Health Care Interpreter Services Quality Initiative: Report of Plans for a Registry and Certification

Report to the Minnesota Legislature 2010

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I. Executive Summary

In Minnesota Laws 2008, Chapter 363, Article 17, the Legislature directed the Department of Health (Department) to establish a voluntary statewide roster of all available interpreters to address health access concerns. The legislation also required the Department, in consultation with the Interpreting Stakeholder Group (ISG) of the Upper Midwest Translators and Interpreters Association (UMTIA), to develop a plan for a registry and certification process for spoken[1] language healthcare interpreters. This document details the plan for creation of a registry to promote quality in the provision of healthcare interpreter services.

The following information summarizes the Department's findings and recommendations concerning: 1) the healthcare interpreter roster; 2) the elements for training, education and other standards in a plan for a registry and certification for healthcare interpreters; and 3) the state administration of government systems to regulate quality of spoken language interpreter services.

- In SFY2009, the Department established a voluntary statewide roster for interpreters who provide spoken language healthcare interpreter services in Minnesota. Though the Department estimated 500 healthcare interpreters participating in the roster, at this date about 100 interpreters have applied and are listed as available to provide interpreter services in healthcare settings throughout Minnesota.

- The voluntary nature of the roster has not been effective in obtaining participation of most of the interpreters currently providing interpreter services in healthcare settings. Information from interpreters and interpreter agencies is that there is no real benefit commensurate with the $50 annual roster application fee. In addition, healthcare employers of interpreters, interpreter agencies and current business and market conditions could further encourage or require greater participation.

- The Roster needs to continue to exist to function as a mechanism for including and finding interpreters of less commonly spoken languages in designated geographic areas. The plan for a Registry assumes full participation by interpreters, and Legislature needs to consider methods that will achieve this purpose. In addition, some new requirements for participation in the Roster need to be added such as a minimum age limit and state criminal background check for all interpreters.

- A broad group of Minnesota stakeholders agree on a common set of standards for a registry for healthcare interpreters. Consensus was obtained through distribution and comments on seven successive drafts of proposed registry requirements detailing experience, training, and education and testing. In addition, focus group meetings were held from July through September 2009 with major employers, interpreters and other affected constituencies. Thus, the standards in the plan for the Registry contained in this report have been vetted by interpreters working for major healthcare facilities, free-lance or contract interpreters, interpreters working for agencies, clinic managers and representatives of healthcare plans and managed care organizations. There is broad

[1] The law does not intend to include sign language interpreters for the deaf.

support and consensus for the standards recommended in the plan for a registry described in this document.

- Standards agreed upon for the Registry address language proficiency, medical terminology, interpreting skill and accuracy, ethics and standards of practice. Specific requirements for healthcare interpreters to meet registry standards include an informal, experience-based and temporary method (grandparenting), and a method with minimum qualifications to be met until such time as the requirements and process may be modified to be consistent with national certification standards currently in development.

- An advisory council or board is needed to provide the expertise needed to define, clarify and adjust standards related to the training, education and testing requirements for interpreters of languages for which such measures do not currently exist. In addition to new languages, the geographic distribution of speakers of uncommon languages and interpreters will continually fluctuate, and these factors will also affect roster and registry requirements.

- A plan for Minnesota certification of spoken language healthcare interpreters is dependent on national certification activity, estimated to be completed in one or more years. National efforts to establish standards are just beginning and are underway through two competing initiatives. In addition to setting standards for training and education of interpreters, it is expected that the outcome will be a valid, reliable and defensible certification examination for evaluating healthcare interpreter competency in medical terminology, interpreting skills and ethics.

- If the Legislature enacts standards for healthcare interpreters consistent with its policy in Minn. Stat. Ch. 214, the fees to pay for state agency administration of the roster and registry systems will depend on the number of participants. The Department estimates that the annual interpreter fee could range from $27.00 to $270.00 for the roster and from $76.00 to $760.00 for the registry if as many as 1,000 or as few as 100 interpreters are assumed to participate in the systems.

The plan recommends that the Legislature consider a single agency and administrative system for all spoken language interpreters in lieu of establishing a separate healthcare interpreter registry. A court interpreter registry and a Department of Education list of school interpreters currently exist. One centralized system for all spoken language interpreters is consistent with general principles of occupational regulation, 2009 legislation to fund creation of a common electronic entry point for all Minnesota credentialing activities, and the goals of the Health Department and other state agencies to more effectively address health access issues in Minnesota's minority and ethnic communities. Administration of a centralized system would be carried out by a new independent board or by an advisory council subordinate to an existing agency or licensing board.

