*Home for Trainers* Interpreter Trainers Webinars Work Group
An initiative of the Standards and Training Committee

NCIHC

NATIONAL COUNCIL ON INTERPRETING IN HEALTH CARE

# No Interpreter Left Behind:

## Ensuring Language Access for Less Common and indigenous Language Communities


*Guest Trainer:*
Katharine Allen, M.A.

*Webinar Work Group Hosts:*
*Linda Golley & Eliana Lobo*


December 11, 2014

www.ncihc.org/home-for-trainers

# Housekeeping

- This session is being recorded
- Certificate of Attendance
  *must attend full 90 minutes
  *trainerswebinars@ncihc.org
- Audio and technical problems


- Questions to organizers
- Q & A
- Twitter #NCIHCWebinar

NCIHC

NATIONAL COUNCIL ON INTERPRETING IN HEALTH CARE

# Welcome!

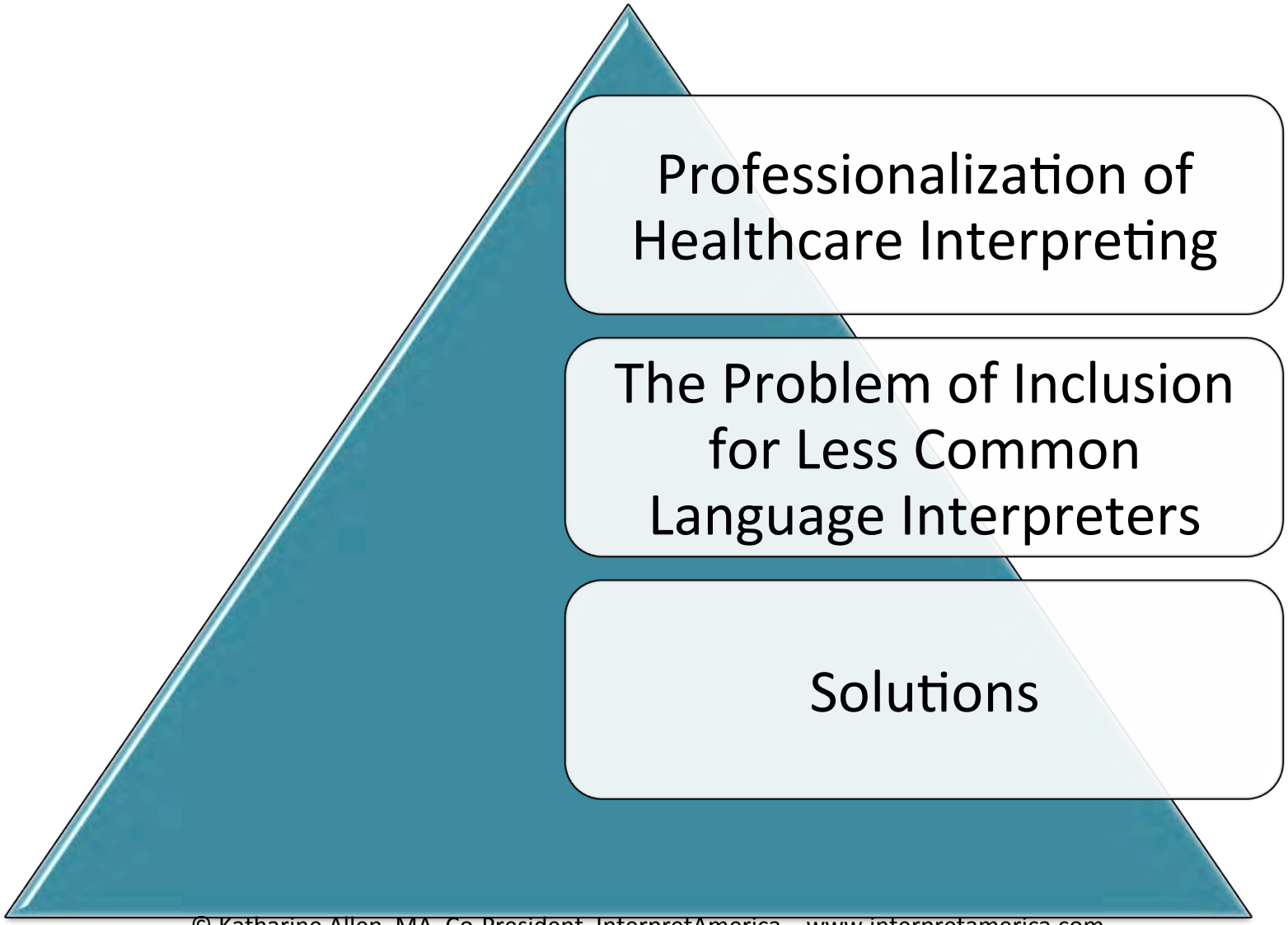
## Guest Trainer:

## Katharine Allen, M.A.

- Community Interpreter
- Trainer
- Curriculum developer
- Public speaker

**...everything supports facilitating communication.**

# Today's Agenda



# Polls: Audience Background

# Problem #1

The **partial professionalization** of healthcare interpreting is threatening to **exclude interpreters** from less-common but high-demand language groups

# Problem #2

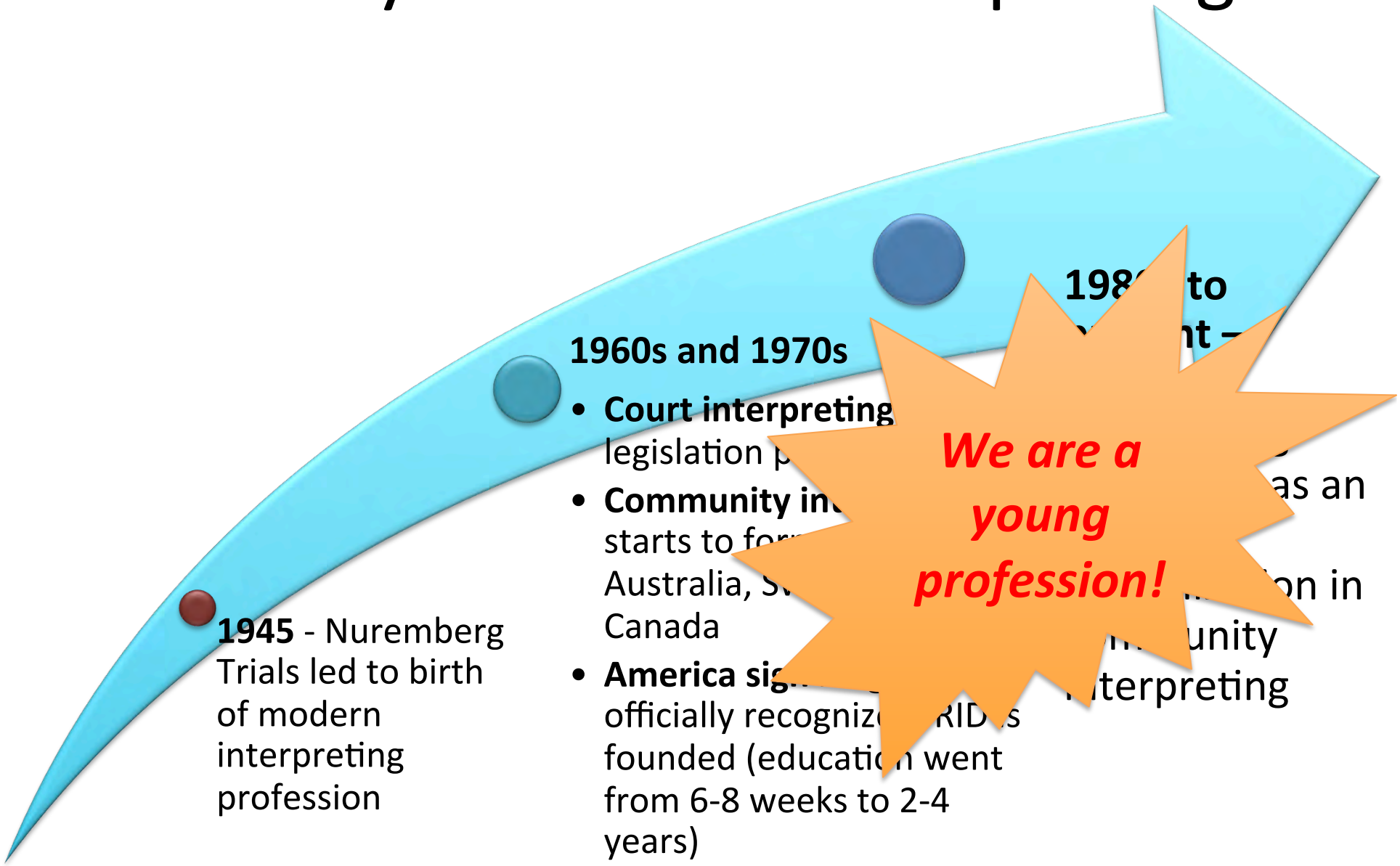
Low **literacy** and **numeracy** skills in interpreters of less common languages is excluding them from our **training programs**.

