

CHOICE

Regional
Health Network



Long-Term Systemic Change in *iTu Salud!* (including State-Level Policy Change)

Process Paper

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Long-Term Systemic Change in *iTu Salud!* Hablamos Juntos Lessons Learned

Goals addressed:

Our “signature” area of work has been referred to as state-level policy change. It includes pursuing a vision of long-term, sustainable improvements in language access through a combination of:

- **State level policy changes** – building on the political will evident in Washington’s commitment of Medicaid dollars to interpreting;
- **Sustainable regional financing for interpreting** – putting resources for interpreting into a population-based low-income coverage model that we hope to implement region-wide by 2010, along with innovative governmental and private sector approaches to subsidize interpreting in the shorter term; and
- **Regional and statewide mobilization of community support for language access** – without which the other changes will not “take” and be maintained.

These are all strategies for accomplishing the underlying goals of language access. We want all limited English proficient (LEP) residents to have access at every health care encounter to:

- Services from a provider who speaks their language, or supported by qualified interpreting; and
- Appropriate written material in a language they can understand.

The problem and relation to language access:

Our region is large and rural, with a population of about 425,000 people spread throughout five counties and a total of 7,000 square miles. LEP Latino population growth is most rapid in the widespread rural areas, where the health care system is overwhelmingly composed of small-scale provider organizations. The largest hospital (400 beds) and county health department in the region are located in Olympia, the regional medical referral center. The region’s six other hospitals are considerably smaller; four are federally designated Critical Access Hospitals and three of these have under 25 beds. The other four public health departments are small, and there are very few medical practices over four providers in the region.

The general problems of language access that we encounter in our region are similar to what is experienced elsewhere, though probably more acute due to rural factors.

- LEP Latino patients’ options to receive care in Spanish are limited by the small number of bilingual providers, by variable linguistic ability among providers who think of themselves as able to provide care in Spanish, and sometimes by significant gaps in the linguistic capacity of other staff in clinics, provider offices and other settings.
- Clinical encounters with a non-Spanish speaking provider are not consistently interpreted by skilled professional interpreters.
- Even where bilingual providers or interpreters are available, there often are inadequate Spanish language materials for administrative transactions, patient education and other essential purposes.
- The options for linguistically competent care are especially limited for uninsured LEP patients because there is no one to pay for interpreting and other language access expenses. Latino residents of our region have the highest percent uninsured of any major demographic group (21.5% compared to the average of 10.5% for all residents). With the exception of emergency care and continuing treatment (“patient abandonment” issues), most providers are under no legal or contractual obligation to see a patient who cannot pay, and costs of interpreting add to the economic cost (loss) of doing so.

Health care providers do want to deliver quality care and this can be a motivator to include medical interpreting in their core clinical practices. However, most providers in our region work in small practices rather than large formal organizations and the route to change needs to reflect this reality.

The *Hablamos Juntos* strategy is to figure out how to deploy population-based community strategies where patients have a consistent experience among multiple providers and organizations. As with any change in standards of care,

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replicability is most easily achieved in the larger health systems where resources can be applied to driving the change as an employer. The methods that work best in larger systems need to be modified to be equally effective as community-based strategies are applied in rural areas, and the period of time to achieve full impact may be longer:

- Standards-driven visions of quality improvements are important regardless of organizational setting or size. However, the response is faster in large hospitals and clinics, which respond more strongly to governmental, accreditation and professional standards. Small medical practices have many of the characteristics of other small businesses and do not always respond immediately to standards and regulations; while in very small hospitals the need for flexibility and generalists often overpowers the ability to fully and immediately incorporate complex specialized standards.
- The quality advantages of professional full-time interpreters are hard to capture with low volume. Full-time interpreter jobs with benefits tend to exist in large organizations that have the volume of interpreter demand and organizational economies of scale to have specialist positions with adequate supervision.
- Rural areas are not promising environments for initiating the longer and more sophisticated training programs that are consistent with the state of the art in interpreting. Educational institutions in rural areas respond to the local demand for graduates. More intensive training programs are likely to be urban-based and their graduates are likely to “trickle down” more slowly to rural areas.
- In Spanish language materials, identifying and standardizing the state of the art in translation is now underway at the national level. The policies and procedures supportive of these best practices are easier to institute in organizations that purchase or perform in-house a large volume of custom interpreting.

