Speaking of Language Access: Interpreter Requests and Availability – Impact on Patients' Ratings of Healthcare Quality in a Complex Provider Network, Within a Large and Diverse Medicaid Health Plan, 2011

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L.A. Care HEALTH PLAN®

Presenter Disclosures

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The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

I am employed as a Senior Biostatistician at L.A. Care Health Plan – the Local Initiative Health Authority of Los Angeles County, California.

L.A. Care is a public entity competing with commercial insurers in the Medicaid and S-CHIP markets in L.A. County.

Notes:
CAHPS® is a registered trade name of the Agency for Healthcare Research and Quality (AHRQ).
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I. Learning Objectives

1. Discuss best practices in measuring/analyzing interpreter access, using surveys done already for other purposes.
2. Describe the role of interpreter access in communication between patients and doctors and their staffs.
3. Discuss the proportion of patients reporting need for a medical interpreter in a large urban Medicaid population.
4. Compare interpreter access among language groups, and Medicaid cohorts (adult vs pediatric).
5. Discuss the willingness of Medicaid members to request interpreters when needed, and potential barriers to such requests.
6. Describe potential barriers (and solutions) for members and providers to request and set up interpreter access.
7. Demonstrate the impact of interpreter access on patients' ratings of the quality of care and services.
8. Discuss methods for making the findings actionable within a medical group, clinic, health plan, or agency.

II. Background – Population Surveyed

L.A. Care Health Plan -- large, diverse membership:

- Mostly Medicaid, urban, 2/3rd pediatric, often Spanish-speaking.
- Roughly 21% of Medicaid managed care population in California.
- Roughly 2.1% of Medicaid managed care population in the U.S.
- Los Angeles County, California: Roughly 1-in-14 residents is an L.A. Care member.
- Mostly Medicaid, some S-CHIP, SNP, and special programs.
- Serves 10 distinct language concentrations ("threshold languages"):
  Spanish, English, Armenian, Korean, Cambodian, Chinese, Russian, Vietnamese, Farsi, Tagalog.
- Mostly urban and suburban; 1 semi-rural region in the high desert.

L.A. P4P PAS 2011 survey at L.A. Care:

- Measured patient experience with quality of health care services.
- The Patient Assessment Survey (PAS)* is similar to AHRQ CG CAHPS v2.0 12-month survey. PAS allowed the health plan's P4P program somewhat more focus on authorizations and statistical sensitivity (6-point scales).
- Survey mode: 2 mail waves, telephone follow-up; surveyed in English and Spanish.
- Sampled 39 provider groups: 49,549 sent, 16,288 completed: 32.9% response rate.
- Adult and Child samples in their naturally-occurring proportions.

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LA P4P PAS 2011 Provider Group Survey

Survey process:

- Patients with outpatient visits between 05/01/2010 and 04/30/2011.
- Patients who were continuously enrolled (<=1 month break) with health plan, and within sampling groups below, and still enrolled at time of sampling and survey.
  - Ensures correct attribution of patient ratings to provider group that rendered the service.
- Sampled provider groups with n>=1,200 eligible adult and child patients with visits.
  - Samples for 39 large provider group aggregates and 5 samples for other entities:
  - 2 partnered health plans with direct networks.
  - County clinics (Safety Net).
  - Catch-All for small provider groups.
  - Patients who switched provider groups but were continuously enrolled in health plan.
    - Permits generalizing back to plan level: weighting results to calculate Plan-level results.
- Samples of n=1,200, separated into adult and child samples in their naturally-occurring percents in the provider group's patient population (adult = age 18+ on 04/30/2011).
  - Urban TANF population is largely moms and children. Adult samples were weak.
- 8 survey instruments: (Adult , Child) * (PCP, Specialist) * (English, Spanish).
- Mixed mode (Mail + Phone): Fielded 08/03/2011 to 11/01/2011 (90 days).
- Response rates in samples ranged from 23.1% to 41.6%, 32.9% overall.
- Respondents: Adults: 3,160. Parents of children: 9,875.
- Lowest response rates were for Adult and Child specialist surveys (Spanish-speaking).

