

# **QUALITY ASSURANCE RECOMMENDATIONS FOR HEALTH CARE INTERPRETING IN WASHINGTON STATE**

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## I. SUMMARY

Limited English proficiency (LEP) contributes to disparities in health care. A system without adequate language provision and cultural competence can lead to substandard care and poor health outcomes. The use of trained interpreters in health care can improve access to quality care by supporting more accurate health care encounters. Over the long term, interpreter services may also decrease health care costs by reducing medical errors and unnecessary procedures. With changing demographics, the need for interpreter services is likely to increase.

The purpose of this paper is to present, to a broad group of stakeholders, recommendations that we believe will contribute to improvement in quality assurance regarding medical interpreting in Washington State. The recommendations have been developed during a yearlong process, which was funded by the Robert Wood Johnson Foundation (RWJF). The process has included expert consultation, individual and small group discussions, findings and knowledge previously gained in the course of our three-year grant (2002-2005) under the Foundation's *Hablamos Juntos* program, group stakeholder input at a large facilitated meeting, and on-line comments.

During this process, we considered a spectrum of opportunities for improving health care interpreter quality, from actions that single entities could undertake, to collaborative actions on a statewide and national scale. We took a broad and systematic approach to "quality assurance" and took into account feedback from stakeholders so that we could suggest realistic improvements. We attempted to include recommendations that will have more immediate impacts as well as recommendations that will take more concerted effort and time to produce results. We hope that these recommendations will be helpful to those affected when considering how to improve interpreting quality in Washington.

Throughout our process, we used a new interpreting quality model<sup>1</sup> based on national best practices and expertise in the field of health care interpreting. The summary graphic in Appendix A details the model that we used. It divides quality assurance activities into two distinct, but linked aspects:

- 1) **Interpreter** quality assurance (including competence): Assuring that the interpreter present for a health care encounter is doing a good job.
- 2) **Interpreter service delivery** quality assurance: Assuring that an appropriate interpreter is actually present to interpret for the encounter.

With the model as a guide, we developed interlinked and collaborative recommendations addressing eighteen entities in the interpreting system. This report<sup>2</sup> first presents recommendations in relation to the quality assurance model. Section V, presents recommendations sorted by the organization(s) most-suited to play a role in moving the recommendations forward. These are provided as a cross-reference to the model sections.

Our recommendations are more extensive for the interpreter quality assurance side of the model. This reflects RWJF priorities as well as our own judgment, based on experience and input about which recommendations are most actionable. We also have preferred to err in the direction of specificity. It is much harder to generate action based on vague recommendations, which we have sought to avoid.

The recommendations contained in this paper are intended to be approached collaboratively and cohesively. From the very first discussions we convened in 2002, participants identified collaboration and improved

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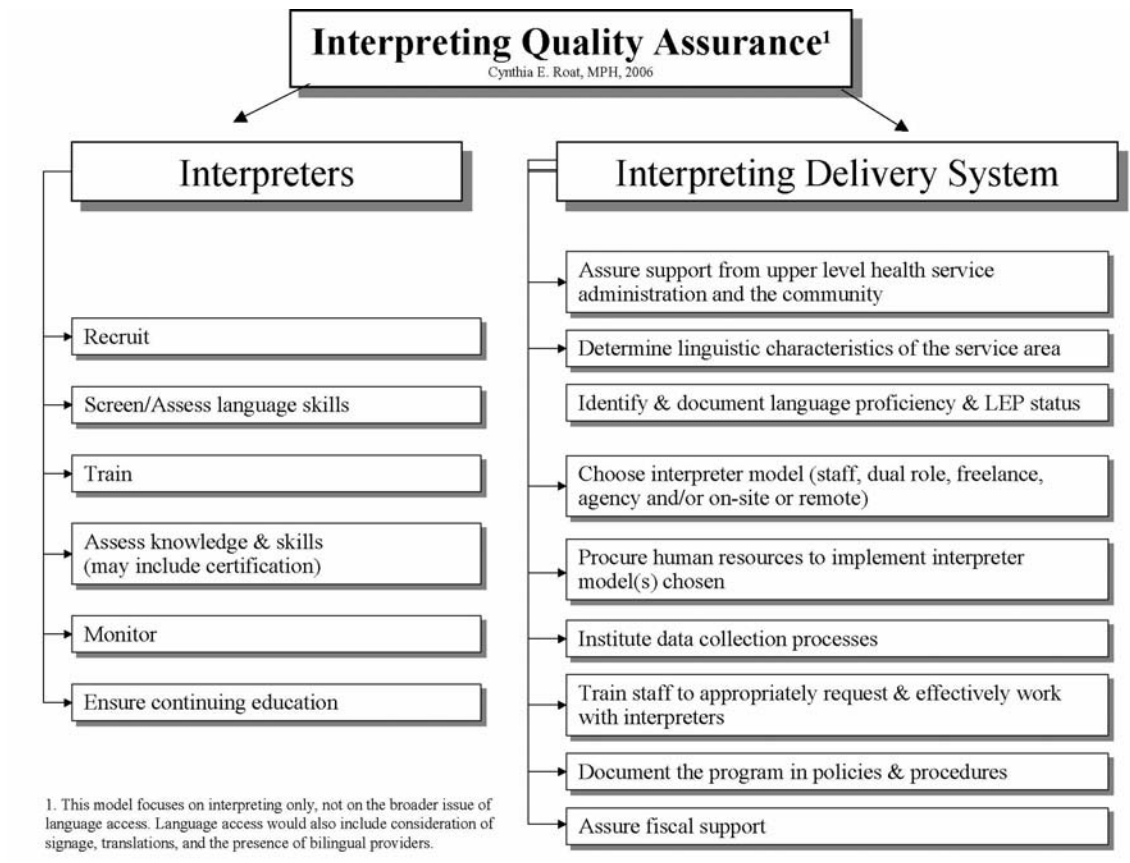
<sup>1</sup> Cynthia E. Roat, MPH, a national consultant in language access in healthcare, based in Seattle, developed the model.

<sup>2</sup> Other deliverables for the current grant are: Quality Assurance Approaches for Health Care Interpreting: Nationwide and Washington State, August 2006: <http://www.crhn.org/tusalud/wings/QualityAssuranceApproaches.pdf>. Quality Assurance Options for Health Care Interpreting in Washington State, October 2006: <http://www.crhn.org/tusalud/wings/QAoptions.pdf>.

communication, among participants and across systems, as critical for forward progress. This has only increased in importance the more we listened. No one entity can do everything that is required to improve interpreting quality. We urge recipients of these recommendations to seek ways to work together in order to amplify the benefits of what might otherwise be individual or disconnected modifications of interpreting. This will allow Washington State to maintain the reputation it now enjoys for leadership in health care language access.

Some recommendations are important for all stakeholders to adopt. These are listed in the table below. Recommendations specific to organizations can be found in section V.

<b>RECOMMENDATIONS TO ALL STAKEHOLDERS</b>
<ul style="list-style-type: none"> <li>▪ Adopt the Quality Assurance (QA) model (below and full size in Appendix A), recognizing that assuring interpreter quality requires a sequence of interconnected steps, especially with regard to screening, training, and assessment.</li> <li>▪ Where possible, collaborate and move toward standardization of expectations for interpreters and interpreter use.</li> <li>▪ Determine convening and participating roles among stakeholders and determine leadership in order to follow through on our recommendations or other improvements.</li> <li>▪ Establish a timeframe that allows for transition in interpreter requirements.</li> </ul>



## **II. RECOMMENDATIONS FOR HEALTH CARE INTERPRETER QUALITY ASSURANCE**

These recommendations are presented in relation to each element of the QA model in Appendix A; however, the recommendations are not comprehensive and detailed in every area. We have emphasized areas of the model that are more easily addressed, especially in the near term. For longer-term actions, transition strategies are often needed as recommendations are implemented. Recommendations overlap between several sub-sections of the model, such as screening and training.

### **II.A. RECRUITING INTERPRETERS**

While this is an important part of the model, we have not developed specific recommendations. There are advantages to stakeholders collaborating in recruitment, and using principles such as those developed by the State Board of Health. Likely stakeholders include: Community and Technical College system, Commission on Hispanic Affairs (CHA), Washington Association of Community and Migrant Health Centers (WACMHC), and Northwest Translators and Interpreters Society (NOTIS).

### **II.B. SCREENING/ASSESSING LANGUAGE SKILLS**

**Recommendation:** Screening should be better integrated with training, and eventually should be required, as part of the process for becoming a health care interpreter.

**Rationale:** Screening provides information on whether an individual is linguistically prepared to benefit from training. Screening before investing time and money in training and testing allows better use of resources and time. Screening is often not performed. Anecdotally, interpreters who took the Language and Interpreter Skills Assessment (L&ISA) as part of our RWJF project commented that screening allowed them to independently determine whether to pursue training or to improve linguistic skills before training. Candidates also approached training with a better understanding of any skill deficits.

**Stakeholder buy-in:** Generally, stakeholders agree that increased availability of screening and training are important and make sense. In order to maximize the benefit from screening, however, stakeholders identified a need for related actions, such as: increasing screening capacity; ensuring acceptable, standardized screening options; moving through an interim period of optional screening toward required screening; and exploring financing of screening, including how to finance and who would be responsible for costs.

