WASCLA SUMMIT II
WASHINGTON STATE COALITION FOR LANGUAGE ACCESS

October 12, 2006

Wrap-up

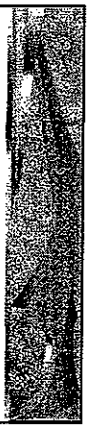
Martha Cohen

Next Steps

- Continue to work with others around the state in substantive area groups to develop and implement LEP policies
- Monthly phone calls 1-800-973-7370 access code 81110889 posted on website www.wascla.org as a way to update on progress
- Conference in June 2007 to discuss implementation, curriculum and language bank

Next Steps, Conference June 2007 (cont'd)

- Work on model curriculum for working with interpreters and developing cultural competence
- Develop interpreter/translator funding
- Work on Washington State interpreter/translator Bank



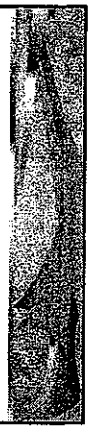
Interpreter/Translator Language Banks –Some Examples

- Seattle hospitals have worked together to pool resources
- San Diego Language bank requires training and test, sets fees and mileage
- Maryland Bank also requires training and recruits candidates
- San Joaquin California videoconferencing medical interpreter bank project requires economy of scale of multiple hospitals to be successful

Thanks to all of you who have contributed to today's conference!

Special thanks to:

- WASCLA members for planning and designing the conference
- Central Washington University for hosting
- Seattle University Law School Access to Justice Institute for funding
- Northwest Justice staff JoAnn Guzman and Jessica Conrad for registration and numerous other tasks
- And special thanks to fantastic volunteers Jenny Diez Caldwell and Jodi Sullivan for research and materials! !



INTERPRETER BANKS: HOW THEY WORK

The two agencies profiled below—both resettlement agencies—have established interpreter banks to provide trained interpreters for their respective communities.

The San Diego Language Bank

Funded in part by a grant from United Way and by fees charged for services, the Language Bank is a project of Catholic Charities' Department of Refugee and Immigrant Services in San Diego. It includes both interpreters and translators, representing 34 languages from Acholi to Pashto to Vietnamese. Their current clients include such agencies as Child Protective Services, Children's Hospital, the special education programs of several public school districts and Department of Social Services' disability evaluators.

All interpreters must attend a 40-hour training course and pass a final exam before being hired. The training includes medical terminology, cultural competency, psychological testing and ethics. The medical terminology section of the training is over 17 hours, covers each of the anatomical systems and is taught by a nurse practitioner from a local university's school of medicine. The curriculum is adapted from Seattle's Bridging the Gap project (see page 4) with additions from the University of Minnesota's School of Medical Interpreting.

The Bank's fee schedule is detailed on the accompanying chart. Travel time and mileage are included in the base rate. For in-person interpreting, fees are charged beginning at the time the interpreter arrives and continuing until the interpreter is dismissed to leave, including any needed trips to the pharmacy, office or lab.

For more information, contact Terry Clark, tclark@ccdsd.org or 619/287-9454.

Fee Schedule San Diego Language Bank

Our current rates for interpretation and translation services for health care and social service providers are as follows:

In-Person Interpreting
$40.00 per hour with a one hour minimum per visit. For any time after the first hour, prorated in 15-minute increments.

Telephone Interpreting
$40.00 per hour with a $10.00 minimum. Thereafter prorated in 5-minute increments.

Proofreading/Editing
$30.00 per hour with a $30.00 minimum (proofreading materials produced by another translation service)

Written Translation
Per word, from $24 per word and up; $30.00 minimum. Price varies depending on the language requested, text difficulty, delivery and formatting requirements. We must see the document before we can quote a price.

Other
Charges for other specialized services, such as field testing, focus groups, back-translation and foreign language typing are negotiable.

Community Interpreter Service of Sioux Falls

Since July 1998 the Community Interpreter Service of Sioux Falls (CISSF) has provided doctors, schools, police, community agencies, for-profit companies and LEP individuals with essential interpreting and translating service in 39 languages. It is operated as a program of Lutheran Social Services of South Dakota (LSSSD).

According to LSSSD Program Director Donna Magnuson, CISSF differs from most other interpreter banks in two important ways: first, the interpreter training curriculum has been developed in-house, and second, its 40 interpreters are part-time employees, rather than contractors, of LSSSD. Services are available 24 hours a day, 7 days a week, and include on-site interpretation, message relay, written translation and telephone calls. The interpreters attend bimonthly staff meetings and receive in-service training in terminology specific to work environments such as courts and health care.

Magnuson indicated that the program is growing and now uses an answering service for off-hour requests. Already self-funded, CISSF employs one full-time coordinator in addition to the part-time interpreters.

For more information, contact Donna Magnuson, dmagnus@lsssd.org or 605/731-2002.

LEARNING TO BECOME AN INTERPRETER

BRIDGING THE GAP'S TRAINING CURRICULUM

Cross Cultural Health Care Program (CCHCP) of Seattle has conducted medical interpreter training and train-the-trainers sessions throughout the United States since 1995. In 2001 alone, 90 trainers were certified and over 2,000 interpreters were trained directly or through the nonprofit's 50 affiliates (including two featured elsewhere in this issue—Catholic Charities of San Antonio, Texas, and Jewish Vocational Services of Kansas City, Mo.). According to Lead Trainer Julie Burns, CCHCP is the largest interpreter training organization in the nation.

Bridging the Gap is CCHCP's 40-hour basic/intermediate training course covering...

- basic interpreting skills (role, ethics, conduit and clarifier interpreting, intervening, managing the flow of the session);
- information on health care (introduction to the health care system, how doctors think, anatomy, basic medical procedures);
- culture in interpreting (self-awareness, basic characteristics of specific cultures, traditional health care in specific communities, culture-brokering);
- communication skills for advocacy (listening skills, communication styles, appropriate advocacy); and
- professional development.

