

A framework for mainstreaming patient-centered communication in community-based healthcare organizations

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Abstract

This study examines the improvement of health centers' organizational ability to reach and serve communication vulnerable patient populations (i.e. defined as patients who are Limited English Proficient (LEP) and do not speak the dominant language of providers). The objectives are to develop a Language Access Framework tailored to the needs of community-based health centers. Outcome of the study includes a portrait of challenges and opportunities for language assistance in community-based health centers and a replicable model for language assistance that is applicable to similar settings. We conducted a cross-sectional study of family planning administrators on language assistance policies, practices and programs and a quasi-experimental study of organizational development intervention on language assistance policies, practices and programs. The study took place in New York State from September 2009 – August 2012.

Keywords: Language Assistance, communication vulnerable patients, healthcare

Introduction

Communication Vulnerable patients are a marginalized minority in society. They face significant barriers in accessing culturally and linguistically competent services. They are a growing segment of the population that experience disparities. There is significant evidence that when communication is hindered because of lack of language and cultural concordance, the ability of the healthcare system to provide quality care to Limited English Proficient (LEP) patients is seriously compromised (Hale, 2008). Poor communication due to language and cultural non-concordance results in lack of access to preventive services (Derose & Baker, 2000); denial of and/or receipt of wrong benefits and services; misunderstanding of treatment; significant delays in treatment; poor shared decision-making; ethical compromises; difficulty obtaining informed consent, not being given all available options for care (Commonwealth Fund, 2003); increased risks for medical errors; misdiagnoses, legal liabilities, malpractice and negligence; compromised comprehension of required treatments and medication instructions; decreased ability to manage chronic conditions with appropriate

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follow-up care (Youdelman, 2003), and unnecessary and expensive diagnostic testing (Hampers et. al.1999).

Moreover, women's reproductive healthcare is highly sensitive in many cultures. Candid discussions are often obstructed by cultural taboos. There is often a reluctance to speak about sexual matters. Bodily exposure and touch are taboo in certain cultures (US Department of Health & Human Services, 2000). Homosexuality and STDs are stigmatized. There are varying views on contraceptive methods, and some cultures use traditional medicines. Women who are survivors of rape, sexual torture and/or female genital mutilation may be reluctant to seek care or speak openly. These are factors that may cause great complications and require effective linguistic and cultural mediation.

The healthcare system in the U.S. struggles to provide patient-centered culturally and linguistically competent care to its LEP patients. Organizational level interventions that are not patient-centered do not always yield improvement in patient health outcomes - There are significant gaps in the provision of effective linguistic and cultural mediation. Despite the existence of legal frameworks and policies that mandate the provision of language services in healthcare facilities, a recent study in New York State points to the existence of major disparities in the application of laws and regulations (Center for Popular Democracy, 2013), with less than half of this segment of the population able to access linguistically sensitive information. Currently providing language services is the law in New York State. There is, however, wide variation between healthcare facilities we studied in the quality and quantity of the services provided (Rand, 2007 ; Rudmin, 2007). Practices range from the provision of dedicated bilingual staff interpreters who serve as patient advocates and cultural bridge builders, to the provision of an impersonal and time limited telephone interpretation that serves as a translator machine. The latter has become the default for many healthcare facilities especially for non-Spanish speaking LEP patients.

Overcoming linguistic and cultural disparities demands a deliberate proactive patient-focused approach - Among LEP patients there is need for health advocates/coaches who will guide them, redress power imbalance and empower their voice (Morris, 2010; Bahadir, 2010; Apostolou, 2009). They also are in need of linguistic and cultural mediators. Having effective linguistic and cultural mediation decreases communication errors, increases patient comprehension, equalizes healthcare utilization, improves clinical outcomes, and increases satisfaction with communication and clinical services for LEP patients (Karliner, Jacobs, Chen & Mutha, 2007).

