

# QUALITY ASSURANCE OPTIONS FOR HEALTH CARE INTERPRETING IN WASHINGTON STATE

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## **I. INTRODUCTION**

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 options for improvements in quality assurance regarding medical interpreting in Washington State. It also is the foundation for a meeting on October 27, 2006 in Olympia at which we will seek further input before preparing a final report with project recommendations for action by various parties.

As part of the process leading to this “options” paper, CHOICE Regional Health Network previously developed a paper on *Quality Assurance Approaches for Health Care Interpreting: Nationwide and Washington State*<sup>1</sup> which:

- 1) Reviewed the history of the project;
- 2) Presented a general medical interpreter competency assurance model, based on leading national thought;
- 3) Summarized current approaches for Medicaid-funded interpreting in Washington State;
- 4) Synthesized input heard from advocates and participants in health care interpreting during the course of our RWJF-funded *¡Tu Salud!* Project. This was a three-year effort to improve language access in our own five-county regions that included a series of public forums in 2004-2005.
- 5) Solicited input from stakeholders on realistic options for language access improvements in Washington State.

For this “Options” paper, we combined feedback on the “Quality Assurance Approaches” report with our community experience in the *¡Tu Salud!* Project.

In the current document, we have attempted to include a spectrum of responses to opportunities for improvement, ranging from the status quo, to 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” so that we can contribute to consideration of realistic improvements. We hope that these options will be helpful to those affected in considering how to improve interpreting quality in Washington.

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<sup>1</sup> Our initial report document can be reviewed electronically at the following link:  
<http://www.crhn.org/tusalud/wings/QualityAssuranceApproaches.pdf>

## **II. THE MODEL OF INTERPRETING QUALITY ASSURANCE**

Our model<sup>2</sup> is based on national best practices and expertise in the field of health care interpreting. The summary graphic on the following page shows two distinct, but linked processes, that are required to assure quality in interpreter services in health care. Broadly, these areas are:

- 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.

Of note, while interpreter quality assurance is the focus of our work, it is clear from feedback that at least some areas of the service delivery side of the model are important to discuss in the context of interpreter quality improvement. Thus, we have included some aspects of the model's service delivery system components in our options presentation.

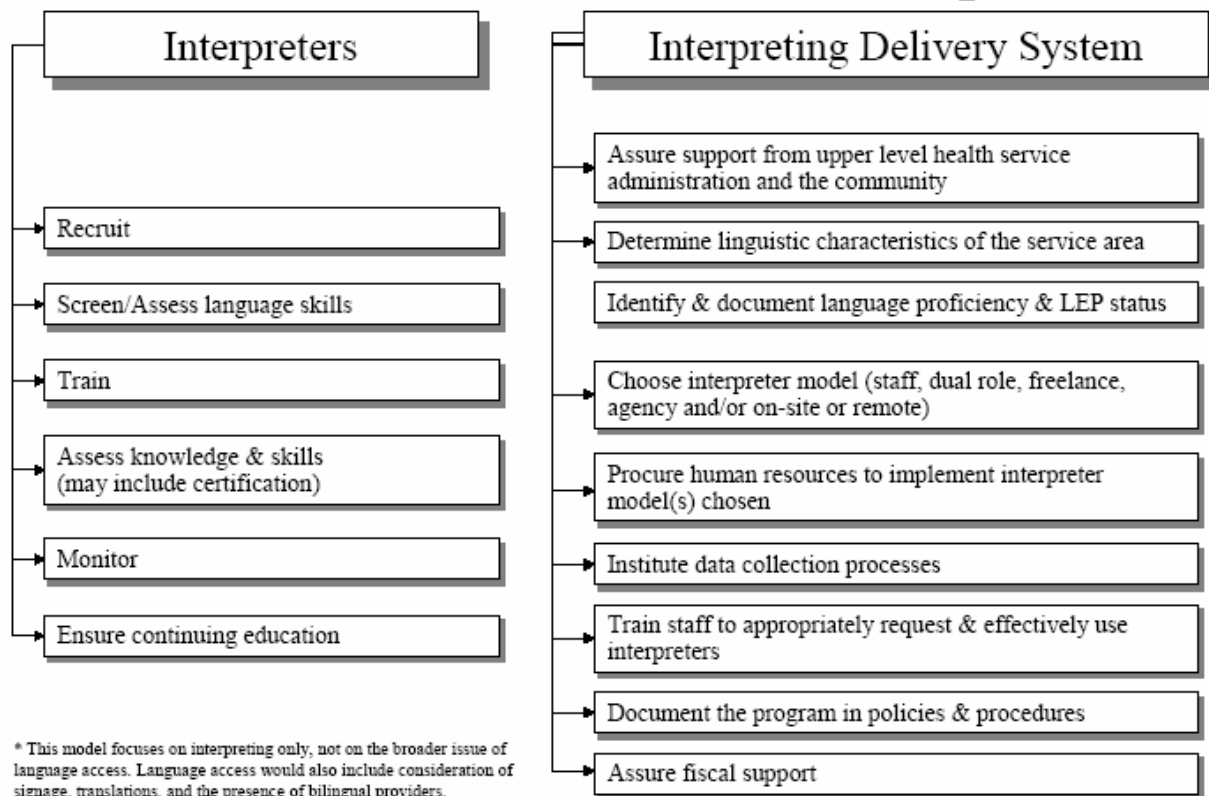
While each side of our model allows us to put forward options relative to the individual components of the model, there are also options that span the entire model. For example: there are multiple participants who could benefit from working together in terms of developing and requiring quality assurance for health care interpreters. Before addressing the individual components and options, we will present an overarching option for collaboration among system participants.

