August 2017

Strengthening the Health Care Interpreter Workforce: A Learning Collaborative Model

Final Evaluation Report

Oregon Health Authority | Office of Equity & Inclusion

Just because you're bilingual doesn't mean you know how to be a health care interpreter.

-Learning Collaborative Participant

A cohort of learning collaborative trainees

Acknowledgments

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Executive summary

There is strong evidence that culturally and linguistically appropriate care, including the use of trained health care interpreters, increases access to health care for limited English proficient (LEP)* populations, eliminates health disparities and reduces health care costs. As a result, the Office of Equity and Inclusion (OEI) submitted a health care interpreter (HCI) learning collaborative project proposal for developing Oregon's HCI workforce. The Oregon Health Authority (OHA) allocated part of a State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Innovation (CMMI) in 2013 to recruit, train and certify health care interpreters (HCIs).

This evaluation report analyzed pre-post data from six training sessions and key informant interviews to determine the effectiveness of the training required to become a state-recognized interpreter. This evaluation's key findings, barriers and recommendations follow.

Key findings:

Growth in the size of the HCI workforce

- The size of the HCI workforce grew through increasing the number of trained interpreters and the qualified† and certified‡ interpreters on the HCI State Registry. A total of 157 interpreters completed the training in various locations throughout Oregon. Of these participants:
  - » 29 (18 percent) also completed the testing requirements for HCI certification;
  - » 26 (17 percent) also completed the testing requirements for HCI qualification; and
  - » 37 (24 percent) were still in the process of completing their certification testing.
  - » 65 participants (42 percent) did not access the testing before the testing contracts ended.

* According to the Office of Civil Rights, an LEP person is an individual who does not speak English as their primary language and who has a limited ability to read, speak, write or understand English.

† Qualified interpreters have completed 64 hours of training and are proficient in English and the language they interpret. See Appendix C for more on the qualification process.

‡ Certified interpreters have completed 64 hours of training and passed the national certification exam. See Appendix D for more on the certification process.

Diversity in the languages trainees interpret

- Training participants interpret in:
  - » 19 different languages;
  - » 71 percent Spanish, 8 percent Vietnamese, 7 percent Russian, 3 percent Arabic, 3 percent Cantonese, 2 percent Persian and nine other languages (each of which had less than 1 percent of trainees).

> "Just because you're bilingual doesn't mean you know how to be a health care interpreter."
>
> –Learning Collaborative Participant

Benefits of training interpreters to the health system

- HCI training participants affirmed the training's value, its potential benefits to the delivery system and patient-level outcomes, as well as the need to sustain this type of training.
  - » 99 percent of respondents felt the training had improved their interpreter skills and will help them become better interpreters.
  - » The average pre-post test score for trainees on their knowledge and interpreting skills improved from 59 percent pre-test to 90 percent post-test.
  - » Approximately 99 percent of trainees were also very satisfied with the content of their training and the level of facilitation.

Interpreters' job satisfaction after training

- Many HCIs observed that their jobs changed for the better after the training. The changes included improved interpreting skills; improved quality of interpreting; increased feelings of confidence; job satisfaction; empowerment; and increased compensation. Some HCIs said practitioners and provider teams treated them differently after the training, while others improved their employment by moving into better paying jobs.

Removing barriers:

Financial

- The cost of training and testing required to become state-credentialed was the most mentioned individual-level financial barrier. The SIM-funded training's removal of this financial barrier was very helpful because they would not have

otherwise pursued this state-required professional training. Current interpreter wage rates are also disincentives to pursuing this training; without financial support, interpreters may not be able to take time off for the training or recoup the training cost from their wages alone.

Health systems

- Some respondents suggested that some clinics and providers try to avoid spending funds on services such as health care interpreters. Some providers do not understand how to schedule sufficient time for appointments requiring interpretation. Some interpreters were reluctant to ask for pay raises after they completed their training because they feared their requests would result in higher operational costs for their employers and trigger reduced interpreter appointments and work hours.
- Very few respondents mentioned anything supportive about the health care system and using HCIs. A few respondents felt health care system providers' awareness and support of HCIs has improved. However, the majority felt health care practitioners need more education about HCIs' value and benefits to their practices.

Recommendations:

Continue the learning collaborative model

- Many respondents acknowledged this program was a pilot and therefore was "working out the kinks," but they also made suggestions for improvement. They asked for the language and certification testing to immediately follow the learning collaborative, rather than having such a long time period between the two. See the full recommendations on pages 30–32.

Strengthening the learning collaborative training

The SIM-funded training enhanced the HCI workforce. However, there is still a high unmet demand for interpreters, especially for lesser diffused languages in some regions of the state. Increasing the supply of trained interpreters statewide will be important as the state's population becomes more ethnically diverse. Securing other funding streams to continue this training will help ensure access to culturally appropriate health care services for the state's growing LEP populations.

Removing financial barriers

- There is a need for direct Medicaid reimbursement for interpreter services. Doing so will help address most of the systems-level and individual-level problems to the training and effective use of interpreters in the health system.

Technical assistance

- Health systems and everyone who uses interpreters need education about the value of using trained interpreters.

Background

In February 2013, the Centers for Medicare and Medicaid Innovation (CMMI) awarded the Oregon Health Authority (OHA) a State Innovation Model (SIM) grant of $45 million over three years. The grant supports states taking innovative approaches to improving health and lowering costs across the health care system, including Medicaid, Medicare, and the private sector. Oregon was one of six states to receive the grant to reduce costs, improve quality and spread coordinated care, all of which align with Oregon's Triple Aim to create a health system that:

- Improves the lifelong health of all Oregonians;
- Increases the quality, reliability and availability of care for all Oregonians; and
- Lowers or contains cost of care so it is affordable for everyone.

The grant supported Oregon's ongoing health system transformation by strengthening, supporting and expanding the coordinated care model for Medicaid and other payers, and facilitating partnerships to reduce inequities.

A portion of the grant was allocated to OHA's Office of Equity and Inclusion (OEI) for the Strengthening the Health Care Interpreter (HCI) Workforce project. The purpose of this project was to increase the number of qualified and certified HCIs in Oregon and to better understand the barriers to using HCIs in health care settings.

Need for the project

Providing culturally and linguistically appropriate care with high quality health care interpretation is a fundamental strategy to ensure equitable health care delivery and, ultimately, to eliminate health disparities. Research demonstrates that language barriers between patient and provider greatly affect health care and, consequently, restrict the ability of limited English proficiency (LEP) patients to obtain quality health care. (1,2,3) Research shows that the use of language services, such as interpretation by qualified or certified HCIs, improves cross-cultural communication. This leads to enhanced patient access to care, increased compliance with recommended treatment plans and overall reduction of health care costs.

Ultimately, quality health care interpretation can help reduce disparities and improve health outcomes. (4)

Health care interpretation is no longer only a concern for large medical centers; it is an issue facing all clinics, health centers and physicians' offices. Title VI of the

Federal Civil Rights Act requires that all health system and service providers (including health plans, hospitals and clinics) accepting any federal funds (i.e., Medicaid, Medicare) must provide free language access services (e.g., interpretation services, translated materials) to all LEP clients. To comply with the requirements under Title VI of the Civil Rights Act, Oregon passed statutes requiring coordinated care organizations (CCO) use qualified or certified HCIs.

Interpreting role play

However, many CCOs lack sufficient numbers of qualified or certified HCIs to provide effective health care to their patients and to comply with the new statute. Simultaneously, Oregon's demographic composition is rapidly changing, resulting in increased demand for HCIs. In 2012, OHA estimated there were approximately 3,500 individuals providing health care interpreter services but, of those, only 44 were qualified or certified based on Oregon's requirements.