Our project has placed great emphasis on strategies to address these challenges. While we need more time to show success, we have made significant progress.

Approach:

We have taken a community development approach to accomplishing the large, costly and long-term changes in language access that we want to promote. The approach builds on what CHOICE has learned in ten years of work to improve health and health care access in our region:

- Relationships are paramount in dealing with tough issues, whether you are at the stage of convening discussion, reaching agreement on the nature of a problem, finding the leaders and energy to proceed, developing support for strategies, or securing the commitments and resources to implement and sustain changes.
- Leaders and issue “champions” need to be recruited, supported and publicly thanked. This is even more true when there is no money to provide financial incentives.
- There often are resources that can be tapped to address a problem once there is a shared will to solve it and a shared belief that the situation is not hopeless. Community assets such as personal relationships, influence networks and hopes for the future can be tapped when the chemistry is right. People and organizations are more willing to consider new ways of using existing resources once a positive momentum exists.
- Leadership involves some risk. While speaking from the heart, acknowledging organizational interests openly and starting to do something without a “complete plan” for implementation and resources can backfire, they also can be essential to create momentum and surmount barriers.
- Governments and other powerful institutions often make rules that others have to follow, but they may have less power to shape and enforce those rules than would be assumed from the outside. Government policy responds very strongly to widespread public opinion and organized influence. Therefore the “issue campaign” is a good model for thinking about how to influence government policy and purchasing.

Our initial approach to interventions in language access emphasized a combination of community development and market development approaches. We sought to build on what we felt were some assets in our region, as viewed at the inception of the *iTu Salud!* Project:

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- Senior leaders in the hospital and public health community agreed that the increasing number of monolingual and LEP Spanish speaking patients represented a significant problem for health care, and one that they would need to address somehow.
- Washington State was already paying for most interpreting within the Medicaid program, and setting standards for who can be paid to do this interpreting. While the procedures and standards were not perfect, they provided a much better basis for improvement, and for sustained investment, than existed in most states.
- Within the Latino community, there were a number of effective organizations, a strong sense of collaboration, and additional individuals who appeared ready to take a next step in supporting language access.
- CHOICE had developed good relationships with an extensive number of health care providers, as well as health and social services organizations serving low-income people. This provided a foundation for relationship-based exploration of solutions.
- Key leaders at CHOICE and among our partners had strong networks of relationships with influential figures in Washington State government. CHOICE's Executive Director and Deputy Director both had careers in state health policy, purchasing and regulation before coming to CHOICE.

Building on this foundation we pursued four strategies for stimulating sustainable, significant improvements in language access in our region. They have not all been equally successful but among them, we have made substantial headway.

Strategy 1: State level policy changes

We sought to use the *¡Tu Salud!* Project and Robert Wood Johnson Foundation sponsorship to develop dialogue aimed at strengthening state policies on language access. One clear focus was the Medicaid program's interpreting program. Washington State is unusual in that Medicaid pays for much medical interpreting. Starting in 1991, the state Department of Social and Health Services (DSHS) developed a list of certified interpreters eligible to receive payment from Medicaid, based on a written and oral test (currently focused on linguistic capability). In January 2003, faced with a legislative requirement to cut cost by \$8 million or lose funding for the interpreter program, DSHS implemented an interpreting broker system that does not allow for booking by a patient or interpreter. Providers must contact a contracted regional broker agency, which in turn verifies client enrollment in Medicaid and arranges for one of its contracted language agencies to select and assign an interpreter to the job. A single agency, based in Tacoma (outside our region), has the contract to serve as language broker for our entire region. The brokerage currently pays language agencies \$32/hour for interpreter services. Language agencies negotiate the prices they pay interpreters as part of contracting with the interpreters.

Critiques of the Medicaid interpreting system have included:

- Medicaid only covers the 28% of LEP Latino population in our region: the ones who are Medicaid recipients. Procedures further reduce technical eligibility. For example, Medicaid eligibility is sometimes determined on a month-to-month basis, making it impossible to schedule an interpreter at the end of one month for an appointment early the next month.
- The Medicaid interpreter certification process is somewhat limited; it does not include training or continuing education requirements. There also are widespread perceptions that the pass rate for the oral exam (38%, across all languages) is lower than reasonable in relation to candidates' skills.
- The Medicaid broker/agency/contracted interpreter system does not build local capacity in our region. Interpreters often are called in from far away, with high no-show rates, while local interpreters are not contacted. Local people who might become good interpreters do not have the organizational framework to be trained, mentored and employed for this role.
- The three-tier system of brokers, agencies and contractors is an efficient way to meet state management requirements, but is cumbersome in terms of meeting patients' needs. Providers must contact the state-contracted regional broker at least 48 hours in advance of the appointment and wait for assignment of an interpreter (which is not guaranteed). In theory there are exceptions for urgent same day appointments, but there is still no guarantee. The assignment of urban interpreters to rural areas leads to problems (interpreters

