National Council on Interpreting in Health Care

First Annual Membership Meeting
June 30 - July 1, 2007

Report

Over 90 participants attended NCIHC's First Annual Membership Meeting held in downtown Chicago. The two-day event opened with welcoming remarks, introductions, and instructions for how the meeting would be structured. In addition, the new Board of Directors was officially accepted and installed by vote of the membership. Before the group split up to go to their Work Groups, there was general discussion about what members would like to see from the NCIHC:

- Workshop for Interpreter Services Managers
- Cultural Competence courses
- How to develop Language Access Programs
- Events other than a membership meeting
- Regarding upcoming national elections: a forum in which members could reflect on possible new health care legislation with the new president
- Train the trainer standards for interpreter trainers
- Provider training standards
- Standards to determine who is a qualified mentor
- Template for laws on certification at the state levels

Work Group Proceedings

CERTIFICATION

Almost every attendee participated in the NCIHC's Certification Forum. A formal report will be prepared for public dissemination in October which will indicate the issues related to the creation of a national certification, including the benefits and challenges that need to be met. The NCIHC currently has a proposal which has been submitted to The California Endowment to fund the first planning phase of certification which will allow stakeholders to come together and identify the members who can constitute an expert subject committee. While the NCIHC will organize efforts, it will be a stakeholder group with representatives from around the country and across the industry, including providers, interpreters, trainers, and consumers, who will be making key decisions regarding certification. Eventually funding will be sought for the services of a psychometrician to develop the testing tool itself.

NCIHC Certification Forum – Session #2

Welcome – Explanation of background of Forums around the country.
Statements – Results to be posted on Consensogram. Then breakout into groups to discuss each question.

Statement #1: I think we are ready for national certification now.
How do you feel about this statement?

1) You strongly disagree. (3)
2) You disagree. (4)
3) You agree. (4)
4) You strongly agree. (4)

No consensus in the room.

Statement #2: I think that national certification will eliminate many good interpreters who are currently practicing.

1) You strongly disagree. (3)

2) You disagree. (6)
3) You agree. (5)
4) You strongly agree. (2)

Evenly divided between those who agree and those who disagree.

Statement: I think national certification at this time will answer concerns about the quality of health care interpreting.

1) You strongly disagree. (0)
2) You disagree. (3)
3) You agree. (9)
4) You strongly agree. (4)

Overwhelmingly, most people think yes.

This is the first group to be so evenly divided on the 1st statement. (Elsewhere, most people start out agreeing yes.)

[Break into 2 groups.]

First, definitions:

Assessment – evaluation, screening
How is it different from certification? A person can do an assessment. A person can not certify.

What is needed then for certification? A law? For enforcement of any certification legislation. What about accreditation? Implies credibility.

A certificate of successful completion is just a certificate of attendance, perhaps includes a final exam.

Licensure – even after finishing school, some professions require individuals to pass boards for licensure. State designation.

Accreditation – peer review, such as for universities, done by an organization as opposed to a government.

Certification as part of quality assurance. Actual exam is only one piece of quality assurance. Need to include recruiting – need to recruit those who are likely to pass exam.

Language screening – see if candidate possesses language skills required for exam. Training, assessment, monitoring, are all part of what is involved in certification beyond just the test.

Is the exam reliable, is it valid, is the certifying body credible? Does the test test what it's supposed to test? Is the exam given in a consistent manner? Do the graders grade it in a consistent manner? Needs to be an open process in which everyone knows what is going to be tested.

Why push for national certification?
Certification exams expensive.
Increases interpreter credibility.
Evens out individual state by state exams – reciprocity.
Attract developmental funding.

1st Question: What are the conditions that need to be in place for national certification to be credible and successful?

Group 1:
Support from Joint Commission to show that there is a need, then there would be compliance.
Network of test sites to prove accessibility, ensure that everyone has chance to take test
Administration by a neutral agency, such as the NCIHC

Timeframe for making it a requirement.
Continuing education.

Group 2:
Language proficiency test for candidates
(LEP to use TOEFL or similar guidelines)
Minimum standards for training programs
Standards of practice for the field
A certifying body, perhaps NCIHC
Recognition of the body
Access to the test and testing materials
Publish parameters of what will be tested (driving manual)
Validated test
Qualified testers
Plan for managing diverse languages – what languages could be included in the beginning, what others could be added, how to include others.

Phase-in of certification at different levels – RID example.

Question: What are the potential benefits and pitfalls of certification? Who will it help and who will it hurt? How and why?

Group 1:
Benefits: Help patients
Increase access, reduce disparities
No downfall for pts (except risk of some interpreters, who speak pt's language best, may not pass test)
For providers:
Communication far more effective for providers
Recruitment tool for doctors who know that only certified interpreters will be available
Hospitals – less risk, more likely to get reimbursement
Agencies and hospitals will have easier time knowing who to hire.

Downside: They will have to pay more for their interpreters' time and potentially face a shortage.

Interpreters – More credibility, self-respect, and better pay
For some, there will be intimidation, they may leave the field, may face potential discrimination, may find it too expensive to take exam
Training organizations – guidelines for training will be in place, some orgs would have to totally revamp their curriculum.

Group 2:
Certification will connect interpreters, interdisciplinary support form other professions in healthcare, more research, interps better educated and better compensated
Pts will have better service
Government reimbursement
Hospital will see benefit to hiring interps
Higher profile for interpreters
Reduce liability
Hurdles: Cost factor and time, not all languages could be tested at the same time, may eliminate some good interpreters

Question: What more do we need to know about what makes a competent interpreter before we move toward certification?

Group 1:
Education – BA or equivalent in interpreting hours and experience
Short- term memory
Ethics

Cultural fluency
Ability to adapt to changes
Various cultures
Familiar with healthcare procedures
Strong professional boundaries
Strong interpersonal skills
Training programs

Group 2:
3 elements: certification and degree, training, and practice
Medical terminology
Culture of medicine
Good working skills with people
Mastery of the skills of the profession: listening, etc
Interpreter is not a machine
Personal skills
Fluency in medical terminology
Desire to learn and grow
Self-motivated
Understands boundaries
Self –respect
Respect for others
Support from system, public recognition
Ability to command respect
Not imposing values
Part of team of professionals

Question: What are biggest challenges to implementing a national certification program?

Getting everyone in the same direction, too many different ideas on how to move forward.
Egos
Opportunism created by environment
Need to make sure next president is a democrat.
Conflict of interest – too many concerned about own personal interests.
Need dialogue among all stakeholders to decide who the leader will be. There should be no personal interests that benefit from this.
Name recognition of NCIHC has been helpful.
How to do follow-up with training and government organizations?
Mountain of resistance in the South from hospital administrators who see this as a threat because they believe that it attracts illegal immigrants. Good quality resulted in closing of programs (Hablamos Juntos program was shut down).
Need to bring in champions from major orgs, as allies. The decisionmakers need to be won. Impact of immigration on the healthcare interpreting field.
AMA and JCAHO efforts will bring more opportunities, more acceptance.
Need to have NCIHC and local organizations work together, so that people understand that there is no clash.
Need to fight stereotypes and prejudice regarding notion that Latinos don't have money to pay for services.
Engage support of already-established orgs such as the ATA to help us overcome these barriers.
Collaboration with nursing orgs.
Importance of having association with OMH and JCAHO help to support sending people to conferences.
Fred Hobby, AHA, also a champion.
Training for medical students on working with interpreters.

Summary – Moving Forward:

This is the 7th forum, 2 more this summer.
In 2005, MMIA pre-conference meeting.
May 1st, 2007 meeting in Cambridge.

Meeting June 13-15, 2007 in Minnesota – 15-member Expert Panel:
Interp competencies, Test development and administration, Implementation, State Representatives
Implementation Group –
Need to secure funding for more meetings, targeting September
By December, formation of national committee

1. Compile existing information on certification in other disciplines, and across the world.
2. Job analysis
3. How to market
4. How to make sure process flows to and from all stakeholders.
5. Secure funds for test development
6. Conduct forums, surveys, feedback

Need for umbrella organization to do secretary's job.
National Committee must be manageable number, with many, many subcommittees.
Many thought the NCIHC should be the organizer. Some thought the group should become a new non-profit organization.

Questions from group:
What about certification in state of Washington?
Does the NCIHC have a goal, timewise, when it would like to see it happen? 3-5 years

Statement: I think we are ready for national certification now.

1) You strongly disagree. (3)
2) You disagree. (7)
3) You agree. (3)
4) You strongly agree. (1)

Session 2 Participant Demographics

Dedicated FT health care interpreter	7
Dedicated PT health care interpreter	2
Freelance (contract or agency) interpreter	2
Volunteer interpreter	2
Manager of interpreter services	8
Health care administrator	3
Health care provider	1
Interpreter trainer	10
Other	5

Venue:	Hospital	14
	Clinic	10
	Home health	5
	Nursing home	4
	Other:	7

(1 workmen's comp insurance; 1 schools; 1 hospice, mental health; 1 hospice; 1 community – international Red Cross program; 1 county health and human services, economic support, youth and family services)

Modality:	Face-to-face	13
	Telephonic	6
	Video interpreting	1
	Other	1 (translations)

Training:	Less than 40 hours	1
	40 – 80 hours	6
	80-120 hours	3
	More than 120 hours	2

B.A. in T & I	1
M.A. in T & I	0
Other	7

(1 Certificate in Medical Interpreting; 1 2-year degree; 1 continuing ed; 1 conferencing; 1 no interpreter training, but degree in international studies)

States: FL, GA, IL, IN, MA, MI, NC, NE, NH, NY, OH, SC, TN, WI,

Sunday, July 1, 2007
Certification Session

Presenters: Karin Ruschke & Cindy Roat
11 Participants

Demographics of Session:

In what way are you related to health care interpreting?

1 Other – Health Care Marketing Manager
1 Dedicated part-time health care interpreter
4 Manager of Interpreter Services
3 Interpreter Trainer
1 Freelance interpreter
1 Other – Director of training programs for culture, language and interpreting

In what venue do you work?

5 Hospital
5 Clinic
1 Other – Training
1 Other – Business
2 Home Health
2 Nursing Home
1 Other - Doctor's Offices – mostly worker's comp
1 Other – Colleges

In what modality do you most commonly interpret or use interpreter services?

5 Face-to-face
4 Telephonic

If you are an interpreter, what formal training have you received as an interpreter?

3 40 – 80 hours
1 Other – DOD Cert.
1 80 – 120 hours
2 More than 120 hours
1 Other – Certificate in Translation Studies, IUPUI, State Court Certified

In what state do you work?

Wisconsin
Nebraska
Arizona

Indiana
New York
Massachusetts
Pennsylvania
Virginia

Presentation:
This is the 5th place we have done this series regarding certification.
We will be compiling the data and placing on the list serve.
People can go on and see the data that was collected.
Cindy will give update on some of the efforts around the country.

Where are we right now with regard to opinions in this room? We will put them on the censogram. Give us demographic information.

We will give you three statements; we would like to write a 1, a 2, a three or a four.

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Write the number on the post-it that corresponds with how you feel about the following statements.

1. I think we are ready for national certification now
   1:3 2:5 3:2 4:0
2. I think Certification will eliminate will eliminate a lot of good practicing interpreters.
   1:3 2:5 3:3 4:0
   a. The question, "What is good?" was raised.
3. I think national certification at this time will answer concerns about the quality of health care interpreting.
   1:0 2:1 3:5 4:4

One of the reasons for these focus groups is because we realized that there are a lot of different ideas about what certification is and all the parameters surrounding certification - we need to learn what it is.

Terms we use when talking about certification:

Assessment: Tool that measures something
Key thing is that there is no standard, it's just measuring

How does that differ from **certification**?
It just means that somebody has guaranteed that somebody is capable of a certain task up to a particular standard.

Certificate – no measurement, no guarantee.

