eAudiology: The Perils of Using Untrained Interpreters and Translated Materials with Spanish Speakers

Presenters: Edward Garcia, AuD, Laura Gaeta, PhD

Thank you. So the title is the Perils of Using Untrained Interpreters and Translating Materials with Spanish Speakers. And to this next part, the disclosures. I'm an employee of the California State University of Long beach, and there's another financial or non financial disclosure related to this presentation.

And then I also am employee of California State University in Sacramento, and I have no financial or non financial disclosures related to this presentation.

So the outcomes you're going to describe, considerations when working with Spanish speaking adult patients, list recommendations for creating written materials in the clinic, and we're going to explain the need for and use of interpreters in the clinic.

Some of the terms that we'll be using, Hispanic and Latino, refer to culture and ethnicity, not race. Hispanic, Spanish speaking, country of origin, Latino people of Latin American origin, and Spanish people from Spain.

All right. And so before we begin, we wanted to reference some of those terms because they are sometimes used interchangeably, but they do have different meanings depending on the source material. And so, based on what we're covering in this webinar, the terms that we're going to use are vary based on the context of what we're saying or the source that we're referencing. To frame our presentation around this population, we're going to start by providing some background. In the last 10 years, we've seen a large increase in the Hispanic population in the US in California, where Dr.

Garcia and IR Hispanics have become the largest ethnic group. The majority are from Mexico or have Mexican origin, and the next largest in the US Is the population from Puerto Rico. If you look here across the map, we've seen more growth in the Southern and Midwestern states for the Latino population. And that growth is noted for about half of the states in the United States. Next slide, please.

Thank you. Among Latinos, English generally is not the home language. We also see limited English proficiency in this population. Looking at these figures from the Pew Research center, we can see that the percentages have been increasing over the past few decades with more speaking English proficiency and only English at home and fewer speaking Spanish at home. More data have shown increases in English proficiency.

The most recent Data shows that 72% are speaking English proficiently, compared to 59% in 1980. Next slide, please. And there are also fewer who are speaking Spanish at home, which we saw on that previous figure. And there are also English speaking Hispanics who don't speak any Spanish, but identify with that Hispanic background. Next slide.

Thank you. Despite those increases that we just reviewed, limited English proficiency is still a consideration, as 64% of those with limited English proficiency or LEP, speak Spanish. And as part of legislation like Title 6 and the ACA or the Affordable Care act, discrimination against a person's ability to understand English is prohibited. And this is also true for organizations or agencies that receive federal funding. These acts, though, pave the way for language access for these individuals.

We also see discrimination represented through our professional organization's code of ethics documents. Next slide, please. And so that brings us to the motivation for this presentation. We hope that this first part has introduced you to the population that we're going to be discussing today. And this population's unique needs and considerations are why we wanted to present on this topic.

Those who speak Spanish, particularly those who have liberal English proficiency, are a growing population that deserves attention in the changing landscape of the United States. Dr. Garcia and I have collective experiences with clinic or research that we will share based on what we have learned when working with this population so that we can provide you all with resources and help to increase

awareness on how to better serve these patients in audiology through our oral communication written materials and work with interpreters for oral communication. I will turn it over to Dr. Garcia.

Thank you, Laura. As a clinician for 30 years, working primarily with this population, I'm bilingual. My parents are immigrants. And so I've had a lot of experience watching this evolve over the years. So we're going to discuss a little bit about oral communication.

Okay. So some of the things we'll be covering is interacting and responding to others, asking for help or assistance and how this is affected. Dialectical differences, specifically in these populations, cultural factors that actually affect our practices as audiologists.

So the effects of cultural values on clinical interactions. Specifically, I'm going to speak to you about. In my experiences now as children and later as adults, we have this thing. We had to respond, it was called, and it was the default response to anyone who spoke to us. It basically means, as you command.

And this is how many Latinos, especially Mexicans, commonly respond. It's still the most comfortable response that I use when I'm speaking Spanish, especially with older individuals, which is most of our patients.

Mexican girls, usually expected to respond this way to everyone except for a child. You don't respond that way to a child, and it would look strange if you did. As children, we knew it was how we were supposed to respond. And it would actually be shocking to hear a young person respond to an adult's request in any other way. And it would be much worse than if somebody just responded, what do you want?

It wouldn't Be that simple, it would be disrespectful and it would actually reflect poorly on the family. It is just much worse than it sounds.

