Collaborative Strategies
For
Language Access
In Health Care
In
Seattle & King County

Meeting Report

Prepared by Christine Wilson Owens and J. Carey Jackson
At The Refugee and Immigrant Health Promotion Program
At Harborview Medical Center
These are turbulent times for “safety net” providers in King County, especially those caring for the non-English speaking poor. The downturn in the economy has diminished the tax base and thereby state and county budgets. Cost cutting directly affects services at the Health Department, the Community Clinics and Harborview creating an atmosphere of anxiety and mistrust.

Immigrant communities are suffering. The lowest skilled and the last to be hired are often the first to be laid off. Many recent immigrants find themselves unemployed without hope of new employment. As they lose benefits they fall into the “safety net” infrastructure, as it is unraveling. This is the same scenario for many native Washingtonians, as a result low-income or unemployed natives and immigrants compete for the same jobs and for the same limited pool of social services. The war on terrorism has made many fear and resent immigrants, especially those from Moslem countries. Tolerance and compassion for immigrants is disappearing, and public opinion is beginning to shift. These streams run together contributing to the turbulence experienced daily in local clinics and hospitals that serve non-English speaking patients.

There is a general sense that programs and resources burnished with the effort of 25 years of work are now corroding. We called this meeting intending to build new initiatives, to build new creative collaborations, to rediscover our origins and build on our shared history. On the one hand it could not have come at a worse time, as resources dwindle, morale declines, the temptation is to retreat to a bunker mentality. On the other hand, this is exactly the time that those committed to what has been developed thus far in our parallel institutions must step forward to protect those resources through information exchange and innovative design. The effort should be toward shared efficiencies in order to contain, if not reduce costs, while creating a more seamless service for immigrant communities. From this view there is no choice but to be proactive or to retreat.

We have specifically invited administrators, program managers, health care providers, interpreters and policy makers from key safety net institutions in King County. In this room Community Based Organizations, Community Clinics, Harborview Medical Center, the Health Department, Hopelink, Pacific Medical Center and the University of Washington Medical Center are represented. Through the next day and a half we ask you to use your combined talents to envision a way forward. Let us use our knowledge and creativity to reduce redundancy, share information, and build networks that will extend the resources of each “safety net” institution working with immigrant communities. As we move forward we must insist on a hardheaded look at the cost of these possibilities. If there is common ground, if there are shared priorities, and if the possibility of collaboration exists, however small or experimental, those of us working in the “safety net” who serve these communities, and the communities themselves have the most to gain.

Carey Jackson MD
Medical Director, Interpreter Services/Community House Calls
Harborview Medical Center

<table>
<thead>
<tr>
<th>Meeting Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify common priorities.</td>
</tr>
<tr>
<td>2. Formulate ideas to address these priorities.</td>
</tr>
<tr>
<td>3. Form groups to implement pilot programs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 1 Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Finding Common Ground to Address Language Access</td>
</tr>
<tr>
<td>• The Access Project Report &amp; The Importance of Health Literacy</td>
</tr>
<tr>
<td>• Expectations &amp; Norms of the Meeting</td>
</tr>
<tr>
<td>• Realities of the Landscape: Past &amp; Present; Local &amp; National Contexts; Interpreter Models</td>
</tr>
<tr>
<td>• Baseline Survey Information: Local Realities for Providers re: language services, funding, strengths, challenges, priorities of specific stakeholder institutions</td>
</tr>
<tr>
<td>• Brainstorming Ultimate Goals, Creative Ideas</td>
</tr>
<tr>
<td>• Identifying Priorities</td>
</tr>
<tr>
<td>• Designing Strategies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 2 Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrating Feedback</td>
</tr>
<tr>
<td>• Designing Strategies as Potential Pilots</td>
</tr>
<tr>
<td>• Working Groups Next Steps</td>
</tr>
</tbody>
</table>
Collaborative Strategies for Language Access in Seattle & King County

On February 6-7, 2003, Harborview Medical Center convened a meeting of key stakeholders involved in providing language access services in health care in the City of Seattle and in King County, Washington. The objective was to identify collaborative approaches to the dilemmas facing the “safety net” providers for non-English speaking patients. These are the proceedings and discussions of that meeting.

Making Sense of Shared Priorities:

The work process we used during the two days to identify shared priorities will help explain how the work product emerged. The day and a half session began with introductory remarks by Harborview’s Carey Jackson, followed by a short description of Philadelphia’s Access Project presented by Aracely Rosales. Cindy Roat, trainer and consultant locally and nationally, recounted the history of language access services in Seattle and Shari Wilson, of the Health Department, then provided the attendees with aggregate answers to the pre-meeting survey which identified the range of needs and priorities of participating institutions (see Appendix A).

The group then broke into sub-groups for conversations about the realities of language access services currently challenging their work. These small group conversations were followed by a shared discussion of idealized solutions to these current challenges. At this point the group was asked to return to sub-groups and "brainstorm" to identify "out of the box" solutions to current dilemmas to be reported later to the whole group. Once presented with these new ideas, the group was asked to divide into pre-arranged work groups to develop the most promising of these ideas into strategic priority areas. These working groups were each comprised of interpreters, managers, administrators, and service providers.

The “mixed-discipline” working groups were given the following guidelines: 1) Develop strategies while considering 10 suggested components of a language access model (see sidebar) and reflecting on the priorities brought up in the meeting so far. 2) The priority area must be a concern for most, if not all, of the stakeholder institutions present. In other words, avoid developing strategies that don’t address priority concerns of the key safety net stakeholders. 3) The hard realities of cost and limited resources must be considered as given factors of the current environment that will shape collaborative new priorities and determine their feasibility.

Once strategies were identified and developed further according to the guidelines, the working groups re-combined so that, as much as possible, people met with other stakeholders of the same skill set to review and critique the work product.

Finally, working groups re-assembled on the second day according to participants’ own choices of which strategies they would take forward beyond the meeting. The groups considered the critiques and comments on their work product given the day before and then further refined their strategies into possible pilot projects to take forward. The three priority areas the attendees felt warranted future collaborative effort are: I. Shared Scheduling Capacity, II. Centralized Interpreter Recruitment, Training, Screening, and Assessment, III. Community Access Networks. Five potential pilot projects emerged from these three priority areas, as detailed in the following pages.

I. Shared Scheduling Capacity………………………………………… ……………………………..Pg.3-4

II. Centralized Interpreter Recruitment, Training, Screening and Assessment…………………………………………………………………………………………………….Pg.5-7

III. Community Access Networks……………………………………………………………………………………………………………………………………………………………………..Pg.8-11
Priority I: Scheduling

Author: Martine Pierre-Louis, Harborview Medical Center
Lynn Moody, Hopelink
Lysieng Ngo, Center for Multicultural Health
Shelley Cooper-Ashford, Center for Multicultural Health
Paula Taylor, Rainer Park Medical Clinic,
Louisa Benitez, The Language Connection

Problem Statement:
There are losses of efficiencies and human resources in scheduling dedicated interpreters and stress on interpreters who are often driving across town, appointment to appointment.

Interpreter agencies and health care institutions - their providers, interpreters, and patients - all have different, competing scheduling needs. Solutions may look somewhat different to each of these parties, but the approach is toward centralized scheduling or shared resources.

How can we organize scheduling based on the availability of the interpreters, especially for rare languages allowing for the different institutions’ internal patient scheduling systems?

It is important to recognize that multiple agencies are scheduling the same interpreters and there are competing demands for interpreters for both social services and medical services.

The total number of interpreters in the “pool” is unknown.

Pilot #1 Shared Interpreters and Schedules among Health Institutions
Pilot #2 Centralized Scheduling System for Interpreter Agencies

Proposal/Solutions:
Interpreter agencies commit to hiring full time interpreters. Part of that commitment to pay the interpreter, even without full time need, is to also use interpreters as experts in that language in other ways, such as for telephonic/remote interpreting, translation and other non-related services such as computer work/scheduling (maybe also in training with the “disease-promotora” priority described in a separate priority section below).

For both agencies and institutions, first steps for coordinated scheduling would be to determine the pool of interpreters per language in order to provide a picture of available resources.

Hopelink, the broker for Medicaid interpreter services to some of the safety net, has committed to producing the actual numbers and names of qualified interpreters, by language, who work within King County – our common service area.
Long term, both agencies and institutions may want a “resource availability picture” available to all providers and agencies linked from one place - a web site or physical place, where interpreters are able to get and give a picture of their schedule.

For block scheduling interpreters, providers could use their on-call pool of interpreters, so that mainly the web site or databank would be most helpful for harder-to-find languages.