Licensure: Authorization to perform a certain job. Most states license only with certification

Accreditation: For organizations not individuals.

We need to differentiate between licensure and certification. Just because we have national certification doesn't mean that it would be required. Unless we have a national law saying that all interps must certified, it's not a requirement.

Question was raised about certification for court interpreters. Cindy gave overview of current situation.

Another key concept is what role does certification play? Why do we certify interpreters, why do it at all?

Participant: To raise the bar

Why?

Credibility. To improve patient health outcomes.

We are really interested in quality assurance. Certification is part of QA process. There are a number of ways to assure QA. What else can you do?

What else needs to happen for interpreters? Training

Break up into two groups of six - discuss this question, use a scribe who will report back. You have 15 minutes. What are the conditions that need to be in place for certification to be credible and successful?

What did you discuss?
Group 1
Standardized Training and the availability of that training throughout the country
That it be administered by a credible body and who decides if that body is credible
That there be a training of trainers program to enforce the standardized training
To have a plan of attack for the diversity of languages. And how do we deal with individuals who can't pass the test , but have been working for long time, i.e. grandfathering.

Group 2
Valid Test, people have to believe that it's a valid test, there has to be consensus that there is a demand by providers for certification.
Must be a managed by a disinterested or neutral third party. So that means a party that doesn't have a vested interest in the outcome.
Training: if competencies are defined then the trainer can decide how to train to the competencies. Training doesn't have to be standardized but the competencies should be standardized. Training should be available and affordable and there should be review sessions and study materials. For people who don't want to take the coursework – they can do a self study. There should be a law in place like a national law that requires standards similar to those in the national certification law; current laws are too vague. In order for this to be credible and successful, there needs to be a market for certified interpreters. Also the law that creates certification should identify the competencies. There should be specific tests for non-readers or those languages that aren't written. Continuing education is part of certification - beyond certification. We talked about a registry, that there should be a registry in place that would help disseminate the fact that there are certified interpreters.

The issue of continuing ed without licensing was raised because not every state will license. It could go both ways. Because in Australia after 30 years they are starting to re-certify interpreters and the recertification will include continuing ed.

Participants were broken up into new groups and asked to discuss:
What are potential benefits and potential pitfalls of national certification, who will it help, and who will it hurt?

Group 1
Benefits: It will help patients - they will get better outcomes. It'll help healthcare providers and it'll help interpreters - they will have a credential, better training, higher salary, more of a professional community for support and network.

How will it help providers - communication, dependability - will help patients by better care - safer.

It will help trainers because they will have a better idea of what needs to be trained on and they will know what materials to use. It will help students at Universities because they will have a career option. Trainers can get more students. Trainers will be able to provide advanced courses.

Who could it hurt - the patients. Healthcare facilities might decide not to use certified interps because the cost will be driven up. If it's a billable service patient can't afford. Patient could elect to use ad-hoc interpreters.

For profit companies being able to increase their rates because they can provide different services by certified interpreters and their ability to offer insurance of those services - again it drives up cost.

Group 2
Benefits: administrators who already have really good policies in place won't really have much work to do. It will help the administrators who already have strong programs. Within the organization it will help risk management avoid lawsuits. It could help organizations with their marketing of statistics, mortality rates, success rates.

It will help human resources by helping them more easily determine who is qualified.
Another pitfall was resistance from interpreters to the certification process. Why do I need to do that, Why should I spend my money to do that, the test is unfair, etc.

Culture sensitive and education level sensitive test. What if someone doesn't have a degree. If the test is written at a level of college education, we may eliminate really good interpreters because of the level of difficulty of the testing tool.

One more benefit: we thought it would be easier for training programs to collaborate. Programs have the same goals - easier to create training networks.

Pitfalls: pool of human resources is smaller.

Why Pitfalls -- we really want to know what people see as the pitfalls because of lot of pitfalls can be avoided through careful design. Some of the problems, there is no way we can avoid them but at least we will be prepared for them. We educate and let people know this is coming. We can take time to let people get used to the ideas.

Next Question:
What are the things you think a medical interpreter needs to be competent, what skills? And what do we need to know about interpreter competencies?

Group 1
Accuracy: What constitutes accuracy? What specific skills are involved in fulfilling the interpreter code of ethics, i. e. advocacy. What abilities are required to be a cultural broker and that it was important to identify the culture that was being tested. How to test the ability to be a culture broker. The issue of interpreters who interp for pts of many cultural groups. Specific cultural bumps, a record of how they were resolved, how were they successfully mediated or resolved by the interpreter. We tried to look at what competencies pose difficulties to testers.

Bedside manner, interpersonal skills, customer service, understanding of health care setting. Problem solving skills, critical thinking, linguistic adaptability and flexibility, so if there are no linguistic equivalents how to manage.

Maintaining professionalism in stressful situations, both in the hospital and home care. Ongoing professional development regarding culture, that they understand the avenues or protocol when they need to take on the role of the advocate, mental stability. Documenting our encounters.

Doesn't Joint Commission require that the fact that an interpreter is present during informed consent be documented. No, it could be that one surveyor said that. Cindy is collecting stories about differences in Joint Commission Surveys regarding language issues so that Joint Commission can effectively train their surveyors to be consistent.

Next question:
What are the biggest challenges to implementing a successful national certification program?

- Gaining community/political/professional support.
- Being able to provide a clear benchmark that is standard enough to allow for new emerging communities
- Provide adequate available and affordable training that is geared to fulfill the certification requirements
- Being able to train the trainers and exam raters
- Racism/ignorance – if we need political support - constituents will be loud strong voices against this. Both government officials and the public.

- Gaining professional recognition
- Element of decision making - moving forward, who will make the decisions and will there be willingness to collaborate on all levels
- Establishing threshold or balance, what will it be? To make sure that everybody is in the picture and all voices are heard, not being exclusive
- Cost consciousness, affordability
- Governing body - who is going to over see this. To assemble and keep records, who is going to police it.

Get out your green post-it notes and on it pick the number that best describes how you feel about this:
I think we ready for national certification now.
Based on all our discussions, answer with 1, 2, 3 or 4.

1:6 2:1 3:2 4:0

People think that we may be ready for national certification and are pushing for it without really understanding what's involved, and the reason we do these sessions is to create awareness of the process and what needs to happen for us to have national certification.

We talked about certification falling into QA, but it isn't the only piece of QA and there are other things we could be doing to ensure Quality. There are other things that we could be doing. Aside from testing interpreting what can we do:
Monitoring
Supervision
Training
Basic training
Continuing education

A way to remove people who commit unethical acts
There are skills that are used in Med Interp that you can't learn in a 40 hour course, they come from life experience.

Appropriate recruiting
Screening their language skills
Then train them
Then assess them
Then make sure there is continuing education and supervision
And then if they don't get it, some way to remove them

People see certification as the way to solve all ills, but it isn't. The other thing is, unless we have a law requiring certification, we have to get buy-in to be credible.
What makes a credible certifying body?

It's a body where there's a belief that people in the org know what they are talking about, has to be an org above ethical reproach, that they are really doing what they say they are doing.

The group should be neutral, no conflict of interest, should be nationwide. There is no such thing as no conflict of interest. Anybody will gain prestige from certifying interpreters. In truth there is always something to be gained from being involved in this line of work. But are there things that undermine the trust that an org is fair and equitable.

What does it mean that a test is valid:
Tests what it says it tests. Construct validity - the way that you test, are you actually testing different things. If you're testing spoken language, you can't give a written test. We need to ensure reliability. Two people who are at the same skill level get similar scores. Cut score - 70 % what is that based on? It should be based on a scientific calculation. You have to let people know what, in general, is going to be on the test.

The only states that have what they are calling certification are Washington and Oklahoma. We have two states that are going to down a road of qualifying interpreters based on training and then will test them later. They will qualify

interpreters who have completed certain training requirements. Those are Oregon and Indiana. Iowa is qualifying based on training. In Mass., the IMIA is working on an instrument to test, and North Carolina, there are also efforts in New York and Kentucky.

Dear Marjory and NCIHC Board:

The names of people and organizations were hard to catch and should be verified in the event of quoting or publishing the remarks of any person in particular. Some names were too hard to hear or understand and therefore were omitted. I did the best I could to take notes that are neutral, relevant, and complete.

Respectfully submitted,

Barbara Rayes

DUAL-ROLE INTERPRETERS

Dual role interpreter (#2): An individual who is tested for language skills, trained as a medical interpreter, receives extra compensation, and assumes the task of part-time medical interpreting willingly.

- Adapted from an NCIHC Open Call on 3/23/07

The Dual Role Interpreters discussion groups drew a broad sector of participants, from researchers, accreditation experts, trainers and interpreter services coordinators to freelance and dual role interpreters. Participants of this session came armed with passion, fire and enthusiasm. They offered their input on the state of dual role interpreting today. After discussing what dual role interpreting means, participants explored three questions: 1) What is the current state of the field? 2) Where *should* we be—what has to be in place to ensure quality healthcare interpreting from dual role interpreters? 3) How do we get there? i.e., what recommendations could participants share to support dual role interpreters?

Feelings ran strong. Many participants agreed to disagree on specifics. On one point everyone concurred: all healthcare interpreters should meet high standards, including dual role interpreters. In addition, healthcare interpreters who are dual role (like all others) should be trained in medical interpreting and tested for language proficiency. Finally, they should respect NCIHC national ethics and standards of practice. Dual role interpreters face many challenges and urgently need institutional support. As a result, participants largely accepted that NCIHC takes no position on whether dual role interpreters are "good or bad." Even participants who supported medical interpreting as a stand-alone profession willingly shared detailed strategies and plans to help ensure quality performance. Everyone agreed that in dual role interpreting only support for programs that ensure rigorous, high standards will promote beneficial outcomes, protect patient safety and enhance equal access to health care.

Saturday, June 30, 2007

Facilitator
Marjory Bancroft

Assistants
Lois Steele, 10:30 a.m. and Montserrat Zuckerman, 2:00 p.m.

Scribe
Barbara Rayes

Handouts

Dual Role Interpreters: Advantages and Disadvantages of Using Bilingual Employees as Dual Role Interpreters, Marjory Bancroft, MA

Bilingual Employees: Issues and Concerns for Dual Role and Adjunct Interpreters, Marjory Bancroft, MA

Dual Role Interpreters in Health Care: A Discussion Group: NCIHC First Annual Membership Meeting, June 30 – July 1, 2007, Chicago, IL

NCIHC "Position" on Dual Role

Disclaimer: The NCIHC believes that the topic of dual role interpreters is an important one because it is often brought up in discussions as an issue that many NCIHC members face. Allowing for geographical differences, there are many dual role interpreters "out there in the field." They are less common in some places and more common in others.

There is ongoing controversy about the use and management of dual role interpreters. In facilitating discussion of this topic, the NCIHC is not taking a formal position about whether dual role interpreters are good or bad. Rather, it seeks to provide a forum for discussion. It is the NCIHC's belief that an open national exchange of ideas such as this is an important way to develop the field of medical interpreting.

Objectives

1. Define critical issues in the field of dual-role interpreting.
2. Discuss the assessment, training, testing and support needs of dual-role interpreters.
3. Develop a list of recommendations to support the appropriate use of dual-role interpreters.

Definitions

Bilingual Employee
An employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited-English proficient patients, but who is usally not trained as a professional interpreter.

- NCIHC website

Dual-role interpreter (#1)
An employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called up to interpret for limited English proficient patients, and who has undergone training and testing.

- *Hablamos Juntos* website

Dual-role interpreter (#2)
An individual who is tested for language skills, trained as a medical interpreter, receives extra compensation, and assumes the task of part-time medical interpreting voluntarily.