#### ***Reservations about screening:***

In general:

- Concerns about availability of valid screening options
- Cost and time

Interpreters:

- Cost-benefit of the screening effort, especially for low diffusion languages

Organizations that contract or hire interpreters, including Department of Social and Health Services (DSHS):

- Potentially decreased number of candidates
- Administrative costs to perform or verify screening

#### ***Benefits of screening:***

- May increase the quality of interpreters
- Screening is likely to maximize the number of interpreters who pass a certification test by screening out those who are not linguistically prepared.
- May lead to improved collaboration among organizations that define a list of acceptable screening options and/or in contracting out for screening services.
- Required screening will increase screening options by creating demand for screening.

## II.B. SCREENING/ASSESSING LANGUAGE SKILLS

### Who:

- Interpreters
  - Pursue screening, independently or in response to future requirements
- Community and Technical College System
  - Define screening pre-requisites for entrance into interpreter training programs
- DSHS
  - Work with others to agree on mutually acceptable minimum level screening options to demonstrate language skills. Be prepared to work together to develop mutually acceptable criteria for screening.
  - Adopt a list of acceptable screening options.
  - Establish a timeframe and a transition strategy to require screening for new interpreters, prior to training or assessment/certification
- Organizations that contract or hire interpreters
  - Agree on mutually acceptable minimum level screening options to demonstrate language skills. Be prepared to work together to develop mutually acceptable criteria for screening.
  - Coordinate requirements for screening with others who use interpreter services
  - Integrate and require screening for interpreters, prior to training and/or certification
- Washington State Coalition For Language Access (WASCLA)
  - Serve as a repository of available means of screening language skills, perhaps via web site information
- NOTIS, CHA, Commission on Asian-Pacific American Affairs (CAPAA)
  - Provide referral information about available resources for screening and training
- Legislature
  - Clearly authorize DSHS to collaborate with other entities in the interest of creating more collaborative or unified expectations for interpreters, similar to how DSHS and Health Care Authority (HCA) partner with other health care purchasers to create consistent expectations for health care providers.

## II.C. TRAINING INTERPRETERS

**Recommendation:** Maximize coordination among stakeholders on transition strategies, time frame, requirements for training interpreters, and identification of acceptable training alternatives.

**Recommendation:** After transition, require standardized, valid training of interpreters, for common languages.<sup>3</sup>

**Recommendation:** Increase the availability of affordable short courses (40 hours or less) in health care interpreting.

**Rationale:** At this time, there are no national standards or accreditation for training in health care interpreting. The quality of interpreters is likely to increase if there are improved opportunities and expectations for participating in reliable and valid training. Training is generally optional and often occurs in isolation. Anecdotally, interpreters with training report increased confidence in certification testing and belief that it improved their scores. National standards for interpreter training are likely to be developed in the next two years, by national leaders such as the National Council on Interpreting in Health Care (NCIHC). While it is beneficial to participate and have a stake in that process, the complete incorporation of national standards will take time. It would be wise to begin the process of standardizing training in Washington now so that benefits are not delayed.

**Stakeholder buy-in:** Most stakeholders expressed support for improved interpreter training. Stakeholders saw a need for assessing/addressing capacity issues, and maximizing current training options. While stakeholders agree that training is an important step for improving interpreter quality, as with screening, an interim period is needed to improve the availability of training prior to requiring it. Currently, there are several options to obtain interpreter training, including: the community college system (more legal interpreting), Cross Cultural Health Care Program

<sup>3</sup> These recommendations may not be as appropriate for less commonly spoken languages (languages of limited diffusion), due to the reduced pool of potential interpreter candidates. Where few candidates exist, quality may be better served by allowing flexibility in the standards.

## II.C. TRAINING INTERPRETERS

(CCHCP), independent trainers, and some limited ad-hoc training.

### **Reservations** about training:

#### In general:

- Cost and time
- May decrease number of candidates who seek to become interpreters
- Availability and quality of existing training (including courses, curricula, trainers, and contracted all-inclusive services)
- Administrative costs
- There is a perception among some organizations that requiring training of contracted workers might create difficulties with regard to IRS issues of employee vs. contractor <sup>4</sup>

#### Community and Technical College system:

- Consistency of demand for training
- Autonomy of community colleges regarding curriculum development

#### DSHS:

- Not required by the consent decree

#### Organizations that contract or hire interpreters:

- Currently not required

### **Benefits** from training:

#### In general:

- Likely to have positive outcomes, such as an improved pool of interpreters who are also more aware of roles, ethics and professional behavior
- Opportunity to influence the NCIHC standards development process now underway
- Improved patient safety and error reduction
- Improved consistency of interpretation

#### Community and Technical College system:

- Potential for augmenting or developing interpreter training curricula
- May be a logical location for shorter and longer course trainings, especially if integrated with other Allied Health curricula

#### Provider organizations and associations:

- Train providers on how to work effectively with interpreters

#### Interpreters

- Increased awareness that training, maintenance of skills, and continuing education are important next steps in the profession

### **Who:**

- Community and Technical College system
  - State Board for Community and Technical Colleges work with individual community and technical colleges and experts to agree on a feasible method for coordinating or standardizing expectations and instruction in health care interpreting.
  - Expand offerings for training as a health care interpreter
  - Collaborate with local and national experts to develop standards for interpreter training offered by community colleges in order for the State Board for Community and Technical Colleges to augment or develop requirements for interpreter training curricula, especially as integrated with other Allied Health curricula
  - Consider flexible methods of training, possibly including contracting for established curricula and integrating with Allied Health programs as a public service
  - Bellevue Community College collaborate with CCHCP and others to explore expanding the health care interpreting module in its current interpreting program (focused more on legal interpreting).
- Department of Social and Health Services
  - Develop a timeframe and transition strategy to introduce training requirements for new Medicaid-reimbursed interpreters
  - Adopt a list of DSHS accepted interpreter training courses, and agree on such a list with others
- Organizations that contract or hire interpreters
  - Develop timeframe and require training
  - Agree on a list of accepted interpreter training courses (or contract out for training)
  - Explore funding strategies/subsidies to keep the cost of training and/or assessment affordable for interpreters
- CCHCP
  - Collaborate with potential partners, including hospitals and community health collaboratives (including

<sup>4</sup> However, within DSHS, Division of Alcohol & Substance Abuse (DASA) has long maintained certification requirements for alcohol treatment counselors, employed by contractors, including required training

## II.C. TRAINING INTERPRETERS

CHOICE Regional Health Network), to refine a business plan for increasing Bridging the Gap (BTG) training opportunities in terms of geographic availability and affordability to trainees in Washington State, as well as other locales as appropriate. Explore funding strategies (subsidies and sponsorships) to keep the cost of training and/or assessment of interpreters affordable. Consider continuing education opportunities in business planning.

- Collaborate with local and national experts to develop mutually agreeable standards for interpreter training offered by community colleges
- In Washington State, offer assistance to the Community and Technical Colleges system to develop or offer short courses (40-hours) in health care interpreting.
- Offer assistance to Bellevue Community College to explore expanding its current interpreting program to include health care interpreting.
- As part of Bridging the Gap training, provide information to participants regarding available resources for language screening, generally accepted assessment/certification tools, and the importance of continuing education.
- As guidelines develop, promote Continuing Education (CE)
- CCHCP and others (perhaps hospitals through subsidies and community colleges through financial aid)
  - Explore funding strategies/subsidies to keep the cost of training and/or assessment of interpreters affordable
- WASCLA
  - Work with NOTIS to create and maintain a centralized list of interpreter training opportunities. This might be linked to a searchable interpreter registry (see section IID).

## II.D. ASSESSING KNOWLEDGE AND SKILLS (MAY INCLUDE CERTIFICATION)

**Recommendation:** Maximize coordination among stakeholders on transition strategies, time frame, requirements for assessing interpreters, and identification of acceptable assessment alternatives.

**Recommendation:** After transition, require an assessment of interpreting knowledge and skills, prior to employment or contracting as a health care interpreter. (We assume that improved screening and training will accompany this step.)

**Recommendation:** Develop a shared list of acceptable evidence of ongoing competence. (For example, continuing education or re-certification.)

**Recommendation:** Develop or adapt existing searchable registries for access to validated information about interpreters. This might be accomplished through enhancement of the existing DSHS registry, or through a separate and broader system.

**Recommendation:** Do not pursue legislation for licensing or statutory certification of interpreters at this time, but recognize that as national standards develop, this issue may need to be revisited.

**Rationale:** Knowledge assessment is an important component of the model for *all* interpreters. Currently, not all interpreters are formally assessed or required to be certified. For interpreters to be reimbursed for Medicaid health care encounters, the interpreter must be certified or qualified by DSHS. Without screening, training, and requirements to stay up-to-date in the field, assessment/certification is likely to be less effective. It also is difficult to determine and verify the qualifications of interpreters because currently there are various methods to document competency but no central source, such as a clearinghouse, available. It is probable, as national standards develop, that interpreters will need to demonstrate ongoing competence through continuing education and/or re-certification, as in other health fields.

**Stakeholder buy-in:** There was general agreement among stakeholders that assessing the knowledge and skills of interpreters will increase confidence in the quality of interpreted sessions. Many stakeholders agreed that adequate assessment of interpreter quality is needed. Stakeholders highlighted the importance of being mindful of the rigor of the assessment, relative to screening/training and the availability of assessment tools. Stakeholders noted that an important step in assessing interpreter quality, as with screening, is an interim period to improve the availability and quality of assessment, before requiring it. Screening, training, assessment, and certification are linked to some degree

## II.D. ASSESSING KNOWLEDGE AND SKILLS (MAY INCLUDE CERTIFICATION)

and need to be pursued in collaboration. Specifics in Washington’s Medicaid assessment may be beneficial to modify, especially as assessment requirements are promoted more broadly among *all* interpreters. All stakeholders expressed reservations about pursuing licensure, at this time, due to concerns about expense, the developing nature of the field, and the likelihood that it would reduce the pool of interpreters.

