Audience Questions and Answers
Language Access Webinar #1: "Addressing the Language Access Barrier When Serving Refugee Patients"

During the "Addressing the Language Access Barrier When Serving Refugee Patients" webinar, participants had the opportunity to submit questions to the presenter, Cynthia Roat. Due to time constraints, not all questions were answered during the webinar. Questions and responses are provided here for those questions that were not covered during the webinar. The webinar can be viewed on the Refugee Health Technical Assistance Center (RHTAC) website www.refugeehealthta.org. For further questions or comments, please contact RHTAC by email at refugeehealthTA@jsi.com.

Q: You mentioned that the overall cost of care for a patient who had an interpreter at the initial appointment was LESS than the overall care (over time) for a patient who had no interpreter. You noted that even if the patient was not an LEP needing an interpreter, the overall costs came out LESS for patients using interpreters since their initial appointments. Could you please provide citations for the cost of care research item?

A: Yes. The study is:

Bernstein J, Bernstein E, Dave A, et al. Trained medical interpreters in the emergency department: Effects on services, subsequent charges, and follow-up. Journal of Immigrant Health. 2002; 4(4):171-176.

Q: Is the quantitative data analysis for cost of care based on face-to-face or does it also include telephonic and other modes of interpretation?

A: The quantitative data on cost of care that I referenced in my presentation was based on the provision of face-to-face interpreting services. At the time of the study, telephonic interpreting was not widely available and video-interpreting was not being done at all.

Q: Are there any already created webinars or on-line trainings that would be available for an orientation to interpreting? (low cost or free of charge)

A: I do not know of any. However, when looking for an orientation for your interpreters in languages of limited diffusion, consider whether online training would be appropriate for your target group. Interpreting is a skill that is best built through practice, which is very hard to accomplish in an online medium. In addition, online trainings are most effective for individuals who are highly literate in English and very comfortable with computer-based technologies. You would have to consider whether your speakers of languages of limited diffusion met these criteria before expecting them to learn through this medium. I think you would do better to hire a local interpreter trainer to provide a one-day orientation to your interpreters in these languages.

Q: Do you have any ideas on funding interpretation services/training?

A: Interpreter services is usually funded out of an institution's operating budget, just like the phones, the IT department, and other services without which the institution could not function. About 13 states around the country have opted into pulling down a Federal Medicaid Match to help pay for interpreter services for patients receiving Medicaid. In California, both public and private health plans are required to cover language services.

Finding funding for training is more difficult. If the interpreters in question are staff at a healthcare institution, then new standards from The Joint Commission might convince the administration to pay for training. If the interpreters in question are freelancers, sometimes hospital foundations will contribute towards scholarships for training, especially for interpreters in languages that are hard to find. Grants are always a possibility, and of course, it is not inappropriate to ask freelance interpreters themselves to pay something toward their training.

Q: How do you handle large research institutions that simply refuse to treat certain language groups unless they bring their own interpreter?

A: First, I try to identify providers in the institution that might become "champions" for our concerns and get them to help advocate from within. Then I carefully prepare my most compelling and persuasive arguments and meet with and educate key administrators in the organization: high-level nursing administrators and risk managers are often sympathetic to our concerns, the former responding to quality-of-care arguments and the latter responding more to legal and financial arguments. If this creates no traction, I try to find a community advocacy organization that will engage the institution in a dialogue on behalf of their constituency (refugees, or Latinos, or the hearing impaired, for example). And, if that stalls out, and assuming the institution is receiving some kind of federal funding, I submit a formal complaint to the Office of Civil Rights and The Joint Commission.

Another approach is to see whether the institution has a contract with the state Medicaid office and see whether the contract requires them to provide interpreters. If both of these are the case, the Medicaid office may get involved with enforcing their contract. The media can also be brought to bear, depending on whether you have a "critical incident" that might be of particular interest.

Remember, however, that if you are the ones to bring a formal complaint to OCR, The Joint Commission or the State Medicaid Office, the institution will not turn to you to help solve the resulting problem.

Q: From a refugee resettlement agency perspective, our clients often experience barriers to their health care when providers either refuse to provide interpretation, or are unsure of how to systematize an interpretation protocol within their organization. How might we, as social service providers, help the health providers to meet their obligation under the Civil Rights Act to provide linguistically appropriate care?

A:

1. Build relationships inside the institutions.
2. Educate key decision-makers.
3. Build relationships with other community-based agencies that also have this concern.
4. Be prepared to lodge formal complaints if the institution is non-responsive.

If the institution honestly wants to improve but doesn't know how, there are many resources online and through the Office of Civil Rights. There are also individuals such as myself who provide consulting services in this area.

