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Cirrhosis

By Howard J. Worman, M.D., with permission to print by author and Columbia University.

What is Cirrhosis?

Cirrhosis is characterized anatomically by widespread nodules in the liver combined with fibrosis. The fibrosis and nodule formation causes distortion of the normal liver architecture which interferes with blood flow through the liver. Cirrhosis can also lead to an inability of the liver to perform its biochemical functions. To understand the pathophysiology of cirrhosis, the normal anatomy and physiology of the liver must first be briefly reviewed.

Liver Blood Flow

Oxygenated blood that has returned from the lungs to the left ventricle of the heart is pumped to all of the tissues the body. This is called the systemic circulation. After reaching the tissues, blood is returned to the right side of the heart, from where it is pumped to the lungs and then returned to the left side of the heart after taking up oxygen and giving off carbon dioxide. This is called the pulmonary circulation. Blood from the gut and spleen flow to and through the liver before returning to the right side of the heart. This is called the portal circulation and the large vein through which blood is brought to the liver is called the portal vein. After passing through the liver, blood flows into the hepatic vein, which leads into the inferior vena cava to the right side of the heart. The liver also receives some blood directly from the heart via the hepatic artery. In the esophagus, stomach, small intestine and rectum, the portal circulation and veins of the systemic circulation are connected. Under normal conditions, there is little to no back flow from the portal circulation into the systemic circulation.

Bilirubin Secretion

The liver is the site of bile formation. Bile contains bile salts, fatty acids, cholesterol, bilirubin and other compounds. The components of bile are synthesized and modified in hepatocytes (the predominant cell type in the liver) and secreted into small bile ducts within the liver itself. These small bile ducts form a branching network of progressively larger ducts that ultimately become the common bile duct that takes bile to the small intestine. Bilirubin is a yellow pigment that derives primarily from old red blood cells. Bilirubin is taken up by hepatocytes from the blood, modified in the hepatocytes to a water soluble form and secreted into the bile.

Biochemical Functions

The liver performs many biochemical functions. Blood clotting factors are synthesized in the liver. Albumin, the major protein in the blood, is also synthesized in and secreted from the liver. The modification and/or synthesis of bile components also take place in the liver. Many of the body's metabolic functions occur primarily in the liver including the metabolism functions occur primarily in the liver including the metabolism of cholesterol and the conversion of proteins and fats into glucose. The liver is also where most drugs and toxins, including alcohol, are metabolized.

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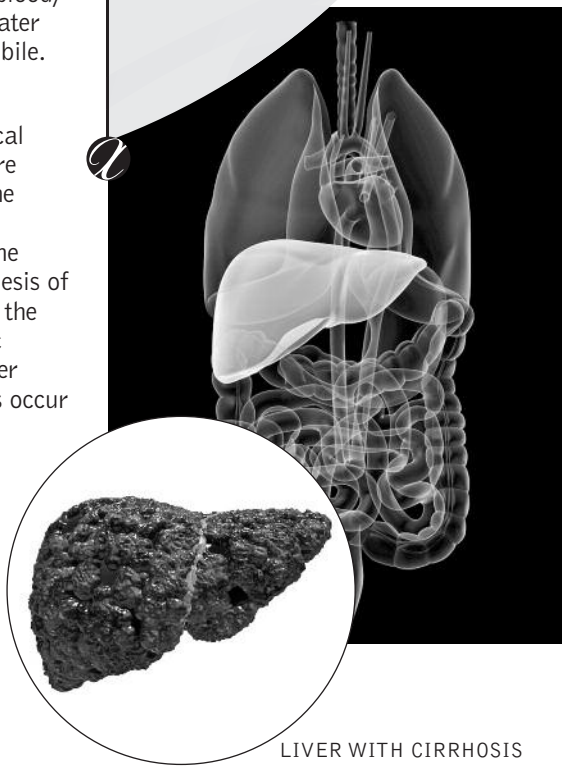

LIVER WITH CIRRHOSIS

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What Goes Wrong in Cirrhosis?

Cirrhosis results from damage to liver cells from toxins, inflammation, metabolic derangements and other causes. Damaged and dead liver cells are replaced by fibrous tissue which leads to fibrosis (scarring). Liver cells regenerate in an abnormal pattern primarily forming nodules that are surrounded by fibrous tissue. Grossly abnormal liver architecture eventually ensues that can lead to decreased blood flow to and through the liver.

