



**Nebraska Department of Health and Human Services**  
**Division of Public Health**  
**Office of Minority Health and Health Equity**  
*Equalizing health outcomes and eliminating health disparities*

**College of Saint Mary**  
**Center for Transcultural Learning**  
*Responding to the gifts and needs of our growing multicultural community*

# **Interpreters Speak Out**

## *Nebraska Language Access Survey*

### **Report of Findings**

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## *Nebraska Language Access Survey*

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# Chapter 1

# Preface

## PREFACE

This survey has been created and conducted in addition to the writing of this *Report of Findings* by the Center for Transcultural Learning (CTL) at College of Saint Mary (CSM) at the request of the Office of Minority Health and Health Equity, Nebraska Department of Health and Human Services. Survey software consultation, analysis of survey results, and editing has been provided by the Nebraska Office of Minority Health and Health Equity.

Due to the rapidly changing demographics in the state of Nebraska, interpretive services and language access provision in the health care setting have cried out loudly in the state of Nebraska over the past few years, building to a crescendo in the summer of 2007. Three statewide conferences focused exclusively or in part on the issues and challenges of interpretive service provision: Missing Links I in July, Nebraska Association of Translators and Interpreters (NATI) Conference in August, and Nebraska Minority Health Conference in August. Lincoln's New Americans Task Force, Omaha's Refugee Task Force subcommittee for health care interpreting, and the Region V CLAS Coalition are other strong examples of the commitment and concern among individuals and groups responding to the need for Nebraska's health care systems to reach out to all persons seeking health care regardless of ethnicity, country of origin, and English language ability. The question of national certification for health care interpreters is being raised more and more frequently. States, language agencies, and academic institutions are making valuable headway in developing assessment instruments, with the end goal of quality assurance.<sup>i</sup> Members of the Refugee Task Force in Omaha, the Douglas County Health Department, and the College of Saint Mary are currently leading an initiative to design an assessment tool to verify at least a minimum skill level in Nebraska health care interpreters.

In the recent past, there have been efforts to garner qualitative and quantitative data about the availability and caliber of language access services within Nebraska's health system. One such example is a ten-question survey completed in 2006 to assess the attitudes of Lincoln/Lancaster County medical providers. The survey was conducted by the Medical Translation & Interpretation (MTI) Leadership Group, a community task force out of Lincoln, Nebraska.<sup>ii</sup> The 72% response rate was noteworthy with 126 surveys sent and 91 completed and returned. It was evident in the findings that a significant proportion of medical providers are either not aware

of or are unclear about their responsibilities in providing quality interpretive services or qualified bilingual staff and clinicians in order to communicate with patients of limited English proficiency. Most notably, 68% of the providers said that they are most likely to use patients' family and friends to provide interpretation and translation services. Of those 118 respondents who were most likely to use friends and family to interpret, 49 (or 41%) reported this method as probably or definitely adequate. Moreover, 58% of all respondents claim they do not offer written health information or forms, such as teaching sheets and discharge instructions, in other languages.

The purpose of our survey is to help eliminate health disparities caused by lack of adequate and quality language access services to limited-English-proficient (LEP) and non-English-proficient (NEP) patients in the state of Nebraska by gathering information about:

1. What is working well and where there may be gaps or barriers regarding language access services within our state's health care system; and
2. The quality of interpreter skills as reflected in their professionalism, education, training, and knowledge.

To expand our understanding of the quality of language services available in Nebraska's health care settings, we asked people who interpret in those settings about their experiences. We also assessed the characteristics of Nebraska health care interpreters such as education level, interpreter training, and knowledge of ethics related to health care interpretation. As a member of the treatment team who, due to his/her role, consistently observes medical encounters objectively, the interpreter is an excellent eye and ear witness to the manner in which organizations provide culturally and linguistically appropriate care to all patients regardless of country of origin, culture, or preferred language. In addition to the analysis of data gleaned from the interpreters' voice, this narrative offers highlights of the data, with considerations and recommendations for the level of the interpreter, the organization, and the state.



## Chapter 2

# Highlights

## HIGHLIGHTS

The need for language access services in Nebraska's health care system (as in all sectors) is driven by the quantitative reality, as revealed in the U.S. Census Bureau data, that our state's foreign-born population is growing at an exponential rate – faster than 43 of the other 49 states. The Nebraska Department of Education in 2007 reports 76 languages spoken in Omaha public schools and 48 in Lincoln public schools. <sup>iii</sup>

Until now, no study in Nebraska has explored the landscape of language access in a systematic fashion from the point of view of the people on the ground providing the language services. This report highlights findings from the survey data collected in addition to comments within each section related to local and national contextual issues surrounding the challenging task to provide safe, quality health care to all persons regardless of national origin and language.

The 30-question survey was generously completed by interpreters who work in various health care settings all across the state of Nebraska. This chapter briefly outlines the results detailed in Chapter Four.

### A GLANCE AT RESPONDENTS' CHARACTERISTICS

- 179 persons completed the survey
- 68% have two years or more experience in health care interpreting
- 94% have high school diplomas, 86% have some college education, 29% have a Bachelor's Degree, 10% have a Master's Degree, and 5.8% have not graduated from high school
- 31% were born in the U.S. and 69% were born outside the U.S.
- 19 languages were spoken among the respondents (excluding English)
- 71% are Spanish language interpreters
- 40% conduct more than 35 sessions per month, 54% conduct more than 20, and 66% conduct at least 10 per month
- Each interpreter on average works in 2.5 different types of facilities
- 60% are hired as interpreters and/or translators; 40% are not hired with the position of interpreter in their primary title or are in a dual-role position

- 34% work full-time, 18% part-time, 40% on-call, and 8% on-call either part- or full-time
- 43% earn \$8-15 per hour, 23% earn \$15-20, 15% earn \$20-25, 10% earn \$25-30, and 8% earn over \$40 per hour
- American Sign Language Interpreters consistently earn the highest pay
- 79% have had some medical interpreter training, yet it is unclear whether the training was a brief 1-2 hour session or full-length course of 40+ hours
- Nearly 60% of those with medical interpreting training earn above the lowest salary range; only 44% of those with *no* specific medical interpreter training are above the lowest range

## ASSESSING INTERPRETER COMPETENCIES

In an attempt to measure competencies, we chose three areas for which professional medical interpreters should have a high degree of expertise:

1. Role of culture broker
2. Professional standards and ethical codes
3. Briefing pre-session

***The role of culture broker*** should be assumed by an interpreter only when cultural differences lead to a misunderstanding on the part of the provider or patient. From our sample:

- 37% have a *misconception* of the culture broker role
- 28% *seem to understand* the culture broker role but did not cite an example
- 35% *clearly understand* the culture broker role and cited appropriate examples

We explore in this report the correct utilization of the role of culture broker, possible reasons for the misconceptions, and the impact training and standards of practice have on this critical role.

***Standards of practice*** are a set of guidelines that define what an interpreter does in the performance of his or her role. Standards are concerned with the “hows” and codes of ethics focus on the “shoulds.” 30% did not respond to the question about which standards they follow, and 15% answered “none.” It could be assumed that 45% do not follow any professional guidelines. Of those that identified a set of standards:

- 26% follow the National Council for Interpreting in Health Care
- 17% follow American Medical Interpreters Translators Association
- 10% follow American Translators Association

- 5% follow Registry of Interpreters for the Deaf
- 2% follow California Healthcare Interpreters Association
- 2% follow Massachusetts Medical Interpreter Association

**The briefing pre-session** gives the interpreter the opportunity to obtain patient demographic and appointment information, explain how the interpretation will work, determine the linguistic level of the patient, and ensure that all messages are communicated in a complete and accurate manner.

- 25-31% did not conduct a briefing pre-session.
- 75% always or often conducted the pre-session.
- From the 25% who *did not conduct* briefing pre-sessions, only 45% had some medical interpreter training, compared with the 75% who *always or often conduct* a pre-session, 90% of those have had medical interpreter training.
- Interpreters following NCIHC Standards of Practice most often conduct pre-sessions.

## ASSESSING ORGANIZATIONAL EFFORTS

From the interpreters' perspective, how well do Nebraska health care organizations fulfill their responsibilities to provide equal care to all patients regardless of language and cultural differences? Without overtly naming the Culturally and Linguistically Appropriate Services (CLAS) Standards, five survey questions gave us an insight into the level of organizational compliance to CLAS mandates # 4, 5, 6, and 7. Here are the interpreters' ratings:

- *Are organizations hiring bilingual staff?* 38% rate organizational efforts as excellent to very good; and 62% say fair, inadequate, or poor.
- *Do organizations inform limited-English-proficient patients of their right to a professional interpreter?* 55% say excellent or very good, and 45% say fair, inadequate, or poor.
- *Are organizations ensuring that patients have a professional medical interpreter rather than allowing family and friends to interpret?* 60% say excellent or very good, and 40% rate them as poor, inadequate, or fair.
- *Do organizations display signs in multiple languages for patients to see?* 52% give a higher rating and 48% say that organizations are poor, inadequate, or fair.
- *Are organizations making health documents readily available in multiple languages for patients?* 55% say excellent or very good, and 45% say poor, inadequate, or fair.

Following are the most frequent responses to a series of questions about the quality of services to LEP patients delivered by Nebraska health care organizations:

*What constitutes an organization's quality service to LEP patients?*

1. Having interpreters and bilingual staff available
2. The quality of the interpreter staff
3. Treating the patient well

*What do organizations need to improve in their service to LEP patients?*

1. Lack of respect and/or quality services for LEP patients
2. Not enough interpreters
3. No interpreters on staff or no interpreters at all
4. Allowing family and friends to interpret

*Are there incidents in the medical interpretive encounter that interpreters are reporting?*

- 20 did not respond; 113 said "no;" 46 said "yes" with top reasons given:
  1. Abuse or intent to harm self or others
  2. Provider blatant disrespect toward patient
  3. Incompetent interpreter

*What are the main barriers faced by LEP patients?*

1. Lack of language access services
2. Lack of health insurance
3. Cultural differences
4. Lack of bilingual health providers

## **INTERPRETERS SPEAK OUT ABOUT THEIR PROFESSION**

An interpreter is a member of the treatment team who consistently observes medical encounters yet rarely has the opportunity to voice their observations about the manner in which LEP patients are served. How do they feel and think about their role and how others perceive their role within the organization?

- Interpreters feel more valued and respected by patients compared to staff or providers.
- Their most negative experience is the general lack of respect for their profession.

*What are interpreters' most positive experiences?*

1. Opportunity to help people
2. Working in the health care field
3. Using language skills

*What are interpreters' most negative experiences?*

1. Lack of respect for interpreters as professionals
2. Providers' lack of cultural competence
3. Having to give bad news
4. Lack of proper training

## **SAMPLE SIZE AND REPRESENTATION**

In this statewide survey, careful attention was paid to ensure that sample size was representative of the whole state and proportionate to the foreign-born population. The foreign-born population in the capital city of Lincoln is 7.38% of its total population, compared with 5.35% for the Omaha Metro area, and 4.88% in the rest of the state. With our sample as indication, Lincoln and Omaha Metro have nearly the same ratio of medical interpreters per foreign-born (25 per 10,000), with 25% fewer interpreters per foreign-born (19 per 10,000) outside these two large city areas. In terms of the three Congressional Districts, Districts Two and Three have similar ratios of 24 medical interpreters per 10,000 foreign-born, compared with District One at 13% fewer (21 per 10,000).

## **KEY ISSUES**

The findings from this survey prompt us to focus attention on several issues: the professionalization and validation of the role of the medical interpreter in the state of Nebraska; the quagmire into which dual role interpreters are placed; the impact of organizational compliance in regards to effective language access service delivery; the importance of substantive interpreter training especially in the areas of standards of practice, culture brokering, and briefing pre-sessions; the educational needs of organizations, staff, and providers about the role of professional interpreters and language access regulations; and the positive impact excellence in culturally and linguistically appropriate services has on health disparities, patient satisfaction, and the outcomes of care. These key issues are addressed in greater detail within the report. Further Considerations and Recommendations can be found in Chapter Five.



## Chapter 3

# Background

## BACKGROUND

As a sparsely populated state in the center of the country, Nebraska can be perceived by east and west coasters to be in the middle of nowhere. Not so, says Mary Pipher, in her book *The Middle of Everywhere: The World's Refugees Come to our Town*,<sup>iv</sup> a bestseller about Nebraska's diverse immigrant population. U.S. Census data in 2000 ranked Nebraska as the 7<sup>th</sup> fastest growing state in the country in terms of foreign-born population. Nebraska is a desirable destination for immigrants and refugees due in large part to the employment opportunities in the agricultural and meat processing industries. Latino population growth and consequently its complex diversity are other reasons why Nebraska is designated as a new and resurgent immigrant destination. These changes will shape the future of the state.<sup>v</sup> Forty-five percent of the state's overall population growth consists of people born abroad, and the top ten birthplaces as:

**Table 3.1: Top 10 Nebraska Foreign-Born Birthplaces**

1. Mexico	44,532
2. Central America	10,893
3. Africa	7,351
4. Vietnam	6,891
5. China	4,655
6. Eastern Europe	3,478
7. India	3,216
8. Germany	2,320
9. Korea	1,823
10. Canada	1,479

U.S. Census Bureau, American Community Survey 2006

One prominent example is the city of Schuyler, where the immigrant population soared from 4 percent to 32 percent during the 1990's, ranking it sixth among all United States cities in terms of increased percentage of foreigners. "This year's kindergarten class is 140 children, the largest ever, with only about 20 white pupils," Schuyler Community Schools Superintendent Robin Stevens said.<sup>vi</sup> The changes that have taken place in Nebraska since

1990 have created the need for language access services. The chart below list the Nebraska cities with the largest change in LEP population from 1990-2000.

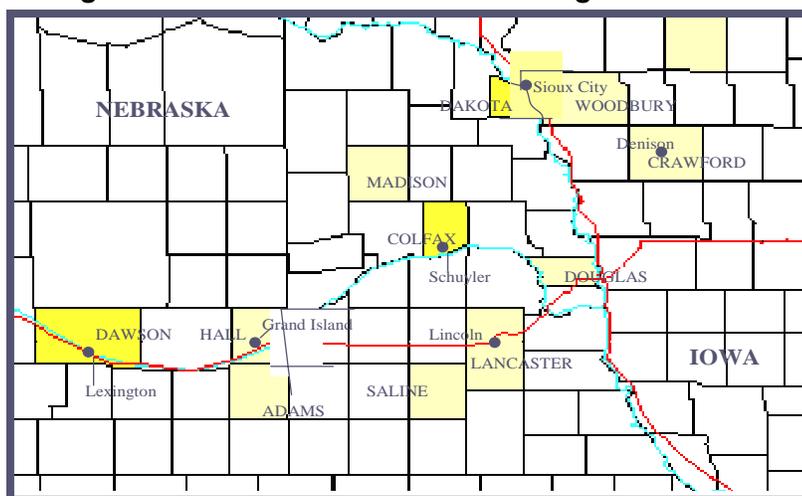
**Table 3.2: Nebraska Cities with No English or Don't Speak English Well**

CITY	COUNTY	1990	2000
Schuyler	Colfax	3.4%	33.5%
Lexington	Dawson	1.3%	31.9%
Madison	Madison	4.5%	20.6%
South Sioux City	Dakota	3.7%	15.2%

U.S. Census Data 2000

Nebraska counties with the highest percentages of persons who claimed “No English” or “Don't speak English well” were highlighted in the 2000 Census Data for Central Nebraska and Western Iowa. Counties with high Limited English Proficient (LEP) populations are shown below.

**Figure 3.1: Nebraska Counties with high LEP**



U.S. Census Data 2000

The Omaha Public Schools' (OPS) Board Report in June 2007 listed 76 different languages spoken by OPS students. The Lincoln/Lancaster County Report to the Nebraska Department of Education in September 2007 listed 48 languages and dialects. Limited English Proficiency (LEP) presents a daunting challenge to schools, businesses, law enforcement, courts, and health care. These challenges lead to an imbalance in services rendered.

Ethnic and racial inequalities are documented across the country, across sectors, and across minority groups. As we focus this report on the health care sector, and specifically the quality of language access services in Nebraska, it is helpful to look at local and national data and regulations. The Institute of Medicine in its report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* revealed that “racial and ethnic minorities tend to receive less care than non-minorities for the same condition, and when they receive care, it is often of lower quality, even when access-related factors such as patients’ insurance status and income are controlled.”<sup>vii</sup>

In December 2000, the Office of Minority Health, U.S. Department of Health and Human Services published the final recommendations on national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. Federal and State health agencies and policy makers now have a blueprint to follow to build culturally competent health care organizations, and to begin the elimination of the inequalities in care and treatment of patients with limited English proficiency and culturally diverse backgrounds. The CLAS standards are the foundation from which several questions of this survey were derived. The survey aimed to solicit the opinions of the Nebraska medical interpreter about the effectiveness and efficiency of language access services in our state.

## DESIGN AND METHOD OF RESEARCH

Because our target group was medical interpreters, any person who had experience interpreting in a medical/health care setting was eligible to take part in the survey, regardless of his or her official job title. The survey was not limited to interpreters of oral foreign languages. American Sign Language (ASL) interpreters who provide services in health care settings also participated.

### **Instrument Development**

A committee of five persons was formed to assist in devising the questions for the instrument, to reflect the objectives and purpose of the survey. The committee consisted of the training coordinator and the director of the Center for Transcultural Learning, a member of the board of directors from the National Council on Interpreters in Health Care, an employee of a social service agency involved in interpretive services, and an employee of a

Nebraska county health department. The committee did not have access to confidential data on returned surveys.

The survey design was a written, structured, self-administered questionnaire in English, with a combination of open-ended, closed-ended, and fixed alternative questions. The survey consisted of 30 questions which, according to respondents, took 15-20 minutes to complete.

One part-time research assistant, two consultants, a statistician, and an interpreter trainer assisted in coding the open-ended questions. All persons with access to the returned surveys and data signed a confidentiality agreement.

### **Data Collection**

Data was collected via hospitals, clinics, community health clinics, county departments, interpreter agencies, interpreter training programs, and interpreter organizations across the state of Nebraska that staff, utilize, or work with interpreters. The interpreters were given a choice regarding the method of survey distribution: hard copy version, email version, or telephone survey. When sending hard copies by mail, we included pre-addressed postage-paid envelopes to make it easy for respondents to return their surveys.

