



CERTIFICATION OF HEALTH CARE INTERPRETERS IN THE UNITED STATES

A Primer, a Status Report and Considerations for National Certification

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**PREPARED FOR THE CALIFORNIA ENDOWMENT
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INTRODUCTION

Many factors have combined during the past two decades in the United States to increase awareness of the need for quality interpreting in health care settings. A changing demographic, bringing Limited English Proficient populations into previously homogeneous geographic regions; the growing body of research documenting the impact of poor interpreting on patient care, satisfaction, access and cost; and guidance from the U.S. Department of Health and Human Services Office for Civil Rights regarding the legal responsibilities of recipients of federal funds to provide equal access to services have all resulted in a growing understanding of the serious nature of language barriers in health care. In the early years of responding to these concerns, the field as a whole focused to a large degree on identifying need and on assuring the presence of an interpreter – any interpreter – to meet that need. As systems have matured, however, more emphasis is being placed on assuring not just quality in the delivery system, but quality in the actual interpretation delivered.

Within the scope of this discussion on quality assurance, the question of certification for health care interpreters is being raised more frequently. Many groups have a particular interest in the creation of interpreter certification. Health care administrators, for example, would like to be able to count on a credible external system to guarantee the quality of their interpreters, just as they are able to depend on external certification/licensure programs to assure the capacity of other professionals they hire, such as physicians, nurses, pharmacists and sonographers. Skilled interpreters themselves are often anxious for certification in order to increase respect for their work and to differentiate themselves from other interpreters with less skill. Many language agencies would welcome a valid certification as a means of foregoing the often expensive screening programs they currently must employ.

However, for interpreters serving in health care settings, national certification currently exists only for sign language interpreters. Why is this? The answer has to do with cost, the nature of certification and the current stage of development of spoken language health care interpreting as a field. Certification programs are emerging on the state and commercial level though, and interest in a national certification is high.

This report was written with the goal of providing the reader with an overview of certification issues for health care interpreters in the United States at this time. What does certification mean? How are certification tests developed? What options exist for certification of health care interpreters right now? When will we have national certification? To answer these questions, the report is organized into four sections, each of which will help the reader to understand part of the overall state of the art.

Part I: Understanding Certification provides the reader with a basic understanding of what constitutes certification, how certification differs from assessment and how to evaluate the credibility of any given certification program.

Part II: Current Certification Processes provides detailed information on nine programs currently available that assess the skills of health care interpreters. In a number of cases, the host organization chooses not to call the process “certification,” however, as the tests were developed with a serious scientific method, they have been included here.

Part III: Initiatives to Establish State Certification/Qualification summarizes the experiences of eight states that have developed, are currently developing or tried to develop state certification for health care interpreters. These states are Washington, Oklahoma, Oregon, Indiana, Iowa, Massachusetts, North Carolina and Texas. The lessons learned from these efforts will inform the development of other certifications, either at a state or national level. The information included here is current as of January 2006; for up-to-date information on a given state’s progress, it will be necessary to contact the individuals involved.

Part IV: The Road to National Certification explores the potential for the development of a national certification process for spoken-language health care interpreters, suggesting steps that would need to be taken and caveats to ensure an effective and implementable process.

Whether you are an administrator, a health care provider, an interpreter or any one of the thousands of thoughtful professionals concerned about language access in health care, this report will help you better understand the issues surrounding certification and provide a background for developing or finding a certification program that meets your needs.

PART ONE - UNDERSTANDING CERTIFICATION

Definition of terms

In order to begin a national discussion on certification, it is important to develop a shared understanding of the relevant terminology.

Assessment

Assessment simply means evaluation. The American Heritage Dictionary defines it this way:

assess (v): To determine the value, significance, or extent of; appraise.¹

To assess a person's interpreting skills means to evaluate how well they perform a certain set of interpreting skills. In the language field, assessment usually refers to evaluation through testing. The test may result in "passing" or "failing," which implies comparison to a set standard, or it may simply help a candidate identify his or her strengths and limitations, without comparison to any required standard.

Certification

In the strictest sense, *certification* means that a particular certifying body is guaranteeing that the certified individual has the capacity to perform a particular set of skills up to an established criterion. The American Heritage® Dictionary gives this definition:

*certify (v): To confirm formally as true, accurate, or genuine.
To guarantee as meeting a standard.²*

There are two key concepts in this definition. First, a certification is guarantee of the candidate's abilities, and second, the candidate's skills have been compared to an established standard. In most cases, certification includes testing, however certification can also include or be based on education and experience alone. A certification without concrete skills testing in a field like health care interpreting, however, would have little credibility.

In itself, the word *certification* has little meaning; it simply indicates that somebody said that a candidate is good enough to do the job. For a given certification process to have significance, it is necessary to judge the certification's credibility. What is the nature of the body that is doing the certifying? Has the process been shown to be valid and reliable? How was the passing grade established? These issues will be discussed further.

A certificate of (successful) completion

A *certificate of completion* is often awarded to a candidate upon completion of a training program. A certificate of successful completion means that the candidate successfully finished the class, usually by passing a final exam. At this time, however, the final exams of most short interpreter trainings consist of a written test that does not require the candidate to demonstrate mastery of actual interpreting skills and that was not developed with scientific rigor. Therefore, a certificate of successful completion should not be confused with certification.

¹ The American Heritage® Dictionary of the English Language, Fourth Edition Copyright © 2000 by Houghton Mifflin Company.

² The American Heritage® Dictionary of the English Language, Fourth Edition Copyright © 2000 by Houghton Mifflin Company.

Licensure

Licensure is legal permission to engage in a certain activity. A licensed interpreter is one who has been granted legal permission to interpret. Licensure can be, but is not necessarily, linked to certification. Judicial interpreters in Texas, for example, can be licensed based on their years of experience, without being tested at all.

Accreditation

Accreditation is similar to certification, but the term is usually applied to institutions instead of individuals.

