NCIHC Open Call
October 18, 2007
12:00 – 1:30 PDT

Topic:
Interim Quality Standards:
How do we guarantee quality in interpreting until national certification is in place?

Note: Many thanks to William Griffith, a member of the Board of the Multicultural Association of Medical Interpreters of Central New York [MAMI] for taking the minutes for this Open Call.

The NCIHC Open Calls are held quarterly, as a means of encouraging exchange among professionals working in the field of language access and soliciting input from practitioners in the field to inform NCIHC policy making.

Participants: about 35 total (from freeconference.com report)

Introduction
The call was convened at Noon EST (9am PST, 11amCST) by Dr. Cornelia Brown of MAMI Interpreters in Central New York. The subject was: Interim Quality Standards: how do we guarantee quality in interpreting until national certification is in place?

The call began with presentations by Maria Michalczyk, Chair of the Oregon Council on Health Care Interpreters and by Armando Villareal, Administrator of the Iowa Commission on Latino Affairs.

Oregon is implementing a two-phase qualification and certification program for healthcare interpreters. The state has been working since 1997 on standardization in interpreting. Oregon originally tried to standardize all interpreting. In 1995 legal interpreting legislation passed. In 2000 medical interpreting was prioritized. The Governor, an MD, signed a new health care plan. From 2001 to 2007 the Oregon Council

worked on creating administrative rules. The $50,000 awarded for this purpose in the state budget was removed, so the effort went forward without specific state financing. The Council decided to maintain a Central Registry of interpreters who have passed one or both of the two phases of quality standards. These standards are voluntary rather than mandatory.

Phase one prepares students to become a Qualified Health Care Interpreters. It consists of 60 hours of education, a state orientation, and a language skill demonstration. These three components contain written and oral examinations. Phase two will prepare students to become Certified Health Care Interpreters. This phase is on hold while phase one is being implemented. In Oregon any community college or university can offer the class work and any language can be included in the qualification program. Only the seven most widely used non-English languages in the state will be included in the certification program.

Following are some of Oregon's key lessons from this process:

- Obtaining legislative support is not an easy process. The pushback against expanding services to illegal aliens has also hurt funding to legal permanent residents and U.S. citizens with limited English proficiency.
- If one goes the route of making a law to address the issue, one should be available to testify and review bills. Read and stay on top of the legislative proposals carefully. Read every iteration of the draft and ask the reason for every change, however small.
- Oregon had a 25-member council on legislation concerning health care interpreting; this number was too large.
- Secure money and put it where the state cannot take it away.
- The timeline from development of legislation to implementation can be long and involve much education.

Details of the Oregon experience can be found online at http://www.oregon.gov/DHS/ph/omh/intrprtr/index.shtml.

In 2004 the Iowa legislature charged the Division of Latino Affairs to develop a statewide roster of foreign language interpreters. The Iowa Interpreter Program is administered by the Division of Latino Affairs and has created a standard system to qualify interpreters for generalized and special purposes and to maintain a roster of individuals qualified to provide interpreter services for courts, health care and social service agencies. Latino Affairs works with Des Moines Area Community College to enroll, provide financial assistance, and to graduate qualified interpreters. The first class in the field of general interpretation entered the program in August 2006 and fourteen graduated in June 2007.

The program is partly funded by the U.S. Department of Labor. Twelve credit-hours (one semester) of study are required for generalist certification and an additional 8 credit hours are required for the health care and other specialist certifications. Video interpreting is provided through Iowa Communication Networks (ICN) videoconferencing.

There was a preexisting certification process in state courts, but not for health care, workers compensation or other venues. In preparing the certification legislation in Iowa the state Office of Court Administration, Department of Social Services and Health and Human Services Department all testified and coordinated their wish lists of requirements.

Details of the program can be found online at http://www.state.ia.us/government/dhr/la/Pages/Interpreter.htm.

Medicaid reimbursement is not yet available through either the Oregon or Iowa HHS administered programs.

Following the presentations, the open call took up the questions of

1) What minimum knowledge and skills should be required of interpreters?
2) What efforts should be made on a state level to implement interim interpreter standards?
3) What are the ideal final standards to be implemented on a state level?

The Iowa example points to the equivalent of 12 credit-hours of instruction as an interim standard for a generalist interpreter.

The question of whether a criminal background check for certification as a medical interpreter should be mandatory was discussed. In Oregon it is not mandatory. In Minnesota it is for court interpreters only at this time but has been proposed for other interpreters in the future. The questions of legal liability vs. exclusion of otherwise qualified individuals were debated.

Some participants felt that everything present in the National Council Standards needs to be included in interim state standards.

The question of whether college education is necessary was extensively discussed. Some participants felt that an AA degree including cultural competency should be a minimum requirement. Others felt that shorter training programs rather than academic degree granting programs were more appropriate, especially for pre-literate language communities and for language communities small enough not to justify an interpreter investing in long term academic training. MN has a shorter training and a six-semester sequence for more common languages. Advocates in Minnesota are currently proposing that the two-semester sequence be required. The ideal of different training levels for

different languages was accepted, with a high benchmark for the eight most commonly used languages and lower benchmarks for 200 other languages.

All participants agreed that interpreters needed to demonstrate fluency in both languages used and command of specialized medical terminology in both languages. A single general assessment standard was not agreed upon.

All participants agreed that the deaf community nationwide is a useful resource to draw on for advice and experience in training, certification, and legislative or administrative enforcement of interpreter availability.

A fruitful discussion took place on the issue of whether the efforts on a state level to establish interim standards should be pursued legislatively or administratively. The Iowa experience was that used Administrative Rules was more effective and easier to implement. Representatives from Minnesota agreed and shared that this is the reason that they are organizing an interpreting stakeholders' group and pursuing administrative directives instead of trying to get a law passed. Once a requirement gets into statute law it cannot be changed very easily. Legislation should be kept very, very simple.

On the state level a series of questions revolve around the issue of centralization vs. decentralization. Should there be a central office of language assistance crossing multiple agencies or should implementation be decentralized? Should provision of services be geographically centralized or provided regionally? Should standards be centralized or vary regionally within a state depending on population density and interpreter availability? Should contracts by state agencies be let statewide to a limited number of providers or through regional contractors?

The issue of in person vs. remote interpreting was extensively discussed. The consensus seemed to be that there was a hierarchy of standards in interpreting, with trained medical interpreters physically present during the interview or treatment being clearly preferable. Videoconferencing would be the next most useful option, with telephone interpreting usually the least desirable option. Clearly all three have their own utility. There was concern that telephone interpreting is frequently be utilized when, in fact, in-person might be preferable. Many felt that the use of in-person vs. remote interpreting would be a good open call topic

Questions about interim standards for health care interpreters are similar across the country. Rather than reinvent the wheel we need to continue to share experience with each other.

The next open call will be on Friday, December 7. The subject will be mental health care interpreting.