Materials include a student handbook and a medical glossary translated into 10 languages (Spanish, Russian, Vietnamese, Amharic, Tigrignia, Cambodian, Lao, Somali, Korean and Chinese) resources on culture and traditional healing specific to 18 cultural communities, and a guide to medications. The course is heavily participatory, utilizing practice sessions, role-plays and small group discussions.

Although the curriculum focuses on medical interpreting, Burns stated that many affiliates have successfully adapted the program to other interpreting environments.

For more information, contact CCHCP Marketing Director Dick Barns, 206/621-4586.

NEW CCHCP AFFILIATE BEGINS BI-STATE TRAINING

Last year Jewish Vocational Service (JVS) of Kansas City applied for and received funding under Missouri's Set Aside Interpreter Training announcement. The agency's first step was a contract with Cross Cultural Health Care Program (CCHCP) of Seattle to conduct train-the-trainer sessions for its Bridging the Gap curriculum. Seven local trainers, including four JVS staff members, completed this training block. JVS has since been licensed by CCHCP to deliver this training, and has trained over 40 interpreters so far.

Interpreter Training Class—July 2001, Kansas City

Subsequently, JVS was awarded funding from the Kansas State Refugee Coordinator's office to deliver the Bridging the Gap curriculum across Kansas and Missouri renewed its contract as well. In addition, the Kansas Department of Health and Environment requested interpreter training specifically tailored to local public health care providers in heavily impacted LEP regions. The newest component of JVS's program is the establishment of an interpreter bank.

Program Manager Gabriela Flores stresses the importance of outreach and marketing to the potential customer base, including local health care and social service providers. "Without their institutional buy-in," she states, "you end up with a pool of qualified interpreters who are out of work, and the quality of care for LEP communities suffers significantly." Flores points to the growing litigation relative to language access in her area. Her advice? "These administrators must hear it in terms they understand: the bottom line."

HELP WANTED: INTERPRETER

Interpreters may work on a part- or full-time basis. Some are independent contractors paid directly by the user of service such as a hospital or school while others are employees of a third party such as a nonprofit interpreter bank. The hourly rates for interpreting depend on location and the type of interpreting. Generally, medical and community interpreters receive $8-25 per hour and court interpreters command as much as $45 per hour. Here are three refugees who have become successful as interpreters.

During the 10 years **Mr. Chethaketo Tan** spent in a refugee camp after fleeing Cambodia in 1984, he worked as a Khmer/English interpreter for the US Embassy. He was resettled in Stockton, California, then left for Lowell, Massachusetts where he eventually completed a degree in Political Science at the University of Massachusetts - Amherst. As part of his degree program, Tan studied Court Interpretation Theory for one year. Graduated in 1999, Tan passed the Massachusetts exam for Court Interpreters in 2000 and began work as a self-employed contractor for the State Trail Court System.

Tan asserts that there is a strong and growing demand for competent interpreters. He recommends professional training for aspiring interpreters, as well as certification. Although certification is not required in Massachusetts, certified interpreters commend double the standard hourly fee. A strong advocate for the advancement of the Cambodian community in Lowell, Tan loves his work. He currently interprets about 30 hours per week for the state of Massachusetts, works for a translation service company and provides voluntary translation/interpreting to non-profits in the area. Contact Mr. Tan at ketoten@hotmail.com.

Hisham Elhussien arrived in San Antonio, Texas, in August 2000 as a refugee from Sudan. Although he held degrees in computer science and international relations, Elhussien began his life in the United States as an employee of Pizza Hut. In October 2000 he was asked by his resettlement agency, Catholic Charities of San Antonio, to act as an interpreter for other refugees. In addition to English, Elhussien is fluent in Arabic, Hindi and Urdu. He became a full-time interpreter working primarily with Arabic speakers. His assignments have brought him into contact with professionals in a variety of fields including medicine, law and television broadcasting. Elhussien emphasizes the importance of specialized interpreter training and of maintaining the confidentiality of his clients.

The professional exposure he gained while interpreting helped him to secure a position as a case manager and began university studies in the United States. Still a part-time interpreter, Elhussien especially enjoys being able to assist the LEP community.

Nithal Hussien arrived in San Diego in 1998 under the auspices of the International Rescue Committee. An Iraqi refugee, she had taught microbiology at the University of Baghdad and later served as an interpreter for the United Nations High Commissioner for Refugees in Syria. Upon arrival in the United States, Hussein received interpreter training. She then took on interpreting assignments for Catholic Charities in Arabic, starting as an independent contractor working two-three hours per week. She is now a full-time employee of the agency, spending as many as five hours a day interpreting in addition to her functions as a health case manager. "I love my work as an interpreter," Hussien says. "The opportunity to hear refugees' stories and being able to help is most rewarding." She recommends that bilingual refugees consider interpreting jobs while establishing themselves and regularizing their credentials.

"Requests for translators in the courts have shot up in the past several years, as the clientele served by Massachusetts' courts has grown increasingly diverse. In 1997, the courts had 7,209 requests for interpreters; last year that number had grown to about 57,000...The 11 full-time court interpreters are paid from $45,000 to $57,000 a year. Freelancers hired by the day make either $250 daily if they're certified, or $160 if they're not...."

—From the Boston Globe, March 4, 2002

Marketing Your Linguistic Services: Appeal To The Bottom Line

Operating a revenue-producing program requires a traditional not-for-profit organization to think and act in for-profit ways. In the case of an interpreter services program, the organization must market a service built around identified customers' needs and desires while remaining true to its nonprofit mission and complying with the law. Catholic Charities of San Antonio began its Linguistic Services Network in early 2000 in response to a request from the Texas Department of Health. Financed with ORR set-aside funds, and using Seattle's *Bridging the Gap* medical interpreter training program, Catholic Charities trained a group of independent contractors fluent in 14 languages.