Decreased blood flow to the liver and blood back up in the portal vein and portal circulation leads to some of the serious complications of cirrhosis. Blood can back up in the spleen causing it to enlarge and sequester blood cells. Most often, the platelet count falls because of splenic sequestration leading to abnormal bleeding. If the pressure in the portal circulation increases because of cirrhosis and blood back up (note: this can also sometimes occur in severe cases of acute hepatitis and liver damage), blood can flow backwards from the portal circulation to the systematic circulation where they are connected. This can lead to varicose veins in the stomach and esophagus (gastric and esophageal varices) and rectum (hemorrhoids). Gastric and esophageal varices can rupture, bleed massively and even cause death. Hypertension in the portal circulation, along with other hormonal, metabolic and kidney abnormalities in cirrhosis, can also lead to fluid accumulation the abdomen (ascites) and the peripheral tissue (peripheral edema).

Decreased bilirubin secretion from hepatocytes in cirrhosis leads to the back up of bilirubin in the blood. This leads to jaundice, the yellow discoloration of the skin and eyes. As the water-soluble form of bilirubin also backs up in the blood, bilirubin can also spill into the urine giving it a bright yellow to dark brown color. Abnormal biochemical functions of the liver in cirrhosis can lead to several complications. The serum albumin concentration falls which can lead to aggravation of ascites and edema. The metabolism of drugs can change requiring dose adjustments. In men, breast enlargement (gynecomastia) sometimes occurs because metabolism of estrogen in the liver is decreased.

Decreased production of blood clotting factors can lead to bleeding complications. Derangements in the metabolism of triglycerides, cholesterol and sugar can occur. In earlier stages, cirrhosis frequently can cause insulin resistance and diabetes mellitus. In later stages or in severe liver failure, blood glucose may be low because it cannot be synthesized from fats or proteins.

Cirrhosis, especially in advanced cases, can cause profound abnormalities in the brain. In cirrhosis, some blood leaving the gut bypasses the liver as blood flow through the liver is decreased. Metabolism of components absorbed in the gut can also be decreased as liver cell function deteriorates. Both of these derangements can lead to hepatic encephalopathy as toxic metabolites, normally removed from the blood by the liver, can reach the brain. In its early stages, subtle mental changes such as poor concentration or the inability to construct simple objects occurs. In severe cases, hepatic encephalopathy can lead to stupor, coma, brain swelling and death.

Cirrhosis of the liver can also cause abnormalities in other organ systems. Cirrhosis can lead to immune system dysfunction causing an increased risk of infection. Ascites fluid in the abdomen often becomes infected with bacteria normally present in the gut (spontaneous bacterial peritonitis). Cirrhosis can also lead to kidney dysfunction and failure. In end-stage cirrhosis, a type of kidney dysfunction called hepatorenal syndrome can occur. Hepatorenal syndrome is almost always fatal unless liver transplantation is performed.

Clinical Symptoms and Diagnosis of Cirrhosis

Cirrhosis is usually an easy diagnosis to make when any or all of the above abnormalities and complications are present. This is especially true when the underlying liver disease can be identified. The underlying liver disease is identified in most patients, however, sometimes it will not be discovered. Such cases are called "cryptogenic" cirrhosis. Sometimes, other conditions such as metastatic cancer, hepatic or portal vein thrombosis, severe acute hepatitis or acute bile duct obstruction can cause some of the abnormalities seen in cirrhosis. A careful history combined with special diagnostic tests will usually identify these conditions.

Some patients with cirrhosis, especially early in the course of the disease, will have no overt clinical signs or symptoms. Some may have only subtle physical changes such as red palms, red spots that blanch on their upper body (spider angiomata), hypertrophy of the parotid glands, gynecomastia or fibrosis of tendons in the palms. Some patients may only have subtle abnormalities on blood tests, and in some cases, all blood tests may be normal. Radiological and nuclear medicine tests may give clues as to the presence of cirrhosis, but the diagnosis of cirrhosis must often be made by liver biopsy.