# The Big Picture

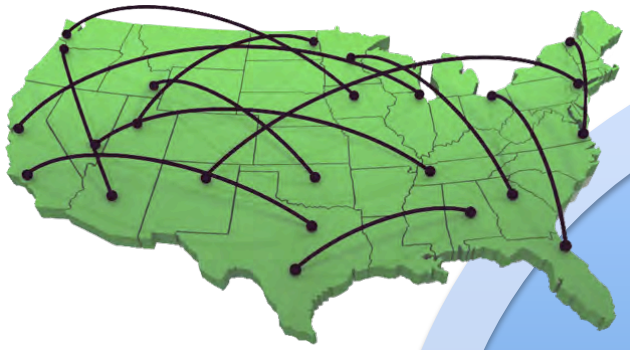


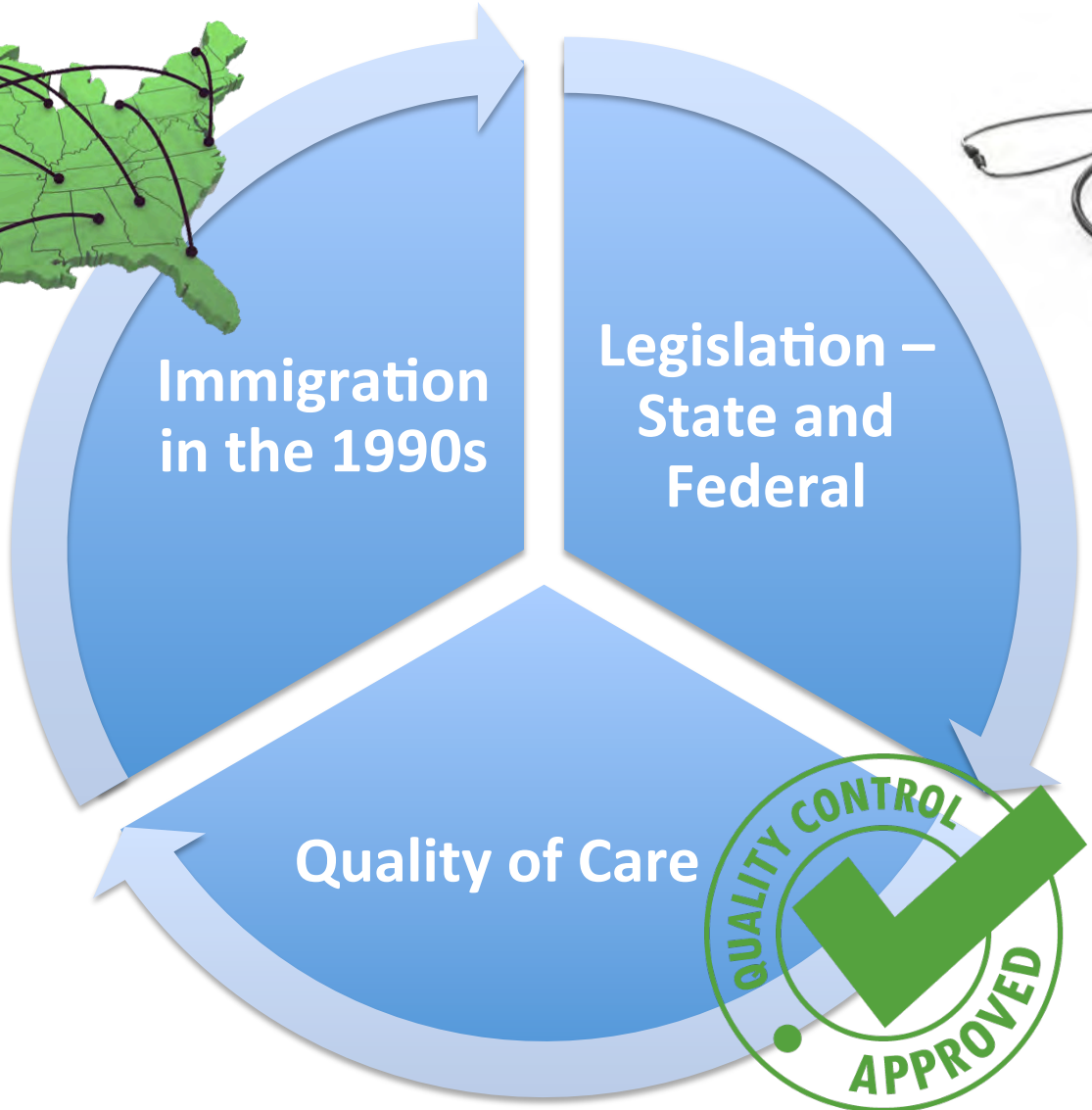
Photo Credit: Earth to Sky Calculus Club, https://www.facebook.com/pages/Earth-to-Sky-Calculus/174490502634920?ref=aymt_homepage_panel

# History of Modern Interpreting

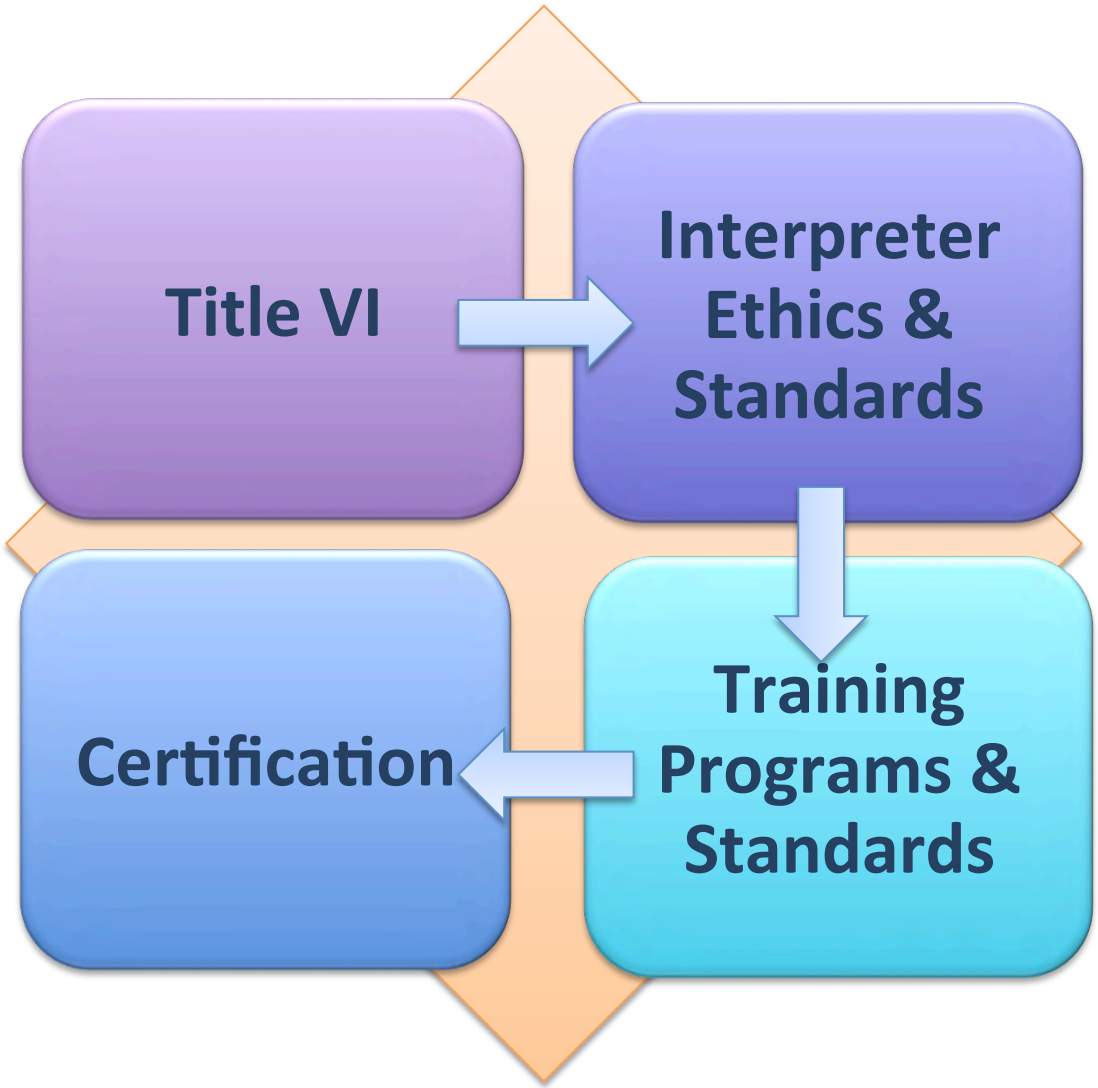


# Forces Driving Healthcare Interpreting





# Medical Interpreting Milestones




- Increasing recognition of healthcare interpreting as a professional activity.
- Increasing buy-in for certification by interpreters and employers.
- Healthcare interpreting included in state legislation.
- Increasing unionization.

# How Do Professions Mature?

# Professionalization

*Professionalization is the social process dating back to the Middle ages by which any trade or occupation transforms itself into a true "profession of the highest integrity and competence."*

http://en.wikipedia.org/wiki/Professionalization

# Elements of a Profession

**Has an accepted body of knowledge that practitioners possess.**

**Has a defined and prolonged period of academic preparation.**

**Requires a certification or licensure exam to prove competence.**

**Ongoing requirement for continuing education and/or trainee period.**

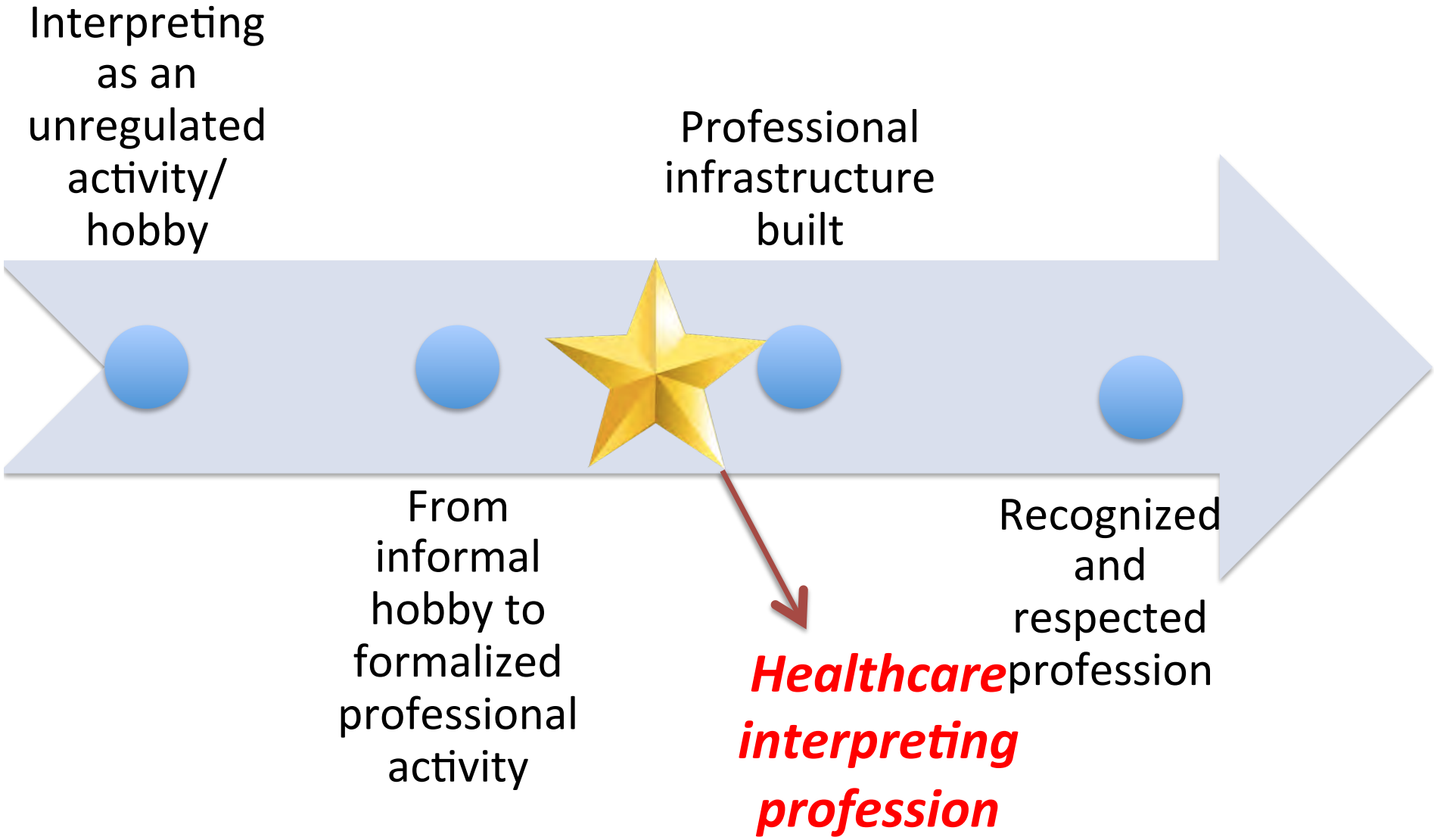
http://en.wikipedia.org/wiki/Profession#Characteristics_of_a_profession

