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Interpreting in Health Care Settings: Recommendations for a Tiered Registry

Minnesota Department of Health

Report to the Minnesota Legislature 2015

February 2015

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I. Executive Summary

The 2014 Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop recommendations to promote health equity and quality health outcomes through changes to laws governing spoken language health care interpreting in Minnesota. MDH consulted with a broad range of stakeholders and conducted research regarding interpreter qualifications, system structure and oversight, the role of an advisory council, and management of complaints. Based on the information and input gathered, MDH recommends a tiered registry for spoken language health care interpreters.

Nearly eleven percent of Minnesotans (ages 5 and older) speak a language other than English at home. An estimated 213,100 residents have a limited ability to speak, read, write, or understand English,[i] limiting their ability to understand health information in their non-primary language. Research[ii] shows that high-quality spoken language health care interpretation services result in improved health outcomes for limited English proficient (LEP) patients. The lack of state-mandated standards for interpreter ethics, qualifications, skills, education, or training leaves Minnesota's LEP population at risk.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Title VI requires medical providers receiving federal assistance to make interpretation services available to LEP patients free of charge. Additional federal guidance has reinforced the application of Title VI to LEP issues.

Minnesota law does not establish minimum standards for health care interpreting. In 2009, Minnesota established a voluntary statewide roster for its spoken language health care interpreters. No requirements need be met to be listed on the roster and MDH does not verify any of the information provided by interpreters. There is a $50 annual roster fee. The roster allows interpreters to display their contact information, affiliations with interpreting agencies, the geographic regions in which they are available, and the languages in which they interpret.

As of January 1, 2011, health care interpreters must be listed on the roster to receive reimbursement for their services from Medical Assistance and MinnesotaCare. As a result, the number of interpreters on the roster increased from around 100 in January 2010, to over 2,000 in January 2011. As of December 1, 2014, there are approximately 3,600 interpreters on the roster.

States and stakeholder groups across the nation have grappled with how to best establish and enforce minimum standards, and progress has been made. Two organizations offer nationally-accredited certifications for interpreters. Codes of ethics and standards of practice have been established and widely accepted in the industry. Some states have established regulations for interpreters. These successes and areas for improvement have informed the recommendations in this report.

This report incorporates input from individuals and groups with a stake in health care interpreting in Minnesota. To ensure comprehensive representation, MDH identified and

engaged key informants and a broad range of stakeholders through a variety of means. These stakeholder groups included: interpreters; interpreter organizations and groups; educators and trainers of interpreters; interpreter agencies; interpreter services departments within health systems; health plans; health care providers and local public health; community organizations representing LEP populations; national certifying bodies; and LEP individuals. Contacts were invited to participate in individual and community-scale stakeholder meetings held in the metro, St. Cloud and Rochester. Website and e-mail updates were sent to contacts and a survey was disseminated.

Key findings from stakeholder engagement and research:

- Minimum interpreter qualifications, such as understanding interpreter ethics, are necessary to ensure a baseline standard of care.
- Increases in standards must avoid decreasing patient access to interpreters.
- Unverified information about interpreters' qualifications, experience, and background has little value to users of health care interpreters.
- Interpreters have a broad range of qualifications, skills, and experience. The system should allow for a range of qualifications but differentiate among different degrees of training and experience.
- Bilingual ability, on its own, does not qualify anyone to interpret. Mastery of interpreting skills, knowledge of medical terminology, and adherence to an interpreting code of ethics and standards of practice are also necessary.
- Interpreters are concerned about fee amounts, their use, and future increases.
- Stakeholders are concerned regulation will result in additional costs to interpreters with no rise in their income.
- Any proposed system must be flexible enough to meet the needs of interpreters of rare languages and must be able to adapt to the changing local and national interpreting landscape.
- Instances of abuse have brought to light the need for a mechanism in which complaints can be reported and investigated, which is currently lacking.

Recommendations:

To promote quality health care interpreting for Minnesota's LEP population while addressing concerns of stakeholders, MDH recommends implementation of a registry system with four tiers representing increasing qualifications.

- For all tiers, interpreters must be eighteen years of age, demonstrate knowledge of interpreting ethics and standards of practice, and demonstrate knowledge of basic medical terminology in English.
- For Tier 1, interpreters must pass exams on basic medical terminology in English, and ethics and standards of practice, and be at least eighteen years of age.
- For Tier 2, interpreters must complete an approved health care interpreter training program of forty or more hours, and pass exams on basic medical terminology in English, and ethics and standards of practice.
- For Tier 3, interpreters must hold valid national certification in basic interpreter knowledge and skills, or have a certificate in interpreting from an approved institution, and pass exams on basic medical terminology in English, and ethics and standards of practice.
- For Tier 4, interpreters must have national certification in interpreting which includes a non-English language component, or have an Associates' degree or higher in interpreting from an approved program and receive an Advanced Mid or higher score on an approved oral proficiency exam in the non-English language.

Qualifications would be verified. Interpreters' qualifications and assigned tiers would be displayed online for consumers of health care interpretation. For renewal, interpreters in the second, third, and fourth tiers would respectively be required to complete four, six, or eight hours of approved continuing education every year.

MDH further recommends:

- Development of an exam on ethics and standards of practice, and an exam on basic medical terminology in English.
- Establishment of an advisory council to provide expertise and guidance to the Commissioner of the Department of Health or a designee.
- Establishment and authorization of a complaint and oversight process.
- Expansion of the MDH website to include a compilation of available resources for interpreters to support their education and skill development.

II. Background

A. Spoken language health care interpreting defined

The terms "translator" and "interpreter" are often used interchangeably, but are in fact very different in practice. Both move a message from one language into a second language, but translators work only with written text while interpreters work with the spoken word.

Providing medical interpretation requires more than just being bilingual. Bilingual individuals not trained as interpreters are often referred to as "ad hoc" or "informal" interpreters. They may be health care providers, members of a patient's family, or non-clinical hospital staff. Ad hoc interpreters often lack fluency in one or both languages, have incomplete knowledge of medical terminology, or otherwise lack the necessary skills to accurately transmit oral messages between English and the non-English language.

For clarity, the term "spoken language health care interpreter" must be deconstructed and defined. The qualifier "spoken language" differentiates spoken language interpreters from sign language interpreters, who also provide health care interpretation. Sign language interpreters have their own national certification body and fall outside the scope of this report and bill proposal. Hereafter, "health care interpreter" will be used in this report without the "spoken language" qualifier.

The qualifier "health care" clarifies that the scope of the report and recommendations include only interpreters working in medical settings. It differentiates health care from other areas in which interpreters commonly work, such as legal, educational, commercial, or conference settings. Many interpreters work in more than one of these areas, though these areas do not share systems of oversight in Minnesota. Each of these settings require knowledge of specialized terminology and an understanding of the setting and environment.

Interpreter availability varies greatly by both language and location. A language that is rare in one area may be much more common in another, even within the same state. The limited availability of in-person interpreters for rare languages raises a host of challenges.

Interpretation may be provided in-person or remotely. In-person interpretation, in which the interpreter, patient, and provider are in the same room, is widely recognized by stakeholders in the interpreting community as the preferred means of providing interpretation. It is also known as face-to-face interpretation.

Remote interpretation occurs when the interpreter is not in the same room as the patient and provider. Remote interpretation has traditionally occurred over the telephone, with the interpreter on one end, and the patient and provider on the other.

Though interpreting via phone remains prevalent, technological developments allow more dynamic options for providing remote interpretation. Examples include the use of various programs for sharing live, streaming video over a wireless internet connection on an electronic tablet device provided in the patient's room. These technologies allow the remote interpreter and the patient and

provider to see and hear one another. Although these technologies have rapidly improved, technological difficulties can hamper the effective use of these options. While face-to-face interpretation is preferred, remote interpreting must remain an option, particularly to meet the need for "rare language" interpreting.

1. Modes of interpreting

Each of the three modes of interpreting listed below is utilized in the interpreting profession. Each serves different needs and is appropriate in different circumstances. In all three modes, the interpreter must accurately transmit the messages between source (i.e. English) and target (i.e. non-English) languages without additions, omissions, or editorializing. Health care interpreters use all three modes.

a. Consecutive interpreting. In consecutive interpreting, the interpreter waits until the speaker has finished speaking before rendering the message into another language. Consecutive interpreting occurs when limited English proficient (LEP) patients and health care providers are speaking back and forth and takes the form of brief sound bites spoken successively by the interpreters. Consecutive interpreting requires the interpreter to switch rapidly between the English and the non-English language, for example, transmitting messages from English to Somali and Somali to English in quick succession. It is appropriate whenever LEP patients and health care providers are both playing an active role, speaking and responding.

b. Simultaneous interpreting. In simultaneous interpreting, the interpreter renders one spoken language into another when running dialogue occurs uninterrupted in either the English or non-English language. It is appropriate when an LEP patient or a health care provider is conveying extended amounts of information which does not require an interactive response.

c. Sight translation. In sight translation, the interpreter renders material written in one language into speech in another language. This occurs when English-language medical documents need to be explained to LEP patients or foreign-language documents, such as birth certificates or identification, need to be explained to hospital staff. Accepted standards of practice for health care interpreters caution that the interpreter avoids sight translation.[iii]

B. The health care interpreting landscape in Minnesota

The vast majority of health care interpreters in Minnesota work as independent contractors. The bulk of these independent contractors secure interpreting assignments from interpreting agencies, referred to as interpreter service providers or brokers in some states. Most interpreters secure work through multiple agencies. Only a small portion of interpreters are directly employed by hospitals or health systems, some of whom may also accept contract work from agencies.

Some agencies and health systems have their own requirements or guidelines for interpreters, such as the completion of training programs, proof of fluency in the English and/or non-English language, and proof of vaccinations. However, these requirements vary significantly and there are no universal

standards required for interpreters to practice in Minnesota. Additionally, agency provision of training is restricted by the bounds of their interpreters' status as independent contractors.

The actual wage that a Minnesota interpreter receives varies widely. The Department of Human Services reimburses for interpreter services at a rate of $46.20/hour, as do most health plans. Interpreters generally receive less than this as some of the money is allocated to agency overhead and fees. There is no industry standard for the proportion of the reimbursement rate that an interpreter actually receives. Based on conversations with the interpreting community in Minnesota, interpreters working as independent contractors through agencies generally state that they receive around fifty percent of the rate ($20-25), although this varies by language and location.

There is no differential in the rate of reimbursement for interpreters based on their qualifications or experience. As a result Minnesota's interpreters generally lack financial incentive to pursue increased training or education in interpreting.

In-person interpreting in Minnesota is provided by hospital staff interpreters or by interpreters working as independent contractors. Health systems usually contract with national vendors for remote telephonic interpretation, as do other organizations, such as MDH. This option is generally used only if in-person or other remote options are not readily available, but is still heavily utilized.

Remote interpretation may also be provided by in-house hospital or clinic staff interpreters. This option is used by some health systems with multiple locations and/or which serve high numbers of LEP patients. It has replaced the in-person standard in some hospitals with a large need for interpretation. Some Minnesota hospitals are a part of a network of health systems across the nation that share remote interpreting resources and costs. Some Minnesota interpreting agencies also offer remote interpreting from their local interpreter pool.

Rare languages vary across different areas of Minnesota. Areas of greater Minnesota generally face greater challenges in meeting the need for in-person interpreters across a larger number of languages than the metro area.

In many parts of the world, interpreters commonly hold Bachelor's or Master's degrees in interpreting, and these qualifications may be required to work in the field. This is not the case in the United States, where advanced degree programs in interpreting are far less prevalent. As a result, the percentage of Minnesota interpreters with an advanced degree in interpreting is limited. Interpreting programs in Minnesota include Associate's and Certificate programs offered by Century College, and a Certificate program offered through the University of Minnesota's College of Continuing Education.

C. Interpreter knowledge, skills, and abilities

While skilled health care interpreters do not share a universal set of qualifications and experiences, the components outlined below were consistently mentioned during MDH conversations with stakeholders. These qualifications are strongly supported by the literature and are generally

prerequisites or components of certificate programs, advanced degree programs in interpreting, and national certification.

- *Interpreter training* via one of several forty or more hour health care interpreter training programs, interpreter certificate programs from education institutions, or advanced degrees in interpreting.
- *Knowledge of medical terminology*, including anatomical, technological, and health system-related vocabulary.
- Understanding and adherence to health care interpreting codes of ethics and standards of practice, such as the National Council on Interpreting in Health Care's *National Code of Ethics* and *National Standards of Practice*.[iv]
- Ability in *interpreter skills*, including knowledge of the modes of interpreting and when to use them, and the ability to accurately transmit messages between languages.
- *English language proficiency* established via formal testing or by informal means, such as attainment of a certain level of education in the English language.
- *Non-English language proficiency* established via formal testing or by informal means, such as attainment of a certain level of education in the non-English language.
- Completion of *general education*, such as a high school diploma or equivalent, or an advanced degree.
- *Continuing education* undertaken by interpreters to maintain and improve skills.
- Ability to anticipate and recognize misunderstandings that arise from the differing *cultural assumptions and expectations* of providers and patients and to respond to such issues appropriately.[v]

D. Increasing need for spoken language health care interpreting

Comprehensive data on the number, location, languages spoken, or health status of limited English proficient (LEP) individuals in Minnesota does not exist. This complicates efforts to accurately quantify the level of need for health care interpretation services. However, available data cumulatively demonstrate the need for spoken language health care interpretation services in Minnesota is ongoing and increasing.

Nearly eleven percent of Minnesotans (ages 5 and older) speak a language other than English at home, according to the U.S. Census Bureau. English is not the primary language of an estimated 213,100 Minnesota residents who have a limited ability to speak, read, write, or understand English.[i]

Minnesota Department of Education county-by-county totals of the primary language spoken at home by children in Minnesota public schools further underscore the need for health care interpretation throughout the state. Maps included in Appendix B show the number of homes in each county with school-aged children speaking ten of the most commonly spoken languages in the state, other than English. These maps illustrate that the need for interpretation services goes beyond a handful of languages, and that need in a particular language varies greatly across the state and is not limited to the Minneapolis-St. Paul metro area.

Over every decade from 1980 to 2010, the United States experienced increases in both the total number of individuals and the percentage of individuals in the population speaking a language other than English at home. Minnesota also experienced this trend.[vi] Furthermore, in 2013, over four percent of Minnesotans self-reported speaking English "less than very well." This percentage increased from the beginning of the decade.[vii]

Data provided to MDH staff by two large health systems in Minnesota reflected this increase in the use of health care interpretation in recent years. At one of these health systems, spending on interpreter services increased 26.7 percent between 2010 and 2013. This increase was not merely a reflection of the overall rise in health care costs. It occurred despite no increase in the DHS reimbursement rate for interpreters over this period. Another large health system experienced increases in patient requests for interpreters from 2013 to 2014, with year-over-year increases of 14.6 percent for the first quarter and 17.4 percent for the second quarter.

E. Impact of spoken language health care interpreting[viii]

A growing body of scientific literature shows that having a trained, spoken language interpreter can improve the quality of care a LEP patient receives. The literature shows that the use of a trained interpreter can benefit patients and help them to: 1) have a better perceived understanding of their diagnosis and treatment; 2) have greater satisfaction with their care; 3) receive more appropriate care; and 4) achieve outcomes equal to English speakers; as well as 5) reducing overall medical costs.

In the literature "professional" or "trained" interpreters are often distinguished from ad hoc or informal interpreters, although a common standard is not used to define "professional" or "trained." However, the literature is clear that using a trained interpreter generally produces higher quality results than using an ad hoc interpreter.[ix]

1. Patient understanding. A study in the Journal of the American Medical Association found that LEP patients who need, but do not receive interpretation services do not understand their diagnosis and treatment as well as patients who do receive interpretive services, and 90% wish that their provider had explained things better.[x] When trained interpreters are not utilized, language barriers can result in inefficient care. For example, when providers are unable to determine LEP patients' symptoms and, therefore, use more diagnostic resources or invasive procedures.[xi]

Additionally, medical consent documents can be difficult to understand, even for native English speakers. The importance of LEP patients providing true informed consent and understanding other legal issues was described in a report to the U.S. Congress by the Office for Management of the Budget (OMB).[xii] The report mentioned that if medical procedures and associated documents, such as power of attorney forms, are successfully explained to LEP patients or their family members, legal as well as medical problems might also be avoided.

2. Patient satisfaction. The effects of language barriers on LEP patients are well-documented and appear to negatively impact LEP patient satisfaction.[xiii] Despite apparent communication difficulties, less than one-half of non-English speakers who said that they needed an interpreter said that they

were always or usually provided with one.[xiv] Research shows that LEP patients' satisfaction with health care increases and their health outcomes improve when receiving high-quality spoken language health care interpretation services.[xv]

Numerous studies have examined limited English proficient patients' satisfaction with their care and the impact of having a trained interpreter, an ad hoc interpreter, and not having an interpreter. The results of these surveys can be summarized as:

- Limited English proficient patients with trained, professional interpreters present when care is delivered have higher satisfaction with care;[xvi] [xvii]
- Limited English proficient patients who need, but do not get interpreters are least satisfied with their care;[xviii] [xix]
- Limited English proficient patients and clinicians have higher satisfaction when using professional interpreters than when using ad hoc interpreters. [xvi] [xvii] [xviii]

3. Care received and outcomes. Language barriers pose risks to LEP patient safety.[xx] LEP individuals' access to care and the quality of the care they receive are issues of particular concern. Studies that have looked at the impact of trained interpreters on the amount and outcomes of health care services have generally found that the use of interpreters helps achieve the desired outcomes, such as:

- Use of trained professional interpreters was associated with a decrease in disparities for utilization of outpatient preventive services,[xxi] increased intensity of emergency department services,[xxii] reduced emergency department return and referral rates,[xxii] and lower admission rates from the emergency department;[xxiii]
- LEP patients using trained, professional interpreters received care that met the American Diabetes Association guidelines and received care that was as good as the care for English-speaking patients;[xxiv]
- LEP patients who need, but do not get interpreters have more tests done creating a higher overall cost,[xxiii] are more likely to receive intravenous hydration and to be admitted to the hospitalized,[xxiii] and are at greater risk of being discharged from the emergency department without a follow-up appointment.[xxv]

4. Costs and benefits. According to the federal Office of Management and Budget (OMB), the benefits of language-assistance services for LEP individuals, while not readily quantifiable in dollar units, can be "significant." The OMB states that improved access to the delivery of health care can substantially improve the health and quality of life of many LEP individuals and their families, may increase the efficiency of distribution of government services to LEP individuals, and may measurably increase the effectiveness of public health programs.[xii]

The OMB report states that "increasing access to government programs may lead to cheaper, more targeted intervention, avoiding long-term and more costly services to government and society. For example, the use of primary health care services aimed at prevention or early detection and treatment of disease could reduce the cost of late-stage disease treatment or emergency visits."

There is also strong evidence that higher qualified interpreters both improve LEP patient outcomes and save health systems money by reducing readmission rates and the incidence of severe outcomes. One study[xxvi] found that the length of a hospital stay for LEP patients was significantly longer (between .75 days and nearly 1.5 days) when professional interpreters were not used at admission or both admission/discharge. Patients receiving interpretation at admission and/or discharge were less likely than patients receiving no interpretation to be readmitted with 30 days.

Failure to provide LEP patients with adequate interpretation services can result in a range of consequences, some of which can be serious and even fatal.[xxvii] In one example, the misinterpretation of the Spanish word *intoxicado,* meaning nauseous, as intoxicated, resulted in the misdiagnosis of an 18-year old patient's brain aneurysm as a drug overdose. This led to his becoming a permanent quadriplegic. In addition to the tragic human cost, this case resulted in a $71 million malpractice settlement.[xxviii]

Health care systems' potential exposure to legal liability as a result of tragedies related to a failure to adequately provide qualified interpretation is well documented.[xxix] Washington State's pioneering early implementation of statewide certification of health care interpreters in 1995 was spurred forward by a class action lawsuit brought forward on behalf of LEP individuals.

F. Federal statutes and guidance

A number of federal statutes apply to the field of spoken language health care interpreting. Additional federal guidance supports the statutory directives.[xxx] Title VI of the 1964 Civil Rights Act prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.[xxxi] In 1975, the U.S. Supreme Court ruled that language and national origin are so closely interrelated they should be treated as equivalent.[xxxii] Title VI requires that medical providers, as recipients of federal financial assistance, make interpretation services free and available so that LEP patients can access a standard of health care equivalent to that of English speakers.

In 2000, former President Clinton signed Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency."[xxxiii] The Executive Order requires every federal agency[xxxiv] to examine the services it provides, identify any need for services to LEP individuals, and develop and implement a system to provide such services so LEP persons can have meaningful access to them.[xxxv]

In 2004, the U.S. Department of Health and Human Service Office for Civil Rights issued policy guidance for Title VI compliance, which states that LEP persons must be notified of the availability of free interpreting services and providers must not require friends or family to provide interpretation.[xxxvi] It stipulates that interpreters must be competent in medical terminology and understand issues of confidentiality and impartiality.

Section 1557 of the Affordable Care Act also prohibits discrimination in health care programs on the basis of national origin. Health insurers, hospitals, the health insurance exchanges, and any other

entities that receive federal funds are covered by this law. It became effective upon passage of the Act.[xxxvii]

The Equal Protection Clause is part of the Fourteenth Amendment to the U.S. Constitution and took effect in 1868. The clause provides that no state shall deny to any person within its jurisdiction "the equal protection of the laws." This means that states must apply the law equally and cannot give preference to one person or class of persons over another. Programs receiving federal financial assistance must make interpretation services available so that LEP patients can access a standard of health care equivalent to that of English speakers.

G. Development of the health care interpreting field

The health care interpreting field in the U.S. has evolved over the last three decades and continues to professionalize. Stemming from the growing recognition of the critical role interpreters play in increasing access to care, this process has included efforts to standardize what is expected of interpreters, raise the quality of interpreting, and establish a shared understanding of high quality and ethically appropriate principles and practice.

From the late 1980s to the present, several organizations have developed and updated codes of ethics and standards of practice for health care interpreters. These organizations include the International Medical Interpreters Association, the National Council on Interpreting in Health Care (NCIHC), the American Translators Association, and the California Healthcare Interpreters Association. The codes and standards are intended to help improve the quality and consistency of interpreting in health care.

Two organizations recently began offering national certification for health care interpreters. In late 2009, the National Board of Certification for Medical Interpreters (NBCMI) began offering the Certified Medical Interpreter (CMI) credential. In 2011, the Certification Commission for Healthcare Interpreters (CCHI) began offering the Certified Healthcare Interpreter (CHI) credential. Both certifications have been nationally accredited by the National Commission for Certifying Agencies.

The CMI and CHI certifications contain oral proficiency components in the interpreter’s non-English language, which also test interpreting skills. English language proficiency is assumed, as the written exam is conducted in English, and interpreters would be unlikely to pass without strong English skills.

Due to high costs associated with establishing oral language exams for additional non-English languages, as well as limited demand, these certifications are currently available to interpreters in only seven languages. As of December 1, 2014, the CMI credential is available in Spanish, Mandarin, Russian, Cantonese, Korean and Vietnamese, and the CHI is available in Spanish, Mandarin, and Arabic. Some very common languages in Minnesota, such as Hmong and Somali, are not currently available.

Alternatively, CCHI offers the CoreCHI, which was accredited in June 2014. The CoreCHI exam lacks an oral proficiency component and, thus, does not test non-English language proficiency or

interpreting skills, but otherwise is identical to the CHI exam. The CoreCHI makes nationally accredited "language neutral" certification available to interpreters of all languages.

Some states have developed requirements for their interpreters. These vary significantly by state and include state certification and other systems of requirements. Those instituted prior to the establishment of national certification were more likely to favor individual state certification (e.g. Washington State). Those established or updated more recently generally incorporate national certification (e.g. California and Oregon).

Oregon has been a national leader in this area, has implemented a tiered system, and shared their ongoing experience in conversations with MDH. As a result, Oregon's system for interpreters is referenced throughout this report.

H. History of Minnesota State legislative efforts

Minnesota law does not establish minimum standards for health care interpreters. In 2007, the Minnesota Legislature began exploring the regulation of health care interpreters, with the Interpreter Services Working Group Law[xxxviii]. This working group developed findings and recommendations on: ensuring access to interpreters; compliance with requirements of Federal law and guidance; developing a program to guarantee quality of health care interpretation; and identifying funding mechanisms for interpreter services. The working group presented their report to the Legislature in 2008.

As a result, the Interpreter Services Quality Initiative Law (ISQIL)[xxxix] was passed in 2008. The ISQIL directed MDH to develop a plan for a registry and to establish a statewide roster. Under the ISQL, a roster is publicly available and none of the member information is verified by MDH, while a registry contains some or all verified information.

In 2009, Minnesota established a voluntary statewide roster for its spoken language health care interpreters. Interpreters pay a $50 annual roster fee. The roster allows interpreters to display their contact information, affiliations with interpreting agencies, the geographic regions in which they are available, and the languages in which they interpret. There are no requirements minimum requirements to be listed on the roster. Under the current legislation, MDH is not mandated and does not have the capacity to verify any of the information interpreters provide.

The ISQIL plan for the registry was presented in a report to the Legislature in 2010. It proposed standards and requirements for education and training, the demonstration of language proficiency and interpreting skills, and recommended that an interpreter agree to abide by a code of ethics and pass a criminal background study to be on the registry.[xl]

Although participation on the roster remains voluntary, as of January 2011, health care interpreters must be listed on the roster in order to receive reimbursement for their services from Medical Assistance and MinnesotaCare.[xli] As a result, the number of interpreters on the roster increased from approximately 100 in January 2010, to over 2000 in January 2011. As of December 1, 2014, there are roughly 3,600 interpreters listed on the roster.

The roster was intended to serve as a first step in guaranteeing the quality of interpreting through regulation. In 2008, the ISQIL stipulated that Minnesota would develop a plan for a system for interpreters based upon a national certification process 12 months after its establishment, and this was codified in statute in 2013.

In 2014 the Minnesota Legislature considered a bill that proposed a dual roster/registry for health care interpreters. To inform its deliberations, the 2014 Legislature directed MDH to seek stakeholder input and develop recommendations addressing health care interpreting in Minnesota.[xlii] This report and the accompanying draft statutory language are the result of that mandate.

III. Stakeholder engagement: process and findings

A. Overview of stakeholder engagement process

A central objective of this project was to ensure that all stakeholders of the Minnesota interpreter community were informed about the project and were encouraged to share their thoughts. To ensure comprehensive representation, we identified stakeholders through a variety of means including the MDH interpreter roster, contacts of other groups at MDH, research on the interpreting field, referrals from other contacts, and information dissemination through multiple sources. Furthermore, each e-mail update and meeting invitation sent to stakeholder groups included a request to share the information with colleagues and others in the field.

Individuals and groups integral to the field or involved in previous legislative initiatives were identified and served as "key informants." We invited key informants to one-on-one meetings with MDH representatives in order to learn about interpreting generally, education and training opportunities for health care interpreters, and the history of efforts to develop standards for health care interpreters in Minnesota. Additionally, we met with, spoke with, or emailed all other individuals and groups that contacted us for information or requested the opportunity to provide input.

MDH created a survey that asked questions similar to those discussed at stakeholder meetings. All identified contacts as well as all members of the interpreter roster were invited to respond.

B. Stakeholder meeting structure

Community-scale stakeholder meetings were held in the metro, St. Cloud and Rochester. Each meeting in the metro was geared toward a certain audience of stakeholders such as interpreters, agencies, health care providers, payers, LEP organizations, etc. The meetings in St. Cloud and Rochester were modified to engage a broad range of stakeholders.

Stakeholder meetings began with a PowerPoint presentation about the project, information about the status of the interpreting field in Minnesota, and an explanation of the meeting objectives and

expectations. Participants were given a hard copy of the discussion questions and the remaining time was spent discussing these topics. After the meeting, the community engagement representative e-mailed a copy of the PowerPoint and discussion questions to participants as well as those who registered but were unable to attend.

To accommodate the high attendance at the meetings for interpreters, ten to twelve MDH staff facilitated and took notes at these meetings so that interpreters had a greater opportunity to share their thoughts. One MDH facilitator and one note taker were assigned to a topic category and were positioned at a table that could accommodate 6-8 interpreters. Interpreters spent 15-minute sessions at each table so that they could discuss each topic. This allowed each interpreter more time to share their thoughts and promoted discussion and debate between small groups of interpreters.

C. Updates, survey and comments

Throughout the process, we updated the MDH interpreter website[xliii] to provide information on the project and encourage stakeholder involvement. Information about the project was included in the MDH Refugee Health Quarterly Newsletter published on October 27th, 2014. An e-mail update was sent to all identified stakeholders on October 31st, 2014 and was forwarded through many MDH listservs.