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<sup>2</sup> Developed by Cynthia E. Roat, MPH, a national consultant in language access in healthcare based in Seattle.

# Interpreting Quality Assurance\*

Cynthia E. Root, MPH, 2006



### **III. HOW SYSTEM PARTICIPANTS MAY ACT JOINTLY TO INCREASE THEIR IMPACT ON INTERPRETER QUALITY**

**Problem statement:** DSHS is an important economic actor in Washington's market for interpreter services, resulting in the creation of de facto standards for others who wish to follow some established approach. DSHS also operates from a fairly narrow mandate in relation to the full quality assurance model. The agency is required to do certain things under the terms of a consent decree, but other actions could be envisioned if resources, interest and organizational sanction all were present within DSHS. More systematic concerted action with others might strengthen the potential for achieving quality assurance (QA) ideals, both in interpreter quality assurance and interpreter service delivery, without requiring DSHS to spend state funds in ways that exceed legislative intent.

Options for improvement:

- a) **Status Quo:** DSHS continues to act in areas where it has a mandate, (e.g. interpreter certification and the provision of interpreters for LEP patients receiving Medicaid), seeking advice as it does currently from key stakeholders but operating autonomously.
- b) DSHS plays<sup>3</sup> a larger **convener role**, inviting others with a strong stake in providing, supplying and financing health care interpreting to join in a voluntary shared effort to define collaborative approaches to the functions in which DSHS has a role, so that the same actions have more impact and alignment.
  - i) The scope of this joint exploration could be limited to functions where DSHS has a role.<sup>4</sup>
  - ii) There could be a broader scope with the understanding that actions can complement each other without DSHS itself moving outside its responsibilities.
- c) Organizations including DSHS form a **consortium** to act jointly. This differs from b in that DSHS may not play the only or primary convening role. The type of consortium could take several forms.
  - i) DSHS works more closely with other state agencies that need to actively manage the interpreting for their health care clients (especially Labor and Industries and Department of Corrections).
  - ii) The partners might include a variety of organizations in Washington.
  - iii) Washington could be part of a multi-state consortium.
- d) **Wait** for a broader national process to define de facto or regulatory standards. For example, it appears likely that 2006 will witness the beginning of discussions regarding national certification for healthcare interpreters. While the implementation of any nationally standardized testing and certification is several years away, efforts in Washington State could be directed toward participating in a national process rather than investing resources in revamping the Medicaid test. Similar decisions on whether to approach the issues locally, regionally or nationally exist in other aspects of the QA model such as establishing standards for interpreter training programs, training curricula,

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<sup>3</sup> As a matter of style, in this paper we present each major option as a simple declarative statement about who does what. It is understood that all options are just that until the necessary parties agree to proceed.

<sup>4</sup> Roles such as: recruiting, testing, certifying interpreters; contracting with brokerages; investigating complaints.

development of online training for healthcare interpreters, and establishing a national clearinghouse for information on culturally and linguistically appropriate care.

## IV. OPTIONS FOR HEALTH CARE INTERPRETER QUALITY ASSURANCE

### A. OPTIONS FOR RECRUITING INTERPRETERS

Problem statement: Recruitment means more than just finding people to train and hire as interpreters; it means finding the *right* people to train and hire. It means finding people with the personality and life skills necessary to become good interpreters. In the context of the Medicaid interpreting system, it includes finding additional qualified candidates to take the DSHS test and become available for Medicaid interpreting.

Options:

- a) **Status Quo:** Individual organizations that hire or contract interpreters carry out some recruiting functions, but there is little local or statewide coordination and no shared standards. In addition, individuals hiring interpreters often view the task at hand narrowly and urgently rather than as part of a broader quality assurance process.
- b) Incorporate **awareness** of interpreting as an occupation into broader efforts to attract qualified candidates into health care.
  - i) **Adapt applicable State Board of Health recommendations** on recruiting minority health care providers<sup>5</sup> to interpreters. These recommendations include coordination of health care work force efforts and establishing guidelines for health career development programs.
- c) Expand **health career development** programs, as found in educational institutions, to increase awareness of and preparation for interpreting as an occupation. Activities in such programs commonly feature linkages to high schools and include mentoring, tutoring, and career awareness building.
- d) Develop **qualification standards** for individuals interested in becoming trained as interpreters.

### B. OPTIONS FOR SCREENING/ASSESSING LANGUAGE SKILLS

Problem statement: There is little local or statewide focus on screening. Screening for *language skills* is distinct from assessing *interpreting knowledge* and skills. It is used to determine whether a candidate is linguistically prepared to benefit from interpreter training. As conceptualized in the model, screening precedes training, which in turn precedes skill assessment/testing/certifying.