**General reservations** about assessment (certification). In general, reservations about assessment (certification) varied across a spectrum of issues that include:

- If not linked to screening and training, assessment may not be a good indicator of quality and capability
- Burden on interpreter candidates
- Potential reduction in the available pool of interpreters, especially if assessment is rigorous and not accompanied by training
- Cost and time, to administer and maintain
- Concerns about the adequacy of the DSHS certification process
- Validity and reliability and availability of other current assessment tools
- Ability and willingness to create apply sufficiently rigorous standards and assessments
- Current lack of requirements for continuing education, re-certification, availability and accuracy of certification information

**Reservations** about *registries*:

- Reliability of information, especially if self-reported
- Potential liability issues for the entity maintaining the registry
- Registries alone are not adequate and support of registries could dilute or weaken the push for certification

**Concerns about licensing:**

- Expensive
- Risks excessive professionalization of a “grass roots” occupation

**General benefits** about assessment (certification):

- Method to ensure minimum capabilities of interpreters
- Provides employers with a benchmark/guideline for interpreter capabilities
- Once in place assessment/certification could be linked with continuing education and expiration dates to encourage up-to-date interpreter expertise

**Benefits** from *registries*:

- Provide clearinghouse to search for an interpreter
- Could be easier and less expensive to develop and implement compared to certification
- Can be designed to address experience and continuing education

**Who:**

- Other organizations that contract and hire interpreters, including other state agencies such as Department of Corrections (DOC) and Department of Labor and Industries (L & I):
  - Require some kind of skills assessment of all new interpreters
  - Adopt a list of acceptable assessment/certification options
  - Specify requirements needed to provide evidence of ongoing competence, such as continuing education and/or certification
  - Participate in an interpreter registry. This would involve using the registry and providing information on interpreters, and may also include help in funding start-up and maintenance of the registry
- Department of Social and Health Services:
  - Consider re-certification requirements for current and future interpreters, with appropriate transition.
  - Modify/expand the current interpreter registry to include additional information, such as certification date,

## II.D. ASSESSING KNOWLEDGE AND SKILLS (MAY INCLUDE CERTIFICATION)

status (active vs. inactive), and continuing education; or participate with others in development and use of common registry. For example, collaborate with Pacific Medical Centers (Pac Med), to pilot or adapt the searchable registry of the California Healthcare Interpreting Association (CHIA).

- Require pre-requisites (such as screening and training) prior to assessment/certification.
- Work with others to seek agreement on acceptable forms of interpreter skill assessment, as developed.
- NOTIS
  - Using member expertise, assist other stakeholders in the national process to develop tests for health care interpreters
- PacMed and DSHS
  - Collaborate with California Healthcare Interpreting Association to pilot or adapt the CHIA interpreter self-reported and searchable registry
- CCHCP and others (perhaps hospitals through subsidies and community colleges through financial aid)
  - Explore funding strategies/subsidies to keep the cost of training and/or assessment of interpreters affordable. (See training under CCHCP recommendation)
- Legislature
  - Given the need for a more extensive and shared interpreter registry, and the need for fiscal responsibility, authorize DSHS to expand its registry in collaboration with the public and private sector, or to shift to shared use of an independent registry, in order to avoid duplicative effort and provide more up-to-date interpreter data.

## II.E. MONITORING HOW WELL INTERPRETERS DO THEIR JOB

While this is an important part of the model, we have not developed specific recommendations. Many aspects of monitoring interpreters are related to organizational policies and procedures, and we leave these to individual organizations.

## II.F. ENSURING CONTINUING EDUCATION

**Recommendation:** Create and promote opportunities for continuing education for interpreters

**Recommendation:** As CE opportunities increase, plan to implement standardized continuing education requirements that interpreters must meet in order to maintain active status.

- Establish a time frame/transition strategy for this

**Rationale:** The availability of continuing education for interpreters is limited and inconsistent. Without continuing education in some form, even experienced and active interpreters have few opportunities to hone their skills, develop new skills, or keep up with rapidly evolving developments in the interpreter field, as well as new medical terminology. Any continuing education requirement for interpreters should be phased-in as the number of opportunities increase.

**Stakeholder buy-in:** A complete approach to quality assurance requires CE, however, many organizations that contract for or hire interpreters, including DSHS, do not address or require continuing education. The Northwest Translators and Interpreters Society is currently leading monthly educational forums for interpreters in the Seattle area, and is interested in diversifying and expanding that role.

*Reservations* about requiring continuing education:

In general:

- Availability
- Cost and time

*Benefits* of requiring continuing education:

- Improved quality of interpreter pool
- Improved ability of organizations that hire or contract out interpreters to evaluate what interpreters are active
- Can be made accessible via distance learning
- Opportunity for collaboration with others (to develop or contract for CE) and develop standards for CE

## **II.F. ENSURING CONTINUING EDUCATION**

### **Who:**

- DSHS
  - With appropriate transition, require continuing education in order to stay on the registry.
- Organizations that hire or contract out interpreters:
  - Develop options and directions for encouraging and possibly requiring continuing education from future and current interpreters.
  - Within any interpreter training provided, stress the importance of continuing education, provide information about opportunities, and promote continuing education guidelines once they exist
  - Promote and financially support existing opportunities for interpreter continuing education.
- NOTIS
  - Diversify and expand offerings for continuing education for interpreters, possibly through the Medical Interpreters Special Interest Group (MedSIG), a subgroup of NOTIS
- Community and Technical College System
  - Explore hosting continuing education courses for interpreters, including use of distant learning equipment and networks

### III. RECOMMENDATIONS FOR INTERPRETING DELIVERY SYSTEM QUALITY ASSURANCE

The focus of the RWJF in funding this project was interpreter quality, and our recommendations are generally more detailed on the “left side” of our quality assurance model. In this section, dealing with the “right side” of the model, we present recommendations for selected components of the model that are particularly amenable to collaborative action.

#### **III.A. ASSURING SUPPORT FROM UPPER LEVEL HEALTH SERVICE ADMINISTRATION AND THE COMMUNITY**

**Recommendation:** Health care organizations, malpractice carriers, and others who sponsor risk reduction training address language access-related risk of error and patient safety. This would bring interpreting into a framework that has a clear financial impact including insurance rates.

**Recommendation:** Language Access advocates can ask managed care health plans contracted under Healthy Options/Basic Health to provide information about how they comply with specific requirements in the contract.

**Recommendation:** Interested parties bring informal stories and anecdotes as well as formal data and regulations together in order to provide reasons to use the QA model and provide improved interpreter services.

**Rationale:** Motivation to improve language access is a complex mix of finance, mission, data on patient safety/risk reduction needs, and regulations. Without the full support of upper level administrators and influential community leaders, language access issues are not likely to receive optimal attention in the provision or financing of health care. Upper level support is a critical step to progressing through the steps of the QA model infrastructure. Senior managers already give attention and resources to quality and safety issues; they need to be shown how language access fits into this category of concern. While senior managers tend not to prefer regulatory or accreditation requirements as a way to make decisions, once requirements exist, they certainly pay attention to them. Knowledge of health plan requirements, empirical evidence of risks due to language failures, and anecdotal stories can draw attention to language access issues and potentially adjust the focus of existing quality improvement efforts.

**Stakeholder buy-in:** Variable, in part because of the complex mix of finance, mission, patient safety/risk reduction needs, and regulations. Buy-in among stakeholders is also influenced by perceived or documented needs related to language access, institutional history of services, mission, and legal challenges. Advocates and organizations may approach solutions in differing ways. Advocates clearly understand the need for support of language access by senior level managers.

**Reservations** expressed by stakeholders about seeking and building support by upper level administrators:

- Time and cost to organizations to implement language access policies and procedures
- Unclear or no requirements/regulations for organizations
- Inadequate knowledge base among administrators to plan and/or implement language access services
- Among administrators, lack of perceived or documented need for language access policies and procedures

**Benefits** of seeking and building upper level support:

- Clear guidance and integrated policy within organizations
- Risk reduction and improved patient safety
- Greater likelihood of meeting or surpassing regulatory guidelines/standards
- Upper level administrator commitment to language access issues builds community support for the organizational language access efforts
- Advocates more comfortable about bringing data (formal or informal) to organizations in collaborative non-adversarial terms
- Reward to community and organizations for making visible improvement in language access issues

### **III.A. ASSURING SUPPORT FROM UPPER LEVEL HEALTH SERVICE ADMINISTRATION AND THE COMMUNITY**

#### **Who:**

- Organizations that hire or contract interpreters
  - Use data, accreditation and risk management processes to motivate upper level management to address language access. Share successful strategies.
- Washington State Hospital Association (WSHA) and its members
  - Seek ways to share successful language access practices among hospitals
- Governor’s Interagency Council on Health Disparities
  - Seek information from DSHS and the Health Care Authority on health plans’ manner and level of compliance with requirements to assure language access that are contained in managed care contracts for Healthy Options and Basic Health
- WASCLA
  - Act as a repository of validated stories illustrating how language access is a risk element within the broader concern of patient safety and error reduction.
- Experts in the field, for example: NCIHC, CHIA, CCHCP, PacMed, Massachusetts Medical Interpreters Association (MMIA)
  - Develop national research strategies and provide data to demonstrate language access safety issues.

### **III.B. CHOOSING AN INTERPRETER MODEL (STAFF, DUAL ROLE, FREELANCE, AGENCY AND/OR ON-SITE OR REMOTE)**

Choosing a model for interpreting is generally an institutional decision, reflecting organizational capacity; the volume and range of interpreting needs; the funds available; requirements that accompany funding; and the market for personnel who would be appropriate to use in varying models.

