

Medi-Cal Language Access Services Task Force

April 23, 2007

Meeting Notes

I. Introductions – see sign in sheet

II. Work Group Reports:

- Quality Assistance

Marty Martinez provided an update on the current efforts of the workgroup. The group is currently looking at 3 different levels of quality assurance, including certification process and standards, and looking at various models to replicate and/or draw from. The group also wanted to pose the question to the committee: How can consumers be educated about their rights to an interpreter and to complain without the burden for quality control being placed on the consumer?

- Cost-Finance

This workgroup did not meet but is currently working gathering data. The direction of this group will depend on the other groups.

III. Notes from the Field (Presentations)

- Melinda Paras, Health Care Interpreter Network (see copy of presentation)

Melinda presented information on the Health Care Interpreter Network (HCIN) which operates in 5 counties in Northern California (50 clinics and 3 hospital systems). The HCIN uses a videophone system that allows providers to access 300 interpreters using an internet broadband connection. Although the HCIN is publicly owned by various Northern California hospitals, providers pay annual fees ranging from \$40,000-60,000 to access it. Although the HCIN is similar to a broker model, the system has an enormous capacity itself. It is capable of serving the entire Medi-Cal population (California population in general) in administrative, medical, and some specialty care interpretive services. Most interpreters are employees of the various hospitals in the HCIN and are subject to the HCIN's certification and licensing standards. Besides having a high capacity, Melinda stated that the system is more cost-effective than other interpretation models.

- Jerry Wallerstein, Santa Clara Valley Health and Hospital System (SCVHS) (see copy of presentation)

Jerry provided an overview of their current system that employs 27 certified medical interpreters. On-site facilities include; 1) Language Services Department, 2) a Language Bank (of bilingual employees with primary responsibilities in other areas), and 3) use of outside contractors when necessary (telephonic, face-to-face, rare languages and American Sign Language). Primary responsibilities for interpreting are assigned to the Language Services Department that employs certified (with an internal certification process) medical translation primarily over the phone with some face-to-face appointments according to specified medical procedures (see presentation). Other interpretation includes use of the Language Bank that includes 450 bilingual employees who generally have an 'on-call' status. Participation in the Language Bank is voluntarily, with a salary differential and participants provide primarily clerical and basic medical interpretation. This arrangement has proven difficult in that it pulls employees away from their primary duties. Third party vendors also provide interpretation

services primarily for rare language. SVCHS attempted to train bilingual physicians but was unsuccessful in getting participation in the certification process because of busy schedules.

- Linda Okahara, Asian Health Services (see copy of presentation)
Linda provided an overview on Asian Health Services who both coordinates interpretation through the Language and Cultural Access Program (LCAP) and operates as a clinic that utilizes interpretation. The LCAP was established in 1994 in anticipation of the transition from Medi-Cal fee-for-service to managed care. Interpreters are available onsite, and via phone, although mostly onsite interpreters are requested. The LCAP includes a curriculum for training interpreters, as well as ongoing training opportunities.

IV. Creating the Model

Vivian Huang and Elia Gallardo, co-chairs of the Delivery Sub Group, presented and facilitated a discussion of the model (for diagram, see last page). The Delivery Sub Group presented a recommendation to the Task Force (Feb. 2007 meeting) that the Broker system be used for further exploration of what a model could look like in California. Some discussion has ensued about what a 'hybrid' version of the Broker system could include. The Task Force discussed a two-way process where some entities could contract directly with the state to receive reimbursement for interpretation services already provided and all others could participate via a broker system.

Some points for consideration were raised by the group:

- Brokers add an additional layer and additional administrative costs.
- If it is a provider-only (direct contracting with the state) system, would this eventually lead to under-funding (e.g. might be considered a 'lump package' with all other services on the provider claim)
- The taskforce should hear perspectives from other groups such as Kaiser, Sutter, employees and Medi-Cal providers and patients themselves.
- Mental health, where do they fit in the model?
- Who determines that a beneficiary is limited English proficient (LEP) (e.g. social services worker, self declaration, provider)?
- There is an administrative burden for Denti-Cal and Medi-Cal providers?
- Need a system to provide consumer education.
- Why not do direct billing?
- Need to consider how to address mixed counties (counties with both Fee For Service and managed care plans).

Vivian and Elia also identified questions which they need to have resolved in order to further guide their work, including:

- Who would the model serve?
- If we did decide to proceed, would the State allow various and numerous contracts?
- For direct contractors: How would we address fraud issue (for the small percentage that might abuse the entire system, how do we protect others)?
- How many direct contractors would be interested?
- For the state: Is this type of direct contracting feasible?
- Do we have an existing agency in California that would be able to become a broker?

V. Work Group Break-Outs

See: Individual meeting notes for the Delivery, Quality, and Cost Sub Groups.

VI. Next Steps

Task Force reconvened with report-outs from each sub group:

Cost & Finance:

- Graduate student (Ana Bagtas) will assist in reviewing utilization data to determine the number of Medi-Cal beneficiaries who have a 2nd language identified. Will also determine the types of medical services, the access points and frequency of access by LEP Medi-Cal beneficiaries.
- Will hold a conference call in 2 weeks.

Quality & Standards:

- Will continue considering alternatives for an interpreter the Certification System (name to be determined)
- Will need to review how to begin establishing interpreter medical competencies, how (or whether) to grandfather-in current interpreters, possible review of a phase-in for core competencies, and how to address the needs for mental health interpretation due to different jargon and training.
- Developing a statewide workforce: In order to ensure that at a minimum, current interpreters are available to continue to provide their services, certification standards need to initially be very basic. As training opportunities become available and vocational interest in interpretation increases the standards would be tightened to reflect a “high quality” level. A phase in of higher standards would occur over 5 to 7 years.

Delivery System:

- Next conference call in three weeks [update: next call is **May 11, 2007 @ 3pm**].
- Sub group has reviewed sample RFAs (Request for Applications) for both agencies (direct contractors) and broker. Sub group members have two weeks to review and submit any edits or feedback to the co-chairs (Elia & Vivian) by **Friday, May 4th**.
- Co-Chairs will be checking in with Carolyn and Irv (state representatives) to review the possible contract model for feasibility.
- Further information will be forwarded to the entire Task Force for review and feedback.

Other announcements:

- David had asked that members and guest complete a card that identified key decisions that still needed to be made and indicate who should be making the decision. Reminded members and guests to submit those cards before leaving.

Debriefing: David led group in debriefing the meeting

Gift:

- Lunch
- presentations
- visuals of hybrid model
- workgroup time
- facilitation of anxious people
- Lively discussion/dialogue
- We all fit in the room

EBI (Even Better If):

- Linking presentation with tasks (transition from presentations into discussion)
- Start meeting w/ objective (clarify)
- Coffee in the afternoon
- Specific presentation on Medi-Cal
- Someone from ‘purchaser’ community
- Addition input from other entities

Upcoming Task Force meetings:

All meetings are from 10:00 a.m. until 4:00 p.m. Meetings will all be held at:
Department of Health Services
1500 Capitol Avenue, Room 167
Sacramento CA

- Monday, April 23rd
- Friday, June 29th
- Monday, August 20th
- Monday, October 15th
- Monday, December 10th



Possible Hybrid Discussion

