

QUALITY ASSURANCE APPROACHES FOR HEALTH CARE INTERPRETING

NATIONWIDE AND WASHINGTON STATE
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Prepared by CHOICE Regional Health Network
Contact: Kathleen O'Connor, MD
800.981.2123 – 360.493.4550 - www.crhn.org
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NATIONWIDE AND WASHINGTON STATE

INTRODUCTION

The purpose of this paper is to:

- Provide an overview of medical interpreter competency assurance and testing models occurring nationwide;
- Summarize current approaches for Medicaid-funded interpreting in Washington State;
- Synthesize input heard from advocates of health care interpreting in Washington State during a series of public discussions in 2003-2006; and
- Seek input on realistic, multilateral options to improve language access in Washington State.

This document does not pretend to be a comprehensive compendium, however, we hope to highlight key activities, examples, and resources for further consideration.

CHOICE Regional Health Network, the non-profit health collaborative that authored this paper, began to focus more closely on systemic issues of language access in 2003, after several years of increasing our own internal capacity in order to serve the region's growing limited English proficient (LEP) community, primarily Latinos. With funding provided by The Robert Wood Johnson Foundation's *Hablamos Juntos* initiative, intended to improve language access to health care for LEP Spanish speakers in areas of the country with rapidly growing Latino populations, CHOICE initiated a project called *¡Tu Salud!*

During the planning and then implementation stages of *¡Tu Salud!*, CHOICE worked to develop greater mutual understanding of language access issues in Washington State among stakeholders; increase collaboration among multiple sectors; pilot and stabilize new training opportunities and peer support in Spanish language health interpreting; and participate in research on language access, technologies, and assessment of interpreters as part of the Foundation's national program.

In late fall of 2005, as the *Hablamos Juntos* project was wrapping up nationwide, CHOICE was fortunate to receive a small amount of additional funding from the Foundation through December 2006. We were asked to undertake additional work to facilitate discussions regarding a more standardized approach to health care interpreter competency. We hope that this paper provides a springboard for developing formal options to consider as recommendations for improving health care interpreting in Washington State.

Washington State has been considered a pioneer in the certification of medical interpreters. Since its start in 1995, Washington's Medicaid-based medical interpreter certification model has evolved along with the field of health care interpreting. Additional models for determining and assuring the quality of health care interpreters have emerged elsewhere in the U.S. These models may have important lessons to share with Washington State, or contain elements that could be replicated here to strengthen the current system.

This paper is structured around a comprehensive Quality Assurance model for spoken medical interpreting. There is currently no nationally accepted quality standard for medical interpreters, although discussions are happening nationwide to establish a process for developing one. We believe that a

comprehensive quality assurance model is critical in order to more fully understand and discuss the range of issues and options. In the absence of such a model, important, well-motivated steps toward quality assurance taken by institutions, individuals, and organizations risk remaining isolated and fragmented. Shared understanding of the broad context of quality assurance will increase the potential for diverse efforts to be collaborative and to stimulate improvement that no one party can achieve alone. We recognize that the breadth of our Quality Assurance model creates some tension in relation to tendencies to narrow the discussion:

- Almost without exception, there is stronger national interest and momentum concerning certification than any other single aspect of the Quality Assurance model, or toward the model as a whole.
- The interests of our funder, The Robert Wood Johnson Foundation, also align more closely with moving forward specific components of the Quality Assurance model rather than the model as a whole.
- In Washington State, there is a strong tendency to focus discussions entirely around the details of the Washington State medical DSHS certification exam and brokerage system, rather than on broader quality assurance issues. While these Medicaid administrative practices were not intended to provide comprehensive assurance let alone address the entire state LEP population, they often end up under the microscope in the absence of any organized and highly visible approach.

As a reflection of these tendencies, this paper offers uneven detail regarding various components of the Quality Assurance model; more information is provided about components that have generated the highest interest, such as certification (one form of verifiable assessment). This does not mean that our interest is limited to certification of medical interpreters. As is true for any field facing a decision point about increasing professionalization, a move toward certification has risks as well as advantages.

THE COMPREHENSIVE HEALTH CARE INTERPRETING QUALITY ASSURANCE MODEL

The following model of Quality Assurance in Interpreting was developed by language access consultant Cynthia E. Roat, MPH¹. It is based on national best practices and her expertise in the field. The summary graphic on page 7 shows two distinct, but linked processes, with multiple components, that are required to assure quality in interpreter services in health care:

- ***Interpreter*** quality assurance (including competence): Assuring that the interpreter present for a health care encounter is appropriate and doing a good job. This area is the focus of our work and is illustrated with examples in the table below and on page 7.

¹ Cynthia E. Roat, MPH is a consultant and trainer on issues related to language access in health care. She started working as a medical interpreter in 1992, after earning her MPH in International Health from the University of Washington. Ms. Roat is certified by the Washington State Department of Social and Health Services for both medical and social service interpreting. Her interest in systems change led her into training interpreters and interpreter instructors, then into training providers to work with interpreters, and finally into working with administrators on improving language access programs. Over the past decade, Ms. Roat has worked with large and small public and private institutions, in urban and rural areas all over the United States, making significant contributions in the areas of training, program development, policy formulation, advocacy and organizational outreach. She has written widely for the field, and her works are key resources for interpreters, providers and administrators alike. Ms. Roat is a founding member and former Co-chair of the National Council on Interpreting in Health Care (NCIHC), as well as being known nationally as an energetic advocate for the field of health care interpreting and for language access in general.

- ***Interpreter service delivery*** quality assurance: Assuring that an appropriate interpreter is actually available to interpret for the encounter. Service delivery is critically important for quality assurance in health care interpreting, and we are interested in gathering ideas for innovative models.

An even broader view of language access would also include signage, translations, and the presence of bilingual providers. These are not included in the model, which addresses only health care *interpreting*.

According to the Roat model, six steps are required in order to assure interpreter quality. The table on the following page focuses on the interpreting side of the model, along with examples to further illustrate the meaning of each component.