# Elements of a Profession

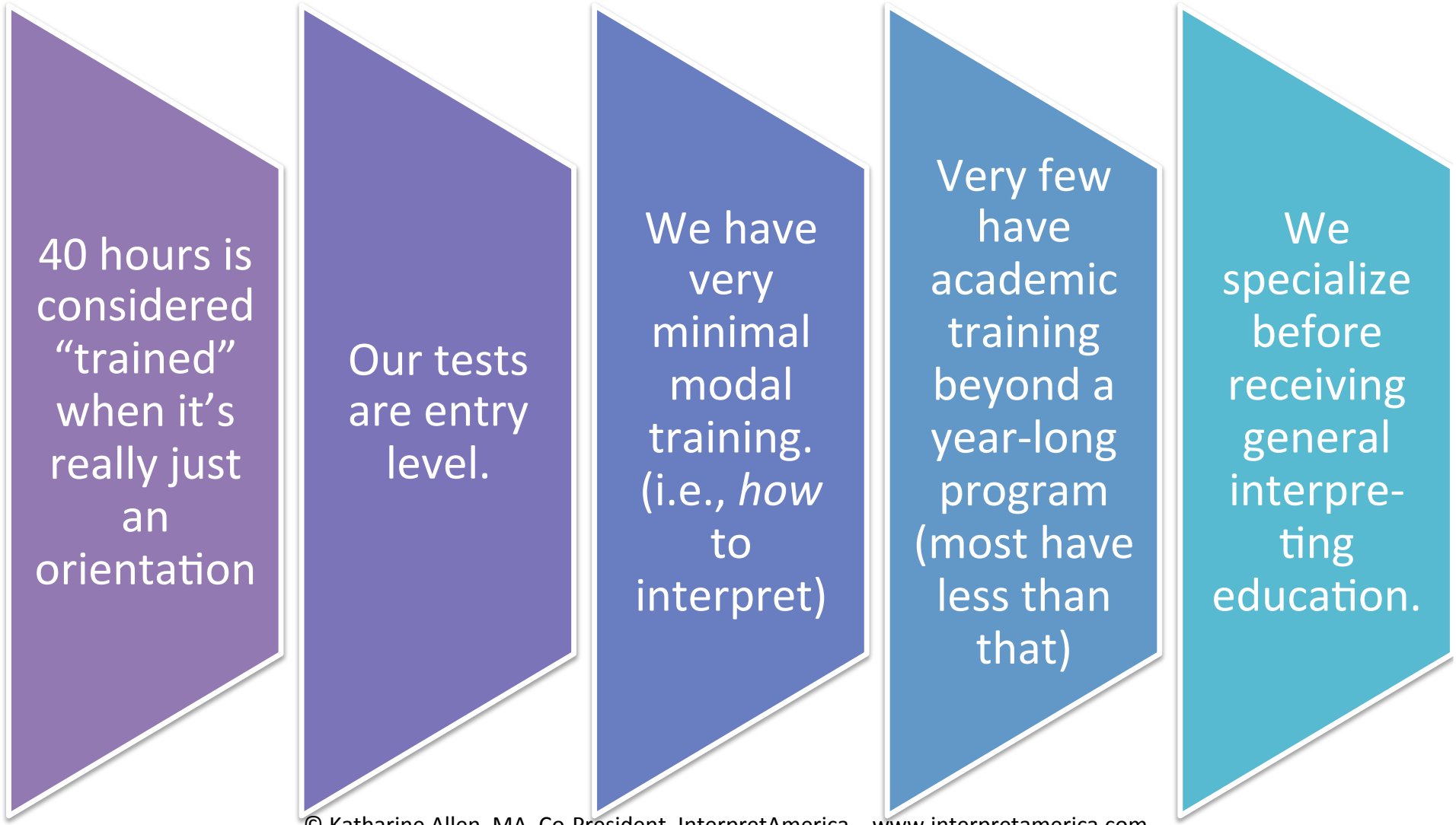
- Has a code of ethics, standards of conduct that are enforceable.
- Profession serves a higher public good.
- Has professional associations overseeing field.
- Members are regulated by professional body or Federal Gov't
- Exclusion, monopoly and legal recognition
- Control of remuneration and advertising

http://en.wikipedia.org/wiki/Profession#Characteristics_of_a_profession

# Where We are Now



# Where We Are Really




**…as Interpreter trainers and leaders, we have a lot of work left to do.**

# Problem #1

The **partial professionalization** of healthcare interpreting is threatening to **exclude interpreters** from less-common but high-demand language groups

# Professionalization Paradox

The more we succeed in getting people to value professional interpreting services…

The more people expect professional-level services…

As one end of our profession successfully increases levels of professionalization (more common languages)…

Our most vulnerable language communities are getting locked out…

# Certification Today

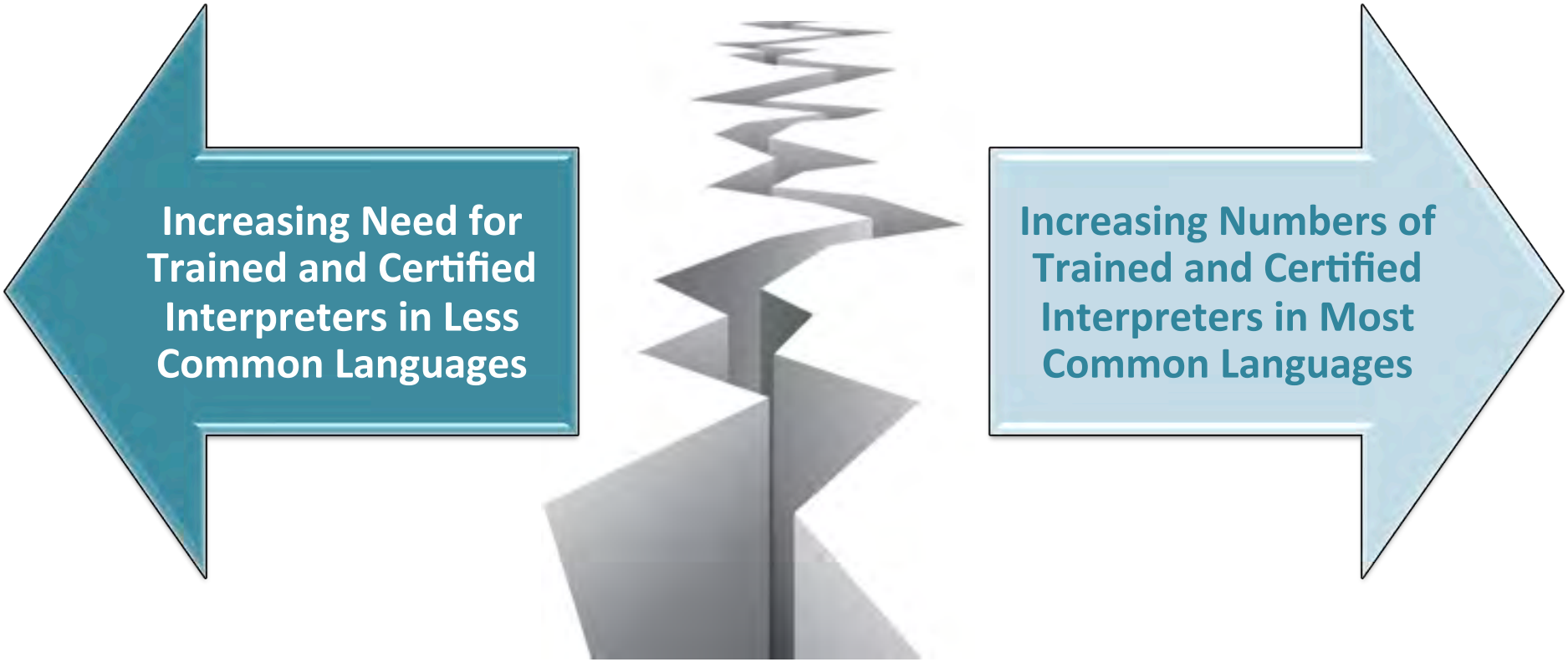
## For Common Languages certification means:

- Proficiency testing in all languages spoken.
- Written exam for ethics/ terminology skills.
- Interpreting skill established in oral performance exam.
- Full certification credential (CHI, CMI)
- Greater access to continuing education

## For Less Common Languages certification means:

- Ad hoc proof of proficiency in non-English language
- Written exam for ethics/ terminology skills
- Interpreting skills not formally test / established.
- Ad hoc interview and proof process to show skills.
- Partial or no certification credential.
- "Qualified" status conferred.
- Continuing education expensive and hard to access.

# Consequences of Success

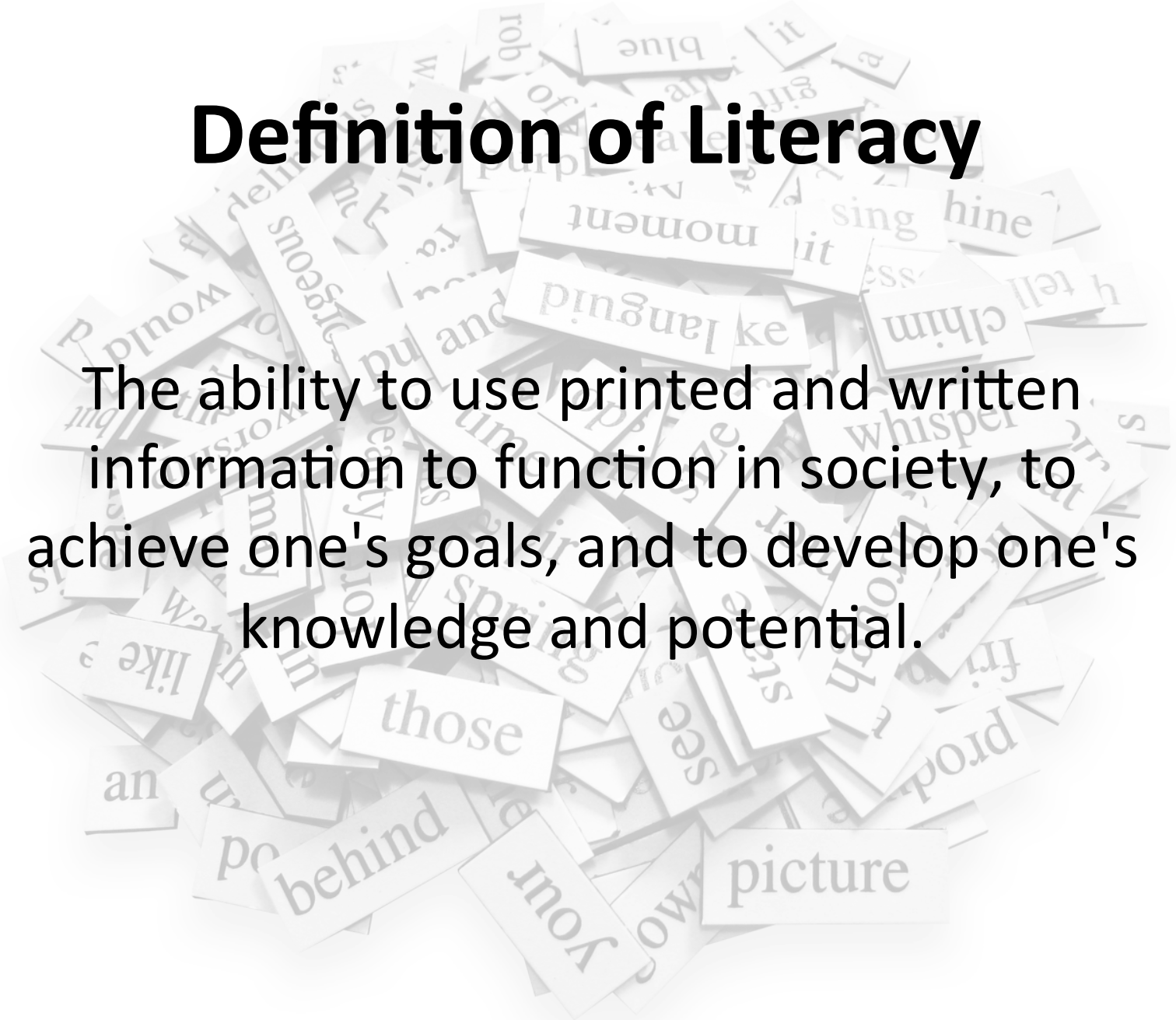



"HONESTLY? I PREFERRED WHEN WE DIDN'T TALK ABOUT THE ELEPHANT"

# Problem #2

Low **literacy** and **numeracy** skills in interpreters of less common languages are excluding them from our **training programs**.