II. Background

In 2008 the Legislature enacted and the Governor signed into law the Interpreter Services Quality Initiative.[2] See, Appendix A. The law required the Commissioner of Health to establish a voluntary statewide roster of all available interpreters by January 1, 2009. In addition, it required the Commissioner to develop by January 15, 2010, a plan for a registry of spoken language health care interpreters and a plan for implementing a certification process.

The Interpreter Services Quality Initiative (ISQI) law directed the Commissioner to base the roster and plans for a registry and certification on the findings and recommendations of the Interpreter Services Work Group formed and conducted under Minnesota Laws 2007, chapter 147, article 12, section 13. Findings and recommendations of the Work Group are referenced in this document where appropriate. One of the key recommendations was to form "a statewide registry that identifies and documents spoken language health care interpreters that meet minimal requirements for preparation, skills, and commitment."

The ISQI also directed the Commissioner to develop the plan standards for registry and certification processes in consultation with the Interpreter Stakeholder Group (ISG) of the Upper Midwest Translators and Interpreters Association (UMTIA). The mission of UMTIA is to promote quality and professionalism in the field of translating and interpreting in Minnesota, Wisconsin, Iowa, South Dakota, and North Dakota. The ISG is a committee of UMTIA, and perhaps due to its membership, agendas and activities over the last two years have been almost entirely focused on spoken language interpreter issues in Minnesota and more specifically in the healthcare arena.

During CY2009 and throughout development of the registry and certification plans described in this report, Department staff attended monthly ISG meetings and met weekly with a Roster/Registry Subcommittee of the ISG. As a "working member" of the subcommittee, Department staff contributed to development of the grandparenting and ongoing minimum training and education requirements comprising the standards in the plan for a healthcare interpreter services registry.

The standards for a registry for healthcare interpreters developed by the Roster/Registry Subcommittee were reviewed by Minnesota healthcare interpreter stakeholders through distribution and feedback on seven successive drafts of proposed experience, training, and education and testing requirements. In addition, from July through September 2009 the Department and Subcommittee members hosted focus group meetings with major employers and affected constituencies to present and obtain comments on iterative versions of the proposed registry requirements. Thus, the standards in the plan for a registry contained in this report and have been vetted by interpreters working for major healthcare facilities, free-lance or contract interpreters, interpreters working for agencies, clinic managers and representatives of healthcare plans and managed care organizations. There is broad support and consensus for the standards recommended in the plan for a registry described in this document.

[2] Minnesota Laws 2008, Chapter 363, Article 17, §2; codified at 144.058

III. The Roster of Spoken Language Healthcare Interpreters

A. Development and Participation to Date.
The ISQI required the Department of Health to establish a roster of all available interpreters by January 2009. The Department created a website, online and paper applications and processes and a searchable database.[3] Interpreters in the roster are searchable by language and/or geographic regions in Minnesota. Interpreter names found by a search are each linked to additional information provided by the interpreter and detailing the demographic, contact and healthcare specialty experience of the interpreter. Further development of the database will enable adding interpreter training and education information. Presently, none of the information provided by the interpreters is verified by the Department, and it is the responsibility of the hiring entity to do that.

The ISQI does not require interpreter participation in the Minnesota Spoken Language Healthcare Interpreter Roster (hereinafter, the Roster); it is voluntary. The Roster has been slowly populated by interpreters throughout 2009. The number of healthcare interpreters listed in the Roster was 54 through June, 2009, had increased to 63 on September 30, 2009 and is about 100 as of December, 2009. Though the Department and the Interpreter Stakeholder Group (ISG) have engaged in numerous and various outreach efforts, interpreter participation in the roster is far from the 750 to 1,000 interpreters estimated by the ISG to be working in healthcare settings in Minnesota. Clearly, participation is not at the level expected and necessary for the ISQI to be successful.

Department and ISG review of interpreters currently in the Roster indicates that most are contract or freelance interpreters. It appears that interpreters who have not applied to the roster are those employed in major hospitals and large clinics. Information obtained from directors of interpreter services at these healthcare facilities is that the interpreters do not perceive receiving any tangible benefit in return for the $50 cost. But information from these employers and many interpreting agencies also indicates that these entities have not encouraged or required their interpreters to apply to the Roster, in part because of concern that they may lose their interpreters to other employers or agencies.