### **III.C. PROCURING HUMAN RESOURCES TO IMPLEMENT INTERPRETER MODEL(S) CHOSEN**

This element of the model is from the point of view of a hiring institution. As a systems issue, the observations about recruitment, training and other issues on the “left side” of the model contain recommendations that are relevant and we will not repeat the information here.

### III.D. TRAINING STAFF ON HOW TO EFFECTIVELY WORK WITH INTERPRETERS

**Recommendation:** Require training for health care providers and staff on how to effectively *work with an interpreter*, and provide incentives for them to do so.

**Rationale:** It is fairly common to find training in health care organizations about how to *request* interpreter services (generally a matter of organization-specific procedures). It's much less common to encounter training in how to *effectively work with interpreters* (which is about individual skills that clinical providers and their support staff must possess). Both are important if interpreters are to be obtained and used in ways that minimize dangerous communication problems.

**Stakeholder buy-in:** Most stakeholders expressed that training on how to effectively work with an interpreter is beneficial. Stakeholders have variable opportunities and requirements for training.

**Reservations** about training on how to effectively work with interpreters:

- Cost and time to conduct training
- Low priority for training on working with interpreters, often due to organizational or provider lack of understanding regarding the need for training
- Limited availability of trainings
- Questions about validity of trainings that are available

**Benefits** of training on how to effectively work with interpreters:

- Improved patient-provider communication
- Improved patient safety
- Reduced inefficiencies in interpreted sessions since those involved better know how to conduct an interpreted session

**Who:**

- Interpreters
  - Encourage health care organizations to provide or require training for medical staff and employees on how to effectively work with interpreters
- Organizations that hire or contract for interpreting services, including DSHS if appropriate:
  - Train health care providers and staff in the skills to more effectively work with interpreters.
  - Partner with organizations with expertise in cultural competency and interpreter training to determine most effective ways to provide training in working with an interpreter (i.e. develop own, use on-line or video modules, bring in an external trainer).
- Washington State Medical Association (WSMA) and its members
  - Work with CCHCP, WACMHC and others with expertise to take a leadership role in developing or promoting staff and provider training for issues related to language and how to effectively work with interpreters. An example is the existing WSMA Power Point presentation for provider training about interpreting services.
- WASCLA, NOTIS
  - Work together to create and maintain a centralized list for training focused on how to effectively work with interpreters. This could, for example, be attached to the searchable interpreter registry.
- WASCLA and WSHA
  - Identify local and national organizations, for example: CCHCP, Pac Med, CHIA, NCIHC& MMIA, with successful processes to train staff on how to effectively work with interpreters. Consider sharing the techniques with members and other stakeholders.
- Community and Technical College system
  - Add content to allied health programs on how to work with interpreters.
- CCHCP
  - Partner with WSMA and others to offer continuing education and training in how to effectively work with interpreters
- Experts in the field for example: CHIA, NCIHC, MMIA
  - Identify successful processes to train staff on how to effectively work with interpreters. Share the techniques with other stakeholders.

### **III.E. ASSURING FISCAL SUPPORT FOR INTERPRETING**

“Assuring fiscal support” shows up on the “right side” of the quality assurance model (“Interpreting Delivery System”) but the financial issues actually crosscut all elements of the model, so we are addressing them later in this paper, among other cross-cutting recommendations. (See Section IV.C.)

### **III.F. PROCEDURAL AREAS WITH NO RECOMMENDATIONS LISTED**

The following four areas on the “right side” of the interpreting QA model are closely related to institution-specific procedures and processes. This paper contains no separate, specific recommendations related to these areas of the model, but each component is vital to assuring quality and stands as a recommended practice even without further explanation.

For further discussion of the model see <http://www.crh.n.org/tusalud/wings/QualityAssuranceApproaches.pdf>

No recommendations listed:

- 1) Determine linguistic characteristics of the service area
- 2) Better identify and document language proficiency and LEP status
- 3) Data collection
- 4) Document the program in policies and procedures

## IV. RECOMMENDATIONS THAT CUT ACROSS ELEMENTS OF THE MODEL

### IV.A. INTEGRATING INTERPRETER PRE-REQUISITES AND ASSESSMENT ELEMENTS OF THE MODEL

**Recommendation:** Require screening and training in addition to assessment (certification).

**Rationale:** Sections on screening, training, and assessment include separate recommendations, however the three are heavily inter-connected. Health care interpreter quality assurance may be better served by integrating these elements. Hard of Hearing and Court Interpreter models have prerequisites and requirements to become an interpreter and maintain active interpreter status that may be helpful models for health care interpreting.

**Stakeholder Buy-in:** Better integration of screening, training and assessment makes sense to stakeholders. Details about time frame, requirements, and pre-requisites need to be clarified.

**Reservations** about integrating elements of the model:

- See individual reservations for screening, training, and assessment

**Benefits** of integrating elements of the model:

- Benefits exist for requiring each individual component (screening, training, assessment), however the combined benefit is even greater. (See Sections on screening, training, and assessment.)

**Who:**

- All those concerned with putting in place better standards for screening, training, and assessment/certification should work together to:
  - Develop acceptable criteria standards for screening, training, and assessment. (Determine appropriate convener, might possibly include DSHS, CCHCP, Community and Technical College system, and WASCLA)
  - Collaborate with other stakeholders in developing, integrating, and requiring *pre-requisites* of screening and training prior to assessment (certification)
  - Collaborate on integrating *requirements* for screening with other organizations who use interpreter services
- DSHS
  - Work with others to agree on mutually acceptable and integrated screening, training, and certification requirements for interpreters, which can be used as a pre-requisite for reimbursement by DSHS.
- Experts in the field, for example: NCIHC, MMIA, CHIA
  - As possible, make available, to state entities, minimum criteria for acceptable interpreter screening, training, and assessment.
  - Provide input/expertise on short-term strategies to improve interpreter screening, training, and assessment pending development of national standards.

## IV.B. TRANSITION STRATEGIES

**Recommendation:** Recognizing that national standards are likely to be developed, plan for transition to integrated interpreter quality assurance requirements and new pre-requisites.

**Rationale:** Building transition strategies will allow current interpreters to continue practicing while setting the stage for improved quality assurance. An immediate change from limited requirements to more rigorous requirements will likely have negative effects.

**Stakeholder Buy-in:** Stakeholders are in clear agreement that transition strategies are necessary.

**Reservations** about transition strategies:

- None expressed

**Benefits** of transition strategies:

- Allows for more logical progression of interpreter preparation
- Builds on expected professional standards
- Prevents loss of and/or potential decrease in number of interpreters due to increased requirements

**Who:**

Specific recommendations, to each organization, related to transitions are under each category of the model as appropriate. All general recommendations apply here as well (See Sections IIB, C, and D on Screening, Training, and Assessment/Certification). Developing a transition to new standards requires overall leadership. (See Section IV.D on Sustainability.)

**IV.C. RECOMMENDATIONS FOR ASSURING FISCAL SUPPORT FOR INTERPRETING AND INTERPRETING DELIVERY SYSTEM QA**

**Jumpstart/Single Source fiscal support**

**Recommendation:** Collaborate to seek short term funding to jump start progress through a \$50,000 to \$100,000 package of specific financial incentives to improve interpreter Quality Assurance and extend available interpreter training. (The Governor’s Interagency Council on Health Disparities would be in a good position to develop recommendations for such a package.)

**Recommendation:** Stakeholders create a business plan and source(s) of sponsorship/contributions for interpreter training short courses.

**Rationale:** A small amount of start-up funds (legislative or otherwise guaranteed) could get things going fast, especially if there is a local match component. From our experience it appears reasonable to believe that the amount of money needed for training courses could be found through existing charitable and organizational sources, given collaboration.

**Ongoing fiscal support**

**Recommendation:** Maintain sponsorship/contributions for interpreter training short courses.

**Recommendation:** Support the efforts of organized community health care collaboratives to create a local focus on actions and investment to improve language access issues as part of improved health care outcomes.

**Recommendation:** Long-term, develop advocacy for more direct funding for interpreting outside of Medicaid.

**Rationale:** While Washington is unusual among states in that a significant portion of funding for language access comes through the Medicaid programs, this funding is always at risk of being reduced or eliminated in state budgets. Interpreting is almost certainly under-provided in aggregate. Improved QA methods and sustaining any kind of leadership role will also cost money. Existing financing approaches are limited. A significant portion of the state’s LEP population does not qualify for Medicaid-reimbursed interpreter services

For ongoing actions such as interpreter training, the cost of the short course (40 hours) is modest, approximately \$7,000 to \$10,000, depending on contracted trainer rate. More extensive training, perhaps linked to Allied Healthcare curricula within the community college system, has a longer start-up time but once it exists, has stable funding and provides long-term benefits.

Currently, at least nine community collaboratives operate in Washington State. Some have special interest in the problem of language access, which has been recognized as an issue by Communities Connect, a statewide affiliation of community healthcare collaboratives with members active in 25 of Washington’s 39 counties.<sup>5</sup>

**Stakeholder Buy-in:** Many stakeholders agree on the need for funding, but differ as to how to obtain it. Funding alone is not adequate because, time, leadership, effort, and infrastructure are needed, as well as funding.

**Reservations:**

- Cost, time, and administrative cost
- Potential loss of initial funding
- Varied agenda and priorities among participant stakeholders

**Benefits:**

- If long-term funding is made available, a greater proportion of LEP individuals’ needs can be met (not just those who are Medicaid-eligible)
- Build and maintain infrastructure and capacity
- Better able to implement the QA model

<sup>5</sup> For more information on Communities Connect and the Community Health Management District concept, contact Sue Sharpe at [suesharpe@msn.com](mailto:suesharpe@msn.com).