# Definition of Literacy

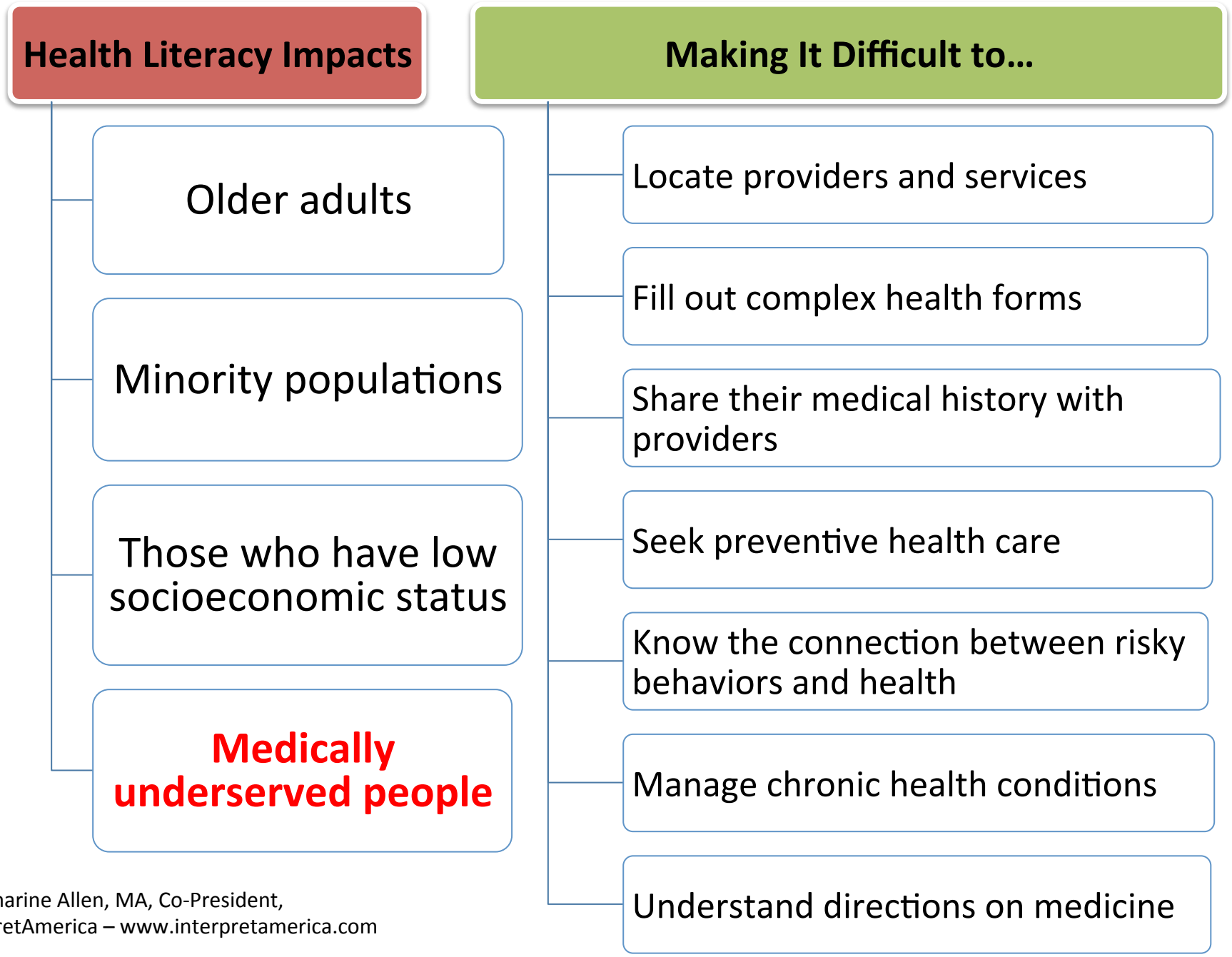



The ability to use printed and written information to function in society, to achieve one's goals, and to develop one's knowledge and potential.

# Definition of Health Literacy

The degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.


Health Resources and Services Administration
http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html






Health Resources and Services Administration http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html

# Numeracy

- The concept of “at-homeness” with numbers and an ability to use math skills, which enable an individual to cope with practical mathematical demands of everyday life.

- It includes having some appreciation and understanding of information that is presented in terms of numbers.

# Health Numeracy

The individual-level skills to obtain, interpret, and process quantitative information for health behavior and decisions.

# Low Health Numeracy

- Less use of health information
- Difficulty scheduling appointments
- Problems following complex health regimens
- Trouble evaluating risks and benefits of health options



Ancker & Kaufman, 2007

Peters, Hibbard, Slovic & Dieckmann, 2007

Numbers are ubiquitous in health decisions, whether determining the number of pills somebody takes, deciding what time of day to take those pills, or choosing among different treatment options based on risks and benefits.

*Numbers instruct, inform, and give meaning to information about health plans, medications, and treatments.*

WHAT IS NUMERACY?: IT'S MORE THAN MATHEMATICS Edited by Lynda Ginsburg, Ph.D. http://www.ncbi.nlm.nih.gov/books/NBK224825/

# Patient Online Portal

# Electronic Health Record

- Help
- Logout

**Patient Record**

- Summary
- Lab Results
- Diagnostic Images
- Details
- Notes or Comments

**Patient Details**

**GME0000**
**Smith, Caroline**

**Sex:** Female
**DOB:** 1940/01/01
**Next of kin:** John Smith

**Phone:** 365-565-9090
**Address:** 19 Provincial Rd. Edmonton AB T6M 1R7

**Alerts**

Allergies – Sulfa Drugs
- Pap smear due
- Td due
- A1C above target

| Diagnosis | State | Status |
|---|---|---|
| Hypertension | 11/1989 | Ongoing |
| Diabetes | 05/1996 | Ongoing |
| Coronary Artery Disease | 02/2002 | Ongoing |
| Fasting lipids | 12/2005 | |
| Exercise stress test | 1/2005 | |
| Coronary angiogram / Cellulitis | 02/2005 | Resolved |
| Cholecystectomy | 05/1981 | Resolved |
| Cesarian section | 01/1967 | Resolved |

**GP Details**

| Name: | Phone: | Address: |
|---|---|---|
| Jones, Evans | 333-465-5545 | 11 Terrence Ave., Edmonton, AB T4Y 8U9 |

**Other Healthcare Providers**

| Name | Disp. | Last Encounter | Next encounter | Right of Access |
|---|---|---|---|---|
| Diaz, Ellen | Cardiology | 01/2006 | 07/2006 | Y |
| Fournier, Janice | RN | 08/2005 | | N |
| Cohen, Richard | Dermatology | 07/2005 | | N |

**Medications**

| Date | Medications | Prescriptions | Last Filled |
|---|---|---|---|
| 11/1989 | Hydrochlorothiazide 25 mg | One tab at breakfast | 12/2005 |
| 03/1999 | Glyburide 5 mg | One tab twice daily | 12/2005 |
| 01/2001 | Metformin 500 mg | Two tabs twice daily | 12/2005 |
| 03/2001 | Atorvastatin 20 mg | One tab at supper | 12/2005 |
| 02/2002 | Atenolol 50 mg | One tab at breakfast | 12/2005 |
| 02/2002 | ECASA 325 mg | One tab at breakfast | 12/2005 |
| 02/2006 | Ramipril 10mg | One tab at supper | 02/2006 |
| 06/2005 | Cloxacillin 500 mg | Discontinued | |
| 05/2004 | Beclomethasone Cream | Discontinued | |

**Encounter History**

| Date | Facility | Speciality | Clinician | Reason | Type |
|---|---|---|---|---|---|
| 02/2006 | GP | | | Hypertension | - |
| 01/2006 | Cardio Assoc | Cardiology | Diaz, E. | CAD | Outpatient |
| 12/2005 | GP | | | Diabetes | - |
| 10/2005 | General Hosp | Dietician | Johnson, H. | Diabetes teaching | Outpatient |
| 08/2005 | GP | | | Diabetes | - |
| 08/2005 | GP | | | Cellulitis | - |
| 08/2005 | Home Visit | RN | Fournier, J. | Cellulitis | - |
| 08/2005 | GP | - | - | Cellulitis | - |
| 07/2005 | Polyclinic | Dermatology | Cohen, R. | Stasis dermatitis | Outpatient |

**Immunizations**

| Type | Most Recent | Number Received |
|---|---|---|
| Influenza | 11/2005 | 7 |
| Pneumovax | 03/2005 | 1 |
| Twinrix | 08/2002 | 3 |
| Td | 04/1996 | 1 |

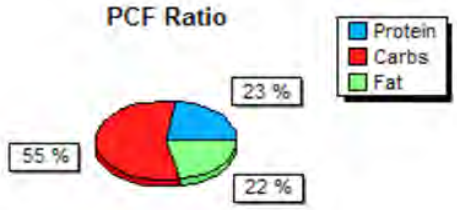
**Diabetic Indices**

| Type | Value | Most Recent |
|---|---|---|
| A1C | 0.071 | 12/2005 |
| LDL | 2.41 | 12/2005 |
| BP | 135/75 | 02/2006 |
| Urine Microalb | 0.02 | 08/2005 |
| Eye Exam | | 05/2005 |
| Home Gluc (average) | 7.4 | 01/2006 |

