Question & Answer (Q&A): Identifying and Meeting the Language Preferences of Health Plan Members

Webinar participants asked these questions during the Q&A portion of the Identifying and Meeting the Language Preferences of Health Plan Members webinar held on September 11, 2018. Please note, the responses in this document have been edited for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website: https://resourcesforintegratedcare.com/CulturalCompetency/2018_CC_Webinar/Language_Preferences

Featured Webinar Speakers:

- Darci Graves, Special Assistant to the Director, CMS Office of Minority Health
- Albert Cardenas, Director, Customer Service, CalOptima
- Marta Pereyra, Executive Director, Coalition of Limited English Speaking Elderly (CLESE)

Hiring and Recruiting Multilingual Staff

Q1: Do you have recommendations for how to recruit multilingual customer service staff who speak threshold languages?

Albert Cardenas: Starting from the very beginning, I would recommend ensuring that the staff you are recruiting truly have the capability of speaking a certain language. We run into résumés that say they speak a language, but when we conduct testing in an interview, they are actually unable to speak that language. The other suggestion is to make sure that the candidate has customer service experience. We prefer that when staff get into the call center and are dealing with members' health needs, that they already have a background in customer service. This experience does not necessarily need to be in health care, but needs to include experience interacting with and helping members (or clients). Lastly, and equally important, is the need to identify candidates that have natural empathy, a positive attitude, and who enjoy interacting with seniors. Seniors may sometimes feel confused, and customer service staff are most effective if they exhibit the patience and a positive attitude that allow them to really connect with members.

Q2: Do you use a certain language test for your bilingual and multilingual staff to assess for competency?

Albert Cardenas: We have a verbal test that we administer through a contracted vendor that conducts a conversational phone interview. For example, if the position requires Spanish, the interview would be conducted in Spanish. It would not necessarily discuss health care specifically, but would make sure the applicant can carry on a conversation and that they have sufficient understanding of the language.

Q3: Proficiency in a language and proficiency in medical terminology in that language are slightly different competencies. How do you ensure staff are equipped to translate medical terminology?

Albert Cardenas: As part of our training, we cover a medical terminology guide in different languages. As we come across new terms, we submit them to our cultural and linguistic department, and they update the guide to include the new terms. Representatives complete the training when they are hired and on an ongoing basis we remind the staff to ensure they are using appropriate terminology for medical terms. Supervisors monitor this, as well, through our auditing process and listening to calls. We identify inappropriate or incorrect terminology, use it as a training opportunity, and then revise the medical terminology guide.

Marta Pereyra: CLESE works closely with the National Council on Interpreting in Health Care. We follow their standards in terms of proper interpretation accuracy, and ethics and standards of conduct during interactions with a member and plan. When CLESE staff work with plans regarding the content of needs assessment tools, we ask them for the list of vocabulary or a glossary of certain terms. We work with them to determine the most appropriate terms and use those terms to train our interpreters as well.

Partnerships with Community-Based Organizations

Q4: Marta, you mentioned how valuable partnerships with community-based organizations can be for plans. Can you say a little bit more about how plans might go about identifying those partnerships?

Marta Pereyra: I recommend focusing on the state's Medicaid Agency, the Department of Health, and the Department of Aging. These are just examples of entities and there are a variety of options in many states. The structure and governance of these agencies will vary by state. Also, Area Agencies on Aging are a good resource for learning about diverse resources in particular counties or regions within a state. These agencies can be a good source of information for how to start and where to find those organizations that might be helpful resources to plans.

In-Person Interpretation and Written Translation

Q5: Have you encountered any situations where the pool of qualified interpreters is shallow, and what were you able to do about it?

Marta Pereyra: We definitely feel the shortage of qualified speakers for certain languages, especially rare languages. If we receive requests for these languages, we may have a shortage of professional interpreters. We do a have a slight advantage because we are comprised of various immigrant and refugee groups in the region, so people recognize CLESE and help identify individuals that we could work with. Providers help in recruiting and screening

appropriate people who can become interpreters. This ability to reach out to various people through our provider network puts us in a better position when these shortages arise. When we needed an interpreter of South Sudanese language, for example, we worked with the plan to recruit outside of our state and were able to identify an interpreter through the network of refugee resettlement agencies. We were able to link the member and the care coordinator via phone with that rare language interpreter.

Albert Cardenas: We are in an area where our community is very diverse, so we have access to interpreters of a multitude of languages. For our face-to-face interpreters, we have vendors that are able to provide language services for not only our threshold languages, but other languages as well. We have not felt a shortage because we are able to rely on our vendors. If we are unable to secure a face-to-face interpreter, we rely on telephonic interpreters. Our telephonic interpretation vendors can provide interpretation for over 200 languages.

Q6: Do you have any translation software recommendations for written materials?