III. Measuring Language Access and Identifying Barriers

Two approaches to analyzing and addressing language access problems, summarized in the hypotheses below:

1. Provider-oriented: Patients don't get interpreters because doctors and staff don't request them, due to workflow pressures.
   - Assumptions: Doctors and staff have more power than the patient does in the clinic setting. Without buy-in from providers, the patient won't get medical interpretation services.
   - Since there are fewer doctors and staff members than patients, intervention at the clinic level should be most effective.
2. Patient-oriented: Patients don't ask for interpreters when they need them.
   - Assumptions: Doctors and clinic staff may be more willing to use interpreter services offered by health systems, if more patients ask for the services.
   - Since patients give ratings that CMS and NCQA use to rate health plans, interventions targeted to groups needing language access, could improve ratings for providing interpreters, and for visibly responding to needs.

Analytic Approach For Interpreter Access Study

The unweighted statistics presented in this briefing reflect the average experience of the average patient at the average provider group in this pilot study.

The results are usable as a general guide as to which provider groups need intervention by the health plan to improve their use of interpreter services at clinics.

That approach is suitable for relatively simple interventions that can be distributed widely to any number of provider groups regardless of patient panel size. Examples include newsletters or reminders of the available of telephonic interpreter services that the health plan provides at no cost to clinics.

If, however, more serious intervention (such as auditing or training staff at clinics regarding language access requirements) is typically resource-intensive, and administrators will desire to know where to focus staff resources, toward getting the best return on the work.

Toward that end, later work may expand this analysis by weighting the data to be representative of the patient population. Such analysis would provide insight on where to focus efforts, to impact the most members with language needs; or to focus efforts on language groups or geographical regions that exhibit the greatest unmet need for interpreter access.

IV. INTERPRETER ACCESS QUESTIONS ADDED TO CORE SURVEY

"LANGUAGE AND INTERPRETATION

As part of your child's health care you may need to talk with doctors, pharmacists, or office staff about medications, conditions, or treatments. This often requires talking about complex questions, instructions, and explanations about your child's health insurance, health conditions, or treatments.

[Q49. Preferred spoken language for medical and insurance matters.]

[Q50. Preferred written language for medical and insurance materials.]

An interpreter is someone who repeats or signs what one person says in a language used by another person.

Q51. In the last 12 months, did you or your child need a professional interpreter to help you speak with your child's doctors, clinic staff, or pharmacists?

[1] Yes [2] No

Q52. In the last 12 months, when you or your child needed a professional interpreter to help you speak with your child's doctors, clinic staff, or pharmacists did you ask them for an interpreter?

[1] Yes [2] No

Q53. In the last 12 months, when you or your child needed a professional interpreter to help you speak with your child's doctors, clinic staff, or pharmacists, how often did you get one?

[1] Never [2] Almost never [3] Sometimes [4] Usually
[5] Almost always [6] Always

V. FINDINGS

- ***Caution: For intervention purposes, these unweighted results represent "the typical patient in the typical provider group".***

Adults 2011	Pediatric (Parents), 2011	Response text
Q49. Needed an interpreter.		
40.5%	66.5%	[1] Yes
59.5%	33.5%	[2] No
Q50. Asked for an interpreter.		
33.9%	58.7%	[1] Yes
66.1%	41.3%	[2] No
Patients who needed interpreters but didn't request:		
6.6%	7.8%	
Q51. Got an interpreter. (Pediatric cohort only.)		
	19.9%	[1] Never
35.8% -->	4.0%	[2] Almost never
	11.9%	[3] Sometimes
	5.9%	[4] Usually
64.2% -->	19.2%	[5] Almost always
	39.1%	[6] Always

Notes:

Patients responding to this block:
n= 797 adults Q49, Q50
n=2,191 parents Q49, Q50, Q51

Some interaction between survey language and compliance with survey gate questions.

(Q51: No equiv. info from adult survey.)

FINDINGS (Cont.)

Q51. Got an interpreter when needed and requested one.

Parents of Pediatric Patients (n=1,163)

Notes: No equivalent info from adult survey.

