Access

HEALTHCARE LANGUAGE ACCESS ECOSYSTEM

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National Council on Interpreting in Health Care

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From the President

Dear Reader,

On behalf of the National Council on Interpreting in Healthcare (NCIHC), I want to welcome you to the second edition of ACCESS: The NCIHC Journal.

I am so pleased with the hard work and amazing resources and content that our committees and work groups are creating. The quality of the content is the result of passionate language access champions who invest hundreds of volunteer hours to make a difference! This journal started as a dream to publish a professional journal that would inspire, enlighten, and educate about the importance of language access. Language access is a civil and human right–what more important cause can we be inspired to champion?

Many of the topics presented in ACCESS are inspired by you, our members. Ideas for article topics as well as other NCIHC initiatives come from our member listserv and discussions at our Annual Membership Meeting (AMM) Language Cafe. We invite you, our members, to be a part of this dynamic and thriving organization. Share your unique talents, interests, and experience by serving on one of our committees or work groups, or by participating in our 2023 AMM Language Cafe. The NCIHC Board is committed to incorporating the work product of our Language Cafe into Council initiatives.

We are a welcoming organization that needs your input. Please share it!

Erika Shell Castro, President
National Council on Interpreting in Health Care

Erika Shell Castro,
President NCIHC.

From the Editors

Welcome to the second issue of ACCESS, the journal of the NCIHC.

In this second issue of ACCESS, the editorial team has taken an active role in the writing process and, with the valuable help of well-known, meaningful contributors, is glad to present a selection of topics we think will play an important role in one way or another in the future of healthcare interpreting.

Many of the issues included are intricate, and we are well aware that the scope and variety of our professional services is broad and complex. It is impossible for us to include all the topics that deserve attention, but we have done our best to provide a reliable, detailed analysis that incorporates different perspectives and points of view, always keeping in mind the importance of quality service to patients, the relationship with other professionals and entities, and our professional interests.

The result is a longer-than-usual, voluminous issue that we believe is full of useful information, analysis, and diverse points of view.

In "Why Language Access," we describe law and regulatory mandates for language access, both spoken and written. Throughout the issue we identify holes in implementation of mandated language support.

In our Stakeholders in Healthcare Language Access feature, we present a current snapshot of our patient communities, clinicians providing care, interpreters and translators, interpreter services managers, language service companies, and educators and trainers of linguists.

The Research feature presents more data from the NCIHC survey of interpreters on how they were impacted by the COVID-19 pandemic—specifically, on how the major shift toward remote technology for healthcare interpretation affected their practice.

We shine a light on mental health as a subset of health care that has its own processes and that requires extra care and training for both providers and interpreters.

We call out translation as a key aspect of language support for patients.

In "Business Practice Spotlight," we look at language access employment and contracting models for healthcare inter-preters, including contracting arrange-ments, employment opportunities, certification, and unionization.

We visualize "Barriers to Care" from the patient's point of view.

The Language Association Spotlight takes us to Florida to meet our very motivated colleagues there.

The Linguist Spotlight gives "voice" to Helen Tayar, a dual-role Arabic interpreter.

For each article in this issue of ACCESS, we point out what we know and what we do not know but need to know more about. We present a magic-wand wish piece asking clinicians to design research studies on health outcomes that directly specify language need and language need fulfillment as key variables.

We are very excited to introduce you to the brand-new Reference Library at NCIHC's website, which is an annotated bibliography for the use of anyone interested in healthcare language access. It was just created and launched and will grow quickly!

And last but not least, check out the fascinating map of language associations we have begun to create.

We solicit your opinion about the usefulness of our two issues so far. Please use these links to provide your feedback!

We hope you find this second issue useful and enjoy reading it as much as we did putting it together.

Editorial Group
Linda Golley, Tatiana Cestari, Jaime Fatás-Cabeza, Michelle Scott, Gabriela Siebach, Eva Stitt, & Tracy Young

Why Language Access?

By Gabriela E. Siebach, MATI, CHI–Spanish

A question that many may ask themselves in relation to language access in healthcare settings is: Why provide language access? Although for some it may simply be the right thing to do, for many entities receiving federal financial assistance it is a legislative requirement. Therefore, as we explore the current state of language access, we will begin by understanding why language access is necessary in health care.

Patient receiving infusion for cancer treatment.

But first, let's take a look at what language access is. As described by Mara Youdelman in the Executive Summary of the Summary of State Law Requirements Addressing Language Needs in Health Care, language access includes all services that are provided to an individual with limited English proficiency so that they may access services, including interpreting, translation, and direct communication in a language other than English.

Often, Title VI of the Civil Rights Act of 1964 is referenced in relation to provision of language access—specifically, the prohibition of discrimination on the basis of national origin in programs and activities receiving federal financial assistance. And, although the law does not specifically mandate that language access be provided, it is the U.S. Department of Health and Human Services's "long standing position" that in order to avoid discriminating on the basis of national origin, "adequate steps [must be taken] to ensure that [Limited-English-Proficient patients]

receive the language assistance necessary to afford them meaningful access" (HHS, 2000). Additional policy, such as Executive Order 13166 and Section 1557 of the Patient Protection and Affordable Care Act (ACA), is also often cited in relation to language access; both of these examples stem from Title VI's prohibition on national origin discrimination.

The U.S. Department of Health and Human Services (HHS) published Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, which addresses how all of the previously mentioned policy may be implemented by federal financial assistance recipients to provide access to Limited-English-Proficient persons; it includes important topics such as how language access can be provided through tested bilingual staff, staff interpreters or translators, volunteers, and on-site or remote contracted language services (Section VI, B) who are "qualified" (Section V, 4), as well as how self-identification as bilingual does not suffice to establish competency (Section VI, A).

Additionally, the Office of Minority Health (OMH) published the National Standards for Culturally and

Example of required notice to patients that language support is available.

Linguistically Appropriate Services (CLAS) in Health and Health Care, which are intended to advance health equity. The OMH's intentions in developing the CLAS standards are clear in the principal standard: The goal is to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (HHS, 2020, para. 2).

In addition to the legislative requirements for language access, accreditation entities such as the Joint Commission have aligned their standards and auditing process to ensure language access is provided. For example, the Joint Commission has published Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care, which outlines key standards and specific requirements related to the expectations for the provision of language access by Joint Commission–accredited hospitals, specifically stating that "untrained individuals—including family members, friends, other patients, or untrained bilingual staff—should not be used to provide language access services during medical encounters" (HR.01.02.01).

Finally, although the above-cited legislation, regulation, and guidance do not provide specific information about how to identify what type of language access to provide, how interpreters and translators should be qualified or vetted, or the level of language proficiency required to provide direct patient care in a language other than English, NCIHC has developed the peer-reviewed Code of Ethics and Professional Standards of Practice for healthcare interpreters. Additionally, HHS has developed many resources to help

healthcare entities comply with language access plan development, and even foreign organizations like the Australia Centre for Culture, Ethnicity & Health can prove useful to U.S.-based healthcare entities.

References and Resources

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Language Access in Health Care in 2022

By Linda Golley, MA

Healthcare Language Access Stakeholders

Patients

Foreign Language-Speaking Communities	Native American, Alaska Native, Indigenous Hawaiian Communities	Deaf, Blind, and Deafblind Communities

Key relationship

Communication Triad

Care Teams

Doctors, PAs, NPs, Nurses, Pharmacists, Clinical Social Workers, Techs, Receptionists, Financial Counselors, MAs, Therapists...

Interpreters

Trainers

Interpreter Trainers and Translation Trainers

Language Companies

Translators

Language Program Mangers

Language Program Managers in hospitals, clinics, direct care organizations...

Imagine that a person from another country wanted to understand how we in the United States provide health services to people who do not speak English.

NCIHC is in a perfect position to describe how healthcare language access works because our stakeholders are exactly those key actors in the complicated system that supports people to access healthcare services in the language they prefer.

The stakeholders in healthcare language access, the key actors, are:

- patients, families, and communities that need communication support for healthcare.
- doctors, nurses, social workers, and the entire team of care providers and staff who interact with patients.
- interpreters and translators, the linguists who provide the communication support.

- healthcare organizations' interpreter services managers, who ensure that patients receive the communication support that they need.
- language companies that organize the huge number of daily requests for interpreter and translator work and connect these requests with available linguists.
- trainers of interpreters and translators, who continuously deepen and broaden their instruction to promote the increasing need for professionalization of healthcare linguists.

In this issue, we shine a clear light on the status of each stakeholder group today, about 40 years after healthcare interpreters first began to be paid for helping SouthEast Asian refugees and Deaf patients communicate with their health providers.

For each stakeholder group, we look at three topics:
- What do we **know** about the stakeholder group today regarding their needs and activity related to healthcare language access?
- What important **concepts and trends** inform the stakeholder group's progress in improving healthcare language access?
- What do we **need to know** more about?

A common theme throughout this section is the necessity of keeping the patient's needs at the center of all healthcare language access activity (patient-centered care), and the importance of coordination between the stakeholder groups. Patients need engaged, appropriate care from their care team, which must move forward from an impersonal bio-medicine culture to one that pays close attention to the goals and needs of each patient. Care teams require competent and professional interpretation and translation from linguists in order to engage fully with patients. Interpreters and translators must keep up with ever-increasing complexity in the medical field while also embodying the soft skills needed to gain the trust of patients and providers. The interpreter services manager needs tireless support from language companies to recruit linguists for assignments. Interpreters need forward-looking trainers to move them steadily along the path of professionalization.

Why Language Access? References and Resources continued

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At the end of each stakeholder section is our wish list of topics we want to know more about. If you are in a position to collect statistics or conduct studies or surveys, please get in touch!

Patients and Families Who Prefer to Receive Healthcare Services in Languages Other than English

By Linda Golley, MA, & Tracy Young, CHI–Spanish, RN, BSN, MA

Healthcare language access is first and foremost about the patient. **The goal is to ensure that all patients can communicate with their care team effectively to achieve the best possible health outcomes.**

The standard for healthcare language access, both legally and operationally, is that patients who do not communicate well in English can secure and utilize health services to the same extent as English–speaking patients.

In this article about patients as the key stakeholders of healthcare language access, first we introduce the patients who need language support to access healthcare.

We point out the lack of data related directly to language support in improving health outcomes.

We discuss the health status of the broader communities that language–need patients belong to, acknowledging the limitations of the proxy data that is available.

We describe some of the many ways that patients, their families, and their communities advocate for themselves to receive health care that meets their needs.

Three sets of people in the USA today require language support for health services.

A patient needs language support if she needs to access health services that are offered in English but when she herself prefers to communicate with the care team in a language other than English.

The three sets of people who need language support are:

- Immigrants and refugees who do not speak much English;
- Native Americans and Alaska Native and Hawaiian Native people who do not speak much English; and

- Deaf, deaf, and Deaf–blind people who use sign language or other means to communicate.

These categories are further delineated below.

1) Immigrants and refugees who are not proficient in English

Immigrants are people who migrate into a new country for reasons such as family reunification, employment opportunity, marriage, education, or staking a new future. Refugees are a special category of immigrants. According to the United Nations High Commissioner for Refugees (UNHCR, 2010), a refugee is "someone who is unable or unwilling to return to their country of origin owing to a well–founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (p. 3).

The need for language support for immigrants is most acute for:

- recent arrivals from non-English-speaking countries,
- those who work in isolated labor sectors where they learn English only slowly, and
- elderly individuals who integrate slowly, if at all, into United States society.

2) Native American, Alaska Native, and Indigenous Hawaiian people who are not proficient in English

Up to the 1500s, the land that is now the United States was home to many Native American communities that spoke hundreds of different languages. White settlers displaced many of these communities and carried out a systematic campaign to suppress their ancestral languages.

Native American children were taken away from their communities and interned in boarding schools where they were forbidden to speak the language of their parents. Today, many people of Native American ancestry can no longer speak their ancestral language, and they speak English only. However, some Native Americans in Alaska, Hawai'i, and the "lower 48" or the "Mainland" particularly in remote rural areas, do still speak and prefer to use their ancestral languages for health services.

Native American and other First Peoples still live across North America and Hawai'i. There is a vibrant movement to re-establish identity, language, and culture, including health ways handed down over millennia.

3) Deaf, deaf, and Deaf-blind people who use sign language or other means to communicate

The designation "Deaf," with a capital D, refers to people who are deaf and self-identify as members of the cultural community. Members of the cultural Deaf community communicate primarily in American Sign Language (ASL) and view their deafness as more than just a clinical diagnosis but rather as an identity-enriching quality. ASL, like other languages, is rich with expression and dialects that are unique to each person and may vary depending on where they learned ASL. Many Deaf people read English fluently, but many do not. The Deaf community is vibrantly self-aware, particularly in larger cities where there are many Deaf people.

People who are "deaf" (as opposed to "Deaf") may have had limited or no exposure to signed languages, or may have been deafened later in life by illness or trauma. They usually do not identify with the cultural Deaf community and may not use ASL fluently or at all. Written English and visual video serve as communication pathways for some.

Deaf-blind people cannot see or hear. They may or may not be networked into the Deaf community, may or may not use a touch version of ASL called Tactile, and may or may not use Braille.

Does language support ensure better outcomes?

The whole point of language support for people who do not speak English is to achieve good health outcomes. But do patients who have interpreters and translated materials available to them enjoy better health outcomes than patients who do not have interpreters or translated materials? For those of us who spend our lives trying to improve health care, this seems a sacrilegious question to ask. But our approach to language support should be grounded in science and data. We should be able to show that people who need language support and get it have better outcomes than those who need it but do not get it. But we have only proxy variables to look at, at this point.

Newborn being placed on mother's chest after delivery.

Black and Hispanic Women Are Diagnosed with Cervical Cancer at Higher Rates

Visit www.cdc.gov/cancer/dataviz for more information.

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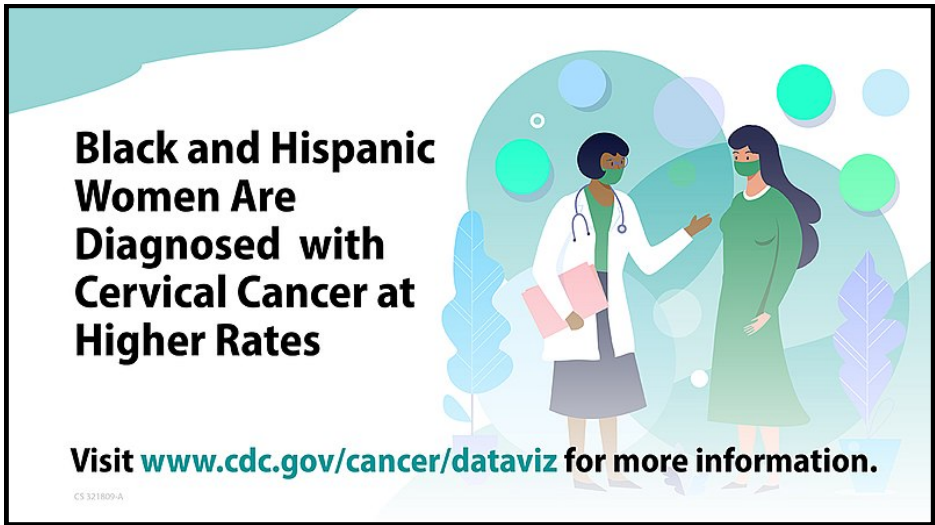
Female provider speaking with patient about cervical cancer.

For example, we know that Latina women in the United States are diagnosed with breast cancer at a later stage than white women and thus have a worse prognosis. But "Latina women" as a category includes women who speak English fine as well as women who need language support because their preferred language for health care is Spanish, Mam, Zapoteco, Mixteco, etc.

We do **not** know:
- What percentage of "Latina women" <u>need </u>language support
- Whether they <u>receive </u>language support for encounters if they DO need it
- Whether those women who need language support and <u>receive it</u> have <u>different </u>outcomes from those who need language support and <u>do not receive it</u>.

We know that many people who need language support have poor health outcomes. But we do not know why they have poor health outcomes. Is it because they needed language support and did not get it in the past, or now? Do they have poor health outcomes because of some other aspect of their situation?

We can report some large trends in health for the communities that have members who need language support. These communities definitely have a different health profile from non–Latino white, hearing people.

What we do know: Immigrants and Refugees – Health Status

The Immigrant Health Paradox

Immigrant communities in the United States present a surprising health profile, which is called the Immigrant Health Paradox. Those individuals who arrive in the United States as first-generation immigrants have better health across a great variety of health indicators than do people who have been living in the United States for their entire lives. For example, they have better cardiovascular health, better mental health, and a lower incidence of cancer. This is true for both children and adults. And it is true for immigrants from all parts of the world, including India, Africa, and Latin America.

Here is the paradox: The children and grandchildren of immigrants, who are born in the United States, experience higher and higher rates of disease with each successive generation, until they actually have higher rates of disease than the mainstream, let alone compared with their own healthy ancestors several generations back. The short summary of this paradox is that new immigrants arrive in good shape, ready to work and build families. Their children born here (second generation) live some aspects of the lifestyle prevalent in the United States but still follow the diet and some of the healthy habits of their parents. When their own children (third generation) grow up, they eat the American diet and follow the American lifestyle. Obesity, alcohol and drug use, depression, diabetes, and cardiovascular disease all increase in each subsequent generation after immigration. Some of these second- and third- generation immigrants may still need an interpreter if they have grown up in areas of the United States where the ancestral language is predominantly spoken.

Exceptions to the Healthy Immigrant Syndrome

However, many immigrants are at higher risk than mainstream U.S. residents for certain physical and mental health problems, including:

- incomplete vaccination history.
- lack of routine cancer screening such as Pap smears or provider breast exams, resulting in people presenting with well-advanced cancer.
- undiagnosed Hepatitis B contracted in utero and passed on to their own children in utero.
- female genital cutting, which affects urinary and reproductive health.
- undiagnosed rheumatic heart damage from untreated Streptococcus in childhood.
- preference for a diet of meat, white bread, and sweets because these are viewed as high status and desirable, with resultant physical and dental pathology Similarly, preference for baby formula over breastfeeding.
- mental distress from the reasons that they left home in the first place, along with trauma accumulated along the immigration path that they experienced, plus stress from grief, loss, and discrimination here in the United States.

Great Variation in Health Status between Groups of Immigrants and Refugees

We also know that health status varies greatly among immigrants. The large groupings such as "Asian" and "Hispanic" used by the Census and by other statistical research programs do yield warnings and reassurances about certain topics that are valid. However, it is essential to refine these categories to finer and finer detail in order to obtain actionable health data. For example, doctors researching sexually transmitted diseases in Latino men have found that the incidence of STDs in immigrant Puerto Rican men and in Mexican men varies significantly.

What we do know: Native Americans, Alaskan Natives, and Indigenous Hawaiians – Health Status

Native Americans, Alaskan Native people, and Indigenous Hawaiians are not immigrants. They predated white settlers here by thousands of years. What was the health status of these people before the white settlers arrived? Threads of oral history survive in specific communities, but if any statistics were kept about morbidity, mortality, and health patterns, these have been lost. A federal government–managed health system was put in place on the reservations, with little funding and no consultation from local communities.

Red flags for Native American and Alaska Native health are waving on these topics: COVID-19 mortality, obesity, cardiovascular disease, diabetes, alcoholism, drug addiction, mental health issues, suicide, maternal and infant health, dental health, life expectancy, infectious disease, and more.

To quote the Indian Health Service of the federal government:

Calling out Mental Health Risk in All Three Populations That Need Language Support

By Eva P. Stitt, PhD, M.Ed., & Linda Golley, MA

Most human beings strive to be healthy in mind and in body. Mental health and physical health are unquestionably connected and interrelated.

In the United States, mental health is a poor stepchild to physical health when it comes to attention and funding. Mental health care is often not provided at all until a person is in crisis. And then, mental health is attended to by separate providers, separate facilities, and separate payors than physical health.

Patients who need language support for health care need it for both physical health care and mental health care. We who work to improve healthcare language access must always include attention to the mental health environment of care. We must work with patients, providers, interpreters, language companies, interpreter service managers, and interpreter trainers to optimize communication and engagement in mental health settings.

Patients who need language support may be immigrant, Native American, or Deaf people who prefer to use a language other than spoken English. Although

Calling out Mental Health Risk... continued

many people in every community on earth need mental health care, those people in the United States who do not speak English are at higher risk of needing mental health services because of their life experience and the difficulties that they and their communities may face.

