Working With Interpreters as a Team in Health Care (WITH Care) Curriculum Tool Kit for Oral Health Professions

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Abstract

Introduction: Limited English proficiency (LEP) patients face multiple care barriers and disproportionate risks for communication errors. Working with trained interpreters as a health care team can improve communication and drive high-quality care for LEP patients. Simulation and interprofessional education provide key strategies to address the critical training gap that exists at the intersection of patient safety, interprofessional practice, and cultural competence. Methods: Using action research principles across 16 months, we created a 3.5-hour simulation-based training for oral health and interpreting learners. The curriculum included profession-specific orientations with didactic and experiential content, three immersive simulations using start-stop-rewind methodology, virtual scenarios, and summary reflection discussions. A comprehensive tool kit facilitated curriculum implementation and standardization. Results: Forty-nine students from dentistry (first- through third-year predoctoral), dental hygiene, and dental therapy participated in this elective training during the 2017-2018 academic year; as required training, 126 third-year dental students participated in fall 2018. Students’ familiarity with provider and interpreter best practices, appreciation of challenges faced by LEP patients, and confidence in skills working with spoken language interpreters increased. For all evaluation parameters, pre- and postsurvey ratings were statistically significant (chi-square tests, \( p < .001 \)). Discussion: The curriculum efficiently and effectively develops oral health and interpreting learners’ abilities to work as a team with LEP patients. Curriculum design and resources address key barriers to feasibility and sustainability. The curriculum informs communication across all patient populations, revealing that getting by with partial understanding can be insufficient for any patient and any health care team.

Keywords
Editor’s Choice, Patient Safety, Communication, Simulation, Health Care Interpreting, Limited English Proficiency, Interprofessional Education, Standardized Patients, Cultural Competency, Dental Education, Diversity, Inclusion, Health Equity

Educational Objectives

By the end of this training, learners will be able to:

1. Articulate the value of working with a trained interpreter in the patient-provider-interpreter relationship.
2. Articulate the complexity of the patient-provider-interpreter relationship.
3. Describe challenges for limited English proficiency (LEP) patients in accessing and receiving health care.
4. Identify challenges and complexities of working as an interpreter in patient encounters in oral health care.
5. Identify challenges for oral health professionals in providing care in interpreter-mediated patient encounters.
6. Articulate ethical and legal implications of providing care to LEP patients without trained interpreters (for oral health learners only).
7. Use the INTERPRET framework to work more effectively with interpreters (for oral health learners only).
8. Interpret common dental terminology and concepts in the patient’s spoken language (for interpreting learners only).

Introduction

Effective communication is central to providing safe, high-quality care for patients. Communication problems have been attributed to the majority of serious adverse events and poor outcomes, and not surprisingly, limited English proficiency (LEP) patients experience a significantly higher proportion of adverse events causing harm, are negatively impacted more frequently by
communication error, and experience more serious harm from those errors than English-speaking patients. Medical errors have a profound impact on the health care team as well; team members can become the second victims.

Health care professionals often employ a variety of strategies to get by without the use of a trained interpreter, including using family members or friends, untrained staff, or providers with limited skills in the patient’s language to provide patient care. Some do not use an interpreter at all. This creates opportunities for misunderstanding, omission, and error that increase threats to patient safety.

For LEP patients, trained interpreters provide the safest communication experience and are linked to the highest patient experience ratings and care outcomes. However, the presence of a trained interpreter does not assure the essential team performance at the foundation of high-quality patient care. The type of team performance required to mitigate risk and reduce adverse events requires a deeper understanding of how to work together, through an emphasis on the coordination between team members and on the integration of all team members as equals. It requires approaching the problem with the expectation that the interpreter is truly part of the health care team.

