

**Centers for Disease Control and Prevention
EARLY HEARING DETECTION AND INTERVENTION
Special Topics Teleconference**

**September 12, 2006
2:00 – 3:00 PM EST**

Working with Non-English Speaking Families

Agenda

- I. **Welcome**, Jamie Elliott, CDC EHDI
- II. **The CDC EHDI Diversity Committee**, Susan Chacon, New Mexico Department of Health, Children's MEHDIcal Services / Diversity Committee Chair
- III. **A Guide for Families of Children with Hearing Loss, en Español**, Claudia Gaffney, CDC EHDI
- IV. **Hispanic Culture: How to facilitate more effective communication with Non-English speaking Hispanic Populations**, Valerie Hernandez, Associate Member NAD-RID-NIC, MEHDIcal Spanish Interpreter / Liaison at the University of Colorado Hospital
- V. **Questions / Discussion**

EDITED TRANSCRIPT

Jamie Elliott: This is Jamie Elliott from CDC, and I would like to welcome you to the Special Topics teleconference, *Working with Non-English Speaking Families*. There are a few announcements and couple administrative details I would like to address. First of all, many of you I am sure are aware that the 2007 EHDI Conference is scheduled for March 26-27 and is being held in Salt Lake City, Utah. If you would like to submit an abstract for the EHDI Conference, the deadline is this Friday, September 15th, and abstracts are due by 5 p.m. Eastern Time zone. That is Friday September 15th, this Friday, by 5 p.m. For abstracts guidelines and information about the 2007 EHDI Conference, you can visit the CDC website (<http://www.cdc.gov/ncbddd/ehdi/meeting.htm>) or the NCHAM website has a bit more information (<http://www.infanthearing.org/meeting/ehdi2007/index.html>). The third announcement I would like to make before we get started is that many of you know we hold these teleconferences regularly on various topics of relevance to the EHDI community. I will be sending you an e-mail within the next two weeks or so to ask for your comments on these teleconferences and also for ideas of future topics or speakers. I hope you will take advantage and send us feedback or information on what you would like to hear more about.

At this time I will ask you to please be sure that your phone is on mute. If you do not have a mute button, please try pressing star and then 6 to mute your phone. Also, a reminder, please do not use the hold feature on your phone while you're on this teleconference or we all hear the music playing while on hold. If you must take another call, dial back in afterwards.

With that I would like to welcome our speakers, Susan Chacon, Claudia Gaffney, and Valerie Hernandez. Ms. Chacon works with the New Mexico EHDI program under the auspices of the NM Department of Health, Children's Medical Services program, the Title V Maternal and Child Health program for Children and Youth with Special Health Care Needs. Susan is currently the Chairperson of the CDC Diversity Committee, and she will be speaking about that committee and its activities. Ms. Gaffney joined the CDC EHDI Team in 2004 to develop materials and programs that help educate minorities and expand a public health initiative within hard-to-reach populations. Her work includes producing educational materials in Spanish, disseminating critical information, and creating partnerships at both state and national level. She'll be introducing newly created materials in Spanish for families of children with hearing loss.

Finally we have an addition to the agenda that was sent out earlier this afternoon. Ms. Valerie Hernandez will be joining us this afternoon. She is a medical Spanish interpreter and liaison to the University of Colorado Hospital, and her presentation is about communicating effectively with non-English speaking Hispanic populations through an interpreter. Again, thank you to our presenters for being with us, and thank you all for joining today. With that, please go ahead when you're ready, Susan.

Susan Chacon: Okay. Good afternoon, everyone. I appreciate having some time on the agenda today. I was asked to talk about the CDC EHDI Diversity Committee that I have been the Chair of since May of 2005. I don't have a PowerPoint, so I am just going to spend a few minutes talking about the work of the committee, and hopefully you will be able to follow along with me.

In the spring of 2005, I was asked by the CDC EHDI program to help in facilitating an interagency, multi-state group to begin to identify and address disparities that families who are racially and ethnically diverse may encounter when trying to access EHDI services across the continuum. There was some research that indicated that children lost to follow-up were more likely to be nonwhite, have young mothers who had late onset of prenatal care, and were uninsured.

The CDC EHDI Diversity Committee was formed, and we began to have monthly conference calls. The Committee is made of several state EHDI coordinators, family members, University staff, and some federal agencies, including the CDC and Indian health services. Some of the states currently represented include Colorado, Pennsylvania, Wisconsin, New Jersey, Maryland, Washington D.C., Arizona, Texas, California, Utah, Massachusetts, Puerto Rico, and of course New Mexico.