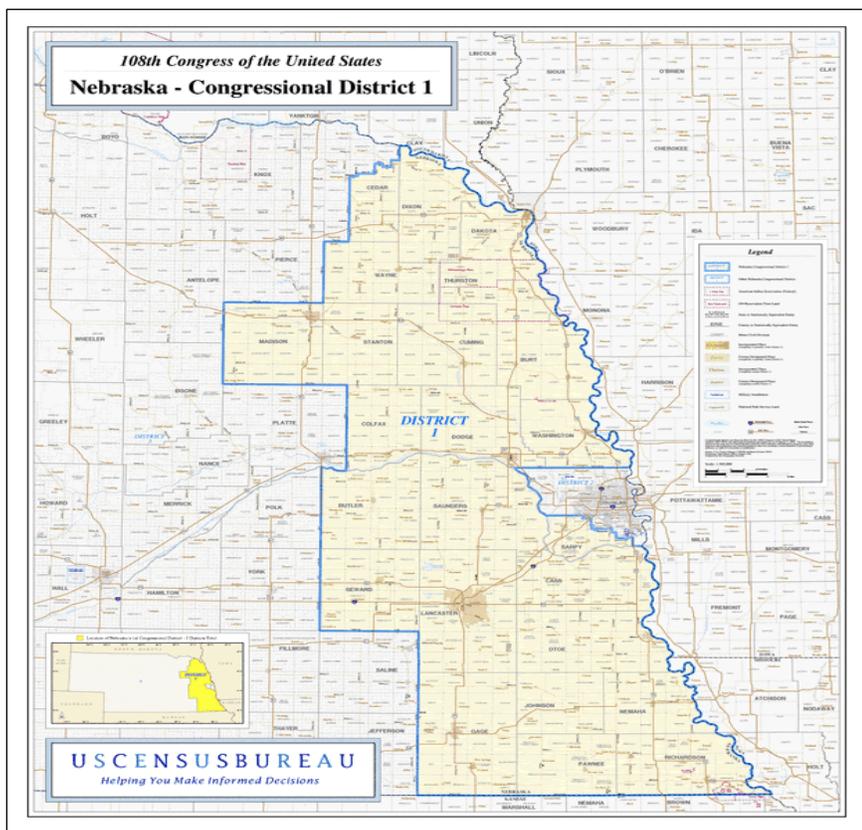
Our strategy to maximize response rate was to initially telephone the interpreters or facilities and agencies with connections to interpreters, to inform them of the background and reason for the study. We asked how many other interpreters were in their department, facility, or network. We then sent the survey to each person willing to participate, asking him or her to forward it to all persons in their network. Our research project was announced and the surveys distributed at three statewide conferences in August 2007: Nebraska Association of Translators and Interpreters (NATI): Speaking of the Future: Enhancing Language Proficiency<sup>viii</sup>; Missing Links I: Improving Health Care by Removing Language Barriers<sup>ix</sup>; and the Nebraska Minority Health Conference: Equalizing Health Outcomes and Eliminating Health Disparities.<sup>x</sup> As a result of these efforts 179 completed surveys were collected.

Some of the respondents serve in more than one area or congressional district, creating a larger number of “responses” than respondents to the question “In which cities or towns do you provide interpretive services; list all if more than one.” Nebraska’s three congressional

districts range narrowly in population from 546 to 572 thousand inhabitants. There was considerable thought and dialogue about what constitutes representation of the entire state, and from which population to compare the sample group. Although the Bureau of Labor Statistics 2006 estimates there are 420 Translators and Interpreters in the state of Nebraska, our survey was not intended to target translators (those who interpret written text) nor was it focused on interpreters in general (court, legal, community, or education interpreters). Only interpreters who serve in a health care setting were asked to participate, no matter their job title. Indeed, lack of “interpreter” in the job title of employees who provide this function is one of the major challenges in the field of interpreting. Some organizations often require dual-role functions from their bilingual employees, such as clerical workers “dubbing” as interpreters, and consequently remain under the radar when it comes to compliance with interpreter quality standards and training.

These are but some of the reasons it was determined that adequacy of sample size should be in comparison to foreign-born population in the areas and congressional districts of Nebraska. The following tables and graphs offer a glimpse of Nebraska’s total population and its foreign born population with a comparison ratio to sample.

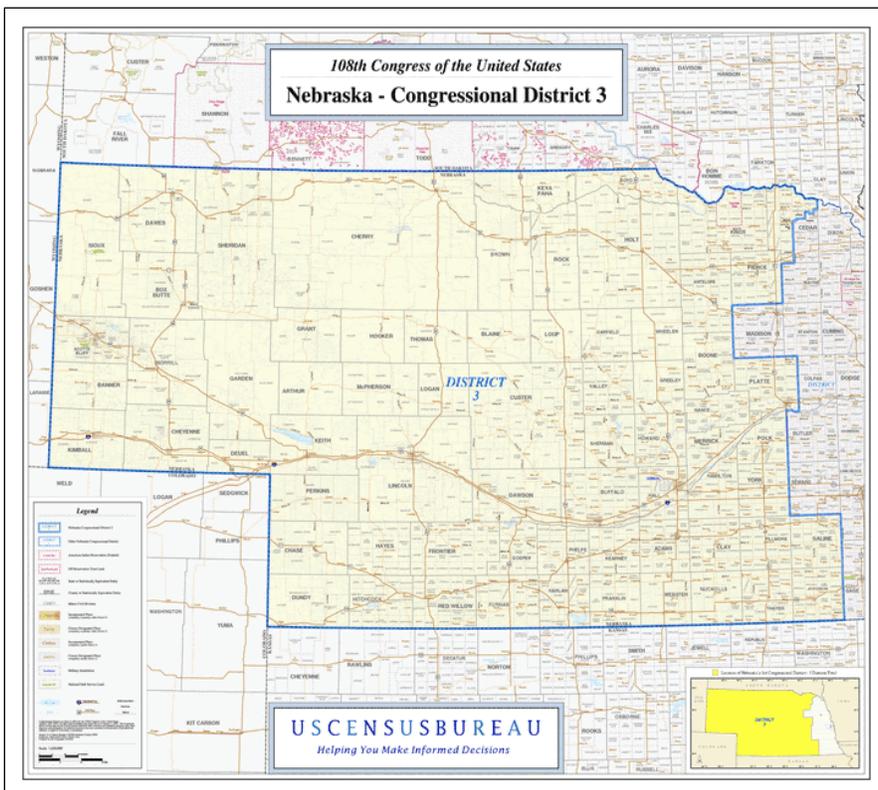
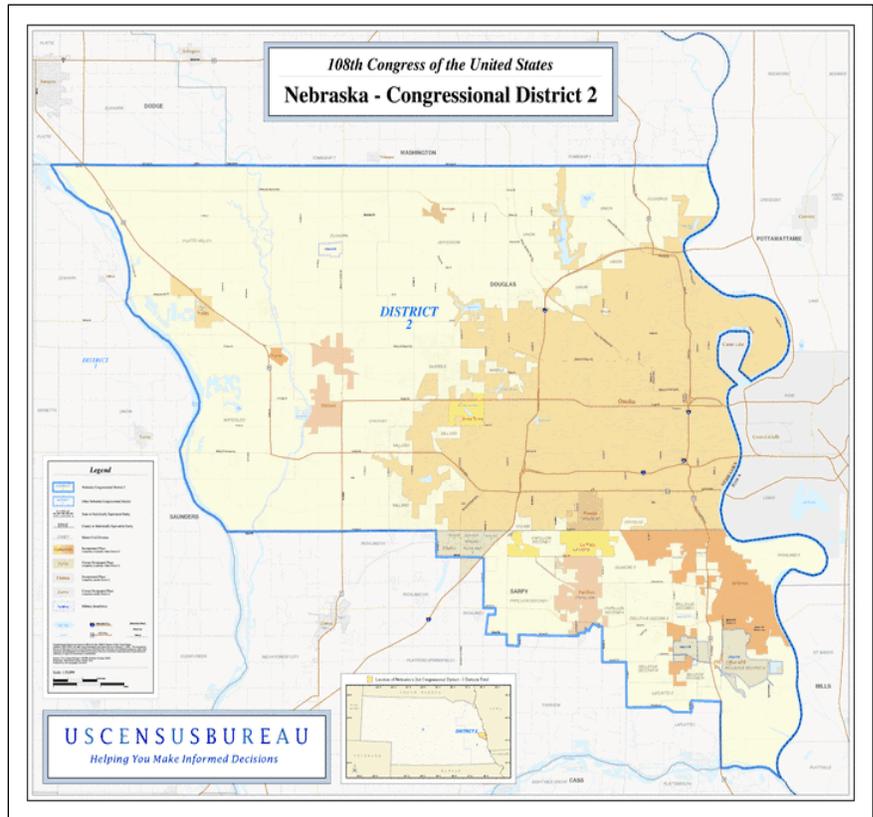
See maps of congressional districts below.



**Figure 3.2**  
**Nebraska Congressional**  
**Districts**  
 U.S. Census Wall Maps<sup>xi</sup>

**District One** encompasses most of the eastern quarter of the state. It includes the state capital, Lincoln, Fremont, Norfolk, Beatrice, and South Sioux City.

**District Two** encompasses the core of the Omaha metropolitan area. It includes all of Douglas County and the urbanized areas of Sarpy County.



**District Three** encompasses the western three-fourths of the state; it is one of the largest non-at-large Congressional districts in the country. It includes Grand Island, Kearney, Hastings, North Platte, Scottsbluff, and Columbus.

**Table 3.3: Representation of Sample Size to Total and Foreign-born Population**

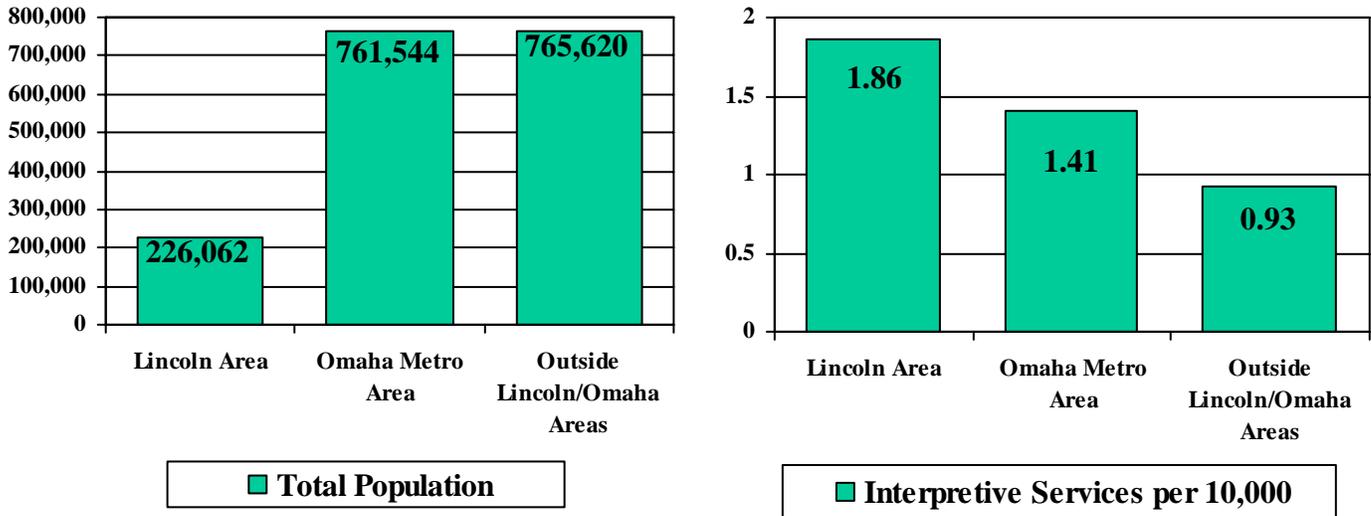
*179 respondents serving in more than one area and district create a larger number of “responses” than “respondents.”*

<b>Number of Respondents</b>	<b>179</b>	<b>Total Population (2005)</b>	<b>Ratio Interp Services per 10,000</b>	<b>Total Foreign Born Population (2005)</b>	<b>Ratio Interp Services per 10,000</b>	<b>Ratio Foreign Born to Total Population</b>
<b>AREAS</b>	<b>Responses</b>					
Lincoln Area	<b>42</b>	226,062	1.86	16,678	25.18	7.38%
Omaha Metro Area	<b>107</b>	761,544	1.41	42,115	25.41	5.53%
Outside Lincoln/Omaha	<b>71</b>	765,620	.93	37,334	19.02	4.88%
<b>Total Responses AREAS Served</b>	<b>220</b>	<b>1,753,226</b>		<b>96,127</b>		<b>5.48%</b>
<b>CONGRESSIONAL DISTRICTS</b>						
Subtotal District 1	<b>65</b>	572,745	1.13	31,190	20.84	5.45%
Subtotal District 2	<b>107</b>	587,927	1.82	44,905	23.83	7.64%
Subtotal District 3	<b>48</b>	546,304	.88	20,032	23.96	3.67%
<b>Total Responses DISTRICTS Served</b>	<b>220</b>	<b>1,706,976</b>		<b>96,127</b>		<b>5.63%</b>

*Note: Some respondents wrote “All of Nebraska” as the city or town in which they provided services. For this table these 16 responses were distributed respectively – 5-5-6 – into the three districts and areas. See Figure 4.10 for a detailed listing of the cities and towns.*

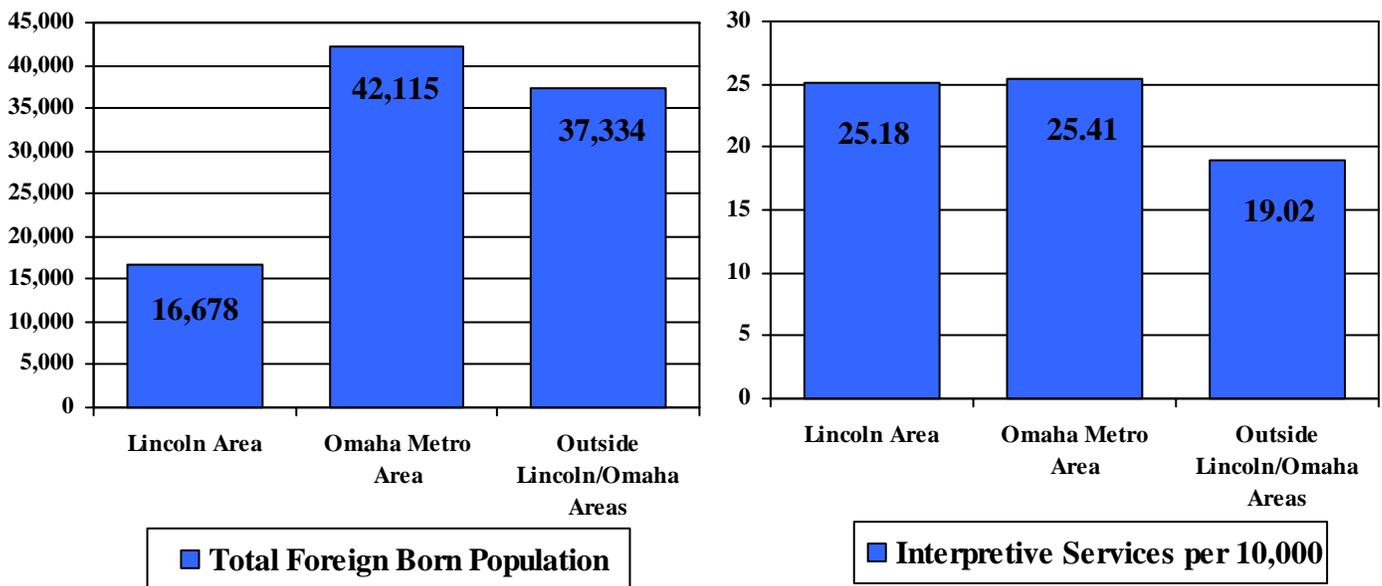
Our sample indicates that there are more medical interpreters per 10,000 serving in Lincoln, and even fewer in the area outside Lincoln and Metro areas.

**Figure 3.3: By AREA – Interpretive Services to Total Population**



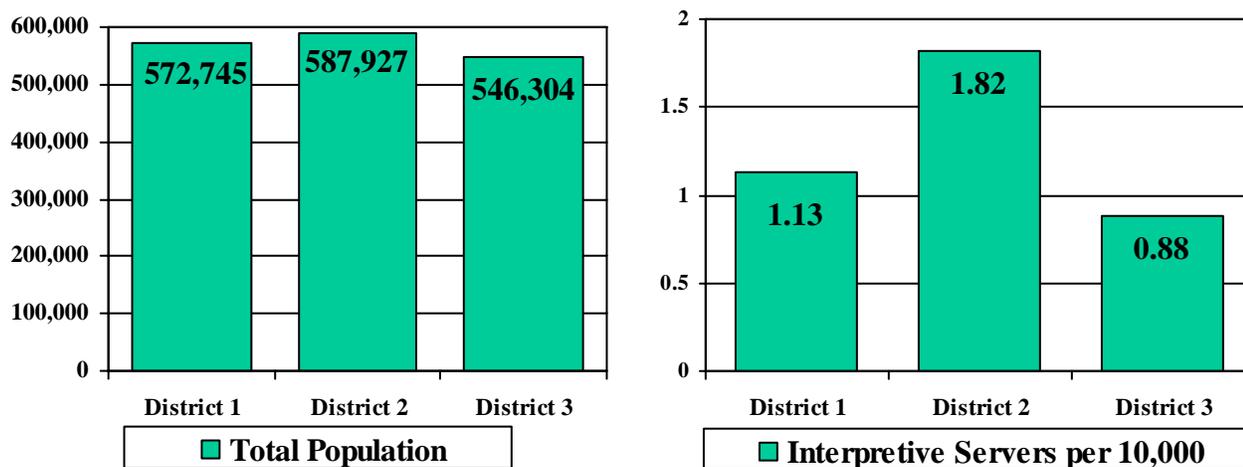
As shown on Table 3.3 above, Lincoln has a higher percentage of foreign born, 7.38%, than the Omaha Metro area, 5.53%. Outside these two areas, the percentage is 4.88%. From our sample, both Lincoln and Omaha Metro areas have the same number of interpreters per foreign-born, yet there are fewer interpreters per foreign-born outside these two areas.