Interpreters, along with agency and provider institutions, might explore setting their own schedule, versus the “dispatch or day-to-day” scheduling that is the current norm. Issues to explore might include negotiation with institutions and agencies, rescheduling conflicts, abuse of system, opportunity to establish continuity of care and shared blocked interpreting system between institutions.

A solution for agencies to control costs may be to receive multiple requests as Excel files entered directly by clinic or hospital.

A solution for provider institutions might be to share rare language interpreters and to block schedule some others.

Scheduling interpreters by geographical region in consideration of travel time for interpreters is a possible approach.

For multiple approaches to scheduling, we can explore technology. Some coordination may be found with Microsoft Access database.

Each location and institution could access the database with its own password, and this could be secure.

There would be a centralized database where all encounters could be entered and it could show interpreter availability, geographical location, etc.

**Primary Players:**
Agencies, Health Care Institutions, Interpreters, Hopelink

**Next Steps:**
Hopelink: develop a list of interpreters; begin with a list of trained interpreters.
Institutions: interpreter services managers meet to discuss sharing rare language interpreters between institutions.

**Explore Further:**
Interpreter scheduling works best for the institution when it is integrated within the overall patient scheduling system. We need to develop a program that addresses several problems, and we would need funding and a commitment to make it work. Fully integrated tracking technology, with all listed players linked up, may not be fast enough for volumes or easily compatible with different databases at the separate institutions. A question for any new scheduling system is the consideration of guidelines for best practices for scheduling that address ethics as well as logistics.

Productive work of interpreters goes beyond interpreting at the clinical encounter; it is also facilitating the patient to the appointment, assisting with explanations of payment or insurance information, etc. Some patients will call interpreters directly for appointment scheduling and even health concerns, if they are allowed. The notion of including other measures of productivity (in addition to time spent interpreting in the provider encounter) as standard practice could be explored further.
Priority II: Interpreter Recruitment, Screening, Training and Assessment

Author: Cindy Roat, Independent Consultant
Lorane West, Independent Spanish Interpreter
Mary Rynerson, Pacific Interpreters
Bob Putsch, Cross Cultural Health Care Program
Oleg Pynda, Ukrainian Community Center of Washington
Brenda Lloyd, PacMed Clinics

Problem Statement
Current LIST certification for health care interpreters in Washington State is low-level and does not guarantee adequate skill levels.

Because the state certification is not adequate, each agency and health care institution has developed its own recruitment and screening programs. These programs waste resources to implement and waste the interpreters’ time in having to be screened over and over.

Grading for the in-house screening tests is not objective, as it is often done by members of the candidate’s same (often small) ethnic community.

Each agency/institution focuses only a small amount of attention on recruitment. Everyone uses the same techniques, meaning that everyone ends up trying to recruit the same candidates.

Recruitment, screening, and training are currently done in a piecemeal fashion, not as a coherent process.

Some groups may need assistance to become trained and certified. Our current system does not provide support and nurturance to these potential interpreters.

Current processes focus only on health care interpreters; the process needs to be widened to accommodate the multiple types of bilingual staff who provide interpreter services along with other services. ALSO, the process needs to be widened to support other types of community interpreting (except judicial interpreting, which has other systems to support it).

Small language groups do not fair well in the current system of recruiting and screening, and need special attention.

Once interpreters are hired or contracted, the contracting agency has difficulty requiring them to get trained.

Pilot #3 Centralized Community Language Access Development

Proposal
The working group proposed the establishment of a program, to be housed at an already existing non-profit organization, that would dedicate itself to recruiting and preparing all types of professionals needed to make a language access program work. The recruiting, screening and training processes for interpreters would replace the multiple processes currently in use by each safety-net provider, thereby avoiding redundancy and wasted resources. If the safety-net providers were to commit to hiring/contracting first from graduates of this program, the standard of practice of interpreting would be elevated and standardized. This program would not employ interpreters. Following are some of the activities such a program could take on:

Shortest term
Recruiting interpreters: Effective recruiting requires building and maintaining trusting relationships with communities and institutions. This would be part of the focus of the program.

Screening interpreters: Instead of undergoing a different screening test at every agency/institution, interpreters would be screened once only by this program.
Training interpreters: The program would offer three types of training for interpreters. **Full basic training** would be available for interpreters of major language groups and others who wished to take it. For interpreters of languages in lesser demand, there would be an **abbreviated program followed by shadowing** of an experienced interpreter. Finally, the program would support **continuing education** programs, in collaboration with the Society of Medical Interpreters (SOMI). A **mentoring program** would be set up in conjunction with local provider organizations.

Assessing interpreters: At the end of this process, the program would conduct an assessment on each interpreter to help him or her identify his/her strengths, weaknesses and areas that need work. This final assessment report would be given to the candidate to present to potential employers/contractors as proof of having completed the program. Institutions and agencies would maintain the freedom to contract with whom they choose.

**Medium term**

Support for interpreters having difficulty getting certified: Some interpreters have difficulty getting certified because they are not familiar with standardized testing protocols or they panic when asked to interpret into a tape recorder. Experience has shown that tutoring can help these interpreters build confidence and pass their test. This program would establish a tutorial program for such interpreters.

Training dual-role interpreters: In addition to training dedicated interpreters, the program would also train interpreters who would like to bring another skill to the health care arena. Training to do diabetes education, AIDS outreach, etc. could accompany training as an interpreter, making these individuals more employable and with a greater number of options in the health care field.

Training all allied health workers: This program would begin a strategic plan to bring training on working with interpreters into every allied health training program in the city, including medicine, nursing, social work, dentistry, pharmacy, public health, etc.

Training administrators: Staff from this program would also be available to train and consult with health care administrators on many levels around the establishment of language access services.

Testing bilingual providers: This program would provide language assessment for bilingual providers.

Orientation of interpreters to particular institutions: This program would coordinate a web-based service to orient interpreters to the various health care institutions where they might be asked to interpret.

**Longer term**

Training schedulers and Interpreter Services managers: The program would also train schedulers and managers.

Writing a manual on establishing Interpreter Services: Once the program develops its expertise, it could produce a manual on how to establish an interpreter service. There is a tremendous need for such a manual on a national level.

Research: This program might eventually engage in and/or support research into language access issues.
Pre-med students shadowing interpreters before medical school: This program would train pre-med students as interpreters, then have them shadow trained interpreters until they were ready to work alone.

Taking all of the above to a national level: After developing expertise locally, the program would make its expertise available on a national level.

Potential funding
The major costs of this work are in human resources to design and implement the programs. Potential sources of support include:

Foundations:
Soros and Casey are both interested in new immigrant and refugee populations.

Agencies contribute to support, or pay a finder’s fee if they contract an interpreter who went through the program.

Provider institutions.

The State’s Medical Assistance Administration donates $.05 per encounter to the organization to support work.

Interpreters, pay for training.

Workforce or community development angle may open up some education funds.

Americorp.

In-kind donations from supporting groups.

Mary Rynerson, of Pacific Interpreters, offered to allow the program the use of PI’s interpreter assessment tool, which is currently being piloted.

Primary Players:
One candidate is The Cross Cultural Health Care Program. CCHCP already has a reputation for working on interpreter issues in the city. It is a non-profit organization that already does most of the health care interpreter training locally. While CCHCP does not have staff on board right now that could take this on, the program does have the staff to initiate a grant process.

Next steps
1. Consultation with CCHCP or other potential hosts for such a program.
2. Vision planning
3. Finding pilot funding for doing a baseline study

Explore Further:
1. The difference between not hiring interpreters and recruiting for needed languages.
2. There is an urgent need to have a training/assessments tool for new contractors.
3. Instead of paying for training per participant, perhaps stakeholder institutions could contribute lump sums to have training for rare languages.
4. There is a need for a very short training, perhaps of 8 hours, to be held quarterly.
Priority III: Strengthening Community Access
Carey Jackson: Harborview Medical Center
Shari Wilson: Public Health -Seattle & King County
Thu Van Nguyen: Society of Medical Interpreters
Anthony Chen: Holly Park Medical and Dental Clinic
Mohamed Jama: Somali Community Services of Seattle
Dorothy Wong: International Community Health Services
Ellen Howard: Harborview Medical Center
Linda Golley: UW Medical Center

Pilot #4 Build Education and Community Access Networks
Author: Shari Wilson

Problem Statement:
Many refugee and immigrant communities, as well as mainstream providers, do not know what health care resources and/or social services are available to the limited English speaking (LEP) client. There is limited interaction between the Community Based Organization/Mutual Assistance Association (CBO-MAA) and the mainstream providers before a medical crisis happens. The lack of close interaction leads to cultural misunderstandings, lost opportunities for preventive health education, misunderstanding of diseases and lack of continuity of care.