Barriers to these patient-centered care approaches include funding limitations. Healthcare providers are under extreme pressure to cut costs and increase patient visits and volume so they can stay financially viable. Serving LEP patients is a complex effort that requires longer visit time and increases service costs. Institutionalization of LEP interventions may be hindered by the perception that they place an undue financial and/or human resource burden on the organization. There is strong evidence, however, that these interventions actually reduce medical costs and improve the bottom line (Youdelman, 2003). Facilitative factors of language access intervention uptake include an ability to capture a bigger share of the patient market; ability to comply with existing legal requirements and accreditation policies; and a high degree of leadership awareness of the changing patient demographics and commitment to the need to address disparities affecting LEP patients.

Methods

The study sought to understand how implementation of organizational level language access intervention may improve the organizational management system with the potential of

improving patient health outcomes. Enhanced management system was measured by ability to achieve 3 outcomes: identify/document language of communication; secure language assistance to enable communication and monitor and evaluate language assistance and health outcomes of LEP. Patient outcomes were measured through increased testing for STD with Latina patients. We defined increased testing as an indicator of success since language barriers hinder the provision of prevention services such as STD testing. An increase in testing is considered increased provision of preventive services.

Participants

Participants in the study were members of Family Planning Advocates of New York State, a statewide organization with approximately 200 member health centers throughout the State.

Design and Procedures

The study was conducted in two phases. In Phase 1, a Baseline Survey was administered to deepen understanding of the operating systems, policies, protocols and procedures related to communicating with LEP patients at family planning clinics in New York State. The survey also assessed perceptions of whether clinics thought that language access was important and whether they felt satisfied with the way language assistance is provided at their clinics. Staff knowledgeable about language assistance within each clinic completed the survey instrument.

In Phase 2, six clinics purposively selected from the pool of survey respondents were invited to participate in developing and testing a language access organizational intervention at their clinic.⁴ These clinics were selected based on the following criteria: interest, Limited English Proficient Latina Patient volume; having a service area with sizable population of LEP residents. The 6 clinics were divided into two groups; A and B. A delayed intervention methodology was used. Group A received the intervention 4 months before Group B receives its intervention. Delayed intervention allowed an opportunity to use Group B as a control Group for the initial 4 months. Data collection in phase 2 included, observational site visits; key informant interviews, action plan development sessions, technical assistance sessions, patient chart reviews and review of organizational records.

Social Learning Theory and Behavioral Ecological Model guided the study (Glanz et. al., 2008). The study emphasized factors in the physical environment (e.g., healthcare system, time and staff pressures) as well as history of personal and organizational performance (e.g., clinic policies) that may shape patient-centered communication. We also used prior work in the area of language access including Refki et. al, 2007, 2012, and Wilson-Stronks& Galvez, 2006. The analysis plan examined relationships among variables related to the quantity and quality of language assistance. The University of Albany Institutional Review Board reviewed conduct of the research.

Results

1. *Cross-sectional study of family planning administrators*

⁴ Development and implementation of the Language Access Intervention used the following process: (a) each clinic established a Language Access Team composed of staff members who are serving in key and different roles in the organization; (b) using an organizational self-assessment, each team individually and collectively rated the organization on the patient centered communication scale; (c) the team then collectively identified gap areas that are of priority to the organization and created an action plan which included the following components: goals, measurable, quantifiable objectives, activities, organizational resources that are needed to accomplish each objective, timeline for each activity; and an evaluation plan that clearly delineates process efficiency and outcome effectiveness measures. The Team selected strategies from a toolbox of possible interventions that the authors developed based on a review of literature, and executed the action plan.

The Family Planning project is aimed at understanding how family planning organizations can use language assistance services to improve preventative services for limited English proficient (LEP) patients. The current cross-sectional interview study was conducted with administrators of family planning clinics to investigate factors, organizational history, resources, and availability to participate in this research, as well as quantity and quality of language assistance services offered. Sixty family planning clinics from 11 New York State Regions participated. A variety of organization factors were observed, such as number of staff, languages spoken at the clinic, number of bilingual staff, staff training, number of patients seen per week, etc. Community factors included racial make-up of surrounding community, languages spoken in the community, political climate, etc.

