The Lewin Group
Identifying and Meeting the Language Preferences of Health Plan Members
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Alana Nur: Thank you. My name is Alana Nur. I'm with the Lewin Group. Welcome to the webinar, ***Identifying and Meeting the Language Preferences of Health Plan Members***. Today's session will include a 60-minute, presenter-led discussion followed up with 30 minutes for a discussion among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at resourcesforintegratedcare.com.

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At this time, I'd like to introduce our speakers for today's webinar.

Darci Graves serves as special assistant to the Director of the Office of Minority Health at the Centers for Medicare & Medicaid Services. In this role, she assists in the coordination and implementation of priority office-wide programs, policies and products. In addition, she provides subject-matter expertise in areas such as culturally and linguistically appropriate services, cancer, health disparities and health equity. Ms. Graves holds graduate degrees in communications, religion and society, sociology and public policy, and has nearly 20 years of professional and academic experience in the fields of cultural and linguistic competence and health education. Her commitment to sharing her insights from her experiences and a profound sense of community guides her work to enhance the quality of people's lives.

Albert Cardenas has served as the director of the Customer Service Call Center, cultural and linguistics, and enrollment and reconciliation departments at CalOptima since 2015. He

previously served as the manager for the Customer Service Call Center. Mr. Cardenas has over 20 years of experience in health care and has extensive experience interacting with health plan members. Due to his experience in the Customer Service Call Center, he knows the on-the-ground experience that members have with health plan staff. He has built on these experiences through his work as the director and aims to bring a strong commitment to cultural and linguistic competency into his department.

Marta Pereyra has been the executive director of CLESE, the Coalition of Limited English Speaking Elderly, for the past 10 years, with four years of previous experience on their board of directors. Marta has 25 years of experience in mental health and non-profit management. Prior to joining CLESE, she held the position of director of clinical services at the Polish American Association, where she implemented a variety of programs addressing the needs of minority older adults and conducted cultural competency training. Marta shares her experience and knowledge on issues of aging and policy through speaking at conferences and developing cultural competency training. As executive director of CLESE, she manages the network of HCBS minority providers, and she was instrumental in creating CLESE's care coordination language access assistance services for health plans in Illinois.

After the presentations from each of the speakers today, you will be able to recognize the need for identifying and meeting language needs of members with limited English proficiency; identify a variety of methods for collecting member language preferences, such as using data provided by the state or health plan-generated data; recognize approaches to meeting language needs, including translation and interpretation services; and identify strategies for hiring and training health plan staff to provide linguistically and culturally competent services.

Today's webinar will begin with a poll, and then we'll move into a presentation from Darci Graves on effective communication with individuals with limited English proficiency. After Darci, Albert Cardenas will share strategies from CalOptima on identifying member language preferences. Marta Pereyra will share her experience partnering with plans to meet member language preferences. And lastly, we'll have plenty of time for a question-and-answer period with our speakers.

We will now move into the presentation part of the webinar. I will pass the presentation off to Darci Graves to get us started.

Darci Graves: Thank you so much, Alana. Good morning and good afternoon, everyone. It's great to be here today to talk to you about effective communication and the importance of effective communication in working with not only individuals with limited English proficiency but all of our patients and beneficiaries.

In that vein, on the next slide you will see one of my favorite quotes when it comes to talking about communication. It's a quote attributed to George Bernard Shaw, and it's, "The single biggest problem in communication is the illusion that is has taken place." I think this is a quote that we can all relate to because we've probably all seen conversations happening between either our parents or our children or our neighbors where people think they are communicating, but in reality, it is just an illusion.

This illusion is deeply problematic when we look at it within the health care setting, and one of the things that we know is that poor communication can end up being one of the primary reasons for litigation, for poor health outcomes and many other things which I'll highlight during my brief overview today.

If we go on to the next slide, I want to talk a little bit about health care quality. These six domains of health care quality were identified by the Institute of Medicine back in 2001. We talk about quality in terms of safety, effectiveness, patient-centeredness, timeliness, efficiency and equality, and I think it is safe to argue that if you don't have effective communication, if you're not truly communicating with someone, with your patient or with your provider, then it's easy to say that your care is not safe. It is not necessarily going to be effective. It certainly isn't patient-centered or efficient or equitable if you're not successfully understanding your diagnosis or giving permission to do whatever, to do treatment, to do surgery and any of those things.

Communication, when we look at it in the health care setting, it's exponential. I think we lose track sometimes of how much communication takes place during the health care encounter, both behind the scenes and just in all of the moving parts.

If we go on to the next slide and into this video, it shows the number of communications between providers and patients. Hopefully the video will start playing in just a moment. Here we go.

This is an illustration of the complexity of patient care that came from a Dr. Matthew Press, who described the interactions he had on behalf of a single patient who he had referred for a tumor resection. This diagram shows all of the different kinds of communication that took place over the course of 80 days. There were over 40 communications, five procedures and 11 office visits. You can imagine that during the course of all of these things, the patient was receiving written communications, they were receiving phone calls, rescheduling, they were receiving emails about where to go and what to do. And then there were also the office visits themselves.

That just shows the plethora of communication. And then that's just in the clinical setting. When we go to the next slide, we think about more aspects of the patient's experience. While many of these points may be outside of your purview or your organization's purview, they all still culminate in the patient experience. You can look at the three green boxes as being the boxes that were addressed in the video we just saw, the meeting with the nurse, the physician's assistant, meeting with your clinician, going through therapy or surgery or treatment.

But then you see all of these other parts of the patient experience in blue, and you see that there's a lot of other points of contact where communication and being able to understand what's going on is important to the patient. Making sure they have insurance coverage. Finding a doctor that is included in that coverage. Getting an appointment to see the doctor. Arriving at the office or hospital or clinic, wherever that is, so did they have to take public transportation and understand that, or where they able to get the GPS on their phone to navigate to where you're located?