Description of the HCI project

Evidence clearly showed that Oregon lacked the ability to meet the need for qualified and certified interpreters. Based on feedback and informal assessments with HCIs working in Oregon, OEI understood some of the barriers to becoming qualified or certified were financial, training availability and testing preparation. OEI attempted to remove the financial barrier by supporting the cost of health care interpreter training and requisite testing by forming a subsidized HCI learning collaborative (LC). In addition, OEI developed several criteria for the learning collaborative series, including use of a state-approved curriculum, limited cohort size and additional practice activities and preparation for testing.

The objectives of the learning collaborative model for developing Oregon's HCI workforce were to:

1. Conduct a learning collaborative series with three or more cohorts over the project period.
2. Recruit cohorts of health care interpreters, untrained interpreters and others interested in joining the HCI workforce.
3. Increase the number of qualified or certified HCIs by a minimum of 150 over the project period.

OEI contracted with the Immigrant and Refugee Community Organization (IRCO) to provide 64 hours of HCI learning collaborative trainings with no more than 35 participants in each cohort. IRCO conducted 48 hours of training in a six-day in-person format and 16 hours of online training (see curriculum topics below in Learning Collaborative Section). OEI also contracted with two certification testing agencies, the National Board of Certification for Medical Interpreters (NBCMI) and the Certification Commission for Healthcare Interpreters (CCHI), and two language testing companies, Language Line Solutions and Language Testing International, to provide language and certification testing for participants who completed the collaborative.

Evaluation

OEI contracted with Program Design and Evaluation Services (PDES) to conduct this evaluation. PDES is a research and evaluation unit within both the Multnomah County Health Department and Oregon Health Authority. This evaluation covered all six learning collaborative series over the course of the SIM grant period and addressed the following three questions:

- Does the learning collaborative model increase the number of qualified and certified HCIs?
- What additional barriers/challenges do HCIs face in the qualification/certification process?
- What are the systems barriers or challenges (for CCOs and health care providers) to using qualified or certified HCIs?

Methods

We used a mixed-methods approach to evaluate process, formative and outcome measures related to the learning collaborative training. PDES collected quantitative data through a variety of methods:

- Surveys conducted at appropriate time points during each learning collaborative to assess participant satisfaction, applicability of training to interpreters' profession and recommendations for improvement;
- Process data, collected by the trainers, including target language, attendance records, pre- and post-test scores, and demographic information; and
- HCI Registry data submitted by OHA to assess achievement of qualification and certification standards and registration.

PDES collected qualitative data through semi-structured phone interviews with key informant HCIs approximately 6–12 months after they completed the learning collaborative series. The interviews assessed the learning collaborative's benefits and how it contributed to their qualification or certification efforts.

This report combines findings from all of the above data collection tools, resources and methods to address the above-mentioned evaluation questions.

Learning collaborative

OEI issued a request for proposal for an organization to provide culturally and linguistically appropriate training for HCIs attempting to be qualified or certified according to Oregon's standards. As mentioned above, the training had to use a state-approved curriculum with a cohort no larger than 35 participants. The training also had to include additional practice opportunities and testing preparation. A committee of stakeholders, program representatives and the program evaluator scored proposals to determine the best fit for the needs of the program.

OEI contracted with IRCO to conduct the learning collaborative series using an OHA-approved curriculum (Bridging the Gap) developed by the Cross Cultural Health Care Program in Seattle, WA. The curriculum, provided in English, trained multiple-language speakers and included language-specific practice. HCI participants were recruited statewide and selected through an application process. (See Appendix A for application.)

Table 1: Curriculum for the HCI learning collaborative

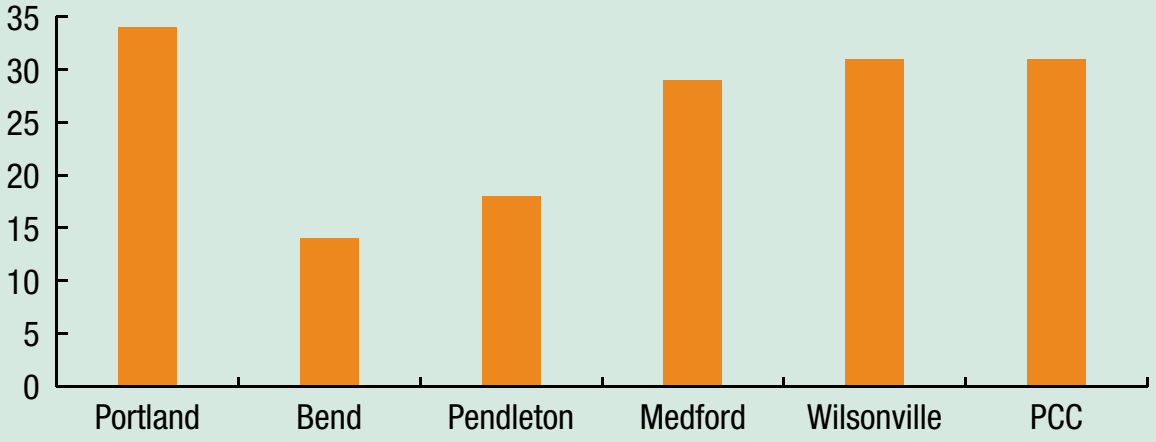
Bridging The Gap curriculum topic	Delivery method
Day 1 — Roles of the Interpreter • Medical Terminology for Medical Interpreters	Online
Day 2 — Modes of Interpreting • The U.S. Health Care System • Professional Conduct and Self Care • Medical Terminology for Medical Interpreters Cont'd	Online
Day 3 — Interpreter Skills (Part I) • Being a Conduit • Communicating Effectively through an Interpreter	In-person
Day 4 — Medical Interpreter Codes of Ethics • Advocacy • Confidentiality • Cultural Competency • Impartiality • Professionalism • Respect • Ethical Decision Making • Case Studies	In-person
Day 5 — Communication and its Impact on Interpreting • Intervening for the Purpose of Clarifying • Managing the Flow of the Session	In-person

Bridging The Gap curriculum topic	Delivery method
Day 6 — Interpreter Skills (Part II) • Memory Development • Sight Translation • Introduction to Culture	In-person
Day 7 — Culture and Advocacy • The Culture Broker Role • Pain Descriptors • Defining the Advocate Role • Effective Advocacy and the Controversy Surrounding It	In-person
Day 8 — Review and Final Exam • Telephonic and Video Remote Interpreting	In-person