Descriptive analyses were run to examine frequencies of specific variables across clinics. Table 1 describes the number of patient languages and ethnicities/races that clinics serve. Patients could choose more than one language and ethnicity/race, so percentages may not add up to 100%.

Over half (59%) of the clinics reported having patients who spoke Spanish, with other (44%) and Chinese (44%) being the next two popular patient languages spoken. All clinics served patients who identified themselves as other with respect to ethnicity/race. 76% of clinics served White patients and 75% of clinics served Black patients. Table 2 describes the availability of funding sources and availability of staff at clinics.

A few number of clinics reported receiving funding, outside of Title X, for language assistance services. None of the clinics reported receiving County Council Office funding, 9% reported receiving state funding, and 7% reported receiving federal funding. 93% of the clinics had full time staff, 88% had employed part time staff, and 29% of clinics used volunteers. 64% of clinics had bilingual staff and 76% of clinics provided an incentive to bilingual staff to interpret. Table 3 describes the specific types of language services provided, funding for each service, and the number of patients who use particular services.

Ninety-eight percent of clinics provided language assistance services. The types of services provided had little variation between clinics. More than 90% of clinics had bilingual providers/nurses, bilingual staff, telephone interpreters/language line, professional interpreters, translated educational material, multilingual signs/pictograms, and multilingual videos. 85% of clinics provided language assistance services for deaf and hard of hearing patients. With respect to funding for specific types of language assistance services, 75% of clinics received funding for both bilingual providers/nurses and telephone interpreters/language lines. 73% of clinics received funding for bilingual staff, translated educational client material, and multilingual signs/pictograms. Only 68% of clinics received funding for multilingual videos and professional interpreters. Further, 70% of clinics received funding to provide language assistance services to the deaf and hard of hearing.

The number of LEP patients who used specific services across clinics varied. All of the clinics reported patients using translated educational materials and support for deaf and hard of hearing. 66% of clinics reported patients using bilingual staff and 61% of clinics reported telephone interpreters/language lines being used by LEP patients. A little more than half (53%) of the clinics reported LEP patients using professional interpreters. However, less than half of the clinics reported multilingual signs/pictograms and multilingual videos being used by LEP patients. 75% of the clinics reported that their strategic plan included goals for language assistance services, but only 64% confirmed that their strategic plan measures the success of these services. 98% of clinics reported using language posters, language signs, and bilingual

staff/providers to identify a patient's language. Table 4 describes the reported barriers that clinics face when serving LEP patients.

There was little variability between clinics and perceived barriers. The majority of clinics felt that all barriers affected their ability to serve LEP patients, with language differences being the highest reported barrier among clinics. Eighty percent of clinics reported hiring bilingual staff to speak Spanish, 76% of clinics reported using language lines, and 70% of clinics reported working with professional interpreters. Table 6 describes the ways clinics monitor LEP patients' use of their language assistance services.

Sixty-eight percent of clinics reported having hard copy access to patient charts and 20% reported having electronic access. Only 12% of clinics used both. 95% of the clinics verified that they collect information on LEP patients getting some form of help to communicate and document the patient's language. All of the clinics reported document LEP patient use of their language assistance services. More than half (78%) of clinics evaluated their staffs' ability to speak the languages for which they interpreted. Tables 7 and 8 describe the different language assistance services offered for common and rare languages. Table 9 illustrates the different assistance/training that clinics provide to their staff to enable them to better serve LEP patients.

Ninety-three percent of clinics reported training staff on identifying LEP patients, helping staff correctly and consistently getting patients the right type of help they need to communicate, and assisting staff in using the interpreter services offered. 85% of clinics verified that they helped their staff learn how to communicate best through an interpreter and 81% of clinics train staff who interpret know how to interpret correctly.

Bivariate correlations were run on three main dependent variables: 1) how are different types of languages identified by the clinics, 2) how the clinics provide language assistance services, and 3) whether or not clinics track/monitor the use of these services. Several predictors were expected to be correlated with each of these dependent variables.

