Provincial Medical Sign Language Interpreting Service Engagement

Summary of Input Received – Phase II

September 2018

PROVINCIAL LANGUAGE SERVICE
Provincial Health Services Authority

Table of Contents

Phase II Report Summary

Since late 2016, the Provincial Language Service, a program of the Provincial Health Services Authority (PHSA), engaged in a process to review the current service delivery model for provincial medical Sign language interpreting services. This service is provided for the Deaf, Deaf-Blind and hard of hearing community under a contract administered by Provincial Language Service.

Based on the initial feedback received from the community, Provincial Language Service determined more discussion and feedback was required from clients using medical Sign language interpreting services to access health care. To enable this input, Delaney + Associates were hired to facilitate and report on meetings with the community (*see Appendix A: Background and Stakeholder Consultation*).

The purpose of the community meetings was to understand the values and specific needs of the Deaf, Deaf-Blind and hard of hearing communities in British Columbia and to help Provincial Language Service improve the provincial medical Sign language interpreting services to meet their needs.

The engagement had four phases (*see Appendix D: Engagement Plan*). The purpose of Phase I was to communicate the project and generate interest with Deaf, Deaf-Blind and hard of hearing communities in becoming engaged. Phase II consisted of five engagement workshops across the province with community stakeholders. Phase III was a follow-up workshop to report on the input that had been received in all the sessions, and to present and seek input on the proposed interpreting service model. Phase IV will communicate the input received on the proposed model and outline the next steps for the provincial medical Sign language interpreting services.

This report summarizes the input received during Phase II of the engagement project.

Phase II sessions were organized and hosted with Deaf and hard of hearing community members in Greater Vancouver, Kelowna, Victoria and Prince George, as well as a specific session with Deaf-blind community members in Greater Vancouver.

An online survey, with American Sign Language (ASL) vlog translation, was set up for any community members unable to attend in-person.

The input received from community participants across all the engagement sessions can be themed into six sub-categories and sixteen key statements (*see Appendix C: Key Statement Summary*):

1. Service Principles

- *Communication, respect and access (to communication) are the three key values that should lead the future design of the medical Sign language interpreting services.*
- *Understanding what services are covered, to what extent, and why or why not - needs to be clearly and continuously communicated to deaf, deaf-blind and hard of hearing patients.*

2. Intake/Dispatch Expectations

- *When organizing schedules, interpreters should not be double-booked, or booked for appointments that are tightly scheduled. An interpreter needs to stay with the patient for the entire appointment.*

- *Deaf, deaf-blind and hard of hearing persons should have a greater say in the selection of interpreters for their appointments.*
- *Deaf Interpreters should have a clearly defined role in interpreting, and deaf, deaf-blind and hard of hearing patients should have the option of choosing the services of a Deaf Interpreter in addition to a hearing interpreter (in such cases, the interpreting team would include a Deaf Interpreter AND a hearing interpreter).*

3. Interpreter Resources

- *Rural, remote and isolated communities struggle with the lack of interpreter resources. This needs to be addressed in creative ways – training local people who are fluent in ASL, setting up technology (such as Video Remote Interpreting (VRI)[1]), and providing incentives for interpreters to move to the North.*
- *More interpreters, including Deaf interpreters[2], need to be trained and certified to work as medical Sign language interpreters. Deaf interpreters are not always available and they should be a common option for interpreting, and deaf, deaf-blind and hard of hearing patients should have the option of choosing the services of a Deaf Interpreter with a hearing interpreter.*
- *There are some basic requirements that clients expect from interpreters: Medical Sign language interpreters have to be qualified and well-versed in medical terminology; have their background checks and screening done prior to getting employed; be respectful; have an understanding of the Deaf culture and Indigenous culture, as well as an understanding of their role; and, be timely, professional and follow the Code of Ethics.*

4. Health Care System/Provider

- *Information about a patient being deaf/deaf-blind/hard of hearing should be part of a patient's medical record and should be accessible by health professionals ahead of time.*
- *Medical professionals need to understand the role of the interpreter, and its importance for effective communication, awareness of Deaf culture, and the basics of communicating with the deaf, deaf-blind and hard of hearing persons.*
- *Emergency Rooms need trained staff, information on how to book interpreters and communication tools for establishing contact with patients until an interpreter arrives.*
- *Aboriginal Provincial Liaison workers should work closely with American Sign Language (ASL) Interpreters (both deaf and hearing) to ensure deaf people from Indigenous communities receive culturally-appropriate service.*

5. Technology

- *In-person interpreting should be the priority, but technology can be beneficial in emergency situations, for interpreting in rural and remote areas, and for times when an interpreter is not present or is unavailable.*

6. Community Engagement/Outreach

[1] Video remote interpreting (VRI) is a video-telecommunication service that uses devices such as web cameras or video-phones to provide sign language or spoken language interpreting services.

- *The provincial medical Sign language interpreting services should have a clear and transparent complaints process, and there should be a variety of ways to submit input.*
- *The work of the provincial medical Sign language interpreting services should be overseen by a Deaf Committee, Commissioner, or another body that would understand the needs of the deaf, deaf-blind, and hard of hearing British Columbians.*
- *Communication with the community members can be directed through representative organizations; however, many deaf, deaf-blind and hard or hearing do not affiliate with any of the organizations above, and the communication should also be shared in other ways (via a website, email blasts, or snail mail).*

The engagement with Deaf, Deaf-Blind and hard of hearing communities across British Columbia provided some insight into the needs and expectations of the community (*see Appendix B: Engagement Sessions: Community Input Summary*), and how the provincial medical Sign language interpreting services could be improved.

Some of the input suggests increasing awareness about Deaf culture and how to communicate with deaf, deaf-blind and hard of hearing persons, and specific input on how to facilitate easier access to interpreters, how to enable communication when interpreters are not present, and how to improve access to interpreting services in rural and remote communities.

Appendix A: Background and Stakeholder Consultation

The Provincial Language Service is committed to providing top-quality interpreting services for deaf, deaf-blind and hard of hearing people who access health care service across BC. Through a review and engagement process that began in 2016 Provincial Language Service learned there is confusion regarding what medical services are covered and how decisions about service provision are made. Provincial Language Service also learned the Deaf, Deaf-Blind and hard of hearing communities wants to provide regular input so the service remains current, and that there needs to be a comprehensive approach to ensure the service is delivered consistently across BC.

Provincial Language Service believes the Deaf community has an integral role in improving equitable access in the delivery of interpreting services. For this reason, Provincial Language Service has been actively involving community members to better understand their needs and in particular to focus on future planning for a provincial medical Sign language interpreting service. This engagement project was seeking input about opportunities to innovate, redesign and improve the provincial medical Sign language interpreting services within existing available resources.

This work has been conducted in three phases, followed by a fourth phase being planned for fall 2018.

Phase I
In Phase I, Provincial Language Service communicated information about the project through established media channels, shared an ASL vlog about the project, and recruited participants for the five workshops across the province.

Phase II
Discussion and focus group sessions took place as follows:

- A focus group with the Deaf and hard of hearing community in Kelowna (February 3, 2018) with six participants
- A focus group with the Deaf and hard of hearing community in Greater Vancouver (February 16, 2018) with 19 participants
- A focus group with the Deaf-Blind community in Greater Vancouver (February 27, 2018) with five participants
- A focus group with the Deaf and hard of hearing community in Victoria (March 10, 2018) with 19 participants
- A focus group with the Deaf, Deaf-Blind and hard of hearing community and hearing people (parents of deaf children, members of Northern B.C. Children and Families Hearing Society) in Prince George (May 6, 2018) with 14 participants.

In addition, an online survey with ASL translation was active from February 3 to May 6 (https://tinyurl.com/Provincial Language Service-sign-language-engagement) for anyone unable to attend an in-person session.

In consultation with stakeholders, Phase II of the project expanded beyond the initial planned two sessions to include three additional engagement events, to involve a greater and more diverse cross-section of community members with varying barriers to health access; and to include deaf and hard of hearing persons living in rural and remote communities.

The online survey mirrored the questions asked in the in-person sessions. It was promoted in all of the engagement sessions, and posters and promotional materials were shared with all of the organizations that were invited to participate in the engagement. Six participants responded to the online survey.

In each session, the participants were asked for input about the key characteristics they would like to see in a provincial medical Sign language interpreting service. This report summarizes the input received from all sessions.

REACHING STAKEHOLDERS

- All sessions were widely promoted.
- A poster and ASL vlog were created for each engagement and they were posted on the Deaf BC website.
- The events were also promoted via Greater Vancouver Association of the Deaf (GVAD) and the Okanagan Valley Association of the Deaf (OVAD).
- Individual invitations were sent to all the deaf and hard of hearing persons that were on the Delaney + Associates mailing list.
- The engagement project and events were described and promoted on the PHSA website, and the Deaf BC Facebook page.
- In addition to this, email invitations were sent to the following organizations and key stakeholders:
    - Vancouver Community College Deaf and Hard of Hearing Department (instructor teaching ASL and English to deaf newcomers)
    - Family Network for Deaf Children
    - Island Deaf + Hard of Hearing Centre
    - Northern B.C. Children and Families Hearing Society
    - UBC Professor and Co-Director, Program in Education of the Deaf and Hard of Hearing
    - Well-Being Program, Vancouver Coastal Health
    - BC Deaf Sports
    - Happy Hands Club of the Deaf
    - Vancouver Community College Sign Language Program
    - Western Institute for the Deaf and Hard of Hearing
    - BC Rainbow Alliance for the Deaf
    - BC School for the Deaf
    - Douglas College Sign Language Interpretation Program
    - Provincial Outreach Program for the Deaf and Hard of Hearing.