And then, is it easy to determine where to park? I know I'm a native English speaker, and there are some times where I arrive at a new health care facility and I struggle with where am I

allowed to park, how much is it going to cost, what are the chances I'm going to get a ticket? And trying to figure out all of those things.

And then finding the front door. Finding your doctor. Checking in. Filling out any additional paperwork that you might have. Then seeing your clinician. Checking out, next steps. Going to the pharmacy. I saw we had a couple of pharmacy folks on this webinar, and I'm always excited to see that point in the health care continuum included in these webinars.

Thinking about the tests, the bloodwork, radiology, any of those prescriptions and orders that the clinicians might have written. And then getting home.

All of those pieces all kind of contribute to the patient experience and all involve a great deal of communication on behalf of the patient, the family and those that are serving them.

So, now we've talked a little bit about all the different places that communication takes place. Why is it important? When we look at the next slide, we see that patients who report effective communication are more likely to be satisfied with their care. They're more likely to share pertinent information for accurate diagnosis of their problems. If you're not feeling like you're being listened to or if the communication doesn't feel effective, you're less likely to share information that may be relevant to your diagnosis and to coming up with your treatment plan.

They're more likely to follow advice, and they're more likely to adhere to the treatment that was prescribed to them.

On the flip side, we look at the next slide and we see what ineffective communication is attributed to, and now we're going to the next slide on ineffective communication, Slide 18. We see ineffective communication results in patient-provider miscommunication, which may result in delayed diagnoses, misunderstanding of care plans, medication errors, lack of follow-through by the patient and a misuse of health services.

There's also that lack of trust and confidence in the provider that we just alluded to before, and that may result in low patient satisfaction and lack of patient willingness to ask questions or to even answer questions, follow the prescribed treatment plans or share information vital to making sure that the plans that are being made, that are being negotiated, are accurate.

All of that is just strictly communication, and then we add that layer on about communicating with individuals with limited English proficiency, and we see that on Slide 19, over 1.8 million individuals who are dually eligible for Medicare and Medicaid speak a language other than English at home or do not speak English fluently.

LEP individuals are defined based on a census question: How well do you speak English? It's Very Well, Well, Not Well or Not At All. If you answer anything less than Very Well, you're considered limited English proficient.

As we've noted, individuals with limited English proficiency face a greater risk for poor communication during health care encounters, and it's associated with lower quality of care.

Identifying and meeting the needs of individuals' language preferences is vital for effective communication and high-quality patient experience.

When we're talking about language preferences, and I'm sure my colleagues are going to hit on this as well, there can be language preferences for both spoken and written, so that's another nuance that we should be cognizant of.

In addition to what I'm sure are going to be great presentations from my colleagues, I just wanted to share two quick resources that we have at the CMS Office of Minority Health, the first being—this is some of many, but when we talk about identifying language preferences, data collection standards are out there, and so what we've done is created this Compendium of Resources for the Standardized Collection of Demographic and Language Data. It highlights best practices and guidelines for health care organizations in implementing standardized data collection. It includes links to training tools, webinars probably such as this one, and sentinel articles and books that provide in-depth discussion of issues and challenges, recommendations and best practices in standardized data collection.

And then another resource which I helped to lead is the development of a Guide to Developing a Language Access Plan. Now, language access plans are not required, but they're just a good idea to have because undoubtedly your plan or your clinic or your organization is going to encounter individuals with limited English proficiency, and having a plan in place allows you to be proactive rather than reactive in providing the best possible care to these individuals.

So rather than saying thou shalt have a language access plan, we came up with what we hope is a really user-friendly guide to developing a language access plan, and it walks organizations through some of the basic sections or common sections of a language access plan. The needs assessment. Language services, so oral interpretation versus written translation. Providing notices about availability of these services. Training. It's so important that everybody in your organization knows that you provide language services and how to access them and how to use them effectively. And then always making sure that you're evaluating the services that you're providing, not only to make sure that they are high quality but that they are meeting your patient and beneficiary stakeholder needs. Making sure that the language is both linguistically but as well as culturally appropriate.

That's just a real quick overview of things. We will get down to the website where the two resources I just mentioned and many, many more are located on go.cms.gov/omh. Please feel free to check that out. There's a wealth of resources there.

With that, I will end my part of the presentation and turn it over to Albert to talk about CalOptima. Thank you.

Albert Cardenas: Thank you, Darci, and thank you, everyone, for joining today's webinar. We hope that the information provided today will be beneficial for your organization. Today I will be covering CalOptima's process for identifying member language preferences. Next slide, please.

Just a brief bio on CalOptima. We are a county-organized health plan. We are one of six county-organized health plans in the state of California. We were established in 1993. We are the largest health insurer and the only Medicaid/Medicare plan in Orange County. Our membership is over 750,000 members, which is comprised of dually eligible beneficiaries, children, adults, seniors and people with disabilities. We also offer a Dual Eligible Special Needs Plan, or D-SNP. Our membership is very diverse. Our members speak over 50 languages. Next slide, please.

In Orange County, we have six threshold languages. We have Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic. When a threshold language is reached, what it means is that we are required to provide written material in that language. The state sets the guidance on when a threshold language needs to be implemented. The threshold languages are required when a non-English language reaches 3,000 members or those that meet the concentration standards of 1,000 members in one ZIP Code or 1,500 members in two continuous ZIP Codes.