All these terms, then, are related but not interchangeable. They are all linked to showing that a particular interpreter is qualified to do the job. Of course, this focus on quality assurance is admirable; everyone gains when the interpreters who provide services in health care institutions are providing accurate and appropriate interpretation. Certification, however, is only one step in quality assurance, and it not even the first. In order to place certification in proper perspective, the next section will discuss how certification fits into quality assurance in interpreting.

Certification as Part of Quality Assurance

Quality assurance in interpreting can be assured through six steps: appropriate recruiting, language screening, training, assessment, monitoring and continuing education.

Appropriate recruiting

Health care interpreting is complex and challenging work. Like all interpreting, it requires highly developed language skills, a command of both formal and informal registers of speech, an understanding of interpreting ethics and protocols, and the ability to grasp and convert meaning instantaneously from one linguistic and cultural context to another. Health care interpreters must also master the language of health care, from the medical shorthand used by providers to the euphemisms used by patients in describing anatomy and symptoms. While challenging, these are skills that can be taught in interpreting classes.

Interpreting in health care, however, also involves other aptitudes which cannot be taught in a classroom, in order to handle the socially complex context in which these interpreters work. Health care interpreters are routinely exposed to intense human interactions and to emotionally stressful situations. They are in close contact with people who are worried, sick, contagious or dying. They have neither the anonymity of the interpreting booth that is enjoyed by conference interpreters, nor the formality of the courtroom that protects judicial interpreters, to isolate them from the human relationships formed in health care interactions. They often run from one appointment to the next, with little or no information about the probable content of the next medical interview. While both patients and providers depend on them, providers in particular often undervalue their contribution. In small communities especially, they find themselves at the nexus of conflicting expectations and so struggle to maintain credibility with both institution and community.

Health care interpreters, then, must bring to their job excellent interpersonal skills, maturity, a calm demeanor and a clear sense of their own value and boundaries. They must be able to communicate a sense of caring without getting overinvolved in a patient's problems. They must be forceful enough to define the rules for an interpreted session and self-effacing enough to fade into the background once the interview begins. They must be able to maintain professional boundaries, often in communities that do not recognize even the concept of professional boundaries. They must be emotionally stable individuals, able to cope with the unexpected and sometimes difficult emotions and events of the health care setting.

These are not skills that can be taught in a 40-hour training. These are life skills and personality traits that must be present in individuals before they are recruited. The first level of quality assurance in health care interpreting, then, lies in choosing the right people to be trained for the job. By skipping this step, time and resources are spent in training people who may learn some interpreting skills, but who will never be skilled health care interpreters.

Sadly, it is still common at this time to allow anyone who is interested to become an interpreter. This practice, while understandable considering the limited resources available to health care administrators, does not assure quality in interpreting, but merely provides a greater number of names on a list of supposed language resources.

Language screening

The basis of interpreting is, of course, language. Interpreting requires a high level of fluency in both languages in a given interaction, both in order to precisely grasp what is being said and to replicate that meaning in a completely different linguistic and cultural context, in a way that sounds natural to the listener. Interpreters must be able to understand regional dialects and accents, and they must have a command of both formal ("high register") and informal ("low register") speech. Quite apart from technical terminology, they must have a wide vocabulary in both languages.

These linguistic skills are learned over time, through education and experience. Most training programs do not have time to teach these skills, and so it is important to screen for them before allowing candidates to enter training. Training candidates with sub-standard language skills is a waste of time and money both for them and for the training program.

The past few years have seen a significant increase in the number of interpreting programs and training programs that require language screening of candidates. The most informal of these are done in-house through unstructured interviews conducted with the candidate by a trusted bilingual. On the other end of the formality scale, a growing number of commercial programs have emerged that provide language screening over the telephone for a fee. This increase in language screening is a good sign that bodes well for eventual national certification.

Training

“A bilingual doth not an interpreter make.” As this saying implies, good language skills, however important to an interpreter, are not enough. Interpreters must learn their role, including professional ethics, techniques for linguistic conversion, protocols for a smooth interaction, medical vocabulary, how to handle cultural differences and how to manage misunderstanding. The skill comes more easily to some than to others, but practice is essential. Untrained interpreters are at high risk for editing the message, adding in their own opinions and becoming a barrier instead of a bridge between provider and patient.

A decade ago, few training programs existed for health care interpreters in the United States. However, the introduction of short, 40-hour courses, replicated through programs to prepare trainers, has made at least some degree of training available across the country. Increased interest is now growing among community colleges to provide longer courses of study, and some are experimenting with distance learning as well.

Assessment

Finally, we come to assessment, under which we can include certification. Only after candidates have been carefully recruited, after their language skills have been screened and after they have received basic training does it make sense to test their interpreting skills. Testing candidates who have had no language screening or training is a waste of resources and is unfair to candidates, who are set up to fail.

Monitoring

Assessing or certifying an interpreter, however, is not the end of quality assurance. Training and certification show that an interpreter **can** provide quality interpreting, not that he or she **is** providing quality interpreting. In many health care institutions, there is pressure on interpreters to compromise the good practices they have learned. A lack of understanding by health care staff of the interpreter’s role, time pressures, conflicting expectations from patient and provider – all of these can lead even a highly skilled interpreter to become sloppy, to cut corners, to engage in practices that do not lead to clear communication.

Like any professional, interpreters need to be monitored to assure that they are implementing the skills they have learned. The best way to do this is through periodic observation by another trained interpreter. As this is time consuming, some institutions use feedback forms instead, which are filled out by providers and patients served by interpreters.

At this point in time, relatively little attention is being paid to monitoring interpreters, partly because many work as freelancers and so cannot be “supervised,” and partly due to lack of resources. As the profession evolves, this is an area that deserves more attention.

