Core Competencies for Health Care Interpreters Research Report

A Report of the Center for Women in Government & Civil Society, University at Albany, State University of New York & The Education Development Center, Inc.

Dina H. Refki, D.A.
Maria-Paz B. Avery, Ph.D.
Angela C. Dalton, Ph.D.

This study was generously sponsored by the AIDS Institute and the Office of Minority Health, New York State Department of Health

Acknowledgement

The study was made possible by the generous sponsorship of the NYS Department of Health. It was directed by Richard Cotroneo, Director, HIV Education and Training Programs, AIDS Institute, Wilma Waithe, Director, Office of Minority Health and Dara Shapiro, Assistant Director, HIV Education and Training Programs, AIDS Institute.

This study was guided by the expert advice of a workgroup of policy makers, practitioners and field experts. We express our deep appreciation to the following members of the workgroup for their thoughtful and valuable contributions to the study in each phase of its implementation. We are also grateful to members of the board of the National Council on Interpreting in Health Care who served as advisors, for guiding the study throughout all of its phases.

We would like to extend our heart-felt appreciation to the following individuals for their contribution to our project: Wilma Alvarado Little, University at Albany; Cathy Cave, New York State Office of Mental Health; Eric Cleghorn, NYSDOH Refugee Health Program; Ruth Concepcion, St. Elizabeth Medical Center; Ruth Leslie, NYSDOH Office of Health Systems Management; Deborah Dewey, NYSDOH AIDS Institute Division of HIV Healthcare; Efrain Dones, NYSDOH Office of Minority Health; Alma Escobar-Godi, NYS OTDA Bureau of Refugee & Immigrant Assistance; Felicidad Frenette, International Institute of Buffalo Language Services Department; Henry Gonzalez, NYS OASAS; Eric Hardt, Boston Medical Center; Grace Mose, Family Planning Advocates of New York State; Jenny Rejeski, New York Immigration Coalition; Lisa Roland-Labiosa, NYSDOH AIDS Institute Bureau of Ambulatory Care; Lynn Stone, NYS OTDA Bureau of Refugee & Immigrants Assistance; James M. Tesoriero, NYSDOH AIDS Institute; Virginia S. Tong, Vice President of Cultural Competence at Lutheran HealthCare; Stephanie Trice, New York City Health and Hospitals Corporation, and Mara Youdelman, National Health Law Program.

Table of Contents

Executive Summary

Background and Significance

With New York State's foreign-born population reaching approximately 3.9 million in 2000 according to the U.S. Census Bureau, healthcare providers across the state are facing major challenges in developing adequate language assistance services to communicate effectively with their immigrant, limited English proficient (LEP) patients. The purpose of the study is to advance linguistic access in healthcare by identifying core competencies for language interpreters and standards for interpreter training programs.

Methodology

To achieve these goals and create an inclusive research model, the authors conducted extensive research with a broad range of stakeholders, including service providers, health care interpreters, trainers, policy makers, and subject experts. A variety of research methods were utilized to obtain original and comprehensive data to assess the field of health care interpreting training and the existing needs and disparities in language access provision. As the initial endeavor in the research process, a listening session with an Advisory Panel comprised of state program planners, practitioners and health care professionals was established to guide the conduct of this project. The investigators then organized a strategy roundtable with healthcare administrators and front-line workers to gauge these service providers' perspectives about best practices and promising strategies that can facilitate the adoption and institutionalization of language access in health care.

In addition, the investigators conducted an extensive literature review, surveyed health care interpreter training curricula around the country, and solicited expert opinion and feedback from language access curricular developers, trainers, trainees, and interpreters. With the information obtained from these diverse sources and in collaboration with subject experts, the investigators developed two survey instruments with both close-ended and open-ended questions to examine the attitudinal and perceptual consensus and difference between two cohorts of respondents: health care interpreter trainers and curriculum developers, and practicing interpreters and interpreters-in-training, regarding the core competencies essential to providing high quality health care interpreting and standards for interpreter training programs. Telephone and in-person follow-up interviews were conducted with trainers and interpreters to gather additional insights into language access education and service delivery.

Key Findings

The literature review suggests that there are several important determinants of institutionalization of linguistic access. These factors include (a) leadership commitment; (b) workforce diversity; (c) availability of systemic data collection of LEP patient linguistic needs in the community; (d) understanding and enforcement of policies, procedures and processes for language access; (e) strategic planning; and (f) partnership and collaborations with community-based organizations.

The listening session and the strategy round table reported a host of real-life barriers to institutionalizing language access in New York State. It was widely shared among the participants that the lack of resources most critically hinders health care providers from making language assistance an integral component of health care services. Lack of resources also impairs providers' capacity to collect uniform demographic data on the LEP population and update existing, fragmented data to analyze patients' language needs. Lack of resources further hinders health care providers from providing language training to enhance their staff's ability to serve LEP patients, recruit and maintain a more linguistically diversified staff. For those organizations that have bilingual staff, these staff members often voice a sense of frustration and stress toward the challenges associated with working as both care providers and interpreters. In addition, it was suggested that many health care organizations are not fully aware of the existing policies or regulations regarding language assistance, which prevented issues related to language assistance from receiving the managerial attention that it deserves. Also, organizational cultural differences often hamper the creation of productive partnerships between health care providers and community-based organizations or other health care providers in the community to effectively address service gaps and disparities in language access.

The survey of the two-cohorts of respondents generated some interesting findings regarding what constitutes the core competencies for healthcare interpreting services. The survey results show that a number of program and individual characteristics can impact the respondents' belief about whether or not a certain knowledge or skill should be a core competency. These characteristics include length of training; size of the training program staff; the number of trainees who graduated; trainees' experience with previous training or having gained knowledge from taking relevant courses; and the number of interpreting encounters performed.

Perceptual divergence also emerged between the two cohorts of respondents when comparing their rankings of knowledge and skill items listed in the surveys, (See the Appendices section). Specifically, trainees perceived that the most necessary knowledge they needed focused both on developing a solid knowledge of the terminology that was required and grounding themselves in a sound understanding of the role of the health care interpreter as a professional. Next, they perceived the importance of understanding key aspects of language, and how culture influences health care and the transmission of meaning within the health care setting. These highlight areas of knowledge that have a direct impact on how the interpreter performs while in the interpreting encounter. Knowledge of the context of health care interpreting, for the most part, was seen as good

background information but not necessary for beginning interpreters or appropriate for more advanced interpreters.

With regard to the effectiveness of instructional methods, the results show that between 70 and 84 percent of trainees picked as effective those instructional methods that brought the "real world" into the classroom through role plays and case scenarios, and that exposed them to professionals in the field. A large percentage of respondents also found instructional strategies that provided them with feedback and opportunities for error analysis to be very effective. Some drill type activities were also perceived as effective but other types of drill activities such as memory and note taking exercises were not perceived to be as effective.

Despite the perceptual divergence among our survey respondents, we were able to consolidate the responses from both trainers and trainees, and developed a list of core competency items that are critical to all beginning health care interpreters. We advocate that the incorporation of these items into health care interpreter training curricula in New York State will help make the field of language assistance education more consistent and standardized, improve the quality of interpreters, and better serve the LEP populations in the state.

1. Background

1.1 Introduction

New York State has the second largest immigrant population in the nation, with immigrants and their children making up a large portion of its residents. One-third of the NYS population is foreign-born or children of foreign-born parents. Of these, more than 40% of foreign-born NYS residents have arrived since 1990. Between 1990 and 2000, the New York City metropolitan region moved from the nation's second most preferred destination for new immigrants to the nation's top chosen location (Lewis Mumford Center, 2004).[1]

With New York State's foreign-born population reaching approximately 3.9 million according to Census 2000 data, healthcare providers across the state are facing major challenges in developing adequate language services to communicate effectively. In New York City, where over 150 languages are now spoken, providers must devise services flexible enough to meet the needs of an enormously diverse population (Lewis Mumford Center, 2004). In upstate cities like Utica, where newcomers speak 30 different languages, health systems previously devised for a relatively homogenous population must develop new strategies for patient-provider communication. Even in the most rural counties, Spanish interpretation is necessary to care for immigrant farm workers. Sixteen counties in NYS have more than 4,000 people living in linguistically isolated households (households in which no member 14 years or older speaks English very well). Given these numbers, overcoming language barriers is critical to addressing the health care needs of NYS residents.

Research has documented how the absence of linguistic access in healthcare seriously affects quality of care and its health outcome.[2] However, research shows that attending to linguistic access strategies can narrow the quality gap, decrease disparities, minimize unnecessary costs of care, and help healthcare institutions comply with laws and regulations.[3] Federal, state and local laws and regulations have sought to promote the institutionalization of linguistic access within health care organizations. While this top-down approach has facilitated progress, institutionalization has remained slow and uneven. Health care institutions are hampered in their attempts to comply with these laws and regulations since there are few tools available for navigating this still largely uncharted territory and overcoming structural and financial barriers. The provision of quality language services continues to be challenged by the absence of standards to assess what constitutes a qualified interpreter, by the lack of measures of interpreter competency, and the scarcity of best practices for institutionalizing language access within organizations.

One of the major approaches to meeting the need to provide language access services has been the development and implementation of professional interpreter services. However, an effective interpreter service is premised on the availability of well-prepared, competent professional health care interpreters in the range of languages needed. Interpreter training programs are striving to fill this need but with little guidance on the core competencies all interpreters should have, the proficiency standards required to

practice, and tested pedagogical practices needed to ensure that interpreters are well equipped to effectively and efficiently fulfill their roles.

A national demonstration study conducted in 2007 highlighted the need to develop comprehensive training programs for healthcare interpreting. The study found that "there was no agreement across sites as to how much training is appropriate and there are no universally accepted benchmarks by which to judge the proficiency of interpreters….. The field still lacks benchmarks and tools to measure proficiency…. interpreter proficiency standards are lacking" (Wu et al., 2007).[4] Currently, the interpreter training landscape is diverse and uneven. There is wide variation among training programs in course content and sequencing, length, intensity levels, delivery approaches, and pedagogical practices. Students arrive at the programs with different backgrounds, linguistic readiness, and learning styles.

1.2 Goals and Objectives of the Study

The study was designed to contribute to an understanding of (a) the core competencies that a beginning healthcare interpreter needs to function as a competent interpreter; and (b) the pedagogical strategies used by training programs to impart these core competencies. The identification of core competencies is seen as a foundation towards consistent assessment of interpreter qualifications and the development of effective training. The study will help advance the institutionalization of language access by examining the conditions that have been identified as critical to providing effective language access for Limited English Proficient (LEP) patients and by identifying strategies that can alleviate barriers to creating these ideal conditions as well as identifying the stakeholders who can move the language access agenda forward.

1.3 Organization of the Report

Following the section on background, the methodology section will describe the research methods employed, approaches to data collection and analysis, and the background characteristics of the survey respondents. Then research findings will be synthesized and presented in the Results section to describe the various barriers identified through our research and provide an analysis of what constitutes core competencies in health care interpreting and effective instructional methods, based on our survey data. All the survey instruments, and graphs and charts are included in the appendices for reference.

2. Methodology

In this study, both quantitative and qualitative research methods, such as focus groups, surveys, and interviews, were employed to obtain original and comprehensive data from a wide range of stakeholders including service providers, health care interpreter trainers and interpreters, policy makers and subject experts. Table 1 provides an overview of the methodology used, information generated and outcome produced.

To oversee and guide the conduct of this study, an advisory panel was formed, consisting of NYS program planners, practitioners, and healthcare professionals from diverse backgrounds. The panel assumed responsibilities of reviewing and commenting on proposed core competencies for language interpreters and advise the researchers during all phases of the project. In addition, the National Council on Interpreting in Health Care (NCIHC), through its Standards, Training and Certification Committee, participated as expert advisors to ensure that the study would inform the development of national standards for the training of health care interpreters.

2.1 Listening Session and Strategy Roundtable

As the first step in the research process, the study team convened a listening session and a strategy roundtable to elicit the perspectives of key stakeholders on best practices and promising strategies that create and nurture the conditions which facilitate language access to healthcare. In addition, a literature review was conducted to inform the listening session and strategy roundtable discussions on evidence based practices for integrating linguistic access in healthcare institutions.

The listening session was held with members of the advisory panel in November 2007. Members on the Panel included state program planners, practitioners, and other healthcare professionals from diverse background. A list of the panel is included in the acknowledgment section of this report. Participants were asked to reflect on the institutional support they thought was needed to ensure the availability and quality of linguistic access and other related services. Discussion topics included interpreter core competencies, training standards, real world barriers to the provision of healthcare interpreter services, effective service models, strategies for promoting senior leadership buy-in, recruiting and retaining qualified interpreters, and patient and provider perspectives.

The strategy roundtable was held with healthcare practitioners in February 2008. Participants for the roundtable were purposively selected to represent expertise in administration and direct service provision as well as familiarity with the internal operations in a healthcare setting. Collectively, the participants combined administrative, managerial, and clinical experience as well a program planning expertise. Of the participants, two were physicians, one program administrator, and five language competency administrators. They represented the following institutions: Asian & Pacific Islander Coalition on HIV/AIDS, Lenox Hill Hospital, Woodhull Medical Center, Mount Sinai Hospital, Lutheran Healthcare, and NYC Health & Hospital Corporation.