In the first Vancouver session, participants talked about the diversity in the Deaf and hard of hearing community and strongly suggested Provincial Language Service also engage with deaf-blind community members. Deaf-Blind patients rely on intervenors[3] for medical Sign language interpreting, and their needs are quite different than those of the deaf and hard of hearing patients. Barriers for access to care are greater for deaf-blind patients. Because of this feedback, a session with the Deaf-Blind community was scheduled and promoted through intervenors working with deaf-blind patients and the Deaf-Blind Planning Committee.

Provincial Language Service was contacted by the Island Deaf and Hard of Hearing Centre with a request that the Island community be included in these discussions. As a result, a session in Victoria was added.

[3] Intervenor is a person that mediates between the person who is deaf-blind and his or her environment to enable him or her to communicate effectively with and receive non-distorted information from the world around them. Intervenor acts as the eyes and ears of the person who is deaf-blind. Generally, that is a deaf interpreter, or a person skilled in tactile ASL.

In the Victoria session, several participants spoke about the challenges faced by deaf and hard of hearing community members in the North. The same participants strongly recommended that a session be organized with the community members in the North. That was followed by several requests from community members living in Prince George, Williams Lake, and Terrace also advocating for a session in the North. Again, as a result of the feedback from the community, a fifth and final session was held in Prince George.

APPENDIX B: ENGAGEMENT SESSIONS: COMMUNITY INPUT SUMMARY

SHARED VALUES

In all of the engagement sessions (including the online survey), the participants were asked about the values that are most important to them, and that should guide the provincial medial Sign language interpreting service in the years ahead.

The participants across British Columbia spoke about the values listed below. **Communication**, **respect** and **access** emerged as three key values throughout all discussions and the survey responses.

COMMUNICATION

In the Prince George session, the participants highlighted communication – the importance of clear communication, and different methods of communication (video, video relay, via an interpreter, etc.).

For communication to take place, participants highlighted the importance of having an interpreter. A few participants would even consider having an interpreter that is not medically trained in cases when no other interpreter is available. Participants said that when there is no interpreter, they need to rely on pen and paper or family for interpreting. Relying on a pen and paper can be very frustrating and a waste of time for everyone involved – the deaf persons and the medical professionals. Signing makes communication possible.

Some participants said that they need an interpreter who understands the Deaf culture and is friendly. Although some participants in Prince George said they would prefer any interpreter over none at all, most participants in all of the sessions agreed that interpreters need to be medically trained and have a good knowledge of medical terminology.

English can be difficult for deaf and deaf-blind persons to understand, and interpreters often need to ask for the information to be told in a different way so that it can be interpreted. Some participants said communication to them means having an interpreter who understands Deaf culture and is open to learning about Deaf culture.

Communication was also one of the top six values listed in the Kelowna session, and it was brought up in the Vancouver session. In Vancouver, the participants explained that communication also involves asking the Deaf community what they want, and listening to and communicating with community members (by email, TTY, or other forms of communication). Deaf, deaf-blind and hard of hearing persons should also be asked about their preference for communication: “How do you communicate? How do you want to be communicated with?”

In the session with the deaf-blind patients, communication was brought up in the context of the need for intervenors as for deaf-blind persons, it is imperative that interpreters accompany them to the hospital and for doctor visits. Interpreters/intervenors need to make sure that the language used for communication is accessible to their deaf-blind client.

The value of clear communication and feeling supported through communication was also one of the key values brought up in the Victoria engagement session.

ACCESSIBILITY/ACCESS

In Kelowna, Victoria and Vancouver session with deaf-blind participants, one of the key values mentioned was accessibility/access.

In the deaf-blind engagement, participants said that it is important for health care providers to have information about patients being deaf, deaf-blind or hard of hearing. It is important healthcare providers know there will be a need for an interpreter prior to an appointment and then book an interpreter in a timely manner. This will allow a deaf-blind person to access an interpreter, and more importantly, care without delays.

In the Victoria session, access to language was one of the key values expressed. Deaf individuals, in general, do not receive the same level of care because of the lack of access to language resources, and this lack of access leads to isolation.

RESPECT

Respect was a key value brought up in the Kelowna engagement session. In the deaf-blind session respect was also one of the values highlighted as participants thought it was important that interpreters are punctual as a demonstration of respect. In the Victoria session, respect stood out in reference to the respect for Deaf culture, its own language, and also the unique language of Indigenous deaf people. Respect for senior deaf individuals and the care they receive was another way this value was expressed in Victoria. It was also expressed that deaf patients feel they are being marginalized and not respected as patients.

Other emerging values included the following:

SAFETY

The participants in the Prince George session explained that communication is closely tied with safety. Communication is needed for safety reasons and is one of the most important values to deaf and deaf-blind persons.

HEALTH

Participants in the Prince George session also highly ranked health. To protect their health, members of Deaf community need to have an interpreter who can help them understand what a medical professional is saying.

CONFIDENTIALITY

In the Prince George session, the participants also mentioned confidentiality as they would like the information about their health to be treated with confidentiality.

EDUCATION

Participants in the Prince George session also value education. Education, communication and health have been tied together, and participants would like to have access to all three like any hearing person.

Education was also brought up in the Vancouver session in terms that when a program is being built, hospitals and their staff need to be educated about the program so that knowing how to access interpreters for communication with the deaf, deaf-blind, and hard of hearing patients is widely understood and becomes common knowledge amongst the staff.

TRUST

In the Victoria session, the community members expressed their belief the Deaf, Deaf-Blind and hard of hearing community needs to trust people who are providing interpreting services.

The four other values brought up by the participants were fairness, equality, quality, and professionalism.

In addition to the question about values, the participants were asked to provide input into different elements of the interpreting service process. The input received is summarized based on the elements of the service they refer to.

TOPIC 1: INTAKE

On the topic of INTAKE, at all the engagement sessions, the participants were given the following information:

> *"INTAKE is when a Deaf, Deaf-Blind or hard of hearing person requests an interpreter. The intake person takes all the necessary information (name of physician or health care provider, location, the type of meeting, information about MSP coverage, etc.). The intake also checks if the request for an interpreter is covered by the service."*

Then, participants were asked the following questions:

> *"Based on your experience, what is the best and most efficient way to book an interpreter? If the request for an interpreter is made by a health care provider, what information does the health care provider need? "*

The responses from the participants across all the sessions could be grouped under the following emerging themes:

UNDERSTANDING AND EXPANDING THE SCOPE OF COVERAGE

Across all the sessions, participants felt strongly that interpreters needed to be made available for all aspects of life, not just medical needs.

Participants have asked whether interpreting for mental health services is covered, and whether community members could be provided with an interpreter for attending mental health workshops.

The participants expressed their concern that first aid courses are not covered and that getting access to first aid courses is very hard. This is viewed as an inequity. Participants felt it was unfair that a hearing person could take a first aid course, but a deaf person does not have this opportunity.

Access to communication was seen as a fundamental issue, especially in the areas where interpreting is generally not covered – dental heath, eye exams, physical therapy, x-rays, ambulance, emergency situations, alternative medicine, walk-in clinics, etc. Participants asked that the scope of service be addressed, and eventually expanded. Interpreters are generally not provided for many of the above settings, and the participants expressed their frustration with the lack of clear understanding of when an interpreter is provided (i.e. it is approved in some cases and not in others). There is also a discrepancy in terms of what is covered and what deaf patients need for their health. The participants expressed strongly the belief in a holistic approach to providing interpreters in the health care setting. Participants also asked for a summary and explanations of the services that are provided so there is less confusion in the future.

Medical Services Plan (MSP) includes doctors and hospitals, but based on the input received, a greater range of access is needed. Deaf persons need communication for their overall health.

The participants in the Kelowna session, for instance, stated that any medical service accessed by other British Columbians should also be accessible to deaf and hard of hearing people and cited the Canadian Charter of

Rights and Freedoms.[4] An interpreter is key as they clarify everything in a medical appointment, and an appointment without an interpreter is pointless.

The participants in Prince George also stated that patients should be provided with an explanation if they are not going to receive an interpreter for a medical appointment - is this because no one is available that day, or because that type of appointment is not covered, or that something else might be covered instead.

In the online survey responses, one participant mentioned that deaf clients should be kept apprised of the updates to the booking process through regular updates via text messages or video calls.