Given the task of marketing the program, Coordinator Ezequiel Quijano persuaded graduate students at St. Edward's University to conduct market research and develop a marketing plan. The San Antonio Plan includes the following components:

Advertising: The education of service providers and clients regarding the rights of LEP individuals under Title VI of the Civil Rights Act. This includes the distribution of business cards (at lower right) to LEP individuals for presentation to service providers.

Sales: In addition, Title VI LEP requirements focus on the target's bottom line—for example, poor communication between doctor and patient often results in misdiagnosis and possible malpractice charges. The courts have decided that a language barrier does not exonerate a healthcare provider from blame.

Public Relations: Collect success stories for distribution to funders, clients and the press.

Promotion: Provide no-cost interpretation demonstrations. Trained interpreters are clearly more effective than occasional interpreters. Face-to-face interpretations are more effective than language lines.

Pricing: Offer affordable interpreter services, competitively priced to generate adequate business and provide reasonable income to the interpreter and the sponsoring agency.

Distribution: Clients access the program 24 hours a day using a toll-free number. Services are provided on site (scheduled) or via telephone (emergency).

Quijano reports that requests for assistance are up by over 30 percent. The San Antonio program has extended its interpreter services to schools, other service providers and for profit companies. The interpreter bank currently counts 80 individuals (including 8 refugees) interpreting in 50 languages.

For more information, contact Ezequiel Quijano, linguistic@flash.net.

"Being bilingual does not an interpreter make."
— Ezequiel Quijano, Catholic Charities San Antonio

The ideal interpreter has acquired the following skills through training and life experiences:

- an excellent command of the target languages
- good memory
- knowledge of his or her work setting—medical, court or community
- a strong understanding of and adherence to interpreting ethics and professionalism
- an understanding of indigenous cultural issues and practices
- good interpersonal communication skills
- a commitment to ongoing professional development

I would like to request that a bilingual interpreter be provided for my appointment.

If you do not have someone available from your staff, please contact:

Health Care Interpreter Program

WASHINGTON UPDATE

"Empty Seats on a Lifeboat": Senate Holds Hearings on Refugee Admissions Crisis

On February 12 the Senate Judiciary's Subcommittee on Immigration heard an afternoon of testimony on "Empty Seats on a Lifeboat: Are There Problems with the U.S. Refugee Program?" in response to the near-suspension of refugee arrivals since September 11. The hearing's government panel consisted of James Ziglar, commissioner of the U.S. Immigration and Naturalization Service (INS), and Gene Dewey, the new assistant secretary of state for the Bureau of Population, Refugees, and Migration (PRM). Lenny Glickman, chairman of Refugee Council USA, which represents 19 organizations including all national voluntary resettlement agencies, was on the resettlement panel.

Ziglar reiterated the administration's strong commitment to meeting the 70,000 refugee arrival ceiling and laid out an INS action plan to speed up refugee processing activities overseas. These measures include increasing the number of officers available to conduct refugee interviews, increasing the pool of applicants eligible for INS interviews and accommodating more refugee arrivals at ports of entry. Dewey has also authorized the hiring of additional staff at several overseas processing locations to implement new security requirements. PRM will also assume all pre-screening tasks in Moscow, freeing INS for work elsewhere, and has given to the International Organization of Migration all medical screening activities in Africa.

Glickman praised these recent actions but expressed concern that their commitment may not be able to be maintained with the president's fiscal year 2003 budget request of only $705 million for the Migration and Refugee Assistance (MRA) account. This budget request is $10 million less that the administration sought in fiscal year 2002. And since enhanced security measures will "likely cause an overall increase in the cost of resettlement...a higher level of funding for MRA will be needed." Among Refugee Council USA's recommendations are an expansion of family reunification with a "universal P-3 designation to facilitate processing of refugees with close relatives in the U.S." and the granting of permission for direct registration of identified refugee caseloads without a referral from the U.N. High Commissioner for Refugees.

Agreement Reached to Correct Social Security Number Snafu

The Social Security Administration (SSA) has entered into an agreement with the Department of State's Refugee Data Center (RDC) for verification of refugee status. Refugees often apply for Social Security numbers within days of arriving in the United States and often before data is available through an online Systematic Alien Verification for Entitlement (SAVE) query. On January 29 SSA released instructions to field office employees on how to verify refugee status using the RDC. The instructions state that if the online SAVE query does not confirm refugee status, field office employees must now obtain RDC verification on the status of any individual presenting an I-94 Arrival/Departure Card indicating refugee admittance. ORR State Letter 02-04, dated February 8, provides information on the new SSA instructions and a detailed attachment of procedure from SSA.

ONLINE CONNECTION

www.usdoj.gov/crt/spectop.html

U.S. Department of Justice Civil Rights Division—Special Topics

Scroll down to the section entitled "National Origin Discrimination" for a pamphlet on "Federal Protections Against National Origin Discrimination," available in Arabic, Cambodian, Chinese, English, French, Haitian Creole, Korean, Laotian, Russian, Spanish, Tagalog and Vietnamese.

www.acf.dhhs.gov/programs/orr/policy/index.htm#letter

US Office of Refugee Resettlement—State Letters

Follow links to State Letter 02-04, dated February 8, "Verification of Refugee Status with the Department of State Refugee Data" and State Letter 01-12, dated April 27, 2001, "Proposed Notice of Allocations to States of FY 2001 Funds for Refugee Social Services."