As illustrated in the table below, assuring quality in health care interpreting requires many steps before a candidate interpreter is ready to have interpreting skills assessed. It could include multiple forms of assessment (certification is only one example), and requires maintenance activities long after the exam has been satisfactorily passed.

In real-life practice, some health care entities are actively implementing a thoughtful quality assurance model, specifically tailored to their organizational needs, which addresses nearly all of the components of the Roat model. Others are approaching quality assurance in medical interpreting more haphazardly for a variety of reasons, including resource constraints, a lack of understanding of the complexity inherent in providing quality medical interpreting, and poor interpreting infrastructure beyond what exists for Medicaid. Likewise, individual interpreters approach their occupation unevenly; some actively seek out opportunities for training and continuing education, while others are not aware of these resources or are not motivated to pursue them.

As conceptualized by Roat, it is not only the quality of the interpreters that must be assured, but also the quality of the interpreting delivery system. Having well-prepared individuals available to interpret does not necessarily mean that an effective, smoothly functioning procedure exists throughout an institution, a service system or a community to provide appropriate, resource-effective interpretation (or other appropriate language access) at every encounter an LEP patient has with the health care system. This critical structure is known as the Interpreting Delivery System, and its quality must also be assured.

The full Quality Assurance model for Interpreters and the Interpreting Delivery System is illustrated on page 7. The breadth of the overall quality assurance model is comparable to contemporary ways of looking at other aspects of health care quality assurance. It's been a long time since the focus of quality was believed to rest exclusively on personnel and other inputs; the current focus is on quality improvement involving processes and infrastructure as well as people and facilities. The field of interpreting is at a different point of development, but still needs a broad conceptualization that does not confuse the need for highly trained people with a total problem statement.

To be most effective, any quality assurance process must be supported by multiple parties. Designing and consistently implementing a whole set of complex processes and standards is difficult, especially in the face of limited resources. Because Washington State has some processes and standards in place, it can be tempting for advocates to believe that state government alone can establish, finance, and staff a "better system." However, we believe that achieving rapid improvement will require integrated participation by all who will benefit from better and more accessible interpreting in health care. Therefore this paper, and our approach to quality assurance, purposely goes beyond the DSHS role in order to explore approaches to quality assurance in health care interpreting that may require actions by us all.

Interpreter Quality Assurance²

Cynthia E. Roat, MPH, 2006

<i>Component</i>	<i>Examples</i>
Recruit appropriate interpreter candidates	<ul style="list-style-type: none"> ■ A large hospital develops clear personnel skill requirements for candidates for a full-time staff interpreter position. ■ A community clinic system interviews interpreter candidates with a view to their maturity, boundaries, compassion and ability to deal with stressful situations. ■ An interpreter training program asks trusted community mentors to urge bilingual individuals who are mature, compassionate, and deal well with stressful situations to consider interpreter training.
Screen/Assess language skills of bilingual candidates to determine whether they are prepared to benefit from health care interpreter training	<ul style="list-style-type: none"> ■ Bilingual employees at a health department participate in job interviews with candidates applying for a bilingual front desk position by conducting a 15-minute guided conversation in the non-English language. After each interview, they are asked by their supervisor to offer a brief verbal assessment of their observations of the candidates' fluency, based on a series of guidelines they have been given ■ A 100-hour medical interpreter training program requires students to pass a 30-minute written and 45-minute oral language <i>screening</i> exam prior to entering their training program.
Provide health care interpreter training	<ul style="list-style-type: none"> ■ 40-hour training specific to health care interpreting offered at multiple locations nationwide. ■ Health care interpreting as an optional one-semester modular class for bilingual students enrolled in an allied health program at a local community college.
Assess knowledge & skills upon completion of training; and provide some method for public verification. (May include certification.)	<ul style="list-style-type: none"> ■ State certification exam for medical interpreters reimbursed with state funds. ■ Governmental or independent registry is developed and includes information on how and when a candidate's interpreting skills were verified. ■ Company-specific written or oral exam that must be passed prior to interpreting for clients.

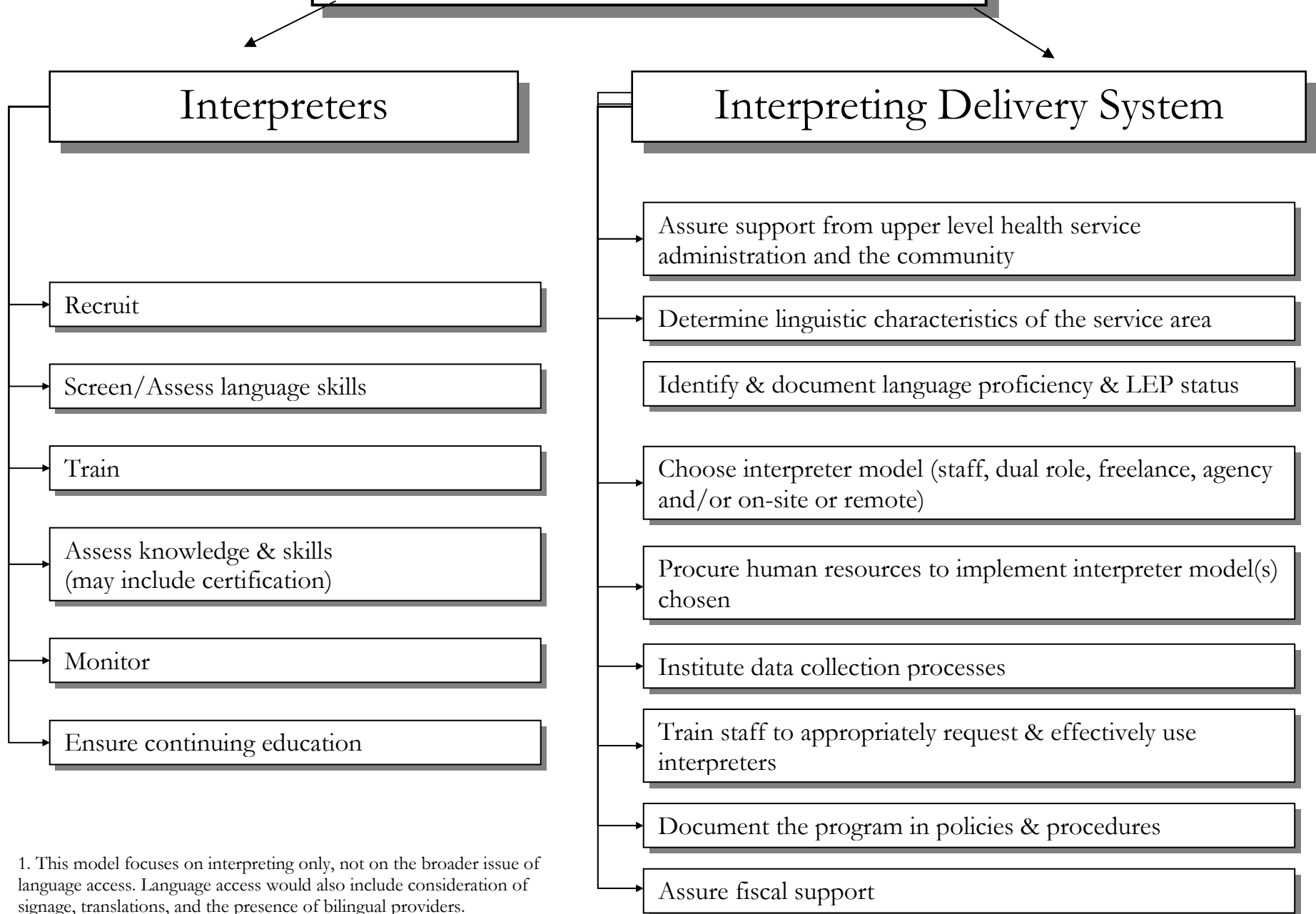
² This table elaborates and illustrates the left side of the full model. See page 7 for both sides of the model. This model focuses on interpreting only, not on the broader issue of language access.