THE ROLE OF A DEAF INTERPRETER

The role of Deaf Interpreters was stated as very important multiple times at all engagements events. Participants expressed their concern that the medical community and hearing ASL interpreters often do not understand what a Deaf Interpreter does, and that the common thinking is that a Deaf Interpreter is required in a situation when a patient is not intelligent. This notion is wrong. Deaf Interpreters are extremely valuable because they speak the same language as the patient. The participants thought that there should be a clear understanding of the role of the Deaf Interpreter by both patients and professionals (health care providers and hearing ASL interpreters).

A Deaf Interpreter has the language proficiency and in-depth cultural knowledge that allows for understanding nuances that a hearing ASL interpreter often does not have. In any situation where a patient and a hearing ASL Interpreter are present, a Deaf Interpreter can be present to clarify any potential miscommunication. If a medical professional or a patient does not understand what is being communicated, a Deaf Interpreter can be brought in to help with interpreting.

Some participants in Kelowna, Victoria and Vancouver also felt that clients should not be denied service if they request a Deaf Interpreter, and that a deaf client should have the power to pick the type of interpreter or interpreters they would like.

In the Vancouver engagement session, participants also stated that for people in palliative care, there is a greater need for a Deaf Interpreter because people in palliative care often have “sloppy-looking” ASL (ASL that is hard to understand).

Going forward, the participants see the role of a Deaf Interpreter as an important one. Deaf Interpreters can be provided with required training (medical interpreter training and Code of Ethics), and screening, and a team of two interpreters (a Deaf Interpreter and an ASL hearing interpreter) should then be an available option for deaf or deaf-blind clients as this adds the connection with Deaf culture to clients who need it.

USE OF TECHNOLOGY FOR INTAKE

Throughout all engagements, whether related to the intake processes or for a direct connection to an interpreter via video, technology was described as a tool that can augment service as well as a vehicle to achieve access where it is currently limited.

Participants were careful to state that technology can definitely be useful, but the level of usefulness will depend on the individual. Having clear communication with each person seeking care is the best first step whether it is through technology or otherwise.

[4]The section referenced was the Constitution Act Part I, 14: “A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.”

Video Relay Service[5] (VRS) is one of the technology tools that many deaf and hard of hearing patients use for intake (to book an interpreter).

In the Prince George session, however, participants mentioned that many deaf people are not trained on how to use VRS and would not have the ability to use it. They asked for a VRS workshop to be hosted in the North as based on the input received, Deaf community members have had opportunities to take the VRS workshops in Vancouver, Victoria, and Kelowna, but not in Prince George.

Deaf-blind engagement participants stated the use of technology for intake is not an option for them. Many of the participants in the deaf-blind engagement session said they are unable to see screens clearly (especially if they are of a small size), so VRS or any other voice to video service would not be an option for many as they could only use a Teletypewriter (TTY).

In the Prince George session, participants mentioned that they frequently use VRS to book interpreters and to get connected to the service office; however, many of the participants in this session think email is the best way to book an interpreter, mainly because then there is proof of communication (a paper trail). Other suitable options with a paper trail would be a TTY, or a fax, especially for community members who don't have access to email. A few deaf people do not have computers or smart phones.

Prince George participants are in favour of the model where the service provider checks on an interpreter's schedule and calls the patient back with availability or confirmation. The intake system should also regularly use videoconferencing technology and the technology should be readily available in hospitals. Hospitals should also provide reliable WiFi so that patients can use technology that supports language access. In some of the remote communities, internet service is an issue. The Prince George hospital has Telehealth and the participants suggest that a similar system be set up in doctors' offices so that deaf patients in Prince George could connect with specialists in Vancouver.

The participants in all the engagement sessions also stated that texting is used more frequently, and they would like it to be a standard option.

In the online survey responses, respondents also mentioned mobile apps (with date, time, location and name of interpreter), text message, video, FaceTime, Google Hangout, WhatsApp, and online forms as the best and most efficient ways to book an interpreter.

SIMPLIFIED PROCESS FOR BOOKING INTERPRETERS

Participants in all the engagements spoke in favour of a simplified process for booking interpreters. Emailing/texting could be a solution to many intake challenges and many participants would like to see doctors' offices use email on a regular basis as phoning a doctor's office requires the help of a family member or someone else. In the Prince George and Kelowna sessions, for instance, the participants mentioned that when phone services with long automated messages and telephone trees (with "press one," "press two" instructions) can cause a lot of frustration. Many deaf-blind, deaf and hard of hearing people depend on text and email.

Furthermore, the participants mentioned that it should easier for patients to book interpreters. Deaf, deaf-blind and hard of hearing persons should be able to call and book their own appointments. They might have an interpreter that they want or prefer, and if that interpreter is not available, the information should be

[5] VRS enables Deaf or Hard of Hearing Canadians who use ASL or LSQ to make telephone calls via Internet-based videoconferencing technology to connect to a sign language interpreter, who provides real-time interpretation of telephone conversations.

immediately accessible. One suggested option is to have a pool of interpreters whose availability is viewable online by those requiring their service.

In the North, many of the community members rely on family members for interpreting.

In the online survey responses, for information required by health providers when booking interpreters, the respondents also added that health providers should know the language preference, gender preference, and interpreter preference (as well as knowing that the loop should be closed with the patient that/if an interpreter will be booked) prior to booking an interpreter.

AVAILABILITY OF INTERPRETERS

Participants across engagement sessions spoke about times when they had interpreters booked for their medical appointments, but then their interpreters were "pulled last minute for a more urgent task."

Participants expressed their dissatisfaction with such situations and described in length the challenge this created. Participants asked for back-up interpreters so that everyone's needs are met.

Online systems and apps would be very useful, but the key issue is often availability of interpreters. Online tools would not be helpful if there are not enough interpreters for each assignment.

Overall, it was felt that more interpreters need to be trained and available. It was also suggested that the provincial medical Sign language interpreting service provide funding for more interpreters.

RURAL AND REMOTE AREAS

In the engagement session in Prince George, the availability of interpreters or lack thereof was a theme that came up in relation to all the questions posed, and in all the participants' input.

There is a general sense that other parts of British Columbia receive good service, but that everything stops in Kelowna and the North is forgotten. The participants have called for a better, more equitable system. Some of the participants mentioned having to go to Vancouver for medical appointments to receive interpreting services.

Many of the community members who used to live in Vancouver spoke about the big difference in service levels between the two communities.

Often, in Prince George, interpreters are booked for several appointments at the same time, so there can be scheduling conflicts. In addition to this, participants are unable to connect with the interpreting service provider, and it can be up to three to five weeks until they hear back or can book an interpreter.

The participants would like to see the acknowledgement of the geographic challenges in the North and for establishment of Prince George as a hub for Sign language interpreting in the North. Patients from the communities north of Prince George go to Prince George for services and setting up Prince George as a hub would address the need for these essential services.

The availability of interpreters in rural, remote and isolated communities was brought up at other engagement sessions as well.

The participants would like a solution to this issue and would like to be provided with more information about the availability of interpreters in rural and remote communities. The participants asked to receive lists of names of interpreters in rural and remote communities, information on how to access interpreters, and information on how to use Video Remote Interpreting (VRI) and have the option to use VRI.

For interpreting in remote communities, a patient currently needs to phone in the service in Vancouver, and request that an interpreter be sent to Prince George (an interpreter would need to fly to Prince George). VRI could be of assistance when an interpreter cannot be arranged.

In all the engagement sessions, overall participants agree that small, rural and remote communities have no interpreter resources, and as areas that are lacking in these resources, rural and remote areas need to have a greater access and funding for VRI and other assisting technology.

INFORMATION ON THE MEDICAL RECORD

The participants in all the engagement sessions brought up examples from other countries and efficiencies in other countries' health care systems (New Zealand, for instance), where information about a patient being deaf is identified right away, and interpreters can be booked and ready for a medical appointment.

The participants in all the sessions felt there was a need to identify a patient who is deaf on the medical record and by not doing so; there is a safety risk for deaf patients.

The participants in the deaf-blind engagement thought that the intake system should be similar to the intake system in Toronto, Ontario, where if a patient needs an interpreter last minute, the database already has information about the deaf patient stored, and the needs of a deaf/deaf-blind person are known ahead of time. This makes the process efficient as it is known in advance that a patient needs an interpreter, and an interpreter can be booked for a medical appointment.

Some participants also stated that the medical record should have information on whether a patient prefers a male or female interpreter.

UNDERSTANDING DIVERSE COMMUNITY NEEDS

Diversity in the Deaf, Deaf-Blind and hard of hearing communities was brought up in all the sessions.

The input from the hard of hearing participants indicated that they might not need interpreters if they can lip-read, but if they need to remove their hearing aids (surgery is one such example), they would need to rely on an interpreter for assistance.

In the Vancouver and Victoria session, diversity was mentioned in the context of deaf people who are deaf-blind, new immigrant and people of colour facing greater barriers to health care access.

In the deaf-blind session, the participants spoke about the difference between patients with tunnel vision, and patients with no vision, and how large printing and large screens with VRI might work for patients with tunnel vision but would not benefit at all deaf patients with no vision.