And always responding with mangus that might easily be perceived as negative or excessively submissive to an outsider, but as part of the community, as culturally, we see it very differently. It's tethered to the strength and the pride that comes with those words. It isn't about shame or submission or anything like that. So Ancient Way is a demonstration of respect and a guide on how we're supposed to interact with others. And to some extent, this is the type of formal interaction that Latinos expect in a clinical setting.

That's why everyone's a doctor or a doctora, and it's just inherent into the interaction interactions that we have. So some personal observations from 30 years of doing this. Over the years, I've noticed that there's a common mentality among my patients. I call it maguanto, which roughly translates to I will tolerate this or no saguantamos, which is we will tolerate it. And the mentality, unfortunately means that complaining is not allowed.

It's seen as negative to complain because the foundation is to suck it up and tolerate it. That's sometimes a problem when there's a clinical complaint. My huanto reflects a common attitude that I've seen towards asking for help in Latino cultures, especially in the Mexican culture. This is often the case in clinical settings when pursuing services for their children. That applies there as well.

I've never questioned why we have the attitude or why it applied to all of us. With Nosa1 Tamos, it's just understood that we would tolerate whatever came along. That's how we were reared. And we're just not supposed to complain. So think of this.

This is when it applies clinically. So in this Mad one mentality, it makes it difficult for many of my patients to seek services. And my experience seeking help may actually threaten the inner strength that

is required to maintain that strict work ethic that's such a big part of the culture. So expecting my Latino patients to simply openly express their needs, whatever they're suffering from the difficulties they're having, it's not realistic. I mean, it might be very simple for someone else from another culture, from another understanding, or someone who's trained to think that should be just as simple as explaining what's going on and your difficulties, and it should be that simple.

But it isn't when it's linked to this. So it's simply to openly express their complaints. Isn't Realistic. And asking them is kind of asking them to deny an important part of the culture, which is to kind of suck it up and be tough. And you'll see this a lot with grown children and their parents.

The parents will come in and say, nothing's wrong, I'm good, I'm fine, I'm fine. And then the daughter or the son will say, no, no, no, you need to tell them what you've been telling me for weeks about the problems you're having, because that's why we're here and you need to talk. And they've told me before just straight out say, look, I just don't want to bother you.

It doesn't have to be logical to me to say, but that's why you're here. No, I understand.

So this work ethnic mentality defines many Latinos culture and also affects how we provide clinical service to these individuals. Individuals who are inherently uncomfortable with sharing their complaints. I think we can start by creating an environment where our clinical interactions are not perceived as complaining, but maybe something more of a casual conversation that's based on mutual respect. You can't draw them out. You have to interact and maybe ask questions and look for responses and guide yourself that way clinically.

Because it's not going to be a check off this complaint kind of thing, it's going to be an interaction. It's really important to create that safe place and to do that sometimes the cultural humility comes into play and that can be interesting. So the effects of country and dialect languages can differ greatly between

Spanish speaking communities. Mexico, Cuba, Peru, etc, they can even differ within those individual communities. And also there's often other indigenous languages that are being spoken in the countries.

There are some individuals who will come from Mexico and their accents perfect, their English accents perfect because their indigenous languages have those phonings. And even though they're very limited proficiency in English, they're English pronunciation could be almost perfect. So there is a lot of other effects and you can't assume things based on the way they produce the words. So Spanish can differ greatly from country to country. A Spanish speaking Peruvian who's in Mexico and asks for a torta wouldn't be expecting a big French bread cut in half with smeared with beans and lots of meat.

They would actually be expecting a dessert. In Peru a torta is a dessert. It is kind of general, the general term for desserts. And a torta in Mexico is the general term for a big sandwich and you just differ in what you put in it. But there's a big Bread and there's beans always, and some cheese.

Other than that, a torta would never be a dessert. And these types of regional dialectal differences can be critical when dealing with a patient's history or symptoms. There is, we'll have more that we'll talk about as far as that goes, especially when you're collecting the history. It is, it's critical that you make no assumptions because it can get, it can get confusing for both you and the patient. So you want to avoid, you might want to avoid the word chambia altogether because in Mexico, Peru, Ecuador, it's pretty much working.

And then, you know, it's used, it's used here in California a lot in different ways, but it means work. But to a Puerto Rican it can mean starting a car or even loading a gun. And in the Dominican Republic, it actually is linked to drug abuse and drug use. So there are some words where they might be very practical words in one country, but controversial or confusing in another. So that's something to consider.