Continuing education

Like all professionals, interpreters must engage in continuing education. Participants in shorter interpreter trainings typically need to widen their bilingual medical vocabulary, increase their memory capacity and engage in supervised practice, with an unrelenting

focus on accuracy and completeness. Even graduates of longer courses can benefit greatly from attendance at conferences and short courses in specialized areas of health care interpreting.

Conclusion

Although this report is focused on certification, the discussion of quality assurance in general is important for two reasons.

1. There is a tendency to turn to certification as the sole answer to concerns about interpreter quality. It is not uncommon for administrators to feel that if only interpreters were certified, the hospital would not have to worry about the quality of the interpreting services it is providing. However, setting up certification in the absence of these other quality assurance steps will not lead to quality, and indeed, may create backlash instead as a large percentage of those currently providing interpreting services are found to be lacking in the requisite skills.
2. In the absence of certification, administrators can still take these other steps to ensure the quality of interpreting in their institutions. We cannot wait for a national certification process in order to address quality in interpreting, just as we cannot depend on certification alone to guarantee it.

Keeping in mind these caveats, we can turn our attention to certification. As mentioned above, it is not difficult to call a process *certification*. What is of interest is the degree of credibility any given certification process really has.

Judging the Credibility of a Certification Program

Credible certification programs in any discipline have certain common characteristics.

The certifying body is itself credible.

Certification can be offered by many classes of organization: governmental agencies, professional associations, educational institutions, private companies. The more expertise a body has in the subject matter being certified, and the less vested interest it has in a candidate's certification, the more credible the certifying body is. For example, a state health department that does not hire interpreters might have no conflict of interest in certifying interpreters, but if it lacks expertise in the field, its credibility is diminished. In the same way, a language agency that gains market share by having certified interpreters that it has itself certified might have a high degree of expertise in the field, but it has an equally high level of conflict of interest, making it as well a questionable certifying body. In contrast, a profit organization formed with the sole purpose of certifying interpreters, that hires professionals and content experts to design the test, unites both expertise and a lack of conflict of interest. The national Consortium for State Court Interpreter Certification is a perfect example of a highly credible certifying body. It embodies expertise in the field of judicial interpreting, and, since it does not train or hire interpreters, it has no inherent conflict of interest.

The certification process has been validated.

A certification process must be valid in several ways. It must have content validity, construct validity, concurrent validity and predictive validity.

Content validity is the degree to which a certification process tests knowledge and skills that are generally agreed to be necessary for the minimal adequate performance of the task. For example, most experts in health care interpreting agree that a capacity to accurately convert a spoken message from one language to the other is a key interpreting skill. A valid certification process, then, would need to include some testing of language conversion skills. In the same way, there is agreement that interpreters are not expected to diagnose patients, so a test that requires the interpreter to supply a diagnosis based on a case history would not have content validity. In judging a certification process, then, it is important to know what is being tested and how the certifying body chose to include that particular content. In the absence of a nationally vetted body of core interpreting skills, most certification processes have relied on consensus from a body of Subject Matter Experts (SMEs) to establish content validity. With the publication in fall 2005 of the National Standards for Interpreters in Health care by the National Council on Interpreting in Health Care, it is hoped that certification process designers will now turn to these standards as a guide to content validity.

In addition to content validity, a credible certification process must show **construct validity**. This means that the process tests what it purports to test and nothing else. If a certification claimed to test the ability of a candidate to accurately convert meaning, the most valid way to do it might be to record a live interpreted encounter. On the other hand, a test for oral interpreting conducted over the Internet would have lower construct validity, as it is actually testing a candidate's ability to use the computer in addition to her or his ability to interpret. Similarly, a paper-and-pencil test of medical terminology assesses both a candidate's medical vocabulary and ability to read and write. These testing techniques compromise the test's construct validity.

In reality, test designers struggle to find a balance between construct validity and feasibility. The most valid testing mechanisms are often expensive and time consuming and therefore impractical. Designers will seek to apply the most valid testing mechanism possible within the confines of budget and time. In evaluating a particular certification test, then, it is important to know how the designers chose the testing mechanisms they did and how they established both content and construct validity.

Concurrent validity is a measure of the degree to which the test results are equivalent to the results of other tests that purport to assess the same skills against the same standard. At this time, there are no widely accepted tests against which to measure concurrent validity of a test of health care interpreting; however, in the future this may become a more important measure of a test's credibility.

The final sort of validity that a certification test should show is **predictive validity**. Predictive validity in a certification of interpreting is the degree to which the process can predict who will actually provide quality interpreting in the field. If many people are

certified through a process, and then go on to interpret poorly, the test has poor predictive validity. If the process fails a large number of interpreters who are actually very good, the test also has poor predictive ability. If the test does a good job, however, of separating those who have strong skills and those who do not, the test has predictive validity.

How do you determine if a test has predictive validity? One way is to observe interpreters after certification and evaluate how they do on the job. This would be, of course, too labor intensive and expensive. A second technique is to pilot the test on interpreters whose skill level is known to the testers, to see if the test will distinguish between the different levels of proficiency. Again, in evaluating a given certification process, it is reasonable to ask the certifying body how it established predictive validity.

The certification process is reliable.

A test is reliable when it gives the same result for people of similar skill levels regardless of who administers the test, who rates the test, when the test is given or what version of the test is applied.

To assure that a certification is reliable, the certifying body usually starts by developing careful recruiting and training standards for its test administrators and test raters. Both are given ample time to learn and practice their roles. Assuring that each test is administered exactly the same and rated according to the exact same standards is much more difficult than it seems and requires considerable effort. While a certifying body may reasonably choose not to disclose the names of the individuals who rate a certification test, the certifiers should be willing to make public the recruiting and training standards they apply to their administrators and raters.

The second step in assuring reliability involves piloting the test with a group of candidates. Multiple raters will be asked to independently rate the same test. When the candidate group is large enough, statistics can be run on the results to see if the raters were consistent between candidates and comparable among themselves, or if some consistently rated higher or lower than others. Inter-rater reliability is then reported as a decimal less than one. One would be a perfect score, meaning that two raters scored a test exactly the same. The lower the decimal, the worse the inter-rater reliability. A certifying body should be willing to publish this data to show to what degree its rating system is reliable.