<i>Component</i>	<i>Examples</i>
Monitor interpreter performance during actual patient encounters	<ul style="list-style-type: none"> <li data-bbox="526 237 1307 363">■ Interpreter supervisor at major medical institution has a “shadowing” schedule and sits in on interpreted patient-provider encounters, later providing feedback to the interpreter regarding ways to improve performance. <li data-bbox="526 394 1284 489">■ Interpreters working at a telephonic (distance) interpreting agency are randomly monitored during 5 telephone encounters per month, based on which the monitor offers feedback.
Ensure continuing education	<ul style="list-style-type: none"> <li data-bbox="526 531 1307 625">■ A consortium of community health centers provides registration, mileage, and paid time off for bilingual employees to attend an annual 3-day conference of medical interpreters. <li data-bbox="526 657 1292 751">■ A state mandates a minimum number of hours of continuing education that a health care interpreter must complete online in order to maintain their status as certified or licensed. <li data-bbox="526 783 1263 856">■ Interpreters work together to form a professional association chapter that will sponsor brown-bag educational events.

Please see the model on the following page.

Interpreting Quality Assurance¹

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.

OVERVIEW OF INTERPRETER COMPETENCY ASSURANCE AND TESTING NATIONWIDE

During the first two decades of concerted work toward linguistic access in health care, the focus of language access advocates was on improving access to an interpreter – often any interpreter. In 1989, Carmen Palomera Rockwell of Region X of the Department of Health and Human Services Office for Civil Rights became the first OCR officer to publish a guidance memorandum reminding recipients of federal funds that they have an obligation to provide language access under Title VI of the 1964 Civil Rights Act. In 2000, the Federal DHHS Office for Civil Rights followed suit. Then President Clinton signed Executive Order 13166, applying these same language access rules to the Federal Government itself and requiring all federal government departments to provide similar guidance to the recipients of their funding. In 2003, the DHHS Office of Minority Health published the Culturally and Linguistically Appropriate Service standards (CLAS), which included complementary standards regarding the provision of interpreters. The non-profit Joint Commission on the Accreditation of Health Care Organizations (JCAHO) began pointing out how many of its safety and patient rights standards could not be met for LEP patients without language access services. However, all of these guidelines and regulations said virtually nothing about the quality of the interpreting to be provided, or the preparation of the interpreter who would provide it.

As more and more people become aware of the need for quality assurance in health care interpreting, initiatives are emerging across the country in an effort to do something, given the absence of national consensus. With funding from The California Endowment, Cynthia Roat recently conducted a nationwide review of efforts relating to health care interpreter certification. Her work is to be released in summer 2006 and available on the website of The California Endowment at www.calendow.org. Roat's work identifies two major motivating factors that help explain why language companies, states, health care institutions, and other entities would choose to undertake the piloting or modification of models of interpreter quality assurance or testing:

- Private organizations striving to meet their own quality assurance needs, sometimes resulting in a broader impact on the surrounding area or through the organization's client network; and
- State policy processes responding to an evident need for broader accountability for quality interpreter services, sometimes at the urging of language access advocates.

Additional motivating factors include:

- States emulating each other's models in order to meet quality or financial goals;
- Desire among interpreters to further professionalize their field;
- Concerns regarding enforcement of federal requirements or institutional accreditation standards; and
- Desire to raise the state-of-the-art for health care interpreting.

Along with the variety of motivating factors, efforts to assure interpreter quality have distinct goals and approaches. Roat's findings include a catalogue of important lessons identified by those implementing certification programs. We paraphrase and summarize the lessons derived from the certification programs below.