We spent the beginning of our meetings trying to define our purpose and our mission. Our purpose is to identify and prioritize the issues and barriers minority populations may face in receiving EHDI services and to develop strategies that ensure equal access for all families. A representative from each state who is knowledgeable of the state's minority issues would be invited to participate in this Committee as well as national and local organizations working with minority populations. Interactions with other states and organizations will be helpful in highlighting potential minority issues that should be addressed and sharing information and intervention models that have been implemented.

We defined our role as to identify the most relevant minority issues within the EHDI process, to prioritize those issues, to offer direction and expertise on a long-term basis, to help EHDI program to provide culturally sensitive services, to promote evidence-based strategies to provide outreach to minority populations, to raise awareness and open the dialog related to minority issue access through different activities such as educational campaigns, newsletters, conferences, websites, partnering with other minority organizations, and to identify ways to implement strategies developed by our committee.

The first few meetings we spent some time identifying issues that minority families may face when trying to access services. As we looked at each point of access into the EHDI system, we found some similar and different issues. Just for an example, at the hospital level during the hearing screening process, families may encounter language and cultural barriers when interacting with hospital personnel. Some families may choose to waive the hearing screen. This could be because of cultural, religious, or immigration issues or a lack of understanding of the importance of screening.

At follow-up, some of the issues we identified included families not understanding the results of the hearing test due to language, literacy levels, or cultural reasons. State programs often have difficulty locating parents once they leave the hospital because of rural access issues. Often there is a wrong name on the information provided by the hospital. Hispanic babies usually have two last names. Sometimes parents don't want to be found, so they give the wrong address on admission to the hospital. That could be because of immigration status or no insurance. Sometimes families are afraid they're going to get the bill for the hospital, so they don't provide the correct demographic information at admission. Young parents may be less likely to come back for follow-up. Transportation can be a huge issue for many families. Parents may have several young children at home and need help with child care. Again, a lack of insurance, socio economic issues could be a priority, and again cultural issues.

At the level of early intervention, we identified other issues. For example, the lack of racially and ethnically diverse healthcare workforce. It may be difficult to assess children from families who are non-English speaking. Some of the questions we thought to ask were: Are the assessment tools appropriate? Are there any cultural barriers that interfere with outcomes and follow-up in the home? Are the written materials given to families effective?

Providers may have difficulty communicating with parents due to language and low literacy level. Parents may have difficulty communicating with their children when they're trying to use three different languages such as English, ASL, and their native language. Minority deaf children may be less likely to have access to technology such as hearing aids and cochlear implants, and this could be due to a lack of information or socio economic barriers. Determining the best intervention process also could be difficult. Of course, there are immigration issues. Families may not be aware of services that they could be eligible for or are hesitant to receive services from the state in fear that it would affect their ability to apply for permanent citizenship.

Our work is still in progress, and there are many other issues that we have not identified yet that would certainly be relevant. After identifying some of the issues, the committee was invited by the CDC EHDI program to assist them in developing culturally and linguistically appropriate materials for Hispanic families. My colleague, Claudia Gaffney from the CDC, will describe in more detail the process we took over the past year to develop those materials. Some of the other activities we have undertaken to get our message across include presentation of some of these issues at the National Conference on Minority Health in Washington, D.C. in January of 2006. We did a presentation in February of 2006 at the National EHDI Conference. We developed a guidance document with recommendations for EHDI professionals when working with minority families, which we hope to release soon. It is still under CDC review at this time, and some of the materials that we created were incorporated into some University curriculums being used to educate the new generation of EHDI healthcare professionals.

Over the next year or so, our goals include possibly the development of a handbook for providers to help raise awareness of the impact of cultural and linguistic issues, and to distribute the fact sheet on strategies and recommendations in working with diverse communities. Additional goals include possibly writing an article about the process we took to develop culturally and linguistic appropriate documents for non-English speaking families, examining the reason for high incidence of loss to follow up within inner city families, and continuing the dialogue on how to reach racially and ethnically diverse families.

We still have a lot of work to do. We're always looking for new members and new ideas, and if anyone is interested in joining, we would love to have you. That's about it on our work for now. I think I am going to pass it onto Claudia, and I guess are we going to take questions after?

Jamie Elliott: We'll leave some time at the end for questions.

Susan Chacon: Okay. I will turn it over to Claudia Gaffney.

