Communicator Express

cross cultural communication systems, inc.

April 2011

Ask Dr. Lane

Update on Hypertension

Hypertension is a painless increase in pressure found inside arteries and it is one of the five major conditions, including cholesterol, obesity, smoking and diabetes that put individuals at risk for coronary artery disease, and cerebrovascular disease. In fact, diabetes, obesity and hypertension have been on the rise since 1988 in U.S.A. Smoking is the only risk factor that has decreased since then.

Normal blood pressure has been traditionally felt to be any pressure below systolic of 140 and diastolic of 90. These numbers have been the numbers above which it has been recommended to treat with antihypertensive medicines. It has been recommended to have at least three separate blood pressure readings above this number before giving the diagnosis of hypertension and considering antihypertensive medicine. Normal blood pressure is now felt to be below 130 systolic. Prehypertension is 130-139, and hypertension is 140 and above.

In fact, if one tracks the mortality from cardiovascular disease in each decade of life, starting at 40, cardiovascular deaths begin at systolic blood pressure of 110. This does not mean that to be safe, one must have a systolic less than 110 because cardiovascular disease is influenced by four other risk factors.

Why hypertension is on the rise is unclear. It may have to do with concurrent increase in obesity in this country. Another reason may be diet: specifically salt in the diet. Salt has traditionally been thought to contribute to hypertension, but in recent times, with the availability of medicines to treat hypertension, the strategies of weight loss, and exercise, decreasing salt intake has taken a back seat. Increased salt in the diet delivers more sodium to the body which contributes to lower potassium retention. Increased sodium in the intracellular and extracellular compartments in the body and less available potassium contribute to increased vascular smooth muscle contraction and thus hypertension. It is recommended to have less than 5.8 gm of salt per day which is less than 2300mg of sodium. (1 gram of salt consists of 400mg of sodium.) Those who have hypertension are recommended to have less than 3.8 gram of salt per day which translates to less than 1500mg of sodium. Currently it is estimated that the average American eats 9.4gm of salt per day.

Where in our diet do we find the most salt? 80% is found in processed or pre-prepared foods. Can you guess what food category is responsible for the majority of salt in the US diet? Choose between soup, snack foods, bread, tomato sauce or pizza? Well, it's bread. Of course pizza is the largest contributor of salt in the average teenager's diet. However in general most bread contains flour that has salt mixed into it, such as in the case of self-rising flour. For this reason the consumption of bread is the leading contributor to high salt intake in the American diet. There are both observational studies and random control studies which implicate salt as a cause of hypertension. And apparently the

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Ask Dr. Lane

Update on Hypertension

(CONTINUED FROM PAGE 1)

evidence is mounting. It is also now shown that decreasing the salt intake can decrease the systolic blood pressure. A recent study has shown that a 3 gm/day reduction in salt per day has a significant improvement in incident coronary artery disease. This means the average was 6gm salt per day in the study, which is still greater than the recommended amount for Americans (less than 5.8 grams) and far greater than the amount recommended for those with high blood pressure (less than 3.8 grams.) The National Sodium Reduction Initiative calculates that we must decrease processed foods by 50%, thus dropping the amount of sodium in the diet by 40%percent and once this is accomplished we can save 150,000 lives per year.

Decreasing salt is not easy because we are used to the taste that salt brings to our food. But the good news is that it is felt that most adults can get used to the low salt taste within six weeks of cutting down.

Clinicians have always been taught that once the diagnosis is made of hypertension that the first treatment should be lifestyle modification including weight loss, decreased salt and exercise. Now these interventions including decreased Na (sodium) are clearly important and are taking on a new precedence. However, if after a reasonable amount of time the blood pressure is 140/90 or above, or if the patient has diabetes or kidney disease and the blood pressure is 130/80 or above, medical management is recommended.

Now there are three classes of drugs recommended for first line blood pressure control: thiazide diuretics, ACE inhibitors/angiotensin receptor blockers and calcium channel blockers. A thiazide diuretic may be chlorthalidone or hydrochlorothiazide. An ACE Inhibitor would be lisinipril or enalipril. An angiotensin receptor blocker might be irbesartan or losartan. Examples of calcium channel blockers include nifedipine and amlodipine. The beta blockers including atenolol, lopressor or propranolol are felt to be helpful when there are comorbidities like coronary artery disease, congestive heart failure, or arrhythmias present.