So when using interpreters, a clinician must be aware of how much a language can vary from country to country. So someone not familiar with the different variations of English might think, well, how much difference? How much can there be? English is English. So for example, is it appropriate to use an interpreter from the US to interpret from someone that's in English?

So remember to them, braces, they're not used for their teeth, you know, and they're basically parts of their belts, things like that, calipers, braces, hold up their pants. And cars have boots, not trunks. And there's a few words you really can't use. But if someone had limited knowledge of our language of English, they would assume, well, how much can it differ if you have an Australian or a British, British person helping me with this English speaking patient? And yet it could be catastrophic actually in some ways.

So imagine how important picking the right interpreter can be in a clinical setting for a Spanish speaking patient especially, there's 20 plus countries respect Spanish as an official language. So let me get this over to.

Okay, so Dr. Garcia has covered the oral communication part and now we're going to get into written materials and with both of these you'll see there's a lot of commonalities in terms of being mindful of the population that is actually reading or who you're speaking to for those materials or for that communication. The next slide please. Thank you. So if you're familiar with the healthy people initiatives, you've probably seen that health literacy has been a component for the Past few iterations, however, 2030's version has further defined health literacy and broken it down into these two main categories, personal health literacy and organizational health literacy.

With both of these, you can see that they're about health care decision making for individuals. But the organization's part now has greater acknowledgement in its responsibility to address health literacy. Previously, it was more focused on the individual. Next slide, please. Thank you.

Health literacy is an important part of Healthy People 2030 because many Americans have low health literacy. These are a few groups here that have been shown to have lower levels of health literacy, and those with limited English proficiency are part of this list. Couple the limited English proficiency or LEP with older adults and you have a large part of the patients that are coming into audiology clinics like the one that Dr. Garcia works in. Next slide.

Readability is one of the ways that we can address health literacy, and readability refers to the reading grade level that is needed to read and comprehend text. With the average American level at about eighth grade, the national recommendations are just below that at about the fifth or sixth grade reading level. And so for those with low health literacy, such as the LEP population, it's important to make sure that we're addressing readability with the written materials that we provide. Next slide, please.

Now, in audiology, we're limited in the materials that are available in Spanish. In English, though, we've seen that written materials like hearing aid user guides and hearing aid orientation documentation had high readability, meaning that they were at very high reading grade levels and were not suitable because of that readability. The terms that were used, the layout of the text, and the overall scope of the document in Spanish, patient reported outcome measures or PROMs were also found to have high readability, and that high readability in this case is referring to the high reading grade level, so it's more difficult to read. Next slide, please.

Dr. Garcia and I collaborated on a study that evaluated the readability and suitability of Spanish language hearing aid user guides. Because we knew the English ones had high reading grade levels or poor readability and low suitability. We evaluated English and Spanish user guides from nine different manufacturers for custom and behind the ear models of hearing aids. The readability was calculated for each one in English and Spanish using the different readability formula, which we'll cover in a moment, and then we also use the suitability assessment of materials for determining the overall suitability of the

guides.

Next slide, please. Perhaps not surprisingly, we found that there were more English language guides available than Spanish, and reading grade levels were still high and still above that recommended reading grade level of the sixth grade grade. From that we need to develop more materials in Spanish and make those materials have better readability. And that readability is really applying to both languages, English and Spanish. And then when designing those materials, the content, the layout, the design, the readability, all of those things should be taken into consideration to meet the needs of those who have low health literacy.

Next slide. So coming off of that study, here are some recommendations for making your written materials more accessible in terms of readability and health literacy. Use simple short words and sentences just like we would recommend as a communication strategy. Use active voice instead of passive voice. When you're introducing a new term, provide the definition first.

Keep the sentence to just one main idea. For another idea, make it a new sentence. Next slide thank you. Take advantage of white space and use subheadings with bulleted lists. Where possible, use images instead of text.

Try to give instructions with the steps shown as images with captions underneath them. Write in a conversational tone to improve health literacy as the formal or professional tone can make it more difficult to read, it's going to increase the difficulty and the increase in reading grade level that we've seen. At the end of each section, provide a summary or a quick assessment for the reader to check their knowledge. Doing this can also be helpful for determining a patient's self efficacy. And now although these recommendations are for written content, the same suggestions about active voice conversational tone, for example, would apply to any online content and that and that includes videos as well.