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Causes of Cirrhosis

Although most often associated with alcohol abuse, cirrhosis of the liver can result from many causes. Almost any chronic liver disease can lead to cirrhosis. This list gives some of the many causes:

- Alcoholic liver disease (most common cause in the U.S.A.)
- Chronic viral hepatitis B, C and D
- Chronic autoimmune hepatitis
- Inherited metabolic diseases (e.g. hemochromatosis, Wilson disease)
- Chronic bile duct diseases (e.g. primary biliary cirrhosis)
- Chronic congestive heart failure
- Parasitic infections (e.g. schistosomiasis)
- Nonalcoholic steatohepatitis (liver inflammation that can be caused by fatty liver)
- Long term exposure to toxins or drugs

Treatment

Cirrhosis of the liver is irreversible but treatment of the underlying liver disease may slow or stop the progression. Such treatment depends upon the underlying etiology. Termination of alcohol intake will stop the progression in alcoholic cirrhosis and for this reason, it is important to make the diagnosis early in a chronic alcohol abuser. Similarly, discontinuation of a hepatotoxic drug or removal of an environmental toxin will stop progression. Treatment of metabolic diseases, such as treatment of iron overload in hemochromatosis or copper overload in Wilson disease, are also effective therapies. Chronic viral hepatitis B and C may respond to treatment with interferon and autoimmune hepatitis may improve with prednisone and azathioprine (Imuran). Drugs such as ursodiol (Actigall) may slow the progression of primary biliary cirrhosis and possibly sclerosing cholangitis.

In patients with cirrhosis of the liver, treatment must also be directed at the complications. Bleeding esophageal varices can be treated with endoscopic sclerotherapy or rubber band ligation. Ascites and edema are often responsive to a low sodium diet and such a diet must be emphasized in patients with these symptoms. More advanced ascites and edema can respond to diuretic therapy. A low protein diet and agents such as lactulose may help hepatic encephalopathy. Infections such as spontaneous bacterial peritonitis must be rapidly treated with appropriate antibiotics. Drugs metabolized in the liver must be given with caution. Coagulation disorders will sometimes respond to vitamin K.

Liver transplantation is highly effective for the treatment of end-stage cirrhosis. Transplantation is usually needed when complications such as encephalopathy, ascites or bleeding varices are uncontrollable or when biochemical function is severely depressed. In patients with primary biliary cirrhosis, a rising bilirubin indicates a poor prognosis and such patients should be considered for transplantation as the serum bilirubin concentration begins to rise. Active drug or alcohol abuse are contraindications to liver transplantation. However, alcoholics who have abstained from drinking for an extended period of time (usually more than six months), and have participated in rehabilitation programs and support groups such as Alcoholics Anonymous, can be considered as candidates and will often have a good prognosis. Liver cancer is usually a contraindication to transplantation, except in experimental protocols. Liver transplantation is usually not performed in patients more than 70 years old.

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http:/cpmcnet.columbia.edu/dept/gi/cirrhosis.html.

PRESIDENT'S CORNER

Summer is a time to be with our family and friends as we celebrate graduations and holidays such as July 4th, and as we take time off to go on vacation. This time of the year reminds me of when as a family therapist these happy occasions or times were not always felt as "happy times" by all family members. This is the case because according to the video Living a Lie by Human Relations Media, Inc., 1999, "an estimated 11 million children under the age of 18 live with at least one alcoholic parent." When I was an active therapist, it was not uncommon to have one parent struggling with his or her alcoholism and then have a teenage child from the same family experimenting with illicit drugs. The identified patient or IP was in general the adult who was arrested for drinking and driving and soon thereafter we would have the middle or high school child show some behavior issues at home and at school requiring a family intervention.

Alcoholism is often called a family illness; it impacts all in an emotional, financial, and or legal way. Often each family member takes different roles; there is the "enabler" who minimizes, protects and often encourages the drinking as a way to keep peace. The "scapegoat" is the one who acts out by doing illicit drugs, and then the "mascot" is often the clown of the family, making everyone laugh and entertaining the family out of fear of what could happen.

Substance abuse is erroneously commonly viewed as a moral weakness on the part of the abuser. Interpreters who share this concept of substance abuse may find themselves unable to render to the patient and provider the high quality of service that they deserve.

Interpreters who have themselves abused substances or who have friends or family members that have history of abuse may experience transference issues when working with substance abusers and their families. Some of the feelings felt by interpreters are pity, anger, shame and confusion, and these feelings often times end up being directed at the abuser or at the therapist conducting the intervention. We believe that interpreters who become familiar with common behavior patterns such as denial, minimization, and all codependency related behaviors in the spectrum of substance abuse-related illnesses, along with their diagnoses and treatment, will develop the necessary skills to remain transparent while interpreting. In this way the interpreter will not act on their emotional triggers, but rather, will learn how to monitor them and keep them in check.