(Continued on page 8)

REFUGEEWORKS
700 Light Street, 1st Floor
Baltimore, MD 21230

FOCUS ON
INTERPRETERS

VOL. 3, NO. 1
WINTER 2002

ONLINE CONNECTION

(Continued from page 7)

www.diversityrx.org

DiversityRx

DiversityRx offers practical information on how to design programs that address linguistic and cultural barriers to health care.

www.ncsc.dni.us

National Center for State Courts (NCSC)

NCSC is an independent, nonprofit organization dedicated to the improvement of justice. Site includes a wealth of information regarding court Interpreting, including certification, testing, state contacts and training.

www.ttig.org

Translators and Interpreters Guild (TTIG)

The only nationwide union of translators and interpreters, TTIG runs referral services for clients.

Visit us on the web at www.LIRS.ORG

www.najit.org

National Association of Judiciary Interpreters & Translators (NAJIT)

A nonprofit organization dedicated to the furtherance of the court interpreting and legal translation profession, NAJIT's site includes an online database of members and languages.

www.atanet.org

American Translators Association (ATA)

A membership organization, this site will help you learn more about the translation and interpretation professions. ATA includes online directories and job bank.

www.criticallink.org

Critical Link provides information for community interpreters.

www.xculture.org

Cross Cultural Health Care Program

Provides nationwide training programs in medical interpretation, linguistics and cultural competency. Site includes a list of other interpreter training organizations throughout North America.

REFUGEEWORKS

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Jane Bloom, ACSW
Director for RefugeeWorks

Karen Heist
Contract Manager

Terri Kee
Administrative Assistant

Ralston H. Deffenbaugh Jr.
LIRS President

Barbara Day
Vice President for Resettlement

700 Light Street, 1st Floor
Baltimore, MD 21230
410/230-2767
Fax: 410/230-2890
tkee@refugeeworks.org

REFUGEEWORKS

THE NATIONAL CENTER FOR REFUGEE EMPLOYMENT AND SELF-SUFFICIENCY

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VOL. 3, ISSUE #1 WINTER 2002

DIRECTOR'S MESSAGE

This issue of our RefugeeWorks newsletter focuses for the first time on a particular occupation, one that we believe holds great promise for refugees and the employment network designed to serve them: the ever-growing field of *interpreter services*. With agencies nationwide now scrambling to implement policies and actions to comply with the executive order assuring program access to persons with limited English proficiency (LEP) under Title VI of the Civil Rights Act, our network is ideally poised to fill the need—and the timing could not be better.

Interpretation—as a job, as a service, and as an industry—is a win-win proposition for all parties involved. For *refugees,* it can be an excellent, flexible, well-paid, recession-proof career. For *service providers* from all sectors of our network, interpreter banks have shown themselves to be vital, demand-driven, income-generating profit centers. For *customers*—including hospitals, courts, food stamp offices, departments of motor vehicles and skills training programs—well-trained interpreters are the solution to the new Title VI LEP mandates. And for *LEP users of services,* translators may mean the difference between inclusion or exclusion from a program, activity, service or entitlement.

Some of the programs covered in this issue have gotten their start in the last two years from the U.S. Office of Refugee Resettlement (ORR) "set aside" allocation to state social services. In FY 2000 and FY 2001, "interpreters and interpreter services" were among the three or four program areas for which set-aside funds were made available by formula to each state.

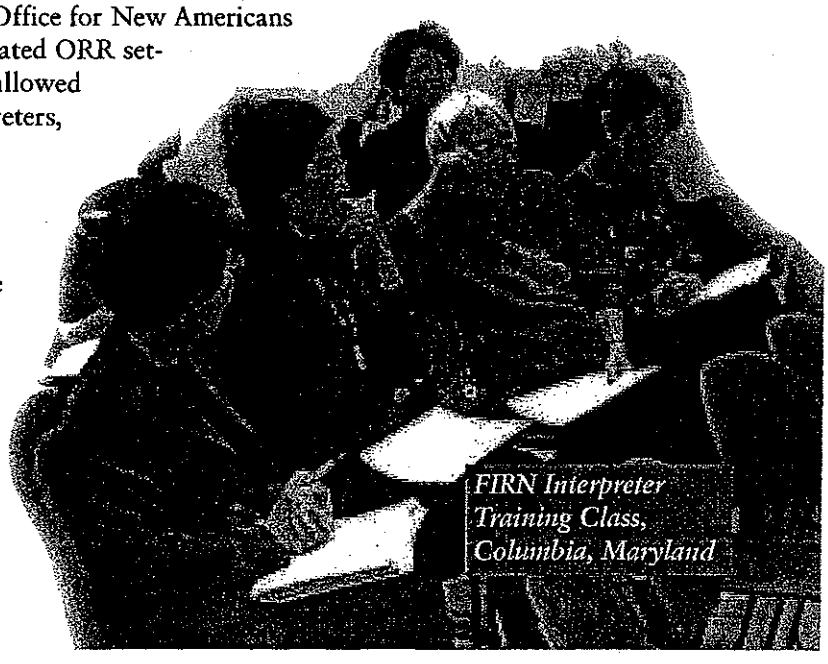
My thanks to the many contributors who made this issue possible. I am particularly indebted to Martin Ford, Tom Giossi, Gabriela Flores and Michael Scott for their articles and hard work on our behalf, and to the agency professionals of the programs showcased who enthusiastically responded to our calls. To all our readers, we would welcome hearing from you about interpreter programs in your area, how they are funded, and what other occupations or growth industries you suggest we target in future issues.