- Adapted from an NCIHC open call on 3/23/07

note to Council from Barbara Rayes: Please consider changing "voluntarily" to "willingly." Saying "voluntarily" gives the impression that the dual-role interpreter is offering service without pay. "Willingly" more closely conveys the idea of choosing to engage in an activity and does not have the double meaning that voluntarily does.

Small Group Activity #1

Using handout, "Dual Role Interpreters: Advantages and Disadvantages of Using Bilingual Employees as Dual Role Interpreters" by Marjory Bancroft, MA, add to or subtract from the list of advantages and disadvantages of using contract (CI) or staff (SI) interpreters. Then, identify what you feel are some of the critical issues that we need to tackle in the next hour.

Small Group Activity #2

We want to move toward a system in which dual-role interpreters are tested and held to the same standards as all interpreters. There are papers on the wall with strategies for creating this system. Each participant has 10 stickers. Put a higher number of stickers on the strategy that you feel is best. Of the 10 stickers, 2 are yellow. Yellow indicates highest priority. Place the yellow stickers to indicate your highest priority. Each small group also has 5 group stickers to place where they collectively decide to place priority / emphasis.

Strategies on the papers on the wall

1. Interpreter Training
2. Language Proficiency Testing (In-house Test, Validated external test)
3. Testing for Medical Terminology
4. Interpreter Skills Testing (Oral and/or Written and/or Role Plays)
5. Monitoring and Supervision (Mentoring, shadowing, assigning an LEP coordinator, plans to re-test, etc.)
6. Policies and Procedures and other organizational support
7. Staff Training – training for providers and front-line staff on how to work with interpreters and dual role issues; general staff training on cultural and linguistic competence
8. Pay Differentials and other incentives for dual role
9. Tiers and Levels – Assigning levels according to the skills and assessment of dual role interpreters' capability (e.g., Level I: Hospitality interpreting; Levell II: standard medical encounters; Level III: Specialized, urgent care and/or complex medical encounters)
10. Professional Development

Film preview
NACHOS: Addressing the Language Barrier in Health Care
Language Initiative, Center for Immigrant Health, NYU School of Medicine
550 First Ave., OBV CD402, New York, NY 10016
212-263-8242
www.med.nyu.edu/cih

Saturday, June 30, 2007, 10:30 a.m.

Introductions

Marjory Bancroft, originally from Canada, over 20 years in the U.S.
I have spent my career in languages, linguistics, and translation.
I have taught English and French as a second language.
In the U.S. I have spent my career in health care. The first thing that happens to you in the U.S. when you work in health care and speak two languages is, "Marjory! Can you please come here and translate?" Did I have training as an interpreter? Was I doing it right? I'll let you answer that. One day I found a copy – a bootleg copy! – of Bridging the Gap. I was supervising over 200 interpreters at the time and I decided they all needed this training. Along with Barbara Rayes, I'm one of only 2 people in the country insane enough to specialize in dual-role interpreting.

Orlando: This is one of my biggest issues in the hospital right now, is testing.

Vilma Seymour, Language Services Coordinator, VCU Health Services, Richmond VA. Last year I became a trained trainer for a modified BTG in Virginia. We just wrote policies last year. I quote Glenn Flores often. I sit on the Board of Governor's Council on Health Professions. My advocacy is to make medical interpreting the same as court interpreting in terms of certification, throughout the state of Virginia. Don't say "using" about interpreters – pay the interpreters, don't use them.

Suzanne Coutoure, medical translator interpreter, Children's Hospital Milwaukee. I like hands-on workshop atmosphere. Dual-role bilingual is definitely an issue where I work.

Shelby Dunster, JCAHO. I'm here because of the JCAHO grant on hospitals, language and culture. We have a table outside. I encourage folks to grab a copy of our research paper. It's interesting because there's information here on the use of bilingual staff, dual role interpreters, who's trained, who's not. I go back to the OMH development on the CLAS Standards. I'm fascinated by this and would like to learn everything I can on this. JCAHO will be revisiting standards. We have a standard under human resources that anybody who is involved in patient care on any level that they be assessed in terms of competency. Then what do we do in terms of interpreters and dual-role interpreters.

Robert Bruno, LS Coordinator, Fremont Medical Services, Fremont NE

We don't have many dual-role interpreters. Small hospital, rural area. As part of the health care team or part of the hospital, part of the policies, being a hospital employee, you have to be a patient advocate. I kind of consider our staff interpreters to be dual-role in a certain way, especially in our little hospital. Since we are employees for the hospital we can do patient teaching, documentation. Not only bilingual staff having some training, I don't think we've taken that into consideration that dedicated staff interpreters, not contract interpreters, but dedicated staff interpreters are actually dual-role.

Julio Sepeda, T/I, Children's, Memphis TN
I encounter a problem every day that doctors and nurses believe that they are bilingual but they are not. There are times when families are misinformed because of this and then they call me – it's very frustrating! There has to be a way to test these people. They may have taken 4 years in college.

Pablo, Michigan, medical interpreter, translator, Oak Brook Hospital.
We have a large number of bilingual staff. We rely on them a lot. Most of them are not qualified. The way we accept them is to screen them to see if they can handle the job but we are not sure of the quality of the interpreting. I hope this session will give me ideas of how to help these people, enhance the way they interpret.

Diana Cientez, International Language Services, Chicago, interpreter/trainer for the agency
I do training with providers on how to work with an interpreter. A big part of that is working with them to help them understand why they should use an interpreter. I use concrete examples of misdiagnosis, misleading information, and you can't imagine how things change after I teach this – policy changes and updates.

Lois Steele, Pennsylvania, Sign Language Interpreter, free lance
Serve in Delaware on the state of DE on mental health needs of the deaf. A lot of the mental health stuff falls to me. Interpreters tell me, no, I don't like mental health interpreting, so I tell them, then stop it! In DE there are no standards, no requirements. It's frustrating when someone is "interpreting" and they just throw words out and the therapist is writing this stuff down but the wrong interpretation is what's making the client look crazy! You show up to interpret and they say "Where's the client?" and I say I'll go with you to get them but I'm not medically qualified [to transport patients!].

Daniella, MI, from Argentina originally, conference interpreter for wine industry 20 years ago. I became medical interpreter and now almost exclusively a medical translator. I want us to get to the point where people look at medical interpreters and translators with the same respect as doctors, other health care professionals. Speaking a foreign language in a hospital becomes a punishment.

James Weller, QA, Michigan
Linguist by education, interpreter by profession. Push and advocate for role of interpreter. If anybody has dual-role it should be that she's trained as a nurse and she's trained as an interpreter. None of this ad hoc, oh, we'll get you as you go along, we'll train you

Betsy White, Grand Rapids, SL interpreter, Manager
I was raised with standards and from a risk management perspective I see them putting their license at risk, their hospital at risk, and they're disrespecting the patient. We have to be clear about our own expectations or we're bastardizing the profession.

Barbara Rayes, Medical Interpreter Project at Phoenix Children's Hospital

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Suggestion: Instead of "used" say hired, assigned, called in.

Used = Exploited

Idea of changing the register: The parents don't understand! We have to lower the register. The standards say we must not lower the register. JCAHO information on health literacy.

MARJORY BANCROFT
Clarity about where I stand: When we host and deliver trainings, who shows up? From when we started in 2001, it has been 90% bilingual staff. Untested, untrained, in a two-day workshop as a freelance interpreter.

Do you support the concept of dual-role interpreting?
1 Green – I support it, it might not be working, but I want to make it work
5 ½ Yellow – It's a mess but I want to make it work
3 ½ Red – I don't support it. Medical interpreting is a stand-alone profession.
4 abstentions

The NCIHC has not taken a position on dual-role and doesn't plan to. We can't pretend that dual-role interpreters aren't there. The Council has taken a very strong position that anyone who interprets should be qualified.

Gradations, distinctions within the medical interpreting profession

There are not many statistics, but from what evidence that exists, about 50% of the interpreting going on in hospitals is done by bilingual employees who may or may not have been trained and tested.

An awful lot of interpreting is still done by friends and family members.

Many interpreters started as child interpreters.

Contract interpreting is a growing profession. It's not known what percentage of interpreting is done by contract interpreters.

JCAHO – we had a small sample size. Our study suggests but does not necessarily show due to small size –
79% using family or friends
50% still using family or friends in the judgment group
See pages 55 and 56.
88% using bilingual staff to interpret during all the site visits

MARJORY BANCROFT These are representative snapshots. We can safely say that as a general trend, we have a problem.

Volunteer: usually a Language Bank volunteer who may have some training, may sign confidentiality agreement.

Ad Hoc: you just grab somebody

The problem is that some people are not interpreting. They are just killing communication.

When this discussion group ends, we'll put together a paper and publish it. We hope to say that you should only allow people to interpret who have been trained and will actually interpret, not take people for coffee, etc.

Why is this taking so long to get respect for the medical interpreting profession? America has been isolated from foreign languages. Most of America speaks Spanish. This is a very big continent.

Wrestle with one basic concept: Get everybody on the same level with standards and training. If everybody who is interpreting, even volunteers and dual-role, has to conform to the same standards, then we would still have the problem of how to say no to particular requests.

Discussion of Small Group Activity #1

/ MARJORY BANCROFT The state of the field: We have moved to a place where we can say, “There will be dual-role interpreters, but we want to hold everyone to the same standards.” /

Defining who dual-role interpreters are – is it a heritage speaker, first generation, someone who learned the language as a foreign language? That would determine whether or not they would be able to understand and screen for culture. Children may be exposed to Cuban culture at home but not in the same way as if they grew up in Cuba. If you grow up with both culture then wouldn’t that make you a better interpreter? / MARJORY BANCROFT tests have shown that most heritage speakers should not be interpreting. /

Example of heritage speaker not knowing how to say Pap smear and therefore explaining in her own terms instead of interpreting

Puerto Ricans in New York – New Yoricans – is a subculture of the bigger culture.

/ MARJORY BANCROFT If you even have a day for culture it’s lucky in a 40 hour training. /

/ BR To make the day go more efficiently, can we focus on how to keep communication going when different cultures come in contact instead of the impossible task of learning every one of the many cultures that speak a particular language? /
Kleinman’s tool is good for patient-centered care

Saying something in a different register means we’ve shown who we are, not who the patient is. If one interpreter does that and not everybody does, that’s inconsistent care.

We can’t take on the liability associated with changing messages.

If a doctor won’t explain or if he brushes things off with the patient who uses an interpreter, he does it with all his patients.

Use the existing system to report the doctor, tell the doctor.

It’s a reflection of the doctor’s personality, behavior pattern.

For some people in the room, this is against their hospital policy and they are supposed to be more of an advocate as an interpreter, change the register.

We need to have standard rules. Do I need to advocate? When? How?

The Council has general guidance for advocating but not strict rules.

One hospital: It comes down to common sense to know when to advocate.
Other hospital: My employees would be let go for doing what you say is hospital policy.

Other hospital: It’s a training issue.
One hospital: Then you obviously don’t work in a hospital. You’re just dismissing me.

When you have two people in a room, and one speaks a foreign language, and another speaks English, the doctor spends 2 minutes with the foreign language patient and 10 minutes with another.

Nurse brought me up on charges because she said in front of the patient this patient is out of control and needs meds and I interpreted it and the patient went out of control for the 2nd time in 2 minutes. She wound up getting fired.

In another hospital two employees were taking a medical history. They refused to use the telephone interpreter. Then outside the room they were joking about the gestures they used to take the medical history. They joked about gestures you could use for vomiting and diarreah. As a hospital employee, I used my power to go to their vice president. By 2:00 that afternoon, they were no longer employees of our hospital. They got fired.

Let’s focus on equal access. Yes, that’s the focus of the Council.

Discussion of Small Group Activity #2

Situation: I say, no, that’s not my role. I answer to the Council. How do I make that carry the same weight as what doctor answers to? Maybe partner with JCAHO, Departments of Health, to include Council standards in their guidelines. Involve all stakeholder organizations.