For the outcome "identifying different languages" we examined number of patients by race/ethnicity, languages in the community, and number of people in the community by race/ethnicity. Bivariate correlations were run examining the relationship of these predictors with what languages were spoken at the clinics. As expected, a significant correlation emerged between languages spoken at the clinic and number of patients by race/ethnicity. Significant relationships were also found for all languages in the community, except Spanish, and languages spoken in the clinic. The number of people in the community by race/ethnicity was also significantly correlated with the types of languages spoken at clinics.

Next, analyses were run to investigate the outcome "how are language assistance services provided" with various predictors. A dichotomous variable was created to account for whether or not a clinic provided any type of language assistance service. Bivariate correlations were run to examine whether a significant relationship existed between if a clinic offered language assistance services and several predictors. We expected several clinic demographic factors to be correlated with a clinic's language services such as what languages exist at the clinic, number of staff, funding for each form of language service, the number of bilingual staff, number of patients of different ethnicities, number of patients who use language services in an average week, date the clinic hired bilingual staff, and if the clinic offers an incentive to bilingual staff to interpret. Clinic factors related directly to serving LEP patients were also predicted to be correlated. These included if the clinic has written procedures for staff working with LEP patients, date the clinic began serving LEP patients, what actions a clinic takes to serve LEP

patients, if the clinic has written policies for helping LEP patients, clinic's perceived barriers in serving LEP patients, and whether or not the clinic includes providing language assistance services in their strategic plan.

In addition, several community factors, such as the number of people in the community of different ethnicities, availability of bilingual staff in the community, and the public policy climate of the surrounding community, were also predicted to be significantly correlated with a clinic's availability of language assistance services. Training opportunities provided by clinics were also expected to be related. These included if the clinic trains staff on helping LEP patients, if the clinic evaluates staff's ability to speak the language they interpret, and clinic's perceived barriers to training staff. Results suggest that funding is the only predictor significantly correlated with a clinic's availability of language services, but only for the telephone interpreters/language line ($p < .0001$, $r = .567$) and translated client educational materials ($p < .001$, $r = .431$). All other predictors were not significantly correlated with whether or not language assistance services were provided at clinics.

Lastly, we examined relationships with the outcome "how language assistance services are tracked." The number of staff, availability of patient charts, if clinics collect any information on LEP patients, the methods staff use to identify LEP patients, and if clinics prepare reports on language difference outcomes were expected to be predictors. The number of staff ($p < .05$, $r = -.345$), availability of patient charts ($p < .05$, $r = -.377$), and method used to identify LEP patients ($p < .05$, $r = .367$) were significantly correlated with whether or not a clinic tracks language services. Whether or not clinics prepare reports on language outcomes and collect information on LEP patients were not significantly related to a clinic's likelihood of monitoring the use of language services.

Taken together, the descriptive results suggest that all of the clinics provide language assistance services, with some providing several different kinds. All clinics reported offering language assistance services for both common and rare languages (see Tables 7 and 8). Very few of the clinics receive funding beyond Title X, but the majority of clinics receive funding for the different types of language services (see Table 2). Further, all clinics reported that LEP patients use their translated educational material and that they provide language assistance services for the deaf and hard of hearing. All clinics also reported using various methods to identify patients' languages (see Table 3). Various barriers to serving LEP patients were shared among the majority of clinics, with language differences, cultural differences, and limited availability of bilingual staff/interpreters being the three biggest barriers (see Table 4). In addition, all clinics reported documenting LEP patients use of their language assistance services and documenting patients' languages (see Table 6). Lastly, the majority of clinics provide training and assistance to their staff on serving LEP patients (see Table 9).