<i>Component</i>	<i>Lessons Learned from Certification Programs in Relation to the Model</i>
Provide health care interpreter training (“Interpreting” side of model)	<ul style="list-style-type: none"> ■ Prior to initiating any new training program, it is important to understand and coordinate with any nearby training opportunities. Consider early on issues of transferability of training “credits” into other programs.
Assess knowledge & skills (May include certification) (“Interpreting” side of model)	<ul style="list-style-type: none"> ■ Having testing and certification mechanisms in place does not ensure retention of valuable human interpreters ■ Attempting to create a statewide certification process requires significant political will ■ Certification tools that are developed hurriedly can later backfire ■ The more closely an assessment approach simulates actual interpreting conditions the more challenging it becomes to administer it consistently ■ Maintaining a certification tool requires significant investment of resources to account for changes in languages, industry expertise, and target populations
Procure human resources to implement interpreter model chosen (“Interpreting Delivery” side of model)	<ul style="list-style-type: none"> ■ It is important to remember that human resources for interpreting don’t necessarily exist in the geographic areas where they are needed ■ Consider whether provisional certification will be available for certain languages or in certain rural areas due to supply concerns
Assure fiscal support (“Interpreting Delivery” side of model)	<ul style="list-style-type: none"> ■ It is common to downplay the importance of fiscal support for interpreter certification projects and quality assurance issues when working toward a legislative policy victory; however the importance of a budget cannot be overestimated

Oregon and Washington are two states whose efforts have often been emulated; Washington for its DSHS certification exam and Oregon for its policy process. Where the goal is state policy change, it is common for proponents to first set their sights on certification as a way to improve quality in health care interpreting. Oregon has taken the cycle of state policy change the farthest. After a lengthy initial process in the direction of creating a state certification, Oregon stopped short of *requiring* certification, but rather anticipates a process that is voluntary.

The components of the Quality Assurance model have been given differing amounts of attention around the country. Training received the most initial attention, and more recently interest in screening/assessment of language skills is increasing, however, to a large degree recruitment, monitoring and ensuring continuing education are still largely ignored. While the delivery system is not the focus of this paper, it is worth noting that nationwide, assuring fiscal support is one of the areas of greatest challenge.

MEDICAL INTERPRETING IN WASHINGTON STATE

As mentioned in the introduction, Washington State has long been considered a pioneer in the field of medical interpreter quality assurance. This reputation began when Washington became the first state to use public funds to pay for interpreting for Medicaid patients. It was reinforced when Washington became the first state to introduce certification for medical interpreters. Washington State requires certification of medical interpreters who are paid through the Medicaid Program within the Department of Social and Health Services (DSHS). Many states have looked to Washington to understand the successes and challenges related to the development and maintenance of a certification exam, and have sought to replicate aspects of Washington's DSHS certification program.

The origins of the Washington State DSHS certification exam date back to the 1980s, when a DSHS task force began meeting to determine how to improve health services through improving the quality of language access services; how to help non-profit organizations faced with overwhelming interpreting needs; and how to maintain a balance between advocacy and interpretation. While the task force was developing a plan, several other factors began to push toward rapid change, including legal action taken on behalf of Limited English Proficient clients who had lost their welfare benefits due to poor interpreting. As a result of these factors, DSHS committed to ensure interpreter quality through the development and administration of a standardized written and oral test and the development of a list of certified interpreters³. A DSHS certification exam for social service interpreters was implemented in 1992 and an analogous exam for medical interpreters was developed in 1995.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES CERTIFICATION EXAM AND PROCESS FOR NON-CERTIFICATED LANGUAGES⁴

DSHS provides certification testing for eight languages: Cambodian, Chinese-Cantonese, Chinese-Mandarin, Korean, Laotian, Russian, Spanish, and Vietnamese. There are two portions to the DSHS certification exam, written and oral. An interpreter must pass the written test before proceeding to the oral test. The development of these exams followed the rigorous procedures common to professional test development and validation. Candidates make an appointment to take the exam at one of six locations statewide. No pre-screening is done of the candidate, and no prior interpreter training or experience is required. The written test is 90 minutes in duration and costs \$30 for each attempt. The oral test is 30 minutes in duration and costs \$45 per attempt. The written exam is scored by machine and the oral exam is scored by trained raters. Test results are available within four to six weeks. The overall pass rate for all languages in the written test was about 85% as of January 2005; the overall pass rate for all languages in the oral test was about 42% including re-takes⁵.

In response to concerns about interpretation quality in non-certificated languages (all those other than the eight languages listed above), DSHS developed a process to authorize interpreters using a non-language-specific screening test in 1996. Screening is available in any language that does not have a DSHS certification exam. In order to be authorized to receive reimbursement for Medicaid interpreter encounters, interpreters who speak non-certificated languages must meet written and oral testing requirements. The written test for non-certificated languages is entirely in English, consisting of four multiple-choice sections: professional

³ This decision was made in the context of a legal consent decree entered into by DSHS and described in greater detail in Appendix 1.

⁴ Additional detail regarding the Washington State certification exam is included in Appendix 1 and in *Summary of Current Approaches for Washington State-Funded Medical Interpreting*, under RWJF Grant 55804.

⁵ Overall pass rates revised via personal communication, Brian Lindgren, DSHS ASD, July 2006. Per Dr. Hungling Fu, this specifically includes re-takes, Aug 2006.

ethics, medical terminology, clinical/medical procedures, and an additional writing test in the English language. The oral screening test has three parts: a sight translation exercise of ten unrelated sentences from English into the target language; a memory retention test; and a back-interpretation exercise from the target language into English. The oral test is audio recorded for scoring purposes. Unlike language testing for the certificated languages, the screening process does not require grading by experts in the non-English language.

THE BROKERAGE SYSTEM

Since January 2003, the state has used a brokerage system to provide interpreter services for Medicaid patients. Under the brokerage model for interpreting, based on a similar system used to purchase transportation for Medicaid patients, each region of Washington State is assigned a broker: an organization that is contracted by competitive bid to arrange and schedule transportation and interpretation services for a wide variety of DSHS clients, including Medicaid. Both medical and social service interpreters are included in the system. Eight brokerages serve thirteen regions in Washington State. The broker only provides interpreter services for spoken languages. Sign language and translation are handled under other contracts.