- 1) Options for how *screening* might be used:
  - a) **Optional** screening for the purpose of feedback to the individual
  - b) Required screening – as a **prerequisite** to employment, entering training, or testing.
  - c) A **mixture** of optional, required or none
- 2) Options for how *screening* is *provided* and by whom:

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<sup>5</sup>See Washington State Board of Health. Committee on Health Disparities. *Final Report, State Board of Health Priority: Health Disparities*. May 2001. Available online at: [http://www.doh.wa.gov/sboh/Priorities/Disparities/documents/2001\\_HD\\_Report.pdf](http://www.doh.wa.gov/sboh/Priorities/Disparities/documents/2001_HD_Report.pdf).

- a) **Status Quo:** Organizations that hire or train interpreters use varying methods and levels of screening, generally in isolation from each other. Often this is informal screening, such as a phone conversation with an interpreter coordinator or bilingual manager or provider.
  - b) Interested parties create a **list** of multiple acceptable screening services or tests that they will accept.
  - c) Interested parties **develop** their own formal screening mechanisms and tests
  - d) Entities **contract out** phone-based or computer-based screening services, individually or collectively. Examples of existing and potential sources of contracted screening include:
    - i) Phone: Language Line Services, Pacific Interpreters
    - ii) Computer: L&ISA (Language and Interpreter Skills Assessment), a system that was piloted at ten sites nationally but is on hold pending further development.
  - e) If it appears likely that a national screening test will be developed, **wait** for this test while using more ad hoc methods in the interim.
    - i) See transition strategies on page 21.
- 3) Options for how *screening is integrated* with other training or aspects of a QA model: See the discussion in “options that cut across elements of the model” on page 21.

### **C. OPTIONS FOR TRAINING INTERPRETERS**

Problem statement: At this time, there are no systematic requirements for health care interpreter training. Among major institutions and Medicaid, there is considerable variability in the availability of training, requirements for training, characteristics and validation of training, and completion of training. There are limited reliable and valid training offerings, and as a result some curricula in use are ad hoc in nature.

- 1) Options for improving the *availability* of good training for interpreters.
  - a) **Status quo:** Availability of training, requirements for training, characteristics and validation of training, and completion of training all are variable. There is no systematic requirement for training that cuts across major institutions and Medicaid.
  - b) **Require training:** Organizations with a stake in interpreter training can do this independently or collaborate in varying ways.
    - i) Develop their **own training** and tests – the tests may range from informal to formal and may be developed locally or in a statewide fashion. Participants may include: hospitals, community colleges, DSHS, Northwest Translators and Interpreters Society (NOTIS).
      - (1) Content materials are available for those that wish to develop their own curriculum and training (e.g. University of Minnesota College of Continuing Education Interpreter Training materials).
    - ii) Work together to create a **list** of training resources that will be accepted by collaborating organizations such as Community Colleges, hospitals, DSHS, and interpreter agencies.
    - iii) **Contract out** training, as individual organizations or as a consortium. This can include in-person or computer-based methods. Pooling resources as a purchasing

cooperative would allow entities wishing to co-sponsor training to put out an RFP and choose among bidders that have developed curricula and trainers.

- (1) Existing sources from which complete training packages can be purchased include Cross Cultural Health's "Bridging the Gap" in-person training, and University of Massachusetts-Amherst on-line training.
  - c) Pursue increased **agreement** on curricula and instructional standards for health care interpreting among educational institutions that have interest in providing such training. State educational coordinating bodies, especially the State Board for Community and Technical Colleges, are in a good position to lead such joint work.
  - d) **Wait** for national training standards to evolve. The National Council on Interpreting in Health Care (NCIHC) is currently seeking funding to develop national consensus on standards for training programs.
    - i) Develop formal and informal methods for collecting and contributing Washington State input to the development of national training standards (e.g. through the NCIHC process under development)
- 2) Options for how screening is *integrated* with other training or aspects of a QA model: See the discussion in "cross-cutting issues"

#### **D. OPTIONS FOR ASSESSING KNOWLEDGE AND SKILLS (MAY INCLUDE CERTIFICATION)**

Problem statement: Within the current system, certification testing rarely includes prerequisite training or screening. Ideally assessment includes more than testing, such as prerequisites. 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.