Informal interpreters (such as family, friends, community members) are not trained to interpret and often do not know about existing community resources. Many of these individuals are not paid to interpret. Informal interpreters have little knowledge of diseases and do not adhere to an interpreter code of ethics. Many “bilingual individuals” are asked to serve as interpreters without having appropriate training and screening. There is a need to clarify who is qualified to serve as a “bilingual provider”. An assumption should not be automatically made that because someone perceives himself or herself to be bilingual that they actually have the medical vocabulary to interpret or to provide the encounter in the client’s language.

Interpreters are not all fully trained and there are not enough interpreters for certain language groups. There is a perception among some interpreters that the pay is inadequate. There are limited affordable training opportunities for interpreters. For many interpreters from small language groups, the main training program “Bridging the Gap”, which currently costs $300 for 40 hours, is too expensive. There is no standardized supervision (policing) for contract interpreters.

Appropriate utilization of resources and other institutional factors also limit access, having to do with finances, sustainability, turf issues, competition, quality of care, patients not understanding disease and not complying with care, and systems of closed referrals and institutional boundaries.

Proposal/Solutions:
The solutions may include disease-specific training curriculum and trainings at higher levels for interpreters with additional responsibilities such as community caseworker mediators/family health workers/outreach workers. These interpreters will then teach general classes of outreach; develop support groups; create Web resources. Institutions will open up closed systems by sharing community caseworker mediators/family health workers/outreach workers between their organizations and, in turn, open up funding to be shared.
Knowledge of resources can be improved through solutions like web-based information sharing; compilation of international, national and local websites relevant to LEP populations; making translated and written materials available through web-based directories; connecting community groups with existing listserves as well as developing new listserv systems; actively promoting the use of Cross Cultural Health Care Program’s video “Working Effectively with An Interpreter.”

Education in the community via community-based organizations is powerful for information sharing and helping to build the skill level and knowledge base of individuals who are already serving as natural helpers. Group education like a dental session, diabetic information session, and a prenatal information session will be utilized. Information repositories, like the Web, Red Cross, crisis clinic, community centers, etc. will make information more widely available.

Training for communities can begin by using the natural helpers in the community to start information dissemination and development and empowerment of community workers through video training, sharing translated brochures and quality-evaluated web sites that have community resources.

Other activities include:

- Creating an e-mail list/web site where information about access to services and a database of each organization’s procedures can easily be shared.
- Improving patient relations work with healthcare organizations and providers’ patient relations department.
- Making liaison to “promotoras” to review best procedures.
- Developing procedures with healthcare organizations and providers.
- Creating a network to facilitate communications standards and best procedures.
- Establishing a 24-hour access system with voicemail, pager, or cell phone carried by a community member who can respond in situations where a community liaison is needed.
- Creating multi-lingual phone access lines with partners in healthcare organizations, the Red Cross, hospitals, and professional organizations.

Potential Funding:

*Funding in the form of staff time and/or dollars can be targeted for specific disease conditions or services.* Health maintenance organizations, hospital insurers, Harborview Medical Center, Community Clinics, Public Health, Red Cross, phone companies (supporting specific services like phone lines), pharmacies, emergency rooms, Office of Refugee and Immigrant Assistance (ORIA) via CDC-Health grants. Funding and resources from Centers for Disease Control (CDC), American Cancer Society (ACS), American Diabetes Association (ADA), and Department of Social and Health Services (DSHS). Funding from the refugee program funds of ORIA and ORIA funded organizations, and from health-care organizations (through staff time).

Primary Players:
Public Health, Harborview (International Medicine Clinic and Community House Calls Program), PacMed, Group Health, Swedish Medical Center, Washington State Medical Association, Community Based Organizations, King County Emergency Management System, 911

Others Players: Partners at university libraries, especially social work, The Red Cross Language Bank, Seattle Public Library.
Next Steps:
Find a community organization partner to pilot, like the Somali Community Services of Seattle; share the interpreter video with community members and staff at organizations; target high schools and LEP classes, after school tutoring programs, vocational training programs; investigate Office of Refugee and Immigrants Assistance (ORIA) financial support. Organize family health workers, community caseworker mediators, outreach workers and other interpreters who perform like-roles for a resource-sharing meeting (Harborview and International Community Health Centers)

Already, steps have been taken toward implementation of pieces of this proposal. A presentation of the “Working Effectively with Interpreters” video, and dissemination of a list of helpful web sites happened at a recent meeting of the Refugee Forum of King County. At the time of this report, another presentation of the video and web resources will happen at an Eastside Refugee/Immigrant Forum. In addition, a commitment was made by ORIA to provide Public Health with funding to develop and implement interpreter training.

Explore Further: Check with Office of Refugee and Immigrant Assistance about CDC-Health grants as funding opportunities. ORIA has already expressed interest in supporting this work. A doula (natural helper) associated with PALS (Pregnancy and labor Support) approached the lead person for this working group about interest in helping interpreters become doulas and this can be explored further.

Pilot #5 Combine a Cultural Mediator/Case Management (“Promotora”) Model With Chronic Disease Management
Author: Carey Jackson
Problem Statement:
Providers in “safety net” settings do not have enough time to explain the physiology and medical management of many chronic disease conditions such as hypertension, diabetes, congestive heart failure, asthma, and hepatitis B to their patients. They often rely upon written materials, nurses and pharmacists to do much of this education. Similarly, the rationale for prevention, such as cancer screening and immunizations, is not always understood. Many of the patients are illiterate in their native languages as well as in English and so translated materials are of limited use. There is a need for disease education and management assistance outside of clinical encounters for many patients in non-English speaking communities with a high prevalence of illnesses new to these communities. Similarly, many of the strategies for dietary control of hypertension, diabetes, hyperlipidemia, or heart failure, do not recognize dietary sources of salt, carbohydrate, and lipids in traditional African and Asian diets.

Immigrants may not trust the diagnoses of providers they feel do not know their country, their history, and their cultural practices. This is especially true when expectations for cure from an idealized medical system are frustrated and the patient learns there is no cure and they will need to take medications for life. At this time they need information from trusted sources in a language and educational register that is tailored to their experience. Only someone from their country who can gauge those socio-economic qualities can adjust the message adequately. The skilled and trained medical interpreter is perfect to convey medical education, and to monitor individual patients through the course of a chronic illness.
Providing disease specific education to interpreters is time consuming and expensive. No single clinic or hospital can afford to hire and train chronic disease managers for the myriad of language groups it serves. Yet, there may be a way of sharing this expertise across institutions.

**Solution:**
At Harborview, the International District Clinic and Health Services, (including Holly Park), and Country Doctor Clinic there are interpreters who work as family advocates, case managers and outreach workers. These individuals usually advocate for many patients within the system, assisting with specialty visits, helping with forms, and educating them about the health system. It might be possible to attempt a shared training of these individuals in the chronic disease management of common illnesses like hypertension, diabetes, and asthma. The pool of experienced peer educators could be tapped and coordinated from the community to do public education, to alternate office hours to answer specific questions, and to manage patients with the condition for the clinic or hospital. The clinics can pool their resources to train and supervise these health workers so that no single nurse, physician, or pharmacist carries the burden for training the interpreters in managing chronic disease for a community or patient pool.

**Possible Funding:**
There are frequent requests for proposals from private foundations and NIH targeting specific chronic disease states such as diabetes or depression that could fund an experimental effort to train and share efforts across institutions. Partnerships across institutions partnered with specific ethnic communities would be particularly attractive. This is particularly useful for small communities where no single institution could justify employing a case manager.

Most health care grants targeting chronic diseases have specific disease outcomes in mind. Many of these are written to address health disparities, but really want to target a specific disease outcome. The problem of adequate cases of hypertensive Somalis or Mien becomes an issue. Pooling our efforts across languages at collaborating institutions will enable us to compete for disease specific grants with adequate numbers of patients, while maintaining the services and patients within a health system. Similarly, cross-training existing staff across institutions in chronic disease expertise will obviate the need to hire increasing numbers of language specific disease managers.

**Next Steps:**
**Short Term Strategies:** Introducing existing interpreters and program managers working in chronic disease management and health promotion is the first step to identifying possible synergy and collaboration between institutions. An incremental approach where institutions learn from one another what community education and disease management programs are in operation, what are their goals, and financial or institutional constraints.

**Medium Term:** After introductions, and before committing the participants to any longer term collaborations we could identify one or two potential areas to share resources, training, and referrals. If joint education or resource development possibilities exist these may be the easiest first attempts at collaborative activity.