The voluntary nature of the Roster and the absence of hiring entity incentives are factors working against accomplishing the goal of creating a useful list of available healthcare interpreters. Some stakeholders believe employers and agencies can do more to prompt their interpreters to participate in the Roster. Employers and agencies are in the singular position of tying their interpreters' compensation levels to participation in the roster. Alternatively, employers and agencies could pay or reimburse their interpreters the annual fee amount. In focus groups convened by the Department and the Roster/Registry Committee over the summer 2009, hospital, health plan and clinic managers stated in the strongest terms that quality standards for interpreters needed to be established in Minnesota as soon as possible. Nevertheless, to some it appears that these hiring entities could do more to support the Roster as the initial and preliminary step to establishing a registry in Minnesota.

[3] Go to: http://www.health.state.mn.us/divs/pqc/hci/index.html

B. Future of the Roster.
As described in the next chapter of this report, the plan for a registry proposes that the Roster would continue to function for two reasons. First, the roster is needed to list interpreters of languages less commonly spoken in Minnesota and for identifying geographic areas in Minnesota where interpreting services for specific languages are less available. Second, over time, languages needing interpreting will change, as will the number and location of populations speaking them. Interpreting services for new immigrants to Minnesota will initially be less available and interpreters for these languages will not likely meet requirements for the Registry for several years.

The Legislature could consider making the following changes regarding the future and ongoing operation of the Roster:

- Require interpreters in the Roster to be at least 18 years of age, pass a criminal background check, and agree to abide by the NCIHC Code of Ethics and the Standards of Practice. These three requirements are basic elements to support the experience, education and testing requirements in the plan for a registry.
- Require full participation in the Roster. The Legislature could authorize enforcement of such a requirement by making hiring entity failure to use interpreters in the Roster subject to monetary penalties. Alternatively, participation in the roster could be required for all healthcare interpreters whose services are paid for from publicly-funded health care programs and workers compensation. Services provided by interpreters in the Registry, if created, would be reimbursed in full.

Together, these changes would support greater participation in the Roster and establish a minimum age and a foundation for ethical and professional conduct for all interpreters.

C. Fiscal Considerations.
Expenditures to develop the ISQI website and database for the roster exceed $50,000 to date and include only IT developer costs. Not included in this figure and absorbed by the Department is staff support incurred during calendar 2009 for the interpreter application process and policy work to develop the standards in the plan for a registry. Revenues from the $50 roster application fee are about $5,000 in total, $2700 received in SFY 2009 and $2300 received in SFY2010 to date.

The expectation that the ISQI can be supported by interpreter application and renewal fees is not presently realistic. As noted above, there was and continues to be interpreter concern that the $50 annual fee does not provide a commensurate benefit. In addition, because of the manner of providing interpreting services, many interpreters do not work full time and have significant travel and parking expenses associated with each interpreting encounter. Therefore, interpreters also state that the $50 fee is a financial burden.

As detailed in the next chapter, Department estimates of interpreter fees for the Roster range from $27 to $270 annually, depending upon the number of participating interpreters. The Legislature must consider whether alternative funding methods and sources need to be used if it decides to implement the ISQI.

With the goal of creating a larger pool of participating interpreters and generating more fee revenue to minimize a growing Roster account deficit, the Department pursued the idea of

partnering with persons and agencies active in healthcare interpreting efforts in bordering states to create an “Upper Midwest Roster” of available healthcare interpreters. The Roster website and search function has been created so that the main page can be easily and inexpensively modified to include maps of other states and facilitate finding local available interpreters in the language needed. The Department invited participation of surrounding states through UMTIA members and contacts. There was no response from other states, a result the Department attributes to the fact that UMTIA is a voluntary, private organization, and as such cannot commit or speak for state governments, even if the members are employees of the state. Also, similar to Minnesota, there may be separate branches or agencies of government, or nongovernmental organization initiatives to improve interpreting services in courts, education and health arenas and for the deaf. Essentially, activity in other states may be taking place in several autonomous areas, none of which can speak for or commit the others.

The idea of expanding the ISQI to include other professional areas was not pursued by the Department, but the Legislature could consider combining the current interpreter activities of the Minnesota court and educational systems and/or expanding the Roster to include human and social service, insurance and other commercial and business areas.