Jane E. Bloom

STATEWIDE APPROACH TO INTERPRETER SERVICES LAUNCHED: MARYLAND WORKS TO MEET CHALLENGES

When the Maryland Office for New Americans (MONA) was allocated ORR set-aside funding that allowed states to train and hire interpreters, the initiative posed special challenges. While the state's annual arrival numbers are modest, averaging 909 during each of the past five years, the refugees who come during any given quarter may speak more than twenty languages. Their linguistic diversity, varied sponsorships and overall modest numbers promised

(Continued on page 2)



FIRN Interpreter Training Class, Columbia, Maryland

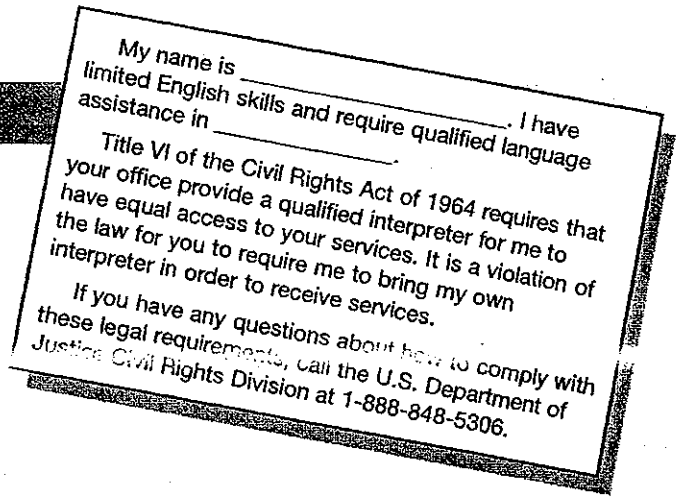
MARYLAND WORKS TO MEET CHALLENGES

(Continued from page 1)

to make hiring interpreters for particular languages an inefficient use of limited funds. Instead, MONA opted to build interpreting capacity within Maryland's refugee communities by investing resources in training and management.

In June 2001 MONA contracted with the Columbia, Md.-based Foreign-Born Information and Referral Network, Inc. (FIRN), and the Vancouver, Wash.-based CTS LanguageLink to provide interpreter training and management services for Maryland's refugees for a 12-month period. FIRN subsequently partnered with the Northern Virginia Area Health Education Center, whose certified trainers offered the 40-hour Bridging the Gap curriculum described on page 4. Annual objectives for 2001 were to train at least 75 interpreters in professional standards of interpretation for social services, health care and legal assistance, and to manage language bank services for at least 200 interpreter service encounters.

The first step toward achieving these objectives was to recruit candidates for training. Working with local voluntary agency affiliates and others in MONA's network of refugee service providers, FIRN and LanguageLink interviewed nearly 180 prospective trainees, testing nearly half for proficiency and selecting 60 for training. By the end of the first contract quarter,


My name is _____. I have limited English skills and require qualified language assistance in _____.

Title VI of the Civil Rights Act of 1964 requires that your office provide a qualified interpreter for me to have equal access to your services. It is a violation of the law for you to require me to bring my own interpreter in order to receive services.

If you have any questions about how to comply with these legal requirements, call the U.S. Department of Justice Civil Rights Division at 1-888-848-5306.

FIRN and CTS had trained a total of 50 interpreters of 18 languages including Russian, Vietnamese, Serbo-Croatian, Arabic, Farsi, Swahili and French.

According to Martin Ford, MONA's Associate Director, the program now faces several related challenges. "First, we must publicize the availability of trained interpreters working in different languages. Second, we must link interpreters to mainstream service providers and refugees in the most efficient and cost-effective way. Third, and perhaps most important, we must persuade service providers to invest in their agency's compliance with the new LEP Title VI provisions."

To address these needs, MONA is producing basic information on the program in eight languages. As for the mechanics of delivering interpretation services, the office is setting up toll-free numbers to request and schedule an interpreter; it is also preparing "I speak_____ cards" for distribution to agencies for their caseworkers to use with LEP clients and relevant service providers. These cards will encourage clients to ask for professional interpretation and enable providers to offer interpretation in a timely and economical way.

"Compensation of interpreters and cost to providers are clearly major issues that require a creative and concerted response," says Ford. "While both project budgets do subsidize interpretation for refugees in a limited way, there is also an urgent need to remind federally funded agencies that interpretation is *their* responsibility."

MONA, its partners and its clients are all working at the front end of what Ford terms "a steep learning curve." "We have a lot to do, but excitement propels the project."

For more information, contact Ford, mford@dhr.state.md.us, or MONA's LEP Project Coordinator Michael Scott, mscott@dhr.state.md.us.

Interpreting vs Translating

■ **Translators** are responsible for translating *written* documents.

■ **Interpreters** interpret *spoken* language. Interpreters are classified into three groups depending on their work setting:

- **Medical Interpreters** work in healthcare settings. California and Washington require certification for medical interpreters.
- **Court Interpreters** work in legal settings. Federal and many state courts require certification for court interpreters.
- **Community Interpreters** work in settings not covered by medical and court interpreters. Certification is not currently required.

REMOTE VIDEO MEDICAL INTERPRETER BANK PROJECT
SAN JOAQUIN GENERAL HOSPITAL

Problem Statement

The access to quality healthcare services for America's limited English proficient (LEP) patients has been a longstanding challenge to U.S. healthcare providers. The U.S. Census of 2000, notes that over 21 million people speak English "less than very well" with 11 million households linguistically isolated [1].

In Northern California, safety-net healthcare providers, who serve low-income and uninsured population are overwhelmed in their effort treat these immigrant populations. The numbers alone are staggering. Between 30% and 60% of the patient populations of the county healthcare systems in San Joaquin, Contra Costa and San Francisco are LEP. Their patient base includes wide variation in languages with at least 20 languages in regular encounters, including Spanish, Vietnamese, Cantonese, Mandarin, Russian, American Sign Language, Hmong, Mien, Farsi, Hindi, Korean, Arabic, Amharic, and others.