# Diabetic Meal Plan - 1200 calories

**Avg Calories Per Day:** 1227

**PCF Ratio:** 23-55-22




## Week 1

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| BR | Oatmeal, Fortified, Instant - 4 Oz<br>Milk, Cow's, Nonfat (skim) - 1 Cup | Milk, Cow's, Nonfat, Vit-a (skim) - 8 Oz<br>All-bran, Rte - 1/2 Cup | Milk, Cow's, Nonfat, Vit-a (skim) - 1 Cup<br>Ham And Eggs - 1 Serving | English Muffin, Plain - 1 Serving<br>Milk, Cow's, Nonfat, Nfms, Vit-a (skim) - 4 Fl Oz<br>Peanut Butter, Smooth, No Salt - 2 Tbsp | Milk, Cow's, Nonfat, Vit-a (skim) - 1 Cup<br>Blackberry, Raw - 1/2 Cup<br>All-bran, Rte - 1 Cup | Milk, Cow's, Nonfat, Nfms, Vit-a (skim) - 1/2 Cup<br>Puffed Wheat, Fortified, Rte - 1 Oz | Milk, Cow's, Nonfat, Vit-a (skim) - 1/2 Cup<br>Special K, Rte - 1/2 Cup |
| MS | Apple, Raw - 1/2 Medium | Pear, Raw - 1 Pear | Egg Bagel - 1 Mini-bagel<br>Cheddar Cheese - 1 Cubic-inch<br>Milk, Cow's, Nonfat, Vit-a (skim) - 8 Fl Oz | Cottage Cheese, 1% Fat - 2 Oz<br>Kiwifruit, Raw - 1 Medium | Fruit Smoothie - 1 Serving | Yogurt, Strawberry, Nonfat - 8 Oz | Carrot, Raw - 1 Cup<br>Salad Dressing, French, Diet - 1 Oz |
| L | Chicken Sandwich - 1 Serving<br>Carrot, Baby, Raw - 6 Oz | Cheese And Fruit Submarine Sandwich - 1 Serving<br>Salad Dressing, French, Diet - 1 Tbsp<br>Iceberg Lettuce, Raw - 1/2 Cup | Mixed Vegetables, Boiled, No Salt - 1/2 Cup<br>Tuna On Pita Bread - 1 Serving | Turkey Sandwich - 1 Serving | Spinach Pasta With Olive Oil - 1 Serving<br>Zucchini W/skin, Boiled, No Salt - 1 Cup | Salmon Pasta Salad - 1 Serving | Enchilada Vegetable Wrap - 1 Serving |
| AS | Raisin, Seedless - 25 Raisins<br>Peanut, Dry Roasted, No Salt - 1 Oz | Carrot, Raw - 10 Large Strip | Broccoli, Raw - 1/2 Cup<br>Salsa, Chunky Chili Dip, Canned - 2 Tbsp<br>Apple, Raw - 1 Medium<br>Cheddar Cheese - 1 Cubic-inch | Salad Dressing, 1000 Island, Diet - 1 Tbsp<br>Carrot, Baby, Raw - 4 Oz | Celery, Raw - 2 Medium Stalk | Carrot, Baby, Raw - 4 Oz<br>Salad Dressing, French, Diet - 1 Tsp | Apple, Raw - 1 Medium |
| D | Jambalaya - 1 Serving<br>Broccoli Vinaigrette - 1 Serving | Mixed Vegetables, Boiled, No Salt - 4 Oz<br>Kale, Boiled, No Salt - 1/2 Cup<br>Eggplant Parmesan - 1 Serving<br>Spaghetti Pasta, Cooked, Enriched - 1 Cup | Salad Dressing, French, Diet - 2 Oz<br>Sloppy Joes - 1 Serving<br>Cauliflower, Frozen - 1/2 Cup<br>Iceberg Lettuce, Raw - 4 Oz | Pasta, Kale And Chickpeas - 1 Serving | Turnip Greens, Boiled, No Salt - 1 Cup<br>Beef Tenderloin - 1 Serving<br>Brown Rice, Long Grain, Cooked - 1 Cup | Asparagus, Boiled - 1/2 Cup<br>Beef Roast Au Jus - 1 Serving<br>Polenta - 1/2 Serving | Fish With Tomatoes - 1 Serving<br>Spaghetti Pasta, Cooked, Enriched - 1 Cup |
| ES | Yogurt, Strawberry, Nonfat - 8 Oz | Applegurt - 1 Serving | Cantaloupe, Raw - 1 Wedge<br>Milk, Cow's, Nonfat, Nfms, Vit-a (skim) - 1 Cup | Diabetic Baked Banana - 1 Serving | Cottage Cheese, 1% Fat - 2 Oz<br>Mixed Fruit, Dried - 1/2 Oz | Banana, Raw - 1 Medium | Watermelon, Raw - 1 Cup |
| | 1237 Calories(kcal); 84 Protein(g); 174 Carbs(g); 28 Fat(g); 5 Sat Fat(g); 227 Cholest(mg); 25 Fiber(g); 1291 Sodium(mg) | 1276 Calories(kcal); 74 Protein(g); 211 Carbs(g); 24 Fat(g); 11 Sat Fat(g); 55 Cholest(mg); 38 Fiber(g); 1633 Sodium(mg) | 1159 Calories(kcal); 84 Protein(g); 160 Carbs(g); 24 Fat(g); 11 Sat Fat(g); 105 Cholest(mg); 16 Fiber(g); 1674 Sodium(mg) | 1205 Calories(kcal); 73 Protein(g); 170 Carbs(g); 31 Fat(g); 7 Sat Fat(g); 81 Cholest(mg); 22 Fiber(g); 1310 Sodium(mg) | 1258 Calories(kcal); 67 Protein(g); 177 Carbs(g); 40 Fat(g); 16 Sat Fat(g); 101 Cholest(mg); 41 Fiber(g); 1002 Sodium(mg) | 1218 Calories(kcal); 70 Protein(g); 163 Carbs(g); 34 Fat(g); 9 Sat Fat(g); 118 Cholest(mg); 13 Fiber(g); 958 Sodium(mg) | 1238 Calories(kcal); 61 Protein(g); 174 Carbs(g); 36 Fat(g); 14 Sat Fat(g); 98 Cholest(mg); 17 Fiber(g); 1301 Sodium(mg) |


# Immunization Timing

| Age 2 months | Interval from previous dose |
|---|---|
| DTaP | |
| Hib | |
| PCV (Pneumo) | |
| Polio (IPV) | |
| RV[2] (Rotavirus) | |
| HepB[1] | |

| Age 4 months | Interval from previous dose |
|---|---|
| DTaP | 1-2 months |
| Hib | 1-2 months |
| PCV (Pneumo) | 1-2 months |
| Polio (IPV) | 1-2 months |
| RV[2] (Rotavirus) | 4-10 weeks |
| HepB[1] | |

| Age 6 months | Interval from previous dose |
|---|---|
| DTaP | 1-2 months |
| Hib[3] | 1-2 months |
| PCV (Pneumo) | 1-2 months |
| Polio[6] (IPV) | 1-14 months |
| RV[2] (Rotavirus) | 4-10 weeks |
| HepB[1] | |

| Age 12 months | Interval from previous dose |
|---|---|
| DTaP[4] | |
| Hib[4] | 2-9 months |
| PCV[4] (Pneumo) | 2-6 months |
| MMR[5] | |
| Varicella[5] (Chickenpox) | |
| HepA | |

| Age 18 months | Interval from previous dose |
|---|---|
| HepA | 6-12 months |

| Age 6 mos and older | and high risk kids |
|---|---|
| Flu | Every Year |

**Early Childhood Program Entry (Age Appropriate)**

DTaP, Polio, Hib, Pneumococcal, Hepatitis A, Hepatitis B, MMR, Varicella

**Kindergarten Entry**

DTaP, Polio, MMR, Varicella, Hepatitis A, Hepatitis B

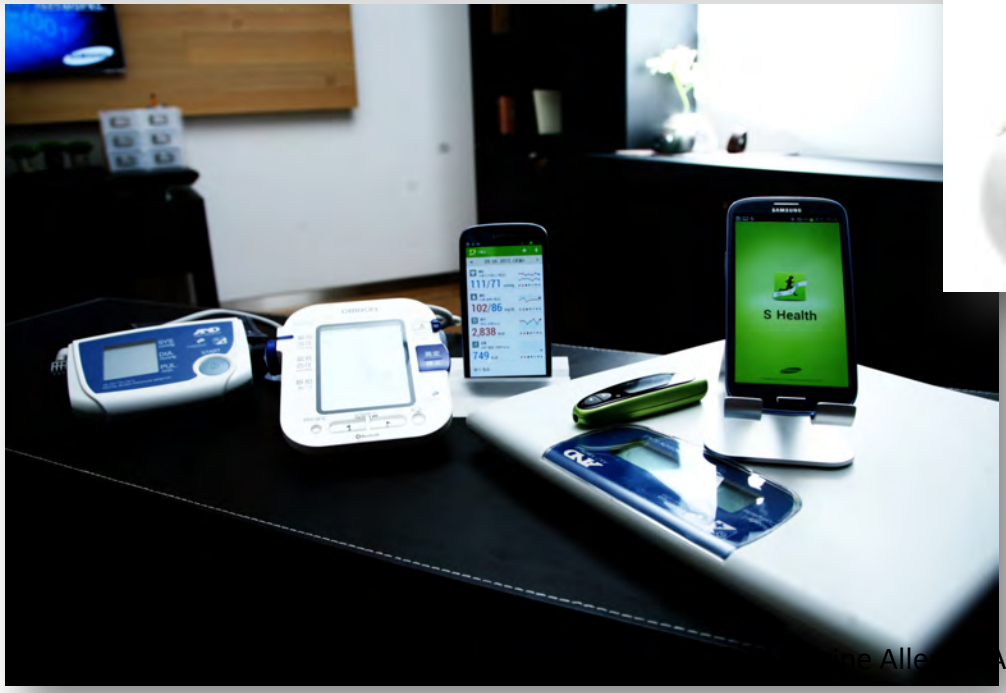
UTAH DEPARTMENT OF HEALTH
Immunization Program