Participants in the Kelowna session addressed the range in English reading fluency between community members. While some Deaf community members are not fluent readers of English, others might have graduate degrees and be very well versed in reading and writing English.

In Victoria, the focus of the discussion on diversity related to Indigenous deaf patients and their level of comfort with interpreters who are generally not of First Nations descent and have very limited understanding of First Nations' cultures.

It is important to note that there is a wide range and many variations in the needs of the Deaf, Deaf-Blind and hard of hearing community members. This must be one of the key considerations in the design of the interpreting services program.

TOPIC 2: DISPATCH

On the topic of DISPATCH, the participants were provided with the following information:

> *"DISPATCH is a process in which an interpreter is matched to a request. Selection of an interpreter is based on availability, geographic location, their interpreting skill and the client's preference. Dispatch also tells the client who the interpreter is, and when an interpreter is not available."*

The participants in all the engagement sessions were asked the following questions:

> *"What is the best way to dispatch interpreters? Please give examples of when you were satisfied with the dispatch service.*
>
> *What is the best way to handle requests that were not met (when an interpreter is not available)?"*

The input received could be themed as follows:

INTERPRETER MATCHING AND ASSOCIATED CHALLENGES

Based on the input received from the participants in the engagement session in Kelowna, Sign language abilities vary from interpreter to interpreter and as ASL is a second language to almost all hearing interpreters, many of them naturally use "broken ASL." Even when an interpreter has a high-level of ASL that interpreter might not be understood by deaf people if deaf people are not signing the same way.

ASL interpreters need intensive training, and skilled freelance interpreters should receive incentives to pursue medical interpreting certification. The goal should be to have more ASL interpreters graduating from Sign Language Interpreting programs and pursue certification to qualify as medical Sign language interpreters.

An interpreter needs to be able to match the language of the deaf client. An interpreter should also be able to evaluate the English language skill level of the deaf patient and adjust accordingly.

In Prince George, the availability of interpreters was the main concern. In general, in rural and remote areas, options are limited and deaf persons might not have the luxury of being selective about their choice of interpreters.

The participants also suggested that because there is a lack of interpreters in the North, the medical community should be provided with the required education in order to be able to assist patients.

The participants, in general, believe that the role of the dispatcher is very important as the dispatcher needs to understand everyone's unique needs (i.e. whether a person needs an interpreter or an intervenor, etc.). Deaf-blind patients, for instance, would prefer that the interpreter knows prior to the medical appointment that the patient is deaf-blind.

In the online survey responses, however, one of the respondents wrote that the best dispatch scenario is simply when an interpreter is available to accompany a patient to a medical appointment.

SCHEDULING CHALLENGES

Many patients expressed that the time before and after a medical procedure or appointment is equally as challenging for communication and this is why an interpreter needs to be present with a deaf patient from the beginning to the end of an appointment.

In the Kelowna session, the participants spoke about frequent cases where interpreters arrive at the beginning of the session, and then said they needed to leave early for another appointment. The participants expressed

that interpreters need to accompany a deaf and hard of hearing patient for the entire length of a scheduled appointment.

In the Prince George session, the participants said that even though an interpreter might have multiple appointments booked back to back, patients need an interpreter for the entire procedure, and ideally, they would be assisted by the same interpreter for the entire duration of their appointment. At minimum, the interpreters should be present with the deaf patient while the patient is awake (prior to a surgery starting, for instance). A participant explained how there may be a lot of lead-up appointments before a surgery, and that the interpreting service should be provided from the start. Participants explained that a deaf patient would need to see many health care providers prior to the surgery, but they might receive an interpreter only for the surgery (when they are actually not awake for the entire time). Also, if a deaf person does not have an interpreter for the entire time while in the hospital, the deaf person misses a lot of what is going on around them.

Many of the participants across the engagement sessions asked for very specific improvements in the future – making everything accessible by email and text, and having technology ready and accessible so that community members can use a variety of modes of communication.

In the online survey responses, the respondents asked that if an interpreter is not found, the doctor's office should be notified so that the appointment could be rescheduled when an interpreter is available. Another option is to find an interpreter that is available.

Overall, there needs to be an improvement with the scheduling of interpreters, and on-call interpreters should be available at all times.

ABILITY TO SELECT AN INTERPRETER OF CHOICE

The participants spoke about their wish to select an interpreter of their choice. Choice of interpreter should be considered an integral part of the service because it allows for continuity in service delivery. An interpreter's familiarity with a patient's story, medical history or family circumstances also results in higher quality of interpreting and it provides a greater degree of ease between parties. In case a patient is not satisfied with an interpreter, the patient would need to be able to inform the interpreting service provider, and the provider should proactively share information on which interpreter they would send instead.

Participant input also indicated that there should not be confusion on how to book an interpreter and there should be one approach in all communities. Participants stated that they would like to see a database of interpreters, which would also identify the interpreters that are qualified for medical interpreting. Participants also mentioned that they would like to generally have more information and on-going information about the service, especially with regards to new interpreters in the communities.

The participants in the Kelowna session expressed how much of a difference it makes when a patient knows the interpreter. Continuity and an existing relationship with an interpreter are both very important for the quality of service provided.

The participants in the Victoria session expressed that, often, they don't have a lot of choice in terms of which interpreters are available. They stated that deaf people are disempowered, and can only book the interpreter that answers the request first, but some patients, for instance, prefer a local interpreter than someone traveling for an interpreting assignment.

One participant in Victoria also asked that more consideration be given to making sure that an interpreter is the right fit in the case of First Nations deaf patients. A patient needs to be comfortable with the selected

interpreter, and the patient needs to be given the opportunity to refuse an interpreter if not comfortable with the person selected for the appointment.

Participants in the Deaf-Blind engagement understood the fact that interpreters need to be booked in advance and that booking interpreters last minute may mean their requested interpreter is not available.

HIGH COST OF INTERPRETING IN THE NORTH

In Prince George, the participants spoke about their perception that centres with the biggest population receive more services. If a community has only four deaf people, services are non-existent, even though access is still of crucial importance to smaller communities (places like the Cariboo).

It was further suggested that the manager of the interpreting service provider should visit small towns on a regular basis and deliver information about available services. The sense is that currently in the North, many things get missed.

The participants asked that their voices be heard as they bear witness to the challenges in the North first-hand, and they also requested that community members from Terrace and other smaller communities join the consultation on a regular basis.

The participants also raised the issue of limited funds and how that impacts prioritization or triaging of requests. A surgery might be a higher priority than a routine appointment; therefore, a patient might not receive an interpreter for a routine appointment.

Topic 3: INTERPRETER RESOURCES

On the topic of INTERPRETER RESOURCES, the participants across all the engagements were provided with the following definition:

> *"INTERPRETER RESOURCES is the availability of qualified, proficient and skilled interpreters.*

The participants were asked the following questions:

> *What does an interpreter working in health care need to know?*
>
> *What is your expectation of the interpreter attending a medical appointment with you?"*

The information received could be themed based on the following general areas of input:

QUALITY OF INTERPRETING

Quality of interpreting was a topic that was raised in all the engagement sessions. In general, participants agree that a person that knows basic Sign language is not qualified for interpreting. Interpreters need to have a high level of ASL to be able to interpret for patients in medical settings. If an interpreter misunderstands the information in a medical appointment, a patient could be tested for something they do not have or have a test or diagnosis they do not understand.

In Kelowna, the participants stated that generally the quality of interpreting has improved, but in certain areas, there is still a lack of good interpreters. Participants also mentioned that employers of VRS companies attract highly skilled interpreters and draw on the pool of interpreters that are used for medical Sign language interpreting.

In Vancouver, participants said that some interpreters are just not good at being interpreters; they might have a poor attitude or are not ethically representing the profession.

In both the Victoria and deaf-blind engagement sessions, the participants described a qualified medical interpreter as someone who has completed the medical Sign Language interpreting training, knows medical jargon, understands anatomy, and knows how to explain medical terms.

Overall, the participants stressed the importance of interpreters being regularly immersed in ASL and knowledgeable with regards to medical terminology. The participants also spoke about the importance of adequate payment structure for maintaining the quality of interpreting services.

TRAINING INTERPRETERS

The need for more trained interpreters and for more training opportunities was communicated across all the engagement sessions.

The participants in Kelowna also requested more funding be assigned to training of interpreters as some interpreters require ongoing training to improve their knowledge of medical vocabulary.

The need for more funding for interpreter training was also expressed in the Vancouver session. A hearing person cannot have the fluency and sensibilities of a deaf person. Also, ASL continues to change and it is important that the interpreters are aware of these changes and use updated ASL. Just as other professional designations need to take courses and undergo training at their own expense, interpreters should also take professional development courses as part of the requirement to remain licensed.

As there is more demand for interpreters, there needs to also be more training of interpreters, but also training of health care staff and patients on how best to communicate with the assistance of an interpreter as well as how to communicate when an interpreter is not present.

AVAILABILITY OF INTERPRETERS

Availability of interpreters was discussed in all the engagement sessions (for more on this topic, please see above under Intake; Interpreter Matching and Associated Challenges).