San Joaquin County has an extensive immigrant population, which is limited English proficient (LEP), including an extensive Spanish speaking population and increasing numbers of immigrants from Asian and Pacific Island nations. The communities facing the obstacles to quality care related to language access are, typically immigrants and their families, of diverse ethnicities and ages, presenting with the full range of health care problems. California has both the largest number and the highest percentage of immigrants of any state in the nation. Census data estimates that 24% of the California population is foreign born and this is projected to grow to 34%, or 16,756,000, by the year 2025 [1]. Approximately 10% of California's population is comprised of Asian Pacific Islanders . Of these, 43% of Asians and 17% of Pacific Islanders "do not speak English very well." [1] Nearly one-quarter of the state's Latinos, who comprise about 30% of the population, speak "little or no English." [1]

Medical service provision in San Joaquin County is challenged by almost 59,000 residents born in Latin American countries and more than 40,000 born in the Asian and Pacific region. More than 90,000 San Joaquin County residents identified that they speak English "less than very well" [1]. These residents are seen predominately at safety-net health service providers of San Joaquin County, especially San Joaquin General Hospital, because of their high concentrations in the low-income economic bracket and employment in industries such as agriculture, which traditionally do not offer health insurance.

A recent study conducted by a community organization Mujeres Unidas y Activas (United and Active Women) cited the problems faced by members of their community in accessing health services at a local public hospital. An example of individual testimony included this poignant story; "They had given me an appointment for 6:00 in the morning. We arrived on time at the reception desk to ask what was going on. When my husband said I had a headache, they sent me to the emergency room because I had had an aneurysm a few years before. I waited there until 9:30 at night. They did some tests on me, but the main problem was there were no interpreters available. I hadn't

eaten since the night before and I told them I was hungry, but they just said "No Spanish. Wait a minute please." [2].

According to the Institute of Medicine report on Racial and Ethnic Disparities, language barriers can "affect the delivery of adequate care through poor exchange of physician instruction, poor shared decision-making, or ethical compromises" and result in decreased adherence to medication regimes, poor appointment attendance, and decreased satisfaction with services." [3]

Groundwork for Proposal

This projected collaboration has a critical foundation of more than five years of pioneering videoconference-based medical interpreter systems. This foundation has included the first clinical trials of the use of Videoconferenced Medical Interpretation (VMI) led by Health Access Foundation. Demonstrating strong ties with the leadership of two major public hospital systems in Northern California, Health Access Foundation organized the clinical trials of VMI at San Francisco General Hospital and Highland Hospital (a part of the Alameda County Medical Center system).

Since the release of that report, Health Access created a comprehensive implementation proposal for Alameda County Medical Center (ACMC), including all of its facilities (a long-term care facility and scattered community based primary care clinic sites). Over the last two years, Health Access Foundation has led the implementation of this plan at ACMC and a partial implementation of VMI utilization at San Francisco General Hospital. Connectivity within the hospital Wide Area Network (WAN) environment has proven to be easy and reliable. These experiences present a strong foundation to develop an implementation plan among multiple healthcare providers

While these results have proven the possibilities of introducing videoconferencing technology into day-to-day utilization by a hospital system, it has not yet demonstrated the possibilities of the shared economies of scale, which can only be achieved by a multiple hospital bank of shared interpreters.

IP based end-points for videoconferencing have undergone extensive testing at each of the participating hospital sites, led by the Health Access Foundation technology team. A wide variety of videoconferencing endpoints have been tested in laboratory and real clinical settings to determine the optimal configurations for video and audio quality, reliability, mobility, and ease of use.

Finally, an important project, funded through a Technology Opportunities Program grant, based at Michigan's Metropolitan hospital has tested the utilization of remote medical interpreters between several local community sites utilizing videoconferencing technology. The Michigan project has successfully demonstrated the real feasibility of exchanging interpretive services between medical providers using this technology.

These experiences clearly indicate the importance and growing future of the use of medical interpreters through videoconferencing technology. What has yet to be tested and demonstrated is the system-wide exchange of medical interpreter services between large-scale users of medical interpreters.

The hospital systems preparing to implement the Remote Video Medical Interpreter Bank expect to manage more than 100,000 LEP patient encounters per year through their projected cooperative.

A Remote Video Medical Interpreter Bank

The model design for this project is a service of medical interpreters shared among multiple hospital and clinic providers. Interpreters will be in stationary sites at multiple locations among the various providers (including some in a call center configuration), equipped with videoconferencing technology. They will be trained to a common standard accepted among all of the medical providers. Calls from videoconferencing units throughout the hospital systems and clinics will be initiated and managed through IP video call center technologies to route calls to an available video based interpreter. Software to automate the dispatch and tracking functions of this process are critical to the ability organize the dispatch and assignment of hundreds of calls a day to the appropriate interpreter. In addition, identification and tracking of every session is critical in creating the ability to bill each system to ensure equitable participation in the venture.

The projected information and communication technologies anticipated for consideration in this planning process: are video endpoints; using broadband connections to carry IP video calls; IP video call center technologies; and the necessary routers to connect various enterprise wide-area networks to a regional call center.

Our proposed technological solutions for video conferencing interpretation, includes the use of Tandberg 1000 video endpoints and Cisco networking and video telephony call center equipment. In several years of testing, Tandberg 1000 has remained our endpoint of choice for video medical interpretation use. The audio and video are of high quality and the Tandberg 1000 is easy to use in a medical setting. We hope that with the grant we can leverage Tandberg to customize the 1000 to best-fit video medical interpretation. While the Tandberg enhancements will be important, the most significant development for our five medical center collaboration, is that Tandberg and Cisco Networks have entered into a partnership to make video telephony a part of Cisco's IP-PBX telephony systems. The first step in this partnership has been that Tandberg equipment can now be used as a "video phone" in Cisco's IP-PBX environment. The newly released Call Center 4.0/IP Call Center provides telephone-like functions such as call forwarding, automatic call distribution to agents, etc. for video calls between Tandberg systems (and Cisco compatible phones). We propose to build a Video Interpretation Call Center around these technological solutions.