On November 19th, 2014, we sent all interpreters on the roster and all previously identified contacts an invitation to participate on a survey. A total of 468 individuals responded to the survey, 361 of whom had not participated in previous engagement opportunities. Please refer to Appendix C for a copy of the survey questions. The data collected in the survey engaged both individuals who had previously participated in-person at the community meetings as well as others who did not participate in-person. The data from the survey cannot be generalized to the Minnesota interpreter community as a whole, but provides valuable insight into the diversity of viewpoints and proposed approaches.

An update containing drafted recommendations was sent to interpreters on the roster and all other identified contacts on December 19th, 2014. Stakeholders were encouraged to provide feedback on these drafted recommendations by January 6th, 2015. Twenty-eight stakeholders commented. Please refer to Appendix F for a copy of the drafted recommendations and Appendix G for comments in response to these recommendations.

D. Stakeholder group engagement process

Note: For a complete list of meetings and participating stakeholders, please refer to Appendix D. For a calendar of meetings, please refer to Appendix E.

1. Interpreters. The 3,602 interpreters listed on the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster as of September 1st, 2014 were e-mailed and invited to attend one of five scheduled "community conversation" sessions. Three "conversations" were held in the metro area; one was held in St. Cloud; and another was held in Rochester. Community

partners such as organizations working with the Refugee and International Health Unit at MDH were encouraged to share the meeting invitation to reach all interested parties. Those who were unable to attend in-person were encouraged to share their thoughts by completing a survey or contacting MDH directly. Over 93 interpreters representing a broad range of languages signed attendance sheets for the in-person meetings, and many more were present.

2. Interpreter Organizations and Groups. Interpreter Organizations and Groups are defined as regularly-meeting groups of individuals who work to support interpreters and the interpreting industry. We identified and engaged both local and national/international organizations and groups through existing community partners, research, referrals from other contacts, and from requests for engagement from the groups themselves.

3. Educators and Trainers. Interpreters obtain education and training through many venues. For this reason, we held meetings with local educational institutions such as colleges and universities with interpreting programs as well as companies that provide training opportunities for interpreters. We informally engaged certified trainers of common 40-hour training programs through their participation at other stakeholder meetings.

4. Interpreter Agencies. Interpreters on the Spoken Language Health Care Interpreter Roster, may list agencies with which they contract. We used contact information for agencies listed on the roster as well as other referrals to identify agencies. We e-mailed invitations to four in-person meetings: two in the metro area; one in St. Cloud; and another in Rochester. Fifteen agencies attended the in-person meetings and others submitted input through a survey, described later in this section.

5. Interpreter Services Departments within Health Systems. This category encompasses both staff interpreters at hospitals and other health facilities and within health systems, and interpreter services managers at those locations. The “Interpreter Services Leadership Group” (ISLG), comprised of managers across the state, invited us to speak their meeting. We presented the project and engaged the members with questions applicable to their perspectives on interpreting. ISLG also helped us identify and contact other stakeholder groups. As a result of our engagement with ISLG, we were invited to meet with interpreter services departments at three hospitals in the metro. These meetings included both managers and staff interpreters.

6. Health Plans. We identified health plan representatives through the Minnesota Council of Health Plans (MNCHP). Contacts were invited to attend a stakeholder meeting held October 8, 2014 in the metro area.

7. Health Care Providers and Local Public Health. Health care providers and clinics that frequently use interpreters were identified through contact lists maintained by MDH Refugee and International Health staff. These identified contacts were also strongly encouraged to reach out to colleagues in the field. Local Public Health professionals were also identified through MDH contact lists. These stakeholders were invited to attend two meetings in the metro; one meeting in St. Cloud; and another in Rochester.

8. Community Organizations Representing LEP Populations. Community organizations such as refugee resettlement agencies, local nonprofits that advocate for limited English proficient (LEP)

populations, engagement and outreach organizations, and social workers were identified through community partners and MDH contact lists. Representatives were invited to participate in two meetings held in the metro; one meeting was held in St. Cloud; and another in Rochester. Contacts were also encouraged to share the information with colleagues in the field.

9. National Certifying Bodies. Representatives from both of the accredited national certifying bodies for interpreters (NBCMI and CCHI) met with MDH staff via teleconference. Additionally, local representatives from these certifying bodies were engaged informally at other stakeholder meetings.

10. Key Informants. We identified Individuals and organizations that had active roles in previous legislative initiatives or that have extensive knowledge of those initiatives or the interpreting field. We met with individuals and representatives of these organizations individually, as well as inviting them to the larger stakeholder meetings.

11. LEP Individuals. We identified and contacted community English Language Learner (ELL) courses. We attended six ELL classes and discussed with the students their experiences with interpreters. Additionally, other instructors of ELL classes agreed to ask a standard set of questions on our behalf and to record the answers for us.

12. Others requesting involvement. Through in-person meetings, teleconferences and e-mail, we engaged with all other individuals and groups that requested the opportunity to provide input.

E. Findings from Stakeholder Engagement

For a complete explanation of the findings from engaging stakeholders, please see Appendix H. For findings from LEP individuals, please see Appendix I. The key findings in these appendices represent recurrent and important themes presented by a broad range of individuals and organizations that participated in the process. MDH project staff strived to give all stakeholders opportunities to share their views and to convey this information in an impartial manner.

The findings are sorted by topic to demonstrate how viewpoints vary both within and between stakeholder groups. At the face-to-face meetings as well as via the survey, stakeholders were asked about key topics surrounding health care interpreting.

The information gathered from stakeholders directly contributed to the creation of the proposed registry system. Attention to concerns about access issues for LEP patients if standards were set too high relative to the current general level of interpreter qualifications in Minnesota provided strong rationale for the proposed system and the inclusion of a standardized, entry-level tier.

Some of the proposed solutions to current issues in the interpreter community are beyond the scope and capacity of MDH. These recommendations included calls for MDH to provide training, testing and other opportunities currently fulfilled by organizations within the interpreter community. MDH does not offer these types of services for other health professions and is not funded to do so.

1. Interpreter qualifications. Stakeholders emphasized that interpreters must have a broad range of skills, including proficiency in English and the non-English language, an understanding of interpreter ethics and standards of practice, a strong medical vocabulary, and cultural competency. The ways in which interpreters acquire and evaluate these skills varies significantly, from 40-hour interpreter training programs to college degrees and national certification. Health care providers prefer to work with better-trained interpreters, though they are unsure of how to identify these interpreters. Most stakeholders named continuing education as a critical way in which interpreters can maintain and enhance their skills.

2. Rare-language interpreters. There is not a high enough demand for many rare-language interpreters to make medical interpreting their primary career. Training requires a significant time commitment and often costs more than a rare-language interpreter makes from interpreting in a given year. Stakeholders were concerned that if minimum standards are set too high, rare-language interpreters may leave the field, leading to an interpreter shortage for LEP Minnesotans.

3. Cost. Interpreters face many career-related expenses including roster fees, training and continuing education fees, and parking and transportation. Independent interpreters generally face more of these costs than staff interpreters. Although the standard reimbursement rate through DHS is currently $46.20/hour, the amount an interpreter receives varies by agency, length of appointment, language, and other factors. Better-trained interpreters are not guaranteed greater reimbursement, so many interpreters see no financial incentive to get trained. Interpreter agencies also encounter expenses, including background checks, interpreter testing, employee orientation and record keeping.

4. Remote Interpreting. Video and telephone remote interpreting are emerging technologies that improve timely access to interpreters in rural areas, in emergency situations, and with rare languages. However, many stakeholders are concerned about the quality, privacy, and appropriateness of remote interpreting. The ability to interpret non-verbal cues is impaired or even impossible with remote interpreting, leading to poorer communication. Stakeholders are concerned that out-of-state interpreters may not be required to comply with Minnesota laws, and this lack of regulation could put Minnesota interpreters and companies at a disadvantage.

5. Technical Assistance and Support. Interpreters felt that they will need a moderate amount of technical assistance with integrating into a new registry system. Stakeholders emphasized that existing communication channels such as interpreter organizations and agencies could be utilized to help explain the recommended registry.

6. Communication and Feedback. The best way to communicate with interpreters about important information is through e-mail. Stakeholders felt that it is important that they can give feedback to MDH about the recommended registry and about changes that should be made.

7. Other Important Issues. Stakeholders were concerned that there is no mechanism for complaints with the current MDH interpreter roster. They felt MDH should create this capacity so that cases of fraud, abuse and unethical behavior can be addressed. Some stakeholders were concerned that changes that set standards too high could disrupt the interpreter system and create an access issue for patients. They felt that changes such as the recommended registry need to be made incrementally, to allow for time for the interpreter field to professionalize. Greater Minnesota interpreters were also

concerned about their ability to comply with high standards due to fewer training and continuing education opportunities outside of the Twin Cities. Finally, LEP patients need more information about their right to an interpreter and what they can do when they are concerned about the quality of their interpreter.

8. Concerns from LEP Minnesotans. LEP individuals felt that there are generally enough interpreters in Minnesota, but there may not be enough high-quality interpreters. Interpreters book busy schedules which results in cases when interpreters arrive late to appointments, forcing LEP individuals to reschedule or try to understand the doctor on their own. LEP individuals pointed to many positive results of having a good interpreter, including better communication with the doctor, a positive perspective on the overall health care experience, empowerment to seek care in the future, and confidence in understanding and improving their health status. However, LEP individuals also have experienced situations in which interpreters could not provide clear communication for the doctor and patient, or even cases when poor interpreting negatively impacted their health. The most common issues LEP individuals had with interpreters were their focus and timeliness, language proficiency, and ability to explain medical terms.

IV. Recommendations

Findings from the extensive stakeholder engagement process informed the recommendations in this report. Additionally, MDH staff reviewed published literature and web resources on developments in health care interpreting, research in the field, and best practices in health care interpreting. Parallel processes that promote quality interpreting were also reviewed, including: the legislation of health care interpreting in a number of other states; court interpretation systems, including the Minnesota Court system; and the national Registry of Interpreters for the Deaf.

Conversations with members of MDH Health Occupations Program (HOP) staff also contributed to the recommendations. This provided a more comprehensive understanding of the credentialing process, lessons learned from the regulation of other health-related occupations, and information about mechanisms for investigation and enforcement.

A. Tiered registry with minimum requirements

In order to ensure access to spoken language health care interpretation while improving the quality of those services, MDH recommends that Minnesota establish minimum requirements for all interpreters, and establish a tiered registry of interpreters recognizing increasing qualifications in each tier. A graphic visually depicting the proposed minimum qualifications and registry system can be found on the next page and in Appendix J.

Minnesota's interpreters possess a broad array of education, training, skills, and experience. A multi-tiered system would serve both to identify and maximize utilization of those interpreters with more

Spoken Language Health Care Interpreter Registry Guide

Tier	Requirements
Tier 1	1. Minimum age of 18 2. Pass MDH Medical Interpreter Ethics and Standards of Practice Test 3. Pass MDH Medical Terminology Test
Tier 2	1. All tier 1 requirements 2. 40+ hours of medical interpreter training through an approved training body[2] 3. Provide proof of 4 hours of continuing education[1] per year for renewal
Tier 3	1. Minimum age of 18 2a. **Option a:** National certification in medical interpreting that **does not** include language proficiency component in the non-English language[3] 2b. **Option b:** Certificate in interpreting from an accredited US educational institution[5] →**Including:** 18 or more semester credits →**And:** Pass MDH Interpreter Ethics and Standards of Practice Test →**And:** Pass MDH Medical Terminology Test 3. Provide proof of 6 hours of continuing education[1] per year for renewal
Tier 4	1. Minimum age of 18 2a. **Option a:** National certification in medical interpreting that **does** include language proficiency component in the non-English language[4] 2b. **Option b:** Associate's Degree or greater in interpreting from an accredited US institution[5] →**Including:** a minimum of 3 semester credits in medical terminology or medical interpreting →**And:** Pass an oral proficiency exam[6] in the non-English language 3. Provide proof of 8 hours of continuing education[1] per year for renewal

All interpreters including those located outside of Minnesota whose services are used for LEP individuals in Minnesota must be at least a Tier 1 member

→Or fulfill equivalent as verified through language services provider

*Other options will be evaluated as necessary by the advisory council

Preapproved options to fulfill requirements*

1. Continuing education accredited by
- American Translators Association (ATA)
- International Medical Interpreters Association (IMIA)
- Certification Commission for Healthcare Interpreters (CCHI)

2. Medical interpreter training (40+ hours)
- Bridging the Gap
- The Community Interpreter (medical focus)
- The Interpreter Advantage
- Requirement to change to 60 hours for new enrollees on 7/1/2018

3. National certification in medical interpreting (No language proficiency component)
- CoreCHI from CCHI

4. National certification in medical interpreting (Including language proficiency component)
- Certified Medical Interpreter (CMI) from National Board of Certification for Medical Interpreters (NBCMI)
- Certified Healthcare Interpreter (CHI) from CCHI

5. Educational institution
- All accredited US institutions
- Foreign institutions as approved by advisory council

6. Oral proficiency exam
- Oral Proficiency Interview (OPI) from American Council on the Teaching of Foreign Languages (ACTFL) →Score of Advanced Mid or greater

skills and provide incentive for other interpreters to improve their skills. This, in turn, should lead to better health status and better health outcomes among LEP Minnesotans.

In order to maintain access to interpreting services for patients who speak rare languages, the state should not universally require a high level of qualifications for all interpreters. However, the state should ensure a minimum level of service for all and increase the quality of interpretive services generally through the establishment of a tiered registry with minimum standards required for tier 1.

The education, training, and skills presented by Minnesota interpreters could be grouped in many different ways to establish a tiered regulatory structure. Factors we considered in these recommendations include the following:

- the need to ensure that interpretation is available to health care patients in all parts of Minnesota;
- the need to provide competent interpretation, i.e. at a minimum, interpretation that is accurate and complete;
- the proportion of existing interpreters that could currently meet a particular requirement;
- whether a specific recommendation would incent interpreters to seek additional training or education to improve their skills;
- whether there are well-established and/or accepted means of documenting particular knowledge, achievement, or skill;
- the cost to interpreters of achieving base level requirements; and
- the cost to MDH of requiring and verifying a particular type of credential.

Relevant precedents for a tiered system exist in both the interpreting and the health care fields. Examples include the court systems of several states, including Minnesota; Oregon's three-tiered system for health care interpreters; the Registry for Interpreters of the Deaf; and the various credentials within the nursing profession.

The recommended tiered system does the following:

- establishes base level requirements so that all interpreters have basic knowledge of medical terminology and the ethical responsibilities and boundaries of their position;
- sets entry level standards low enough to allow meaningful access to speakers of all languages;
- provides differentiation of interpreters with varying levels of qualifications to encourage use of more qualified interpreters;
- keeps costs for entry into the system low by relying on on-line testing administered by MDH;
- recognizes national certification and advanced degrees in interpreting, which include proficiency in interpretive skills and testing in English and the non-English language, as the highest tier;
- recognizes basic training in interpretive skills as a tiered step, thereby encouraging all interpreters to achieve at least this initial level of training;

- establishes a tier for individuals who have attained training or education in interpreting beyond the basic level, but have not completed an advanced degree in interpreting and for whom national certification with a language component may not be available.

Since any system implemented for spoken language health care interpreters would likely be dependent on practitioner fees, we sought the lowest-cost options for verifying qualifications where possible. The recommended requirements for each tier represent our judgment as to those qualifications that have the highest value added to verification cost ratio.

To ensure the proposed registry system is flexible and adapts to changes in the interpreting field, stakeholders recommended the state establish an advisory council to provide guidance and expertise to MDH. The recommendations below indicate where an advisory council could guide MDH in reviewing changes to qualifications as the industry changes or unique situations arise over time.

B. Recommended qualifications

1. Minimum qualifications

MDH recommends all interpreters meet minimum qualifications to promote quality health care interpreting for Minnesota's limited English population while addressing concerns of stakeholders. The minimum qualifications are:

- Knowledge of basic medical terminology,
- Knowledge of health care interpreting ethics and standards of practice, and
- Being 18 years of age or older.

These minimum requirements are low enough that all patients, particularly those who speak rare languages, maintain access to spoken language health interpreters regardless of their location in the state. Within Minnesota, many interpreting agencies and most health systems already have more comprehensive minimum requirements.

Given the frequent use of remote interpreters, MDH further recommends that remote interpreters be required to meet the minimum qualifications in Tier 1 to provide services in Minnesota.

Applying the minimum requirements to remote interpreters ensures a universal standard of care throughout the state and does not put Minnesota interpreters at a disadvantage to interpreters outside the state. To address logistical concerns for out of state firms, remote interpreters could be allowed to meet these requirements by alternative means upon review by an advisory council or by MDH staff.

a. Medical terminology

Recommendation. All applicants be required to demonstrate knowledge of basic medical terminology in English. At Tier 1 and Tier 2, applicants meet this requirement by taking and passing

an examination. Interpreters at Tier 3 and Tier 4 have additional options for meeting this requirement.

Rationale. Stakeholders consistently cited the roster's lack of requirements as a serious shortcoming and identified understanding of basic medical terminology in English as a core competency that should be required for all interpreters.

Relevant literature and stakeholder groups stress the fact that being bilingual does not necessarily qualify someone to interpret in a medical setting. An understanding of medical terminology is one of the factors that separates qualified interpreters from untrained or undertrained individuals. Misinterpretation can occur as a result of a lack of competency in medical terminology which, as previously discussed, is a serious matter which can result in consequences for the patient as severe as permanent disability or death.

The medical terminology test is not meant to be a comprehensive representation of all medical terms that an interpreter will encounter, but encourages interpreters to better familiarize themselves with anatomical, medicinal, technological, and health system-related words and phrases that they will regularly encounter in the field.

Interpreters who have achieved certain standards of training or education and qualify for Tier 3 or Tier 4 will be allowed to meet this requirement via other means. These include: completion of national certification (CMI, CHI, CoreCHI), as these cover medical terminology; or completion of an Associate's degree of higher in interpreting, which should cover medical terminology in some form. Applicants qualifying for Tier 3 by virtue of a Certificate in interpreting approved by the Commissioner will still be required to pass the examination.

MDH's recommended training programs of forty or more hours in health care interpreting include a medical terminology component. Medical terminology is included in the exams for both national certification programs, and is a part of the Certificate and Associate programs in Translation and Interpreting at Century College and the Certificate program at the University of Minnesota.

This recommendation provides a check on one of the most basic of competencies without mandating costly additional training programs or testing from an external vendor for Tier 1 and Tier 2, a step which could push interpreters for rare languages out of the field.

Discussion of other options. One option would be to maintain the status quo of not requiring any demonstration of medical terminology. This would allow all individuals currently working as interpreters to continue working in the field. However, inaccurate and incomplete interpretation places patients at risk and does not provide "meaningful access" to health care.

Furthermore, it requires taxpayers to pay for services that are less than competent and, in some cases, even harmful. Seasoned interpreters repeatedly pointed out that members of other professions are expected to obtain education or training to work, and interpreters should be subject to this same expectation.

Another alternative would be to additionally require a basic medical terminology exam in the interpreter's non-English language. While this check on interpreters' abilities would add

considerable value to a regulatory system, it is logistically and financially unfeasible to develop or identify appropriate tests in all the languages spoken in Minnesota. As of December 1, 2014 there are 225 languages listed on the roster. This number does not reflect all the languages and dialects spoken by LEP patients in Minnesota, nor does it account for the fact that this composition is continually evolving.

b. Interpreting ethics and standards of practice

Recommendation. All applicants be required to demonstrate knowledge of health care interpreting ethics and standards of practice. In addition, all applicants be required to certify, by electronic signature, that they have read and agree to abide by the National Council for Interpreting in Health Care's (NCIHC) (1) Code of Ethics for Interpreters in Health Care and (2) National Standards of Practice for Interpreters in Health Care.

Rationale. Failure to enforce standards of practice or ethics is a serious weakness in the current roster system. While MDH is not currently authorized to act on complaints, MDH has received complaints and is aware that serious abuse of the system is not uncommon.

Testing is intended to ensure that all interpreters at Tier 1 and Tier 2 are familiar with the code of ethics and standards of practice generally accepted in the field of health care interpreting. With the exception of applicants qualifying for Tier 3 by virtue of a Certificate in interpreting approved by the Commission, applicants for Tier 3 or Tier 4 will be exempt from testing, as these interpreters will have demonstrated knowledge in meeting their tier prerequisites.

Requiring health care interpreters at all tiers to read and agree to abide by these ethics and standards of practices establishes the expectation that they will be met by all interpreter at all four tiers, and that they will conduct themselves in accordance with the ethics and standards.

Interpreters and LEP patients come from many different cultures and may have differing behavioral norms surrounding appropriate behavior related to the field of health care. While this requirement does not guarantee ethical or professional behavior, it does attempt to ensure that all interpreters are knowledgeable about expected behavior.

Stakeholders described an understanding of and adherence to the code of ethics and standards of practice as highly correlated to the quality of care patients receive. Interpreters mentioned this as an area in which testing would benefit not only newcomers to the profession but also some long-time interpreters.

Because of the nature of their work, it is especially important that health care interpreters have an understanding of and adhere to data privacy laws and standards. Health care interpreters frequently come in contact with sensitive and private health data of clients that is protected under The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[xliv]. In addition, in their role conveying information between the client and provider, they may learn of sensitive and personal patient information. Finally, the reliance of LEP patients on their interpreters can make them

vulnerable to misinformation and potential abuse of the system. Subpopulations within the LEP community, such as children and the elderly, may be even more vulnerable.

The Minnesota Court System requires their certified and non-certified court interpreters to receive a passing score on a written ethics exam administered by the State Court Administrator. Both national certifying bodies for health care interpreters include ethics and standards of practice as a substantial part of their written examinations, and the State of Oregon requires interpreters to read and abide by the NCIHC's National Standards of Practice and National Code of Ethics for Interpreters in Health Care.

Discussion of other options. Requiring only an electronic signature that the standards of practice and ethics have been read, understood, and will be upheld by the interpreters would be an improvement. However, many stakeholders, including interpreters, expressed reservations that only requiring an electronic signature would not be effective. The inclusion of an exam was highly recommended, and the rationale and precedent for this is discussed above.

Requiring exams to be taken in-person was considered but deemed impractical, particularly from a cost perspective.

c. Age

Recommendation. All applicants be eighteen years of age or older to provide interpreting services in Minnesota.

Rationale. Eighteen is the age of majority in Minnesota and at the federal level. It is the age at which an individual is liable for their own actions, such as contractual obligations or liability for negligence.

The array of potential negative consequences that accompany the use of medical interpreters under the age of 18, including underage family, have been well documented.[xv] Underage interpreters may avoid or inadequately interpret embarrassing or challenging topics, ranging from sexual health to mental health. Ethical issues, such as an underage child having to deliver news of a terminal illness to a parent, must also be considered.

An individual must be eighteen years of age in order to participate in the Minnesota Court Interpreter Program, to receive national health care interpreter certification, to register as a health care interpreter in Oregon, and to receive National Interpreter Certification via the Registry of Interpreters for the Deaf. Currently, there is no age requirement to join the Minnesota health care interpreter roster.

Discussion of other options. The use of health care interpreters less than eighteen years of age should be strongly discouraged under any proposed system. Some stakeholders suggested an age requirement of 21 years of age. This was by no means a broad suggestion, is not supported by precedent in the interpreting profession, and may unnecessarily prevent qualified interpreters from being able to practice their profession, thereby reducing access.

B. Tier 1 requirements

Tier 1 is the entry level tier for spoken language health care interpreters in Minnesota. This tier would be comparable to Minnesota's current roster with the exception of the proposed minimum requirements. To qualify for this tier, applicants need only meet the minimum qualifications: pass exams on medical terminology, and ethics and standards of practice and be at least eighteen years of age.

To maintain sufficient access to interpreter services, in particular for new and rare languages, a basic tier must be included. Including the age requirement and requiring applicants to pass basic testing aims to ensure minimal competency to safeguard patient safety and to increase the quality of interpreting received by LEP patients. The minimal nature of these requirements ensures currently working interpreters do not face unreasonable obstacles to entry to the system and Title VI is not violated due to a reduction in LEP patient access to interpreting.

The recommendations for this tier are made in recognition that certain languages with limited populations in Minnesota will continue to need access to interpreting via a basic tier. Attaining higher tiers may be cost-prohibitive for some interpreters, particularly those working limited numbers of interpreting encounters. This is particularly relevant for rare-language interpreters, in which it is challenging to meet demand, as well as for areas in greater Minnesota.

Furthermore, incoming immigrant and refugee groups continue to change over time. Interpreting agencies and directors of various health care interpreting staff at several health systems described the challenges of finding interpreters at any skill level for certain recently established groups in Minnesota. MDH's Refugee and International Health staff also detailed this challenge.

Some interpreters have cited a fear of losing their jobs due to minimum qualifications. The recommended requirements for inclusion on the entry level tier are the minimum necessary to protect patient safety. The proposed entry level tier is intended to be achievable by the majority of currently working interpreters.

Interpreters who do not know basic medical terminology cannot provide "meaningful access" to medical care for the patients they serve and thus place the state in the position of violating its duty to provide meaningful access. Likewise, individuals who are unaware of and/or unwilling to abide by ethics and standards of practice widely accepted in the field should not be allowed to interpret in health care settings. The potential for abuse is simply too great.

It is anticipated that over time Tier 1 will fall into disuse for interpreters of more common languages. It is recommended that an advisory council annually review whether Tier 1 may be eliminated as a registry option for some more commonly-spoken languages in Minnesota.

C. Tier 2 requirements

Recommendation. To qualify for Tier 2, an applicant must provide proof of successful completion of an approved training program for medical interpreters of a minimum of forty hours. For those who apply on or after July 1, 2018, the requirement would be a minimum of sixty hours. An applicant for Tier 2 must also meet all the Tier 1 requirements (i.e. pass exams on medical terminology, ethics, and standards of practice and be at least eighteen years of age).

Rationale. Completion of basic training in interpreting skills represents a significant advance beyond the entry level requirements of Tier 1. Established training programs, which cover interpreting skills, communication skills, and an understanding of the U.S. health care system, provide interpreters with a foundational understanding in areas critical to interpreter success.

The majority of interpreting agencies and health systems with which MDH spoke currently require or encourage successful completion of a medical interpreting program of forty hours or greater, and, thus, a large percentage of interpreters currently on the roster would qualify for this tier. The majority of interpreters MDH spoke with support completion of such training as a requirement for interpreting.

Most training programs are currently a minimum of forty hours in length, but the national industry trend is shifting to training of sixty or more hours. MDH recommends that acceptable training programs be shifted to a minimum of sixty hours starting July 1, 2018. This provides current interpreters who have completed forty hour trainings the ability to grandparent into the new system. It also may encourage interpreters who have not completed any training to complete a forty hour training prior to the 2018 shift to sixty hours of training. MDH recommends that the system be flexible enough to advance with the national trend, and that an advisory council annually review whether the minimum hours of training to meet Tier 2 requirements be increased.

In-person trainings are offered widely. Bridging the Gap and The Community Interpreter (Medical) are two programs that are utilized across the nation, and Language Access' The Interpreter Advantage is a local program.[xlv] We recommend that these three programs be initially accepted as meeting the training requirement for Tier 2. Other programs, including on-line options, could be added at the discretion of an advisory council or upon review and recommendation by MDH staff.

The base cost to interpreters for trainings is around $750. However, several Minnesota interpreting agencies have staff members whom have completed train-the-trainer programs. These local agencies offer these trainings at a reduced cost to interpreters, around $400-$500.

D. Tier 3 requirements

Recommendation: To qualify for Tier 3, an applicant must be at least 18 years old; affirm by signature, including electronic signature, that he or she has read the Code of Ethics and Standards of Practice for the National Council on Interpreting in Health Care or its successor, and agree to abide by them; and provide one of the following:

> 1) Evidence of current national certification in interpreting that does not include a language proficiency component in the non-English language (currently CoreCHI).

OR

2) Evidence of completion of an approved interpreting certificate program of eighteen semester credits or more from an accredited U.S. academic institution which program is approved by the Commissioner; and demonstrate basic knowledge of medical terminology in English by passing an examination approved by the Commissioner; and demonstrate knowledge of interpreter ethics and standards of practice by passing an examination approved by the Commissioner.

Rationale. Interpreters meeting the requirements for this tier have demonstrated knowledge, skills, and abilities in areas critical to accurate and proficient interpreting. A minimum proficiency level in English can be presumed by the ability to complete either the certificate program or national certification, both of which contain English proficiency requirements.

All of the recommended means of demonstrating competence utilize existing qualifications rather than requiring that Minnesota establish and support an independent means of testing and verification. This has a number of advantages, including economic efficiency and the acceptance of interpreter qualifications outside of Minnesota. This portability provides greater flexibility to interpreters who provide remote interpretation for those outside of the state and to interpreters who relocate outside of Minnesota.

