

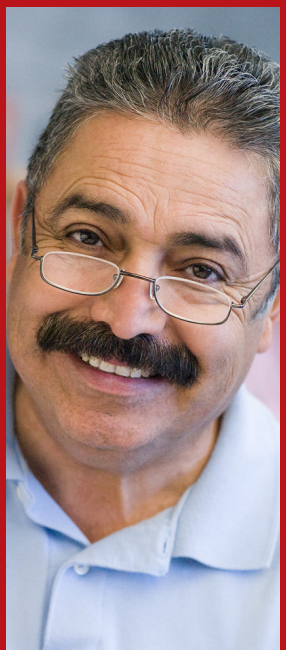


WORKING VOICES

Elevating Health Care Interpretation in Oregon

OHCIA
OREGON HEALTH CARE INTERPRETERS ASSOCIATION

MAY 2018

EXECUTIVE SUMMARY

ABOUT

The Oregon Health Care Interpreters Association (OHCIA) was formed in 2010 with the mission of advancing the Health Care Interpreter (HCI) profession in order to improve health outcomes for our communities. Our vision is to create highly skilled HCIs who are economically successful and valued as integral members of the health care team.

PURPOSE

HCI face systemic challenges when providing interpreter services for limited English patients. Thanks to a grant from the Oregon Community Foundation, we conducted a research study to hear directly from HCIs about the barriers, attitudes, cultural issues, and specific problems affecting their work. Findings from this research can be used to identify best practices for programs to reach, train, mentor, coach, retain, and develop the HCI workforce.

This is the first report of its kind and, as such, provides new information beneficial to industry stakeholders. Health care providers, interpreter agencies, healthcare regulatory bodies, HCIs themselves, and OHCIA can work together to bring about effective system changes. Our hope is that these system changes will elevate this workforce with improved skills, employment conditions, and greater economic opportunities while creating the foundation for healthier communities.

METHODS

Focus groups and interviews were conducted with 96 health care interpreters representing 20 language group communities including Amharic, Arabic, Burmese/Zomi, Cambodian, Cantonese/Mandarin, Chuukese, Hmong, Indigenous Peoples of Mexico, Korean, Marshallese, Mien, Nepali, Russian, Samoan/Tongan, Somali/Maay Maay, Spanish, Swahili, Thai, Tigrinya, and Vietnamese.

This report can be found at: http://OHCIA.org/working-voices

An appendix describing the methodology can be found at: http://OHCIA.org/working-voices-appendix

KEY FACTS

96
health care interpreters interviewed

20
Language group communities represented

KEY FINDINGS

These key findings identify systemic failures that create less than ideal working conditions and limit compensation for HCIs, as well as hamper meaningful language access services in Oregon. The concerns expressed by HCI participants also relate to matters of social justice that adversely affect historically underserved communities, including those of color, people experiencing poverty, people with disabilities, immigrants, and refugees.

- Low pay and unreliable work don't justify the cost of education for Oregon State HCI accreditation.
- Compensation is reduced by one hour appointment limits and lack of transportation reimbursements.
- HCIs experience inequitable business practices.
- Health care providers and staff lack cultural awareness.
- HCIs lack industry representation, training, support, and appropriate testing standards.
- Cultural bridging, clarifying, and advocacy are important roles for HCI.
- HCIs strive to assist their communities and aspire to be trusted care team members.

KEY RECOMMENDATIONS

1. Interpreters should be paid in full for booked hours, for excess time spent in appointments at the request of the provider, and reimbursed for travel expenses.
2. Providers should require verification that the HCI is credentialed.
3. A professional, regulatory board should be established with the State of Oregon.
4. Guidelines should be instituted for regulatory bodies to improve testing standards and practices.
5. The conventional health care industry model for working with limited English patients should be updated to include HCI roles of clarifier, cultural bridge, and advocate.
6. Language-specific HCI support programs and resources should be expanded. HCIs should have convenient access to a broad spectrum of medical specialty trainings provided by the health care provider.

The participant opinions provided in this report do not reflect the ideas or beliefs of OHCIA, its board members, staff, contractors, or volunteers. The opinions were obtained during interviews and focus group meetings with members of the different communities and are presented as accurately as possible. OHCIA maintains confidentiality regarding participant names and personal information.

KEY FINDINGS

Low pay and unreliable work don't justify the cost of education for Oregon State HCI accreditation.

Insufficient compensation, lack of policy enforcement requiring use of credentialed HCIs in medical appointments, and insufficient work hours are problematic. These conditions discourage HCIs from attaining more education, accreditation, and remaining in the profession. HCIs want increased compensation for their credentialed status and enforced policies around hiring credentialed HCIs.