Operationally, interpreters in the medical centers with Tandberg videophones would log into a single regional system (Regional Cisco IP Call Center). This login would put the interpreters into two queues, one for a priority in one's "local" medical center's language queue, and the other into the regional language queue. Video calls made from Tandberg videophones by requestors, would be routed to the Regional Interpretation Call Center. Here the video call would be automatically distributed based on a requestor's inputted "local" medical center identified code. Based on that code, the call would first to see if one's own medical center interpreters were available, and if a "local" interpreter were not available, the search would be to the interpreters in the

regional language queue. If there were no response at the regional queue, then the call would be automatically forwarded to an "overflow/ backup" of contracted non-medical center interpreters. Electronically, records would be logged for all calls, and appropriate accounting of services could be reconciled from those records.

All projected technologies for IP based videoconferencing utilize the H.323 family of standard multimedia protocols. Tandberg video endpoints support H.323. It is likely that we will the use of the popular Cisco proprietary SCCP standard for video and voice IP-PBX and Call Distribution functions. The SCCP protocol is supported by Tandberg in its partnership with Cisco. The data captured in call monitoring by the Cisco IP-PBX is SQL accessible. This enables easy data sharing across the enterprises should the need for distributing detail call records is required.

Project Stages of Implementation

The project plan for the creation of a Remote Video Medical Interpretation Bank calls for a three year process, with the first 12 months concentrating on laying a very careful groundwork for implementation, the second 18 months focused on implementation and the final six months on the summation of lessons and conclusion of the project. The goals of each stage and projected activities are listed below:

1) Planning Stage – 12 months

The planning stage is expected to accomplish the following elements as the groundwork for the implementation of the Remote Video Medical Interpreter Bank.

For the design of Interpreter Services:

- The collection of data on current language service utilization for each provider, including each identified threshold language, services requesting service, days of the week, shift, and projected time of utilization. This data will be collected through the combination of data from all medical interpretation staff and billing information for all contracted language service.
- The collection of data regarding bilingual designated staff, number and specifics of languages represented, job classifications of bilingual staff, and staff perceptions regarding the real availability of bilingual staff for interpretive services outside of their specific work unit.
- Review of each provider's existing protocols for the request of interpreter services and identification of best practices which might be commonly adopted by all providers
- Creation of commonly accepted standards for medical interpretation qualifications and training between the participating providers

The technical groundwork for implementation will focus on the "proof of concept" working model of video and audio telephony over IP, linked with IP based call center technologies and a technical implementation plan to manage and route a regional medical interpreters bank. To produce this "proof of concept" we will:

- Test IP based videoconferencing use between firewall protected enterprise systems to ensure viability of these technologies
- Test IP based video/audio call center technology to test viability to manage IP video and voice telephone calls. This would include essential call center functions such as automated queuing by language; skills based routing, agent supervision tools, call transfer, hold, tracking and billing functions.
- Test IP based video/audio call center technology to test viability to direct IP video calls in an automated call distribution (ACD) to interpreters across all enterprises (i.e. from participating enterprise systems and to participating enterprise systems)
- Recommend to Tandberg and other videoconference vendors a "best design" for a video medical interpretation device. This might include recommendations for attached carts and an embedded numeric touchpad.

To prepare for the creation of governance structure and business plan for a sustainable system of shared medical interpreter services among San Joaquin safety-net health care providers and participating Northern California public hospitals the planning stage will conduct the following activities:

- Review current financial data and utilization patterns of participating medical providers to evaluate current expenditures for interpreter services
- Create a service delivery model, which can best utilize existing interpreter resources among the participating medical providers,
- Create a plan for additional resources to be added creating the optimal economies of scale for language utilization.
- Evaluate outside contracting services as a potential secondary bank of interpreter services to respond to overflow requirements

After an examination of utilization patterns and creation of an optimal staffing pattern of resources within the partnership and opportunities for external contracted partners, we will create a new business model for the pooling of existing resources. The business model will include mechanisms for ensuring equitable compensation for the "sale" of each organizations interpreter services and a fair payment scale for the "purchase" of interpreter services from the pool, and the rates for potential sale of excess interpreter services to other hospitals and healthcare systems. Included in the business model would be the creation of tracking and billing mechanisms for the flow of all interpreter services. Also included in the business plan will be the identification of the ongoing responsibility for the upkeep, maintenance and replacement of videoconferencing equipment at each provider. The business plan will demonstrate the on-going sustainability of the Remote Medical Interpretation Bank, through the shared contributions of participating providers and through the potential sale of excess language capacity to other hospital and healthcare systems. The legal groundwork for this cooperative business will be created by the end of the first year.

2) Implementation Stage – 18 months

a) Bring a skeletal version of the entire complement of physical sites on line and demonstrate test calling between them to test, and perfect seamless connectivity, map scripts for IP call center management, and effective routing and tracking systems in place (projected to take place for 4 months)
b) The business plan and new organizational model for the cooperative will be taken to each organization for endorsement and agreement for financial support during the first six months of the implementation phase. By the completion of the implementation phase, the new organization will be funded and staffed and prepared to take over the management of the bank when the full exchange of services comes on line.
c) Implementation of VMI installation by all providers in a sequenced process over ten months. Beginning with San Francisco General and San Joaquin General, then moving to community providers in San Joaquin and to Contra Costa County providers. (Implementation models have already been created for this purpose). All providers will traffic interpretations only within their WAN and among their staff for this period. San Joaquin General will share interpretive service with other San Joaquin providers during this period. Implementation plans include the 1-hour training of key physicians, nurses, and clerical staff expected to utilize VMI technology and acquire interpretive services through the new procedures.
d) Entire system comes on line with the sharing of interpretive services across entire grid. (projected to take place over a 4-month period).
e) New enterprise will initiate service at the end of this period, beginning to take on the functions previously held by project staff.