A critical training gap currently exists at the intersection of patient safety, interprofessional practice, and cultural competence (Figure 1), and addressing this gap requires developing health care teams that can work together effectively. To do that, training needs to target key power differentials currently inherent in the patient-provider-interpreter triad. The expectations and preexisting perceptions of each team member, including the patient, impact how they each seek help and speak up about concerns, which has profound implications for how care is provided. As a profession, interpreting currently lacks recognized national program accreditation for all languages and a clear national regulatory framework, and the ad hoc work structure for many interpreters also leads to significant differences in pay among providers on the health care team. Additionally, interpreters are often from the same marginalized communities as the LEP patients. These factors can contribute to a false sense of inferiority on the part of the interpreter—in the eyes of both the health care provider and the interpreter. Perhaps more importantly, the LEP patient is often disempowered to speak up in the triad although he or she has the key answers necessary for safe, high-quality care. The desired goals of improved teamwork through training can only be achieved if professional identity and hidden status are explicit from the start.

Creating an interprofessional education (IPE) context to understand and address this training gap can provide an important contribution to existing curricular innovations. IPE principles frame an approach that addresses patient safety, team coordination, and underappreciated power differentials in the patient-provider-interpreter team. This can help equalize interpreters’ status as team members, cement a professional identity in their own eyes, and elevate expectations about what interpreters can do. Interpreting to assure effective communication requires more than simply relaying what is said. Meaning often needs to be negotiated among participants. Furthermore, being able to read silence, body language, facial expressions, and verbal tone and understand or anticipate any communication gap is essential—and with LEP patients, health literacy becomes an even greater obstacle to effective communication. Interpreters can play a key role in bridging the gap from the patient’s lack of experience with health care and serve as a vital advocate for the patient.

Interprofessional training can help disrupt the notion that superficial communication with LEP patients and families is sufficient. Instead of relying on addressing patients’ needs with limited information obtained by getting the gist of what is said, team members can be trained to function in a deeper, coordinated way. They can leverage patient involvement in the delivery of care.

Simulation is a key educational strategy that allows interprofessional training to augment existing systems-based interventions by providing individuals with opportunities to practice working together, apply knowledge and processes,
develop relationships, break down disciplinary silos, and work to provide patient-centered care. The social and intellectual risk-taking required to practice new skills, explore professional relationships, and address power dynamics in the patient-provider-interpreter triad relies on a low-stakes, low-threat environment; this work requires the safe space of simulation. Additionally, simulation can provide deliberate practice through frequent debriefing and repetition of skills. Numerous opportunities for debriefing in simulation also help develop learners’ reflective capacity and ultimately build the habits of mind that are fundamental to changing individual professional practice and team performance.

We developed the WITH Care (Working With Interpreters as a Team in Health Care) curriculum using action research methodology to create an efficient, simulation-based training addressing this critical need for providers and interpreters and to improve care to LEP patients, focusing initially on oral health care. By embracing an IPE approach, we aimed to create a novel curriculum that would uniquely engage interpreting students. Additionally, we aimed to create a comprehensive tool kit that would enable external audiences to easily and effectively implement this curriculum.

Methods

Curriculum Development and Implementation

We developed a simulation-based 3.5-hour foundational training for oral health students and interpreting students on working together as a health care team. The training was developed over a 16-month period (December 2016–April 2018) and evolved through six separate elective iterations using action research principles. This collaborative approach was characterized by a continual process of evaluation and reflection that informed iterative design. Our original work emerged from a partnership between the University of Minnesota School of Dentistry, the university’s simulation team, and a local community college translating and interpreting program and involved the participation of 89 oral health professions students (programs: predoctoral dental, dental hygiene, and dental therapy) and 41 translating and interpreting students.

The developed training was then embedded in the University of Minnesota School of Dentistry as a required curriculum and provided to third-year predoctoral dental students in fall 2018. The required training was offered a total of six times to reach 126 students. Each training session accommodated up to 24 dental students and required four facilitators, three interpreters, and three bilingual standardized patients (SPs). The training utilized three simulation rooms and a classroom in our simulation facilities, although simulation facility features were not required.