#### IV.C. RECOMMENDATIONS FOR ASSURING FISCAL SUPPORT FOR INTERPRETING AND INTERPRETING DELIVERY SYSTEM QA

**Who:**

- WSHA/WSMA and its members
  - Advocate for health insurance coverage to include earmarked funds for the cost of interpreting
- Community and Technical College system
  - Collaborate with community organizations that hire or contract with interpreters to subsidize the cost of training in a way that is mutually beneficial to interpreter training, programs and organizations
- Legislature
  - Consider appropriating funding at the \$50,000 to \$100,000 level for a package of specific financial incentives to improve interpreter Quality Assurance and extend available interpreter training
  - Clearly authorize DSHS to collaborate with other entities in the interest of creating more collaborative or unified expectations for interpreters, similar to how DSHS and Health Care Authority partner with private health care purchasers to create consistent messages for providers of health care. For example, given the need for a more extensive and shared interpreter registry, and the need for fiscal responsibility, indicate support for DSHS to participate in a process to expand its registry in collaboration with the public and private sector in order to build on currently available registries and provide more up-to-date interpreter data.
- Washington Health Foundation (WHF)
  - Consider continuing to support the expansion of interpreter training in geographic areas that lack it. Existing WHF grant programs provide potential funding, but more focused participation in a collaborative plan of action might produce more sustainable results for the investment.
- Other organizations that hire or contract interpreters
  - Explore funding strategies/subsidies to keep the cost of training and/or assessment of interpreters affordable

#### IV.D. SUSTAINABILITY

**Recommendation:** Establish leadership roles among language access stakeholders. We see two main alternatives:

- A new organization or an existing organization (with enhanced resources) could assume the collaborative leadership in all areas. For example: Washington State Coalition for Language Access (WASCLA) could do so with an additional focus on health care interpreting.
- Develop a collaborative structure among stakeholders with sub-groups of existing organizations leading on specific issues. For example: State Board for Community and Technical Colleges might provide leadership in defining adequate interpreter training

**Recommendation:** Interpreters explore how they can participate in a way that creates better opportunities for a livelihood from interpreting.

**See also:** Recommendations regarding assuring fiscal support (Section IV.C above).

**Rationale:** For our recommendations to succeed longer-term, they must become part of a more enduring process for developing and sustaining public policy and private collaborative action. WASCLA and NOTIS are specifically mentioned in this recommendation because of their current roles and potential to take on expanded leadership. Conceivably, DSHS could take this leadership role, but it would be such an expansion of current roles that it likely is not realistic. The Governor’s Interagency Council on Health Disparities could play an invaluable role, but it is unclear whether it has the long-term capacity to exercise public/private leadership. This issue needs to be better clarified in order to determine its leadership role. Interpreters need to participate because they have day-to-day perspective and are impacted by issues of livelihood.

**Stakeholder buy-in:** Stakeholders agree that language access is important, and recognize that a leadership role, especially without mandate and/or funding, is challenging. They expressed that if organizations take on a leadership role they deserve financial support such as might be possible a modest legislative request or through pooling of community benefit donations from health care improvement organizations. WASCLA is willing and motivated to

#### IV.D. SUSTAINABILITY

provide leadership and would need to broaden its focus to include a greater emphasis on health care. NOTIS intends to collaborate with other stakeholders, and bring their expertise to areas such as providing training and CE opportunities. Other stakeholders appeared to welcome leadership from these organizations.

##### **Reservations** about sustainability and collaboration:

- Building trust among disparate collaborators may be difficult
- Moving from discussion to effective action will be challenging, especially given the fiscal needs
- Varied agenda and priorities among participants
- Uneven development and resources among stakeholders in terms of language access

##### **Benefits** of sustainability and collaboration:

- Ability to sustain progress
- Improved ability to impact policy on a broader scale
- Better integrating policy on language access with broader health care policy
- Potential cost savings from collaboration
- Improved consistency in policies and expectations
- More likely to encourage acceptance of our overall QA model

**Who:** Some of these recommendations are associated with individual components of the model. Specific recommendations related to sustainability that are not found elsewhere are listed below.

- In general:
  - Determine convening and participating roles among stakeholders and assign more specific leadership in order to follow through on recommendations.
  - All stakeholders should participate in developing the collaborative leadership structure including sub-groups.
- WASCLA/NOTIS
  - Leadership recommendation: NOTIS and WASCLA are well qualified and motivated to provide leadership. WASCLA would need to broaden its focus to include greater emphasis on health care, and NOTIS would need more capacity. We recommend that the two groups discuss their interest and needs regarding sustaining future leadership. WASCLA may be better prepared to take this role, but some combination of the two groups would provide an excellent core.
  - Approach Governor's Interagency Council on Health Disparities to test their interest in a leadership/host role.
- Community and Technical College system
  - Consider leadership in broader efforts to define adequate interpreter training.
- DSHS
  - Participate in policy development with other collaborators
  - Take a leadership role in developing collaborative strategies to integrate screening, training, and assessment
- Governor's Interagency Council on Health Disparities
  - Consider ways to develop partnership approaches to leadership with private organizations such as NOTIS and WASCLA as well as to state agencies. Develop funding and government policy recommendations for language access.
- WACMHC
  - Provide assistance to other stakeholders in developing staff and provider training for issues related to language and how to effectively work with interpreters. This training should be available to other organizations serving underserved populations in Washington State.
- CCHCP
  - Work with the community college system to provide leadership in defining adequate interpreter training
- Interpreters
  - Seek participation in leadership processes.

#### IV.E. PURSUE GROUP AGREEMENT AND CONTRACTING

**Recommendation:** Seek opportunities for setting joint policies or contract jointly in areas such as, interpreter screening, training, and purchased interpreting (including telephonic and video interpreting).

**Rationale:** Collaborative policies and group contracting can increase impact and decrease costs for implementing and maintaining the QA model.

**Stakeholder Buy-in:** Variable among institutions.

**Reservations** about group contracting:

- Less independence
- Potentially increased costs initially
- Logistically complicated

**Benefits** about group contracting:

- Improved interpreter system quality with likely improved interpreter availability
- Bulk/cooperative purchasing may reduce institutional/organizational costs
- Increased efficiencies

**Who:**

- Organizations that contract or hire interpreters
  - Pool resources in order to pursue group agreements or contracts for such services as screening, training, continuing education, and interpreting under various models including telephonic and video-interpreting.
- WSHA (if supported by its members)
  - Explore whether collaborative services and joint purchasing strategies among hospitals could effectively be expanded to include economical acquisition of the services such as: interpretive services (may include purchased or video-interpreting), language screening for interpreters, interpreter training (may include potential subsidies or scholarships for trainees).

**IV.F. FINE-TUNE THE BROKERAGE MODEL (LIKELY TO HAVE IMPACTS ON OTHER PARTS OF THE SYSTEM)**

**Recommendation:** Fine-tune some aspects of the brokerage model.

**Rationale:** The brokerage system, as it is currently administered, can be cumbersome for users and for interpreters. It does not encourage, let alone require all aspects of the interpreter QA model.

**Stakeholder buy-in:** The QA model, in the ideal, is broadly accepted. The efforts, collaboration, and expense for implementation, along with the time frame for change, may be challenging.

**Reservations** about brokerage model changes:

- Limited funding and statutory role.
- Consent decree (1991) specifies approaches
- Adopting some recommendations such as performance indicators for interpreters, brokers, and health care contracts or contracting directly with interpreters may be challenging.

**Benefits** to fine-tuning the brokerage model: variable depending on which changes occur in the brokerage system

- Greater flexibility in the system
- Strengthen the interpreting infrastructure
- Improve efficiencies
- Increased interpreter willingness to remain in the system
- Audits and performance indicators provide data to evaluate and improve QA model elements.

**Who:**

- Interpreters
  - Urge DSHS to consider a pilot project allowing the best qualified interpreters to contract directly with brokers
- DSHS
  - Require brokers to audit whether language agencies are sending trained and are certified interpreters.
  - Where possible, modify interpreter scheduling procedures to allow providers to schedule appointments more than a month in advance. For example, this may be possible for aged, blind, and disabled Medicaid patients whose eligibility status is very unlikely to change.
  - Create strategies to benchmark or share performance indicators on brokers and/or agencies. Possible approaches range from anonymous data to full public disclosure.
  - Allow pilots of alternatives to the brokerage system through interlocal agreements with local public health departments or other qualified local government entities that may be interested in innovations
  - As a pilot project, allow interested brokers to contract directly with the best qualified interpreters who meet additional requirements associated with quality (language screening, basic training, certification/qualification and a certain number of hours of continuing education per year) in addition to working through agencies, and to pay them the amount that would have gone toward agency fees.
  - Consider reopening the consent decree, if this is necessary, in order to update processes.
  - Remain open to change the current certification process, especially as national consensus models emerge

## **V.RECOMMENDATIONS TO INDIVIDUAL ORGANIZATIONS**

This section sorts recommendations according to the organization(s) most-suited to play a role in moving the recommendations forward. The body of the report presents recommendations in greater detail by components of the model.