We recommend that only certificates from an accredited U.S. academic institution be accepted. The cost of translating documentation of foreign programs and assessing whether they should be accepted as meeting Tier 3 requirements is prohibitive. Within this limitation, an advisory council should determine base requirements for certificate programs, such as required content areas. An advisory council could also review any new national certifications in interpreting as they become available and determine if they will be accepted as a means of qualification for Tier 3.

***Discussion of other options*.** Determining how to measure increasing qualifications for each tier was a key challenge in developing recommendations for the registry. High quality health care interpreting requires knowledge of medical terminology, proficiency in English and the non-English language, and experience and training in interpretation. To promote quality interpreting and health equity, each tier of the registry should reflect increasingly higher qualifications in each of these three categories. Therefore, as the second-highest tier, it is important for Tier 3 qualifications to reflect higher interpreting ability compared to the two lower tiers.

When analyzing how to verify increasing qualifications for each tier, MDH initially determined that verifying English directly via testing would not add significant value in any tier given that a certain level of English proficiency would be required to complete the medical terminology and ethics tests required in lower tiers and to complete the educational or certification programs required in higher tiers.

MDH further determined that verifying non-English proficiency via testing should be recommended for only the highest tier. The recommended qualifications for Tier 4 directly verify all three skill areas: medical terminology, language proficiency, and training in interpretation. In contrast, the recommended qualifications for lower tiers reflect increasing levels of interpreter training but do not

directly verify all three skill areas. In particular, the recommended qualifications for Tier 3 do not directly verify non-English language proficiency and, under option 2, do not require more knowledge of medical terminology than in the two lower tiers.

Stakeholder feedback to MDH's draft recommendations included suggestions that a foreign language proficiency exam be required in Tier 3 (Appendix J). As a result, MDH reconsidered whether to recommend directly verifying non-English language proficiency in Tier 3. Requiring a non-English language proficiency exam at Tier 3 could improve the quality of interpretation provided at this tier and thereby have a positive impact on health equity for LEP patients. However, the largest concerns voiced by interpreters throughout the engagement process were keeping the costs of a new system as low as possible, and maintaining an appropriate balance between cost to interpreters and quality-improvement measures. Therefore, as with all other aspects of the recommended tiered registry system, MDH carefully considered the cost-value tradeoff of including non-English language testing in Tier 3.

Upon reconsideration, MDH made some changes to Tier 3 recommendations but ultimately determined it would most cost effective for Tier 3 requirements to directly verify higher levels of interpreter training, but not directly verify non-English language proficiency through testing. This recommendation recognizes that the national certification and accredited certificate programs included in Tier 3 do require some level of non-English language proficiency.

Under option 1, CCHI has both English and non-English language proficiency prerequisites for the CoreCHI exam. Although CCHI does not require evidence of successful completion of language proficiency tests from applicants to become certified or renew certification, it does require evidence from a portion of its certified interpreters selected for audits.

Under option 2, interpreting certificate programs generally contain language proficiency requirements in both the English and the non-English language, although accepted proficiency levels vary significantly. These indirect checks on proficiency were determined by MDH to be adequate when weighed against the cost of including foreign language proficiency exams for Tier 3.

The cost of including foreign language proficiency exams includes not only the cost of MDH staff time in verifying the exam results, but also the direct and sometimes substantial cost to the applicant of having the exam results sent. For languages for which no widely accepted exam exists, there is also the cost of verifying the accuracy and rigor of the exam.

MDH further determined that the additional cost and large gap between Tier 2 and Tier 3 could cause many Tier 1 and Tier 2 interpreters to view Tier 3 as unachievable. Thus, interpreters may become discouraged and plateau at Tier 2, ceasing to seek any additional training or improvement of their skills that would improve the quality of interpreting in Minnesota. Focusing Tier 3 qualifications on national certification or accredited certificate programs without direct verification of non-English language proficiency is intended to encourage more interpreter training while minimizing the cost and gap compared to Tier 2 as much as possible.

Since Tier 3 requirements play a major role in the ability of the registry system to improve the quality of health care interpreting in Minnesota, MDH recommends that Tier 3 requirements be revisited by the advisory council in the future.

E. Tier 4 requirements

Recommendation. To qualify for Tier 4, an applicant must be at least 18 years old; affirm by signature, including electronic signature, that he or she has read the Code of Ethics and Standards of Practice for the National Council on Interpreting in Health Care or its successor and agree to abide by them; and provide one of the following:

> 1) Evidence of current national certification in interpreting that does include language proficiency in the non-English language (currently CMI or CHI).
>
> **OR**
>
> 2) Evidence of successful completion of an Associate's Degree or higher in interpreting from an accredited U.S. academic institution, which program is approved by the Commissioner and includes a minimum of three semester credits in medical terminology or medical interpreting; and evidence of a score of Advanced Mid or higher on the American Council on the Teaching of Foreign Language's Oral Proficiency Interview (OPI) in the non-English language. Equivalent means of meeting the oral proficiency requirement for languages in which the OPI is not available will be recommended by an advisory council or by MDH staff.

Rationale. Both of these means of qualification are intended to ensure interpreters in this tier have a combination of training, experience, education, command of medical terminology, and an established level of oral proficiency in both English and the non-English language. This tier more rigorously tests and ensures interpreting skills similar to those used on the job than the other tiers.

Interpreters at this tier will only represent a small fraction of all Minnesota interpreters. However, highlighting the skills of this group will allow registry users to preferentially choose more skilled interpreters. Greater use of more-qualified interpreters will result in improved outcomes for those LEP patients they serve and may provide interpreters with incentives to pursue advanced qualifications.

Integrating pre-existing qualifications reduces redundancy and it saves interpreters significant costs. The cost to develop and score oral language proficiency exams alone would not be feasible under a state program supported by fees.

Both national certification and Associate's Degrees or higher in interpreting are standards recognized and transferable outside of Minnesota. This portability provides interpreters at this tier with flexibility if relocating outside of Minnesota or providing remote interpreting beyond Minnesota's borders. The inclusion of multiple pathways allows interpreters of all languages the opportunity to reach the top tier.

As discussed, a 2013 Minnesota statute called for development of a system based on the national certification process twelve months after its establishment. The requirements of Tier 3 and Tier 4 satisfy this mandate.

We recommend that an advisory council review additional Associate's or higher degrees in interpreting for acceptance. Stakeholders recommended that these degrees are comprised of sixty or more semester credits and include an interpreting internship or equivalent experiential component in interpreting (such as shadowing of an experienced interpreter). This would include degrees from foreign institutions, on a case-by-case basis, but the costs of translating and verifying those credentials would be borne by the particular applicant.

We further recommend that a council review additional foreign language exams beyond the OPI to determine if additional language proficiency exams should be accepted and to establish necessary qualifying scores.

For Tier 4, MDH determined language proficiency in both English and the non-English language(s) to be necessary to ensure high quality interpreting at this tier.

The completion of an Associate's degree or greater in interpreting is in itself a measure of English proficiency. In addition, degree programs in interpreting generally require demonstration of language proficiency in both languages for admission. For example, the Associate's degree program offered by Century College requires interpreter ACTFL Oral Proficiency Interview (OPI) scores of Advanced High or greater in both the English and the non-English languages. MDH is recommending that Tier 4 applicants qualifying via an Associate's degree pass an oral proficiency exam in the non-English language (i.e. either the OPI with a score of Advanced Mid or higher or an advisory council-approved alternative) to ensure non-English language proficiency. Many of the applicants for Tier 4 will already have met this requirement.

The other means of meeting Tier 4 requirements is via national certification which includes a language component (CMI or CHI). NBCMI requires applicants for the CMI to provide proof of proficiency in both English and the non-English language via a variety of means.[xlvi] CCHI has similar prerequisites for applicants for CHI and CoreCHI certification.[xlvii] CCHI does not require evidence from applicants to become certified or renew certification, but does require it from the portion of its certified interpreters selected for audits. The national certification exams also require interpreters to actively demonstrate interpreting ability in English and in the non-English language in which they being certified.

These checks on interpreter language proficiency at Tier 4 were determined sufficiently adequate that it would be both duplicative and an unnecessary financial burden on interpreters to require additional testing in the English and non-English languages.

F. Renewal requirements

***Recommendation*.** Require interpreters at Tier 2, Tier 3, and Tier 4 to provide evidence of successful completion of approved continuing education every year for renewal of his or her status on the

registry. The requirement would be four, six, and eight hours of continuing education per year, respectively. No continuing education is recommended for Tier 1.

Rationale. The importance of continuing education was mentioned by many stakeholders and is supported by the literature surrounding the field. Practices, technology, and terminology are frequently changing and developing in the medical field. Requiring continuing education helps prevent stagnation and encourages continuing professional development. It functions as a means to both maintain and improve interpreter quality. The tiered nature of the required hours of continuing education parallels progressive requirements for advancement along the tiers.

Precedent for requiring continuing education is well-established. Continuing education requirements are common throughout the medical industry, as well as in many other fields. Both organizations offering national certification have continuing education requirements. The CMI currently requires thirty contact hours every five years and the CHI requires thirty-two contact hours every four years. MDH's continuing education recommendation of four, six, and eight hours for Tiers 2-4 is in line with the national certification organizations' requirement of between six and eight hours of continuing education per year.

Continuing education accredited or approved by the American Translators Association, the International Medical Interpreters Association, or the Certification Commission for Healthcare Interpreters would be accepted. Additional continuing education may be accepted based on approval by an advisory council or MDH staff recommendation and approval.

Discussion of other options. Not including a continuing education component would go against the precedent in health care interpreting and in the medical field. In this situation, an interpreter could pass a forty-hour training program and continue to interpret for years on end with no refresher or updating of knowledge and skills along with the development of the health care and the interpreting fields.

V. Cost considerations

Interpreters were clear that fees must remain low for any recommended regulatory system. While no practitioner group wants to pay high fees for regulation, considerations dictate that fees for this group remain low.

It is essential that every patient have access to interpretation at health care encounters, regardless of the language he or she speaks. Thus, fees cannot drive the number of individuals willing to provide interpretation below a level needed to provide access.

Additionally, demand for the services of interpreters who speak rare languages may be so low that, were fees raised significantly, their income from health care interpreting might not even cover regulatory fees. Thus, designing a system that could verify qualifications and monitor interpreters' performance and conduct without substantial fee levels was an overriding goal of this project.

It is important to note that practitioner-based programs overseen by MDH's Health Occupations Program (HOP) are completely funded by fees paid by credentialed practitioners. All aspects of oversight, including credentialing, technical assistance, investigation and enforcement, and electronic systems, are funded by the fees paid by the credentialed practitioners working in a particular field. For each HOP program, the legislature establishes the fee amounts in law and provides an appropriation of the fee revenue to support MDH oversight activities.

Since 2009, interpreters on the Minnesota roster have been paying an annual fee of $50. At that time, it was estimated that 500 health care interpreters worked in Minnesota. A fee of $50 per interpreter was estimated to be necessary to cover the establishment and maintenance of the unverified roster. When listing became mandatory for reimbursement through medical assistance a few years later, the number of interpreters greatly increased, to approximately 3,600 as of December 1, 2014. The appropriation to MDH to operate the roster was not adjusted at that time.

As a result, MDH has historically collected more fee revenue each year than has been authorized to spend on the roster. Beginning in FY 2011, the annual appropriation has been $21,000. The 2014 Legislature increased the annual appropriation for roster activities by $48,000. Estimated annual program revenues were around $172,000 for both FY 2013 and 2014.

Recognizing that cost is a significant concern to stakeholders of the interpreter community, the recommendations in this report reflect our best efforts to identify the lowest-cost options for verifying qualifications and operating the registry.

To design a registry program to verify and display the qualifications recommended in the previous section, the legislature can select and combine program functions in various ways. The number and scope of functions selected by the legislature will determine the fee levels necessary to support the registry system.

The next section describes potential program components to establish and maintain the proposed tiered registry system and explains cost considerations for each. A graphic depicting the costs by program function, start-up costs, and the necessary fees members of each tier would be required to pay to fund them can be found on the next page and in Appendix K.

A. Program components

Potential program components include start-up costs, verification, technical assistance, an advisory council, and a complaint and oversight function. These functions are described separately in order to provide the legislature with options for selecting and combining program functions to build a registry system. The estimated costs and associated fee levels are based on the recommended qualifications in the previous section. If qualifications are modified, costs and, thus fees, will change.

For program components in which the level of effort is the same for all applicants, fee amounts are estimated to be the same across all tiers (e.g. every applicant's contribution to funding the advisory council is identical, regardless of tier). Applicant fees are estimated to be higher for tiers where the

Legislative Guide – Options for Spoken Language Health Care Interpreter Registry Program

The Legislature can select and combine program functions to build a regulatory system for spoken language health care interpreters. The functions selected determine the amount of the fees. The fees necessary to fund each function are shown in the columns on the right.

Program Function	Description of Program Function	Contribution to Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
● **Verification**	• Verify that applicants have passed ethics and medical terminology tests if applicable • Verify that applicants have provided adequate documentation of qualification for Tiers 2, 3, or 4 • Ongoing IT support for online application system • This does NOT include technical assistance to interpreters in applying to the registry	$33.00	$56.00	$73.00
■ **Technical Assistance**	• Assist registry applicants in understanding qualifications for each tier • Assist registry applicants in completing application process	$8.00	$8.00	$8.00
▲ **Advisory Council**	• Advise MDH on issues relating to interpreting skills, standards of practice, and ethics • Inform MDH of emerging issues in the field • Provide consultation on need to draft and request legislative changes to interpreter law	$10.00	$10.00	$10.00
Complaints & Oversight	**Two options:**			
◢ **Option 1: Complaint & Advisement**	• Accept complaints and send letters of advisement , there is NO investigation ○ Interpreters are informed that there has been a complaint, told the nature of the complaint, and referred to appropriate ethical standards or standards of practice • Instances of fraud, abuse, and coercion are referred to local law enforcement	$11.00	$11.00	$11.00
◆ **Option 2: Investigation & Enforcement**	• Accept and investigate complaints; obtain translation and interpretation where necessary to read complaints and interview witnesses ○ Bring enforcement action (fines, remedial action, or remove from registry) against interpreters where complaints are substantiated	$46.00	$46.00	$46.00
Start-Up Costs	• Complete computer programming to expand data collected • Allow online administration and result reporting of ethics and legal terminology tests • Allow attachment and transmittal of supporting documentation • Provide application status reports to applicants • Develop ethics and medical terminology tests • Support staffing to plan and create regulatory infrastructure	Approximate one time start-up costs: • $478,000, FY16 • $95,000, FY17 • $73,000, FY18		

The examples below assume start-up costs will be funded by non-fee sources. Fee amounts would replace the existing fee under current law.

Registry System	Program Functions Included	Total Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
1. Minimal System	● Verification + ◢ Option 1: Complaint & Advisement	**$44.00**	**$67.00**	**$84.00**
2. Basic System	● Verification + ■ Technical Assistance + ▲ Advisory Council + ◢ Option 1: Complaint & Advisement	**$62.00**	**$85.00**	**$102.00**
3. Comprehensive Regulatory Program	● Verification + ■ Technical Assistance + ▲ Advisory Council + ◆ Option 2: Investigation & Enforcement	**$97.00**	**$120.00**	**$137.00**

For example: if the "Basic System" were enacted by the Legislature at these rates, a Tier 1 interpreter would pay $62.00.

level of effort is higher (e.g. applicants for higher tiers pay higher verification costs, as more information is being verified). Estimated fee amounts assume start-up costs will be funded by sources other than future fee revenues. Estimated fee amounts would replace the existing fees collected under current law. Estimated fee amounts are per applicant per year.

1. Start-up costs. Start-up costs for the proposed tiered registry system include:

- Development of online interpreter ethics and medical terminology tests
- Allow online administration and result reporting of ethics and medical terminology tests
- Allow attachment and transmittal of interpreter's supporting documentation
- Provide application status reports to applicants, and
- Provide staffing necessary to support MN.IT and test development contractors in the development of items above, as well as help interpreters transition to the new system

To keep estimated start-up costs low, MDH considered a range of options for data systems and test development. For medical terminology and interpreter ethics tests, we compared the cost of using a national test or developing a Minnesota test, and compared the cost of delivering the tests online or at third party onsite testing locations across the state. When costs to both the interpreters and MDH were considered, MDH development or purchase of a test and online administration was determined to be the most cost-effective option.

Based on MDH staff conversations with a national test provider, the cost per test paid by each interpreter would be approximately $300-$400, as well as $85 per test paid by MDH. Additionally, it would cost MDH approximately $20,000 in first-year setup and maintenance fees, and $10,000 in annual maintenance fees thereafter.

To minimize long-term program costs, a highly-automated technology application is necessary to operate the registry system. Although start-up costs for a system are significant, an automated system will greatly reduce the number of staff positions required long-term to accomplish the required tasks for the registry. An automated system will allow limited staff to focus on verifying interpreters' qualifications and help keep fee levels low. If the electronic system does not include the functionality to administer necessary exams, the number of licensing staff required to implement the system will increase two to three times.

There are numerous areas in which automated system processes would limit the increase in additional staffing. The process of applying for registration would also be entirely online. The system would include a view that allows an applicant to check the status of his or her application. Tracking the status of their application and following up to ensure that required documentation is sent would be the responsibility of the applicant. This reduces time-intensive follow-up by staff.

The three year start-up costs for these activities are estimated at $478,000 for FY16, $95,000 for FY17, and $73,000 for FY18. To ensure fee levels do not drive interpreters out of the field and therefore reduce access to interpreters for LEP patients who speak rare languages, it is not a realistic expectation for practitioners in this field to cover these start-up costs through future fee revenue. In order to maintain access to qualified health care interpreters for the wide range of languages spoken

in Minnesota, other funding sources should be identified for the start-up funds necessary to establish the registry system.

2. Verification. Verification is the backbone of nearly all occupational regulation. It ensures that interpreters have the training and/or skill they represent themselves to have. This includes, but is not limited to: verification that applicants have passed the ethics and medical terminology tests; verification of applicant age and identity from the submitted photocopy applicant identification; verification of interpreter documentation for qualification for Tier 2, Tier 3, and Tier 4; and ongoing IT support and maintenance for the online system. This does not include technical assistance from MDH to interpreters applying to the registry.

To minimize long-term program costs and fee levels, the recommendations focus on qualifications that would be widely shared and easy to verify. Relying upon national certification, well-known national training programs which are available locally, and formal higher education programs that can be verified with a transcript reduces the staff time necessary to verify qualifications. Recommendations do not include qualifications that might add considerable value but would be difficult, time intensive, and/or expensive to verify. Examples of these qualifications are discussed in the next section. Once the registry system is established and costs are more known, the legislature may want to revisit these qualifications.

The cost of verification would be $33 for Tier 1, $56 for Tier 2, and $73 for Tier 3 and Tier 4.

3. Technical assistance. Making MDH staff available to assist applicants in understanding the qualifications for each tier in the registry, and in completing the application process would be $8 per applicant at all tiers.

4. Advisory council. An advisory council would play a critical role in ensuring stakeholder input to the registry system, as well as ensuring that the system is flexible enough to adapt to changes in the field in an adequate and timely manner. An advisory council would advise MDH on issues relating to interpreting skills, ethics and standards of practice; advise MDH on recommended changes to accepted interpreter qualifications, including degree and training programs and non-English language proficiency exams; inform MDH of emerging issues in the field; and provide consultation on the need to draft and request legislative changes to Minnesota interpreter law.

If a council is not established, MDH staff would necessarily have to take on most of these functions, requiring increases in staff hours and positions and higher fees.

MDH recommends that an advisory council be comprised of the following nine members:

> 1) One member representing Limited English Proficient individuals through their role in a community organization
>
> 2, 3, 4) Three interpreters who are Minnesota residents and members of the registry. Each interpreter must interpret a different language and at least one must interpret for a language rare to Minnesota.
>
> 5) One member representing a health maintenance organization or health care insurer

6) One member who is not an interpreter representing a Minnesota health system such as a health care provider or language services coordinator

7) One member representing an interpreter agency

8) One member representing either an interpreter training program, or post-secondary educational institution program providing interpreter courses or skills assessment

9) One member of a Minnesota-based or Minnesota chapter of a national or international organization representing interpreters

The cost of an advisory council component would be $10 per applicant at all tiers.

5. Complaint and oversight. The complaint and oversight function plays a vital role in establishing standards and maintaining quality assurance. The two options provided for complaint and oversight are Complaint and Advisement, or Investigation and Enforcement.

Under the Complaint and Advisement option, MDH would accept complaints and send letters of advisement to interpreters, but no investigation would be undertaken. The letters to interpreters would inform interpreters of the nature of the complaint and refer them to appropriate ethical standards and standards of practice. Instances such as fraud, abuse, and coercion would be referred to appropriate local law enforcement agencies. To date, no regulatory system at MDH utilizes this approach.

Under the Investigation and Enforcement option, MDH would accept and investigate complaints, obtain translation and interpretation where necessary to read complaints, and interview witnesses. MDH staff would bring enforcement action (e.g. fines, remedial action, or removal from registry) against interpreters where complaints were substantiated. The MDH Health Occupations Program has investigation and enforcement authority for all other health-related occupations it regulates.

The cost a Complaint and Advisement component would be $11 per applicant at all tiers. The cost of an Investigation and Enforcement component would be $46 per applicant at all tiers.

6. Examples of regulatory systems. Combinations of program functions and their associated costs allow a range of possible total program costs. All of these examples assume start-up costs will be funded by sources other than future fee revenue. The chart in Appendix K shows three possible combinations, with more comprehensive registry systems requiring higher fee revenue to support.

These examples include:

a) **Minimal System** comprised of Verification and Complaint and Advisement. The costs for this system would $44 for Tier 1, $67 for Tier 2, and $84 for Tier 3 and Tier 4.
b) **Basic System** comprised of Verification, Technical Assistance, an advisory council, and Complaint and Advisement. The costs for this system would be $62 for Tier 1, $85 for Tier 2, and $102 for Tier 3 and Tier 4.
c) **Comprehensive Regulatory Program** comprised of Verification, Technical Assistance, an advisory council, and Investigation and Enforcement. The costs for this system would be $97 for Tier 1, $120 for Tier 2, and $137 for Tier 3 and Tier 4.

Different combinations of components will yield different costs and fee levels. Cost estimates may change based on how actual legislation is drafted to establish a registry system.

B. Other qualifications considered

MDH considered including background studies, general education requirements, and testing to verify proficiency in both the English and non-English languages within the system. MDH is not recommending these at this time. While these requirements would add value, their cost to value ratio is high.

1. Background studies. MDH examined whether all applicants should be required to sign consent forms and undergo a background study, with participation on the registry contingent on successfully passing a background study according to pre-determined criteria.

As mentioned, interpreters frequently come in contact with patient data that is protected under HIPAA or is otherwise sensitive or personal, often work with vulnerable populations, and work independently with no direct supervision.

Currently, most interpreting agencies perform background studies on their interpreters as a requirement for working with them as independent contractors. As interpreters often work for several agencies, the background study is often redundant. Successful passage of a background study by interpreters is required by most health systems prior to hiring or contracting with an interpreter. This is not to say that all interpreters are already undergoing background studies, but rather, that those frequently interpreting are likely to have done so.

Currently, this places the cost burden of paying for background studies and handling associated administrative duties on the interpreting agencies and health care systems rather than on interpreters and MDH.

Many professions in the health care industry are required to successfully pass a background check. Additionally, by 2018, the Health Occupations Programs is mandated to complete background studies for practitioners of certain health-related occupations it regulates.

In the past, background studies have imposed considerable costs upon regulated practitioners: costs for fingerprinting; costs for conducting the check; and administrative costs for assuring that MDH has consent for the check, that MDH has received the results, and that any positive results are analyzed to determine whether they are a bar to practice.

At the time this report is being prepared, the Minnesota Department of Human Services, which conducts background studies on behalf of MDH, is transitioning to a streamlined method of conducting criminal background checks, known as NET Study 2.0. This transition should result in significant reductions in the costs of background studies in the near future. It is recommended that an advisory council annually reconsider whether background studies are appropriate for inclusion in the registry system.

2. Education level. MDH examined whether all applicants should be required to submit proof of attainment of a minimum level of general education, such as a high school degree or equivalent from a U.S. institution or a foreign equivalent.

While this requirement would add value to the system, attempting to acquire school records from foreign countries, have them translated, and then adjudicate whether the experience so documented is equivalent to a high school degree in the United States would add significant complexity and effort and, thus, cost to the system.

As a result, this item is not included among base-level requirements.

3. Language proficiency testing. MDH determined that requiring applicants at all tiers to provide proof of oral language proficiency in both English and the non-English language would not be financially feasible and would reduce LEP patients' access to interpreters. The cost of language testing to interpreters at the lower tiers, as well as the reality that interpreters in rare languages, particularly those of recently-established communities in Minnesota, may have imperfect language skills, were factors in reaching this decision. Another option would be to accept a broader range of means of establishing language proficiency, such as high school diplomas or extensive work experience in either language, but the costs and challenges associated with this verification process removed this from consideration.

MDH further examined whether applicants for Tier 4 and Tier 3 should be required to provide proof of oral language proficiency in the non-English and/or English language via testing. These decisions are discussed in detail in the Tier 3 and Tier 4 areas of the Recommendations Section.

VI. Other findings and considerations

Discussions with stakeholders brought to light concerns shared by many interpreters. Some of these concerns relate to situations and conditions that affect their income, effectiveness, and safety, but are outside the scope of the analysis authorized for this report. Many are outside the current authority of MDH. Due to their impact on interpreters and, thus, on the critical services they provide to LEP populations, these concerns are summarized below. Additional findings from stakeholder engagement can be found in Appendix H.

A. Costs.

The cost of obtaining training and education was frequently noted as a barrier by interpreters. Interpreters requested that scholarships or subsidized training be made available.

Interpreters incur significant additional costs, including gas, parking, and paperwork. These costs must come out of the amount they are paid which, as noted above is approximately $20-$25 per

hour. Some individuals have left the practice because, after costs, they don't earn enough to make continuing to interpret a viable course.

B. Reimbursement.

Interpreters report considerable unreimbursed time, including time spent driving and waiting, and sometimes calling an LEP patient to confirm an appointment the night before.

Interpreters expressed frustration that their pay rate was not currently linked to skill, training, or education. They questioned where else skilled and unskilled workers receive identical pay. Interpreters suggested tying reimbursement levels to certain tiers. This could present challenges for rare languages or otherwise restrict access to interpreting services, as lower pay rates might serve as a further disincentive for rare-language interpreters with limited qualifications.

DHS currently requiring interpreters to be listed on the roster in order to receive reimbursement from medical assistance. The statute (MINN. STAT. 256B.0625, subdiv. 18a - 2014) will need to be amended prior to implementation of an interpreter registry in order to incorporate the registry.

Stakeholders also highlighted the importance of holding remote interpreters to the same requirements as in-state interpreters in order to receive reimbursement from medical assistance. This maintains a universal statewide standard of care and does not place Minnesota works at a disadvantage.

C. Continuing education.

Interpreters communicated that they would like more opportunities for continuing education, especially in the out-state area. They suggested that online options would make training accessible to interpreters across the state. They also reported concerns about affordability and suggested that continuing education be subsidized with grants.

D. Variable skill levels.

MDH staff consistently heard from health systems, agencies, and interpreters that languages of lesser diffusion are often held to lower expectations and standards out of necessity.

E. Variance between the standards and practices of agencies.

Standards and ethical practices vary significantly between agencies. Interpreters suggested that certification of interpreting agencies be considered. Similarly, the hiring process varies greatly from agency to agency. Although some agencies do a good job and are thorough in this process, some do little to no testing or examining of qualifications.

F. Sight translation.

Many interpreters reported that they had been asked to perform lengthy sight translation. Sight translation requires a different set of skills than interpreting. When done for lengthy and/or sensitive documents, such as consent forms, it falls outside the scope of their practice as spoken language health interpreters. These requests illustrate a lack of understanding of the interpreter's role. While interpreters who don't provide this service are actually more properly following the scope of practice, they may be perceived as unprofessional or unskilled for doing so, and may get fewer call backs as a result. Providers and hospital staff should be educated about the proper role of an interpreter. Interpreters also expressed interest in an Interpreter Bill of Rights that could cover these concerns.

VII. Appendices

A. Relevant legislation

B. Minnesota Department of Education maps of primary home language counts by county 2012-2013

C. Survey about health care interpreting for stakeholders

D. Identification of stakeholders and list of participants

E. Project calendar

F. Drafted recommendations sent to stakeholders on December 19th 2014

G. Stakeholder response to drafted recommendations

H. Key findings from informants, stakeholders and survey participants

I. Perspectives on medical interpreters from LEP Minnesotans

J. Registry guide

K. Legislative guide

L. Draft legislation

Appendix A – Relevant legislation

88th Session

H.F. No. 3172

Article 30.