IV. The Plan for a Minnesota Registry for Interpreters

A. Standards for the Registry:
The plan for the Healthcare Interpreter Registry (Registry) requires that the Roster continue and be incorporated into the Registry. The Legislature will need designate an agency-administrator for the Registry as the plan does not presume the Department is the most appropriate entity. The agency-administrator will need to form an advisory council comprised of stakeholders and interpreting subject matter experts to support the making of detailed decisions required for successful operation of the Registry and the Roster. The plan sets forth the standards for qualifying for the Registry and provides a set of grandparenting requirements and a set of ongoing and more formal requirements. As suggested by the ISQI, the Registry is a credentialing scheme and intermediate step to eventual Minnesota certification to be based on national testing and establishment of a national certification process.

1. Basic Requirements:
The plan assumes all interpreters working in healthcare settings will be listed on either the Roster or on a new Registry. In addition, after 2011, the plan recommends establishing a requirement that hiring entities reimbursed by public funds use interpreters on the Registry first and interpreters on the Roster second. Only if no interpreter in the needed language is available from either the Registry or Roster would an interpreter not on the Roster or Registry be used. Further, when an interpreter not on the Roster or Registry is used, the plan recommends that the hiring entity be required to complete and submit a form to the Agency-administrator of the Registry. The purpose of the form and report is to monitor compliance as well as collect and disseminate information about geographic areas of need and identify individuals and geographic areas needing training opportunities.

Some type of regulatory (i.e., enforcement) support will be needed to ensure full participation of interpreters in the Roster and Registry. One option is monetary penalties for noncompliance. Another alternative the Legislature may consider is placing restrictions on payments or setting payment amounts for interpreter services from public health and worker's compensation programs.

2. The Healthcare Interpreter Roster:
As noted above in Chapter III, Section B, the Registry plan intends that the Roster continue, but change from a voluntary scheme with no requirements to a mandatory list of all active health care interpreters not on the Registry. The plan recommends interpreters on the Roster meet the following three minimum requirements after July 1, 2011:

- At least 18 years old;
- Criminal Background Check (to be included in the application fee);
- Agree to abide by NCIHC's Code of Ethics for Healthcare Interpreters and the Standards of Practice for Healthcare Interpreters.

Except for a criminal background check, information supplied by interpreters in the Roster would continue to be unverified by the agency-administrator, and employers/contractors must verify interpreter qualifications during the hiring/contracting process. The Roster will be upgraded to include fields for interpreters to enter any education and tests completed.

3. Restricted Listing on the Roster:
The plan recommends the agency-administrator be authorized to establish criteria and a process for closing applications or removing or ceasing inclusion on the Roster those interpreters of particular languages in all or some geographic areas of the state so that only the interpreters on the Registry appear as available and are used. The agency-administrator may need provide expedited rulemaking authority as described below for these criteria and the process.

4. The Healthcare Interpreter Registry Requirements and Process:
The plan recommends that there be two sets of requirements to qualify for the Healthcare Interpreter Registry. The first set of requirements should be more informal, experienced-based and temporary. For ease of understanding and communicating, this set of requirements is referenced as "registry grandparenting requirements." The second set of requirements should be more academic, test-based, and permanent, and will be referenced as "ongoing registry requirements." The requirements for each are detailed in this section below, and are summarized in a table in Appendix B.

The Registry will be available to interpreters of all languages in all areas of the state who meet the requirements. An interpreter may gain listing on the Registry either by meeting the grandparenting requirements or by meeting the ongoing requirements. However, the plan provides that after July 1, 2013 the grandparenting requirements will expire. Thereafter, more formal education and skill tests are required to be listed on the Registry. All interpreters on the Registry must renew annually and submit evidence of completing continuing education courses. To renew, an interpreter on the Registry by means of the grandparenting requirements will be required to meet the same continuing education requirement as interpreters on the Registry who met the more formal education and skill test requirements.

a. Grandparenting Process
To qualify for grandparenting the Registry applicant must have worked as an interpreter in Minnesota for at least 500 hours before July 1, 2011. Initial applications to the Registry utilizing the grandparenting process must be made prior to July 1, 2013. Any approved courses and tests taken at any point prior to July 1, 2013 will be acceptable.

b. Grandparenting Requirements:

1) **Meet the three Roster requirements listed above.**
2) **Language proficiency:**
   Pass a test of language proficiency in both English and the other language with score equivalent to the ACTFL OPI Advanced Mid or ILR 2[4] rating,
   OR pass a normed spoken language interpreter state-recognized certification exam in any discipline,
   OR have a 4 year degree from a university whose language of instruction is the specified language,
   OR receive an exemption if no test is available in the language.
3) **Medical terminology:**
   Pass a test or course demonstrating knowledge of medical terminology, including the Phoenix, Arizona Children's Hospital terminology course and courses taken abroad.