Addressing Language Concordance

As an educational strategy and to establish language-concordant patient-interpreter pairs for the simulations, interpreting learners filled the interpreter and patient roles. For the six elective iterations, half of the interpreting learners were trained as SPs to participate in the simulations with a language-concordant peer as the interpreter. Translating and Interpreting program faculty provided extra-credit incentives for their students to participate in this elective experience.

For the six required training iterations, an alternate recruitment strategy assured language-concordant pairs. Trained interpreters served as interpreters in the simulations, with bilingual SPs acting as patients. These trained interpreters joined their patient partner in training to become familiar with the workshop format and content. Several trained interpreters were recruited from the SP program, and others were recruited through relationships with interpreter training programs. Additional recruitment sources were considered but not needed, including local interpreting associations, health care systems’ interpreting networks, international student offices, public school systems, and refugee resettlement or international aid programs.

Training Format

The training began with separate orientations for the oral health professions students and the interpreters. Orientations focused on learning about the other profession and profession-specific frameworks to facilitate interprofessional teamwork. The interpreter orientation also included patient training to achieve desired performance standardization for the SP role; exposure to specialized vocabulary was a simultaneous goal for the interpreter role. In alignment with established best practices, SP methodology was adapted to balance the needs for sustainability and replicability with the rigor of standardization.

Oral health professions students were divided into four groups (with four to six students per group) to rotate through four stations. Three of the stations were immersive simulations of language-mediated interactions with SPs and interpreters and were facilitated in a fishbowl, or hot-seat, format using start-stop-rewind methodology. This format allowed learners to take turns practicing skills, observing peers, reflecting on performance, and giving and receiving feedback. The fourth station consisted of a facilitated discussion of virtual scenarios considering legal and ethical issues in working with interpreters and LEP patients.
After the final station, learners participated in summary reflection discussions, first as uniprofessional groups and then as a full interprofessional group. The training concluded with a short presentation to promote ongoing reflection and transfer to actual care. Figure 2 details the training format.

Tool Kit Resources
We created tool kit resources to standardize the curriculum, provide instruction for facilitators, and enable implementation as an IPE or uniprofessional activity. In considering transferability, we anticipated potential challenges accessing interpreter training programs, SPs, simulation programs and facilities, and other expert knowledge. Facilitation of the orientations, virtual scenarios for discussion, and conclusion was supported through suggested content in the training materials, although additional facilitation strategies and instructions were provided in the tool kit. Simulation facilitation required specific skills and methodological understanding. Thus, we developed materials to support a separate 2-hour simulation facilitator training.

The following tools were used in advance of the training to prepare for implementation:

- The implementation guide (Appendix A) provided an overview of the curriculum and implementation options, instructions for implementing the different training sections, and instructions for facilitators for each training section, which included reviewing some of the materials used during the training (listed below). Within this guide, in-room
reference tools were provided for use during facilitation to simplify station flow and promote learning. The Learner Frequently Asked Questions and Glossary sections provided additional resources facilitators could use at any time.

- The simulation facilitator training presentation (Appendix B) was a PowerPoint presentation with suggested narration provided as part of facilitator preparation in advance of the simulations.
- The simulation facilitation demonstration video (Appendix C) was a video providing additional training activities for simulation facilitator preparation.

The following tools were used during the orientation for oral health learners:

- The orientation for oral health learners (Appendix D) was a PowerPoint presentation for oral health learners with suggested narration for the facilitator.
- The memory exercises (Appendix E) were a text document with two sets of instructions for oral health learners to complete an activity in their orientation.
- The INTERPRET video (Appendix F) was a video presentation of the INTERPRET (introduce, negotiate, treat, enable, recognize, prepare, relay, empower, trust) framework used with oral health and interpreting learners in their respective orientations.
- The INTERPRET pocket card (Appendix G) was a reference tool provided to the oral health learners during their orientations to use in the simulations. The pocket card reviewed the INTERPRET framework.