**Figure 3.4: By AREA – Interpretive Services to Foreign-born Population**



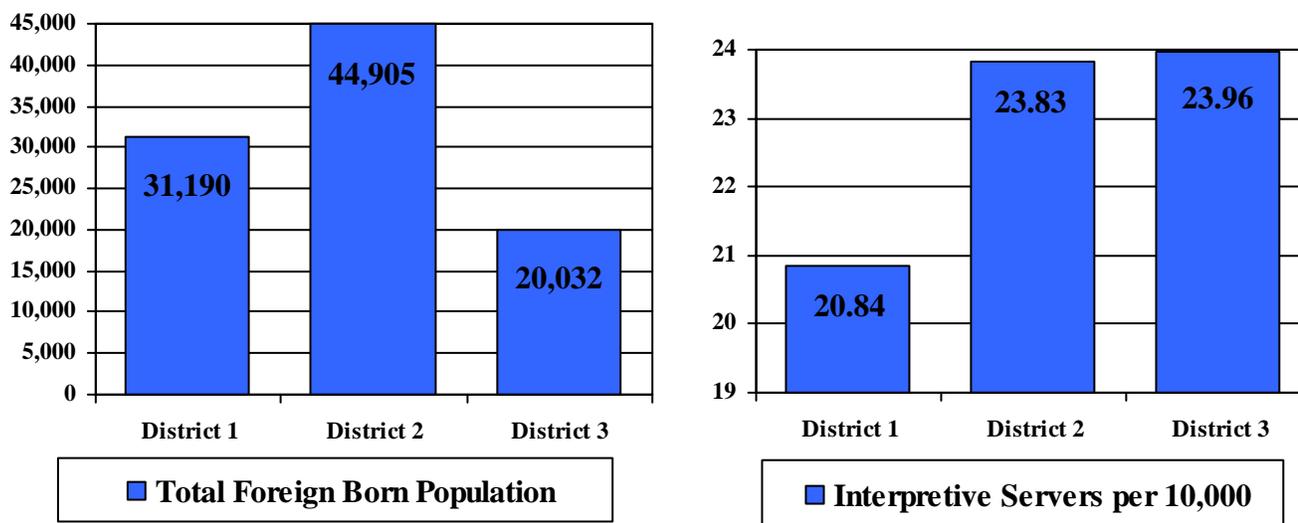
Continuing our look at the interpreter survey sample size, below is the relationship of congressional districts, total population, and interpreters. While the three districts are almost equal in total population, there are more than double the interpreters serving in District Two compared to District Three. District One has 72% fewer interpreters than District Two. While limitations in our data collection could be a reason for this disproportion, we explore this and other possibilities in the Considerations chapter.

**Figure 3.5: By DISTRICT – Interpretive Services to Total Population**



In relation to foreign-born population, there is a slight disproportion (13% fewer) of interpreters serving in District One as compared with Districts Two and Three, in relation to the foreign-born population in these districts.

**Figures 3.6: By DISTRICT – Interpretive Services to Foreign-born Population**



## **Confidentiality**

Strict rules of confidentiality were followed during data collection, analysis, and reporting of this survey project. Respondents were requested to refrain from writing their names on the completed survey forms. As surveys were returned, we attributed a numeric code in order to track the input of data in the software and enable our research assistant to check and double check for errors in data entry.

Included with the survey was a cover letter or email with instructions for completing and returning the survey and a promise of confidentiality and anonymity. The promise was reiterated at the top of the survey tool stating:

*“We do not need your name on the survey. Your individual identity will not be revealed. The written survey results will be presented in grouped data only, and the individual surveys will remain confidential. Thank you very much for your help in our mission to eliminate health disparities.”*

The committee of interpretive services experts that were chosen to assist in the formulation of questions for the instrument was not shown the results of the returned surveys. We mandated a strict adherence to procedures protecting the confidentiality of the information linking the identification, numbers, or codes. Only key project personnel have access to information linking groups who returned the surveys with numbers or codes.

## **Data Analysis**

With the assistance of Anthony Zhang, Health Surveillance Specialist for the Office of Minority Health and Health Equity, the survey questions were set up in a data file in SPSS software. After the data entry was completed, Mr. Zhang lent his expertise by providing the raw data and comparative data analysis as the basis for this report. The responses to open-ended questions were written out in full, and later coded by giving variable attributes. To determine inter-rater reliability, three raters were assigned to each variable response, to ensure different raters gave consistent coding of the same response. Responses where no common characteristics were found among other responses to same questions were coded as “other.”



## Chapter 4

# Results

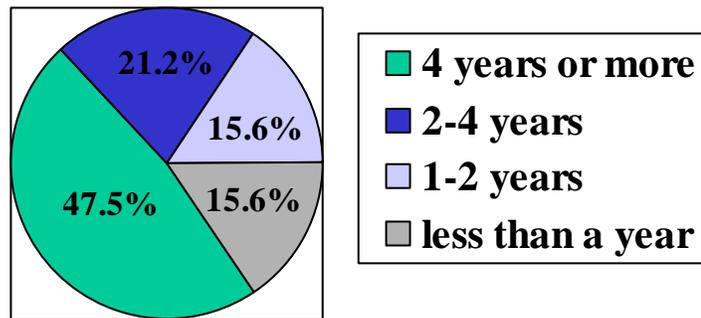
# RESULTS

## DEMOGRAPHICS OF RESPONDENTS

### EXPERIENCE

It was important for research purposes to gain an insight into Nebraska's language access services from the perspective of interpreters who had sufficient experience in health care settings in the state. When asked how long the respondent has been serving as a medical interpreter, all 179 respondents answered the question. Thirty-four, or 19%, have been working in this capacity for over ten years. Almost half have been in the field for more than four years, and over 68% have had experience interpreting in the health care field for two years or more.

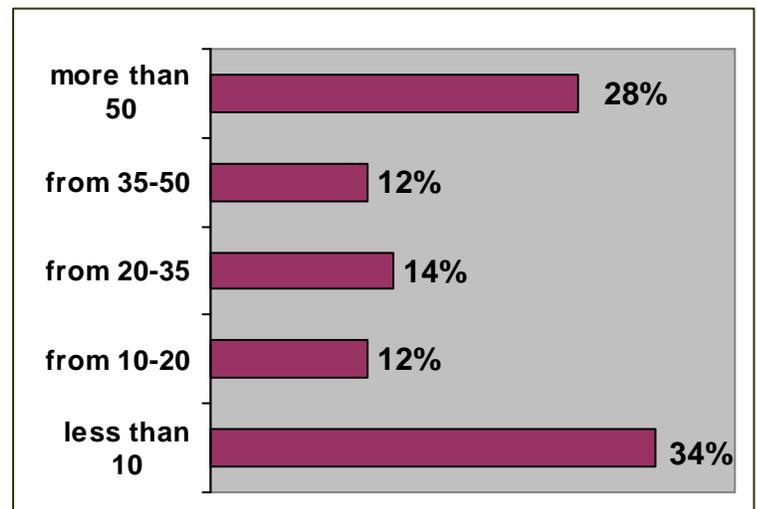
**Figure 4.1: Years as Medical Interpreter**



**Figure 4.2: Number of Sessions per Month**

### NUMBER OF SESSIONS

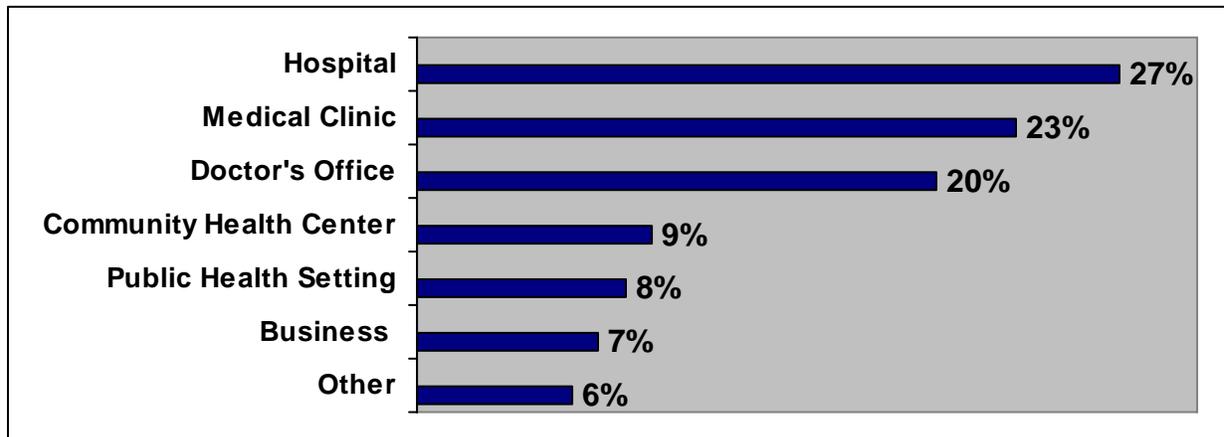
In terms of number of medical interpretive sessions conducted monthly, 174 of the 179 responded to the question "How many interpretive sessions do you currently have each month?" Of those who responded, 40% conduct more than 35 sessions per month, 54% conduct more than 20 sessions per month; and 66% conduct at least ten sessions per month.



## **WORKPLACE**

Interpreters are working in various types of medical and health care facilities. The 179 respondents offered a total of 465 answers to the question “What type of facility do you interpret (or work) for?” On average, each interpreter works in 2.5 different facilities. Hospitals, Doctors’ Offices, and Medical Clinics comprised 70% of the answers.

**Figure 4.3: Types of Facilities Worked For**



## **JOB TITLE**

When asked about their job title, 18 of the 179 did not respond. Similar titles, such as *Secretary* and *Receptionist*, were consolidated to *Administrative*. Half of the 161 identified their title as *Interpreter* or *Medical Interpreter*. *Interpreter-Translator* was identified by 10.6%. Almost 40% were not hired with the position of interpreter in their primary title. If the assumption is correct that those not responding to this question do not have the formal title of interpreter, then approximately 50% were not hired primarily as interpreters.

The issue of “Dual Role Interpreters” is prevalent in regard to the potential de-professionalization of medical interpreters. At the first annual membership meeting in August 2007 of the National Council on Interpreting in Health Care (NCIHC), one of the five breakout sessions was entitled “Dual Role Interpreters: Where Do they Fit in a Language Access Program.” The key questions and discussion were about the benefits and drawbacks of programs that promote dual role interpreters; whether dual-role interpreters have a place in language access and if so, what that is; and the key steps to assuring the quality of interpreting when dual role interpreters are used. To read the report from this breakout session, please see the NCIHC reference.<sup>xii</sup>

Utilizing Dual Role Interpreters can be challenging for the interpreter, the organization, and ultimately the patient. The responsibilities of the primary role are often in direct conflict with the role of interpreter. The interpreter has a finite set of limitations about how and when to interact with patients, whereas most other roles have much wider parameters in the communication and relationship with the patient. There are also issues of productivity, training, and the patient being confused about which role the person is in at the time. Other reasons Dual Role Interpreters should be utilized with caution are that the hiring and training requirements are often overlooked. Self-identification as bilingual is inadequate and is not the same as possessing the skills of interpreting. As the Office on Civil Rights noted in its limited-English proficient (LEP) guidance, self-identification as bilingual is not necessarily indicative of an individual’s ability to interpret or translate. Thus concomitant with ensuring linguistic diversity, it is vital that bilingual individuals have sufficient competency to interpret, translate, or provide services directly in a non-English language.<sup>xiii</sup> The first half of CLAS Standard #6, one of the four mandates, places the responsibility for training on the organization: “Health care organizations must assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff.”<sup>xiv</sup> When an employee is hired as a “bilingual liaison” or “receptionist/interpreter” or “patient support specialist,” and is serving as an interpreter during a solid portion of their time on duty, that person needs the formation and foundation of the professional skills of interpreting. In the table below, the position title separated by a slash (/) indicates a dual role position. Titles other than Interpreter, Medical Interpreter, and Translator normally indicate the respondent is acting in a dual role position.

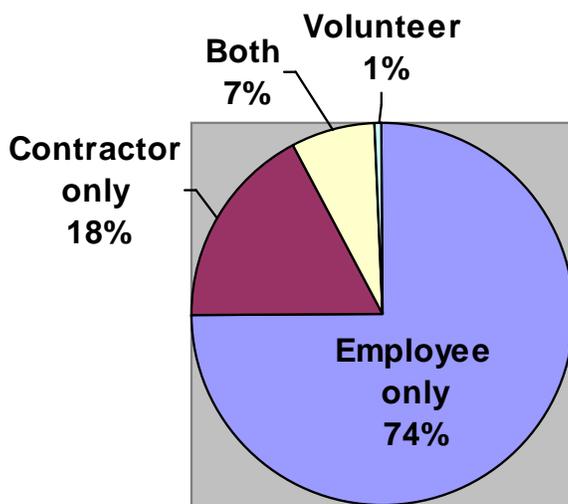
**Table 4.1: Job Title**

Interpreter or Medical Interpreter	50%
Interpreter and Translator	11%
Health Provider	8%
Coordinator of Interpreter Services	7%
Patient Support/Interpreter	6%
Administrative Position	5%
Community Health Worker	5%
Health Provider/Interpreter	3%
Interpreter/Administrative Position	3%
Other	2%

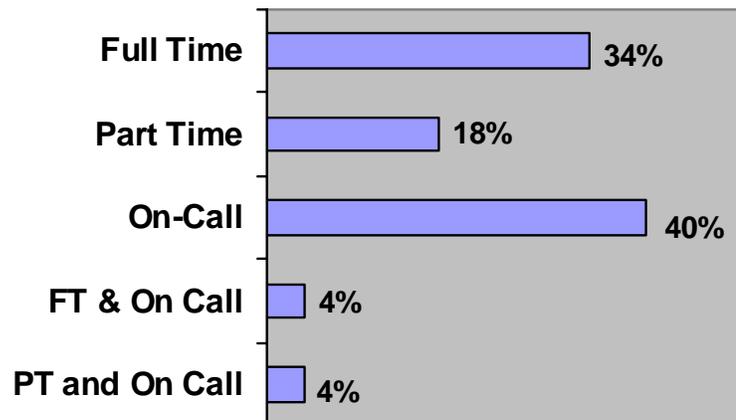
## **EMPLOYEE OR CONTRACTOR**

One-hundred-twenty-four of the 166 interpreters are hired as employees, revealed by the question “Are you on the payroll as an employee, or do you contract out your services?” Twenty-nine interpreters, or almost 18%, are an employee at one organization and a contractor at another. There was only one person who indicated she/he provided medical interpretive services on a volunteer basis. We know from a previous question that our respondents are on average working at 2.5 facilities, which could be with the same employer, especially if the employer is a large health system including hospitals, clinics, doctor’s offices, etc. It should be noted that “employee” does not necessarily mean full-time, as some health care organizations choose to hire their interpreters as part-time or on-call employees. When asked whether respondents were serving as medical interpreter full-time (over 30 hours per week) or other, 162 responded. Of those, 34% were working full-time, 18% were part-time, 40% were on-call, and an equal number, 3.7% each, were both on-call and either full- or part-time.

**Figure 4.4: Employee Status**

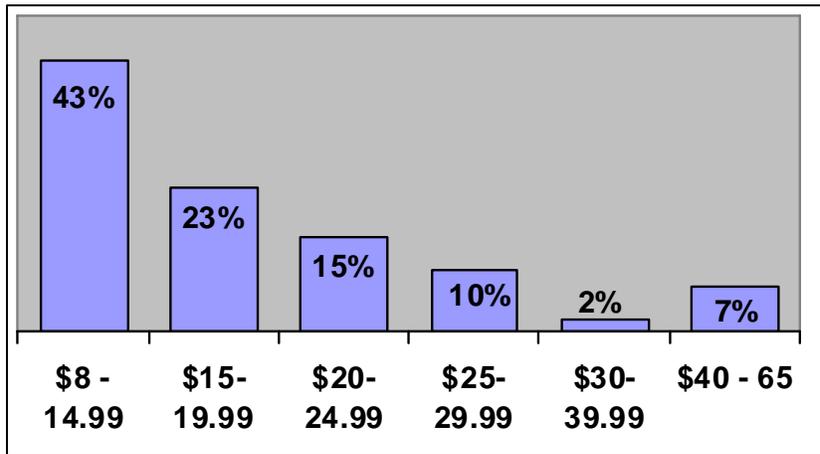


**Figure 4.5: Full-time or Part-time Status**



## **SALARY**

One-hundred-twenty-three respondents answered the question about approximate hourly salary. As only 26 respondents answered the question about monthly salary we can make the assumption that most of the respondents are paid hourly. Of those who responded, 43% earn the lower end of \$8-15 per hour; 22.8% earn between \$15-20, and six persons (almost 5%) earn \$45-\$66 per hour.

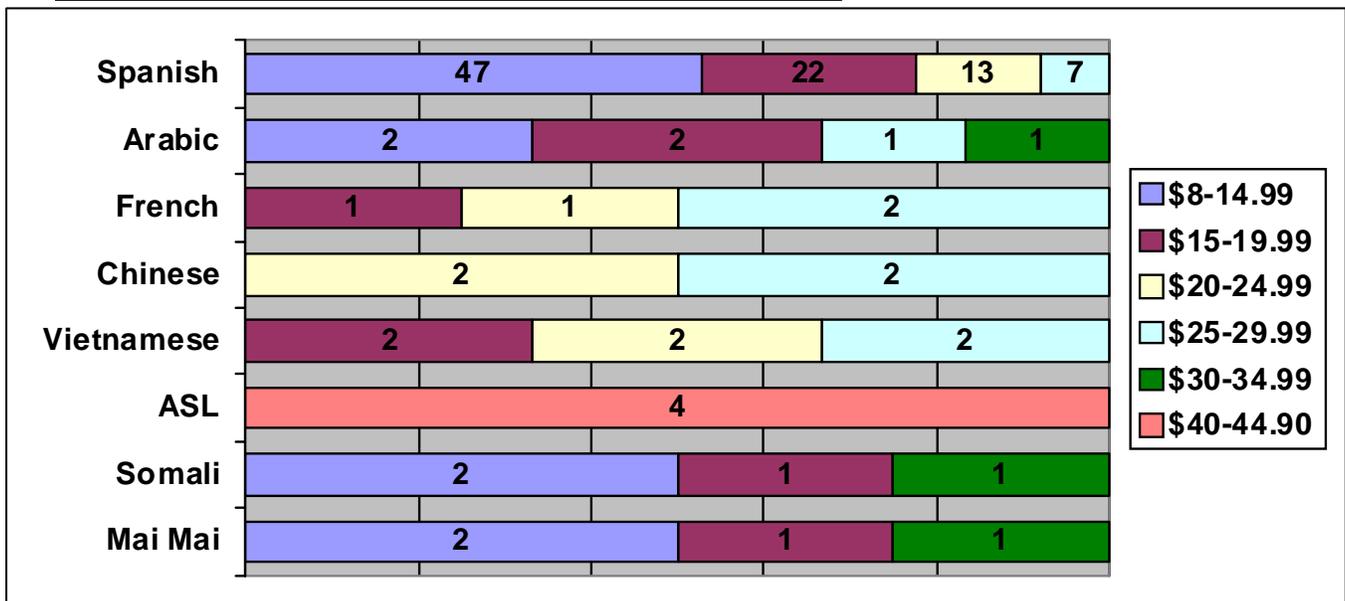


**Figure 4.6: Hourly Salary**

Of the 10 people in the \$40+ hourly range, only four also listed the language for which they interpret. Those four were American Sign Language (ASL) interpreters. Unlike Nebraska medical interpreters of foreign spoken languages who have no certification process, ASL interpreters must receive a sign language interpreter license from the Nebraska Commission for the Deaf and Hard of Hearing (NCDHH).<sup>xv</sup> It is likely that for reasons of state certification, and because the NCDHH has been well organized since its inception in 1979, ASL interpreters are paid substantially more for their professional services.

Of the 53 persons earning the lowest hourly rate, the languages interpreted for are: 47 Spanish, 2 Nuer; 2 Arabic, 2 Somali, 2 Mai Mai (a Somali language), 1 Kizi Gua (a Somali Bantu language), and 1 Shilluk (the third largest minority ethnic group of South Sudan).