[4] These are standardized tests used by governments and international agencies.

4) Ethics and standards of practice:

Pass Marjory Bancroft's Introduction to Community Interpreting Course,
OR any 40 hour course, such as Bridging the Gap plus a 24 hour Orientation to Medical Interpreting,
OR any 3 credit course on ethics of interpreting and standards of practice
OR any of the credit or non-credit courses which are part of the evolution of the 3 credit course on ethics of interpreting and standards of practice at the U of M or Century College

5) Accuracy:

Pass a normed basic interpreting skills test, such as Language Line basic interpreting skills test,
OR Fluency Inc. interpreting skills tests,
OR CyraCom's basic interpreting skills test
OR a normed interpreter certification exam, such as the court certification exam,
OR WA state interpreter certification exams or CA interpreter certification exams

c. Ongoing Registry Requirements (coinciding with and following expiration of the grandparenting requirements):

1) Meet three Roster requirements listed above

2) Oral proficiency requirement:

a. Demonstrate oral language proficiency in both/all working languages by passing an approved test,
b. OR being exempted by taking an approved course which has a language proficiency requirement,
c. OR meeting one of the equivalency definitions.
d. OR being an exempt language which does not have a proficiency exam available.

3) Medical terminology:

a. Pass an approved 3 credit course on Medical Terminology and Glossary Development to include the development of a sample bilingual glossary;
b. OR pass an approved 2 credit course on Medical Terminology and approved 1 credit course on Glossary Development,
c. OR meet one of the equivalency definitions,

4) Ethics of interpreting and role of the interpreter:

a. Pass an approved 3 credit course on ethics of interpreting, the role of the interpreter, and situational management; including at least 10 classroom hours of practical exercises.

5) Accuracy:

a. Pass an approved 3 credit course on interpreter skills training to include note-taking, role-plays, memory exercises, and error analysis of the students' own interpreting;
b. Pass an approved 3 credit course on language equivalence and variation, such as Introduction to Translation or Introduction to Sociolinguistics.
c. Pass an approved skills test, (exemptions available for languages in which tests are not available)

The Plan recommends that all approvals and exemptions in the grandparenting and ongoing Registry requirements be made by the agency-administrator and become effective after the requirements for public notification have been met as described below.

d. Evolution of the Registry and the Roster:
The agency-administrator may recommend and initiate legislation to create different categories (e.g., a registry of social services interpreters) within the Registry if and when such categories are appropriate. Searches of the Registry and Roster should display interpreters in the Registry first and interpreters in the Roster second. A notice such as the following must be posted on each Roster search result "The Roster contains unverified information submitted by the interpreter. Employers/Contractors must verify information during the hiring/contracting process. No tests of language proficiency, accuracy, or medical terminology have been verified. No training has been verified."

B. Recommendations for Fees:
An application and annual renewal fee will be paid by each interpreter for the Roster and the Registry. The fees will recover, over a three year period, the average annual cost of establishing and maintaining the Roster, the Registry and if available in SFY13, certification. Expenditures detailed below include all costs for the three systems. Fees will vary for an interpreter in the Roster, the Registry and certification systems and will depend on the estimates of numbers assumed for interpreters participating in each system.

Estimated Expenditures (000's) for
Healthcare Interpreter Roster, Registry and Certification Systems

EXPENDITURES	SFY09	SFY10	SFY11	SFY12	SFY13
Salaries	0	0	$140	$110	$168
Other Operating Costs	0	0	$20	$16	$14
Grants	0	0	0	0	0
Administrative Services	0	0	0	0	0
OR Indirect Cost	0	0	$35	$28	$40
TOTAL EXPENSES*	0	0	$195	$154	$222

* Figures are rounded to nearest thousand.

Estimated Annual Fees for the
Healthcare Interpreter Roster, Registry and Certification Systems

System	**Number of Interpreters in Each System**		
	100	**500**	**1000**
Roster Fee*	$270	$54	$27
Registry Fee	$760	$152	$76
Certification Fee	$600	$120	$60

* The roster fee calculation includes recovery of a FY2009-2010 operating deficit from the Department's startup and administration of the voluntary roster.

It is assumed the Roster, Registry and certification systems will be ongoing activities, even after such time as national certification is available, because not all interpreters will qualify at the certification level.