We believe that adult learners best develop new skills when they are exposed to information that is meaningful and relevant to their daily activities. Thus, in this newsletter special emphasis is given to alcoholism as a common illness that defies cultural and socioeconomic boundaries.

Knowledge regarding alcoholism is so important because of the negative affects and major physical illnesses that can result from it such as stroke, liver disease, pancreatitis, myocardial infarction, and various forms of cancer such as liver, breast, esophagus and colon.

Interpreters may want to become familiar with the different treatment options for substance abusers and their families. Support groups, such as Alcoholics Anonymous, and Al-noon for families are still very common forms of treatment that help the abuser "become dry" or move progressively towards sobriety and recovery. These treatments also help his or her family to understand their roles in the family, and how they can show love by setting limits. In these Twelve-step programs, which characterize the support group movement, sobriety is based on the "one day at a time" philosophy and the belief in God. However not all patients are comfortable with this model and they may opt instead for individual, group and family treatment which also may include medications.

We hope by means of this article you were able to get a better understanding of the issues involved with alcoholism. Additionally, we hope that this article will encourage you to reevaluate or reflect on how you feel about working with patients and families who are faced with an illness that still carries an enormous stigma!

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NATIONAL PERSPECTIVE:

I. Increase in States' Medicaid Funding

On July 1, 2010, The Center for Medicare & Medicaid Services (CMS) under the Department of Health and Human Services sent a letter to States Medical Directors and State Health Officials. The purpose of the letter was to inform and provide guidance to states regarding the *Increased Federal Matching Funds for Translation and Interpretation Services under Medicaid and CHIP*, which became effective as of February 4, 2009 under the "Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3. For more information visit the CMS website at www.cms.gov.

The new CHIPRA provision affects both the Children's Health Insurance Program (CHIP) and Medicaid. The provision stated that under section 201(b) of CHIPRA, in connection with enrollment retention, there will be an increase in administrative funding for translation and interpretation services for LEP (Limited English Proficient) children of families when the states claim these services as administrative costs. Under this section, the legislation *"will facilitate States' ability to enroll and provide services to eligible individuals and to meet some of the responsibilities to individuals who are protected from discrimination under Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973."*

However, the increased federal matching funds are not identical for both CHIP and Medicaid. For example, as the letter indicates, the Medicaid matching fund is 75% of the allowed expenditure and for CHIP the match is 75%, or the states enhanced FMAP plus 5%, or whichever is higher. It should be noted that the increased funds for federal matching for translation and interpretation costs can only be claimed for eligible administration of the Medicaid or CHIP plans and therefore cannot be claimed for benefits. Also, the guide states that the matching fund is subject to the 10% cap on the state's administrative cost.

CMSA also specifies that existing Medicaid and CHIP regulations will be amended to reflect the matching rates for administrative expenditures for translation and interpretation services under the new CHIPRA matching fund increase.
In addition to the July 1, 2010 letter to the states, CHIPRA's increase in matching funds to states for translation and interpretation services, CMS has developed a "Strategic Language Access Plan (LAP)" draft. The plan is the result of federal agencies being tasked with (a) developing "guidance for recipients of federal funds concerning their obligations under Title VI of the Civil Rights to provide language assistance; and (b) developing a plan for improving LEP (Limited English Proficient) individuals' access to and participation in

Federally-conducted programs and activities." The first task was completed by the HHS Office of Civil Rights (OCR) and the second task required each federal department to submit to the DOJ (Department of Justice) "a plan to improve the language accessibility of its own federally conducted program and activities." Agencies were asked to survey "its programs and activities with direct public contact in order to identify the needs of LEP customers as well as those current activities and resources available to support language access." Also, agencies were asked to "develop a three-year plan reflecting the institutionalization efforts to improve language access for their customers."

The Strategic Language Access Plan (LAP) draft that was developed contains specific elements which "are components of CMS Strategic LAP goals." They include:

1. Objective of the Element
2. Implementation of the Strategy
3. Outcome Objective
5. Outcome Measurement
6. Funding Requirement
7. Implementation Timeline

In addition, CMS is working towards establishing a "baseline beginning fiscal year 2011 through fiscal year 2013 by establishing priorities that will best meet the needs of LEP individuals." The proposed timeline to begin the projected mandates is the fiscal year (FY) 2014 where "each CMS federally conducted activity must (a) ensure at least 90% of the beneficiaries who request LEP related materials and/or assistance receives it during the first attempt. Measurement for this requirement will begin at the conclusion of the establishment of FY 2013 baseline. And (b) ensure that beneficiaries request LEP related materials or assistance are satisfied or very

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National Perspective

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satisfied with the customer service provided at least 80% of the time. Measurement of this requirement will begin at the conclusion of the establishment of the FY 2013 baseline.'' (CMS Strategic Language Access Plan (LAP) to improve access to CMS federally conducted activities by persons with Limited English Proficiency (LEP).