My friend got a qualification from the State of Oregon, and she asked for a raise. She got $2.00 an hour pay raise from the agency, but they reduced her hours and they also let her know that, "Why do I have to pay you more, when another person can do the job? The business has to make a profit." So, they give the jobs to the unqualified person, so they can pay less.

Kids just out of high school or in college summer break will say they speak two languages and then agencies will hire them for a few dollars cheaper.

Compensation is reduced by one hour appointment limits and lack of transportation reimbursements.

HCIs travel up to 90 minutes to appointments, often for only a 60 to 75 minute appointment. They are also asked to arrive 15 minutes early and pay for parking fees and gas. Usually, they spend time confirming appointments the day before with often hard to locate clients. Further, interpreters are frequently asked to stay on if the appointment runs long, usually for no compensation for the extra time spent.

People are on the road all day long from morning to night, and it is easy to get into accidents. Sometimes the providers delay and that makes us late for the next appointment and puts a lot of stress on us. If we cancel for the delay, then the provider has to cancel and reschedule in order to have an interpreter. It makes it very hard on the patient. Mental health patients can get very angry in that case and get in arguments among themselves and with the doctor. They can yell at or even hit the interpreter.

HCIs experience inequitable business practices.

A majority of HCIs report unfair treatment by interpreter agencies. For example, some agencies book the interpreter for hours they may not need and refuse to pay them for the time not used. As a result, the HCI loses pay hours that could otherwise have been booked with other jobs.

One time I didn't get paid and the agency that scheduled me refused to pay me. I went to the Labor Board and they said as a contractor I have to hire my own lawyer. It isn't worth it.

A 6-hour surgery was booked and then it was cancelled when I came in, and I only was paid for one hour.

KEY FINDINGS

Health care providers and staff lack cultural awareness.

HCI participants are aware of the complexities of the interpreter-mediated medical encounter, and that it calls for "negotiating meanings across various languages, cultures, and expertise" (Hsieh, 2016, pp.185). Due to a lack of cultural awareness on the part of the provider and agencies, and because of rigid expectations of the interpreter role, needless mistakes and disruptive communications occur during medical encounters.

One difficulty to me is the provider doesn't understand that the party may not answer the question directly – it's a cultural thing – and the provider insists on what they perceive they should be getting as an answer and becomes angry with me.

I find that judges will be respectful, but on the flip side, some doctors and especially nurses, are not, and call me "just the interpreter". I was educated at Columbia, Ivy League.

It would be great to have provider information that pays attention to the gender and the patient region of origin.

Even glossaries may not help sometimes—there aren't really the words in our language for so much. Providers need to be open-minded and educated on the background of the patient. Providers should know it will take a long time to explain English words.

Sometimes the provider will say something that doesn't even exist in your language. We also have many people that didn't go to school, so one word in English requires so many words in in our language.

HCIs lack industry representation, training, support, and appropriate testing standards.

HCIs expressed a desire to be considered worthy and respected members of the medical team. As independent contractors, HCIs are isolated and often face difficulties due to lack of language-specific training support, and in coping with conflicting agency and provider policies. Dialect and regional language differences can cause unfair qualification and certification test failures. Accessibility and reliability of tests can also be inequitable.

Then I contracted an illness from a patient, and I wasn't mad at the patient, she didn't know. We interpreters should be trained and advised about our health risks.

We need an organization to represent us, protect us, and help us resolve problems for the benefit of everybody in the industry. Networking among interpreters would help us treat the patients with more humanity as we connect with each other and learn more about our work and our community.

I most want more training. Recently, there were some terms that the doctor said—I had to tell him, I am so sorry, there are no words in our language for that.

The large majority of the people in our language cannot read, especially the elders, because ours has been only an oral language. Because we don't have a standard written language, that is a problem with studying, creating a standard test, and evaluating results.

KEY FINDINGS

Cultural bridging, clarifying, and advocacy are important HCI roles.

HCIs believe that in order to achieve quality and equality of health care for their limited English patients, they must be allowed to transcend the traditional industry "conduit model" which is limited to word for word interpretation of the patient and provider.

Our people are not used to having healthcare in our country, so our people need deep and careful instruction. We have to be very careful about our interpreter roles, some of our people are very simple, they are friendly and innocent, very innocent. They don't know about the law, etiquette, rules, requirements; they need help with how to interact with the provider, and what are the boundaries and expectations.