### **V.A. RECOMMENDATIONS TO ORGANIZATIONS THAT CONTRACT OR HIRE INTERPRETERS**

#### Why this group is in a position to act

All organizations that contract and hire interpreters, regardless of size, have the opportunity and responsibility to provide high quality interpretive services. These organizations can phase-in requirements and standards for interpreters and can choose the appropriate amount of involvement and support to help interpreters meet those standards. Organizations should work together in order to save costs, to avoid reinventing the wheel, and to promote consistent expectations from interpreters, staff and providers, and patients around how language access will be assured across institutions. Examples of organizations that contract or hire health care interpreters include but are not limited to: hospitals, community health clinics, interpreter agencies, L&I, Department of Corrections and public health departments.

*General Recommendation:* Agree on mutually acceptable minimum level screening options, training programs, and assessment options to demonstrate language skills. Be prepared to work together to develop mutually acceptable criteria

#### *Screening/Assessing language skills*

- Agree on mutually acceptable minimum level screening options to demonstrate language skills. Be prepared to work together to develop mutually acceptable criteria.
- Coordinate screening requirements with others who use interpreter services
- Integrate and require screening for interpreters, prior to training and/or certification

#### *Training interpreters*

- Develop timeframe for transitioning to required training of interpreters
- Agree on a list of accepted interpreter training courses (or contract out for training)
- Explore funding strategies/subsidies to keep the cost of training and/or assessment affordable for interpreters

#### *Assessing knowledge and skills (certification)*

- Require some sort of skills assessment of all new interpreters
- Adopt a list of acceptable assessment/certification options.
- Specify requirements needed to provide evidence of ongoing competence, such as continuing education with or without certification
- Participate in an interpreter registry. This would involve using the registry and providing information on interpreters, and may also include help in funding start-up and maintenance of the registry

#### *Ensuring continuing education*

- Develop options and directions for encouraging and possibly requiring continuing education from future and current interpreters.
- Within any interpreter training provided, stress the importance of continuing education, provide information about opportunities, and promote continuing education guidelines once they exist.
- Promote and financially support existing opportunities for interpreter continuing education.

#### *Assuring support from upper level health service administration*

- Use data, accreditation and risk management processes to motivate upper level management to address language access. Share successful strategies.

#### *Training staff to effectively work with interpreters*

- Train health care providers and staff in the skills to more effectively work with interpreters
- Partner with organizations with expertise in cultural competency and interpreter training to determine most

## **V.A. RECOMMENDATIONS TO ORGANIZATIONS THAT CONTRACT OR HIRE INTERPRETERS**

effective ways to provide training in working with an interpreter (i.e. develop own, use on-line or video modules, bring in an external trainer).

### *Fiscal support*

- Explore funding strategies/subsidies to keep the cost of training and/or assessment of interpreters affordable.

### *Integrate interpreter pre-requisites and assessment elements of the model*

- Collaborate with other stakeholders in developing and requiring pre-requisites of screening and training prior to assessment (certification)
- Integrate requirements for screening with others who use interpreter services

### *Group agreement and contracting*

- Pool resources in order to pursue group agreements or contracts for such services as screening, training, continuing education, and interpreting under various models including telephonic and video-interpreting

## V.B. RECOMMENDATIONS TO DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)

### Why this group is in a position to act

These recommendations are made to DSHS because of its pivotal role in interpreter testing and certification (assessment), its status as a de facto trendsetter in statewide and national interpreting policy, and development and oversight of the brokerage model. Because DSHS has contact with so many health care interpreters as the administrator of the DSHS certification exam, it is in a unique position to model leadership in establishing and integrating a wide range of standards and requirements.

*General Recommendation:* Agree on mutually acceptable minimum level screening options, training programs, and assessment options to demonstrate language skills. Be prepared to work together to develop mutually acceptable criteria

### *Screening/Assessing language skills*

- Work with others to agree on mutually acceptable minimum level screening options to demonstrate language skills.
- Adopt a list of acceptable screening options.
- Establish a timeframe and a transition strategy to require screening for new interpreters, prior to training or assessment/certification

### *Training interpreters*

- Develop a timeframe and transition strategy to introduce training requirements for new Medicaid-reimbursed interpreters
- Adopt a list of DSHS accepted interpreter training courses, and agree on such a list with others

### *Assessing knowledge and skills (certification)*

- Consider re-certification requirements for current and future interpreters, with appropriate transition.
- Modify/expand the current interpreter registry to include additional information. For example, collaborate with PacMed, to pilot or adapt CHIA's searchable registry.
- Require pre-requisites (such as screening and training) prior to assessment/certification.
- Work with others to seek agreement on acceptable forms of interpreter skill assessment, as developed.

### *Ensuring continuing education*

- With appropriate transition, require continuing education in order to stay on the registry.

### *Integrate interpreter pre-requisites and assessment elements of the model*

- Work with others to agree on mutually acceptable and integrated screening, training, and certification requirements for interpreters, which can be used as a pre-requisite for reimbursement by DSHS.

### *Fine-tune the brokerage model*

- Require brokers to audit whether language agencies are sending trained and are certified interpreters.
- Where possible, modify interpreter scheduling procedures to allow providers to schedule appointments more than a month in advance. For example, this may be possible for aged, blind, and disabled Medicaid patients whose eligibility status is very unlikely to change.
- Create strategies to benchmark or share performance indicators on brokers and/or agencies. Possible approaches range from anonymous data to full public disclosure.
- Allow pilots of alternatives to the brokerage system through interlocal agreements with local public health departments or other qualified local government entities that may be interested in innovations
- As a pilot project, allow interested brokers to contract directly with the best qualified interpreters who meet additional requirements associated with quality (language screening, basic training, certification/qualification and a certain number of hours of continuing education per year) in addition to working through agencies, and to pay them the amount that would have gone toward agency fees.
- Consider reopening the consent decree, if this is necessary, in order to update processes.
- Remain open to change the current certification process, especially as national consensus models emerge

**V.B. RECOMMENDATIONS TO DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)**

*Sustainability*

- Participate in policy development with others. Take a leadership role in developing collaborative strategies to integrate screening, training, and assessment.

**V.C. RECOMMENDATIONS TO ALL STATE AGENCIES THAT PURCHASE HEALTH CARE INTERPRETING (E.G. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, DEPARTMENT OF LABOR AND INDUSTRIES, AND DEPARTMENT OF CORRECTIONS)**

Why this group is in a position to act

While it's beneficial for all stakeholders to work together, state agencies are in a unique position to share knowledge and expertise with each other. State agencies could serve as an example of collaborative process to help move interpreter quality assurance forward in an efficient way that achieves economies of scale. This collaboration, however, can also benefit other stakeholders. The expectation is that there will also be collaboration across systems. In order to better integrate interpreter pre-requisites and assessment elements of the model, collaborate together to meet the general recommendations. Not only plan to join together but also potentially collaborate with other entities involved in health care interpreting in order to jointly define requirements and desired attributes for improved interpreter quality through screening, training, and assessment.

*Integrating interpreter pre-requisites and assessment of the model*

- Collaborate, with other stakeholders, to meet the general recommendations in order to better integrate interpreter pre-requisites and assessment elements of the model.
- Work together to jointly define requirements and desired attributes for improved interpreter quality through screening, training, and assessment.

**V.D. RECOMMENDATION SPECIFIC TO PACIFIC MEDICAL CENTERS (PAC MED)**

Why this group is in a position to act

Since PacMed and others (Seattle-King County Public Health, Harborview Medical Center, and the University of Washington) are currently in the process of developing an interpreter registry, it is in a position to lead this process, especially in collaboration with CHIA, which has already developed a pilot searchable registry.

*Assessment of knowledge and skills (certification)*

- Along with DSHS, collaborate with California Healthcare Interpreting Association to pilot and/or adapt the CHIA interpreter self-reported and searchable registry

## V.E. RECOMMENDATIONS TO THE COMMUNITY AND TECHNICAL COLLEGE SYSTEM

### Why this group is in a position to act

Community and technical colleges are a core public investment in preparing graduates for the workforce and are well positioned to meet the growing need for interpreter training. The community college system, by state law, governs curricula and educational and training programs. There is, however, a strong tradition of curriculum and program development autonomy at individual institutions. The board and individual institutions, in collaboration, are more likely to develop a realistic approach to change. Furthermore, at this time, there is no accrediting organization for health care interpreting, leaving variability of programs greater than in most health care-related training programs.

### *General Recommendation:*

- State Board for Community and Technical Colleges work with individual community and technical colleges and experts agree on a feasible method for coordinating and standardizing expectations and instruction in health care interpreting.

### *Screen/Assess language skills*

- Define screening pre-requisites for entrance into interpreter training programs

### *Training interpreters*

- Expand offerings for training as a health care interpreter
- Collaborate with local and national experts to develop standards for interpreter training offered by community colleges in order for the State Board for Community and Technical Colleges to augment or develop requirements for interpreter training curricula, especially as integrated with other Allied Health curricula
- In state board leadership and individual institutions, consider flexible methods of training, possibly including contracting for established curricula and integrating with Allied Health programs as a public service
- Bellevue Community College collaborate with CCHCP and others to explore expanding the health care interpreting module in its current interpreting program (focused more on legal interpreting).

### *Ensuring continuing education*

- Explore hosting continuing education courses for interpreters, including use of Distant Learning equipment and networks.

### *Training staff how to effectively work with interpreters*

- Add content to allied health programs on how to work with interpreters.

### *Fiscal support*

- Collaborate with community organizations that hire or contract with interpreters to subsidize the cost of training in a way that is mutually beneficial to interpreter training, programs and organizations.

### *Sustainability*

- Consider leadership in broader efforts to define adequate interpreter training.