Claudia Gaffney: Thank you, Susan. Good afternoon, everybody. My presentation today is about a product we are about to release for families of children with hearing loss. The title of this product is *Guía para familias de niños con pérdida auditiva*. That's the title in Spanish; in English it translates to "Guide for Families of Children with Hearing

Loss”. First I will give you a little background on this product, and then I will speak about the process that we went through to develop this. Some of you may be familiar with the product that CDC developed a couple of years ago called “A Parent’s Guide to Hearing Loss”. This is a CD-Rom that provides information that parents need when they have a child with hearing loss. When CDC was developing this product, they asked for feedback from professionals and parents, and some of these people said it was important to have this translated into Spanish. So CDC invited me to help them with this translation. We had a meeting to decide how we were going to do this, and we came to realize that it was better to start from the beginning and develop something that addressed the needs of the Spanish speaking Hispanic families of children with hearing loss. So the first step we took was to assess the need for a product like this. We found out that since the Hispanic is the largest minority group, and it is growing at a rate higher than any other minority group, it was a product they needed. 24% of children attending the schools for the deaf around the country are Hispanic. Many of these children live with families that don't speak English.

Our second step was to define what was important to Hispanic families of children with hearing loss. To do this we conducted focus groups. The first one was a teleconference with professionals that have experience working with Hispanic speaking families. Many of these professionals belong to our Diversity Committee, and we asked them about the services they have available in their own states and also about the information they consider important for Hispanic families. They said many of their brochures and materials are translated into Spanish, and they also have community brokers that help them to reach the communities they serve. However, none of them have specific programs for the Hispanic population, and they think it is difficult to know what to include in products for this population. They also mentioned some of the barriers they have when providing services to non-English speaking families. For example, when a family wants to learn American Sign Language and they don't speak English, it is difficult to find resources for these people that don't speak English. And, of course, professionals also mentioned language barriers, cultural barriers, and immigration issues. They feel it is important to not only address the medical needs of the population, but also their social needs. For example, families need to know how to navigate the system, how to find resources, and how to work with interpreters.

After collecting information from these professionals, we met with the CDC en español team and the contractors who were developing the materials to design some concepts to be tested. You can see these designs on the slide #7. Six designs were tested. We conducted focus group in New Mexico and another one here in Georgia to test these materials and to collect additional information from Hispanic parents of children with hearing loss. We obtained very good information from parents. Today I don't have time to go through all of the findings, but I can tell you some of the things that we learned. For example, we learned how these families communicate with physicians. Some of them said that they use family members to communicate with their physicians, some of them use interpreters, and also, some institutions provide bilingual staff. When we asked the parents about communication with their child, many said that the child learned faster, and sometimes the child gets frustrated because the parents don't understand them. They also

use family signs. We found that many of these families are confused about the method of communication, so they don't really know what is appropriate for their child. They don't know if the child, for example, can learn English, Spanish, and sign language. Some of the parents think they need to learn English so they can communicate with their children, but some say that the children can learn two languages, or in this case three languages.

After doing these focus groups and getting the results and information, we decided to create the materials in Spanish. We wrote a short story about a family with a child with hearing loss, this family relates how the process of identifying and getting help for their child was for them. In addition to the story, we developed fact sheets talking about different issues, including parts of the ear, doctors and professionals that families may need to visit with their child, technology, resources available, how to communicate with the newborn, information on national organizations, and information about communication options. We also added a glossary in Spanish and English to hopefully help the families understand some of the language that professionals use in English.

We developed these materials in cooperation with several partners here at CDC, and we received feedback from members of the Diversity Committee and had interviews with parents all around the country. They gave us feedback about the pictures that we were using, the words we were using, and, in general, if they liked the materials and understood everything. We got very good feedback, which we used to make some changes. The final product is a folder in which we have the short story and the fact sheets in an inside pocket in the back of the folder along with the glossary. Since these materials are not for English speaking families and many providers may not speak Spanish, we provide a letter explaining what these materials are. An English translation is also included so providers can understand what the materials say. We're going to post the materials on the CDC website so people can order a limited number of copies, or they can also download a PDF file and make photocopies of the materials. The materials are easy to copy for parents. I think we wait until the end for any questions of these materials. And next Valerie is going to talk to us about interpreters.

Valerie Hernandez: Hello, everyone. I am very pleased you have allowed me to join your conference today. I would like to share a power point presentation regarding how to facilitate more effective communication with non-English speaking populations when using an interpreter. Although much of the information is about working with the Hispanic population, this information is also applicable to other languages and cultures when using an interpreter. I have prepared a quiz at the end of the presentation, so I will need a couple of assistants later on.

Participant: Can you refer to the PowerPoint one more time?

Valerie Hernandez: The PowerPoint is called, "Hispanic Culture, How to Facilitate More Effective Communication with Non-English Speaking Hispanic Populations".

Participant: Is there a website we can check while you're talking in case we don't have it?

Valerie Hernandez: If you can e-mail Jamie, I think she can send it to you.