C. Recommendations for Continued Inclusion in the Registry:
The plan recommends that interpreters in the Registry obtain 8 hours of continuing education each year. Continuing education course work may include attending workshops, conferences, "brown bag" lunch seminars, and professionally-related reflective reading groups, presenting to co-workers on professionally related topics, attending such presentations, participating in volunteer leadership and service activities to the profession, and writing articles for professional journals.

D. Other Recommendations:
There are several administrative issues that must be addressed by the Legislature if it adopts the plan for the Registry and establishes standards for spoken language healthcare interpreters. The Legislature must decide the type of administrative agency authorized to implement and operate the Roster and Registry, and the degree of authority the agency-administrator will have to make detailed decisions about the standards affecting the interpreters in the Roster and Registry. These matters are discussed in the subsections below.

1. Agency-Administrator:
In the mid -1970's the Legislature enacted Minnesota Statutes Chapter 214, establishing policies for determining whether to regulate occupations, and if so, the type of regulation most appropriate to establish. In succeeding decades, the Legislature has employed several different administrative models when designating authority to regulate health-related occupations. The Legislature has created new licensing boards for some occupations, and for others it has delegated authority to the Department of Health or to an existing board.

The Registry plan requires creation of an Advisory Council or Board, the administrative model to be used may depend on whether the Legislature chooses to set standards for only healthcare interpreters, or for all types of interpreters. Currently, a roster of court interpreters is administered by the Judicial Branch, a Registry for Interpreters of the Deaf is hosted in the Department of Human Services, and the Department of Education maintains a list of interpreters used in Minnesota school districts.

The plan recommends the Legislature consider administering together in a single board structure the Roster, Registry and eventual certification schemes for spoken language interpreters in various public service areas. The approach that appears to be evolving for spoken language interpreters, that of establishing separate registries or rosters in discrete public service areas, is arguably antagonistic to several policy principles and initiatives:

- For economic and subject matter reasons, regulation of distinct disciplines within professional areas is most often administered by a single agency-administrator. Thus, for example, the Board of Medical Practice regulates all types of physicians regardless of specialty practices, the Board of Dentistry regulates dentists, dental hygienists and dental assistants, and so on;
- From the perspective of "purchasers" and consumers of interpreter services, a single entry point and administrative system for governing quality is logically most effective

and efficient. This rationale is a driver of the Governor's E-licensing initiative to provide one point of entry for access to all professional licensing activity in Minnesota.

- To address the difficulties faced by immigrant, refugee and Minnesota's ethnic communities, the language access to public services that interpreters facilitate may be most effectively achieved by administering interpreter systems for health, education, social and financial services together.

Whether the Legislature creates consolidated or separate systems for establishing and maintaining standards of quality in interpreter services, the administrative entity will have similar duties and responsibilities, and these may be delegated in the manner used by licensing boards or by advisory councils to agencies or boards.

2. Advisory Council or Interpreter Board: Membership and Duties

The plan provides for creation of an advisory council or board to administer the Registry and the Roster. If a separate board is to be created, the governor would appoint members. Appointments to an advisory council within an existing agency or board would be made by the agency commissioner or board members. The plan specifies a broad membership of 15 subject matter and stakeholder representatives to include: a public member; three interpreters who are all residents of the state but working in different healthcare settings and each interpreting one of the three most commonly spoken non-English languages in Minnesota; one member each representing a health plan or managed care organization and healthcare insurer; two members representing hospitals, one metro and one outstate; two members representing an interpreter agency, one metro and one outstate; a member from the Department of Human Services or Department of Health; a member with expertise in oral proficiency assessment or interpreter skills assessment; two members representing an accredited post-secondary education program; and one member representing the ISG of UMTIA.

An advisory council would operate in the manner similar to that provided for advisory councils in Minn. Stat. Ch. 15. The duties of an advisory council or board would include: advising administrative staff on the definitions and standards for the roster and registry, particularly defining and determining the data sources for calculating the languages less and more commonly spoken in Minnesota and the weighting to be given this data in the roster and registry; advising the administrative staff regarding approval of available oral language proficiency tests, courses for interpreter training, medical interpreting examinations and interpreting skills tests, and when exemptions should be made because such tests and courses are not available; providing for distribution of information regarding the roster and registry; advising the administrative staff on applications for the roster and registry, issues related to investigation of complaints, and approval of continuing education activities.