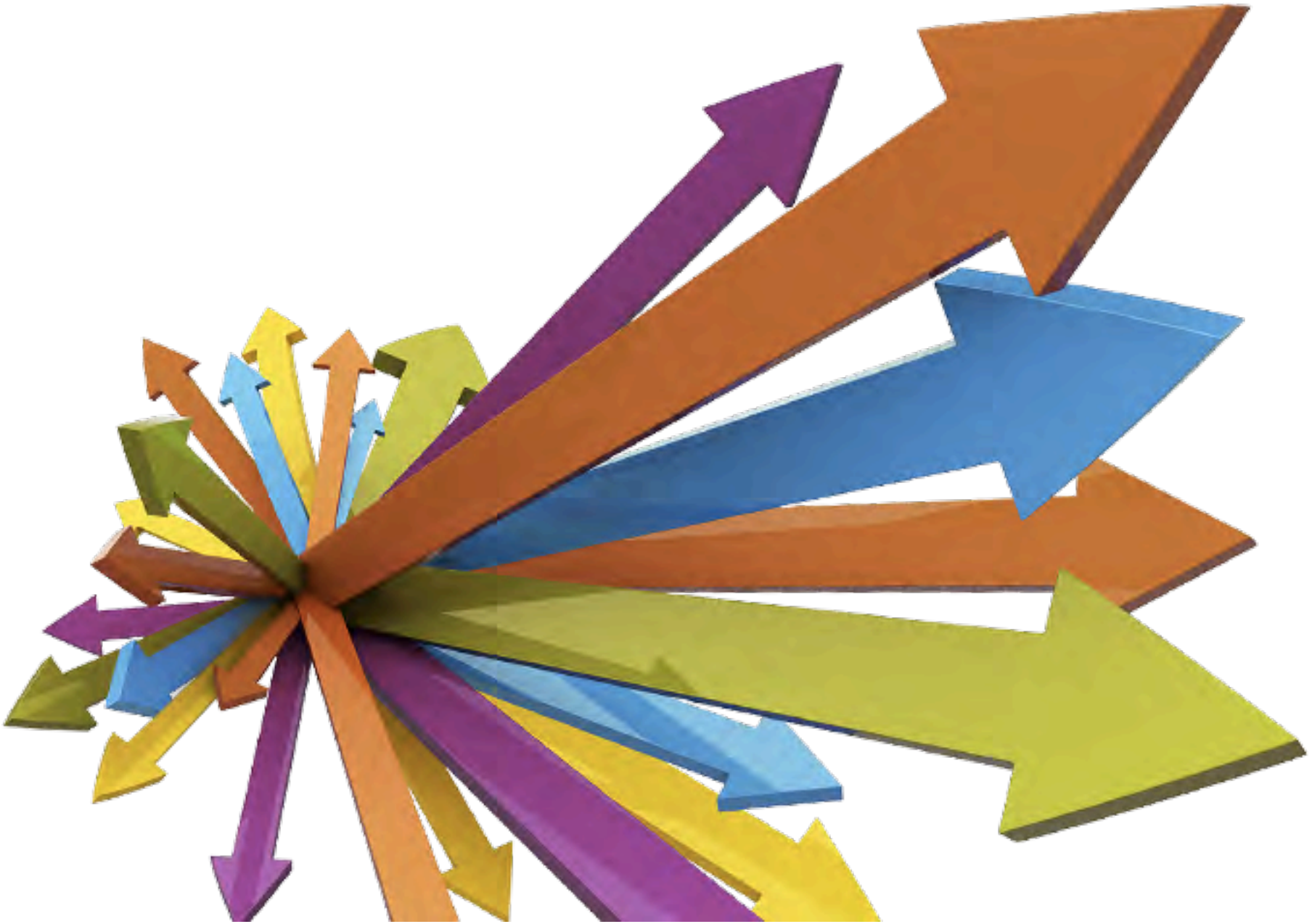


1-800-275-0659 • www.immunize-utah.org

# Mobile Health Technology



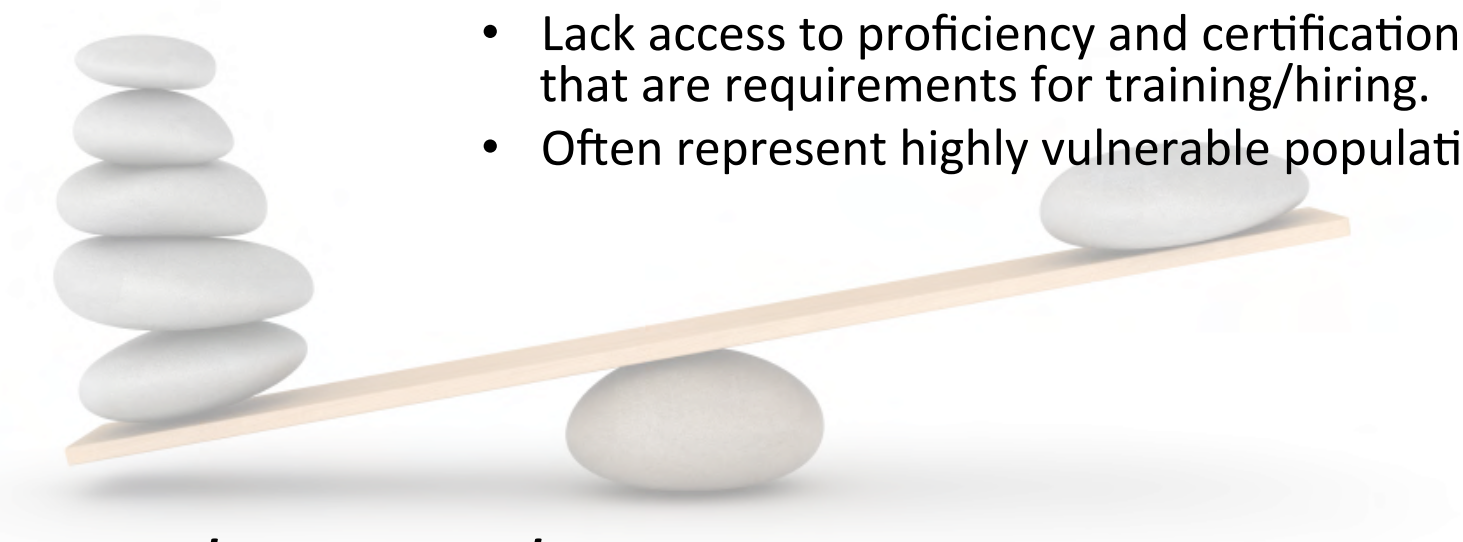




# The looming loss…

***Less common language speakers:***

- May lack formal education
- May lack literacy in any language
- Lack access to language specific interpreter training.
- Lack access to proficiency and certification tests that are requirements for training/hiring.
- Often represent highly vulnerable populations



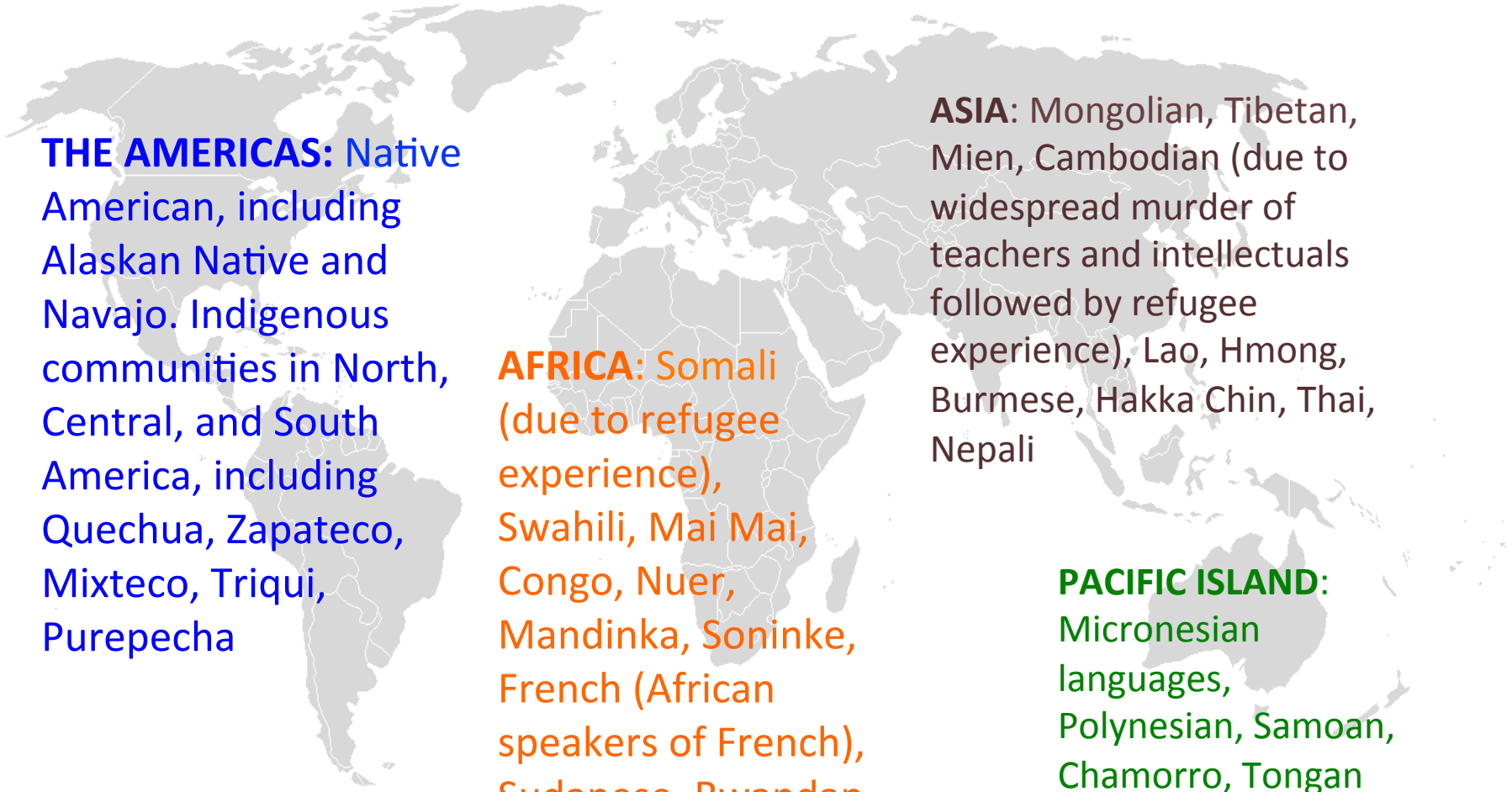
***More common language speakers:***

- Certification/Assessment preconditions for hiring
- Literacy in English and target language required.
- Sometimes have higher levels of education.
- Have sufficient numbers who can succeed in existing training programs

# In danger of being left behind:

- ***Long term medical interpreters with a lot of accumulated knowledge and community trust***, but with low education background due to growing up in:
  - refugee camps
  - war zones
  - indigenous areas with few schools
  - communities which do not school their gender or their specific ethnic group
- ***Potential new interpreters*** coming to this country from similar backgrounds
- ***Potential new heritage speaker interpreters*** of less common languages

# Immigrant Communities Getting Left Behind



**THE AMERICAS:** Native American, including Alaskan Native and Navajo. Indigenous communities in North, Central, and South America, including Quechua, Zapateco, Mixteco, Triqui, Purepecha

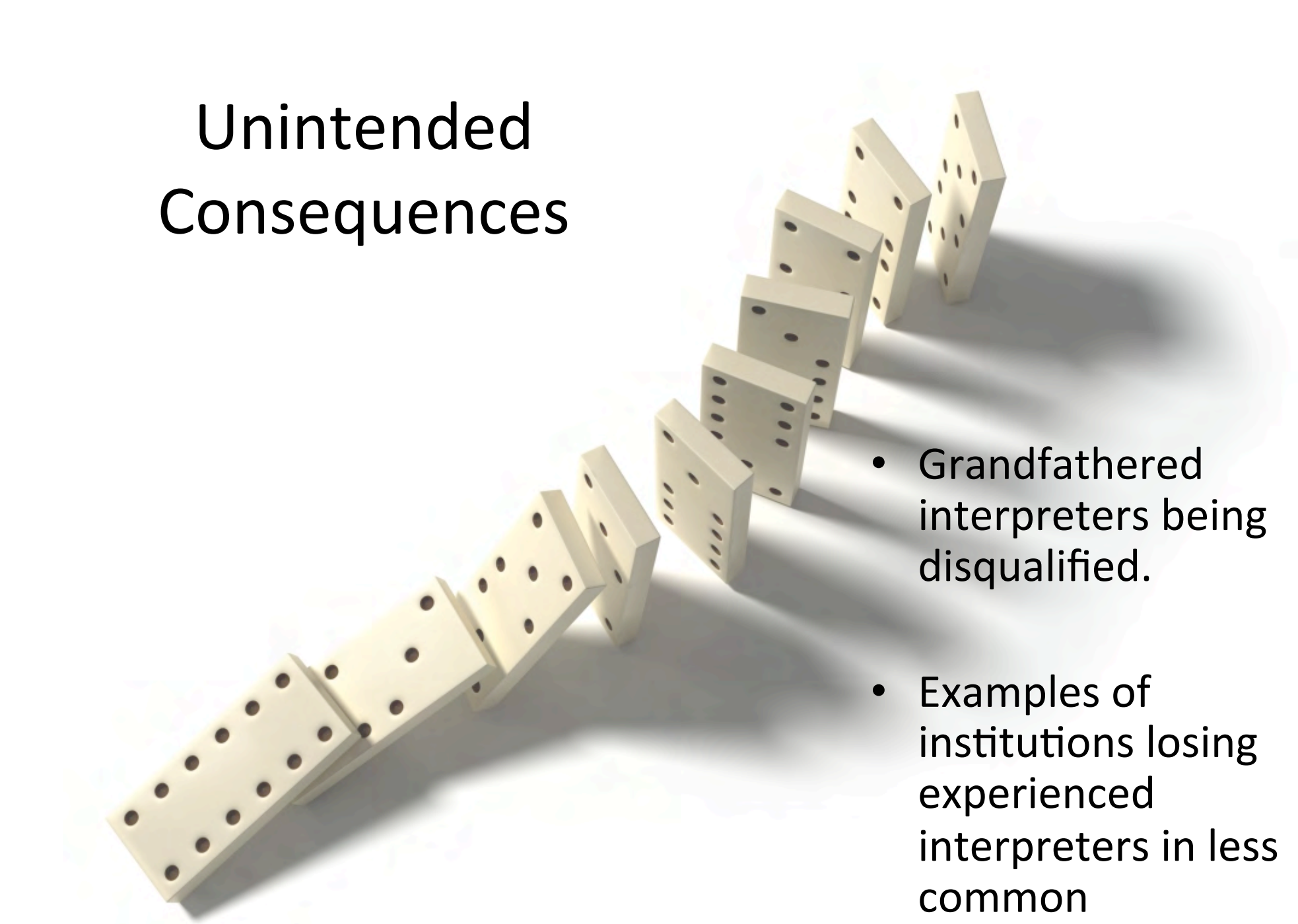
**AFRICA**: Somali (due to refugee experience), Swahili, Mai Mai, Congo, Nuer, Mandinka, Soninke, French (African speakers of French), Sudanese, Rwandan