The following tools were used during the orientation for interpreters and patients:

- The orientation for interpreters and patients (Appendix H) was a PowerPoint presentation for interpreting learners, trained interpreters, and SPs with suggested narration for the facilitator.
- The dental terminology for interpreters document (Appendix I) was a reference tool with common dental terminology provided to the interpreting learners to prepare for and use during the simulations.
- Simulation 1 SP Case: Bad Breath (Appendix J) was a text document provided to SPs and interpreting learners to help prepare these individuals to be the SP for this case.
- Simulation 2 SP Case: Caries (Appendix K) was a text document provided to SPs and interpreting learners to help prepare these individuals to be the SP for this case.
- Simulation 3 SP Case: Wisdom Tooth (Appendix L) was a text document provided to SPs and interpreting learners to help prepare these individuals to be the SP for this case.

The following tools were used during the stations (i.e., the three immersive simulations and virtual scenarios):

- The virtual scenarios for discussion video (Appendix M) was a video presentation of five vignettes for oral health learners to discuss during the virtual scenarios station, with provided responses from professionals in dentistry and interpreting.
- The Simulation 1 learner instructions (Appendix N) were a text document provided to oral health learners at the start of Simulation 1 listing pertinent patient information and tasks for this station.
- The Simulation 1 patient history questionnaire (Appendix O) was a text document provided to oral health learners at the start of Simulation 1 detailing additional patient history information for this station.
- The Simulation 2 learner instructions (Appendix P) were a text document provided to oral health learners at the start of Simulation 2 listing pertinent patient information and tasks for this station.
- The Simulation 2 patient history questionnaire (Appendix Q) was a text document provided to oral health learners at the start of Simulation 2 detailing additional patient history information for this station.
- The Simulation 3 learner instructions (Appendix R) were a text document provided to oral health learners at the start of Simulation 3 listing pertinent patient information and tasks for this station.
- The Simulation 3 patient history questionnaire (Appendix S) was a text document provided to oral health learners at the start of Simulation 3 detailing additional patient history information for this station.

The following tool could be used as an alternate activity to the simulations during the training, as a strategy for utilizing the curriculum despite critical access limitations to language-concordant interpreter-patient pairs:

- The simulation demonstration video (Appendix T) was a video showing a reenactment of Simulation 1 and portions of subsequent facilitated discussions with simulated learners.

The following tool was used during the conclusion:

- The conclusion presentation (Appendix U) was a PowerPoint presentation for all learners to conclude the
training experience, with suggested narration for the facilitator provided to structure this section of the training.

Evaluation Strategy
A pre- and posttest evaluation design was used with oral health professions students across all training implementations. Survey items were developed in consultation with subject matter experts including interpreting, dentistry, and simulation faculty and a program evaluator. Items were further refined based on data collected in early iterations of the training. Surveys included seven items with 5-point rating scales (1 = not at all familiar or not at all confident, 5 = extremely familiar or extremely confident). Evaluation parameters included familiarity with best practices for working with interpreters and LEP patients, experience of LEP patients, and confidence in patient-provider-interpreter communication skills. Descriptive and comparative statistics were used to analyze these data.

Learner Assessment
Learner assessment was formative, consisting of facilitator and peer feedback. Facilitator training materials provided examples of learner performance elements for discussion. Facilitators identified additional dynamics between oral health providers, interpreters, and patients meriting discussion.