Demographics

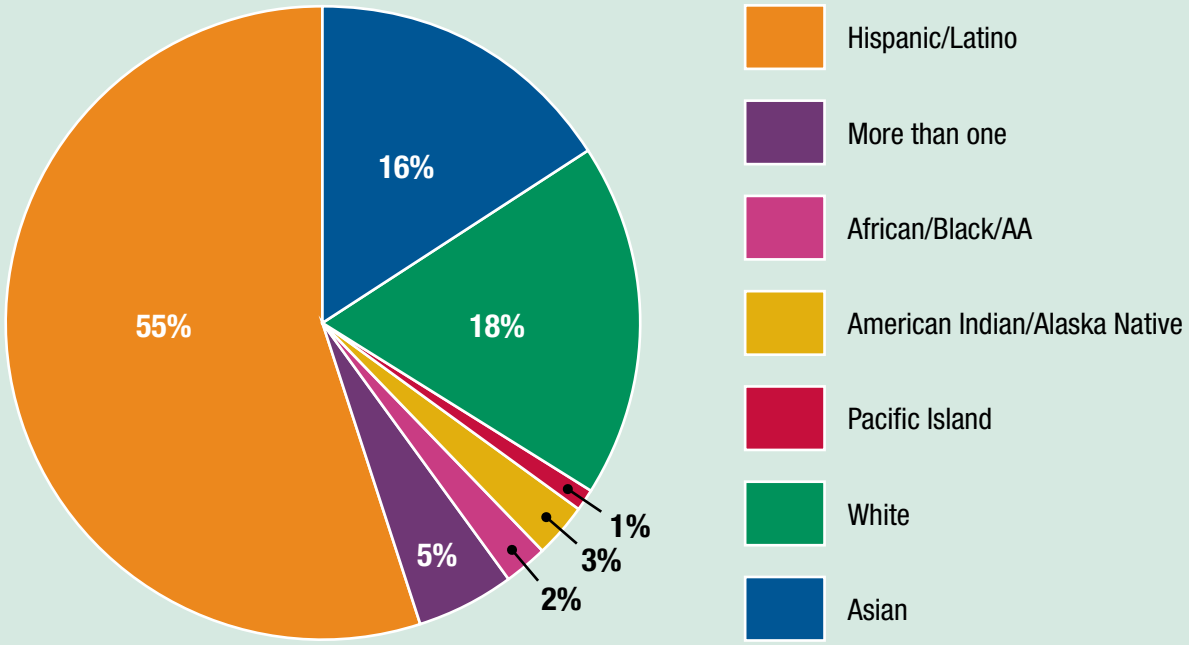
A total of 169 HCIs registered and participated in at least part of the learning collaborative series, but only 157 completed the entire 64-hour training. In an effort to reach the most HCIs, OEI conducted the learning collaborative series in various locations around the state of Oregon: Portland, Bend, Pendleton, Medford, Wilsonville and Portland Community College (PCC). Originally, OEI and IRCO contracted for five learning collaborative series; however, due to the demand, one additional training was included for a total of six trainings. This report will refer to the series' locations in order to differentiate between them.

Figure 1: Number of participants per LC location, N=157



Participants were asked to complete a demographic form at their first in-person session. The forms were optional and anonymous; not all participants responded and it is impossible to limit responses to those who completed the training series. Figure 2 provides a snapshot of 155 of the 169 HCIs who participated in, but did not necessarily complete, the entire 64 hours. More than half (55%) identified as Hispanic/Latino, followed by 18% White, and 16% Asian. More than half (52%) were 34 years or younger and over three-quarters (78%) were female.

Figure 2: Participants' race and ethnicity



The learning collaborative pre- and post-tests identified target language, i.e., the language in which the HCI interprets. Ten participants identified more than one target language. The pre- and post-tests identified primary target languages (see Table 2) and an additional five secondary target languages. Because of the overlap in primary and secondary target languages, the learning collaborative series represented 19 languages. Spanish was the most common with 71% of the participants identifying it as their primary target language, followed by 8% Vietnamese and 7% Russian. Of the 10 participants who identified secondary target languages, five identified Ukrainian, and one each identified Russian, Vietnamese, Mandarin, Dari or Kurdish as their second target language.

Participants took pre- and post-tests in order to assess knowledge gained over the course of the learning collaborative series. The tests, conducted at the first

and last in-person sessions, were part of the Bridging the Gap curriculum. IRCO administered and scored the tests. Anonymous test scores did not identify individual participants. **The average pre-test score was 59%, ranging from 13 to 100%, and the average post-test score was 90%, ranging from 20 to 100%. The majority of participants** (98%) **scored 75% or higher on the post-test.**

Satisfaction

Surveys, administered at the end of each session of the learning collaborative, assessed satisfaction with the facilitation and content. The overall response rate for all of the daily surveys was 85%, with a range between 38 and 100%. IRCO received individual summaries of the daily evaluations as a method of continuous quality improvement. Table 3 below shows the overall levels of satisfaction for all six learning collaborative series. **Clearly, respondents were very satisfied, with 97–99% of the respondents strongly agreeing or agreeing with the six elements of satisfaction.** Not all percentages will sum to 100% because there was a "no opinion" answer category that is not included in the table, though only a few respondents used it.

Table 2: Primary target language, N=169

Primary target language	Percentage of total learning collaborative participants from each language group
Spanish	71%
Vietnamese	8%
Russian	7%
Arabic	3%
Cantonese	3%
Persian	2%
Hindi	1%
Amharic	<1%
ASL	<1%
Burmese	<1%
Cambodian	<1%
Chinese	<1%
Korean	<1%
Romanian	<1%
Swahili	<1%

Table 3: Participant satisfaction

	Strongly agree/ agree	Disagree/ strongly disagree
I could clearly hear the presenter.	98%	2%
The material was clearly presented.	98%	2%
The presenter encouraged participation from all students.	99%	1%
The presenter's facilitation style contributed to my learning experience.	97%	2%
The presenter answered all of my questions.	97%	1%
The information in this training is relevant and applicable to my work as a health care interpreter.	99%	<1%

On the final day of the learning collaborative series, participants were given an additional survey to assess their overall expectations and satisfaction with the learning collaborative training experience. Their responses are summarized in Table 4. **Again, 97% or more of the respondents indicated the four different elements either met or exceeded their expectations.**

Table 4: Participants' expectations

	Exceeded expectations	Met expectations	Did not meet expectations
Content of training	64%	34%	1%
Training materials	61%	37%	1%
Training space	63%	34%	3%
Presenter's training style	58%	41%	0%

Finally, 99% of the respondents felt the learning collaborative would help them become a qualified or certified HCI. The daily evaluation surveys asked about the most valuable elements of that day's session. Aside from appreciating the opportunity to attend the training, the responses fell into two categories: classroom experience and actual curriculum content.

In terms of the classroom experience, respondents valued the role-playing and other practical experiences that helped reinforce learning; the opportunity to learn from others and hear about their experiences including class discussions; and interactions with other interpreters.

For the session content, respondents found the following to be most valuable: learning medical terminology and the review of the body systems; learning about the roles of an interpreter, including the difference between interpretation and translation; the code of ethics; modes of interpretation and when they are appropriate; and cultural competency. In addition, respondents appreciated learning specific and practical skills, such as techniques to improve memory, positioning, rules around advocacy, and getting out of uncomfortable situations. Many participants responded that "everything" was valuable.

However, 27% indicated they faced barriers to becoming qualified or certified. The most common barriers mentioned were:

- Financial (though some respondents also mentioned appreciation that OEI was paying for the training and testing, others described the training as a forfeiture of income since they could not work during that time period);
- Lack of time to complete the 64 hours of training; and
- Accumulating or proving work experience needed to be certified or qualified.

The final overall evaluation survey also asked what respondents would do differently when interpreting because of this learning collaborative. They mentioned a variety of practices (in order of most- to least-often mentioned): conduct a pre-session, act more professionally, "do everything better," clarify role as an interpreter, be more of a conduit than an advocate, and not stay alone in rooms with patients.

Qualification and certification process

Oregon has two different types of credentialing –– qualification and certification –– to acknowledge a candidate is properly trained for health care interpretation. OEI is responsible for determining that candidates have met appropriate standards to qualify or certify an HCI. OEI also maintains the Oregon HCI Registry.