Here are some all-too-common mental/social/emotional wounds for which patients may need care and language support:

- Discrimination/abuse/attack / torture for their ethnic, racial, or tribal/national identity, either in the USA or elsewhere
- Discrimination/abuse/attack / torture for their religion, lack of religious belief, or politics
- Discrimination/abuse/attack / torture for their gender identity or sexual preference
- Discrimination/abuse/attack / torture because they are female
- Discrimination/abuse/attack / torture for their physical or intellectual disability or other vulnerability
- Detention, incarceration, military service

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. . . . Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011).

American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively).

American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/ suicide, and chronic lower respiratory diseases. (HHS, 2019, paras. 2–5).

Red flags for Native Hawaiian people include lower life expectancy than for other groups on the islands, and relatively higher mortality from cancer, heart disease, diabetes, and stroke (Mokuau et al., 2016).

Assortment of medicinal herbs at market place.

What we do know: Deaf, deaf, and Deaf-blind communities – Health Status

There are red flags for Deaf people, as well. Mainstream U.S. business is organized for hearing people. Every process for accessing health services of any kind is based on spoken and written English.

Deaf people are less likely to be able to get appointments for routine visits, less likely to get preventive health care, less likely to understand health information, more likely to use the ER for all care, less likely to understand exactly what is happening while in care, and more likely to have higher morbidity or mortality than the mainstream for conditions such as labor and delivery, cardiovascular disease, and testicular cancer (Barnett et al., 2011; Hoglind, 2018; Schniedewind, 2021; Sheppard, 2013). [Barriers of Care Map link](#)

Patients and Communities Advocate for Better Health Outcomes and a Responsive Healthcare System

Patients, the main stakeholder in healthcare language access, make many efforts to improve their health situation, including by making sure that they can communicate with their care team. The following statements are true of immigrants, Native Americans, and Deaf people:

- Patients and family members complain to the care team, to the interpreter manager, to the Patient Relations staff, and to administrators when they do not get language support.
- Patients sue their healthcare providers and alert regulators to protest poor care. This remedy is used most effectively by Deaf patients.
- Patients seek out providers, clinics, and health organizations that welcome them and that provide language support via interpreters, dual-role staff, or bilingual staff and providers. Clinics that integrate culturally appropriate health practices are well-attended.
- Patients may follow traditional health practices, either on their own or with the guidance of a traditional healer. Some patients use only these traditional practices, while others use traditional and Western medicine practices in parallel.

- Some patients abandon the biomedical healthcare system because it does not work for them and they cannot make themselves heard or understood. They instead seek out traditional health practices, often set up and managed by practitioners who speak their own language. (paras. 2–5).
- Patients study up on their health issues on the internet, often in their own language, and then ask for what they want from their providers. If local providers are not responsive, patients may go elsewhere, even out of the country, to get care.
- Patient communities call for more specific research rather than research that lumps broad categories of people into studies. For example, AAPI (Asian American and Pacific Islander) health coalitions demand that health researchers stop grouping East Asians with SouthEast Asians, South Asians, and Pacific Islanders to report useless data about averaged Asian American health status. (Mokuau et al., 2016)
- Patients participate in focus groups. For example, Somali women used focus groups to lobby the two university hospitals in Seattle to reduce the pressure on Somali pregnant women to agree to a C-section.

Calling out Mental Health Risk… continued

- War, famine, displacement, natural disaster, poverty, hunger
- Substance abuse, behavioral addiction

Care teams at every point of care must be alert for mental stress on the part of their patients who may have experienced such trauma or difficulty. And for discussions and treatment related to mental health, care teams must partner closely with their interpreters to optimize communication. Interpreters may suggest when to clarify topics where the parties may be missing each other's meaning because of cultural or linguistic complexity. Providers may direct the interpreter in adapting the mode of interpretation to support the encounter needs of the moment.

Here is an illustrative case of care gone badly wrong, a sad story, a wake-up call, that really happened: A person was taken to ER for suspicion of mental health crisis. There was no qualified interpreter at the time of admission to ER. The care team went with their gut feeling and decided to hold him "under observation." The individual was bored and agitated at being detained for an unknown reason. He tried to speak to every person

Calling out Mental Health Risk... continued

within speaking distance, but because he did not speak English, it was perceived by the care team as "talking to himself," "signs of hallucination," and "risk for suicide." The individual was given anti-depressive and anti-psychotic medications. Each time the medication wore off and he regained consciousness, he would physically struggle to express his anger. The care team perceived these actions as "combative" and "delusional." It was not until after 30 days in a mental health facility and a fourth session of thorough interview and assessment by a psychiatrist supported by a qualified interpreter that the psychiatrist concluded that the patient had no qualifying mental disorder and should not have been confined in a mental health facility in the first place.

There are thousands of individuals with similar cases across the country. When the collective social and financial cost is accounted for, it runs to billions of dollars and great mental anguish; yet there is no serious effort to ensure that language access is available to all Limited-English-Proficient patients. More importantly, research related to such cases is sparse.

Stakeholder Group: Patients... continued

Patients can carry out all of the above activities if they have language support to make complaints, get their records, attend focus groups, and learn about supportive services in their own language. Most health surveys, studies, focus groups, and questionnaires are conducted in spoken English or presented in written English. Many data-gathering projects on health access and health outcomes intentionally or unintentionally exclude people who are not fluent in English, be they immigrant, Native American, or Deaf people (Barnett et al., 2011).

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Language Access Support Leads to Better Outcomes: A Research Framework

By Linda Golley, MA, & Eva P. Stitt, PhD, M.Ed.

How Effective is Language Support in Assuring Better Health Outcomes?

What DO we actually know?

Considering that there is such a definite mandate to ensure that limited English proficient patients receive language support, one would think that there was definitive proof that carrying out care processes with language support yields objectively better outcomes than carrying out care processes without language support.

Just as there are national crash statistics for cars with and without airbags, surely there are national statistics about care outcomes with and without language support.

But no. There are no such national statistics. As we show in the Patient Stakeholder section, we do know some facts about disease incidence, risk, and outcomes in US populations of patients in which SOME of the individuals need language support.

Of course, we know that both care teams and patients feel better about their interactions if they can communicate fully and freely. And we have individual case studies that show how badly health care can go wrong when the parties do not communicate successfully.

To find out what we DO NOT know, we propose the following research framework:

But in order to know whether and to what extent language support in health care leads to better health outcomes for those individuals who DO receive language support, studies must be undertaken which are organized as follows:

Identification of Eligible Participants

Substantial cohorts of individual patients who need language support must be identified.

Payors like Medicare and Medicaid have access to large enough data sets from patients across different care settings. Payors are in the best position to perform the definitive studies on the efficacy of language support in improving health outcomes because they can compare patients from settings which provide language support and which do not provide language support.

National Institute on Minority Health and Health Disparities Research Framework

		Levels of Influence*			
		Individual	Interpersonal	Community	Societal
Domains of Influence *(Over the Lifecourse)*	Biological	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen Exposure
	Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
	Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
	Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Social Norms Societal Structural Discrimination
	Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes		Individual Health	Family/ Organizational Health	Community Health	Population Health

National Institute on Minority Health and Health Disparities, 2018
*Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority
Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region

Diagram describing language access proxy variables.

Identification of Research Variables

For language access outcomes research, the key variable is set to whether the patient did receive language support at ALL points of the care process involved in leading to the specific health outcome, or did not. It may be necessary to set a binary variable of yes received or no did not receive for each node of care.

Additional variables are defined and captured: specific language needed, age, gender, immigration generation, health coverage status with payor detail, address, socio-economic status, patient diagnosis (ICD codes), what services are provided (CPT codes). These variables are required in order to separate out these influences over patient outcomes versus provision of language support as influencer over outcomes.

Establish Language Access Support in all Points of Care

Intake forms, patient education materials, instructions for self-care, medication instructions, telephone answering system, electronic communication portal (possibly an app) for the patient to communicate with the care team, receive lab results, and correspond with the care team, are all nodes of care.

In order to compare outcomes for patients based on whether they received full language support, researchers have to have subjects who do receive full language support as well as subjects who do not. For

example, a clinic which has full language support for its breast cancer patients must be compared to a clinic in which full language support is not available. Research studies focused on specific points, such as written instructions for glucometer use, will prove to be valuable.

Research Study Design

Patients are assigned categories based on their stage of disease for each diagnostic grouping. For example: Breast cancer type X, stage X; HIV viral load; bipolar disorder; or Attention Deficit Disorder.

Patients are separated out into two groups of patients who needed language support based on whether they generally received language support over most of the nodes, or whether they did not receive language support over most of the nodes. Patients are asked or documentation is checked about language support supplied at each in-person or remote encounter with the care team, and about documentation and instruction that were provided, and about language support for using the telephone system and portal.

Mapping Out Health Outcomes

Outcomes are looked at for the two groups, those who DID and did NOT receive language support consistently.

Infographic showing elements of social determinants of health.

A control group is created of English-speaking patients with the same health status and who received care in the same hospitals and organizations as the study group received their care. This is necessary because Hospital A which routinely provides language support may provide better care for ALL patients compared with healthcare organizations which do not routinely provide language support. Hospital B may have poor outcomes for both English-speaking and users of foreign-language, Native language, or ASL. Hospital C may have better outcomes for English-speakers than for those who require language support.

Analysis is performed measuring the key variable of YES or NO language support against health outcomes. Then, separate analysis of YES or NO language support for patients by language, age, gender, immigration generation, health coverage, or socio-economic status, etc.

Patients Who Drop Out of Care

Another key piece to the research involves patients who drop out of care. Most research studies remove patients who fall out of care from the final

analysis, as not all data points cannot be filled in for them. However, falling out of care is a major failure of care, a very poor outcome in and of itself, and must be looked at for clues as to why the patient dropped out of care. For this study design related to the efficacy of language support, it is essential to record at what point each patient dropped out of care, and then to look at whether language support was provided at each node of service leading up to the patient dropping out of care. Both spoken and written communication nodes must be examined.

For example, a patient with diabetes may have participated in care at his clinic, been diagnosed, been prescribed medication, been referred to a class on how to measure his blood glucose at home, been referred to a nutritionist for dietary guidance, then stopped going to his doctor. It is critical to ascertain whether language support was provided for all nodes of spoken and written aspects of care. Many diabetic patients recount that they do not receive translated written instructions for their glucometer, for example, so they give up on trying to measure their blood sugar and are treated as non-compliant by their care team.

This research design is complex, but it will yield clear data about the effectiveness of language support for health care services. Now, who is going to DO this? Calling all researchers! perc@ncihc.org

Barriers to Care Visualization Poster

By Linda Golley, MA
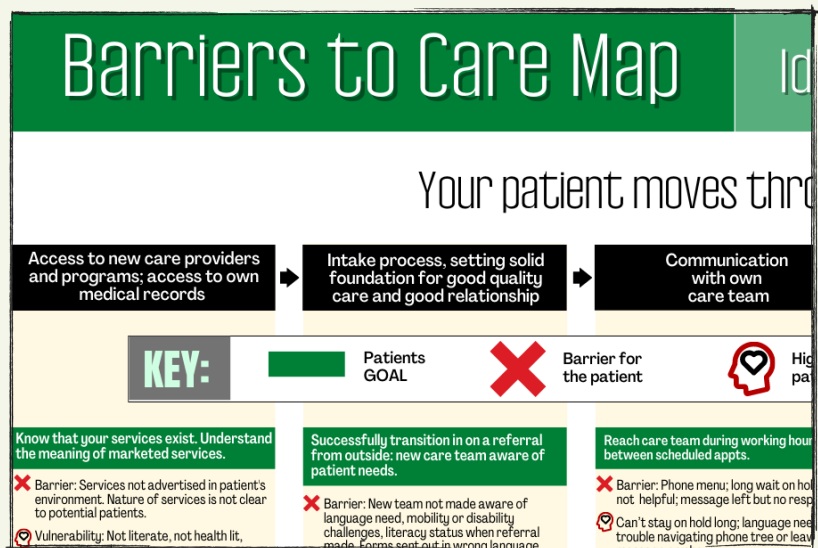
A tiny piece of the Barriers To Care Poster.

Patients must do many tasks to access care. They must find a source of care, contact the care team, establish care, engage with care, and move through the care process with all of its contact points and requirements. The care system is fractured into many pieces, so the patient may need to engage with multiple health organizations, programs, pharmacies, providers, and payors. The patient may encounter barriers at each step of the way. This poster presents a visual image of the many tasks that a patient has as s/he accesses care and shows the barriers that can pop up. The poster also shows the likely consequences of each of these barriers if the patient cannot navigate past that step.

This poster is viewable in its entirety at this link on the NCIHC website. Barriers To Care Poster link

You will also find a link there to the PowerPoint presentation that walks through the concept of barriers to care, and information about how to get a copy of these materials for use in your own environment of care.

Care Team of doctors, nurses, social workers, and the entire team of care providers and staff who interact with patients

By Linda Golley, MA, &
Tracy Young, CHI-Spanish, RN, BSN, MA

Health care is carried out for patients by the care team. The essential relationship in healthcare is that between the patient and her:

- <u>licensed provider</u>: doctor, nurse, clinical social worker, therapist, pharmacist, etc.
- <u>ancillary health staff</u>: medical assistant, tech, receptionist, etc.
- <u>extended care staff</u>: financial counselor, patient educator, chaplain, etc.
- <u>community-based health workers</u>: suicide-prevention call center workers, EMTs, health campaign outreach workers, public health infection trackers, nursing home staff, support group leaders for specific health conditions such as cancer, Alzheimer's, ALS, brain injury.

Healthcare teams provide medical care and health advice in hospitals, clinics, SNFs, hospice, nursing homes, schools, immigration detention centers, prisons, disaster areas, and patient homes, and on the street.

Legislation requires that the patient be provided with language support, both oral and written, for all communication with the care team. Also, CLAS Standards mandate that the care team approach the patient in a culturally competent way so as to support the patient's own care goals, needs, and preferences. (See article "Why Language Access?" on page 6)

How does this language access situation look from the care team's point of view?

In this article, we present the resources and challenges that providers and care teams have regarding caring for patients who do not speak English, as things stand today. And we look at initiatives that originate in the provider team itself.

We will look at how care teams are approaching:
- persistent disparities in health outcomes.
- logistics and technology involved in language support.

- provider best practices, including partnering with the interpreter and the patient.

Disparities in Health Outcomes and Reducing Barriers to Care

To be horrified by inequality and early death and not have any kind of plan for responding that would not work for me. —Dr. Paul Farmer (as quoted in Public Health Insight, 2021).

Each provider is motivated to provide the best possible care to each patient in order to secure good health outcomes for that patient. The patient's welfare is the driving force behind health care.

Disparities in health outcomes are more widely recognized day by day. As we outlined in the article on Patients, page 10, patients who are immigrants, Native Americans, and Deaf experience significantly worse health in many ways than do non-Latino hearing white people born in the USA. Many individuals in these communities have a need for language support.

Providers and researchers are increasingly researching disparities, trying to differentiate the different factors contributing to poor health outcomes. We are very excited to see the explosion of studies carried out by different branches of medicine. Instead of presenting average outcomes for all patients experiencing certain pathology or undergoing certain treatment, researchers are finally separating out those patients who do well from those who do poorly and looking at their demographic characteristics. Researchers are beginning to interview individual patients from groups whose outcomes are poor, trying to identify what aspects of access to care or barriers during care contribute to poor outcomes.

As Smedley et al. (2002) noted, "Participants' stories and opinions are presented in their own words, providing evidence of health care inequity that participants attributed directly or indirectly to racial or ethnic discrimination, their lack of English-language proficiency, or both" (para. 1).

Please visit the brand new NCIHC Annotated Bibliography on Healthcare Language Access on the NCIHC

website. We have gathered hundreds of research articles and news stories, with our searchable notes on the key topics covered. This repository will grow rapidly as we annotate more studies. You can access the annotated bibliography by using this link [Annotated Bibliography link](#)

We are also delighted to see that some researchers are going beyond the variables of income, gender, geographical location, ethnic group, and race to explain disparities in care. It is at this interface, of detailed parsing of variables, that two key language variables will finally be included as variables in research on health disparities:

1. language need: Does the patient need language support?
2. language support: Did the patient get language support?

Some case studies of individual LEP patient mishaps have been published and analyzed (Day Translations, 2019). Now we await aggregate studies on disparities that analyze outcomes based on the variables of language need and language support, such as the study on medical interpretation errors and their potential clinical consequences (Flores et al., 2012).

Logistics: Mechanisms Available for Providing Language Support to Patients Today

We have come a long way in language access logistics. Today there are well-developed ways to ensure complete and accurate information exchange between the care team and the patient in most care situations. We acknowledge that there are administrative and financial barriers to implementing these forms of language support in many healthcare environments, which impact the care team's ability and willingness to engage them.

The following scene illustrates some examples of difficulties. Imagine that the rounding doctor on the cancer ward needs to round earlier than usual, and the assigned interpreter is not there yet. The bedside nurse finds that the video device has been left uncharged in the cupboard. As a result, the doctor may try to talk to the patient in English, talk to a family member who speaks English instead of to the patient, use a family member as an interpreter, or speak to the patient using her own inadequate language skills. And neither the doctor nor the bedside nurse may be aware that the hospital has translated materials in the patient's language to give her. All too often, the lack of language support is not documented in the patient's chart. Providing proper language support may appear too difficult to comply with to particular members of the care team at a particular moment.

TIMELINE: RESEARCH ON DISPARITIES IN HEALTH OUTCOMES

1975	2000	2010	2020	Future	>>>>> >>>>> >>>>>
SE ASIA REFUGEES		BETTER DATA, PERSISTENT DISPARITIES			

Aggregate studies with language	****
Focus groups to identify barriers, including language	***
Case studies on language-need individuals with poor outcomes due to language	**
Ethnic-based disparities, no language need variable, averaged over large groups like "Asians"	*
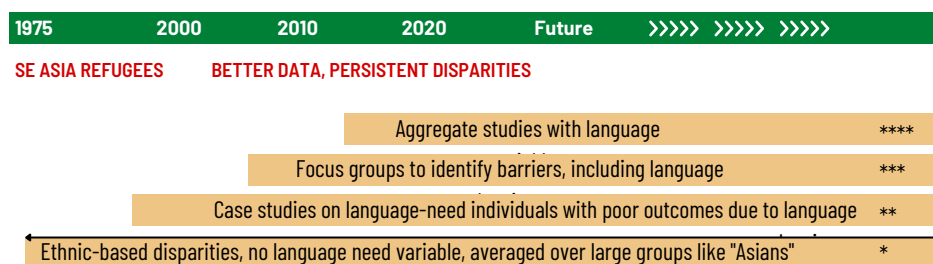
Timeline.

Acceptance and Adoption of Language Support Options by the Care Team – Historical to Present

TIMELINE CARE TEAM: LANGUAGE SUPPORT MECHANISM

1945	1975	2000	2010	2020	Future >>>>>
	SE ASIA REFUGEES			COVID-19	
None	Ad hoc community interpreter	Professional Interpreter: Onsite, Phone, Video, Telehealth >>>>>			AI triage, Dx, Tx

Dual role staff, ad hoc then formal status, assessed and trained

Bilingual staff and providers, ad hoc then formal status, assessed

Clinic or unit dedicated to bilingual, bicultural care

Care via portal, telehealth, app care (scheduling, insurance EOB, Communicate with MD)
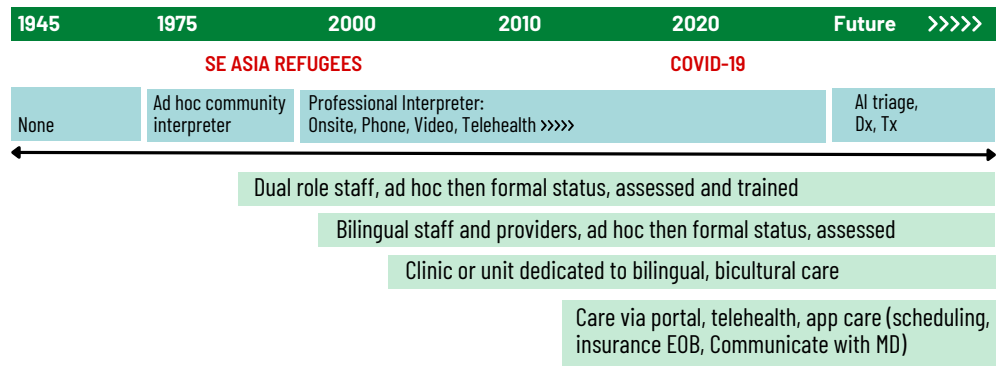
Timeline.