Results
As an elective experience, 49 oral health professions (dental, dental hygiene, and dental therapy) students participated in the WITH Care trainings over three offerings during the 2017-2018 academic year. During fall semester 2018, 126 third-year dental students participated in the required training (scheduled in groups of 21) over six sessions embedded in the formal curriculum. Descriptive and comparative statistics are summarized in Table 1 (in Table 1, data from the fall 2017-spring 2018 trainings were reported previously and in full in Quick, Selameab, Woll, Mazzei, and Miller, whereas data from the fall 2018 trainings have not been previously reported). For all evaluation parameters, pre- and postsurvey ratings were found to be statistically significant (chi-square tests, \( p < .001 \)). Students’ familiarity with provider and interpreter best practices, appreciation of challenges faced by LEP patients, and confidence in skills working with spoken-language interpreters increased. These results were consistent across the 2017-2018 elective experiences and the fall 2018 required trainings.

Discussion
The WITH Care curriculum is an effective foundational training aimed at developing oral health and interpreting students’ abilities to work together as a health care team to provide care for LEP patients. Data from the elective sessions verify the effectiveness of the curriculum design, and data from subsequent required training iterations for third-year dental students further establish the training’s impact. Additionally, data from the elective iterations speak to the curriculum’s effectiveness when utilized deliberately as an IPE activity. Data from the subsequent required training demonstrate a similar impact with the uniprofessional training format, using trained interpreters. The curriculum also fulfills key recommendations from the Guide for Hospitals to “develop strategies and systems to prevent medical errors among LEP patients” by specifically addressing training on team communication, interpreter use, cultural competency, and advocacy.

Through action research and an IPE framework, we developed a simulation-based curriculum uniting historically distant professions and transforming training. The integration of multiple educational methodologies supports a vital learner-and patient-centered approach. Key design features enable learners to deliberately practice skills, negotiate relationships between professions, and achieve new understanding of the possibility of team care with the patient at the center. Separate orientations provide just-in-time training content that learners in each profession can intentionally apply during the stations. This content focuses on LEP patient disparities, professional roles, and profession-specific strategies to improve team performance. Reflection and discussion deliberately target these concepts. The fishbowl strategy and use of start-stop-rewind for the simulations are logistically pragmatic for larger groups and also provide essential opportunities for oral health participants to learn through observation. With these strategies, the simulations emphasize skill repetition alternating with continuous feedback from multiple faculty facilitators. These shorter simulation bursts are distinctly different from more traditional simulation uses but are similar to the emerging strategy of rapid cycle deliberate practice. Teaming in this format is different, too, as learners are empowered to provide feedback to one another. Case construction across the three simulations is deliberately complementary. Rather than challenging learners with distinctly different clinical situations, similar learner tasks provide opportunities to use subsequent stations as do-overs to build on skills acquired in the previous station. The virtual scenarios provide a pause from performance to reflect on related legal and ethical considerations, thereby enhancing emphasis on transferability of training to actual practice.

Reflection is a primary feature of the curriculum pedagogy, and its impact is evident in data indicating learners’ responses following
## Table 1. Pre- and Postsurvey Results—Oral Health Professional Students