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not showing up, or lacking local familiarity) that stand out to rural providers and patients as barriers to continuity of care.

State policy issues also go a lot broader than Medicaid, however. As *¡Tu Salud!* Project staff met with stakeholders, discussions expanded to involve:

- The Health Care Authority – which operates another low-income coverage program, the sliding-scale Basic Health Plan, that is implemented through managed care contracts.
- The Department of Labor and Industries – whose Workers Compensation medical program is the third largest health care purchase budget in state government.
- The Department of Health – with a statewide role related to health education materials that has brought it into the world of translation and access to Spanish language materials.
- The Department of Corrections – which faces language access issues in providing health care to a large number of Latino prisoners.
- The Commission on Hispanic Affairs – a key partner in assessing needs of the Hispanic community and advocating for the policies that will best address them.

Following individual discussions, the *¡Tu Salud!* Project conducted a series of “Language Access Events” (see “Things That Worked”) to build an open public discussion around interpreting issues. The response was so strong that we realized this also was a good avenue for building broader grassroots support for language access (Strategy 3).

Throughout our work in the state policy arena, we have remained aware that there must be an interested and mobilized community in order to optimize the way that state programs operate, and their positive impacts. We present this as Strategy 3. A good example, discussed under Strategy 3, is how CHOICE also brought language access issues into Communities Connect, a much broader alliance of community health collaboratives in Washington State that CHOICE was instrumental in forming.

Strategy 2: Sustainable regional financing for interpreting

The lack of dedicated resources for interpreting and other language access expenses is a huge problem. Safety net clinics and public health departments have strong mission commitments in this area and find some way (however imperfect) to accommodate language needs, but in a region dominated by small clinical practices this leaves enormous gaps.

Prior to receiving our *Hablamos Juntos* grant, CHOICE was working to develop a strategy and financial model to pool and supplement available resources in order to guarantee everyone of low income (under 250% of the federal poverty level) access to essential health services. This effort, now called Community Health Works, received initial funding in 2001 under the federal Healthy Communities Access Program. That funding declined every year and is now winding down. However, we have always viewed this as a seven to ten year effort. Our development of the demonstration idea and its viability within state and national contexts are on track and we are actively seeking the grant and/or investment funds to proceed to the next stage of financial modeling and implementation.

We integrated language access values and financial requirements into the broader Community Health Works effort.

- Consistent with our overall approaches to community development and “issue campaign” mobilization, we put a great deal of effort into how to communicate an undertaking as large as comprehensive regional health system reform for low-income people in a way that galvanizes energy rather than overwhelming partners. We developed frameworks (“six principles” in our region, “eight critical activities” in national work heavily influenced by CHOICE) for describing mutually complementary clusters of work that, in combination, bring us to comprehensive solutions. These clusters of activity can also be put in place cumulatively over time with different champions – so long as they remain coordinated within the community. For each of these “principles” or “critical activities” we identified “best practice” stories from other US communities that have successfully implemented system changes. We started to consistently communicate that language access is a critical component of one of those principles, delivering evidence- and relationship-based care through health teams.

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- We also built an increasingly detailed service, benefit, finance and coverage technical model. The most recent stage in this process was a two-day retreat in early October 2004 at which the key leaders of Community Health Works studied, modified and adopted an actuarial pricing model for coverage and an assessment of how much short we are of financing its implementation. In actuarial work, language access costs tend to be classified as part of a large undifferentiated “administrative expense” category, so our actuaries suggested that CHOICE build the pricing for interpreting services ourselves. CHOICE did that and the adopted high-level model includes an allowance of \$2.40 per member per month (2003 dollars) – or \$2.7 million dollars for our entire demonstration population – to cover medical interpreting in all languages. The per member per month pricing is based on total people in the coverage universe – not just the much smaller number who need interpreting due to limited English proficiency. The total dollars allotted would be more than ten times the amount now paid by the state Medicaid program for interpreter services in our region. Funding would come from the same sources that support medical care. This requires greater pooling of existing resources (Medicaid, Basic Health, current amounts paid by both insured and uninsured patients) and funds from new sources (community contributions or local taxes, increased employer support, increased tax-leveraging of patient contributions, and resources saved through greater efficiency and reduced service fragmentation).