When a health care provider needs an interpreter, the provider's office calls the regional broker. The broker then gives the assignment to one of the language agencies or sometimes an individual interpreter who is subcontracted according to state guidelines. The language agency then assigns or attempts to assign one of its contracted interpreters. Each step of the process is described in greater detail below:

1. The provider determines whether the LEP patient needs an interpreter. If need is determined, the provider calls the broker and provides the necessary information about the appointment and the client. A provider is expected to request an interpreter at least 48 hours prior to the patient's scheduled appointment. Note: The only entity that can request an interpreter for an LEP patient is a Provider Office. Also, the provider determines whether an appointment is verifiably urgent.
2. The broker verifies that the provider has a contract with the state and that the service to be provided is a Medicaid-covered service. They also determine whether the patient will have a valid medical coupon for the date of the appointment. If the patient is eligible, the information is entered into a database; a control number is assigned for tracking and it is given to the provider's office for their records; and the broker calls a language agency and offers the appointment.

If the patient is not eligible, the broker calls the provider and a decision is made on how to proceed – either the provider decides to see the patient without utilizing the Medicaid interpreter broker system or the appointment is scheduled when eligibility can be determined. **Note:** An appointment is usually not scheduled more than 30 days in advance; since eligibility can't be determined further in advance than the current month.

3. The language agency attempts to fill the request. If the agency cannot fill the request within the period of time required by the brokerage, they will send it back to the broker, and the cycle will repeat with a different language agency until or if an interpreter can be found for the appointment. Only interpreters who have been certified or authorized through DSHS are used.⁶
4. If the language agency is successful, the interpreter accepts the assignment. Most interpreters contract with more than one language agency. This can cause confusion in scheduling and in completion of the appropriate paperwork.⁷

⁶ As described above, certification is available in eight language pairs; interpreters who speak other languages and meet testing requirements are referred to as "authorized".

⁷ Final Report, Language Access in Health care Series Part II: Lost in interpretation. Event held 9/14/04, Lacey Community Center.

REIMBURSEMENT UNDER THE BROKERAGE SYSTEM

Reimbursement to brokerages, for direct services, is passed directly on to language agencies and from language agencies to interpreters. Brokerages also receive separate DSHS-negotiated reimbursement for their administrative costs.

Interpreters receive payment by the hour. After the first hour of the encounter, payment is determined by 15-minute increments. An exception is made for consecutive appointments, which are paid for by the actual time of each encounter. The maximum payment rate that brokerages are allowed to pay agencies is \$33 per hour. The rate received by the interpreter varies, depending on the contract with the agency. Some agencies allot a high percentage of the maximum hourly amount to the interpreter, while other agencies retain a higher portion to supplement their administrative allowance. If a patient does not arrive for the scheduled appointment, interpreters receive compensation for one half-hour. In order to be eligible for mileage reimbursement, an interpreter must travel a minimum of 10 miles point-to-point to the site.

OTHER METHODS BY WHICH INTERPRETING OCCURS IN WASHINGTON ⁸

Outside of the brokerage system, there are other interpreting options which include: free lance interpreters, bilingual providers/staff, public entities (hospitals and health departments), and Community Health Centers (CHCs). Free lance interpreters may work within the brokerage system or through an agency, public entities often provide interpretive services through interlocal agreements, and CHCs frequently employ dual role/bilingual personnel and tend not to use the brokerage system.

INPUT AND COMMENTARY ABOUT INTERPRETING IN WASHINGTON STATE

As a result of our work with the Robert Wood Johnson Foundation *Hablamos Juntos* Program, which helped create a forum for dialogue regarding language access issues in Washington State, CHOICE has heard many perspectives on interpreting in Washington. Without attempting to validate all comments, we have included, for discussion purposes, a summary of those that came from multiple sources.

SCREEN/ASSESS LANGUAGE SKILLS:

- No language screening requirements exist for candidates who wish to take the DSHS certification exam. As a result, candidates can waste their time and money when their language skills are not sufficient to the task of interpreting.
- Provider offices may perform brief screening or assessment (or none at all) of candidates for dual-role interpreter positions. As a result, unknown or unacceptable quality of interpretation may exist, due to inadequate language skills in English, the target language, or both.
- Language skills assessment, independent of the resulting score, may provide very valuable and surprising feedback to interpreters who perceived their skill level to be higher than assessed. In this way, assessment may serve to motivate interpreters or interpreter candidates to seek training, even if it is not required.

⁸ See Summary of Current Approaches for Washington State-Funded Medical Interpreting, under RWJF Grant 55804 for additional detail.

TRAIN:

- No training requirements exist for candidates who wish to take the DSHS certification exam. A candidate can pass the exam and still be a poor interpreter.
- Many working interpreters, both certified and uncertified, are unaware of how they might benefit from training, until they attend one. It is common for even experienced interpreters to complete an initial round of training and then realize how significantly they could improve their skills with further training and practice.
- Many interpreters and interpreter candidates have difficulty finding, accessing and affording training opportunities to advance their skills, or are unaware of opportunities that exist.

ASSESS KNOWLEDGE AND SKILLS:

- We are lucky to have the DSHS certification exam as one option for assessing skills.
- The DSHS certification tests only a small part of the knowledge, attitudes and skills identified by the National Standards of Practice for Interpreters in Health Care.
- No requirements exist for ongoing assessment or recertification of health care interpreters.
- The current certification system treats all interpreters as interchangeable. No mechanism exists to distinguish between minimally qualified interpreters and highly skilled ones, and only one level of certification exists. The certification system provides no incentive for interpreters to maintain or improve their skills or stay in the interpreting field at all.

ENSURE CONTINUING EDUCATION:

- No continuing education requirements exist for interpreters.
- Formal continuing education opportunities are not widely available.

CHOOSE INTERPRETER MODEL:

- Some provider offices consistently overestimate the ability for a “bilingual provider” to adequately communicate with LEP patients, and do not request an interpreter through the broker system (or other means), resulting at times in potentially dangerous miscommunication.
- Due to the unwieldiness of the brokerage system, many providers are turning to the use of uncertified dual-role interpreters, i.e. nominally bilingual staff who have been hired for some other job and who are called ad-hoc to interpret.
- The brokerages do not commit to booking interpreters for appointments sooner than 48 hours. This means that brokered interpreters are rarely supplied for urgent care..
- The brokerages commonly call providers back to inform them that they couldn’t get an interpreter – leaving the provider scrambling to find his or her own interpreter on short notice.
- DSHS-certified interpreters contracted through the brokerage may not be paid more than the capped hourly rate through a language agency. Non-certified interpreters, not being bound by the brokerage system, may negotiate their own fee, which may be higher than that paid to certified interpreters.