| Item and Response Level | Fall 2017-Spring 2018 Trainings | Fall 2018 Trainings |
|-------------------------|----------------------------------|--------------------|
|                         | Pre: No. (%) | Post: No. (%) | Pre vs. Post | Pre: No. (%) | Post: No. (%) | Pre vs. Post |
| 1. Familiarity with provider best practices when working with an LEP patient and interpreter | | | | | | |
| Low                     | 30 (61%)     | 1 (2%)       | <.001       | 32 (37%)     | 0 (0%)        | <.001          |
| Medium                  | 14 (29%)     | 9 (18%)      |             | 34 (39%)     | 8 (9%)        |               |
| High                    | 5 (10%)      | 39 (80%)     |             | 21 (24%)     | 76 (91%)      |               |
| Total                   | 49           | 49           |             | 87           | 84            |               |
| 2. Familiarity with interpreter best practices when working with an LEP patient (i.e., how interpreters work with LEP patients and their providers) | | | | | | |
| Low                     | 35 (71%)     | 1 (2%)       | <.001       | 43 (49%)     | 0 (0%)        | <.001          |
| Medium                  | 10 (20%)     | 8 (16%)      |             | 27 (31%)     | 11 (13%)      |               |
| High                    | 4 (8%)       | 40 (82%)     |             | 17 (20%)     | 74 (87%)      |               |
| Total                   | 49           | 49           |             | 87           | 85            |               |
| 3. Familiarity with legal protections for LEP patients | | | | | | |
| Low                     | 42 (86%)     | 14 (29%)     | <.001       | 65 (76%)     | 12 (14%)      | <.001          |
| Medium                  | 7 (14%)      | 17 (35%)     |             | 15 (17%)     | 25 (29%)      |               |
| High                    | 0 (0%)       | 17 (35%)     |             | 6 (7%)       | 49 (57%)      |               |
| Total                   | 49           | 49           |             | 86           | 86            |               |
| 4. Familiarity with health disparities experienced | | | | | | |
| Low                     | 29 (59%)     | 6 (12%)      | <.001       | 50 (58%)     | 6 (7%)        | <.001          |
| Medium                  | 15 (31%)     | 19 (39%)     |             | 25 (29%)     | 23 (27%)      |               |
| High                    | 5 (10%)      | 24 (49%)     |             | 11 (13%)     | 56 (66%)      |               |
| Total                   | 49           | 49           |             | 86           | 86            |               |
| 5. Familiarity with patient safety issues with LEP patients | | | | | | |
| Low                     | 41 (84%)     | 6 (12%)      | <.001       | 49 (57%)     | 2 (2%)        | <.001          |
| Medium                  | 6 (12%)      | 16 (33%)     |             | 31 (36%)     | 14 (16%)      |               |
| High                    | 2 (4%)       | 27 (55%)     |             | 6 (7%)       | 70 (81%)      |               |
| Total                   | 49           | 49           |             | 86           | 86            |               |
| 6. Confidence with leading a patient encounter with an LEP patient and interpreter | | | | | | |
| Low                     | 25 (52%)     | 0 (0%)       | <.001       | 20 (23%)     | 1 (1%)        | <.001          |
| Medium                  | 15 (31%)     | 10 (20%)     |             | 32 (37%)     | 4 (5%)        |               |
| High                    | 8 (17%)      | 39 (80%)     |             | 35 (40%)     | 81 (94%)      |               |
| Total                   | 48           | 49           |             | 87           | 86            |               |
| 7. Confidence with employing provider best practices for patient encounters with an LEP patient and interpreter | | | | | | |
| Low                     | 35 (71%)     | 0 (0%)       | <.001       | 32 (37%)     | 1 (1%)        | <.001          |
| Medium                  | 11 (22%)     | 12 (25%)     |             | 30 (35%)     | 6 (7%)        |               |
| High                    | 3 (6%)       | 37 (75%)     |             | 25 (29%)     | 79 (92%)      |               |
| Total                   | 49           | 49           |             | 87           | 86            |               |

Abbreviation: LEP, limited English proficiency.

*Rated on a 5-point scale (1 = not at all familiar or not at all confident, 5 = extremely familiar or extremely confident).

*n Dental (n = 48) and dental hygiene or dental therapy (n = 1) students—all years participating in final three iterations of the elective training.

*Year 3 dental students (n = 126) participating in required training embedded in the predoctoral curriculum.