	2011	Response text
	1.5%	[1] Never
16.8% ->	2.1%	[2] Almost never
	13.2%	[3] Sometimes
	7.1%	[4] Usually
83.2% ->	24.1%	[5] Almost always
	52.0%	[6] Always

Good news. Many clinics and pharmacies are either providing interpreter services as required; or may have competent bilingual staff (*in the perception of patients*).

Q51. Got an interpreter when needed and *did not* request one.

Parents of Pediatric Patients (n=295)

2011	Response text
20.7%	[1] Never
10.8%	[2] Almost never
14.6%	[3] Sometimes
5.8%	[4] Usually
12.9%	[5] Almost always
35.2%	[6] Always

Staff at many clinics and pharmacies might be recognizing when patients need interpreter services, and may be providing interpreter services *without being asked*.

Among patients who didn't need or request interpreters,

n=610 reported getting one "sometimes" … "always": 37.9%.

Paradoxically, among patients who said they didn't need an interpreter, n=123 reported asking for an interpreter – but received an interpreter "sometimes" … "always": 92.7%.

An Example of Analysis For Targeting Interventions: Interaction Between Language and Provider Group Structure

- IPAs have a higher concentration of ESL/LEP members.
  - Possible focus for demonstration projects?
- Mixed provider groups (MG+IPA) have lowest percent of non-white adults.

Language Pref. (% non-English) *	Adult	Child
Staff Model	48.2%	66.6%
Medical Group (MG)	48.7%	71.3%
Mixed (MG+IPA)	44.2%	68.1%
IPA	57.1%	77.2%
Clinic	71.4%	88.0%

Ethnicity (% non-white) *	Adult	Child
Staff Model	87.8%	96.9%
Medical Group (MG)	81.7%	96.3%
Mixed (MG+IPA)	77.3%	97.0%
IPA	89.2%	94.5%
Clinic	91.4%	98.9%

* Includes no resp./declined; assumption that non-white, ESL/LEP may have systemic reasons to refuse.

Findings: Measuring Language Access and Barriers

The above analysis examined how often patients needed interpreters, asked for them, and got them.

The analysis seeks to assess which of the original two hypotheses is most empirically supported, toward guiding interventions:

1. Most respondents report requesting interpreters when they perceive the need – and most of them report getting interpreters.
2. Some respondents report not needing interpreters and not asking for interpreters, yet report receiving interpreter services. Evidently, clinic staff or doctors perceive needs and initiate the interpreter request.

The evidence tends to suggest that most patients have the language access they want. However, because health plans likely have more influence on clinics than on patients, *training of clinic staff in identifying clinically-sensitive language barriers and initiating interpreter services,* may be important – particularly for languages other than English or Spanish (the predominant languages, and the languages in which the survey evidence was gathered).

Other: Small-but-noticeable sets of members reported bilingual preferences in languages not paired with dominant languages (English or Spanish):

- Armenian & Farsi; Chinese & Vietnamese (& Khmer)

Limitations of the Data and Analysis

The findings are limited to one collection period for the survey.

- Provider Group surveys in large populations can be expensive, so are not repeated annually. Questions not in the CAHPS core (such as interpreter access questions) easily get bumped from the instrument to keep mailing/printing costs mailing costs feasible.

- Un-weighted data in this analysis are sufficient to open discussion regarding an intervention strategy. The provider group samples require no weighting for intervention. However, to identify how the population fared as a whole, the weighting will be necessary.

VI. Recap of Learning Objectives

1. Discuss best practices in measuring/analyzing interpreter access, using surveys done already for other purposes.

   Reforms to promote PCMH and ACO principles, are creating a felt need for patient surveys to assess service quality at the medical group and individual clinic level. Although expensive, such surveys may often have whitespace available to carry interpreter access questions.

2. Describe the role of interpreter access in communication between patients and doctors and their staffs.

   Language barriers either block access or make miscommunication more likely in Q&A about symptoms, medical conditions, options and solutions.

3. Discuss the proportion of patients reporting need for a medical interpreter in a large urban Medicaid population.

   In this urban Medicaid population, more than half of adults report not needing interpreters, and most adults did not request interpreters.