Table 1 Overview of Methodology

Methods	*Scope*	*Participants Composition*	*Information Generated*	*Outcome*
Literature Review	N= 80	Peer-reviewed journal articles Research reports issued by research institutions, key organizations specializing in language assistance and immigrant advocacy groups around the country	Gained an understanding of the current research on language assistance and issues regarding health disparities and immigrants Identified the lack of standardization in health care interpreting training programs Identified key factors affecting institutionalization of language assistance in health care provider organizations Informed the development of draft survey instruments	Development of research questions Research-based conceptual model to be used in steering the Strategy Roundtable discussions Draft survey instruments Discussion topics for the Listening Session and the Strategy Roundtable
Listening Session	N = 21	Advisory Panel consisting of policy makers, health care providers, immigrant advocates, and health care interpreting experts from the National Council on Interpreting in Health Care	Exchanged information about the development of language assistance policy and implementation Provided strategies for research and identified barriers to policy implementation Provided feedback on draft survey instruments	Improved survey instruments Meeting notes specifying strategies and guidelines for research
Strategy Roundtable	N=7	Health care providers with both direct service and managerial-administrative experience in serving LEP patients in NYC	Examined institutional barriers to implementing language access Strategies to increase language access in provider organizations	Documented insights into real-world institutional barriers Strategies to increase institutional acceptance and implementation efforts of language assistance services
Trainer/ Curricular Developer Survey	N =101	Health care interpreting training programs around the country	Consensus regarding core competencies in knowledge, skills and attitudes from trainers' perspective	Electronic survey at surveymonkey.com See Appendix A for Instrument
Trainee/ Interpreter-in-Training Survey	N= 120	Individuals enrolled in health care interpreting training programs in New York State	Consensus regarding core competencies in knowledge, skills and attitudes from the trainees' perspective	Electronic survey at surveymonkey.com Hard copy of the survey distributed to trainees without Internet access See Appendix B for Instrument

Participants were asked to reflect on the organizational building blocks of linguistic access and the internal operations of healthcare settings, identified by research studies. These building blocks highlight five domains of focus (Wilson-Stronks and Galvez, 2006):[5] leadership, workforce, information systems, policies, procedures and processes, and community engagement, partnerships and collaborations. For each of these domains, participants identified the ideal condition and defined the gaps between them. They explored how healthcare institutions could successfully transcend language access barriers and create sustainable infrastructures and mechanisms to support language access.

2.2 Comparative Surveys

To develop sufficiently inclusive competencies for healthcare interpreters, the authors conducted an extensive review of the academic and applied research literature and of existing interpreter training curricula. A literature review conducted on evidence-based practices for integrating linguistic access strategies in healthcare institutions and used to inform the Listening Session and the Strategy Roundtable. The analysis of this information also helped the researchers produce a preliminary pool of 81 core competency knowledge or skill items representing nine competency domains. These items served as the foundation for the development of the competency section of the surveys.

Two surveys were conducted to identify the core competencies that interpreters need before stepping into a medical/clinical encounter.[6] The surveys gauged the perspectives of practicing interpreters/interpreters-in-training, and interpreter trainers/curricular developers on the core competencies. The first survey was a national survey of trainers and curricular developers' perspectives (See Appendix A: Trainer/Curriculum Developer Survey), and the second targeted the perspectives of practicing interpreters and interpreters-in-training (See Appendix B: Practicing Interpreter/Interpreter-in-training Survey). The Trainer/Curriculum Developer Survey focused on eliciting the perceptions of trainers and curricular developers on what they considered to be the core competencies for healthcare interpreters and information on pedagogical strategies they used in their training program.

To identify a preliminary list of potential core competencies, the authors conducted an extensive review of the literature and reviewed existing training curricula. This analysis produced an initial list of 81 items representing nine competency domains. Members of the Advisory Panel and the National Council on Interpreting in Health Care were asked to review this initial set of 81 items and to suggest revisions, clarifications, additions, deletions or alternative options in order to develop a comprehensive yet concise and user-friendly set of items. This process resulted in the consolidation of the 81 items into 60 and the domains into five. Trainers and curricular developers were asked to identify which of the 60 competency items they considered "core" and to suggest additional core competencies that were not included. They were also asked to identify which of the pedagogical practices listed they used in their training programs and to add any that were not listed.

To map the infrastructure of interpreter training and identify trends in course offerings, respondents were also asked to provide a description of their program, the number of instructional staff they had, the qualifications of their instructors, the number of students they trained, their recruitment strategies and the criteria they used to select students for their training programs.

The Trainer/Curriculum Developer Survey was administered electronically using surveymonkey.com. The authors developed an initial list of 135 programs nationwide through existing literature, internet search, and referrals from experts and colleagues in the field. E-mail messages inviting participation in the survey were circulated. The survey was also posted on a number of listservs, including the listserv maintained by the National Council on Interpreting in Health Care. Responses submitted by individuals who were not affiliated with a training program and were not themselves trainers or curricular developers were eliminated from the pool of responses.

The Practicing Interpreters and Interpreters-in-Training survey focused on eliciting information from interpreters who had participated in a formal healthcare interpreter training program or were currently participating in such a program. Respondents were asked to identify the knowledge and skills they considered essential for beginner interpreters as distinct from those for advanced interpreters. The survey included 41 knowledge items and 31 skill items. Respondents were also asked to rank pedagogical strategies on a scale from "not effective/not helpful" to "very effective/helpful".

Open-ended questions were included to elicit more detailed information from respondents about the training program in which they had participated or were currently participating. Questions were asked about the adequacy of the program, the content taught, and the instructional methods.

Respondents from two training programs in New York state were also asked if they were willing to be interviewed and, if so, to enter their name and contact information at the end of the survey. Ten of these respondents were picked to be interviewed on the basis of their responses to the open-ended questions and with a view to including a diverse set of languages. The final count of interviewees, all from one training program, was seven. These interviewees represented a number of different languages prevalent in that area (Russian, Ukrainian, Spanish, and Somali) as well as experienced and novice interpreters.

A preliminary draft of the survey was piloted in January 2008 with a convenience sample of practicing and in-training interpreters (10), and with trainers and curricular developers (7) from an upstate New York program. Both interpreters and trainers were asked to review the survey instrument for clarity and understandability. As a result of the feedback, the language of the survey was modified to increase its level of comprehension. The final Trainee Survey was developed using the Trainer/Curriculum Developer Survey as the foundation with additional items included based on the curricula of two New York State-based training programs that were reviewed for the purpose of this study.

The survey was administered electronically using surveymonkey.com, although respondents from the New York State training programs also had the option of completing the survey in hard copy. With the two New York State programs, training coordinators and staff actively recruited their former and current trainees. In addition, respondents from other training programs were also contacted; these respondents completed the survey online.

To assess what knowledge, skills and beliefs should be regarded as core competencies by both trainers and trainees in the field of health care interpreting, the researchers surveyed two cohorts of subjects: trainers and curricula developers, and interpreters and interpreters in training. The survey was divided into two parts. Part I focused on different aspects of a training program, including respondent perceptions of the adequacy of the training they received, the knowledge base (what an interpreter should know and understand) and skill base (what an interpreter should be able to do), and the instructional methodologies. Part II asked respondents for demographic and background information.

3. Findings and Discussion

Our research suggests that effective and sustainable implementation of language assistance in health care depends largely on the successful synergistic integration of a host of critical forces across the health care policy community. For care providers, health care organizations' leadership and institutional commitment is critically valuable in incorporating language access into essential health care service provision. Health care organizations need to strengthen their social responsiveness and cultural competency to adapt to the rapidly changing immigrant demographic context. On the educational front, the health care interpreting field is thriving but with vast differences in terms of training duration, curriculum design, internship availability, instructional and testing methods, and student characteristics. These tremendous diversities may often lead to variations in the quality of interpreters who graduate from these programs. Therefore, the creation of a standardized educational program design and curriculum is important in producing well-trained health care interpreters who are capable of providing consistent, high quality and culturally appropriate services to LEP patients. In the policy arena, the establishment and furtherance of a statewide policy network that disseminates research and best practices among all stakeholders and connects policy makers with service providers, community-based organizations, and LEP patients to bring about positive policy change can help improve health care outcomes for LEP patients and reduce or eliminate health care disparities in New York State. It is our hope that the barriers identified in our study can be addressed in an integrated fashion and language access can be effectively built into the New York State health care infrastructure to better serve the needs of the state's growing immigrant population.

In the following section, we will address a diverse range of factors that affect the institutionalization of language assistance identified through the listening session and the strategy round table. We will discuss the findings generated from the surveys. We will compare the degree to which trainers, curriculum developers, interpreters and

interpreters-in-training agree/disagree regarding the elements that should be considered core competencies and standardization of health care interpreting.

3.1 Organizational Barriers to Institutionalizing Language Access

The Listening Session participants were asked to reflect on the organizational building blocks of linguistic access and the internal operations of healthcare settings, identified by research studies. These building blocks highlight five domains of focus: leadership, workforce diversity, information systems, policies and procedures, and community engagement. [7] A host of institutional barriers to institutionalizing language access in health care were identified within each domain during the discussion. The following discussion is structured along each of five dimensions delineated above.

Lack of commitment to linguistic access from top leadership

The success of any language access initiative is dependent on the commitment of the health facility's leadership. Leadership not only regulates organizational culture but also provides the framework for planning, directing, coordinating and providing care. However, what do you do when you have a case of an unmotivated CEO? The discussants unanimously expressed a need to transform awareness to motivation and motivation to action resulting in inclusion in the strategic planning. More specifically, they provided more in-depth discussion on some of the critical systemic factors that are in need of urgent attention.

Financial burden was identified as one of the key barriers to institutionalizing language assistance. Providing language assistance must make business sense, as a participant commented, "Financial expenses are always a barrier. At the end of the day, hospitals are businesses." **"**Funding is a challenge – unfunded mandate – but some hospitals have been able to identify resources," another participant remarked. One approach to addressing the issues associated with financial constraints is to mobilize physicians and other allies to act as stakeholders and advocates of language assistance programs within health care organizations. One participant observed, "Physicians find it difficult when they do not have resources to communicate with patients who do not speak English… They feel frustrated. We had prominent physicians go to the CEO and to leaders and ask them to meet their needs."

In addition, the lack of systematic data collection in existing services presents another tremendous challenge. Without accurately tracking the growth of immigrant population in their serve catchment areas, providers are unable to identify potential increase and diversification of LEP patients' needs and create strategies to meet these needs. Data can also be used to assess the quality and safety issues in serving LEP patients. However, data collection incurs considerable financial and time commitments that many providers cannot afford. A participant pointed out, "Data collection is critical (to prove need), but the data collection process is very expensive. It is always a secondary function… Data collection also takes a long time." Some solutions have been proposed to resolve the tension between limited resources and the data collection needs. For instance, it was

suggested that implementing and developing data collection strategies might lead to more effective leadership buy-in if it can be framed as a business strategy. A participant with years of experience in language assistance shared her story: "From her standpoint (Vice president), it was a business decision… These are patients that can bring revenues. This is a market that we want to tap into… Hers was a business-oriented strategy….They (leaders) need to see past the initial expenses."

Moreover, in many health clinics, language access competes with other program areas and often times is simply not viewed as a priority of the service provider organizations, as confirmed by a participant, "One of the barriers is making this (linguistic access) just as important as other priorities." Among the recommendations surfaced from the discussion, the push to enforce regulations regarding implementing language assistance may lead to effective institutional adoption of language assistance as a priority area. According to one participant, "Regulations enhanced it (ability to provide language access). For us, we were always doing it ….the regulations helped us get quality indicators (related to language barriers), before it wasn't of importance, now it is."

Lastly, sharing best practices among service providers many also enhance leadership commitment to institutionalizing language access. Instead of perceiving providers as competitors, fostering collaboration among them can help utilize efficient and cost-effective means and approaches to offering language access, as concurred by one of the participants, "Share resources… not competition… We collaborate with other institutions by sharing interpreters and cost. "

Diversification of Work force in Language Access

Another factor that emerged from the discussion is the importance of a workforce that is racially and linguistically in concordance with the patient population. Diversification is not only good for increasing the market share of diverse patients but also critical for retaining diverse staff.

Three major barriers in this domain were identified and potential solutions provided. The most pressing barrier is the lack of qualified staff. According to the participants, there is a shortage of diverse and professionally trained staff that is able to perform health care interpreting. This observation was widely shared among the respondents, as one discussant voiced his frustration, "Everybody is looking for a diverse workforce, but it is very difficult because of shortages of that workforce." In addition to trained staff, there is also a shortage of linguistically competent volunteers or support staff, even in communities that experience rapid growth in immigrant population. One health care provider commented, "(It is) Hard to draw on the community for support staff when cost of living in the community is prohibitive to staff." In order to tap into the resources in the community, providers should conduct outreach programs in the community through advertising in ethnic newspaper or other forms of ethnic media. One participant shared her strategies: "Part of it is how you recruit diverse staff…Your recruitment strategies. Our HR is very creative. Advertise in ethnic newspapers, have relations with community-

based organizations, do employment trainings…. These training programs look for students they know we want to hire." Other organizations have implemented volunteer programs to capitalize on the potential of the community to provide language access, as one provider shared, "We have a volunteer program. We are reaching out to people in our community and to local schools to offer an opportunity to experience working in a hospital." On the institutional level, some policy measures aiming at diversifying the staff has been implemented. In one of the sampled health care clinics, the staff successfully convinced their chief operation officer to set hiring goals to increase the Spanish speaking staff by a certain percentage. In addition, securing Union support may also enable dual-role staff to play a larger role in serving LEP patients.

Secondly, even with bilingual or multi-lingual staff carrying out some interpreting functions in clinics, they find playing the dual-role both as provider and interpreter to be very demanding. In particular, compensation and time are the two most unfavorable factors in utilizing dual-role staff at clinics. For instance, one participant explained, "When we use staff with dual roles, we often face challenges. Compensation becomes an issue. Unions get involved and cases reach grievance points." In some provider organizations, finding backfill dollars and scheduling training of mainstream staff presents another key challenge. One participant in charge of her organization's language assistance program revealed, "Time…. No one has time. Every time I prepare a training (session), I have to have backfill dollars so that if I pull a nurse for 3 hours, I've got to put (another) nurse for 3 hours. Even with backfill sometimes, they say we're really busy. They just don't have time. Who's gonna do patient care while you're training?" To alleviate the tension between dual role challenges and shortage of time, participants suggested that emphasis should be put on regulations to make health care interpreting a regular component of the services rather than being conducted ad hoc. To that end, institutions should play a more active role in securing resources for and raise the awareness of language access, as a respondent concurred, "Institutions have different resources and different ways of accessing them. But I think it is important that providers get at least the minimum… when you do orientation with new staff." Another respondent commented, "Regulations may give us that back up to push our agenda…To say that language access is just as important as HIPAA, just as important as infection control…helps to get it on the agenda as mandatory orientation or mandatory refresher."

Lack of Integrated Information and Data Systems

There was a consensus among focus group attendees that information systems that systematically and consistently collect data and facilitate integration of demographic and outcome data need to be implemented and maintained to identify and address health care disparities. Numerous studies indicated that systematic collecting of a patient's race, ethnicity and language data is the starting point for hospitals who are interested in providing language access. But what research also documented is that this is an area where there is a need for improvement.[8] There is a lack of systematic collection of data and when data is collected, it is often fragmented and systems of data do not speak to

each other. As one physician pointed out, although some demographic data and linguistic data were collected at his clinic, these data cannot be integrated into the main data frame due to lack of capacity and expertise to update existing systems. As a result, this information cannot be fully utilized to inform decision making and reduce health care disparities based on language needs. To address these issues, it is critical to create an integrated data system that links demographic and outcome data to effectively monitor and record the dynamics in language access needs and provide appropriate language services accordingly.