Jamie Elliott: This is Jamie. You can send me a quick e-mail at jei2@cdc.gov . The PowerPoint was sent out, but it was sent late today.

Valerie Hernandez: Beginning with the rules of language in slide 1. There are rules to every language, whether it is Hispanic or Russian whatever language we speak and communicate in. This information is basically about language as a whole and what it consists of. There is interaction. There is turn-taking, complexity, completeness, sentence structure, and vocabulary. The reason why I wanted to start with this as a basis is because, when you use an interpreter, all of these rules of language come into play in one instance or another. This goes hand-in-hand with slide 2; All languages have five registers. I am going to explain those registers to you: *Frozen language, formal language, consultative, informal or intimate*. These are called registers and are identifiable in all languages.

Each register has specific characteristics and unwritten rules as well, which can determine what rule of language you're going to use. When using an interpreter, it is very important that you utilize the correct rule of language in order to achieve clear and concise communication.

Many times when you're using an interpreter, you may have an interpreter that is culturally the same language as the target language but from a different part of the country. Say you have a Puerto Rican interpreter interpreting for someone from Mexico. The cultures are similar yes, they're Hispanic, but they're very different. The rules of language might have to change a bit in order to actually achieve good communication.

For example the interpreter would probably use an Informal register for introductions making the client feel "connected," especially if they know about the culture and dialogue. Then the interpreter might change to a formal register when explaining information given by the provider. In addition, some interpreters have a first language other than English. If you say a word or phrase, they will first interpret it in their minds into their first language and then into the target language. During this process, the interpreter may interpret from their culture and then out into the target language which may or may not be the same culture. So let's say a Puerto Rican interpreter interprets to someone from Mexico. The person from Mexico might receive the interpretation in a totally different way.

#1 register: *Frozen language* refers to, for example, when someone is speaking to an audience, at a conference, or at a special event where others are listening only. A video is a form of frozen language. Radio is also a form of frozen language, as is television. You're sitting and receiving but not saying anything back. That is a frozen register of language.

#2 register: *Formal language* refers to, for example, when someone is speaking to a specific audience using specific terminology understandable to all present. In other words, doctor to doctor, lawyer to lawyer etc. There is a learned vocabulary which is not commonly used among lay people. So if you're a professional, and you are speaking to a client who is in your office for the first time, trying to explain to them what a cochlear implant does using specific terminology, unless a person is educated in this area prior to the conversation, they're not going to understand. The interpreter or the client will not typically understand the formal language. Unless the interpreter is specifically trained in the area of audiology or knows the terminology, then it would be a hard job to change the registry to an informal level or a level that the client can understand. This is why it is so important and so critical that we adhere strictly to professional interpreters and not depend on our staff or people who know the target language but are not professional interpreters.

#3 register: *Consultative language* counsels. One directs the other in conversation, most times by question and answer. So at many of your meetings or appointments, you're in a position of consulting or directing people, saying, "this is what you need to do... this is what's going to happen next..." When speaking in this register, unless you actually prod for an answer, you probably won't get much response from your client, especially if they are of Hispanic decent. The interpreter is only there to do just that, to interpret, so you would need to facilitate by asking a question in several different ways to assure communication is happening when critical information is being discussed.

#4 register: *Informal language* is the day-to-day language that you speak with your co-workers or friends or at home-- just chit chat. This register of informal language is probably the most effective when using an interpreter only because it is most easily understood.

#5 register: *Intimate language* is shared, verbal, emotion, or nonverbal, an Interpreter would use this register on special occasions. For example if someone has had a great loss or when parents come in and learn for the first time their child didn't pass the ABR, and they're devastated and just don't know what to do. This is a time when you can change the register to an intimate kind of language and more heartfelt and more consoling kind of language. Sometimes silence.

Ok, those are the five registers of language. Now you can begin to recognize them and begin conducting clearer communication with the non-English speaking populations. Changing register modes to assure the most effective meeting will assure that you understand and understanding is also happening thus total communication. You are in charge of the communication, and you can lead the interpreter into doing what you want as far as communicating in the way or fashion that you feel is most appropriate.