**Long Term:** If the collaborations prove to be workable and fruitful, a combination of institutions may elect to pursue specific partnerships more formally through grant funded activities, or simple increased institutional commitment to teamwork in specific communities.
Baseline for King County Providers
Before the meeting, sixteen participants from 7 stakeholder institutions and clinics contributed information in a survey about their establishments’ language access services, including funding sources, languages in most demand, annual number of interpreted encounters, models of interpreting being used, current challenges and strengths of programs and services, and types of medical services provided to LEP persons. (The complete survey results are included in Appendix A).

At the meeting, Shari Wilson, Program Manager of Refugee Health Access and Interpreter Services for Public Health – Seattle & King County, presented highlights and trends from the collection of providers’ baseline information. Here is a sample:

- Almost 200,000 interpreted encounters, annually, were collectively reported by seven stakeholder institutions
- Only two of the seven institutions (Public Health and Puget Sound Neighborhood Health Centers) tracked the number of encounters in which bi-lingual practitioners provided language access services directly to their patients. Together they reported more than 20,000 such encounters.
- Spanish tops the list of languages in demand at most stakeholder institutions. Other top languages include Vietnamese, Somali, Russian, Ukrainian, Khmer, Chinese, Bosnian/Serbo-Croatian, and various East African languages (depending on the institution, the order of top languages varies)
- All seven stakeholders surveyed responded that their language access services include contracts with one or more agencies that provide face-to-face interpreting services; five institutions reported contracts with agencies for telephonic interpreting services.
- Three of the seven stakeholder institutions request interpreters for Medicaid patients through Hopelink, the State’s independent broker with a mandate to schedule interpreters and to manage reimbursement of services for Medicaid clients, as of January 2003.
- Most institutions named staff interpreters as a main strength of their language access programs.
- Finding and scheduling interpreters for rare languages was a challenge identified by several institutions.

Out of 30 meeting participants, 15 responded ahead of time to a questionnaire about priority discussion topics for the meeting. The complete results of that questionnaire are also included in appendix A. Eight discussion topics about interpreter services were listed, and three were identified as priority areas for the discussion.

1. **Interpreter screening, training and certification**: how we assess and monitor quality.

2. **The cost of interpreter services**: who pays, who could or should pay, cost containment strategies, the role of the private sector.

3. **Gap analysis**: where the contradictions to improved scheduling, collaboration and consumer service lie.
National Context

- **Title VI of the Civil Rights Act of 1964** prohibits discrimination based on race, color, or national origin by any entity receiving federal financial assistance;

- **Executive Order 13166** mandated improvements of limited English-proficient (LEP) persons’ access to government-funded programs

- **2002 Bush Administration’s “Softer Approach”**
  “In 2000, President Clinton ordered federal agencies to pull down language barriers to government and government-funded activities. He cited the 1964 Civil Rights Act ban on discrimination based on national origin. The mandate was meant for anyone receiving federal funds, including most doctors and hospitals. Applying the broad order, the Department of Health and Human Services issued standards that year saying that patients deserve "competency" from medical interpreters and that the use of amateurs is "life threatening." The standards didn't say who should pay for these services – only that patients should get them free.”

  “Last April, the Bush Administration signaled a softer approach when it stepped in with a model standard for all federal agencies: Non-English speakers who "feel more comfortable when a trusted family member or friend" is available, it said, "should be permitted to use an interpreter of their own choosing."


  – From **“Doctors’ Orders Can Get Lost: Physicians Question the Cost and Need of Breaking- Down the Language Barrier”** By Barry Newman, Staff Reporter of The Wall Street Journal, January 9, 2003

Context in Washington State

In January 2003 Washington’s Department of Social and Health Services (DSHS) established a new brokerage system for providing Interpreter Services to Medicaid patients and their providers, modeled after a successful Medicaid transportation system, at the same time that statewide Medicaid rolls were cut for 29,000 immigrants, 90% children. Other factors exist in Washington in 2003 that demand attention to language access issues:

- Washington State is the 4th largest refugee resettlement state in the U.S. and considered to be the state with the highest number of secondary migrant groups.
- At the time of the meeting, Washington State had unemployment and hunger rates ranking among the highest in the country.
- Washington State has a $24 billion budget shortfall in 2003 and programs are being cut.

Context in King County

- King County is the 12th largest county in the nation.
- King County has 16% (272,000 persons) foreign born.
- 20% of the county population over the age of 5 speak a language other than English at home; 80% of that number speak a language other than Spanish.
- There is a growing demand for interpreters at Harborview (the county hospital) and throughout King County.
- The Spanish-speaking population is the largest language group for Public Health-Seattle and King County; interpreting services provided in Spanish at Public Health have doubled from 1995 – 2002.
- South King County, in particular, is experiencing growth in limited or non-English speaking patient populations.
- Non-English Languages spoken in the county include, but are not limited to, Spanish, Ukrainian, Russian, Cantonese, Vietnamese, Hmong, Khmer, Somali, Amharic, Arabic, Oromo, Tigrigna, Laotian, Albanian, Serbo-Croatian, Kurdish, Tagalog, Dinka, Portuguese, Samoan, French, Korean, Farsi, Persian and Mandarin.
1969 Altrusa Club of Seattle forms The Language Bank, a volunteer group of non-professional interpreters and translators

1975-1979 International District Community Health Centers provides the only available bilingual medical care in Asian languages.

1978 Sea Mar Community Health Center is established to provide comprehensive, affordable, and culturally sensitive health and human services to the Latino, low income, disadvantaged, migrant and seasonal farm worker population. Later, a local community need was recognized, beyond the original intent, so the same mission was expanded to include ALL populations, ethnic, income and social groups.

1979 Seattle-King County Public Health Department begins Refugee Screening Program, employing SE Asian staff to interpret for their patients. These staff, as well as bilingual staff from other refugee service organizations, such as the International Rescue Committee, are frequently called on to interpret for patients at hospitals and clinics.

1980 Indochinese Language Bank (later named the Community Health Interpretation Service or CHIS), a joint enterprise of two non-profit organizations representing 10 community clinics, operate a grant-funded initiative that makes their services accessible through sharing a pool of trained interpreters. These interpreters rotate services with fixed schedules at clinics depending on the languages most commonly needed.

1981 Health Department & Hospitals Share Interpreters and Cost. The Health Department pays half the salary of a single interpreter to serve three hospitals; the hospitals split the other half salary between their institutions. Hospitals and hospital council begin discussing alternatives for 24-hour interpreter coverage.

1981 Office for Civil Rights (OCR) Complaints and Agreements. The hospitals are still not committed to paying for interpretation services for their non or limited English speaking patients. This situation results in complaints filed with the OCR, U.S. Department of Health and Human Services, on behalf of clients at three different hospitals, under Title VI of the Civil Rights Act of 1965. The complaints allege that, by not providing service in a language their patients can understand, the hospitals are discriminating against patients on the basis of national origin. These complaints, along with several suits, bring about hospitals' acknowledgments of their responsibility and obligation to provide qualified bilingual interpretation services free of charge to patients. OCR and the hospitals sign voluntary agreements.

1982 The Indochinese Medical Interpretation Service (IMIS), later named the Hospital Interpretation Program or HIP is formed. The local hospital association contracts with a local non-profit organization, Central Seattle Community Health Centers, experienced in providing interpreter services for community clinics through the CHIS. Operating 24 hours a day, with on-call coverage, and initially focused on SE Asian languages, this program grew to serve over 20 hospital with 8000 patient encounters each year in 40+ languages and with over 150 on-call interpreters by 1995. Hospitals are charged an hourly fee to use the service. Later, MAA’s (Medical Assistance Administration of Washington’s Department of Social and Health Services) reimbursement program decreases the hospitals' share of financial reimbursement for those patients on Medicaid.

1983 HIP develops a formal training curriculum for medical interpreters. It has a heavy medical focus, is expensive, and requires 5 full days of training with limited attention on interpretation skills.

1984 the Seattle Red Cross takes on Altrusa’s Language Bank.
1984-1990 Community Health Advocacy Program is a certificate program conducted at North Seattle Community College, with emphasis on training refugees to be interpreters/medical assistants who can assist refugees and immigrants to access the health care system. Many of these people go on to work at community clinics and other health facilities where they play important roles as culture brokers and interpreters.

1988 "The Art of Interpreting" a 12-hour training course, is offered quarterly in Seattle. Developed jointly with the Red Cross Language Bank, HIP, Public Health’s Refugee Screening Program, and others who are involved in interpretation, this course is designed to meet the need for interpreters to have a foundation in the ethics, role and problems of the community interpreter.