The cut scores are based on real data.

How is a passing grade established? It is common to simply choose a score familiar from public schools, – 70 percent as a passing grade. In a credible certification process, however, the passing grade is based on a more scientific process.

One approach, called the Angoff method, brings together stakeholders to act as judges. Each judge rates each item separately as to the probability that a minimally qualified candidate would get this item right. On a multiple choice test with four options per question, a probability of 100 percent means that a minimally qualified candidate would always get this question right; 25 percent is chance score. The judge's scores are then averaged to arrive at the passing grade.

In evaluating the credibility of a certification process, it is of interest to know how the cut scores were established.

The certification process tests to generally accepted and published standards of practice.

In order for a certification process to be credible, it must somehow reflect generally accepted standards of practice which candidates can reference and practice before taking the exam. Test preparation materials must be made available so that candidates are prepared for what type of content will be covered on the test and how that content will be tested.

As mentioned at the beginning of this section, *certification* is a term often used loosely, when in fact it should denote a formal assessment using a process that is valid and reliable. By applying the standards noted beforehand, it becomes easier to judge just how credible any given certification process is.

Who Benefits?

Assuming then a credible certification process, developed as part of a wider quality assurance program, who benefits from interpreter certification? The answer is: everybody. Or nobody.

Patients could benefit from interpreter certification. If interpreters were certified, patients would be able to count on having a qualified interpreter who will do an effective job of facilitating understanding with the provider. The service would be more standardized between interpreters, and trust in the professional interpreter – and in the health care institution – would grow.

Health care institutions could benefit from interpreter certification. With a credible certification process, individual hospitals and clinics would not need to invest so many resources in internal interpreter screening processes. An interpreter's certification would help protect the institution from legal liability and would certainly boost the institution's credibility in the case of reviews from organizations such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or the U.S. Department of Health and Human Services Office for Civil Rights. Additionally, the existence of a quality standard for interpretation, as embodied in a certification process, might make legislators more willing to dedicate public funds to the reimbursement of interpreter services. And, most importantly, providers in the institutions would be able to count on accurate and appropriate interpreting, leading to clearer communication with all the health, legal and financial benefits associated with it.

And interpreters could benefit from certification. With a certification process that is fair and appropriate, qualified interpreters would be able to differentiate themselves from their less skilled colleagues. They could receive preference in hiring or increased remuneration. Certification would bring increased recognition of the field of health care interpreting and a more respected place on the health care team. Skilled individuals would find health care interpreting a more appealing career choice, and the overall qualifications of health care interpreters would increase.

There is, a dark lining to this silver cloud. Health care institutions, already strapped financially, may choose not to implement any pay differential for certification among their staff.

As a matter of fact, if institutions decide that it is too hard to get certified interpreters, they may ignore certification altogether. Or even worse, if certified interpreters come at a higher price, they may choose to use less qualified, less expensive interpreters as a means of controlling costs.

If certification is made mandatory, then the problem of supply can arise. Clearly not everyone will pass a certification test. In fact, experience suggests that pass rates, depending on the language, may be as low as 20-30 percent. What will happen when there are not enough certified interpreters to meet the need? Experience with judicial interpreter certification and with the health care interpreting certification process in Washington State suggests one of two scenarios: Either uncertified interpreters will be used or patients will be made to wait until a certified interpreter can be found. In the other scenario, institutions may turn increasingly to remote interpreting (telephonic and video) as a means of accessing a larger national pool of certified interpreters if the local pool is too small. And while the use of remote interpreters is not in itself a bad thing, there is a general consensus that both telephonic and on-site interpreters are needed to appropriately meet different patient needs.

Certification can also become problematic when it ends up excluding individuals who are good interpreters but poor test takers. Especially in immigrant and refugee groups that were historically denied stable formal education, testing in itself may create a barrier for otherwise capable interpreters to practice. Interpreters of non-written languages may pose an additional challenge, if the testing template requires literacy in the non-English language.

So, if very few interpreters in a particular language group can pass the test and patients end up being rescheduled due to lack of a certified interpreter, or if health care institutions decide that using certified interpreters is too logistically complex, too politically fraught or just too costly, then certification of health care interpreters will benefit no one. If a lack of certified interpreters leads to patients not being seen, the certification is actually harmful.

Does this mean we should not pursue certification? No – it simply means we must pursue certification with caution and with an eye to the logical consequence of implementation.

Conclusion

Certification plays an important role in quality assurance in any field, and language access is no different. A carefully crafted, valid and reliable certification program can provide a useful measure of who is qualified to provide accurate and appropriate interpreting services. Care must be taken to assure that the certification process is credible and that it is implemented in such a way as to provide a net benefit to patients, health care institutions and interpreters.

The following section will introduce a number of working certification processes available for health care interpreters in the U.S. today. While none qualify as a “national certification,” they all have lessons to teach.

PART TWO - CURRENT CERTIFICATION PROGRAMS

Introduction

It has already been noted that there is no national certification for spoken-language health care interpreters at this time, but there are a number of certification processes that have been developed by state agencies, commercial language companies, foundations and academic institutions. A look at these processes will document what testing resources currently exist in the U.S. for health care interpreters, as well as affording the reader the opportunity to judge each process' credibility. In addition, these profiles reveal important lessons that may be useful in the design of a national certification.

The interpreter testing programs described in the following pages are all based on skills assessment. Many programs that informants initially identified as “certifying” interpreters were in fact training interpreters and presenting a certificate of completion at the conclusion of the course. Two other programs that identify themselves as “certifying” health care interpreters (Wishard Hospital’s Hispanic Health Initiative and Transperfect, Inc.) were contacted but did not respond.