However, they no longer are felt to be appropriate for first line medicines for simple, uncomplicated hypertension.

The thiazide diuretics are effective and inexpensive however they can cause depletion of potassium and they can cause the serum sodium to decline especially in the elderly, so they require careful monitoring of blood tests when they are used, especially in the elderly.

If blood pressure cannot be controlled with diet, exercise and the use of at least three medicines, or if the patient requires 4 medicines a day to control the blood pressure, we say that the patient has resistant hypertension. If resistant hypertension is uncontrolled, the doctor will begin to look for less common physiologic or structural problems that might be contributing to the high blood pressure like renal artery stenosis or adrenal tumors called pheochromocytomas. These are very rare and bear diagnostic effort only when common approaches fail to control the blood pressure. The clinician may order a Magnetic Resonance Angiogram to look for renal artery stenosis, or 24 hour urine collections to check for the adrenal tumors.

Hypertension remains a prevalent and insidious disease, especially because it contributes to so much mortality in the world and due to the fact that it is painless. Its being painless makes it easy to forget at the moment we are considering what to eat. Making choices to decrease salt by just 3gms per day, or choices that bring the weight down as little as 5 lbs can make a big difference, helping to decrease or avoid taking certain medicines.

Cross Cultural Communication Systems Inc., PO Box 2308, Woburn, MA 01888, 781-729-3736; New Hampshire Regional Office: 43 Technology Way, Suite 2E3, Nashua, NH 03060, 1-888-678-CCCS

Sodium Content of Foods

Food	Weight (grams)	Portion	Sodium (milligrams)
Orange Juice, raw	248	1 cup	2
Butter, with salt	14.2	1 tbsp	117
Butter, without salt	14.2	1 tbsp	2
Cheese sauce, prepared from recipe	243	1 cup	1,198
Egg, whole, hard-boiled	50	1 large	62
Ham, sliced, extra lean	56.7	2 slices	810
Cheeseburger, with bacon and condiments	195	1 sandwich	1,043
Breakfast biscuit with egg and sausage	180	1 biscuit	1,141
Tomato sauce, canned	245	1 cup	1,482
Wheat flour, white, all purpose, self rising	125	1 cup	1,588
Broccoli, raw	88	1 cup	24

The information found in the table above is based on an article published by the University of Maine. Please see the link provided below.

http://www.umaine.edu/publications/4059e/

Vocabulary

Intracellular	Inside a cell
Extracellular	Outside a cell
Systolic Blood Pressure	The rate of blood pressure when the heart beats
ACE (angiotensin-converting enzyme) Inhibitors	A medication that is designed to help lower a patient's blood pressure
Stenosis	Narrowing of a blood vessel
Prehypertension	Blood pressure that is slightly elevated and if not controlled may lead to hypertension
Hypertension	Systolic blood pressure of 140 and above (high blood pressure)
Insidious	A disease that presents itself in a slow, gradual way, with no or few symptons to indicate how pontentially lethal it may be
Comorbidity	Two or more disorders or illnesses that occur in a person at the same time

Bibliography for Vocabulary-Hypertension

www.thefreedictionary.com
www.cdc.gov

Going Green

Earth Day

April 22, 2011 wasn't an ordinary day. It was Earth Day. It was a day of celebration as we should commit to protect this beautiful planet. It was a day to reflect that we must do more in order to preserve our natural resources. But how was your April 22? Was it just another day or a day of reflection?

Earth Day is the day that organizations and individuals throughout the world dedicate to promote sustainability and environmental consciousness by acting and educating; but although it was earth day, many didn't stop polluting the air as well as our seas or destroying our forests. For many it was business as usual.

Instead of viewing earth preservation as something that is highlighted once a year, we should think about how individually we can take care of our planet on a daily basis.

This mission is our mission. We would like to invite you to celebrate Earth Day not only once a year but every day. Recycle, plant a tree, promote sustainability, conserve, and if you can, join a movement. Our planet is counting on you!

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President's Corner

Living Healthy

Living healthy is an interaction of so many aspects of our lives as individuals, families, local and global communities.

For the first time in my life, I stopped listening to the news as I woke up early in the morning. I have to confess that I am a WBUR addict, so I felt that I was betraying my other partner! The winter was intense, not too much sun, and I need my vitamin D for my aging bones and for my soul!