Dual-role interpreter training should be exactly the same as interpreter training, except that it should also include how to say, “No, I’m not prepared to interpret.” / MARJORY BANCROFT The Community Interpreter, 40 hours./

Train management on standards for interpreting, on the medical interpreting profession.

There’s no movement across the country to train nurses as radiology techs, except never spend money on sending them to the actual training. This type of thinking is exclusive to us.

Training people to interpret involves training to the code of ethics. Part of the code of ethics is to self assess and say no when you can’t do what you’re being asked to do.

We need the same training for dual role interpreters.

No! Dual-role interpreter training must also include development of professional boundaries, how to juggle jobs and say when to say no. Training in wearing one hat at a time and how to decide which hat to wear.

Continuing education – CEUs.

We need to create some forums where the non-bilingual people can express what they need from us, how we can best serve them. Research, focus groups with both providers and LEP patients.

Advocacy training for
management
interpreters

Partnering support from authorities of job limits
JAMA
JCAHO

Across the board interpreter training
dual
contract
staff
including periodic updates

Train management
re intro ethics & standards

create forums for other staff

focus groups & research with patients and providers

training
same standard / content
plus specialized sectors, for example, setting boundaries

training in “wearing one hat a time”

CEUs and annual updates

Saturday, June 30, 2007, 2:00 p.m.

Welcome, Marjory Bancroft
Assistant, Montserrat Zuckerman
Scribe, Barbara Rayes

Introductions

Marjory Bancroft, “invisible” immigrant to this country
Masters in Linuistics, teaching English & French, speak 5 languages

Montserrat Zuckerman, freelance interpreter, company owner, medical & legal, training in biology and nursing
Dual role is interesting to me because, being a nurse, I didn’t work in a hospital but I for sure can see how that can happen that you get pulled in to interpret

Aurelia, U of Chicago Hospital, interpreter since 94, background is accounting but I started interpreting because they pulled me to interpret, then I went to training to interpret Spanish. I want to learn about staff competency assessments

_____ Interpreter, Rush University, Chicago
I realized that interpreting was the best part of my job so I quit managing the office to concentrate on interpret. I found course, took it, and here I am loving it. I see a lot of dual role interpreting and hear a lot of complaints from DRIs who need more support

Marguerite, upstate NY
My boss forced me to come today. I was hired as a quality assurance manager. I just started part time last month. Training and attending this kind of activity is part of my job

Javier Gonzalez, NYC
I work with all aspects of language access, training, assessment, especially DRI

Karen, Barcelona, degree in Language Education / Spanish
I was teaching, came back to the states to live. I’m coordinator of interpreter services at Holland Hospital. I love the people and what I do. I feel privileged and blessed. I came today because we are struggling with this. I’m here to learn.

Josefina Singlton
Medical field since Aug 19. Volunteered as ED interpreter 4 years in California. Also have worked in Georgia in insurance registration. In my job now we do a lot more than just interpreting.

Omar Torres, Children’s in Chicago, Manager of Interpreter Services
I’m here because we have a dedicated interpreting program, have had for a very long time, initiated by Wilma Alavarado, very strong program. The reality of the hospital keeps changing, and there’s a lot of pressure to test bilingual people to help with increasing need for interpreters

Maria Alvarez, Children’s Memorial Hospital, Chicago
12 years in hospital, working interpreter. I’m here to learn, keep updated

_____ Tellez, Children’s Mem Hosp, Chicago
Interpreter. The hospital struggles and our bilingual staff is always being pulled in different directions.

Amy Wilson Strunks, JCAHO, Chicago
Working on project called Hospitals, Language, and Culture. 53 of our 60 hospitals studied rely on bilingual staff

Aida Hanson, Minneapolis
Experience as a free lance interpreter, now taking certificate program and decided to come here to learn more

_____, Medical Interpreter, freelance translator, Children's Memorial Hospital, Chicago
Interpreting for many years including court interpreting in Dominican Republic
During a class I took, we were doing research into interpreters as mediators, cultural brokers. It's not just a matter of knowing the culture of the person you're interpreting for, but a matter of knowing the culture of hospitals. It's important in interpreter training to learn how to mediate between two cultures.

Dolores Hernandez, Children's Memorial Hospital, Chicago
Interpreter. Originally from Mexico. I want to learn and take what I learn back so we can be better interpreters.

Martine Pierre-Louis, Seattle
We have a really good interpreter program. It's important for the health care staff population to become more diverse. How can that fit within this overall picture?

Nasby Hamad, International Relief Services
I'm here to explore more, learn more about this business

Jennifer, AMA, Chicago, Institute for Ethics
We're doing some research into cross cultural health care. We're finding a lot of organizations rely on bilingual staff to interpret. We are exploring the best guidance we can offer physicians on this issue.

Ada Casas, cross cultural communications, Ft Worth TX
Trained as a medical interpreter, started interpreting in mental health field. I lasted only 6 months and thought, I can't do this! Because I was surrounded by people who were not qualified to do the job of interpreting, I have to change this. Dual role interpreter is so talented but they're not valued and trained to do what they can do.

Tina Cordero, Research Associate, JCAHO, working with Amy

___ name – County Hospital, New York
Interpreter, Trainer. I'm wondering if it's possible not to struggle but to combine.

Manager, Interpreter Services, Cinncinati Children's Hospital
We have a program in place but also bilingual employees being pulled to interpret. I need to explore policies.

Tara Gibbs, ELL Teacher, Minnesota
My grandmother was a hospice nurse. She was working with a lot of older women who only spoke German, so my family sent me to Germany to learn German so I could interpret. Not enough! Now I have a Master's in Linguistics. Also I lived in Japan. It's ridiculous that people would think I could interpret Japanese at that point. Studied and worked with Professor Downing, but I'm not an interpreter. My profession is teaching, and I work with interpreters on a daily basis. We hire paraprofessionals with the purpose of interpreting

_____, All Saints Health Care System, Interpreter, Wisconsin

Repeat of introduction to topic
Definitions of Dual-Role Interpreting, Bilingual Employees

The Council is not planning to take a position on whether dual-role interpreting is good or bad. We know that there are also contract, staff, volunteer, ad hoc interpreters. Also bilingual employees. About ½ of the current discussion group is still seeing family and friends interpret. Also nothing – purely veterinarian medicine. About 2/3 of the current discussion group are seeing volunteers interpret. Most of the current discussion group is seeing staff interpreters. Now, this is not representative of the country, but of this group motivated to come learn about interpreting. One WI hospital has 63 staff interpreters. Most of the current discussion group is seeing contract and freelance interpreters. _____ of the current

discussion group is seeing formal dual role programs in which they are using testing and training. Comment from the group is that the interpreter who is an employee of the hospital, even if only per diem or very part time, provides much higher quality service than the contract interpreter because of continuing education, being part of an ongoing process…

Council is more concerned with supporting quality interpreting in health care as a means to promote equal access to health care.

Do you support the concept of dual-role interpreting?
2 Green – I support it, it might not be working, but I want to make it work
18 Yellow – It's a mess but I want to make it work
2 Red – We shouldn't have dual role interpreting. Medical interpreting is a stand-alone profession.
0 abstentions

Discussion of Small Group Activity #1

The idea that interpreters themselves could move into other roles in the health care system, for example, becoming a nurse. To me, this person would be the perfect candidate for a dual role interpreter.

Saying that they usually know the health care provider better should be taken out, as well as saying that they generally know medical terminology better.

Take into consideration that redundancy is good – having a person interpret only in the same area where they become familiar with the specific terminology.

You can give someone full time employment where you wouldn't otherwise be able to, so this is an advantage of using dual role interpreters.

Do dual-role interpreting programs really exist? Yes, Philadelphia, Phoenix, other areas. Create a program that is specifically designed to test and train them, with follow up supervision and mentoring.

Page Health Care sent me to a training for interpreters and that's how I got started.

Disadvantage: increased work load, lack of support due to lack of understanding

Having dual-role interpreters might affect the morale of the staff interpreter, who could feel threatened, and also say, "What does that say about *my* profession?" Diluting of the profession. You don't see dual role doctors or dual role nurses.

You don't see interpreters going around saying, "Don't give that medicine. It's wrong." But you translate a form, you are the language expert, you send your translation to the ED, and they say the translation is wrong.

An interpreter was working and the nurse told her right in front of the patient that she had used the wrong word. But she had used the correct translation of the word.

What a dual role interpreter is supposed to do is stop whatever their primary role is, take off that hat of nurse, etc., and put on the hat of interpreter.

We are going to hire a ½ time sign language interpreter who will also work ½ time in our family resource center. We are only able to do that because we already know that on the same time on the same day every week our deaf patients have an appointment with audiology.

As a result of some of these discussions, we see that obviously we have a problem at a national level. What are some of the critical issues that you think the Council needs to tackle as we look at the state of the field of where we need to be?

Educate administrators, providers, the whole system about what an interpreter is

Be clear that a dual role interpreter has a job description that is different from an interpreter job description. HR issues in general, including job descriptions. Set it up in the job description what percentage of your time will be spent interpreting, which drives the creation of procedures for what to do when you can't interpret, how to handle multiple requests for your time.

Reaction to Nachos:

Security guard was embarrassed to interpret for a woman, especially when it had to do with breast cancer.

We don't want to put employees in an uncomfortable position.

Wrong information was conveyed.

It's a liability issue.

The doctor was concentrating so much on speaking Spanish that he wasn't concentrating on providing care.

Javier: This was inspired by pure reality.

Presenting real-life issues in an amusing way makes the topic easy to discuss for health care providers.

Discussion of Small Group Activity #2

When you hear a strategy, please hold up a circle
green = I agree
red = I disagree
yellow = proceed with caution

Interpreter Skills Testing
Implement mandatory refresher training annually, either training sessions or workshops, that interpreters would be required to complete, public speaking, diversity awareness, etc., and this would help set the bar at a higher level

green: overwhelming yes
red: nobody

Training should include boundary issues, roles, and they would have the training prior to coming into their role. The hospital should train or pay for the training and it should be done on company time vs. personal time.

green: overwhelming yes
red: nobody

Support language proficiency testing: Everyone who self declares bilingual proficiency, they should be made to take a validated test. Everyone – including bilingual providers, including dual role interpreters, everybody.

green: overwhelming yes
red: nobody

Professional Development: Require CEUs to maintain in-house certification.
green: overwhelming yes
red: nobody

Health Care Staff Training: Training needs to include all levels of staff: leadership, front line staff, physicians. Specifically needs to explain the difference between a bilingual individual and an interpreter. The training should include

data, specifically related to legal ramifications, the monetary cost vs. safety cost, the general impact on quality and safety. The training should include how to work with an interpreter. It should be offered annually for staff, perhaps be part of orientation.

Training on medical interpreting and dual-role interpreting should be done organization-wide, including medical residents.

green: overwhelming yes
red: nobody

Screening, Testing, Training
Who passes through the training etc.? Willingness to interpret vs. ability to pass a language test. Is your personality consistent with being able to work in a fast-paced environment? Guidelines for managers, training for them on how to talk with them about who should go through this process and what happens when they can't get through the process.

green: overwhelming yes
red: nobody

Monitoring and Supervision
Institutions need to have an LEP coordinator or office, somebody within the system to hold the organization accountable for gathering the interpreters into a group, supporting them, and acting as a liasion between the interpreters and the rest of the organization.

green: overwhelming yes
red: nobody

Comment: coordinator vs. manager – coordinator has a different status from manager

Policies and Procedures
We need policy to define boundaries
when to interpret
when not to interpret
when & how to opt out
job description
Depending on what the primary job is, perhaps block times like Mon and Wed afternoon etc. to exclusively be used to interpret
Also have a log in place so they can account and be held accountable for time spent as a dual role interpreter
Consider DRI as an added proficiency profession
Make training available for managers on those policies and procedures

green: overwhelming yes
red: nobody

Comment: Discussion on when it's appropriate to have dual role interpreters vs. dedicated interpreters. It's much more appropriate for a rural area with need three times a week to have dual role interpreters. Or seasonal interpreters, for example, when migrant workers arrive from May to October, hire a seasonal interpreter. Consider tracking the dual role hours or contract to know when it's time to hire a staff interpreter.