Next slide please. For any documents that you create, you can check the readability in Word with its readability functions. Here are the two sets of instructions for both Windows and Mac operating systems to enable it. In both versions, you'll want to look under the Spelling and grammar feature and make sure that readability statistics are enabled so that they appear when you check your document. Next slide.

This is what it will look like once the readability function is enabled and you check the spelling and grammar and this window will pop up on your screen. The bottom part under Readability shows the Flesch Reading Ease and the Flesch Kincaid Grade level. This image shows a reading ease of 58.0 and then a grade level of 10.2, which would be the 10th reading grade or the 10th grade. Next slide please.

So those numbers the the Flesch Reading Ease and the Flesch Kincaid Grade Level are two commonly used measures of readability and reading grade level, respectively. The Flesch Reading Ease is a measure of readability between 1 and 100, with 1 being the lowest and 100 being the highest. In this case, a higher value means the text is easier to read than a lower value. So you would want your text to have a number closer to 100. For the Flesch Kincaid grade level, that is the educational level that someone would need to have to be able to comprehend the text.

So in that previous example when it was a 10.2 reading grade level, that would mean that the person would have to have at least the 10th grade level of educational attainment to understand that text. And so following those earlier guidelines for the sixth grade as a recommended level, you would want that value to be less than OR equal to 6.0. Next slide please.

The Academy has some resources listed here at this link to help you with assessing literacy and understanding in your patients. Keep in mind though, that a person's ability to understand spoken

English does not equate to their ability to understand written text in that language. Those are two independent abilities. You can use the teach back method of having the patient say in their own words what they learned as key points. You can also summarize those key points for the patient and you can give some information in a take home format for later reference.

With all of these areas, base your support and the amount of support that you give on the patient and then tailor it to their needs and Next slide. And this last section for today is about interpreters, and it's one that we will, Dr. Garcia and I will present on together as a combination of research and clinical practice experiences. Next slide please. So interpreters defined is an individual who has received training and is able to convey messages from one language into another.

As the audiologist, you can identify cases where an interpreter is necessary. Doing this though does require advance notice, so be prepared to advocate for an interpreter. Check that they're certified or have undergone training. Schedule additional time for the appointment, arrange the physical space in advance for ease of conversation with the interpreter present. Review your materials and information to identify any key terms and needs for further assessment, and if you can share these with the interpreter ahead of time, that would be helpful for them.

And then also just make sure that you're prepared for any concepts or vocabulary that could have a different meaning by communing your intention for that meaning with the interpreter. Next slide. So interpreting face to face is the gold standard, and that includes when working with patients with hearing loss. Alternatively, those can be done by phone. Other methods of interpreting include these listed here, which is consecutive or when you take turns simultaneous, which is when the interpreter starts talking to the patient after you have begun speaking.

Site translation for documents that the interpreter presents to the patient verbally and then a summarization which is a summary of what was said in general terms without any of the details. Next

slide, please.

There are few bilingual providers in health care, but even more so as a problem here in audiology. There's also a problem having more languages spoken by patients than there are providers available who can speak that language in every site or practice. So this part of our presentation will extend to other languages beyond Spanish. Legally and ethically, as we said in the introduction, interpreters are required for language access. Those regulations are going to vary by state, but are provided, arranged for and vetted by the site at no cost to the patient.

Even if a patient declines an interpreter, it is important that the provider document that an interpreter was offered and the patient's decision to accept or decline was also noted. Next slide, please.

The question of training is an important one for interpreters, as sometimes we can have family members act as interpreters in the absence of one or at the preference of a patient. However, there are noted disadvantages for using a family member as an interpreter bias. A patient's family members may choose not to share the full message or tailor it for what they believe the patient should know, lack of training as an interpreter and their limited knowledge of medical, or in this case, audiology terminology. For trained interpreters, and probably even more so for untrained interpreters, the selection of words that you use is very important. This selection begins with any consent and case history forms and continues with the instructions that you give to the patient and the stimulus that you choose for testing like speech audiometry.

Next slide, please. Efforts to assess health literacy, which we just covered as a way to determine a person's understanding of terminology, have a mate in healthcare. For example, you see here, the salsa s a h l s a 50 is the short assessment of health literacy of Spanish adults. You can gauge a person's health literacy by assessing with this tool and then you could modify your message based on their level within audiology. Dr.