3. Exemption from Rulemaking

Decisions of the agency-administrator concerning course and test approval and exceptions when courses and tests are not available will need to be exempt from the rulemaking requirements of Minn. Stat. Ch. 14. Decisions on these items will be prompted by applications from interpreters to the Roster and the Registry. The decisions are detailed and will be recurring as new courses and tests are developed and recognized by accredited institutions and organizations. None of the tools usually available to credentialing authorities presently exist in the field of interpreting, and

it is not yet possible to specify education and examination requirements in law or rule. For example, a national accreditation authority for educational programs of interpreting does not yet exist, standards for healthcare interpreter training programs are in development, and valid, reliable and defensible examinations of interpreter skills have not yet been created. The occupation of interpreting can be described as actively professionalizing, but progress is in its infancy. The field of spoken language interpreting is currently engaged in a national process of developing standards that will define and measure the body of knowledge and skill-set required for competency. In the absence of established measures for training, education and skills, the collective judgment of persons appointed to the advisory council or board must be authorized to quickly determine substitute indicators of competency for interpreters to be listed on the Registry. These decisions must factor the status and quality of training and education available in Minnesota and elsewhere, in an efficient and responsive manner.

4. Internal Operating Procedure Requirement for Decision-making and Public Notification.

The decisions and results of activity of the agency-administrator must be transparent and adequately inform all affected persons and organizations. If the Legislature grants a rulemaking exemption, in lieu of rulemaking, the agency-administrator must develop, adopt and publish internal operating procedures. When acting under its rulemaking exemption, the agency must follow its published internal operating procedures. The procedure should provide for publicly posting meetings, agendas and the minutes of decisions concerning any changes to training, education, examinations and language prevalence on the Roster and Registry website. Decisions concerning training, coursework and examinations that will be accepted as meeting Registry requirements must also be posted. The Agency must immediately publicize decisions so that the community of interpreters and hiring entities know which training, education and examinations meet registry requirements and which do not.

5. Expedited Rulemaking Authority.

The plan provides for creation of an agency advisory council or board with responsibility for determining the less and more common languages spoken in Minnesota, the number and location of available interpreters for those languages and then whether interpreters of those languages may be on the roster or will be restricted from the roster and must be on the registry. Restricting application to and listing in the Roster to interpreters of uncommon languages will require evaluation and melding of data sets from four sources: the State Demographer's Office, Department of Human Services, Department of Education and the 2008 census estimates. This activity is a key regulator of quality of interpreting services because the requirements to be on the roster are minimal and those for the Registry are more stringent. This decision-making process and its results will have the most significant impacts on interpreters and users of interpreting services.

While the different languages in Minnesota that need interpreting and the fluctuating number and availability of interpreters of those languages throughout various geographic areas of the state are not expected to change quickly or radically, they should be monitored for changes quarterly. Decisions affecting interpreter listing on the Roster or the Registry will likely need to be made immediately. Expedited rulemaking authority will allow for efficiently carrying out this activity.

V. THE PLAN FOR IMPLEMENTING A CERTIFICATION PROCESS

A. Status of National Certification Process.

The ISQI states that a plan for Minnesota certification of spoken language healthcare interpreters is to be based on national testing and certification processes for spoken language interpreters 12 months after the establishment of a national certification process. National efforts to establish standards are just beginning and are underway through two competing initiatives and organizations.

One effort is by the National Board of Certification for Medical Interpreters, founded in March 2009. This organization is in the process of filing for 501c3 non-profit status, and its purpose is to be a national certifying entity for medical interpreters.

The second national effort is by the Certification Commission for Healthcare Interpreters (CCHI). The CCHI was incorporated in July 2009 as a 501 (c)(6) "business league." This organization intends to serve as an independent certification agency with a "vendor-neutral) business plan to provide "one voice, one set of industry-formed and approved standards, and an assurance of competency through an accredited, professional certification program."

In addition to setting standards for training and education of interpreters, it is expected that one outcome of these organizations' efforts will be a single certification examination for evaluating, at a minimum, healthcare interpreter competency in medical terminology, interpreting skills and ethics. However, neither organization has yet to make available written and oral examinations covering areas such as medical terminology in English and other languages, roles of the medical interpreter, ethics and standards of practice, cultural competence, medical specialties, knowledge of related law and regulations, linguistic proficiency, and interpreting and sight translation skills, or any educational qualifications for taking the exam.

As noted by the February 2008 report of the Interpreter Services Work Group:

> "There are practical issues that must be resolved prior to the creation of a certification system for spoken language interpreters. The most significant barrier is the need to construct testing mechanisms that are valid for different languages, cultures, and medical situations. A spoken language system would need to address tens of language pairings."