I was waking up with big dark circles under my eyes as my Mediterrean ancestry stamp, but feeling also depressed, overwhelmed, with a deep feeling of hopelessness, due to observing so much suffering in the world. Constantly I had images of Japan and the earthquake, the tsunami and the nuclear power disasters running through my head. Part of me wanted to move to Japan and help, but I have a family in two countries that also need me and I need them. I was also worried about how the economy in the USA and globally, would impact the services we provide.

I wanted to reach out to our interpreters and staff members and thank them for all their excellent work, but I had to work writing proposals and on finishing up other major projects!

Finally though, I was forced out of this circle of negativity and immobility by attending two weddings in two different parts of the U.S.

Worrying about travelling and making sure all was set for these two wonderful weddings took my mind off of the impossible to the possible. I witnessed two young couples getting married; I was transformed by the love and commitment they had towards each other, their families and the world. They were full of contagious hope and still cognizant of all the "bad things" happening around us. I had a chance to spend time with my family and my three daughters, which has not always been easy for all of us as they are growing up and working things out with "mommy." See, I always thought I was a cool and good mother, but I have been challenged on this perception.

The feeling of living in the present, going for walks, being available to have family talks with my daughters and my husband and not thinking in the future was healing and it reenergized me. So now I can go back to listening to WBUR every morning as I have faithfully done for many years!

I came back home from vacation, and I started to plant in our garden, although it was a bit cold still. I started going for walks, no matter if it was dark and cold. I started to eat food that gave me energy and not food that made me feel full. I looked for the vegetables and the fresh foods that I enjoyed so much on my trip. I tried not to forget my shopping bags when I went to the market so that slowly I could make a small difference in the world that I love and respect. I realized that small steps could bring back some control and joy. I started to appreciate what I had, a great community of customers who in the time of a few days agreed to write great letters of unconditional support for a proposal that we were preparing. Although a stressful time for all of us, we got through it and it ended up being a big success.

As we worked together, we understood CCCS better and we felt good about what we have done. CCCS covered over 15,000 appointments in the past few years. We were able to help customers save money, therefore saving job opportunities for our wonderful and qualified interpreters. Also a practical way in which we were able to help by creating a system that allowed many of our customers to go from a model of one interpreter for one appointment, to one interpreter for multiple appointments within the scheduled two hours.

At CCCS, we have the comfort of knowing that we have done our best to represent what we passionately believe is the best linguistic services. We have kept our promises and delivery even more than was required by industry standards. With your help we have made CCCS a place where the sun shines even on cold dark days.

Living healthy is being and not always doing. It is about being part of a company, a community, a family, and lastly on a larger scale, the world. It is about enjoying what you have and working towards something even better in the future.

I am a lucky woman for having you,

Zarita

News Release

FOR IMMEDIATE RELEASE
Friday, April 8, 2011

Contact: OASH Press Office
(202)205-0143

HHS Announces Plan to Reduce Health Disparities

National Partnership for Action launches strategy to strengthen and expand community-led efforts to achieve health equity.

The U.S. Department of Health and Human Services today launched two strategic plans aimed at reducing health disparities.

The HHS Action Plan to Reduce Health Disparities outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities.

HHS also released the National Stakeholder Strategy for Achieving Health Equity, a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities and other underserved groups reach their full health potential. The strategy, a product of the National Partnership for Action (NPA), incorporates ideas, suggestions and comments from thousands of individuals and organizations across the country. The NPA was coordinated by the HHS Office of Minority Health.

Racial and ethnic minorities still lag behind in many health outcome measures. They are less likely to get the preventive care they need to stay healthy, more likely to suffer from serious illnesses, such as diabetes or heart disease, and when they do get sick, are less likely to have access to quality health care.

The Affordable Care Act offers the potential to address the needs of racial and ethnic minority populations, by bringing down health care costs, investing in prevention and wellness, supporting improvements in primary care, and creating linkages between the traditional realms of health and social services.

"For the first time, the United States has a coordinated road map designed to give everyone the chance to live a healthy life," said HHS Secretary Kathleen Sebelius. "We all need to work together to combat this persistent problem so that we can build healthier communities and a stronger nation."

Today, Secretary Sebelius will meet with patients, community leaders and advocates at the Boriken Community Health Center in East Harlem, N.Y., to see firsthand how communities are addressing gaps in coverage. Later today, she also will keynote the National Action Network's Women's Power Lunch to outline the "call to action" to end disparities in health and health care. Goals of the HHS Action Plan include transforming health care and expanding access, building on the provisions of the Affordable Care Act related to expanded insurance coverage and increased access to care. The plan also calls for more opportunities to increase the number of students from populations underrepresented in the health professions, train more people in medical interpretation to help serve patients with a limited command of English, and train community workers to help people navigate the system.