As noted, this financing approach is longer-term. We also have been working with two shorter-term strategies for subsidizing interpreting services.

- Community Health Management Districts – As part of the Community Health Works strategy, we developed the concept of Community Health Management Districts, local entities with at least quasi-governmental structure that could be the organizational point of accountability for blending funds, taking the risk of financial coverage, guaranteeing effective and responsible use of funds, and putting adequate weight on the goal of improving health at the community or population level. We also are working with local leaders in some parts of our region, including elected officials, to explore the formation of one or more local taxing districts under existing state laws that could subsidize selected health care services and infrastructure. Language access improvements are on a list of possible candidates for such funding, but it is premature to guess about outcomes.
- We also have explored asking employers that have significant Latino workforces to dedicate some pre-tax dollars for interpreter needs. This is a means to get more money on the table in situations where employers do not offer health coverage but do agree that they would experience less time loss, and their employees would get better health care, if interpreting problems were not an added barrier as employees and their families seek care from available sources as uninsured people.

The agenda of Communities Connect (see Strategy 3) is also likely to include promoting a state interpreter payment or subsidy program with significantly broader eligibility than Medicaid. It is difficult to say how long- or short-term this effort will be.

Strategy 3: Regional and statewide mobilization of community support for language access

Language Access Events: During the planning year, it became clear to project staff that there was no public forum for language access stakeholders – interpreters, health care providers, language agencies, consumer advocates, the Medicaid interpreting services broker, and representatives of the State Medicaid Program – to discuss language access issues and concerns. We envisioned a series of events to bring people together, provide education about the current system, and begin to create dialogue and momentum about strategies for improvement. The four-part Language Access in Health Care Series addressed the following topics:

- June 2004 – Understanding the current interpreter system from all points of view
- September 2004 – Lost in interpretation (improving communication among all parties)
- January 2005 – Medical interpreter training and certification
- April 2005 – Getting organized for long-term change

Combined attendance at the events included over 100 people including interpreters and representatives of state agencies, language agencies, provider offices, public schools, social services, hospitals, non-profit organizations, the legislature, the judicial system, and higher education. All the events included high-energy, fast-paced, interactive

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discussions, and participants expressed appreciation for achieving a better understanding of the Medicaid interpreter system and having the opportunity to clarify misconceptions and voice concerns about language access issues.

Communities Connect: CHOICE has devoted substantial time over a number of years to developing a statewide alliance of community health collaboratives. Communities Connect was formed to replace earlier, less formal groups. Communities Connect has successfully championed community-initiated programs to improve access to health care during the 2004 and 2005 state legislative sessions. In June 2005 Communities Connect identified improving language access as one of four shared policy objectives for 2006. With CHOICE leadership, Communities Connect is in the process of developing an educational issue paper on language access.¹ The current draft of the issue paper requests the State's Joint Legislative and Audit Review Committee to undertake a study that (1) examines barriers to accessing health care for Washington State's 394,000 Limited English Proficient residents and (2) makes recommendations to the Legislature for language access improvements and health disparities reductions. We expect that Communities Connect will request that the study include the following more specific components:

- Identify and recommend necessary improvements to the Medicaid interpreter system, especially with regard to training of interpreters;
- Explore options to expand the existing publicly-funded interpreter system to include LEP residents not eligible for Medicaid;
- Assess the legal liability resulting from non-conformance with federal law; and
- Recommend options for video interpreting in rural areas.

Other community mobilization: *¡Tu Salud!* has also engaged in other community skill-building activities to garner support for language access activities, including the following:

- Support for the development of local Hispanic roundtable groups formed to discuss issues of importance to the Hispanic/Latino community, including strong emphasis on language access;
- Relationship-building with organizations interested in improving language access for LEP residents whose primary language is not Spanish (Commission on Asian-Pacific American Affairs, Refugee and Immigrant Service Center);
- Identification of language access partners in other areas of the state who are interested in carrying the torch for language access in their region to establish greater communication statewide; and
- Development of strategies to mount a communication and awareness-raising campaign at the grassroots and community level, including identification of partners to approach, a system for collecting and publicizing regional language access stories, and identifying opportunities to reach LEP individuals at Latino community events.