Medical Terminology
They should be required to take a medical terminology course at a community college or university, just the same as any other provider or allied health professional.

green: about half
yellow: some
red:

Medical terminology is not universally available in different languages. But in English it's available everywhere, including online, and should be part of a skill set for every interpreter. It only takes about two months. It should be made a requirement but it's not all that needs to be required.

We all agree that we want to hold dual role interpreters to same standards as all interpreters.

Pay Differentials
It has to be very clearly established in policy and procedures. The DRI should document, including who the doctor is, and then the DRI can present the log and receive differential pay.

Scope of Service
The dual role interpreter should only be used in a focused, limited way, not for complex or long encounters. This has to be a clear part of policy.

Restrict dual role interpreters from complex medical encounters?
reds and yellows

As long as there is training and payment for service, there should be dual role interpreters. But they need to operate to the same level as all interpreters.

Tiers need to be clearly defined in policies and procedures. Different tiers, different responsibilities, different differentials.

Staff vs. contract: Staff stays. They'll be there. And they know the culture of the hospital. Contract interpreters may have much less experience and you never know whom you will get.

Nationally we need discussion about where pay should come from. What department? Centralized? From a federal office?

Data collection from organizations that have a tier system would be helpful.

Session #3
Dual-role Interpreters: Scribe Notes (koh)

"The elephant in the waiting room" == Marjory Bancroft

With all her linguistic and intercultural background, she still committed every interpreting error we warn against in training; then, a bootleg copy of "Bridging the Gap" magically appeared on her bookshelf….

Bilingual employees become *de facto* "interpreters," but get no deadline extensions on the work they were hired to do in their job descriptions.

Health care interpreter training: Marjory says everyone but housekeeping and cafeteria shows up at her trainings: 90-95 percent are bilingual employees.

Two participants mentioned this **challenge**: how to manage what *agencies* want their interpreters to do versus what *providers* want their interpreters to do.

Another **challenge**: "We don't need outside interpreters; everyone here is bilingual."
(Orlando FL area)

Another **challenge**: Bilinguals don't know the "other" lang. and don't know the culture, so they ask their supervisors, "What can we do?"

[Phyllis Stallman: Translation Station, Atlanta, GA (75 percent interp., 25 percent trans.), do largely medical and legal work]

Question: Embrace or resist the concept of dual-role interpreters? One participant from St. Jude's in Memphis has classic reasons for resisting it but wants to learn how he might see it more positively. He has to develop a computer-learning program for providers who act as interpreters for other providers within a hospital environment. Purpose: To educate about role of interpreter and standards of practice.

QHC/Stephanie from New York (Sorry—Name not on the attendance list): All interps. must meet certain performance standards, and a lot of dual-role interps. have fallen by the wayside. Full-time and volunteer interps. generally perform better than dual-role.
50 percent are LEP patients; 2 FTE interps. Developing basic test for any of the city colleges so hospitals could use them. DOUBTS about dual role, although received a grant to train them.

Linda Coronado: director of interp. services for 10 years at Cook County Hospital in Chicago.

Before: Employee lang. bank, no incentives, "volunteer multilingual list"

Got interps. In '84, only because the community protested to county board president, and county courts already had interps.

In '91, immigrant-refugee task force got started, and interps. started to get professionalized. Hospital gave additional PT staff, and the admin.said, "We're going to start a dept." partly because OCR visited.

In 2005 had Span. interps. 24/7 and Polish 16 hrs./day 7 days a week. The Chinese community came and demanded interps and got them. Got grant to do cultural competency, but Hispanics had the poorest pass rate.

Linda now works in DuPage County, a "collar county" of Chicago, which has seen one of the largest increases in LEP population in 2000. There, she sees a total lack of awareness about dual lang. v. prof. interp. role.

IL has "Lang. Assistance Services Act."

Linda has taught a 200-hr. med. interp. training course at one of the Chicago city colleges for 10 years.

The NCICH has consciously refused to state a judgement on whether dual-role interps. are "good" or "bad."

Categories of people who perform interpreting services:
Bilingual employees
Dual-Role Interps.
Contract Interpreters: face to face, telephonic, VMI
Volunteers (part of a structured training often, impartial)—St. Jude's training for volunteer interps. admirable; just a generic "volunteer" training in many areas)
Ad hoc (families and friends; not likely to be impartial or trained at all)

Telephonic: making inroads even supplanting trained DRR in some cases; Cook County hospital refused to use telephonic; it's replacing ad hoc in some communities.
Telephonic: Why? Liability: Administrators like the "tested" component; Agency interpreters (Do they meet ANY standard? Was the question asked.)

Issues in Dual-role Interpreting:
Liability
Pay Differential: monolinguals get upset; it's a delicate issue.
Budgetary Issues
Cultural Competence
Quality Management
Role Slippage—one person said it's more severe in one's own area of practice, i.e., when ped. Nurse works as interp. in ped.; another, that supervisor can have too much sway.

VMI: is going to explode in the next 10 years—DC is exploring it. IS wants to replace face-to-face w/video in one NY hospital.

Robot to be used to do interpreting; seen on news.—Linda mentioned.
"Converser" is marketed to do "med. interpreting."—Marjory mentioned.

"MedBridge" is a push-button program that supposedly "interprets" for the patient; but they should know upfront that at any time, they can speak to a person.

Do you support DR interps. (Trained & tested?)
7 yellows
2 yellow-reds
2 green-yellows

[Interps. as intercultural mediators: Belgium—Expected to jump in and advocate]

Problems w/video:
Positioning/Personal space
Guard's uniform could be intimidating—He was bilingual staff.
Physician speaking "Spanish"—horrible linguistic event
Intimidating—two males, one w/a uniform, talking about breasts, saying "Muy bonito—Mirame!" He starts yelling right in her face.
Lack of cultural competency—downcast eyes

Spanish for HC Providers: A few icebreakers taught, not to replace interpreters, lots of cultural competency training provided—They will be better providers al tomar este curso—Bigger asset to hc community

Bilingual Provider v. Dual-role Interpreter—Should be testing for bilingual provider re language interpreter

OCR/HHS think bilingual provider is ideal situation, but who interprets before and after the med. exam? Isn't the nurse supposed to monitor the doctor's conversation w/the doctor?

"Transparent" interpreting—alternate phrasing, apparently, for simultaneous interpreting

Statistics are grim re reluctance by doctors to use even telephonic interpreting.

QHC: No more money to do the training
Doctors and nurses? Should they get the pay differential?

ALL hospital staff should get cultural competency, including what interps. roles are.

CEU's for physicians to go on-line to get training on using interps, cultural competency, etc. [Find out more from Cindy Roat.]

Should be some way to readily *distinguish* dual-role interpreters from other (bilingual) staff for peace of mind of patient and provider.

[Two nationally-recognized valid lang. proficiency tests: IRL and ACTFL]

ADVANTAGES
Know providers well CI/SI/DR
Tend to know limits CI/SI/DR
Remove "slightly" from DR/SI
Decrease liability CI/Agency
Networking/support for interp. and institution CI/Agency
Easy Access CI/ SI

DISADVANTAGES
No time to finish task(s), so providers blame DR

Solutions to Challenges/Areas Identified

1) Quality Management:
formalize structure of lang. services dept.

create process for screening applicants
create budget for lang. services
specific job descriptions
periodic eval. and assessment
policies/procedures part of operating manual
hire consultant to I.D. needs and highlight key issues
periodic independent audit of quality of lang. dept.'s work

2) Skills Testing
Dual-role interps. must demonstrate same level of skills as regular interpreters to earn the title.

3) Role slippage
Add "interpretation" to job description.
Have % of time interpreted on books to determine the job differential.
Essential to have training and monitoring to insure adherence to role boundaries.

4) Ideas to restrict role
Only interpret outside immediate area.
Interpret anywhere, but incentivize documentation of the interpreter's role through one of following:
Compensation
Linking to recertification
Informing of full-time job opportunities

5) Pay Differentials
Do benchmarking on other industries
Do salary structure reviews
Pay according to feedback from clients

POLICY AND RESEARCH

Participants in this work group tackled a number of research and policy issues, including the issue of reimbursement. Concrete examples of research areas that needed more attention included rate of pay for interpreters and rate of reimbursement so that a range could be available to use as a guide. Participants felt that more research on languages of limited diffusion was also needed. In terms of cultural competence, questions were raised regarding standards for cultural competence itself, along with standards for its training, and the possible role that the council could play in that. In the ongoing professional development of interpreters, even if we had certification after certification already in place, then what? There was discussion regarding face-to-face versus telephonic interpreters; full-time equivalents, how an organization determines whether they need a full-time equivalent staff person; training for managers to use resources more effectively.

Ideas for future activities of the Policy and Research Committee included publishing a resource guide and keeping it current; supporting language services by reporting on language-based research and providing updates on any new information; changes in laws or new regulations/requirements that occur. In terms of patient satisfaction surveys, it was suggested that the organization hire a national vendor to do a patient satisfaction survey. A specific example was JCAHO and the possibility of working with them to do some research on patient satisfaction.

Session Scribe: Patricia González

Introduction:

P&R Committee established to look at literature and research to see if it could support language services.

1) Language program assessment tool is one of Committee's first projects

2) Committee pulled together the research found into one reference manual (2003). It has been updated and will be available on-line next month. It will be searchable.

3) Developing a research agenda through Policy & Research Committee made up of several researchers.

4) Language services resource guide. Contains language assessment tools, listing of interpretation agencies, training programs available by state.

Ideas for other projects will hopefully arise from this discussion.

The P&R Committee does a lot of volunteer work writing letters to respond to publications or policies.

Presentations:

[WILMA'S PRESENTATION "Language Access Research: Key Findings and Evidence-based Policy Implications" – HANDOUTS]

[DOREENA'S PRESENTATION "Policy & Research Committee Work Group – Policy Update" – HANDOUTS]

Ideas/comments for potential research projects arising from discussion:

- Potential for interpreters – range of reimbursement of bilingual staff vs. interpreters
- Telephonic and remote interpreting
- Cultural competency standards
- Professional development of interpreters
- How to work with interpreters – Guide for providers
- Preference among doctors on the use of face-to-face vs. telephonic interpreting
- Training of managers to use resources more effectively
- Update council members on new articles and studies that come out and that can help support arguments
- Partner with vendors to conduct patient satisfaction surveys
- Potentially partner with Joint Commission on patient satisfaction surveys
- Joint Commission has asked Council to give recommendations on chapters to be published

<u>Policy and Research</u> – Scribe Notes (koh)

Purposes:

Affect policy and improve access for LEP individuals
Keep up w/interpreter-related research—Use research to advocate for policy change

Project 1: Lang. assessment tool for h.c. organizations. On-line as policy paper. Consolidating research—whole committee to do research in this area. Annotated biblio. for research on web-site. Update now in progress—last pub.in Aug. 2003. Will be website as searchable document—put in keyword to get studies about that topic.

Project 2: PPoint or Toolkit: w/research summaries, demo. info. to support need for services.

Project 3: In response to different articles/issues, respond: Example: Journal of Internal Med. saying interps interfered; we wrote more research to counteract that. Court Cases: Ninth Circuit Fed. Court re LEP guy—Wrote amicus brief to support LEP policies.

What other projects should committee do to help us?

Hart presentation in NY on increasing lang. access in h.c.: (Following)

What is needed? Try to see it through the eyes of those who are uninformed.

Change attitudes of lawmakers

Basis for remodeling provider behavior—How far along is each provider?