Let's do a walk-through of what language support has been available to the care team up until now. We will look at both spoken/signed and written mechanisms.

Providers have seen continuous change in both the primary mechanism and the number of mechanisms of language support available to them since the 1980s. Before the 1970s, there were no interpreters. If a patient did not speak English, he either did not seek care or he arrived for care accompanied by a family or community member. This was true for patients whose primary language was Spanish, German, Swedish, Navajo, or ASL.

With the arrival of the SE Asian refugees from the war in Vietnam, community interpreters began to be paid. ASL interpreters were also now paid. The healthcare organization was able to make arrangements ahead of time for an interpreter to appear. These interpreters came to the healthcare encounter in person. Health materials and forms were not translated at this time.

Interpretation over the phone began to be available in the late 1990s, enabling patients speaking less common languages to benefit from interpreters in other parts of the country. Phone interpreting took decades to implement broadly, however, because patient rooms did not have phone outlets, and phones had to be bought and then installed at all points of service. Many providers rebelled against using the phone because they could not hear as well and also because the interpreter was no longer physically present to assist the patient with navigation and forms. The phone interface did not work well for patients who were hard-of-hearing, Deaf, demented, confused, pediatric, or traumatized. The availability of inexpensive phone interpretation was neither known nor implemented by smaller clinics and doctor/dental offices, nor by community health teams out in the field. This was and still is a significant lost opportunity for huge numbers of patients who need language support.

Some written healthcare materials and forms began to be translated into major languages by larger organizations in the early 2000s. But the Joint Commission had not yet included written translations in its checklist for review of facilities. Providers who recognized the importance of translated materials sometimes asked a bilingual colleague to translate something important. But the cost of professional translation was not written into budgets. Please see the article "Accessing the Paper Chase" on page 43.

Video remote interpreting for health care began to be tested in beta format in about 2005 and gradually was adopted by larger health organizations. Only ASL and a few major languages were offered at first, and only for specific parts of each day. Care teams preferred video remote (VRI) to phone (OPI) because the video device lets all the parties see and hear each other well. However, video is more expensive than phone interpretation, both for the minutes and for the video equipment, so video devices were and still are located only in certain areas of the healthcare facility, usually in the ER and on inpatient floors. Even today, care teams in many settings do not have video in place. On the other hand, some facilities allow their doctors and nurses to install the interpreter app directly on their personal phones so that they can carry around interpreter access with them in their pocket.

Some care teams prefer to have an interpreter on site rather than on video, both for the richer interaction and so that they don't have to manage equipment and connection issues. VRI is not effective for patients who are undergoing procedures or who are not alert.

Community care teams that function out in the field, such as paramedics and visiting nurses, can utilize pre-contracted phone or video interpreter services over their cell phones. Video supports ASL interpretation, which cannot be done by phone audio only.

By 2020, many healthcare facilities could provide language support with a mix of professional interpreter mechanisms: on-site, phone, and video. Thanks to regulatory enforcement, translations are now available in at least the major languages for some key documents in most healthcare facilities.

The COVID-19 pandemic that started in 2019 disrupted normal care pathways. The care team itself had to operate differently, often canceling routine care to provide urgent care, or simply being closed down for

Dentist working on patient's mouth.

extended periods. Many patients with language needs became cut off from care, as they were unable to navigate the phone system to reschedule canceled appointments or to contact their care team via automated pathways. The vast majority of routine care was interrupted. People went without checkups, had trouble getting medications refilled, had procedures canceled, could not get a response to urgent situations, did not receive lab reports, and did not have the health screenings that normally take place (Bookmark, 2020). Telehealth was initiated in some places, but it rarely included built-in language support mechanisms (Wetsman, 2020).

Providers who did see patients during the pandemic often experienced a shift of interpreter availability from on-site to remote. This transition to remote was an abrupt shift in relationship for all stakeholders: the care team, the patient, and the interpreter (Le Neveu et al., 2020). Remote modality has inherent challenges: The parties cannot fully see body language and how the encounter is unfolding. COVID-19 added the difficulties of parties wearing masks and thus being less audible and visible. In acute care settings it must have been very difficult to manage remote interpreter devices in the midst of ICU activity.

EMS workers wheeling a patient into hospital on gurney.

As COVID-19 retreats ever so slowly into the background of the healthcare landscape, we mark its advent as one of the most difficult times in which to provide equal access to care to patients needing language support.

Moving into the future, providers will carry out patient contact through less direct means, including the patient portal and artificial intelligence algorithms, instead of through hands-on appointments. These newer care pathways, like telehealth, do not usually have language support built into them, so they pose serious challenges for equal access to care. We encourage our care team stakeholders to advocate strongly for language support to be built into every care pathway.

Provider Best Practices in Engaging With the Patient

Licensed professionals are both convinced of the importance of language support and impatient with

the logistics of having to rely on a third party to bridge the language gap with patients. Many providers push for either eliminating the need for an interpreter, or, if that is not possible, for making the most out of the interpreter interface. Let's consider bilingual care teams, provider cultural competence, and partnering with the interpreter and with the community.

There is a strong movement in the American medical profession today to develop bilingual providers. Although there have always been solo providers who happened to share a language with some of their patients, today there is a broader realization that being a bilingual provider requires language proficiency at a provider level in both languages. Bilingual providers have a better chance to engage their patients directly, as long as they are also culturally competent (Abuelo, 2020; Fernandez et al., 2010).

Administrators are getting on board with the bilingual provider trend because it helps them advertise their services to the community and it saves on interpreter costs.

Providers also appreciate having competent, trained dual role and bilingual staff on their teams. You can read an interview with a dual-role interpreter on page 26.

Language access is also supported by other trends in medical and nursing practice, including those toward cultural competence, palliative care, community-based medicine, and new techniques in patient education. All of these movements or practice styles

Emergency Medical Services vehicle.

share the recognition that health outcomes are better if the patient is engaged with the care team and invested in the care plan.

Cultural competence requires attention to the patient's language needs. Palliative care requires deep discussion of the patient's goals, needs, and preferences for care, and thus demands full communication. Community-based medicine takes care out to the community and often requires a mix of English plus another language, whether spoken or signed. Patient education now stresses presenting information to the patient in a format that she can understand and interact with, thereby forcing attention to language and literacy. A key point of patient education is now recognized to be teach-back. All of these practice styles benefit patients who need language support.

Providers Partnering With Interpreters and Directly With Patients and Communities

We celebrate the evolution toward providers partnering with their professional interpreter.

First, let's take a moment to acknowledge the sometimes ambivalent relationship of the provider to the interpreter. In biomedicine, the interpreter is a costly but mandated business practice, just like sterilized instruments and clean sheets. It takes longer to speak to the patient via an interpreter than it does to ignore the patient and just talk with a relative of the patient who speaks English. The provider might not appreciate having the interpreter as a witness to care. The provider could be frustrated that the interpreter is not significantly trained to perform accurately or ethically.

As interpreters become better trained, providers appreciate them more. Interpreters today understand that they are members of the care team and that as such they are expected to keep up with advances in medical

care. Beyond accuracy, and in accordance with the CLAS mandate, many providers now partner with their interpreters to really listen to and understand their patients. The interpreter does not explain the patient's message to the provider. Rather, the interpreter identifies moments when the patient and provider are not catching each other's meaning and suggests to each that they describe what they mean to the other principal party.

The interpreter can help by suggesting a teach-back in any part of the care process to make sure that all information was successfully conveyed. Teach-back is critical in self-care instructions such as stoma care, patient education about a medical condition like diabetes, and consent for a procedure or treatment.

As providers grow in their partnership with professional interpreters, they teach interpreters important facts about medical practice in their specific environment of care.

Below are quotations from three healthcare providers.

◆

❝In a childhood development assessment the interpreter can destroy the value of our study by not following the exact protocol that is laid out by the psychologist. If there is any variation in the phrasing of the questions, the register of the instructions, or the distraction level for the child, our study is invalid. ❞

◆

❝When we do a forensic medical examination on a woman who has been raped, every word that the patient says is significant, both for us to understand what happened, but also for later use in court. The interpreter must pay very close attention to transmitting the exact meaning to us. ❞

◆

❝When we ask a patient about her sexual behavior and experience, it is for a specific reason. We need the interpreter to follow our lead both in words and in tone. Our medical practice involves building a relationship with the patient so that we can lead the patient on a journey of learning. I want to be able to debrief with my interpreters after encounters that went well, and after those that did not go well. ❞

Sometimes healthcare providers reach out to collaborate with the interpreter services manager (and vice-versa) and with the local interpreter association to develop technical courses for local interpreters. For example, the inpatient specialist nurses at Seattle Children's Hospital authored and presented classes on pediatric cancer and pediatric cardiac surgery specifically for the local cadre of medical interpreters. In another example, the 15-person multidisciplinary provider team at the Center on Human Development and Disability (CHDD) in Seattle created an in-service for interpreters on how to interpret during each very different segment of the all-day childhood development assessment.

Now let's take a look at the care team partnering with the patients and community.

Healthcare institutions and processes are driven by the healthcare industry and by healthcare providers, not by

Medical worker pulling a paper patient chart.

patients or the community. This seems backwards, considering that patients are the customers for health care and the ultimate payors for health care.

There are some rare instances in which care teams work with the community to provide care in a way that fits the needs of the community. These initiatives include making the care accessible and affordable, and they include cultural appropriateness and language support as fundamental elements. Most often, these initiatives are driven by licensed providers who are themselves members of a community that is culturally distinct and that may prefer a language other than English. The SeaMar Clinic in Washington State, started by two Peruvian physicians for the Latino community, is an example, as is the Somali Health Board, started by a

community that is culturally distinct and that may prefer a language other than English. The SeaMar Clinic in Washington State, started by two Peruvian physicians for the Latino community, is an example, as is the Somali Health Board, started by a Somali pharmacist and nurse husband-and-wife team. Mental health services require both linguistic and cultural competence. The Asian Counseling and Referral Service is such an organization in Seattle: "ACRS promotes social justice and the well-being and empowerment of Asian Americans and Pacific Islanders and other underserved communities—including immigrants, refugees, and American-born—by developing, providing and advocating for innovative, effective and efficient community-based multilingual and multicultural services" (acrs.org, "Asian Counseling and Referral Service").

Physicians also create valuable resources to bridge the language gap, such as the new cancer terms glossary in the Navajo language (Rosetta, 2008).

What do we want to learn more about regarding care teams and language access?

We want to know more about how many healthcare providers and care teams do and do not routinely include an interpreter in their on-site, phone, and portal interactions. What do they do when they suspect that the interpreter is not technically competent at the level of the conversation? How are they partnering with their interpreters? What stories, case studies, and aggregate studies do they have to share with us for our NCIHC website's annotated bibliography?

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Announcing the
NCIHC Annotated Resource Library

By Tatiana Cestari, PhD, CHI–Spanish

The National Council on Interpreting in Health Care is excited to announce its new Annotated Resource Library!

This Annotated Resource Library serves as a compendium of resources related to language access in the U.S. healthcare system.

Resource Library items address issues of interest to the various NCIHC stakeholders, such as healthcare interpreters and translators, healthcare providers and members of the care team, language companies, language program managers, interpreter trainers, patients and families, and community health/advocacy organizations.

Visitors to the Resource Library can search for items based on major content categories, date, and authorship without having to open the actual items.

Each resource item is reviewed and annotated by the NCIHC Education Work Group. See the Notes column in each section of the Resource database.

We have ~50 annotated pieces, and the list will continue to grow. Click here
Annotated Bibliography Link

INTERPRETER SPOTLIGHT

Helen Tayar: Fully Supported in My Interpreting Dual-Role

By Danielle Meder, RID-NIC &
Gabriela E. Siebach, MATI, CHI-Spanish

Picture of Helen Tayar in field of sunflowers.

At many hospitals and healthcare systems throughout the United States, bilingual employees play a vital role in the provision of language access. Some bilingual staff use their language skills to communicate directly with patients only after being tested for language proficiency. However, others use their skills to interpret between patients and other colleagues, serving in a dual-role capacity.

Guidance and best practices is limited when it comes to dual-role staff who both serve as interpreters and hold a second role in a hospital or healthcare system. As a result, interpreters serving in dual-role functions throughout the United States do not necessarily receive the same level of support from their employers. In this interview, Helen Tayar, a dual-role patient care assistant (PCA) and Arabic interpreter at Cincinnati Children's Hospital Medical Center, describes the level of support provided by her employer's policies, both as a bilingual PCA who provides direct care to patients in a language other than English and as a staff interpreter.

ACCESS Editors: Describe the training you have received for your role as a PCA and as an interpreter. How did it differ?

Helen Tayar: I was already working as a freelance interpreter before being hired by Cincinnati Children's and had already completed an 80-hour Bridging the Gap interpreter training program. And Cincinnati Children's was one of the hospitals where I was providing interpreting services through an agency.

When I was hired by Cincinnati Children's, I was hired as a PCA. For that role, I received 3-4 weeks of training on the floor. The training I received was first with other PCAs who were showing me how to do this new role, and then with a nurse. As a bilingual Arabic native speaker, I took the bilingual staff assessment. This assessment was to qualify me to speak directly to patients and to have

> The program at Cincinnati Children's has gone through many changes. Currently, there are two qualifications: Qualified Bilingual Staff (QBS) for direct communication and Qualified Interpreter for interpreting. Qualified interpreters must provide proof of completing 40 hours of medical interpreter training and pass a medical interpreter assessment. To interpret for more complex situations, interpreters must pass evaluations and complete terminology work.
>
> **–Fabiola Munafo, Manager, Language Access Services**

direct customer service-type conversations that are non medical with patients in Arabic. The assessment was only in Arabic. I passed the test and now have a qualified bilingual staff badge in addition to my PCA badge.

Although some people may think that being bilingual is enough to interpret, I know that is not true, and at Cincinnati Children's they know that, too. So I had to take additional training and tests to serve as an interpreter (dual role staff). The test was in both Arabic and English, not just in Arabic like the bilingual staff test.

All of the tests I took were provided by an outside company. My test results are kept on file and were also provided to me.

ACCESS Editors: Can anyone who takes the interpreter training and the test interpret at Cincinnati Children's?

Two hats to symbolize dual roles.

Helen Tayar: When I was qualified, there were three different levels of interpreters. After I finished the training and passed the test I was cleared to interpret, but then I was also observed and evaluated by established staff interpreters. My understanding is that their feedback was instrumental in qualifying me to interpret for all settings.

ACCESS Editors: What percentage of your time is spent interpreting in comparison to your PCA role?

Helen Tayar: My schedule as a PCA is 20 hours per week, every week, and I work about 4 hours or so as an interpreter per week.

I should mention that I am currently in school to become a nurse, and my schedule is very limited by that. So if I were not going to school, I could probably work more hours as an interpreter.

At Cincinnati Children's both dual-role staff and qualified interpreters are required to:

- take an interpreter proficiency test every three years.
- be shadowed to check competencies once a year.
- complete 4 hours of medical interpreter continuing education per year.

–Fabiola Munafo, Manager, Language Access Services

ACCESS Editors: As a dual-role interpreter, do you ever need or want to step out of the role of the interpreter to serve in your PCA role while interpreting for a colleague, or vice versa?

Helen Tayar: This is a good question because I interpret on the same floor where I work as a PCA and I do feel a lot of conflict. At Cincinnati Children's I cannot usually interpret when I am working as a PCA, and when I interpret I cannot work as a PCA. I actually have different supervisors for each of my roles, different badges, and even different pay. My interpreting pay is actually higher.

Both of my roles are day jobs, but I have a different schedule for each; for example, my PCA job may be 7 a.m. to 3 p.m. on certain days, and my interpreting schedule is based on the availability I have after my PCA work and school.

I don't remember signing a policy or anything, but my interpreting manager has made it very clear that I need to keep the roles separate. And everyone at Cincinnati Children's seems to understand, because they already know. At one point a doctor told me, "You. I need you," and I said, "I am sorry, I am doing my PCA work" and showed him my badge. Then [I] referred him to other staff interpreters or to the video interpreting services we have available.

It really hurts to have to say no when I know that the family does not speak English at all and that I could help. What I feel is very difficult to put into words; I just know I could help, and I want to, but I know I can't, so I don't.

ACCESS Editors: There are those who believe that you cannot be effective in two different roles and provide meaningful language access. What are your thoughts? How do you maintain your interpreting skills when you spend most of your time as a PCA?

Helen Tayar: At Cincinnati Children's, we are required to regularly retake the test for interpreting. And when it comes to maintaining my interpreting skills, I am always interpreting in my head. When I hear something in English, I put it into my language, understand what they are talking about, and then bring it back to English.

At Children's, dual-role staff can only interpret during their primary role shifts for end-of-life, trauma, sexual abuse, physical abuse, or when acute events require immediate intervention.
–Fabiola Munafo, Manager, Language Access Services

ACCESS Editors: What challenges do you face in both roles?

Helen Tayar: At Cincinnati Children's there is a shortage of PCAs, which makes that role challenging. As an interpreter, the biggest challenge is having to tell parents their child is dying.

ACCESS Editors: What are your plans after finishing your schooling and becoming a nurse?

Helen Tayar: I am really looking forward to becoming a nurse after completing my schooling, and providing LEP patients the care they need. And I plan to stay at Cincinnati Children's after becoming a nurse. I also want to keep interpreting, because I love it.

I interpret because I am compassionate and love being an interpreter. The healthcare system in the U.S. is so complicated, and if patients from other countries do not understand that healthcare works differently in the U.S. from what it is like back home, where you can call the doctor's cellphone, navigating the system will be difficult for them.

Interpreters and Translators providing the language bridge

By Linda Golley, MA, Jaime Fatás-Cabeza, MMA, USCCI & Tracy Young, CHI-Spanish, RN, BSN, MA

Interpreters and Translators – Language Bridge

We have just presented snapshots of patient communities and of care teams, the two primary stakeholders in healthcare language access. If we had a magic wand, these two stakeholder groups would be able to communicate with each other directly via ESP (extra-sensory perception). However, as of 2022, that is still not possible. Instead, patients and care teams communicate with each other via professional linguists in either spoken, signed, or written format.

Healthcare linguists comprise a talented, hard-working cadre of professionals. Everyone who works in healthcare appreciates the individuals involved. Many of us have either served as a linguist or worked with linguists on a daily basis. Our Interpreter Highlight on page 28 illustrates the depth of experience that linguists bring to patient care.

But how much do we know about the linguist profession in aggregate? Today's corps of linguists who work in healthcare settings make up one of the least homogeneous professional groups in the country. We will describe what we do and do not know about healthcare interpreters and translators.

Healthcare Interpreters

As defined in ISO/DIS standard 21998 (2020), an interpreter is someone who will "render spoken or signed information from a source language . . . to a target language . . . in oral or signed form, conveying both the register and meaning of the source language content" (3.1.1).

A healthcare/medical interpreter is an interpreter who is "qualified to provide healthcare interpreting . . . services" (3.1.4SCC).

We call a person a professional healthcare interpreter when she is paid to interpret for patients, family members, or health service clients. This definition distinguishes paid interpreters from ad-hoc interpreters who accompany the patient or who step in to provide a language bridge but who are not paid for the assignment. Healthcare interpreters are also distinguished from interpreters who do not interpret in the healthcare environment. Professional healthcare interpreters may interpret in English, a foreign spoken language, a Native American language, and/or a signed language.

Beyond this definition, what do we know about healthcare interpreters and their working environment? To illustrate how little we know about practicing professional healthcare interpreters, let's compare what we know about them with what we know about registered nurses in the United States. We know how many registered

nurses there are in each state and in the entire country at any point because each state centralizes licensure of registered nurses, and this licensure must be renewed every few years, so even nurses who die or stop practicing can be tracked. There is a finite number of accredited nursing schools, and their curricula are standardized. Nurses must pass their state board exam to become licensed, and these exams are also standardized. Continuing education is required of all licensed nurses. The Census and many business surveys track nursing employment statistics and demographic statistics in detail. Not only do we know how many nurses are practicing, but the actual names of currently licensed registered nurses are also known, at least at the state level. State Boards of Registered Nurses also track when licensure is removed because of unethical behavior, and they have procedures for revoking and reactivating the right to practice.

By contrast, we cannot answer any of the following questions to get an idea of the state of the professional force in healthcare interpreting:

How many healthcare interpreters are there? Who are they? Where do they live and practice? How old are they? What is the ratio of men to women? What languages do they speak or sign? What training did they have? How long have they been practicing?