the training. Their self-reported increases in knowledge and skills concerning interpreting and interprofessional teamwork suggest a transformative shift from unconscious incompetence to awareness of their limitations—that is, a new realization for learners about what they did not know, what they still do not know, and what they have just gained. The integration of facilitated reflection provides the key modeling that Epstein suggests is required for developing mindful practice. Mindful practice—developing the habits of mind to continually examine one’s actions and thoughts—is integral to being aware of one’s own strengths and limitations, biases, and values. Mindfulness is key to adapting one’s functioning as a team member. Using an IPE intervention to address the training gap in providing safe, high-quality care to LEP patients achieves unique and essential outcomes. This IPE training helps surface the role and identity of the interpreter, which have a central impact on how these teams function. Confronting individuals’ expectations and addressing value and status require more than telling people to speak up or declaring their equality on the team; they require practicing those behaviors and receiving feedback confirming their effect. The training establishes a shared mental model for interpreters and oral health learners and identifies patient safety as their common goal, helping break down professional silos that can prevent cooperative learning.
The development of this curriculum as an interprofessional endeavor from its inception has also resulted in key discoveries. For our research team, no single profession held all the answers. Instead, design decisions and content choices were discovered through true research collaboration. Our vision of distinctly separate uniprofessional and interprofessional training formats has been challenged. That is, the process of the oral health and interpreting participants practicing skills and reflecting together has blurred any distinction between professional and trainee. By embracing a stance of reflective inquiry, we are all professionals and learners simultaneously. Thus, even when trained interpreters participate in the required trainings (i.e., instead of using learners in training programs), the interpreters’ understanding of the patient-provider-interpreter team is expanded—they, too, are learners. Similarly, facilitators who are seasoned faculty members experience important discoveries by using genuine inquiry to explore team dynamics in simulations. Learning from, with, and about one another can transform how we work together, both as learners and as professionals.

Many concepts about effective communication uncovered during these trainings are applicable across all patient populations. The simulations shed light on problematic choices made by oral health learners to limit communication with LEP patients for efficiency and revealed learners’ deeper assumptions about what the patient actually understands and needs to know. This hidden curriculum addresses patient-centered care and reveals not only where communication can derail but also that getting by with partial understanding can be insufficient for any patient.

Expanding the audience for this training was an initial goal. The comparability of learner evaluation data across the elective and required iterations points to the applicability of the curriculum for a range of oral health learners and training levels. The successful implementation of the IPE format (i.e., using interpreting students) and the uniprofessional format (i.e., using trained interpreters) also supports broader utilization for interpreter training. Additionally, this curriculum does not require any prework for any participant, including SPs. All knowledge content is deliberately embedded in profession-specific learner orientations, resulting in one efficient training experience.

Curriculum design and tool kit resources also address key barriers to feasibility and sustainability in order to enhance replicability with external audiences. Training presentations and videos capture required expertise in dentistry, interpreting, and simulation and minimize requirements for specific facilitator expertise. Successfully using trained interpreters and other bilingual individuals as SPs helps address language-related recruitment challenges. By adapting SP methodology to meet these unique training needs, we have been better able to accommodate the range of SPs’ experience levels, support any potential lack of SP trainer access, and complete training during limited orientation time—all helping advance SP methodology. Additionally, case materials have been developed to assure ease in SP training and performance while remaining clinically relevant. Developing simulation curriculum dissemination strategies that minimize required resources and expertise is an innovation that supports the advancement of the simulation profession. Despite these adaptations to support implementation, simulation may remain an insurmountable barrier for some audiences. An alternate activity has been developed for groups that are unable to facilitate simulations but that may benefit from the curriculum. Although not equivalent to the live simulation experience, the alternate activity provides video reenactments of simulations and mini-debriefings so that viewers can observe skills in action and reflect actively on the impact to patient care.

The WITH Care curriculum is a formative, foundational training used with learners in oral health professions programs at one university. Although replicability with external audiences was a driver in tool kit development, the curriculum has not been validated in other institutions or settings. Skill transferability to actual patient care has also not yet been measured. Additional advanced training is needed to more fully address deficits in LEP patient care attributed to poor communication.