1988-89 Negotiations for consent decrees are the result of Evergreen Legal Service's continuing complaints (and court dealings) that Washington State’s Department of Social and Health Services (DSHS) was not living up to its earlier agreed upon measures to provide translation/interpretation service.

1989 Region X, OCR issues a brief guidance on the need to provide qualified interpreter assistance if receiving federal funds. This guidance is not widely disseminated and does not have the approval of the federal office of OCR.

1989 MAA at DSHS sends a reminder letter to Medicaid contracted providers that they must provide language access services to their clients.

1991 The State agrees to pay for interpreting services for Medicaid patients.

1991 Interpreter suit brought against the State leads to a certification process.

1992 Cross Cultural Health Care Program (CCHCP) based at Pacific Medical Center begins with a grant from the W.K. Kellogg Foundation. The CCHCP is a response to an increasingly urgent need to decipher and to negotiate the diverse health care needs of the growing non-mainstream, limited English speaking populations in the Seattle area.

1993 Society of Medical Interpreters (SOMI) is founded.

1994 "Bridging the Gap" a 40-hour training course is developed by the Cross Cultural Health Care Program and is introduced in Seattle.

1994 First meeting of the National Working Group that becomes the National Council on Interpreting in Health Care, NCIHC, sponsored by CCHCP.

1996 MAA contracts with interpreter agencies for the delivery of interpreter services to Medicaid patients. Interpreters are therefore no longer allowed to negotiate their own rates and many see a dramatic reduction in hourly payment.

1998 Interlocal Agreements are established between the Medical Assistance Administration and Public Health-Seattle and King County. The University of Washington, Harborview and Pacific Medical Center (all public health institutions) also have access to the Federal Match Program meaning that interpreter services become “matchable” at a rate of 50% of the institutions’ Medicaid clients.

2002 Governor Locke proposes elimination of all State support to interpreter services. After significant lobbying efforts by SOMI and other groups the Washington State legislature agrees to provide resources to fund a model of service delivery based on the MAA transportation broker. Hopelink, a non-profit organization in King County who serves as the transportation broker, was given the task of implementing the brokerage role for Medicaid interpreting services.

2003 Collaborative Strategies for Language Access Meeting
Stakeholders from clinics, hospitals, agencies, and communities meet to address current challenges and possibilities in language access locally. Working groups are formed to pursue priorities of education and community capacity building, shared scheduling and centralized training and standards.

Low-hanging fruit
Some meeting ideas that may be relatively easy, quick or cost-effective to implement:

- Create an on-line “Interpreter Orientation” to each institution
- Share training brochures and health education materials across institutions
- Create and share phone/voice mail LEP patient information lines across institutions
Dedicated Interpreting, Cultural Mediating, Case Managing, And Other Models of Language Access utilized in Seattle

Language access services developed locally as a mostly “dedicated” interpreter system throughout the safety net, in which staff, contract and agency interpreters are employed to perform interpreting services as their sole job function. Interpreting in Seattle and King County is recognized as a profession, and the field has many highly skilled and dedicated medical interpreters.

In many places in the U.S. the dominant language access model is non-dedicated, in which people with roles other than or in addition to interpreting (commonly family members, clinical and non clinical bi-lingual staff, and bilingual health providers) are providing language access services. In Seattle, “promotora” models like family health worker, outreach worker, and cultural mediator have emerged, in which individuals interpret and may also provide some continuity of care and support for patient’s social and other needs beyond the single health care encounter. Bi-lingual clinical staff and providers also provide language access services throughout Seattle-King County’s local safety net. *(To read more on various types of models for interpreting and language access, see Appendix B)*

What’s New…Telephonic Interpreting

Discussion about new technologies and innovations prompted a question about telephonic...has there been a study to see if there is a patient preference for interpreter services, face to face or telephone? A study at the Santa Clara Valley Medical Center was cited that showed patients offered more information and talked more freely using a telephonic interpreter, while the physician or provider talked less. The idea of creating a toolbox for telephonic interpreting was put forth.

All safety-net institutions in Seattle currently use telephonic interpretation to some extent, most often as a back-up plan for when in-person interpretation is unavailable due to demands for rare languages or unavailable interpreters. The meeting participants agreed that there is a need for more information about the effectiveness of telephonic interpreting vs. face-to-face interpreting. Eventually, a uniform policy leading to use of a telephone interpreter, based on research, could be formulated.

A Need for Data…

Participants agreed there is a need to have real hard data to create a realistic economy for language access.

- The numbers of insured people and other population data is often gathered by ethnicities not language, and yet it is the language information that’s pertinent to knowing the real numbers of patients who need language access services.
- Some patients come for health care services to places where they know interpreters will be provided. If interpreters were not provided, how many patients would be lost to the health care institution?
- Is continuity of interpreting services – a patient having the same interpreter repeatedly over time – significant in a patient’s decision to return to the same institution or go elsewhere? Some research institutions, like Seattle’s Fred Hutchinson Cancer Research Center, intentionally do not use a continuity approach, in order to maintain interpreter objectivity in the patient encounter. Does continuity of interpreting services impact objectivity in research?
- In the language access field where there is a complex diversity of skill levels and training, without set standards or measures across institutions, what measures and what standards are needed?
Stakeholders’ Goal:
Revisit and Assess Progress in Priority Areas and Pilots in 6 Months to 1 Year

Brainstorming Unmet Needs and Creative Solutions for the Safety Net: Ideas were discussed and integrated into the strategic priorities and pilots
- A certification process that is competency-based
- A campaign to recruit interpreters/language access professionals systematically in schools and linguistic minority communities.
- Written pamphlets shared across institutions.
- Centralized place for recruiting, testing, support, training interpreters
- More medical training of family health workers
- Increase capacity of culturally competent people.
- Sharing rare language availability
- Managing the complexity of scheduling
- Standards for quality of interpreters and need for training
- Bilingual assessment: well-trained providers who can instruct patients at patient education level
- Patient education beyond 15-minutes with providers
- Acknowledging cultural competence and people skills in interpreting
- Continuing education – for interpreters, communities and providers
- Using technology
- Finding appropriate funding
- There is a need to establish consequences for breach of ethical principles.
- A campaign to educate insurers, policymakers, and to organize provider groups who can advocate for funding that is needed.

Goals for Institutions and Interpreters…a sample
- Improvement in health care outcomes for LEP patients
- High quality interpreters
- Language access services viewed as proud assets in institutions
- Integration of interpreter into the health care team
- Financial stability with decent wages and benefits for interpreters
- Career development for interpreters, fitting into the institution with skills in related or non-related fields
- Health providers trained how to best structure time for efficient use of interpreters
- Sharing limited resources
The Robert Wood Johnson Foundation Community Health Leadership Program (CHLP) each year honors ten outstanding individuals who overcome daunting odds to expand access to health care and social services to underserved and isolated populations in communities across the United States. CHLP's national award recognizes individuals whose innovation, accomplishment and compassion often go unrecognized. It seeks individuals whose leadership goes beyond caring and commitment. Nominees must be catalysts for change and have significant impact upon the larger community.

Three of the stakeholders in the meeting have been recognized as Robert Wood Johnson Foundation Community Health Leaders since the Program began in 1991. Aracely Rosales received the award in 1997, Carey Jackson in 1999, and Lysieng Ngo in 1994.

The Access Project has served as a resource center for local communities working to improve health and healthcare access since 1998. Initiated through a grant from The Robert Wood Johnson Foundation, it currently receives funding from a variety of public and private sources. It works to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. By supporting local initiatives and community leaders, The Access Project is dedicated to strengthening the voice of under-served communities in the public and private policy discussions that directly affect them. The Access Project report “What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency” was included in participants’ meeting materials. Copies of the report can be accessed by calling 617-654-9911, or emailing a request to info@accessproject.org.

The Access Project and the National Health Law Program have developed a Language Services Action Kit, due in May 2003, accenting where to get funding and showing how other states and groups are successfully using federal funding. Requests for more information about the Tool Kit can be sent to LEPactionkit@accessproject.org.

Aracely Rosales came from Philadelphia on behalf of the Access Project to join the meeting. On Thursday morning, Ms. Rosales spoke to the gathering of stakeholders about potential implications the Access Project may have for local use in Seattle’s safety-net health care for Limited English Proficiency (LEP) patients. She highlighted the importance of considering health literacy in addressing language access strategies, so the patient can understand and act on what the doctor instructs and so that they feel confident about knowing what to do. Providers, Ms. Rosales said, must be educated to talk at the health literacy levels of their patients, so that the interpreter can help both parties ensure a best level of compliance with medical care and instructions. She stressed the need for interpreters, providers, and patients to work together as a team.