The increase in matching rates may encourage states to apply for help in paying for interpreting and translation services through various types of reimbursement structures. Currently, it is estimated that only 13 states and the District of Columbia are presently enrolled to receive federal matching funding assistance.

As part of CCCS, Inc. continued interest in issues affecting the LEP population, interpreters, healthcare and social service organizations, we recently participated in a CMS listening session webinar where we were able to ask questions and offer suggestions regarding how these services should be used.

We strongly recommend that you become familiar with the July 1, 2010 letter from the HHS, CMS (Center for Medicare and Medicaid Services) and the draft of the Strategic Language Access Plan (LAP) by visiting CMS at https://www.cms.gov/home/regsguidance.asp. Additionally, the site has other resources, tools, regulations and manuals to guide the reader through the complexity of many of these policies.

Furthermore, there are several other helpful guides developed by organizations such as NHeLP (National Health Law Program); i.e., January 2010 revised document, ''How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?'' and the 2009 updated guide, ''Medicaid and SCHIP Reimbursement Models for Language Service,'' by Mara Youdelman. NHeLP has been a leader and partner with the Center for Medicare and Medicaid Services, working to ensure funds are available for interpretation and translation services. For more information visit www.healthlaw.org. Both of these NHeLP guides provide additional information on the various States Medicaid/SCHIP Reimbursement Models for Language Services in the United States (from Hawaii to Virginia) and information regarding the technical requirements which vary from state to state. Another document summarizing the funding program is ''Improving Language Access: CHIPRA Provides Increased Funding for Language Services,'' written by Sherice Perry, Program Manager of Minority Health Initiatives, of Families USA.

Please note that this article is for information purposes only and should not be used as a final guideline for acquiring specific information or for implementing a program. For more details on how your state can benefit from the new provisions for interpretation and translation matching funds, we recommend that you contact HHS, CMS, OCR directly.

Information was gathered and copied from HHS, CMS letter dated July 1, 2010 and NHeLP guides: https://www.cms.gov/home/regsguidance.asp, www.hhs.gov, www.healthlaw.org and the ''Strategic Language Access Plan (LAP) draft found at www.cms.gov.

II. Interpreter Certification: A Summary

Recently, a flyer for a conference came across our desk stating that ''certification will be required by hospitals and agencies.'' This topic is of the utmost interest to those of us in the interpretation and translation field, because we want to stay current on all new information, especially when certification is addressed. Regarding the statement that ''certification will be required by hospitals and agencies,'' we thought that it would be a good idea to investigate this affirmation and also to ask ourselves the following questions:

1. Does the Joint Commission require that interpreters become certified?
2. At present, is it necessary for interpreters to become certified?
3. Are states requiring or providing ''interpreter certification.''
4. Are interpreter certification requirements accredited?
5. In the future will certification become a requirement for all medical interpreters?

In order to help us understand these questions regarding certification, we visited several websites that are known to be both accurate and current. For the first question we went to the site www.jointcommission.org. Here is what we found.

1. Does the Joint Commission require that interpreters become certified?

Based on the Joint Commission's website, the recently completed work entitled the ''New and Revised Hospital Elements of Performance (EPs) to Improve Patient-Provider communication'' addressed the specific qualifications for language interpreters and translators (EP1 of HR.01.02.01). As indicated, under the new and revised element of performance, ''certification'' is **not** included or

mandated as a requirement for hiring or working with a professional interpreter. It does, however, indicate how professional interpreters must meet qualifications through assessment, education, training, etc. In summary, the Joint Commission is not requiring interpreters to have "certification" credentialing. However, hospitals and other healthcare organizations have also began to implement a process of determining how to qualify interpreters to make sure that they have both the linguistic and interpreting skills necessary to be proficient.

2. At present, is it necessary for interpreters to become certified?

To answer this question, we visited the two certification processes currently in progress at the national level for interpreters: CCHI and the NBCMI.