- 1) Options for how *assessment is conducted*:
  - a) **Status Quo:** DSHS administers its own examination; see our previous report<sup>6</sup> for details. Other entities carry out a variety of assessment processes, and some use interpreters with no formal prior assessment.
  - b) **DSHS sets prerequisites** for taking the certification test, for example, required pre-screening and training.
    - i) This would be a more powerful change if the prerequisites were developed in conjunction with others.
  - c) **DSHS revises** its current certification test.
    - i) This would be a more powerful change if the test revisions were developed in conjunction with others.
  - d) Other entities **create** their **own** assessment methods, individually or in collaboration with a consortium, academics, and/or NCIHC.
  - e) Agree on a **list:** DSHS and others review multiple interpreting skill assessment tests or certifications and agree on a list of acceptable substitutes.
    - i) Existing independent testing or certification sources for consideration:<sup>7</sup>

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<sup>6</sup> *Quality Assurance Approaches for Health Care Interpreting.*

- (1) Language Line Medical Interpreter certification
  - (2) Cyra Com (not scientifically validated)
  - (3) NetworkOmni (not specific to medical)
  - ii) Existing independent training and certification
    - (1) National Center for Interpretation Testing, Research and Policy at the University of Arizona
    - (2) University of North Carolina at Greensboro – in development
  - f) Depending on how other elements of the model are integrated (see “Options that cut across elements of the model” on page 21), it might not be necessary to have a formal assessment (for example, if well-standardized training and screening are pre-requisites).
- 2) Options for how assessment is *linked* with certification or registries:
- a) **Status quo:** DSHS requires its exam as a condition of receiving payment to interpret for Medicaid patients through the brokered interpreter system. DSHS maintains a registry of people who have passed the exam, indicating language(s) they are permitted to interpret and whether it is for health care, social services, or both. DSHS practices reflect a 1991 consent decree; some changes would require modification of the decree in court. Some other organizations choose to rely on DSHS certification as a standard in their own employment or contracting processes.
  - b) **DSHS expand** the current registry to include and validate additional information about an individual’s assessments and credentials relevant to interpreting. Examples that have been mentioned include: successfully completed training, continuing education credits, date of certification examination, and status of practice (active/inactive). This would go beyond DSHS’ current understanding of its funded and legislatively mandated role.
  - c) Create a separate voluntary **registry** that includes a greater variety of information regarding an individual’s assessments and credentials relevant to interpreting.
    - i) The California Healthcare Interpreters Association (CHIA) is piloting a self-reported, web-based registry for health care interpreters.
    - ii) As an outgrowth of legislation passed in 2001, the state of Oregon plans to launch a voluntary registry of qualified health care interpreters based on training requirements. Iowa is also in the process of establishing a voluntary credentialing process.
    - iii) Voluntary registries are used in other fields. For example, a voluntary professional registry exists for medical practitioners of complementary and alternative health care in the U.S. Documentation of credentials is submitted to a peer review panel for consideration, and accepted candidates are listed in a database.<sup>8</sup>
  - d) Pursue **legislation establishing mandatory registration** of health care interpreters in Washington. Washington state law distinguishes “registration” from licensing or certification.<sup>9</sup> “Registration” is not required in order to legally work in the field, but it is

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<sup>7</sup> Other options exist which are not related to medical interpreting, such as the Federal Court certification, National Association of Judiciary Interpreters and Translators certification, and State Court Consortium certification.

<sup>8</sup> American Integrative Medical Association. See [www.aihcp-norfolkva.org/AIMA/index.html](http://www.aihcp-norfolkva.org/AIMA/index.html).

<sup>9</sup> See Chapter 18.120 RCW, “Regulation of health professions – criteria,” and the definitions in RCW 18.120.020. The statutory definition of “registration” is “the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.” The initiation of any new statutory requirement for a health-related profession or occupation is a highly political matter and the Legislature has the option of requiring those advocating such regulation to provide a detailed report defending why this is necessary under public-interest criteria in RCW 18.120.030.

a method to have validated information that employers or the public can access. For example, Texas requires registration of court interpreters (though not health care interpreters).

- e) Pursue **legislation establishing mandatory certification** of all health care interpreters in Washington. “Certification” implies that it is illegal to claim the title (for example, “certified interpreter”) without a state determination that statutory requirements have been met. To our knowledge, no state requires certification of interpreters.
- f) Pursue **legislation establishing mandatory licensing** of all health care interpreters in Washington. Licensing implies that it is illegal to carry out the activity of interpreting without a license, regardless of whether some other term is used for what you are doing. To our knowledge, no state requires licensing.

#### **E. OPTIONS FOR MONITORING HOW WELL INTERPRETERS DO THEIR JOB**

Problem statement: This is often an internal procedure and this paper places less emphasis on generating options that are primarily internal matters for how a health care organization manages its own services. It is generally more difficult to actively monitor independent contractors than employees, but both are difficult if the organization that needs interpreters has no independent way to identify quality of performance.

Options:

- a) **Status Quo:** Variable as to whether and how monitoring occurs.
- b) Employers and contractors consistently perform some **assessment** of the **performance** of the interpreters that work for them, but methods continue to be diverse.
  - i) Greater uniformity in methods evolve through a gradual process of national accreditation and professional standards. This may link with options to increase top-level buy-in through standards (see page 15).
  - ii) Some organizations mentor and/or shadow employed interpreter to help ensure quality
- c) **Voluntary** peer **assessment** and feedback.
  - i) Interpreters in Southwest Washington formed an informal support network after receiving training.<sup>10</sup> Further development of more formal interpreter support groups and possibly a professional chapter may occur.

#### **F. OPTIONS FOR ENSURING CONTINUING EDUCATION**

There may be collaborative opportunities for ensuring continuing education (CE) which are similar to those outlined in assessment and training. Continuing education for interpreters is likely to be fertile ground for distance learning.