Support Structures

Another common problem associated with inadequate provision of language access in health care has to do with the lack of clear policies, procedures and processes for language access that direct planning, set priorities and guide programming. For instance, insufficient staff training is often times due to inaccessibility of policy, as a participant remarked, "Policies are out there, but they are not easy to access. New staff needs training and education. Sometimes it breaks down and we do re-education when we find out where it breaks down." Therefore, it is important to strengthen communication channels across institutions to develop and implement strategies including "putting in place sufficient communication strategies to make sure that every staff member understands the policies and procedures."

Community Engagement

Lastly, it is also beneficial for providers to establish and strengthen partnerships and collaboration with community resources, diverse community members and ethnic community-based organizations (CBOs). However, due to vastly differently organizational cultures and limited resources devoted to community engagement, outreach to immigrant communities is fraught with cultural and linguistic barriers that impair the fruition of these efforts, as one participant shared his frustration, "It is not easy. People think it's easy but it is not." Another participant agreed, "If you do not have a full time person to do this (build community partnerships), it's really hard." "There are politics among organizations and within communities. There is often tension within groups that complicates partnerships."

To enhance health care provider organizations' community engagement, it was suggested that these organizations may wish to include community members on their board, and create and staff a community relations department that prioritizes community outreach as its core mission. Also, it may be beneficial if clinics can reach out to retired persons and stay-at-home moms in the community to utilize these untapped human resources in providing language access.

3.2 Health Care Interpreting Education: Core Competencies and Effective Instructional Methods

Creating a receptive environment within health care provider organizations is a critical step toward institutionalizing language access. Another key step is to establish a pool of well-trained, high quality interpreters who are linguistically and culturally competent in carrying out these services. The research literature and the survey of training programs nationwide suggest a lack of consensus among training programs and interpreters themselves with regard to what basic knowledge, skills and abilities should be included in their training and what constitute core competencies.

To help shed some light on these issues, we surveyed two cohorts of individuals from the field of health care interpreting who have direct experience in language access training or providing interpreting services to LEP patients. One cohort consisted of practicing health care interpreters and interpreters-in-training and the other cohort was comprised of health care interpreting trainers and curriculum developers. For the purpose of simplification, in the following section, the former cohort will be referred to as "trainees" and the latter cohort "trainers."

For purposes of the analysis, the competency items in both the Trainer Survey and the Trainee Survey were grouped into three general categories; Knowledge Base; Skill Base; and Professional Qualities and Behaviors

The knowledge base consisted of 41items that were categorized into five domains of knowledge:

(1) the context of health care interpreting: general, regulatory, and legal requirements;
(2) the health care interpreting profession;
(3) medical terminology and the human body;
(4) culture in health care; and
(5) language aspects of interpretation.

However, in the survey, the items were not grouped by category but rather were randomly listed so as not to encourage bias in answering. [9] Respondents were asked to check whether the item represented an area of knowledge that every beginning interpreter must know (necessary); whether they considered it to be good background information but not necessary for a beginning interpreter; or whether they thought it was important for advanced interpreters. Respondents were also given the option of answering that they did not understand what the item meant. Very few respondents checked this option.

The Skill Base category was classified into six topics as follows:

1) set expectations;
2) use different modes of interpreting/translation;
3) maintain accuracy and completeness;
4) manage the interaction;
5) address cross-cultural communication; and
6) behave ethically and make ethical decisions.

Professional Qualities and Behaviors consisted of a single category: Professional Attributes. The section of the survey focused on the skills base.[10] Respondents were asked to check whether the item represented a skill that every beginning interpreter needed to be able to do (necessary) or whether it was an advanced skill and not necessary for a beginning interpreter. Respondents were again given the option of checking that they did not understand what the item meant. Again, very few respondents checked this option.

This third category was developed after the survey had been administered. Two items, one from the knowledge base and another from the skill base, were moved to this category as they seemed to have a better fit with this category. These two items were: "importance of ongoing professional development," and "show respect for all parties in professionally and culturally appropriate ways."

In addition, in order to gain the perspectives of trainees on how they were taught, the survey asked respondents to judge the effectiveness of different instructional methods used by the training programs in which they participated or were participating, from "not effective at all" to "very effective in helping me understand and know what to do with confidence." This section consisted of items that reflected instructional methods used in training programs across the country. For this reason, respondents were given the option of checking that the training they took did not use a particular instructional method.

Lastly, open-ended questions were included to elicit more detailed information from respondents about the training program in which they had participated or were currently participating. Questions were asked about the adequacy of the program, the content taught, and the instructional methods.

3.2.1 Survey Respondents Profile

a) Trainee Survey

A total of 120 trainees responded to the Trainee Survey. Background information on the trainees was obtained in order to allow for a comparative analysis among trainees with different levels of educational experience, linguistic background, and experience as "dedicated/paid" or "volunteer" interpreters prior to entry into the training program.

Of the 120 trainee respondents, 76% were female; 50% were between the ages of 31 and 50; and a little over a quarter (28%) were in the 51-70 age range.

Table 2: Participants Gender

Gender	#	%
Female	91	75.8%
Male	27	22.5%
Transgender	2	1.7%
Answered question	120	100.0%

Table3: Participants Age

Age	#	%
18-30	25	20.8%
31-50	60	50.0%
51-70	34	28.3%
Over 70	1	0.8%
Answered question	120	100.0%

Among them, the majority were from a training program in upstate New York with 71 respondents (59%), 24 (20%) were from a New York City program that trained primarily dual role interpreters, and 25 (21%) were from other training programs. Since the 25 respondents from other training programs answered the survey through the internet, we have no information on where they received their training.

Of these respondents, 23% were born in the U.S; 43% had been living in the U.S. for 11 or more years, and 33% for 10 or less years. The largest linguistic group represented was Spanish (44%); the second largest represented Eastern European languages (24%). Half of the respondents had learned English in elementary school indicating that while a large number had not been born in the U.S., it is likely that many had come at an early age.

Table 3: How long have you lived in the United States?

	#	%
I was born here	**28**	**23.3%**
1-5 years	22	18.3%
6-10 years	18	15.0%
11-20 years	25	20.8%
More than 20 years	27	22.5%
Answered question	120	100.0%

Seventy-six percent of respondents reported that they had not received training in health care interpreting prior to taking the training they were using as their reference point for completing this survey. Of those that had had previous training, 36% reported having received training in medical/health care interpreting of 40-80 hours in length. In addition, 44% reported having completed courses related to health care prior to participating in the health care interpreter training program.

Among the 118 respondents who answered the question about the length of their basic training, 70 interpreters (59%) reported that their program consisted of 71- 80 hours, 15 (13%) reported 61-70 hours of training, and 13 (11%) reported that their training exceeded 80 hours. The percentage for those who reported less than 40 hours, exactly 40 hours, and between 41 and 60 hours are 1%, 9%, and 6%, respectively.

Table 4: How many hours of basic training did you receive?		
	#	%
Less than 40 hours	1	0.8%
40 hours	10	8.5%
41-60 hours	7	5.9%
61-70	15	12.7%
71-80 hours	**70**	**59.3%**
More than 80 hours	13	11.0%
Answered question	118	100.0%

Fifty-one percent of the trainee respondents reported that their training program included an internship or supervised on-the-job component. Ninety-seven percent reported having to take an exam at the end of the training. Of these, 96% indicated that their exam consisted of a written test, 48% indicated that it included a role play, and 9% indicated some other form of exam (e.g., clinical, telephone or computer testing of skills, a listening and oral exam, and a state medical interpreter certification that consisted of both written and oral components.)

Of 118 respondents, 69% reported that they had functioned as interpreters prior to taking the training; 22% had already worked as paid interpreters, either part time, full time or as freelance/independent interpreters; and 18% had done volunteer interpreting.

Forty-six percent of the respondents reported that they were currently working as paid interpreters, either fulltime (19%) or part time (27%). Another 27% were working as full or part time paid freelance/independent interpreters and another 22% served as dual role interpreters. This latter group can be accounted for by the fact that the New York City trainees participated in a training program designed to meet the needs of dual role interpreters.

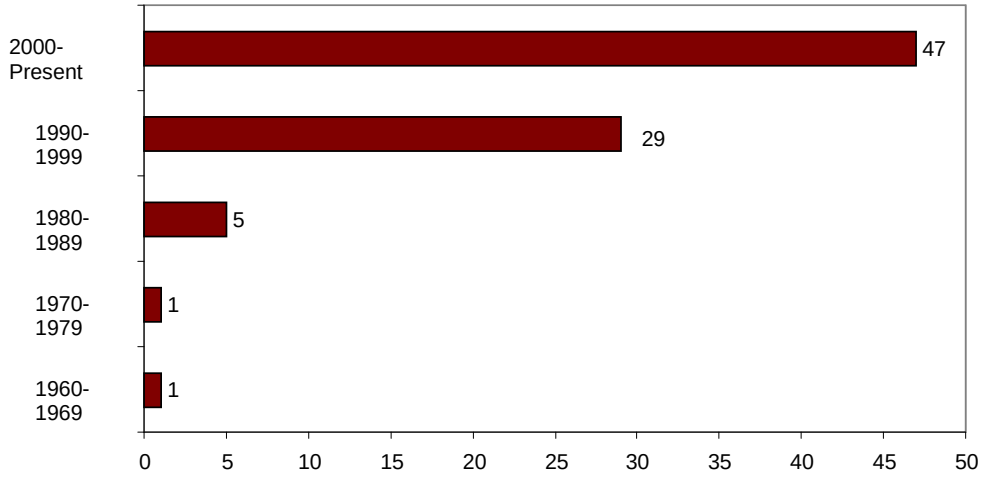
Since receiving the training, 40% estimated that they had done over 150 interpretations while 36% estimated having done only between 1 and 25 interpretations. This range in number of interpretations is due to the fact that some of the respondents had received their initial training 10 or more years ago while others were still in training.

b) Trainer Survey

In the trainer survey, information about the available training programs was collected. A total of 101 trainers responded to the survey. [11] As Figure 2 shows, most programs are recent arrivals on the scene of health care interpreting. The majority of the programs (47) were established recently in the 2000s. Twenty-nine programs were established in the 1990s, while only five were established in the 1980s. A total of 85 responses were

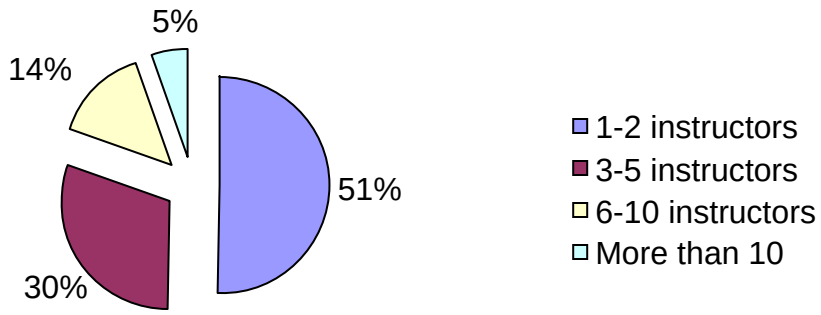
received for the question, “how many interpreters have you trained since the inception of your program?” Sixty-six survey participants trained from eight students to over 2000 students, while eight said they had not trained any students yet since their program had just started. Eleven programs responded that either information was not available or their responses were not specific enough to account for.

Figure 2: When training programs were founded



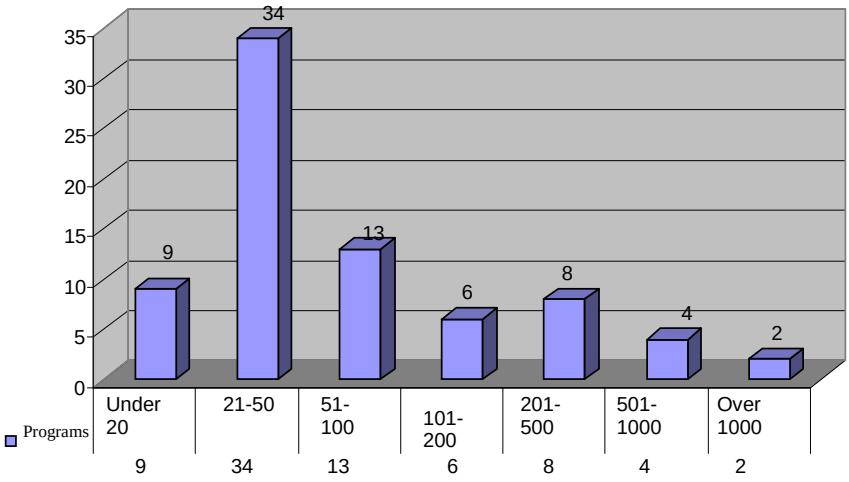
In terms of the number of instructors employed by training programs, eighty-four responses were received in reply to the question of how many instructors are employed by the training program. Seventy-six training programs employed from one to more than 10 instructors. As Figure 3 shows, most responding programs (51%) employed from one to two instructors, while 30% employed three to five instructors. Three programs indicated that they did not have instructors at the time of completing the survey since they were just starting their program. Five programs gave non-specific answers.

Figure 3: Number of Instructors by Training Programs



Among the training programs, 34 programs (45%) provide trainings that range from 21 to 50 hours. Thirteen programs or 17% provide trainings that range from 51 to 100 hours. Nine programs (12%) provide trainings that are under 20 hours. Eight programs or 10% provide trainings ranging from 201 to 500 hours. Those programs providing 501 to 1000 hours were 5% of responding programs. Four programs (2%) provided the longest trainings of over 1000 hours.

Figure 4: Hours of Training Provided by Training Programs



3.2.2 Consensus Building: Core Competencies

The results from the survey of both trainers and trainees suggest that although the perception of or belief in a number of knowledge, skill and professional attribute items on

the survey is conditioned on factors associated with the program type, duration, number of trainees graduated, prior experience in interpreting, and language capabilities, there is considerable consensus that exists between trainers and trainees regarding what constitute a set of core competencies that should be taught in all health care interpreting training programs and utilized by all qualified health care interpreters.