This Meeting Report is based on notes recorded during the meeting “Collaborative Strategies for Language Access in Health Care” held on February 6 and 7, 2003. Meeting Planners participated in reviewing and editing the report. They are: Ellen Howard, Carey Jackson, Brenda Lloyd, Cindy Roat, Shari Wilson and Christine Wilson Owens.

A Web version of the Meeting Report can be found online at http://ethnomed.org
Meeting Sponsors

- Financial support for the meeting was from The Robert Wood Johnson Foundation’s Community Health Leadership Program, The Nesholm Family Foundation, and Harborview Medical Center.
- The Access Project supported the meeting through the participation of Aracely Rosales, and the Report “What a difference an interpreter can make: health care experiences of uninsured with limited English proficiency”
- The staff at The Cross Cultural Health Care Program helpfully and hospitably opened their library and meeting facilities, in-kind.
- Planning was a collaborative effort with support contributed by language access stakeholders from Harborview Medical Center, Public Health – Seattle & King County, Pacific Medical Center, The Community Health Council of Seattle and by Cynthia E. Roat (independent consultant).
- Neighboring Union Station Starbucks donated fresh coffee, and staff of Harborview’s Refugee and Immigrant Health Promotion Program arranged flavorful feasting.

Meeting Participants:

**Someirch Amirfaiz**  
Executive Director  
Refugee Women’s Alliance (REWA)

**Louisa Benitez**  
Owner, The Language Connection

**Elise Chayet**  
Director of Planning & Regulatory Affairs, Harborview Medical Center

**Dr. Anthony Chen**  
Physician  
Holly Park Medical and Dental Clinic

**Shelley Cooper-Ashford**  
Executive Director  
Center for Multicultural Health

**Douglas Carmen**  
Legal Advocate  
Refugee and Immigrant Advocacy Project, Northwest Justice Project

**Gillian Dutton**  
Director, Refugee and Immigrant Advocacy Project, Northwest Justice Project

**Linda Golley**  
Manager, Interpreter Services  
UW Medical Center

**James H. Heng**  
Cambodian/Chou-Jo Interpreter  
PacMed Clinics

**Ellen Howard**  
Head Medical Librarian  
K.K. Sherwood Library

**Dr. J. Carey Jackson**  
Medical Director, Interpreter Services, Harborview Medical Center

**Meg Kerrigan**  
Associate Administrator, Ambulatory and Allied Care Services  
Harborview Medical Center

**Brenda Lloyd**  
Manager, Interpreter Services  
PacMed Clinics

**Mohamed Jama Mohamed**  
President, Somali Community Services of Seattle, Somali Interpreter

**Lynn Moody**  
Director of Transportation  
And Interpreter Services, Hopelink

**Lysien Ngo**  
Family Health Worker  
Cambodian/Chinese Interpreter Center for Multicultural Health

**Thu-Van Nguyen**  
President, Society of Medical Interpreters;  
French/Vietnamese Interpreter

**Oleg Pynda**  
Executive Director, Ukrainian Community Center of Washington

**Martine Pierre-Louis**  
Manager, Interpreter Services and Community House Calls, Harborview Medical Center

**Cynthia E. Roat**  
Training and Consultant

**Aracely Rosales**  
Principal, Rosales Communications

**Mary Rynerson**  
Pres./CEO  
Pacific Interpreters

**Mark Secord**  
Executive Director  
Puget Sound Neighborhood Health Centers

**Paula Taylor**  
Coordinator, Interpreter Services  
Rainer Park Medical Clinic

**Crystal Tetrick, MPH**  
Operations Coordinator Seattle Indian Health Board

**Lorane West de Patino**  
Spanish Interpreter

**Shari Wilson**  
Manager, Refugee Health Access and Interpreter Services Program, Public Health - Seattle & King County

**Christine Wilson Owens**  
Etnomed.org  
Harborview Medical Center

**Dorothy Wong**  
Executive Director  
International Community Health Services

Facilitator Carolyn Gellermann guided the meeting planners and participants toward achieving the meeting objectives. Ms. Gellermann is owner and principal consultant of Gellermann and Associates, an Organization Development firm. With 25 years of experience, her areas of expertise include strategic planning and team building.
Please indicate the three discussion topics that you would consider most important to explore at the Roundtable. N=15 Total Respondents

<table>
<thead>
<tr>
<th>Discussion Topic</th>
<th>Number of stakeholders who picked the topic as one of three most important to explore</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community perspectives as to how interpreter services impact access to care.</td>
<td>5</td>
</tr>
<tr>
<td>• Interpreter screening, training and certification: how we assess and monitor quality.</td>
<td>9</td>
</tr>
<tr>
<td>• Need for continuing education for interpreters. *</td>
<td></td>
</tr>
<tr>
<td>• Interpreter availability: information systems for scheduling in large institutions or between institutions.</td>
<td>4</td>
</tr>
<tr>
<td>• Keeping the good interpreters: How do we provide incentives for skilled interpreters to continue in the field?</td>
<td>4</td>
</tr>
<tr>
<td>• The cost of interpreter services: who pays, who could or should pay, cost containment strategies, the role of the private sector.</td>
<td>9</td>
</tr>
<tr>
<td>• Technology in the mix: in-person, telephonic, video, Web tutorials, distance learning over telephone or video.</td>
<td>2</td>
</tr>
<tr>
<td>• Gap analysis: where the contradictions and barriers to improved scheduling, collaboration, and consumer service lie.</td>
<td>9</td>
</tr>
<tr>
<td>• Other:</td>
<td></td>
</tr>
<tr>
<td>- How to assure limited/non-English speaking clients have access to culturally and linguistically appropriate health care services in an environment of shrinking resources.</td>
<td></td>
</tr>
<tr>
<td>- How to assure bilingual providers and interpreters are able to provide culturally and linguistically appropriate health care services to the clients needs.</td>
<td></td>
</tr>
<tr>
<td>- How to consolidate and better share interpreter resources between institutions- i.e. share testing and training information, as well as interpreters.</td>
<td></td>
</tr>
<tr>
<td>- Need for standardized code of ethics</td>
<td></td>
</tr>
<tr>
<td>- Provider Training</td>
<td></td>
</tr>
</tbody>
</table>

*mistakenly not included on all questionnaires
<table>
<thead>
<tr>
<th>Medical Services Provided to Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harborview Medical Center (HMC)</strong></td>
</tr>
<tr>
<td>• Primary</td>
</tr>
<tr>
<td>• Specialty</td>
</tr>
<tr>
<td>• Ancillary</td>
</tr>
<tr>
<td>• ER-trauma</td>
</tr>
<tr>
<td>• In-Patient</td>
</tr>
<tr>
<td>• Rehabilitation</td>
</tr>
<tr>
<td>• Surgery</td>
</tr>
<tr>
<td>• Center for Community Mental Health</td>
</tr>
<tr>
<td>• Psychiatric Care</td>
</tr>
<tr>
<td>• Obstetrics</td>
</tr>
<tr>
<td>• Dental</td>
</tr>
<tr>
<td><strong>Public Health – Seattle &amp; King County</strong></td>
</tr>
<tr>
<td>• Infectious disease outbreak response and control</td>
</tr>
<tr>
<td>• Sexually transmitted disease, HIV, and TB testing and treatment</td>
</tr>
<tr>
<td>• Immunizations and family planning services for the entire Community</td>
</tr>
<tr>
<td>• Alcohol and substance abuse prevention services</td>
</tr>
<tr>
<td>• Emergency medical services (Medic One)</td>
</tr>
<tr>
<td>• Restaurant inspections, assurance of safe drinking water, local hazardous waste control</td>
</tr>
<tr>
<td>• Primary medical and dental services for Medicaid and low-income clients</td>
</tr>
<tr>
<td>• Refugee Health Access</td>
</tr>
<tr>
<td>• Autopsies and maintenance of birth and death records.</td>
</tr>
<tr>
<td><strong>University of Washington Medical Center (UWMC)</strong></td>
</tr>
<tr>
<td>• Primary care</td>
</tr>
<tr>
<td>• Specialty</td>
</tr>
<tr>
<td>• Ancillary</td>
</tr>
<tr>
<td>• In patient</td>
</tr>
<tr>
<td>• Emergency Room</td>
</tr>
<tr>
<td>• Obstetrics</td>
</tr>
<tr>
<td><strong>Puget Sound Neighborhood Health Centers (PSNHC)</strong></td>
</tr>
<tr>
<td>• Comprehensive primary care</td>
</tr>
<tr>
<td>• Obstetrics</td>
</tr>
<tr>
<td>• Dental</td>
</tr>
<tr>
<td>• Limited mental health</td>
</tr>
<tr>
<td>• Substance abuse counseling/Treatment</td>
</tr>
<tr>
<td>• School-based teen health services</td>
</tr>
<tr>
<td><strong>PACMED</strong></td>
</tr>
<tr>
<td>• Primary</td>
</tr>
<tr>
<td>• Specialty Care</td>
</tr>
<tr>
<td><strong>Seattle Indian Health Board (SIHB)</strong></td>
</tr>
<tr>
<td>• Medicine</td>
</tr>
<tr>
<td>• Dental</td>
</tr>
<tr>
<td>• Mental and WIC</td>
</tr>
<tr>
<td><strong>The Country Doctor</strong></td>
</tr>
<tr>
<td>• Primary Care</td>
</tr>
<tr>
<td>• Behavioral Health</td>
</tr>
</tbody>
</table>
Appendix A: Pre-Meeting Survey

How are language access services provided to LEP patients?