Section 3.

Subdivision 3.

Spoken language health care interpreters.
$81,000 in fiscal year 2015 from the state government special revenue fund is to develop a proposal to promote health equity and quality health outcomes through changes to laws governing spoken language health care interpreters. The commissioner shall consult with a broad range of spoken language health care interpreters, including independent contractors and those who speak rare languages, organizations that employ these interpreters, organizations that pay for interpreter services, health care providers who use interpreters, clients who use interpreters, community organizations serving non-English-speaking populations, and other relevant organizations including but not limited to Interpreter Agencies of Minnesota and the Interpreters Stakeholder Group. The commissioner shall draft legislation and submit a report that documents the process followed and the rationale for the recommendations to the committees with jurisdiction over health and human services by January 15, 2015.

In drafting the legislation and report, the commissioner must consider input received from individuals and organizations consulted and must address issues related to:

(1) qualifications for spoken language health care interpreters that assure quality service to health care providers and their patients, considering differences for common and rare languages;
(2) methods to support the education and skills development of spoken language health care interpreters serving Minnesotans;
(3) the role of an advisory council in maintaining a quality system for spoken language health care interpreting in Minnesota;
(4) management of complaints regarding spoken language health care interpreters, including investigation and enforcement actions;

(5) an appropriate structure for oversight of spoken language health care interpreters, including administrative and technology requirements; and

(6) other issues that address qualifications, quality, access, and affordability of spoken language interpreter services.

This is a onetime appropriation.

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.

History:

2008 c 363 art 17 s 2

256B.0625 COVERED SERVICES.

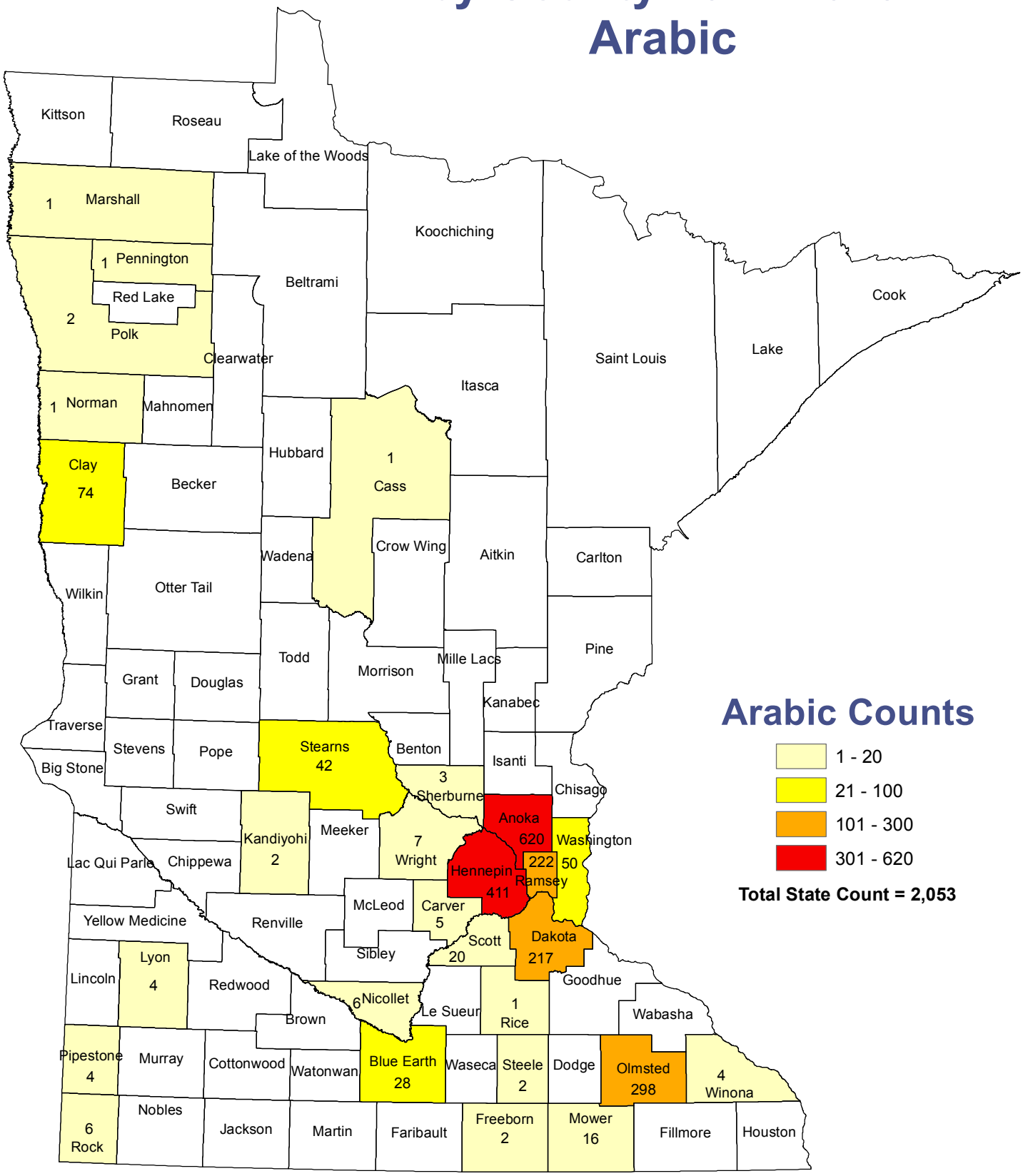
Subd. 18a.**Access to medical services.**

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and spoken language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face spoken language interpreter services shall be provided only if the spoken language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

Appendix B – Minnesota Department of Education maps of primary home language counts by county 2012-2013

These 2013 Minnesota Department of Education maps show the number of homes in each county with school-aged children speaking ten of the most commonly spoken non-English languages in the state.

Primary Home Language Counts by County 2012-2013
Arabic



Arabic Counts

- 1 - 20
- 21 - 100
- 101 - 300
- 301 - 620

Total State Count = 2,053

0 15 30 60 90 Miles

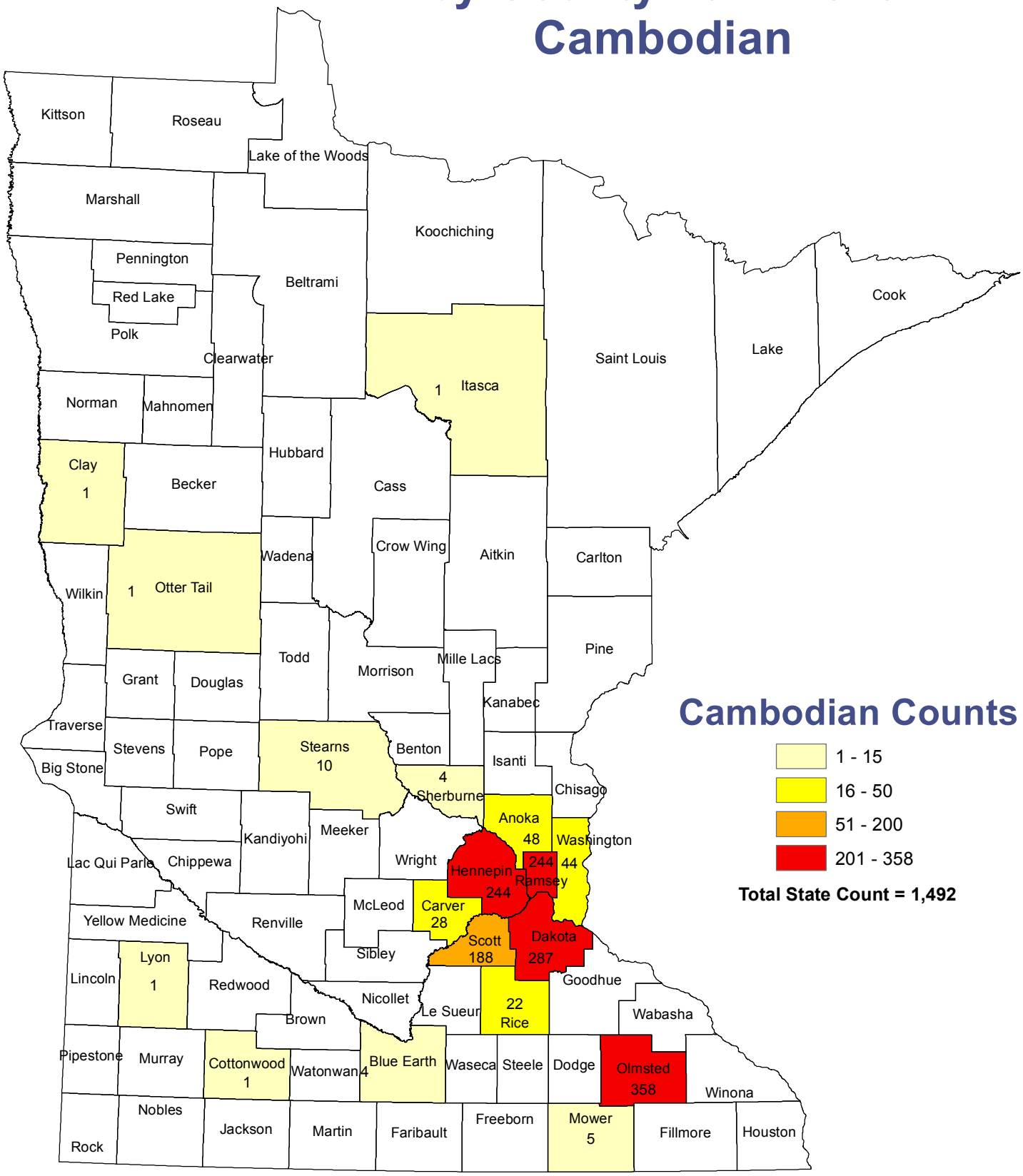
Date: 3/11/2013
Project Track #:: M0118 JS/IT

Minnesota Department of Education

Arabic Primary Home Language Counts by County 2012-2013

Aitkin	0	Lincoln	0	Waseca	0
Anoka	620	Lyon	4	Washington	50
Becker	0	Mahnomen	0	Watonwan	0
Beltrami	0	Marshall	1	Wilkin	0
Benton	0	Martin	0	Winona	4
Big Stone	0	McLeod	0	Wright	7
Blue Earth	28	Meeker	0	Yellow Medicine	0
Brown	0	Mille Lacs	0		
Carlton	0	Morrison	0	Total State Count	2,053
Carver	5	Mower	16		
Cass	1	Murray	0		
Chippewa	0	Nicollet	6		
Chisago	0	Nobles	0		
Clay	74	Norman	1		
Clearwater	0	Olmsted	298		
Cook	0	Otter Tail	0		
Cottonwood	0	Pennington	1		
Crow Wing	0	Pine	0		
Dakota	217	Pipestone	4		
Dodge	0	Polk	2		
Douglas	0	Pope	0		
Faribault	0	Ramsey	222		
Fillmore	0	Red Lake	0		
Freeborn	2	Redwood	0		
Goodhue	0	Renville	0		
Grant	0	Rice	1		
Hennepin	411	Rock	6		
Houston	0	Roseau	0		
Hubbard	0	Scott	20		
Isanti	0	Sherburne	3		
Itasca	0	Sibley	0		
Jackson	0	St. Louis	3		
Kanabec	0	Stearns	42		
Kandiyohi	2	Steele	2		
Kittson	0	Stevens	0		
Koochiching	0	Swift	0		
Lac qui Parle	0	Todd	0		
Lake	0	Traverse	0		
Lake of the Woods	0	Wabasha	0		
Le Sueur	0	Wadena	0		

Primary Home Language Counts by County 2012-2013 Cambodian



Cambodian Counts

- 1 - 15
- 16 - 50
- 51 - 200
- 201 - 358

Total State Count = 1,492

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

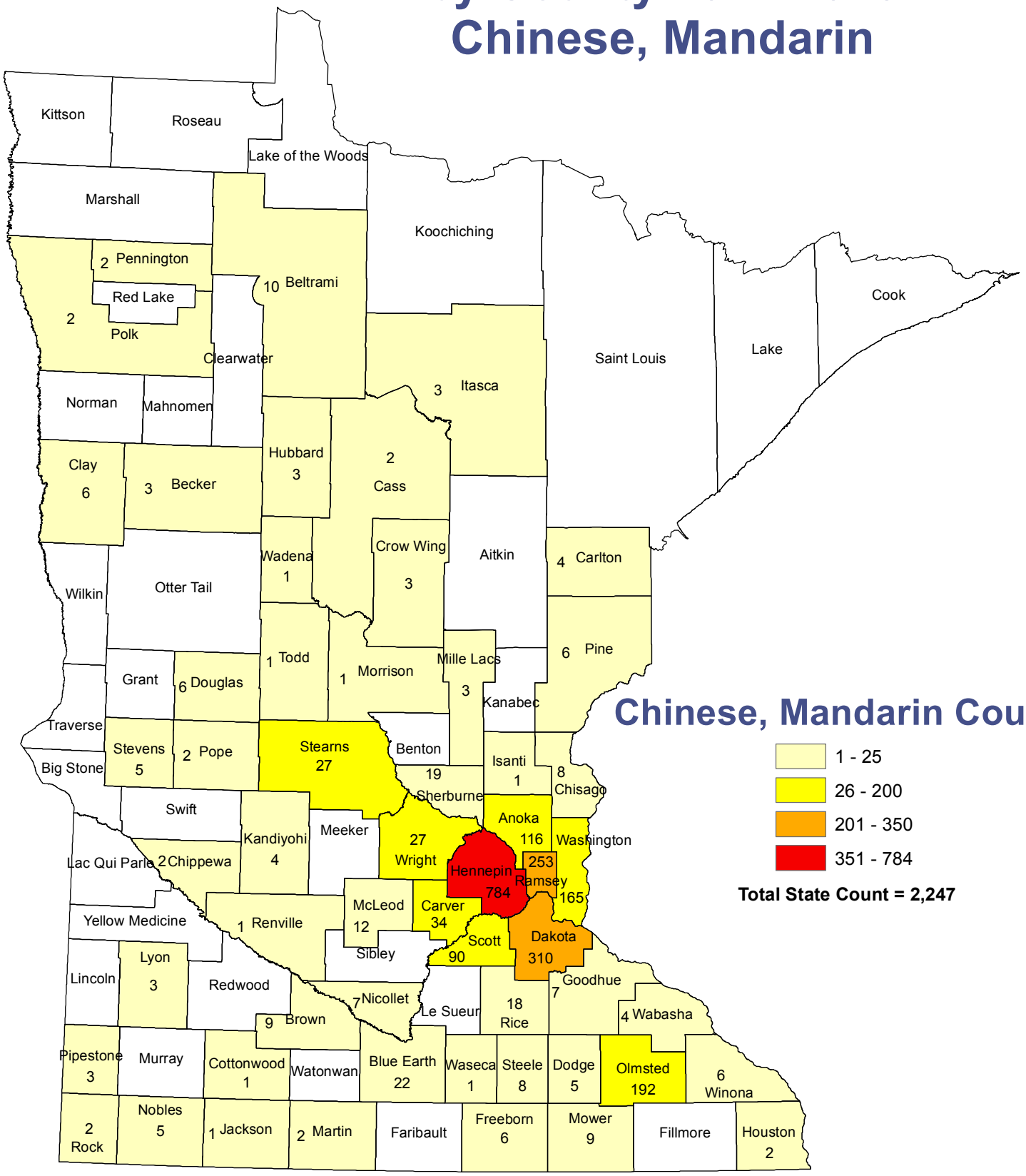
Minnesota Department of Education

Cambodian Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	48
Becker	0
Beltrami	0
Benton	0
Big Stone	0
Blue Earth	4
Brown	0
Carlton	0
Carver	28
Cass	0
Chippewa	0
Chisago	0
Clay	1
Clearwater	0
Cook	0
Cottonwood	1
Crow Wing	0
Dakota	287
Dodge	0
Douglas	0
Faribault	0
Fillmore	0
Freeborn	0
Goodhue	0
Grant	0
Hennepin	244
Houston	0
Hubbard	0
Isanti	0
Itasca	1
Jackson	0
Kanabec	0
Kandiyohi	0
Kittson	0
Koochiching	0
Lac qui Parle	0
Lake	0
Lake of the Woods	0
Le Sueur	0
Lincoln	0
Lyon	1
Mahnomen	0
Marshall	0
Martin	0
McLeod	0
Meeker	0
Mille Lacs	0
Morrison	0
Mower	5
Murray	0
Nicollet	0
Nobles	0
Norman	0
Olmsted	358
Otter Tail	1
Pennington	0
Pine	0
Pipestone	0
Polk	0
Pope	0
Ramsey	244
Red Lake	0
Redwood	0
Renville	0
Rice	22
Rock	0
Roseau	0
Scott	188
Sherburne	4
Sibley	0
St. Louis	1
Stearns	10
Steele	0
Stevens	0
Swift	0
Todd	0
Traverse	0
Wabasha	0
Wadena	0
Waseca	0
Washington	44
Watonwan	0
Wilkin	0
Winona	0
Wright	0
Yellow Medicine	0

Total State Count: 1,492

Primary Home Language Counts by County 2012-2013
Chinese, Mandarin



Chinese, Mandarin Counts

- 1 - 25
- 26 - 200
- 201 - 350
- 351 - 784

Total State Count = 2,247

0 15 30 60 90 Miles

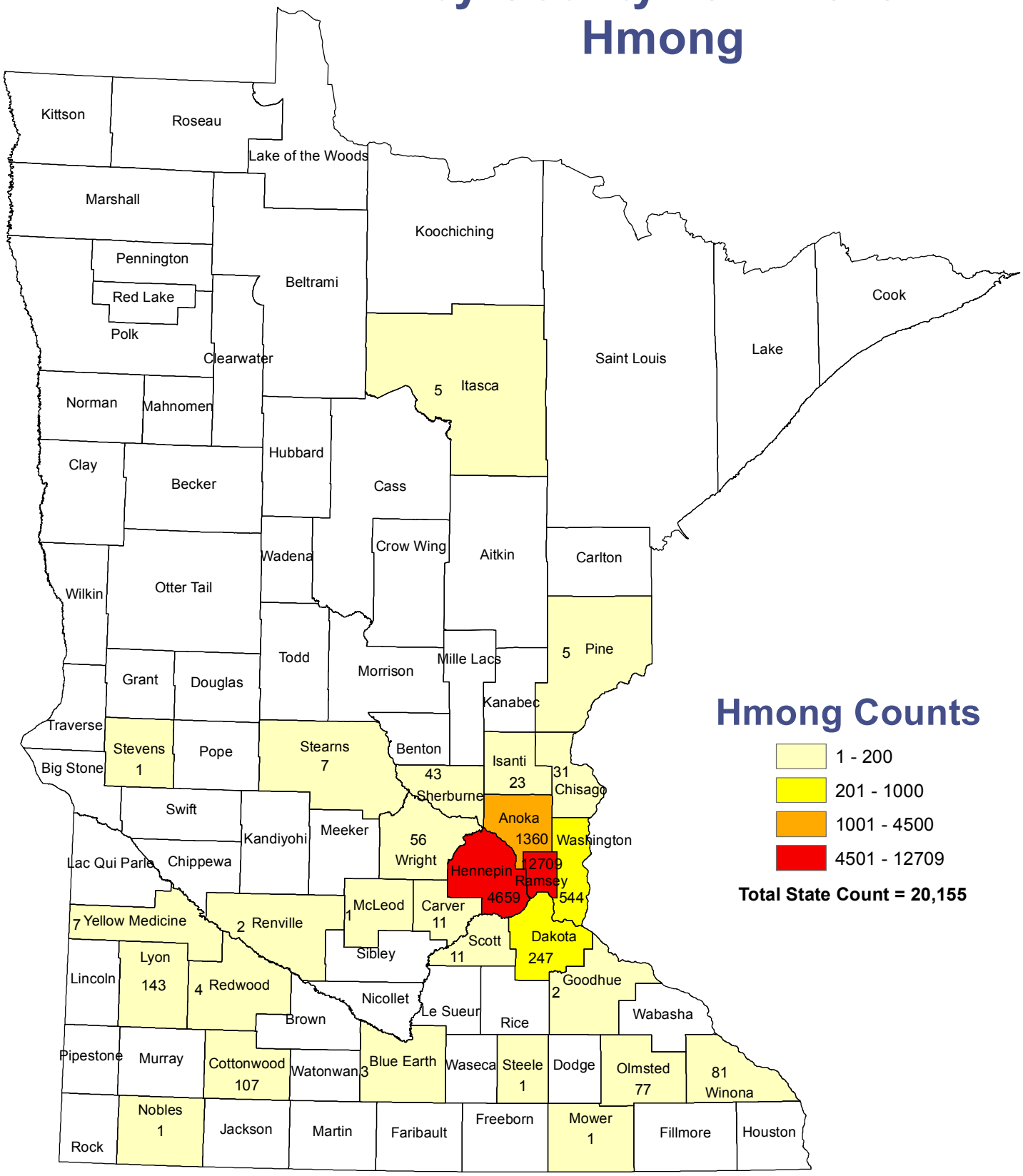
Date: 3/11/2013
Project Track #:: M0118 JS/IT

Minnesota Department of Education

Chinese, Mandarin Primary Home Language Counts by County 2012-2013

Aitkin	0	Le Sueur	0	Traverse	0
Anoka	116	Lincoln	0	Wabasha	4
Becker	3	Lyon	3	Wadena	1
Beltrami	10	Mahnomen	0	Waseca	1
Benton	0	Marshall	0	Washington	165
Big Stone	0	Martin	2	Watonwan	0
Blue Earth	22	McLeod	12	Wilkin	0
Brown	9	Meeker	0	Winona	6
Carlton	4	Mille Lacs	3	Wright	27
Carver	34	Morrison	1	Yellow Medicine	0
Cass	2	Mower	9		
Chippewa	2	Murray	0	Total State Count: 2,247	
Chisago	8	Nicollet	7		
Clay	6	Nobles	5		
Clearwater	0	Norman	0		
Cook	0	Olmsted	192		
Cottonwood	1	Otter Tail	0		
Crow Wing	3	Pennington	2		
Dakota	310	Pine	6		
Dodge	5	Pipestone	3		
Douglas	6	Polk	2		
Faribault	0	Pope	2		
Fillmore	0	Ramsey	253		
Freeborn	6	Red Lake	0		
Goodhue	7	Redwood	0		
Grant	0	Renville	1		
Hennepin	784	Rice	18		
Houston	2	Rock	2		
Hubbard	3	Roseau	0		
Isanti	1	Scott	90		
Itasca	3	Sherburne	19		
Jackson	1	Sibley	0		
Kanabec	0	St. Louis	18		
Kandiyohi	4	Stearns	27		
Kittson	0	Steele	8		
Koochiching	0	Stevens	5		
Lac qui Parle	0	Swift	0		
Lake	0	Todd	1		
Lake of the Woods	0				

Primary Home Language Counts by County 2012-2013
Hmong



Hmong Counts

- 1 - 200
- 201 - 1000
- 1001 - 4500
- 4501 - 12709

Total State Count = 20,155

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

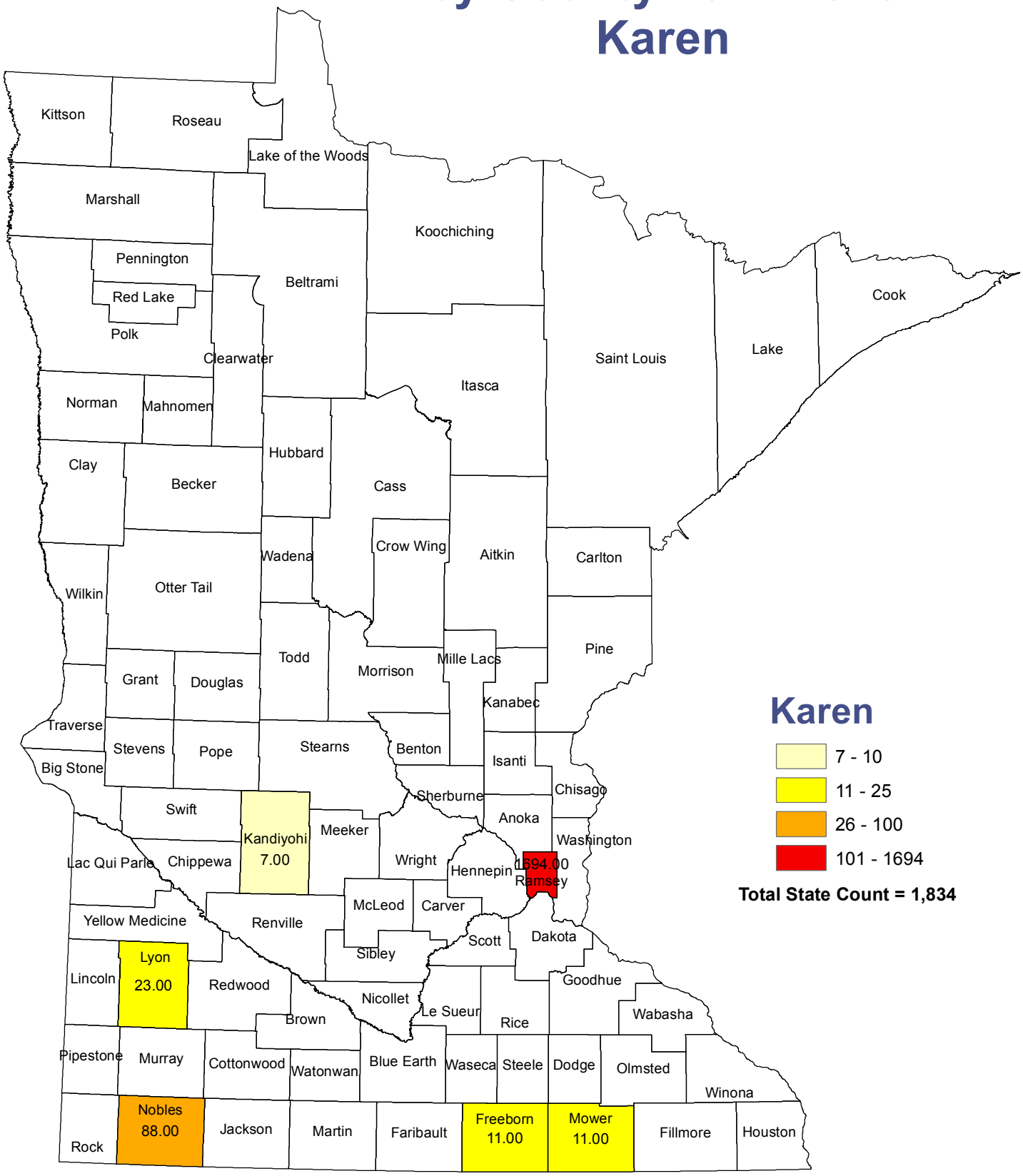
Minnesota Department of Education

Hmong Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	1360
Becker	0
Beltrami	0
Benton	0
Big Stone	0
Blue Earth	3
Brown	0
Carlton	0
Carver	11
Cass	0
Chippewa	0
Chisago	31
Clay	0
Clearwater	0
Cook	0
Cottonwood	107
Crow Wing	0
Dakota	247
Dodge	0
Douglas	0
Faribault	0
Fillmore	0
Freeborn	0
Goodhue	2
Grant	0
Hennepin	4659
Houston	0
Hubbard	0
Isanti	23
Itasca	5
Jackson	0
Kanabec	0
Kandiyohi	0
Kittson	0
Koochiching	0
Lac qui Parle	0
Lake	0
Lake of the Woods	0
Le Sueur	0
Lincoln	0
Lyon	143
Mahnomen	0
Marshall	0
Martin	0
McLeod	1
Meeker	0
Mille Lacs	0
Morrison	0
Mower	1
Murray	0
Nicollet	0
Nobles	1
Norman	0
Olmsted	77
Otter Tail	0
Pennington	0
Pine	5
Pipestone	0
Polk	0
Pope	0
Ramsey	12,709
Red Lake	0
Redwood	4
Renville	2
Rice	0
Rock	0
Roseau	0
Scott	11
Sherburne	43
Sibley	0
St. Louis	13
Stearns	7
Steele	1
Stevens	1
Swift	0
Todd	0
Traverse	0
Wabasha	0
Wadena	0
Waseca	0
Washington	544
Watonwan	0
Wilkin	0
Winona	81
Wright	56
Yellow Medicine	7