PROCURE HUMAN RESOURCES TO IMPLEMENT INTERPRETER MODEL CHOSEN:

- The Medicaid broker/agency/contracted interpreter system does not build local capacity. Local people who might become good interpreters do not have the organizational framework to be trained, mentored and employed for this role.
- While meeting state management requirements, the three-tier system of brokers, language agencies, and contracted interpreters is viewed by advocates as a cumbersome and ineffective way to meet patients' needs.
- Some brokers underutilize certified interpreters who live in rural areas in favor of assigning interpreters who live in more distant urban areas where the brokerage is located. This wastes travel time and compounds structural barriers to services resulting from the rules about how and when service requests can be initiated.
- It is difficult for interpreters outside of major metropolitan areas to assemble adequate blocks of work to make interpreting a career. Since interpreters can no longer be requested by name, those who had built up a good reputation among providers through their excellent service and knowledge of local conditions have lost whatever advantage they might have had over other interpreters.
- Interpreters sometimes have to wait up to three months to get paid.
- Some providers bypass the brokerage system because it is too cumbersome to use.

ASSURE SUPPORT FROM UPPER LEVEL HEALTH SERVICE ADMINISTRATION AND THE COMMUNITY:

- Without outside assistance, feedback from LEP communities regarding interpreter services offered at large institutions often does not make it back to upper level health service administration. Sometimes feedback is not communicated to the institution in any form due to discomfort about making complaints.
- In some rural communities that have experienced recent rapid growth in the local immigrant population, LEP patients report that they experience discrimination when trying to access services.

INSTITUTE DATA COLLECTION PROCESSES:

- The majority of the names on the DSHS list of certified interpreters have inaccurate contact data. No data is maintained regarding the number of DSHS certified interpreters who are still actively interpreting, making it difficult to track the state's real capacity and need.

TRAIN STAFF TO APPROPRIATELY REQUEST AND EFFECTIVELY USE INTERPRETERS:

- If a provider office does not request an interpreter from the brokerage system for a Medicaid client, that client has no way of knowing that an interpreter has not been requested and no way of requesting an interpreter themselves.

ASSURE FISCAL SUPPORT:

- Washington State is unique in devoting any funding to health care interpreting through the Medicaid system. Of note, funding has been maintained despite significant challenges, including reductions mandated by legislation.

- A significant portion of the state's Limited English Proficient population does not qualify for Medicaid. Health care organizations must develop parallel systems to request and pay for interpreters for this population. There is concern among advocates that a percentage of this population goes without needed interpreting.
- Providers of uncompensated care often feel it is unreasonable for them to be expected to also provide or pay for an interpreter.
- Funding for the state-funded interpreter program is always at risk of being reduced or eliminated in biennial budgets.

CONCLUDING QUESTIONS FOR STAKEHOLDERS/AUDIENCE TO CONSIDER AND RESPOND TO:

(Note: If you would like to respond electronically, please go to the following link

<http://www.crhn.org/tusalud/wings/q01.htm>)

- Does this document present a realistic view of the current status of health care interpreting, both nationally and in Washington State? If not, what is missing?
- What else is going on within the scope of the interpreter competency assurance model for health care interpreting that is missing from this document and should be incorporated? (We know we cannot be comprehensive in this project, so the most important additions would be examples of successful activities or policies that fill important gaps or illustrate new options.)
- Our project will look at options and generate some recommendations, but will not have the permanence needed to influence policy over the long term. What other processes are underway that you think will have the ability to bring people together to solve problems in the realm of health care interpreting?
- What key findings from other studies and reports should be included here? (Please bring them to our attention and provide us with a copy.)
- The breadth of the quality assurance model suggests that there are roles for all stakeholders. Thinking of your role in the health care interpreting system, is there anything you believe you and your peers could be doing differently to help improve outcomes?
- Are there things you believe others should be doing differently to improve outcomes? Brief but specific ideas will be the most helpful.
- Are there any factual issues whose resolution might open the way to identifying additional valuable options?

APPENDIX I:

PURPOSE AND ORIGINS OF WASHINGTON STATE-FUNDED MEDICAL INTERPRETING

PURPOSE AND ORIGINS OF WASHINGTON STATE-FUNDED MEDICAL INTERPRETING

The original DSHS taskforce on interpretation and translation was formed in the 1980s due to the following observations:

- a) Clients/patients of DSHS were forced to wait long periods or use their friends or their children to provide interpretation for them
- b) There were quite a few local church and community organizations providing services on a volunteer basis and paying people very minimally, \$5 or \$6 per hour

The original intent of the task force (which included Liz Dunbar, the current Deputy Secretary of DSHS) was three-fold. It was charged with determining:

1. How to improve health services by improving the quality of provision of language access services - such as by meeting a certain minimum standard, so clients wouldn't have to rely on their children, and institutions wouldn't have to turn to untrained and inappropriate employees to provide interpreting services.
2. How to create a system where non-profit organizations could get some help so they could use volunteer interpreters to fill the gaps.
3. How to maintain a balance between advocacy and interpretation – so that interpreters could be used not only to provide interpretation but also to help clients access services.

While the taskforce was developing a plan that addressed the above issues, four factors impacted the outcome:

1. Evergreen Legal Services took legal action on behalf of Limited English Proficient (LEP) clients who had lost their Welfare benefits due to poor interpreting. The resulting consent decree required DSHS to test and qualify the interpreters paid by DSHS.
2. A growing number of for-profit language agencies and independent interpreters wanted to participate, as interpretation services were becoming a big budget item.
3. The IRS mandated that DSHS Community Service Offices (CSOs), which were using contracted interpreters almost full-time, treat them as DSHS employees, with full benefits.
4. Some bilingual DSHS employees, who were being asked to provide interpreter services, were requesting a salary differential.