We use **tested bilingual employees to provide services directly** in their non-English language:
- Puget Sound Neighborhood Health Centers (PSNHC)

We use **non-tested bilingual employees provide services directly** in their non-English language:
- PSNHC
- Public Health – Seattle & King County
- The Country Doctor
- Harborview Medical Center (HMC)

We use **tested bilingual employees acting as interpreters**:  
- PSNHC
- HMC

We use **non-tested bilingual employees acting as interpreters**:  
- PSNHC
- Public Health – Seattle & King County
- The Country Doctor
- HMC

We have **dedicated staff interpreters**:  
- PSNHC
- Public Health – Seattle & King County
- UWMC
- The Country Doctor
- HMC
- PacMed

We have **contracted interpreters who come when needed**:  
- PSNHC
- Public Health – Seattle & King County
- UWMC
- The Country Doctor
- HMC
- PacMed

We have **contracts with one or more language agencies that provide face-to-face interpreting services**:  
- PSNHC
- Public Health – Seattle & King County
- UWMC
- Seattle Indian Health Board
- The Country Doctor
- HMC
- PacMed

We have **contracts with one or more language agencies that provide telephonic interpreting services**:  
- Public Health – Seattle & King County
- UWMC
- Seattle Indian Health Board
- HMC
- PacMed

We call **HopeLink when we need an interpreter for a Medicaid patient**:  
- PSNHC
- Seattle Indian Health Board
- The Country Doctor
## Appendix A: Pre-Meeting Survey

<table>
<thead>
<tr>
<th></th>
<th>Number of interpreted encounters in 1 year:</th>
<th>Number of encounters with bilingual providers:</th>
<th>Top languages:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harborview Medical Center</strong></td>
<td>FY 2001-2002</td>
<td>No track record of this</td>
<td>• Spanish 20,966</td>
</tr>
<tr>
<td></td>
<td>89,647 face to face encounters</td>
<td></td>
<td>• Somali 19,768</td>
</tr>
<tr>
<td></td>
<td>2,722 telephonic</td>
<td></td>
<td>• Vietnamese 13,823</td>
</tr>
<tr>
<td></td>
<td>=92,369</td>
<td></td>
<td>• Cambodian 3,989</td>
</tr>
<tr>
<td><strong>Public Health - Seattle &amp; King County</strong></td>
<td>36,244*</td>
<td>10,172</td>
<td>• Spanish 30,306</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Russian 3,584</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ukrainian 1,558</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Vietnamese 3,538</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Somali 1,721</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Bosnian/Serbo-Croatian 879</td>
</tr>
<tr>
<td><strong>University of Washington Medical Center (UWMC)</strong></td>
<td>Approximately 24,000</td>
<td>Not known</td>
<td>• Spanish</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Russian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Vietnamese</td>
</tr>
<tr>
<td><strong>Puget Sound Neighborhood Health Centers (PSNHC)</strong></td>
<td>Approximately 10,000</td>
<td>Approximately 10,000</td>
<td>• Vietnamese</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(with bi- or multi-lingual providers)</td>
<td>• Cambodian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Spanish</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Various East African</td>
</tr>
<tr>
<td><strong>PACMED</strong></td>
<td>18, 500 interpreter encounters</td>
<td>We are not capturing data on encounters with bilingual providers as in most cases we still schedule an interpreter to assist with other parts of the patient visit, ie. Check in, nurse.</td>
<td>• Spanish 4200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cantonese 4200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Vietnamese 3000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cambodian 1000</td>
</tr>
<tr>
<td><strong>Seattle Indian Health Board</strong></td>
<td>168</td>
<td></td>
<td>• Spanish</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Chinese</td>
</tr>
<tr>
<td><strong>The Country Doctor</strong></td>
<td>Not available</td>
<td>Not available</td>
<td>• Spanish</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cambodian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Chinese (Mandarin/Cantonese)</td>
</tr>
</tbody>
</table>

* Please note Data provided in this report does not include all of our WIC interpreted encounters. Mid-year data for WIC was eliminated from main Public Health data system. Please also note that the above number represents the total number of encounters where specific language assistance was recorded as being needed. Numbers may slightly under represent overall demand.
<table>
<thead>
<tr>
<th>Facility Name</th>
<th>How communication assistance is funded:</th>
<th>Foreseeing future changes to communication assistance programs?</th>
</tr>
</thead>
</table>
| Harborview Medical Center                 | • HMC operating funds.  
• Partial federal reimbursement through interlocal agreement for HCFA Medicaid Match Funds via State DSHS MAA (Medical Assistance Administration).  
• Federal funds locally administered. | • Institutional pressures to reduce expenses.  
• DSHS plans to cancel the Interlocal agreements earlier than their original 12/04 end date. DSHS is looking to bring the Interlocals more in line with the statewide brokerage system. They may also be interested in cost savings on the reimbursements.  
• Uneven access to language assistance by patients served by Hopelink may bring more patients to HMC's door. |
| Public Health - Seattle & King County     | • Partial federal reimbursement through interlocal agreement for HCFA Medicaid Match Funds via State DSHS MAA (Medical Assistance Administration)  
• Office of Refugee Resettlement supports interpretation services for Refugee Screening.  
• County and City Funds  
• Translation Service Fee  
• Civil Surgeon Fees | • New funding strategies need to be developed to address growing language needs and shrinking County and City resources and to avoid reduction of Public Health services. |
| University of Washington Medical Center (UWMC) | • Partial federal reimbursement through interlocal agreement for HCFA Medicaid Match Funds via State DSHS MAA (Medical Assistance Administration); based on % of Medicaid patients | • We have been advised that the “inter-local” agreement will change, but do not know any specifics |
| Puget Sound Neighborhood HealthCenters (PSNHC) | • Reliance on Medicaid funding for much of it.  
• General grant support. | • Depends on what happens in Olympia this year! |
| PACMED                                    | • Partial federal reimbursement through interlocal agreement for HCFA Medicaid Match Funds via State DSHS MAA (Medical Assistance Administration) | • Rumored changes to the Interlocal agreement. |
| Seattle Indian Health Board               |                                                                                                            | • No changes foreseen |
| The Country Doctor                         | • Medicaid  
• General revenue | • Serious problems with Hopelink necessitate major changes with Medicaid Interpretation services |
Appendix A: Pre-Meeting Survey

What are the main challenges/unmet needs and strengths of your communication assistance system?

<table>
<thead>
<tr>
<th>Challenges / Unmet Needs</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harborview Medical Center</strong></td>
<td>• multiple options for language assistance</td>
</tr>
<tr>
<td>• Antiquated scheduling system</td>
<td>• access to large pool of interpreters and many languages</td>
</tr>
<tr>
<td>• Quality gaps</td>
<td>• Institutional commitment (mission)</td>
</tr>
<tr>
<td>• Not enough training</td>
<td></td>
</tr>
<tr>
<td><strong>Public Health -Seattle &amp; King County</strong></td>
<td>• Multi-tiered approach to assuring language access</td>
</tr>
<tr>
<td>• Shrinking County and City support to interpretation</td>
<td>• Centralized Unit that assures language needs are being addressed within system and troubleshoots language access issues.</td>
</tr>
<tr>
<td>• Growing client base of Non-English speakers because of State Program Cuts.</td>
<td>• Responsibilities include: recruitment of interpreters, monitoring needs and filling voids.</td>
</tr>
<tr>
<td>• Data collection system</td>
<td>• Over 40 languages/dialects in pool of interpreters.</td>
</tr>
<tr>
<td>• Affordable training resources</td>
<td>• Limited translation service to Public Health Programs</td>
</tr>
<tr>
<td>• Testing tool needed to assure competence level of bilingual staff.</td>
<td>• Provision of Refugee Screening services provides grounding in changing language needs and linkages to multiple communities.</td>
</tr>
<tr>
<td></td>
<td>• Community Resource re. needs and services for LEP clients.</td>
</tr>
</tbody>
</table>
Appendix A: Pre-Meeting Survey

What are the main challenges/unmet needs and strengths of your communication assistance system?