Why do we want to know these things? Interpreters play a critical role on the healthcare team. We want to know whether there are enough of them, if they are adequately trained

and skilled, and what their working conditions are. Only then can we recruit effectively, train appropriately, and advocate for professional practice conditions.

There has never been a national survey of all healthcare interpreters, because we do not know who they are or how to reach them. The federal Census does collect information about people's livelihood, but it lumps all linguists into one category, which includes court, school, general American Sign Language, business, conference, police, immigration, and healthcare interpreters, as well as translators.

There are some other sources of information about interpreters who accept at least some healthcare assignments:

Two states, Washington and Oregon, require healthcare interpreters to register, at least if they see Medicaid patients. These lists of interpreters are published on the Washington and Oregon state websites. But there is no way to know whether these interpreters are actively taking assignments, because the actual payments made to interpreters for assignments completed are not publicly available.

State and regional professional linguist associations serve various combinations of interpreters and translators. For example, there are associations just for healthcare interpreters, others just for court interpreters, and still others for all interpreters and for translators. Most healthcare interpreters do not

choose to pay for membership in their local or national associations. Even looking at association membership lists, it is not possible to know who is actively taking patient assignments. Most association lists are not published and are closely guarded.

ASL interpreters have a more organized training, testing, and certification structure. The Registry for Interpreters for the Deaf (RID) keeps track of how many signed language interpreters are currently certified, but the signed language certification is a general certification for interpreting and has no specific healthcare component. Many currently certified signed language interpreters do not take healthcare assignments. It is possible to look up specific interpreters on the RID registry, but it is not possible to see the list.

Language companies are constantly updating their lists of contracted linguists, and they keep good track of healthcare specialization versus other knowledge bases. However, many linguists contract with two or more language companies, so all of the language company lists from across the country would need to be reconciled against each other in order to count individual interpreters. Information would need to include the growing number of offshore interpreters who work assignments in U.S. healthcare through remote modalities. Language companies guard their lists of interpreters because that is their "bread and butter." Hospitals and clinics have lists of their staff interpreters. These lists are not shared.

Finally, the national certification bodies for interpreters in the healthcare space, the Certification Commission for Healthcare Interpreters (CCHI) and the National Board of Certification for Medical Interpreters (NBCMI) keep up-to-date information on the number of currently certified healthcare interpreters, in addition to demographic information about them. They share the number of certified interpreters openly and will provide a more detailed breakdown on demographics to bona fide researchers (interpreter languages, geographical location, gender, etc.). Most healthcare interpreters in the United States are not yet nationally certified, although the trend is definitely toward steadily increasing numbers of nationally certified healthcare interpreters.

As of 2022, CCHI has close to 4,930 currently certified interpreters, and NBCMI has over 3,935 currently certified interpreters. There is a small amount of overlap between interpreters who are certified by both organizations.

Language skills and method of language acquisition:

Are the interpreters immigrants, or born in the USA? Is their mother tongue English or something else? If they sign, did they grow up using sign language in their home? If they are Native American, did they grow up in a home where the ancestral language was spoken, or did they learn it as an adult in a program to reclaim the language? Have they taken a test for language proficiency in both of their working languages?

Because we do not know how to identify all the healthcare interpreters in the country, we cannot survey them about how they acquired their language skills; nor can we administer any standardized general linguistic proficiency assessment, let alone administer a specialized healthcare language proficiency assessment.

Number of hours spent on healthcare assignments versus assignments in other domains such as court, conference, or education:

We want to survey interpreters about their mix of assignments, both when working on-site and when taking remote calls. We need to include interpreters who take industrial medicine assignments as healthcare interpreters in our survey. The industrial medicine niche is often overlooked as part of the healthcare domain because patients with industrial injury claims are directed to

get care from specified doctors and payment for the interpreters comes through the industrial insurance system rather than from standard health insurance payors.

Interpreting work versus non-linguist work:

How many healthcare interpreters work at interpreting only? How many make a living just with interpreting work? How many healthcare interpreters also work on a regular basis at some different type of occupation?

We know anecdotally that many interpreters, especially of languages that are not as common in the United States, have to support themselves with some completely different form of work because demand for their services is not enough and they may not have any employment benefits for their family through interpreting.
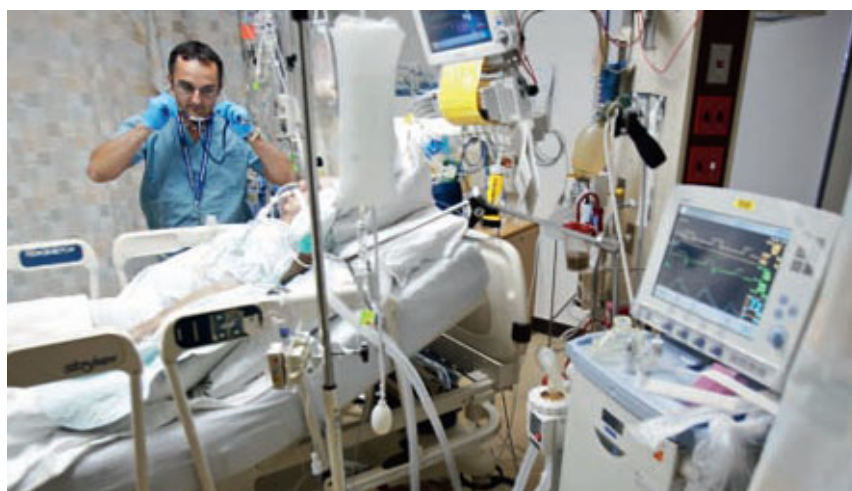
View of provider standing over patient in ICU bed.

Types of healthcare environments in which healthcare interpreters see patients:

What percentage of interpreting sessions take place in outpatient clinics, emergency rooms, inpatient, procedure, mental health, public health outreach, dental health, disaster response, etc.? What is the percentage of assignments across various specialty clinics?

This information is collected and analyzed by individual language companies and certainly by individual healthcare organizations. But this data is not shared with anyone or aggregated over companies or organizations at present. This information would be very valuable to know for training interpreters and the state of the industry.

Employment status of healthcare interpreters:

For those who are employed as staff by either a healthcare organization or a language company, what are their working conditions, benefits, requirements for hire, training? Do

they have additional linguist duties, such as translator, added to interpreting? Employment status is a moving target right now, as many healthcare organizations are dissolving their interpreter services departments in favor of contracting all assignments out to language companies.

For those healthcare interpreters who contract as independent professionals and take assignments through language companies, we want to know: What orientation were they provided? Were they assessed for language proficiency? Did they receive healthcare interpreter training? Are they prepared for on-site and for remote interpreting, depending on the case? Are their vaccinations current? Did they undergo criminal background checks?

Please see the article "Language Access Employment and Contracting Models" on page 57 for in-depth discussion of working conditions and employment status.

Union membership:

Are the interpreters represented by no union, by one union, or by more than one union? For example, in Washington State, only interpreters represented by Interpreters United are permitted to be paid for Medicaid patient assignments, which constitute the great majority of foreign language assignments. In

parallel, staff interpreters at the public university and county hospitals must be represented by the Service Employees International Union (SEIU), which also represents staff medical assistants and techs. Union jobs at healthcare organizations often provide solid benefits.

Work technology environment:

It would be interesting to survey interpreters, language companies, and healthcare organizations to see whether their data is consistent with each other's: What is the percentage of assignments provided on-site in person, on-site remote from a booth, and remote from home? It is important to know how this mix has changed because of COVID-19 in order to best support interpreters with training and to ensure decent working conditions. The National Council on Interpreting in Health Care conducted a survey of healthcare interpreters a year into the COVID-19 pandemic. In this issue, we present the results of the survey related to how technology use for interpreters has changed during the pandemic and to how the current technology environment affects interpreters' effectiveness, and stress. Please see the article "Remote Interpreting Modalities in Health Care Settings" on page 36.

Path to Professionalization:

What are the interpreters' credentials regarding healthcare interpreter training, experience, and certification? How many have academic degrees as linguists? How many have professional training in health professions, such as credentials as physicians, nurses,

Two male interpreting students back to back practicing consecutive dialogue.

pharmacists, therapists, medical assistants?

We need to survey individual interpreters about these variables to get a clear idea of how far along the path to professionalization the entire corps of healthcare interpreters is today. We know anecdotally that many interpreters have had no training, no assessment, and no background education in health or linguistics but have great experience in supporting their community in accessing health services. At the same time, we have many healthcare interpreters who have solid training both in linguistics and in health science.

TRANSLATORS:

Translators are also critical to patients' access to health services. Translators provide the language bridge for written materials. Please see the article "Accessing the Paper Chase" on page 45 for a discussion of the need for translated materials in the health sector.

Unlike interpreters, who interact directly with patients and care teams, translators receive assignments in digital format and work at a desk supported by translation programs and dictionaries. They coordinate with the interpreter services manager if they are on staff, or through a language company if they are independent contractors.

As we said at the beginning of this article, linguists are lumped into one category for the Census. How, then, do we find them? Some translators belong to the national American

Translators Association, and others belong to local and regional linguist associations. However, most are not certified and do not belong to an association. As with interpreters, we cannot answer basic questions about translators such as:

How many healthcare translators are there? This answer depends on whether we count crossover interpreters/translators, and crossover translators who take both healthcare and other sector assignments. We would need to aggregate data from all the language companies, the interpreter and translator associations, and the hospital systems.

For specific languages, are there competent translators available for healthcare content? For many languages, it is very difficult to find a translator who is competent in health content, so communities and healthcare organizations train their own translators for the local health programs. It would be of tremendous benefit to the country at large to be able to identify such community-trained translators. For example, a rare language translator competent in health topics who lives in Nevada might be able to perform needed health translations for the entire country.

What is their employment/contracted status? We have no aggregate data, but anecdotally we know that many healthcare translators contract with language companies and accept whatever assignments they feel they are capable of and willing to take on.

What conditions do they work under— at home, in an office at a company or

at a healthcare organization? How are they paid—by job, by word, by the hour? What are the trends in the industry? More and more professional healthcare translators use translation software which speeds up and makes consistent the material that they produce. To an increasing extent, these programs perform the translation and the translator then reviews and corrects it. It is possible that eventually Artificial Intelligence will supplant translators for all but the most complex and sensitive materials. AI may be suitable for leaflets describing how a machine product works, but for health topics with their embedded cultural content, solo machine translation may result in incomplete or inaccurate renditions of message.

What training, experience, and credentials do they have? Many translators have had academic preparation for translation, but many have not, particularly in smaller demand languages. Often, competent general translators have trouble producing effective healthcare translations because of a lack of specialized knowledge about health care. Therefore, it is important that the translated material be checked by a second person who can read for health content accuracy and other nuances in that language and for the population being served.

References

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Remote Interpreting Modalities in Health Care Settings: Insight from Interpreters

By Gabriela E. Siebach, MATI, CHI–Spanish, Linda Golley, MA, Jaime Fatás–Cabeza, MMA, USCCI, Eva P. Stitt, PhD, M.Ed., & Michelle Scott, RN

Introduction

The National Council on Interpreting in Health Care (NCIHC) is a multi-disciplinary organization whose mission is to promote and enhance language access in health care in the United States. One of its goals is to develop and monitor policies, research, and best practices. The recent pandemic created a different landscape locally, nationally, and internationally, and healthcare interpreters have had to adapt and adjust to help themselves and the communities that rely on them for support.

In 2021, the NCIHC issued a survey for healthcare interpreters. Although the overarching goal of this study was to understand the impact of the COVID-19 pandemic on language access in health care in the United States through the experience of interpreters, the responses provided insights into remote interpreting modalities.

The feedback received from respondents in relation to remote modalities of interpreting is presented in this paper. The survey consisted of 64 questions. The analysis and interpretation of the data presented here are limited to Questions 18–20 and 40–47 only.

Analysis

The majority of respondents indicated that the modality in which they interpreted had changed since the onset of the pandemic, with the vast majority noting an increase in remote modalities (including telephone, video, and either telephone or video telemedicine), which was an expected result, as in response to the pandemic the CDC recommended the use of telehealth when appropriate (CDC, 2020).

In relation to challenges and issues faced in remote modalities since the onset of the pandemic, the most common challenges included the use of masks or ventilators hindering communication and the provider or staff speaking in a manner that is difficult to understand. Additionally, in relation to challenges with the reliability of the equipment or the internet connection, the majority of respondents indicated that they experienced problems. The most common problems reported were problems with the internet connection and problems with background noise at the patient end. Considering that message reception (hearing the message) is the first stage for interpretation and that challenges to hearing the message will affect subsequent stages in the interpreting process (Cokely, 1992), the high number of respondents that reported challenges in this initial stage is meaningful. Another issue commonly encountered during remote interpreting was a lack of briefing about issues related to the medical situation.

Survey responses also indicate that interactions have been impacted by remote interpreting as a result of COVID-19; many respondents noted that, in their opinion, the rapport between the provider and the patient had been affected, which merits further investigation, as early pioneer studies have shown a correlation between provider–patient rapport and health outcomes (Leach, 2005). Respondents also indicated that, in their opinion, accuracy may have been affected. Both findings merit further investigation and measurement to understand whether the perception of the interpreter is based on their COVID-induced stress or on actual changes in accuracy and/or rapport.

Responses also confirm previous studies, conducted prior to the COVID-19 pandemic, that found that interpreters are more likely to prefer on-site encounters to telephone or video interpreting encounters (Locatis et al., 2010) and that there is a preference for video over telephone

interpreting (Lion et al., 2015) when a remote modality is needed or required, as has been the case during the COVID-19 pandemic. In relation to interpreters' response to modality changes since the onset of COVID-19, most respondents reported that they have learned to adapt and adjust to remote interpreting as they take assignments, and only a few reported being hesitant to accept remote interpreting assignments because they lacked the skill or the technology.

Communication between healthcare providers and English-speaking hearing patients was negatively impacted by COVID-19 conditions. These same conditions had an even greater negative impact on interpreted interactions. Further investigation on such effects of COVID-19 on healthcare language access is required.

<u>What Do We Want to Know More About?</u> (Hint: Please do this research!)

- Experience of the three members of the triad (patients, care team, interpreters) in interpreted sessions during COVID-19, comparing perception to actual quality of communication.

- Bigger sample size of interpreters, maybe better spread over geographic locations, language groups, or types of encounter environments (surgical, specialty, procedure, inpatient, ER, clinic, etc.)

- Extension of these same questions of challenges and adaptation over time as remote interpreting becomes a more commonly used modality. For new interpreters coming into the field, do they perceive challenges similar to those described by the interpreters who answered the first NCIHC survey about changes to interpreting experience during COVID-19?

- Patient perception of remote interpreting modalities, given COVID-19. Do they miss the many forms of emotional, social, and navigation support provided by on-site interpreters, if they had ever experienced that? Do they appreciate the privacy of having a remote interpreter from some other place rather than a local on-site interpreter? To what extent do patients just go quiet when the interpreter is remote, for whatever reason (such as confusion, inability to hear, shyness to speak up for the interface, etc.)?

- Provider perception of remote interpretation modalities, given COVID-19. What do providers say about whether they have had to switch from on-site to remote interpreter availability, and if they did, did they have challenges and what kinds of challenges, better availability, etc.? Have providers learned how to partner with their interpreters to verbalize what they are doing so that the interpreter does not have to guess? Have providers learned to enunciate more clearly through their mask, to do a teach-back to check that the patient has understood them? How have providers compensated for the lack of an on-site interpreter to assist patients with filling out forms?

As true telehealth becomes a more established way for care teams to interact with patients, in other words, the patient and provider are not in the same building as each other:

- What do we know about the percentage of time an interpreter is included as the third point in the triad?

- Is the digital nature of telehealth simply not accessible to most language-need patients, or to some segments of the non-English-speaking patient population more than to others?
- When an interpreter is included in the telehealth encounter, what challenges are there for the interpreter to manage optimal communication with all parties over three locations?

Background

For the millions of Limited-English-Proficient (LEP) individuals living in the United States, language can be a "barrier to accessing important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, or understanding other information provided by federally funded programs and activities" (U.S. DOJ, 2002, p. 41457). Title VI of the Civil Rights Act of 1964 and other subsequent legislation require healthcare providers who receive federal funds to offer meaningful access to individuals with limited ability to read, write, speak, or understand English, generally called LEP individuals (U.S. DOJ, 2002).

In 2016, a job task analysis survey conducted by the Certification Commission for Healthcare Interpreting (CCHI) indicated that 88% of respondents (n = 1,525) reported that their primary modality of interpreting was in-person.

Accurate and effective interpretation contributes to eliminating health care disparities, increasing patient engagement, providing accurate diagnosis, enhancing treatment plan compliance, and improving overall health outcome for the LEP patient (Hassan, 2020).

Even though many interpreters were able to continue working during the pandemic thanks to remote interpreting, video interpreting had already introduced specific barriers to communication prior to the pandemic in other countries (Feiring & Westdahl, 2020). Considering the rapid increase in demand for and use of remote interpreting services brought about by the COVID-19 pandemic, coupled with the potential for continued high demand for remote interpreting services after the pandemic, the NCIHC Research Work Group sought to understand the challenges faced by interpreters who provide remote interpreting services in healthcare settings.

Method

The survey questionnaire had 64 answerable items with multiple-choice and open-ended responses. The NCIHC Research Work Group distributed the questionnaire online with the support of the NCIHC Board, several interpreting organizations, and numerous language service companies. The survey was open from February 14 to April 23 of 2021. A total of 1,673 working healthcare interpreters responded; of these 1,114 self-identified as female, 199 as male,

4 as nonbinary, 3 as other, and 25 indicated they preferred not to answer, while 328 did not respond to this question. The interpreters were from 38 states, communicating in 87 different languages.

For this article, the responses to Questions 18–20 and 40–47, which relate to interpreting modalities, are presented. The results of both quantitative and qualitative responses were considered. The quantitative data were subjected to Fisher's one-tailed test with 1 degree of freedom, 99% degree of confidence, and 0.01 degree of error. The open-ended questions were examined and tabulated based on identified categories.

Results

Out of 1554 respondents who answered Question 19 (see table below), only 9% (n = 84) reported an increase in on-site interpreting. The majority (61%, n = 949) indicated that the modality in which they interpret changed as a result of COVID-19. When indicating how the modality had changed, in Question 20 (see table below), several respondents indicated that the change is an increase in providing interpreting services over video remote (46%, n = 437) and telephone interpreting (49%, n = 466), where the patient and provider are at the same location. This change represented a total of 95% (n = 903) of participants switching to remote interpreting. Additionally, many respondents indicated an increase in the use of telemedicine or telehealth solutions, where the patient and

provider are located in different settings—50% of respondents (n = 474) noted an increase in interpreting over a video telemedicine solution, and 47% of respondents (n = 443) noted an increase in interpreting over a telephone telemedicine solution.

Q19: Has the modality in which you interpret changed as a result of COVID-19?

Q19	Count	%
No	605	39%
Yes	949	61%

Q20: How has the modality changed? Mark all that apply.

Q20	Count	%
More on-site (face-to-face)	84	9%
More remote telephone (patient and provider in the same setting)	466	49%
More remote video (patient and provider in the same setting)	437	46%
More telemedicine/telehealth via telephone (patient and provider in different settings)	443	47%
More telemedicine/telehealth via video (patient and provider in different settings)	474	50%

Q40: Since the onset of COVID-19, have you provided remote interpreting services in health care?

Q40	Count	%
No	328	22%
Yes	1131	78%

Healthcare provider wearing a mask in ICU.

Responses to Question 41 are available below. A full analysis of responses to Question 41(n = 1,131) is available in Issue 1 of Access: The NCIHC Journal.

Q41: In working with providers and patients using remote interpreting, what challenges have you frequently encountered? Mark all that apply.