Next, I'll discuss how to work with an interpreter using consecutive or simultaneous interpreting. It is very, very important to know how to work with an interpreter. Scenario; the scheduler makes an appointment for your client who needs an interpreter. Now you're in the room with the client(s) and the interpreter, and then what? Most times

professionals will not know the difference between consecutive interpreting and simultaneous interpreting. They're not aware of the body positioning that is most effective when using an interpreter. They're not aware of dual tasking and what that means to an Interpreter. They really won't know or even care, because it is not up to the provider to know the code of ethics for communicating through interpreters. They're not aware of which language register they want to use with a particular client to assure that they're getting their message across. And these are very important considerations when you're dealing with difficult topics like pre-surgery or first-hand news that their child did not pass the screening or follow-up. It is very critical that a patient or client understands and feels comfortable, because if they're fearful or intimidated or if things feel unorganized, they won't come back. The interpreter at times has to be an advocate as well as interpreter, and this would be considered a dual role. Being an advocate is sometimes questionable, especially when there is no probable cause. The National Council on Interpreting for Health Care (NCIHC) is working on a code of ethics for interpreting in healthcare, but the present code of ethics states that, when the patient's health, well-being or dignity is at risk, the interpreter may be justified in acting as an advocate.

Advocacy (for an interpreter) is understood as action taken on behalf of the individual that goes beyond facilitating communication with the intention of supporting good health outcomes. Advocacy must only be undertaken as careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem. When an interpreter crosses the line into advocacy, it becomes a different type of interpreting session. It becomes more of a liaison role.

Please find slide #9. It explains three particular categories of being bilingual, fluent, and bicultural. *Bilingual* means one who has the ability to use at least two languages fluently with little or no accent. Everyone that speaks Spanish is not bilingual. Everyone that speaks Spanish, even though they can speak fluently, might not have the capacity to speak English well, meaning with little or no accent.

The next slide is *fluent*. Fluent is described as able to manipulate the language with the accuracy of a native or near-native user of the language. That's fluent. Registry of Interpreters for the Deaf (RID) certified ASL interpreters must achieve fluency as well Spanish Interpreters. That's when you see the difference between a home language, a slang language, and someone who is proficient in a foreign language that is able to achieve the finesse as if they were of that particular culture.

Next is *Bicultural*. Now, this goes a little deeper. This is where I love to delve because understanding the culture is more than just understanding the language. Bicultural is having knowledge of two cultures. Bicultural means to have knowledge of two cultures, to develop socially appropriate behaviors which is very necessary to fit in each of the two cultures and are able to switch from culture to culture, displaying appropriate behaviors at the right time with the right group.

Now, this in-depth study of culture and language leads to why it is very important that when you're interpreting or you request an interpreter that you try to match the interpreter

with the culture. Not all Spanish interpreters can interpret for Hispanic people. I know that seems ironic, but a lot of times I've seen it myself and experienced it being a liaison and not acting as an interpreter. There will be two different Hispanic cultures in the room, and what is okay for one is not okay for the other. Culturally inappropriate interpretation can really muddy up the interpretation.

The interpreter and client then are not then using the informal register. They're just trying to understand each others' dialect rather than going to an informal register, and sometimes they're just not getting the message even though they're speaking the same language. I know it sounds confusing.

But this is why many times when information on paper is translated-- not interpreted but when documents are *translated*-- it is important that they use the correct register of language that fits the culture. For example, you have a professional Spanish language translator, a master of the language, who has translated this document into a beautiful masterpiece of language, it is grammatically perfect, punctuation, sentence structure, and are perfect! But when you give it to the Spanish speaking only family, they understand very little or nothing. It is not because the master didn't do the job correctly. It is because the register of language did not match the culture. It's the same with the interpreter.

When you call for an interpreter, especially for critical meetings, ask the question, "Where is the interpreter from?" You should try to match that interpreter with the target language of the client. I understand there are not that many available but it never hurts to ask. That way you know that the register of language and vocabulary are going to be more of a match. More understanding will take place instead of having to wonder if communication really happened.

Please refer to slide number 6. They are basically two types of interpreting when you're using an interpreter. One is consecutive interpreting, and the other is simultaneous interpreting. If someone would act as a volunteer, I can give you an example of these two types of interpreting methods. Do I have one person? Hello? Claudia?

Claudia Gaffney: Yes.

Valerie Hernandez: Okay. Can you help me?

Claudia Gaffney: Yes, sure.

Valerie Hernandez: All right. I am going to do consecutive interpreting and then simultaneous interpreting. I will first play the professional. And then I am going to be the interpreter, and you're going to be the client.

Valerie Hernandez as Professional: Hello, Mrs. Martinez, how are you today?

Valerie Hernandez as Interpreter: (Now I am the interpreter.) Hola señora Martínez, ¿Cómo está usted hoy? (Now you respond.)

Claudia Gaffney as Client: Estoy bien, gracias.

Valerie Hernandez as Interpreter: I am very fine. Thank you.