LEGISLATIVE DEMAND FOR EXPENDITURE REDUCTION AND THE STATE'S RESPONSE

Since the mid-1990s, DSHS has struggled to keep interpreter services afloat. In 1997, the interpreter services budget was reduced by 70%⁹. In the proposed supplemental state budget for 2002, then-Governor Gary Locke eliminated the medical interpreting portion of the program altogether, on the basis that the medical portion was optional, per interpretation of Title VI of the Civil Rights Act of 1964 and the Office for Civil Rights guidance memorandum.

This decision was part of a larger cost containment initiative by the state to save money and was based on the high cost of providing interpreter services and the fact that most other states did not pay for these services. In addition, there was increasing documentation of manipulation of the system, for individual financial benefit, by some interpreters in specific language groups. Community advocates responded to the cuts by lobbying the legislature to have the program restored to the budget. Key legislators approached the Medical Assistance Administration (MAA), and asked how the program could be run on a more limited budget. MAA responded by proposing a broker system to handle interpreter requests, rather than direct booking of interpreters by interpreter agencies, as had occurred in the past. The legislature funded this proposal, but required DSHS to save approximately \$8 million in the first 18 months.

The 2002 supplemental budget mandated that the interpreter brokerage model be implemented on January 1, 2003. The model was based on the State's non-emergency transportation brokerage model, which was implemented in 1988 and was also operated by MAA. The state pays the brokers a flat administrative fee and a pass-through per-hour fee for the interpreter. This latter is passed on to the language agencies, which then pay the interpreters some of the fee. The administrative fee received by the broker is negotiated by DSHS and is based on a set amount per month over a specified contract period.

At the time the brokerage system was implemented, MAA was required to establish lower rates to meet the legislatively mandated savings amounts. The brokerage model applies to state/federal-funded encounters that aren't covered by the three alternative models (public entities, Community Health Centers, and contracted health plans). In 2004, Washington State was projected, prior to establishment of the brokerage system, to spend \$36 million over two years for all DSHS interpreter services, including approximately \$24 million for Medicaid and SCHIP enrollees¹⁰.

ADDITIONAL DETAIL REGARDING THE WASHINGTON STATE DSHS MEDICAL INTERPRETING CERTIFICATION EXAM

The level of education needed in order to understand the test materials verbatim was identified as equivalent to 10th grade.

CANDIDATE APPLICATION PROCESS

While a pre-test study package is provided to all interpreters when they register to take the test, organized training of medical interpreters has not been part of the DSHS certification process. DSHS officials have emphasized that the legal requirements of the consent decree do not include training, only testing.

⁹ Nora Guzman-Dyrseth, Language Access in Health care Series Part I: Understanding our Interpreter System from All Points of View, 6/17/04, Lacey Community Center.

¹⁰ Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency. National Health Law Program and The Access Project, February 2004.

WRITTEN EXAM:

The written test has five sections, all in multiple-choice format. Sections one, three, and four are in English; section two includes both English and the non-English target language; and section five is the same as section four, but entirely in the non-English target language. Section one covers the professional code of ethics; section two covers medical terminology (symptoms, diseases, treatments, etc.); section three covers clinical/medical procedures; and sections four and five test syntax and grammar.

ORAL EXAM:

The oral test has two parts: a test on sight translation and one on consecutive interpretation. In the sight translation test, the candidate has six minutes to verbally render an English text into the target language, and another six minutes to render a non-English text into English. In the consecutive interpretation test, the candidate plays the role of the interpreter, using pre-recorded audio materials with built-in pauses to perform the interpretation. The entire oral test is audio-recorded, then scored by independent graders retained by LTC.

DURATION:

For non-certificated languages where only screening exists, the written screening test is 75 minutes in duration, and the oral screening test is approximately 20 minutes in duration.

SCORING PROCESS:

Because the machine is not capable of scoring the test section by section, no breakdown of candidate performance beyond passing or failing is provided to candidates. A total score is automatically printed on the written test answer sheet by the grading machine.

The oral exam is scored by trained raters whose backgrounds include court interpreters, DSHS certified interpreters holding at least medical and social service certification, language teachers, and professionals with high academic attainment and language proficiency. All raters are trained to follow detailed scoring guidelines to be aware of varieties in language usage. They are instructed to accept appropriate regional variations if the rendition conveys the same meaning as the source language. Oral test scores are reported to candidates by test sections, together with the composite total score, pass/fail information, and the passing benchmark. Candidates who don't pass the oral exam may request an individualized critique of their oral test performance.

PASS/FAIL RATES:¹¹

Certification rate by language and number of certified interpreters by language is listed below.

**Certification Rate By Language
(As of 8/1/06)**

Spanish	39%
Vietnamese	33%
Cambodian	38%
Laotian	27%

**Number of Certified Interpreters by Language
(as of 8/1/06)**

Spanish	1586
Vietnamese	201
Cambodian	47
Laotian	13

¹¹ Dr. Hungling Fu, DSHS Language Testing and Certification - revised information, as of Aug 1, 2006.

CERTIFICATION AND REGISTRY:

The LTC office maintains a list of people who have successfully passed the DSHS certification exam for each language. The state of Washington also recognizes the Federal and State Court Certification Tests and the Language Line Services Medical Interpreter Certification Test as acceptable measures of language proficiency, making interpreters who hold those certifications eligible for reimbursement.

PILOT PROJECT:

Within DSHS some consideration has been given to launching a pilot for an alternative method for testing individuals in specific Southeast Asian language groups. However, the idea was not accepted by DSHS because the suggested proposal might not comply with the requirements of the consent decree described above.

APPENDIX II: INTERPRETERS – AREAS OF QUALITY ASSURANCE MODEL UNDERWAY

(Note: if you are aware of other efforts that should be listed here, please write them in and get us a copy!)