Research/advocacy for end-users, to reframe old bad expectations

Do we have health-care disparities; because of LEP?

How big? How to document? What are people doing?

Def. of LEP person: no Eng. As primary lang. 4 skills limited. Access emotions: What language do you get sick in?

Jewel Eng. As opposed getting around a hospital and a system

Linda Hafner: "Family members as interps.' "I couldn't explain to my mom everything that the doctor was saying to me." – 7 yr. old girl hearing that her baby brother had died.

NY regs. No one less than 16 yrs. old can interpret, except in cases of emergency.

CA also except in case of emergency.

Impact of lang. barriers at ER: patient satisfaction survey 5 urban acad. Ed.

52 percent for non-Eng.

71 percent for Eng.

86 percent non-Eng. Likely to return

91 percent Eng. Likely to return

If we train the provider, better outcomes and higher satisfaction w/med. care results.

Ethnic and racial differences: children. Use of preventive services, Ontario. Fr/ speaking women less likely to receive some exams, other non-Eng. Speakers less likely to get pap smears.

Length of stay: influenced by lang. Stay longer if LEP.

Ethnicity as a risk factor in ER visits, Diabetes education.
"Which treatment plan do I choose?"

Office of Civil Rights talks about what providers must do.

Researchers; Admin. version of reality was way different from what was actually done.
Fictitious patient—how would staff handle LEP patient?

"Language Services Resource Guide"—publication on-line at their website

NY City: 38 million a year for two years—funding

Thecalendow.org – annotated biblio. mentioned above, free download

Fed. Level—Less activity than on state level.

NLAAP—National Coalition convened by Cal Endow—Cultural and Linguistic Competency—Funding Leaders around the country.—To bring together stakeholders, including AMA, Amer. Hosp. Assoc., HMOs, community clinics—to improve health care since 2004

Created a statement of 10 principles—over 70 organizations, incl. AMA and AETNA (first of its kind)

Everyone involved should provide these services, and they should be quality, and training to assure care, and ESL classes should be available to community at large

Funded different research projects.

Fact: Lang. services not reimbursed by Medicare. NLAAP studied this.

Evidenced-based research and services to have something to CITE when arguing our point.

Another project: Model Legislation—Ling. Appropriate Health Care _____
Many states don't want to do the 50 percent match.

Another: Provide grants so hospitals could ….

Another: Clearinghouse Project: LEP person needs help? 1-800-service. Or internet-based directories of interps. And banks of documents like consent forms.

Working group to develop standards. Would help enforce the action plan all fed. agencies are to have, more accountability.

Medicare reimbursement for lang. services.

CHIP: Children's Health Insurance Program—Low income kids to be covered. 75 percent match for lang. services.

STATE LEVEL

43 have requirements in state laws: 3 states require cultural competency training for hc workers incl. doctors. TX has pilot program. NC is going to seek reimbursement.

CA: passed bill 853 S. unique: First requirement for all insurers to provide "culturally and linguistically appropriate services."

CHIA = California Health Care Interpreters Association

NY – Complaints to Office of Civil Rights and AG's Offices—Results: Lang. services in hospitals pretty good. Regulation has the force of law: Interp. must be supplied to ER patient within 10 mins. Inpatient/outpatient w/in 20 mins. Probably wasn't being enforced. Hopefully, hospitals are more aware of that. NY Immigrants Coalition has published things like "Know Your Rights."

Video Medical Interpreting—but we have to educate providers about "how to get on my bad side"—Interpreter's role. Hospital networks are sharing this system using on-staff trained interpreters. $5,000 for the unit equipment.

NY state regs. (78 million, 2 years): How do we count "encounters"? Every 15 mins.? Every time the venue changes? If it's the same family = 1 encounter.

Should it include travel time, waiting time, only "work" time, is an encounter 5 mins? 1 hour? How should freelancers be paid? Money only for NYC pilot program?

Pay rates to be suggested by NCIHC? RID has a range. Light years ahead of us—We don't even agree on training yet. Advantages/disadvantages to setting or suggesting ranges.

Washington State; recently passed requirement all hc has to file w/commissioner an LEP action plan.

Hawaii: July 2006: State agencies have to implement plans to provide interpretation and written documents translation. Get reimbursement from Medicaid for patients.

NJ and CA; NJ have mandatory cultural competency training or CEU for already licenses doctors. CA is to "integrate" cultural competency into all its CEUs. NLAAP is studying this to see how it's being implemented.

Washington: for hc professionals: ongoing training to care for a diverse population—needs to be studied, just passed.

AZ, IL, OH, NY; Cultural competency for hc is being proposed.

Interpreter Competence: WA is ONLY state to have state cert. program since 1994; top 7 certified, others assessed, State registry lists them.

OK: 2005

Oregon: looking at it

Indiana looking at it.

Iowa looking at qualifications based on training.

MA, NC piloting an Interp. credentialing test, WY interps. must sign the NCIHC's Code of Ethics and Standards of Practice. This could be useful to try to apply nationally.

VA pilot program for reimbursement—proficiency as 40-hr. training model.

CA: want reimbursement model: state to contract w/an accrediting agency to approve training programs that include tests.

GA discussing accreditation and registry for med. interps.

Most 40-hr. training programs end with an exam—Bridging the Gap is a 40-hr. program.

Pre-Test in Span.Eng. Project by R. McDonald House: 25 pediatric hospitals around the country—midterm and finals. Do front-line interpretations: Spanish bilingual assistants. No raise, but bonus

Grady Health Systems, Atlanta, GA: Bilingual staff assistants interpreting just in their areas. Used Language Line tests and final exams. 16 of 16 passed; One failed, and was demoted. They got differentials: $50/hr.

Hospitals give from little passes to the gift shop to differentials for passing the training and interpreting. Some are obliged to take it for no reward.

L.A. County $100/mo. extra wages for people who interpret.

Funding issues: Guy who pays gets to set the qualifications.

Model Payment Plan: Broker, agency/freelance, provider gets reimbursed, broker makes sure work gets done, less fraud on behalf of the agency, another layer of payment before money gets to interpreter.

Misgivings about patient having direct access to an interpreter were mentioned, but not specified.

www.LEP.gov – Excellent video of worst- and better-case scenarios

Video: "The Burnt Heart" – cross-cultural communications—on internet
And other
Video: "Working with an Interpreter" -- Teaches the provider to take control of the situation – cross cultural health care program –Washington State

Put "I Speak" card on staff badges, along with hours of operation, pager number for services, etc.

Connecticut: Funding: Coalition to support legislation: Estimate after research: 4.7 million. Lobbied w/buttons, etc. Trying to pass for next year; didn't pass this year.
Also working with requirements for qualification standards for interpreters.

What model would fit your state? Managed care v. fee for service.
Who can request the interpreter?
What the rate should be?
Should reimbursement be for ALL providers, or just for hospitals?
Most plans pay for interps., but not bilingual doctors or bilingual staff: "You're just doing your job."
"Interpreting" is not the same as "doing your job in another language." Staff must keep track of hours they spend only interpreting. Sometimes staff interpreters have to step in and "save" the bilinguals when they get in over their head.
Analogy: Go get your car repaired in Spanish and English.
Not paying them for bilingualism is a disincentive.

CMS says it wont' pay for equipment, but other states have, so we have to push back and say, "Why won't you pay for that?"
More technology in the future? We can learn from the RID. Laptops now have webcams.
When is face-to-face better than VMI or audio-only remote? (See Nataly Kelly, ATA, this month.) Anonymity and confidentiality and privacy are benefits of remote interp. in medical settings.

Questions from Group: langs. Of limited diffusion. CA has had a huge influx, and Atlanta has had some indigenous from Mex. And Central Am., as well. Linda Joyce does relay by phone w/family member speaking Spanish.

Video preferred to audio only.

Code of Ethics and Standards has to be culturally competent.

Professional Development: Asking Council about advocating for more CEUs for interpreting.

Eng. And Span. On Net: PubMed – Source of Vocab.

Discussions w/Supervisor about how things went, how we could have handled a difficult situation differently, what words mean instantly, etc.

Policy and Research

Research of outcome based / costs, eg. Cost of provider vs cost benefits.
Need research re health disparities are in relation to LEPs
How are interpreter encounters documented? ISSUES OF funding: definition of encounter, how will it be reimbursed. How does interpreter define encounter?

Who should be doing this function of research and advocacy? What are the costs of doing research/advocacy

How do we define who is an LEP? Individuals who don't speak EN, inability to read, write, read language: emotions access in EN or other

Language services resource guide suggest that it be posted online

Policy and Research Committee

Introductions
Background about committee
Update of research language services,
Research agenda

Fed and state update re policy issues
Advocacy and policy issues locally

What kinds of projects would be helpful locally?

National HealthLaw program description ,

Publications re Language access

Attendees introduced themselves; Doreena has list of names and emails
Some names I got: Martine Pierre-Louise, Kristoff Haavik (
LEP Program at Kings County, NYU, interpreter, MD
LEP services for ….NYC hospital
Nefertiti Casado, Chicago
R Ramirez, med interpreter in Chicago
Cornelio Brown
Cecilia Salazar, Wisconsin, manager
Tina Cordero
Maria Schweiter, El Puente, med interpreter trainer and interpreter
AMA representative

Federal Update
Council's role, larger impact on profession
Established to find out what research was out there, not clear what research there was and benefits of providing services.
Promote policies and advocate on behalf of LEP and interpreters.

Information re: documents, etc. available on website, projects that Council has worked on

2002: language assessment, tool for organizations to determine language needs, staff
Pull together all research, bibliography of research available online
Update of 2003 book is current work. Want to put searchable annotated bibliography; eg studies on costs for advocacy.

Toolkit of slides, legal requirements, arguments in support of services, etc. for member use for advocacy

Language services resource guide. Identifies training programs and providers. Available online. NO longer available in print. Interpreter providers: how did you compile the list? Resource guide only, not rated, just word of mouth. Asked to have resources identified and divided in categories re; training programs, criteria. Not endorsing. ATA provided some of the info as well as language services. Telephonic interpreting: reasons for not providing rates.
Cornelia: wonderful resource, **suggest that it be posted online** so it can be updated regularly

2005: Researchers form part of committee, practicing physicians. Meeting to bring together main research and policy advocates to develop research agenda. Need **research of outcome based / costs, eg. Cost of provider vs cost benefits**.

Wilma gave Eric's presentation:

change attitudes: lack of communication not perceived as problem by providers.

Basis for change in medical students? Challenge
Health disparities have been shown.
Providers generally not aware of interpreter training, how to work with interpreters.

Need to research re health **disparities are in relation to LEPs**.

How are interpreter encounters documented? ISSUES OF funding and reinforcement: definition of encounter, how will it be reimbursed. How does interpreter define encounter?

Who should be doing this ? what are the costs of doing research/advocacy

How do we define who is an LEP? Individuals who don't speak EN, inability to read, write, read language: emotions access in EN or other.

NY State: no minors! Minor is person under 16.

Maria Schweiter: no federal law regarding minors; for confidentiality person has to be 18: contradiction

Loophole: emergency, depends on what is an emergency?

Language barriers for utilization of health: need research
Patient satisfaction: Carrasquillo study: 52% vs 71% satisfaction
Willingness to return: overall problems 86 vs 95
Huge need, 1/5 have gone without care because of LEP
Length of stay affected
Inadequate
Quality of diabetes care, other

CLASS standards: 4 mandated; Mass ER bill: mandated interpreters in ER
Joint commission
AMA
Research impacts our role; providers don't remember we can be subpoenaed; providers not aware that interpreters need to know why they do what they do, decisions

What does it mean that interpreter be available in ER? Interpreter has to be present in ER.
Few circumstances in which interpreter doesn't have to be provided: Class standards, meaningful access

OCR guidance states competent, knowledge of terminology, ethics confidentiality issues. It does not refer to length of trainings.