Total State Count: 20,155

Primary Home Language Counts by County 2012-2013
Karen



Karen

- 7 - 10
- 11 - 25
- 26 - 100
- 101 - 1694

Total State Count = 1,834

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

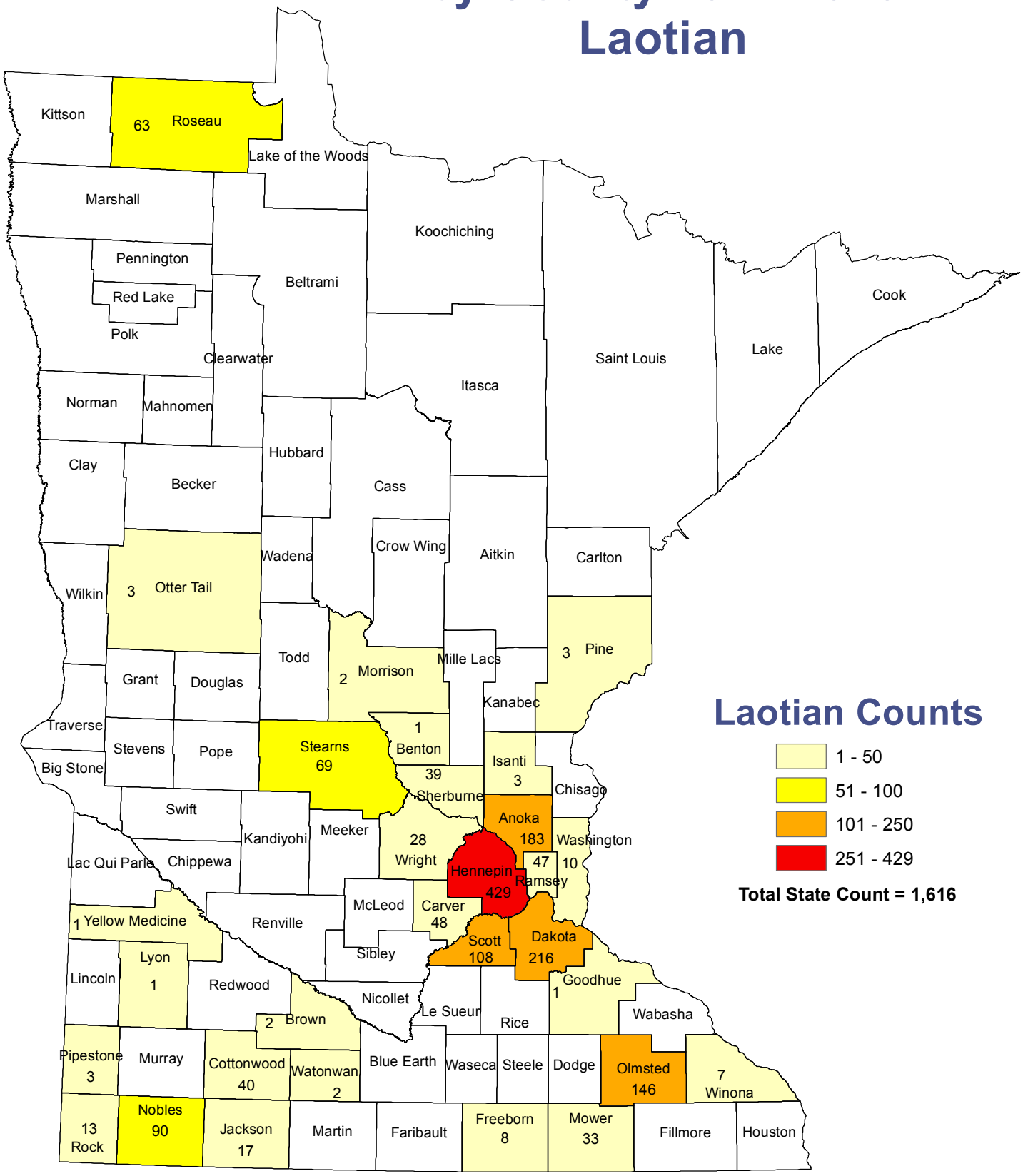
Minnesota Department of Education

Karen Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	0
Becker	0
Beltrami	0
Benton	0
Big Stone	0
Blue Earth	0
Brown	0
Carlton	0
Carver	0
Cass	0
Chippewa	0
Chisago	0
Clay	0
Clearwater	0
Cook	0
Cottonwood	0
Crow Wing	0
Dakota	0
Dodge	0
Douglas	0
Faribault	0
Fillmore	0
Freeborn	11
Goodhue	0
Grant	0
Hennepin	0
Houston	0
Hubbard	0
Isanti	0
Itasca	0
Jackson	0
Kanabec	0
Kandiyohi	7
Kittson	0
Koochiching	0
Lac qui Parle	0
Lake	0
Lake of the Woods	0
Le Sueur	0
Lincoln	0
Lyon	23
Mahnomen	0
Marshall	0
Martin	0
McLeod	0
Meeker	0
Mille Lacs	0
Morrison	0
Mower	11
Murray	0
Nicollet	0
Nobles	88
Norman	0
Olmsted	0
Otter Tail	0
Pennington	0
Pine	0
Pipestone	0
Polk	0
Pope	0
Ramsey	1694
Red Lake	0
Redwood	0
Renville	0
Rice	0
Rock	0
Roseau	0
Scott	0
Sherburne	0
Sibley	0
St. Louis	0
Stearns	0
Steele	0
Stevens	0
Swift	0
Todd	0
Traverse	0
Wabasha	0
Wadena	0
Waseca	0
Washington	0
Watonwan	0
Wilkin	0
Winona	0
Wright	0
Yellow Medicine	0

Total State Count: 1,834

Primary Home Language Counts by County 2012-2013
Laotian



Laotian Counts

- 1 - 50
- 51 - 100
- 101 - 250
- 251 - 429

Total State Count = 1,616

0 15 30 60 90 Miles

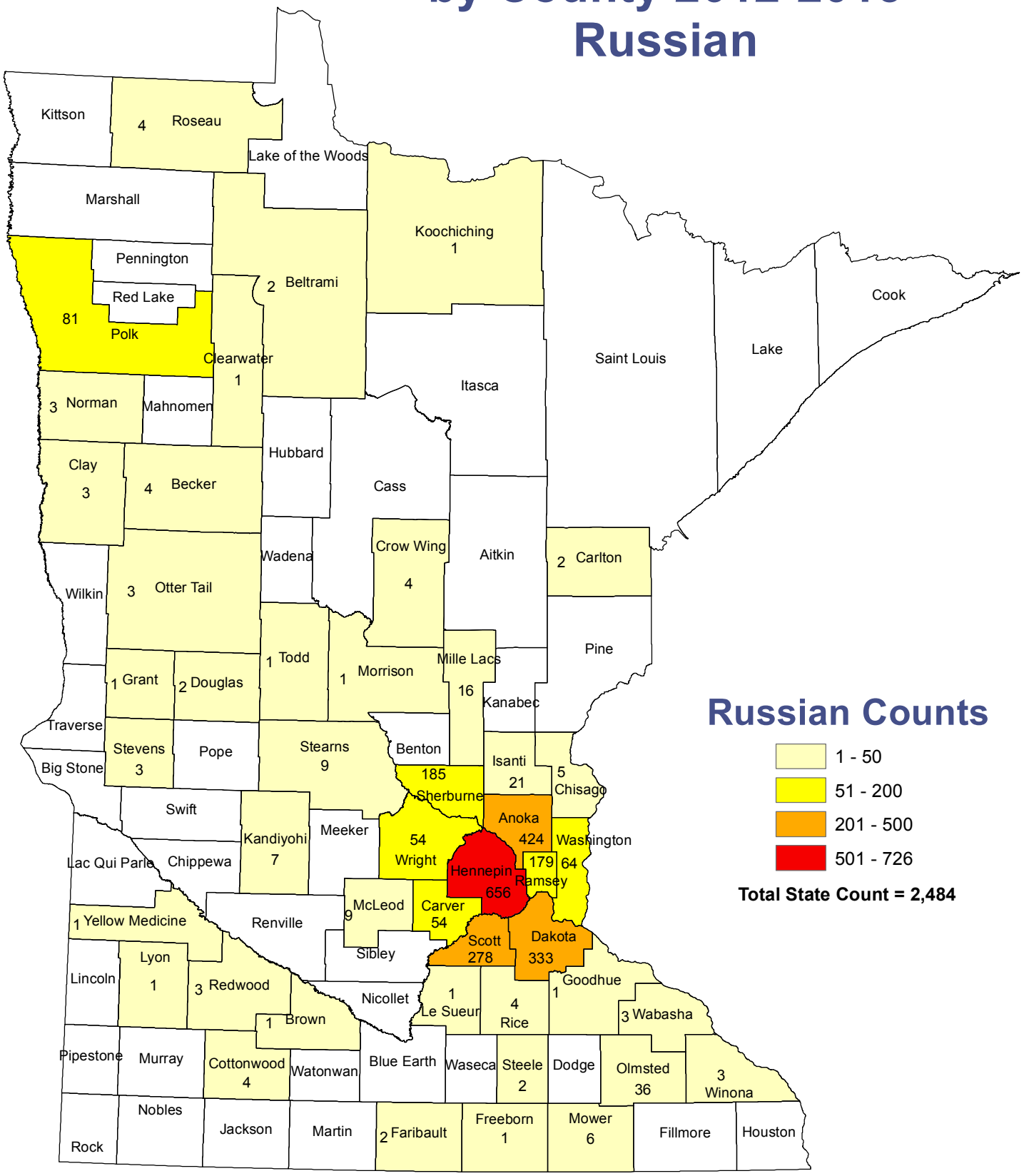
Date: 3/11/2013
Project Track #:: M0118 JS/IT

Minnesota Department of Education

Laotian Primary Home Language Counts by County 2012-2013

Aitkin	0	Lincoln	0	Waseca	0
Anoka	0	Lyon	23	Washington	0
Becker	0	Mahnomen	0	Watonwan	0
Beltrami	0	Marshall	0	Wilkin	0
Benton	0	Martin	0	Winona	0
Big Stone	0	McLeod	0	Wright	0
Blue Earth	0	Meeker	0	Yellow Medicine	0
Brown	0	Mille Lacs	0		
Carlton	0	Morrison	0	Total State Count: 1,834	
Carver	0	Mower	11		
Cass	0	Murray	0		
Chippewa	0	Nicollet	0		
Chisago	0	Nobles	88		
Clay	0	Norman	0		
Clearwater	0	Olmsted	0		
Cook	0	Otter Tail	0		
Cottonwood	0	Pennington	0		
Crow Wing	0	Pine	0		
Dakota	0	Pipestone	0		
Dodge	0	Polk	0		
Douglas	0	Pope	0		
Faribault	0	Ramsey	1694		
Fillmore	0	Red Lake	0		
Freeborn	11	Redwood	0		
Goodhue	0	Renville	0		
Grant	0	Rice	0		
Hennepin	0	Rock	0		
Houston	0	Roseau	0		
Hubbard	0	Scott	0		
Isanti	0	Sherburne	0		
Itasca	0	Sibley	0		
Jackson	0	St. Louis	0		
Kanabec	0	Stearns	0		
Kandiyohi	7	Steele	0		
Kittson	0	Stevens	0		
Koochiching	0	Swift	0		
Lac qui Parle	0	Todd	0		
Lake	0	Traverse	0		
Lake of the Woods	0	Wabasha	0		
Le Sueur	0	Wadena	0		

Primary Home Language Counts by County 2012-2013 Russian



Russian Counts

- 1 - 50
- 51 - 200
- 201 - 500
- 501 - 726

Total State Count = 2,484

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

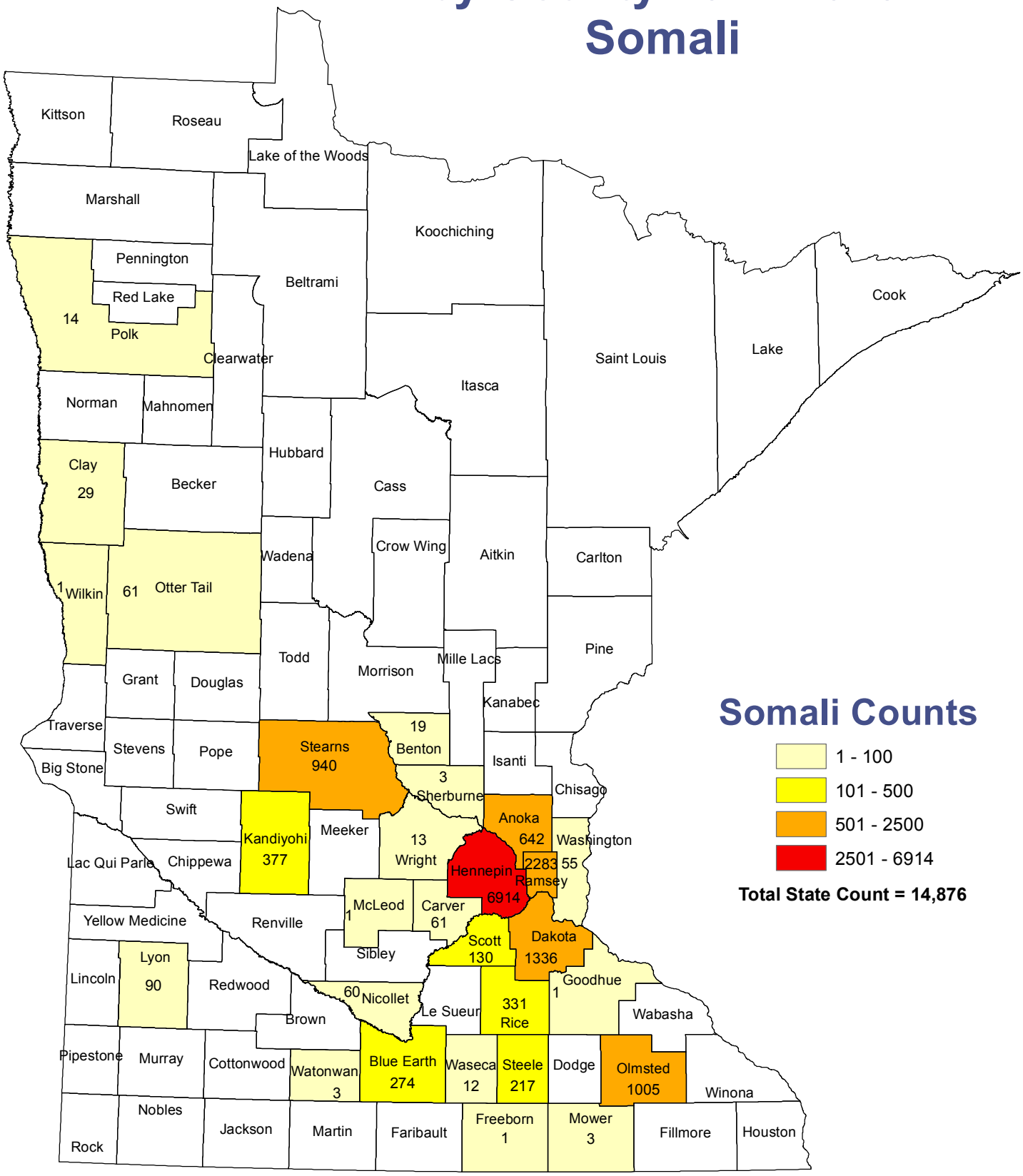
Minnesota Department of Education

Russian Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	424
Becker	4
Beltrami	2
Benton	0
Big Stone	0
Blue Earth	0
Brown	1
Carlton	2
Carver	54
Cass	0
Chippewa	0
Chisago	5
Clay	3
Clearwater	1
Cook	0
Cottonwood	4
Crow Wing	4
Dakota	333
Dodge	0
Douglas	2
Faribault	2
Fillmore	0
Freeborn	1
Goodhue	1
Grant	1
Hennepin	656
Houston	0
Hubbard	0
Isanti	21
Itasca	0
Jackson	0
Kanabec	0
Kandiyohi	7
Kittson	0
Koochiching	1
Lac qui Parle	0
Lake	0
Lake of the Woods	0
Le Sueur	1
Lincoln	0
Lyon	1
Mahnomen	0
Marshall	0
Martin	0
McLeod	9
Meeker	0
Mille Lacs	16
Morrison	1
Mower	6
Murray	0
Nicollet	0
Nobles	0
Norman	3
Olmsted	36
Otter Tail	3
Pennington	0
Pine	0
Pipestone	0
Polk	81
Pope	0
Ramsey	179
Red Lake	0
Redwood	3
Renville	0
Rice	4
Rock	0
Roseau	4
Scott	278
Sherburne	185
Sibley	0
St. Louis	5
Stearns	9
Steele	2
Stevens	3
Swift	0
Todd	1
Traverse	0
Wabasha	3
Wadena	0
Waseca	0
Washington	64
Watonwan	0
Wilkin	0
Winona	3
Wright	54
Yellow Medicine	1

Total State Count: 2,484

Primary Home Language Counts by County 2012-2013
Somali



Somali Counts

- 1 - 100
- 101 - 500
- 501 - 2500
- 2501 - 6914

Total State Count = 14,876

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

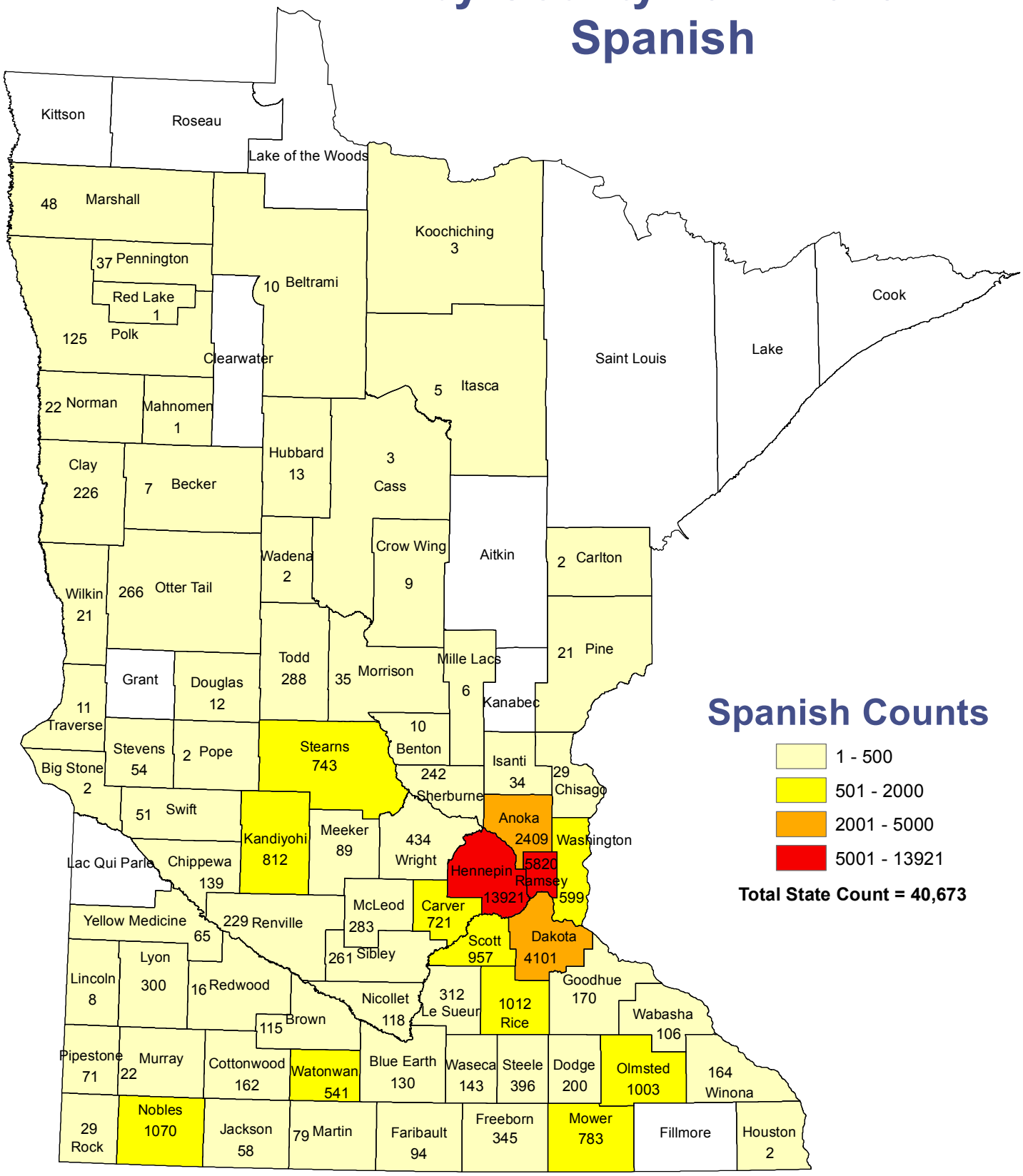
Minnesota Department of Education

Somali Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	642
Becker	0
Beltrami	0
Benton	19
Big Stone	0
Blue Earth	274
Brown	0
Carlton	0
Carver	61
Cass	0
Chippewa	0
Chisago	0
Clay	29
Clearwater	0
Cook	0
Cottonwood	0
Crow Wing	0
Dakota	1336
Dodge	0
Douglas	0
Faribault	0
Fillmore	0
Freeborn	1
Goodhue	1
Grant	0
Hennepin	6914
Houston	0
Hubbard	0
Isanti	0
Itasca	0
Jackson	0
Kanabec	0
Kandiyohi	377
Kittson	0
Koochiching	0
Lac qui Parle	0
Lake	0
Lake of the Woods	0
Le Sueur	0
Lincoln	0
Lyon	90
Mahnomen	0
Marshall	0
Martin	0
McLeod	1
Meeker	0
Mille Lacs	0
Morrison	0
Mower	3
Murray	0
Nicollet	60
Nobles	0
Norman	0
Olmsted	1005
Otter Tail	61
Pennington	0
Pine	0
Pipestone	0
Polk	14
Pope	0
Ramsey	2283
Red Lake	0
Redwood	0
Renville	0
Rice	331
Rock	0
Roseau	0
Scott	130
Sherburne	3
Sibley	0
St. Louis	0
Stearns	940
Steele	217
Stevens	0
Swift	0
Todd	0
Traverse	0
Wabasha	0
Wadena	0
Waseca	12
Washington	55
Watonwan	3
Wilkin	1
Winona	0
Wright	13
Yellow Medicine	0

Total State Count: 14,876

Primary Home Language Counts by County 2012-2013 Spanish



Spanish Counts

- 1 - 500
- 501 - 2000
- 2001 - 5000
- 5001 - 13921

Total State Count = 40,673

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

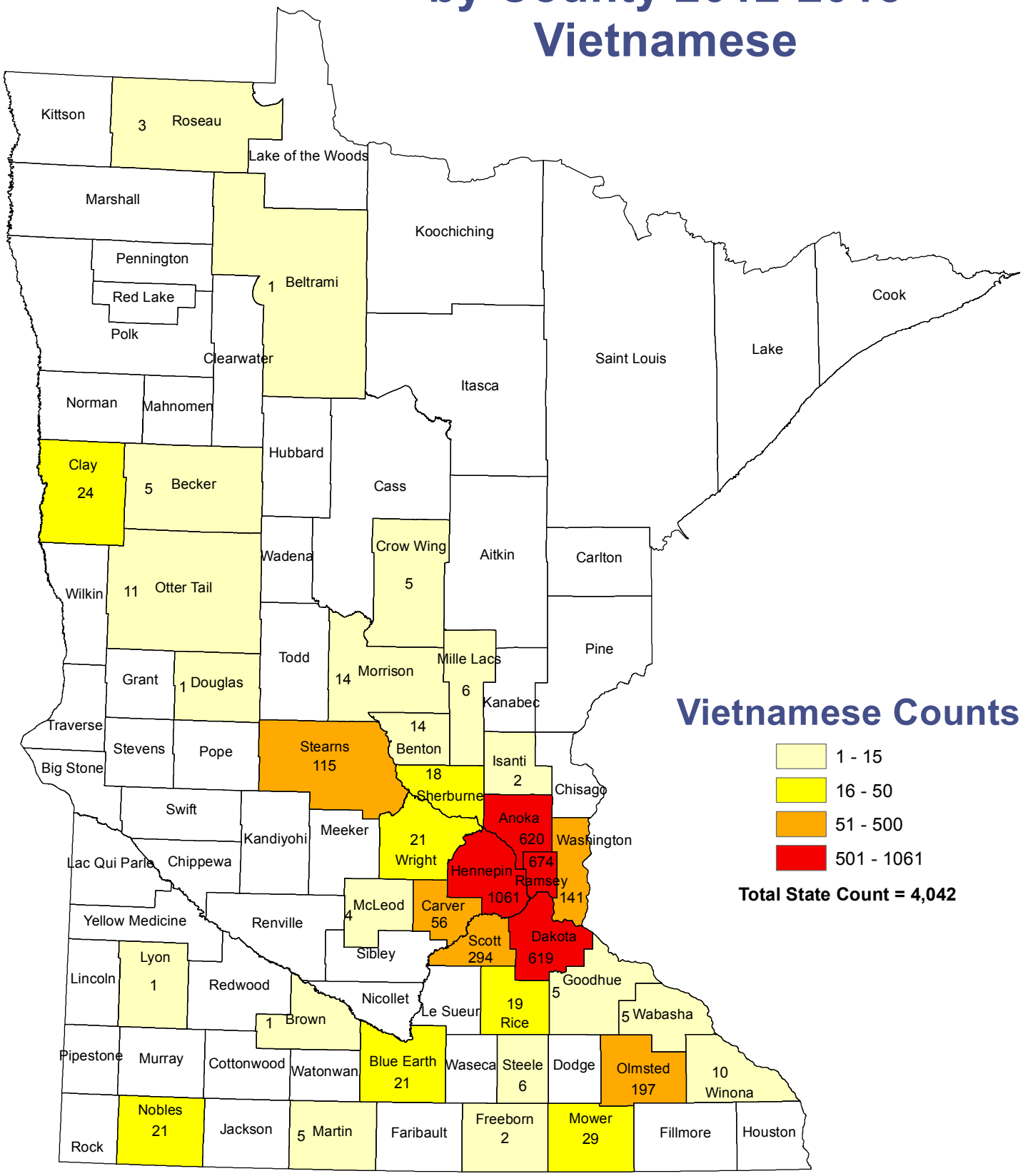
Minnesota Department of Education

Spanish Primary Home Language Counts by County 2012-2013

Aitkin	0
Anoka	2409
Becker	7
Beltrami	10
Benton	10
Big Stone	2
Blue Earth	130
Brown	115
Carlton	2
Carver	721
Cass	3
Chippewa	139
Chisago	29
Clay	226
Clearwater	0
Cook	0
Cottonwood	162
Crow Wing	9
Dakota	4101
Dodge	200
Douglas	12
Faribault	94
Fillmore	0
Freeborn	345
Goodhue	170
Grant	0
Hennepin	13921
Houston	2
Hubbard	13
Isanti	34
Itasca	5
Jackson	58
Kanabec	0
Kandiyohi	812
Kittson	0
Koochiching	3
Lac qui Parle	20
Lake	0
Lake of the Woods	0
Le Sueur	312
Lincoln	8
Lyon	300
Mahnomen	1
Marshall	48
Martin	79
McLeod	283
Meeker	89
Mille Lacs	6
Morrison	35
Mower	783
Murray	22
Nicollet	118
Nobles	1070
Norman	22
Olmsted	1003
Otter Tail	266
Pennington	37
Pine	21
Pipestone	71
Polk	125
Pope	2
Ramsey	5820
Red Lake	1
Redwood	16
Renville	229
Rice	1012
Rock	29
Roseau	0
Scott	957
Sherburne	242
Sibley	261
St. Louis	23
Stearns	743
Steele	396
Stevens	54
Swift	51
Todd	288
Traverse	11
Wabasha	106
Wadena	2
Waseca	143
Washington	599
Watonwan	541
Wilkin	21
Winona	164
Wright	434
Yellow Medicine	65

Total State Count: 40,673

Primary Home Language Counts by County 2012-2013 Vietnamese



Vietnamese Counts

- 1 - 15
- 16 - 50
- 51 - 500
- 501 - 1061

Total State Count = 4,042

0 15 30 60 90 Miles

Date: 3/11/2013
Project Track #:: M0118 JS/IT

Minnesota Department of Education

Vietnamese Primary Home Language Counts by County 2012-2013

Aitkin	0	Lincoln	0	Waseca	0
Anoka	620	Lyon	1	Washington	141
Becker	5	Mahnomen	0	Watonwan	0
Beltrami	1	Marshall	0	Wilkin	0
Benton	14	Martin	5	Winona	10
Big Stone	0	McLeod	4	Wright	21
Blue Earth	21	Meeker	0	Yellow Medicine	0
Brown	1	Mille Lacs	6		
Carlton	0	Morrison	14	Total State Count: 4,042	
Carver	56	Mower	29		
Cass	0	Murray	0		
Chippewa	0	Nicollet	0		
Chisago	0	Nobles	21		
Clay	24	Norman	0		
Clearwater	0	Olmsted	197		
Cook	0	Otter Tail	11		
Cottonwood	0	Pennington	0		
Crow Wing	5	Pine	0		
Dakota	619	Pipestone	0		
Dodge	0	Polk	0		
Douglas	1	Pope	0		
Faribault	0	Ramsey	674		
Fillmore	0	Red Lake	0		
Freeborn	2	Redwood	0		
Goodhue	5	Renville	0		
Grant	0	Rice	19		
Hennepin	1061	Rock	0		
Houston	0	Roseau	3		
Hubbard	0	Scott	294		
Isanti	2	Sherburne	18		
Itasca	0	Sibley	0		
Jackson	0	St. Louis	11		
Kanabec	0	Stearns	115		
Kandiyohi	0	Steele	6		
Kittson	0	Stevens	0		
Koochiching	0	Swift	0		
Lac qui Parle	0	Todd	0		
Lake	0	Traverse	0		
Lake of the Woods	0	Wabasha	5		
Le Sueur	0	Wadena	0		

Appendix C – Survey about Health Care Interpreting for Stakeholders

An invitation to participate in an online version of the following survey was emailed to all interpreters on the roster and all identified contacts on November 19th, 2014. The following survey was open until December 5th, 2014. A total of 468 individuals participated in the survey.