Qualification, the less rigorous standard, is available for those languages of lesser diffusion. Certification, which is more rigorous, is available for seven languages: Arabic, Cantonese, Korean, Mandarin, Russian, Spanish and Vietnamese. Both standards require candidates to complete 60 hours of an approved training curriculum, 15 (for qualification) or 30 (for certification) hours of documented interpreting experience, and proof of English proficiency and/or proficiency in the interpreted (i.e., target) language, either through experience or language testing (See Appendix B for requirements). To become qualified, HCIs must submit to OEI an application and the appropriate documentation proving language proficiency. For those HCIs pursuing certification, they must also pass a certification test (written and oral) from an OHA-approved testing center. Both credentials –– qualification and certification –– are valid for three years. (See Appendix C and Appendix D for flowcharts of the process for learning collaborative participants to become qualified and certified.)

Additionally, Oregon recently passed a new policy whereby HCIs whose target language is certifiable must be certified within three years of qualification; if the HCI does not pass the certification exam within three years, that person will be removed from the registry. Essentially, all currently registered HCIs who interpret a certifiable language must attain certification at their next renewal in order to remain on the HCI Registry. Qualification will not be sufficient if their target language is certifiable.

As part of this SIM Strengthening the HCI Workforce project, candidates who completed the IRCO learning collaborative series were eligible for the following series of testing to complete their HCI qualification or certification credentialing:

- Language proficiency and certification if their target language is certifiable;
- Language proficiency testing only if their target language is not certifiable.

Outcomes

The SIM sponsorship for this learning collaborative project officially ended May 31, 2017. Because testing occurs in a specific sequence with waiting periods between each test, there are candidates still in process; therefore, the data presented in tables 5, 6 and 7 are as of June 1, 2017.

There were 29 (18%) participants certified, 26 (17%) qualified and 37 (24%) still in the process of testing. Sixty-five participants (42%) did not access the testing opportunities provided by OEI. Of those 65, there were 42 participants who did not contact OEI for testing and another 23 whose contact information had changed and were therefore lost to follow-up.

Table 5: Certified HCIs by target language, N=29

Language	Number of certified trainees	Percentage of certified trainees
Spanish	27	93%
ASL	1	3%
Korean	1	3%

Table 6: Qualified HCIs by target language, N=26

Language	Number of qualified trainees	Percentage of qualified trainees
Spanish	12	46%
Vietnamese	5	19%
Amharic	2	8%
Hindi/Punjabi	2	8%
Arabic	1	4%
Korean	1	4%
Persian (Farsi)	1	4%
Russian	1	4%
Swahili	1	4%

Table 7: HCIs in testing process by target language, N=37

Language	Number of trainees still testing	Percentage of trainees still testing
Spanish	25	68%
Russian	5	14%
Cantonese	3	8%
Vietnamese	3	8%
Korean	1	3%

Testing challenges

Unanticipated challenges to the testing process might explain the low numbers of successful qualification and certification. First, several participants experienced unforeseen circumstances that impeded their ability to pursue testing. Second, OEI's attempts to contract with two testing agencies, NBCMI and CCHI, met with many barriers, including approval and release of funds that significantly delayed the availability of certification and language testing.

Given the delay and in an effort to support the process, OEI made considerable attempts to encourage testing once funding became available. The program:

- Sent five emails at various intervals to encourage participants to complete testing;
- Spoke directly to trainees to answer questions and address concerns;
- Worked with peers from each cohort to spread the word about certification testing; and
- Conducted two phone banks to call and remind participants to schedule and complete their testing.

Throughout this process, OEI received a variety of explanations for why some participants chose not to pursue testing. A summary of these reasons include:

- Delay in the testing availability caused some candidates to lose interest or trust in the process.
- The passing rate for certification exams, which varies by language, created testing anxiety and fear. Even though the training design prepared participants for testing, there remained a fear of failure for some.
- The initial design of the program and policy to offer only one testing opportunity per participant may have been a disincentive. Based on this feedback, OEI offered re-testing to some applicants who failed initial testing.
- Unforeseen circumstances:
  - » Social: bereavement, relocation from the state, travel abroad.
  - » Medical: sickness, declining health.
  - » Personal: career change, disinterest in the process, work and family commitments.
  - » Loss to follow-up: contact information changed and, despite repeated attempts, OEI was unable to locate participants' current information.
  - » Technical issues with scheduling and taking tests.

Participant key informant interviews

Purpose

The purpose of the in-depth participant interviews was to delve deeper into the participants' satisfaction with the program, learn more about the program's impact on their qualification or certification process, and better understand their perspective on health systems' barriers and facilitators to using HCIs.

Methods

We used a purposeful sample design in which PDES categorized participants by whether they were qualified, certified or in process. After a few initial interviews, two more categories were included. PDES interviewed a sample of participants from the following categories:

1. Those who completed the process and were qualified;
2. Those who completed the process and were certified;
3. Those still completing the process of becoming certified or qualified;
4. Those who speak a certifiable language but only completed the process for qualification; and
5. Those who chose not to pursue any credentials.

PDES scheduled and conducted the interviews by telephone. PDES interviewed 19 participants, 84% of whom were female. The average age was 41 years (range was 22–65 years). Target languages for the respondents were Spanish, American Sign Language (ASL), Arabic, Cantonese, Russian, Swahili and Vietnamese. (See Table 8.)

Two respondents whose target language was Spanish and one whose target language was Russian were qualified; however, they were also trying to become certified because both languages are certifiable. The remaining three Spanish-speaking qualified HCIs had unique situations. One acknowledged she was not confident in her

Table 8: Categories of respondents, N=19

Target language	Status	Number
Spanish	Qualified	5
	Certified	4
	In process	2
	Not testing	2
ASL	Certified	1
Arabic	In process	1
Cantonese	Not testing	1
Russian	Qualified	1
Swahili	Qualified	1
Vietnamese	Qualified	1

Spanish language skills and therefore wanted more time before certification testing. For the other two, interpretation was not their primary goal. They participated in the learning collaborative as a way to enhance their interpretation skills; however, they did not intend to become certified because they did not see certification as necessary given their primary employment was not interpretation.

Findings

This section presents themes identified during analysis of the interview transcripts. Themes represent the views of multiple individuals. Quotes that illustrate and allow the participants' voices to describe a theme are included in italics. Quotes provide good examples of themes, but are not exhaustive. Opinions or thoughts expressed by only one or two individuals are minor themes indicated in the description.

Theme: The learning collaborative sufficiently prepared HCIs for testing.

Although we heard from 99% of the respondents upon completion of the learning collaborative series that they felt sufficiently prepared for the credentialing process, we wanted to hear from HCIs after they completed the process. All but one respondent agreed the learning collaborative series sufficiently prepared them; however, a few voiced exceptions or caveats to their positive response. Their reasons did not specifically relate to the training but were more about the process of becoming qualified or certified. For example, some who had years of experience felt the learning collaborative was not necessary. Others felt too much time had passed between the collaborative and the testing. It is important to note that the few respondents who felt they had a level of expertise that rendered the collaborative "unnecessary" still found the series beneficial because they experienced a resurgence of energy for their work and an appreciation for the best practice reminders.

> *I was an interpreter before I did the training, but I learned so much. I wish all interpreters can go through this because there are lots of interpreters who need it ... There is a need to improve the professionalism of the HCI field and this training is very helpful for that.*

> *The program is great, especially for those who can't afford the training. It's good for polishing skills of experienced HCIs.*

Theme: Being in the collaborative improved job satisfaction.