Q41	Count	%
Provider or staff speaks in a manner which is difficult for me to understand (for example: speaks with a strong accent, mumbles, does not articulate clearly, speaks too fast, etc.).	606	54%
Managing linguistic/vocabulary challenges related to technical terms or specific medical information (like treatment instructions, medication guidance, diagnostic explanations, patient education, etc.).	209	18%
The conversation is highly emotional (for example: anxiety expressed by the patient or a family member, expression of sympathy to the patient, adverse reactions by the patient to explanations given by the provider, etc.).	305	27%
The conversation involves written documents requiring me to see the paperwork or do sight translation.	266	24%
The conversation involves visual cues (like gestures, facial expressions, full view of the room).	414	37%
The conversation involves body movement (like 'Move your foot like this,' 'Can you bend this way?', 'You'll want to insert that tab here').	501	44%
Use of masks and/or ventilators hinder communication.	641	57%
Other (please specify)	299	26%

Q41 Cont. Other (Please specify) responses	Count
Technical Issues	138
Audio/Visual Quality	89
Inadequate knowledge of Provider, Staff, & Patient	125
Environment	28
Others	35
No Challenges	22
Incomplete/invalid entries	10

Of those 1,131 respondents that indicated that they have provided remote interpreting services in health care since the onset of the pandemic, 31% (n = 350) indicated that they did not believe any interactions have been impacted by remote interpreting as a result of COVID-19. However, 50% (n = 561) of said respondents indicated that rapport between the provider and the patient has been impacted by remote interpreting as a result of COVID-19. Additionally, 42% (n = 479) indicated that rapport between the provider and the patient has been impacted, and 39% (n = 439) indicated that rapport between the interpreter and the provider has been impacted.

Q42	Count	%
Rapport between the provider and the patient	561	50%
Rapport between the interpreter and the patient	479	42%
Rapport between the interpreter and the provider	439	39%
I do not believe any interactions have been impacted.	350	31%

Healthcare worker with PPE and COVID 19 swab and specimen.

When the 1,131 respondents that indicated that they have provided remote interpreting services in health care since the onset of the pandemic were asked to compare telephone interpreting to on-site interpreting, more respondents seem to favor on-site interpreting; 47% (n = 528) indicated that telephone/video interpreting is more tiring and 16% (n = 184) indicated it is less tiring, 46% (n = 517) indicated that telephone/video interpreting is less accurate and 4% (n = 49) indicated it is more accurate, and 21% (n = 240) indicated that telephone/video interpreting is less confidential and 11% (n = 124) indicated that it is more confidential. It is important to note that 8% (n = 85) indicated that they have not worked on-site, and 18% (n = 198) of respondents selected "Other" and provided a written response. In their written answers, 65 respondents expressed that telephone/video interpreting required more effort and was less convenient than on-site interpreting, often citing technical and audio/visual issues along with the lack of personal interactions and poor working conditions. On the other hand, 39 respondents described telephone/video interpreting as requiring less effort

and being more convenient because it saves interpreters from long and stressful commutes and allows interpreters to use time more efficiently and interpret for more patients. Furthermore, through written responses, 46 respondents indicated that telephone/video interpreting is less effective than on-site interpreting, compared to only 7 who indicated the contrary. In written responses, 15 respondents indicated that telephone/video interpreting and on-site interpreting are equivalent, and 15 respondents provided other responses that did not fit any of the other categories, with some noting that each modality is appropriate for different situations, others highlighting that remote modalities (like telephone or video) are an adequate alternative to providing no language or communication access, and several noting a preference for video over the telephone if a remote modality must be utilized. Finally, there were 30 written responses that were incomplete, did not address the question at hand, or simply elaborated on their selection.

Q43: Comparing telephone/video interpreting with on-site interpreting, which statements best describe your experience? Mark all that apply.

Q43	Count	%
I have not worked on-site	85	8%
Telephone/video interpreting is more tiring than on-site interpreting.	528	47%
Telephone/video interpreting is less tiring than on-site interpreting.	184	16%
Telephone/video interpreting is more accurate than on-site interpreting.	49	4%
Telephone/video interpreting is less accurate than on-site interpreting.	517	46%
Telephone/video interpreting is more confidential than on-site interpreting.	124	11%
Telephone/video interpreting is less confidential than on-site interpreting.	240	21%
Other (please specify)	198	18%

Q43 Cont. Other (Please specify) responses	Count
Telephone/video interpreting requires more effort and is less convenient than on-site interpreting.	65
Telephone/video interpreting requires less effort and is more convenient than on-site interpreting.	39
Telephone/video interpreting is more effective than on-site interpreting.	7
Telephone/video interpreting is less effective than on-site interpreting.	46
Telephone/video interpreting is equivalent to on-site interpreting.	15
Other	15
Incomplete/invalid entries	30

When evaluating their level of personal readiness for remote interpreting, 67% (n = 754) of respondents indicated that they have learned to adapt and adjust to remote interpreting as they take assignments, 60% (n = 679) of respondents indicated that they have a designated workplace at home to conduct remote interpreting, and 45% (n = 513) of respondents indicated that they have invested time and money to be ready for remote interpreting. Only 4% (n = 48) of respondents indicated that they were hesitant to accept assignments because

thet did not have the skill or technology to do it. In written responses to "Other (please specify)," 21 respondents indicated that they started working in remote modalities before the pandemic, and 25 reported that either their employer provided the equipment or provided both the equipment and location for remote interpreting. Additional written responses were categorized as "Other" if they either elaborated on the respondents' selections or were incomplete responses.

Q44: In terms of personal readiness for remote interpreting, which of the following apply to you since the onset of COVID? Mark all that apply.

Q44	Count	%
I have invested time and money to be ready for remote interpreting.	513	45%
I have a designated workplace at home to conduct remote interpreting.	679	60%
I learned to adapt and adjust to remote interpreting as I take assignments.	754	67%
I am hesitant to accept remote interpreting assignments because I don't have the skill or technology to do it.	48	4%
Other (please specify)	112	10%

Q44 Cont. Other (Please specify) responses	Count
Worked in remote modalities before the pandemic and/or already had the needed equipment	21
Employer provides remote interpreting location and/or equipment	25
Other	6

Of 1,581 respondents that answered Question 45, 62% (n = 656) indicated that they have experienced problems with the reliability of the equipment or internet connection, with the most common problems experienced reported (in Question 46) as internet connection problems (83%, n = 547) and problems with background noise at the patient end (74%, n = 487).

Q45: Have you experienced problems with the reliability of the equipment or the internet connection you use to conduct telephone/ video interpreting during the pandemic?

Q45	Count	%
No	406	38%
Yes	656	62%

Q46: Please specify what problems you have experienced. Mark all that apply.

Q46	Count	%
Problems with internet connection (such as slow to activate, gets pixelated, slows down, freezes mid-session or drops without notice)	547	35%
When using platforms such as Zoom, Google Team, etc. I have had difficulty accessing the platform or connecting with others in the session	246	16%
The Voice Over Internet Program that I use has poor audio quality	102	6%
Problems with headsets	142	9%
Problems with background noise at my end	160	10%
Problems with background noise at the patient end	487	31%
Other (please specify)	100	6%

Q46 Cont. Other (Please specify) responses	Count
Inadequate technology	26
Inadequate knowledge of Provider, Staff, & Patient	13
Problems with background noise at the provider end	25
Technical Issues	11
Other	17
No Issues	3
Incomplete/invalid entries	4

When asked about common issues encountered during remote interpreting as a result of COVID-19, 25% (n = 285) of respondents indicated that they did not experience any issues, with an additional 5 respondents indicating the same in written form; 44% (n = 493) of respondents indicated that lack of briefing about issues related to the medical situation is a common problem, and 24% (n = 271) selected pressure from the provider to end conversation within a certain time as another common problem. A total of 70 responses were related to technical issues and/or environment (ambiance), which include any written responses that indicated any issues like poor connection or inadequate equipment, platform, and/or environment. In written form, under the "Other" category there are responses related to lower pay provided for remote interpreting services and a variety of other issues that did not fit any of the other categories, including one comment that suggested that providers may opt to "get away with no interpreter" or resort to family/friends because of issues encountered with remote modalities. Additionally, some respondents suggested that said issues may be producing greater health disparities for vulnerable patient populations who either lack knowledge of how to interact with the technology; are provided instructions only in English; receive information through methods of communication that are not monitored by patients, such as email; and/or lack adequate resources to secure the ideal technology. These statements merit further investigation. Finally, a couple of written responses indicated that none of the issues respondents encountered are unique to COVID-19 but rather are a result of the use of remote modalities.

Two people conversing with third person via video.

Q47: What issues (if any) do you commonly encounter during remote interpreting as a result of COVID-19? Mark all that apply.

| Q47	Count	%
I do not experience any issues.	285	25%
Lack of briefing about issues related to the medical situation	493	44%
Lack of briefing about issues with the equipment	173	15%
Equipment set-up takes up a large amount of time.	148	13%
Pressure from the provider to end conversation within a certain time	271	24%
The whole assignment takes much longer than I expected.	194	17%
Other (please specify)	166	15%

Q47 Cont. Other (Please specify) responses	Count
Technical issues and/or environment	70
Inadequate knowledge of Provider, Staff, & Patient	18
Flow of communication	20
Delays that prevent appointments from starting as scheduled	14
Other	41
No issues	5
Incomplete/invalid entries	4

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Accessing the Paper Chase

By Cindy Roat, MPH
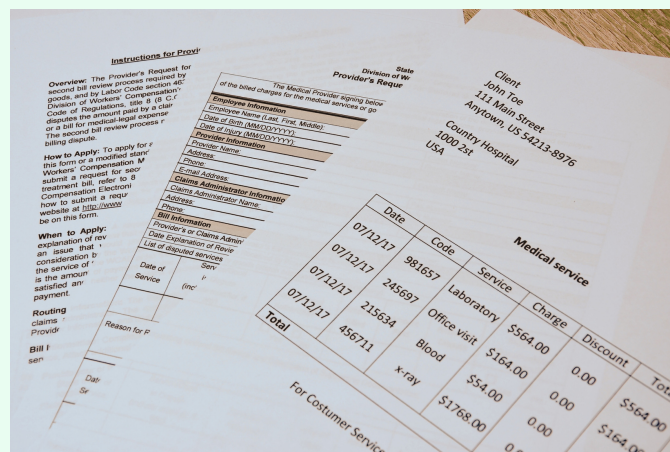
Translated documents.

The need for translation in health care

Thirteen. I counted. That's the number of documents that I received at a recent healthcare visit. There was a general consent for treatment, a rights-and-responsibilities handout, a consent to share PHI with my insurance company, a health history form, a routine depression screen, a review of current medications, a procedure consent, procedure preparation instructions, an after-visit summary, and three different patient education handouts. Then I got a patient satisfaction survey by email. And that was just a primary care appointment—imagine if it had been heart surgery!

The U.S. healthcare system loves documents. We give them to patients in order to fulfill legal requirements, to save time in the appointment, to send the patient home with something as a reference. What does this mean for patients who do not easily read English? How do we create "equal access" to information written in a language that patients do not understand?

What needs translating?

In healthcare settings, documents fall into various categories:
- Legal information forms ("This is what you need to know about receiving care here.")
- Consent forms ("This is what we are going to do to you.")
- Patient health information forms ("We'd like to know the following about you.")
- Patient education forms ("Here's some general information about your illness or condition, about our services and programs.")

In the best of all possible worlds, all of these materials would be translated into all languages, but this is clearly not feasible. So, federal and state governments, and accrediting bodies have created standards to address which of these must be provided to patients in a language they can understand. The "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" requires that the following be translated into any language spoken by 5% of the Limited-English-Proficient (LEP) population served, or spoken by 1,000 LEP individuals, whichever is less:

a. Notices of free language assistance
b. Notices of eligibility criteria for services
c. Informed consent documents
d. Intake forms that have clinical consequences
e. Discharge instructions
f. Complaint forms

The Joint Commission accreditation standards also address the need for translation, while in some states legislation or state contracts with Medicaid providers specify stricter standards than the national requirements.

The current state of the provision of translated documents

At this time, most large health systems provide some documents in some languages, but not all documents in all languages. Private companies that sell bundles of patient education pamphlets to hospitals for their patient-facing websites, such as Krames, are increasingly including translated patient education materials as part of their software packages. These patient education pamphlets are integrated into the Electronic Health Record (EHR), so providers can print off an English or translated health information document during an encounter and hand it to the patient.

Static documents that have legal implications, such as consent forms, are more likely to be made available in a translated version than, for example, patient surveys. Documents are more likely to be translated into Spanish

than any other language. Some large health systems hire full-time in-house translators, while others have their staff interpreters use downtime to do translations. More commonly, health systems send documents out to commercial translation companies to manage the entire process of translation from beginning to end.

What does that process involve? Translation companies are responsible for recruiting and vetting translators for each project, one of whom will do the initial translation while another will review it. The two translators will discuss any disagreements and create a final, acceptable version. A third professional may handle document layout, as the translated text will almost always take up more or less space on the page than the original source text. If the translation company does a great deal of work with a specific healthcare institution, it may maintain an electronic translation memory, so that commonly occurring text can be consistently translated the same way in every document.

This process works well for documents that do not change much, such as consent forms. But what about documents such as discharge instructions, which need to be personalized for every individual patient, translated, and made available, all within mere hours? These represent more of a challenge. In these cases, pre-translated templates can be useful, in which the care team prepares a template of instructions for self-care, for example, with space to write in individualized medication doses by hand, which can then be translated by the interpreter.

Why don't we have a centralized national translated document bank?

An easily accessible database of pre-translated and vetted healthcare documents could be helpful. Such a resource, however, is not as easy to create and maintain as it may seem. First of all, there is a stunning lack of standardization of written documents between healthcare systems. A general consent for care may be structured completely differently from one system to another system.

Many health systems have Document Review Committees that are responsible for vetting anything that goes out to patients in written format. Each has its own idea of what any given document should say, so achieving consensus on the original standardized English text for documents becomes very difficult. And finally, healthcare documents are changing all the time, so any documents in a national database would have to keep up. A further challenge is that providers need these documents – especially consent forms – to be integrated into the EHR, and the companies that create the EHR software see no profit in investing in translation.

What about machine translation?

Every healthcare administrator's dream is a computer program that will, instantaneously and for free, accurately translate a document from English into any other language,

adjust the document's layout, and allow the user to print it on demand. Well, that's Google Translate, isn't it? Almost? The critical word here is "accurate." Although machine translation has certainly improved substantially since it was first introduced, and particularly since Google introduced its neural machine algorithm in 2016, accuracy for healthcare material is not there yet. Often it can figure out the general meaning and transfer it into a grammatically acceptable form in the target language. However, context is lost, so "dressing" as in a wound covering can end up as "dressing" as in putting on clothes. In addition, translations often do not sound native, nuance is lost, and any specialized words or nonstandard linguistic structure leads to significant error.

Inaccuracies become more pronounced the further the target language is from English linguistically. A simple English text translated into Spanish might come out just fine, because Spanish is structurally very similar to English. But AI translations into Chinese or Thai are very likely to be significantly substandard. Any material translated by artificial intelligence such as

Example of an educational healthcare website in a non-English language. This information may have been translated from another language or simply developed in Spanish.

Google Translate must be reviewed by a health-literate person fluent in the language before it is handed to a patient.

Other issues related to accessibility of information in written materials

The very high register (linguistic complexity) of many healthcare documents makes them difficult to understand even for native readers of English. Translators are not empowered to lower the register, so a document that is confusing and complex in English will be just as confusing and complex in any other language. Advocates of "plain English" argue that all patient-facing documents in health care ought to be written at a 6th-grade reading level. This way, English speakers, as well as the readers of the translated versions of these documents, will all understand what the documents contain.

Patient portals host programs such as MyChart, which enable patients to email their providers with questions in a HIPAA-secure environment. The purpose of portals is to increase access to care, improve patient–provider communication, and diminish the need for patients to travel to a hospital or clinic to discuss health issues. However, to date, portals do not support translation of information that resides on the portal or that is put into the portal by either the care team or the patient. One wonders why this is not a violation of the "equal access" guaranteed by Title VI, and, if it is, when the Office for Civil Rights will start to enforce Title VI as it applies here.

Are there situations in which the written word itself is not the best means to patient understanding? For example, instead of English language signage, some hospitals are employing images, paint color, and colored lines on the floor to assist patients in navigating the hospital building. In order to give the patient discharge instructions, healthcare providers hand out translated written discharge instructions as well as recording the instructions onto the patient's phone through an interpreter. The instructions can also be recorded onto a digital audio greeting card–style cards via an interpreter, that patients can take home and listen to repeatedly.

Finally, we must solve the question of how to pay for all this translation. Translation services are expensive, and although technology can help reduce costs (in the form of translation memory for example), there is nothing on the horizon that will, any time soon, make translation cheap. How do we find the balance between wanting all documents to be available in all languages and needing to use our resources wisely?

Conclusion

Early on, the healthcare language access movement was focused on oral communication: the need to provide a qualified interpreter for healthcare encounters for any patient who spoke limited English, at no cost to the patient. Today, decades later, horizons have broadened, and we now understand that true access to care must include access to written materials related to that care. So whether it is through better access to qualified translators, to improved technology simplifying the translation process, or to creative new approaches to information transfer, let us work for the day when any document a patient could receive in English is one they could receive in their preferred language. Or maybe we could just work to reduce the amount of paper we give to patients. Thirteen documents! Really?!
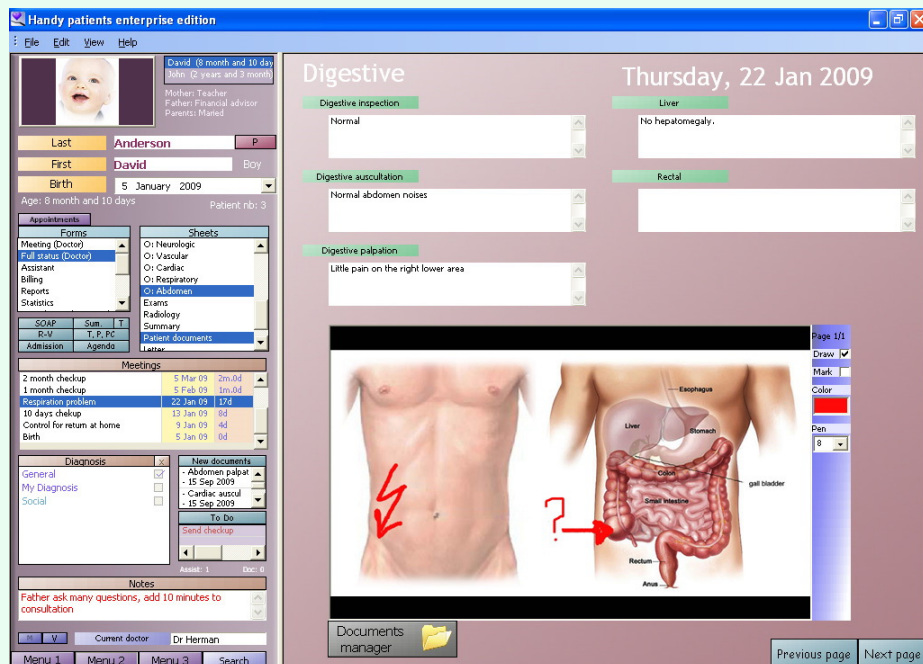
Sample page of electronic medical record (not real patient).

Healthcare Language Access Stakeholder: Interpreter Services Manager at a Hospital or Clinic System

By Andy Schwieter, CMI-Spanish
& Linda Golley, MA

Many of the larger hospitals and clinic systems in the United States assign responsibility for coordinating language support services to an interpreter services manager.

The interpreter services manager partners closely with care teams, language companies, interpreters, translators, patients, and families. She is directly responsible for how language access happens in the organization. She must also represent the Administration and C Suite priorities.

The chain of command for interpreter services managers varies quite a lot. Interpreter Services may be part of Nursing, Admitting, Customer Service, the Medical Staff Office, Diversity, Risk Management, or Outpatient Administration.

Many interpreter services managers are dedicated solely to managing language services, while in other organizations an administrator with many other responsibilities has interpreter services tacked on to her other duties.

> "Hi, Interpreter Manager? This is Dr. Karen Mendoza on the Ante-Partum unit. We have just admitted a woman at seven months of pregnancy for labile diabetes. We expect her to be here until delivery. She speaks Mandinka. The nurses say they have been unable to get an interpreter for this language on the phone or video interpreter systems."
>
> **Question from hospital staff member**

The Interpreter Services program reflects the social and political culture of the organization. Some organizations treat language services as an important part of patient care, expecting the interpreter services manager to sit on many operations committees and consult with providers, staff, patients, and administrators about optimizing care communication.

Other organizations consider Interpreter Services to be an unfortunate cost required by regulatory mandates. They seek to reduce this cost by awarding contracts to the lowest bidder rather than to those who provide high quality of service.

The culture of the organization shapes how the interpreter services manager is recruited. In organizations that focus on quality patient care, the interpreter services manager usually has experience in direct patient care, healthcare interpreting, business management, community outreach, or a combination of these.

It is helpful for the interpreter services manager to have second language skills in addition to personal connections to various language communities served by the organization.