The reason why we focus on identifying and meeting language preferences is to ensure that our members receive member materials and notifications in their threshold languages and are greeted in their native language when they request assistance. It also allows us to monitor and determine how close we are to reaching a new threshold language, so we can prepare and plan for implementation. Next slide, please.

We use several methods to identify members' primary language and language preference. One is through the state eligibility data file that we receive; through the enrollment process when a member enrolls into our MMP or Medicare/Medicaid plan or D-SNP plan; during the Health Risk Assessment or the HRA process; and during daily customer service interactions. Next slide.

CalOptima is the only Medicaid provider in Orange County, so all beneficiaries who reside in Orange County are automatically enrolled upon qualifying for Medicaid. We initially learn of the members' language preference through the state Medicaid eligibility file. The file contains enrollment information, eligibility information, which includes the language preference data. Now at times, the data in the eligibility file is incomplete or inaccurate, so we do use other methods to identify language preference directly from our members. Next slide, please.

As I mentioned before, we offer a Medicare/Medicaid plan and a D-SNP plan, so members that are already enrolled in our Medicaid plan and meet the eligibility criteria for these plans can elect to enroll. During the enrollment process, the sales agent confirms the member's spoken and written language preference. The agent records that information in the enrollment application. That application when it's sent to the enrollment department, the language information is recorded in our eligibility system. Next slide, please.

Upon enrolling in CalOptima's MMP or D-SNP plan, all members are assigned a personal care coordinator or a PCC. A PCC is a member's main appointed person who helps with all aspects of their health care needs. In customer service, we work closely with them to coordinate our efforts to help the members. This includes assisting the members with completing the HRA.

When possible for threshold languages, the member is matched to a PCC who speaks their language. The HRAs are mailed to all new members when they enroll and annually in the

language preference on record for our threshold languages. The PCC conducts outreach to members at least three attempts to assist the member with completing the HRA, using an interpreter when necessary. Any members that do not speak a threshold language receive an HRA in English, which the PCC along with an interpreter can assist in completing over the phone.

The PCC will confirm and update the member's language preference during this process so it can be updated in our system. Next slide, please.

Our Customer Service Call Center staff frequently interacts with members through routine incoming calls or during outreach calls. Because we are a local plan, we receive office visits from our members daily. Some members, especially our LEP members, they prefer to come in in person to request assistance rather than calling over the phone.

When a member calls our call center, the calls are routed to a bilingual customer service rep based on the threshold language prompt the member selects, and we have prompts for every threshold language that we offer. And of course for non-threshold languages, we use the Language Line to assist.

During their interaction, the customer service rep follows our established process for checking the language on record in our eligibility system and the language that is being spoken during the call. If the language on record and the language being spoken during the call match our eligibility system, then no action is taken because we know that the information is accurate. If the language on record and the language being spoken during the call do not match our eligibility system, the customer service rep asks for the preferred language and whether they would like for us to update our system. If there is a language preference change or update request, that information is sent to our enrollment department to process and update our system.

Now, there are instances where a member wants the written material sent in English, even though they speak a threshold language, because their family members manage the health care, so we also take that into account and are able to enter the preferred spoken and written language in our system. But for the most part, the members that fall into our threshold languages want written information in the language they speak. And sometimes they ask for both. They ask us to keep the English language indicator in our system so all the information goes out in English, but they do call and request information in their threshold language, and that's upon request. Next slide, please.

As the language preferences are updated in our system, the information is also shared with the providers. We share them in two ways. Our capitated providers, captitated contract providers, receive daily and monthly eligibility files which contain this information. Non-capitated or non-contract providers can access the information through CalOptima's provider portal.

Any update received by the Customer Service Call Center and other means will be added to the data file and the provider portal once our core eligibility system has been updated. So any further written correspondence and member materials will be sent in the threshold language. Next slide, please.

We hire multilingual staff to support our six threshold languages. Bilingual and multilingual staff are hired in several departments: customer service, cultural and linguistics, grievance and appeals, community relations, case management, and behavioral health. And we believe that by hiring bilingual/multilingual staff rather than just hiring telephonic interpreters helps members feel more connected to our plan. Members tend to call more often when they have issues because they know they will be connected to a familiar voice, someone they know, rather than having a different interpreter every time they call. Next slide, please.

Our customer service staff goes through five weeks of training during onboarding. Additional training is provided as needed during monthly staff meetings and in one-on-one situations. The trainer addresses cultural competency in a step-by-step process, which I went over on Slide 28, in identifying language preference.

Now, part of the training is to include recordings of calls that were handled by existing staff so the new staff that's coming onboard can get an idea of what to expect when they begin taking calls. The customer service trainers stress the importance of capturing the member's language preference as part of our overall customer service high-value, person-centered care that we provide. The trainer also reports to the supervisor and managers twice a week or more often on the status of each trainee and brings up any concerns that were observed because we found that we can get a good indication of how a representative coming on board is going to perform based on the training, how they're handled in the training, how they're absorbing the information, so we get a good sense of what kind of rep that's going to be on the floor.

Customer service supervisors also conduct daily call audits throughout the month to ensure the call was handled based on our established processes. The audit form contains a section that scores the customer service rep on how well and accurately they identified the language preference of the member during the call. So even our call documentation templates have a Q&A, questions and answers, to remind the staff as they're going through the call what are the standard questions to ask, like the PHI and did the member request an interpreter, did the member's language match our system, yes and no, and if no, the actions they took. So every time the rep takes a call and opens up a documentation template, that information is always there so they won't forget to ask or to go through that process with the members. Next slide, please.

Language preference data is used to determine how CalOptima's staff serves members through written materials and interpretation. For written materials, the information is used to identify members that would benefit from materials in threshold languages other than English, as I mentioned before. So members want that information in English but also request that information in their language so they can be able to read and also have their family members who are, in most cases, mainly English-speaking family members who handle their affairs.