Garcia and I have been collecting some pilot data for a health literacy measure for audiology and otolaryngology terms to use with Spanish speaking patients. We hope to have more to share about that soon once data collection collection wraps up. So stay tuned on that then I'll now turn it over to Dr. Garcia to give us some examples of words and phrases that are part of this measure and how they can be interpreted differently. Okay, thank you, Laura.

So while doing some of this work and some of the research that we did, we found that there was a lot of confusion with the words that were being used.

And I think it's because we were pursuing what would be the correct term, not necessarily the effective term when we were interpreting the. So some of the examples that we had were really basic things like is the hearing loss affecting his speech? The correct term should be habla, but it's not used. So latical, which is to chat or conversad, which is just to speak, to talk. That would be.

There would be alternates. Maybe they wouldn't be the correct term, but they would be the ones that would be more effective. And you have to consider that as someone using an interpreter, you have no idea how the words they're using will work, because that's why you need an interpreter, because you're not aware of those words, you're not familiar with them. So just to give you some ideas, like expose, exposed. So if you say, has the patient been exposed to loud noises?

Expressed was the correct term, which is exposed, exposure, but it's not used. Again, you have to consider the level of education, the health literacy, all these things. So espresso isn't going to be used regularly by these individuals. They will probably use espuesto, which is actually means willing. It just seems like the right word.

But there is. Isn't commonly used. So again, the correct term wouldn't be very useful, simple stuff. And there's different reasons, like with swallow. Swallow is, you know, do your ears pop when you swallow?

The correct term would be when you swallow. That's the correct term. The problem is that it's considered by. Especially by Mexican Americans, it's considered a very crude term for eating. The.

The correct word is tagar. But you're. The response you're going to get is probably going to be. It could be laughter, it could be embarrassment because you're saying basically shove it down your throat. It is a crude way of saying swallow.

And what's used for eating? So probably pasar, saliva, which is to pass saliva or omada, to eat. So do your ears pop when you eat, when you pass saliva? You wouldn't use the word again, would be the correct term, but it wouldn't be very effective. It wouldn't work.

If you have an interpreter that's using correct terms that they may not be very effective. Simple stuff like disorders, they're a neurological disorder. The correct term is trastorno. Again, it's not used a lot. It really is like me coming into a room and saying we can minimize your lumbar pain if you ambulate more regularly.

We wouldn't use words like that clinically for some of the reasons that Laura was mentioning. But if they were to be used literally as an interpreted sentence, it would be a correct sentence. But again, we wouldn't use it in English because it wouldn't be a very effective sentence and it wouldn't be in Spanish either. And that's what you have to look at out for. And all the things that she mentioned is you have to consider everything from readability to health literacy when you're interacting with a patient.

So for, let's see, there's different reasons too. Like oracion is good because oracion is the correct term for sentence. Can you hear the whole sentence? Is there a problem with hearing soul sentences?

Oracion is the correct term.

The problem is no one uses it because especially for Mexican Americans, oracion is prayer. And even though it's the correct term. So an educated person from a Spanish speaking country would know the correct term for sentence. But based on 30 years of interacting with patients, they don't use the word oracion for sentence. They use frase, which is phrase.

Or you get creative, you just don't use the word. It's not going to work. So you say Fraser or something else, even language itself, do you think he has a language delay? You know, something like that, that's hablar. Language should be hablar.

But if you say which sounds perfectly right, that's a style of speaking that isn't language or yoma, that's the language that's being spoken. English, Spanish, for example. Again, that wouldn't be, that wouldn't be work when you're trying to find out that there's a language delay. So again, you have to, like she said, you have to adjust to the individual. You have to assess the capabilities.

And again, you wouldn't say I can minimize your lumbar pain if you ambulate. It's just you wouldn't, you wouldn't use it. Even though most of us would understand what it means, we can't assume that they do. There's especially the really good one for our professions are the fact that no one knows what high pitch or low pitch is. Very, very few Spanish speaking people in most, even in Spanish speaking countries know that agudo is high pitched.

One word means high pitch and grave means low pitch. But there's no way that most first generation people that are maybe interpreting are going to know. That's going to be one of the issues that you're going to deal with when you're using interpreters, which is what we're talking about next. So there's several concerns to consider when using family members to interpret. Keep in mind that it's common for older Latino patients to not want their families to worry.