Valerie Hernandez: Thank you, Claudia. Stay on the line. That was consecutive interpreting. We each took a turn. The professional took a turn, asked the question, made the greeting to the client. Then the interpreter interpreted the comment, and then the client responded. Each person had a turn. There was no overlapping of voices. Each person spoke consecutively. That kind of interpreting you would use when you really, really want to emphasize what's being said, when you really want to enhance the communication that's being presented when you have something very critical and important. You must try to always use consecutive interpreting. There are no overlapping voices or sounds that are going to distract or confuse.

Now we're going to try simultaneous interpreting. Claudia, all I want you to do is just start to speak, and then I will go ahead and interpret simultaneously.

Claudia Gaffney: Start to speak about anything I want?

Claudia Gaffney (in Spanish) and Valerie Hernandez (interpreting in English Simultaneously: [Multiple people speaking...] problem with his ears... [multiple speakers...]. I don't know that he can hear me very well...simultaneous interpreting is mostly conducted in emergencies when there is no time for turn taking.

Participant: We can hear you. We understand.

Valerie Hernandez: Okay. This is the simultaneous interpreting, and it can be very confusing. Those are two types of interpreting and I just wanted to give an example of each.

Please refer to slide #8, the triad of communication. You have the service provider speaking to the interpreter, the interpreter speaking to the client, the service provider should always speak to the client. Many times the service provider will think, okay, I have to speak to the interpreter because they're the one that understand me. In all actuality your eye contact and everything being said should be directed to the client and the client to you, not on the interpreter. I don't know how many of you have ever had the experience where you have an interpreter, and she/he and the client are speaking to each other like forever, and you're sitting there thinking, *what are they saying? I don't understand what they're saying? Or, did I speak that long in order for them to go on this long? You do have to kind of jump in and say, "Excuse me? Can you repeat what I just said or reiterate the message so I know what is being conveyed?"*

The interpreter should not carry a conversation. They should not be the center of the conversation. They should only be the bridge. The service provider and the client should be the communicators.

Now I will take you through the test I told you about, and you can answer these in your head or just think about the answers. I'll give you the answers when I am done with the questions.

#1. When I use a Spanish interpreter, I can use the same interpreter for all Spanish cultures and expect excellent communication.

Participant: False.

Valerie Hernandez: Correct. We discussed this reason earlier regarding cultural differences and language.

#2. When I need to ask the patient something, I must first ask the interpreter to ask for me, and she or he can communicate in the target language. I can't speak the target language. True or false?

It is false because you need to speak to the client not the interpreter.

#3. My communication should be directly with the interpreter at all times.

Participant: False.

Valerie Hernandez: Correct.

#4. If there are more than four people in a session, plus the patient or client, and the meeting is anticipated to be more than a half-hour long, I need to request two interpreters. True or false?

Participant: True.

Valerie Hernandez: This is true. Otherwise burnout syndrome will happen. After 20 to 30 minutes of interpreting, a person's mind is going to be tired. They're not going to be as sharp, not able to receive or execute information as effectively as a fresh interpreter every half-hour. I know it is not cost effective, but it is more effective communication and a better use of interpreters.

#5. I need to tell the patient some very delicate news. The interpreter relays the information and the patient starts crying. I tell the interpreter to console her/him while I step out of the room and let the interpreter calm the patient down. Since I don't speak the target language, I can't do the patient any good.

Participant: False.

Valerie Hernandez: Thank you.

#6. The patient shared some very difficult life-threatening news with me through the interpreter. I must ask the interpreter to find out all the details and ask whatever questions necessary. The interpreter should cooperate since that's why they're there to communicate. True or false?

That's a false. The person who is in charge of the meeting is the professional and the client, not the interpreter. But if the Interpreter picks up on something that the facilitator does not it is his/her duty to advocate at this time.

#7. The interpreter should only interpret what I tell them to. If I make a personal comment, they should pretend they didn't hear it and only interpret the medical stuff.

Participant: False.

Valerie Hernandez: False. Right! When an interpreter comes to you as a professional, the first thing they should do is introduce themselves as your interpreter and state that they will interpret everything you say. That means that they're putting everything out on the table up front. They're saying, "please don't make any comments that you don't want me to interpret."

#8 I can leave the interpreter with the patient before and after an appointment, and they can keep each other company until I am ready to see the patient. True or false?

That's a false. An interpreter is only there to interpret. When the interpreter is expected to do more, it's called dual tasking. When you have an interpreter dual task, you're taking the interpreter out that position or role of interpreter and asking them to be a something else. That's why there is a very fine line between liaison, advocacy, and interpreting. When servicing a family who does not speak English, the family may have a tendency to rely solely on the interpreter for information. The interpreter might feel obligated to do more, but at that point they become something more than an interpreter. They can become too involved.

#9. I don't need to know word for word what is being said. If the interpreter uses her own words or changes what I am saying so the patient understands, I don't mind. There are three answers to this. True, false, or depends.