Those knowledgeable about interpreting in California may wonder why the Medical Interpreter Certification formerly administered by the California State Personnel Board is not included in this compendium. This certification process targets interpreters who serve at administrative hearings or in worker’s compensation cases. As such, the test focuses on a different set of vocabulary and skills than those of a health care interpreter working in a broader range of clinical settings. For this reason, the test is not an adequate certification vehicle for health care interpreters and so it is not profiled here. Those interested can find more information about this testing process at <http://www.cps.ca.gov/spb/spbta/index.asp>.

The following interpreter assessments, which are profiled here, are at different stages of development and availability.

- | | |
|--|--|
| • Connecting Worlds Partnership | Available to the public |
| • CyraCom, Inc. | Available to the public |
| • Language Line University / Language Line Services | Available to the public |
| • Massachusetts Medical Interpreter Association | In development |
| • NetworkOmni® Multilingual Communications | Available to NetworkOmni® interpreters only |
| • Oklahoma State University in conjunction with the Oklahoma State Department of Health | Available to the public |
| • Registry of Interpreters for the Deaf (RID) | Available to the public |
| • University of Arizona, National Center for Interpretation Testing, Research and Policy | Available to the public |
| • Washington State Department of Social and Health Services | Available to Washington State residents only |

With three exceptions, the information included about each certification process was copied directly from a standard survey that was filled out by the test developers, and edited by the author only for style, voice and grammar. The information thus provided was not independently verified by the author, nor was the content modified or corrected. Only under Limitations of the Process as it Currently Stands did the author occasionally add comments. The survey for the Connecting Worlds Partnership test was completed by the test custodian; information on the test of the Registry of Interpreters for the Deaf (RID) was gleaned from the RID Web site and through an interview with staff at the national office; and information on the Oklahoma test was gathered through interviews with key informants.

It is important to remember that the information provided on these testing processes is accurate as of January 2006. However, many of these tests will continue to be developed, adapted and improved as time goes by. For updated information on any given test, it is necessary to contact the test administrators listed on each profile.

CONNECTING WORLDS PARTNERSHIP INTERPRETER SKILLS ASSESSMENT

Statement on Certification

The training/skills assessment process described below was not designed as a certification process, nor does the Connecting Worlds Partnership call it *certification*. The three tests and the 40-hour training that comprise this process were designed to: 1) assess language proficiency, 2) assess interpreter skills pre-training, 3) prepare interpreters using the Connecting Worlds Healthcare Interpreter Training Program, and 4) assess interpreting skills upon completion of the training. The care with which the tests were created, however, suggests that the final testing protocol could serve as a certification tool as well.

Contact:

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Nature of the testing organization

The Connecting Worlds Partnership (CWP) is a consortium of five Californian nonprofit organizations that provide interpreter services and training to surrounding medical and social services. The consortium is comprised of Asian Health Services, Healthy House within a MATCH Coalition, PALS for Health, Las Clínicas de Salud and Vista Community Clinic.

Test developers

Claudia Angelelli, Ph.D., Assistant Professor, San Diego State University, Lead Test Designer
Guadalupe Valdés, Ph.D., Stanford University
Edward Haertel, Ph.D., Stanford University
Mary Ann Lyman-Hager, Ph.D., San Diego State University
Christian Degueldre, Professor, Monterey Institute of International Studies
Jean Turner, Ph.D., Monterey Institute of International Studies
Renee Jourdenais, Ph.D., Monterey Institute of International Studies, English Proficiency Test

Languages in which this test is currently offered

Cantonese, Hmong, Spanish, English

For what purposes, if any, is this assessment required?

The Final Interpreter Readiness Test is offered to candidates completing the Connecting Worlds training, but it is not required.

Components of the certification process

1. English Language Proficiency Assessment
2. Non-English Language Proficiency Assessment
3. First Interpreter Readiness Test
4. Connecting Worlds Training Certificate (a 40-hour course)
5. Final Interpreter Readiness Test, conducted through a recorded bi-directional interpretation based on video-mediated encounters in a health care setting.

Test development process

The Connecting Worlds Health Care Interpreter Training Program has been in development for a number of years. In 2003, Dr. Claudia Angelelli, assistant professor at the Spanish and Portuguese Department of San Diego State University, was contracted by CWP to create a language assessment and pre/post-tests in four languages (English, Spanish, Hmong and Cantonese) to accompany the training curriculum.

Dr. Angelelli convened an expert team to develop the tests. It became immediately clear that, unlike many other tests, this assessment would need to be designed specifically with heritage speakers in mind.³ The team took the following steps:

1. Extensive collection of authentic data (392 medical encounters) to select the types of communicative functions common to the medical setting.
2. Review of existing tests.
3. Review of literature related to interpreting pedagogy and to the cognitive and linguistic skills required in interpreting.
4. Discourse analysis of recorded interpreted interactions taking place in real health care settings to identify common interpreting tasks.
5. Development of the Spanish testing script, based on the authentic recorded patient-provider interactions.
6. Development of the Hmong and Cantonese testing scripts based on input from focus groups.
7. Piloting of the tests with volunteers chosen on the basis of background and competence. The pilot test helped designers determine how much time would need to be left on the tape for interpreting.
8. Submission of script to content medical experts for review. Contents were reviewed for accuracy and the crucial/relevant information starred.
9. Final piloting.
10. Videotaping of the test interactions.
11. Development of test scoring guidelines and test scoring rubrics.
12. Training of test administrators and raters.

It is worth noting that the Hablamos Juntos program of the Robert Wood Johnson Foundation later adapted the Spanish language proficiency and interpreter readiness tests for use with its 10 sites around the U.S. The tests referred to the LISA (Language and Interpreters Skills Assessment) were adapted to be administered by computer.

Determination of validity

In 2004, The California Endowment contracted with Second Language Testing, Inc. (SLT) to assess the validity and reliability of the Spanish Language Assessment and Interpreter Readiness Tests. As of this writing, SLT estimates that this assessment will be completed later in 2006.