(a) CCHI: On September 15, 2009, Mara Youdelman, Chair of CCHI, along with a diverse group of professionals launched the Certification Commission for Healthcare Interpreters (CCHI). After years of focus work group sessions and input from professional medical interpreters, providers and healthcare professionals, the "interpreter certification" project became a reality. According to the CCHI, the certification process and the assessment of interpreters leading to certification, is based on field work and outlines interpreter knowledge, skills, performance and expectations rather on than on any "existing" vendor tests. For more information visit, www.healthcareinterpretercertification.org.

For example, in September 18, 2009, CCHI conducted an up to date Job Task Analysis (JTA) in order to define the current status and existing job functions of current professional interpreters working in the field. It is estimated that almost 3000 interpreters, supervisors and trainers responded to the JTA, providing a wealth of current information crucial to the process of developing a valid and neutral testing for a certification process that would reflect the current interpreter job requirements.

Another step in the development of a certification process is the "accrediting" process. In order to establish all the compliance requirements for accreditation, CCHI became the only member focusing on certification for healthcare interpreters with the Institute for Credentialing Excellence (formerly known as NOCA). In addition, CCHI was "established in compliance with the accreditation requirements as set forth by the Institute for Credentialing Excellence's National Commission for Certifying Agencies (NCCA)."

Currently, the CCHI certification pilot exam is ready and they are encouraging interpreters from across the country to participate. Individuals who participate in the pilot and pass the exam will be granted the relevant credential/certification. Both information and an application can be found at www.healthcareinterpretercertification.org/certification/apply-now.html." If you would like to participate or would like more information, visit the CCHI website or contact: Mara Youdelman, Chair, Certification Commission for Healthcare Interpreters at youdelman@healthlaw.org.

CCHI has provided several webinar workshops to continue informing members of the healthcare field, state and national government agencies, interpreting and training organizations, etc., of the progress being made with respect to national certification.

(b) The National Board of Certification for Medical Interpreters was the second site that we visited. After years of working, testing and developing a process for certification, IMIA joined Language Line Services to create a national medical certification program. On October 12, 2009, the National Board of Certification for Medical Interpreters (National Board) was launched to begin work on the process of "interpreter certification." The National Board is also a nonprofit group with 12 board members which includes a diverse group of professionals in the healthcare profession some of which are interpreters. According to a statement by Mr. Martin Conroy senior manager of Language Line Services in article dated October 14, 2009 "the groups will seek the blessings from the National Commission for Certifying agencies, an organization that certifies professional competence." NBCMI continues to provide webinars on the topic of certification. For more information on NBCMI webinars on certification visit www.certifiedmedicalinterpreters.org

In summary, both organizations are developing a certification process, although at the moment certification is not a requirement, it is hoped that in the near future it will be an additional tool for validating professional interpreters working in the field.

Both CCHI and NBCMI have provided presentations and free webinars discussing their process.

The most recent webinar held July 23, 2010 by CCHI gave its listeners a thorough detail of the CCHI "interpreting certification" process. This webinar offered an in-depth look at the development of CCHI's certification program, and gave reasons why interpreters are signing up to take the CCHI Certification and

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II. Interpreter Certification: A Summary

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credentials exams this fall.

CCHI outlined that their certification process complies with the Joint Commission's requirements for "competent healthcare interpreters." Also, as indicated by the webinar, CCHI is working closely with NCCA Standards (National commission for Certifying Agencies formerly known as NOCA) to ensure that the "certification" process meets accreditation standards. Some of these standards and requirements include: published policies and procedures, scoring reliability, reliable tests, etc.

To register for the test, go to www.certifiedmedicalinterpreters.org.

3. Are states requiring or providing "interpreter certification?"

State Requirements: Another important discussion regarding "interpreter certification" is how individual states are determining the quality of interpreters working in the field. Currently several states have taken various steps in addressing the qualifications of interpreters, either through legislation, enrolling in Medicaid/CHIP matching funds program, or as a result of state advocacy programs. For example, several states have implemented various degrees of assessing the language and interpreting skills of their bilingual staff, developing interpreting standards, registering of interpreters and/or evaluating interpreters leading to their individual state certification processes. For more information on what individuals states are requiring or if they have a process of certifying state interpreters, visit www.healthaw.org for the publication "Summary of State Law Requirements Addressing Language Needs in Health Care" dated March 2008.

Therefore, answering the question of who is currently requiring interpreter "certification" is not a simple one. Although there are two organizations that are developing and offering interpreter certifications currently "certification" as a federal mandate has not begun. In other words, how an interpreter is "certified" as a qualified interpreter depends on individual state requirements, and/or hospital requisites for hiring or contracting interpreters individually or through an agency.