Albert Cardenas: CalOptima's contracted vendors use two translation software programs, Trados Translation Memory (TM) and XTM. CalOptima is also in the process of implementing Trados TM for our in-house CalOptima translators. As new documents are entered into Trados TM software, the program identifies and translates all previously stored words, sentences, and paragraphs and then highlights the sections that still need to be translated. This software helps the translator streamline the process and increases productivity, quality, and consistency of each translated document.

Q7: When considering persons with low literacy, are there organizations or reference materials you would recommend for strategies for providing written materials to members?

Darci Graves: I would recommend CMS' *Toolkit for Making Written Material Clear and Effective*. The toolkit is aimed at ensuring documents are appropriate based on plain language as well as helping to address low health literacy. You can find the toolkit here: https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit/.

Q8: How does CalOptima assist members whose language preference is American Sign Language (ASL) in completing Health Risk Assessments (HRAs)?

Albert Cardenas: Members whose language preference is ASL have the following options when requesting assistance from our plan (including assistance with completing the HRA):

1. Members can communicate telephonically through California Relay Service.
2. Members can come into our office and we can schedule an ASL interpreter with advanced notice. If no advance notice is given, we assist the member through our video relay service.

3. We provide video relay via iPad. We contract with a vendor that supplies us with iPads with a built-in application; the application connects with a live interpreter.
4. Members can schedule an in-home visit with an ALS interpreter and their Personal Care Coordinator.

Q9: What happens when a CalOptima member who speaks a non-threshold language receives correspondence in English, as is CalOptima's policy? Is there a process for helping them understand that material?

Albert Cardenas: We do have a process for this. The majority of our member notices and materials that we send out have a material ID number at the bottom. If a member calls and they have received a correspondence, we get an interpreter on the line for that language and ask the member to provide the ID number on the correspondence. Our customer service representatives have access to these materials, so they identify the type of correspondence, and through the interpreter, read the letter to the member. We can help all members in this way, including English-speaking members with limited literacy.

Q10: How do you determine the quality of the translation– written, telephonic, and in-person– in terms of accuracy and comprehensiveness? Is there any process in place to ensure interpreters translate accurately?

Albert Cardenas: For written translation, 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 requests, we either translate internally or send translation requests out to our vendors to translate. For both internal and vendor translation, translators go through the three-step process of translating the document, sending it to a second translator to review for accuracy, and then the original translator finalizes the document. We find this three-step process ensures that the translation is accurate.

For telephonic interpretation, we audit the calls. The call audits evaluate whether the representative interpreted the content of the call accurately. We include this as part of our process for evaluation. We do not have a direct process for auditing in-person interpretation, but we do conduct annual audits of contracted vendors. During the vendor audit, CalOptima obtains the names of interpreters that provide services to our members and proof of their qualifications. For our internal employees, a language assessment is conducted upon hiring to ensure they are able to speak the language fluently.

Q11: Given the benefits of face-to-face interpretation, how frequently do members receive face-to-face interpretation versus telephonic?

Albert Cardenas: Members use both telephonic and face-to-face interpretation daily. The most common use for face-to-face interpretation is for medical appointments and when members come in to CalOptima's office. We average over 1000 requests per month for face-to-face

interpretation and over 38,000 requests for telephonic interpretation for both Medicare and Medicaid.

Meeting Language Preferences

Q12: Does CalOptima have Personal Care Coordinators (PCCs) for all of the threshold languages?

Albert Cardenas: Yes, we have Personal Care Coordinators for all the threshold languages. The major threshold languages with the largest populations are Spanish, Vietnamese, and Farsi. Korean, Chinese, and Arabic are the other three threshold languages, but they tend to be spoken by smaller populations than the others. We try to match members with a Personal Care Coordinator that speaks their language.

Q13: What types of training do you conduct during your five-week new employee orientation?

Albert Cardenas: New employees go through rigorous training to ensure they are prepared to handle any type of member call. The training begins with the required organization compliance training and ends with a final assessment to ensure the training was effective. Our training manual contains content on call center expectations, HIPAA/privacy, cultural linguistic services, plan benefits, internal/external systems training, policies and procedures, and community resources, among others.

Q14: Could you say more about the importance of having bilingual customer service representatives and how that helps create a comfortable and great experience for limited English proficiency members?

Albert Cardenas: In my experience, members develop a greater connection and a higher level of trust with their plan when they are able to speak in their preferred language. We have members that develop an attachment to certain customer service representatives because they speak their language, and they usually have a higher comfort level and trust that their issues will be addressed and resolved. When these members call or come in, they request the specific representative they are comfortable with. We do our best to accommodate their requests whenever possible. We also have members that develop a relationship with face-to-face interpreters. Some members want the same interpreter every time they have a doctor's appointment. Sometimes, if that specific interpreter is not available, they want to reschedule their appointment so that their preferred interpreter can attend. We evaluate that and try to meet the member's needs whenever possible. I also want to highlight one of Darci Graves' points about effective communication. Effective communication does create a better experience because members are more satisfied with the plan, and they tend to share more detailed information about their health with the customer service representatives and face-to-

face interpreters. This is a benefit for CalOptima because we can identify members' conditions faster without that language barrier.