In a number of sessions, the lack of male interpreters was raised as a concern. Participants expressed that when male patients would like to have a male interpreter, they are very hard to find. Male patients need to wait for a long time to have a male medical Sign Language interpreter accompany them to an appointment. This is why it would be beneficial for the community to have more men trained as interpreters.

In the online survey, one respondent suggested that the lack of certified interpreters can be addressed by allowing persons skilled in ASL to challenge licensing tests, and by offering incentives similar to the ones offered to trades' apprentices. This can also be done by making training more accessible by offering it across the province, as night or evening classes, and/or distance education.

There was also a suggestion to potentially have interpreters ranked. For example, highly skilled interpreters can be reserved for complex interpreting situations, while less skilled interpreters can be booked for routine appointments.

QUALITIES OF A GOOD INTERPRETER

For the participants across the engagement sessions, it was important that medical Sign Language interpreters:

- are qualified

- go through medical interpreting screening
- have their background checks done by the time they are hired
- understand the health care system
- are well-versed in medical terminology and are able to make the terminology culturally relevant
- communicate if they are qualified to be interpreting for surgery (especially important for new interpreters)
- know both the rights of the Deaf, and their own rights
- have an awareness of the Deaf community and Deaf culture
- follow the Code of Ethics
- understand Indigenous culture and the unique gesturing that is part of the culture
- have a cultural connection with Indigenous people.

Across the engagement sessions, there were certain additional aspects that were important to the participants.

The participants would like to see the following:

- interpreters arriving a few moments before the medical appointment to get to know the patient
- interpreters staying for the entire length of appointment
- continuity with same interpreters booked for certain appointments (for safety reasons, it would better to have the same interpreter for a series of appointments).
- interpreters presenting their identity card (with the agency and interpreter name)
- interpreters dressing appropriately (i.e. wearing dark clothes, not wearing distracting jewelry)
- interpreters having their flu shots and other vaccinations to protect patients' health
- interpreters who are courteous, respectful, and respect confidentiality
- interpreters understanding their role and do not overtake the conversation in a medical appointment
- interpreters with the right attitude
- timely and professional interpreters, who are also, if possible, local to the community where they are booked to work.

In the Prince George session, the expectations of interpreters were noticeably less extensive than that of the input received in sessions in other parts of British Columbia. Many of the community members in Prince George attend medical appointments in Vancouver because they cannot access medical interpreting in Prince George.

In the online survey responses, it was also stated that interpreters should be confident enough to ask questions if they do not understand what the health professional is saying.

TRAINING LOCALS IN THE NORTH

Many of the participants in the Prince George session said that the service provider in Prince George needs to be creative with the resources they already have and provide local people with training.

For example, participants thought that for emergencies, the community could rely on assistance of local people who can sign well. The concern is that these people may be hesitant to provide interpreting services because they may be worried of being sued or not wanting to make an error in a medical setting. Participants suggest that people with the ability to sign should be provided with adequate training to become more proficient and feel more comfortable.

Several participants, however, would prefer to have interpreters from Vancouver because the community in Prince George is small, and for confidentiality reasons, the participants said that they would prefer to have interpreters that they did not grow up with; their preference is to have interpreters they do not know.

TOPIC 4: HEALTH CARE PROVIDER EDUCATION

With regards to HEALTH CARE PROVIDER EDUCATION**,** the participants in the engagement sessions were provided with the following definition:

> *"the health providers' awareness about available resources – understanding that interpreters are available, how to arrange for interpreters, and how to communicate with patients who have an interpreter."*

The participants were asked the following questions:

> *"Based on your experience, what does a health care provider (i.e. doctor, nurse, etc.) need to know to ensure that deaf, deaf blind or hard of hearing persons receive timely and appropriate care? In which settings have you had the most challenges in accessing service?"*

DEAF AND DEAF CULTURE TRAINING

Participants across the engagement sessions said that medical professionals need to understand the role of the interpreter, and there is a difference between deaf, hard of hearing, deaf-blind patients, as well as a great deal of diversity in the Deaf, hard of hearing and Deaf-Blind community.

Medical professionals also need to know they are unable to just talk to a deaf person. They need to know that to establish first contact and communication, they can try to write or use pictures. For a more meaningful conversation, however, an interpreter needs to be present. An online survey respondent also added that health professionals should wait for an interpreter before starting to speak to a patient.

Medical staff should also be trained on how to initiate communication with a deaf person. An option is to use an iPad to write down questions. For this reason, it is important for hospital emergencies to have iPads available.

The participants in the Kelowna session said that they have issues with doctors who insist on writing notes instead of booking an interpreter. This approach is not serving the deaf client as it does not enable clear communication.

Medical staff should also know that a 10-minute appointment is not sufficient for a meeting with a deaf, deaf-blind or hard of hearing patient. Interpreters are a little behind the spoken language, and a 10-minute appointment feels very rushed with interpreting. A 20-minute appointment is better suited for deaf and deaf-blind patients. It should also become common knowledge that it is inappropriate to rely on family members to do the interpreting.

Medical staff, and especially emergency personnel should take Deaf culture sensitivity training, and the training should happen every few years.

In the deaf-blind session, the participants said that medical staff needs to know the basics of how to communicate with deaf-blind patients, such as use dark ink and make their printing really big.

In Prince George, participants also thought that medical staff should be encouraged to learn ASL, and that a doctor or any other medical professional should know that they should be addressing a patient, and not the assisting interpreter. Patients should also be addressed with professionalism and with patients' confidentiality in mind.

It was also stated by the Vancouver participants that deaf persons should be ready to request an interpreter and have the information on how to request an interpreter ready to be presented to health care staff (in the form of a key chain tag, a card, or another tool).

INDIGENOUS PATIENTS

Based on the input from an Indigenous participant in Victoria, Indigenous patients need to be able to trust medical interpreting services, and especially so for services such as surgery. Currently, First Nations patients are unable to fully trust interpreters as they are generally White or Asian, and there are no Indigenous interpreters available.

The suggestion is that when a person is going for a surgery, and an interpreter is hired, an Aboriginal Provincial Liaison (APL)[6] should also be involved to help coordinate and ensure that people from indigenous communities are feeling comfortable. Aboriginal Liaison workers are part of the health care system and interpreting services could work more closely with this program. Provincial Language Service and APL program should, in general, work closely together. This would provide Provincial Language Service with a better understanding of the Aboriginal health coverage. In addition, APLs could visit Indigenous communities and educate individuals in those communities on the interpreting services that are available. Also, in emergency situations, Provincial Language Service working with APLs would ensure that information gets appropriately passed around. This would, overall, improve the service and Indigenous patients would face fewer barriers and receive better care.

Also, when a First Nations person is flown to Vancouver General Hospital (VGH), there should be a support system in place for this person like access to the Aboriginal Liaison Workers within the Health Authorities.

ACCESS TO INFORMATION IN AN EMERGENCY

Communication in an emergency was raised as a major issue across all the engagements, including the online survey.

The participants in all the engagement sessions asked that information on how to access an interpreter be easily accessible in all emergency departments. This should also be further supported by introducing care cards that carry crucial information – that the patient is deaf and requires an interpreter.

Patients gave examples of going to the emergency and being met with the emergency department staff not knowing what to do.

Some deaf people have a card that specifies the patient is deaf, but not all deaf persons have been issued such a card.

Hospital staff needs to be prepared to communicate with patients who are deaf, deaf-blind and hard of hearing, and ideally, hospitals would have an interpreter available at all times. Before an intervenor or an

[6] Aboriginal Provincial Liaisons work as part of the health care team to enhance the health care experience for Aboriginal patients and their families, and to support Aboriginal patients and their families with navigating the hospital systems.

interpreter arrives, emergency staff could have access to a service book (a book with simple questions and images) that could help emergency staff establish the preliminary communication.

Patients in the Kelowna session thought that it is Provincial Language Service' responsibility to inform all the health authorities (as well as clinics and allied professionals) that an interpreter is needed for communication with the Deaf and how to initiate a request for an interpreter.

Information on how to access an interpreter needs to be clear, accessible, and the staff should be able to easily access this information. It was suggested that this information be supplied as a book or a pamphlet. Doctors and nurses need to have it ready ahead of time so that when they have a deaf patient come to the emergency, they are prepared and know what to do.

In the Prince George session, participants said that doctors and nurses need to have a better understanding of the Deaf culture and what it means to be a deaf person, and not expect deaf patients to be able to lip-read.

The participants in the Victoria session asked that paramedics be trained to work with deaf patients as well - what to do and how to communicate with a patient who is deaf, deaf-blind or hard of hearing. The participants also thought that Provincial Language Service has an opportunity to become a leader in the field and provide regular training on how to communicate with deaf patients for health care workforce, emergency professionals, ambulance and firefighters.

THE ISSUE OF HEALTH CARE STAFF TURNOVER

In the Vancouver and Victoria sessions, the participants described the need to educate medical staff as a long-term issue. One of the main reasons for this is the constant staff turn-over. Medical staff attends training, and then new staff are hired and need to be trained all over again.