Demographic Questions

1. I am a(n):

- ☐ Interpreter
- ☐ Interpreter agency representative
- ☐ Other

_____

Interpreter Qualifications

2. What minimum qualifications should a competent health care interpreter have?

Should have	Not necessary	
☐	☐	Background check
☐	☐	High school education
☐	☐	40-hour training
☐	☐	Medical terminology
☐	☐	Language proficiency test
	☐	There should be no minimum qualifications
	☐	Not applicable

Other: please share your thoughts below

_____

3. If a voluntary **registry*** were to be added to the system, what should the minimum requirements be for interpreters to join the registry (as opposed to the baseline roster)?

Should have	Not necessary	
☐	☐	40-hour training
☐	☐	Associate or Bachelor's degree in a related field
☐	☐	CoreCHI/ CMI / Other Certification
☐	☐	Language proficiency test
	☐	Not applicable

Other: please share your thoughts below

_____

***If MDH were to add a verified registry to the system, it would likely have higher standards for membership than the current roster. We do not envision eliminating the roster.

Rare-Language Interpreters

4. What unique challenges are faced by rare-language interpreters?

A challenge	Not a challenge	
☐	☐	Training and education is expensive
☐	☐	Not enough resources
☐	☐	Other costs associated with interpreting
☐	☐	The demand for work is low
	☐	Not applicable

Other: please share your thoughts below

_____

5. How can we make a registry that meets the needs of interpreters for less common languages in Minnesota?

MDH should	Not necessary	
☐	☐	Subsidize fees for certain rare languages
☐	☐	Create different standards for rare languages
☐	☐	Provide technical assistance and information about the new system

Other: please share your thoughts below

_____

Cost to Interpreters

6. What are some concerns you have about the costs interpreters currently face?

Concern	**Not** a concern	
☐	☐	Roster fees
☐	☐	The price of training
☐	☐	The price and time commitment of education
☐	☐	Costs such as gas, parking
	☐	Not applicable

Other: please share your thoughts below

_____

7. What are some concerns you have about costs that would be associated with a potential registry?

Concern	**Not** a concern	
☐	☐	Will the registry cost even more than the roster?
☐	☐	Are there any financial benefits to being on the registry?
	☐	Not applicable

Other: please share your thoughts below

Technical Assistance and Communication

8. What kind of technical assistance, resources or other support might interpreters need to transition to a new system?

I will need	I will **not** need	
☐	☐	Ways to get informed about the new system
☐	☐	Access to a computer or a paper version of the application
☐	☐	A helpline to guide me through the registration process
	☐	Not applicable

Other: please share your thoughts below

_____

9. How can MDH best address questions or concerns that interpreters may have about the new system? How should MDH promote and explain the system?

MDH should	Not necessary	
☐	☐	Hold more discussions and info sessions with the community
☐	☐	Create a web page that explains the system
☐	☐	Have a helpline where I can ask questions
☐	☐	Send out newsletters to me via my roster e-mail
	☐	Not applicable

Other: please share your thoughts below

_____

10. How can MDH ensure there is ongoing feedback regarding the new system (what's working well, what needs improvement)?

MDH should	Not necessary	
☐	☐	Create an online survey where we can share our feedback at any time
☐	☐	Create an advisory board that represents many different interpreter interests
	☐	Not applicable

Other: please share your thoughts below

_____

Most Important Issues

11. From your perspective, what is the most important issue regarding interpreters that MDH should consider when drafting the legislation?

Please share your thoughts below

_____

Appendix D – Identification of Stakeholders and List of Participants

Stakeholder category	How stakeholders were identified	First e-mail correspondence	Meeting location and date	Attending parties
1. Interpreters	All active* members of Interpreter Roster and referrals from other contacts. *Active as of 9/1/2014	10/1/14	Metro 10/22/14	27+ Interpreters
			Metro 10/27/14	26+ Interpreters
			St. Cloud 10/29/14	6+ Interpreters
			Rochester 11/5/14	9+ Interpreters
			Metro 11/12/14	25+ Interpreters
				Total: 93+ Interpreters
2. Interpreter Organizations and Groups	Identified as known organizations, requests for meetings, and referrals from other contacts	Engaged each independently	MDH 8/28/14	Interpreting Stakeholder Group
			MDH 10/3/14	Upper Midwest Translators and Interpreters Association
			MDH 10/6/14	Interpreter Agencies of Minnesota
			MDH 11/12/14	International Medical Interpreters Association
3. Educators and Trainers	Identified by research and referrals from other contacts	Engaged each independently	Metro 9/19/14	Century College Translating and Interpreting Program
			MDH 9/24/14	University of Minnesota Program in Translation and Interpreting
			MDH 9/26/14	Language Access Consulting and Training
			Informally	Bridging The Gap
			Informally	The Community Interpreter
4. Interpreter Agencies	Phone numbers identified from roster list of agencies. E-mail addresses identified by agency websites and calls/voice mails to agencies. Referrals from other contacts.	9/29/14	Metro 10/15/14	Aldo Ramos and Associates DialogOne, LLC GBR Interpreting INGCO International Translation Bureau Kim Tong Translation Services Pillsbury United Communities Agency
			Metro 10/20/14	Garden & Associates Multilingual Word The Language Banc University Language Center
			St. Cloud 10/29/14	The Bridge World Language Center West Central Interpreting Services
			Rochester 11/5/14	Intercultural Mutual Assistance Association Project FINE
5. Interpreter Services Departments at Health Systems	Referrals from other contacts, Interpreter Services Leadership Group (ISLG) e-mail listserv	9/17/14 (Through ISLG)	Metro 9/24/14	HCMC Interpreter Services Director & Staff Interpreters
			Metro 10/2/14	Allina Fairview Hospitals and Clinics Health East Health Partners Lakeview Park Nicollet
			Metro 10/22/14	Regions Hospital Interpreter Services Director & Staff Interpreters

Stakeholder category	How stakeholders were identified	First e-mail correspondence	Meeting location and date	Attending parties
5. Interpreter Services Departments at Health Systems (continued)	Referrals from other contacts, ISLG e-mail listserv	9/17/14 (Through ISLG)	Metro 10/23/14	Park Nicollet Interpreter Services Director & Staff Interpreters
			Rochester 11/5/14	Mayo Interpreter Services Directors
6. Health Plans	Minnesota Council of Health Plans (MNCHP) e-mail list, referrals from other contacts	9/17/14 (Through MNCHP)	Metro 10/8/14	Blue Cross Blue Shield Health Partners Medica Preferred One UCare
7. Health Care Providers and Local Public Health	MDH contact lists and community partners, referrals from other contacts, listservs	10/10/14	St. Cloud 10/29/14	CentraCare St. Cloud Medical Stearns Co Human Services
			Rochester 11/5/14	Olmsted County Public Health Services Olmsted Medical Center
			Metro 11/10/14	Health Partners North Memorial Medical Center Pediatric Home Service Regions Hospital
			Metro 11/17/14	Community Dental Care Golden Life Home Health Care Health East Outreach Counseling St. Mary's Health Clinics
8. Community Organizations Representing LEP Populations	MDH contact lists and community partners, referrals from other contacts, listservs	10/22/14	Rochester 11/5/14	Catholic Charities of Winona
			MDH 11/17/14	Amherst Wilder Foundation Arrive Ministries Asian Media Access MORE Community Empowerment St. Thomas School of Social Work
9. National Certifying Bodies	Identified by research and referrals from other contacts	Engaged each independently	Phone 10/15/14	National Board of Certification for Medical Interpreters
			Phone 10/29/14	Certification Commission for Healthcare Interpreters
			Phone 10/30/14	Certification Commission for Healthcare Interpreters
10.,12. Key Informants and Others Requesting Involvement	Identified by research, community partners, referrals from other contacts, requests from stakeholders	Engaged each independently	Metro 9/10/14	Minnesota State Senator
			MDH 9/17/14	MDH Refugee and International Health Staff
			MDH 9/22/14	Garden & Associates
			Metro 9/25/14	UCare
			Metro 10/10/14	MN Court Interpreter Program Developer
			Phone 10/15/14	Language Line
			Phone 10/31/14	An Interpreter in MN
			Phone 11/12/14	The Bridge World Language Center
			DHS 11/18/14	Minnesota Department of Human Services
			Phone 12/5/14	Oregon Health Authority
			Informally	MDH Health Occupations Program Staff

Stakeholder category	How stakeholders were identified	First e-mail correspondence	Meeting location and date	Attending parties
11. LEP Individuals	Community partners	Engaged through community partners	Metro 1/7/15 Metro 1/7/15 Metro 1/7/15 Metro 1/8/15 Metro 1/8/15 Metro 1/8/15	LEP individuals attending English Language Learner Community Education Courses
Updates and Survey	Recipients identified through above engagement, MDH roster, MDH community partners and listservs	9/29/14 (no e-mail)	Website Update	http://www.health.state.mn.us/interpreters
		10/27/14	Newsletter Update	MDH Refugee Health Quarterly
		10/31/14	E-mail Update	All previously identified contacts Forwarded through MDH listservs
		11/17/14 (no e-mail)	Website Update	http://www.health.state.mn.us/interpreters
		11/19/14	Survey Invitation	All previously identified contacts MDH Interpreter Roster Forwarded through MDH listservs **Total Survey Participants: 468**
		12/19/14	Update with Draft Recommendations	All previously identified contacts MDH Interpreter Roster Forwarded through MDH listservs **Total Comments Received: 28**
		12/22/14 (no e-mail)	Website Update	http://www.health.state.mn.us/interpreters

MDH Interpreter Project Team Meetings	8/15/14 8/20/14 8/26/14 9/3/14 9/9/14 9/15/14 9/22/14 10/1/14 10/6/14 10/15/14 11/6/14 11/12/14 11/17/14 11/24/14 12/5/14 12/8/14 12/15/14 1/6/15

Appendix E – Project Calendar

August 2014				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
				1
4	5	6	7	8
11	12	13	14	15 Initial team planning meeting
18	19	20 Team meeting	21	22
25	26 Team meeting	27	28 Meeting with Interpreting Stakeholder Group (ISG) leaders	29

September 2014				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1	2	3 Team meeting	4	5
8	9 Team meeting	10 Meeting with Senator Sharen	11	12 ISG member meeting
15 Team meeting	16	17 Meeting with MDH Refugee-International Health Staff	18	19 Meeting with Century College
22 Team meeting Meeting with Garden & Associates	23	24 Meeting with Univ. of MN Meeting with HCMC	25 Meeting with UCare	26 Meeting with Language Access Consulting and Training
29 Website update	30			

October 2014				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1 Team meeting	2 Interpreter Services Leadership Group **(ISLG) stakeholder meeting**	3 Meeting with Upper Midwest Translators and Interpreters Association (UMTIA)
6 Team meeting Meeting with Interpreter Agencies of Minnesota	7	8 Health plans stakeholder meeting	9	10 Meeting with Ramsey Co. Human Resources
13	14	15 Team meeting Meeting with Language Line **Agency stakeholder meeting**	16 ←Meeting with NBCMI	17 Facilitator and note taker training
20 Facilitator and note taker training **Agency stakeholder meeting**	21	22 Meeting with Regions Hospital **Interpreter stakeholder meeting**	23 Meeting with Park Nicollet	24
27 Facilitator and note taker training **Interpreter stakeholder meeting**	28 ←Refugee Health Quarterly Newsletter published	29 **St. Cloud stakeholder meeting** Meeting with CCHI	30 Meeting with CCHI	31 Meeting with an interpreter E-mail update to all contacts

November 2014				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
3	4	5 Meeting with Mayo Lang. Services **Rochester stakeholder meeting**	6 Team meeting	7
10 **Health care providers stakeholder meeting**	11	12 Team meeting Meeting with IMIA **Interpreter stakeholder meeting**	13 ←Meeting with The Bridge Language Center	14
17Team meeting **Community organization stakeholder meeting** Website updated	18 Meeting with Department of Human Services	19 Survey sent to contacts, interpreters on roster	20	21
24 Team meeting	25	26	27	28

December 2014				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1	2	3	4	5 Team meeting Meeting with Oregon Health Authority
8 Team meeting	9	10	11	12
15 Team meeting	16	17	18	19 E-mail and website update to all contacts
22	23	24	25	26
29	30	31		

January 2015				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1	2
5	6 Team meeting	7 3 meetings with LEP individuals	8 3 meetings with LEP individuals	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

Appendix F - Drafted Recommendations Sent to Stakeholders 12/19/14

Dear Interpreter Stakeholder Community,

We are sending this email to update you on the work the Minnesota Department of Health (MDH) has been doing to recommend qualifications for spoken language health interpreters. In this work, our goals have been to:

- Make sure there are interpreters for all patients who need them, no matter what language they speak;
- Aim for high quality interpreting;
- Make requirements as simple as possible to keep costs to interpreters low;
- Make the system flexible to include interpreters with different training, education and experience;
- Include input from interpreters about what is needed and what will work.

The attached update includes:

- A summary of our drafted recommendations and other updates
    - Including how we involved interpreters and other stakeholders and asked for their input
- The Registry Guide, explaining the recommended registry tiers
- The Legislative Guide, explaining the costs of different systems the legislature could potentially enact

We know cost is important to you. We want to keep fees as low as possible. However, the more comprehensive the system is, the more the registry will cost.

Please remember that **the recommendations are not final.** There is still time to change them before they go to the legislature. They will not become law unless and until the Minnesota legislature votes to enact them.

We welcome your feedback about the drafted recommendations. If you would like to share your thoughts, please respond to the following three questions and send your response to Hannah.Volkman@state.mn.us. We will accept responses until January 6th, 2015.

1. What details of the recommendations do you feel will improve the quality of care for limited English proficient individuals?
2. Do you have any concerns with the drafted recommendations?
3. What changes would you recommend to reduce those concerns?

Thank you to the more than 650 interpreters and stakeholders who helped with this process in so many ways.

Warm regards,

Anne Kukowski and Josh Hill
Representatives from Health Regulation

Sara Chute, Danushka Wanduragala, and Hannah Volkman
Representatives from Refugee and International Health

Minnesota Department of Health
625 Robert Street North, P.O. Box 64975, Saint Paul, MN 55164

Note: You are receiving this update from the Minnesota Department of Health because you have been listed as an interpreter-related contact. If you are not interested in further updates, please respond to this e-mail and we will remove you from the list. Thank you.

Update for Interpreters and Stakeholders

The 2014 Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop recommendations to promote equitable access to health services for limited English proficient (LEP) Minnesotans. After gathering information and engaging many members of the interpreter community, MDH recommends a tiered registry system. This is a summary of our process and recommendations. The full report will be available in early 2015.

Currently there are no regulations in Minnesota that set minimum standards for health care interpreters. In 2009, Minnesota created a voluntary statewide roster for spoken language health care interpreters. There is a $50 annual roster fee. There are no credentials required to be listed on the roster, and MDH does not verify any of the information provided by interpreters. As of December 1, 2014, there are approximately 3,600 interpreters listed on the roster.

Recommendations

1. Establish a tiered registry system with four distinct tiers and verified qualifications

- An entry-level tier with minimum qualifications. All interpreters, including those in higher tiers, must meet these entry-level requirements.
- Three higher tiers containing increasing qualifications. All three upper tiers require completion of continuing education for renewal.
- See attached guide for a draft of proposed tiers.

2. Develop ethics and basic medical terminology exams in English for all interpreters

3. Expand MDH's website to better serve as a resource for interpreters and other stakeholders

4. Form an advisory council comprised of a broad range of stakeholders

- The council will provide guidance and expertise to MDH and ensure the system is flexible and adapts to the changing field.

5. Establish a means of investigation and enforcement consistent with state and federal laws

Key findings – What we heard from the community

Quality standards: Minimum interpreter qualifications, such as understanding interpreter ethics, are necessary to ensure a baseline standard of care.

- The need for standards for all interpreters must be balanced with LEP patients' need for access to interpreters.
- Unverified information about an interpreter's qualifications and experience is not useful to people using interpreter services.
- Interpreters have a broad range of qualifications, skills, and experience. The system should allow for this range but show differences in qualification levels.

- Bilingual ability on its own does not qualify anyone to interpret. Interpreting skills, knowledge of medical terminology, and ethics are also necessary.

Costs: Interpreters are concerned about current roster fees, the potential for future increases, and how fees are spent. MDH collects more in roster fees than is required to run the current program. MDH must receive legislative approval to spend surplus funds on interpreter initiatives. Stakeholders are concerned that regulation will result in additional costs to interpreters with no increase in their wage or income.

Adaptability: The system must be flexible enough to meet the needs of interpreters of rare languages and must be able to adapt to future changes in interpreting.

Complaints: The current system has no way to report or investigate complaints.

Background information

The Need for Interpreters. Nearly eleven percent of Minnesotans (ages 5 and older) speak a language other than English at home. An estimated 213,100 Minnesotans have a limited ability to speak, read, write, or understand English,[1] so they may not be able to understand health information in English. High-quality health care interpreting results in better health outcomes for LEP patients.[2] The lack of state standards for interpreter ethics, skills, and training has left Minnesota's LEP population at risk of worse health outcomes.

Federal Guidance. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving any federal funding. Because of Title VI, health care providers must provide interpretation services to all LEP patients free of charge, so they have equal access to health care.

Developments Outside of Minnesota. Certain states and organizations have established standards for health care interpreters. For example, two organizations now offer nationally-accredited certifications for interpreters. Codes of ethics and standards of practice have been accepted by the interpreting industry. In the process of creating our recommendations, MDH researched other states' and organizations' work on health care interpreting, as well as standards for interpreting in other fields.

Engagement process

An important part of this project was making sure that all stakeholders were informed and encouraged to share their ideas. MDH identified and engaged a broad range of stakeholder individuals and groups in a variety of ways. We reached stakeholders through the interpreter roster, community groups, referrals from other contacts, and e-mail lists. Each e-mail and meeting invitation sent to stakeholders included a request to share the information with others. Throughout the process, we sent e-mail updates and updated the MDH interpreter website[3] to provide information on the project and encourage stakeholder involvement.

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[1] 2013 data from the American Community Survey undertaken by the U.S. Census Bureau.

[2] Australian College for Emergency Medicine. Resource list covering interpreters and language access barriers. https://www.acem.org.au/getmedia/d06a150a-8f9f-49f6-9647-eda5ac438af1/Module-4-Further-Learning-Resources.pdf.aspx

[3] http://www.health.state.mn.us/interpreters

Contacts were invited to participate in individual and community meetings held in the Twin Cities, St. Cloud, and Rochester. We also invited experts in the interpreting field, and people who were involved with interpreter legislation in the past, to meet with MDH and share their knowledge as *key informants*. Additionally, we emailed, met, or spoke with all other individuals and groups that contacted us for information or requested the opportunity to provide input. Over 300 members of the interpreter community participated in these meetings.

MDH also invited all interpreters on the roster and all previously identified contacts to participate in a survey. A total of 468 individuals responded to the survey, 361 of whom had not participated in previous engagement opportunities. Data from the survey provide valuable insight into the diversity of viewpoints in the Minnesota interpreter community.

Key stakeholder groups

- Interpreters
- Interpreter Organizations and Groups
- Educators and Trainers
- Interpreter Agencies
- Interpreter Services Departments within Health Systems
- Health Plans
- Health Care Providers and Local Public Health
- Community Organizations Representing LEP Populations
- National Certifying Bodies
- Key Informants
- Limited English Proficient Individuals
- Others Requesting Involvement

DRAFT Registry Guide – Spoken Language Health Care Interpreters

Tier	Requirements
Tier 1	Minimum age of 18 **Plus:** Pass MDH Interpreter Ethics Test (Online) **Plus:** Pass MDH Medical Terminology Test (Online) → **All interpreters** must fulfill these requirements*
Tier 2	**All Tier 1 requirements** **Plus:** 4 hours of continuing education[1] per year **Plus:** 40 hours of interpreter training through an approved training body[2] (Requirement will change to 60 hour minimum on 1/1/2018)
Tier 3	**All Tier 1 requirements** **Plus:** 6 hours of continuing education[1] per year **Plus:** National certification in interpreting that **does not** include language proficiency component in the non-English language[3] **Or:** Certificate in interpreting from an accredited US educational institution[5]
Tier 4	**All Tier 1 requirements** **Plus:** 8 hours of continuing education[1] per year **Plus:** National certification in interpreting that **does** include language proficiency component in the non-English language[4] **Or:** National certification in interpreting that **does not** include language proficiency component in the non-English language[3] **AND** Pass an oral proficiency exam[6] in non-English language (Only available for interpreters of languages for which proficiency component does not exist at the time interpreter seeks certification) **Or:** Associate's Degree or greater in interpreting from an accredited US institution[5] (60 or more semester credits with internship or experience component)

Preapproved options to fulfill requirements^

1. Continuing education accredited by
-American Translators Association (ATA)
-International Medical Interpreters Association (IMIA)
-Certification Commission for Healthcare Interpreters (CCHI)

2. Interpreter training (40+ hours)
-Bridging the Gap
-The Community Interpreter
-Language Access Consulting and Training

3. National certification in interpreting (No language proficiency component)
-CoreCHI from CCHI

4. National certification in interpreting (Including language proficiency component)
-Certified Medical Interpreter (CMI) from National Board of Certification for Medical Interpreters (NBCMI)
-Certified Healthcare Interpreter (CHI) from CCHI

5. Educational institution
-Century College
-University of Minnesota
-All accredited US institutions
-Foreign institutions as approved by advisory council

6. Oral proficiency exam
-American Council on the Teaching of Foreign Languages (ACTFL) →Score of Advanced Mid or greater

***All interpreters including those located outside of Minnesota** whose services are used for LEP individuals in Minnesota must be at least a Tier 1 member
→Or fulfill equivalent as verified through language services provider

^Other options will be evaluated as necessary by the advisory council

DRAFT Legislative Guide – Options for Spoken Language Health Care Interpreter Registry Program

The Legislature can select and combine program functions to build a regulatory system for spoken language health care interpreters. The functions selected determine the amount of the fees. The fees necessary to fund each function are shown in the columns on the right.

Program Function	Description of Program Function	Contribution to Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
● **Regulation**	• Verify that applicants have passed ethics and medical terminology tests • Verify that applicants have provided adequate documentation of qualification for Tiers 2, 3, or 4 • Ongoing IT support for online application system • This does NOT include technical assistance to interpreters in applying to the registry	$33.00	$56.00	$73.00
■ **Technical Assistance**	• Assist registry applicants in understanding qualifications for each tier • Assist registry applicants in completing application process	$8.00	$8.00	$8.00
▲ **Advisory Council**	• Advise MDH on issues relating to interpreting skills, standards of practice, and ethics • Inform MDH of emerging issues in the field • Provide consultation on need to draft and request legislative changes to interpreter law	$10.00	$10.00	$10.00
Complaints & Oversight	**Two options:**			
◢ **Option 1: Complaint & Advisement**	• Accept complaints and send letters of advisement , there is NO investigation ○ Interpreters are informed that there has been a complaint, told the nature of the complaint, and referred to appropriate ethical standards or standards of practice • Instances of fraud, abuse, and coercion are referred to local law enforcement	$11.00	$11.00	$11.00
◆ **Option 2: Investigation & Enforcement**	• Accept and investigate complaints; obtain translation and interpretation where necessary to read complaints and interview witnesses ○ Bring enforcement action (fines, remedial action, or remove from registry) against interpreters where complaints are substantiated	$46.00	$46.00	$46.00
Start-Up Costs	• Complete computer programming to expand data collected • Allow online administration and result reporting of ethics and legal terminology tests • Allow attachment and transmittal of supporting documentation • Provide application status reports to applicants • Develop ethics and legal terminology tests • Support staffing to plan and create regulatory infrastructure	Approximate one time start-up costs: • $478,000, FY16 • $95,000, FY17 • $73,000, FY18		

The examples below assume start-up costs will be funded by non-fee sources. Fee amounts would replace the existing fee under current law.

Registry System	Program Functions Included	Total Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
1. Minimal System	● Regulation + ◢ Option 1: Complaint & Advisement	**$44.00**	**$67.00**	**$84.00**
2. Basic System	● Regulation + ■ Technical Assistance + ▲ Advisory Council + ◢ Option 1: Complaint & Advisement	**$62.00**	**$85.00**	**$102.00**
3. Comprehensive Regulatory Program	● Regulation + ■ Technical Assistance + ▲ Advisory Council + ◆ Option 2: Investigation & Enforcement	**$97.00**	**$120.00**	**$137.00**

For example: if the "Basic System" were enacted by the Legislature at these rates, a Tier 1 interpreter would pay $62.00.

Appendix G – Stakeholder Response to Drafted Recommendations

The following comments were shared by stakeholders in response to the drafted recommendations sent to all interpreters and stakeholders on December 19th, 2014. Please see Appendix F for a copy of the drafted recommendations.