Problem statement: DSHS standards do not address continuing education. There are limited opportunities for interpreter continuing education.

Options:

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<sup>10</sup> Training was funded through a Robert Wood Johnson Foundation, Hablamos Juntos Grant to CHOICE.

- a) **Status quo:** Some interpreters seek CE on their own. Some organizations may have CE for their employee interpreters. Monthly educational forums for interpreters have been taking place almost without interruption since 1989, but only in the Seattle area. They were organized by PacMed Clinics, then by the Cross Cultural Health Care Program, then by the Society of Medical Interpreters, and now by the Northwest Translators and Interpreters Society (NOTIS).
- b) Require CE
  - i) **Develop** CE independently or collaboratively
  - ii) **Organize** CE – by interpreters for themselves
    - (1) With more support, NOTIS could potentially provide CE around the state.
    - (2) Institutions employing interpreters could support CE activities financially or by requiring staff interpreters to attend.
  - iii) **Contract** CE
    - (1) Consortia of hospitals could hire a professional interpreter trainer to develop and provide continuing education for interpreters.

## **V. OPTIONS FOR INTERPRETING DELIVERY SYSTEM QA**

### Overview

The focus in this project is interpreter quality, and we have explored options in greater detail on the “left side” of our quality assurance model. In this section, dealing with the “right side” of the model, we do present options for some components of the model that are amenable to collaborative action.

Other components (determining linguistic characteristics, identifying language proficiency/LEP status, instituting data collection procedures, and documenting policies and procedures) are more related to individual health care institution procedures than to collaborative processes. Many hospitals and organizations are already carrying out these activities in some fashion. The details of their activities may correspond with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, Census tracking questions, or practical guides such as *Straight Talk - Model Hospital Policies and Procedures on Language Access*.<sup>11</sup> For these procedural areas, we do not present specific options, but we are open to hearing about whether there are collaborative actions that would improve outcomes.

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

**Problem Statement:** Without the full support of upper level administration and influential community leaders, language access issues are not likely to receive optimal attention within health care, both in terms of provision and of financing. Grassroots efforts intended to build support for language-related issues are more likely to be effective when they result in additional options for action by senior managers and opinion leaders. Within healthcare organizations, internal champions for improved language access are often critical to success.

Options:

- a) **Status quo:** How senior administrators address language access appears to depend on individual attitudes, perceived or documented need, and institutional history of services, mission, and (sometimes) legal challenge.
- b) **Emphasize regulatory and accreditation leverages:** Advocates for language access continue to provide input to standard-setting and regulatory processes as expectations related to language access begin to be codified. While senior managers in health care tend not to prefer regulatory or accreditation requirements as a way to make decisions, once requirements exist, they certainly pay attention to them.
  - i) JCAHO and other accreditation and standards
    - (1) Several JCAHO standards specify that organizations do certain things to support communication and language access improvement. For example, standard

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<sup>11</sup> *Straight Talk* is a collection of model practices and policies for hospitals from the California Health Care Safety Net Institute that is adaptable to other venues. See <http://www.safetynetinstitute.org/publications/documents/StraightTalkFinal.pdf>.

- RI.2.100 requires that organizations ensure effective communication between the patient and the organization through the provision of the interpreter services.<sup>12</sup>
- (2) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) recommendations are all relevant. For example, they state that organizations should provide language assistance services at no cost to each LEP patient at all points of contact (standard 4) and ensure interpreter bilingual staff competence (standard 6).<sup>13</sup>
  - (3) National Committee for Quality Assurance (NCQA) standards requires that managed care organizations track language preference and provide publications in non-English languages spoken by 10% of their membership.<sup>14</sup>
- ii) State regulatory requirement for quality assurance:
    - (1) State law requires hospitals to have a plan for quality improvement. While language access is not separately addressed in state regulations, measures taken to improve communication with LEP patients would contribute to the law's intent for hospitals to strive for "continuous improvement of patient health outcomes"<sup>15</sup>. The RCW does emphasize the importance of offering "education programs dealing with improved communication with patients."<sup>16</sup>
  - iii) Medicaid Managed Care contracts:
    - (1) Language Access advocates can ask managed care health plans contracted under Healthy Options/SCHIP to provide information about how they comply with specific language in the contract. This can draw attention to language access requirements by working with health plans rather than only turning to providers.<sup>17</sup>
  - iv) Federal Office of Civil Rights:
    - (1) The federal DHHS Office for Civil Rights has issued guidance clarifying expectations that recipients of federal funds have an obligation to provide language access under Title VI of the 1964 Civil Rights Act.<sup>18</sup>
- c) Researchers and advocates for language access work to increase awareness of language access as a risk element within the broader concern of **patient safety and error reduction**. Throughout health care, the emphasis on error reduction, patient safety and quality improvement has greatly increased through a combination of demonstrated successes from quality improvement processes and a series of seminal research and

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<sup>12</sup> Executive Summary: A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, submitted to OMH-HHS by American Institutes on Research. See [www.omhrc.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf](http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf).