One of the suggestions to address this has been to put more information on video and invest more funds in resources and materials. Another suggestion was to create policy manuals about Deaf culture and community values, a manual that could be regularly updated, and that all staff would have a responsibility to review.

EDUCATION ABOUT DEAF CULTURE AS PART OF MEDICAL TRAINING

The participants in all the engagement sessions agreed that medical staff need to be trained (and the training should not be optional). This is especially relevant for the workforce in hospital settings.

Participants in the Vancouver and Victoria engagement sessions, and online survey respondents thought that medical schools (such as the UBC Medical School) should make the training part of the medical students' training. When encountering a deaf person, a medical doctor should automatically know to ask: "Do you need an interpreter? Yes or No?"

A small percentage of persons need medical Sign Language interpreting service, so it is easily ignored or skipped, but if medical doctors are required to take the training as part of their medical program, it will have greater importance, and the medical doctors will be better prepared to treat deaf, deaf-blind and hard of hearing patients. In the online survey, one respondent suggested that the training be in the form of a video or training done by a deaf instructor assisted by an interpreter.

In the online survey, it was also mentioned that hospital/healthcare office policies should incorporate a standard procedure on accommodating deaf, deaf-blind and hard of hearing patients.

TOPIC 5: TECHNOLOGY SUPPORTS

On the topic of TECHNOLOGY SUPPORTS, the participants in all the engagement sessions received the following description:

> *"TECHNOLOGY SUPPORTS are used in addition to the services of in-person interpreters. As medical Sign language interpreting services is a province-wide service, and ASL interpreters can be difficult to recruit in rural and remote areas of British Columbia, technology can make interpreting more available. Technology can also help in emergency appointments where the time of the actual appointment is not known in advance."*

The description was followed by the three questions:

> *"Based on your experience, what technology would be required to make medical Sign interpreting more available across the province?*
>
> *How should technology be used for provincial medical Sign interpreting?*
>
> *With the reality of limited funds, is it possible to use technology to increase efficiencies around emergency appointments?"*

The input received was consistent across the engagements.

TECHNOLOGY FOR REMOTE AREAS

If people live in rural areas, VRI should be made available, and hospitals should be prepared to provide strong and consistent WiFi for VRI.

The majority of participants across the engagements felt that technology can be a decent alternative to a live interpreter if health facilities provide the required technology, and if technology is only used until an interpreter arrives or when an interpreter is not available in rural and remote settings.

In the online survey, one respondent also mentioned that VRI interpreters can also be used for last-minute appointments.

TEXTING

Texting is being used more frequently by community members. This was brought up in all of the engagement sessions, and it was also noted in the online survey responses. Texting or email is the best and most efficient way to book an interpreter. This could be either text messaging or using apps like WhatsApp.

LYNC, OOVOO AND OTHER SIMILAR TOOLS

In Prince George, one of the participants mentioned that at the Ministry of Environment, they use a system called Lync[7], which is available all over BC. For the meeting, an interpreter is also invited, and can be set up remotely.

Participants also mentioned video technology and making direct video calls as an option.

Many of the community members know how to use various technologies like ooVoo[8], but some community members cannot use technology and technology changes too quickly for them. ooVoo has been described as very practical, and with capabilities to talk to persons in other countries.

[7] Lync is a Microsoft app that provides instant messaging, audio and video calls, online meetings, availability information and sharing capabilities. Lync was renamed Skype for Business in April 2015.

Skype was another option identified as useful when an interpreter cannot be present in-person.

In the Prince George session, many of the participants mentioned using FaceTime as a very effective tool.

One participant in the Victoria session suggested that a booking app should be developed. This app would ideally provide live updates on interpreter availability and based on the user's geographic location, it would inform a user whether an interpreter is available and allow them to book an appointment.

ASL VIDEOS

Any surveys or written materials that are produced for deaf, deaf-blind and hard of hearing persons need to be accompanied by professionally produced ASL videos.

DEAF-BLIND

Based on the input from deaf-blind participants, it is important to remember that every person has individual needs. Persons with tunnel vision might be able to use VRI, if the signing is presented on a large screen, but would not be able to see it on an iPad or a cell phone. Some people would be able to use it, but would find it extremely tiring and exhausting. At the same time, there are deaf-blind persons who would not be able to use VRI at all. Some can only communicate with the help of a brailler[9], and would find it useful if hospitals had a brailler.

For the deaf-blind who are able to use iPhones, the biggest issue is often the hospital WiFi. It is often weak, and technology then proves to be useless.

VIDEO REMOTE INTERPRETING AND VIDEO RELAY SERVICE

VRI and VRS are both video-based services that enable communication between deaf and hard of hearing individuals and hearing English speakers.

There are significant differences between VRI and VRS.

VRS is a service that allows deaf people to access the telephone system. It allows them to use ASL instead of English to call a hearing person over a telephone line.

VRI is a service where the deaf person and hearing person are in the same room with a videophone. The video interpreter works from another site and uses a videophone or a web camera to interpret the communication between a deaf or hard of hearing person and a hearing person.

Participants in all the engagement sessions said that VRI is easy, fast, and needs to be easily accessible in hospitals/medical settings, so it can be used at any time (and there is no need to go to a special teleconference room). VRI needs to have high-speed internet (with low-speed internet, VRI freezes up.)

VRI is beneficial and can be used in an emergency, but for a deep conversation about a medical condition, a deaf, deaf-blind or hard of hearing person needs a medical interpreter in the room.

VRI would also be very beneficial in rural and remote areas.

Participants mentioned that all doctors who have deaf patients should also be aware of the VRS. VRS makes it easy for a deaf or hard of hearing patient to call and arrange a medical appointment.

[8] ooVoo is a video chat and messaging app used for high-quality chat and messaging with up to 12 friends.
[9] A brailler is a device used for typing in braille.

Several participants suggested that medical Sign language interpreting service could offer on-demand interpreting service that is similar to VRI or VRS – a combination of live interpreting via video phone for people to be able to phone in and receive support. This service could be offered on-demand, in case of an emergency or when an interpreter does not arrive to a medical appointment. Lots of family doctors have computers, so this would be a system that could work quite smoothly. Also, a system like this could be set up as a portable station in the emergency, so that patients could receive on-demand interpreting for emergency situations.

Some participants would, however, rather have a non-qualified interpreter in-person than a certified interpreter via VRI. Some patients are not very comfortable with technology. One online survey respondent said that VRI services should be provided to patients, but this should be secondary to having a certified interpreter on call 24/7 at emergency departments.

TOPIC 6: QUALITY PROCESSES

On the topic of QUALITY PROCESSES, the participants across the engagements were provided with the following definition:

> *"QUALITY PROCESSES give clients an opportunity to provide feedback on the services they receive (an opportunity for clients to submit a comment, feedback or complaint)."*

The participants were asked the following questions:

> *"Based on your experience, what processes are required to maintain the quality of the provincial medical Sign interpreting?*
>
> *What systems are needed, so that clients can provide feedback on the services?"*

The input received could be themed as follows:

NEED FOR A CLEAR AND TRANSPARENT COMPLAINTS PROCESS

The participants expressed that a standard process for complaints is necessary, and the information related to the complaint needs to be forwarded to the one person who has oversight.

Participants also mentioned that currently, when there is a grievance against a doctor, the grievance needs to go up the ladder, and then it becomes adversarial. This is not the best way to file suggestions or complaints.

In the Victoria session, the participants asked for a formalized process. Once a patient files a complaint, it should be written up, and the patient should receive a copy. There should also be one centralized place where deaf people can file a complaint. It was felt that a centralization of the process would help with the collection of data and understanding the areas in the process that will need to be addressed. Every complaint should also be followed by an incident report, and a copy should be given to the deaf complainant.

Overall, participants would like to have a standardized complaints process to ensure the quality of service is maintained. Participants also suggested creating an email address, website, a form, or a specific place or person that can respond to a complaint. Also, it would be good to provide a variety of ways to provide feedback (i.e. TTY), so that everyone has an opportunity to do so.

In the online survey, one respondent called for a "real" complaints process similar to a process for other health care professionals.

RESTRUCTURING OF INTERPRETING SERVICES

Participants in Victoria asked that other models in other countries be more closely studied (such as New Zealand, Arizona, etc.) as this was an opportunity to start from scratch and re-build a new service.

The participants stated that service reviews should take place every four to five years.

In the online survey, one respondent suggested that there should be a neutral web-based grading system set up for interpreters, so that interpreters can be evaluated based on the quality of service provide and compensated based on their evaluations. A system like this would incentivize a customer-focused service.

DEAF PERSON OVERSEEING THE QUALITY PROCESS

A recommendation that came up in all of the engagement was that the provincial medical Sign language interpreting service quality process needs to be overseen by a deaf person.

In the Victoria session, the input was that there should be a committee in place to oversee the work with the deaf, deaf-blind and hard of hearing persons as committee members. The participants thought that this would be an effective model for quality.

The participants in the Kelowna session asked for a Deaf Commissioner - a deaf person who would manage incoming complaints and problems. This person would be working with or at Provincial Language Service, and the role of the Deaf Commissioner would act as a watchdog.