   More than half of parents report needing interpreters, and most parents reported requesting interpreters.

   One surprise was the modest subset of members listing language combinations that didn't include English.

Recap of Learning Objectives (Cont.)

4. Compare interpreter access among language groups, and Medicaid cohorts (adult vs pediatric).

   Among this urban Medicaid population, adults reported less need for interpreters; and parents reported needing and requesting interpreters more. Portions of this finding might be demographic (adult Medicaid patients tend to speak English, while Spanish is more common among parents of Child Medicaid pediatric patients); and portions might be methodological: Spanish-speaking adults responded at somewhat lower rates than other patient cohorts.

5. Discuss the willingness of Medicaid members to request interpreters when needed, and potential barriers to such requests.

   Willingness appears strong. The percents of patients (adult or pediatric) who report needing interpreters are very close to the percents of those cohorts who request interpreters.

   Caveats: Patients' perceived lack of need for interpreters may underestimate actual need. Even among patients with perceived need, about 7% of parents and 8% of adults don't request interpreters, despite expressing the need.

Recap of Learning Objectives (Cont.)

6. Describe potential barriers (and solutions) for members and providers to request and set up interpreter access.

   Except where providers or staff are fluent, setting up face-to-face or telephonic interpretation can impact clinic workflow. The extent of impact needs measurement to verify if it is actual and significant, or minor and perceived.

6. Demonstrate the impact of interpreter access on patients' ratings of the quality of care and services.

   Pending weighted analysis at the health plan level.

7. Discuss methods for making the findings actionable within a medical group, clinic, health plan, or agency.

   Pay-For-Performance (P4P) programs emphasize measurable indicators of clinical and service quality. Interpreter access can be added to the incentive equation impacting revenue given to provider groups. But primarily if (a) linkage is shown to CAHPS and HEDIS, and if (b)interpreter access questions are inserted into CAHPS.

VII. ACTIONABILITY

Given economic constraints, actions focus first on targets of opportunity: Actions piggybacked on projects and processes that will occur anyway.

Using interpreter access ratings at the provider group level, a health plan can push target-ability one level closer to the point-of-service where the patient receives health care and where interpreter services are most relevant.

Any department having touch-points with members or providers is a potential vehicle for intervention. Examples of potential actions follow.

Information and reporting:

- Report the study findings within quality improvement committees to solicit support for provider group interventions. Insert content on interpreter access into employee newsletters for Call Center staff who communicate directly with ESL/LEP patients.
- Use advisory committees and community-based organizations (CBOs) to identify barriers to patients' asking for interpreter services.
- Place articles on interpreter access in member newsletters; and place announcements on external web-pages and patient portals.
- Expand in-language video program to instruct patients on how to request interpreter services. (http://www.lacare.org/members/medi-cal/helpfulinformation/yourlanguage)

ACTIONABILITY (Cont.)

Obtain further information for root cause analysis:

- Do a small pilot study to assess how many members recognize when they need a medical interpreter for complex medical information and coverage information.
- Conduct a similar study of providers and office staff.
- Analyze whether interpreter access correlates with measures that health plans care about: scores for quality-of-care, quality-of-services, and member retention.

Auditing:

- Monitoring provider groups, clinics and providers to assess compliance with interpreter requirements. Consider mystery shopper approach.
- Q51 notes patients who got an interpreter without requesting one. This implies that some clinics are complying with best practices. Analyze the data to see if the clinics associated with those instances, differ in any way from other clinics.
- Use existing CME program on use of healthcare interpreters to communicate with ESL/LEP patients. Analyze whether patients of providers who take this training, exhibit better adherence to medical advice, and patient satisfaction.
- Add questions to existing surveys to assess awareness by providers and staff about interpreter access requirements, and how to use cost-free interpreter services.

ACTIONABILITY (Cont.)

Incentivizing:

- If analysis demonstrates a tie between interpreter access and measures of quality of care, services, and member retention, petition for incentives (through pay-for-performance (P4P) programs, etc.) to reward and encourage use of interpreters when appropriate.

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