<sup>13</sup> CLAS standards. See [www.med.umich.edu/multicultural/ccp/CLASpage.htm#JCAHO](http://www.med.umich.edu/multicultural/ccp/CLASpage.htm#JCAHO) for an analytic crosswalk of CLAS standards and JCAHO requirements.

<sup>14</sup> See footnote 11

<sup>15</sup> WAC 246-320-225

<sup>16</sup> RCW 70.41.200

<sup>17</sup> Washington State Healthy Options and SCHIP contracts for managed care plans states: "The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers." (section 8.2, page 49) and "The Contractor shall participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds," (section 3.3, page 16). See <http://fortress.wa.gov/dshs/maa/HealthyOptions/pdf/files/2006> and click on "Managed Care Contract" on left-hand menu.

<sup>18</sup> Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. See <http://www.hhs.gov/ocr/lep/revisedlep.html>.

policy studies putting a spotlight on failings.<sup>19</sup> However, the link between language access breakdowns and quality/error reduction has not been made as persuasively as with other areas of risk, such as medication error and coordination among health care providers. As empirical evidence of risks due to language failures mounts and is made visible to administrators, it is likely that existing quality improvement efforts will adjust their focus to include language access. 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.

- i) Language access researchers could play a strong role in moving forward this process by providing new and compelling evidence of the connection and making sure that it is disseminated.
  - ii) Internal language access champions within any organization can play a role by making sure that breakdowns of communication that cause, or might have caused, harm are brought to the attention of internal quality committees and QA managers. That will tap internal processes designed to shift attention to whatever is causing demonstrable risk to patients.
  - iii) Researchers and others may be able to assemble benchmark data that emphasize the variability of language access. Quantitative benchmarking is often a key part of quality improvement processes.
- d) Heighten the **financial motivation** of managers to improve language access.
- i) In hospitals and other large health care organizations, budgeting interpretive services separately from the costs for separate departments or clinical service areas is likely to create managerial incentives to use interpreting resources effectively, rather than incentives to minimize interpreter expenses.
  - ii) Health care organizations, malpractice carriers, and others sponsoring risk reduction training address language access-related risk of error. This would bring interpreting into a framework that has a clear financial impact through insurance rates.
- e) Language access advocates and their champions within business and civic organizations work together to **build shared commitment** to health care interpreting as part of the community response to residents' and employees' needs. Achieving this may require discussion of volatile issues such as immigrant rights, but the payoff is a clearer understanding about how the people in a community (including employers and consumers) would benefit. Once a community consensus exists, a wide variety of leaders start to act accordingly.
- f) Senior health care managers and language access advocates **collaborate and communicate** about problems openly. Opinions and strategies vary within the advocacy community about how best to exert influence, with some preferring discreet methods for honest discussion of problems and others preferring more confrontational approaches that gain a profile in the community. Either way, realistic attention must be given to how to move beyond awareness into some form of positive momentum that can bring people together.

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<sup>19</sup> The most widely known have been a series of Institute of Medicine studies launched in 1996 with "Crossing the Quality Chasm: IOM Health Care Quality Initiative." Key reports include *To Err is Human: Building a Safer Health System* (1999) and *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* (2001). See [www.iom.edu/CMS/8089.aspx](http://www.iom.edu/CMS/8089.aspx).

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

Problem statement: In Washington, a major “model” decision was made by DSHS and the legislature when a brokered system for providing interpreters for Medicaid-paid service encounters was selected. With this exception, 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. Health care organizations’ ability to choose the most effective interpreting solutions will be enhanced by improvements in interpreter training, assessment, and other potential actions addressed above. The options for institutions also may be increased if Medicaid “brokered interpreting” requirements are modified.

- 1) Options for improving performance of the *brokerage system*:
  - a) **Status quo:** Brokerage system as it now exists.
  - b) Modify the brokerage system:
    - i) Have brokers **audit** the agencies they are using to assure that they are really sending interpreters who have been trained and are certified.
    - ii) Allow brokers to contract directly with interpreters who meet certain **criteria** – language screening, basic training, certification/qualification and a certain number of hours of continuing education per year. By contracting directly, these interpreters could earn the fee that is being paid to agencies. This would provide an incentive for the best interpreters to stay in the system and for the newer interpreters to get screening and training and to participate in continuing education.
    - iii) Create **benchmarking** strategies/share performance indicators on brokers and/or agencies. Possible approaches range from anonymous data to full public disclosure.
  - c) Create some **other approach** that can meet legislative expectations for financial management while providing quality interpreting.
  
- 2) *Other* options for improving health care organizations’ ability to successfully execute the interpreter model that they believe will work best for them:
  - a) **Group contracting** for telephonic services. Various hospital groups across the country have negotiated extremely low cost telephonic interpreting through group contracting.
    - i) The Hospital Association of New York State, for example, has a contract with Language Line Services that allows members to access LLS services for a reduced rate.
  - b) **Group agreement** for a single standard for screening, so that each institution doesn’t have to do it separately.
  - c) Improve and upgrade **technology**
    - i) Maintain a centralized interpreter registry, which is on-line and searchable.
    - ii) Link video-conferencing capabilities for interpretive sessions in more remote locales and for efficient use of interpreters
      - (1) Organize larger staff interpreter organizations to “sell” interpreting at more remote venues

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

Problem statement: 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 options that are relevant and we will not repeat the information here. See pages 9-14.