Participant: Depends.

Valerie Hernandez: Yes. Depends. Sometimes the person has to change the register in order to effectively communicate with the client. The interpreter sometimes will feel like, *oh, they're not getting it, I need to ask the question or explain it a different way* and at this time should ask the facilitator, "Excuse me, can you please repeat that?"

If the interpreter never interrupts you, and you have a feeling clear communication is not happening or you don't know if they have experience in the area of which they are interpreting, you should be asking question of the interpreter. This is what's going to

bring up the standard. You should say, "How much experience do you have in this area, or do you know anything about the area of which you will be Interpreting?" If they don't, clue them in on some key vocabulary and explanation of terminology you will be using. Clue them in on what you're going to be talking about. The interpreter's job is to say, "Do you have any information or materials that I can look over?" Anything that can help facilitate better communication between the client and interpreter is greatly appreciated by both the interpreter and the professional, but mostly by the client. Okay.

#10: It is up to me (the professional) to find out what is being discussed between the patient and the interpreter when they talk for three minutes straight.

Participant: Yes, true.

Valerie Hernandez: Yes. Thank you. Many times professionals don't know when to cue in, maybe because we're waiting to see if the interpreter is really trying to get information to the client. However, there are some interpreters, not formally trained, that will block out and omit or include things or misstatements or misunderstand things that are being said. And that's the difference between a professional interpreter and a nonprofessional interpreter.

A professional interpreter would never let you wait all that time in order for you to respond. If the time frame of your statement changes, the interpreter might go a little over or a little under, but the time frame should never be very different for what's being said and what's being interpreted.

#11. When should an interpreter advocate? An interpreter should always advocate for the patient no matter what. Do you think this is true or false?

Participant: False.

Valerie Hernandez: Correct. That's never a job of an interpreter. An advocate is to advocate and an interpreter should only interpret. When should an Interpreter advocate? If they feel like communication is not happening, they should interrupt and say to the professional, "Excuse me, can you please reiterate that? I don't think they really understood what you meant." Then they can ask the professional to restate what is being said.

The only time an interpreter should advocate is when they're in a life-threatening situation or when the health and welfare of the client is being jeopardized. Even in a life-threatening situation, though, the interpreter should never become the center of communication. The client and the provider are the center of communication. However, when a patient shares an abuse or suicidal thoughts or something like this with the interpreter, then, yes, the interpreter should immediately advocate for the family by informing the provider, and then the provider can resume and ask the appropriate questions to the client.

There is so much information regarding interpreters and the proper use of this service, but this would be the end of my presentation. I just wanted to reiterate how important it is to work with an interpreter and how to set up for effective communication session when you have a client who needs an interpreter. The Colorado Association for Professional Interpreters is working diligently to try to get the interpreters licensed through the state, because right now, we have no state license for medical interpreters. We only have license for court interpreters.

If you feel the interpreter is not interpreting to your satisfaction - remember this: Everything that an interpreter relays to the client is a reflection of what you're telling them, so if the interpreter isn't interpreting well, the client isn't going to look to you as the final authority. In other words, what you are saying through an interpreter is only as good as what the interpreter relays. You need to really scrutinize for an interpreter for very critical and important appointments. This will make a difference in the outcome. It will make a difference in how much a person will respond back to you – not just a lot of head nodding or just agreeing and never seeing them again. If the interpreter is good, they will know when to change registers of language in order to relay effective communication.

Thank you very much for your time today.

Jamie Elliott: Thank you, Ms. Hernandez, and also Ms. Chacon and Ms. Gaffney. We have about five minutes for questions. If you have questions for any of today's presenters, please take yourself off mute and ask away.

Natalie: This is Natalie. I have a question for Claudia.

Claudia Gaffney: Okay.

Natalie: Claudia, can you access the fact sheets and such on the CDC website? Is that the information I got?

Claudia Gaffney: Which fact sheets?

Natalie: The Spanish material that you talked about. Is that in the manual - the things that you talked about copying for families?

Claudia Gaffney: Ok. They are not on our website yet. They will be available this month. We are going to add this to the order form that we already have on our website, so you're going to be able to go to our website and order it. If you want some copies now, you can send me an e-mail, and I can mail some to you.

Natalie: Okay. Is your e-mail on the PowerPoint?

Claudia Gaffney: Let me see if it is. It is cgaffney@cdc.gov .

Jamie Elliott: This is Jamie. I just want to add to that we will send an announcement out when these materials are ready. They're just about ready, but they have not hit the ground quite yet. We'll let you know when they will be posted on the website as Claudia said.

Natalie: Okay. Thank you.