The correlational results reveal that the types of languages that exist in the surrounding community of a clinic significantly influences what kinds of languages are spoken at that clinic. Similarly, the ethnic make-up of the community and clinic patients also significantly affects what languages are spoken at the clinic. In addition, results indicate that only funding significantly impacts whether a clinic offers language assistance services, particularly funding for telephone interpreters/language line and translated client educational materials. The more funding a clinic has, the more likely it is to offer these types of services to LEP patients. Further, whether a clinic monitors the use of their language services depends on the number of staff, availability of patient charts, and the method used to identify LEP patients. Two reasons for the lack of significant correlations in this study are its small sample size and low variability among clinics who offer language assistance services. It is possible that the 70% of clinics that did not respond

to the survey were less likely to provide language assistance services. All, but one of the clinics, provides at least two kinds of language assistance service to LEP patients. In addition, only 59 clinics participated in this study that may further contribute to low variability among clinics. Future research should strive to include a greater number of clinics.

2. Quasi-experimental study of organizational development Language Access Intervention

Table 10 shows the types of interventions employed by four of the participating clinics. Two of the clinics involved failed to produce consistent data reports. Measurement of intervention impacts for those clinics relied on key informant interviews. The decision to examine how the organizational interventions may have influenced STD rates was driven by our work with family planning clinics for the past 10 years. Clinic administrative leaders and other staff who have been working on linguistic disparities have been struggling to understand if changes in language access influence patient clinical outcomes. This analysis of patient outcomes was a secondary aim of the study because the time period and resources of the study were not designed for a comprehensive and rigorous assessment. Given prior research and the study team's experiences with organizational interventions, it did not seem that 6 months to 1 year of time would be sufficient to all most clinics to fully establish comprehensive interventions with the potential of influencing patient outcomes. However, we designed an approach that might be most sensitive to changes related to the organizational interventions. The target patient group was LEP Latinas aged 40 years or younger. This patient group would be most common of LEP groups across the participating clinics. STD rates were selected as the common outcome because both our clinical advisors and prior research indicated that they may be sensitive to improvements in language assistance services.

Analyses were based on patient records from the participating clinics from December 2010 thru March 2012. This period would provide a long enough baseline (at least 3 months) and long enough follow-up (6 months or more) for both Groups A and B to determine potential changes due to each clinics organizational intervention. STDs included chlamydia and gonorrhea. Clinics were asked to provide monthly STD rates for Latinas in the target age group. If the clinic had information on LEP status, they were asked to provide that information too. Analyses examined each month during the target period as a cross-sectional sample. Given this design, it is possible that some Latinas are represented more than once during the target period, but this was considered to be relatively rare (less than 10%) by the participating clinics. Of the six clinics, four were able to provide all the necessary information for the analysis. Of the two clinics that were not included in this analysis, one grouped chlamydia and gonorrhea along with other conditions into one category called "STI" and the other clinic used a reporting system that could only provide semi-annual aggregate data for the target STDs and not separately for Latinas.

Descriptive analyses were run to examine frequencies of specific variables across clinics. Tables 11 and 12 describe the number of patients, patient languages, races, and ethnicities that clinics serve by site for each STI. Patients could choose more than one language and ethnicity/race, so percentages may add up to greater than 100%.

The two larger sites (Clinic 3 and 4) had a larger proportion of Latinas among their overall patient population for patients with chlamydia and gonorrhea than the two smaller sites. The examination of the descriptive data for the participating clinics indicate that there were differences in how some clinics categorized Latino and Hispanic patients that may have resulted in an undercount of actual patients of that ethnicity.

Analysis of Change in Monthly STD Rates was conducted by running one-way repeated measures ANOVAs to examine significant relationships across and within sites for patient monthly STD screening rates. No significant relationships ($P > 0.05$) were found within each site. The rates across participating sites are described in Tables 13 and 14.

Discussion

The language access intervention induced efficiencies in some participating clinics evidenced by perceptions of staff at the clinics that reflected on improved management of patient flow and increased patient volume. However since the intervention coincided with some of the clinics transitioning to electronic medical records that undoubtedly contributed to increased efficiencies. However, none of the participating clinics showed improvement in patients' outcomes measured by increased testing for STDs for Latina CVP patients.