Materials are translated in all threshold languages through a three-step process, which is the document is translated by a translator, then it goes to a second translator for review, which is now called a reviewer, and any edits or corrections are identified and then sent back to the original translator for final review and completion of the document. This process kind of gives a balance and check to make sure that the document is accurately translated.

In addition to internal interpreters, we contract with vendors to provide face-to-face interpreting, video interpreting and telephonic interpreting for threshold and non-threshold languages. This ensures that we always have adequate interpreters available for our members. The video interpreting, it is helpful because when members come into our office—we have members that speak American Sign Language, so with that, we can get a video interpreter on the line where they can see the person using American Sign Language to communicate, and then we're able to communicate with the member in that manner. Next slide, please.

Telephonic interpretation is always available to members. Face-to-face interpretation for medical appointments is also available. We can provide the service as long as the member requests in advance, usually two weeks. We ask members to call us two weeks in advance. If the member does not provide advanced notice, we will make every effort to schedule the face-to-face interpreter. If that cannot be done, we'll arrange a telephonic interpreter so the member will still be able to communicate with the provider during the office visit.

The first step the member takes to request a face-to-face interpreter is to contact customer service. Customer service will take the request. The request is then forwarded to our cultural and linguistics department. The cultural and linguistics department would then contact the provider to confirm the date and time of the appointment, just to make sure that the information that the member provided during the phone call was correct because we've found that when we didn't have that in place, we've scheduled an interpreter and we found that some appointments were on the wrong date or the wrong hour because the member got confused on the information the doctor gave them or the appointment time. So we put that in place just to ensure that we have the right date and time of the appointment.

After that is done, the C&L rep contacts our vendor to arrange the face-to-face interpreter. Once the interpreter is booked, the representative contacts the member to provide the update.

We also have contracted health networks or medical groups that manage our members as well, and they have this same process. They're required to submit quarterly reports to CalOptima that indicate the number of telephonic and face-to-face interpreters they provided, and this is on a quarterly basis.

CalOptima's motto is "better together." Our mission is to provide members with access to quality health care service delivered in a cost-effective and compassionate manner, and we think it reflects what we do with our LEP members because it ensures that they have access to health care without encountering language barriers.

I'd like to thank you for your time today, and I'll turn it over to Marta.

Alana Nur: Thank you so much, Albert. Marta, we can pass the presentation on.

Marta Pereyra: Good morning, and good afternoon. It is a pleasure to present at this webinar regarding language preferences through partnering with community-based organizations.

I represent the community-based organization—if we can go to the next slide—typical community-based organizations, and I just wanted to say that clearly because often Area Agencies on Aging are considered community-based organizations as well—obviously they are in part. CLESE, however, doesn't have any dedicated funding from any particular federal or state resources. That's why we are sort of getting resources and taking care of our mission and needs simply by writing grants to various institutions such as federal government and state government and private foundations.

CLESE was formed in the late '90s as a group of immigrant and refugee community leaders who were asked to assist the city of Chicago, Department on Aging at that time, to conduct an extensive ethnic elderly assessment in the city and surrounding counties because the city saw culturally different groups, minority seniors, coming or being present in the area; however, not being recipients of services they required. And findings from that assessment showed that lack of language proficiency and cultural barriers obviously prevented those limited English-speaking older adults from getting services and programs they needed.

At that time, those leaders who were assisting in conducting that research project have decided to form a permanent coalition because they worked together very frequently. They were conducting practically those interviews with older adults, and they were moving that research project forward, and they discovered that they have much more in common than differences. So since then, CLESE is in operation for a little over 30 years in the state of Illinois.

On the next slide, you can see that we are composed of about 55 ethnically diverse, community-based social service organizations. Typical social service organizations, again, who are getting grants and programs based on applying for those grants.

We represent more than 50 ethno-linguistic groups and speak over 100 languages.

Illinois is a very welcoming state. It's in the group of 10 states which have the largest number of refugee resettlement process going on.

As a group, as a coalition, our member organizations serve over 200,000 clients every year, and the majority of those clients are older adults, 60 years and older. We have our role as a coalition, as an advocacy group, is twofold. We work with providers who conduct home- and community-based services as well as other services to their respective communities, but we also work with limited English-speaking seniors directly through this providers network.

We do conduct our mission by providing leadership, education and advocacy. We do inform both providers and seniors about various policy changes, system changes, new transitions in the system such as transition to managed care. We also provide some direct services, recently including interpretation services.

In the next slide, you can see that as a group, pretty large group which is comprised of various immigrant and refugee groups, we have that firsthand knowledge of what it means to be an immigrant, what it means not to speak the language well, how to manage, how to understand the reality around me, how to navigate care. This is a very unique experience which we eagerly

wanted to share with plans in our state when managed care transition occurred, to help them better understand that experience.

And that partnership, that partnering process with plans, is definitely mutually beneficial and truly profoundly impacts the lives of members of those plans.

As a result of our partnership with managed care plans, we were able to establish a formalized Language Access Center. That's the direct service unit which basically was created as a result of the process of transition to managed care in our state.

In the next slide, you can see obvious facts such as that the language and cultural differences definitely create barriers. Both of my predecessors so eloquently spoke about it as well. Especially that slide where we talk about—I believe Darci was mentioning that, those six domains of health care quality. One of them is patient-centered approach, which is sort of a dominant idea in health care today.

There's no patient-centered approach without understanding of the process by the patient and being able to communicate back with the health care provider. So those barriers in communication are addressed by the services we provide.