Q: Interpreters are an important necessity in on-site health care provider settings. But what happens after the patient leaves the provider is also important. Translated patient education materials to take home are lacking for those who can read their native language. For those who are illiterate in English and their own language, audio and video posting on YouTube or other specialist sites would be a huge benefit. Who is doing a good job of integrating off-site language access with on-site interpretation?

A: As you can imagine, most institutions have focused first on providing oral language services, then on providing translated vital documents in the most common languages. However, there is growing interest in this as the new Joint Commission standards for communication include the provision of translated vital documents.

Q: Is interpretation a profession? Many interpreters don't have enough assignments and don't see interpretation as full time job hence no respect. Interpreters end up in other fields.

A: Interpreting is a profession, one that has traditionally been exercised more lucratively in the diplomatic and business sectors than in health care. However, community interpreting – or rather, the provision of language services that link LEP individuals to community services such as health care, education, the legal system, police services, etc. – is growing rapidly into a real profession with ethics, standards of practice and standards for training programs. And with respect.

It is true that the level of pay is not where it needs to be, and that many on-site interpreters in languages of limited diffusion do not have enough work, but the profession is changing daily, with remote interpreting providing growing opportunities for interpreters of languages of lesser diffusion, and community interpreters in some states unionizing to fight for increased pay and more reasonable working conditions. I can't wait to see where this field will be in five or ten years!

A few words about respect. It is clear that, despite the advances made in the field of language access over the past 20 years, we still have a lot to do to educate healthcare providers about the value of qualified interpreters. However, respect also has to be earned. Interpreters who behave as professionals are more likely to be treated like professionals. I have seen many staff interpreters who are incredibly skilled at what they do, and they are treated as integrated members of the health care team, with the same respect as social workers, nurses and chaplains. I have also seen many "interpreters" who show up to appointments in flip-flops and shorts, who take cell phone calls in the middle of interpreting, and who are brusque and downright rude to staff. They are not respected; is it any wonder?

Q: Are interpreters certified or licensed?

A: Licensure is a legal permission to conduct a particular activity. To my knowledge, spoken-language interpreters are licensed only in Texas.

Certification means that some certifying body is guaranteeing that the certified individual is capable of performing a specific set of skills at a particular level of proficiency. So, when you hear that someone is "certified," you should ask 1) By whom? 2) To do what? 3) At what level of proficiency?

Sign interpreters were in the past certified either by the Registry of Interpreters for the Deaf or by the National Association of the Deaf. These two groups have merged their two processes into the National Interpreter Certification. Sign interpreters are certified at various levels and for various specialties. See RID's webpage on certification for more information.

Spoken language interpreters are certified nationally by the Certification Commission for Healthcare Interpreters (CCHI) and the National Board for the Certification of Medical Interpreters (NBCMI). As of April 8, 2012, both groups certify only Spanish interpreters, although the CCHI also has a credential that can be earned by interpreters of any language pair, and both organizations are in the process of developing tests for more language pairs. For more information on certification for spoken language interpreters in health care, see the National Council's website on certification.

State certification for healthcare and social service interpreters is conducted Washington State by the Department of Social and Health Services. California also requires "Medically Certified Interpreters" for workers' compensation cases. Oregon is also implementing a state certification program for healthcare interpreters.

Certification is also available for court interpreters at various levels. The Federal Courts certify legal interpreters, as do the National Center for State Courts and the National Association of Judiciary Interpreters and Translators.

Q: The Refugee Health Arrival Notification may list as many as three languages per family. Can you give advice on how to address this when providing interpreter services for those family members?

A: I would suggest you ask the family (in whichever language you can find an interpreter for), which is their MOST comfortable language for healthcare discussions (their "A" language, if you will). Then ask how well they speak the other languages. Often you will be able to get an interpreter in a colonial language (French, Spanish, Portuguese) when you cannot get one in the individual's native language. Depending on how well they speak their "B" and "C" languages, how they feel about the colonial language, and how desirous they are of receiving specific services, they might agree to an interpreter in their non-native language. This should be, however, the patient's decision.

Q: I have had to hire interpreters to do relay interpretation (e.g., French-Ewe combo). What would you recommend regarding paying for both/charging the customer for both interpreters?

A: You should pay for both and charge the customer for both.

Q: Do you have any suggestions on how to coordinate appropriate care for individuals with no native language (e.g., deaf clients not fluent in ASL or their country's sign language)?

A: I recommend you take a look at the website of the Registry of Interpreters for the Deaf. I know that there are some interpreters – usually Certified Deaf Interpreters, I believe – who are especially skilled in working with individuals who use home signs only. This is a bit outside my area of expertise, however, so I encourage you to contact others more knowledgeable at RID or NAD.