Strategy 4: Improving the organization of the market for interpreter services

Our initial *¡Tu Salud!* business plan called for work to help organize the means for available, trained interpreters to have predictable employment in our region. The region's health care system is heavily dependent on contracted interpreters because (1) the volume of demand from most providers is too low to justify full-time in-house interpreters; (2) the availability of (and sometimes demand for) for bilingual providers is limited; (3) Medicaid funding of interpreter services is focused on a system of brokers, interpreter agencies and contracted free-lance interpreters (see Strategy 1); and (4) it is difficult to manage expectations and quality using dual-role interpreters, especially in small organizations where people have multiple hats.

We also hoped to work with the region's typically small-scale providers to stimulate their use of locally based interpreters, initially with subsidy so as to reduce the risk of venturing into more investment in the quality of care for LEP patients. We hoped we could convince them of the economic and health value of this investment using clear quantitative findings from research.

¹ Copies of this document will be available from CHOICE once adopted.

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These efforts have been difficult to advance. They are mentioned here because they reflect a fourth general approach to sustainable long-term change. Some of the issues impeding progress are mentioned under “Challenges.”

Things that worked and evidence of influence:

Cutting across the four strategies, we observe substantial success with several of our strategies.

Careful, personalized relationship building takes time but has paid off.

Jan Crayk, who served as Project Manager until April 2005 when she left to accept a job in state government, spent a great deal of time developing relationships with stakeholders, ranging from Hispanic community leaders and interpreters to health care leaders and state agency officials. Other Project leaders and CHOICE staff likewise used their networks to explore attitudes and openings for language access improvement. This activity often showed little visible benefit for a while, but we believe it has contributed significantly to a current positive outlook. Evidence of influence:

- The project’s initial focus was on Medicaid policy, but through a series of conversations policy openings have emerged at other state agencies responsible for other medical services through the state Workers Compensation program, Basic Health and correctional facilities.
- Project staff’s interactions *with* stakeholders generalized into discussion *among* stakeholders who previously were not interacting directly. We have repeatedly heard comments about how our events and smaller meetings were watershed opportunities for representatives of disparate state agencies to discuss language access issues with each other. We were also pleased to see rich relationships develop between state agency representatives and community leaders who were previously unaware of each other’s work.
- By the time of the RAND evaluation site visit in June 2005, we had an engaged group of representatives from six state agencies who were willing to participate and were knowledgeable about our efforts and positive about the process.

Building on the trust relationships engendered by early project work, the Language Access Events dramatically opened up dialogue on language access in health care.

The project’s four Language Access events, described under Approach (Strategy 3), moved previously more private stakeholder discussions around state policy into a more public forum. They also had a strong mobilizing impact, by the end of the series. Evidence of influence:

- Getting state Medicaid officials to attend and reducing their anxiety level was a sign of success. This may reflect the success of earlier relationship building rather than the success of the Language Access Events themselves, as the processes built on each other.
- We have received repeated comments that these events were the only “real” forums for discussing language access that brought a broad group of interested parties together in a “safe” but frank environment. These Events drew influential participants from as far as Seattle and Central Washington because they saw this as an important forum.
- The State Lieutenant Governor accepted an invitation to provide kick-off remarks at the final event.
- Before the Language Access Events there were many private complaints about perceived shortcomings of the Medicaid interpreter certification process, but it was not being treated as a “live” issue within DSHS. Other agencies felt that their only option for a quality assurance process was to join in using the Medicaid system. By the end of the series of Events, the meaning of “certification” was a subject for active discussion among state agencies and stakeholders.
- Finally, the Language Access Events bore unexpected dividends through the level of excitement they generated for follow-up action. The final event on “Getting organized for long-term change” captured this momentum.

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The Community Health Works strategy for restructuring low-income health coverage in our region continues to provide an essential, “high-risk, high-gain” strategy for paying for interpreter services.