We've noticed when the managed care transition started occurring in our state that it was a very overwhelming process for many people, especially limited English-speaking communities and, among them, older adults. They truly couldn't understand what is happening around them, how to read and understand various correspondence coming from the state regarding enrollment process. The letters that were coming were not necessarily properly addressed, and they were ending up in the garbage can, briefly speaking.

People were not aware of following the deadlines. They didn't observe those deadlines. They didn't understand why they should follow up on those deadlines as well as the opting-out, opting-in process to various plans. That was definitely something that until this day, older adults have difficulty navigating. And how, let's say, opting out of certain plans will affect the rest of their services.

Communicating effectively with care coordinators became a humongous problem because members couldn't do this openly, couldn't say anything back, couldn't talk freely about their needs and wants, as well as weren't able to navigate their care.

On the next slide, you can see that the transition to managed care in our state at least, it was something which came very quickly and nobody was prepared how to navigate that change. It came as a result of ACA as well as the local SMART Act enacted by our General Assembly. It was called the Save Medicaid Access and Resources Together Act. I think it was enacted in the beginning of 2011, which was addressing Medicaid problems in our state.

It mandated that 50% of beneficiaries should be enrolled in the managed care system by January 2015. That was a lot of work, which we realized that if we would not get involved and start working extensively with various stakeholders, it will be a big loss for our clients at that time.

That transition to managed care created confusion obviously for both providers and clients, especially older adults. We didn't have any prior examples of how to proceed during times like that in terms of that transition, so plans also realized, at least some of them—I should say most of them—that it is a challenge for them as well if there's a need for addressing the language preferences among members and how that should be done.

We realized that that process of addressing language preferences has to start at the beginning of the whole process, such as enrollment. We basically took an active role and reached out to the leadership of various medical plans which were present which were coming to Illinois at that time, and we started talking about the needs and language preferences among limited English proficiency populations.

In the next slide, you can see that basically we were doing this various ways, I should say. We were approaching plans. We were approaching our providers in the state. Mostly minority providers but also regular providers, mainstream providers, were joining those meetings. We started organizing bimonthly meetings with plans, various plans, based on their availability as well. And providers of home- and community-based services and generally providers of other services as well. Federally qualified health clinics, for example, we had many of those always present during our meetings as well.

So we were meeting together. We were addressing the issues of language and cultural barriers among limited English-speaking populations in our state. We were then in detail meeting with providers sort of on a separate basis and talking about transition to managed care, particularly processes such as contracting, billing, client transfer. All those aspects were topics for those meetings. We were doing this via webinars or one-on-one consultations.

In the next slide, you can see we also were holding at least quarterly some cultural competency trainings to plans, and it was different than the cultural competency training which plans had ready for us. We were talking about our knowledge, our immigrant experience and our knowledge, of clients whom we know by name and whom we serve for many years, and we were bringing that experience to care coordination staff of plans. They really appreciated that.

We were able to help and assist plans in identifying members and identifying languages spoken as well because we knew. We know our clients for so many years. That was a very useful—CLESE became a very useful resource for plans.

We also worked with an enrollment broker in our state, realizing that there were certain requirements. When people were calling the first time or second time, trying to enroll to some plan, they were expected to say in English what language they speak. For some languages, we realized, it's almost impossible for some Asian dialects to say in English the name of that dialect. It was basically very difficult for that person to do.

So we were working with that enrollment broker and basically making them realize those types of barriers in the caller and how to address them, how to better understand that type of challenge.

We had a number of meetings with that enrollment broker. And that time, it was at the beginning of the transition to the managed care process.

The local Department on Aging in Illinois realized the need for addressing the benefits of assistance in a broader way and embracing the diversity of Illinois. They were subcontracting and contracting with CLESE to provide senior health insurance programs, education, counseling to members. At that time—I think it was 2013—we started working with the department on a partnership program addressing those types of needs. It became a very successful program because there's a lot of need among minority populations regarding those types of issues, benefits accessing their own languages.

The next slide shows that we also worked not only with providers and plans, but we also addressed the population itself. Through the providers network that we are, we were able to reach members, future members of plans, with educational pamphlets, information, discussions about transition to managed care. We tried to at least make some first steps in that process.

Plans obviously came well equipped with their own tools in terms of addressing language preferences, mostly via phone and potentially maybe interpreter services through Language Line or other sources. But we realized that people locally, if they're on the local level, sometimes interpreters who were coming through the phone and trying to talk to our members might lack some specific knowledge regarding the managed care transition in that particular state at any given time, and sometimes those services were not very accurate.

We were just getting that feedback from clients, so that's something we realized simply by talking to clients. We were educating, we were trying to reach clients through various venues such as educational sessions, media campaigns. We have a lot of ethnic media venues in Illinois and the Chicago area, northern Illinois, so all of those were very useful.

And at the same time, we realized that we became a good resource for clients and we established that formalized Language Access Center. Within that capacity, we provide not only in-person and also telephonic interpretation but priority is given to in-person contact. But we also assist care coordinators of plans in scheduling those visits, following up on those visits, scheduling and being part of family meetings if necessary and if requested by care coordination.

We kind of follow the member wherever the member is. Sometimes the care coordination might be asking us to not only assist the home during home visits, during the needs assessment process, but also in the hospital setting, doctors' visits, resolving small issues but which have to be resolved on the spot, sort of speaking. So we are always available to do that.

The next slide is showing the comprehensive, in-person language access assistance to health plans. Our state helps with initially identifying the languages spoken by members, but this is not always accurate. Plans often tell us that the lists or information that is given by the state is not always accurate in terms of what type of language any member speaks.