It's very common using a family member to might cause them to hold back because they know how their family is going to take it. They're going to struggle with letting them know that they've been struggling. Also, there's a strong hierarchy about information in Latino families. It may not be that someone shouldn't know something, but it may be that they shouldn't know before someone else. There's a hierarchy that you know who should be informed first and it would seem disrespectful for them to not know before someone else.

So respect may be what demands that some members be informed before others. And cultural values can affect all aspects of communications. We need to stay open minded and assume very little during our interactions.

Culture humility is, is a tricky thing. And I've interacted with my, my experience has been misgendering people. That has been where I've, I'm, my culture humility has, has really come in lately. I will say, well like he said in the class and then I will just look at their faces and realize that I misgendered them. And so cultural humility doesn't just apply to these things, it applies to so many.

So I know how difficult this can be. But I think if we assess and if we adjust and if we're open minded and ask questions and like they told me, just, you know, apologize profusely when you blow it. Because even things like silence, for example, and Latinas can be complicated to interpret. It very much depends on context. So silence that occurs while individuals looking down or away can actually indicate disapproval, disappointment, even anger.

So silence with eye contact or smell can actually mean the individual doesn't understand. So if I'm speaking to a patient and they smile at me, that's kind of like I'm not sure they hear me, but also I'm not sure if they understood me, but they're being polite about it and it would be rude to say what. And so that's another thing to consider things like as simple as silence, modesty and like humility. Spanish

speakers especially making Mexicans value modesty. So it's really easy to lose these individuals trust if this is overlooked.

And again the culture humility comes into play because I know my beliefs, I know how I would Take something, but I can't assume that they will take it that way. So if you're boasting about your facility and some awards, it probably isn't going to work that way with a 75 year old Hispanic woman. Maybe if you discussed how you've treated other members of the family or how your interactions are with the community, you'll create a safer place and you'll be more effective. Because modesty is something that's valued and so you have to be careful. Again with that.

Because to be effective clinicians, we need to have their trust and it's really easy to create that wall. And most Latinos will call all clinicians a doctor and it's out of respect. They're not naive about education. It's simply a sign of respect and it's an indication of how grateful they are for what you're doing. It's kind of like with the consideration of time.

What I've noticed, and I've had this discussion before where they'll say, okay, but you know, respect for time. And it's interesting because if you're running late and you tell a patient they have to wait for an extra half hour, it also applies there. They'll say no problem, they'll sit and they'll wait an hour, two hours. So it doesn't just apply to scheduling, it applies generally to the way that the culture sees time and including family. Often with Latino families, family, even extended family may want to be involved.

Latino patients of any age might still need family members present when interacting with admission. So if you have a young 25 year old Latina and she says, I can't make a decision about this right now, I have to speak to my parents, it may be simply out of respect. It isn't because they can't make the decision, is that it's disrespectful to make it without discussing it with someone. So we have to be careful to not interpret this behavior as a lack of independence or immaturity as a part of the patient. It is kind of part of the culture to be respectful about making a decision.

Not that you're not going to make the decision, is that you should consult them so that you have their input, because their input is that important. And the spokesperson, so the chosen spokesperson varies among families and it might be based on family norms. It could be a man, a woman, a younger member, or the one that has the most education or influence. I've seen 18 year old young women make all the decisions for the parents and no one sees it. As negative or anything, it is it.

She is the most capable and whether she wants to or not, it's her responsibility to represent the family in that way because she has the ability to do so.

So, in summary, be mindful of communication needs, limited English proficiency, both health literacy. Find cultural linguistically appropriate approaches and material. Seek interpreter for appointments in advance. Be prepared to modify your appointments and content. Have awareness of differences between cultures and languages when using interpreters, including family members.

Thank you.

There's our information and you have anything to say? Laura? No, that's it. Thank you. If you have any questions for either of our presenters today, feel free to go ahead and put them in the chat and they'll answer them for you.

While you're thinking of your question, I'll just go ahead and summarize the CEU information. So just to remind you, you need to do the assessment as well as the evaluation, and those can be found back on the presentation page through the dashboard section of your account on eaudiology. You need to do the assessment and the evaluation in order to get your certificate for CEUS for today's webinar. And again, the verification code is posted in the chat or if you want the live certificate.

Okay, it doesn't look like we have any questions today, so the Academy would like to thank Drs. Garcia and Gaeta for their presentation today and thank you so much for attending.