The majority of respondents felt their jobs as HCIs had changed since the collaborative. All but two said it had definitely changed for the better. Examples included improved HCI skills; improved HCI service quality; increased feelings of confidence, job satisfaction, empowerment and energy; and increased pay. A few

mentioned they felt the practitioners they work with treated them differently and three improved their employment by moving into better jobs.

To me, it's been like a renaissance ... I changed jobs and am getting paid more. I feel very much more empowered in my career trajectory. Providers feel more confident they're being provided a good service. I am a professional interpreter and represent myself as such.

I am a better interpreter for it. Because I got qualified my pay increased. I got a $3 bump. I just clock in with a different time code when I interpret.

There was no change in my work, I just feel better prepared. Training helped me to know the terminology and the nuances that even though I grew up bilingual, are helpful to know.

Theme: Challenges exist to interpretation in the health care system.

Although participants had a wide variety of HCI experience and employment, most responded similarly when asked about how the health care system supports the use of HCIs. First, when asked about support within the system, the responses mostly addressed barriers, or lack of support. Very few respondents mentioned anything supportive about the health care system and using HCIs. A few respondents felt health care system providers' awareness and support of HCIs has improved. However, the majority felt health care practitioners need more education about:

- The benefits of using a qualified or certified HCI;
- The requirements and legal mandates for providing appropriately trained HCIs; and
- Best practices on how to effectively incorporate an HCI as part of the health care team.

Providers don't understand, or are not aware of the research showing why you need qualified or certified health care interpreters. Sometimes they use family, but they don't understand why it's not OK to use family.

There isn't training for the providers (medical assistants, doctors, nurses, etc.). Sometimes they think we're going to interpret simultaneously. There should be more training for them so they're more aware that it will take more time. We should be educating the health care team on best practices for working with health care interpreters.

Several mentioned financial constraints, both at a systems level and at an individual HCI level. On a system level, a few respondents felt that some clinics or offices try to limit spending on "another professional," or they do not understand how to schedule sufficient time for appointments requiring interpretation. On an individual level, one respondent pointed out that HCIs have many requirements to fulfill in order to become credentialed. While that can be a good thing because it ensures professional

and well-qualified HCIs, the HCI does not always recoup the financial benefits. Similarly, one respondent was reluctant to ask for more money since she became certified for fear she would have fewer appointments due to higher operational costs to her employer.

> *We (HCIs) have all these hoops we have to jump through to become qualified or certified, which is great because it raises the professionalism. But, it has to be worth it for the HCI and, right now, it doesn't seem it is.*

> *There should be some enforcement. It's the law that agencies need to send qualified/certified HCIs and agencies aren't doing it. People who are qualified or certified should get paid more but agencies don't use them as much because it costs them more. They send the non-qualified or certified HCI because they're cheaper.*

A few mentioned seeing system improvement, especially after a practitioner has experienced the benefits of using a trained HCI firsthand. One respondent felt that the Title VI mandate to use qualified or certified HCIs benefitted everyone because clinics provided better interpretation services in order to fulfill the requirement. Two respondents embedded in their clinics as HCIs felt that was beneficial because it allowed time to develop a relationship with the team, thus encouraging mutual respect. However, they also indicated it was problematic finding HCIs for languages of lesser diffusion. One also mentioned the technology barrier when relying on skype or telephonic interpretation, especially in areas where there is limited service connection.

> *In the clinic where I'm working, it's very good. Being in the same clinic the providers and the interpreter know each other and work well together. There is a mutual respect and understanding of what needs to happen.*

Theme: Appreciation for the opportunity

Overall, when asked if there was anything else they wanted to discuss about the program, respondents overwhelmingly mentioned their appreciation for the "opportunity" to participate in the learning collaborative series. The respondents greatly appreciated that the grant removed the financial barrier of training costs, and a few mentioned they likely would not have otherwise attempted to get the required training hours.

> *It helped me prepare. For me, it had been a while since I worked as an HCI so it was a fantastic refresher. Plus I needed the hours to get qualified ... Having the costs covered made the biggest difference. I would not have been able to do it if I had to pay out of pocket.*

> *Overall the program was great. I really liked the schedule, that you could complete it in six days, which is much more preferable to extending it over months or having to take it on weekends. The instructors tried to answer all the questions even for the new interpreters. It was great.*

Theme: Key informants' recommendations

Learning collaborative training session

Many respondents acknowledged this program was a pilot and therefore was "working out the kinks" but, with that in mind, they also made suggestions for improvement. They asked for the language and certification testing to immediately follow the learning collaborative, rather than having such a long time period between the two. Several also suggested the process be streamlined and communication about it be clearer. Some mentioned difficulty reaching OEI or a lag time in receiving a response. A few also suggested possibly grouping languages together for the learning collaborative; however, they also saw benefits to being with participants with a variety of experiences, including a variety of languages.

A few people mentioned issues that may be worth researching in the future. One person mentioned that since the testing pass rate for some languages is so low, HCIs are disinclined to pay for it for fear they will fail the test and see it as a waste of money. Additionally, for those low pass-rate languages, there is little opportunity for them to practice and hone their skills. Another issue raised was that interpretation agencies tend not to provide training for their contracted HCIs, who the agencies see as independent workers. Therefore, HCIs are expected to pay for training out of pocket, in addition to taking time away from paid work opportunities, in order to fulfill training requirements and participate in continuing education.

Limitations

Learning collaborative training session

These results are based on several sources of data that provide an overall picture of the Strengthening the HCI Workforce program. However, there are some limitations to the data. First, the self-administered surveys were anonymous, so we were unable to identify and account for any differences between respondents and non-respondents; therefore, the data may not reflect the non-respondents' views, opinions or experiences. Second, some of the quantitative data are presented as averages or percentages, so the individual responses for some questions may vary in range. Third, the responses for each of the surveys represent a specific point in time. Finally, qualitative interviews were conducted with a purposeful sample. While there was an attempt to reach a variety of respondents, their responses may not represent the experiences or opinions of all learning collaborative participants.

Discussion

This project had many successful outcomes, including:

- 6 HCI trainings completed in geographically diverse areas of Oregon;
- 157 participants completed 64 hours of HCI training;
- Near consensus among participants (99%) that the training sufficiently prepared them for testing;
- A 53% average improvement from pre-test to post-test among training participants;
- At least 97% of the respondents satisfied with the content, organization, presentation and logistics of the trainings;
- 97% indicating their expectations were either met or exceeded by the training;
- 26 qualified and 29 certified HCIs added to the HCI Registry;
- Identification of system challenges for using HCIs from the interpreter perspective; and
- Collected baseline data helpful for determining next steps for developing the HCI workforce.

Although several barriers prevented the achievement of the third project goal of increasing the number of qualified or certified HCIs by a minimum of 150 over the project period, the project successfully trained 157 participants. Fifty-five of the trainees are currently certified or qualified. We expect this number to increase because some of the 37 trainees who are at different stages of testing may be able to pay for and complete their testing. Also, the training itself contributed to HCI workforce development even though many participants chose not to be qualified or certified. From the qualitative interviews, even those HCIs who were not attempting to be qualified or certified mentioned feeling empowered and better prepared to provide professional and high-quality interpretation services regardless of their certification status. As a result, the training enhanced the overall workforce despite the lack of participants being credentialed as qualified or certified HCIs.