3) Conclusion Stage – 6 months

This stage will conclude the efforts of the Remote Video Medical Interpretation Bank project. Critical data regarding the outcomes of this new model will be collected, including the numbers of interpretations recorded, the productivity of staff interpreters, and the scale of interpretive services able to be provided with the same level of funding by each provider, and the satisfaction of LEP patients and their health care providers. This data will be compiled in the preparation of final reports, which will complete the project.

A new entity to manage and operate the Bank will have been created and will be in operation managing the newly created Remote Video Medical Interpreter Bank. The evaluator will be compiling the results of the project and the hosting entity will prepare reports for the project funders.

Projected Outcomes

The projected outcomes of the Remote Video Medical Interpretation Bank are as follows:

1) The equipping of all participating providers with working videoconferencing endpoints in medical encounter sites for the purpose of the provision medical interpretation.
2) The establishment of stationary medical interpreters among participating medical providers, offering interpretive services through videoconferencing.
3) The creation of a regional IP telephony/PBX call center, which can manage, route, and track the utilization of video calls between medical providers and interpreters.
4) The creation of a new entity, which is funded and staffed, which will manage the ongoing activity of the Remote Video Medical Interpreter Bank with a sustainable business plan.
5) To create and implement an optimized plan to provide most cost effective use of staff interpreters and outside interpretive services, including the increased coverage of staff interpreters for pm and weekend coverage of emergency rooms and inpatient care in three to four key languages and improved coverage in remaining high concentration languages during typical outpatient hours.
6) Operational IP Video call center, which will manage more than 10,000 calls in its first quarter of operation.

Qualifications of Key Staff

The lead consultant to manage the Remote Video Medical Interpretation Bank Project will be furnished through a consulting contract with Health Access Foundation. The lead consultant and project director will be **Melinda Paras**, past Director of Communications, Policy and Planning for the Alameda County Medical Center. Paras served as a senior executive of the Alameda County Medical Center and has led language access efforts in California public hospital systems through the Videoconferencing Medical Interpretation Project for the last 5 years . Prior to her role at ACMC, Paras was the Executive Director of Health Access, a Health Commissioner for the City and County of San Francisco and past President of the Board of Trustees for the Alameda County Medical Center. Health Access will also furnish services the services of **Bruce Occena**, M.P.H., M.B.A, the chief implementation leader of VMI technology currently underway at two public hospitals in the S.F. Bay Area.

In his role as Chief Information Officer for Health Access, **Raymond N. Otake**, J.D., has functioned as the lead technical advisor on language access issues for Health Access Foundation. Mr. Otake, has been the Technical Director of the Videoconferencing Medical Interpretation Project, including the testing and evaluation of new technology and its application to the issues of language access.

Key personnel for the project from San Joaquin General hospital include **Susan Watson** R.N., who will serve as the senior administrator to the project from San Joaquin General Hospital. Ms. Watson is the Senior Deputy Director of San Joaquin General Hospital and heads the Ambulatory Care services for the hospital system. The project will also be staffed by **Pardeep Sidhu,** a Department Applications Analyst from San

Joaquin General Hospital. He is a project analyst with project management and IT experience. Mr. Sidhu will be responsible for analytical and IT support to the project, including the tracking of the extensive in-kind donations of the applicant and project partners.

Replication Opportunities

Hospitals and healthcare providers in virtually every urban setting of the United States face the enormous challenge to provide medical interpreter services for LEP patients. In addition, healthcare providers in even areas of smaller concentrations of immigrant communities remain confronted with patients who are unable to communicate with their physicians because of language differences.

The opportunities for replication are provided through two different forms, first once the system of connecting, sharing, and billing various healthcare providers has been established, additional systems could join the cooperative. In addition, other healthcare systems or regional concentrations of healthcare providers will consider creating a similar model for operation in their region, focusing on the specific languages in high demand in their areas.

Other Available Federal Funding

The Remote Video Medical Interpretation Bank project does project seeking additional federal funding for this project, from the Agency for Health Quality Research, Transforming Healthcare Quality Through Information Technology (THQIT) funding stream. These funds would be directed to a wide-scale health outcomes research project seeking quantification of specific improvements in healthcare which are projected to occur as a result of the implementation of this project; such as the reduction in medical errors; improvements in patient compliance with prescribed regimens; improvements in patient safety; and measurable positive clinical outcomes.

The THQIT funding stream places significant restrictions on the utilization of monies for the purchase of hardware and software, which are necessary for the full implementation of our proposed project. Any projected funding received from this or any other federal grant for this project would not be attributed to the local matching funds for the TOP proposal.

Evaluation

Ms. Beatriz Solis, M.P.H. will lead the evaluation of the Remote Video Medical Interpretation Bank project. Ms. Solis is the Director of Cultural and Linguistic Services at the Los Angeles Care Health Plan, where she is an expert in the delivery of services to the LEP populations and an experienced health program evaluator, project manager, and researcher in issues of minority health. Her CV is attached (see appendix p.14).

The evaluation process will be assisted by the program design, which calls for the extensive collection of baseline data as a responsibility of the program staff during the initial stages of the project. In addition, supplemental evaluation mechanisms to study clinical improvements in health outcomes will be sought by the project.