In the next sections, we will provide a detailed discussion about the similarities and differences in opinion and attitudes in relation to survey respondents' characteristics and how they influence the respondents' rating and raking of the competency items.

Trainees' Perspective

Ranking the knowledge items in order of the highest percentage picking an item as necessary for every beginning interpreter irrespective of domain shows that the majority of items that were picked by 90% or more of the respondents were in Domain 2: The Health Care Interpreting Profession (See Appendix C). These items have to do with knowledge of the responsibilities and boundaries of the role; the Code of Ethics for Health Care Interpreters and specific principles of the code such as confidentiality, advocacy, and transparency; the difference between interpreting and translating; and the difference among the functions that an interpreter might perform (e.g., conduit, cultural broker).

Among those items picked by 90% or more of the respondents as necessary for beginner interpreters only three were not in Domain 2. Two of the items were in Domain 3: Medical Terminology and the Human Body and specified the need for knowledge of the names of major body parts in both languages and of other medical terms (e.g., diseases, specialties, treatments) related to the major body systems. Both these items are integral to the content of health care interpreting. The third item recognizes the need to understand the difference between true and false cognates, an aspect of language (Domain 5) that can sometimes lead to serious errors in interpretations.

The next tier of items – those items that were picked by 80-89% of the respondents as necessary for a beginner interpreter – included items primarily from Domain 4: Culture, and Domain 5: Language. Only two items from Domain 1 showed up in this tier. These two items have to do with legal and liability considerations related to confidentiality and mandated reporting of information and with HIPAA rules and regulations. Both these items have direct ethical implications that are at the core of Domain 2. An item from Domain 2: the Healthcare Interpreting Profession also showed up in this tier. This item has to do with the responsibilities of dual language interpreters.

Finally, the last tier of items – those picked by 79% or fewer of the respondents - included mostly items from Domain 1: The Context of Healthcare Interpreting. Only one item outside this domain showed up in this tier. This item – how the profession of health care interpreting developed – had been categorized under Domain 2 but, in retrospect, can be seen as a context setting item.

Another way of looking at these data highlights the order of importance of the domains from the perspective of trainees. Trainees perceived that the most necessary knowledge they needed focused both on developing a solid knowledge of the terminology that was required and grounding themselves in a sound understanding of the role of the health care interpreter as a professional (Domains 3 and 2). Next, they perceived the importance of understanding key aspects of language (Domain 5), and how culture influences health care and the transmission of meaning within the health care setting (Domain 4). The items in both these domains highlight areas of knowledge that have a direct impact on how the interpreter performs while in the interpreting encounter. Knowledge of the context of health care interpreting (Domain 1) for the most part was seen as good background information but not necessary for beginning interpreters or appropriate for more advanced interpreters.

An analysis of trainee responses by key trainee characteristics was also done to see whether these characteristics were related to how the trainees thought about the knowledge base. The key characteristics that were looked at were number of training hours received, whether or not the trainee had had previous training in health care interpreting, whether or not the trainee had taken other relevant courses, and estimated number of interpretations the trainee had done. While there were no marked differences across the items, several interesting variations were noted.

Trainee Characteristics and Perception of Core Competencies

Regarding the relationship between trainees' ranking of knowledge-base items and the number of hours of basic training they received, the chi-square test results show that in most cases no statistically significant correlations were found. Only in 4 items were respondents' perceptions significantly related to the duration of basic training they received: (1) Patient responsibilities in their own health care ($p < .05$); (2) Help facilitate communication between patient & provider when values clash ($p < .01$); (3) Analyze situations and make linguistic decisions such as register, tone, etc. ($p < .05$); and (4) Interpret in the mental health setting ($p < .05$). The findings suggest that the longer the training, the more value respondents place on these competency items.

With regard to the relationship between respondents' core competency choices and whether or not they had received previous training, the test results show that trainees' experience with previous training significantly affects their perception of the following competency items: (1) the meaning of interpreter confidentiality ($p < .05$); (2) how stereotypes and prejudices can influence behavior and communication ($p < .05$). The findings suggest that the respondents who have more experience with previous training are more likely to place a higher value on these competency items.

In addition, a higher percentage of trainees who had had previous training in health care interpreting than those without indicated that the following context items (Domain 1) were necessary for beginning interpreters: insurance and referral procedures, and the implementation and enforcement of CLAS standards. Other items that received higher

percentages from trainees with previous training were: responsibilities of a dual role interpreter, understanding your own cultural heritage, and end of life issues.

Taking relevant courses prior to the training also affects how trainees perceive core competency. When responses were examined in light of whether or not trainees had prior exposure to relevant courses, a higher percentage of trainees who had taken relevant courses indicated that knowledge of legal and liability considerations related to confidentiality and mandated reporting were necessary. Other items considered necessary by a higher percentage of this group were: insurance procedures, medical terminology related to major body systems, and knowing our own cultural heritage. The chi square test results suggest no statistically significant correlation in most of the cases except in the following items: (1) the culture (values & beliefs) of the U.S. health care system (biomedical model) ($p < .05$); (2) your own cultural heritage and how it affects your thinking and behavior ($p < .05$); (3) HIPAA rules and regulations ($p < .01$); (4) medical terminology related to major body systems (e.g., diseases, specialties, and treatments) ($p < .05$); (5) legal and liability considerations related to confidentiality and mandated reporting of information ($p < .01$).

Finally, when responses were looked at by estimated number of interpretations, Domain 1 showed the greatest variation by group with lower percentages for those who had had no experience and those with more experience possibly indicating that those with no experience were more concerned about the basics of interpreting than they were with contextual information, while those with more experience realized that such knowledge was not essential. The chi square test results show that trainees who had performed more interpretations tend to identify the following items as core competencies: (1) importance of on-going professional development ($p < .05$); (2) legal foundations of linguistic access in health care ($p < .05$); (3) referral procedures for in-hospital services ($p < .05$); (6) maintain completeness in converting messages from one language to another ($p < .05$); (7) maintain neutrality and not impose personal beliefs, judgments or values into your interpretations ($p < .05$); (8) interpret in the simultaneous mode ($p < .01$); (9) translate written materials such as informed consent forms ($p < .05$); (10) interpret in the mental health setting ($p < .05$).

Comparisons across different respondents' characteristics tend to show that interpreters with more experience on a number of dimensions tend to perceive the importance of certain knowledge items differently than trainees with less experience. Many of these knowledge items picked as important by experienced interpreters tend to be of a more contextual nature.

Analysis of the items in the Skill Base category indicates that respondents perceived all except four of the 30 items as necessary for beginner interpreters. The majority of items that had 90 or more percent of respondents identifying them as necessary can be described as skills that assure accuracy, including correcting errors and attending to cultural meanings. Other items focused on the role of the interpreter, including setting the parameters of the interpreter role and maintaining neutrality. Items that were chosen by 80-89% percent of the respondents as necessary tended to be skills that required subtler

and more analytic skills such as such as facilitating communication when values clash, advocating, and assisting with the negotiation of meaning where there is a lack of equivalence.

Also included in the list of skills were items that addressed different modes of interpreting (consecutive, simultaneous, and sight translation), translation skills (of complex, 'legal' documents as well as short instructions), and the ability to interpret in two types of settings that are often mentioned by interpreters as posing unique challenges (emergency room and mental health). Of these skills, those that were considered necessary for beginning interpreters by the highest percentage of respondents were the following: the ability to interpret consecutively (92%); translating short instructions (96%), and interpreting in the emergency room (86%). The other skills received lower percentages showing that at least a fourth to a third of the respondents perceived these as more advanced skills. These included: interpreting in the simultaneous mode, sight translation, and translating written materials such as informed consent forms.

In the area of the skill base, little variation was found in the responses across different demographic characteristics. The only item that showed some variation was on the skill: translate written materials such as informed consent. Lower percentages identifying this as an essential skill were found among those with no interpreting experience and those with the most interpreting experience. While the Trainee Survey did not explicitly set out to identify core competencies in the category of Professional Qualities and Behaviors, two items from the survey were later re-classified into this category.

Trainers' Perspective

Appendix D lists the core competencies in descending order starting with items identified as a core competency by the largest percentages of trainer/curricular developer respondents. Shown in red are items that received 50% or higher. Items shown in green are items that received less than 50% of respondents' votes and items shown in orange are competencies identified as "other" in an open-ended question which asked respondents to list competencies that were not included on the list.

We examined the similarities and differences in the beliefs about interpreter competencies held by respondents from different types of training programs. There were six different types of training programs in our sample: (a) hospital/clinic-based; (b) university/college-based; (c) community-based/nonprofit; (d) for profit/independent consultant; (e) state/county government; and (f) partnership/combination of different organizations.

Regarding the relationship between program type and the respondents' rating of knowledge, skill and professional qualities items, the Fisher Exact test results show that program type is not a significantly linked to the respondents' perception of core competencies. This suggests that there is considerable consensus among trainers across

all settings about which areas of knowledge or skills constitute a set of core competencies.

The authors also ran a Spearman's rho to investigate the differences and similarities in responses by length of training in hours, size of the training program staff, and by number of interpreters trained.[12] With regard to the relationship between hours of training and core competency choices, in most cases no statistically significant correlations were found. There were, however, two exceptions. First, for the competency item "Understand the challenges of assuming dual roles," i.e. serving as an interpreter as well as a healthcare provider/worker at the same institution, there is a negative correlation between training hours and core competency choice ($p < .01$). Respondents whose organizations provide longer training programs less frequently recognized "Understanding of the dual role challenge" as a core competency than those with shorter training programs. A similar relationship is observed for the competency item "Understand and describe the interpreter role as a cultural broker." Programs with more training hours less frequently perceived "Understanding of the cultural broker role as a core competency" ($p < .05$).

As for the relationship between the size of the training program staff and competency choices, in most instances, the size of a training program staff is not related to core competencies. However, for two competency items: "Explain and apply the principles of honesty, integrity, professionalism, and accountability" and "Exhibit abilities to sight translate documents, including patient's informed consent"; staff size is negatively and significantly related to the responses. Programs with a larger instructional staff tended to discount the idea that these two items are core competencies ($p < .01$; $p< .05$, respectively).

Regarding core competencies in relation to the number of interpreters trained by programs, four competency items were found to be significantly and positively related to the number of trainees: (1) Understand potential conflicts of interest and recognize when to withdraw from assignments ($p < .05$); (2) Demonstrate ability to balance values of the U.S. healthcare system and cultural values, such as patient's beliefs about individual autonomy and the right to know ($p <.05$,); (3) Show knowledge of institutional barriers that prevent people from accessing services ($p < .01$); and (4) Recognize and exercise appropriate interventions, strategies and techniques to address bias, prejudice and discriminatory practices ($p < .05$).

These results suggest that those respondents who reported to have trained more medical interpreters tended to perceive the four items listed above as core competencies that are critical for all medical interpreters.

3.2.3 Instructional Methods

As the trainer survey results suggest, pedagogical practices used by 50% or more of trainers surveyed include class discussions, role playing, educational materials, i.e. text books, articles, etc., case examples, student-centered instructions, memory development exercises, in-class practice sessions with same-language facilitators, self-evaluation, sight

translation exercises, terminology games/contests, peer evaluation, shadowing (accompanying a trained healthcare interpreter on the job to observe interpreting medical encounters). Other instructional methods among programs included in our samples include accuracy drills, live recording, listen-ins, journaling and trigger tapes. Additional methods include mandatory practicum in the community with evaluation tools, simulations, in-person assessment by professionals in the field, seminar conducted by professionals addressing the particular culture and health terminology used in various countries as well as the cultural diversity within the Spanish-speaking world. Approaches such as digital audio recordings, customized for individual languages/level, applied learning, graphic organizers, student-created role-plays, word-building games, glossary-quiz games, working glossary memorization and taped oral exams (based on pre-translated written scripts) were reported to have been employed in health care interpreting training programs.

Greater emphasis on training effectiveness was given to trainees who either have completed training or were receiving training at the time of the survey. Appendix D shows the responses to two of the answer choices on instructional methods: "Helped me understand and gave me some idea of what to do" and "Very effective in helping me understand and know what to do with confidence." The percentages in this table were calculated after eliminating those responses indicating that the training program in which the respondent participated did not use that particular method. This was done in order to get a more accurate picture of which methods were perceived as most effective by those who had actually experienced a particular method. The items are listed from highest to lowest percentage on the choice "very effective in helping me understand what to know and what to do.

The results show that 70~84 percent of trainees regarded as effective those instructional methods that brought the "real world" into the classroom through role plays and case scenarios, and that exposed them to professionals in the field. A large percentage of respondents also found instructional strategies that provided them with feedback and opportunities for error analysis to be very effective. Some drill type activities (i.e., terminology building exercises and message conversion practice drills) were also perceived as effective but other types of drill activities such as memory and note taking exercises were not perceived to be as effective.

Appendix F also shows that all the instructional methods listed were reported as used in one training program or another although not all the methods were used in all the programs or iterations of the program. It should also be noted that a review of the two training programs in New York state indicated that these training programs did not remain static but rather evolved over time not only in terms of the content that was included but also in terms of the instructional methods used. As a result, two trainees from the same program could have given different answers about the instructional methods they participated in because they took the training at different points in time. It is likely that this is true for most training programs.

Providing an internship is one of those instructional methodologies that seems to demonstrate this evolution over time. It appears that, at least from information gathered on one of the training programs, the inclusion of a formal internship evolved as the number of training hours increased. Hence we find that of the respondents to this survey, 48% report that their training program did not include an internship even though we know that the two training programs from which most of the respondents come currently have some form of internship experience.

Responses to the open ended questions and interviews conducted with the trainees verified the findings on the instructional methods and offered further insight into what the respondents thought were most important in helping them gain the confidence to function as professional health care interpreters. Irrespective of the way the question was asked – what were the three most effective instructional strategies, what did you want to have emphasized more, and what would you suggest to improve the training – the responses highlighted the importance of hands-on, practical, and practice-oriented learning activities that simulated or exposed trainees to what it was like in "real-life situations."