It is difficult to avoid the conclusion that more money is needed to move interpreter availability and access to the next level in our region. Our strategies for addressing this problem are long-term but not out of touch with what can be achieved. Signs of progress and influence:

- The Community Health Works process built a health care coverage model over about two years, starting with a general services concept that was gradually prioritized, fleshed out, combined with premium and consumer cost-sharing scenarios, and finally priced with actuaries using a combination of methods. As CHOICE staff and language access “champions” began to build assumptions about language access costs into the model, there was little pushback. Straight through to the October 2004 retreat that approved a preliminary pricing model, those at the table responded with relief to see these costs actually quantified, rather than being left in a vague “administrative cost” area which often translates to a squeeze on provider payments.
- Providers have tended to view explicit funding of interpreting as a relief of burden rather than a cost.
- CHOICE’s work to develop national and statewide alliances among community health collaboratives has been successful judged by participation, willingness to pay dues (in the more mature national organization), credibility and ability to mobilize advocacy. One impact is that CHOICE has moved itself onto a “short list” of collaboratives that would receive widespread support from their peer organizations around the country if a limited number of demonstration projects are selected for substantial new pooling of existing health care programs in order to allow local redesign and simplification.

Project staff were able to apply sophisticated approaches and skills for organizing within the statewide environment.

Principal Investigator Kristen West and some other CHOICE staff had the experience and judgment to understand how government responds to outside forces and launch effective statewide and national efforts to structure that environment. Evidence of influence:

- CHOICE was able to take lessons and conclusions from the *iTu Salud!* Project and bring them into the statewide educational agenda for Communities Connect (see Strategy 3).
- At several points in the project, communication strategies involving client and interpreter stories have been used to create a “voice” for LEP individuals’ needs. At the fourth Language Access Event we were able to confirm that there is volunteer energy to collect and use stories effectively for public awareness.

Challenges:

The overall challenges of working in a rural area with predominantly small health care provider organizations were always part of our problem definition, so this has been a major but not unexpected reality in our work.

All community-based approaches to major change in an area as complex and costly as language access take time. It is unclear whether we were able to cross the threshold for advancing language access post-grant or whether we needed a longer period of time to be successful. However, we are pleased at the strong evidence of momentum and we hope that both CHOICE and other motivated actors will continue to seize the opportunity for improvements.

As the end of the grant approaches, it has been impossible to retain some key staff. This does not reflect a lack of commitment; in fact two key staff got “offers they could not refuse” that allow them to continue working on language access issues within state government.

Our goals for improving the local market for interpreter services were complex. They involved helping to organize local supply, promoting demand through work with health care providers, and reducing market inefficiencies through alternatives to the multi-tier Medicaid interpreter system now used, which has little local accountability. We ran into numerous difficulties that required us to reduce expectations in this area.

- Currently available research literature on the benefits of high-quality interpreting is thin. While many providers intuitively agree that interpreting is essential, we have no basis to quantify impacts.

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- We met with the state's largest malpractice insurer to explore whether a reduction in liability insurance could be negotiated for providers that do a good job with language access, but that was not economically realistic from their point of view.
- We did take a first cut at quantifying the magnitude of resources necessary for interpreting for all low-income LEP individuals, but the results tend to underline the need for more direct funding, rather than providing a context to reassure providers that they can afford to voluntarily increase their investments under today's financial realities.
- CHOICE staff are proceeding with the fairly slow process of developing progressively better models of practice finance that can be used to engage physicians and other providers in serious discussion of the financial impact on their businesses if access were improved in various ways. Interpreting costs remain part of this overall work but it is difficult to separate this from the broader issues of financial reform in the region's health care system (our Community Health Works model).

Adjustments in strategy:

Over time our expectations in working with the state Medicaid program shifted. Initially we thought that they would collaborate with us in redesigning how the Medicaid-financed interpreter system works in our region. This shifted to a belief that we would need to engage in a longer, statewide policy discussion about what is the best use of limited Medicaid funds for this purpose, and how to make the system integrate well with available resources in every region.

Early in the project we hoped that national L&ISA testing and the concept of national standards for interpreter competency would lead to a model that we could bring to the state Medicaid program as a better approach to interpreter certification. If the national work moves beyond instrument testing and calibration to development of an implementation model, this hope might become reality.

We added a fourth Language Access Event when we realized that there was a good opportunity to capture and organize momentum for action that had been stimulated by the first three.

We did not predict, at the beginning of the project, that Communities Connect would be a powerful means to shift the state policy dialogue from regional to statewide. We jumped on this opportunity when it became evident.