Jill Ellis: Is Valerie still on?

Valerie Hernandez: Yes, I am here.

Jill Ellis: Hi. This is Jill Ellis in Berkeley, California. It sounds like much of the information you were presenting as the interpreter has been mirrored or lifted from that of like the RID—Registry of Interpreters for the Deaf .

Valerie Hernandez: Yes. One of my sources was a book titled So you want to be an Interpreter by Janice Humphry, but there is the Hispanic aspect that is very different—and in no way lifted, actually. What I covered today was information and Education that I have experienced as a Trilingual Interpreter. I also have taken formal classes in Interpreting both in Spanish and ASL. There is an intense course for Spanish medical interpreters available that I would recommend at FRCC. There is also another source I used which is an organization called CAPI— the Colorado Association of Professional Interpreters. They also have a website.

Jill Ellis: Great.

Valerie Hernandez: You can find more information about medical interpreting on that website. About RID and its formalities, I really appreciated it, having been an interpreter for the deaf for many years. A lot of the roles and responsibilities sound very similar and they are an example of standards. The deaf community has set the standard for ASL interpreting and medical interpreting. Interpreting for the Spanish in the medical field is just beginning to evolve as a profession—we're not even licensed, so we are looking towards those already having the foundation established, like the deaf community, for their interpreting style and standard and where they hold the bar. It is very high and very commendable. Yes, we do uphold a lot of the same standards in interpreting because really interpreting is interpreting no matter what language.

Participant: One of the pieces I appreciated is the body language and the interactions with families. We just did a training a couple weeks ago with our staff here on working with families from the Middle East and also families of Asian background. To me it poses so many challenges and to all of us working in early intervention and diagnosis in terms of-- do you need the information about hearing aids and working with families and cochlear implants? Delivery to so many families is also different.

Participant: Yes. I think working on our Spanish-speaking populations is critical, given the numbers. But I feel like we have so much work to do. Is there, Susan or anybody else in the group, intent to look at some of the other linguistic and cultural backgrounds of

families, for example, Chinese or Vietnamese or Cambodian? Will this committee look at those issues as well?

Susan Chacon: This is Susan. We've been focusing this year on the Hispanic community. We really would like to look at other cultures as well. That is one of our goals.

Valerie Hernandez: Angus McFarland is an Author and professor in New Zealand, and he wrote a book, called "Listen to Culture" and it is excellent. He deals a lot with the Maori people which are very similar to the Hispanic culture – the similarities of how to approach a particular culture, not only Hispanic culture but also Asian and Indian. The list runs very long, and includes approach and body language one thing I really am so keen on is trying to look at the good old art of communication: body language and eye-to-eye contact. For some people, it is not okay to stand more than a leg length away, and for others you have to come very close, so it is very intriguing. Hopefully we can get something established with a multi-cultural focus group or something.

Participant: Right. Actually one of the things I was going to present as an abstract to be presented at EHDI for this next round of presentations is the work we're doing trying to address some of the issues of working with families of such diverse backgrounds. I am working on that abstract now, because even within the Asian community, what we learned is how you might address a family of one background may be completely inappropriate to another.

Valerie Hernandez: Absolutely.

Participant: Just as you were saying with the Spanish-speaking families, you can't make assumptions. In some ways it could be bringing potential harm or the devil to the kids. For example, those of us working in early intervention like to say *wow, doing a great job, good job*. This can be interpreted negatively in some cultures, and I think it is really important for people to know.

Susan Chacon: You're very right.

Valerie Hernandez: Oh, as we began to look at it, it kind of opened up a whole new world to us.

Susan Chacon: Yes, yes.

Jamie Elliott: This is Jamie at CDC. We are at about the end of our time. I want to first of all thank our speakers for taking the time to be with us this afternoon and to everyone for participating. I do want to let you know the transcript for this call will be posted on the CDC/EHDI website in about a month. You can access the transcript there, and please feel free to share the transcript with those who could not participate today. Thank you.

Participant: Valerie, do you have an e-mail or phone number contact?

Valerie Hernandez: I do have a phone number. I am in transition so I don't have e-mail set up just yet. My telephone number is 719-390-0853. Then I have a Denver number still, and that is 303-257-4061.

Participant: You guys have done a great job. Thank you so much.

Valerie Hernandez: Thank you. I did leave my address in case. I would love to hear from anyone who has any information or wants more information. I have a whole file full of information I have been collecting, and doing research on for quite a number of years.

Participant: I will take you up on that. I will follow-up.

Jamie Elliott: All right. Thanks, everyone.

Valerie Hernandez: You're welcome. Thank you.

Participants: Good afternoon. Bye.

End of Transcript