Comment number	Stakeholder type	Comments
01	Interpreter	• Without guaranteed reimbursement levels, more qualified interpreters get "penalized", these interpreters are underpaid • Draft does not address regulation for agencies • Some major issues such as unqualified individuals working as interpreters is left out of the draft • The only issue addressed is how much in fees MDH will collect from interpreters
02	Interpreter (Spanish)	• Address the fact that payers are uninformed about how much interpreters really receive
03	Interpreter (Romanian)	• The draft addresses requirements well but doesn't address all needs of interpreters • MDH should set a minimum reimbursement level and encourage payer to reimburse a minimum of two hours per encounter to account for driving expenses and no-shows • Should include TOEFL exam for English proficiency, other credentials for proficiency should also be considered
04	Interpreter	• Many interpreters with certificates in interpreting from educational institutions are more qualified and educated than those who have Associate's degrees in interpreting • An Associate's degree is too low a qualification to be on the top tier
05	Interpreter (Khmer)	• Patients say that some interpreters are not good, there should be a mechanism for them to leave complaints • Interpreters born in US are good at English but weak at Khmer, interpreters born in Cambodia are good at Khmer but weak at English
06	Interpreter	• Interpreters can cheat on online tests; testing should be done in person • Wanted clarification on how often 40-hour training would be required for interpreters
07	Interpreter	• Each tier should have a different reimbursement rate to reflect the effort and skill of interpreters at each level
08	Interpreter	• The state should create and house an interpreter association to advocate on behalf of interpreters
09	Interpreter	• The system allows interpreters to advance to higher tiers over time which is helpful • Option 2 for Enforcement and Investigation is more appropriate • Wanted clarification on if fees were one-time only or yearly
10	Interpreter	• Reimbursement should be higher for more qualified interpreters • Wanted clarification on the types of educational institutions mentioned
11	Interpreter (Amharic/Oromo)	• Law enforcement action against interpreters where complaints are substantiated is not appropriate • Interpreters already have to take medical terminology, ethics and language proficiency tests, so MDH requiring them would be unnecessary • Pay rates are low specifically for interpreters in the medical field
12	National certifying body	• Interpreters won't be encouraged to move from Tier 1 to Tier 4 • Drafted system could create a situation in which Tier 1 and 2 interpreters charge less for their services and are given more work due to their lower relative cost • MDH should encourage or mandate the use of Tier 4 interpreters first
13	Health plan representative	• Tier 1 interpreters shouldn't receive reimbursement because they are underqualified • Require interpreters to prove they are working to advance themselves to higher tiers • If differential reimbursement is considered, the current $46 rate should be for the top tiers and there should be lower reimbursement for the lower tiers

Comment number	Stakeholder type	Comments
14	Interpreter organization or group	• Associates Degree should include a language proficiency component since US educational institutions have different levels of language proficiency requirements to get into interpreting programs • To better align with the national certification, Associates Degree should also include a medical terminology component, since some interpreters may not get any terminology in general interpreting programs
15	Interpreter	• Streamline interpreter records keeping between interpreters, agencies and clinics • Have agencies send work orders, receptionists print and sign the form, and then interpreter sends form to agency
16	Minnesota Department of Health employee	• MDH could create interpreter ID cards that shows their registry level • Total costs to interpreters seem quite high compared to other health professional • Wanted clarification on regulation of remote and out-of-state interpreting • Wanted clarification of reimbursement
17	Interpreter organization or group	• There is no language proficiency verification until Tier 4, should be required at Tier 1 • Language proficiency is critical for all interpreters • ACTFL passing score should be Advanced High, though ACTFL only test general vocabulary and does not document interpreter proficiency • Tier 3 does not provide proof of interpreter competence, only commitment to training • Bilingual health care providers can work at the ACTFL Advanced Mid level, should be higher for actual interpreters at the top tier • Demonstrated oral proficiency should be part of public record
18	Health care provider	• Online testing does not assure applicant completed the test on their own • Clarify on language services provider verification of skills • 2018 is too distant for upgrade to 60 hours, would be behind national trend • For Tier 3, all Tier 1 and 2 requirements should be necessary • Putting language proficiency only at higher tier suggests it is a long-range goal, instead of a necessary skill • Wanted clarification on MA reimbursement
19	Interpreter	• There should be a minimum requirement of high school diploma for all interpreters
20	Interpreter	• MDH should set industry recommendations for reimbursement rates • A translation competency component should be added because interpreters must frequently translate • Interpreters should be trained in working in emergency events • Publicize tier information to providers so they can make informed choices about interpreters
21	Interpreter	• Developing new ethics and terminology tests is unnecessary because they already exist in the field through NBCMI and CCHI • Tier 1 is obsolete relative to current interpreting field • Tier 1 should have a continuing education requirement • The lowest tier should require a 40 hour training and oral proficiency component
22	Interpreter agency	• Need to better address out of state interpreting and remote interpreting • A medical terminology test may be too high for some interpreters at Tier 1 • Simplify process by not requiring continuing education for those who must do it through their national certification • Taking a language neutral national certification exam and then an oral proficiency exam is not equivalent to a full certification because basic oral proficiency exams lack a medical focus

Comment number	Stakeholder type	Comments
23	Interpreter	• There are not enough options to fulfill the requirements • Licensed health professionals such as paramedics and nurses who are also interpreters should get credit for the medical terminology through their preexisting education
24	Health care provider	• Tier 4 interpreters should be able to bill independently and not be dependent on an agency • This should be available to all Tier 4 interpreters as an incentive to obtain and maintain higher level interpreter services
25	Interpreter (Russian)	• An OPI is not an acceptable equivalent for Tier 4 interpreters who speak a language not currently offered by the national certifications • OPI only tests conversational abilities and does not check interpreting skills and is not medically focused • Eliminate Tier 4 option for CoreCHI plus OPI until better testing for interpreting skills is developed
26	Interpreter (Spanish)	• Interpreters could potentially qualify for Tier 4 without being proficient in English because the CoreCHI is a written test, add OPI in English to CoreCHI requirements • CoreCHI interpreters are also not tested in their interpreting abilities • Different US educational institutions have varying standards for who gets into the program and how challenging the courses are, and may not be related to medical interpreting, allow only educational institutions that require ACTFL Advanced Mid or higher in both English and non-English language • Certificate in Tier 3 does not list number of credit hours, need to have a meaningful difference between Tier 3 and 2 • Could create a Tier 5 for interpreters who have CMI or CHI • To bring down costs and eliminate cheating, eliminate ethics and medical terminology exams from Tier 1 and just require a signature about the ethics and standards of practice • Compromise between Options 1 and 2 by only investigating serious or repeated violations
27	Health plan representative	• DHS needs to structure a reimbursement mechanism for the Minnesota Council of Health Plans in a manner that in incent interpreters to seek more training to move to higher tiers • DHS/MDH should create a model of reimbursement for Tier 1 that is lower than today's current rate with Tier 2 being slightly above Tier 1. The current DHS interpreter fee schedule could be applicable to Tier 3; Tier 4 interpreters could be eligible for a fee schedule that is higher than today's standard rate • These types of incentives will go a long way to improving the quality of interpreters for people enrolled in state public programs
28	Interpreter	• The proposed registry has too many tiers, Tiers 3 and 4 are redundant, and Tier 1 is too low • 40 hours of training should be the minimum for all interpreters • Tiers don't take years/hours of experience into account and there is no grandfathering clause for interpreters who have been working for a long time • Wanted clarification on if Tier 2 interpreters who are already in the system would need to add 20 hours of training by 2018 • Language proficiency should be a component of each tier

Appendix H – Key Findings from Informants, Stakeholders, and Survey Participants

These findings reflect perspectives from key informants, stakeholders and survey participants from the twelve stakeholder categories[1] as defined in Section III: Stakeholder engagement: process and findings.

A. Interpreter Qualifications

1. Minimum qualifications for all interpreters. There was a general consensus among stakeholder groups and key informants that interpreters must be knowledgeable and skilled to ensure the health, safety and privacy of LEP patients, as well as to ensure that interpreters follow the code of ethics as required by law. Ideas of specific ways in which these skills can be developed and evaluated are detailed below.

2. Critical skills and basic knowledge. Interpreters and other stakeholders recognized that language proficiency in both the English and non-English language is essential to interpreting. Many interpreters emphasized that bilingual ability alone does not qualify someone to interpret, especially in a medical situation. Health care interpreters must have a strong understanding of the role of the interpreter, how an interpreter conducts him- or herself, and ethical standards widely accepted within interpreting practice. Some stakeholders pointed to the Code of Ethics and Standards of Practice documents created by the National Council on Interpreting in Health Care as industry standards.

> "The minimum qualifications that MDH decides interpreters need should be meaningful, so that there are minimum expectations all interpreters. The qualifications also need to be reasonable and affordable or no interpreter will be able to achieve them." – Interpreter

a. Ethics. Many individuals emphasized that the vast majority of health care interpreters conduct themselves appropriately and hold themselves to high standards. Nevertheless, we heard anecdotal accounts of interpreters either unaware of what constitutes appropriate conduct or unwilling to follow the guidelines.

> "Some interpreters know the language and terminology but behave so inappropriately."
> – Interpreter

To resolve this concern, stakeholders proposed that MDH explicitly address or create an ethics standard.

> "Creating a baseline expectation of interpreter ethics and standards of practice in Minnesota would standardize the interpreting field and would provide much needed accountability."
> – Community organization representative

[1] 1) Interpreters, 2) Interpreter organizations and groups, 3) Educators and trainers, 4) Interpreter agencies, 5) Interpreter services departments within health systems, 6) Health plans, 7) Health care providers and local public health, 8) Community organizations representing LEP populations, 9) National certifying bodies, 10) Key informants, 11) LEP individuals, and 12) Others requesting involvement.

Health care providers emphasized that acting ethically is important for privacy reasons but also is crucial to the safety of the patient and interpreter. For example, an interpreter should relay the message a provider gives his or her patient, regardless of the interpreter's opinion of the message.

b. Medical terminology. An understanding of medical terminology in both languages was deemed one of the most important skills a health care interpreter must have. Many of the health issues interpreters encounter are complex, and nuances in the ways this terminology is interpreted can have a significant effects on the message and potentially on the health of the LEP patient.

Some interpreters explained that there are not clearly defined standards for knowledge of medical terminology between agencies when hiring medical interpreters.

> "Health care interpreters need knowledge of anatomy, physiology, medical diagnostics and procedures." – Interpreter

Some languages lack a comprehensive vocabulary of medical terms. Interpreters of these languages must know the appropriate way to describe a term to preserve the original message. This skill and knowledge goes beyond having a broad vocabulary of medical terms.

> "Interpreters must know what to do when particular words do not translate well between languages." – Interpreter

> "Languages such as Hmong and Somali are still developing their vocabulary for certain terms and for the written language" – Health care provider

c. Cultural awareness and competency. Another critical skill that interpreters and other stakeholders emphasized is cultural competency. Many individuals explained that this skill is difficult to measure, but can strongly affect how well a patient understands a message. For example:

> "Just because someone is an interpreter, it cannot be assumed that they have cultural expertise. Not all Hmong interpreters know that when an elder says they have "crazy foot" it means gout." – Survey respondent

While there are some continuing education opportunities that address cultural competency, including general courses and training specific to a certain language or ethnic group, stakeholders and key informants stated that training is limited in this area.

d. Background checks. There was a general consensus among stakeholders that background checks are fair and important; however, some felt that certain instances of unethical behavior by interpreters would not be caught by a traditional background check.

> "Background checks are definitely important. At appointments interpreters have access to the patient's information. It would be unsafe to the patient if there is no check to verify that an interpreter will not abuse this access." – Interpreter

3. Differentiating levels of professionalism. Stakeholders described a broad range of interpreter skill levels, training experiences, and education levels. Interpreters who were extensively trained or certified voiced frustration that they were listed at the same level on the roster as those who have no training or formal background in interpreting. Less-trained interpreters voiced this concern in a different way, explaining that there are few perceived benefits to training or certification, as it does not set an interpreter apart from the rest of the field. Many stakeholders proposed that an appropriate way to solve this issue is to create a registry (or other system) that differentiates between these levels of professionalism. A tiered registry would provide recognition for the most professional interpreters and incentive for less-trained interpreters to seek additional training.

In addition to a lack of distinction between interpreters of different skill levels, there is no guarantee of increased reimbursement for interpreters who are more qualified. A discussion on this issue is available below in the section on costs.

4. Education qualifications. Higher education interpreter educators noted that interpreters who complete post-secondary training usually get hired right away, and often in competitive staff positions at hospitals and health systems. The problem is that most interpreters who enter these formal education programs find it very difficult to complete the training due to the expense and time commitment.

> "I try to hire only interpreters who have finished the interpreting certificate … or who have a degree in interpreting. Fortunately, there are now many around… I have found a marked difference between those who have completed a program where skills are intensely practiced and assessed vs. someone who has completed a 40-hour program or any program that does not work on skills over time. Interpreting skills take time to develop and internalize to fully understand." – Survey respondent

Interpreters who completed formal education programs in interpreting emphasized how much their interpreting skills improved as a result of the extensive time invested in and out of class. For example, an associate's degree in interpreting generally takes around 2.5 years to complete. Throughout that time, students practice their interpreting skills, reflect on ways in which they could improve, and receive feedback from other interpreters and instructors. Interpreters who received degrees felt that the skills they learned were a result of this time investment and could not have been achieved in an intensive 40-hour training program.

Furthermore, the skill of interpreting is directly linked to practice. Interpreters must absorb a message in one language, convert it, and then accurately convey that message in another language with sensitivity to cultural nuances. The ability to interpret with minimal error takes years of practice.

> "100+ hours training required would be better [plus] at least a couple courses at a community college. This is because these courses would have homework, grading, testing, etc., which is not typical of the 40 hour courses or of continuing education." – Survey respondent

Some higher learning institutions also require that their students complete an experiential learning component. This allows students to observe actual interpreting encounters and understand how very experienced interpreters conduct themselves.

> "Interpreters need some experiential learning in the field. Whether it's through shadowing or actually interpreting, practice in the field is necessary." – Interpreter

5. Training approaches. Many interpreters opted for 40-hour or 60-hour training programs because of the time and financial commitment that formal education requires. However, they also explained that most 40-hour training programs are still quite a large financial burden, costing between $300 and $800 depending on the vendor. Such training programs are strongly encouraged by many interpreting agencies and health systems.

These programs highlight the role of the interpreter, how an interpreter should behave during an encounter, interpreter ethics and difficult situations an interpreter may encounter, and skills to better remember and interpret messages. Across the field, training for interpreters is gradually transitioning from 40-hour programs to 60-hour or greater training programs with one of the leading companies now offering multiple 60-hour programs.

Some stakeholders voiced concern about the quality of 40-hour training programs. They felt that it would not be appropriate to put these training programs at the highest achievable tier alongside degree programs and national certification. Putting 40-hour training programs at too high a tier could also dissuade interpreters from seeking more comprehensive training and skill development.

> "40 hours of training is too little; it might be possible to include it in the first of a series of steps that would increase over time--for example, 40 hours, then 80, then 120..." – Survey respondent

> "From my experience, 40 hours of training is not enough. Interpreters need to have some kind of medical or biology background. This is because doctors often explain things very quickly and if you don't have that background, you won't be able to relay a good message." – Interpreter

Some interpreters and other stakeholders suggested that MDH could offer its own standardized training program for health care interpreters or subsidize existing programs. If the more than 3000 interpreters in Minnesota were all to receive the same basic training, the cost to each interpreter could be reduced.

> "The 40 hour training should be with a national standardized curriculum. There are too many agencies creating the own curriculums and they are lacking in content and substance. A standardized instrument would provide continuity in the training, and would be more accurate in its content, because it would be based on research" – Survey respondent

> "Interpreters in greater Minnesota do not have the same access to 40-hour training opportunities. MDH should find funding for greater MN interpreters to get trained" – Agency representative

6. National certification. There are currently two accredited national certifying bodies that offer certifications for medical interpreters. The certifications include written examinations and oral examinations focusing on medical interpreting ability. Some stakeholders, such as interpreters, employers of interpreters, and health care providers, consider national certification tests to be a definitive way to evaluate interpreter quality. These exams are difficult—for example, the Certified Medical Interpreter (CMI) exam offered by the National Board of Certification for Medical Interpreters (NBCMI) exam pass rate varies from 65%-80% depending on language—and often interpreters spend months preparing.

> "My patients are surprised that we do not have to certify in order to work as a medical interpreter." – Survey respondent

Although the national certification is based on a strong evaluation of an interpreter's skill, other stakeholders consider national certification an entry-level requirement. These stakeholders emphasized the importance of requiring continuing education of interpreters who are nationally certified so that they continue to develop their skills.

Although national certification is not available for all languages, interpreters of any language can get a partial national certification. There is one language-neutral national certification exam covering interpreting ethics, standards of practice and terminology in a written test. This test does not evaluate interpreting skill. This exam is only moderately common among interpreters in Minnesota and many interpreters do not strive to get nationally certified because of the cost and lack of perceived benefits.

> "I just think the national certification exams are expensive. A cost effective test would be advisable." – Survey respondent

7. Continuing education. Many interpreters in Minnesota attend continuing education courses due to an interest in improving their skill or requirements from their national certification or employer. However, many interpreters felt that there are not enough local opportunities for classes, and sometimes they are quite expensive. Interpreters in Greater Minnesota said it was very difficult for them to get continuing education credits because few, if any, classes take place outside the Twin Cities.

> "Continuing education should … be a requirement for all interpreters on the registry to maintain their status as active." – Survey respondent

> "Since most interpreters get paid very little, requiring too much continuing education is hard economically. I agree that continuing education is important, but do not feel the burden for paying this should be put on the interpreter." – Survey respondent

Some stakeholders suggested that MDH hold continuing education opportunities in the Twin Cities as well as other geographic areas where many interpreters practice. Others suggested that

we list upcoming continuing education opportunities on our website or send periodic newsletters so that interpreters are better informed of existing opportunities.

8. Provider perspectives. Health care providers emphasized that all health-related fields require some training or certification, and this should be expected in the health care interpreting field as well. Across the board, providers prefer to work with better-trained or certified interpreters.

> "The job of an interpreter is extremely important for my clinic to be able to do its job. Therefore, the higher qualifications an interpreter can have the better. Untrained and inexperienced interpreters do very little service to our organization and to all patients who need the interpreter services." – Survey respondent

A common message from interpreters was that health care providers and clinic employees need to be trained on understanding the appropriate role of an interpreter. Many interpreters have been asked by providers to fulfill duties that are inappropriate for an interpreter or contradictory to the interpreter code of ethics. Examples of this have included providers expecting interpreters to sight translate lengthy documents and consent forms in the waiting room or to keep the patient company in the exam room while the doctor or nurse is absent. To solve this issue, some interpreters suggested that MDH develop guidelines for providers on working with interpreters, offer training courses for providers and clinic staff, and advocate for including courses on working with interpreters in medical and nursing education.

9. The current state of the interpreting field with regard to minimum qualifications. Some interpreters, agencies and health system representatives explained that although the minimum qualifications are consistent among the leading agencies and health systems, these standards are not consistent across all organizations, and some have very low standards. Stakeholders felt that standards required by MDH would encourage some organizations to enact higher standards.

> "Agencies should have a harder test for interpreters at their initial interview. Some agencies are willing to hire anyone who will fill an application." – Interpreter

> "Right now, facilities are not very choosy [about the quality of the interpreter] because there is a huge need for interpreters but not all of these interpreters are qualified." – Interpreter

There was concern that too much regulation could put an excess burden upon interpreters and agencies. For example, requiring interpreters to obtain certain qualifications only through MDH or MDH-approved sources could create redundant expenses for interpreters who have already received similar qualifications from other sources. Furthermore, few stakeholders considered the current roster useful. These stakeholders were concerned that if an even more expensive, but not more useful, registry is created, it will be a waste of interpreters' money.

> "The current roster is unused by agencies and health care professionals" – Agency representative

10. Perspectives on qualification standards in past legislative attempts. Some interpreters were very concerned that previous legislative attempts at establishing a registry had standards that

were too high; enacting the legislation could have led to many interpreters losing their jobs. Conversely, others felt that the legislative proposal in April 2014 had standards that were too low to be effective. They felt that the registry did not have sufficiently robust minimum standards to ensure that all LEP patients would have access to quality interpreting. Upon evaluation of the previously proposed bills, MDH found that the 2014 proposal included a level for the current roster, so there would still have been no minimum qualifications to interpret.

B. Rare-Language Interpreters

At the stakeholder meetings, we discussed issues particular to rare-language interpreters. Generally, we learned that rare-language interpreters cannot work as career interpreters because of the inconsistent demand for their services. Additionally, health care providers have a difficult time finding rare-language interpreters, and sometimes dialects are incompatible between interpreter and patient, which reduces their ability to communicate.

1. Access to rare-language interpreters. Health care providers, agencies and interpreters themselves recognized access issues for LEP patients who speak less common languages. There are fewer interpreters and these interpreters usually are not career interpreters, so they are not always available. When an urgent medical issue arises and no interpreter is available, health care providers must turn to video or telephone interpreters. Remote interpreting will be addressed in further detail below.

> "When you get a large influx of refugees at one time … it often is difficult to find an interpreter who can meet the ideal expectations. However, it would be a worse choice to deny services to that population because no one can qualify as an interpreter." – Survey respondent

Health care providers usually consult interpreter agencies to locate interpreters for rare languages. If this is unsuccessful they search the MDH Roster though some languages and dialects are not listed on the roster. Stakeholders suggested that MDH add language and dialect options when interpreters for those languages join the roster. Currently, an interpreter who speaks a rare language not listed on the roster must choose "other" for language spoken. Interpreters indicated that some providers could use more training on understanding the differences between languages and dialects. Some interpreters have been told that they speak a language that is "close enough," even though the interpreters recognize that the language match is not sufficient to ensure quality communication.

Sometimes family members, even children, are used to interpret for patients who speak rare languages, in lieu of trained interpreters. Although some health systems have adopted rules against allowing a family member to interpret, this is not universal, and some patients prefer that family members interpret. One social worker explained that in small communities of very rare languages, sometimes it is even difficult to find an interpreter who is not a member of the family.

In our discussions in St. Cloud and Rochester, providers and interpreter agencies explained that they have a difficult time finding interpreters of languages that are common in the Twin Cities.

> "The definition of what languages are rare is very different in rural areas or Greater Minnesota." – Local public health representative

> "A census should be done to identify the languages that have the greatest need for interpreters and what areas in the state are underrepresented." – Interpreter

2. Demand for rare-language interpreters. Rare-language interpreters explained that they cannot make interpreting, or specifically medical interpreting, a career because there is not a consistent demand for their services. A rare-language interpreter who does try to make a career of interpreting must drive extended distances to attend appointments.

> "Some rare-language interpreters only get one request to interpret per month, sometimes even less. They can't work as an interpreter for their only source of income. How can you expect someone who only interprets occasionally to pay expensive fees and pay to get trained?" – Interpreter

Rare-language interpreters often also fulfill the role of health navigator for newly arrived patients. They do not receive compensation for these services but are often expected to explain the health system to patients. Though it goes against the interpreter code of ethics, some patients and even health care providers request that interpreters drive patients to their appointments.

> "The most challenging for me is living in a small community. Sometimes it is very hard to say no to the patient who really needs help with a ride [to the clinic]." – Survey respondent

There are also differences between the needs of interpreters of various rare languages. For example, both German and Tigrinya are rare languages in Minnesota but present very different interpreting challenges due to differences in education and familiarity with Western medicine.

3. The burden of training and education. Interpreters who only work once or twice per month feel that training is unachievable for them. They would have to take time off and forego pay from other work to get trained. Furthermore, the income they receive from interpreting is much less than one training session or continuing education course may cost. Rare-language interpreters generally understand that training is important to good interpretation and good health outcomes for patients, but it is simply too expensive and time-consuming relative to the benefit they will derive from it.

> "[It is] critical that we recognize access issues. We cannot and should not require high levels of training etc. for rare languages, but rather strive to create affordable opportunities for those that are interpreting for rare languages. Often times, they are only doing it to help their community and we should not penalize that. But rather, encourage them to get additional training by making it affordable and accessible." – Survey respondent

Some organizations offer scholarships and reduced rates for training opportunities for rare-language interpreters. Not all interpreters were aware of these opportunities, and those who were still felt that there are many more interpreters in need of training than there are scholarships

available. Some stakeholders suggested that MDH allocate the surplus money generated from roster fees toward training scholarships for rare-language interpreters. Others suggested that rare-language interpreters pay reduced rates to be a member of the roster, since the $50 yearly cost sometimes is more than the interpreter makes.

> "For rare-language interpreters, there is also limited vocabs in their languages which can precisely explain health conditions, so a lot of the time a lot of explaining needs to be done" – Interpreter

4. Lack of opportunities to prove language proficiency. Rare-language interpreters face limited options to demonstrate language proficiency in the non-English language. Although the American Council on the Teaching of Foreign Languages (ACTFL), a common oral language proficiency testing company, offers testing in many languages, there are no tests available for some languages common among Minnesota LEP individuals. For example, as of December 2014, there are 140 Oromo and 145 Karen interpreters listed on the roster, but there is no standardized oral proficiency test for these languages. Some interpreters suggested that there should be different ways that these interpreters can prove their language proficiency.

C. Cost

1. Costs associated with the medical interpreter profession. With stakeholder groups, we discussed costs associated with either (1) working as an interpreter or (2) employing/utilizing interpreters. Feedback is organized by stakeholder subgroup.

2. Costs to all interpreters. Interpreters face a variety of costs associated with obtaining training, certification, and continuing education units (CEUs). Individuals must fund their own formal interpreter education. While some groups and institutions offer limited scholarship opportunities, many interpreters are unable to pursue further education due to financial constraints.

> "Most interpreters can't work exclusively in health care and the health care pay scale is lower than other fields" – Interpreter

> **"**Training and certification is cost-prohibitive to independent interpreters." – Interpreter

Most often, interpreters pay out-of-pocket for CEU opportunities. Some hospitals and health plans offer CEU opportunities for their full-time staff interpreters.

Currently, all medical interpreters in Minnesota must pay the $50 roster fee each year. The cost for some fully employed interpreters is covered by their employer. Independent interpreters must pay this out-of-pocket. For those who perform a significant amount of interpreter work, this fee is manageable. For those who interpret rare languages, this can sometimes equal or exceed their yearly earnings from interpreter work.

> "Interpreters feel taxed by the MDH roster." – Agency representative

> "It is not as simple as having qualifications. Most interpreting jobs are part time and do not pay enough to live on. I love interpreting and would love to get more qualified and do it as I have never enjoyed a job as much as I do interpreting. However if you make people

> go through [a lot] of steps you may hinder their ability to even do it on a part time basis and if people can't do it on a part time basis there will probably be very few interpreters available. I had to take another job and now must deny all of the requests I get to interpret." – Survey respondent

3. Costs to independent interpreters. Independent contractors, those not employed as full-time staff in agencies or hospitals/clinics, described experiencing more job-related costs than their full-time counterparts. One of the most common complaints was transportation costs. These can be considerable as independent interpreters travel from clinic to clinic within one day. Expenses include unpaid travel time and the cost of public transportation or gas. We also heard many comments on how costly parking at hospitals and clinics can be. Parking is often not reduced or validated for interpreters as they are treated more as guests than hospital personnel. An interpreter doing four appointments, each at a different location, could incur large parking expenses over just one day.

Additionally, independent contractors described the higher cost when working for multiple agencies due to varying, non-standardized training that is required by each agency. Interpreters also described a variety of business-related expenses they must bear, including printer, fax, ink/toner, internet, and cell/smart phones.

> "All of these extra expenses often make our take-home wage under the minimum hourly rate." – Interpreter

Independent interpreters must pay for their own health insurance. Since they are contracted employees without eligible sick time, they must go without pay if illness keeps them from working. These costs can add up, as interpreters are constantly exposed to a variety of illnesses.

4. Costs to interpreter agencies. As mentioned previously, some interpreter agencies pay the roster fee for their full-time interpreters. Interpreter agencies also face a variety of costs associated with the current lack of a regulatory system for medical interpreters. Many independent interpreters work for numerous interpreter agencies, and each agency must bear the cost of conducting its own background check and language testing and performing time-intensive tasks such as gathering immunization records on each individual. This costly process can be redundant as many agencies are carrying out similar tasks on the same individuals.

5. Variability in reimbursement. The actual wage that an interpreter receives varies widely among agencies, languages and locations. Most health plans and the Department of Human Services reimburse at the same rate of $46/hour for interpreter services. Interpreters generally receive less than this, as some of the money is allocated toward agency fees. There is no industry standard for the proportion of the reimbursement rate that an interpreter actually receives. Interpreters are often expected to place reminder calls to patients the day before their visit, and they must arrive to the clinic early, but these expenses are not reimbursed.

Furthermore, interpreters are not guaranteed reimbursement for instances in which the patient misses the appointment. Some interpreters require a two-hour minimum reimbursement for their services, though not all interpreters can negotiate this deal due to the fact that there are many

other interpreters available for their language. Some agencies reduce the reimbursement rate that an interpreter receives for every subsequent hour of an appointment, providing a disincentive for interpreters to provide their services for medical encounters that span multiple hours.

Interpreters for languages for which more interpreters are available, such as Spanish, generally receive a lower hourly rate than interpreters of less common languages. Wages vary across the state because of differing levels of competition for language services.

6. Lack of differential pay for more qualified interpreters. Interpreters with greater qualifications or certification are not guaranteed higher pay than less experienced interpreters. Although an interpreter who has national certification or a degree in interpreting is more likely to be employed as a staff interpreter, this is not guaranteed. Thus, there is currently a notable financial disincentive for interpreters to seek training, education or certification.

> "Most experienced interpreters leave the field because of no standardization and differential pay. The hourly rate has been the same over 15 years. Whether an interpreter starts today or has been in the field for 15 years, the pay at the agencies is even lower now. Some agencies send their interpreters to an hour assignment, and the assignment can be at any corner of the cities. If the interpreter doesn't accept that he/she loses the contract." – Survey respondent

Many stakeholders suggested that there should be differential reimbursement rates for interpreters with varying degrees of qualifications so that there is a greater incentive to improve one's interpreting skills. Other stakeholders felt that reimbursement would be better adjusted in a market-based approach and that highly trained interpreters would start to receive more once there is differentiation between interpreter qualification levels. Also, to address the lack of standardized reimbursement between agencies, some stakeholders suggested that MDH set explicit rules for how interpreters must be reimbursed.

> "MDH should consider how guaranteed reimbursement or other techniques can motivate individuals to seek more training" – Health care provider

> "Let the market adjust for differential reimbursement. If MDH created a registry with different tiers, interpreters in the more qualified tiers will be paid better because providers and payers want to use better interpreters." – Health system representative

7. The need to keep system costs low for interpreters. MDH strongly heard that interpreters want to keep new system costs low. Interpreters encouraged ideas about the creation of a tiered registry, robust technical assistance and the ability to investigate complaints but also emphasized that the cost to enroll in a new system would need to stay low. Costs that are too high could create a disincentive for interpreters to work in the medical setting, potentially shrinking the pool of available interpreters.