Role plays were mentioned repeatedly and frequently as an effective tool that provided opportunities for trainees to practice linguistic conversions, managing the flow of communication, and using other skills that helped them maintain accuracy. In fact, many of the respondents suggested that more time be given to role plays and other techniques that exposed them to real life situations such as watching and analyzing videos of real interpreting encounters, discussing and analyzing case scenarios of real situations faced by interpreters, hearing from experienced interpreters, and shadowing experienced interpreters. A number also expressed the desire to have more contact with health care providers while in training through their participation in role plays in class, by visiting and observing providers at work in health care facilities, and, in general, having more direct exposure to the health care setting.

In addition to stressing the importance of role plays in learning how to handle real-life situations and practice interpreting "in-situ", these trainees also recognized their value in providing them with feedback. Respondents both acknowledged the effectiveness of various opportunities given them to analyze errors they and their fellow trainees made and suggested that more such opportunities be provided through the use of audio and video recordings of their interpretations.

Another set of instructional methods that were reported as effective were exercises, drills, and quizzes that focused on building knowledge of medical terminology and relevant vocabulary. Having the opportunities and the time to build such knowledge was cited by many of the respondents as positive. A number of respondents also highlighted the value of having materials, such as notes and visuals, that they could take home to review during the training program as well as later on when they were already working. Several mentioned that they liked having scripted role plays that they could work on at home to practice their conversion skills and to figure out different ways of saying the same thing. More conversion drills were also suggested by a number of respondents

The interviews brought up an interesting dilemma for training programs: how to accommodate the wide range of English language proficiency and background knowledge about the different systems of the human body and the U.S. health care system among trainees. This dilemma was also reflected in a number of responses to the question "What could have used less time."

With respect to English language proficiency, those who were proficient observed that some members of their class needed more assistance in improving their levels of English proficiency both to ensure accuracy in interpreting and to ensure comprehension of what was being taught in class. Some indicated that screening for fluency in both languages should have been done or adhered to more carefully so that less time could have been spent working on language issues during the training. On the other hand, those who acknowledged that they needed to improve their English proficiency wished for more assistance not just in learning English but also in improving their accent and pronunciation. Several suggested that tape recordings of interpreter encounters, language drills, and recordings of their own role plays could have helped. A number of suggestions requested bilingual coaches, coaches in each of the languages, or a core of trainees in their class who spoke the same language. Related to the issue of language fluency, shadowing, in the sense of repeating exactly what is said in the same language, was mentioned by a number of respondents as an effective tool to gain fluency.

A similar dilemma was highlighted in the interviews with respect to level of background knowledge on the functions of the human body and basic understanding of related diseases and medical specialties. Those who came with background knowledge thought that less time could have been spent in this area and more time given to actually practicing interpreting and related skills. Those who had little or no background knowledge wanted more.

In general, trainee respondents were pleased with the training program in which they participated. They reported that each phase of their program, whether it was the pre-screening session, the classroom work, an internship, or the final exam, made them feel better prepared and more confident in performing the role of interpreter.

Although a number of respondents misunderstood the question about the value of the pre-screening and answered it in terms of the impact of the training on their development as interpreters and English learners, several highlighted the importance of the pre-screening in helping them understand the need for bilingual fluency or decide whether or not they had the language skills to continue with the course. Others mentioned that the pre-screening served as a self-assessment of their language skills or gave them a better understanding of the importance of the interpreter role.

The classroom training was seen as a confidence builder by providing the trainees with opportunities to learn and practice the necessary skills, develop their knowledge of the "rules" of health care interpreting, and develop an appreciation for the "seriousness" of the job. One respondent made the comment: "I learned about the mistakes I was making and so I won't repeat them." Other respondents acknowledged the apprehension they had

about their abilities when they first started but the classroom work helped them "gain the necessary skills (such that) uncertainty about my ability faded."

The internship was found to provide an opportunity to practice and confirm what had been learned in the classroom, to gain exposure to the real setting, and, again, to build confidence. Finally, the exam confirmed what had been learned and further boosted confidence that they were prepared to do the job.

3.3 Limitations

Due to the limitations of the research design, this study did not allow us to address issues related to training program design or required instructor qualifications. We found that survey participants utilized and participated in programs that have a wide range of program designs. Since we are unable to measure the effectiveness of different program designs, we are unable to offer guidance on these aspects of healthcare training programs.

The study also did not delve into the language skills that interpreters must possess in the languages they use. It did not examine the language screening that must take place before a student is accepted into an interpreter training program to ensure that they are truly language proficient or to establish what the minimum level of proficiency is in either language to ensure intelligibility and accuracy. These are key issues that need to be addressed in future research.

Another related aspect which was beyond the scope of this study is the level of formal education required for healthcare interpreters to effectively meet the demands of the job. We believe that the question of the relationship between formal education and the demands of healthcare interpreting needs to be further investigated. There is evidence to show that many interpreters, such as those from linguistic communities where, because of political upheavals, formal education has been disrupted or who come from communities with different traditions for education, have developed these skills without the benefit of formal education.

Core competencies can help healthcare professionals identify job responsibilities and duties that should be included in advertisements and vacant positions, determine minimum requirements for screening applicants, and set performance standards and evaluation criteria. Core competencies can also help interpreter trainers determine training content and methods of training, and design assessment tests to measure effectiveness of the training, the next study should validate the perspectives of those experts by conducting a job analysis of healthcare interpretation. A job analysis will affirm the knowledge, skills and attitudes (KSAs) directly related to performance on the job. This systematic process will build on this study by documenting and analyzing information about the content, context, and requirements of the job. It will provide evidence of the relationship between the tasks performed on the job and the competencies/KSAs required to perform the tasks.

4. Core Competencies of Healthcare Interpreters

The following section list the Core Competencies identified in this study for healthcare interpreters.

Core Competencies for Healthcare Interpreters

KNOWLEDGE BASE

Domain 1: The Context of Healthcare Interpreting: General, Regulatory and Legal Requirements

General Requirements	• Demonstrate basic knowledge and understanding of the U.S. health care system; including public benefits, insurance procedures and insurance terminology, as well as referral procedures of in-hospital services. • Show knowledge of institutional barriers that prevent people from accessing services.
Regulatory Requirements	• Demonstrate awareness of standards pertaining to delivering culturally and linguistically appropriate health care (CLAS standards) and awareness of standards pertaining to the provision of linguistic access, including how CLAS standards are implemented and enforced. • Understand the Patient's Bill of Rights and demonstrate knowledge of patient responsibilities.
Legal Requirements	• Understand and recognize legal and liability considerations of maintaining confidentiality and addressing situations of necessary information disclosure; including confidentiality and mandated reporting information [Mandated reporting of information – federal, state, organization]. • Demonstrate knowledge of HIPAA laws and their application in the medical interpreting profession. • Understand the general legal parameters of linguistic access including local, state and federal legislation

KNOWLEDGE BASE

Domain 2: The Healthcare Interpreting Profession

Interpreter Role & Responsibilities	• Understand and describe the core interpreter functions and the following functions often performed by interpreters: conduit who gives voice to every word said by each party; clarifier who intervenes to verify and validate understanding; and, cultural broker who bridges the cultures of both parties and facilitates deconstruction of cultural misunderstanding. • Understand principles of advocacy and when to utilize advocacy to protect individuals from harm and avoid mistreatment and abuse. • Recognize the importance of maintaining faithfulness to meaning, including offensive content • Understand the concept of transparency in the clinical encounter. • Understand the challenges of assuming dual roles; i.e., serving as an interpreter as well as health care provider/worker at the same institution.
Interpreter Standards and Boundaries	• Recognize the ethical principles in the Code of Ethics and the Standards of Practice of the National Council on Interpreting in Health Care. • The meaning of interpreter confidentiality. • Understand potential conflicts of interest and recognize when to withdraw from assignments.

KNOWLEDGE BASE

Domain 3: Medical Terminology & Understanding the Human Body

Medical Terminology **Understanding the Human Body**	• Demonstrate knowledge of key medical terms related to the basic systems of the human body, including related diseases, specialties, and treatment and human anatomy and physiology. • Show knowledge of medical equipments, tests, medication categories. • Understand the building blocks of medical terminology – e.g., suffixes, prefixes. • Demonstrate knowledge of basic anatomy and physiology including an understanding of the major body systems and their functions.

KNOWLEDGE BASE

Domain 4: Culture

Intersection of culture and healthcare	• Understand the concept of culture and how it affects health care. • Demonstrate knowledge of one's own cultural heritage and how it affects one's thinking and behavior. • Show knowledge of how personal biases and stereotypical attitudes and prejudice can influence interaction and communication. • Demonstrate knowledge of the cultural heritage, values, world views, healing practices, family structures, hierarchies, community characteristics and beliefs of the groups for whom interpreting is provided and how they may influence the medical encounter. • Demonstrate an understanding of the connection between the language and the culture of the speakers of the language. • Understand the biomedical culture (values and beliefs) of the U.S. health care system and how it differs from traditional medicine. • Understand the cultural challenges that end-of-life issues, such as proxy, living will, advanced directives, can raise. • Understand how different levels of acculturation can cause different cultural challenges for the particular groups served.

KNOWLEDGE BASE

Domain 5: language

Linguistic Techniques	• Understand the difference between true and false cognates (words in different languages that are or appear to be related in meaning) • Demonstrate basic understanding of the structure of language (e.g., grammar, how words are constructed, word order, etc.) • Demonstrate understanding of different aspects of language fluency (accents, register, etc.) • Recognize colloquial expressions used in medicine as well as common acronyms • Demonstrate awareness of regional differences/dialects in the interpreter's language pair.

SKILL BASE

Use protocols of medical interpreting	• Introduce oneself in culturally appropriate ways. • Introduce the role of the interpreter in a variety of situations (e.g., provider in a hurry, complete introduction, abbreviated introduction]. • Utilize proper positioning, gaze, and intervention strategies
Use different interpreting & translating techniques	• Demonstrate ability to interpret in consecutive mode. • Ability to translate materials such as informed consent, discharge instructions and medications instructions stated and explained by health care providers.

Maintain accuracy and completeness	• Demonstrate ability to convert a spoken message in one language into its equivalent in a second language without changing the meaning, adding, omitting or substituting. • Recognize mistakes and correct them appropriately. • Utilize strategies to ensure accuracy by asking for pauses or clarifications. • Utilize memory enhancing tools such as note taking. • Ask for clarification in culturally appropriate ways. • Demonstrate ability to analyze the situation, make linguistic decisions and include paralinguistic elements central to conveying equivalence in meaning of the message (e.g. register, style and tone.) • Demonstrate ability to interpret difficult and/or offensive messages fully and accurately

SKILL BASE

Manage the Interaction	• Demonstrate ability to effectively manage the flow of the communication • Exhibit ability to maintain patient privacy and autonomy through proper positioning and facilitating direct communication between patient and provider.
Address cross-cultural communication	• Demonstrate ability to assist provider and patient in understanding cultural issues, clarifying misunderstandings. • Exhibit skill of negotiating the meaning of words and ideas that do not have equivalence in the other language, (culturally bound terms such as idioms, sayings, slang and some technical terminology) • Ability to support patient autonomy and the right to know while respecting the patient's cultural values and belief systems.

Behave ethically and make ethical decisions	• Maintain neutrality/impartiality and refrain from passing judgments or interjecting personal beliefs, values or advice.

PROFESSIONAL ATTRIBUTES

Professional Qualities & Behaviors	• Exhibit ability to respect the dignity of all parties in professional and culturally appropriate ways • Demonstrate ability to respect patient independence • Act in accordance with the principles of honesty, integrity, professionalism, and accountability
Self - Development	• Understand that continuing education and self development are needed to continue to improve performance • Recognize signs of "professional burnout" and demonstrate knowledge of mitigating strategies • Describe relaxation, concentration and stress management techniques

APPENDICES

Appendix A: Trainer/Curriculum Developer Survey

Dear Colleague:

New York State Department of Health, in collaboration with the Center for Women in Government & Civil Society, University at Albany, the Education Development Center and the National Council on Interpreting in Healthcare, are sponsoring a nationwide scan of healthcare interpreter training programs. Please take the time to complete this survey to assist us in identifying medical interpreter core competencies that can be incorporated into your basic interpreter training program as well as the pedagogical tools you use in your trainings.

This information will be instrumental in advancing the medical interpreter profession and professionalizing the field by providing a foundation for the healthcare interpreter professional's education and development. the core competencies are not intended to represent all healthcare interpreter knowledge and skills. Rather, they are intended to represent basic skills and core competencies that all healthcare interpreters must know and be able to do.

As a token of our appreciation, we will send you a final report of study findings. Thank you for participating in this important study. The survey will take approximately 10 minutes to complete. We assure you that the identities of all programs participating in this survey will remain anonymous in all public documents. Should you have any questions please contact Dina Refki at 518.442.5127 and DRefki@albany.edu.

Participation in the survey is limited to individuals 18 years and older. By checking this box, you are providing your informed consent and confirming that you are 18 years and older.

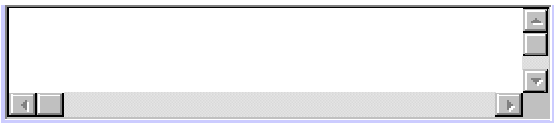
□Yes, I agree to participate in the survey.

A. Please check ONLY the learning objectives you believe are minimally required for appropriate and effective healthcare interpreting and must be incorporated in all basic training programs as "Core Competency" requirements.

	Core Competency
1. Recognize the importance of maintaining faithfulness to the meaning, including offensive content.	
2. Display ability to render the message accurately without adding, omitting, or substituting.	
3. Demonstrate ability to include paralinguistic elements central to conveying equivalence in the meaning of the message (e.g. register, style, and tone).	
4. Recognize the responsibility of the interpreter to advise parties that everything said will be interpreted.	
5. Demonstrate ability to effectively manage and facilitate the flow of the communication.	
6. Recognize one's own mistakes and correct errors in interpretation.	
7. Recognize and demonstrate ability to maintain transparency in the clinical encounter.	
8. Demonstrate ability to maintain professional neutrality, refrain from personal judgment and from imposing one's cultural values.	
9. Understand potential conflicts of interest and recognize when to withdraw from assignments.	