So currently, we have about five contracts with plans, various plans, and we are often asked to investigate, quote-unquote, and identify that language preference when we're scheduling the

visit, when we're establishing that initial report with the client. We have about 10 to 25, as I said. Ten largely spoken languages in the state of Illinois, including Spanish, Polish, Cantonese, Mandarin, various Asian, South Asian languages and dialects, Middle Eastern languages and dialects, East African languages and dialects. But it also grows specifically when a particular refugee group is present and we're dealing with rare languages, as we say, and we are definitely able to identify the interpreter of such language as well.

In terms of training, we are focusing on various aspects of that home visit and care coordination. We are ourselves as a CLESE staff running that type of services. We've been trained by plans on various aspects of care coordination, on the assessment tools, what that entails, what to expect, and we are able to take that knowledge and convey that knowledge to our interpreters, who are already certified, most of them medical interpreters with good experience. But we're also adding to that experience additionally, and there are various aspects of the home visit or scheduling that visit or visits in the hospital setting, nursing home, what they learn new aspects of that type of interaction and accuracy in translating that type of content.

Often our interpreters serve as cultural brokers, and they convey not only the language and the message which is in any given moment crucial, but they also are able to convey the cultural ramification of such message. They are able to help the care coordinator understand why the member behaves a certain way, why certain comments are coming out of the members, why they say, "Well, we never talk about death and dying in our culture. This is something which we would never address." A member of course talks about it a certain way, and that interpreter is able to convey that message to the care coordinator, which is crucial.

In that current slide, you can see that the presence of an in-person interpreter at client environment, home, hospital bed, it really brings them comfort and good understanding of what's going on in that interaction and at any given moment. It empowers the member to truly address their need and encourages the member as well to reveal any significant information, which might be very important at any given moment of that process of caring for that person.

CLESE contributes to building that strong relationship between members, plans and interpreters, and often care coordinators are asking for a particular interpreter to visit members. They're feeling very comfortable. There is a rapport. There is a relationship already established between the care coordinator and the interpreter, and they go together. They are able to address members. They work together well, and they see this as an effective process. And when a care coordinator is satisfied, they're letting us know, "I would like to work with that particular person because I had a great experience for a long time." And we always are able to set it up that way.

We know that when the care coordinator is at a member's home and they leave that business card with them, it is very natural for a care coordinator to do that obviously, "Please call me if you have any questions, and we can translate that." But what that really means for the member, the member usually will never call on his or her own. They will not be able to address that process and going through all those steps of connecting with that care coordinator.

So we are able to sort of step in and say, "This is what you could do." And the care coordinators sometimes say, "We have additional telephonic services. You can use them." Sometimes,

however, we have a situation when the member is calling us, CLESE, and is asking, "Can you please help me call that care coordinator? Because I have a question," and we of course are doing that.

So in that area, when I was mentioning that culture broker function, sometimes we really do that strong relationship which helps members basically be more proactive, and instead of going through various hoops when it comes to calling an authority figure, which care coordinators is exactly who that person is for that particular client member, they call CLESE because they feel like they can speak openly and freely about their needs.

On the next slide, we can see an example of such a visit. For example, we had that situation fairly recently when we were visiting Ms. Torres. Her name was changed, obviously, for the purpose of this presentation. She was about 75 years old. She was an immigrant from Ecuador. Currently in Illinois we have a program called HealthChoice Illinois where the State was choosing a couple of plans and members and people, clients, have to enroll to those plans.

Again, the whole process is a little bit confusing for clients, for older adults who don't speak English, because they don't react necessarily to the letters which have been sent out, so they're being auto-assigned to a new plan without necessarily their knowledge of that process. Because of that barrier and lack of knowledge how to manage that system, Ms. Torres was assigned to some plan, and there was a care coordinator from that new plan calling her, through Language Line or some other vendor, trying to set up a home visit. And she was refusing. She was very upset. She said, "Why they are calling me? I already had some visit recently in my home."

And what we've discovered, in the next slide, obviously that visit indeed took place, but it was with a different plan and different care coordinator. So she was right; however, that was a different medical plan at that time.

The plan, the new plan, was asking CLESE to reach out to Ms. Torres and establish that relationship and ask her if she would be able to accept a home visit. After some conversation and explaining plenty of detail regarding that process of auto-assignment and why she was in a new plan, etc., she was able to accept that visit. In fact, that interpreter who called her worked previously with a previous plan and previous care coordinator with the same member, Ms. Torres. So she recognized that person. She already has some established relationship, and she was able to accept that visit from the new plan, and that's because of the trust established between care coordinator and the member that she felt very much okay accepting that visit and being an active part of it.

Later on the care coordinator told us that she was able to gather all necessary information regarding health risk assessment and other details regarding that particular member, so that was a very successful visit ultimately.

The last slide is talking about potential strategies for plans to partner with local community-based organizations because local CBOs are a great resource for plans in any given state. Based on our experience, we strongly recommend that when you're searching for an ophthalmologist that speaks Cantonese—in some states, Cantonese might be a rare language. In many states,

Cantonese is not such a rare language when it comes to minority languages. But if you have such need, you can definitely utilize local resources. Those community-based organizations have that type of knowledge.

We also encourage plans to recognize an ongoing relationship with community-based organizations. They're a good resource and good information source on languages spoken in your state and among your members as well as various cultural information they might basically present to you regarding minority populations.

And also, based on our experience, CLESE's experience, collaboration with minority leaders in your area might be very useful in helping you understand the cultural language differences and how they affect health outcomes among your members. CLESE is developing more services and expanding its services outside of our state, going to various states, so it might be a good opportunity for us to potentially collaborate together in the future.

Thank you so much.

Alana Nur: Thank you so much. Thank you, Darci, Albert and Marta, for all of your presentations. This has been incredibly informative. Thank you so much for joining us, and with that, we now have a few minutes for questions from the audience. At this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box and present Submit to send it.