In the Vancouver engagement session, the participants expressed that they would like to see a deaf staff person, someone who would work at the PROVINCIAL LANGUAGE SERVICE office and would help with the decision-making process (it could be a deaf person, two deaf people or an advisory committee). It could also be a Deaf Commissioner. This person/role/body would receive deaf, deaf-blind and hard of hearing persons' concerns and would be key to ensuring that quality of service is maintained. It is important that complaints are received by a deaf person as that person would have a greater degree of understanding of filed complaints.

Whatever system is put in place to establish and maintain quality processes, it is important that deaf community members have an opportunity to speak with someone who is knowledgeable. The process can involve a video phone line with a deaf person on the other end to respond. Also, complaints need to be documented in writing, but communication in general needs to be in Sign language (the person needs to be fluent in ASL). The deaf person in this role would be able to do the processing of information gathering and communicate with clients in the same language. Also, vlogs providing information about the quality processes would need to be in ASL, so that they are accessible to people who speak ASL.

In the Vancouver session, the participants also asked that the provincial medical Sign language interpreting service not be given to a hearing company that has no knowledge of the Deaf, Deaf-Blind and hard of hearing communities' needs. They would like to have a deaf person doing the screening of interpreters and running the service. Also, some participant suggested that the Greater Vancouver Association of the Deaf (GVAD) or the Okanagan Valley Association of the Deaf (OVAD) could collect complaints and report back to the community. Other participants mentioned that there should be a neutral body in the Provincial Language Service office to deal with the complaints process.

In the online survey, one participant suggested that the person hired needs to be someone who can relate to community members, but also knows how to liaise with health administrators.

COMPLAINTS ABOUT INTERPRETERS

Participants in the Vancouver session requested that they be able to put an interpreter on the no-hire list, and that they be given a method to show dissatisfaction with an interpreter directly (and not via the interpreter). Deaf persons need to be provided with confidential ways to share their concerns (by submitting a video, for instance).

In the deaf-blind engagement thought that if the interpreting services were better linked to the hospitals (and information was shared directly between the interpreting service and the hospitals), the service would also be better. The deaf-blind participants also said that if they had an opportunity to connect with the hospital directly about the service they received, they would find that functionality useful (it could be via a website).

CONTINUOUS CONSULTATION

The participants in all the engagement sessions stated that deaf, deaf-blind and hard of hearing people across the province need to be asked for input (and not just a handful of people); there are a lot more people in the community, and Provincial Language Service needs to make sure their voice is heard.

In the Kelowna session, participants acknowledged the opportunity to provide feedback, and asked to be able to provide feedback in a similar way in the future.

Also, some participants suggested that deaf patients be surveyed on customer satisfaction immediately after their appointments. The feedback form could be sent to clients after each appointment, and clients could decide whether or not to respond.

Topic 7: COMMUNITY OUTREACH

On the topic of COMMUNITY OUTREACH, the participants were provided the following definition:

> *"COMMUNITY OUTREACH refers to communicating with the members of the Deaf, hard-of-hearing or Deaf-Blind community so there is better understanding of service expectations."*

The participants were also asked the following questions:

> *"Based on your experience, what is the best way to communicate with Deaf, Dead blind and hard of hearing community members?*
>
> *Should there be an advisory committee or a representative organization such as the Greater Vancouver Association of the Deaf or the Okanagan Valley Association of the Deaf, or is there a different system that you prefer?"*

The input received provided several emerging themes:

DEAF COMMUNITY OUTREACH LEAD

In line with the input received about quality processes, the participants in all the engagement sessions asked for a deaf community outreach lead who would understand what needs to be done to effectively deliver the service. Ideally, it would be a person who is familiar with the community, is knowledgeable about Deaf culture, and the needs of deaf-blind and hard of hearing persons, as well as, someone who regularly checks in on various services to ensure that they are living up to their mandate and are progressive. Some participants thought that it would be at least a team of two people working together.

In the Vancouver session, the thinking was that the Deaf Commissioner would oversee any communication that involves the Deaf and hard of hearing community, and this would ideally be a paid position, and not a volunteer role.

In the Kelowna engagement session, the participants would like Provincial Language Service to make an effort to better understand the community, go to and reach out to communities all over BC, and hear first-hand the input on any potential issues with the interpreting service.

REPRESENTATIVE ORGANIZATIONS

In all the engagements, it was stated that associations can be a good way to establish communication and share information; however, the participants cautioned that associations do not necessarily contact or represent everyone.

A suggestion was for these organizations to work together in partnership (symbolically described as a circle or a medicine wheel): the Greater Vancouver Association of the Deaf (GVAD), the Okanagan Valley Association of the Deaf (OVAD), South Vancouver Island Association of the Deaf (SVIAD), the North Association of the Deaf (NIAD), BC Hummingbird Indigenous Group, Deaf-Blind Planning Committee[10], and possibly other existing organizations. It was thought that an advisory committee with each of these organizations represented would be solid representation of the community; and if an individual had an issue with the advisory committee, they could go directly to Provincial Language Service.

The online survey responses also highlighted the importance of impartial and professional representation of the deaf by the associations.

In the Vancouver engagement session, it was brought up that GVAD does not represent people on the Island, and as there is no representative organization for all of British Columbia, communication would need to focus on sharing information with individuals.

In the deaf-blind engagement session, the participants thought that communicating through the association – the Deaf-Blind Planning Committee - works fine, but it depends on what kind of communication it is. Some of the participants were worried that if information goes through an agency, it takes a while to receive it, and would rather communicate directly with Provincial Language Service.

In Victoria, the input varied. The First Nations representative asked that information be sent via email, and as a Chief she would be able to connect to her community and be an intermediary contact.

On the Island, most of the information is generally sent through the Island Deaf and Hard of Hearing Centre (IDHHC), and the participants do not mind receiving information either via IDHHC or SVIAD. Participants in Victoria were also supportive of an advisory committee if the advisory committee had a representative from each of the geographic areas. It was also suggested that community members could be contacted directly, but in cases of low literacy, individuals might be difficult to contact.

In the Prince George engagement, the participants would like to communicate through their association - the NIAD. Information can be shared with NIAD and they can share the information further, but NIAD would not

[10] GVAD represents the deaf and hard of hearing persons in the Greater Vancouver area, OVAD represents the deaf in the Okanagan Valley, SVIAD represents some of the deaf and hard of hearing persons on Vancouver Island, NIAD represents the deaf and hard of hearing in the North, BC Hummingbird Indigenous Group represents some Indigenous deaf in the Greater Vancouver area and on Vancouver Island, and the Deaf-Blind Planning Committee represents the deaf-blind in the Greater Vancouver area

like to take responsibility for community members not receiving the shared information in cases where community members choose not to attend the NIAD meetings.

With regards to an advisory committee, the participants in the Prince George session were more supportive of a regional role – a person that would connect with groups in the North on a regular basis, and report on the community's complaints about interpreting services. This person would also connect with community members, check in on them, and inform them of new or different services. It could be somebody who would come and visit the North once in a while (everybody agreed with this).

In the online survey, it was suggested that a neutral, deaf-centric committee should work closely with GVAD and OVAD to facilitate communication with deaf, deaf-blind and hard of hearing British Columbians. Any deaf, deaf-blind or hard of hearing persons who are not members of an association would be able to register with the neutral committee in order to have the same access to communication as the members of associations.

WAYS TO COMMUNICATE

For communication, ASL vlogs should be available and are essential. Online survey questions should be available in ASL vlog format (vlogs should be attached to any survey that is produced).

In the Victoria session, it was further recommended that communication be sent through Deaf organizations or Facebook, or via the Deaf BC. SVIAD also has social media channels. Participants, however, thought that a dedicated website would be the best way to communicate – Provincial Language Service can make announcements on the website, and community members can contact Provincial Language Service directly by accessing the website.

In Prince George, the suggestion was for Provincial Language Service to hire an outreach person who would meet with remote communities on a regular basis and distribute information. This would require additional funding, but it would be a valuable service, and the role could also be used for education purposes. The input in Prince George was that face-to-face communication is a better method of communication as Deaf communities like to congregate, participate in person and have town hall meetings. Prince George, for instance, has a regular coffee get-together, which is also another possible venue to share new information.

In the online survey, one person suggested that VRI and/or community meetings as the preferred method for the elderly.

COMMUNITY AND FAMILY OUTREACH AND AWARENESS

The participants in the deaf-blind engagement shared examples of how easy it can be to book an interpreter if a community member or a family member understands the process. The process can be simple, and therefore, family members should routinely be taught how to book interpreters.

Often, family members do not have the required information. The deaf-blind engagement participants also suggested that a booklet with information on how to book an interpreter be produced, so that community members and their family understand what they need to do to book an interpreter. The book/booklet could be used to teach any hearing persons (including medical professionals and family members) how to book interpreters.

TOPIC 8: OTHER TOPICS

Under other topics, the participants across the engagements were asked if there was anything else they wanted to share that would help PROVINCIAL LANGUAGE SERVICE create a successful provincial medical Sign language interpreting service.