The plan also calls for HHS to set data standards and upgrade collection and analysis of data on race, ethnicity, primary language and other demographic categories in line with new provisions of the Affordable Care Act.

"Health disparities have burdened our country for too long," said Assistant Secretary for Health Howard K. Koh, MD, MPH. "This plan reaffirms and revitalizes a national commitment to helping all persons reach their full health potential."

Local groups can use the National Stakeholder Strategy to identify which goals are most important for their communities and adopt the most effective strategies and action steps to help reach them.

Both plans call for federal agencies and their partners to work together on social, economic and environmental factors that contribute to health disparities.

"Where people live, learn, work and play affects their health as much as their access to health care," said Garth Graham, MD, MPH, deputy assistant secretary for minority health and director of the HHS Office of Minority Health. "We have to confront the social, economic and environmental factors that contribute to health disparities if we are to fulfill the President's goal of 'winning the future."

The HHS Office of Minority Health is also launching new web pages to provide information and tools for organizations and individuals working to reduce health care disparities.

For more information about the plans and the National Partnership for Action, visit:
http://www.hhs.gov/news/press/2011pres/04/04hdplan04082011.html

This month we are very honored to have Mara Youdelman, Managing Attorney of the National Health Law Program (NHeLP) in Washington DC. with and LLM in Advocacy from Georgetown University Law Center, JD from Boston University School of Law and BA from Tufts University present an article on the topic of Patient Protection and Affordable Care Act (ACA).

Ms. Youdelman is "nationally recognized as an expert on language access and has participated on expert advisory panels by the Robert Wood Johnson Foundation, The National Committee for Quality Assurance, the American Medical Association's Ethical Force Program, The National Quality Forum and The Joint Commission." She has also co-authored "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, Language Services Resource Guide for Pharmacists. In addition, Ms Youdelman has authored three reports for The Commonwealth Fund on "promising practices for providing language services in health care settings, small healthcare provider settings, and state and local benefit offices." Furthermore, Ms Youdelman serves as Chair of the Certification Commission for Healthcare Interpreters. (The above references are from the NHeLP website.)

What's Possible to Improve Language Services in Health Reform Implementation

By Mara Youdelman, Managing Attorney (DC Office), National Health Law Program

Health care reform offered many opportunities to improve language access by including specific provisions to increase funding, resources, and services. While we did gain some improvements in language access in the enactment of the Patient Protection and Affordable Care Act (ACA), many specific issues, particularly around funding, were ultimately not included in the final legislation.

There are a number of provisions in ACA that offer opportunities to specify that language services must be provided or require the provision of certain information in a culturally and linguistically appropriate manner. So what does this mean in practice? A lot is left to the Administration to determine as part of ACA implementation. But that offers many opportunities to influence implementation and improve language services.

We believe language services – including oral interpreting and written translation – should be required in all new demonstration programs, payment systems, and models enacted as part of the ACA. This should include plans participating in the new health insurance Exchanges.

With regard to oral communication, LEP individuals should be able to access competent bilingual staff or interpreters to assist with oral communication at all points of contact with the health care system – from registration/intake and clinical encounters to financial counseling and customer service. When an LEP individual needs oral language services to communicate with health care providers or other participants in the health care system in a way that provides meaningful access, interpreters or bilingual staff should be provided.

With regard to written materials, information should be translated into multiple languages and "taglines" should be included on notices to alert LEP individuals of the importance of a particular document. When information is unavailable in an individual's language, an LEP individual should be able to obtain information orally.

The needs of LEP individuals must be considered as regulations, policies, procedures, and websites are being developed and implemented. This should apply whether the information is provided by federal or state governments, or plans participating in the Exchange.

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What's Possible to Improve Language Services in Health Reform Implementation

(Continued from page 7)

There are a number of provisions which can improve language access. Specific recommendations can be found in a longer issue brief on this topic by the National Health Law Program.