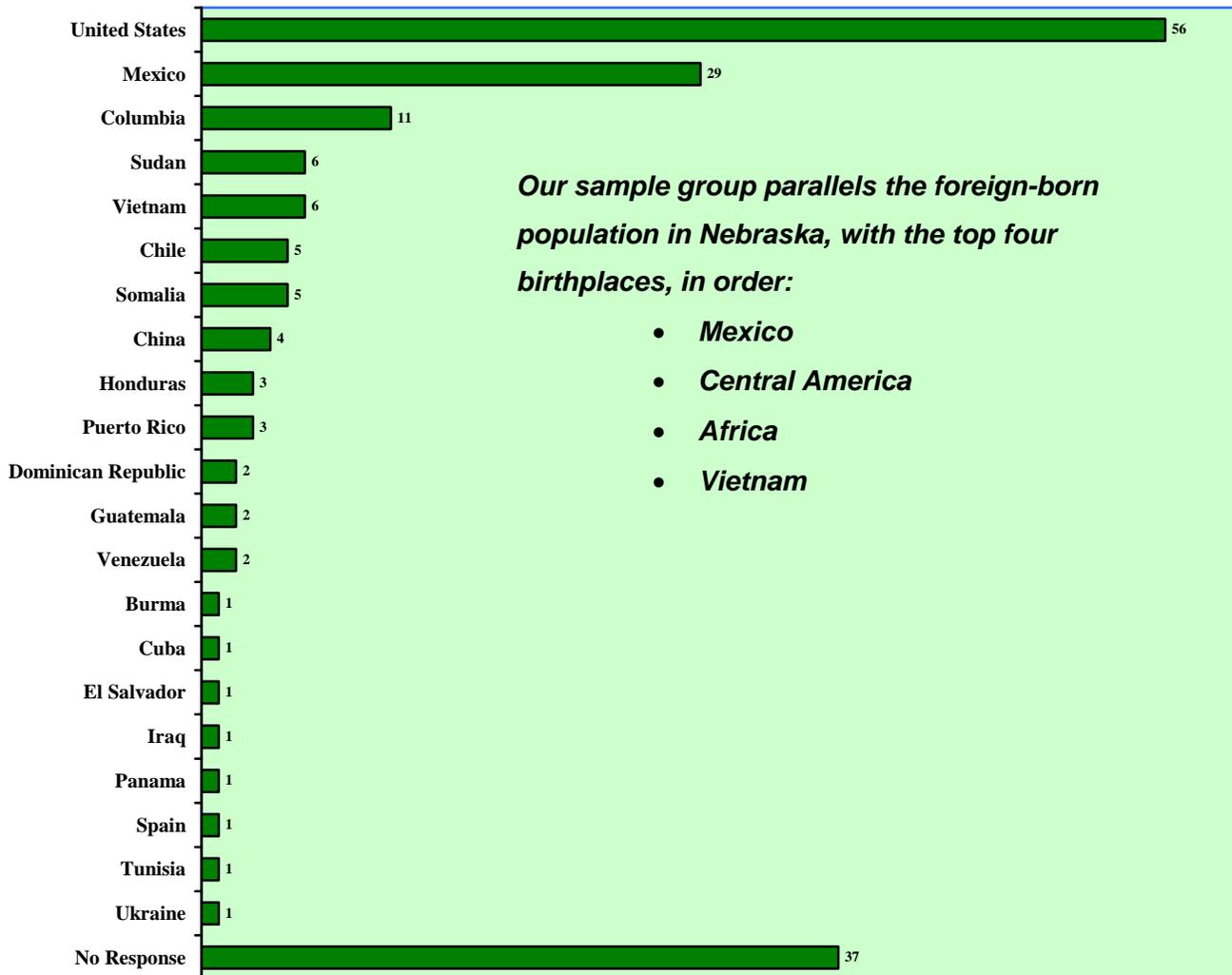
**Figure 4.7: Hourly Salary based on Language Interpreted**



## COUNTRY OF ORIGIN

Thirty-seven people did not respond to the question “What is your country of origin?” Of those who did respond, 31% were born in the United States and 16% were born in Mexico.

**Figure 4.8: Country of Origin**

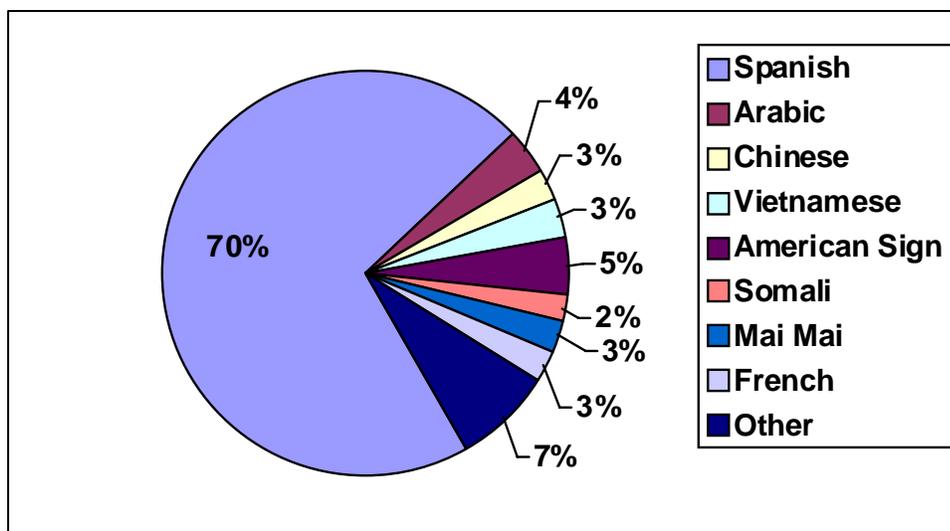


## LANGUAGES

One hundred ninety-five languages are interpreted among the 177 interpreters who responded to the question “What language(s) do you interpret for, excluding English?” Seventy-one percent or 139 interpret for Spanish-speaking patients; 4.6% or nine persons interpret for the deaf and hard of hearing; 3.6% or seven interpret for the Arabic speakers; 3.1% or six for Vietnamese patients; 2.6% or 5 each interpret for French, Chinese Mandarin,

and Mai Mai speaking patients. In the graph below, the “Other” section includes another 19 respondents and their respective languages: 4 Somali; 3 Nuer; 2 Dinka; 2 Portuguese; and one each for Burmese, Russian, Shilluk, Muzi Cuwa, Mina, German, Karen, and Kizi Gua.

**Figure 4.9**  
**Languages Interpreted For**

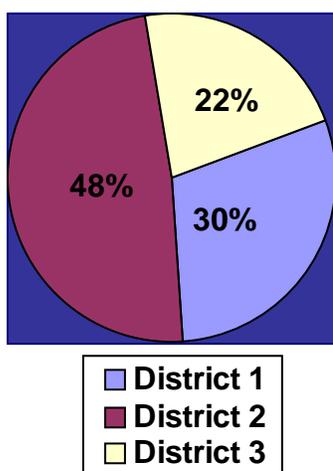


## GEOGRAPHIC AREAS

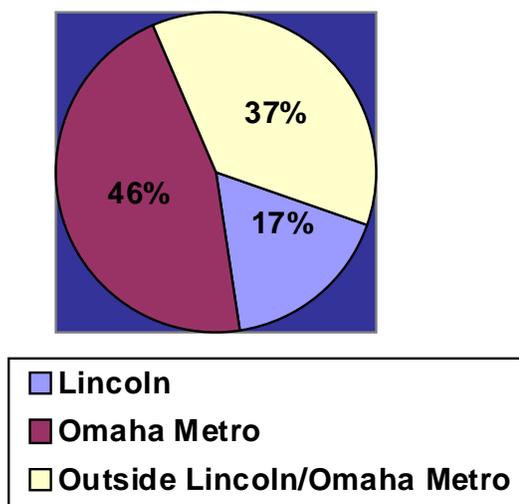
### WHERE ARE SERVICES PROVIDED

All 179 persons taking the survey responded to the question “In which cities or towns do you provide interpretive services?” There were 220 cities and towns named; therefore, the average person in our survey provides interpretive services for 1.5 cities.

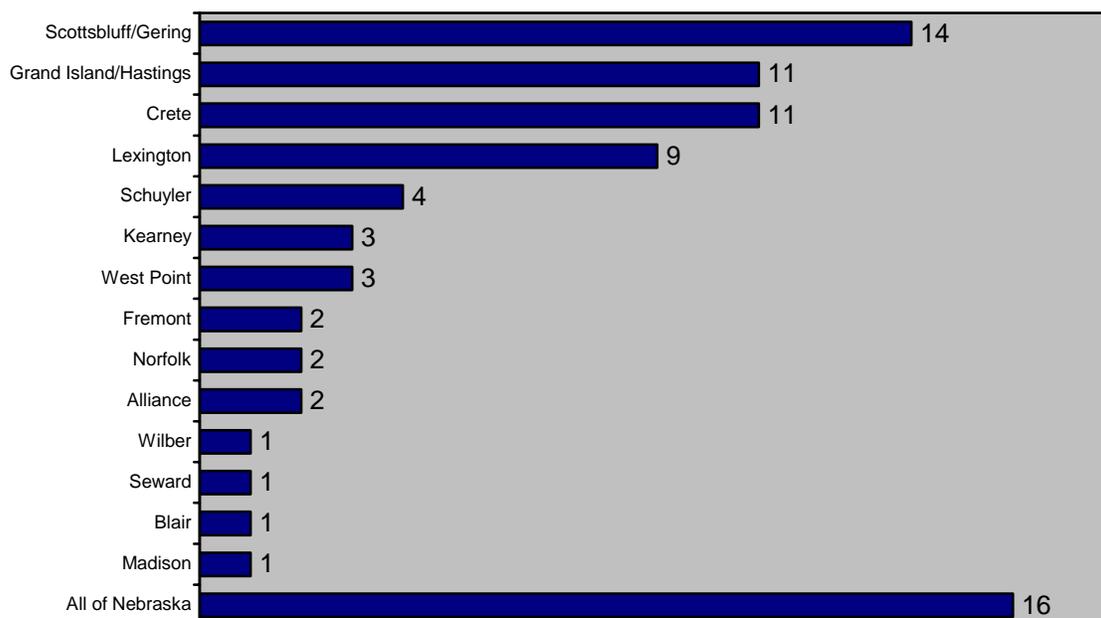
**Figure 4.10: CONGRESSIONAL DISTRICTS**  
**Where Services are Provided**



**Figure 4.11: AREAS**  
**Where Services are Provided**



**Figure 4.12: 81 Cities/Towns included in “Outside Lincoln/Omaha Metro Area”**



*“All of Nebraska” responses are grouped and included as “Outside” [exclusively] the Omaha and Lincoln areas. Table 3.3 distributes these 16 responses among the 3 areas and congressional districts.*

## EDUCATION AND TRAINING

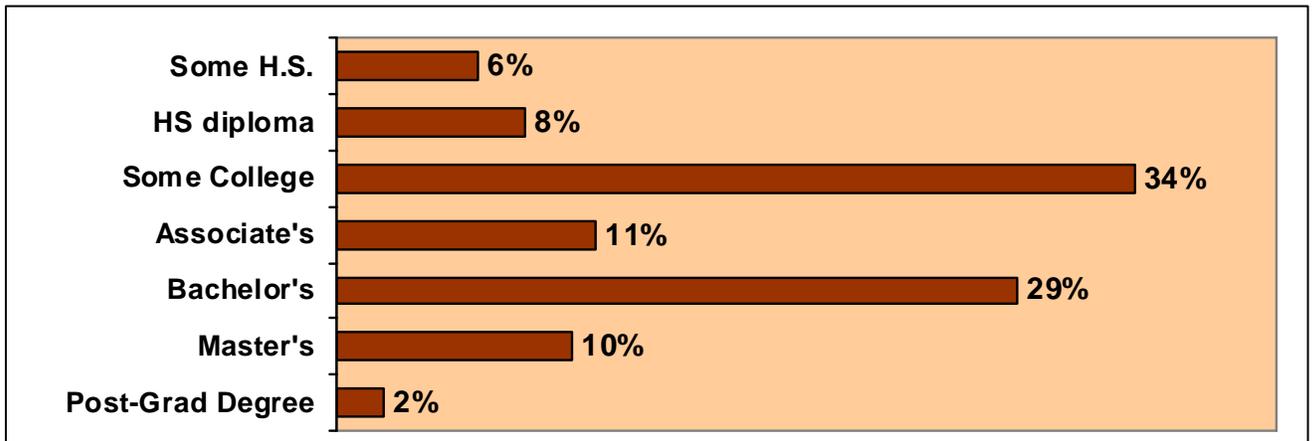
### **FORMAL EDUCATION**

Of the 179 respondents, 172 indicated their level of formal education question. Of those, 86% had at least some college. Twenty-nine percent had a college Bachelor’s Degree (more than half of those had some masters/graduate level courses). Almost 10% had a Master’s Degree. Only 5.8% had not graduated from high school. If our sample is representative, Nebraska medical interpreters are well educated, with 94% having high school diplomas compared to our state’s high school graduation rate of 88.7%.<sup>xvi</sup>

Effective interpreting requires a high degree of cognitive skills such as a sharp and considerable memory capacity. *Integrated Interpreter Skills* refers to the full compliment of skills that a competent interpreter calls upon to ensure the accuracy and completeness of each *converted message*.<sup>xvii</sup> Simultaneous Interpreting is an even more complex skill in which language

comprehension and production take place at the same time in two languages.<sup>xviii</sup> For this reason there is debate among groups researching national certification about whether professional interpreters should have a higher degree of formal education. Another advantage for college-level education comes from the NCIHC, which recommends that interpreters are tested in all languages in which they will be interpreting with the exception that candidates with a college education earned in a particular language would not require testing in that language. They would, however, require testing in the integrated interpreter skills.<sup>xix</sup>

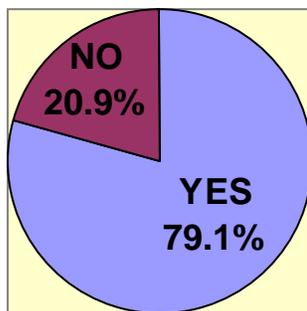
**Figure 4.13: Educational Background** (172 responses out of 179 surveyed)



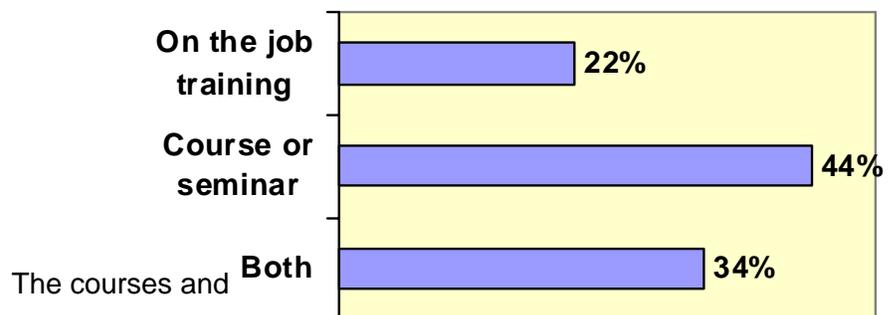
**PROFESSIONAL TRAINING**

There were 140 “Yes” answers from the 177 persons who responded to the question “Have you had training specifically for medical interpreting?” A follow up question was asked for those who responded affirmatively: “If yes, what kind of training was it?” The choices given were “On-the-job training,” “Course or Seminar,” and “Both.” Some persons listed more than one answer totaling 146 responses.

**Figure 4.14**  
**Medical Interpreter Training**



**Figure 4.15**  
**Type of Medical Interpreter Training**



seminars for medical interpreters offered in the state of Nebraska vary in range, length, and type. From the data collected, it was not possible to easily identify the number of hours that coincided with the names of the specific courses listed due to the limited responses to the latter part of the question “Please give the name of the course and the number of hours.”

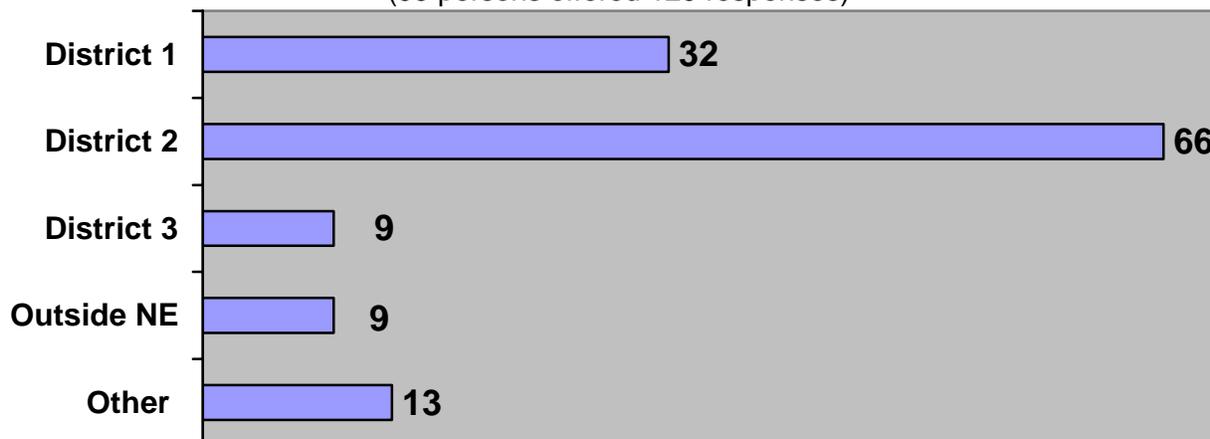
The data did not determine whether those who claim to have medical interpreter training actually received a solid foundational course that covered essential topics such as Code of Ethics, Standards of Practice, Memory Skills, and Roles of the Interpreter including Cultural Brokering, Briefing Pre-Session, and Positioning. In order to learn these professional skills, it is widely agreed among those in the field that a minimum of 40 hours is needed. However, some training courses were listed which are known to be 40+ hours in length. Bridging the Gap, one of the first nationwide training programs created by Cross Cultural Health Care Program (CCHCP), consists of 40 hours. Southeast Community College in Lincoln, District One, and College of Saint Mary in Omaha, District Two, offer introductory and intermediate levels of medical interpreter training with minimum of 40 contact hours for each level; and University of Nebraska at Kearney, District Three, also offers 40+ hour courses.

In our survey, an example of unknown length of the training is demonstrated by 11 respondents who wrote “NATI,” without specifying the number of hours. The Nebraska Association of Translators and Interpreters (NATI) organizes an annual conference that provides training workshops ranging in length from 90 minutes to a full day. Some workshop topics may be specific to health care, yet most are not.