The additional input could be grouped under these two general themes:

HIGHER LEVEL OF EDUCATION FOR THE DEAF

In the Kelowna session, the participants also stated that there should be support for higher level of education for deaf people. Currently, the BC Deaf School goes to Grade 3, and there have been a number of cuts in the deaf education.

DEAF REPRESENTATIVES IN GOVERNMENT

In the Kelowna engagement session, participants asked for deaf representation in leadership positions (Boards of Directors, leadership roles, government). Increased leadership representation was described as a way to address the needs of the Deaf, hard of hearing and Deaf-Blind community. All levels of government need to hear the concerns of the community members, and the government also needs to show better support for deaf people working in government.

Appendix C: Key Statements Summary

Based on the input received in all of the engagement sessions, and despite the diversity in the Deaf, Deaf-blind and hard of hearing community and the range of needs between the participants who took part in the engagement, there were several emerging themes. Participants in the engagements provided their thoughts on the future of the provincial medical Sign language interpreting services, and these are the key ideas that could guide the future of the interpreting services:

> ***Key Statement One:*** *Communication, respect and access (to communication) are the three key values that should lead the provincial medical Sign language interpreting services work.*

Communication, access to communication, access to interpreters for the purposes of communication stand out as the key values that are of utmost importance to the deaf, deaf -blind and hard of hearing community members. Without communication, access to health services is at best difficult, and at worst impossible. Lack of communication causes misunderstandings, inability to participate, wrong diagnoses and treatment, and general feelings of disrespect and being unsafe. Respect is another value of utmost importance to deaf, hard of hearing and deaf-blind patients. Often, they feel disrespected by health care professionals.

> ***Key Statement Two:*** *Understanding what services are covered, to what extent, and why or why not services are provided - needs to be clearly and continuously communicated to deaf, deaf-blind and hard of hearing patients.*

Despite the attempts at clarifying what health care services are covered, the system is still very confusing for most community members, and further clarification is needed as to why certain services are covered and others are not.

> ***Key Statement Three:*** *Deaf Interpreters should have a clearly defined role in interpreting, and deaf, deaf-blind and hard of hearing patients should have the option of choosing the services of a Deaf Interpreter in addition to a hearing interpreter (in such cases, the interpreting team would include a Deaf Interpreter AND a hearing interpreter).*

Fluency in ASL can be an issue for hearing interpreters, and Deaf Interpreters can play an important role in bridging the gap. The combination of a Deaf Interpreter and a hearing interpreter can be ideal for complex situations, or where otherwise meaning would be lost.

> ***Key Statement Four:*** *More interpreters need to be trained and certified to work as medical Sign language interpreters across the province.*

Across the engagements, and especially so in Prince George, the participants spoke about the shortage of trained interpreters, and asked for creative ways to address the shortage – by providing training across the province, and especially so in the North; by allowing persons who are fluent in ASL to challenge the proficiency test, by providing incentives for medical Sign language interpreting training, etc.

> ***Key Statement Five:*** *Information about a patient being deaf/deaf-blind/hard of hearing should be on a patient's medical record and accessible by health professionals ahead of time.*

Health professionals need to be prepared for medical appointments – patient medical records should indicate they are deaf/deaf-blind/hard of hearing and that an interpreter is required.

Key Statement Six: *Interpreters should not be double-booked, or book appointments that are tightly scheduled and should remain available for the minimum hours they are paid (i.e. 1 hour minimum or 2 hour minimum). It is expected that an interpreter needs to stay with the patient for the entire appointment as well as for pre and post appointment matters.*

Patients say they are often left without the interpreter that was booked for their appointment due to their scheduling conflicts. Interpreters are booked for a specific time, and often interpreters need to leave mid-appointment because they have another interpreting appointment afterwards.

Key Statement Seven: *The work of the medical Sign language interpreting service should be overseen by a Deaf Committee, Commissioner, or another body that would understand the needs of the Deaf, Deaf-Blind, and hard of hearing British Columbians.*

The stakeholders across the province have spoken in favour of a deaf outreach person, an overseeing committee or a Deaf Commissioner as a way to ensure effectiveness in the future workings of the provincial medical Sign language interpreting service. The prevalent view is that a hearing person cannot truly understand the challenges with access to health care facing deaf, deaf-blind and hard of hearing persons.

Key Statement Eight: *Deaf, deaf-blind and hard of hearing persons should have a greater say in the selection of interpreters for their appointments.*

More consideration needs to be given to whether an interpreter is the right match for the patient – and the patient should be able to indicate their preferences in the selection of the interpreter: male or female, level of skill, deaf or hearing interpreter, ability to select an interpreter that they have had good experience with in the past, as well as if the interpreter is to be accompanied with an Aboriginal Provincial Liaison.

Key Statement Nine: *Emergency Rooms staff need training and information on how to book interpreters and communication tools for establishing contact with patients until an interpreter arrives.*

Emergency Rooms (as well as other responders and walk-in clinics) seem to be the most unprepared to respond to the deaf, deaf-blind and hard of hearing patients. Staff needs to be trained to know how to respond and how to book interpreters, and there should be tools in place – both in terms of technology and materials that would facilitate communication until an interpreter arrives.

Key Statement Ten: *Rural, remote and isolated communities additionally struggle with the lack of interpreter resources.*

Rural, remote and isolated communities, especially the North of BC faces additional challenges with medical Sign language interpreting. Interpreters need to be flown from Vancouver for medical appointments, and patients often rely on family for interpreting. Participants have suggested addressing the interpreter shortage in new and creative ways such as training locals who are fluent in ASL, setting up technology (such as VRI), and providing incentives for interpreters to move to the North.

Key Statement Eleven: *Medical Sign language interpreters have to be qualified, have their background checks done, go through screening, be well-versed in medical terminology, be respectful, have an understanding of Deaf culture and Indigenous culture, understand their role, be timely and professional and follow the Code of Ethics.*

Expectations of interpreters are lower in areas that have fewer interpreters, but overall interpreters are expected to attend professional development training and stay immersed in ASL to keep up with the changes in the language. They are also expected to understand their role as an interpreter and not take over in a

medical appointment. Punctuality is another requirement that is very important to participants across the province.

> ***Key Statement Twelve:*** *Medical professionals need training to understand the role of the interpreter and the importance for effective communication, awareness of Deaf culture, and the basics of communicating with the deaf, deaf-blind and hard of hearing persons.*

Participants across the engagements expressed that medical professionals should learn about Deaf culture and communication with deaf, deaf-blind and hard of hearing persons as part of their medical training. Medical professionals should also understand how to book an interpreter, how to communicate with patients until an interpreter arrives, and to book longer appointments as more time is needed for an appointment with a deaf, deaf-blind and hard of hearing patient. Training for health care professionals should be delivered on an on-going basis to address the issue of staff turn-over.

> ***Key Statement Thirteen:*** *For Indigenous deaf patients, Aboriginal Provincial Liaisons should work closely with interpreters to ensure people from Indigenous communities receive culturally-appropriate service.*

Aboriginal Provincial Liaison program should work closely with the interpreting services program to provide better service for Aboriginal patients.

> ***Key Statement Fourteen:*** *In-person interpreting should be the priority, but technology can be beneficial in emergency situations, for interpreting in rural and remote areas, and for times when an interpreter is not present or is unavailable.*

Technology cannot and should not replace in-person interpreting, but technological tools, such as Video Remote Interpreting (VRI), ASL videos, Lync, ooVoo, Skype, FaceTime, braillers and texting should all be more readily available to enable communication with the deaf, deaf-blind and hard of hearing persons in rural and remote areas, in emergency situations, and to facilitate communication when interpreters are not present. Strong WiFi needs to be available at hospitals and in other medical settings to enable technological tools to work.

> ***Key Statement Fifteen:*** *The provincial medical Sign language interpreting service should have a clear and transparent complaints process, and a variety of ways for submission of input should be available.*

The complaints process needs to be clearly outlined and explained. There needs to be a written record of it, and follow-up. Also, patients should be able to submit their feedback by email, vlog, and an online form.

> ***Key Statement Sixteen:*** *Communication with the deaf, deaf-blind and hard of hearing British Columbians can be directed through representative organizations[11]; however, many deaf, deaf-blind and hard of hearing people do not affiliate with any of the organizations, and therefore, communication should also be shared in many ways (via website, email blasts, snail mail).*

In most cases, participants were satisfied with communication taking place via the established representative organizations; however, communication channels should not solely rely on the representative organizations and should reach wider audiences. Other communications channels suggested by participants across the province were website announcements, Deaf BC website, a Facebook page, or posts in established Facebook groups, as well as a stronger presence in-person, like an outreach role that would attend meetings with community members on a regular basis across the province.

[11] Representative organizations include Greater Vancouver Association of the Deaf (GVAD), the Okanagan Valley Association of the Deaf (OVAD), South Vancouver Island Association of the Deaf (SVIAD), the Northern Association of the Deaf (NIAD), BC Hummingbird Indigenous Group, and Deaf-Blind Planning Committee.

Appendix D: Engagement Plan

*Note Phase 2 expanded to additional communities/workshops