I'll get started on some questions for our speakers. Albert, I'll start with a question for you. You mentioned that you have customer service staff speaking your threshold languages. Do you have any recommendations for how to recruit multilingual customer service staff that speak threshold languages?

Albert Cardenas: Yeah, I think my recommendation is of course starting from the very beginning, from reading the résumé and making sure that they have the capability of speaking the language, and conduct testing. Because we do run into a lot of résumés that say they speak a certain language, and when we get them in an interview, they don't. So that's one thing.

The other, make sure that the candidate has customer service experience to some level of degree because when they get into the call center and we're dealing with members' health, we prefer, at least in my experience, that somebody already has that experience of a background in customer service. Not necessarily in health care, but dealing with members, interacting with members.

The other aspect which I think is equally important is identifying candidates that have natural empathy, a positive attitude and enjoy interacting with seniors because for those people on the line that work in call centers, this is not an easy job in dealing with seniors. They're challenging at times. They're confused about what to do, and we need people with a lot of patience and just a positive attitude that can connect with those members in their language.

So that's the recommendations that I would give.

Alana Nur: Great. Thank you. To follow up, you mentioned that someone might have on their résumé that they speak a certain language. We had a question from Kathleen in Pennsylvania: Do you use a certain language test for your bilingual and multilingual staff to assess for competency?

Albert Cardenas: Yes, we do have a test that we provide verbally. We do contract with a vendor that conducts a phone interview as far as just having a conversation. For example, if it's Spanish, a conversation in Spanish, asking questions. Not necessarily about health care but just making sure they can carry on a conversation and they understand the language in detail.

Alana Nur: Great. Thank you. This question goes actually really to Marta or Albert in both your experiences, so whoever wants to start first. The question comes from Mya in California: How do you ensure staff are equipped to translate medical terminology? Understanding a language and then being proficient in understanding medical terminology in order to translate are slightly different things.

Albert Cardenas: I can start. As part of our training, we do have medical terminology kind of guide that we go through. It gives the medical terminology in different languages. As we have new terms that we don't have, we submit them to our cultural and linguistics department, and they can translate and then update the guide as new terms come up. But we usually start off with that.

The training is ongoing. We do have initially when reps are hired, on an ongoing basis we do remind the staff, and what we do is we identify—during the audit process, listening to calls, the supervisors identify if the reps are using inappropriate terms or terminology for certain medical words or medical terms. So we identify that as a training opportunity, and then we revisit the list.

Marta Pereyra: If I may also follow up on what Albert is saying, CLESE is following the standards of the National Council on Interpreting in Health Care. We work with that entity closely. Not only we follow their standards in terms of proper interpretation accuracy but also ethics and standards of conduct during that interaction with a member and plan.

We also when we were trained as staff of CLESE by plans regarding the content of needs assessment tools, we asked them for the list of vocabulary, for a glossary, if you will, of certain terms, and we were sort of brainstorming together regarding what are most appropriate terms being used. We then take it with us and train our interpreters on that as well.

Alana Nur: Thank you, Marta. For both of you as well, what kinds of steps have you taken at CalOptima or CLESE to address language speaker shortages? Have you encountered any situations where the pool of qualified speakers is shallow, and what were you able to do about it?

Marta Pereyra: If I may start, just briefly, we definitely feel that in certain languages, especially rare languages, if those requests are coming we might have a shortage of folks who are professional interpreters. I should say we are, in a sense, a little lucky because we are comprised of various immigrant and refugee groups in the state and outside as well. People start to recognize CLESE. So through those provider networks, we are able to identify various

individuals. In fact, providers are helping us in recruiting and screening appropriate people who can become interpreters.

So in that sense, we have sort of this ability to reach out to various people through our providers network. But one situation I can just briefly tell you that was a very rare language and a certain dialect of South Sudanese language, and we were asking the plan if they would be okay with recruiting somebody outside of our state and if it would be okay to have that interpretation done by the phone, not face to face. They agreed, and we were able to identify that type of interpreter through the network of refugee resettlement agencies, for example. CLESE works closely with those types of services as well in the country. And that person was recruited in Colorado, so we were able to link the member and the care coordinator via phone with that rare language speaker.

Albert Cardenas: This is Albert. I agree with Marta. We live in an area where our community is very diverse, so we have a multitude of languages. Our face-to-face interpreters, we have vendors that are able to provide language for not only our threshold languages but other languages as well. We haven't really felt that we have a shortage because we also have our vendors. Like Marta said, if we don't have a face-to-face interpreter, we can always rely on the telephonic interpreters, and our vendors that we contract, they have available over 200 languages that they can provide.

Alana Nur: Great. Thank you both so much. Marta, you talked a little bit about the importance of identifying partnerships with community-based organizations for plans and the value that community-based organizations can bring. Can you say a little bit more about how plans might go about identifying those partnerships?

Marta Pereyra: That's a great question. I would recommend to focus on two state agencies per state. One is one which manages Medicaid in our state. It's the Department of Health Care and Family Services. And the second is Illinois Department on Aging. These are just examples, two entities. In various states, many states, we have a variety of options. I think in some states, Medicaid might be a different name of a particular department.

But I would maybe start there. It's a very good question because I've learned myself that certain states don't have provider networks of common community-based services. Services are being provided by Area Agencies on Aging, and those entities are employing workers directly, so those types of systems are absolutely very different than in our state, for example.

But Area Agencies on Aging are a good resource to learn about diverse sources, resources, in any particular county or larger area, larger region. In our state, we have 13 of them, and they should be a good resource of information how to start, where are those particular CBOs who might be of help to plans or might be useful as a resource to plans.