Another inconclusive variable in the survey is whether or not the interpreter successfully completed the courses. Some programs have rigorous criteria that must be met before receiving the certificate or college credits. In the pilot introductory level medical interpreter course offered at College of Saint Mary’s Center for Transcultural Learning, close to 30% did not pass the final exam on the first attempt. Upon retaking the final exam, the majority of those successfully passed, but the several who failed again were not awarded the certificate. In spite of this, for the purposes of this survey, they could technically answer affirmative to the question about receiving training.

Below is a chart according to districts where the medical interpreter trainings took place, based on 129 open-ended responses naming 11 different places where training was received.

**Figure 4.16: Nebraska Districts Where Medical Interpreter Training Took Place**  
(95 persons offered 129 responses)



In the order of most frequently named places in which respondents received their training, below are the specific institutions or cities identified:

**Table 4.2: Place of Training**

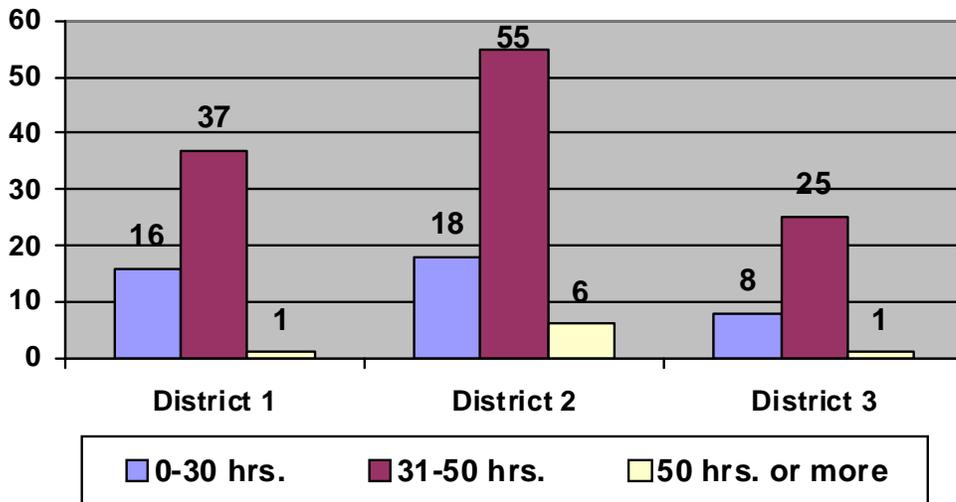
<b><u>District 1</u></b>
<ul style="list-style-type: none"> <li>• Southeast Community College</li> <li>• International Communications Inc. (ICI)</li> </ul>
<b><u>District 2</u></b>
<ul style="list-style-type: none"> <li>• College of Saint Mary</li> <li>• Metro Community College</li> <li>• Alegent</li> <li>• Children’s Hospital</li> <li>• Hope Medical Outreach Coalition</li> </ul>
<b><u>District 3</u></b>
<ul style="list-style-type: none"> <li>• Grand Island, Nebraska</li> <li>• University of Nebraska at Kearney</li> </ul>

**DISTRICTS & HOURS OF MEDICAL INTERPRETER TRAINING**

The following graph cross-tabulates the districts where interpreters provide service with the number of hours the interpreter has undergone medical training. Thirty-seven people serving in Congressional District One have received 31-50 hours of medical interpreter training, compared

with 55 people in District Two, and 25 in District Three. Of those with fewer than 30 hours of medical interpreter training, 16 are from District One, 18 from District Two, and 8 from District Three. Of the respondents with more than 50 hours of training, one is serving in District One, six in District Two, and one in District Three.

**Figure 4.17: Number of Hours Trained in Medical Interpreting**  
*Based On Districts where Service Is Provided*

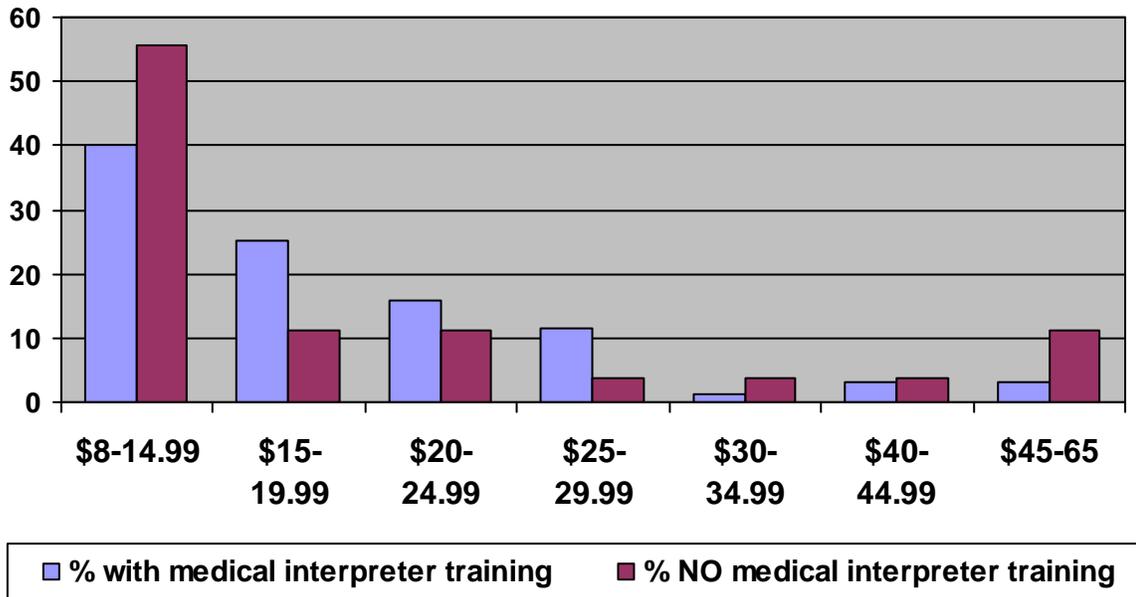


### **SALARY & MEDICAL INTERPRETER TRAINING**

Sixty percent of those with specific medical interpreting training earn \$15 or more per hour, compared with only 44% of those who have *no* specific medical interpreter training. Of the 140 respondents in our survey who have had medical interpreter training (see Education and Training Section), 122 of them also answered the question about hourly salary. Of those 122 respondents, 95 had medical interpreter training and 27 had not been trained specifically in medical interpreting. Although the duration of the training is not known, for example, whether it was a 40+ hour foundational course or a brief half-day workshop, on the whole, those with any kind of medical interpreting training receive higher salaries. 40% of the 95 with medical interpreter training are in the lowest hourly range, while 56% of the 27 without medical interpreter training are in the lowest range. A greater percentage of interpreters with training specific to medical interpreting are earning middle to higher ranges from \$15-30 per hour. It levels off in the \$40-45 range, and changes in the highest range. One explanation that a greater percentage of people in the highest salary range are from the “no medical interpreter” training group could be reflected in Figure 4.7: “Hourly Salary Based on Language Interpreted.” Four out

of ten in the entire sample earning \$45-65 per hour are certified American Sign Language interpreters who have extensive training not specific or exclusive to health care interpreting.

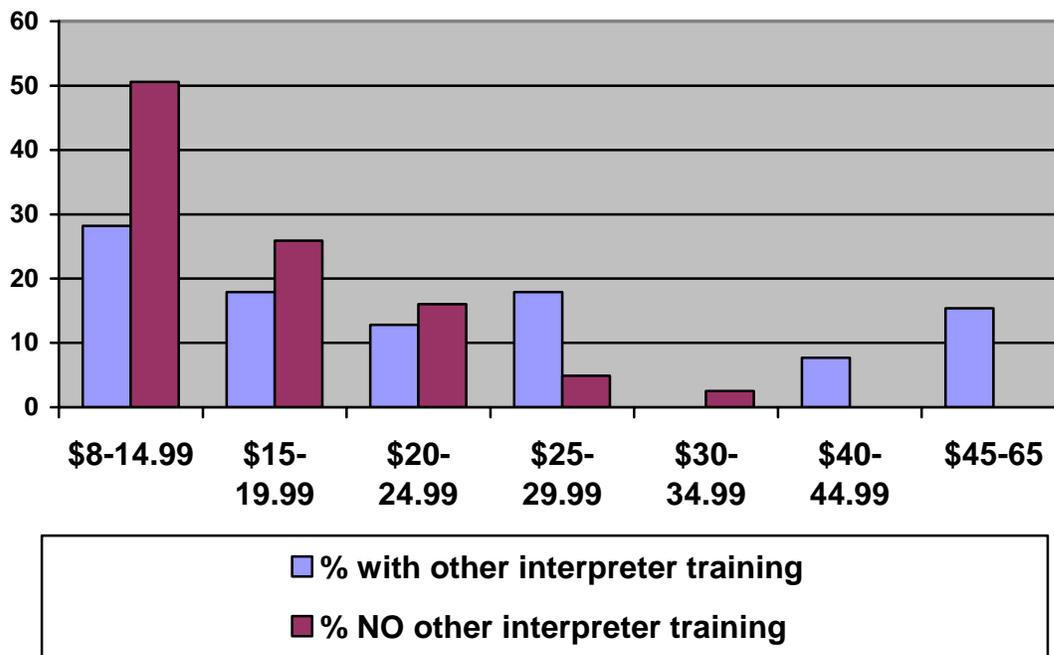
**Figure 4.18: Hourly Salary compared to Yes or No Medical Interpreter Training**



**SALARY & OTHER INTERPRETER TRAINING**

Does any interpreter training, health care focused or not, increase an interpreter’s chances of earning more money as a medical interpreter? Apparently, yes. In the group with some interpreter training, albeit not medical, only 28% are earning the lowest salary range, compared to 51% of interpreters with no other training earning the lowest range. As the salary ranges increase, the percentages of those with any other interpreter training increases, with the exception of the \$30-35 range, although there were too few (0 & 2) in this category to be of significance.

**Figure 4.19: Hourly Salary compared with Yes or No Other Interpreter Training**



## PROFESSIONALISM

There were three questions created with the intention to gain insight into the professionalism and knowledge of the unique skill set necessary to be an effective medical interpreter.

Bilingualism is a prerequisite to entering the field of health care interpreting, and proficiency with extensive medical vocabulary necessitates ongoing learning. Although there are many areas in which professionalism could be measured, we chose three competencies for which trained, experienced medical interpreters should have a high degree of knowledge and practical application:

- 1) The role of culture broker
- 2) Professional standards and ethical code
- 3) Briefing pre-session

## **CULTURE BROKER ROLE**

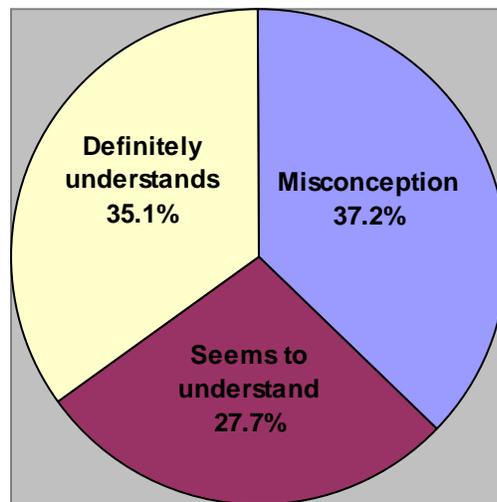
In the role of Culture Broker, the interpreter provides a necessary cultural framework for understanding the message being interpreted. This role should be taken on only when cultural differences are leading to a misunderstanding on the part of either provider or patient.<sup>xx</sup> The survey question about culture broker was written in two parts, to ensure that those who were not familiar with the term could still show their knowledge and understanding of the importance of clarifying cultural misunderstandings should the misunderstanding lead to miscommunication. The open-ended question on the survey was “Under what circumstances do you find that you need to step out of your interpreter role as a *conduit* and into the role of *culture broker*... in other words, what situations require you to explain cultural differences?”

### **Cultural Awareness**

#### **The NCIHC National Standards of Practice – Article 15**

The interpreter alerts all parties to any significant cultural misunderstanding that arise. For example, if a provider asks a patient who is fasting for religious reasons to take an oral medication, an interpreter may call attention to the potential conflict.<sup>xxi</sup>

**Figure 4.20: Understanding the Role of Cultural Broker**



The 94 responses to this question were coded into three categories:

- **Misconception** of culture broker role (35 persons)
- **Seems to understand** culture broker role without citing example (26 persons)
- **Does understand** culture broker role and cited an appropriate example (33 persons)

The missing link in many of the “misconception” and “seems to understand” categories was the important point that interpreters should only step into a culture broker role if the cultural differences are leading to a *misunderstanding* between the patient and provider in the clinical encounter. It is not appropriate to interrupt the dialogue in order to educate the provider or patient on a cultural difference unless it is relevant to the understanding of the message or the outcome of the encounter. For the 85 (47.5%) non-responses to this question, it could be assumed they do not understand the role of cultural broker. If this is the case, then 67% of the sample are not effective or appropriate culture brokers, and are not appropriately alerting the other parties to significant cultural misunderstanding that can lead to unintended negative outcomes. Below are some examples of actual written responses:

**Table 4.3: Examples of Cultural Broker Understanding**

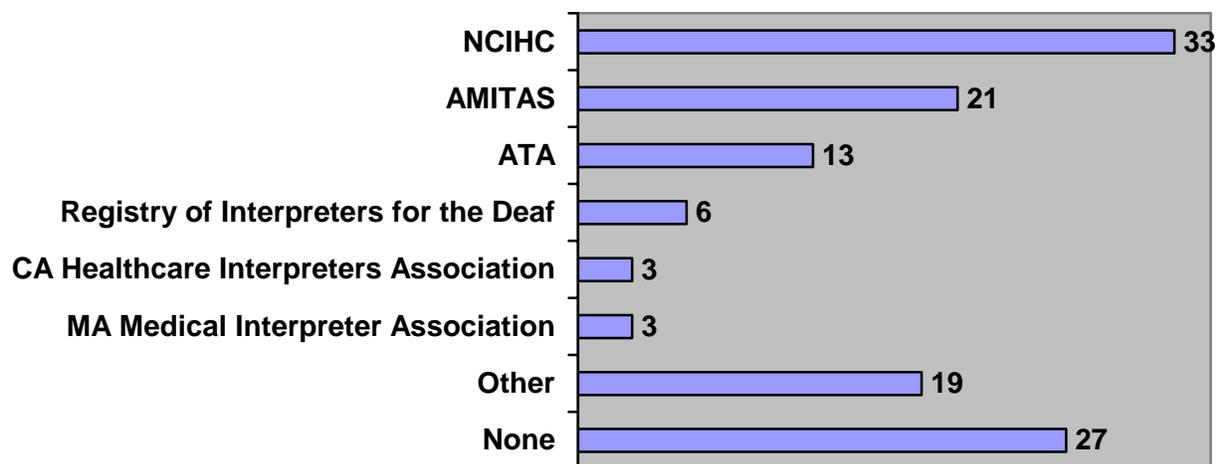
<p><b>Understands culture broker role</b></p>
<ul style="list-style-type: none"> <li>• <i>“When there is a difference in cultural habits/traditions that may lead to misunderstanding, or hurt the feelings of either side, or even affect the treatment”</i></li> <li>• <i>“When a normal health care practice for a culture elsewhere is misunderstood here in America as ‘not rational or educated’”</i></li> <li>• <i>“When someone in the medical staff looks obviously at the patient as if they were ignorant by something that they said. I explain to them [staff] the cultural difference”</i></li> <li>• <i>“When superstitions come into play or when cultural beliefs in medicine are not understood by the provider”</i></li> </ul>
<p><b>Seems to understand the culture broker role</b></p>
<ul style="list-style-type: none"> <li>• <i>“When providers or patients don’t understand why something is done in a certain way, or why it is done at all”</i></li> <li>• <i>“When a provider has a difficult time understanding a behavior based off culture or cultural practices”</i></li> <li>• <i>“In general in some situations that could be explaining cultural differences to the staff and sometimes to the patient”</i></li> </ul>
<p><b>Misconception of culture broker role</b></p>
<ul style="list-style-type: none"> <li>• <i>“Any circumstance where it is required to facilitate understanding between provider and patients”</i></li> <li>• <i>“In surgery, I need to be there when the patients wakes up to let them know how things went; that they are ok”</i></li> <li>• <i>“When patients use dialects”</i></li> <li>• <i>“Financial explanation of our sliding fee scale and the need for household income even when patient has Medicaid”</i></li> <li>• <i>“I don’t think it’s necessary”</i></li> <li>• <i>“When the provider doesn’t understand our culture”</i></li> </ul>

## **PROFESSIONAL STANDARDS AND ETHICAL CODES**

In general, standards of practice are a set of guidelines that define what an interpreter does in the performance of his or her role, that is, the tasks and skills the interpreter should be able to perform in the course of fulfilling the duties of the profession. These are a set of “best practices” used by the profession to ensure a consistent quality of performance. They define acceptable ways by which interpreters can meet the core obligations of their profession, which are the accurate and complete transmission of the messages between a patient and provider who do not speak the same language in order to support the patient-provider therapeutic relationship. As in all professions, the field of interpreting is guided by ethical principles. Standards of practice are concerned with the “hows” and codes of ethics focus on the “shoulds.” The codes of ethics provide “guidelines for making judgments about what is acceptable and desirable behavior in a given context or in a particular relationship.”<sup>xxii</sup>

The question on the survey asked “Which professional Standards of Practice and/or Code of Ethics do you follow as a medical interpreter?” The interpreter was offered a listing of the leading national standards of practice: National Council for Interpreting in Health Care (NCIHC); American Medical Interpreters Translators Association (AMITAS), American Translators Association (ATA), Registry of Interpreters for the Deaf, California Healthcare Interpreters Association, and Massachusetts Interpreter Association. Respondents could mark *none* or *other*. Thirty percent, or 54 persons, did not respond to this question. Adding them to the 27 persons who ticked the choice “none,” it could be assumed that 45% either do not know about or do not follow professional guidelines.

**Figure 4.21: Standards of Practice/Code of Ethics**

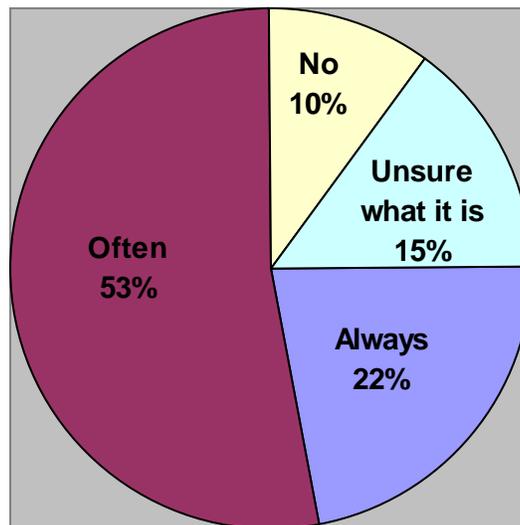


## **BRIEFING PRE-SESSION**

In order to ensure an effective and accurate medical interpretation, it is critical that the interpreter conduct a pre-session discussion with patient representatives, patients, and providers. The pre-session gives the interpreter the opportunity to obtain patient demographic and appointment information, explain how the interpretation will work, determine the linguistic level of the patient, and ensure that all messages are communicated in a complete and accurate manner.<sup>xxiii</sup>

The question on the survey was “Do you typically conduct a briefing pre-session before an interpretation?” There were four choices for answers: 1) Yes always; 2) Yes often; 3) No, I do not think it is necessary; and 4) No, I am not sure what a briefing pre-session is. Of the 164 who responded, 75% always or often conduct a briefing pre-session and 25% either do not think it is necessary or are unsure what a briefing pre-session is. Fifteen persons did not answer the question at all, and they may be added to the 41 respondents who do not understand the nature or necessity of a briefing pre-session. If that is the case, 31% are not conducting briefing pre-session.