The U.S. Department of Health and Human Services' (HHS) Office of Minority Health established the National Partnership for Action to End Health Disparities (NPA). Its report, "National Health Disparities Plan and Regional Blueprints for Action," (5) draws attention to the need for a comprehensive, community-driven and sustained approach to combat health disparities. In order to achieve that goal, the NPA highlights the significance of strategies such as requiring interpreters and bilingual staff providing services in languages other than English in accordance with the national interpretation standards, investing in authentic community-based participatory research, and funding community-originated intervention strategies for ending health disparities and capacity development at the local level. By establishing qualification and certification standards for HCIs that are more rigorous than the federal standard, Oregon is paving the way to ensure well-trained and professional HCIs provide quality interpretation services to the populations with the greatest health disparities.

OEI's project, Strengthening the HCI Workforce, was designed to address health disparities and improve health outcomes for all Oregonians, specifically populations that may be marginalized and face barriers to accessing health care because of their limited English proficiency. However, the project's theory of change relied on the assumption that by reducing or eliminating the most common individual barriers HCIs face to becoming qualified or certified (financial constraints, inadequate training opportunities, and lack of time and experience), more HCIs would achieve qualification or certification.

However, this evaluation suggests the need for addressing additional systems-level problems in order to achieve the goal of increasing the number of qualified and certified HCIs. The HCI workforce is diverse and varied with HCIs providing interpretive services in myriad ways:

- Through contracts with specific interpretation agencies that act as intermediary between the health care providers, the LEP patient and the HCI;
- As self-employed freelance interpreters;
- As interpreters embedded in a hospital or clinic setting; or
- As employees whose primary role is unrelated to interpretation but are called upon as needed to provide interpretation services.

Regardless of the method of initiating an HCI's services, the more significant issue is that using a trained HCI is important to improving health outcomes for LEP patients. While most respondents were satisfied with their employment, many felt there was room for improvement in the overall health care system. The health

care system has its own barriers or challenges to using qualified or certified HCIs, and respondents agreed that OEI must not only strengthen the HCI workforce but also address the need for educating health care practitioners on best practices for using HCIs. While HCIs are very aware of the importance of their work, especially when done professionally by a certified or qualified HCI, not all in the health care system understand or comprehend the impact on the health of their patients when interpretation lacks quality and professionalism.

Learning collaborative training session

Recommendations for program

This project achieved several good outcomes while successfully addressing some individual-level barriers. As a result, Oregon's HCI workforce more than doubled the number of trained HCIs available to LEP patients and the health care system. However, there continues to be a multiplicity of barriers preventing Oregon from reaching its goals. The following recommendations should be considered in OEI's efforts to improve future trainings and address systemic barriers.

Continue the learning collaborative model

If enhancing the HCI workforce continues to be an OEI goal, OEI should continue to support ongoing training opportunities. This project was a very good start as it successfully addressed and reduced individual-level barriers by funding the learning collaborative model. If OEI were to continue using the model, the primary recommendation would be to incorporate some modifications (see below) and expand efforts to address systems-level barriers as well.

Streamline the process

The process for applying to the training should be clear and available on the website with an electronic application. Additionally, if OEI's goal is to increase the number of qualified and certified HCIs, it might be helpful to have a more strict recruitment process offering the training only to HCIs seeking qualification or certification, or requiring applicants sign an agreement committing to full completion of the training and credentialing process, or even ensure applicants complete certain prerequisites. In addition, the testing process should be immediately available upon completion of the training.

Address financial barriers

Though many participants indicated the cost of training had been a barrier and expressed appreciation to OEI for eliminating that barrier, a few participants mentioned their employer planned to pay for their testing if they did not complete the process within the OEI timeframe. That implies some employers are willing to cover at least a portion of the cost of the process. Perhaps OEI could add a few questions to the training application about benefits employers offer to assist with the certification process. Additionally, OEI could provide scholarships to those applicants paying

out of pocket. This information would be useful for tracking the financial burden among HCIs and the level of organizational or agency investment in the training and certification process.

Raise awareness and educate about HCIs' value

Many participants expressed concerns about the barriers to their work in the health care system and felt OEI could help raise awareness of the value of using qualified and certified HCIs.

> *OEI needs to be working with organizations to help them understand the value of using a trained HCI.*

In addition, several also mentioned helping health care practitioners understand best practices and how to effectively engage with an HCI to enhance services provided to the LEP patient as well as the benefits to the practitioner. They often referred to their work as being a part of a "health care team." However, it seems there is a wide spectrum of understanding among health care practitioners about how to include the interpreter as part of the "team" and respondents felt OEI is in a position to educate health care practitioners and address other systems' barriers.

Enhance the program

In a perfect world, where funding is not an issue, a robust HCI program might include two areas of focus: the health care community and the HCI community. One component would interface with the health care community to advocate, answer provider questions, negotiate contracts, educate consumers (providers, schedulers, patients), address barriers and facilitate meetings to discuss issues and barriers. Another component would focus on the HCI community and the registry itself, which is not straightforward given the extensive range of languages, cultures and experience. Activities could include facilitating a forum for mentoring where experienced HCIs provide support or mentor new HCIs, coordinating continuing education, facilitating meetings and helping address barriers to training and becoming credentialed.

Provide continuing education

It is clear the participants gained much more than skills by participating in the training. They enjoyed an exchange among peers, an opportunity to learn from more experienced HCIs, and a reminder about best practices and professional conduct. It might be beneficial to the HCI workforce to periodically provide continuing education opportunities or an HCI forum as a way to address pertinent topics and discuss the latest issues.

Strengthening learning collaborative training

The SIM-funded training enhanced the HCI workforce. However, there is still a high unmet demand for interpreters, especially for lesser diffused languages in some regions of the state. Increasing the supply of trained interpreters statewide will be important as the state's population becomes more ethnically diverse. Securing other funding streams to continue this training will help ensure access to culturally appropriate health care services for the state's growing LEP populations.

There is a need for direct Medicaid reimbursement for interpreter services. Doing so will help address most of the systems-level and individual-level problems to the training and effective use of interpreters in the health system.

Further study

Some of the respondents mentioned the low pass rate for some languages, e.g., Vietnamese, Russian and Arabic, as possible barriers to testing. It might be helpful to better understand why the testing pass rate varies significantly between languages and how OEI can support those HCIs whose target language has a lower pass rate.

Another possible area of future study would be to work with specific health care systems to better understand and address their barriers to using qualified and certified HCIs. While the distribution of interpreters varies widely across the state, adding more qualified and certified HCIs is likely only part of the solution to this complex problem.

Endnotes

1. Green AR, et al. Interpreter services, language concordance, and health care quality. Journal of General Internal Medicine, 20 (2005): 1050–1056.
2. Jacobs E, et al. The need for more research on language barriers in health care: A proposed research agenda. Milbank Quarterly, 84 (2006): 111–133.
3. Karliner LS, et al. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Services Research, 42 (2007): 727–754.
4. Perkins J, Youdelman M. Summary of state law requirements addressing language needs in health care. National Health Law Program. The California Endowment; 2008 January.
5. National Partnership for Action to End Health Disparities. Toolkit for community action. [cited 2017 July 13]. Available from: https://www.minorityhealth.hhs.gov/npa/files/Plans/Toolkit/NPA_Toolkit.pdf.

Health Care Interpreter Learning Collaborative Application

This 60-hour health care interpreter training will prepare interpreters to provide quality interpretation and improve the availability of trained interpreters in the state.

*All trainings are 64 hours long; this includes two days online and six days in person (from 9 a.m. to 5 p.m.).

Please answer the questions below and submit your responses to HCI.Program@state.or.us.

Name: _____

Address: _____

City, ST, ZIP: _____

Phone: (_____) _____ Email: _____

1. How did you hear about the Health Care Interpreter Learning Collaborative?

   _____

2. Have you already completed any portion of a health care interpreter training program? If so, which portions, how many hours and what training program?