In our country, people from different regions have a cultural problem with dialects. They are so polite, they can have a complete conversation without knowing what the other person is saying.

In our culture, we have an attitude, as with Tuberculosis, there is shame in being ill because it removes a person from the community, so they don't want to be identified as sick.

HCIs strive to assist their communities and aspire to be trusted care team members.

HCIs are concerned about increased risks to patient health care outcomes due to poor interpretation. HCIs want more training and more opportunities to work.

I like to learn, I learn medical terminology and about myself. I get to help the people, many that don't know about themselves, either. For instance, if you ask them where their own organs are, they do not know.

Every day is different, so I am excited every day about who I am going to meet and what I am going to do. You have to have a lot of patience, to feel the pain of the people, to do a good job.

I really like the after-visit summaries – it helps with some patient's selective memory. The translations of those are terrible, though. Providers are probably using translation software. It is so bad –maybe 40% incorrect.

I am not a social person, but when I interpret, I learn how to deal with different persons and how to be patient. Some people, it's this ear in and this ear out, and you learn to be patient. … You even can learn how to deliver a baby.

KEY RECOMMENDATIONS

Total number of related statements from 96 participants are shown in parentheses

1 Interpreters should be paid in full for booked hours, for excess time spent in appointments at the request of the provider, and reimbursed for travel expenses.

Over one-third of the participants expressed that the hourly pay ($18-$25) (36) and the low availability of paid working hours (21) did not allow them to rely on the profession to support their families. Unreimbursed mileage, travel time, parking fees, time spent tracking down patients to confirm appointments (22), and appointment overruns at the request of the provider (12), further reduce effective rates of pay.

> *The pay isn't enough because we are limited to one hour—transportation takes another hour, so we are paid half effectively.*

2 Health care providers should require verification that the HCI is credentialed.

The credentials of each HCI should be required and verified by the provider at the time of booking the HCI (4). Lack of credential verification leads to agencies providing low-cost interpreters with poor proficiency and interpreting skills, increasing the risk of mistakes and a loss of respect (11) for the workforce. Non-enforcement of credential standards also leads to a lack of financial incentive (15) for undertaking the credentialing process (23).

> *Once you get qualified, you get fewer calls because you are more expensive, unless the provider makes the demand for a qualified interpreter.*

3 A professional, regulatory board should be established with the State of Oregon.

More than half of HCIs (51) reported inequities in booking and payment policies and disrespectful treatment. As individual contractors, legal representation is prohibitive, and there is no other viable recourse available to address problems (8).

A regulatory board would elevate the interpreting profession through the creation, enforcement, and regulation of the practice of interpretation. This board would oversee licensing, set the scope of practice for interpreters, standardize training requirements, conduct investigations, and take disciplinary actions. Operating as licensed professionals will allow interpreters to be respected partners in team-based care, provide high quality interpretation, and increase the quality of patient care and outcomes.

> *Sometimes there is a big problem with the money, they don't pay. One agency said they sent it to the wrong address, then they say I can pick it up, then when I take it to the bank, there is no money in the bank.*

KEY RECOMMENDATIONS

4 Guidelines should be instituted for regulatory bodies to improve testing standards and practices.

Certification and qualification testing often err in dialect and regional language differences. Additionally, the State of Oregon can take up to a year to process the final accreditation (12).

> *I didn't pass the oral part of the exam because they were using a dialect that they did not alert me they were going to use. There is only one organization that certifies in my language. I have never failed any exam in my life.*

5 Conventional health care industry model for working with limited English patients should be updated to include HCI roles of clarifier, cultural bridge, and advocate.

HCIs reported misunderstood cultural issues that impede care and even prevent appointments from taking place (15). Providers request the wrong language (12), and provider staff can be disrespectful (16).

> *Ours is the backwards way of saying something in English. The doctor can be talking, talking, talking and then say, why are you silent? and we say, we are waiting for you to finish so we can begin to know how to convey the message.*

6 Language-specific HCI support programs and resources should be expanded. HCIs should have convenient access to a broad spectrum of medical specialty trainings from the health care provider.

HCIs know that to be trusted and respected, they need to be proficient in medical knowledge and terminology. They want ongoing HCI training (29), more medical specialty training (25), access to training materials in specific languages (30), and more networking, mentoring, and coaching opportunities in their language group (29).

> *I feel good about doing the extra part to help our people understand the follow up instructions and how to get to the next steps. One patient didn't know how to take medication on an empty stomach. She was angry with the doctor and couldn't figure out what the problem was until I asked her how she took her medicine.*