collecting sources of interpretation data for reporting.

Q: Do clinics need to proactively work on this measure?

A: Yes, clinics should work to identify members with language needs and schedule interpretation services for their appointments.

Q: What if a member declines interpretation service or insists on using a family member?

A: Explain the process and benefits of using qualified/certified interpretation services. If a member still declines, then document that services were offered, declined, and the reason for refusal in the EHR. Only members who refuse interpreter services for the reasons of 1) in-language visit is provided (for example by provider) or 2) member confirms interpreter needs flag in MMIS is inaccurate are acceptable for exclusion from the denominator of the metric.

Q: What if a provider or staff member is bilingual?

A: Bilingual staff services do not automatically qualify for the numerator unless the staff is OHA qualified or certified for interpreter services and they are only performing interpreter services. It's important to accurately document the level of interpreter services provided and the metric is incentivized based on an increasing proportion of interpretation services provided by OHA-certified/qualified providers. For this measure, interpreted visits is defined by an interpreter present (in-person/telephonic/video) whose sole purpose is to interpret. If a person is both interpreting and providing medical services that is NOT an interpreted visit.

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Table 1: Does a visit with bilingual staff count for this measure?

	Staff* is Qualified/ Certified?	Interpreter is Qualified/ Certified?	Interpreter is bilingual staff	Member refuses interpreter	Member refusal reason	Metric reporting result
Bilingual staff providing medical services & interpretation	Yes	No	No	Yes	(1) In-Language Visit Provided	Exclude
	No	No	No	Yes	(1) In-Language Visit Provided	Exclude
Bilingual staff interpreting only	Yes	Yes	Yes	No	N/A	Include in numerator
	No	No	Yes	No	N/A	Not a numerator hit

**This field is not collected for this metric, but shown above to highlight if the staff are OHA qualified or certified*

***In language services are not considered interpreted visits.*

Performance Measure Set:
☒ CCO Incentive Metric ☐ Medicare Star Measure
Quality Measurement Type:
☐ Structure ☒ Process ☐ Outcome ☐ Patient Experience
Data Type:
☐ Claims ☐ Chart Documentation ☐ eCQM ☒ Survey ☒ Other: OHA-developed
2022 State Benchmark:

- Component 1 – CCO-level language access self-assessment: minimum points required = 77
- Component 2 – Must report with 80% interpreter service data collection rate; 2023 is hybrid quantitative report on sample of eligible population.

[1]*https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023%20specs%20(Health%20Equity%20Meaningful%20Access)%202022.12.30.pdf*