   _____

3. In what languages would you be interpreting?

   _____

4. In what geographic region(s) would you be interpreting after completing the collaborative?

   _____

5. How many hours of work experience do you have as a health care interpreter?

   _____

6. Do you have access to a computer and internet to complete the online portion of the training?

   _____

Please check all that apply:

HCI qualification/certification requirements

Bilingual proficiency

❒ I am proficient in English and have documentation to prove this.

❒ I need financial support to get tested for language proficiency in the language I will be interpreting.

❒ I need financial support to get tested for language proficiency in English.

❒ I have already been tested for and passed language proficiency testing, or I meet the equivalency requirements for language proficiency (*see the attached Oregon Health Care Interpreter Program requirements*).

Health care interpreter certification testing

PLEASE NOTE: Testing for certification is only available for the following languages: Arabic, Cantonese, Korean, Mandarin, Russian, Spanish and Vietnamese. If you do not speak any of these languages, you can currently only become **qualified** as an interpreter.

❒ I need financial support to take the written certification exam only.

❒ I need financial support to take the oral certification exam only.

❒ I need support to take both the written and oral exams for certification.

I agree to take all required classes and take the language proficiency and certification tests prior to Sept. 30, 2016.

Signature Printed name Date

For more information, visit our website at www.oregon.gov/oha/oei or email HCI.Program@state.or.us.

You can get this document in other languages, large print, braille or a format you prefer. Contact the Oregon Health Care Interpreter Program at hci.program@state.or.us or 971-673-3328.

Oregon Health Authority | Office of Equity & Inclusion

Oregon Health Care Interpreter Program Requirements

Oregon's Health Care Interpreter Program includes two levels of credentialing (qualification and certification). A qualified or certified health care interpreter must meet all of the requirements listed below and provide all of the supporting documentation.

	Qualification	Certification
Requirements and documentation	• Must be at least 18 years of age. ☐ Copy of an Oregon driver's license or passport • Must not be on the Medicaid Exclusion List: http://exclusions.oig.hhs.gov/. ☐ Printout of search results. • Must pass a background check. • Must have at least 60 hours of formal health care interpreter training. ☐ Proof of successful completion of training at OHA-approved training center or equivalent • Must have language proficiency in English and the target language (see next page for more information). ☐ Proof of passing a language proficiency test at an approved testing center ☐ **Or**, demonstration of having met equivalent language proficiency requirements • Must have at least **15 hours** of documented interpreting experience. • $25 qualification fee payable (by check or money order) to OHA/OEI Health Care Interpreter Program (includes registration fee) • Send completed application and check to: Health Care Interpreter Program Office of Equity and Inclusion 421 SW Oak St. Suite 750 Portland, Oregon 97204	• Must be at least 18 years of age. ☐ Copy of an Oregon driver's license or passport • Must not be on the Medicaid Exclusion List: http://exclusions.oig.hhs.gov/. ☐ Printout of search results. • Must pass a background check. • Must have at least 60 hours of formal health care interpreter training. ☐ Proof of successful completion of training at OHA-approved training center or equivalent • Must have at least **30 hours** of documented interpreting experience. ☐ Proof of passing certification tests from one of the following: • National Board of Certification for Medical Interpreters • Certification Commission for Healthcare Interpreters • Oregon Court Interpreter Certification • Federal Court Interpreter Certification exams • American Sign Language (ASL) Certification • $25 certification fee payable (by check or money order) to OHA/OEI Health Care Interpreter Program (includes registration fee) • Send completed application and check to: Health Care Interpreter Program Office of Equity and Inclusion 421 SW Oak St. Suite 750 Portland, Oregon 97204
Valid period	Three years	Three years

*Oral certification test is available in Spanish, Mandarin, Cantonese, Russian, Korean, Arabic and Vietnamese.

Questions? Contact the Oregon Health Care Interpreter Program: hci.program@state.or.us, 971-673-3328, www.oregon.gov/oha/oei, or call us to schedule an appointment in person.

Oregon Health Authority | Office of Equity & Inclusion

Oregon Health Care Interpreter Program

Meeting the language proficiency requirements for HCI qualification and certification

Oregon Health Authority approved language proficiency testing centers include:

- Language Line University Level 3 or above ((Interavency Language Roundtable (ILR) equivalent, based on website information)).
- Language Testing International testing is based on American Council on the Teaching of Foreign Languages {ACTFL) assessment. Both the optional phone interpreter (OPI — telephonic) and OPIc (computer recording) are acceptable.
- The passing level for all language testing is advanced mid-level on the ACTFL scale.

Oral proficiency in both English and the non-English language (L2) may be demonstrated by passing any of the exams listed above (not expired) plus:

- Oregon Court Interpreter Registered status – not expired

One of the following may demonstrate oral proficiency in English:

- Bachelor, masters, doctorate or any other degree from any U.S. institution of higher education.
- Graduation from any high school in an English language speaking country where English is the primary language of instruction.
- Graduation from a higher education institution abroad where English is the primary language of instruction.
- One of the following tests (subject to change). Test results must be from no more than three years ago to be considered valid.
  - » Test of English as a Foreign Language (TOEFL): 570+ on paper; 230+ on computer version; 90+ on iBT
  - » Certificate in Advanced English (CAE), Level 4: B
  - » Certificate of Proficiency in English (CPE), Level 5: B
  - » International English Language Testing System (IELTS): 7.0+
  - » Interagency Language Roundtable (ILR): 2+
  - » Common European Framework (CEFR): B2
  - » Oral Proficiency Interview at the advanced mid-level on the ACTFL scale

One of the following may demonstrate oral proficiency in the non-English language:

- Bachelor, masters, doctorate or any other degree from an institution of higher education where instruction is primarily in the non-English language and the person submitting proof is a non-English language native speaker.
- Graduation from high school in a country where instruction is primarily in the non-English language and the person submitting proof is a native speaker of the non-English language.
- One of the following tests (subject to change). Test results must be from no more than three years ago to be considered valid:
  - » Interagency Language Round Table (ILR): 2+ from federal government testing agencies
  - » Common European Framework (CEFR): B2
  - » Oral Proficiency Interview at the advanced mid-level on the ACTFL scale