### **D. OPTIONS FOR TRAINING STAFF TO APPROPRIATELY REQUEST AND EFFECTIVELY USE INTERPRETERS**

Problem statement: 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 *use 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.

- 1) Options for *training* about *procedures* for requesting an interpreter.
  - a) **Status quo:** The degree to which institutions train staff regarding policies related to language access is specific to each institution.
  - b) Health care organizations **verify** that they do **train** employees on what they need to do in order to obtain interpreting for health care encounters that require it.
    - i) Organizations that would like to see a model policy can refer to *Straight Talk - Model Hospital Policies and Procedures on Language Access* by California Health Care Safety Net Institute (see footnote on page 15)
  
- 2) Options for training staff of a health care organization on how to make effective *use* of an interpreter:
  - a) **Status Quo:** Some organizations and agencies train staff in skills for effective use of interpreters. Many do not.
  - b) Require staff training in **skills** to effectively **use** interpreters
    - i) Develop own training
    - ii) Use on-line training options – e.g. course on communicating through healthcare interpreters offered at the Virtual Lecture Hall<sup>20</sup> or Office of Minority Health cultural competency training
    - iii) Bring in an external trainer. Several are active in Washington state and other locales.
    - iv) Create a centralized database of trainers. This could be attached to a database of interpreters.
  - c) Identify organizations with successful processes to train staff and share the techniques with others.

### **E. OPTIONS FOR 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

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<sup>20</sup> See [www.vlh.com/shared/courses/course\\_info/cfm?course=1705](http://www.vlh.com/shared/courses/course_info/cfm?course=1705).

model, so we are addressing them later in this paper, among other cross-cutting options. (See page 21.)

#### **F. PROCEDURAL AREAS WITH NO OPTIONS LISTED**

The following four areas on the “right side” of the interpreting QA model are closely related to institution-specific procedures and processes. As noted on page 15, specific options are not identified in this paper.

No options 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

## **VI. OPTIONS THAT CUT ACROSS ELEMENTS OF THE MODEL**

### **A. OPTIONS FOR INTEGRATING TRAINING WITH OTHER MODEL ELEMENTS**

Problem statement: Training often occurs in isolation. Health care interpreter quality assurance may be better served by integrating screening, training, and/or assessment.

Options for integrating QA elements:

- a) **Status quo:** Training is generally optional and often disconnected from screening and certification.
- b) Require training, but still not linked to screening or certification.
- c) Screen **in conjunction** with training.
  - i) Screening separate from training, however both are required
  - ii) Screening as a prerequisite to training:
    - (1) Training + screening may *substitute* for certification process
- d) Link training and screening to a certification process.
  - i) Training + screening may be required *in addition to* certification.
  - ii) Screening, training, and certification may be integrated under a single organization.
- e) Pursue legislative options that would require training in relation to state certification or registration of interpreters (See pages 12-13, options d,e, and f).

### **B. TRANSITION STRATEGIES**

Problem statement: Interpreting quality assurance approaches appear to be in a rapid evolution from non-standardized, ad hoc and “face valid” methods toward more nationally standardized, coordinated and scientifically validated ones. It is predictable that this evolution will require shifts in methods used, and quite likely, increase expense for validation of assessment.

A *transition* policy might include some or all of the following *elements* to increase flexibility:

- a) Collaborative policy on acceptable qualifications, preparation, assessment, etc. to increase job mobility and reduce the need for duplicative steps.
- b) Accept of multiple forms of screening, assessment, training, etc.
- c) Where there is wide agreement that broadly acceptable national standards or accreditation are likely to evolve soon, continue with the status quo and limit investment in costly new approaches in areas of interpreter QA.
  - i) Areas currently under development include: screening (on-line and telephonic), assessment tests, and establishment of core elements of required training (NCIHC).

### **C. OPTIONS FOR ASSURING FISCAL SUPPORT FOR INTERPRETING AND INTERPRETING QA**

Problem statement: Interpreting is almost certainly under-provided in aggregate, and improved QA methods will also cost money. Higher costs are predictable, and the existing financing approaches are limited.

Options For Assuring **Fiscal** Support:

- a) **Status Quo:** Funding for language access in Washington State continues to be routed through several separate, uncoordinated streams, with total expenditure unknown. *Medicaid:* Washington is unique in that a large portion of funding for language access comes through the Medicaid programs; this funding is always at risk of being reduced or eliminated in biennial budgets. Most Medicaid funds pass through the brokerage system, but many public hospitals and local health jurisdictions also receive Medicaid reimbursement in the form of 50% federal match to local dollars spent on interpreting services. *Non-Medicaid funding sources:* Some larger health care institutions contribute financially to language access by funding their own interpreting department. Federally Qualified Health Centers do not have to provide state-certified interpreters, but frequently recruit bilingual or multi-lingual clinicians and support staff. For the significant portion of the state's LEP population that does not qualify for Medicaid, health care organizations develop parallel systems to request and pay for interpreters. Private practices invest unevenly in language access depending on their clientele, philosophy, location and priorities. Some interpreting, done by family and friends in a pinch, continues to be uncompensated.
- b) Perhaps employers with a concentration of LEP workers could be persuaded to **voluntarily** dedicate some **funding** to interpreting needs for those employees without coverage. Legal vehicles exist to dedicate this funding to specified uses, such as interpreting, while maintaining its pre-tax status for both employers and employees.<sup>21</sup>
- c) Language access advocates can **support** the efforts of organized **community** health care **collaboratives** to create a local focus on actions and investment to improve health care and health outcomes, and within these collaboratives, can work to increase awareness and emphasis on language access problems. Currently at least nine community collaboratives operate in Washington State, among them CHOICE Regional Health Network, the sponsor of this paper. They differ in organizational framework, stage of development and focus areas, but all set priorities within their communities and organize practical efforts to improve health and health care, and there is active work among the collaboratives to align their efforts and advocate for governmental support. Some of the collaboratives have special interest in the problem of language access. It 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. State governmental support of collaboratives is increasing, including legislation in 2006 that established a new competitive community grant program (to be administered by the Health Care Authority) and invited presentations to the Blue Ribbon Commission on Healthcare Costs and Access (also established by 2006 legislation). Communities Connect is also developing concepts and support for creating local governmental districts ("Community Health Management Districts" that could assert leadership and perhaps contribute a portion of funding for prioritized improvements.<sup>22</sup>
- d) Lobby the legislature to **increase** the **budget** for the interpreting and/or interpreting QA. With current fiscal circumstance, this is politically unlikely.

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<sup>21</sup> A Health Reimbursement Arrangement under sections 105-106 of the Internal Revenue Code (IRC) allows an employer to contribute pre-tax dollars that can be used only for specified health-related purposes (which could include health care interpreting).

<sup>22</sup> For more information on Communities Connect and the Community Health Management District concept, contact Holly Detzler at [detzlerh@crhn.org](mailto:detzlerh@crhn.org) or (360) 493-4550.

- e) **Start discussions** with major private insurers and health care payers about including interpretation as a **covered service**, rather than an assumed administrative cost of delivering health care.
- f) Reduce costs via **group contracting** so money stretches further (see page 18)

**D. SUSTAINABILITY AND CONNECTING INTERPRETER ISSUES TO ONGOING POLICY DEVELOPMENT AND PURCHASE COORDINATION IN WA**

Problem statement: The Robert Wood Johnson Foundation funding that supports this set of papers will end in December 2006. If ideas generated are to move into action, they must become part of more enduring processes for developing public policy and private collaborative action.

Options for *coordination*:

- a) Develop **collaborative structure** to sustain action
  - i) Groups of organizations lead a specific issue
    - (1) For example: State Board for Community and Technical Colleges could take the lead in defining adequate interpreter training; see page 11
    - ii) A new organization or strengthened existing organization undertakes the collaborative lead in all areas
      - (1) Northwest Translators and Interpreters Society (NOTIS)
      - (2) Washington State Coalition for Language Access (WASCLA) with an additional focus on health care interpreting
  - b) Approach Governor's Interagency Council on Health Disparities to test whether they would be interested in a leadership/**convening role**.
  - c) Establish a **purchaser collaborative** [see page 11].
  - d) Collaborative work **among hospitals**, either regionally<sup>23</sup> or perhaps convened through Washington State Hospital Association.

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<sup>23</sup> For example, multiple hospitals in Southwest Washington meet voluntarily to coordinate language approaches.

## **VII. PROCESS FOR ASSESSING OPTIONS AND PROVIDING FEEDBACK**

Project Staff at CHOICE will consider input we receive, in writing or at our meeting on October 27<sup>th</sup>, as we move from options to recommendations. We will publish recommendations in December 2006.

This document may be found, in an electronic format, at:

<http://www.crhn.org/tusalud/wings/QAoptions.pdf>

Comments about this document may be made electronically, until November 8, 2006. Please use the following link:

<http://www.crhn.org/tusalud/wings/q04.htm>

If you have any questions regarding this paper or the October 27<sup>th</sup> meeting, please contact:

Kathleen O'Connor, MD

(800) 981 - 2123

(360) 493 - 4550

oconnork@crhn.org

**Questions for reference during reading of the document and for group discussions**

- 1) Are there any options that you think are missing? Please add them for the discussion. When defining an additional option, be sure to indicate *who* should do *what*.
- 2) Which options are strongest overall? Consider what options are most realistic to implement in the near future.
- 3) What would be needed to help the option(s) be adopted and implemented?
- 4) How might an option be linked with other areas of the model? For example, how might screening be linked with training?
- 5) What role could you and your institution play in order to help implement options?
- 6) How could you and your institution collaborate with others to help implement options?

**Note:** After Oct 13<sup>th</sup>, you can access the complete document and electronic links for comments at:

<http://www.crhn.org/tusalud/wings/QAoptions.pdf>

<http://www.crhn.org/tusalud/wings/q04.htm>

Electronic comments on the document can be submitted until 11/08/06.