4. Are interpreter certification requirements accredited?

Before any organization can become accredited, they first must follow a strict process outlined by a valid accrediting organization, and receive the required number of participants in order to qualify.

5. In the future will certification become a requirement for all medical interpreters?

As stated above, right now states are exploring ways to determine interpreter qualifications, and hospitals and healthcare facilities have their own process to determine qualifications when hiring interpreters. Therefore at this time, interpreter certification is not a national mandate but some individual states do have a process of "certifying" state interpreters. As far as the future is concerned much is yet to be determined, but we encourage you to stay current as certification moves forward.

WE RECOMMEND THAT READERS GET MORE INFORMATION ON CERTIFICATION BY LOOKING INTO THE VARIOUS RESOURCES, SITES AND INDIVIDUAL STATE GOVERNMENT SITES THAT PROVIDE THE READER WITH MORE UP TO DATE INFORMATION AND RELEVANT DETAILS ADDRESSED IN THE ARTICLE. THE INFORMATION PROVIDED CAN BE FOUND IN THE FOLLOWING SITES: WWW.JOINTCOMMISSION.ORG, HTTP://WWW.HEALTHCAREINTERPRETERCERTIFICATION.ORG, HTTPS://WWW.CERTIFIEDMEDICALINTERPRETERS.ORG AND WWW.HEALTHAW.ORG.

2010 Conferences Update:

CCCS, Inc. is proud to announce that Zarita Araujo-Lane, LICSW, President and Owner will be presenting at the following conferences:

- **Presenting: Language Coaches: The Missing Link for Excellence in Interpreter Training**
  2010 International Medical Interpreters Conference
  Ensuring Patient Safety for Language Minority Patients - A New Standard of Care -
  September 3-5, 2010
  The Joseph B. Martin Conference Center at Harvard Medical School
  Boston, Massachusetts USA
  www.imiaweb.org/conferences/2010conference.asp

- **Presenting: "The Burned Heart"**
  DiversityRx Conference Staff
  Plan to attend the Seventh National Conference on Quality Health Care for Culturally Diverse Populations
  Renaissance Baltimore Harborplace Hotel
  October 18-21, 2010
  www.diversityRxConference.org

- **Presenting: Language Coaches: The Missing Link for Excellence in Interpreter Training**
  American Translators Association
  51st Annual Conference
  Hyatt Regency
  Denver, Colorado
  October 27-30, 2010
  http://www.atanet.org/conf/2010/index.htm

August 2010 Interpreter Conferences:

- **NATI (Nebraska Association for Translators & Interpreters**
  11th Annual Regional Conference
  August 5-7, 2010
  University of Nebraska at Lincoln at the Kauffman Center
  www.natihq.org

- **4th Annual TAHIT (Texas Association of Healthcare Interpreters and Translators)**
  Symposium on Language Access
  August 13 & 14, 2010
  United Way Community Resource Center
  Houston, TX
  http://tahit.us

ZARITA ARAUJO-LANE, LICSW, PRESIDENT AND OWNER

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INTERPRETER'S CORNER

We would like to thank all of our interpreters for your hard work and excellence. Your diligence is not only seen during the triadic encounter but as well in your continued education. We are noticing that many interpreters are filling out the monthly quizzes, that are based on articles from the Communicator Express, and then sending them to our office to have them corrected. No doubt you are finding these medical articles along with their quizzes to be both educational and challenging.

Over the last few months we have been implementing a few electronic changes to the way we handle the interpreter assignments. We have been encouraged to see how many interpreters have opted to receive their assignments via email, rather than through regular mail. This new measure allows us to economize paper, and the interpreter benefits by receiving the assignment information in a written form within a few minutes, rather than a few days if it were to be sent via regular mail.

Also, as was discussed in previous editions of the Communicator Express, we will shortly be using client specific Service Verification Forms. This new step will allow the interpreter to at a glance, see the fire and safety codes in place for the assignment location. To see why this is a necessary step, please take a look at the following example. At a local institution, the code Orange means to *Evacuate the Building,* and yet at another hospital in the same area it means Hazardous Materials. As we can see, one code may have two very different meanings, depending on the institution. We hope that this new measure will help our interpreters to be more successful and confident, in their assignments as they travel from one location to another. Also, it will help hospitals meet their institutional standards. Lastly, we would like to thank all of our clients for sending us the necessary information regarding the codes used at their institution in such a timely manner.