## V.F. RECOMMENDATIONS TO WASHINGTON STATE COALITION FOR LANGUAGE ACCESS (WASCLA)

### Why this group is in a position to act.

WASCLA is a relatively new statewide organization with long-term goals aligned with interpreter quality assurance, including but not limited to: developing quality standards and requirements for training, securing funding to support interpreter services and training, developing a centralized database, and increasing the pool of qualified interpreters. WASCLA is in the process of developing an action plan to improve interpreter/translation services.

### *Sustainability*

- Leadership recommendation: NOTIS and WASCLA are well qualified and motivated to provide leadership. WASCLA would need to broaden its focus to include greater emphasis on health care, and NOTIS would need more capacity. We recommend that the two groups discuss their interest and needs regarding sustaining future leadership. WASCLA may be better prepared to take this role, but some combination of the two groups would provide an excellent core.
- Approach Governor's Interagency Council on Health Disparities to test their interest in a leadership/host role.

### *Screen/assess language skills*

- Serve as a repository of available means of screening language skills, perhaps via web site information

### *Training interpreters*

- Work with NOTIS to create and maintain a centralized list of interpreter training opportunities. This might be linked to a searchable interpreter registry. (See Section IID)

### *Assure support from upper-level health service administration*

- Act as a repository of validated stories illustrating how language access is a risk element within the broader concern of patient safety and error reduction

### *Training staff on how to effectively work with interpreters*

- Work with NOTIS to create and maintain a centralized list for training focused on how to effectively work with interpreters. This could, for example, be attached to the searchable interpreter registry.
- Identify local and national organizations, for example: CCHCP, Pac Med, CHIA, NCIHC & MMIA, with successful processes to train staff on how to effectively work with interpreters. Consider sharing the techniques with members and other stakeholders.

### *Other*

- Consider serving as a repository of available screening and training opportunities, perhaps via web site information

## V.G. RECOMMENDATIONS TO NORTHWEST TRANSLATORS AND INTERPRETERS SOCIETY (NOTIS)

### Why this group is in a position to act

NOTIS provides a forum for professional interpreters and translators in the Pacific Northwest, with the intention to: provide information to newcomers; enhance the abilities of established practitioners; promote high standards; and promote the advancement of the profession. The Medical Special Interest Group (Med SIG), a committee of NOTIS, is dedicated to promoting professionalism and excellence in interpretive services, including: to provide training and CE opportunities, to establish a professional code of ethics and standards of practice, to research, gather and disseminate info affecting interpreters; and promote awareness of the value of interpreter services.

### *Sustainability*

- Leadership recommendation: NOTIS and WASCLA are well qualified and motivated to provide leadership. WASCLA would need to broaden its focus to include greater emphasis on health care, and NOTIS would need more capacity. We recommend that the two groups discuss their interest and needs regarding sustaining future leadership. WASCLA may be better prepared to take this role, but some combination of the two groups would provide an excellent core.
- Approach Governor's Interagency Council on Health Disparities to test their interest in a leadership/host role.

### *Screen/Assess language skills*

- Provide referral information about available resources for screening and training

### *Assessment of knowledge and skills (certification)*

- Using member expertise, assist other stakeholders in the national process to develop tests for health care interpreters.

### *Ensure continuing education*

- Diversify and expand offerings for continuing education for interpreters, possibly through the Med SIG subgroup of NOTIS

### *Training staff on how to effectively work with interpreters*

- Work with WASCLA to create and maintain a centralized list for training focused on how to effectively work with interpreters. This could, for example, be attached to the searchable interpreter registry.

## **V.H. RECOMMENDATIONS TO CROSS CULTURAL HEALTH CARE PROGRAM (CCHCP)**

### Why this group is in a position to act

CCHCP works to serve as a bridge between communities and health care institutions to ensure full access to quality healthcare that is culturally and linguistically appropriate. Goals include: collaborate with ethnic communities in health care system participation, maintain a center for cultural competence to make educational materials available, improve and provide training opportunities for interpreters, and provide awareness of training programs for providers. CCHCP offers interpreter training through the 40-hour Bridging the Gap curriculum, as well as a train-the-trainer curriculum opportunity.

### *Training interpreters*

- Collaborate with potential partners, including hospitals and community health collaboratives (including CHOICE), to refine a business plan for increasing Bridging the Gap (BTG) training opportunities in terms of geographic availability and affordability to trainees in Washington State, as well as other locales as appropriate. Explore funding strategies (subsidies and sponsorships) to keep the cost of training and/or assessment of interpreters affordable. Consider continuing education opportunities in business planning.
- Offer assistance to Bellevue Community college to explore expanding its current interpreting program to include health care interpreting
- In Washington State, offer assistance to the Community and Technical Colleges system to develop or offer short courses (40-hours) in health care interpreting.
- Collaborate with local and national experts to develop standards for interpreter training offered by community colleges
- As part of Bridging the Gap training, provide information to participants regarding available resources for language screening, generally accepted assessment/certification tools, and the importance of continuing education.
- As guidelines develop, promote CE.

### *Training staff how to effectively work with interpreters*

- Partner with WSMA and others to offer continuing education and training in how to effectively work with interpreters

### *Sustainability*

- Work with the community college system to provide leadership in defining adequate interpreter training

**V.I. RECOMMENDATIONS SPECIFIC TO WASHINGTON STATE HOSPITAL ASSOCIATION (WSHA) AND ITS MEMBERS**

Why this group is in a position to act

WSHA is a member organization representing community hospitals and several health-related organizations that provides issues management and analysis, information, advocacy, and support for hospitals to improve patient safety. WSHA works to improve the health of all people in the state by becoming involved in matters affecting delivery, quality, accessibility, affordability, and continuity of care. WSHA, in collaboration with other stakeholders, is in a position to further influence and facilitate language access advances at a hospital level, if member interest and available funding permits.

*Assuring support from upper-level health service administration*

- Seek ways to share successful language access practices among hospitals

*Training staff on how to effectively work with interpreters*

- Identify local and national organizations, for example: CCHCP, Pac Med, CHIA, NCIHC& MMIA, with successful processes to train staff on how to effectively work with interpreters. Consider sharing the techniques with members and other stakeholders.

*Fiscal support*

- Advocate for health insurance coverage to include earmarked funds for the cost of interpreting

*Pursue Group agreement and contracting*

- Explore whether collaborative services and joint purchasing strategies among hospitals (if supported by members) could effectively be expanded to include economical acquisition of:
  - Interpretive services (may include video-interpreting)
  - Language screening for interpreters
  - Interpreter training (may include potential subsidies or scholarships for trainees)

**V.J. RECOMMENDATIONS SPECIFIC TO WASHINGTON STATE MEDICAL ASSOCIATION (WSMA) AND ITS MEMBERS**

Why this group is in a position to act

WSMA works to represent the professional interests of all member physicians in Washington State and to promote effective physician leadership in the evolving health care delivery system. WSMA provides educational seminars, physician advocacy efforts, lobbying and other services. WSMA, in collaboration with other stakeholders, is in a position to further influence and facilitate language access advances, if member interest and available funding permits.

*Training staff on how to effectively work with interpreters*

- Work with CCHCP, WACMHC, and others with expertise, to take a leadership role in developing or promoting staff and provider training for issues related to language and how to effectively work with interpreters. An example is the existing WSMA Power Point presentation for provider training about interpreting services.

*Fiscal support*

- Advocate for health insurance coverage to include specific earmarked funds for the cost of interpreting.

**V.K. RECOMMENDATION SPECIFIC TO WASHINGTON ASSOCIATION OF COMMUNITY AND MIGRANT HEALTH CENTERS (WACMHC)**

Why this group is in a position to act

WACMHC is a membership organization with a mission to promote health and human services to underserved populations in Washington State. It is also WACMHC's mission to help ensure that all Washingtonians have access to primary health care, regardless of geographic location, nationality, or income level.

- Provide assistance to other stakeholders in developing staff and provider training for issues related to language and how to work effectively with interpreters. This training should be available to other organizations serving underserved populations in Washington State.

**V.L. RECOMMENDATIONS TO WASHINGTON HEALTH FOUNDATION**

Why this group is in a position to act

WHF is invested in creating sustainable health care in rural communities through grants, technical assistance and research. It is also involved in targeting the need for major health system change and a campaign for healthiest state in the nation.

*Fiscal support*

- Consider continuing to support the expansion of interpreter training in geographic areas that lack it. Existing WHF grant programs provide potential funding, but more focused participation in a collaborative plan of action might produce more sustainable results for the investment.

**V.M. RECOMMENDATIONS TO THE LEGISLATURE**

Why this group is in a position to act

While interpreting is the responsibility of many parties in the health care field, the legislature can take a role in policy development and modest fiscal support in order to help assure interpreter quality. Modest fiscal support, sooner than later is the ideal, especially given the budget surplus circumstances, however the one-time expenditure suggested below is not necessarily requested for the 2007 legislative session.

- Consider appropriating funding at the \$50,000 to \$100,000 level for a package of specific financial incentives to improve interpreter Quality Assurance and extend available interpreter training
- Clearly authorize DSHS to collaborate with other entities in the interest of creating more collaborative or unified expectations for interpreters, similar to how DSHS and Health Care Authority partner with private health care purchasers to create consistent messages for providers of health care. For example, given the need for a more extensive and shared interpreter registry, and the need for fiscal responsibility, indicate support for DSHS to participate in a process to expand its registry in collaboration with the public and private sector in order to build on currently available registries and provide more up-to-date interpreter data.

## **V.N. RECOMMENDATIONS TO THE GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES**

### Why this group is in a position to act

The Council was established by the legislature in 2006. It will create a state action plan to eliminate health disparities across the state by 2012. Part of its work will include making recommendations for improving the availability of culturally appropriate health literature and interpretive services.