**ASIA**: Mongolian, Tibetan, Mien, Cambodian (due to widespread murder of teachers and intellectuals followed by refugee experience), Lao, Hmong, Burmese, Hakka Chin, Thai, Nepali

**PACIFIC ISLAND**: Micronesian languages, Polynesian, Samoan, Chamorro, Tongan

Courtesy of Linda Gelley, Interpreter Services Manager, University of Washington Medical Center

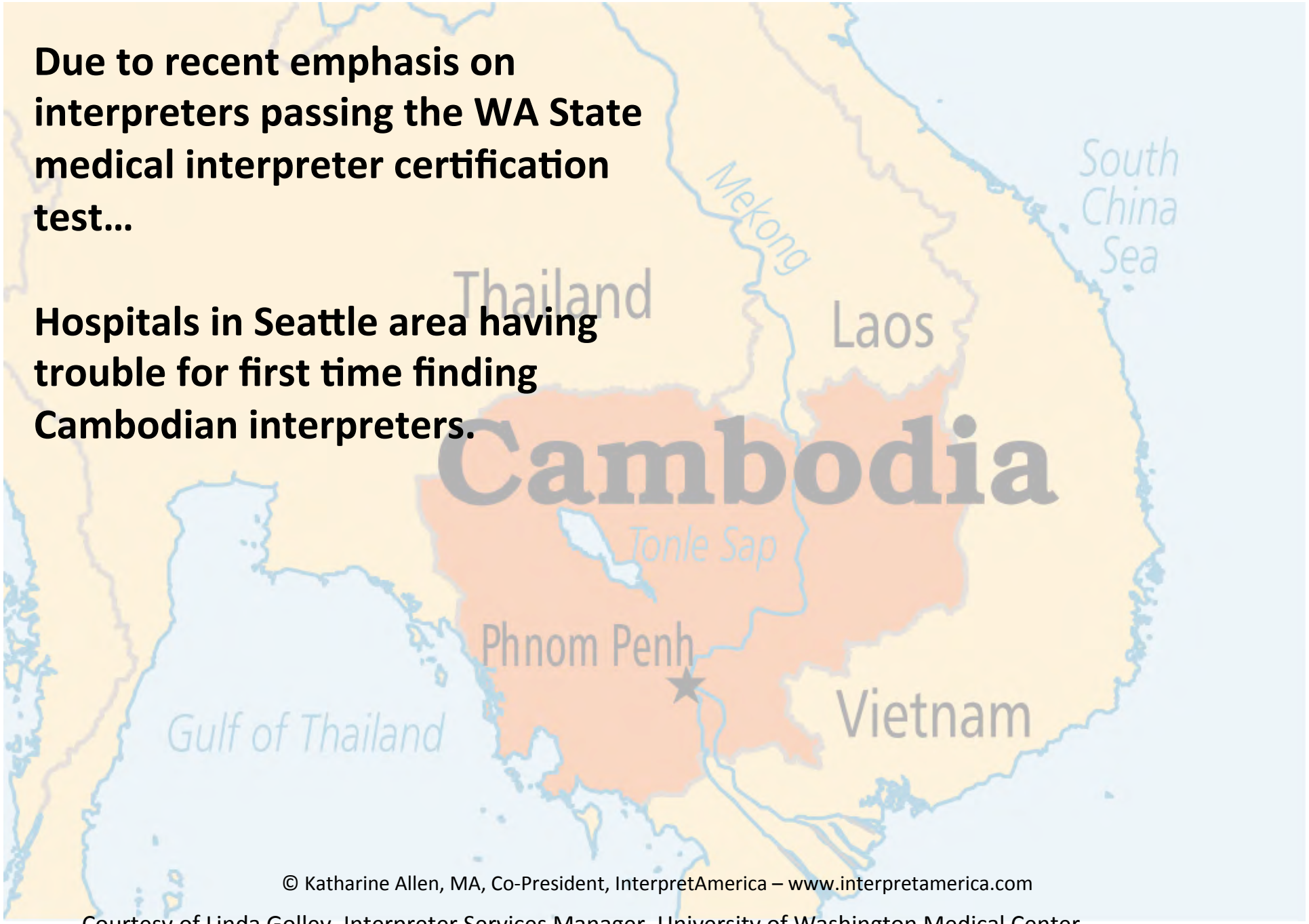
# Unintended Consequences



- Grandfathered interpreters being disqualified.
- Examples of institutions losing experienced interpreters in less common languages

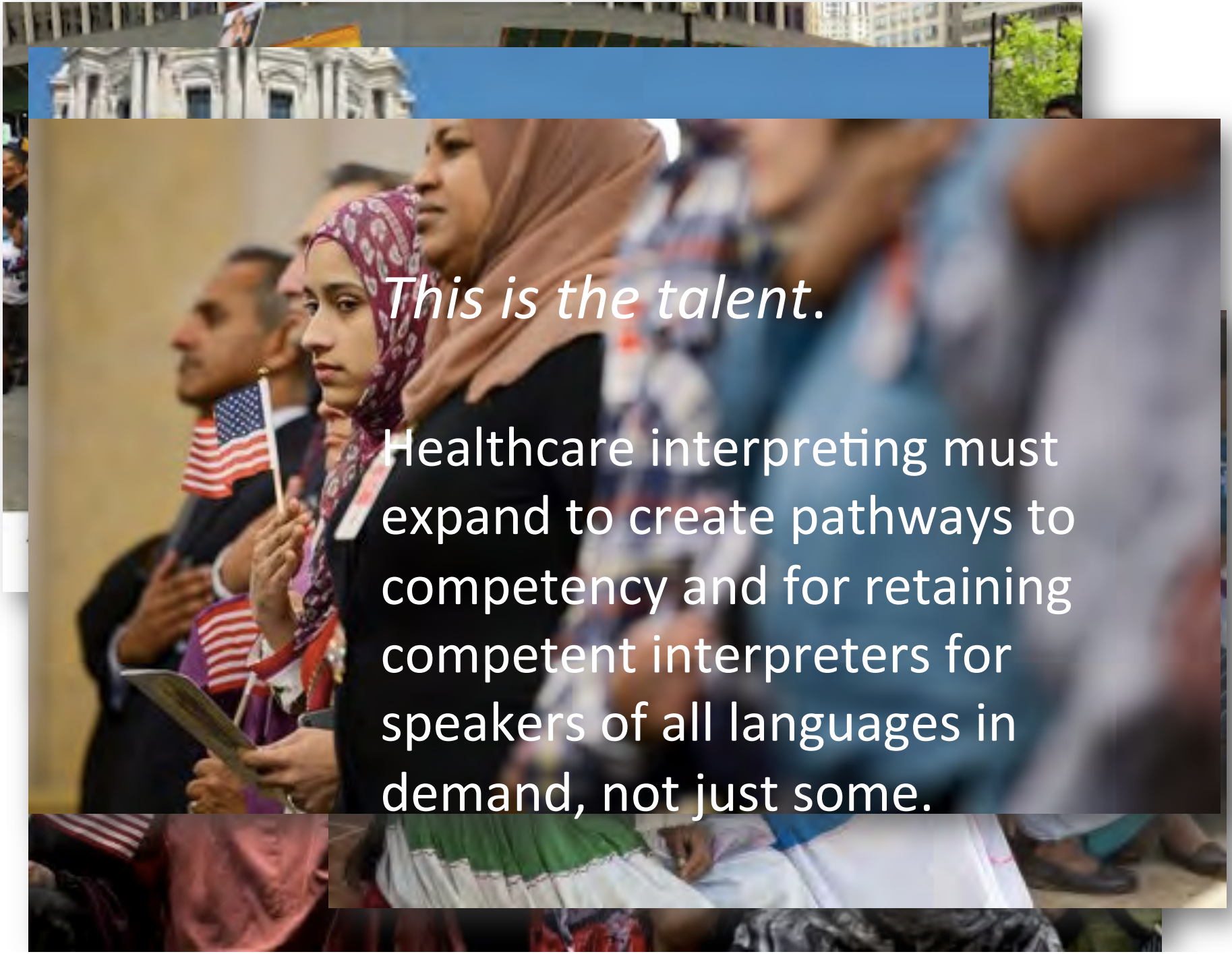
**Due to recent emphasis on interpreters passing the WA State medical interpreter certification test…**

**Hospitals in Seattle area having trouble for first time finding Cambodian interpreters.**






Courtesy of Linda Golley, Interpreter Services Manager, University of Washington Medical Center


*This is the talent*.
Healthcare interpreting must expand to create pathways to competency and for retaining competent interpreters for speakers of all languages in demand, not just some.

~~"Well, we've built it. It's up to them to come."~~

"Well, we've built it. It's up to us to go to them."

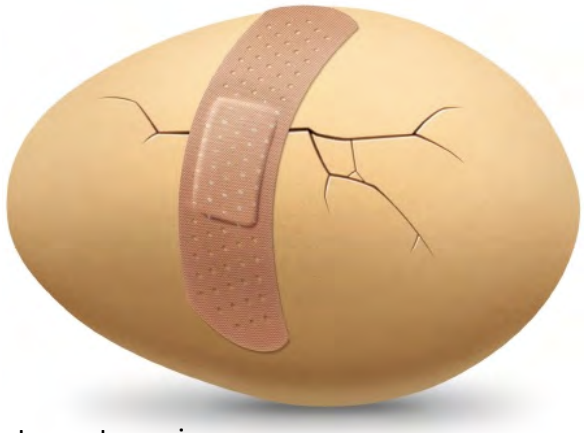
# Solutions

- Stop-gap solutions
- Short-term and mid-term solutions
- Long-term – *promoting literacy*

# Stop Gap Solutions

- **Halt expulsion** of non-credentialed interpreters from working.

- **Identify and engage with** working and potential medical interpreters in these communities, though not fully trained.



# Short-term and mid-term solutions

Teach interpreter skills and knowledge using small reliance on literacy and numeracy

- Explain content, use lots of visuals
- Demonstrate using audio and practical, hands-on methods
- Focus on experiential learning with roles plays, group work and manual activities

# Long-term solutions

- Develop interpreter-relevant training in English and target-language literacy and numeracy.

- Develop relationships with less common language community leaders and community organizations.

- Interpreting leadership can provide tech support with materials and connecting interpreters with resources.