10. Demonstrate ability to analyze situations and take action based on established National Code of Ethics for Interpreters when appropriate.
11. Exhibit ability to respect the dignity of all parties in professional and culturally appropriate ways.
12. Demonstrate the ability to respect patient independence.
13. Understand the scope, limits and boundaries of the interpreter role.
14. Understand the challenges of assuming dual roles; i.e. serving as an interpreter as well as a healthcare provider/worker at the same institution.
15. Explain and apply the principles of honesty, integrity, professionalism, and accountability.
16. Understand principles of advocacy and when to utilize advocacy to protect individuals from harm, and avoid mistreatment and abuse.
17. Describe and be able to apply conflict resolution strategies.
18. Demonstrate ability to balance values of the U.S. healthcare system and cultural values, such as patient's beliefs about individual autonomy and the right to know.
19. Demonstrate an understanding that a language reflects the culture of the speakers of the language.
20. Demonstrate ability to convert a spoken message in one language into its equivalent in a second language without changing the meaning.
21. Demonstrate ability to work with "un-interpretable" and culturally-bound terms such as idioms, sayings and slang that lack equivalent terms in the target language.
22. Utilize note taking strategies to ensure accuracy.
23. Utilize strategies to ensure accuracy by asking for pauses or clarifications
24. Utilize protocols of medical interpreting including positioning, gaze, intervening, introductions, and pausing.
25. Demonstrate knowledge of all 14 standards for delivering culturally and linguistically appropriate health care (CLAS standards) and strong knowledge of standards pertaining to provision of linguistic access.
26. Understand how CLAS standards are enforced and the limitations associated with their implementation/ application,(e.g., poor enforcement, limited funding, high costs of services.)
27. Recognize the 9 ethical codes of the National Council for Interpreters in Healthcare for delivering culturally and linguistically appropriate health care.
28. Demonstrate knowledge of one's own cultural heritage and how personal biases and stereotypical attitudes can influence interaction and communication.
29. Demonstrate the ability to assist the provider and patient in negotiating cultural issues or differences that arise, and alert all parties to any significant cultural misunderstanding.
30. Display knowledge of how differences and one's position as a member of the non-majority can affect one's access to healthcare.
31. Exhibit openness to different worldviews and demonstrate knowledge of the cultural heritage, values, and trends of the groups served.
32. Demonstrate knowledge of family structures, hierarchies and community characteristics that may influence the medical encounter.
33. Show knowledge of institutional barriers that prevent people from accessing services.
34. Recognize and exercise appropriate interventions, strategies and techniques to address bias, prejudice and discriminatory practices.

35. Display professional neutrality with different religious and spiritual beliefs/customs relevant to the health care encounter, and exhibit appreciation for indigenous help-seeking practices.
36. Demonstrate knowledge of key medical terms related to the basic systems of the human body including related diseases, specialties, and treatment, human anatomy and physiology.
37. Recognize colloquial expressions used in medicine as well as common acronyms and initialisms.
38. Understand the biomedical culture and how it differs from folk medicine.
39. Demonstrate basic knowledge and understanding of public benefits and the U.S. health care system.
40. Display knowledge of patient's responsibilities.
41. Describe and explain the Patient's Bill of Rights.
42. Exhibit abilities to sight translate documents, including patient's informed consent.
43. Understand end of life issues including the concepts of proxy, Living Will and advanced directives.
44. Understand and be able to explain the insurance system and referral procedures.
45. Understand and be able to explain the health and health-related needs of the Limited English Proficient population served.
46. Identify issues of access to health care for the Limited English Proficient patient populations.
47. Understand the general legal parameters of linguistic access to healthcare, including U.S. legislation (local, state and national).
48. Identify and be able to explain the general healthcare industry strategies and practices to bridge the language gap.
49. Understand levels of acculturation and cultural challenges for the particular groups served.
50. Identify and apply quality control strategies and performance improvement techniques, including self evaluation and feedback.
51. Demonstrate understanding that continuing education and self-development are needed to continue to improve performance.
52. Recognize signs of "professional burn out" and demonstrate knowledge of mitigating strategies.
53. Describe and be able to apply relaxation, concentration and stress management techniques.
54. Identify definitions of success and one's work expectations.
55. Understand and describe the interpreter role as a conduit.
56. Understand and describe the interpreter role as a clarifier.
57. Understand and describe the interpreter role as a cultural broker.
58. Understand and describe the interpreter role as an advocate.
59. Demonstrate knowledge of HIPPA laws and their application in the medical interpreting profession.
60. Understand and recognize legal and liability considerations of maintaining confidentiality and addressing situations of necessary information disclosure.
Please add learning objectives that were not included above, yet should be considered core competencies:



Check all the pedagogical tools and teaching strategies you use to impart the learning and achieve the objectives:

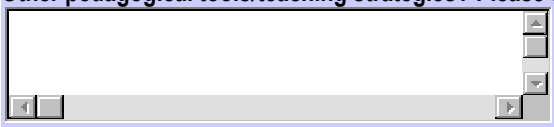
- ☐ Student-centered instructions
- ☐ Class discussions
- ☐ Case examples
- ☐ Memory development exercises
- ☐ Note taking exercises
- ☐ Shadowing (accompanying a trained healthcare interpreter on the job to observe interpreting medical encounters)
- ☐ Role playing
- ☐ Video analysis
- ☐ Educational materials, i.e. text books, articles, etc.

- ☐ Guest speakers
- ☐ Journaling
- ☐ Error analysis
- ☐ Self evaluation
- ☐ Peer evaluation
- ☐ On the job observations
- ☐ Listen-ins
- ☐ Trigger tapes
- ☐ Sight translation exercises
- ☐ Live recording
- ☐ Accuracy drills
- ☐ Terminology games/contests

In-class practice sessions with same language facilitators

Practicum, internship, or reverse shadowing

Other pedagogical tools/teaching strategies? Please specify.



This section asks general questions about your program. This identifying data is important in analyzing our findings. We assure you that the identities of all programs participating in this survey will remain anonymous in all public documents.

Name:	
Organization:	
Address	
Address 2:	
City/Town:	

State: -- select state --

ZIP/Postal Code:

Country:

Email Address:

Phone Number:

When was your interpreter training program founded?

Please describe the type of organization that sponsors the interpreter training program(University, nonprofit community-based organizations, hospital-based, etc.)

Please provide a brief description of your interpreter training program, including hours, and approach.

How many instructional staff work in the interpreter training program?

What qualifications do your instructors have and/or years of experience?

How many interpreters have you trained since the inception of your program?

How do you recruit your students?

What criteria do you use to assess students' skills and what assessment instruments do you use (if any) to determine pre training linguistic abilities and post training competencies.

What languages does your program cover?

Provide any other information you would like to tell us about your program here.

Can we contact you if we had follow-up questions?

Yes

No

Appendix B: Practicing Interpreter/Interpreter-in-Training Survey

Dear Interpreter,

Thank you for agreeing to participate in the study of interpreter training programs sponsored by the New York State Department of Health in collaboration with the Center for Women in Government & Civil Society, The Education Development Center, Inc. and the National Council on Interpreting in Health Care. Your opinions and experiences will help us identify the areas of knowledge and skill that every beginning interpreter must know and be able to do and to develop guidelines for high quality training programs.

There are no right or wrong answers. We simply want to hear what you think helps prepare bilingual adults to become competent health care interpreters. Your answers will be kept anonymous and will not be reported back to any of the training program personnel or to your employers. If you have any questions, please contact Angie Dalton at 518.442.3894.

The questionnaire will take approximately 20-30 minutes to complete.

1. Participation in the survey is limited to individuals 18 years and older. By checking this box, you are providing your informed consent and confirming that you are 18 years or older.

□ Yes, I agree to participate in the survey.

Part I: Training Program - Overall Feedback

There are two parts to this questionnaire. Part I asks you questions about the training of health care interpreters. Part II asks for some background information about yourself. Please read the instructions for each section and follow them very carefully

1. Think back to the time when you applied to enter the training program. How helpful did you find the pre-class screening in understanding what the language demands of the course were going to be?

Very Helpful
Somewhat helpful
Minimally helpful
Not helpful
Don't know

Why? Please explain:

_____

_____

2. Think back to the time after you completed each part of the training program. To what extent did you feel prepared to perform the job of a professional health care interpreter?

After the classroom training
Very prepared
Somewhat prepared
Minimally prepared
Not prepared
Don't know
Why? Please explain:

3. After the internship/advanced on the job training
Very prepared
Somewhat prepared
Minimally prepared
Not prepared
Not Applicable

Why? Please explain:

4. After the final exam
Very prepared
Somewhat prepared
Minimally prepared
Not prepared
Not Applicable

Why? Please explain:

Program Content - Knowledge

In this section, we will focus on the areas of **knowledge** that you think are essential or necessary for every beginning interpreter. Please read the statement on the left side of the table that describes different areas of knowledge. Check the column that best describes what you think about each area of knowledge.

1. Knowledge: know about and understand the following:

	Necessary; every beginning interpreter must know this	Background information but not necessary for an interpreter	Important for advanced interpreters	I don't understand what this means
How the profession of health care interpreting developed				
Overview of how the health care system works in the U.S.				
Code of Ethics for Health Care Interpreters – local and/or national				
Standards of Practice – local and/or national				
Overview of the role of medical interpreter: responsibilities and boundaries				
Basic anatomy and physiology – understanding of the major body systems & their functions				
Names of major body parts in both languages				
Building blocks of terminology – e.g. suffixes, prefixes				
Basic understanding of the structure of language (e.g., grammar, how words are constructed, word order, etc.)				
Awareness of regional differences/dialects in your language pair				

Program Content - Knowledge (cont.)

In this section, we will focus on the areas of knowledge that you think are essential or necessary for every beginning interpreter. Please read the statement on the left side of the table that describes different areas of knowledge. Check the column that best describes what you think about each area of knowledge.

C1. Knowledge: know about and understand the following:

	Necessary; every beginning interpreter must know this	Background information but not necessary for an interpreter	Important for advanced interpreters	I don't understand what this means
Difference between interpreting and translating				
Difference between different interpreter roles and when to use each (conduit, cultural broker, etc.)				
The culture (values & beliefs) of the U.S. health care system (biomedical model)				
Healing practices & beliefs in the cultures for which you interpret				
Concept of culture and how it affects health care				
Understanding different aspects of language fluency (accents, register, etc.)				
Difference between true & false cognates (words in different languages that are or appear to be related in meaning)				
Importance of on-going professional development				
The concept of conflict of interest				
Responsibilities of a "dual role" interpreter –an interpreter who is also a healthcare provider/worker				

Program Content - Knowledge (cont.)

In this section, we will focus on the areas of knowledge that you think are essential or necessary for every beginning interpreter.

Please read the statement on the left side of the table that describes different areas of knowledge. Check the column that best describes what you think about each area of knowledge.

1. Knowledge: know about and understand the following:

	Necessary; every beginning interpreter must know this	Background information but not necessary for an interpreter	Important for advanced interpreters	I don't understand what this means
Standards for the delivery of culturally and linguistically appropriate health care (CLAS standards)				

How CLAS standards are implemented and enforced				
Patient Bill of Rights				
Your own cultural heritage and how it affects your thinking and behavior				
The health related needs of limited English proficient (LEP) populations				
HIPAA rules and regulations				
Patient responsibilities in their own health care				
End of life issues such as proxy, living will, advanced directives and the cultural challenges these raise				
Institutional barriers that affect access to services				
Cultural characteristics of the groups for whom you interpret				

Program Content - Knowledge (cont.)

In this section, we will focus on the areas of knowledge that you think are essential or necessary for every beginning interpreter. Please read the statement on the left side of the table that describes different areas of knowledge. Check the column that best describes what you think about each area of knowledge.

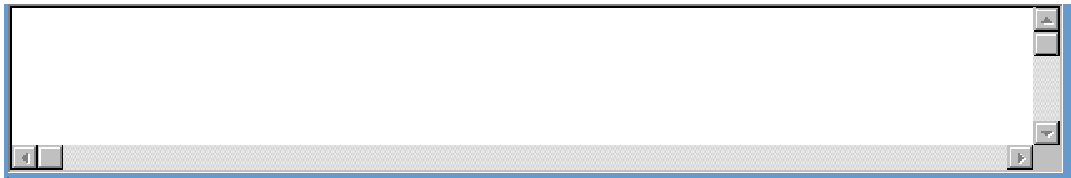
1. Knowledge: know about and understand the following:

	Necessary; every beginning interpreter must know this	Background information but not necessary for an interpreter	Important for advanced interpreters	I don't understand what this means
The meaning of interpreter confidentiality				
How stereotypes and prejudices can influence behavior and communication				
The concept of transparency in the interpreting encounter				

Medical terminology related to major body systems (e.g., diseases, specialties, and treatments)			
Insurance procedures including terminology related to insurance			
Legal foundations of linguistic access in health care			
Referral procedures for in-hospital services			
Hospital protocols, including record keeping, etc.			
The meaning of advocacy & when it is appropriate for the interpreter to advocate			
Legal and liability considerations related to confidentiality and mandated reporting of information			
What it means to behave in an ethical manner			
Program Content - Skills **In this section, we will focus on the skills that you think are essential or necessary for every beginning interpreter.** **Please read the statement on the left side of the table that describes different skills. Check the column that best describes what you think about each skill.**			
1. Skills: Ability to	**Necessary; every beginning interpreter must be able to do this;**	**This is an advanced skill and not necessary for a beginning interpreter**	**I don't understand what this means**
Convert a message in one language into a second language without changing the meaning or adding information			
Maintain completeness in converting messages from one language to another			
Introduce yourself in culturally appropriate ways			
Interpret difficult messages such as offensive language without distorting or changing the meaning			
Show respect for all parties in professional & culturally appropriate ways			
Introduce the role of interpreter in a variety of situations (e.g.,			

provider in a hurry)			
Maintain accuracy when interpreting numbers and frequencies, such as dosages, dates, etc.			
Make it clear to all parties that you will interpret everything that is said			
Ask for clarification in appropriate ways			
Maintain neutrality and not impose personal beliefs, judgments or values into your interpretations			
Program Content - Skills (cont.) In this section, we will focus on the **skills** that you think are essential or necessary for every beginning interpreter. Please read the statement on the left side of the table that describes different skills. Check the column that best describes what you think about each skill. 1. Skills: Ability to			
	Necessary; every beginning interpreter must be able to do this;	This is an advanced skill and not necessary for a beginning interpreter	I don't understand what this means
Help facilitate communication between patient & provider when values clash			
Assist the provider/patient to understand cultural issues that may result in misunderstandings			
Advocate when necessary such as in order to prevent harm or to correct mistreatment or abuse			
Use conflict resolution strategies when necessary			
Interpret in the consecutive mode			
Interpret in the simultaneous mode			
Use memory enhancing tools to maintain accuracy and completeness			
Recognize and correct your mistakes appropriately			
Analyze ethical dilemmas and provide reasons for choices based on code of ethics			

Use the most widely understood terms in the languages in which you interpret			
Program Content - Skills (cont.) In this section, we will focus on the **skills** that you think are essential or necessary for every beginning interpreter. Please read the statement on the left side of the table that describes different skills. Check the column that best describes what you think about each skill. 1. Skills: Ability to			
	Necessary; every beginning interpreter must be able to do this;	This is an advanced skill and not necessary for a beginning interpreter	I don't understand what this means
Sight translate			
Position yourself to promote direct communication between patient and provider			
Position yourself to maintain patient's privacy			
Assist in clarifying cultural misunderstandings between patient and provider			
Manage & facilitate the flow of communication			
Analyze situations and make linguistic decisions such as register, tone, etc.			
Translate written materials such as informed consent forms			
Assist patient and provider negotiate the meaning of words or ideas that do not have an equivalence in the other language			
Interpret in the mental health setting			
Interpret in the emergency room setting			
Translate short instructions such as how to take medications			
Program Content - Comments 1. Was there a time when you felt unprepared and thought "I wish this had been covered in the training?" Please describe the situation and indicate what additional training would have helped you.			