³ Heritage speakers of a language are those who have learned the language exclusively at home, while growing up and/or being educated in a society whose dominant language is different.

Criteria for recruiting test raters

Each organization recommended five practicing interpreters who fulfilled three criteria:

1. They possessed advanced to superior language ability in English and either Spanish, Hmong or Cantonese.
2. They had experience in conducting assessments for hiring, training or supervising interpreters.
3. They were engaged in ongoing professional development.

These criteria were modeled after test administrators requirements of the Massachusetts Medical Interpreters Association.

Training of test raters

A two-day workshop was provided by the lead test developer and several members of the test development team. Each language group practiced scoring separately by watching the video-mediated encounters and listening to the interpretation from real recorded tests.

Test logistics

This certification process is offered upon request and conducted in person. The tests and the completion of related paperwork take about three hours. The training lasts 40 hours.

At this time, this program is funded by grants from The California Endowment, so candidates are not charged for the test. Candidates who fail the test must wait a year to take it again.

Strengths of the process

One of the key strengths of this assessment process is that it is based on authentic recorded patient-provider conversations. It measures some of the most important cognitive and linguistic tasks involved in interpreting. In addition, it measures the ability to understand different registers of speech and to adjust register in interpreting without unduly changing the meaning, a key skill for health care interpreters that is rarely if ever tested in other certification protocols.

Limitation of the process as it currently stands

A limitation to the language-screening portion of this process is that it is designed to test advanced speakers of both languages. Many people interested in attending the training spoke at the intermediate level or below.

The principal limitation of this assessment as it stands now is that, although the Interpreter Readiness tests were designed to be used with the Connecting Worlds curriculum, the skills tests do not reflect the content of the curriculum. In addition, the test is focused on a very selective scope of skills, whereas a full certification might want to include a wider scope of skills.

Content and how it is tested

This content list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

Please note: No information on how each item is tested was submitted for this test.

| What is tested? | | If it is tested, how is it tested? |
|---|----|------------------------------------|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | |
| Sight translation, English to non-English | • | |
| Sight translation, non-English to English | No | |
| Medical terminology, English | • | |
| Medical terminology, non-English | • | |
| Ability to comprehend and produce appropriate register | • | |
| Medical concepts | • | |
| Understanding of interpreter role | No | |
| Understanding of interpreter ethics | No | |
| Pre-session | No | |
| Use of compensation techniques to maximize accuracy (e.g., asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | No | |
| Use of positioning to support the patient-provider relationship | No | |
| Use of the first person | • | |
| Knowledge of cultural practices | • | |
| Culture-brokering skills | No | |
| Understanding of advocacy role | No | |
| Advocacy skills | No | |
| Memory skills | No | |
| Note-taking skills | No | |
| Written translation | No | |
| Other (please specify) | No | |

CYRACOM MEDICAL INTERPRETER ASSESSMENT

Statement on Certification

CyraCom does not refer to its assessment process as a *certification*. Certification must be based on a widely accepted definition of specific minimum competencies or skills that health care interpreters possess in order to perform health care interpretation. In the absence of this widely accepted set of competencies, CyraCom's leadership does not believe that individual assessment processes should be called *certification*. Instead, they call for leaders in the industry, including interpreter associations, language companies and academic institutions to work together to define a competency model for health care interpreters and then define, as an industry, an independent certification process that is valid and reliable.

Contact:

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Nature of the testing organization

CyraCom is a provider of transparent language services, including over-the-phone interpretation, document translation, and testing and training.

Test developers

Bill Prenzno, Master's of Education, University of Arizona, with more than 15 years in assessment and curriculum development

Stephen Gerhart, Bachelor of Arts, Latin American Studies/Economics, with more than 10 years in interpretation and assessment of interpreters

Languages in which this test is currently offered

Spanish, Arabic, Vietnamese, Russian (others added as required)

For what purposes, if any, is this certification required?

For CyraCom interpretation staff, successful completion of the assessment is required to be authorized to interpret on CyraCom's telephonic network. For assessments delivered to CyraCom clients' interpretation staff, successful completion of the assessment **may** be required to function as a staff or contract interpreter, depending on the client's policies and procedures.

Components of the testing process

For CyraCom's interpreter staff, the process involves the following:

- Qualifying verbal assessment to verify proficiency in both English and a non-English language and basic knowledge of medical vocabulary and procedures. Candidates who do not demonstrate proficiency in a working language pair will not be recommended for skills training.

Components of the testing process (continued)

- Hands-on training, including short-term memory skills, note-taking skills, cultural responsiveness, code of ethics, roles of the health care interpreter, modes of interpretation, health care interpretation protocols and session management, medical vocabulary, how to avoid and correct health care interpretation errors, and medical conditions and procedures.
- At the midpoint and conclusion of training, skills are tested using a combination of a written and an oral skills assessment.
- The interpreter staff receives feedback through ongoing monitoring of the interpreter's handling of actual interpretation sessions.
- 90 days post-training the interpreter must pass an oral assessment, which includes advanced simulated health care interpretation scenarios and the assessment of an actual call handled by the interpreter.
- Within the first year after the initial training, each interpreter participates in an advanced training course covering further medical knowledge and skills and cultural competence.

For CyraCom's clients, the process involves assessments based on those used to test CyraCom's staff interpreters at 90 days. CyraCom offers the client training courses to help fill the gaps in knowledge and skills of interpretation and medical vocabulary building.

Test development process

The process was developed and reviewed by a team that includes health care interpreters, subject matter experts in health care and language services, and experts in training and assessment.

Determination of validity

Content validity

CyraCom has established a baseline of skills for health care interpreters that are addressed in training courses. The assessments during the training and post-training are designed to measure these skills with an oral and a written skills assessment. These assessments have been reviewed by subject matter experts ("content experts") on health care interpretation and assessment to ensure that the skills assessed represent the specific skills necessary to perform health care interpretation.