# Solutions

- Effective outreach and partnering with LLD communities – building positive relationships with the communities

open arms
PERINATAL SERVICES

**Micronesian Health Advisory Coalition Interpreter/Translator Training Project**

Indigenous Interpreting+

# What's Working?

Indigenous Interpreting+™

- ✓ Initial outreach
- ✓ Use of ad hoc interpreters
- ✓ Adapted Bridging the Gap
- ✓ Paid Internship
- ✓ II+ permanent jobs

# 5 years in the making and counting…

Indigenous Interpreting+™

# Micronesian Health Advisory Coalition Interpreter/Translator Training Project

Languages:

Kosraen, Pohnpeian, Gilbertese, Chuukese, Nauruan, and Marshallese

Pilot Project Micronesians living in Hawaii with some

interpreting/ translating experience

Micronesians United (MU)

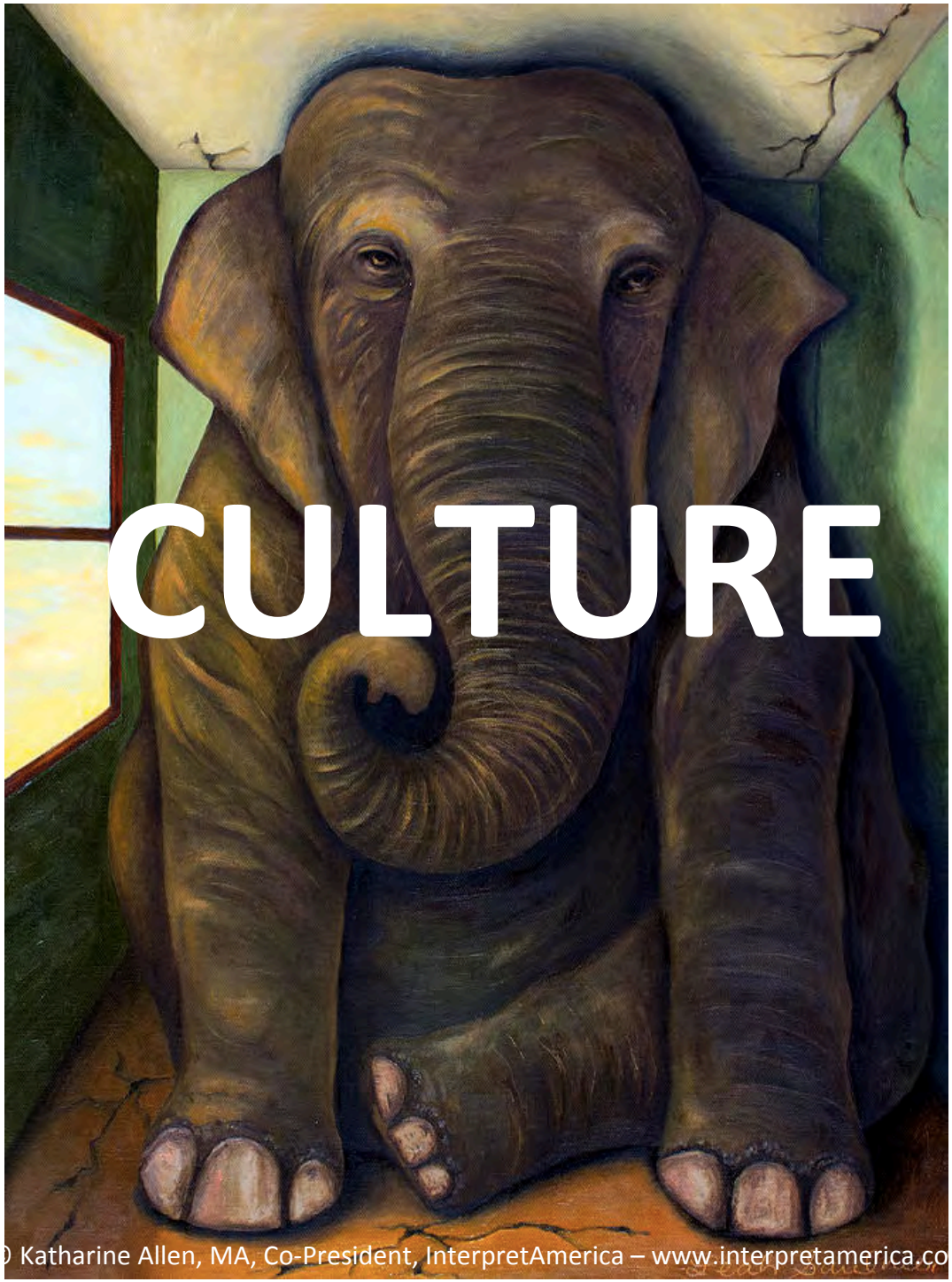
Micronesian Community Network (MCN)

Hawaii Alliance for Non-profit Organizations (HANO)

Hawaii Public Health Association (HPHA) , etc.

Goal: improve access to health related services for Micronesians by developing a medical interpreter/ translation training individuals from the community

"I thought the classes were really cool they taught us what specifically identified our roles as an interpreter and not an advocate. We just bridge the two speakers and not be an advocate.



# 2012 Study of Somali immigrants in Minnesota

…Western healthcare can be alienating for many mothers. Somalis have very different expectations for reproductive medicine..

Western medicine emphasizes preventative care—screening, testing and health management. Somalis typically only go to the doctor once problems emerge and only return if things get worse.

"I've had eight children and everything was fine. I know my baby is healthy because it is moving. Why do I have to be measured every two weeks?"

Both Somali women and men said C-sections are only acceptable if the mother's or child's life were in danger and objected to the high US rates of C-section.

Somalia's 98 percent rate of female circumcision is one of the highest in the world. It leads to difficult deliveries and requires specific types of episiotomies..

"We have no business intervening in a woman's sexual identity. For many Somali women, her circumcision is a beautiful thing that she is proud of," said one provider."

# Technology Is Our Friend

Remote platforms offer:

- Increased training opportunities
- Full-time work opportunities


# Trainers

- Mixed language groups or targeted language training /
- Oral proficiency testing (with identified qualified speakers)
- Respect privacy of low literacy students
- Proactive recruitment strategies
- Collaborative group training models, even with diverse skill levels.
- Encourage active mentorship.
- Inclusive training materials (examples, role plays)
- Techniques for “safe interpreting”
  - How to say “no”
  - Mediation strategies
  - Protocols
  - Assignment preparation
- Community wide graduation ceremonies/PR

# Oralize and Adapt Self Proficiency Tests

- A 1: I can understand familiar words and very basic phrases concerning myself, my family and immediate surroundings when people speak slowly and clearly.

- C 2: I have no difficulty in understanding any kind of spoken language, whether live or broadcast, even when delivered at fast native speed, provided I have some time to get familiar with the accent.

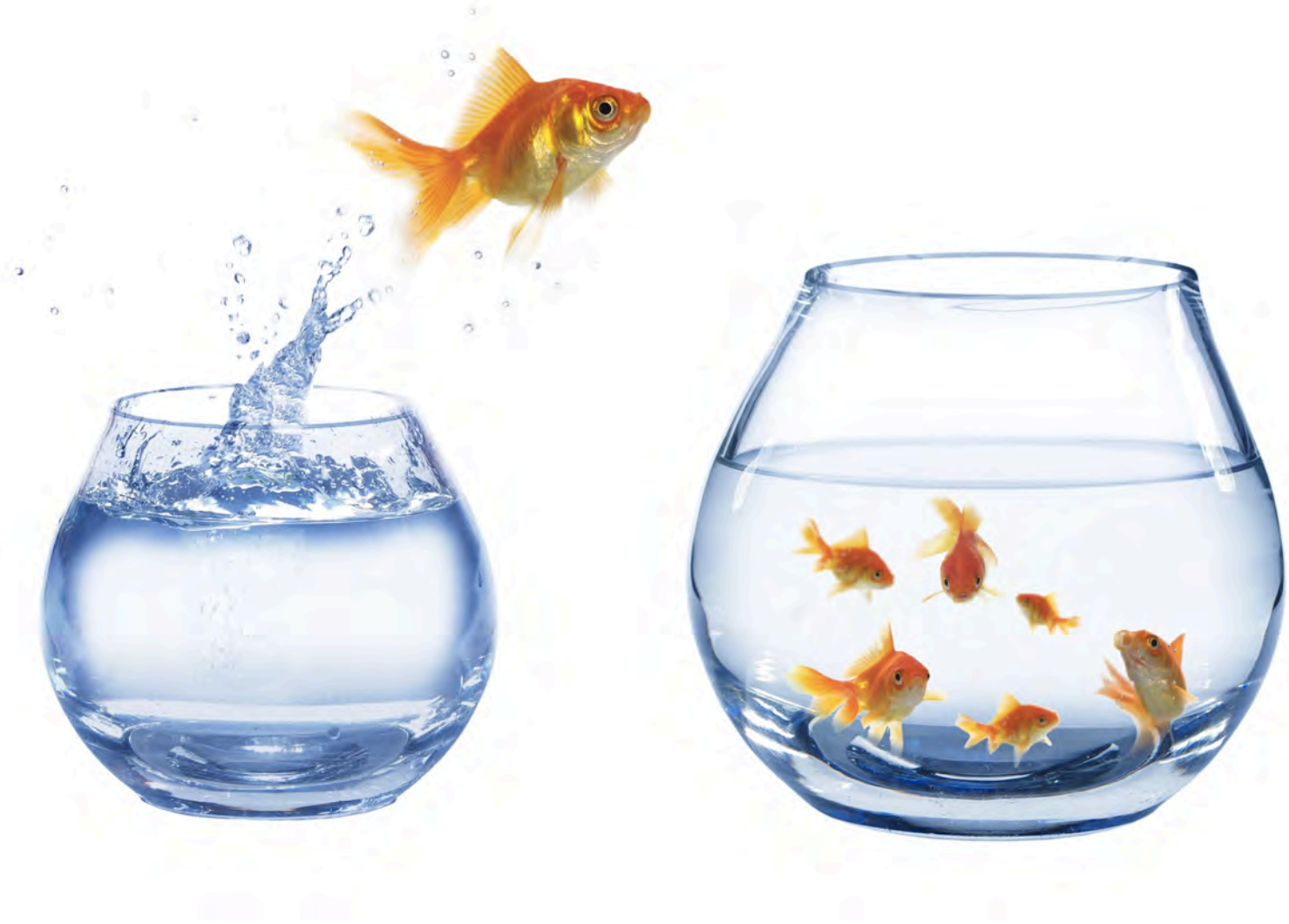
**Example set of progressively more difficult elements:**

- In English: D P H Y etc, name each letter and pronounce correctly in English, give an example of a word with this letter in it, out loud.

- s w q r etc, name each letter and pronounce correctly in English, give an example of a word with this letter in it, out loud.

- Write the letters of the alphabet (or copy a basic character set), in upper and lower case.

# Where To Next?



# A Plumber is Plumber is a Plumber (sort of)

- Healthcare interpreters require more varied skill sets.
- Each language / culture has DISTINCT issues interpreters must master to achieve consistency in quality and competency.
- Each language / cultural group needs leadership in the broader profession.

# Take the first step…

- What are your demographics?
- Who are your community leaders?
- Who is currently doing the interpreting?
- Partner with colleagues.
- Work with your professional association.
- What else?

# Feel free to connect…

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NATIONAL COUNCIL ON INTERPRETING IN HEALTH CARE

# Announcements

- Next webinar: February 19, 2015
- Session Evaluation
- Follow up via email:

  TrainersWebinars@ncihc.org

*Home for Trainers* Interpreter Trainers Webinars Work Group
An initiative of the Standards and Training Committee

NCIHC

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# Thank you!

## No Interpreter Left Behind:

### A Ensuring Language Access for Less Common and Indigenous Language Communities

*Guest Trainer: Katharine Allen, M.A.*

December 11, 2014

www.ncihc.org/home-for-trainers