*

2. What other knowledge or skill training do you wish you had before starting to work as a professional health care interpreter?

Instructional Methods

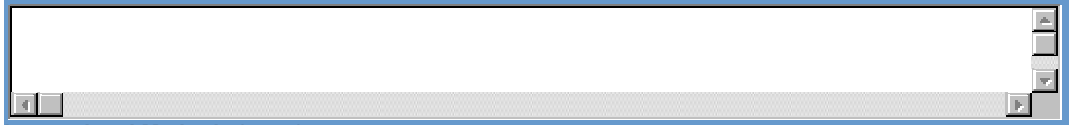
We will now focus on the **methods of instruction** that were used to help you understand the areas of knowledge and learn the skills that are important in the professional practice of health care interpreting.

Think about the different methods of instruction used during your training. Check the column under the phrase that best describes the effectiveness of the method.

1. Methods of Instruction: How effective

	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Role plays to practice linguistic conversions in a "life-like" setting					
Role plays to practice how to manage the flow of communication					
Memory and note-taking exercises					
Scripted role plays					
Spontaneous role plays (no script)					
Self-evaluations/critiques					
Terminology games & quizzes					
Reading about the different roles of the interpreter					
Use of 'graphic organizers' (visual ways of organizing material such as charts, diagrams, etc.					

Language coaches who are bilingual



Instructional Methods (cont.)

We will now focus on the **methods of instruction** that were used to help you understand the areas of knowledge and learn the skills that are important in the professional practice of health care interpreting.

Think about the different methods of instruction used during your training. Check the column under the phrase that best describes the effectiveness of the method.

1. Methods of Instruction: How effective

	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Doing role plays with actual health care professionals					
Analyzing videos					
Analyzing errors made by yourself or others					
Observations & feedback from classmates					
Language coaches who are primarily monolingual in each language					
Observing an experienced interpreter					

Internship	
Observations & feedback from an experienced interpreter	
Keeping a journal	
Listening to recordings of interpreted encounters	
Use of "trigger tapes" (of own interpretations) for error analysis	

Instructional Methods (cont.)

We will now focus on the **methods of instruction** that were used to help you understand the areas of knowledge and learn the skills that are important in the professional practice of health care interpreting.

Think about the different methods of instruction used during your training. Check the column under the phrase that best describes the effectiveness of the method.

1. Methods of Instruction: How effective

	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Drills to practice converting messages from one language to another					
Case examples or scenarios for discussion					
Practice drills through recordings					
Terminology building exercises					
Analyzing messages to identify all the points of meaning in a message					
Shadowing: repeating in the same language exactly what was said					

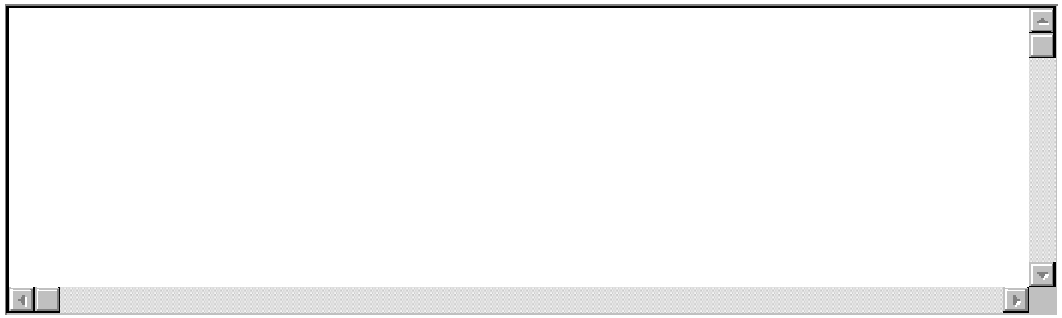
2. What are the three instructional methods that you found most effective? Why?

*

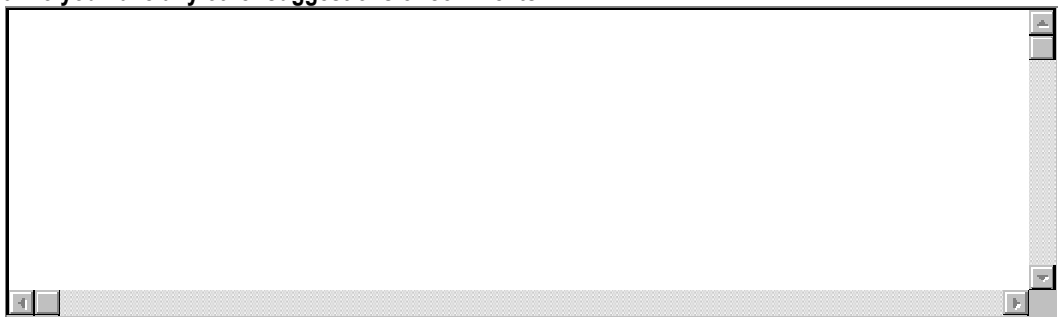
3. What suggestions do you have for other instructional methods that could help you learn the material and skills even better?

4. If you had the opportunity to improve the training program you took, which parts of the training should be given more time and emphasis? Why?

5. Which parts of the training would you give less time and emphasis? Why?



6. Do you have any other suggestions or comments?



Thank you for completing Part I. Please go on to Part II: Background Questionnaire. It is a short section but it is very important that you complete Part II.

Part II: Background Questionnaire

Remember, all this information is anonymous.

1. What is your gender?

Female

Male

Transgender

2. What is your age?

18-30

31-50

51-70

Over 70

Training Program Participation

1. Please enter the name of the basic health care interpreting program in which you participated.

2. How many hours of basic training did you receive?

Less than 40 hours 40 hours 41-60 hours 61-70 hours 71-80 hours More than 80 hours

3. Did your basic training program include an internship or supervised on-the-job training?

No Yes

4. Did you have to take an exam at the end of the basic training?

Yes (continue with #5) No

5. The exam I took consisted of the following (Check all that apply)

a written exam a role play other

Other (please specify)

Language History

1. How long have you lived in the United States?

I was born here

Less than 1 year

1-5 years

6-10 years

11-20 years

More than 20 years

2. What is/are your first or native language(s)?

1.

2.

3.

4.

3. Where did you learn English? (check as many as apply)

At home, from parents and relatives

In the neighborhood I grew up in

At school in the elementary grades (before “high school”)

In high school

In college

In adult education classes

At work

4. In what language other than English do you interpret the most?

5. Where did you learn this language? (check as many as apply)

At home, from parents and relatives

In the neighborhood I grew up in

At school in the elementary grades (before “high school”)

In high school

In college

In adult education classes

At work

Education

1. Enter the language of instruction for each level of formal schooling you have received.

Elementary (up to grade 6)	
Secondary (6-12 grades)	
College (up to 2 years)	
College (up to 4 years)	
Graduate school (e.g., Master's, Doctorate, Medical or Law School, etc.)	
Other (e.g., certificate program, technical school, etc.)	

2. Had you taken any other training in health care interpreting or other interpreting (e.g., court, conference, community, school) or in translation before taking this program's training?

Yes (please go to #3)

No (If no, skip to #4)

3. Type of training (Check all that apply)

	Less than 40 hours	40 hours	40-80 hours	More than 80 hours
Medical/health care				
Court				
Conference				
Community				
Translation				

Other (please specify)

4. Had you completed any other courses related to health care before taking this program's training?

Yes (please, go to #5)

No (If no, skip to #6)

5. I had taken the following courses before receiving health care interpreter training. Check all that apply.

Human Biology

Anatomy/Physiology

Medical Terminology

Cultural Issues in Health Care

Other (please specify)

6. Had you done any health care interpreting before taking this program's training? (check all that apply)

No, have not done any health care interpreting before

Yes, Informally, for family and friends

Yes, As a “recognized” volunteer (i.e., you were on a hospital’s or other health care facility’s roster/list of volunteer interpreters)

Yes, As a paid, freelance/independent interpreter

Yes, As a paid, full time interpreter at a health care facility

Yes, As a paid, part time interpreter at a health care facility

Yes, Other (please specify)

Work as Interpreter

1. Are you currently working as a health care interpreter? (check all that apply)

Full time, paid

Part time, paid

Freelance/independent, full time (this is your primary source of income)

Freelance/independent, part time, paid

“Recognized” volunteer, unpaid (i.e., you were on a hospital’s or other health care facility’s roster/list of volunteer interpreters)

Not currently interpreting

Dual role interpreter (employed in another job at the health care facility but called to interpret)

Indicate other dual role job

2. Please give an estimate of the number of health care interpretation you have done since you received this training.

None

1-25

26-50

51-100

101-150

Over 150

Thank you very much for completing the survey!

Appendix C: Trainee Survey – Knowledge Base

Domain	Knowledge Item	Background Information		Advanced		Necessary for All Beginners	
		#	%	#	%	#	%
D2	The meaning of interpreter confidentiality	0	0.0%	2	1.7%	118	98%
D3	Names of major body parts in both languages	1	0.8%	2	1.7%	116	98%
D2	Overview of the role of medical interpreter: responsibilities and boundaries	2	1.7%	3	2.5%	114	96%
D2	What it means to behave in an ethical manner	3	2.5%	3	2.5%	114	95%
D2	Difference between interpreting and translating	5	4.2%	2	1.7%	113	94%
D2	Code of Ethics for Health Care Interpreters – local and/or national	4	3.4%	3	2.5%	112	94%
D2	Difference between different interpreter roles and when to use each (conduit, cultural broker, etc.)	1	0.8%	7	5.8%	112	93%
D2	The concept of transparency in the interpreting encounter	3	2.5%	6	5.1%	109	92%
D2	The meaning of advocacy & when it is appropriate for the interpreter to advocate	5	4.2%	6	5.0%	109	91%
D3	Medical terminology related to major body systems (e.g., diseases, specialties, and treatments)	5	4.2%	7	5.9%	107	90%

Domain	Knowledge Item	Background Information		Advanced		Necessary for All Beginners	
		#	%	#	%	#	%
D5	Difference between true & false cognates (words in different languages that are or appear to be related in meaning)	3	2.5%	9	7.6%	107	90%
D4	How stereotypes and prejudices can influence behavior and communication	4	3.3%	9	7.5%	107	89%
D4	Cultural characteristics of the groups for whom you interpret	8	6.8%	6	5.1%	104	88%
D3	Basic anatomy and physiology – understanding of the major body systems & their functions	8	6.7%	7	5.9%	104	87%
D2	Standards of Practice – local and/or national	9	7.6%	6	5.1%	103	87%
D5	Basic understanding of the structure of language (e.g., grammar, how words are constructed, word order, etc.)	11	9.3%	4	3.4%	103	87%
D5	Understanding different aspects of language fluency (accents, register, etc.)	9	7.6%	7	5.9%	102	86%
D2	The concept of conflict of interest	9	7.8%	7	6.1%	99	86%
D1	Legal and liability considerations related to confidentiality and mandated reporting of information	10	8.4%	7	5.9%	102	86%
D4	Concept of culture and how it affects health care	9	7.5%	9	7.5%	102	85.0%
D1	HIPAA rules and regulations	11	10.1%	8	7.3%	90	83%

Domain	Knowledge Item	Background Information		Advanced		Necessary for All Beginners	
		#	%	#	%	#	%
D5	Awareness of regional differences/dialects in your language pair	8	6.8%	14	11.9%	96	81%
D4	Healing practices & beliefs in the cultures for which you interpret	13	10.8%	10	8.3%	97	81%
D3	Building blocks of terminology – e.g. suffixes, prefixes	9	7.6%	14	11.9%	95	81%
D4	Your own cultural heritage and how it affects your thinking and behavior	12	10.2%	11	9.3%	95	81%
D2	Responsibilities of a "dual role" interpreter – an interpreter who is also a healthcare provider/worker	10	8.6%	13	11.2%	93	80%
D4	The culture (values & beliefs) of the U.S. health care system (biomedical model)	11	9.2%	13	10.9%	95	80%
D1	Patient Bill of Rights	23	19.2%	3	2.5%	94	78.3%
D4	End of life issues such as proxy, living will, advanced directives and the cultural challenges these raise	10	8.5%	17	14.4%	91	77.1%
D1	The health related needs of limited English proficient (LEP) populations	19	16.4%	12	10.3%	85	73.3%
D1	Overview of how the health care system works in the U.S.	25	21.0%	11	9.2%	83	69.7%
D1	Patient responsibilities in their own health care	25	21.7%	10	8.7%	80	69.6%

Domain	Knowledge Item	Background Information		Advanced		Necessary for All Beginners	
		#	%	#	%	#	%
D1	Standards for the delivery of culturally and linguistically appropriate health care (CLAS standards)	17	14.9%	18	15.8%	79	69.3%
D1	Institutional barriers that affect access to services	28	23.9%	14	12.0%	75	64.1%
D1	How CLAS standards are implemented and enforced	23	20.9%	21	19.1%	66	60.0%
D2	How the profession of health care interpreting developed	38	32.5%	10	8.5%	69	59.0%
D1	Referral procedures for in-hospital services	42	35.9%	12	10.3%	63	53.8%
D1	Insurance procedures including terminology related to insurance	39	32.8%	17	14.3%	63	52.9%
D1	Legal foundations of linguistic access in health care	36	32.1%	21	18.8%	55	49.1%
D1	Hospital protocols, including record keeping, etc.	60	50.0%	17	14.2%	43	35.8%

D1: The Context of Healthcare Interpreting: General, regulatory and legal requirements
D2: The Health Care Interpreting Profession
D3: Understanding and Treating the Human Body
D4: Culture
D5: Language

Appendix D: Core Competencies as Perceived by Trainers/Curricular Developers

Knowledge Base

Domain 1: The Context of Health Care Interpreting: General, Regulatory and Legal Requirements

- Understand and recognize legal and liability considerations of maintaining confidentiality and addressing situations of necessary information disclosure.
- Demonstrate knowledge of HIPPA laws and their application in the medical interpreting profession.
- Understand the general legal parameters of linguistic access to healthcare, including U.S. legislation (local, state and national).
- Demonstrate knowledge of all 14 standards for delivering culturally and linguistically appropriate health care (CLAS standards) and strong knowledge of standards pertaining to provision of linguistic access.
- Demonstrate basic knowledge and understanding of public benefits and the U.S. health care system.