CLASS standards date to 2002. There are now community college trainings, things have changed. Doreena on advisory council. No consensus. Frustration is everyone gives certification.

CLASS discourages minors, but don't define. OCR doesn't say. Hospitals hide behind it. In most recent one, providers have pushed back, so there are loopholes. AS long as provider offers interpreter they are ok. Provider has right to have interpreter, their license is on the line. The other side is that these are unfunded mandates, what is incentive for provider? Doreen would argue that funding is available, state may not choose to seek the funding. Need ot get states to fund Medicare and state beneficiaries. Liability and quality of care issue. Other reasons: legally required. Lot of arguments support use of interpreters, costs of noncompliance. Have to keep promoting argument. Interpreter has to advocate that the person gets to where they are going, the right tests, etc.

Language competency for providers: provider has to be assessed? Interpreter doesn't have to be assessed. Assessment is voluntary. If they fail, don't know what to do about it. Assessment is a recommendation, not law. No one knows how to assess. There are tools being developed to assess providers.

How are assessments done in other areas? (Kristoff) Most personnel has passed test for their function. Is it possible to base licensing based on what has been done for other jobs?

Questions regarding licensure: Each state has licensure for other professions, the profession could go that route. Washington state provides a type of licensure. Certification not possible if you don't have the training: limited pool of interpreters; problem in Washington state.
Maybe could be solved like in teaching: temporary certifications. Analogous situation. There are models of reciprocity in nsg, eg. Written language component for that language. Is certification put together by professional organization or by government entity?

Grandfathering people for qualification. Need programs to bring them in.

Certification relates to policy, it is being discussed as it applies to funding. What is a qualified interpreter? How is interpreter certified?

Federal update:

NLAAP and proposed legislation, statewide issues
Copy of manual that covers all federal requirements up to 2003

Cultural competency for providers
What are states doing about certification vs funding issues
Some states working on funding issues, eg California

NLAAP: California Endowment on forefront of cultural
Increase access for LEP; wanted to have national impact, provider groups, AMA, state holder reps, consumers, civil rights and legal groups to build consensus to increase access

Statement of principles: (10) need effective communication, need to make sure responsibility is shared, financial support for services. Support other efforts, such as English language classes to make sure all stakeholders would agree and start work on model piece of legislation.

Try to come up with Linguistically Appropriate Health Care acts: grants for pilot projects, etc. Drafted and part as are incorporated in other bills, eg. In CHIP bill inc. reimbursement to 75% reimbursement for states. Good chance in house, priority for democrats. Up for reauthorization this year. Model calls for 100% for Medicare and CHIP.

Center for Linguistic competence and health care: central repository of resources. Toll free customer line where providers could call, get forms; translation of forms. Caring house with resources for language assistance. National clearinghouse

Assure that federal agencies are accessible. Agencies don't have action plans, would monitor what agencies are doing. Actually paying for language services in Medicare, not being done currently.

Becerra (congressman). Has included reimbursement piece into bill.

Council could send alerts on these for people to call representative.

Immigration debate has gotten in the way of expansion of services. Uphill battle. Democrats more receptive. Elections are coming up, etc. Change in admin would make a big change.

State level: more potential. States have to move ahead.
43 states have specific laws providing language services in different medical contexts.
California very comprehensive: summary up till 2006 in website. Statutes are listed by state. Eg. Miss has nothing, Cal a ton.

3 states require cultural competency for hc providers and interpreters
13 states have reimbursement mechanisms

Requirements
SBA 53, first of its kind. All health care plans: culturally linguistically good access for LEP, All health insurers and managed care plans. Vital docs translated, interpreters, monitoring about what they are doing. They need to notify about services. Covers whole state. The state requires but doesn't pay for this. Language advocacy project, there was very little push back from legislators and others. May not be hard to get through, Cal doing it, health insurer already do it for Medicare, etc. Text from Doreena. Dept of Insurance and Dept of Managed Health Care. 3 rounds of regs, weakened but have requirements, have to provide interpreter and docs.
Dept of insurance regs will come out with final set soon and will come into effect by end of year. Their regs not as strong, but they require interpreter and materials for any LEp insured. Have promised to strength reg if don't work.

IMPORTANT TO BE INVOLVED. IF THEY DON'T HEAR COMPLAINTS, THEY WON'T FIX IT. IS IT EFFECTIVE?

In NY: complaints to the OCR, have required hospital to comply. ATy gral brought action against some hospitals: regs for all state hospitals. Community based agencies have identified problems and advocated.

Canada as model? Bilingual? (Kristoff) Requirements. See and develop model. Prescription and health care model. Is it good? Health care information network (HIN) process to put together bank of resources that mirrors NCIHC work. Glossaries, etc.
Toronto, organization that works closely with HIN. One would think light years ahead, but not. Dialogue with HIN, good champions. Title VI in existence since 70's. They are looking ot us for guidance. We also look to them.

Australia is dealing with issues of certification as well.

NY has strengthened the regulations. All have to have coordinator, language administrator, ask people if they need services. Have time requirement within 20 minutes in hospital and outpatient. 10 mins for ER. Time requirement calls for telephone interpreting in most circumstances.

In California, looked at NY and cited NY. Example of what impacts policy debate. Need to be informed what really works.
Does it include ASL? ADA different from Title VI, Time requirement is same.

How can ASl and sight interpreters work together? NY regs don't apply to sign. ASL is ahead, there is certification, need ot tap them.

NY STate is state wide regulation, other parts of the state weren't doing it.

Federal legislation applies to all settings. NY State reg only applies to hospital, not to other settings. Joint commission gets pushed back from Home care, programs don't want the regulation. JHACO has a lot of power. Effective communication reg from JHACo is better known than title VI. Patient has right to effective communication. Organization provides or assists patient in providing. Trying to put burden on organization. Vague on competency standards, for example family and friends can't be covered. New change effective July 1, available

Cornelia: one hospital required them to state list of interpreters and where on certification process. Psychiatric dept are requiring info that other places are not. The mental health area is more aware of communication issues. Talk is medium of treatment. Use of friends and family members: even people who have phone interpretation contact would like to use friends and family members. Direct violation of Title VI: file OCR complaint!!

Training of providers and role of telephonic interpret: what can you do? Education of provider to work with telephonic interpreter. Ethical dilemma for interpreter.
Training for interpreter use. Telephonic companies have come to NCIHC to ask for policy regarding use of interpreter for provider.

Are there policies for telephonic interpreting? Not even guidance as to mode of interpreting. Need research re: video and telephonic guidance. Interpret as helper in navigation in hospitals, when go to video and telephonic lose that piece,

Are there restrictions from states? There are guidelines MEDECAL policy letter gives preference to face to face, no requirement. Same with OCR, no hierarchy or guidance of when to use one or the other. Reimbursement mechanism issue: when to use VMI, when to use face to face, when telephonic. Up to hospitals, which has some guidance of when to use live versus other. Open call for VMI, live, etc. Minutes will be posted. One of the presenters works in a program in California. Use all modes and have a policy. Allow the interpreter to choose mode if feel there is a need. Modes and when to incorporate. We as interpreters should have a role. On site is more expensive. Telephonic may be cheaper, driving the field. M.D. From patient perspective it doesn't matter as long as it is professional. Matter of choice: quality is most important! One of fears is that live interpreter provides assistance that is not recorded: navigating. Does it make a difference in outcomes for patient? Compliance? Institution/patient/interpreter preferences and outcomes.

Cost of living wage, language populations are different, teleph interp packages are different everywhere. Cheaper in some places versus others. Patient outcome is most important.
Uses local for teleph and video in California. Doctors think it is a waste of time, longer interview, research to monitor length of encounter with ant without interpreter? If doctors could find that it would save time, they would do it. There are some studies, increase time relative to not interpreted; if not get info: useless appt, need to go back to quality of care, liability, at same time, research that takes into account dr.'s mentality.

JHACO: Sight interviews in hospitals with everybody with a particular scenario. Found differences between the administrators and the staff as to how the situation would be dealt with. Dr. and nurses have different ways of dealing than what administrators

ER physicians were ok with Spanish, but not for rare languages. AMA study.

In person interpreters not available in wide range of languages. Locally better to make the interpreters in different languages available. Train people from population and train them.

Haiti: certification in Washington. People certified in 84 no longer in the profession, no steady work, to convince people to establish themselves as professionals.
What is the threshold of time working? Large turnover. Development of profession to keep people in profession, only there perhaps for high need languages. Have to look at demographic transition as a factor. Advantage of video and phone that you can continue to work despite demographic shift. Payment rates also important. We need to promote wage as policy.

Washington state health net needs to have plans

Cultural competency for physicians. Mandatory requirement: NJ, CA and WA/ Continuing ed 8 hrs in NJ. WA voluntary program to learn foreign language, AB 1195 CA was going to require set hours, push back from physicians: cultural competency across the board in education curriculum and continuing ed'n. Development process.
There are examples of curricula, no consensus. Law doesn't define cultural competency, very general. Advisory bodies to define. Challenge is to ensure that cultural competency is integrated in everything, how is it integrated.

Separate course vs integration across curriculum? Better to integrate, but challenge. More effective, different type of providers need the trainings, receptionists and others also need it. Physicians in CA, other health care professionals in other

Maryland has a voluntary program, different pending legislation.

Competency of interpreters relative to certification. Washington has certification since 84. OK, OR examining it, IN has a state commission looking, IO, MA, NC permission for funding, have credentialing pilot. Credentialing cert program / certify the training institutions, board to oversee, add certification to implement later additions. Need input for decisions made right now. WI has to sign in to NCIHC code of ethics. Proficiency standard and 40 hour training another state.

Funding is a big issue. There is statewide and federal funding. Not unfunded mandate. 4 models that states are using:
Contract with agencies and brokers, arrange with interpreter
Provider makes arrangements and gets reimburses
Interpreter gets reimbursed
Telephonic available to provider

¼ of the states are seeking this, state has to provide 50% match.
Show states that there is cost benefits and savings and also federal money available. Texas has pilot program even though have been cutting medicare programs. Pilot also in NC.

Providers could get reimbursed for a system already in place. Maximize so interpreter. Maximize agencies and providers that can get reimbursed. No reimbursement for some hospitals.

Who is a certified interpreter in WA and how does it affect reimbursement?
Written and oral test corrected by native speaker. Level of passing, reimbursed for providing services if have certification.

Interpreter has to be on list to be reimbursed.

In other systems it is the provider or the agency that decides if interpreter is qualified.

Requirement for insurance for individual, liability? Individual comes through agency which is covered by insurance.

Other examples of states considering funding. CT bill to provide reimbursement: $ 3 million dollar estimated cost, may not cost, ongoing process, advocacy effort by coalition to get funding. Working with subcommittee of Dept of health to define standards.

NY 76 million dollars pilot for NYC. There is a strong coalition to get funding for next year. Recognition for need, follow through Define interpreter competency and certification program in future.

Considerations and questions as examples of issues; delivery system, standards, What should we promote in our own states?

Brainstorm:

Areas of research,
Policy issues
What should the committee be doing? Is that a useful direction? Could other things come out of this committee?

Policy and research committee spears letters in response to situations, such as English only. There is a case challenging OCR on LEP guidelines. Have filed amicus brief. Aaron Gory study relating that interpreter interferes, letter in response to study.

Recommendation: There is research coming out constantly, when relates to language access, short statement about it and get into the bibliography eventually. Kept up on what's published. Get word out through bibliography

eventually. Ability to search bibliography. Articles to go into list, annotation to go online. The newsletter could be the place, policy updates could also go there.