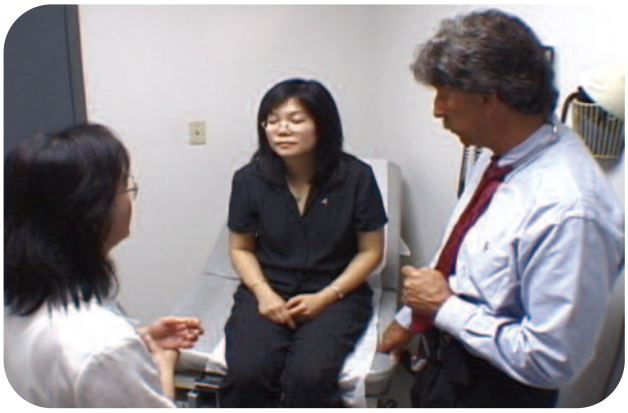
- **Nondiscrimination, ACA § 1557** -- this provision extends the application of Title VI (among other existing federal civil rights laws) prohibiting discrimination on the basis of race, color or national origin to any program or activity administered by an executive agency and entities established under Title 1 of ACA (e.g. Exchanges) as well as to all federal fund recipients.

- **Exchanges** -- we believe language services should be required for both the Exchanges (the new entities where individuals can purchase insurance) themselves and for plans participating in the Exchanges.

- **Patient Navigators, ACA § 1311** – this provision requires that navigators must provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges and thus we think it should include explicit requirements for entities serving as navigators to provide language services including translating materials and offering interpreters.

- **Data Collection, ACA § 4302** -- HHS must collect and report language data in: any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) and any reporting requirement imposed for quality measurement under any ongoing or federally conducted or supported health care or public health program, activity, or survey.

- **Other Payment Systems and Demonstration Programs** -- there are a number of provisions creating new demonstration programs or testing new payment systems including Accountable Care Organizations (ACOs) and medical homes, where language services should be specified including requiring collection of primary language data as well as providing and paying for needed language services.



Conclusion

The gains achieved in enactment of the ACA offer real opportunities for improving access to and quality of care for LEP individuals. The devil will be in the details of implementation, and it is imperative that implementation build on the requirements included in ACA and existing law to improve language access in a meaningful and systematic way. To ensure effective communication and ensure truly patient-centered care, the language a patient speaks must not impede the patient's ability to access the myriad of new opportunities for coverage, access and care offered by health care reform.

i) For more information on the differences between interpreting and translation, see NCIHC, ATA & NHeLP, "What's in a Word: A Guide to Understanding Interpreting and Translation in Health Care," available at http://www.healthlaw.org/images/stories/Whats_in_a_Word_Guide.pdf.
ii) See National Health Law Program, Short Paper 5: The ACA and Language Access (Mara Youdelman, Jan. 4, 2011).
iii) For more information on the application of § 1557 and Title VI of the Civil Rights Act of 1964 to Exchanges, see NHeLP's Issue Brief "The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges", available at http://www.healthlaw.org.
iv) For more information on the application of § 1557 and Title VI of the Civil Rights Act of 1964 to Exchanges, see NHeLP's Issue Brief "The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges", available at www.healthlaw.org.

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English Idioms Explained

Idiom	Explanation	Example
Short end of the stick	Unfair result	Vladimir felt as though he had gotten the short end of the stick because his brother was tall, good-looking, successful, and healthy and yet Vladimir was the complete opposite.
Catch 22, Can't win for losing	Neither option is a good one	It's really a catch 22 because without the medicine this disease is fatal, and yet the medicine is extremely difficult to tolerate and is associated with many severe side effects.
Last Straw, Last straw that broke the camel's back	Not willing to put up or endure anymore	I can't take this anymore; what you did really broke the camel's back.
Birds of a feather flock together	People who have similar interests tend to spend a lot of time together	Teammates, Gladys and Rebecca would always hang out together because birds of a feather flock together.
Hindsight is 20/20	After an event has taken place, it is easy to know what the best option was.	Looking back, knowing what I know now, I would have done things differently, but it is just like they say, hindsight is 20/20.

Answers to the CCCS Crossword - April 2011

Across

2. Insidious
4. ACA
7. Extracellular
10. Salt
11. Bread
12. Sodium
13. Comorbidity

Down

1. Prehypertension
3. Intracellular
4. Ace Inhibitor
5. Stenosis
6. Catch 22
8. LEP
9. Hypertension

Dear Interpreter,
We are happy to announce the following:

*CCCS Awarded **PRF48** Contract*

As of April 1, 2011 CCCS was one of the vendors awarded the state contract PRF48 for Massachusetts. This means that CCCS is a recognized vendor to the state of Massachusetts for:

- Face to Face Oral Interpretation
- Simultaneous Oral Interpretation
- Over the Phone Oral Interpretation
- Written Translations

We realize that we were awarded this contract due to our quality, and dependability. Much of our reputation for quality is based on your excellence as an interpreter. We are grateful for your ethical behavior, your punctuality and your quality of interpretation. You are an asset to the profession.