### *In general:*

- Consider our recommendations and reach your own conclusions about what practical actions would improve quality and consistency in interpreting.

### *Assure support of upper-level health administration*

- Seek information from DSHS and the Health Care Authority on health plans' manner and level of compliance with requirements to assure language access that are contained in managed care contracts for Healthy Options and Basic Health.

### *Sustainability*

- Consider ways to develop partnership approaches to leadership with private organizations such as NOTIS and WASCLA as well as to state agencies. Develop funding and government policy recommendations for language access.

## **V.O. RECOMMENDATION TO THE COMMISSION ON HISPANIC AFFAIRS AND THE COMMISSION ON ASIAN PACIFIC AMERICAN AFFAIRS**

### Why this group is in a position to act

As mandated by the state legislature, the commissions strive to improve public policy development and delivery of public services their respective ethnic communities.

### *Screen/assess language skills*

- Provide referral information about available resources for interpreter screening and training

## **V.P. RECOMMENDATIONS TO INTERPRETERS**

### Why this group is in a position to act

As the focus of our work, interpreters are key components in the quality assurance model. By improving their knowledge and skills, interpreters will not only improve the quality of interpretive services, but also serve to improve the professional nature of the field. They can also provide input in sustainability issues.

### *In general:*

- Until requirements and pre-requisites are developed, pursue screening and training.

### *Training staff on how to effectively work with interpreters*

- Encourage health care organizations to provide or require training for medical staff and employees on how to effectively work with interpreters

### *Sustainability*

- Seek participation in leadership processes.

## **V.Q. RECOMMENDATIONS TO CHOICE REGIONAL HEALTH NETWORK (CHOICE)**

### Why this group is in a position to act.

Over the last four years, in its role as a neutral convener, CHOICE has worked with stakeholders to explore language access and alternatives and options for improving language access. The CHOICE board, as well as community partners (for example: Communities Connect, ConneXions, and Health Works) have recognized the importance of language access issues. There is no ongoing funding, however, for language access-specific work. CHOICE will continue to seek ways to participate and collaborate with others who have leadership roles.

- If funding can be obtained, continue to connect stakeholders to each other about language access issues and share resources such as successful practices.
- Share language access quality assurance model and recommendations with other community health care collaboratives, through Communities Connect, a statewide affiliation of community healthcare collaboratives with members active in 25 of Washington's 39 counties.
- Collaborate with CCHCP to refine the business plan for increasing Bridging the Gap (BTG) training opportunities in terms of geographic availability and affordability to trainees in Washington State, as well as other locales as appropriate. Explore funding strategies (subsidies and sponsorships) to keep the cost of training and/or assessment of interpreters affordable.
- Work with WHF, WASCLA, and others in developing language access proposals/grants that support the expansion of interpreter training in areas that lack it
- Share provider interpreter training module developed during the RWJF-funded *Hablamos Juntos* project with interested parties.
- Provide Pac Med with information on CHIA registry
- Support development of an interpreter registry (voluntary or more formal) by sharing relevant information gathered through *Hablamos Juntos*. (This would require permission from those on the CHOICE database.)

## **V.R. RECOMMENDATIONS TO EXPERTS IN THE FIELD (E.G. NCIHC, MMIA, CHIA, CCHCP, PACMED)**

### Why this group is in a position to act.

As national, state, and local organizations with expertise and commitment to interpreting issues, these groups offer insight into various areas of the model.

- Develop national research strategies and provide data to demonstrate language access safety issues.
- Make available to stakeholders minimum criteria for acceptable interpreter screening, training, and assessment to better enable creation of a list of training options.
- Provide input/expertise on short-term strategies to improve interpreter screening, training, and assessment pending development of national standards.
- Identify successful processes to train staff on how to effectively work with interpreters. Share the techniques with other stakeholders.

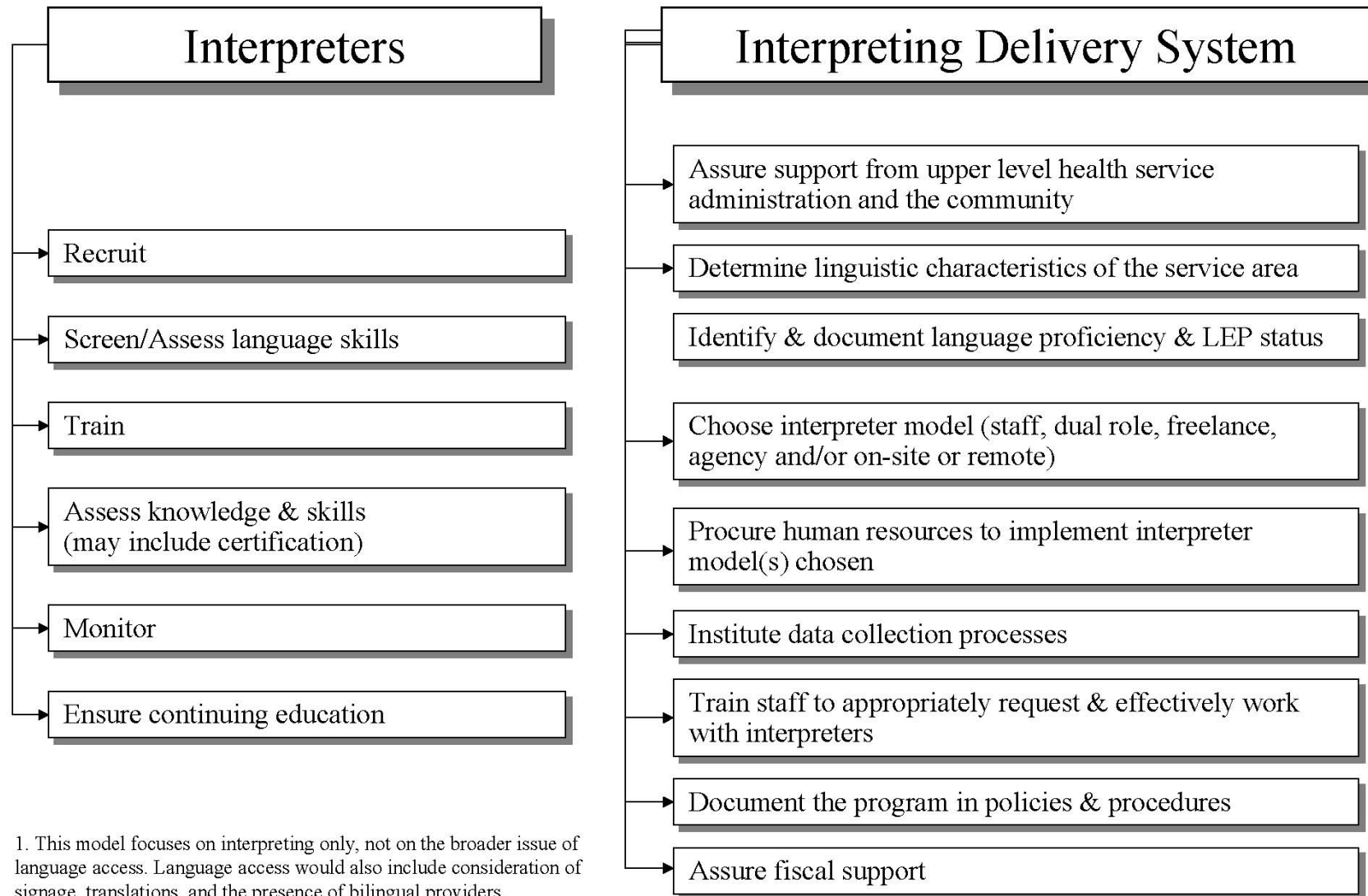
## **VI. APPENDICES**

- A. Interpreting Quality Assurance Model
- B. List of Participating Stakeholders
- C. List of Abbreviations

## A. Interpreting Quality Assurance Model

# Interpreting Quality Assurance<sup>1</sup>

Cynthia E. Roat, MPH, 2006



1. This model focuses on interpreting only, not on the broader issue of language access. Language access would also include consideration of signage, translations, and the presence of bilingual providers.

**B. List of participating stakeholders in Quality Assurance improvement for health care interpreting**  
*December 15, 2005 – December 15, 2006*

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**B. List of participating stakeholders in Quality Assurance improvement for health care interpreting**

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*December 15, 2005 – December 15, 2006*

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## C. List of abbreviations

<b>Abbreviations</b>	<b>Full Name</b>
BTG.....	Bridging the Gap - 40 hour interpreter training course
CAPAA .....	Commission on Asian Pacific American Affairs
CCHCP.....	Cross Cultural Health Care Program
CE.....	Continuing Education
CHA .....	Commission on Hispanic Affairs
CHIA .....	California Healthcare Interpreting Association
CHOICE.....	CHOICE Regional Health Network
DOC .....	Department of Corrections
DSHS.....	Department of Health and Social Services
L&I.....	Department of Labor and Industries
L&ISA.....	Language and Interpreter Skills Assessment
LEP.....	Limited English Proficient
MedSIG .....	Medical Interpreters Special Interest Group (committee of NOTIS)
MMIA.....	Massachusetts Medical Interpreters Association
NCIHC .....	National Council on Interpreting in Health Care
NOTIS .....	Northwest Translators and Interpreters Society
QA.....	Quality Assurance
RWJF.....	Robert Wood Johnson Foundation
WACMHC .....	Washington Association of Community and Migrant Health Centers
WASCLA.....	Washington State Coalition Language Access
WHF .....	Washington Health Foundation
WSHA .....	Washington State Hospital Association
WSMA .....	Washington State Medical Association