We attribute the results to the fact that interventions selected by participating clinics did not take into account the interconnectedness of the levers of change in an organization (its internal infrastructure, people and external environment). Action steps implemented in one domain needed reinforcing and supporting actions in the other two domains to ensure effectiveness. For example, when a clinic chooses to develop language access goals, measurable objectives (internal infrastructure), such action became useless because it was not accompanied by equal efforts to incorporate evaluation of disparities by language in its patient population as well as in the external environment, and staff accountability and oversight to achieve those goals.

An integrated mainstreaming approach of language access need to introduce change on a multi-dimensional level and language access considerations must be integrated within each level in order to be effective. In our study, none of the clinics targeted all three leverage points of intervention; internal environment, people and external environment. Interventions targeted only one or two leverage points without taking into consideration the interplay between these three dimensions in an organization: internal infrastructure, people and external environment. There is a dynamic interplay between situational and personal factors within an organization as well. So to effect change within an organization, there is a need to integrate efforts that are staff-centered and target modification of behaviors and practices with environmentally-focused interventions that enhance organizational systems. Similarly, when instituting policies and procedures to identify, document and assist patients who are communication-vulnerable (internal environment) a clinic must ensure training of staff about these policies, enforcing implementation by including benchmarks in staff performance evaluations (People), and reaching out to the community to disseminate affirmative messages that these policies exist and the clinic provides a welcoming environment. A clinic which institutes language access policies and affirmative patient's Bill of Rights but fails to fortify and reinforce such action in the internal infrastructure with similar actions in the people domain and external environment so as to neutralize the impacts of hostile local policies on access of patients and behavior of its staff is unlikely to see improvement in patient's overall health outcomes or a realization of its mission to provide quality care. The community climate can have tremendous impact on a health center's ability to attract and retain foreign-born patients and the extent these patients can access healthcare services. In recent years, several New York municipalities have considered or enacted local ordinances intended to force undocumented immigrants and their families to leave. Immigrants have become distrustful of local government and fearful of accessing services.

Reinforcing and supporting measures may include training, sensitizing, oversight, accountability measures for staff and consistent linguistically and culturally appropriate outreach programs that

address fear and apprehension to access services in its communities. A clinic that continues to capture data on language assistance needs ought to incorporate evaluation mechanisms that use this data collected to assess disparities in communication vulnerable patient population and implement corrective actions when disparities exist. It needs to incorporate staff training to assess patient satisfaction. Clinics do not exist in a bubble but are significantly affected by the context in which they operate. The high level of satisfaction expressed by clinics in their ability to serve patients is both gratifying and troubling; gratifying because there is a sense of self efficacy, but troubling because such sense of efficacy is misleading when considering the health indicators in communities some of which suffer the worst health indicators in the State in terms of teen pregnancy and STD infections. High levels of disparities exist in ethnically diverse and communication vulnerable residents. A clinic needs to measure its success in relation to the health of the communities it serves.

Overcoming linguistic disparities entails a deliberate proactive approach that consistently and systematically evaluate CVP's outcomes before, during and after services are provided. Mainstreaming occurs at the point of intersection of the three levers of change: internal infrastructure, people and external environment. Access can only be mainstreamed or weaved into the fabric of an organization when the three levers of change support and reinforce each other. Language access interventions need to be institutionalized within three domains; internal organizational infrastructure; people who drive the organization and the external environment.

A framework for mainstreaming language access includes the following components:

Internal Infrastructure:

- Leadership commitment to develop clear language access goals and measurable objectives; reinforce staff accountability; identify gaps through integrating language access in audits, quality improvement programs and patient satisfaction surveys, and include language access in budgets.
- Solid policies and protocols that direct planning and actions, set priorities and guide day-to-day operations. They are widely used, accepted and periodically evaluated and updated. Communication and monitoring strategies ensure that staff understands and consistently implements them.
- Data captured, analyzed and used to implement corrective actions. Data systems record provision of language services during each visit; patients' decision to decline or refuse an interpreter, patients' satisfaction, and patients' health outcomes. Baseline data on LEPs are monitored and evaluated over time.