Construct validity

To ensure that the assessments measure the construct CyraCom has of health care interpretation, the designers have defined the skills necessary for effective health care interpretation (see above). Due to the designers' experience and the evolution of the assessment instruments and methodology, the organization expresses a high level of confidence that it is measuring the construct of health care interpretation.

Predictive validity

Through the assessment and ongoing monitoring procedures, CyraCom expresses confidence that the assessments can predict the future desired behavior – the ability of interpreters to perform effective health care interpretation.

Criteria for recruiting test raters

Raters are chosen based from a pool of interpreters and bilingual trainers.

Training of test raters

New raters are trained in delivering the test in a consistent manner by applying the assessment to staff interpreters, while being observed by an experienced rater. To calibrate, new raters then work with an experienced rater to form a consensus rating and discuss each of the points to ensure agreement on why the rating was given. Finally, the new rater and the experienced rater rate a series of assessments independently and compare results. Once the ratings are consistent over several assessments, the new rater will then assess and rate actual assessments.

A specific percentage and Kappa coefficient for inter-rater reliability have not been calculated. The principal raters have demonstrated consistency, and there is no observed difference in the interpreters’ performance according to who assessed them.

Test logistics

This test is applied either in person or over the telephone and typically takes up to one hour to complete. All the tests are offered as needed, on demand.

For CyraCom interpreter staff there is no charge for the test, as it is included as a requirement of employment.

If the candidate fails the CyraCom staff qualifying assessment, the candidate may retest after seven days up to a total of three tests. For the assessments during and after training, a single retest is offered after a period of additional specific training and mentoring.

Strengths of the process

- Validity
- It continues to be customized for other languages.

Limitation of the process as it currently stands

- Lack of statistical evidence of inter-rater reliability. CyraCom’s test is being continuously improved and subsequent revisions will address this.

Content and how it is tested

This content list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

| What is tested? | If it is tested, how is it tested? |
|---|------------------------------------|
| Accuracy of oral conversion, English to non-English, consecutive mode | • Oral |
| Accuracy of oral conversion, non-English to English, consecutive mode | • Oral |

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | Not applicable |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | Not applicable |
| Sight translation, English to non-English | No | Not applicable |
| Sight translation, non-English to English | No | Not applicable |
| Medical terminology, English | • | Oral for initial assessments in first 90 days; written for the advanced medical and cultural competency training. |
| Medical terminology, non-English | • | Oral for initial assessments in first 90 days; written for the advanced medical and cultural competency training. |
| Ability to comprehend and produce appropriate register | • | Oral |
| Medical concepts | • | Written (for the advanced medical and cultural competency training) |
| Understanding of interpreter role | • | Oral (observation) and written |
| Understanding of interpreter ethics | • | Oral (observation) and written |
| Pre-session | • | Oral (observation) |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Oral (observation) |
| Use of positioning to support the patient-provider relationship | • | Written and observation (for client interpreter assessments) |
| Use of the first person | • | Oral (observation) |
| Knowledge of cultural practices | • | Oral (observation) |
| Culture-brokering skills | • | Oral (observation) |
| Understanding of advocacy role | • | Oral (observation) |
| Advocacy skills | • | Oral (observation) |
| Memory skills | • | Oral (observation) |
| Note-taking skills | • | Oral (observation) |

| What is tested? | | If it is tested, how is it tested? |
|------------------------|----|--|
| Written translation | No | Not applicable. |
| Other (please specify) | • | Post-session: Oral (observation) Transition between languages: Oral (observation) |

LANGUAGE LINE UNIVERSITY / LANGUAGE LINE SERVICES MEDICAL INTERPRETER CERTIFICATION

Contact:

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Nature of certifying organization

Telephonic Interpreting Business

Test developer

Danyune Geertsen, Director of Training and Quality Assurance, M.A. (University of Oregon), Certificate in Training (University of California at Santa Cruz), translator and interpreter, member of the National Council on Interpreting in Health Care and of the Interpretation Subcommittee of the American Society for Testing and Materials (ASTM)

Languages in which this certification process is currently offered

Spanish, Cantonese, Mandarin, Polish, Portuguese, Korean, Khmer, Arabic, German, French, Haitian Creole, Italian, Japanese, Vietnamese, Russian, Tagalog, Somali, Farsi, Serbian, Bosnian, Croatian, Hmong

For what purposes, if any, is this certification required?

Certification is increasingly required by hospitals and clinics for interpreting in medical settings, in order to meet requirements of the federal Office for Civil Rights and the Joint Commission for Accreditation of Healthcare Organizations.

Components of the certification process

There are six components for internal candidates. External candidates take components five and six only.

1. Orientation training
2. Passing score on screening test (Interpreter Skills Assessment)
3. Satisfactory monitoring results
4. Positive on-the-job feedback from clients
5. Completion of industry-specific training
6. Passing score on industry-specific certification exam

Certification process development

The certification test design team utilized various modes of internal research to determine what the scope of the exam should be. The test design team then focused on selecting a format that would realistically reflect interpreters' work, which resulted in the use of a format that provides a context for the categories of content being evaluated. The test was thus designed to reflect situations, topics and terms commonly encountered in clinical settings.

LLS pioneered a holistic approach for its interpreter certification program, which is patent pending. It contains testing, on-the-job evaluation and training. For example, crucial areas such as ethical standards, cultural impact and the role of the interpreter in health care settings are covered in the medical training component.

Determination of validity

Content validity

A psychometrician from the Department of Psychology of a leading university in the United States, with previous experience validating state court certification tests, carried out a validation study of LLS' certification test. He determined it to have content validity, which refers to the appropriateness of the inference that health care interpreter candidates who pass this exam will provide quality interpretation of medical proceedings, and he found this to be a reasonable and appropriate inference to draw.