We lowered our expectations for organizing the market for interpreters. However, we remain convinced that there must be a more stable way to fund interpreter services before we can leverage sweeping changes in the quality of language access.

Possible future strategies:

We are at an important crossroads in how to approach language access strategy. Project funds are winding down at a point when there is strong momentum in two areas that could have major impact on language access:

- Communities Connect is developing an action agenda that could be very positive for language access. However, maintaining this momentum depends in large measure on CHOICE's ability to staff the process. This in turn has financial ramifications within our budget for next year.
- The April Language Access Event created natural, strong momentum to develop a statewide organization capable of carrying on public awareness and "issue campaign" activities to keep language access in high profile. We believe that such an organization could self-sustain with multiple sources of support once well underway, but it appears doubtful that this will happen without some single organization stepping forward to carry through that transition. Everyone looked to CHOICE to take this role but we cannot commit to do so without some form of dedicated funding.

We continue to be passionate about the need for financial restructuring to support a holistic approach to health care for all low-income people, regardless of "eligibility categories." We have built language access into this vision and its model of financial requirements. Moving to implementation with a significantly large regional demonstration probably requires another three to five years and will require some dedicated form of funding for the next push. We are reasonably optimistic about obtaining this backing, whether through grants or "social investment" and business partnerships; and we definitely intend to keep language access on the table and in the model.

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Two of our shorter-term approaches to subsidize language access “have legs”:

- While the notion of comprehensive Community Health Management Districts is closely tied to comprehensive financing reform, we have developed a legal vehicle to establish local government entities that could (1) undertake more limited service subsidies or infrastructure investments to improve health care, and (2) assess taxes (subject to voter approval) to support them. We have interest from elected officials, particularly strong in one county. The agenda for action under such a new public district might or might not include language access, once prioritization occurred.
- The Communities Connect agenda will seek to put broader state funding of interpreter services on the table, but this is not the kind of issue that moves from idea to funded reality in a single year.

Advice to others:

1. If trying to affect government policy, understand how it looks from within government.

Medicaid language access policies provide a good example. From the point of view of providers in Washington State, the Medicaid interpreter system is imperfect and requires improvements. Within government, it is a point of pride that Washington has been able to maintain meaningful financial investment when most other states did not. The history behind why the system is structured as it is includes response to litigation that drove specific decisions. Following the latest program changes, what providers see as a complex brokerage system is, from the point of view of government, a way to pass on financial risk to private business so the legislature can be guaranteed that the program will be run within the funds available. A more “convenient” fee-for-service interpreter system that would be more attractive to advocates risks being unable to guarantee cost savings and therefore could be subject to government cutbacks. These realities do not block further progress, but leaders within government will be far more open to change if their needs are taken into account.

2. Consider adopting a community development and “issue campaign mobilization” approach to significant change, at least as a companion to relying on institutional policies.

The “Approach” section of this paper starts with a summary of what CHOICE has learned over ten years about how to do this well. Consider whether the same principles apply to your own environment.

3. Be in it for the long haul.

Our successes on the road to influencing change build heavily on relationships. It takes time to develop these relationships, and it takes more time for ideas to percolate within large organizations to the point that they become more evident in public.

4. Remain flexible about recognizing and taking unexpected opportunities to progress.

Our project provides many examples of principled opportunism. Having a detailed plan is no excuse to treat it as unchangeable as circumstances evolve. Some examples of opportunities that came our way suddenly or even as the other side of a problem:

- A relatively incidental invitation from the State Lieutenant Governor for bilingual staff members to join him for occasional lunchtime discussions to improve his Spanish evolved into his agreement to speak at the final Language Access Event.
- Several of the interpreter coordinators from local hospitals, whom project staff had been working to connect, got to know each other through their attendance at the Language Access Events. At the final event in April, the group decided to launch quarterly meetings for hospital interpreter coordinators to discuss shared concerns and opportunities.
- Two key staff left this Spring – but both accepted positions in state agencies that have leverage in health care. We had frank discussions with them about how they can continue to advance language access. Both have remained engaged and in one case, we worked with the new employer to allow work time for continuation of some personal language access-related efforts.
- When we needed to replace Jan Crayk on an interim basis, we acted on an opportunity to contract with a public health physician who has a different skill set – and to rev up some of our project work that requires credibility with health care providers in order to build on the assets that she brings.