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Challenges / Unmet Needs</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>University of Washington Medical Center (UWMC)</strong></td>
<td>• Poor technology (scheduling not integrated with appointment system)</td>
<td>• Dedicated, experienced in-house interpreters</td>
</tr>
<tr>
<td><strong>Puget Sound Neighborhood Health Centers (PSNHC)</strong></td>
<td>• Availability of rare languages (e.g. Female Somali, French Creole, etc.), especially given limitations of State's LIST examination; • High cost of working through interpretation companies; • Funding (of course!)</td>
<td>• Our in house interpreters, where we have them, are a great asset.</td>
</tr>
<tr>
<td><strong>PACMED</strong></td>
<td>• Finding interpreters to contract with in the &quot;hard to cover&quot; and some of the not so hard to cover languages and the whole contracting process. • Inability to share resources with other institutions, i.e screening, sharing of interpreters. • Training</td>
<td>• Staff interpreters. • Our scheduling system</td>
</tr>
<tr>
<td><strong>Seattle Indian Health Board</strong></td>
<td>• Internal communication about cancellations</td>
<td>• Very good service with SIS and Language Link</td>
</tr>
<tr>
<td><strong>The Country Doctor</strong></td>
<td>• The DSHS brokerage system with Hopelink is an inadequate system for scheduling interpreters for medical services because it requires 5 days advance notice.</td>
<td>• Staff interpreters • Contract interpreters (other than through the brokerage system with Hopelink)</td>
</tr>
</tbody>
</table>
MODELS FOR THE PROVISION OF LANGUAGE ACCESS IN HEALTH CARE SETTINGS

Summarized from: Downing, B and Roat, C. Models for the Provision of Language Access in Health Care Settings

<table>
<thead>
<tr>
<th>Model</th>
<th>Description/ application</th>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| Bilingual Provider           | Patients receive care in their home language. Bilingual providers may be native speakers of the target language or may have learned through instruction. Costs in this model are centered on the preparation and continuing development of providers or providers-to-be. | • No interpreting cost  
• Approximates services received by English-speaking patients from English-speaking providers | • Works best when there are few target languages.  
• The need to assess the provider’s competency in the target language is often overlooked. |
| Bilingual Patient            | Developing the capacity of patients to speak English, thereby eliminating the need for communication assistance. Costs are centered on developing ESL programs.                                                                 | Excellent long-term strategy.                                                                 | • Language mastery takes a long time for adult learners.  
• ESL programs usually emphasize practical communication for survival and employment. |
| Ad-Hoc Interpreter: Bilingual Clinical Staff | Bilingual clinical staff (nurses, social workers, technicians, physicians, etc) provide interpreting for patients being seen by other providers, usually within the same clinic. Costs in this model are mostly in the loss of productive time by those clinicians. However, there is often the belief that interpreting is being provided at no additional cost to the institution. In some institutions, there is a pay differential for these staff. | • Immediate availability of interpreting  
• Clinical staff’s knowledge of health care concepts and medical terminology | • Ad-hoc interpreters are rarely trained and/or knowledgeable of interpreting techniques and ethics.  
• Patients may have a hard time discerning when the clinical staff is acting in their professional role VS when they are acting as an interpreter.  
• Lower productivity in the Clinical staff’s professional role.  
• High per-hour compensation rate for interpreting. |
## Appendix B: Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Description/ application</th>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad-Hoc Interpreter: Bilingual Non Clinical Staff</td>
<td>Bilingual (non-clinical) staff members are asked to interpret usually anywhere there is a need within the institution and most commonly without notice. In some institutions, there is a pay differential for these staff.</td>
<td>Rapid access to individuals who can be called upon to interpret.</td>
<td>• Ad-hoc interpreters are rarely trained and/or knowledgeable of interpreting techniques and ethics.</td>
</tr>
<tr>
<td>Ad-Hoc Interpreter: Community Service Agency</td>
<td>Community service agencies take on the responsibility of providing interpreters (usually a bilingual staff member or a Case Manager) free of charge to accompany their clients to medical appointments. The costs are incurred by the community service agency.</td>
<td>• No cost to the medical institution and no effort on their part. • The Case manager is usually well known by the patient so there is commonly a great deal of trust between him/her and the patient.</td>
<td>• Ad-hoc interpreters are rarely trained and/or knowledgeable of interpreting techniques and ethics. • Uneven access for LEP patients who are ‘case managed’ and those who are not.</td>
</tr>
<tr>
<td>Ad-Hoc Interpreter: Family and Friends</td>
<td>Interpretation is provided by a patient’s family member or by a friend. This may be a direct request from the patient. There is no cost to the institution.</td>
<td>• The patient’s relationship with the person interpreting may be the source of additional support and advocacy. • Some patients do not wish anyone outside their families to know about their health condition.</td>
<td>• This model has been discouraged by the Office for Civil Rights (DHHS). • Family/friends often withhold information from patients and may dominate the encounter. • Patients may have difficulty revealing personal information in front of relatives.</td>
</tr>
<tr>
<td>Staff Interpreter</td>
<td>Staff interpreters are employees of the institution and are chosen specifically for their language skills, training in interpreting, and certification (where available). Costs incurred by the institution may include recruitment, screening, training, assessment, scheduling and supervision.</td>
<td>• Staff interpreters come to know the patient population and their needs, as well as providers and resources. • They are more likely to be appropriately trained in interpreting skills and ethics.</td>
<td>It is not cost effective for languages with smaller request volumes.</td>
</tr>
<tr>
<td>Model</td>
<td>Description/application</td>
<td>Strengths</td>
<td>Challenges</td>
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</tr>
</tbody>
</table>
| Contract Interpreter | Interpreters hold direct contracts with the institution. Costs incurred by the institution include recruitment, screening, and scheduling.                                                                                                                                                                                                                                           | • Interpreters can be carefully selected to meet language and skill criteria.  
• Good option for languages with smaller volumes or more rare languages.                                                                                                                                                  | • This model depends on the availability of qualified interpreters who are willing to work on contract.  
• This model also depends on the presence of multiple health care institutions (or other venues) that in aggregate will provide the interpreter with enough work to stay in business. |
| Agency Interpreter  | The institution contracts with one or more language agencies that, in turn, recruit, contract and dispatch interpreters on demand. The costs incurred are usually a per hour fee paid to the agency.                                                                                                                                                                           | • Agencies may substitute for an internally based interpreter department, taking responsibility for recruiting, screening, and monitoring interpreters.  
• Because they are likely to have multiple and widespread contracts, large agencies can keep interpreters busy and so may have access to a greater number of interpreters and a wider range of languages. | • Agency interpreters may work in so many venues that they never become familiar enough with any one institution.  
• Of the dedicated interpreter models, this is traditionally the costlier option.                                                                                                                             |
| Volunteer Interpreter | These interpreters are not compensated for their work. They may be immigrants, students, spouses of students, or other individuals willing to volunteer their time. The costs in this option are in administering the program.                                                                                                                                       | This option works best in areas with large numbers of well-educated bilingual individuals who are not working at other jobs, e.g. university towns, areas with a heavy concentration of diplomats or foreign business people. | • Few volunteers have the training necessary to interpret effectively in a health setting. It is difficult to require training or to hold them to high standards.  
• The turnover rate is high, requiring intensive recruiting efforts.  
• Different cultures view volunteering in different lights, making it difficult to recruit volunteers in all language groups.                                                                                                       |
## Remote Interpreters (Telephonic and Video Interpreter)

<table>
<thead>
<tr>
<th>Model</th>
<th>Description/application</th>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
</table>
|       | An interpreter is linked to the patient and provider by telephone or video. The technology involved ranges from a regular phone passed back and forth between patient and provider, to a camera mounted in the examining room. The costs vary greatly depending on the technology used and whether the service is internal to the institution or outsourced. | - Avoiding waiting periods and utilizing interpreter more productively.  
- Clear and limited role for interpreter.  
- Remote interpreters can work from any location and serve a wider public. | - Telephonic interpretation does not capture non-verbal communication. Some important information may go unused.  
- Additional services provided by the interpreter may be lost (culture-brokering, guiding the patient around the health center, advocacy). |