This nearly two-year old statement is currently the status quo. Though both national efforts by the NBCMI and the CCHI advertise completion of certification processes with the next 12 months, the Department believes that it will be two to three years before actual certifications in medical interpreting are available in multiple languages to qualifying persons. In addition accreditation agencies responsible for establishing and maintaining standards for training and education in healthcare interpreting have not been recognized by the United States Department of Education because they do not yet exist.

APPENDIX A

Minnesota Laws 2008, Chapter 363, Article 17, §2.

Sec. 2. **[144.058] INTERPRETER SERVICES QUALITY INITIATIVE.**
(a) The commissioner of health shall establish a voluntary statewide roster, and develop a plan for a registry and certification process for interpreters who provide high quality, spoken language health care interpreter services. The roster, registry, and certification process shall be based on the findings and recommendations set forth by the Interpreter Services Work Group required under Laws 2007, chapter 147, article 12, section 13.
(b) By January 1, 2009, the commissioner shall establish a roster of all available interpreters to address access concerns, particularly in rural areas.
(c) By January 15, 2010, the commissioner shall:
(1) develop a plan for a registry of spoken language health care interpreters, including:
(i) development of standards for registration that set forth educational requirements,
training requirements, demonstration of language proficiency and interpreting skills, agreement to abide by a code of ethics, and a criminal background check;
(ii) recommendations for appropriate alternate requirements in languages for which testing and training programs do not exist;
(iii) recommendations for appropriate fees; and
(iv) recommendations for establishing and maintaining the standards for inclusion in the registry; and
(2) develop a plan for implementing a certification process based on national testing and certification processes for spoken language interpreters 12 months after the establishment of a national certification process.
(d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper Midwest Translators and Interpreters Association for advice on the standards required to plan for the development of a registry and certification process.
(e) The commissioner shall charge an annual fee of $50 to include an interpreter in the roster. Fee revenue shall be deposited in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Minnesota Laws 2008, Chapter 363, ARTICLE 18
HEALTH AND HUMAN SERVICES APPROPRIATIONS

Sec. 4**. COMMISSIONER OF HEALTH**
Subd. 3.**Policy, Quality, and Compliance**
Interpreter Services Quality Initiative. Of the state government special revenue fund appropriation, $32,000 in fiscal year 2009 is for the interpreter services quality initiative under Minnesota Statutes, section 144.058.

APPENDIX B

Table of Proposed Healthcare Interpreter Roster and Registry Requirements

Roster Requirements	Registry Grandparenting Requirements	Registry Ongoing Minimum Qualifications
1: At least 18 years old	18 years old	18 years old
2: Criminal Background Check	Criminal Background Check	Criminal Background Check
3: Test of NCIHC Code of Ethics	Agree to NCIHC Code of Ethics	Agree to NCIHC Code of Ethics
4:	Worked as an interpreter for at least 500 hours before July 1, 2011. Application for grandparenting must be made prior to July 1 of 2013.	
5:	**Language Proficiency:** • Test of language proficiency in both languages with score equivalent to ACTFL OPI Advanced Mid. OR equivalent	**Language Proficiency:** • Test of language proficiency in both languages with score equivalent to ACTFL OPI Advanced High. OR equivalent
6:	**Medical terminology:** • Test or course demonstrating knowledge of English medical terminology Including: Phoenix, AZ Children's Hospital course	**Medical terminology—bilingual ability:** • Approved post-secondary 3 credit course on medical terminology and glossary development Note: This can be broken down into 2 credits of medical terminology and 1 credit of glossary development if needed.
7:	**Ethics and Standards of Practice:** • Credit or non-credit course configuration, including: Bancroft's Intro to Community Interpreting; Bridging the Language Gap plus Orientation; legacy credit and non-credit versions of U of M Intro class, etc	**Ethics and Standards of Practice:** • Approved post-secondary 3 credit course on ethics and standards of practice
8:	**Accuracy:** • Approved skills test Including: Language Line basic interpreting skills test, OR Fluency Inc. interpreting skills tests, OR CyraCom's basic interpreting skills test; Or any advanced skills test, such as the court certification exam, or WA state certification exams or CA certification exams	**Accuracy:** • Approved post-secondary 3 credit course on skills of interpreting • Approved post-secondary 3 credit course on language equivalence and variation, such as Intro to Translation or Intro to Socio-linguistics • Approved skills test