So that's how I would look at that, probably.

Alana Nur: Thank you so much, Marta. Albert, can you talk a little bit about what happens when a member who speaks a non-threshold language—he's given an example of French as a

non-threshold language—if they receive correspondence from CalOptima, you've mentioned that they would get it in English. Is there a process for helping them understand that material?

Albert Cardenas: Yes, we do have a process. The majority of our member notices and material that we send out have what's called a material ID number at the bottom left of each of our correspondence, so if a member calls and they receive a correspondence, what our process is is we would get an interpreter on the line and ask the member to provide that ID number on the correspondence. Our CSRs, customer service reps, they have access to these materials, so they're able to identify the type of correspondence, and through the interpreter, they can read the letter to the member or the correspondence.

This applies to all members also because we get English-speaking members that get letters that they're confused and they're saying they received a letter and they can't read it, so we ask them for that information.

That's our approach to identifying letters and providing that information to non-threshold language members.

Alana Nur: Great. Thank you. Albert, also for you, in terms of the interpretation actually being provided, how do you determine the quality of the translation in terms of both the quality, in terms of the accuracy of the information that's being translated as well as the quantity, making sure that all the information is translated? Those can be particular questions. And this question comes from Min in California.

Albert Cardenas: Well, the quality, like I mentioned in my presentation, we have a three-step process when it comes to translating documents and materials. We have both internal translators and external vendors, so depending on the volume of the request, we either vend stuff out, like correspondence, to our vendors and they translate them. They go through the three-step process as well, so they translate them, they go to a reviewer, the reviewer reviews it for accuracy and makes any edits, and then sends it back to the original translator to finalize the document.

So that's our process. We found it's fairly accurate when we do that. It ensures that the translation is translated accurately.

Alana Nur: And how about ensuring the quality of translation in person? Is there anything you do to make sure that your interpreters are able to translate accurately?

Albert Cardenas: Like I mentioned, we audit the calls. The call audits are part of the evaluation that the representative interpreted the call accurately, so that's part of our process.

Alana Nur: Great. Thank you so much. And another question for you: For your PCCs, personal care coordinators—I'm sorry if I'm misremembering the acronym. This question comes from Richard in Florida. Do you have PCCs for all of your threshold languages?

Albert Cardenas: Yes, we have PCCs for all the threshold languages. The major threshold languages that we have here, we have six threshold languages, but the main ones with the higher

populations are Spanish, Vietnamese and I believe Farsi. Korean, Chinese and Arabic are part of threshold languages, but they tend to be lower than the Spanish and Vietnamese. We do have personal care coordinators, and we try to match them with a member that speaks their language.

Alana Nur: Okay, thank you. We have a couple of questions asking about if you have any staff that might have interest in learning a new language to be able to speak one of those languages, whether it's a threshold language or not, is there anything that you do to support staff or help staff get training in order to learn proficiency in another language?

Marta Pereyra: I think humbly to myself that the whole sense of interpreting for another person, you sort of have to be a native speaker of that language in order to—this is our perception, in order to be accurate and truly be the cultural broker, understand that culture and sort of coming from that culture. But we might have people—for example, our regular staff in the CLESE office, each person speaks at least one additional language, and sometimes we do utilize our staff if it comes to certain particular questions or very short clarification regarding a question from a care coordinator.

So for I would say little things, for the lack of a better word, like that for certain clarifications or other smaller quality things, we might if necessary, if we don't have at any given moment a particular person available at any given second, our staff might step in and do that. But we sort of always believe that the interaction between the care coordinator and the member should be definitely facilitated by a native speaker of the language, a fully qualified professional, a certified person.

Alana Nur: Thank you so much, Marta. Albert, I would love if you have any input or if you have any experience working to train any of your staff members in additional languages if they have interest.

Albert Cardenas: No, we don't have that process here.

Alana Nur: Okay, great. Thank you so much. Albert, a question for you. You mentioned a little bit about the importance of having bilingual customer service representatives and how that makes members feel comfortable and more likely to either call in or come into the office. Can you say a little bit about why that's important and how that helps create a great experience for LEP members?

Albert Cardenas: Yeah, through my experience I think that members develop a greater connection and a higher level of trust with their plan. We have members that develop an attachment to certain customer service reps because they speak their language, and they usually have a higher comfort level that their issues will be addressed and resolved, so when they call in or come in, they request for the specific rep.

We do our best to accommodate whenever possible. And also we have members that also develop a relationship with the face-to-face interpreters. When they go to the doctor's office, usually some members want the same interpreter every time they have an appointment, and

sometimes if the interpreter's not available, they want to reschedule their appointment so the interpreter can go.

We evaluate that and try to meet the member's needs whenever possible. I also want to add one of Darci's slides about effective communication, I think it does create a better experience because I can attest to her presentation that members are more satisfied with the plan and they do tend to share more detailed information about their health, what they're going through, with the customer service reps and also the face-to-face interpreter. So I feel that's a benefit for us because we can sometimes identify members' conditions faster rather than having that language barrier.

Marta Pereyra: I would absolutely agree with you.

Alana Nur: Wonderful. Thank you both so much. I think that's a very important point. At this time, we're wrapping up our Q&A period, but if you have any additional questions or comments, please email RIC@lewin.com. For more information, you can find each of our speakers' contact information listed on this slide.

Slides for today's presentation, a recording and a transcript will be available on the Resources for Integrated Care website shortly.

At this time, the post-test for this webinar is now open. Additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit Guide in the Resource Guide on the left-hand side of your screen, or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations. If you have any questions for us, please email us at RIC@lewin.com.

Thanks again to all of our wonderful speakers. Have a wonderful afternoon, and thank you so much for your participation.