**Figure 4.22:**  
**Do You Conduct a Briefing Pre-Session?**

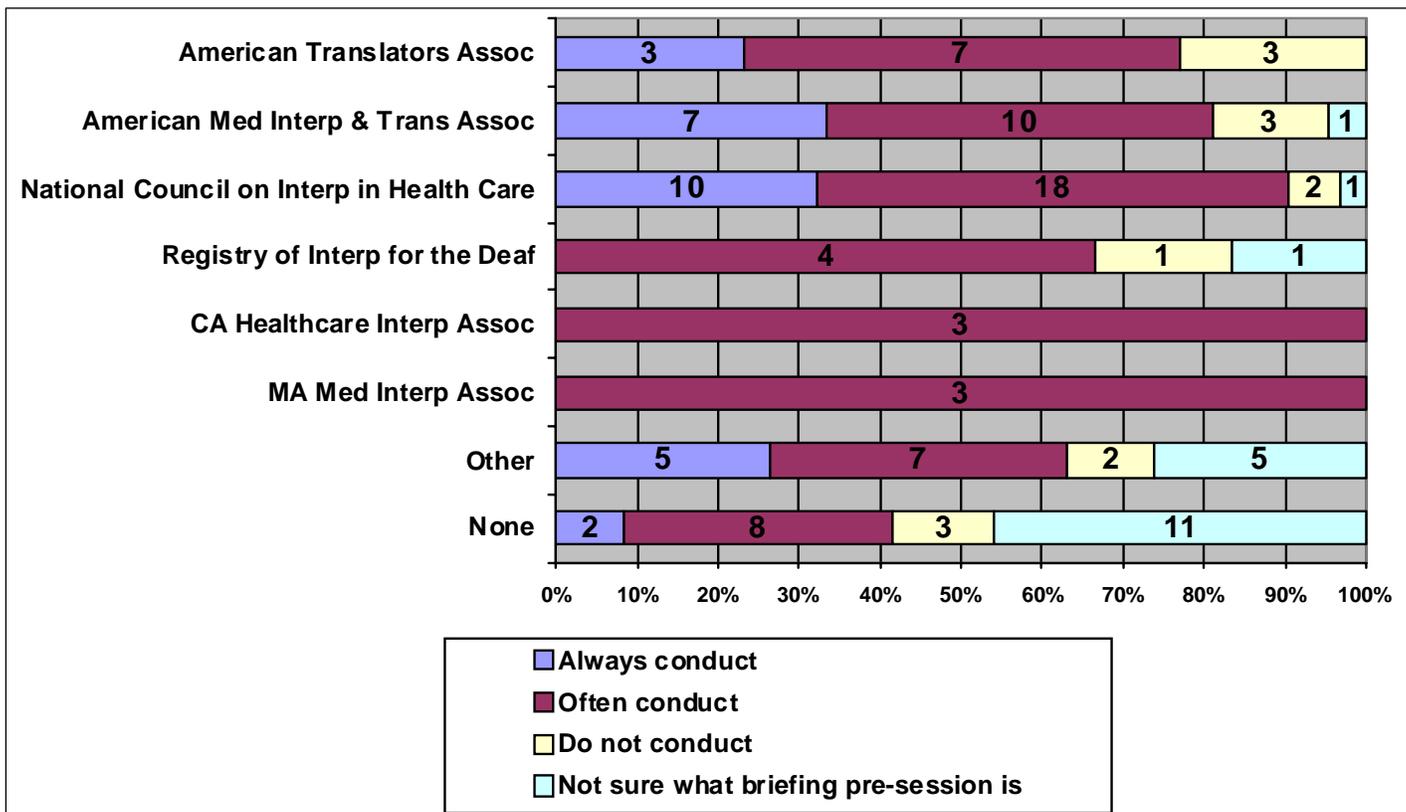


## **CONDUCTING BRIEFING SESSIONS & STANDARDS FOLLOWED**

The importance of conducting a briefing pre-session is paramount to effective interpretive encounters. From this cross-tabulation, the greatest numbers of interpreters who are always or often conducting a briefing session prior to the interpreted event are those following NCIHC's Standards of Practice at 90%. In second place for those always or often conducting briefing pre-sessions are the interpreters following the American Medical Interpreter and Translator

Association's Standards of Practice at 82%, and thirdly, are those following the American Translators Association's Standards of Practice at 77%. Those who follow no standard of practice rank the lowest, with only slightly more than 40% conducting briefing sessions.

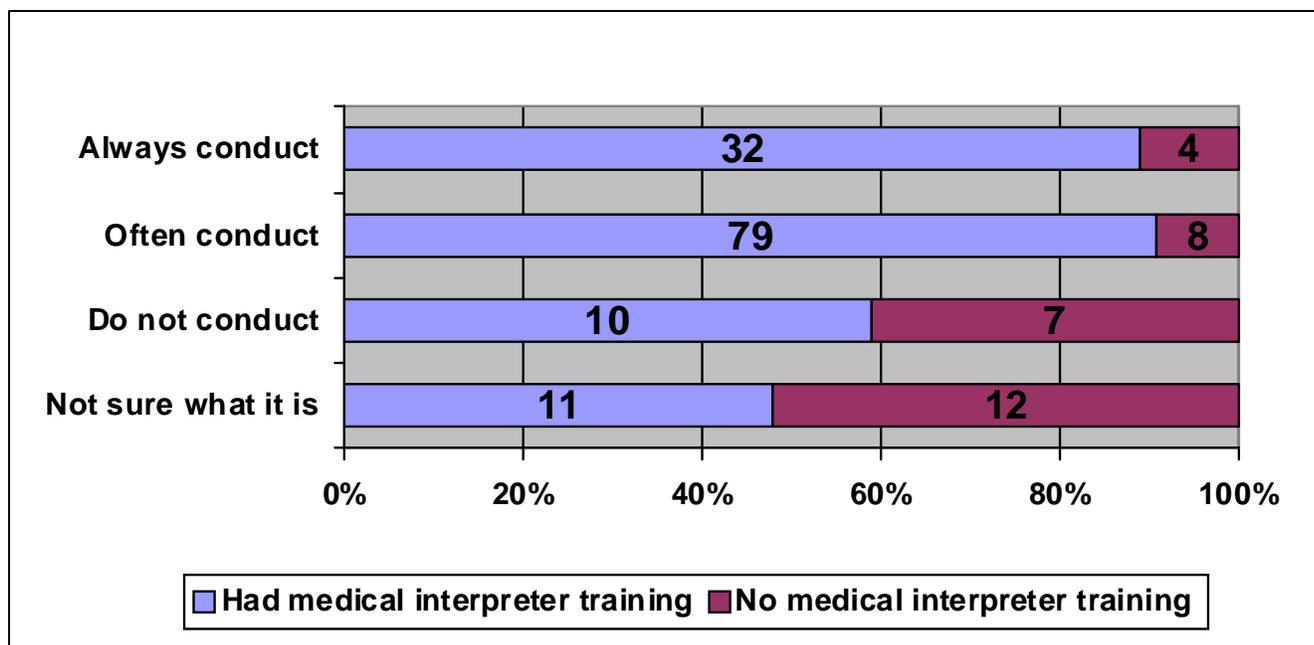
**Figure 4.23: Do You Conduct a Briefing Pre-Session?**  
(based on Standards of Practice followed)



### **CONDUCTING BRIEFING SESSIONS & MEDICAL INTERPRETER TRAINING**

There is a highly significant impact that training in the field of medical interpreter has on whether interpreters are conducting a briefing pre-session. Of those always conducting a briefing session, 89% have had medical interpreter training. Of those who often conduct a briefing session, 91% have had medical interpreter training. Of the 47 respondents who do not conduct or are not sure what a briefing pre-session is, only 45% have had medical interpreter training. We do not know the duration of the medical interpreter training for any of the categories in this cross-tabulation.

**Figure 4.24: Do You Conduct a Briefing Pre-Session?**  
(based on medical interpreter training?)



## ORGANIZATIONAL EFFORTS

This project sought to assess what is working well and where there may be gaps or barriers regarding language access services within our state's health care system. Our sample of medical interpreters, each of whom works on average in 2.5 different facilities and in 1.5 different cities or towns, has distinctively first-hand experience within the health care facilities to view the manner in which the facility attempts to provide services to the immigrant and limited-English proficient populations.

The national report from the Joint Commission and California Endowment released earlier this year, entitled *Hospitals, Language, and Culture: A Snapshot of the Nation* explored cultural and linguistic services in the national's hospitals. They found that hospitals identified many challenges related to providing care to culturally and linguistically diverse patient populations. The most frequently cited challenges related to language and staffing.<sup>xxiv</sup>

Taken from the four mandates of the CLAS Standards listed below, we created five survey questions that would give an insight into the level of compliance to the CLAS standards Nebraska organizations are attaining.

Without mentioning the CLAS Standards, the question on the survey was: "From your experience at any health organization with which you are familiar, please rate the organization's efforts being made in the following areas. Circle the number from 5 (excellent) to 1 (poor)." Of these five questions, there was one question each for Standards 4, 5, and 6, and two questions based on Standard 7.

***National Standards on Culturally and Linguistically Appropriate Services (CLAS)<sup>xxv</sup>***

*The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible.*

*The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).*

**Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

**Standard 5:** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

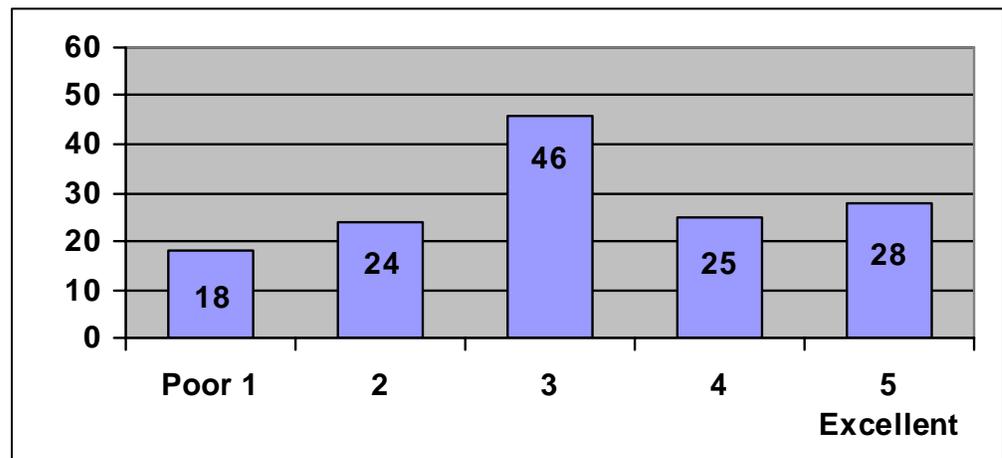
**Standard 6:** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

**Standard 7:** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

#### **STANDARD 4 – Hiring Bilingual Staff**

Part of Standard 4 requires organizations to provide language access to patients at all points of contact at the organization, which would require bilingual staff, as interpreters cannot be at all points of contact during all hours of operation. Our question attempted to discover whether organizations are hiring bilingual health providers in addition to interpreters. This was the lowest rating for organizations in the CLAS standards set of questions. Only 19.9% of the respondents gave an excellent rating and 18% gave a very good rating. 62% ranked the organizations as poor (1), inadequate (2), or fair (3).

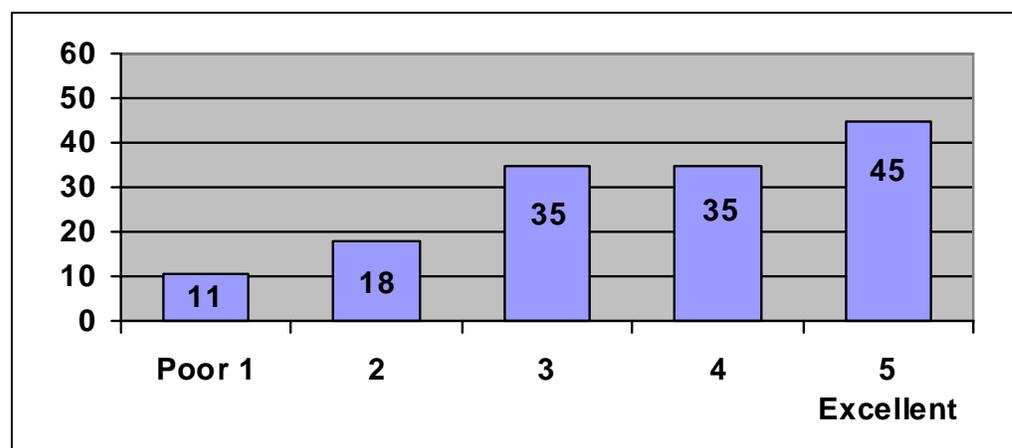
**Figure 4.25:**  
**Hiring Bilingual Health Providers**  
(141 responded)



#### **STANDARD 5 – Informing Patient of Right to Interpreter**

When asked whether organizations were informing limited English-proficient patients of their right to an interpreter free of charge, 35 persons did not respond. Of the 144 who did respond, 31% rated the organizations as excellent in this effort and 24% as very good. Yet 44% of the interpreters believe that organizations are poor, inadequate, or fair in their efforts to inform patients of their right to language access services.

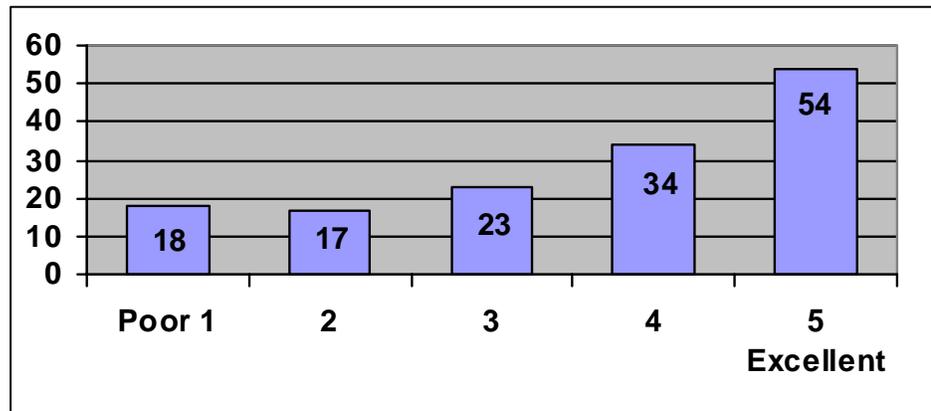
**Figure 4.26:**  
**Informing LEP Patients of Their Right to Interpreter**  
(144 responded)



**STANDARD 6 – No Family or Friends as Interpreters**

Respondents were asked whether organizations are making sure patients have a professional medical interpreter rather than allowing family and friends to interpret. Thirty-seven percent rated the organizations as excellent and 23% rated them as very good. Yet 40% gave the organizations a poor, inadequate, or fair rating.

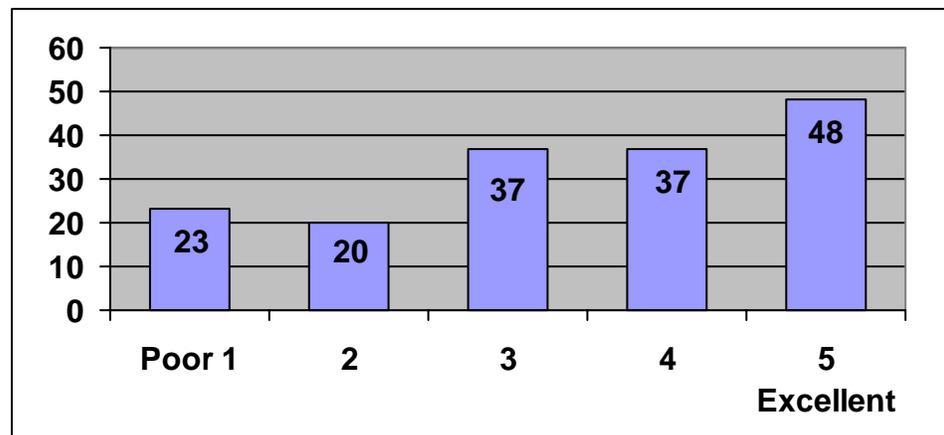
**Figure 4.27: Hiring Medical Interpreters Rather than Family or Friends interpreting**  
(146 responded)



**STANDARD 7 – Posting Signage**

There were 165 interpreters who responded when asked about the efforts of organizations to display signage in multiple languages for patients to see. Although 29% gave organizations an excellent rating and 22% said very well, 48% said that organizations are poor, inadequate, or fair in displaying signs in LEP patients' languages.

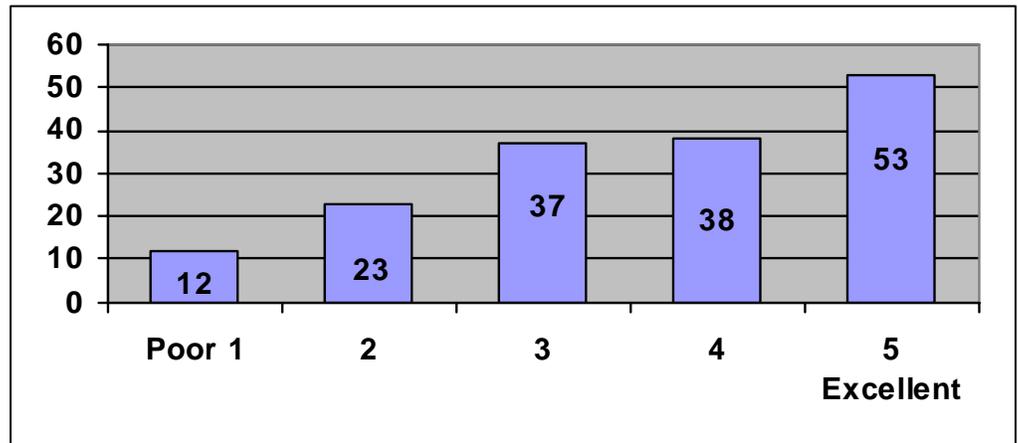
**Figure 4.28: Displayed Signs in Multiple Languages**  
(165 responded)



## **STANDARD 7 – Translated Documents Available**

To the question about whether organizations are making health documents readily available in multiple languages for patients, there were 163 responses. Of those, 32% thought that organizational efforts were excellent, 23% gave them a very good rating, and 44% rated them as poor, inadequate, or fair in making documents available in patients' languages.