If you would like to send your comments electronically, please go to the following link: <http://www.crhn.org/tusalud/wings/q02.htm>

<i>Element</i>	<i>Nationally</i>	<i>Washington State</i>	<i>What else should we be aware of?</i>
Recruit	<ul style="list-style-type: none"> As yet, there are no national standards regarding the capacities and preparation that candidates should have before entering into health care interpreting. Recruiting criteria, then, differ from institution to institution and from language agency to language agency, based on the level of awareness of program directors and the size of the candidate pool. Recruiting criteria also commonly differ by language, with higher skills being required of interpreters in more common languages. Dual-role interpreters, on the other hand, are commonly recruited simply on the basis of their willingness to serve, with no other pre-requisite beside self-assessed language skills. Pro-active efforts exist to attract and retain interpreters, often hand-in hand with efforts to improve work-place diversity, but without a keen understanding of the skills and characteristics of a qualified interpreter. 	<ul style="list-style-type: none"> Recruiting standards in Washington State are variable and mirror those found in the rest of the nation. There are efforts to actively recruit minority and bilingual providers, but we are not aware of similar efforts that target qualified individuals for training as interpreters. 	

<i>Element</i>	<i>Nationally</i>	<i>Washington State</i>	<i>What else should we be aware of?</i>
<p>Screen/Assess language skills (before any training)</p>	<p>Language screening is becoming more common, as a growing number of interpreting programs and a growing number of interpreter training programs around the country require some kind of screening before allowing a candidate entry. Language screening runs from the very informal (a short conversation with a candidate in the non-English language) to the highly formal (valid and reliable language testing). A number formalized language testing programs available to all, usually applied over the telephone, include::</p> <ul style="list-style-type: none"> • Language Testing International (the testing arm of the American Council for the Teaching of Foreign Languages) • The Center for Applied Linguistics • Language Line Services (telephonic interpreting company) • Pacific Interpreters (telephonic interpreting company) 	<ul style="list-style-type: none"> • Washington State DSHS considers the certification exam itself as a screening tool for language proficiency as well as an assessment of interpreting skill. • CHOICE’s <i>¡Tu Salud!</i> Project used the L&ISA assessment described more fully below (Assess knowledge and skills) as a screening tool for entry into Bridging The Gap training in five counties in southwest Washington. • In many cases, no screening occurs prior to interpreter training. 	

<i>Element</i>	<i>Nationally</i>	<i>Washington State</i>	<i>What else should we be aware of?</i>
Train	<ul style="list-style-type: none"> • Over the past decade, the availability of training in health care interpreting has improved exponentially. Short 40-hour courses linked to training of trainers, such as “Bridging the Gap” and “Connecting Worlds,” have resulted in basic training being offered in an increasing number of cities across the country. Community Colleges, such as City College of San Francisco and Cambridge College in Boston, have pioneered year-long courses in health care interpreting. The University of Massachusetts at Amherst even offers a course in medical interpreting over the Internet. Increasingly, dedicated interpreters -- and even to some extent dual-role interpreters -- are being expected to come to the work with at least basic training. • Despite the improvement in availability of training across the county there remain many areas where an interpreter cannot receive training at all. 	<ul style="list-style-type: none"> • Cross-Cultural Health Care Program 40-hour “Bridging the Gap” is offered bi-annually in Seattle. • Training component under development within Allied Health Program of one community college in southwest Washington • We are aware of at least one hospital that has developed a training program geared toward the state certification exam • Washington State DSHS states that language agencies are required to provide interpreter training for certified interpreters used by the brokerage system • In general, however, contract, agency and dual-role health care interpreters working in Washington State are not being required to have even basic training. 	

<i>Element</i>	<i>Nationally</i>	<i>Washington State</i>	<i>What else should we be aware of?</i>
Assess knowledge and skills related to health care interpreting	<ul style="list-style-type: none"> • In addition to Washington, only one state (Oklahoma) has a certification test, and it is voluntary. A state professional organization has developed an assessment tool that is being piloted in Massachusetts, and Indiana is developing an assessment for use in their state. • Four other private entities offer assessment of medical interpreter skills: <ul style="list-style-type: none"> ○ CyraCom (language service provider) ○ Language Line University (telephonic interpreting company) ○ Registry of Interpreters for the Deaf (national membership organization) provides a general certification, but there is no special certificate for health care interpreting. ○ University of Arizona Center for interpretation 	<ul style="list-style-type: none"> • Washington State DSHS certification exam in eight language pairs. • Washington State DSHS qualification exam for all other languages. 	<ul style="list-style-type: none"> •

<i>Element</i>	<i>Nationally</i>	<i>Washington State</i>	<i>What else should we be aware of?</i>
Monitor/peer support	<ul style="list-style-type: none"> Monitoring activities for on-site interpreters, though rare, are more likely to be observed in large institutional settings. Most on-site interpreters do not receive monitoring by a supervisor. Most telephonic interpreting agencies do routinely monitor their interpreters as part of quality assurance activities. Newer interpreters typically get monitored more often than experienced interpreters. Organized peer support among interpreters is also rare. 	<ul style="list-style-type: none"> The situation in Washington State regarding monitoring reflects the situation in the country as a whole. 	<ul style="list-style-type: none">
Ensure continuing education	<ul style="list-style-type: none"> Continuing education opportunities are generally very limited and difficult to find, although Oregon requires 8.5 hours per year to maintain qualification or certification, and qualification under development in Iowa will require 30 hours per year to maintain. The Registry of Interpreters for the Deaf requires continuing education for certification maintenance and might offer a model of value for review. 	<ul style="list-style-type: none"> From 1989 – 2005, monthly Medical Interpreter Forums were held in Seattle, sponsored first by Pacific Medical Center, then by the Cross Cultural Health Care Program, and then by the Society of Medical Interpreters (SOMI). The forums ended with the dissolution of SOMI in late 2005, but may be re-instated by the Medical Interpreting Special Interest Group of NOTIS. Very limited continuing education is available. In mid-June, a workshop for Bridging the Gap participants from the <i>¡Tu Salud!</i> Project will be offered a half-day of continuing education and peer support. 	<ul style="list-style-type: none">