This curriculum is a starting point for providing essential training to work with interpreters as part of the health care team. This training meets the Interprofessional Education Collaborative competency criteria required by academic accrediting bodies (Table 2). Immediate future directions for this work include expanding training across the professions and adding advanced modules to allow learners to practice increasingly complex and high-stakes communication. Practicing oral health professionals may also benefit from adapting this training. We recognize the significance of work in this domain and acknowledge the need to grow a community of practice and expand the research team beyond our institutions, so that additional interventions can be developed collaboratively. Additionally, initial data collection focused on oral health learner outcomes; paying equal attention to the training impact on interpreting learners is necessary. This work points to the importance of continuing to include interpreters not only on the health care team but in developing training strategies that equally serve the needs of all learners. Together, we can better understand the landscape of training and
Table 2. Interprofessional Competency-Accreditation Crosswalk*

| Profession       | Degree Programs       | Accrediting Bodies                                                                 | Websites                        |
|------------------|-----------------------|------------------------------------------------------------------------------------|--------------------------------|
| Dentistry        | DDS/DMD, DH, DT       | Commission on Dental Accreditation (CODA), American Dental Association (ADA)       | www.ada.org/117.aspx            |
| Medical interpreting | Associate's degree/certified medical interpreterb | Commission on Medical Interpreter Education (CMIE), International Medical Interpreters Association (IMIA)b | www.imiaweb.org                |
| Medicine         | MD                    | Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC) | www.lcme.org                   |
| Nursing          | BSN, MS, DNP          | Commission on Collegiate Nursing Education (CCNE)                                | www.aacnnursing.org/CCNE       |
| Nutrition        | BS, MS                | Accreditation Council for Education in Nutrition and Dietetics (ACEND)             | www.eatrightpro.org/accend     |
| Occupational therapy | MS, OTD               | Accreditation Council for Occupational Therapy Education (ACOTE)                  | www.aota.org                   |
| Osteopathic medicine | DO                   | American Association of Colleges of Osteopathic Medicine (AACOM)                  | www.aacom.org                  |
| Pharmacy         | PharmD                | Accreditation Council for Pharmacy Education (ACPE)                               | www.acpe-accredit.org          |
| Physical therapy | DPT                   | Commission on Accreditation in Physical Therapy Education (CAPTE)                  | www.capteonline.org            |
| Public health    | MHA, MPH              | Commission on Accreditation of Healthcare Management Education (CAHME), Council on Education for Public Health (CEPH) | www.cahe.org, www.ceph.org    |
| Social work      | MSW                   | Council on Social Work Education (CSWE)                                           | www.cswe.org                   |

*All of the professions listed include requirements based on the Interprofessional Education Collaborative (IPEC) competencies in their accreditation guidelines. All information is accurate as of December 2018. Applicable IPEC competencies include Domain 1: Values and Ethics, Domain 2: Roles and Responsibilities, Domain 3: Interprofessional Communication, and Domain 4: Teams and Teamwork [www.ipecollaborative.org].

*There is no officially recognized accreditation body for medical interpreting education. However, there is a nationally recognized certification in medical interpreting, and the International Medical Interpreters Association has begun the process of creating criteria and accrediting medical interpreting training programs within and outside of recognized academic institutions. None of these professional entities have an official relationship with the IPEC.

practice and develop educational opportunities that improve care for all patients.

Conclusion
The WITH Care curriculum is an efficient, effective, and flexible IPE intervention that provides foundational skills for oral health learners to work as a team with interpreters. These team skills are at the heart of effective communication with LEP patients and are essential to improving patient safety and delivering high-quality care. This curriculum not only targets the mechanics of team coordination but also transforms relationships between professions to help equalize critical power differentials and promotes mindfulness across the team. This is the path to safe, high-quality care, and it is training needed across the health care professions.

Appendices
A. Implementation Guide.pdf
B. Sim Facilitator Training.pptx
C. Sim Facilitation Demonstration Video.mp4
D. Orientation for Oral Health Learners.pptx
E. Memory Exercises.docx
F. INTERPRET Video.mp4
G. INTERPRET Pocket Card.pdf
H. Orientation for Interpreters and Patients.pptx
I. Dental Terminology for Interpreters.docx

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