He should be well-versed in regulatory guidelines related to language access and cultural

competence so that he can advise staff and providers on compliance.

The interpreter services manager makes key decisions about how language services are provided across the organization. To be effective, the interpreter services manager must know how care is provided in all of the different environments in the organization, from the Financial Counselor Office to the Recovery Room to Interventional Medicine to Labor and Delivery to Outpatient Cardiology. He must know how long the patient spends in each venue, whether written materials are involved, what safety issues an on-site interpreter may encounter, and how to deploy remote devices in that environment of care.

The interpreter services manager has to establish and budget for key operational guidelines:

- How many staff interpreters should the organization have? For what languages?

- Do vendors provide on-site interpreting or only remote interpreting?
- When should staff use on-site interpreting as opposed to remote interpreting?

The interpreter services manager establishes the algorithm for assigning staff interpreters:

- Are highly trained and physically present on-site staff interpreters kept available to respond to the most urgent, most vulnerable patients, or
- Are on-site staff interpreters assigned to routine outpatient clinic appointments months ahead, with urgent and vulnerable patients being assigned to remote or agency interpreters?

The interpreter services manager builds and nurtures relationships with language companies. Each language company provides a different mix of linguist resources. Together, the interpreter services manager and the language company resolve issues concerning availability and quality, including complaints about the performance of specific linguists.

The interpreter services manager can support or suppress interpreting by dual-role staff and bilingual staff and providers. He works with Human Resources to create procedures and qualifications for these roles.

The interpreter services manager identifies content that requires translation, dubbing, or subtitling and maintains the system for ordering translations and storing them for staff and providers.

The interpreter services manager plans for, implements, and manages the organization's technology used to support language access. Dual-handset phones and video remote interpreting systems may be deployed throughout the campus. Staff interpreters may provide interpretation from booths on campus or from home. Translation stations involve computers and translation software.

The interpreter services manager plays a central role in ensuring compliance with regulatory requirements: analyzing data on language need and on support provided, identifying gaps, and training administrators and care team members to consistently use language access services.

In many organizations, the interpreter services manager also:

- trains staff to partner with interpreters, maintains the Interpreter Services website to support staff and providers, and helps to create the hospital's monthly and/or annual staff training.

Staff meeting with manager.

Interview with Andy Schwieter, Director of Language Access Services at Cincinnati Children's Hospital Medical Center

ACCESS: What are some specialized medical needs for language support in the setting of a children's hospital?

Andy Schwieter: Cincinnati Children's provides specialized medical care across many disciplines. From a language access perspective, one of the biggest challenges is group therapy for mental health. It's difficult or impossible to use remote interpreting in that setting, and it is hard to provide in-person interpreting for long shifts with little advance notice.

How do you approach the need to provide language support for parents and caregivers as well as for the pediatric patient?

We train staff to provide language access for each individual who is present. Often this means providing an interpreter for one parent when another parent and the patient prefer to speak in English. This works well when an in-person interpreter can provide simultaneous interpreting, but is very tricky with a remote interpreter.

What modalities for interpreting work best for the children's hospital setting?

I believe that in-person interpreting leads to better patient experience and outcomes in most pediatric settings. However, we do not yet have research to support that claim.

How do you approach the need to provide language support for parents and caregivers as well as for the pediatric patient?

In most of our encounters, the patient speaks English but their parents do not. However, when the patient is a young child who prefers to speak in a language other than English, it's a challenge for interpreters. There are not specific standards of practice for helping young children work effectively with an interpreter.

When the provider switches between high register for parents to low register for a child patient, are interpreters able to follow this change in register successfully?

Yes, once they learn how to say "silly" in their non-English language. In practice, it's harder to navigate register issues with the parents. Providers don't always recognize when a parent is speaking in a lower register and would prefer the provider to do the same.

- sits on committees such as Disaster Response, Forms, Dietary, Readmission Reduction, Customer Care, Memorial Service, Palliative Care, IT planning, Clinical Care Improvement, Marketing and Outreach, special patient projects, support groups, and focus groups.
- orients incoming chaplain interns, psychology interns, residents, volunteers, nursing hires, ER front desk staff, and ER triage personnel on working with interpreters and using translated materials.
- recruits and trains bilingual employees to become professional interpreters.

Interpreter services managers sometimes form informal support groups among themselves across organizations. They benefit from the experience of their peers in many ways, such as implementing new technology for interpreting and translation, responding to new regulatory issues, and finding scarce linguist resources.

"Hi, Interpreter Manager? This is Arnold, the nurse on 7 West. We are discharging a patient with a new colostomy, who speaks Cantonese. I heard that we have translations of self-care instructions for colostomy. How do I find those?"

Question from hospital staff member

What do we know about interpreter services managers today?

We have little data. This very important cadre of managers lacks dedicated training and credentials and is given a wide variety of titles. There is no national association of interpreter services managers. The best source of information about expectations of these managers is job descriptions posted on employment websites, along with personal accounts by colleagues.

Perhaps one day we will have an affinity group. A first national conference for interpreter services managers is presently being planned. Email us at perc@ncihc.org to express interest.

What would we like to know about interpreter services managers? (Hint: Please do this research!)

- How many interpreter services managers are there?
- How many have one main function? How many are responsible for both language services and other, unrelated services?
- Which hospitals and clinic systems do not have any person dedicated to language services? What do we know about compliance with language access regulations in those systems?

"Hi, Interpreter Manager? This is Alfonzo Solares. My father is on 5 East in Intensive Care. His doctor needs to speak with my father's doctor in Bogota. I have the long-distance number for you. Dr. Hillers said that you could set up a three-way call with an interpreter for this afternoon."

Question from hospital staff member

- How many interpreter services managers speak another language?
- How many have healthcare training, experience, or professional licenses in areas such as nursing or social work?
- How many have an academic degree?
- What are the minimum job qualifications?
- What is the average pay?
- What committees do they sit on?
- How stressful or rewarding do they find their job?
- How long do they stay in the job?
- How many receive support for their own professional development from the organization, such as paid time and airfare to attend professional conferences, or paid membership in healthcare access organizations such as NCIHC or local interpreter associations?

- Is there opportunity for moving up in the organization? If so, into which positions?
- To what extent do they feel that they have been instrumental in improving language access in their organization?
- How many create and teach their own interpreter classes for the local area linguists, or contact local interpreter trainers with requests for training for interpreters in needed topics?

Managing Supply and Demand

By Linda Golley, MA, &
Tracy Young, CHI-Spanish, RN, BSN, MA

In the day-to-day work of providing language support to patients, language companies (LCs) partner closely with interpreter services managers or schedulers within healthcare organizations to coordinate demand and supply for interpretation for specific encounters. LCs also coordinate demand and supply for translation of health-related documents and other written materials.

We describe how all of the entities relate to each other. For example, the interaction between LCs and linguists is complex. And look at the evolving status of the healthcare language industry over time. We will bring the article to a close as we review what we do and do not know.

Ecosystem of Linguists and Healthcare Organizations, Connected by Language Companies

LCs take in requests for service from many healthcare organizations (HCO), and they connect those requests with linguists who meet the assignment specifications. The linguists carry out the assignments and then invoice the LC. The LC invoices the healthcare organization, receives payment, and passes payment through to the linguist either before or after the HCO pays. The LC bundles all charges for services from contracted linguists into one invoice for each HCO each month, and the HCO has to review only one itemized invoice per LC and pay the LC with one payment monthly, for example.

There are several essential functions that the LC performs in this ecosystem of matching linguist demand with linguist supply:

- First, the LCs recruit and vet linguists for all demand. Many LCs provide orientation training.
- Second, the LCs match requests with linguists who will accept the assignments.
- Third, the LCs take on the huge administrative burden of bundling the individual linguist invoices into aggregate monthly invoices for HCOs to pay; the LCs also send out payments to individual linguists.

- Fourth, the LCs shoulder the administrative burden of contracting with both HCO and linguists.
- Finally, the LCs have to keep up with changing client demand and evolving regulatory requirements.

History of the Language Industry in the USA

Language companies have played a central, key role in providing language access for immigrants and Deaf people in the United States since the 1970s. Many language companies were formed by immigrants or by family members of Deaf people in efforts to provide support to the communities needing language support.

The early LC owners were essential to recruiting bilingual individuals to become professional interpreters, and ever since, they have supported the development of the healthcare linguist to meet higher and higher demands for competence. Presently, LC owners/managers continue to support and help develop such

professional healthcare language access organizations as NCIHC, IMIA, CCHI, and regional associations across the country. See the Map of Language Associations on page 51.

Landscape of Language Companies Providing Services to Healthcare Organizations

Because LCs employ staff and pay taxes, we know more about their existence than we do about our other stakeholders in healthcare language access.

Some LCs are owned by international corporations and operate on an international basis. The linguists they employ or contract with may be situated anywhere in the world, providing interpretation and translation services remotely. Some of these international companies do not specialize in healthcare content; rather, they serve a mix of business, government, and other specialized markets.

Other LCs are owned and operated within the United States. Some market to the entire nation, while others operate locally or regionally. Some are corporate; others are family-owned and -managed. Some provide spoken languages; others provide signed languages. Some provide a wide variety of spoken languages; others specialize in common languages or in rare languages.

Some LCs operate with a combination of the characteristics mentioned above.

Interpreter services managers favor contracts with LCs that best fit the needs of their particular patient populations. It is common for hospitals and clinic systems to contract with quite a few LCs in order to source linguists. For example, a large urban hospital in a gateway city might contract with: two or more remote interpreting companies for phone and video modalities; over five local companies providing foreign language on-site interpreters; two or more sign language companies; several very specialized language companies that provide just specific spoken languages, such as Central American Indigenous languages; and one or more translation companies. Value, price, and vetted qualifications of linguists are considerations for HCOs as they shop for LCs.

Some LCs employ linguists as staff, others contract with all of their linguists, and still others have a hybrid model of some staff and some contracted linguists. See the article "Language Access Employment and Contracting Models" on page 55.

According to the Association of Language Companies (ALC, n.d.), the language industry is forecast to continue its growth:

The industry has seen continued growth year over year, and it projects to maintain increases into the future. A report by the Centre for Next Generation Localisation places language services as the fourth fastest-growing industry in the United States. And the number of jobs in translation and interpretation services is predicted to increase 29% from 2017 to 2024. (para. 9)

Trends and Challenges in the Language Industry

The language services industry has both grown and changed since the last decade. We discuss what is driving these changes and how the language industry is adapting to specific challenges in the healthcare sector.

Linguists representing many language communites.

Employee vs contractor tax forms.

1. The employer/contractor status challenge

Are linguists employees or independent contractors? Both the tax authority of the federal government and stakeholders in the linguist labor market have thrown down the gauntlet to resolve this question. Depending on how this issue is resolved through legislation and through court rulings, a great number of linguists, language companies, care teams, and patients will be impacted.

For in-depth discussion of working conditions and legal status of healthcare interpreters in the labor environment, please see the article "Language Access Employment and Contracting Models" in this issue, as well as the Policy article "The Voices and Impact of California Legislation on Worker Classification for Interpreters, AB2257" in ACCESS issue 1.

2. Scarcity of qualified healthcare interpreters

- Just as there is scarcity of nurses and teachers, there is scarcity of qualified healthcare interpreters in the United States today. Several factors contribute to this situation:
- retirement of the first generations of professional healthcare interpreters, most of whom began as community interpreters and worked for low pay out of dedication to their communities.
- lack of interest in interpreting in the second and third generations of immigrant communities.
- lack of enforcement of federal language access requirements for interpreters in Native American health settings.
- a broken pipeline in training ASL interpreters and interpreters of foreign or Native spoken languages.
- decades of low pay compared to court interpreter work.
- decades of low pay compared to other jobs in the general marketplace.
- quickly rising expectations of healthcare interpreters with respect to:
  - language proficiency in both languages.
  - literacy, general science background, academic preparation.
  - fundamentals training, and training in specialized healthcare knowledge and skills.

3. Recruiting healthcare interpreters today is difficult

Competition between LCs and HCOs is stiff, which may drive up the pay that some qualified interpreters can command. However, there are simply not enough qualified interpreters to fill the need. Bilingual people with heritage language skills require additional language training. Those bilingual people with little science background or poor basic literacy need additional basic education. And the vast pool of working interpreters who have so far never taken fundamentals training or continuing education classes now has to get that training before being considered competent and qualified. All of the stakeholders in healthcare language access need to both hold firm on the expectations but also join forces to provide the training and education needed for competence.

4. Offshoring

Some interpreters are offshore, which means that they live and perform linguist services from their base outside of the United States. This practice is controversial but rapidly gaining adherents. Offshore recruitment greatly increases the pool of potential interpreters, while raising concerns about the competence of these linguists to follow the ethics and standards of practice expected of healthcare interpreters in the USA. Some language companies which work with offshore interpreters are

developing solutions to train them about the USA-specific healthcare environment.

5. <u>New dependence on technology in the language industry</u>

Translation of written materials has undergone a digital transformation. Please see the article "Accessing the Paper Chase" on page 43. LCs must source translators who are proficient in using the latest technology.

There have also been wide and sweeping advances in technology used for <u>interpretation</u>. These changes were well underway before the COVID-19 pandemic and have been accelerated by it.

Smartphone- and PC-based video remote technology is now widely available to interpreters across the country. LCs maintain huge central switchboards with either live or automated controllers to connect HCO providers with interpreters. Now, in the era of telehealth and patients getting care at home, the central controller also connects the home-located patient to the session. LC tech managers and hospital information technology departments must make sure that interpreters at home, providers in the care environment, and patients at home have a solid connection with the central switch. If the HCO has its own video platform, the LCs have to be able to connect remote linguists to whatever platform is needed for each encounter.

Another technology sea change has taken place inside LCs. Coordination of assignments has shifted away from live coordinators to automated systems in many LCs. Linguists are registered in the database of interpreters with their language, qualifications, and address (for on-site interpreting), or they are included in the platform by which interpreters are connected (for remote interpreting). When an appointment is posted from a hospital, all linguists who fit the language and proximity profile are notified of the available assignment. The first linguist who responds to the automated system is awarded the assignment. This process reduces the need for skilled LC schedulers and speeds up the assignment process. However, unless the automatic scheduling system is extremely fine-tuned and able to manage several layers of skill and qualification, the hospital is no longer assured that the best-qualified interpreter will show up. There are now some automated programs that build in layers of qualification and preference (for example, gender preference for C-section procedure, or mental health experience for a domestic violence victim). Here, too, technology brings us both advantages and perhaps deficits in human "touch."

What Do We Want to Know About Language Companies?

Every LC has a set of contractual relationships with each of its HCO clients, and a different set of contractual relationships with its individual linguist subcontractors.

The terms of these contracts are not transparent (as in many sectors and industries) in that the HCOs do not know how much linguists receive, and the linguists do not know what the HCOs were billed.

An LC may:
- charge some of its clients more than others.
- have contractual rates that differ for different languages, and certainly differ depending on time of day that services are performed.
- charge premiums for last-minute requests.
- allow linguists to bill for parking and travel time.
- set terms for cancellation of requests, late arrival of interpreters, and so on.
- compete with other LCs in the market to obtain HCO contracts and linguists.
- pay their rare language interpreters more to keep them in their "contract pool."
- We would like to know: (Hint: please research, analyze, and share data.)
- What LCs exist, where are they based, and who owns them? What is the profit profile? Is there a trend toward larger companies buying out smaller companies? How many LCs that have been in the business for a long time are leaving the industry, and why?
- How many linguists does each LC contract? How many do they employ directly? In which languages? How many linguists are offshore?

- How are interpreters and translators assessed for skills in the U.S. market?
- What training is required and/or provided by LCs for healthcare interpreters—specifically, what fundamentals and continuing education healthcare interpreter training have they had? What academic preparation do they have?
- What documentation is kept by LCs on their contracted and employed interpreters, such as signed HIPAA agreements, background checks for criminal behavior, TB tests, flu and COVID vaccination, training in Infection Control, complaints from patients or care teams (quality assurance issues)?
- How do pay factors affect compensation?
  - What rates do LCs pay for phone, video, and on-site encounters?
  - What differences are there in pay for different languages for healthcare assignments?
  - What differences are there in pay for interpreters who are nationally or state-certified?
  - How do the LCs manage the following challenges/burdens?

- delayed payments from HCOs
- federal tax investigations regarding employee vs. contractor
- expensive and lengthy contracting processes
- administrative costs: skilled schedulers and IT talent and equipment
- contracted linguist health records/documentation
- recruiting talent
  - delayed payments from HCOs
  - federal tax investigations regarding employee vs. contractor
  - expensive and lengthy contracting processes
  - administrative costs: skilled schedulers and IT talent and equipment
  - contracted linguist health records/ documentation
  - recruiting talent

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ALC. (n.d.). The language service industry. Association of Language Companies. https://www.alcus.org/page/languageserviceindustry

In summary, language companies provide an essential function in connecting the demand for language support in healthcare with linguists, both interpreters and translators. The market for language services is immense yet fractured, the players are many, and conditions vary widely across the country. Collaboration between language companies and other stakeholders is essential for creating cohesive language access support for patients and providers as they work together in the ever-changing healthcare setting.

Language Access Employment and Contracting Models

By Tatiana Cestari, PhD, CHI–Spanish, Jaime Fatás–Cabeza, MMA, USCCI, & Gabriela E. Siebach, MATI, CHI–Spanish

According to the U.S. Bureau of Labor Statistics, ambulatory healthcare services or hospitals directly employ 7,740 spoken and signed language interpreters and translators. However, this figure is not representative of the entire language industry in health care as it excludes interpreters and translators who are self-employed, or employed by language companies. Additionally, there are language companies, interpreters, and translators providing services in health care that are not located in the United States.

The language industry offers various hiring and contracting models for the delivery of interpreting and translation services in the United States. Thus, interpreters and translators have the option to be part-time or full-time employees, contractors or self-employed. In addition, they may partner with a language service company, a hospital, or a university, or provide direct service to users operating as sole proprietorships or Limited Liability Companies. All hiring models have their own characteristics. In this article we will address some of the most common questions regarding the state of language access employment and contracting models in these various business entities, including:

Why do employment and contracting models vary greatly?

What practices do health care entities follow to hire and contract interpreters and translators?

What models do language services companies follow to hire and contract interpreters and translators?

How much are interpreters and translators paid?

Why are employment and contract models important?

Why do employment and contracting models vary greatly?

Health care systems, hospitals, and other recipients of federal funds must provide language access to comply with federal legislative requirements. They are tasked by U.S. Department of Health and Human Services (HHS) guidance with taking "reasonable steps" to determine the extent of their obligation, considering: 1) the number of persons with limited English proficiency (LEP) served or encountered in their service area; 2) how often patients with limited English proficiency seek their services; 3) whether denial of language access

"could have serious or life-threatening implications;" and 4) the resources available and related costs (U.S. Department of Health and Human Services, Guidance for Federal Financial Assistance Recipients–Title VI).

These requirements demand careful planning and flexibility when developing a comprehensive language access plan.

Healthcare organizations also have to take into account a wide variety of demographics and scenarios across the United States, that include rural and urban areas, metropolitan regions or even entire states.

According to census data, in some states, like Florida, Texas, California, and Hawaii, well over 20% of their population speak a language other than English at home, which provides not only a higher LEP patient demographic, but also a larger interpreter and translator workforce. On the other hand, in states like Mississippi, Montana, and Alabama where census data shows that 5% or less of the population speak a language other than English at home, the LEP population is lower, and the interpreter and translator workforce is also smaller.

To be able to provide access to language services to as many people as possible and to meet specific language service demands, healthcare organizations and language service companies consider different models. Some factors to consider when hiring or contracting (directly or indirectly) are the languages requested, the frequency of the requests, the number of qualified interpreters and translators available, the qualifications of the interpreters and translators, and the location of the healthcare organization and the interpreters and translators.

Denial of language access in any healthcare encounter could have serious or life-threatening implications. In complying with language access requirements as well as reducing risks and increasing patient satisfaction rates, healthcare entities, like other businesses, face great challenges (for example, the number of local qualified interpreters and translators or budgetary constraints as language services are not a reimbursable expense in many states in the U.S.).

What practices do healthcare entities follow to hire and contract interpreters and translators?

As mentioned before, healthcare organizations use different hiring and contracting strategies to offer language services. The following strategies are those specifically recommended by HHS:

Sign post pointing to different languages.