D. Remote Interpreting

1. Current use. Video remote interpreting (VRI) and telephone interpreting are becoming more common in health care settings. Some health systems have adopted in-house VRI to meet the

high demand of LEP patients and have created networks with hospitals around the country so that services can be shared.

One of the significant issues stakeholders had with 2014 legislation proposing to establish an interpreter registry was its failure to address remote interpreting. There are many national vendors of interpreter services, and they would not have been regulated under the draft legislation. Minnesota agencies and interpreters were concerned that health systems might choose to use national remote interpreting vendors instead of local in-person interpreters because of cost savings.

> "The 2014 legislation and report did not even mention standards for out-of-state vendors, video remote interpreting and national companies." – Agency representative

2. Merits of remote interpreting. VRI has improved timely access to interpreters in clinics with large LEP populations, rural clinics, and clinics that serve rare-language populations. VRI is used when services are needed immediately and an interpreter is not available. For some health systems with large LEP populations, VRI has been integrated into standard interpreting services so that interpreters can more efficiently use their time. In rural settings, it is sometimes difficult for a health care professional to find an interpreter when the appointment is not scheduled in advance because there are no local medical interpreters.

> "We need quality interpreters available when we need them. For rare languages this can only be done with video interpreters or telephone interpreters." – Survey respondent

> "Video conferencing ensures access to an interpreter, rural areas could benefit greatly from video interpreting." – Health system representative

3. Drawbacks of remote interpreting. Although VRI and telephone interpreting can improve timely access to an interpreter, many stakeholders were concerned about quality and appropriateness. Though technology can be more efficient, stakeholders point to times when VRI systems stall or fail, which can be dangerous for an LEP patient undergoing a critical procedure.

> "There have been situations when VRI has shut down during a colonoscopy." – Agency representative

Another concern is that telephone and video interpreting does not convey nonverbal communication. This can impact the quality of communication and the safety of the patient.

> "Video and phone interpreters miss so many nonverbal cues." – Interpreter

Some interpreters are also concerned about VRI because of its situational and cultural appropriateness. For example, LEP individuals of some cultures and seniors may not be accustomed to communicating through a video screen, which may hinder their ability or willingness to communicate. Additionally, VRI is not appropriate for certain medical encounters, such as the delivery of very sensitive news, mental health visits, and critical procedures.

> "Some clients are actually fearful of VRI, especially the elderly." – Agency representative

Although health systems that use VRI are generally compliant with HIPAA privacy regulations, some patients are also concerned about the privacy of their information as it is shared with an individual who could be across the country or even in another nation. They worry about the potential for hacking.

A final concern associated with VRI is that health systems may choose to use VRI when an in-person interpreter is available, to save money. VRI and telephone interpreting are usually charged by the minute and are cheaper than in-person interpreting. Some were also concerned that national video and telephone interpreting companies may not have high quality standards for their interpreters and that remote interpreters may not specialize in medical situations.

Multiple stakeholders stressed that an in-person interpreter should always be used when available and that VRI should only be used in cases when no other option is available.

> "MDH should mandate that in-person interpreters get priority over telephone and video interpreters." – Interpreter

4. Lack of state regulation. A major concern among interpreters and agencies is that VRI and telephone interpreting take business away from Minnesota interpreters and Minnesota interpreting service providers/agencies. Furthermore, for patients who are on Medical Assistance or MinnesotaCare, the reimbursement for interpreting services goes to a company located outside of the Minnesota.

> "Shouldn't telephone interpreters have the same requirements as those listed in the registry?" – Survey respondent

> "Make sure that in this process you do not disadvantage Minnesota in-person interpreters. Minnesota Medicaid dollars should not be going to non-Minnesota companies." – Agency representative

Minnesota interpreters are concerned that a new system may subject them to increased regulation, while interpreters working from other states will not be subject to any regulation. Some were even concerned that low-quality agencies and interpreters may choose to incorporate in another state and interpret remotely in an attempt to avoid regulation.

> "MDH should have a list of vendors that provide over-the-phone interpreter services who have met minimum standards." – Survey respondent

E. Technical Assistance and Support

We discussed the types and amount of technical support that interpreters and individuals using a new system may need. Although interpreters heard from were generally confident that they would be able to use a new system that is similar to the current roster, they also felt that it is important to have staff at MDH to call on if registration becomes difficult or confusing.

1. Technical assistance needs. Interpreters feel that their technical assistance needs can be met through a MDH interpreter assistance phone line or e-mail address. Although many interpreters

use the internet and phone as a part of their careers, some may need a little more assistance with utilizing an online system.

> "I would like to have a contact person that assists when we have trouble with the registry." – Interpreter

> "Unless the new system is very complicated, I can't imagine needing much help." – Survey respondent

> "I might need to call someone for help." – Interpreter

Some stakeholders pointed to the need for technical support beyond normal business hours since interpreters work long and odd hours. If a phone helpline were created, they recommend including a voicemail system so that interpreters can call at their convenience.

The more numerous the credentials being verified, the more support interpreters expect to need. Interpreters felt it would be especially helpful to have more technical assistance early on, during registry implementation and startup.

> "Because we are considering here people who come from all over the world, with credentials from all over the world, and there will be questions on how those are going to be made equivalent here."– Survey respondent

To make the system effective and efficient, some interpreters recommended that MDH solicit feedback after the registration process in order to understand which parts of the process require the most help.

Interpreters also emphasized the importance of creating a system that can be altered as new languages are needed and as information changes.

> "There needs to be someone who can modify the roster as needs develop. For example, adding new languages to the roster and updating contact information for interpreters and agencies." – Agency representative

2. Working with existing mechanisms. Interpreters and interpreter organizations felt that it would be helpful to work through existing support mechanisms as well. For example, many organizations and groups already have large contact lists that may be utilized when communicating important messages about the technical aspects of a new registry. Interpreters already look to their agencies and organizations for this support, so working with these groups would make communication more efficient.

> "The agencies I work for will tell me what I need to know." – Survey respondent

However, some emphasized that MDH should have its own sources of assistance as well, due to the large workload agencies and organizations have. Also, some felt that a direct message from MDH would eliminate any filtering by these companies and groups.

> "I suspect that much of the information that independent contract interpreters receive is filtered by their agencies (and they can be good and honest and supportive, or not)." – Survey respondent

F. Communication and Feedback

1. Communication by MDH on topics important to interpreters. Interpreters generally felt that email or automated phone calls are the best to contact them with updates and information. Some interpreters have outdated e-mail addresses listed on their roster pages, so they did not receive notice about the engagement opportunities. This difficulty highlights the importance of reaching interpreters through more than one method and MDH should encourage interpreters to keep their contact information updated.

> "The best way to contact me is by e-mail and phone. Working as an interpreter, I have to check my e-mail and phone frequently." – Interpreter

2. Ways stakeholders can provide feedback on a new system. Stakeholders felt that it is important for MDH to solicit and accept feedback about the new system in order to make it a successful transition. Some mentioned that MDH should be very clear in explaining what kinds of changes are feasible after legislation is potentially enacted and what kinds of changes would require subsequent changes in law. Stakeholders who participated in person supported the idea of future information and feedback sessions held by MDH, similar to the ones held to gather and share information about this phase of the project. Survey respondents desired more online opportunities, but some also felt that in-person sessions allow participants to provide more personal feedback.

> "We need community forums and conversations—not just on-line." – Survey respondent

Interpreters we met in person, as well as those who completed the survey, were very receptive to the idea of the creation of an advisory council with representatives who reflect their interests and concerns. Stakeholders emphasized the importance of creating a fair, representative advisory council with rotating membership so that progress can be made.

3. Information and resource needs. Although there is a lot of information about training opportunities and continuing education online, some interpreters felt that this information is difficult to find, compare, and evaluate for authenticity. They suggested that the MDH interpreter website could serve as a better resource guide, especially if MDH sets certain higher requirements for interpreters.

> "Online resources are very important to me, [I need] a place where I can go and check for any type of assistance such as: scholarships, classes etc., that way I can grow in the field." – Survey respondent

Interpreters emphasized the need for a resource guide for Minnesota interpreters and explained that there should be a mechanism in place for complaints and investigation of inappropriate or unethical behavior.

G. Other Important Issues

Other issues about the medical interpreting field that did not directly relate to the other categories were raised in the discussions. These issues are discussed below.

1. Mechanism for complaints. Interpreters as well as health care providers were concerned that despite the fact that MDH houses the current roster, MDH has no authority to receive or investigate complaints about interpreters. There is no standardized process for investigation. Generally, complaints are handled through an interpreter's agency. An interpreter who is disallowed from working with one agency may continue interpreting in medical settings by simply working with a different agency. Stakeholders also emphasized that LEP individuals should have a mechanism for complaints about interpreters.

> "There should also be a way that LEP patients can give their feedback about the quality of the interpreter they had. You would need a voice mail line that is set up to work with many different languages." – Interpreter

Interpreters also emphasized the importance of having a way to give anonymous feedback to clinics about health care providers and clinic staff. Many interpreters have experienced situations in which clinic staff members have expected them to fulfill certain roles that contradict the interpreter code of ethics and then are unhappy when the interpreter says no. Another proposed solution to this issue was that MDH could provide information and resources on its website for health care workers who work or interact with interpreters.

2. The safety and wellbeing of the interpreter. Some interpreters were concerned about their health and safety while interpreting. Clinics and health systems require that health care interpreters receive certain immunizations, and agencies provide verification that interpreters meet these requirements. Interpreters voiced concerns, however, about infectious diseases and frequent illnesses that cause them to miss work. One proposed solution to this issue is that interpreters practice good medical hygiene and are briefed by doctors or nurses if a patient has a concerning infectious disease.

Another concern from interpreters is that there are no resources for them to prepare for, understand and manage grief. Interpreters sometimes have to share devastating news with a patient and their family and are usually not briefed by the provider beforehand.

> "I had to tell someone from my small community that they had just months to live. I didn't know how to deal with the grief." – Interpreter

3. The security of the MDH roster and proposed registry. Interpreters and other stakeholders are concerned about the security of the current MDH roster. Because their e-mail addresses and phone numbers are listed publicly, some interpreters have received spam. Others have even received messages asking them to meet at hotels or other private locations for alleged job offers. Stakeholders emphasized the importance of making the proposed registry more secure by requiring individuals who search for interpreters to log in or use a passcode.

4. The need for incremental change. Many stakeholders emphasized the importance of setting higher standards but balancing these standards with the state of the current interpreter community. Higher standards need to be imposed incrementally to allow interpreters time to get

training. If MDH were to set standards too high in a single step, there would be many interpreters who could not reach the standards, creating an access issue for LEP patients. That being said, stakeholders also felt that it would be appropriate to change the proposed registry over time to reflect changes and professionalization among interpreters.

> "Changes should be incremental to avoid access issues" – Community organization representative

5. The need for more data on interpreter use in Minnesota. Although most health systems with significant populations of LEP patients keep data on the frequency of interpreter use, there is no comprehensive state-level data that could be used to analyze and better understand trends in interpreter use. Some stakeholders proposed that MDH require health systems to enter this information in a standardized e-health records system.

6. Concerns from Greater Minnesota interpreters. Interpreters working in Greater Minnesota were particularly concerned about how a new system with higher requirements would affect them. These interpreters have less access to training opportunities and continuing education classes, as many of these occur around the metro area.

> "We should be careful how many requirements are added because it may adversely affect the availability of interpreters, especially in areas outside the metro." – Survey respondent

7. The use of excess revenue generated by a new system. Many interpreters voiced the need for more scholarships and reduced-rate training opportunities and felt that MDH should offer these. Although the proposed registry system is designed not to generate any excess revenue, interpreters suggested that if there were excess revenue it should be allocated to interpreters through scholarships and more frequent and affordable continuing education opportunities.

8. Repeated costs for interpreter agencies. Interpreter agencies explained that because interpreters usually contract with multiple agencies, the same interpreter undergoes multiple background checks, oral proficiency exams, and requests for immunization records. This generates repeated costs for interpreter agencies. Some interpreter agencies proposed that a clearinghouse be created so that agencies can share this information and reduce unnecessary costs.

9. The need for more information for LEP patients. LEP individuals and community organizations explained that LEP patients are not fully aware of their right to an interpreter in a medical setting. Sometimes LEP patients are encouraged to communicate in English although their ability to communicate and comprehend messages in English is below an appropriate level. Other LEP patients think that they need to bring an interpreter with them, though finding an interpreter is the responsibility of the clinic.

Appendix I – Perspectives on Medical Interpreters from LEP Minnesotans

We spoke with limited English proficient (LEP) Minnesotans about their experiences with medical interpreters. These perspectives are shared separately from other stakeholder groups because the discussions were more focused on *experiences with interpreters*, and less on *specific details about interpreting* discussed with other groups such as costs to interpreters, technical assistance for interpreters, etc.

MDH met with adults attending English Language Learner (ELL) classes. These individuals represented a broad range of non-English languages including: Amharic, Arabic, Chinese, Hmong, Karen, Nepali, Oromo, Somali, Spanish, and Vietnamese, among others. The perspectives below reflect these individuals' direct experiences with interpreters.

A. Availability of medical interpreters. LEP individuals felt that there are generally enough medical interpreters when they need them. In some cases, clinics fail to schedule an interpreter for the appointment, causing the LEP person to have to return to the clinic at a time when an interpreter is available. Although there may be enough interpreters, LEP individuals were concerned that there may not be enough experienced or well-trained interpreters available.

> "Even when I schedule my appointments ahead of time, clinics do not always make sure to have an interpreter there for me." – LEP individual

> "There are lots of interpreters, but few who are experienced." – LEP individual

Another concern about interpreter availability is that interpreters often double-book appointments or do not give themselves enough time to commute between appointments. This leaves the interpreter late or unfocused at the appointment. As a result, LEP individuals have to wait or reschedule their visits. In some cases when an interpreter is late or doesn't show up, LEP individuals are encouraged to communicate with the doctor or nurse on their own.

> "My interpreter called me and wanted me to change my appointment time to better suit their schedule" – LEP individual

B. Positive impacts and good experiences with interpreters. Most LEP individuals have had positive experiences with interpreters. They explained that good interpreters are kind, focused, professional, and willing to take time clarifying and explaining terms. LEP individuals felt that good interpreters are willing to help with scheduling follow-up appointments, picking up prescriptions, and navigating medical buildings. They felt that assistance with these tasks was as important as the time spent interpreting in the exam room.

> "It is important to be able to feel comfortable asking questions." – LEP individual

> "I don't just need an interpreter in the exam room."– LEP individual

> "Sometimes the doctors and nurses speak too fast for me to understand. The interpreters explain things slowly and are willing to clarify things when I don't understand the doctor." – LEP individual

LEP individuals named many benefits of having a high-quality interpreter, including better communication with the doctor, a positive perspective on the overall health care experience, empowerment to seek care in the future, and confidence in understanding and improving their health status.

> "When I have a good interpreter, I feel so much more safe and comfortable. It gives me a better perspective on the health care system." – LEP individual

> "I went to the hospital with burns and felt the interpreter did not give accurate information to the doctors. After six months, I still couldn't feel my hand. I went to another clinic with a good interpreter and they found medicine for me right away. I felt she saved my life." – LEP individual

C. Negative impacts and bad experiences with interpreters. LEP individuals were concerned about the quality of some interpreters. They felt that some interpreters did not have adequate language proficiency to make the communication between doctor and patient clear. Some interpreters are proficient but do not have a strong medical vocabulary; this is especially apparent when communicating regarding medicines and prescriptions. LEP individuals could often tell when their message was not being properly communicated to the doctor, and they feared that the doctor's message may be unclear as well.

> "I said '*I need a doctor for bones*' but the interpreter said to the nurse '*I need Dr. Bones*'." – LEP individual

LEP individuals were also concerned that many interpreters are distracted during their appointments, checking their phones or watches, and not focusing as much as they should on the communication.

> "An impatient interpreter gave me bad information about my insurance coverage when we were talking with the clinic receptionist before my physical. It turned out my insurance didn't cover this clinic and now I have a $700 bill I can't pay." – LEP individual

> "I wanted the doctor to give me a little more explanation of my condition, but the interpreter didn't want to take the extra time and I didn't get the information I wanted." – LEP individual

When the LEP patient has some level of English proficiency, interpreters sometimes choose not to interpret certain things because they assume that the LEP person understands what the doctor is saying in English.

LEP individuals also gave accounts of situations in which interpreting had a negative impact on their health.

> "I lost a tooth because an interpreter didn't clearly explain to me what the dentist was doing." – LEP individual

> "An interpreter told me I was pregnant when the doctor didn't say it." – LEP individual

D. Ideas to improve medical interpreting. LEP individuals recommended that interpreters be tested for their language abilities and understanding of medical terms. Some also recommended that all interpreters get trained to develop their interpreting skills before they are allowed to interpret so that they understand their role.

LEP individuals recommended that clinic staff ask patients if they will need an interpreter when scheduling their visits to avoid situations in which no interpreter is scheduled to help. This would also reduce the number of times when a telephone or video interpreter is needed. Many LEP individuals felt that communication with their doctor was hindered by remote interpreters.

> "The hospital shouldn't use interpreters on phone because they are not good." –LEP individual

One of the main issues LEP individuals have with interpreters is that they are not consistently on time to appointments. One LEP individual suggested that interpreters get paid more or paid a salary so that they do not have to over-book their schedules.

> "Interpreters can't focus at appointments because they're too busy watching the clock about when to leave for their next job. Interpreters should be paid more so they don't have to work this way. It will make them more focused which will help me understand more of what the doctor is saying." – LEP individual

Appendix J – Spoken Language Health Care Interpreter Registry Guide

Tier	Requirements
Tier 1	1. Minimum age of 18 2. Pass MDH Medical Interpreter Ethics and Standards of Practice Test 3. Pass MDH Medical Terminology Test
Tier 2	1. All tier 1 requirements 2. 40+ hours of medical interpreter training through an approved training body[2] 3. Provide proof of 4 hours of continuing education[1] per year for renewal
Tier 3	1. Minimum age of 18 2a. **Option a:** National certification in medical interpreting that **does not** include language proficiency component in the non-English language[3] 2b. **Option b:** Certificate in interpreting from an accredited US educational institution[5] →**Including:** 18 or more semester credits →**And:** Pass MDH Interpreter Ethics and Standards of Practice Test →**And:** Pass MDH Medical Terminology Test 3. Provide proof of 6 hours of continuing education[1] per year for renewal
Tier 4	1. Minimum age of 18 2a. **Option a:** National certification in medical interpreting that **does** include language proficiency component in the non-English language[4] 2b. **Option b:** Associate's Degree or greater in interpreting from an accredited US institution[5] →**Including:** a minimum of 3 semester credits in medical terminology or medical interpreting →**And:** Pass an oral proficiency exam[6] in the non-English language 3. Provide proof of 8 hours of continuing education[1] per year for renewal

All interpreters including those located outside of Minnesota whose services are used for LEP individuals in Minnesota must be at least a Tier 1 member

→Or fulfill equivalent as verified through language services provider

*Other options will be evaluated as necessary by the advisory council

Preapproved options to fulfill requirements*

1. Continuing education accredited by
- American Translators Association (ATA)
- International Medical Interpreters Association (IMIA)
- Certification Commission for Healthcare Interpreters (CCHI)

2. Medical interpreter training (40+ hours)
- Bridging the Gap
- The Community Interpreter (medical focus)
- The Interpreter Advantage
- Requirement to change to 60 hours for new enrollees on 7/1/2018

3. National certification in medical interpreting (No language proficiency component)
- CoreCHI from CCHI

4. National certification in medical interpreting (Including language proficiency component)
- Certified Medical Interpreter (CMI) from National Board of Certification for Medical Interpreters (NBCMI)
- Certified Healthcare Interpreter (CHI) from CCHI

5. Educational institution
- All accredited US institutions
- Foreign institutions as approved by advisory council

6. Oral proficiency exam
- Oral Proficiency Interview (OPI) from American Council on the Teaching of Foreign Languages (ACTFL) →Score of Advanced Mid or greater

Appendix K – Legislative Guide – Options for Spoken Language Health Care Interpreter Registry Program

The Legislature can select and combine program functions to build a regulatory system for spoken language health care interpreters. The functions selected determine the amount of the fees. The fees necessary to fund each function are shown in the columns on the right.

Program Function	Description of Program Function	Contribution to Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
● **Verification**	• Verify that applicants have passed ethics and medical terminology tests if applicable • Verify that applicants have provided adequate documentation of qualification for Tiers 2, 3, or 4 • Ongoing IT support for online application system • This does NOT include technical assistance to interpreters in applying to the registry	$33.00	$56.00	$73.00
■ **Technical Assistance**	• Assist registry applicants in understanding qualifications for each tier • Assist registry applicants in completing application process	$8.00	$8.00	$8.00
▲ **Advisory Council**	• Advise MDH on issues relating to interpreting skills, standards of practice, and ethics • Inform MDH of emerging issues in the field • Provide consultation on need to draft and request legislative changes to interpreter law	$10.00	$10.00	$10.00
Complaints & Oversight	**Two options:**			
◢ **Option 1: Complaint & Advisement**	• Accept complaints and send letters of advisement , there is NO investigation ○ Interpreters are informed that there has been a complaint, told the nature of the complaint, and referred to appropriate ethical standards or standards of practice • Instances of fraud, abuse, and coercion are referred to local law enforcement	$11.00	$11.00	$11.00
◆ **Option 2: Investigation & Enforcement**	• Accept and investigate complaints; obtain translation and interpretation where necessary to read complaints and interview witnesses ○ Bring enforcement action (fines, remedial action, or remove from registry) against interpreters where complaints are substantiated	$46.00	$46.00	$46.00
Start-Up Costs	• Complete computer programming to expand data collected • Allow online administration and result reporting of ethics and legal terminology tests • Allow attachment and transmittal of supporting documentation • Provide application status reports to applicants • Develop ethics and medical terminology tests • Support staffing to plan and create regulatory infrastructure	Approximate one time start-up costs: • $478,000, FY16 • $95,000, FY17 • $73,000, FY18		

The examples below assume start-up costs will be funded by non-fee sources. Fee amounts would replace the existing fee under current law.

Registry System	Program Functions Included	Total Fee		
		Tier 1	Tier 2	Tier 3 & Tier 4
1. Minimal System	● Verification + ◢ Option 1: Complaint & Advisement	**$44.00**	**$67.00**	**$84.00**
2. Basic System	● Verification + ■ Technical Assistance + ▲ Advisory Council + ◢ Option 1: Complaint & Advisement	**$62.00**	**$85.00**	**$102.00**
3. Comprehensive Regulatory Program	● Verification + ■ Technical Assistance + ▲ Advisory Council + ◆ Option 2: Investigation & Enforcement	**$97.00**	**$120.00**	**$137.00**

For example: if the "Basic System" were enacted by the Legislature at these rates, a Tier 1 interpreter would pay $62.00.

Appendix L – Draft legislation to implement tiered registry

Since there are various ways to structure a registry program, the draft statutory language included here focuses solely on identifying the sections of law that would need to be amended to implement the recommended four-tier registry in place of the current roster, and on listing the requirements recommended for each tier. To develop a complete draft statute, MDH would need legislative input to determine:

- Component functions to include in the registry program,
- Fee levels to support the registry system, and
- The transition plan to move from the current roster to the recommended registry.

MDH can draft the necessary legislation upon request.

144.058INTERPRETER SERVICES QUALITY INITIATIVE. ***REPEALED, effective July 1, 2017.***

256B.0625 COVERED SERVICES.

Subd. 18a.**Access to medical services.**
(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and spoken language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face spoken language interpreter services shall be provided only if the spoken language interpreter used by the enrolled health care provider is listed in the registry established under section 148.990

Beginning on July 1, 2017, spoken language interpreter services will be covered only if the interpreter is registered under section 148.990.

SPOKEN LANUGAGE HEALTH CARE INTERPERETERS

148.990. REGISTRY SYSTEM

Subdivision 1. (a) There is established a registry of spoken language health care interpreters, consisting of four tiers representing increasing proficiency.

Beginning July 1, 2017, no individual may provide spoken language health care interpretation to a patient in Minnesota nor is any individual eligible under section 256B.0625, subd. 18 for

payment for spoken language health care interpretation services unless that individual is registered pursuant to this section.

(b) Notwithstanding subdivision 2, an individual may provide spoken language health care interpretation without being registered if:

(1) an emergency situation exists and no registered interpreter who speaks the patient's primary language is available; or
(2) the patient speaks a rare language and no registered interpreter can be located.

Subd. 2. (a) **Tier 1.** To qualify for the first tier of the registry, an applicant must:

(1) be at least 18 years old;
(2) demonstrate basic knowledge of medical terminology in English by passing an examination approved by the Commissioner;
(3) demonstrate knowledge of interpreter ethics and standards of practice by passing an examination approved by the Commissioner; and
(4) affirm by signature, including electronic signature, that the applicant has read the Code of Ethics and Standards of Practice for the National Council on Interpreting in Health Care or its successor and agrees to abide by them.

(b) **Tier 2.** To qualify for the second tier of the registry, an applicant must:

(1) meet the all requirements for Tier 1; and
(2) successfully complete a training course, approved by the Commissioner, on basic interpreter skills.

The training course must be a minimum of 40 hours long. Interpreters who register after July 1, 2018, must complete a course of 60 hours or more.

(c) **Tier 3.** To qualify for the third tier of the registry, an applicant must:

(1) be at least 18 years old; and
(2) affirm by signature, including electronic signature, that the applicant has read the Code of Ethics and Standards of Practice for the National Council on Interpreting in Health Care or its successor and agrees to abide by them; and
(3) (a) have national certification in health care interpreting that does not include language proficiency in the non-English language; or
(b) (i) successfully complete an interpreting certificate program of eighteen semester hours or more from an accredited U.S. academic institution, which program is approved by the Commissioner; and

(ii) demonstrate basic knowledge of medical terminology in English by passing an examination approved by the Commissioner; and

(iii) demonstrate knowledge of interpreter ethics and standards of practice by passing an examination approved by the Commissioner.

(d) **Tier 4.** To qualify for the fourth tier of the registry, an applicant must:

(1) be at least 18 years old; and
(2) affirm by signature, including electronic signature, that the applicant has read the Code of Ethics and Standards of Practice for the National Council on Interpreting in Health Care or its successor and agrees to abide by them; and
(3) (a) have national certification in interpreting that includes language proficiency in the non-English language; or
(b) (i) have an Associate's Degree or higher in interpreting from an accredited U.S. institution, which degree has been approved by the Commissioner and includes a minimum of three semester credits in medical terminology or medical interpreting; and

(ii) have achieved a score of “Advanced Mid” or higher on the American Council on the Teaching of Foreign Language’s Oral Proficiency Interview in the non-English language.

(e) Upon recommendation of the advisory council, the Commissioner may approve alternative means of meeting oral proficiency requirements for tier 4 for languages for which the American Council on the Teaching of Foreign Language’s Oral Proficiency Interview is not available.

(f) Upon recommendation of the advisory council, the Commissioner may approve a degree from a foreign country as meeting the requirement in tier 4 of an Associate’s degree or higher. The applicant will be assessed a fee that represents the costs of translating documents that verify the degree and additional steps needed to process the application.

148.991. CONTINUING EDUCATION.

Tier 2 interpreters must obtain a minimum of four hours of continuing education during the one-year registration period. Tier 3 interpreters must obtain a minimum of six hours of continuing education during the one-year registration period. Tier 4 interpreters must obtain a minimum of eight hours of continuing education during the one-year registration period. All continuing education must be obtained during the year the interpreter is registered. Contact hours will be prorated for interpreters who are assigned to a registration cycle of less than a year.

Interpreters who seek to return to the registry after their listing lapses will be required, prior to re-registration, to complete continuing education hours accrued during their lapse, up to the number of credits required for a three month period. If a returning interpreter qualifies for a higher tier, the number of credits due is based on the interpreter’s tier during the last period of registration.

The Commissioner will approve courses and trainings for continuing education in advance. If the Commissioner has not approved, in advance, a course or training submitted to fulfill the continuing education requirement, the training or course may be disapproved. Disapproved courses will not be counted toward the continuing education requirement.

VIII. Endnotes

[i] 2013 data from the American Community Survey undertaken by the U.S. Census Bureau.
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[vii] Examining the averages of 3-year periods in ACS data, the percentage of Minnesotans (ages 5 years and older) self-identifying as speaking English "less than very well" has been at or above 4% from 2005-2013. The average rate increased from 4.0% in the 2005-2007 period to 4.2% in the 2011-2013 period.
[viii] This section is adapted from, borrows from, and follows the general outline utilized in the 2008 ISWG Report described in Section IX. The report can be found at: http://www.health.state.mn.us/divs/pqc/hci/ISWGreport08.pdf
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