People

- Staff reflects the communities served.
- Staff interpreters are proficient in the languages used as well as in medical terminologies.

External Environment

- Linkages with the external health economy. "Learning organizations" do not exist in a bubble, but proactively engage their communities (O'Conner et. al., 2008). Community partnerships leverage resources, and enables service of hard to reach communities through trusted cultural and linguistic brokers. Outreach and service levels must be responsive and tailored to the magnitude of need in a community. Health indicators of community members must inform levels of outreach and service.

Conclusion

The language access intervention introduced and tested in this study induced efficiencies in some participating clinics in the area of patient flow and management, but none of the participating clinics showed improvement in patients' outcomes measured by increased testing for STDs for Latina CVP patients. This is attributed to the limited focus of the interventions that each clinic opted to adopt. An integrated mainstreaming approach of language access must introduce change on a multi-dimensional level. Language access considerations must be integrated in three leverage points of intervention; internal environment, people and external environment. The interconnectedness between these three dimensions means that the positive impacts of reforms in a single domain can be thwarted by lack of positive interventions in other domains.

References

- Apostolou, F. (2009). Mediation, manipulation, empowerment: Celebrating the complexity of the interpreter's role. *Interpreting: International Journal of Research and Practice in Interpreting*, 11(1), 1–19.
- Bahadır, Ş. (2010). The task of the interpreter in the struggle of the other for empowerment: Mythical utopia or sine qua non of professionalism? *Translation and Interpreting Studies*, 5(1), 124-139.
- Derose, K., Baker, D. (2000). Limited English Proficiency and Latinos' use of physician services. *Medical Care Research and Review*, 57(1), 76-91.
- Glanz, K., Rimer, B and Viswanath, K. (2008) *Health Behavior and Health Education: Theory, Research and Practice*. Jossey Bass.
- Hale, S. (2008, March). The use of interpreters in courts and tribunals. Paper presented at the AIJA Conference. Retrieved from <http://www.ajia.org.au/Interpreters%2009/Papers/Hale%20PPT.pdf>
- Hampers LC. et. al. (1999). Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*, 103(1), 1253.56.
- Morris, R. (2010). Images of the court interpreter: Professional identity, role definition and self-image. Retrieved from <http://www.ruth-morris.info/wp-content/uploads/2010/03/ImagesTIS2010.pdf>
- O'Connor, Nick, Kotze, Beth. (2008). *Learning Organizations: A Clinician's Primer*. Australasian Psychiatry. Vol. 16, No. 3.
- Rand Corporation. (2007). *Language Access Services for Latinos with Limited English Proficiency: Lessons Learned from Hablamos Juntos*. California, United States.
- Refki, D; Anderson, K. and Gany, F. (2007). *Conference Proceedings: New York State Conference on Increasing Language Access to Healthcare: Toward Effective National and State Policy*
- Refki, D; Avery, M.; Dalton, A. (2013). Core Competencies for Healthcare Interpreters. *International Journal for Humanities & Social Science*, Vol. 3. No. 2, 2013.
- Rudvin, M. (2007). Professionalism and ethics in community interpreting: The impact of individualist versus collective group identity. *Interpreting*, 9(1), 47–69.
- The Common Wealth Fund. (2002). *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*. New York, New York: Youdelman, M., Perkins, J. Retrieved from http://www.commonwealthfund.org/usr_doc/youdelman_languageinterp_541.pdf
- U.S. Department of Health and Human Services. (2000). *Family Planning Services for Iowans from Diverse Cultures*. (Family Planning" *Healthy People 2010*). Iowa, United States: Kahler, S. and Leeper, K.
- Youdelman, M. (2003, October). Providing Language Access in Healthcare Settings. Presented at the *Working Together to Increase Immigrant Women's Access to Reproductive Healthcare*. Retrieved from www.albany.edu/womeningov/publications