1. Hire bilingual staff
Some health care organizations deliberately seek, hire, and train bilingual staff to provide language access. Some leverage the bilingual skills of existing employees. The models for leveraging the language skills of bilingual staff vary greatly throughout the U.S. Bilingual staff may be asked to provide direct services in a language other than English to patients, to interpret between other staff and patients, or to provide written translations. The HHS Guidance for Federal Financial Assistance Recipients - Title VI clearly states one of the primary drivers for healthcare entities to leverage their staff's bilingual skills: "hiring bilingual staff offers one of the best, and often most economical, options."

However, in order to provide quality care, there are important aspects that healthcare entities need to take into consideration when leveraging the language skills of bilingual staff. Organizations have to engage in reliable assessments to evaluate

communicative competence in all languages (for language-concordant care and equitable access to related services), interpreting competence and ethical behavior to identify potential role conflicts for dual-role personnel, competence in written translation, as applicable, and understanding of ethical principles. Organizations also need to provide resources, set standards for continuing education, and develop procedures to monitor quality and compliance.

One hospital, for example, completely separates dual-role employees' primary functions from their functions as interpreters to avoid role conflict. Instead of having staff members alternate between their interpreting role and other functions throughout their shift, bilingual staff who have been qualified to interpret, provide interpreting services outside of their work schedule and even report to a different supervisor. Conversely, a different hospital allows **bilingual employees** to interpret between colleagues and patients during their regularly scheduled shift, but specifically outlines the types of encounters where these bilingual interpreters are allowed to provide service to minimize risk and liability.

Most healthcare entities cannot meet all language support needs with bilingual staff alone, and many turn to other options for support.

2. Hire staff interpreters and/or translators

Another HHS recommendation for meeting language access needs is to hire staff interpreters and translators. This option is only practical from a business stand-point for facilities or systems serving large patient populations that require communication in a particular language. Nevertheless, in some communities, even indigenous languages may make the cut. One hospital that serves a large indigenous patient population trained and qualified staff interpreters for indigenous languages. Most health care facilities, however, only have staff interpreters and translators in the most common language or two or three most common languages at the most.

Service models are also very different. For example, for many years a teaching hospital's staff interpreter team was composed exclusively of interpreters providing onsite interpreting services who also provided translation support during non-peak hours. However, in a nearby county hospital the staff interpreter team was primarily over-the-phone and video remote interpreters who provided interpreting services from the hospital's call center. Only one or two staff translators provide onsite interpreting support but primarily focus on written translation. Additionally, hospitals that provided language access through staff onsite interpreters prior to the pandemic have now adopted technology that allows their interpreters to provide remote services; others have laid off their staff interpreters and discontinued their programs altogether and rely exclusively on remote or onsite agency options.[1][2][3][4]

Regardless of the model for staff interpreting or translation services, strategic planning, daily operations, supervision, and related costs also play an important part in the selection of the model. To reduce some of these costs, staff interpreters/translators may report to patient services, marketing, or a different department altogether instead of a language program manager.

Additionally, staff interpreters and translators often have access to employment benefits that are unique to healthcare facility employees.

Staff interpreters may also have access to facility systems, such as medical records, that aid in the execution of their duties, and can often develop partnerships with coworkers for whom they interpret that are not possible for interpreters who are not directly employed by the healthcare entity. Staff translators have a similar advantage in being fully immersed in the culture of the source of the communication they are translating. While translators who are not directly hired by the healthcare entity may have to research special programs or initiatives, staff translators may have access to unpublished information/ resources, may consult with content writers and program directors, or may have creative transcreation liberties that external translators may not have.

While access to benefits, systems, and research are very desirable and offer unquestionable advantages, all come with a cost. Hiring staff interpreters and translators (onsite or remote) may not be the best option for many organizations, or may be impractical

1 https://framinghamsource.com/index.php/2022/04/14/metrowest-medical-center-moves-to-phone-lays-off-staff/
2 https://www.metrowestdailynews.com/story/news/2022/04/19/metrowest-medical-center-framingham-massachusetts-interpreter-services-layoffs/7354537001/
3 https://www.metrowestdailynews.com/story/news/2022/04/19/metrowest-medical-center-framingham-massachusetts-interpreter-services-layoffs/7354537001/
4 http://features.yaledailynews.com/blog/2020/09/14/up-close-transforming-interpretation-at-yale-new-haven-hospital/

Person signing a contract.

to cover all or specific language access needs.

3. Contracting interpreting and translation services

In their Title VI guidance for federal financial assistance recipients, HHS describes contracting of language services as a "cost-effective option when there is no regular need for a particular skill" (HHS, Section VI.B). However, it is common practice among healthcare entities to contract with a language services company or directly with interpreters and translators even for languages with a regular need based on high demand.

Contracting directly with interpreters and translators can be an administrative burden for large healthcare entities that procure a lot of language services. Additionally, many healthcare entities follow procurement practices that require competitive bidding for contracts with values over specific limits to allow purchasers to select the most cost-effective provider who can meet their service needs. Competitive bidding also allows for transparency in the procurement process and prevents perceived or actual favoritism.

When procuring interpreting services, healthcare entities also consider remote and telehealth interpreting solutions. Again, there is a great variety of approaches to how remote or telehealth interpreting solutions are incorporated into a language access plan that take into consideration their needs and budgets. For example a hospital may contract remote interpreting services almost exclusively. On the other hand, prior to the pandemic, a different hospital may have only contracted remote interpreting services when facing time constraints (like afterhours or emergency communication needs), when communicating telephonically with patients, or as a last resort when an onsite interpreter was not available.

What models do language services companies follow to hire and contract interpreters and translators?

Language service companies follow similar hiring and contracting practices as some healthcare entities (Simon, 2022). These companies may have only employed interpreters and translators, only self-employed interpreters and translators, or a combination of employees and contractors (hybrid). In addition, language service companies or agencies may partner with other companies to provide services, and each may have different hiring and contracting models.

Management of linguists and other professionals under the multiple hiring and contracting models is a complex task. Companies are responsible for monitoring, scoring, coaching, and maintaining the quality of services provided by their workforce. They are also accountable for the quality of service provided by any companies with which they partner. To meet these responsibilities, many companies have developed processes to collect, analyze, and address feedback from end users.

And since the healthcare language industry is what could informally be called a "small community," it is not surprising that even competitors unite forces to provide language access and serve the populations in the U.S.

How much are interpreters and translators paid?

Compensation for interpreters and translators also varies throughout the United States. Variations in pay may depend on employment status (employee vs contractor), number of languages, demand and availability of languages, credentials (such as certification and licensure), education, and/or experience. According to the Bureau of Labor and Statistics, the 2021 median pay for interpreters and translators was $49,110 per year or $23.61 per hour, with the average hourly pay for interpreters and translators employed by hospitals being $28.54 per hour and $20.62 for those employed by ambulatory and healthcare services. However, these figures exclude wage data for self-employed interpreters and translators, as well as those hired directly by language service companies who also work in healthcare settings.

The American Translators Association (ATA)'s 2022 Compensation Survey showed that the gross average annual income from language services for all self-employed/freelance interpreters is $58,496 and $48,305 for all self-employed/freelance translators. Unfortunately, the ATA compensation survey does not distinguish between interpreters and translators working in healthcare and others. It is important to note that these figures are calculated including salaries for interpreters and translators working in legal/court and conference settings, which in some markets provide higher compensation.

The true number of total interpreters and translators working in healthcare settings is unknown and data from the U.S. Bureau of Labor and Statistics excludes self-employed interpreters and translators. According to professional organizations, self-employed interpreters and translators are a significant portion of the total workforce. The Certification Commission for Healthcare Interpreters (CCHI)'s 2016 National Job Task Analysis Survey reported that 50% of respondents were freelancers.[5] In a 2021 survey by the National

Labor law paperwork and gavel.

Council on Interpreting in Health Care, 46% (n=694) of healthcare interpreters respondents indicated that they work as independent contractors.

Why are employment and contract models important?

Unlike interpreters who are employed by language companies or healthcare entities, contractors usually do not receive benefit packages. Contracted interpreters and translators must secure their own health insurance (employers typically cover about 80% of cost),[6] pay both halves of their social security tax (employers usually pay half or 6.4%),[7] and lack other common employment perks such as workers compensation insurance, unemployment insurance (varies by state), sick time (an average of 56 hours per year),[8] and paid time off (an average of 80 hours of pay).[9]

Additionally, self-employed interpreters and translators must cover their own business expenses including office space and supplies, insurance, technology (phone, computer, internet, headsets, etc.), transportation, membership fees for professional organizations, continuing education, and certification fees. The trade off is that they operate as a business and are able to choose their clients, rates, and service hours.

While employees may also receive training and are more freely monitored and coached, independent

contractors are responsible for their own professional development and for meeting any state or federal credentialing requirements.

Recent legislative action and contractual models

Both the federal government and several states have recently taken legislative action to regulate the relationship between independent contractors and the companies that contract them. Many self-employed healthcare interpreters and translators have been impacted by gig-worker-style[10] contracting practices as well as the new contractual models brought about by these legislative developments.[11]

5 https://cchicertification.org/uploads/CCHI_JTA2016_Report.pdf

6 https://www.peoplekeep.com/blog/cost-of-employer-sponsored-health-insurance

7 https://www.irs.gov/taxtopics/tc751#:~:text=The%20current%20tax%20rate%20for,employee%2C%20or%2012.4%25%20total

8 https://www.bls.gov/opub/ted/2019/private-industry-workers-with-sick-leave-benefits-received-8-days-per-year-at-20-years-of-service.htm#:~:text=Source%3A%20U.S.%20Bureau%20of%20Labor,End%20of%20interactive%20chart.&text=On%20average%2C%20workers%20in%20private,at%2020%20years%20of%20service.

9 https://www.zippia.com/advice/pto-statistics/

10 We refer to gig-worker-style contracting practices according to the definition offered by the U.S. Chamber of Commerce: gig workers as independent contractors or freelancers who typically do short-term work for multiple clients. The work may be project-based, hourly or part-time, and can either be an ongoing contract or a temporary position. https://www.uschamber.com/co/run/human-resources/what-is-a-gig-worker

These legislative initiatives have generally been supported by some government agencies, language service companies that hire interpreters as employees, and labor rights groups. However, they have met substantial opposition from individual linguists and agencies that want flexibility or independence and find these initiatives to be more restrictive than is necessary. In some instances, these challenges have led to amendments and exceptions that provide flexibility for individuals who hold specific qualifications and skills while setting requirements to prevent exploitation and allow independent contractors to form unions.

These developments have also forced language service companies and healthcare organizations to review their models for compliance with new labor and language access requirements, meet language access needs, and maintain productive contractual relationships with partners. These initiatives and the resulting backlash have made clear the need to adapt traditional employment and contracting models to accommodate present professional

and labor needs and dynamics, and the need for legislative initiatives that consider the complexity, diversity, scope, and size of the language industry.

Conclusion

The professions that support language access in health care are part of an evolving ecosystem in which distinct species of applied linguists with diverse needs interact with many other species in diverse environments with myriad variations and possibilities. It is no surprise that so many employment and contracting models exist or that HCO and LC preferences differ. Currently, healthcare organizations consider a number of different models to comply with language access requirements that may include having bilingual staff, staff interpreters and/or translators, and contracted services. When services are contracted, these may be provided by language services companies that also follow different models to staff or contract interpreters and translators. Interpreters and translators have to choose between seeking employment and contracting opportunities, and they must weigh the advantages and disadvantages in terms of compensation and benefits. With so many options, opinions differ regarding whether the current legislative requirements are in the best interest of the profession, protect the dignity and working conditions of all stakeholders, establish research–based quality standards, and benefit patients and society as a whole.

[11] See The Voices and Impact of California Legislation on Worker Classification for Interpreters, AB2257 by Hadjioannou, Marina and Carlos Pava (2022). Access 1 (1).

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Announcing the
Language Association Map

By Tracy Young, CHI–Spanish, RN, BSN, MA

Please take a look at the interactive map showing many of the state, regional, national, and international associations (healthcare, language, interpreter, translator, and academic associations). More to come as we continually hear from you! Reach out to us at perc@ncihc.org with your organization!

📍 **You can check it out by clicking on the link.**

CLICK HERE

Looking to fill a position?

Did you know NCIHC has its own **Career Center/Job Board**? Consider posting a job to announce your new opening. You can find the link on our home page. Look for the Career Center button on the right-hand side under the Quick Links or use this **link**.

Preparing and Growing Language Professionals

By Linda Golley, MA, Tracy Young, CHI-Spanish, RN, BSN, MA & Jaime Fatás-Cabeza, MMA, USCCI
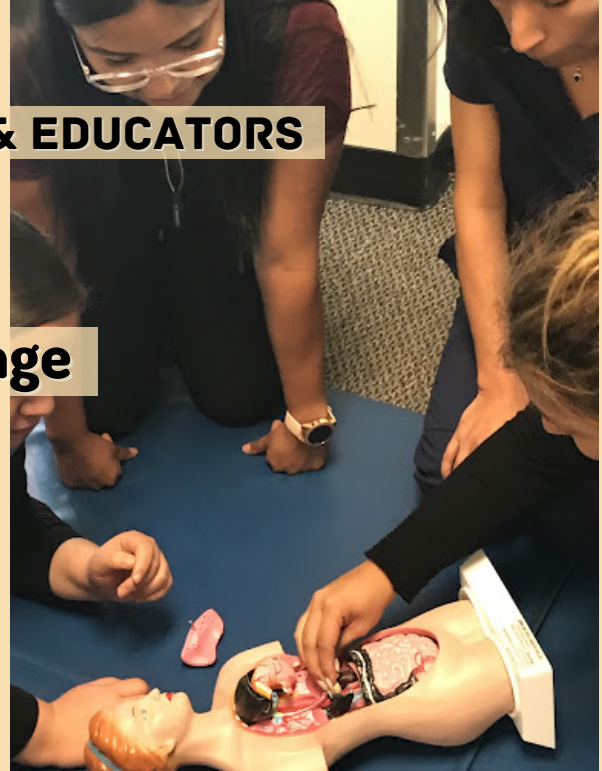
Just as with our other stakeholder groups, healthcare language access would not happen without interpreter educators and trainers. The competence and integrity of any professional cadre such as healthcare interpreters requires a strong and agile training engine to prepare them for their role. Effective training requires a corps of educators and trainers who are highly competent themselves based on their own work experience, assertive in their mastery of needed new content areas, and effective in using the best pedagogical training techniques.

We are using the word "educator" to indicate someone who has an academic preparation and a holistic view of the profession rather than teaching a narrow set of skills.

Parallel to the disjointed edifice of healthcare in the United States, the framework for educating healthcare interpreters across the country is fragmented. Indeed, only NCIHC provides leadership and cohesion regarding standards for training of healthcare interpreters, and the organization does this with no official mandate or support of any kind! We

have mentioned elsewhere in this journal the importance of NCIHC's development of the Code of Ethics and the Standards of Practice. Then, in 2011, NCIHC developed its Standards for Healthcare Interpreter Training (NCIHC, 2011).

These Standards set a high bar for interpreter educators, ensuring that they themselves are soundly literate, academically well-prepared, grounded in evidence-based training techniques, and experienced in the subjects they teach. These Standards are not universally known or adhered to by all interpreter trainers or authors of interpreter classes across the country. But they serve as a guide for educational institutions and professional associations when they are awarding a contract to teach healthcare interpreting fundamentals or CEUs.

What do we know (and not know) about the current status of our stakeholder group of interpreter educators and trainers? In this article,

"I am very discouraged about teaching candidate healthcare interpreters who are recruited from the community by nonprofit or State agencies. The mix of students is heavily weighted toward people with no science or health background. It is not possible to teach medical terminology, basic science concepts, anatomy and physiology, and the framework of the American biomedical approach in a 40- or 60-hour course, in addition to ethics, standards of practice, and the process of interpretation. Most students cannot pass the final exam, and they could not function effectively as medical interpreters. Indeed, most students just drop out."

–Anonymous interpreter trainer

we provide historical context for the training needed by the very recently evolved profession of healthcare interpreters. We describe how linguist training in the United States has no strong, widespread base but rather has arisen piecemeal in areas of highest demand on a just-in-time basis.

We look at who is doing the training, curricular development, challenges to successfully training interpreters, and what is needed to support and recruit trainers in the future.

What healthcare linguist training is needed in 2023?

The core elements of healthcare interpreter training are ethics, managing the encounter, performing the actual interpretation, cultural competence, professionalism, and the healthcare content itself (terminology and medical process).

These elements are not static. Over time, new thinking has arisen about relationships and responsibilities between the parties. There is a realization that topics such as Infection Control are absolutely necessary for any interpreter walking into a patient space. There is growing appreciation for the interpreter's contribution to the therapeutic relationship, which includes entire new approaches to mental health and end-of-life encounters. There is new technology, such as remote interfaces, that must be mastered. And there is an explosion of technical medical knowledge that the interpreter must be able to manage.

We do not know, in aggregate, what healthcare interpreter training is presently offered and what content it covers. We do not know how many interpreters take the offered classes, or how many pass, fail, or drop out. Nor do we know how many of these attendees are duplicates or how many working interpreters have never taken a class of any kind. We do have a vision for creating a dynamic central listing for available interpreter training opportunities.

Background Notes on Lack of Academic Preparation of Interpreters in the United States

Linguist education in the United States differs significantly from that elsewhere, both in the availability of language training and in the structure of linguist training. For example, Europe has valued linguists for millennia. There are strong academic language programs in many European countries. These programs teach both language skills for personal use, such as advanced French for foreign business people working in France, and linguist skills, which prepare people to become professional interpreters and translators. In Europe, translation and interpretation are taught together. Student linguists first perfect their proficiency in both of their working languages, and then they practice interpretation and translation across
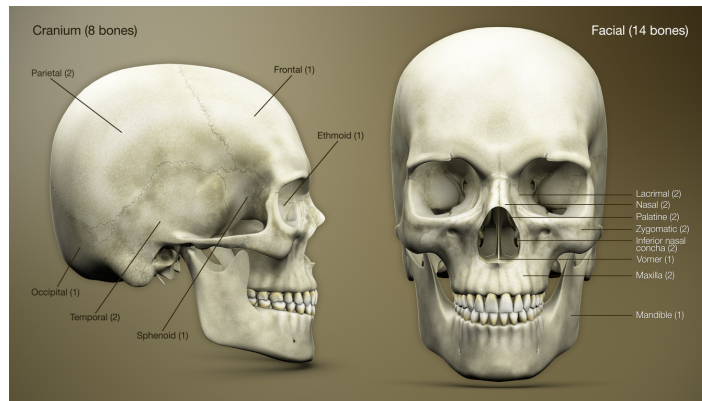
Anatomical diagram of skull side and frontal.

general topics. They do not specialize in fields of interest until later in their career.

In the United States, there are few long-established academic centers for combined language and linguist training. The most famous is the Middlebury Institute of International Studies at Monterey. Academic foreign language programs are generally tied directly into international business, archeology, history, or literature programs rather than into professional linguist studies. ASL studies is an exception. Gallaudet University for the Deaf in New York and the Catie Institute in Minnesota provide academic curricula in both ASL as a language and ASL interpreter training.

In the USA, linguists are not usually trained in academia. Most interpreters do not have any formal training in linguistics. In the United States, most working interpreters and translators bring their own language skills to the work and then take training specialized to the sector that they work in, such as healthcare, courts, or education. This specialized interpreter

training is, in contrast to academic preparation, of very short duration and depth. There is a need for standard curriculum. By the same token, many interpreter educators, instructors, and presenters in the United States are not university professors. Thus there is no agreed-upon academic framework for adequate or exceptional scholarship in the healthcare interpreting profession. Research on healthcare interpreting is sparse, and there is no ladder of increasing professional competence in either interpreting or training of interpreters.

Evolution of Healthcare Interpreter Training in the USA

The foundational 40-hour health interpreter training program was Bridging the Gap, written by Cindy Roat in 1995 under the auspices of the Cross-Cultural Health Care Program (CCHCP) in Seattle (https://xculture.org/about/#history) Based on the author's experience working with patients in South
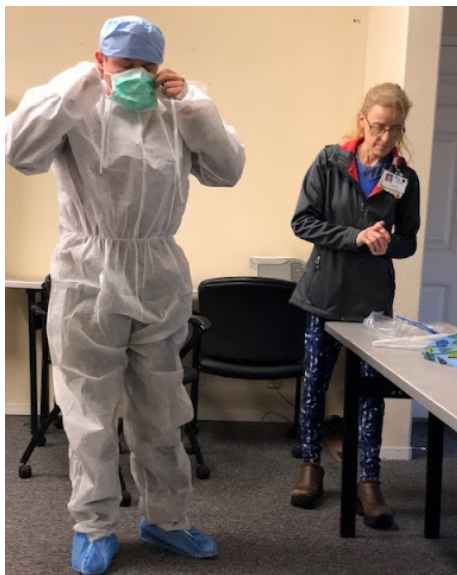
Interpreting student practicing donning personal protective equipment.