If you have any questions regarding this contract or are in need of assistance, please do not hesitate to contact us at 781-729-3736 ext.120 or if you prefer email at aduross@embracingculture.com.

Also, if you have not done so already we invite you to take a look at our recently updated website www.embracingculture.com which contains articles of interest, along with an archive that includes many editions of our popular newsletter the Communicator Express.

Once again, thank you for your hard work.

Sincerely,

Zarita, Amanda and Fatuma

Robinson Mosquera

Interpreter Award of Excellence

When Robinson was contacted regarding this award he was very appreciative and provided us with the following information. He mentioned that worship and spending time with his family of 5 children are his priorities. In addition, he commented on his love of the outdoors.

Robinson is an active medical and legal interpreter that enjoys the challenges associated with interpreting. We commend you on your accuracy as an interpreter and your willingness to help us cover emergency cases.

Congratulations!

Know your Acronyms and Abbrev.	
Dx	Diagnosis
Fx	Fracture
Rx	Prescription
Hx	History
Sx	Symptoms, Surgery
Tx	Treatment

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Upcoming Trainings

GETTING READY FOR YOUR WRITTEN HEALTHCARE CERTIFICATION EXAM

This course will help prepare active qualified healthcare interpreters for both of the national certification written exams. In order to simulate the written certification exams, students will have the opportunity to take online tests during class time. These exams will help prepare the student to get the feel of how the certification exam will be presented and will allow them to receive instant feedback on their progress. Students will be able to use these exams as a tool to help gauge their progress, and as an indicator to help them determine their readiness for the certification exam. Click here for a complete overview of the course.

Cost: $199 (MATERIALS NOT INCLUDED)

November 17, 19, and 20 –Woburn, MA (Thursday 5pm-10pm, Saturday & Sunday 9:00am-4:30pm)

THE FUNDAMENTALS OF LEGAL INTERPRETATION: 60-HOUR CERTIFICATE OF ATTENDANCE PROGRAM

Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level" according to the industry standards. There is a $55 non-refundable fee for this screening examination.

The American Translators Association has approved the Fundamentals of Legal Interpretation: 60-hour Certificate of Attendance Program for 10 Continuing Education Points.

Cost: $850 (MATERIALS ARE NOT INCLUDED)

Sundays 9:00am-2:00pm, September 11, 2011-December 11, 2011

THE ART OF MEDICAL INTERPRETATION: 60-HOUR CERTIFICATE PROGRAM

Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level," according to the industry standards.

The American Translators Association has approved the Art of Medical Interpretation 60-hour training program for 10 Continuing Education Points.

Cost: $695 (MATERIALS ARE NOT INCLUDED)

Woburn,MA: Tuesdays and Thursdays, September 8 – November 1, 6 pm – 10 pm
Orientation: Thursday, September 8, 5:00 pm - 6:00 pm

Manchester, NH:Saturday, September 24 – December 10, 9 am – 3 pm
Orientation: Saturday, September 24, 8 am - 9 am

Click here to download the catalogue. If you are interested in more information please contact us at 781-729-3736 X110 or by email at info@embracingculture.com.

Upcoming Conferences

August 4-6

NATI (Nebraska Association for Translators and Interpreters)
Language RX-The Prescription for Language Access
The University of Nebraska Medical Center
42nd and Emile,
Omaha, NE 68198
(402) 559-4000