Accounting

At times interpreters may run into situations where after having completed the assignment, the staff on hand refuses to sign the interpreter's Service Verification Form. What should the interpreter do in this situation? Definitely we do not want to cause a conflict, so the appropriate thing to do would be to first call CCCS for further direction. During the phone call it would be fitting to discuss and describe the situation so that we can document the case. Please do not leave the location without first calling to let us know of the situation. In advance we thank you for your help in this regard.

Cross Cultural Communication Institute

On July 12 we welcomed nine new medical interpreters to the field as they graduated from our "Art of Medical Interpretation" intensive course held in Nashua, New Hampshire. This intensive course offered 60 hours of instruction over an eight day period. This type of course is offered to all qualified students that are looking to receive their training in an accelerated format. Many brought their family and friends to the graduation to celebrate their success and their hard work. CCCS would like to congratulate these new interpreters and we wish them much success in their new profession.

Ask Dr. Lane

STARTING NEXT MONTH THE COMMUNICATOR EXPRESS WILL BE ADDING A SECTION ENTITLED "ASK DR. LANE." IN THIS PIECE DR. LANE WILL SHARE HIS INSIGHTS ON QUESTIONS SUBMITTED BY INTERPRETERS AND CLIENTS REGARDING MEDICAL TOPICS. WE ENCOURAGE BOTH INTERPRETERS AND CLIENTS TO SUBMIT THEIR QUESTIONS TO THE FOLLOWING EMAIL ADDRESS: AJERGER@EMBRACINGCULTURE.COM. NEXT MONTH DR. LANE WILL BE DISCUSSING THE DIFFERENCES BETWEEN "GOOD" AND "BAD" CHOLESTEROL AND THE DIFFERENT STRATEGIES USED TO CONTROL HIGH CHOLESTEROL LEVELS.

Upcoming Trainings

The Art of Medical Interpretation (60 hour certificate program)

8 week course in Woburn, MA (Tuesdays and Thursdays starting on September 7, 2010)
11 week course in Nashua, NH (Saturdays starting on September 25, 2010)

Our *60 hour -Art of Medical Interpretation* course will be starting up once again in September and will be offered mid-week from 6:00pm-10:00pm at our Woburn, MA location and on Saturdays from 9:00am-3:00pm in Nashua, NH. Enrollment is limited so that we can keep class sizes small, as a result we encourage potential students to apply as soon as possible. The purpose of this course is to help provide bilingual individuals with the necessary skills in order for them to excel as medical interpreters. This course discusses the ethics involved in being an interpreter, as well as the techniques used to overcome obstacles that interpreters face. This course also features Role-plays, which are used to simulate real life interpreting sessions while Language Coaches monitor the students progress and offer constructive feedback.

Training sessions focus on interpreting technique, cultural competency, interpreting ethics, mastering medical terminology through the Samurai! method, developing specialized glossaries and increasing memory power. The classroom work is supported by a new training manual; The Art of Medical Interpretation was designed to accompany this course and includes interpreter practice guidelines, medical terminology, disease information, exercises, diagrams, quizzes and over 90 role-plays.

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

Fundamentals of Legal Interpretation (60 hour program)

12 week course in Woburn, MA (Sundays starting on September 12, 2010)

Also, scheduled for September is the course *Fundamentals of Legal Interpretation*. This 60 hour course will be held in Woburn, MA on Sundays, from 9:00am-2:00pm. This course will focus on clarifying the legal interpreter's role and explore guidelines for legal interpreters. Students will participate in a series of interpreting-related activities designed to encourage short-term and long-term memory development. Such activities include learning to "listen for meaning", memory exercises, shadowing, dual-task training, paraphrasing, and sight translation. Students will also develop an extensive vocabulary with concentration on terminology specific to legal matters.

This program will also familiarize students with basic legal concepts. Language coaches and target language materials will be provided for groups of 4 or more students working in the same language pair. The American Translators Association has approved the Fundamentals of Legal Interpretation 60-hour training program for 10 Continuing Education Points.

FOR MORE INFORMATION REGARDING THESE COURSES, OR OTHERS THAT ARE BEING OFFERED PLEASE CONTACT LINDA DEMMONS AT 781-497-5066.

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Embracing Culture

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Active since 1996, CCCS is a recognized authority on cultural-linguistic services, providing consultation, interpretation, translation and training services to healthcare, educational, legal and business institutions nationwide. CCCI is licensed by the New Hampshire Postsecondary Education Commission as a private, postsecondary career school.