America and on her Master's in Public Health (MPH) training, Ms. Roat created a brilliant framework for respectful, ethical, and accurate professional healthcare interpreting. The role concepts of conduit, clarifier, cultural broker, and advocate that were defined in Bridging the Gap are still taught in classes and followed by many healthcare interpreters working today.

Over the last 20 years, demand has grown for improved, updated, and standardized training for healthcare interpreters:

- Laws and regulatory entities such JCAHO require "qualified" interpreters.
- Care teams push for skilled and competent interpreters.
- National certification for healthcare interpreters requires a minimum of 40 hours of fundamentals training plus yearly continuing education.
- Interpreters increasingly seek fundamentals training plus CEU training for their own professional development as well as to compete for jobs and better pay.

The Healthcare Interpreter Training Landscape Today

There is no one-stop shopping for linguist training to become competent in the healthcare setting. Interpreter educators provide instruction in specific healthcare interpreting topics, but interpreters must acquire other elements of their knowledge base elsewhere.

Interpreter trainers teach:
Fundamentals:
- ethics, standards of practice (conceptual)
- Performance-based skills:
  - consecutive interpretation
  - simultaneous interpretation
  - sight-translation
  - note-taking
  - ethical decision-making practice
  - partnering with the provider
  - techniques for interpreting in specific medical situations and environments of care
  - cultural competence approach

Knowledge-based classes designed for interpreters:
- medical science fundamentals and specialty topics
- medical terminology
- infection control and industrial safety
- healthcare system processes
- barriers to care

Professional development for interpreters:
- soft skills and customer service
- business management
- self-care around grief, vicarious trauma, and stress
- accent awareness
- management of remote technology for interpreting

Interpreters must seek training from other sources, not from interpreter trainers, for the following:
- general health science
- anatomy and physiology
- in-depth medical terminology
- language instruction: grammar, vocabulary, fluency (spoken/signed, written) in working languages
- accent modification, formal

Under Which Auspices Do Interpreter Trainers Teach?

Fundamentals curricula are offered by community colleges, by for-profit online training companies, and by franchised, nonprofit organizations that do pop-up small group classes for healthcare organizations and language associations. Healthcare interpreter fundamentals classes are 40, 60, or 80 hours long. Since the onset of the pandemic, fundamentals curricula can be taken in class, in hybrid format, or online with some or no trainer contact.

Continuing education classes are offered primarily under the auspices of local interpreter associations and local hospitals and clinic systems. These classes are taken by working interpreters to fit their own interests and needs. With rare exceptions, CE classes take 1–4 hours. CE classes are offered both locally and online, and both in recorded format or with a live presenter.

"Every time I teach a continuing education class on a specialized topic, it becomes clear to everyone in the room, again, that many interpreters working today have never had fundamentals training. Untrained interpreters take up valuable time asking basic questions about the interpreting process rather than focusing on the content advertised for that class."

–Anonymous interpreter trainer

Interpreter trainers generally carve out certain types of material to teach rather than trying to teach all of the different types of material needed. Here are some of the main niches:

1. fundamentals training versus continuing education training. Fundamentals training is primarily conceptual. The classes are somewhere between 40 and 80 hours. Most of the students are new to interpreting and require training from the ground up. Instructors must be deeply competent in the healthcare environment and in the healthcare interpreter role. Fundamentals classes require intensive mentoring and coaching. On the other hand, CE classes are short and address specific technical or conceptual topics that require focused expertise on the trainer's part.
2. knowledge instruction versus performance training. Trainers have strong preferences for either presenting information to the class or conducting practice sessions in which the interpreters practice their skills. Both types of training are necessary, as are both types of trainers. The instructional principles are different, so it is critical that trainers be competent in carrying out the type of training they offer. Some educators do both.
3. language-neutral versus language-specific classes. Scientific concepts or ethics concepts can be taught in English. But for many topics, it helps interpreters prepare to interpret in a culturally effective way when interpreters from a specific

"I feel like I'm stranded on an island. . . . I need more resources and camaraderie support."

–Anonymous interpreter trainer

community or language group learn content and practice skills together. For example, a Reproductive Terminology class may be most effectively presented in ASL to a class comprised exclusively of ASL interpreters, so that the entire class gets practice in seeing and then using the signs involved. A Pediatric Medicine class may be effectively presented by a Somali-speaking nurse practitioner to a group of Somali interpreters, so that they can discuss the questions that come up from Somali parents and they can review the terminology for vaccinations and human development currently in use in the Somali language.

Interpreter Trainers: Formal Instructors, Peer-to-Peer Mentors, Patients

Interpreter trainers are the engine that motivates healthcare interpreters to achieve and maintain professional status. As expectations of interpreters increase, interpreter trainers must develop more advanced material and use more effective training techniques. Who are these intrepid educators?

As mentioned earlier, healthcare interpreter training is in demand, but there is no centralized source for

interpreters to go to for training, or for interpreter services managers to go to secure a guest trainer. It is up to individuals who are concerned about the need for interpreter training in a particular geographical area to take it upon themselves to set up classes, find trainers, generate content, and promote the classes to potential recruits and to working interpreters. Often the people who set up training opportunities also create the content, organize the classes, and promote the events themselves. Kudos to these underappreciated organizers.

Healthcare interpreter trainers are generally professional community college instructors, healthcare licensed professionals, experienced healthcare linguists, and interpreter services managers. Licensed healthcare practitioners such as doctors and nurses occasionally present on specialized topics. Patients often volunteer as subjects in training classes.

Here we need to mention the important training function of peer interpreter mentors. Working interpreters benefit hugely from being able to discuss cases and challenges with each other. Such collaboration is important for newer interpreters to learn from more experienced interpreters. Also, every healthcare encounter is unique, including in its linguistic and cultural aspects, and interpreters benefit not just from getting a solution to a problem from a peer, but from describing the situation and laying out possible ways to approach it. The mentor function is also highly valuable during interpreter classes. The instructor can ask a question of the class and receive many useful answers, all of which inform everyone in the room.

Because there is no national or regional framework for educating medical interpreters, it is nearly impossible to make a living as a trainer. Most interpreter educators, with the exception of permanent staff at community colleges, do not have predictable opportunities to teach, or benefits of any kind. Most teach occasional interpreter classes in addition to holding a full-time job. Entire areas of the country go for months without any interpreter classes being offered. As experienced trainers retire from the workforce, it may be difficult to maintain

Three female interpreting students practicing consecutive dialogue.

enough educational offerings for the growing cadre of professional interpreters.

Some trainers develop their own material, own it, can teach it when they like, and set their own price. Or a trainer will be contracted by an organization to create a specific class for its group of interpreters, and the trainer then also teaches the material to the target audience. Other trainers use franchised pre-set fundamentals content that they have spent time and money to be trained in how to present. They are paid per event to present the fundamentals class for healthcare organizations, interpreter associations, or other organizations. Other trainers work on staff at a language company, and their brief includes developing and/or teaching interpreter classes to interpreters on staff with the company.

There is a pressing need for collaboration among healthcare interpreter trainers, and for broad liaison between all healthcare language access stakeholders around training. There is no association for

Who trains the trainers? NCIHC has produced a cutting-edge train-the-trainer webinar series since 2012. Every webinar teaches about topics that interpreters need to learn and the best methods them. The entire archive of recorded webinars is accessible free to any member of NCIHC on the organizational website, or for a small charge to nonmembers. designed for trainers, CEUs for interpreters are available for some of the webinars because the content is directly useful to them in their work.

https://www.ncihc.org/home-for-trainers

Interpreter trainer and student with surgical garb ready to enter the surgery room.

healthcare interpreter trainers. Some trainers make contact through the NCIHC listserv, conferences, online interpreter social media sites, and through linguist associations. But most trainers operate with limited knowledge of what is being taught elsewhere, let alone of what is currently urgently needed by working interpreters. For example, a trainer who is an experienced linguist and who also manages the three staff interpreters at a clinic system, may not

be aware that interpreters today need to be competent at interpreting in genetic medicine and in complex infectious disease topics like MDR TB, HCV, and MPX. A community college instructor who routinely teaches the fundamentals course may not know that there is a critical need to include a 15-minute module on interpreting in mental health encounters.

As mentioned earlier, interpreter trainers and educators step up from their larger existence in the healthcare or educational landscape to provide desperately needed training for healthcare interpreters. This ad-hoc structure for education for a professional workforce is NOT adequate. All of the healthcare language stakeholders should recruit trainers AND support them with the following: venues for training, payment for their time creating materials, realistic pay for presenting classes, opportunities for themselves to

improve their knowledge and skill, and offer a place at the table, preferably free, at conferences, events, and linguist association meetings.

NCIHC is planning an inaugural conference for interpreter trainers to take place soon. This will provide emotional and professional support, updates on the field, educational technique workshops, and sharing of training materials. Anyone interested in helping to plan this event please contact PERC (Policy, Education, Research Committee) at PERC@ncihc.org. Or become an NCIHC member to be updated on this planned event.

References:

NCIHC. (2011, April). Standards for training programs. https://www.ncihc.org/standards-for-training-programs

Interpreting students reading labels on medication boxes.

ORGANIZATIONAL SPOTLIGHT

Association of Translators and Interpreters of Florida – ATIF

By Tatiana Cestari, PhD, CHI-Spanish & Tracy Young, CHI-Spanish, RN, BSN, MA

ATIF Monthly Gathering, Ft. Lauderdale area, FL, 2022. Image courtesy of ATIF.

Our organizational spotlight is "traveling" through the United States. From our spotlight about the California Healthcare Interpreting Association on the Pacific Ocean (latest Access issue) to now about the Association of Translators and Interpreters of Florida (ATIF) on the Atlantic.

Editors of the NCIHC journal ACCESS, Tracy Young and Tatiana Cestari, conducted an interview with ATIF leader Celina Romero, President, in May 2022. They discussed ATIF's impressive accomplishments and future goals and plans for the organization. Here are some highlights.

Tatiana: Celina, what brings you to this work? How did you end up at ATIF?

Celina: I have been a translator and interpreter for many years and from the beginning of my career, after obtaining an BA in Translation and Interpreting from the Central University of Venezuela (Universidad Central de Venezuela, UCV) in Caracas, Venezuela, I became involved in advocacy and professional training. I was on the board of two professional associations and became a faculty instructor at UCV,

where I taught conference interpreting techniques to undergraduate students, as well as helped design and manage continuing education programs for translators and interpreters. After moving permanently to Florida and while attending a college event, I learned of ATIF and met some of its members. I decided to join. I answered the Board's call for volunteers, and I signed up to help organize professional development courses. I have acted as professional development chair, vice president, and now president since January 2022. Florida is really the hub for Latin America and the Caribbean in so many ways. The state is incredibly diverse, and I like being part of that.

Tracy: Thank you, Celina, for graciously sharing your experience with us and your international perspective. You clearly have

experience working with interpreter and translator organizations in Latin America; tell us about how that experience has shaped your work at ATIF.

Celina: That's right, I have been fortunate to learn from translators and interpreters, and professional organizations from many countries in Latin America. It is interesting that, in Latin America, we work and graduate from universities as interpreters and translators, and there is a need for translation and interpreting in many fields, but there is little recognition of the interpreting and translation professions, as we have it for many other professions. So many colleagues in Latin America have been advocating for decades for better visibility and recognition of the language professions, and for standardization of protocols and best practices in interpreting and translation, for professional wages, etc. And that is also something we are still working on here in Florida and the whole U.S., as well.
(Later in this interview you will read how community collaboration enhances professional recognition.)

ATIF training at Miami Dade College Padron Campus, left side of the room, Miami, Fl. 2019. Image courtesy of ATIF.

Tatiana: Celina, how would you describe the membership in ATIF?

Celina: We have approximately 250 members, which includes both translators and interpreters. I know your journal is focused on medical interpreters, so I'll mention that we have approximately 40 members who register as medical interpreters. In addition, we have court interpreters and translators, conference interpreters, translators (some who function as editors as well). Many of us are freelancers.

Tracy: Celina, do you know if you have any ASL interpreters in your organization?

Celina: No, we are definitely behind on recruitment and engagement of ASL interpreters. We need to incorporate this into our plan to widen our membership. There has even been some conversation about including editors and professionals from other industries that surround language access in general.

Tatiana: Florida is such a huge state—how do you involve all of your members on a regular basis? How do you keep them motivated to be active with ATIF?

Celina: It is not easy, but ATIF has been organizing monthly gatherings for some years in quite a number of cities such as Miami, Ft. Lauderdale, Tampa, St. Augustine, and West Palm Beach every third Thursday of the month. We meet to socialize, but also to talk shop, express grievances, and learn from other colleagues. ATIF sometimes foots the bill for the meeting at the restaurant or coffee shop. These gatherings are open to ATIF members, who can extend an invitation to nonmembers. If you do not have an ATIF monthly gathering in your area, you can get in touch and maybe agree to host one!

Tracy: Wow, which is notable and quite commendable. I don't believe that many other associations are meeting so often and footing the bill! So every month, members are meeting all over the state—we love that!

Celina: Yes, but we also like to bring in "out-of-staters" to mix it up a bit. Our "Spring into Action" event is an international event, held in 2018 for the first time, with the idea of meeting every two years. COVID-19 interrupted this. It has been our biggest event after our annual membership meetings. We are excited about getting back on track with "Spring into Action." In addition, we offer our members four to five professional development courses a year, in-person and live-streamed,

ATIF Our vice president Joaquin Fermoselle (standing left) while attending one of our Ethics courses. 2019. Image courtesy of ATIF.

with continuing education units approved by accreditation programs (CICRP, CCHI, IMIA, ATA). And last but not least, ATIF offers its members, at a discount price, a 40-hour training in medical interpreting for those members that want to take the certification exam to become a certified medical interpreter.

We've had great speakers visit us in south Florida. Of course, during the last 2 years, we accommodated to hosting virtual class sessions. But we are working to resume our "normal" courses later this year.

During the preparation for "Spring into Action," we were successful in community outreach, engagement, and support by universities in Florida who have T & I programs. For example, we have partnered with Miami Dade College and Florida International University. In the case of Miami Dade College, we signed a Memorandum of

Understanding, MOU, in 2016 by which they have provided space for our courses and some events. We are in the process of renewing this MOU, which has been a win-win, as it has helped advance recognition of our profession in general. In addition:

- students are able to attend our courses for free, which in turn can help improve student involvement with professional organizations.
- graduate students receive 1-year free membership, and this is aimed at mentorships for the students and eventually internships.

I like to think of ATIF as an informational and training hub for translators and interpreters interested in expanding their knowledge and professional horizons. And I would like to think that ATIF will be able to reach out to other educational institutions around the country and abroad.

**Tatiana**: Celina, please tell us about some challenges faced by ATIF.

Celina: Well, members are part of this organization because they believe in its importance; however, we do need to keep working and reminding ourselves of the advantages of being part of a professional organization. It is volunteer work, and it does take time and effort, so we need to fit this in with our daily lives. I also think many individuals do not volunteer because they don't believe themselves capable to lead a committee or a board within an organization. We need to work on this, as well.

Tracy: Very good points! We believe that every member has much to offer; we are all so diverse and bring valuable input to the organization. Volunteerism is so rewarding! Do you have any other comments for our readers?

Association of Translators and Interpreters of Florida
Welcome to ATA's Florida Chapter
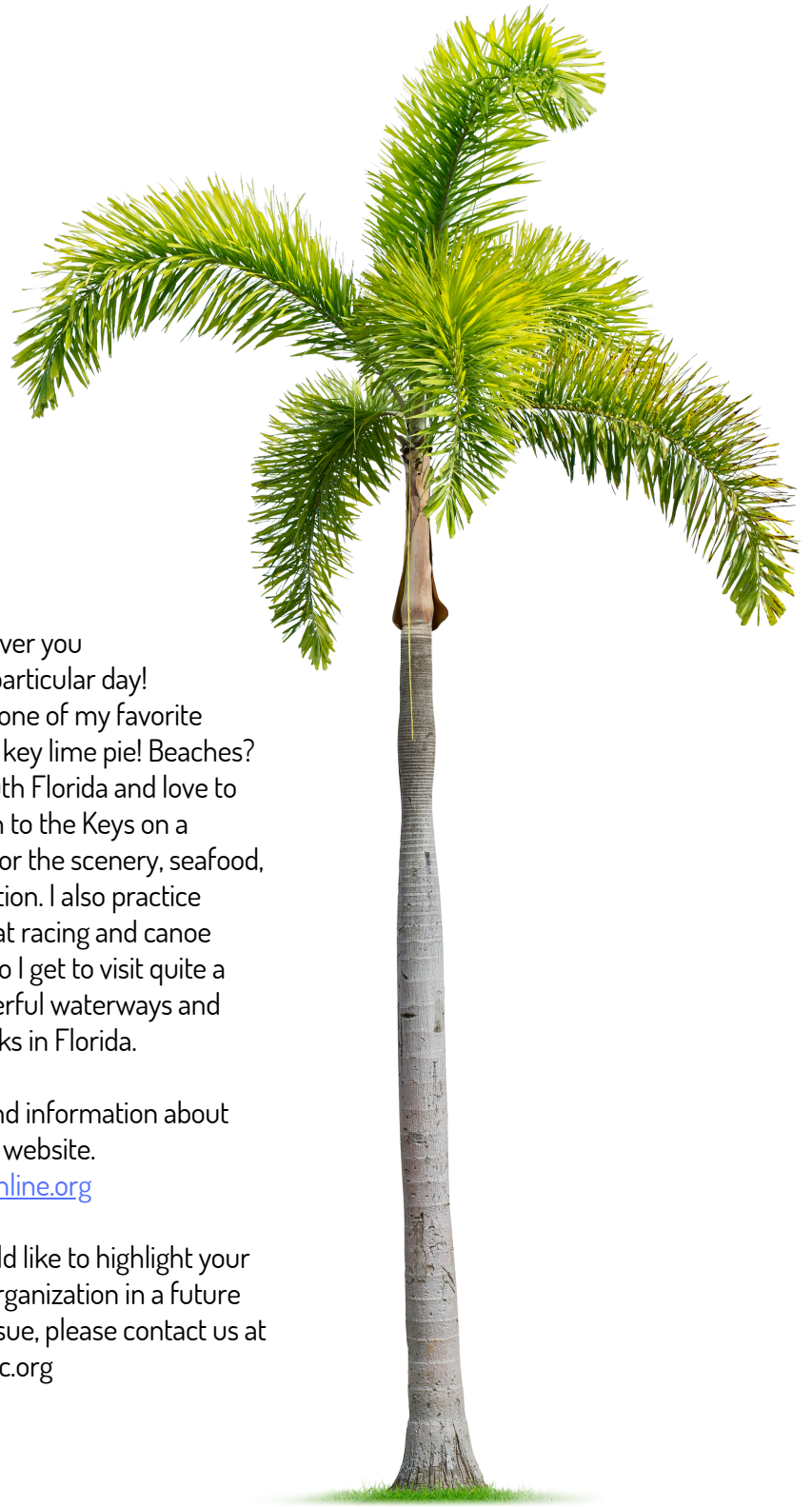
Celina: Oh, I forgot to mention: If you are a translator or interpreter visiting or staying for a few months in Florida, like many people do, think about attending one of our monthly gatherings, meeting colleagues, and even joining ATIF, eventually.

Tatiana: Celina, we are dying to know—what is your favorite beach in Florida? How about your favorite place to go dancing? Favorite restaurant?

Celina: This is difficult to answer because there are many places with great service and greater food in Florida. I like beach restaurants, diners, and small local coffee shops. Florida has any number of places where you can find whatever you want any particular day! Of course, one of my favorite desserts is key lime pie! Beaches? I live in south Florida and love to drive down to the Keys on a weekend for the scenery, seafood, and relaxation. I also practice dragon boat racing and canoe paddling, so I get to visit quite a few wonderful waterways and nature parks in Florida.

You can find information about ATIF on its website.
www.atifonline.org

If you would like to highlight your amazing organization in a future ACCESS issue, please contact us at perc@ncihc.org

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