August 19-20

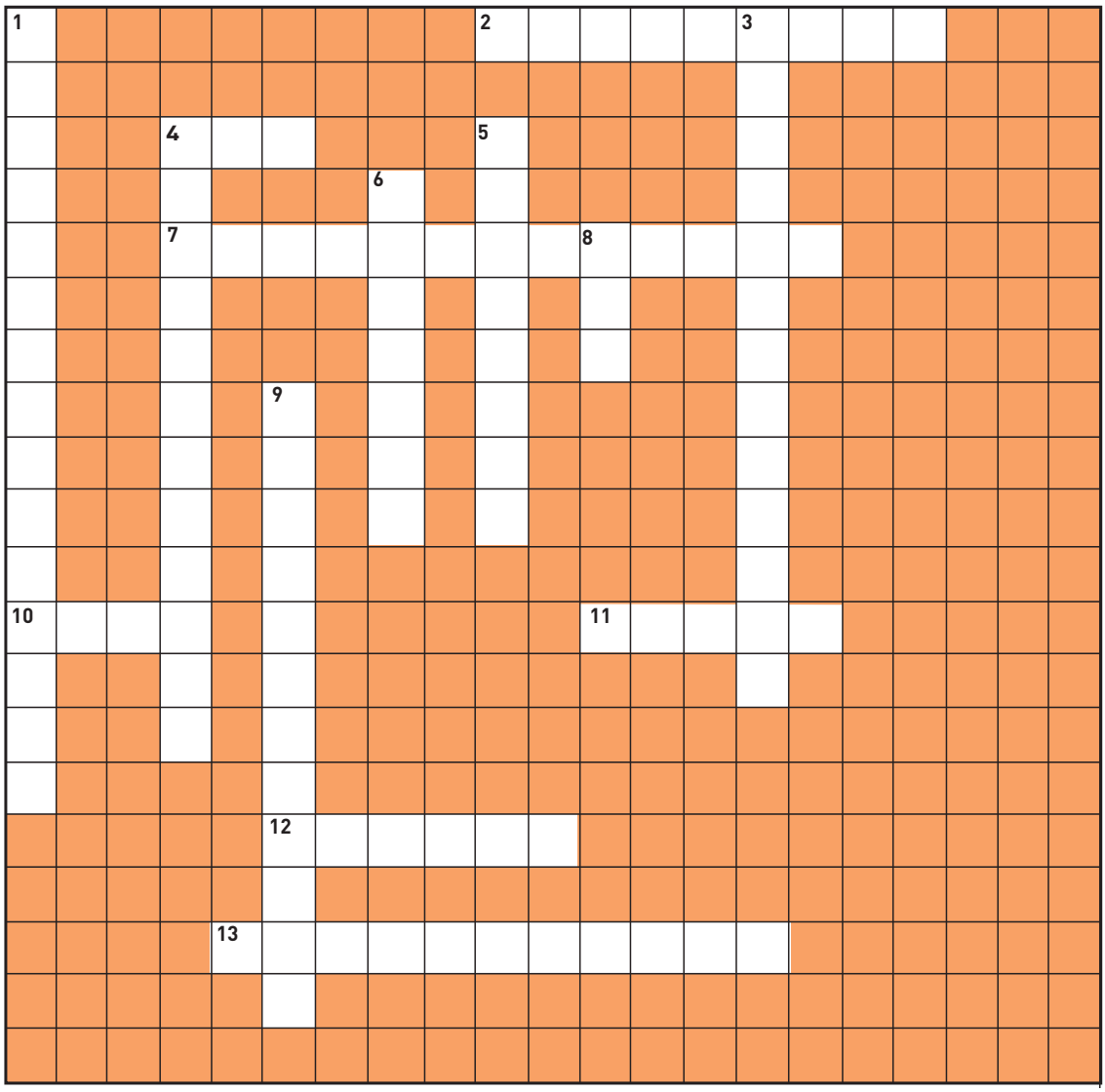
5th Annual TAHIT Symposium on Language Access in Health Care
The Fogelson Forum at
Texas Health Presbyterian Hospital
8200 Walnut Hill Lane;
Dallas, TX 75231-4426
www.tahit.us

September 30-October 2

IMIA Annual Conference

The Joseph B. Martin Conference Center at Harvard Medical School
77 Avenue Louis Pasteur,
Boston, MA 02115
617-636-1798
www.imiaweb.org

Crossword



Across

2. Slow, progressive, potentially lethal
4. New Act to reduce health disparities
7. Outside of a cell
10. Excessive consumption may lead to high BP
11. Food category high in salt
12. Key ingredient in salt
13. Two illnesses at the same time

Down

1. Under 140
3. Inside a cell
4. Medication for high BP (2 words)
5. Narrowing of a blood vessel
6. Can't win for losing (2 words)
8. Individuals that are unable to converse well in English
9. High BP

CCCS Interpreters please go to www.embracingcultureonline.com to take your continuing education quiz.