- Show knowledge of institutional barriers that prevent people from accessing services.
- Display knowledge of patient's responsibilities.
- Understand end of life issues including the concepts of proxy Living Will and advanced directives.
- Identify issues of access to healthcare for the Limited English Proficient patient populations.
- Understand and be able to explain the general health and health-related needs of the Limited English Proficient population served.
- Identify and be able to explain the general healthcare industry strategies and practices to bridge the language gap.
- Describe and explain the Patient's Bill of Rights.
- Understand and be able to explain the insurance system and referral procedures.

- Knowledge of how health care institutions work
- Knowledge of health care norms and procedures
- Knowledge of how to interpret different types of medical procedures such as EKG reading
- Knowledge of nursing.
- Knowledge of how to handle difficult circumstances, e.g., organ donation, life or death decisions (disconnecting a patient), etc.
- Knowledge of different vocabularies used in mental health, cancer, pediatric, drug abuse, etc.
- Knowledge of legal terminology related to the medical field.

Domain 2: The Health Care Interpreting Profession

- Understand the scope, limits and boundaries of the interpreter role.
- Recognize the responsibility of the interpreter to advise parties that everything said will be interpreted.
- Recognize the importance of maintaining faithfulness to the meaning, including offensive contents.
- Understand and describe the interpreter role as a conduit.
- Understand potential conflicts of interest and recognize when to withdraw from assignments.
- Understand and describe the interpreter role as a clarifier.
- Recognize the importance of maintaining transparency in the clinical encounter.
- Understand and describe the interpreter role as a cultural broker.
- Understand and describe the interpreter role as an advocate.

- Recognize the 9 ethical codes of the National Council on Interpreting in Health Care for delivering culturally and linguistically appropriate health care.
- Understand principles of advocacy and when to utilize advocacy to protect individuals from harm, and avoid mistreatment and abuse.
- Understand the challenges of assuming dual roles; i.e. serving as an interpreter as well as a healthcare provider/worker at the same institution.
- Identify definitions of success and one's work expectations.
- Describe and be able to apply conflict resolution strategies.
- Knowledge of Standards of Practice, and how to use them properly.
- In-depth understanding of the notion of the interpreter as a vital member of the medical team

Domain 3: Medical Terminology and Understanding the Human Body

- Demonstrate knowledge of key medical terms related to the basic systems of the human body including related diseases, specialties, and treatment, human anatomy and physiology.

Domain 4: Culture

- Demonstrate knowledge of one's own cultural heritage and how personal biases and stereotypical attitudes can influence interaction and communication.
- Demonstrate an understanding of the connection between the language and culture of the speakers of the language.
- Demonstrate knowledge of the cultural heritage, values, and trends of the groups served and of different worldviews.
- Understand the biomedical culture and how it differs from traditional medicine.
- Understand levels of acculturation and cultural challenges for the particular groups served.
- Demonstrate knowledge of family structures, hierarchies and community characteristics that may influence the medical encounter.
- Display knowledge of how differences and one's position as a member of the non-majority can affect one's access to healthcare.
- Understand how the CLAS standards are enforced and the limitations associated with their implementation/application (e.g. poor enforcement, limited funding. High costs of services.)

Domain 5: Language

- Recognize colloquial expressions used in medicine as well as common acronyms and initialisms.
- Recognize regional differences, localism and different dialects.

Skill Base

Utilize interpreting protocols

- Utilize protocols of medical interpreting including positioning, gaze, intervening, introductions, and pausing.

Use different interpreting/translating techniques

- Exhibit ability to sight translate documents, including patient's informed consent.

Maintain accuracy and completeness

- Display ability to render the message accurately without adding, omitting, or substituting.
- Recognize own mistakes and correct errors in interpretation
- Demonstrate ability to include paralinguistic elements central to conveying equivalence in the meaning of the message (e.g. register, style, and tone).
- Utilize strategies to ensure accuracy by asking for pauses or clarifications
- Demonstrate ability to convert a spoken message in one language into its equivalent in a second language without changing the meaning.
- Identify quality control strategies and performance improvement techniques, including self evaluation and feedback.
- Utilize note-taking strategies to ensure accuracy.

Manage the interaction

- Demonstrate ability to effectively manage and facilitate the flow of the communication.
- Counseling skill
- Demonstrate advocacy skills

Address cross-cultural communication

- Demonstrate ability to work with "un-interpretable" and culturally-bound terms such as idioms, sayings and slang that lack equivalent terms in the target language.
- Demonstrate ability to assist the provider and patient in negotiating cultural issues or differences that arise, and alert all parties to any significant cultural misunderstanding.
- Demonstrate ability to balance values of the U.S. healthcare system and cultural values, such as patient's beliefs about individual autonomy and the right to know.

Behave ethically and make ethical decisions

- Demonstrate ability to maintain professional neutrality, refrain from judgment and from imposing one's cultural values.
- Demonstrate ability to analyze situations and take action based on established National Code of Ethics for Interpreters when appropriate.
- Display professional neutrality with different religious and spiritual beliefs/customs relevant to the health care encounter, and exhibit appreciation for traditional help-seeking practices.
- Recognize and exercise appropriate interventions, strategies and techniques to address bias, prejudice and discriminatory practices.

Professional Qualities and Behaviors

- Exhibit ability to respect the dignity of all parties in professional and culturally appropriate ways.
- Explain the principles of honesty, integrity, professionalism, and accountability.

- Understand that continuing education and self-development are needed to continue to improve performance.
- Demonstrate ability to respect patient independence.
- Recognize signs of “professional burnout” and demonstrate knowledge of mitigating strategies.
- Describe relaxation, concentration and stress management techniques.
- Training on when and how to seek assistance to decompress, after a difficult situation, within health care institutions

Appendix F: Pedagogical Practices from the Learners' Perspectives

Training Methods	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Role plays to practice linguistic conversions in a "life-like" setting	0.8%	5.0%	15.1%	76.5%	2.5%
Role plays to practice how to manage the flow of communication	0.8%	3.4%	11.8%	82.4%	1.7%
Memory and note-taking exercises	3.4%	2.5%	22.7%	55.5%	16.0%
Scripted role plays	3.4%	6.7%	24.4%	61.3%	4.2%
Spontaneous role plays (no script)	3.4%	3.4%	16.8%	64.7%	11.8%
Self-evaluations/critiques	0.8%	2.5%	32.8%	52.1%	11.8%
Terminology games & quizzes	1.7%	6.7%	25.2%	57.1%	9.2%
Reading about the different roles of the interpreter	0.0%	5.9%	25.2%	68.9%	0.0%

Training Methods	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Use of 'graphic organizers' (visual ways of organizing material such as charts, diagrams, etc.	5.0%	7.6%	21.0%	42.9%	23.5%
Language coaches who are bilingual	0.0%	3.4%	19.3%	61.3%	16.0%
Doing role plays with actual health care professionals	0.8%	1.7%	11.7%	46.7%	39.2%
Analyzing videos	0.8%	5.0%	22.5%	35.0%	36.7%
Analyzing errors made by yourself or others	0.0%	3.3%	19.2%	72.5%	5.0%
Observations & feedback from classmates	0.0%	2.5%	28.3%	65.8%	3.3%
Language coaches who are primarily monolingual in each language	2.5%	4.2%	23.3%	33.3%	36.7%
Observing an experienced interpreter	0.8%	5.0%	17.5%	62.5%	14.2%

Training Methods	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Internship	0.8%	1.7%	10.1%	39.5%	47.9%
Observations & feedback from an experienced interpreter	1.7%	3.4%	10.1%	71.4%	13.4%
Keeping a journal	3.3%	3.3%	19.2%	27.5%	46.7%
Listening to recordings of interpreted encounters	1.7%	5.0%	18.3%	35.0%	40.0%
Use of “trigger tapes” (of own interpretations) for error analysis	1.7%	5.0%	15.0%	30.8%	47.5%
Drills to practice converting messages from one language to another	0.8%	4.2%	21.8%	62.2%	10.9%
Case examples or scenarios for discussion	0.0%	4.2%	23.7%	67.8%	4.2%
Practice drills through recordings	1.7%	2.5%	16.8%	32.8%	46.2%

Training Methods	Not effective at all; did not help	Helped me understand but did not help me know what to do	Helped me understand and gave me some idea of what to do	Very effective in helping me understand and know what to do with confidence	The training I took did not use this method
Terminology building exercises	0.0%	5.9%	21.0%	64.7%	8.4%
Analyzing messages to identify all the points of meaning in a message	0.0%	5.0%	21.8%	54.6%	18.5%
Shadowing: repeating in the same language exactly what was said	4.2%	3.4%	20.2%	55.5%	16.8%

ENDNOTES

[1] Lewis Mumford Center, University at Albany, 2004 at www.albany.edu.

[2] Center for Women in Government & Civil Society. Proceedings of a Statewide Conference on Increasing Language Access to Healthcare. www.cwig.albany.edu (2007).

[3] Shin BH, Bruno R. Language use and English speaking ability: census 2000 brief. Washington, DC: US Census Bureau; 2003. Available at http://www.census.gov/prod/2003pubs/c2kbr-29.pdf. Accessed March 1, 2008. Smedley B, Stith A, Nelson A, eds. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC:National Academy of Sciences. Woloshin S, Bickell N, Schwartz L, Gany F, Welch G. Language barriers in medicine in the United States. JAMA. 1995;273:724–8. Timmins CL. The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. J Midwifery Womens Health. 2002;47:80–96. Donovan P. Taking family planning services to hard-to-reach populations. Family Planning Perspectives, 1996 May-Jun;28(3):120-6. COSMOS Corporation. Limited English Proficiency as a Barrier to Family Planning Services. Prepared for US Department of Health and Human Services, March 2003. David R & Rhee M. The Impact of Language as a Barrier to Effective Healthcare in an Underserved Urban Hispanic Community. Mt Sinai J Med. 1998 Oct-Nov;65(5-6):393-7. Providing Language Interpretation Services in Health Care Settings: Examples from the Field, Mara Youdelman and Jane Perkins, The Commonwealth Fund, May 2002. Lee LJ, Batal HA, Maselli JH, Kutner JS. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. J Gen Intern Med. 2002 Aug;17(8):641-5. Language Services Action Kit. National Health Law Program and The Access Project. 2004.

[4] Wu, Shinyi, M. Susan Ridgely, José J. Escarce and Leo S. Morales. (2007). Language Access Services for Latinos with Limited English Proficiency: Lessons Learned from *Hablamos Juntos.* RAND Corporation, Division of General Internal Medicine and Health Services Research, Department of Medicine, David Geffen School of Medicine at the University of California.

[5] Wilson-Stronks, Amy and Erica Galvez. 2006. Hospitals, Language, and Culture: A Snapshot of the Nation: Exploring Cultural and Linguistic Services in the Nation's Hospitals. Report by the Joint Commission and the California Endowment.

[6] A core competency, for the purposes of this study, is defined as a specialized and essential or fundamental knowledge, skill, or expertise that a healthcare interpreter must have in order to be able to function as a professional in the field. In a training curriculum, core competencies are expressed as "learning objectives" or statements that identify the tasks that the learner must perform (behavior), how it will be performed (condition), and how well it must be performed (standard). The focus of this study is on the core competencies that a beginning interpreter must have and that can be addressed and developed through training and other educational programs. The survey results provide direction for further study that will lead to a more comprehensive understanding of what the core competencies are for a beginning professional interpreter and the required components of a training program that will ensure the acquisition of these competencies. In the interim, before national training standards are set, the results of this study have important implications for the improvement of training programs including those at a continuing education level as well as more extensive certificate programs such as those situated in colleges and universities.

[7] Wilson-Stronks, A. and E. Galvez. 2006. Hospitals, Language, and Culture: A Snapshot of the Nation: Exploring Cultural and Linguistic Services in the Nation's Hospitals. Report by the Joint Commission and the California Endowment.

[8] Wilson-Stronks, Amy and Galvez. 2006. Hospitals, Language, and Culture: A Snapshot of the Nation: Exploring Cultural and Linguistic Services in the Nation's Hospitals. Report by the Joint Commission and the California Endowment.

[9] For purposes of the analysis, one of the Knowledge items was moved to a third area of competency, Professional Qualities and Behaviors.

[10] For purposes of the analysis, one of the Skill items was moved to a third area of competency, Professional Qualities and Behaviors.

[11] Although 177 responses were downloaded from Surveymonkey.com, 76 respondents answered no more than one question and were disqualified from the pool. Thus the overall N is 101. Since only few respondents answered all the questions in the survey, the total number of the responses received for each question may vary considerably. The percentage calculation for respondent characteristics was based on the total number of actual responses received for each particular question rather than the overall sample size of 101.

[12] Spearman's Rho was used for two reasons. First, given that our sample is not a random probability sample and that we cannot assume that the variables are normally distributed, a non-parametric statistical measure is more appropriate. Additionally, although the dependent variable is dichotomous (0 = not core and 1 = core), they can also be understood as ordinal variables signifying different levels of importance, which makes Spearman's rank correlation coefficient the suitable measure of correlation. For respondents who reported hours for multiple levels of training, we coded only the most basic level of training. For this study, one college or university credit hour is equal to one hour of contact per week for an average of 16 weeks per semester.