**Figure 4.29: Making Health Documents Readily Available**  
(163 responded)

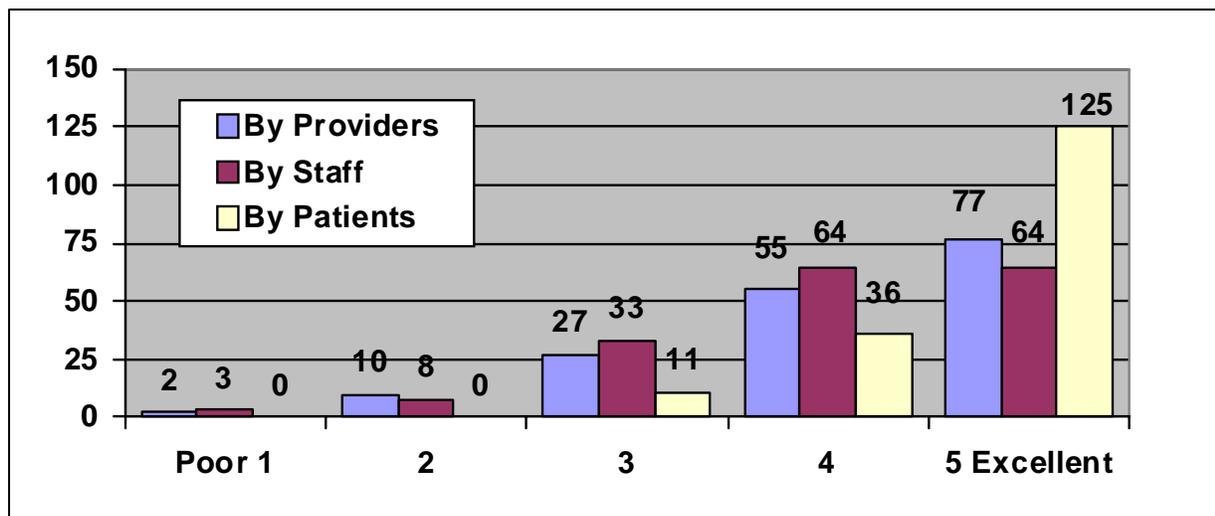


## **INTERPRETERS SPEAK OUT**

### **VALUED AND RESPECTED AS PROFESSIONALS**

Most of the respondents (95.5%) answered the question: “Please rate how you feel your role as a medical interpreter is valued and respected by health care providers, staff persons, and patients (5 = excellent and 1 = poor).” Most significant is that interpreters feel *most* valued and respected by patients. Not one of the 171 respondents rated patients as poor or inadequate in how they respect interpreters. Only 6.4%, or 11 interpreters, rated patients as fair, and 93.6% say very good to excellent in regards to the manner in which patients respect and value the interpreter’s role. Interpreters feel that their role is *least* valued and respected by staff persons, with 74% giving a rating of very good to excellent, and 26% give the staff of health care organizations a rating of fair, inadequate, or poor. Interpreters feel somewhat more valued by providers than staff persons, as demonstrated with a 77% rating of excellent or very good rating, and 23% think that providers are fair, inadequate, or poor in their respect for the role of medical interpreters.

**Figure 4.30: How Interpreters Feel Their Role is Valued & Respected**



**ORGANIZATION’S QUALITY SERVICE TO LEP PATIENTS**

According to our respondents, having interpreters and bilingual staff available is the top determiner whether organizations are delivering outstanding quality of service to LEP patients. When asked “From your observation and experience, name the health care organization that you think provides outstanding quality service to its non-English speaking patients, and please state why,” 72 persons named one or more organizations, and 66 also stated the reasons why. The various reasons were coded into the five categories below. It is evident that interpreters see tremendous value in the provision of language services for patients.

**Table 4.4: Aspects of Outstanding Quality Service**

Have interpreters and/or bilingual staff	29
Quality of interpreter staff	15
Patient treated well	11
Quality of whole staff	9
Multilingual patient related materials	4
Other	4

**Table 4.5: Examples of responses to “Organizations’ Outstanding Quality Services”**

<p><b>Have Interpreters and/or bilingual staff</b></p>
<ul style="list-style-type: none"> <li>• <i>“This hospital provides a department of Spanish interpreters that staff 24/7”</i></li> <li>• <i>“This hospital has nine Spanish interpreters with coverage 24/7, and contracts sign language interpreters for appointments; for emergencies have video conference and for other languages that are not needed everyday, uses a language line”</i></li> <li>• <i>“This hospital has made it a priority to provide assistance to those patients that have limited English proficiency, and has done a great job not only staffing a department with over 30 bilingual employees but also for providing interpretation services 24/7. They are always looking for ways to improve and to better serve its patients regardless of their spoken language”</i></li> <li>• <i>“They are always thinking of hiring bilingual personnel and make the effort to try to find interpreters in different languages”</i></li> </ul>
<p><b>Quality of interpreter staff</b></p>
<ul style="list-style-type: none"> <li>• <i>“This health system’s language access department consists of Spanish and nine different other languages”</i></li> <li>• <i>“This hospital does not allow family and friends as interpreters”</i></li> <li>• <i>“I work here and know first-hand the quality we provide”</i></li> <li>• <i>“The language access department strives to improve professional competencies and assimilation into health care culture/structure”</i></li> </ul>
<p><b>Patient treated well</b></p>
<ul style="list-style-type: none"> <li>• <i>“Non-English speaking patients are consistently treated with respect and dignity and a lot of effort is made to make them feel comfortable about their hospital experience”</i></li> <li>• <i>“Patients seem to have a good experience there”</i></li> <li>• <i>“These hospitals are especially great at treating non-English speaking patients with the same respect [as other patients]”</i></li> <li>• <i>“They exceed in patient satisfaction”</i></li> </ul>
<p><b>Quality of whole staff</b></p>
<ul style="list-style-type: none"> <li>• <i>“This health department for their commitment and readiness of the whole staff”</i></li> <li>• <i>“This community health center has many personnel to assist their [diverse] clients”</i></li> <li>• <i>“They always call for an interpreter and providers and staff are very thankful to have us there”</i></li> </ul>
<p><b>Multilingual patient related materials</b></p>
<ul style="list-style-type: none"> <li>• <i>“The hospital continues to improve on communicating with LEP patients by having signs, documents, and discharge teaching in Spanish”</i></li> <li>• <i>“This hospital system places strict adherence to standards of practice/efforts to offer documents in many languages”</i></li> </ul>
<p><b>Other</b></p>
<ul style="list-style-type: none"> <li>• <i>“I don’t think there is one I can think of. Organizations across the state are trying to learn how to use interpreters”</i></li> <li>• <i>“I don’t think there are any that provide outstanding service; some try but due to organizational failures none are outstanding”</i></li> </ul>

## **SERVICES ORGANIZATIONS NEED TO IMPROVE**

Interpreters responded to the open-ended question “From your observation and experience, name the health care organizations that you think need to improve their services to non-English speaking patients, and please state why” by naming specific facilities, or by writing general statements such as “too many to name,” “no comment,” “specialists,” “doctor’s offices,” “all!,” “all of them need help because I think we need certified medical interpreters,” “private health care offices,” or “eye doctor offices.” There were 58 comments about why the organizations needed to improve that were coded into ten categories. The top reason given 24% of the time was the organization’s lack of respect for and/or quality services for LEP patients.

**Table 4.6: Why organizations need to improve**

Lack of respect for and/or quality services for LEP patients	14
Insufficient number of interpreters	7
No interpreters on staff	7
Do not provide interpreters at all	7
Use of family and friends to interpret	7
Needs to hire more bilingual staff in addition to interpreters	6
Inadequate materials/ signage in multiple languages	4
Language incompetency of interpreters	2
No interpreters other than Spanish	2
Limited hours of language access services	2

**Table 4.7: Examples of responses for “Organizations needs to improve”**

<b>Lack of respect for and/or quality services to LEP patients</b>
<ul style="list-style-type: none"> <li>• <i>“I think all health care organizations need much improvement. Specifically in recruiting bilingual providers. The ones that are more than ‘need to improve’ and are, I believe, NEGLIGENT, are doctor’s offices. They actually will refuse to see patients if they do not speak English and do not bring an interpreter”</i></li> <li>• <i>“Eye surgery clinics and family health centers make [LEP] patients wait a long time”</i></li> <li>• <i>“Very inattentive to deaf patient’s needs”</i></li> </ul>
<b>Insufficient number of interpreters</b>
<ul style="list-style-type: none"> <li>• <i>“This hospital does not have enough interpreters for such a huge hospital, and they make you wait hours before you see someone”</i></li> <li>• <i>“This health department serves many clients and hasn’t enough interpreters, especially in the STD, general assistance, immunization, and dental clinics”</i></li> </ul>

- *This health department in the past, have had limited availability of interpreters and told patients to bring their own interpreters, for example, dental clinic*

**No interpreters on staff**

- *"I understand that [these hospitals] do not have interpreters on staff in a market with many people of limited English proficiency"*
- *"I hear patients complain how hard it is to have an interpreter available at these hospitals"*
- *"No formal language access department"*

**Use of family or friends to interpret**

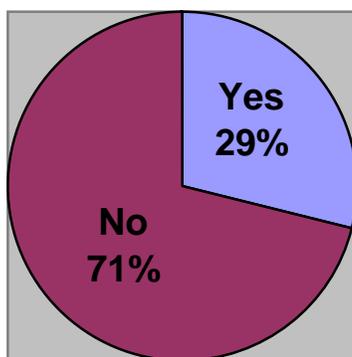
- *"At this hospital's emergency room, the patient's mom needed an interpreter but instead of getting a professional, they preferred the patient's older adult brother"*
- *"Specialty areas in hospitals, these services always ask us to have the patient bring a bilingual person with them"*
- *"Some doctors offices try to get by using patients' family and friends"*

**Needs to hire more bilingual staff in addition to interpreters**

- *"There is no Spanish-speaking personnel at this location at all"*
- *"I think this organization has very few nurses who speak Spanish and I think it would be good if their nurses were proficient so they wouldn't have to hire an outside company"*

**INCIDENTS INTERPRETERS ARE REPORTING**

159 persons responded to the question "In a medical interpretive encounter, has there ever been an incident you reported, or wanted to report, to any type of authority (supervisor, hospital, or police)?" There were 46 who replied "yes" and 113 replied "no."



**Figure 4.31: Incidents to Report**

A follow-up question was asked: "Briefly describe the incident you wanted to report and the outcome." Of the 46 interpreters who had reported or wanted to report an incident, 34 offered descriptions, which were coded into eight categories. The top two types of incidents were abuse or intent to harm and blatant disrespect on the part of the provider.

**Table 4.8: Types of Incidents to Report**

Abuse or intent to harm self or others	8
Provider blatant disrespect toward patient	7
Other	6
Incompetent interpreter	3
Staff/provider using patient's family or friends to interpret	3
No provision of language assistance services	3
Staff/provider's lack of knowledge about available interpreter services	3
Incompetent "semi" bilingual providers	1

**Table 4.9: Examples of responses for “Incidents to Report”**

<b>Abuse or intent to harm self or others</b>	
<ul style="list-style-type: none"> <li>• <i>“Mother confides issue of abuse, so I’m required to notify. Usually happens in the ER”</i></li> <li>• <i>“Domestic violence and underage women married to older men”</i></li> <li>• <i>“As part of the health care team at the hospital we are required by law to report any instances of abuse/negligence involving women, children, and the elderly, also, intent to harm self or others. As employees of the hospital, we are also patient advocates and will report any incident involving staff insensitivity or misconduct and/or documentation errors”</i></li> </ul>	
<b>Provider blatant disrespect toward patient</b>	
<ul style="list-style-type: none"> <li>• <i>“Pregnant woman left bleeding in ER lobby for 2 hours”</i></li> <li>• <i>“Providers asking inappropriate questions and/or making stereotypical and racist remarks”</i></li> <li>• <i>“The doctor was doing rounds with a patient that had recently given birth. He asked her about breastfeeding and if she wanted the nurse to show her how to breastfeed. The patient said no, that she would try to do it herself (she seemed shy). Even though the patient refused the teaching, the doctor himself went ahead and grabbed her breast and simulated. She seemed to be very uncomfortable with him touching her breast without her permission. I reported this to one of the OB nurses. I don’t know if they talked to him about it, but I haven’t seen him do this anymore”</i></li> </ul>	
<b>Other</b>	
<ul style="list-style-type: none"> <li>• <i>“There are way too many”</i></li> <li>• <i>“A patient had gotten hydroquinone one week prior to the appointment (100 pills) and he was asking another doctor for a refill. After the session I reported this to the doctor”</i></li> </ul>	

## **MAIN BARRIERS FACED BY LEP PATIENTS**

161 persons gave 511 responses, when asked about the top three reasons they think LEP patients might not be receiving quality health care. The question was: “In your opinion, what are the main barriers faced by limited- and non-English-speaking patients in receiving high quality health care in Nebraska?” A list of 12 possible choices were given, with “Other (please explain)” as the final option. For the top pick, 84 persons (16.4%) cited lack of interpretive services as a barrier. The next four choices were: little or no health insurance, cultural differences and beliefs, lack of bilingual providers, and financial reasons.

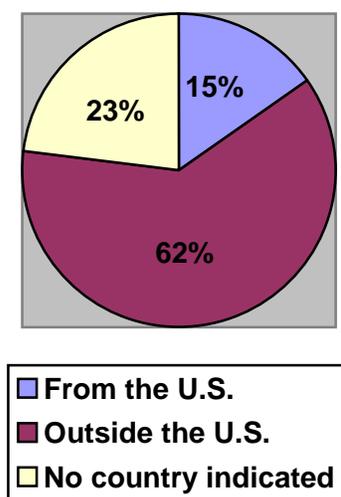
**Table 4.10: Main Barriers Faced by Limited- & Non-English Speaking Patients**

Lack of interpretive services	84
Little or no health insurance	74
Cultural differences and beliefs	60
Lack of bilingual health providers	59
Financial reasons	47
Low level of immigrants’ education	43
Patients’ reluctance to ask questions	42
Fear of deportation	36
No materials in their languages	29
Low intelligence of immigrants	13
Biases or racism of health providers	13
Other	11

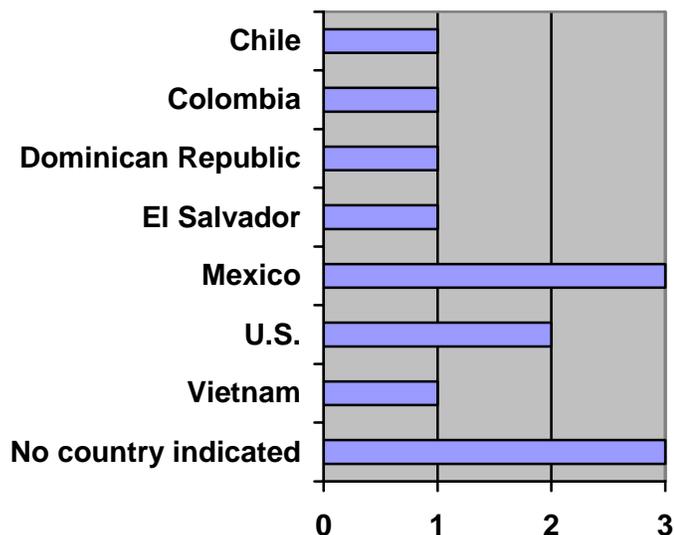
During the data collection phase, a respondent contacted our office via email writing “I am curious why you would ask a question about low intelligence of immigrants! Are you serious about that question? I find it disturbing and racist.” His inquiry gave us the opportunity to explain the reason why this option was included. This choice helped identify bias on the part of the respondents. The Institute of Medicine 2002 report *Unequal Treatment* revealed that 50-75% of White Americans believe that relative to Whites, Black Americans are: “less intelligent, more prone to violence and prefer to live off of welfare.”<sup>xxvi</sup> To more closely examine potential respondents’ racial and ethnic bias, among those who perceive immigrants’ low level of intelligence as a barrier to accessing health care, a cross-referencing of country of origin was conducted. Are the biases about immigrants’ intelligence primarily from non-immigrant (U.S.

born) respondents? The answer is no. From the 13 responses, 15% (two responses) came from U.S. born interpreters; 54% (seven responses) came from Latin American-born interpreters, and three had not listed their country of origin.

**Figure 4.32: Indicated 'low level of intelligence of immigrants' as a barrier**



**Figure 4.33: Breakdown of 'outside the U.S.'**



### **INTERPRETERS' MOST POSITIVE EXPERIENCE**

There was high response (90.5%) to the multiple choice question "What are the positive experiences that you think medical interpreters encounter the most? Please mark 3." Each of the 162 respondents to this question offered three reasons, totaling 486 responses. Thirty percent feel interpreters' most positive experience is their opportunity to help people. Enjoyment of work in the health care field was named by 22%. Only 6.8% feel that salary relates to positive experience. From this evidence, interpreters are not motivated by money; rather, they enjoy helping people within the health care setting, utilizing their language and professional skills.

**Table 4.11: Positive Experiences Medical Interpreters Encounter the Most**

Opportunity to help people (patient satisfaction)	30%
Enjoy working in health care field	22%
Using language skills	20%
Developing my profession	10%
Lessening inequalities in health care delivery	10%
Salary/pay/benefits	7%
Others	1%

## **INTERPRETERS' MOST NEGATIVE EXPERIENCE**

There was a lower response rate (83.8%) to the question about negative experiences, compared with positives ones, that medical interpreters encounter the most. The 150 persons marked an average of 2.5 choices. The most popular choice for negative experiences is the lack of respect for interpreters as professionals. In second place is the interpreter's encounter of low levels of providers' cultural competence. Third is the interpreters' experience of having to give bad news. As the previous question regarding positive experience demonstrates, interpreters most value the opportunity to help people. Giving bad news may conflict with the desire to help others. Professional interpreter training emphasizes that "giving bad news" is not the role of interpreters; rather they are rendering a message. Foundational training develops techniques such as coping skills, emotional distancing, and rapport-building rather than relationship-building with clients.

**Table 4.12: Negative Experiences Medical Interpreters Encounter the Most**

Lack of respect for interpreters as professionals	20%
Providers lack of cultural competence	19%
Having to give bad news (i.e. death, illness, etc.)	16%
Not having proper training	15%
Supervisors who don't understand interpreter's profession	15%
Inefficient organizational or departmental policies	10%
Others	5%



## Chapter 5

# Considerations

**“This hospital has made it a priority to provide assistance to those patients that have limited English proficiency, and has done a great job not only staffing a department with bilingual employees but also for providing interpretation services 24/7”**

**Survey Respondent**

## CONSIDERATIONS

**“We don’t have interpreters... our Mexican cleaning lady interprets for us when necessary”**

Nebraska health care facility nurse  
when asked to participate in this study

### **Nebraska’s Language Access in Health Care**

Working well are the many Nebraska hospitals and clinics that provide quality language access services at all hours of operation. Also working well are the interpreters who follow standards of practice and codes of ethics, and who receive professional training in the complexities of medical terminology and interpreter role dimensions.