State funding to refugee services does not untrained interpreters are funded. Facility uses untrained free interpreters. Good for language access, state funding reimbursing untrained. Reason they are used is that they are very low cost. Trained interpreters are no used. Undermines. Document translation quoting. Using document translators that are not professionally translated. Translation is an issue. Telephonic.
Policy on how provider should deal with document translation.
Police goes to red cross to provide interpreters for police, etc. to go to safehouses, etc.
What organizations are getting money and are they using competent interpreters?
Push for certification so that people who get used are certified.
If there are questions about translations, the ATA should be the one involved.

Dual role: educating the provider!

Don't bother to correct the people, drop the issue.

TRAINING

This was the very first of a series of focus groups, similar to the certification forums, that the NCIHC will be conducting to develop standards for the education and training of interpreters. The NCIHC believes that this is a critical step toward the eventual certification of interpreters. Issues examined include the competencies that an interpreter must master, prerequisites to admission to training programs, training methodology, and post-training requirements.

During the Training Work Groups, there was also discussion of Interpreter Registries as an intermediate solution to addressing the advancement of the profession. Already in use in some states, the Registry or Directory is an opportunity for interpreters to present their qualifications absent a national certification.

As we continue the professionalization of the healthcare interpreting field, the availability and standardization of training is critical.

This forum will use participatory techniques to lead participants through an analysis and discussion of several key questions:

- **Question 1: Should there be any admission requirements to training programs? What are the components of the admissions requirements?**
- **Question 2: What are the competencies that need to be taught in an interpreter training? Use the SOP as a base for the discussion**
- **Question 3: How do interpreters learn best? What methodology should be used for training? What is an appropriate length for training? Should there be any post training requirements? Should there be any testing after training completion?**
- **Question 4: Where should training be housed?**
- **Question 5: Based on our discussions, what are the top 3 challenges to establish programs across the country that meet the standards?**

QUESTION 1

Group 1:
Having requirements AFTER the intro. course.

In Chicago, after Eng. Prof. exam from community college: Very low pass rate (test at 8th grade level), most Eng. Nonnative interps. were disqualified.
Different models for testing proficiency:

Test before
Test after course one
Use admissions requirements from a University lang. proficiency test

Group 2:
2 yrs. Of college proficiency exam: fluency, language skills proficiency (ACTFL), critical thinking skills, listening skills, and cultural competency: (+) higher level thinking skills, linguistic level.
(-) couldn't connect w/underserved populations

Group 3:

- General language fluency tested through a valid test
  - What test should be used to test language proficiency?
  - Waiver may be offered to rare languages

- Test basic medical language knowledge (apart from medical terminology training during course)

- Educational level:
  - College degree
  - "Some college desirable but not required"
  - This depends on the language. Higher education may be feasible for Spanish but not for other languages
  - It may be needed to look at how other professions have developed over time and follow their lead
  - Exceptions may be made depending on the person and the language as this may exclude people from groups without a chance to gain an education.

- Tuition
- Criminal background check

QUESTION 2

Group 1:
Synthesis: **Basic**: Memory skills, transparency of Interp., positioning, ST—Basic or ST in general, accuracy, completeness, med. terminology—all areas, terminology—knowledge of colloquialisms and profanity, cultural cross understanding, managing the flow of conversation, note-taking, maintenance of register, role of interpreter: conduit to advocate?, simultaneous—basic, intermediate or advanced? Understanding the triad, nonverbal communication, understanding what you don't know, your limits—self-awareness, self-management and stress

Intermediate: laws/procedures/role of Interp. team, simul. For 5 mins. Or less, pharmacology & meds—more in-depth, stress management and self-care after traumatic situations, diagnostic procedures and more advanced, improving memory skills, content education, skill of interpreting in group settings, keeping up with training

Advanced: simul. and specialized sight translation, sim. For up to 20 mins,pastoral care, palliative care, mental health, power of attorney for health care, understanding how providers go about making diagnoses (progressive skill, also—put in basic and intermediate, also), understanding the people you serve and how they think (cultural)

Group 2:
Basic: People skills, Ethics (Confidentiality, HPPA, how to be assertive enough to be ethical), Protocols (Understanding the Triad, Conduit/Transparency, Role of Interpreter, Nonverbal communication, professionalism), Consecutive, Simultaneous, Memory Skills, Accuracy, Sight Translation, History-Taking Terminology, Immunizations, Nutrition, Anatomy-Physiology, Directions/PT commands, Common surgical and other procedures, Major Diseases, Medical Consent Form Terminology (Frozen), Insurance Terminology, Medications, Healthcare in U.S. Terminology, Role plays in 10 Most Common Health Problems (from CDC, updated monthly), learning to self-evaluate as to what you know and don't know
Advanced: Simultaneous
Sight Translation – **Basic**: Common, non-specialized instructions, etc.
Adv: All other documents
Basic: Consecutive

Group 3:

Basic

- Apply code of ethics
- Understand interpreting profession role of interpreter
- Be familiar with health care setting (biomedical culture) and procedures
- Ability to interpreter consecutively
- Possess cultural awareness and demonstrate cultural responsiveness (ability to apply knowledge of source and target cultures)
- Sight Translation
- Ability to self-monitor for accuracy and completeness
- Thorough knowledge of medical terminology
- Understanding of anatomy, physiology and most common medical procedures
- Awareness of different regionalisms and registers
- Consecutive

Intermediate

- Different medical specialties
- Acronyms

Advanced

- Mental Health Interpreting
- Interpreting in chaplaincy
- Death of Loss
- Trauma
- ICU – Intensive Care Unit
- Domestic Violence and Sexual Assault

QUESTION 3

Group 1: 40 hrs. is not enough. 6 mos. – 2 years would be ideal. Start w/standards for ANY kind of training so consumers know what is covered.
Mentoring, shadowing and practicum: Practicum really important to apply skills trained. Should be a completion test, w/possible periodic tests. Both written and oral. How practical is 6 mos. To 2 years? Smaller communities, not much need for exotic langs., not much return on investment bcs. Jobs not very available.

Group 2: Learning skills: start w/media = videotapes so people see what good interpreting looks like. Role-plays so people get hands-on practice in class: Doctors play the role, or med. students, or someone to do it. Have interps. Switch roles. Self-evaluation: record your renditions and apply techniques of self-evaluation you've been taught. No one is perfect. Peer review also useful, in a polite but effective and supervised situation. Some trainers use rating forms. Techniques for terminology: No word lists: Terminology into dialogs, role plays, research on internet and dictionaries—TEXTS w/words to learn in context. Word-attack skills. Paraphrase when no direct equiv. exists. Textbook on med. terminology, or have specialists visit to speak and use words. Discussion/mentoring/regional comparisons. Some doctor/interpreters can be a great resource. Learning web-navigation skills. Ethics: Don't' just memorize code, but learn through scenarios/case studies—e.g., "variables" where doctor is nasty or difficult.

Training should give ONE clear certificate, meaning successful completion = EVALUATION OF SKILLS AT COURSE END, NOT JUST PERFECT ATTENDANCE.

Group 3:

- Through multiple methods
- Identify certain learning objectives for a given session
- Case scenario role plays (for interpreting situations, ethical dilemmas, etc.)
- Case scenario discussions
- Listening/watching and discussing video/tape recordings
- Cognitive input
- Practice
- Getting Feedback

- Giving presentations on different topics (for target language production and public speaking)
- Shadowing
- Paraphrasing
- Recording one self and analyze on their own, get critique from instructor/peers
- By doing/observing/classroom instruction/mentoring

What methods should be used for training?

- Pre-interpreting skills
- Interpreting skills
- Classroom + lab or real life practicum
- For terminology: use resources (Internet, glossaries, etc.)
- Take into account different learning styles (by reading, memorizing, watching, listening, etc.)

What is the appropriate length for training?

- Depends on the goals and objectives
- Appropriate length may be better determined once clear standards for training are defined
- Set minimum vs. preferred standards
- Training should be task-oriented as opposed to time-oriented

Should there be post-training requirements?

- Continuing Ed
- Shadowing
- It will be different for basic/intermediate/advanced competencies

Should there be testing after completion or should a certification test be the test?

- Two:
- Testing as we go along
- And testing at the end of the course
- Self-testing

Where is an appropriate home for interpreter training? Community colleges? Universities? Hospitals?

INTERPRETER REGISTRIES

REGISTRY: How do interps. show their qualifications w/no certification or for people who haven't passed yet???

DIRECTORY: database, on line or hard copy—CHIA's including training, experience, what situations….link to your school/training facility bcs. It's a searchable database,

ROSTER: Certified and/or have other qualifications = meet basic requirements AUTHORIZES THE PRACTICE

CREDENTIALING: "umbrella terms that includes the concepts of accreditation, licensure, registration and professional certification"

CERTIFICATION, professional: s.o. has tested you so that they can say "I know that this person can do the job."

NCIHC; FORMAL ASSESSMENT

LICENSURE: Mandatory process by which a gov. agency grants permission to an individual to engage in a given occupation after verifying that he/she has met predetermined and standardized criteria.

REGISTRY:

Display qualifications: database/directory: Disadvantage: self-reported, image can influence; confusion in minds of clients about WHAT IT MEANS. Advantages: networking state-to-state; Problem of implementation: having to go back and verify everything there. Disadvantages: training changes w/time, so you can't know what s.o. achieved a long time ago.

Registry: min. requirements to be on the list--While we wait for national certification. Advantages: We get people now to fill the demand. Disadvantages: Implementation issues. Iowans have to pass an approved training program through the junior colleges. Should we let requirements depend on state in which one lives?

RID: Gives cert. exam, but each state must decide if it's a requirement or not.

One participant said: CEUs should be given.

INTERPRETER REGISTRIES

{POWER POINT PRESENTATION]

Discussion

1) Should there be directories?

Advantages
- It would help people/institutions who look for interpreters
- It would be advantageous for interpreters because they could get their name out there. They can use it to know who their competition is.
- Not costly or time intensive to put up and maintain
-

Disadvantages
- Since there would not be minimum requirements, it would perpetuate the lack of professionalism
- "Use at your own risk" Who would be the clearing house?

Problems of Implementation
- Not much now that the California Endowment has offered to make their database available to other organizations.

2) Should there be registries?

Advantages
- It would identify/promote and encourage minimum skills

Disadvantages
- More costly and task intensive than a directory. Needs more man power to implement and maintain (verifying credentials, etc.)

Problems of Implementation

What should be the minimum qualifications for inclusion in a registry?

- Language proficiency?
- Formal training?
  - Bilingual skill building?
  - Exit exam?
- Ethics test?
- Terminology test?
- What else?
  - Background check?

MEMBERSHIP FORUM

Membership Committee Co-Chair Jorge Ungo addressed all participants during the closing session about the fact that nobody came to the membership workshop. Could this be a reflection of the fact that people were more interested in the "big" topics, and does that mean that members are happy with the way the Council is run? The work group was included for discussion of internal, organizational issues that might be of concern, but everything else the other work groups did

goes right back to membership. Members were asked to please get in touch with the Council regarding any concerns and it was underscored that we want to hear from you about where we are going.

A few individuals, in fact, ended up coming together and a small Membership session was spontaneously generated, resulting in lots of ideas for fundraising.

Participant: Why doesn't the Council become an umbrella organization for all of the state organizations?

Everyone was asked to complete the Evaluations which are very important to us.
All notes from the Membership Meeting will be typed up and distributed to participants and NCIHC members. There will be another membership survey online, so please fill it out and help us know how to serve you!

Closing Session – Sunday, July 1, 2007

Lisa Morris, who had just stepped down from her service as Secretary to the NCIHC, was recognized for her efforts on behalf of the Council and the cause.

Group leaders reported back on their sessions (see notes above).

Thanks were given to all who helped make this meeting a possibility, including our scribes, and especially our sponsors, Pacific Interpreters, Language Line Services, International Language Services, MasterWord Services, The Joint Commission, the American Medical Association-Institute for Ethics, Indiana University Purdue University Indianapolis (IUPUI), and Midwest Association of Translators and Interpreters (MATI) and the American Translators Association (ATA).