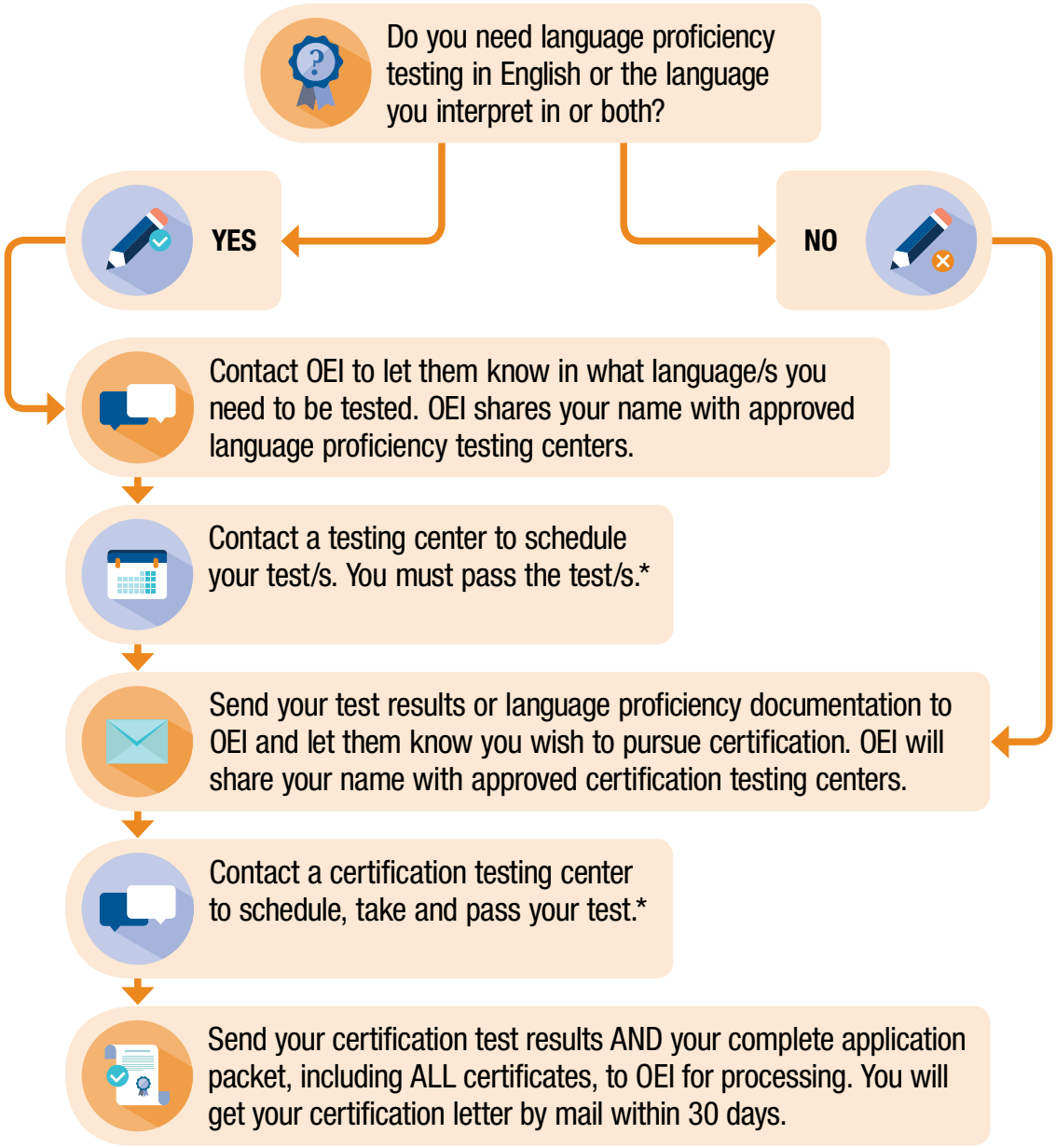
You can get this document in other languages, large print, braille or a format you prefer. Contact the Health Care Interpreter Program, Office of Equity and Inclusion, at 971-673-3328 (711 for TTY) or email hci.program@state.or.us.

OHA 8923 (7/2017)

Steps for Candidates Who Wish to Pursue Health Care Interpreter Certification

Oregon Health Authority

Certification is available only for those who interpret in Arabic, Cantonese, Korean, Mandarin, Russian, Spanish and Vietnamese.



**OEI will pay for your first language proficiency test (English and/or another language) and your first certification test. You will have to pay for any additional tests if you do not pass your first attempt on either test. ALL testing will end by September 2016.*

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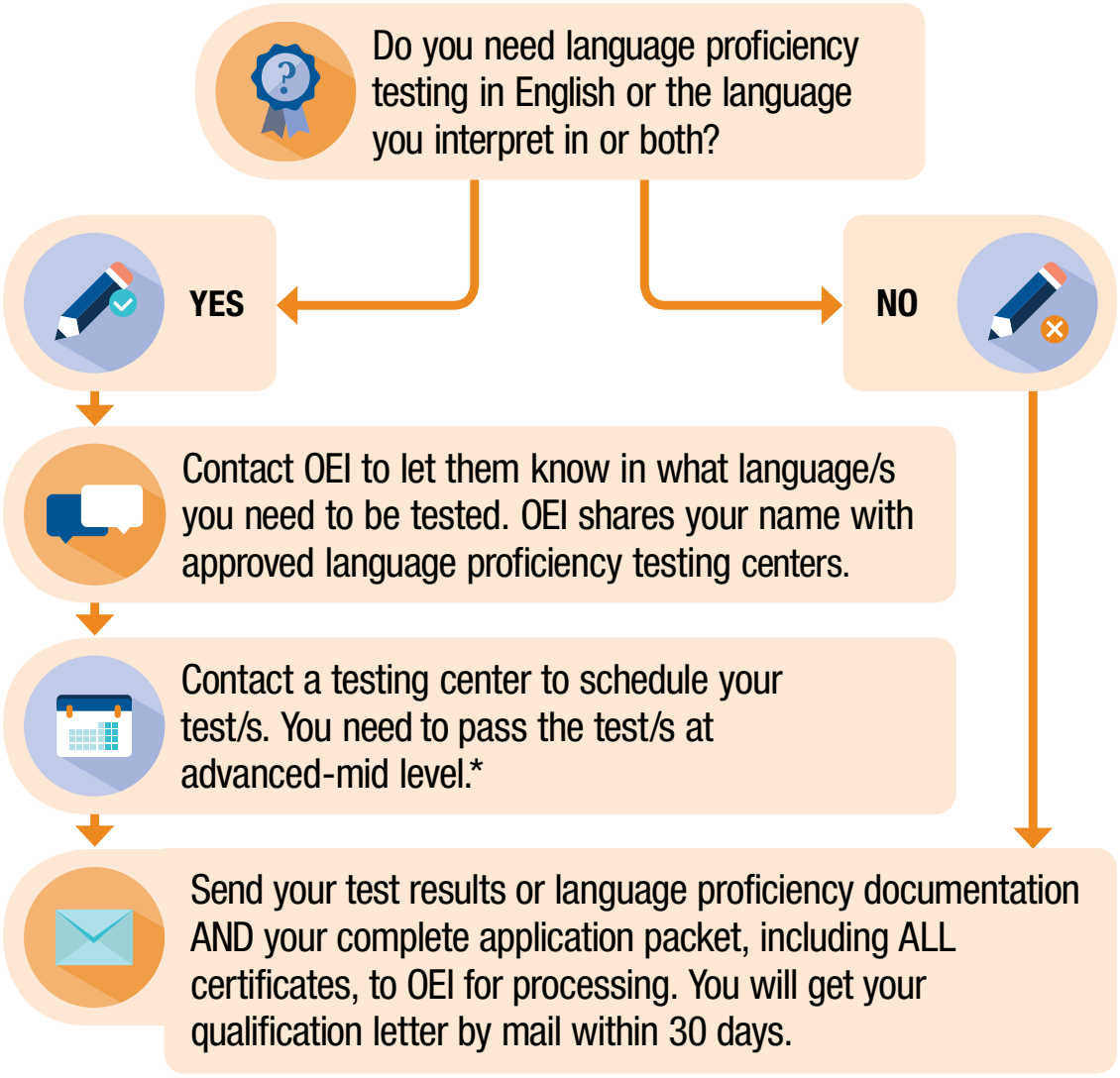
OHA 2002A (7/17) CERT

Steps for Candidates Who Wish to Pursue Health Care Interpreter Qualification

Oregon Health Authority



**OEI will pay for your first language proficiency test (English and/or another language). You will have to pay for any additional tests if you do not pass your first test. ALL testing will end by September 2016.*

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DIVISION OF EQUITY AND INCLUSION
Phone: 503-673-3328

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OHA 2028 (07/17)