The interpreters in our survey are experienced, with almost 70% working in the field for more than two years. They are formally educated, with 86% having some college education. They tell us that their motivation is not monetary reward; rather, they are most passionate about helping people, working in health care, and utilizing language skills. As impartial eye and ear witnesses, their opinion matters. Across the state, 179 interpreters have spoken and the message is clear: half (52%) of Nebraska’s health care organizations are fulfilling regulatory responsibilities to provide equal treatment to LEP patients, and the other half are not. Interpreters tell us that 48% of our state’s health care facilities are doing a poor, inadequate, or fair job offering interpretive services to LEP patients, hiring bilingual staff, informing LEP patients of their right to an interpreter, ensuring family and friends are not interpreting, and displaying signs and providing health documents in multiple languages.

Interpreters tell us that the biggest barrier faced by LEP patients is the organization’s lack of language access services. When services are provided, up to half the interpreters are in a dual role or hired for another position, which can cause ambiguous role boundaries and the avoidance of training requirements. Among interpreters’ negative experiences, top on the list is the lack of respect from staff and providers about their profession – a profession that is central to any organization wishing to abide by mandates, or by a moral imperative, to provide equal access to persons with limited English abilities.

Alongside organizational shortfalls, this survey also brings to light professional inadequacies of Nebraska interpreters, which could partially contribute to or exacerbate the lack of respect they feel from staff and providers. Up to two-thirds are not competent culture brokers, a role that is necessary when miscommunication arises due to cultural misunderstandings. Almost half are not following a code of ethics or standards of practice, which is a set of “best practices” to ensure a consistent quality of performance and accurate and complete transmission of the message. Approximately 40% are not conducting briefing pre-sessions that lay ground rules to the patient and provider for a successful interpreted communicative event.

### **Other considerations and limitations**

Doctors, nurses, and most clinicians are certified by state boards, and translators by the American Translators Association. Court interpreters are state certified. Sign language interpreters are state licensed and certified nationally by the Registry of Interpreters for the Deaf (RID). Yet for medical interpreters, on whom providers and patients often depend in life-and-death situations, there is no official state process to qualify, validate, or certify the knowledge, skills, and abilities necessary to provide competent rendering of the message. Overall, interpreters in this survey who receive higher wages have had training, with state-licensed American Sign Language interpreters the highest among them. Some organizations could myopically view state certification as synonymous with salary increases. In the long run, however, excellence in language access delivery should lower overall costs due to greater efficiency, risk management, and customer satisfaction. This could be a topic for future study.

The survey revealed that more training is taking place in Congressional District Two. Of the possible reasons, four of the five large hospital systems in the Omaha Metro (District Two) have established language access departments employing pools of interpreters. Most hospitals in the Lincoln area (District One) exclusively contract out interpreter services. Health facilities with a stake in their interpreter employees normally pay for professional training and development.

### **Consequences of Failure to Address the Issues**

Equal access to health care provision is seriously diminished when communication is poor and cultural issues go unnoticed. An incorrect interpretation can render insensible an otherwise straightforward clinical encounter, where positive health outcomes become lost in either no, or poor quality, translation. Lack of proper interpreting services not only discourages limited-English proficient patients to seek care, it can ultimately compound health problems and costs.

In the initial data collection phase, as health care facilities across the state were telephoned to inquire about their language access services, several declined to participate. “We use the local Spanish teacher from the high school,” said more than one provider. “We don’t have interpreters... our Mexican cleaning lady interprets for us when necessary,” was another response. Organizations failing to provide equal care to culturally and linguistically diverse patients may be in direct violation of Title VI of the 1964 Civil Rights Act, Executive Order 13166, the Health & Human Services Guidance, and the CLAS Standards. As evidenced in this study and the earlier MTI study cited in the Preface of this report, a significant proportion of Nebraska medical providers are either not aware of or are unclear about their responsibilities in providing quality interpretive services or qualified bilingual staff and clinicians.

## **RECOMMENDATIONS**

- 1) Commit stakeholder leadership at the state level to begin the process toward statewide certification for the purpose of quality assurance in the competencies of medical interpreters within our state’s health facilities.
- 2) Hold accountable health care organizations that are recipients of federal funds to their legal responsibilities for providing equal access to services.
- 3) Require health care organizations to develop the mechanisms to establish the competency and ongoing training for any person providing language services: bilingual staff and clinicians as well as interpreters, translators, and dual role interpreters.
- 4) Encourage health care organizations located in areas of culturally and linguistically diverse populations to create their own language access division, employing interpreters in addition to using telephonic services and/or contracting interpreters.
- 5) Ensure that interpreter training programs are substantive and rigorous, especially in the areas of standards of practice, codes of ethics, culture brokering, and briefing pre-sessions. Award training certificates only upon successful completion based on thorough assessment criteria measuring training objectives.
- 6) Make training mandatory for staff and providers to develop knowledge and skills in the subjects of health disparities, language access regulation and policies, and how to work with and respect the role of the professional interpreter.

From the voice of interpreters – the state, health care organizations, and medical interpreters, are called to take responsibility to improve the manner in which Nebraska health systems are providing language access services to culturally and linguistically diverse patient populations.



# Chapter 6

## Acknowledgements

## ACKNOWLEDGEMENTS

We sincerely thank each and every person who assisted us with this survey and report. Most notably, we are grateful to the interpreters who took the time to respond to the 30-question instrument, and who everyday are in the field with limited-English proficient patients assuming their vital professional roles of language conduits, clarifiers, and when necessary and appropriate, culture brokers and advocates.

We thank our two faithful research assistants: Brandy Palatas who spent countless hours creating graphs and tables from the survey data, and Molly Walsh who initially telephoned hundreds of potential respondents, health care facilities, language access departments, and agencies, and then tracked and input the data when the completed surveys were returned. We are very grateful to Karen Bahr, board member of the NCIHC, who served as consultant at all stages of the project. We thank Jane McGinty and Jeanette Evans, who served on the committee to devise the survey questions. The expert assistance of Anthony Zhang, Health Surveillance Specialist, Office of Minority Health and Health Equity, was invaluable as the main data analyst. Dr. Molly Wernli, College of Saint Mary, assisted as survey consultant for the project in its initial phase. Laura Fuhs and Theresa Ryan, College of Saint Mary, were instrumental in lending administrative support and knowledge of the interpreter field. We would be remiss to fail to acknowledge the program manager, Diane Lowe, Office of Minority Health and Health Equity, without whose vision and support we would not have been able to conduct this study.

We would like to acknowledge the many groups, organizations, and individuals who helped distribute and collect the surveys. Without their network, knowledge, and support we could not have gathered the data needed for this report. Although there were many anonymous organizations which we are not able to mention, the following organizations were instrumental in the collection phase of the project:

Alegent Health System  
Alliance Migrant Health Clinic  
Annie Jeffrey Memorial County Health Center  
Antelope Memorial Hospital  
Aurora Memorial Hospital  
Avera St. Anthony's Hospital  
Beatrice Community Hospital and Health Center

Bergan Mercy Medical Center, Alegant Health  
 Blair Memorial Community Hospital Health System  
 Boone County Health Center  
 Box Butte General Hospital  
 Boys Town National Research Hospital  
 Bridgeport Migrant Health Center  
 Brodstone Memorial Hospital  
 Brown County Hospital  
 Bryan LGH Health System  
 Butler County Health Care Center  
 Callaway District Hospital  
 Central Nebraska Area Health Education Center (CNAHEC)  
 Chadron Community Hospital and Health Services  
 Charles Drew Community Health Center  
 Chase County Community Hospital  
 Cherry County Hospital  
 Children's Hospital  
 College of Saint Mary  
 Columbus Community Hospital  
 Cozad Community Hospital  
 Creighton Area Health Services  
 Creighton University Medical Center  
 Crete Area Medical Center  
 Douglas County Health Department  
 Dundy County Health System  
 East Central District Health Department - Good Neighbor Community Health Center  
 Falls City Community Medical Center, Inc.  
 Fillmore County Hospital  
 FIRST Project, Inc.  
 Franklin County Memorial Hospital  
 Fremont Area Medical Center  
 Garden County Health Services  
 Good Samaritan Health Systems  
 Gordon Memorial Hospital  
 Gothenburg Memorial Hospital  
 Great Plains Regional Medical Center  
 Harlan County Health System  
 Hastings Regional Center  
 Henderson Health Care Services, Inc.  
 Hope Medical Outreach Coalition  
 Howard County Community Hospital  
 Immanuel Medical Center, Alegant Health  
 International Communications Inc. (ICI)  
 Jefferson Community Health Center  
 Jennie M. Melham Memorial Medical Center  
 Johnson County Hospital  
 Kearney County Health Services  
 Kimball Health Services  
 Lakeside Hospital, Alegant Health  
 Language Linc Interpreter Services  
 Lincoln Regional Center  
 Lincoln/Lancaster Health Department  
 Lincoln-Action Program  
 Litzenberg Memorial County Hospital  
 Lutheran Refugee Services  
 Madonna Rehabilitation Hospital

Mary Lanning Memorial Hospital  
 McCook Community Hospital  
 Medical Translation & Interpretation Leadership Group (MTI)  
 Memorial Hospital, Alegent Health  
 Midlands Hospital, Alegent Health  
 Nebraska Association for Translators & Interpreters (NATI)  
 Nebraska Health & Human Services System  
 Nebraska Hospital Association and  
 Nebraska Methodist Health System  
 Nebraska Methodist Hospital  
 Nebraska Office of Minority Health and Health Equity  
 Nebraska Quality Google Group  
 Nebraska Rural Health Association  
 Nemaha County Hospital  
 Niobrara Valley Hospital  
 Norfolk Regional Center  
 Northeast Nebraska Public Health Department  
 Oakland Memorial Hospital  
 Ogallala Community Hospital  
 OneWorld Community Health Clinic  
 Osmond General Hospital  
 Pawnee County Memorial Hospital  
 Pender Community Hospital  
 People's Health Center  
 Perkins County Health Services  
 Phelps Memorial Health Center  
 Plainview Area Health System  
 Providence Medical Center  
 Rock County Hospital  
 Saint Elizabeth Regional Medical Center  
 Saint Elizabeth Sports & Physical Therapy  
 Saint Francis Medical Center  
 Saint Francis Memorial Hospital  
 Saunders County Health Services  
 Select Specialty Hospital - Omaha, Inc.  
 Seward Memorial Health Care Systems  
 Sidney Memorial Health Center  
 Somali Bantu Association  
 Southeast Community College  
 Southern Sudan Community Association  
 Syracuse Community Memorial Hospital  
 Thayer County Health Services  
 The Nebraska Medical Center  
 Three Rivers Public Health Department  
 Tilden Community Hospital  
 Tri-County Hospital  
 Tri-Valley Health System  
 University of Nebraska at Kearney  
 VA Nebraska-Western Iowa Health Care System  
 Valley County Health System  
 Warren Memorial Hospital  
 Webster County Community Hospital  
 West Holt Memorial Hospital  
 York General Hospital

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# APPENDIX A

## Nebraska Interpreter Survey

If you provide services as an interpreter in any healthcare/medical/clinical settings, in the state of Nebraska, regardless of actual position or title, please complete the following survey.

The Center for Transcultural Learning (CTL) in partnership with Nebraska's Office of Minority Health (OMH) would like your help. We want to better understand what is working well and where there are barriers concerning language access services to limited English proficient patients in our health care organizations, and also to assess the background and characteristics of medical interpreters in our state.

We do not need your name on the survey. Your individual identity will not be revealed. The written survey results will be presented in grouped data only, and the individual surveys will remain confidential. Thank you very much for your help!

### **RETURN BY AUGUST 31, 2007, (by mail, email, or fax) TO:**

By Mail: Center for Transcultural Learning  
College of Saint Mary  
7000 Mercy Road  
Omaha, NE 68106

By Email: [ctl@csm.edu](mailto:ctl@csm.edu)  
By Fax: 399-2671

**For Questions Call: (402) 390-1902**

### General Information

1. How long have you been serving as a medical interpreter? – *Mark with X*

1)	For more than 10 years	5)	For 1-2 years
2)	For 7-10 years	6)	For less than 1 year
3)	For 4-7 years	7)	Less than 1 year – ____ Months
4)	For 2-4 years		

2. How many interpretive sessions do you currently have each month? – *Mark with X*

1)	More than 50	4)	From 10 to 20
2)	From 35 to 50	5)	Less than 10
3)	From 20 to 35		

3. What type of facility do you interpret (or work) for? – *Mark with X all that apply*

1)	Doctor's Office	5)	Public Health Setting
2)	Hospital	6)	Business Organization
3)	Medical Clinic	7)	Other:
4)	Community Health Center		

4. What is your job title? \_\_\_\_\_.

5. Please list your approximate hourly salary range, **or** monthly salary?

1) Hourly salary range	
2) Monthly salary	

6. Are you on the payroll as an employee, or do you contract out your services? – *Mark with X*

1)	Employee
2)	Contractor
3)	Other:

7. Are you serving as a medical interpreter full-time (over 30 hrs per week) or other? – *Mark with X*

1)	Full-time
2)	Part-time
3)	On-Call

8. What is your country of origin? \_\_\_\_\_.

9. What language(s) do you interpret for (excluding English)? *List all if more than one*

1)	
2)	
3)	
4)	
5)	

10.

11. In which cities or towns do you provide interpretive services? *List all if more than one*

1)	Schuyler	8)	Wilber
2)	Omaha Metro	9)	West Point
3)	Lincoln	10)	Seward
4)	Grand Island/Hastings	11)	Blair
5)	Crete	12)	Lexington
6)	All of Nebraska	13)	Fremont
7)	Kearney	14)	Other:

**Education & Training Information**

12. Please mark the **highest** education level you have achieved:

1)	Some High School Education	6)	Some Graduate Education
2)	High School Diploma	7)	Master’s Degree
3)	Some College Education	8)	Some Post-Graduate Education
4)	Associates Degree	9)	Post-Graduate Degree
5)	Bachelor’s Degree		

12. Have you had training specifically for medical interpreting? – *Mark with X*

1)	Yes
2)	No

13. If yes, what kind of training was it? – *Mark X on all that apply*

1)	On-the-job training
2)	Course or Seminar

*If you marked a course or seminar, please give the name of the course and the number of hours:*

Course Name		Where		Hours	
Course Name		Where		Hours	
Course Name		Where		Hours	
Course Name		Where		Hours	

14. Have you had any other interpreter training not specifically medical?

1)	Yes
2)	No

*If yes, please list the name of the course and number of hours:*

Course Name		Where		Hours	
Course Name		Where		Hours	

15. Under what circumstances do you find that you need to step out of your interpreter role as “conduit” and into the role of “culture broker”... in other words, what situations require you to explain cultural differences?

16. Which professional Standards of Practice and/or Code of Ethics do you follow as a medical interpreter?

1)	American Translators Association (ATA)	6)	California healthcare Interpreters Association
2)	American Medical Interpreters and Translators Assoc (AMITAS)	7)	Massachusetts Medical Interpreter Association
3)	National Associate for the Deaf (NAD)	8)	Other (list here):
4)	National Council on Interpreting in Health Care (NCIHC)	9)	None
5)	Registry of Interpreters for the Deaf (NCIHC)		

17. Do you typically conduct a briefing pre-session before an interpretation? – *Mark with X*

1)	Yes always	3)	No, I do not think it is necessary
2)	Yes often	4)	No, I am not sure what a briefing pre-session is

**Organization’s Information**

From your experience at any health organizations with which you are familiar, please rate the organization’s efforts being made in the following areas: *Circle the number from 5 (excellent) to 1 (poor).*

18. Informing limited English-proficient patients of their right to an interpreter free of charge?

<i>Excellent Efforts</i>					<i>Poor Efforts</i>	
5	4	3	2	1		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

19. Hiring bi-lingual health providers in addition to interpreters?

<i>Excellent Efforts</i>					<i>Poor Efforts</i>	
5	4	3	2	1		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. Displayed signs in multiple languages for patients to see?

<i>Excellent Efforts</i>					<i>Poor Efforts</i>	
5	4	3	2	1		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

21. Making health documents readily available in multiple languages for patients?

<i>Excellent Efforts</i>					<i>Poor Efforts</i>	
5	4	3	2	1		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

22. Making sure patients have a professional medical interpreter rather than allowing family and friends to interpret?

<i>Excellent Efforts</i>					<i>Poor Efforts</i>	
5	4	3	2	1		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

23. Please rate how you feel your role as a medical interpreter is valued & respected by healthcare providers, staff persons, and patients (5=high and 1=low). – *Circle the corresponding number*

	<i>Highly respected</i>					<i>Not respected at all</i>	
	5	4	3	2	1		
a. <u>By Providers</u>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. <u>By Staff</u>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. <u>By Patients</u>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

24. From your observation and experience, name the healthcare organization(s) that you think provides outstanding quality service to its non-English speaking patients, and please state why:

25. If you were non-English speaking, name the healthcare organization(s) where would you want to go for healthcare?

26. From your observation and experience, name the healthcare organizations that you think need to improve their services to non-English speaking patients, and please state why:

**Your opinion and experience is valuable to us:**

27. In a medical interpretive encounter, has there ever been an incident you reported, or wanted to report, to any type of authority (supervisor, hospital, or police)? – *Mark with X*

1)	Yes
2)	No

If yes, briefly describe the incident and the outcome:

28. In your opinion, what are the main barriers faced by limited & non-English speaking patients in receiving high quality health care in Nebraska? (*Mark three items with numbers 1,2, & 3 – with 1 as the biggest barrier*)

a)	Lack of interpretive services	h)	Low level of immigrants’ education
b)	Lack of bilingual health providers	i)	Low intelligence level of immigrants
c)	Little or no health insurance	j)	Financial reasons
d)	Cultural differences and beliefs	k)	Biases or racism of health providers
e)	No materials in their languages	l)	Other (please explain):
f)	Patients’ reluctance to ask questions		
g)	Fear of deportation		

29. What are the positive experiences that you think medical interpreters encounter the most? (*Mark three items with numbers 1,2, & 3 – with 1 as most positive*)

a)	Enjoy working in the healthcare field
b)	Using language skills
c)	Opportunity to help people (patient satisfaction)
d)	Developing my professionalism
e)	Salary / pay / benefits
f)	Lessening inequalities in healthcare delivery
g)	Other (please explain):

30. What are the negative experiences that you think medical interpreters encounter the most? (*March three items with numbers 1,2, & 3 – with 1 as most negative*)

a)	Providers lack cultural competence
b)	Lack of respect for interpreters as professionals
c)	Having to give bad news like death or grave illness
d)	Not having proper training
e)	Having supervisors who don’t understand the interpreters’ profession
f)	Inefficient organizational or departmental policies
g)	Other (please explain):