Additionally, a faculty member from a well-known Graduate School of Translation and Interpretation and a trainer with experience in interpreter certification test design, also provided validation in terms of the test's breadth and the quality of the test preparation materials. Lastly, a LLS health care customer reviewed and validated the test content, as well.

Construct validity

Language Line Services has been collecting data on the Medical Certification Test since its inception in 1999 in order to test the hypotheses on which the test was constructed and, thus, determine its construct validity. To date, the data has confirmed the test's high degree of construct validity and the integrity of this claim will be further substantiated by the collection of a larger bank of empirical data over time. LLS is dedicated to making sound claims regarding the validity of its tests and, therefore, is conscientiously continuing to collect data to confidently support this assertion.

Concurrent validity

The concurrent validity of LLS' Medical Certification Test has been established by the correlation made with Washington State's Medical Certification Test, which tests for the same knowledge and skills as LLS' test. The Medical Assistance Administration of the Washington State Department of Social and Health Services has determined that LLS' test meets their standards for the testing of health care interpreters.

Predictive validity

LLS' quality assurance program, which includes regular performance monitoring of its interpreter work force, provides data on which to base an assertion that the test has high predictive validity. Observations of the interpreters' on-the-job performance confirm that the test correctly predicts that the interpreters who receive high scores on the certification exam will also be rated highly by service observation standards.

Criteria for recruiting test raters

Raters/examiners were chosen from among the pool of LLS' Senior Language Specialists and Quality Specialists, who represent the most highly qualified interpreters within the LLS interpreter work force. The primary selection factor was a high degree of fluency in their working languages, in combination with other related qualifications in the fields of linguistics, testing and training.

Training of test raters

Once selected, examiners/raters participate in extensive training in exam administration and rating, with a team that includes a Rater of Consortium Court Certification Tests and an experienced Consortium Court Certification Examiner Trainer.

The test data suggest consistency in test results and strong inter-rater reliability. The psychometrician who reviewed the test confirmed that the test's highly structured scoring protocol increases the likelihood that it exhibits a desirable degree of psychometric properties, since research has demonstrated that reliability and validity increase as test structure increases.

Additionally, test results have demonstrated consistency over time, across versions, across languages and across raters.

Test logistics

The test is applied over the telephone. It takes between 30-60 minutes to complete, depending on the language. The entire certification process takes between six to 12 months.

The test is offered three to four times a year internally and upon request externally. The test costs \$145 for external users, but it is free as a benefit for LLS interpreters.

If the candidate fails, he or she may retake the test upon request, but additional training is recommended. Multiple versions of the test are used to ensure the validity of retest results.

Strengths of this certification process

The strengths of LLS' certification process are:

- the provision of test preparation materials
- the detailed Test Results Report provided to each candidate

- the awarding of a professional certificate upon attaining passing results
- external validation by a psychometrician and other subject matter experts
- the reality-based testing content that is practical and reliable for both interpreters and employers
- the cost-effectiveness and accessibility of testing over the phone
- the availability of testing in multiple languages
- quick turn-around time for the candidate's receipt of test results

Limitations of the process as it currently stands

It is an oral, not written, test. However, the very fact that interpreting itself requires an oral skill-set confirms that this type of test is sufficient and appropriate for assessing interpreting abilities.

Another limitation of this test for general health care interpreter testing is that it is designed specifically for telephonic interpreters. Some of the skills needed by on-site interpreters are not, therefore, addressed by this testing process.

Content and how it is tested

This content list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | Proprietary and Confidential |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | Proprietary and Confidential |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | Simultaneous interpreting is not recommended for telephonic interpreting. |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | Simultaneous interpreting is not recommended for telephonic interpreting. |
| Sight translation, English to non-English | No | This is not required for telephonic interpreters. |
| Sight translation, non-English to English | No | This is not required for telephonic interpreters. |
| Medical terminology, English | • | Proprietary and Confidential |
| Medical terminology non-English | • | Proprietary and Confidential |

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Ability to comprehend and produce appropriate register | • | Proprietary and Confidential |
| Medical concepts | • | Proprietary and Confidential |
| Understanding of interpreter role | • | Proprietary and Confidential |
| Understanding of interpreter ethics | No | Interpreter Ethics is covered in the Medical Training component. |
| Pre-session | No | Pre-session is covered in the Medical Training component. |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Proprietary and Confidential |
| Use of positioning to support the patient-provider relationship | No | This is not required for telephonic interpreters |
| Use of the first person | • | Test is conducted in the first person, and first person interpreting is also covered in Medical Training component. |
| Knowledge of cultural practices | • | By consecutive interpreting of utterances that cover cultural issues. |
| Culture-brokering skills | • | By consecutive interpreting of utterances that address cultural issues requiring the candidate to handle the issue correctly. This is also covered in the Medical Training. |
| Understanding of advocacy role | No | Advocacy role is covered in the Medical Training component. |
| Advocacy skills | No | Advocacy role is covered in the Medical Training component. |
| Memory skills | • | Proprietary and Confidential |
| Note-taking skills | • | Proprietary and Confidential |
| Written translation | No | This is not required for telephonic interpreters. |
| Other (please specify) | No | |

MASSACHUSETTS MEDICAL INTERPRETER ASSOCIATION (MMIA) SPANISH HEALTH CARE INTERPRETER CERTIFICATION EXAMINATION

Statement on Certification

The Massachusetts Medical Interpreters Association (MMIA) is the organization that is developing the certification instrument, however, MMIA is not as yet a certifying body. The information about the implementation of the test refers to a formal piloting of the test that took place in 2003-2004 with interpreters in Massachusetts and California. Collaboration with the California Health Care Interpreting Association (CHIA).

Contact

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Nature of organization

The MMIA is a state-based professional association for health care interpreters.

Test developer

Maria-Paz B. Avery, Ph.D.; developed MMIA standards of practice; member of National Council on Interpreting in Health Care's Standards, Training and Certification Committee that developed the National Code of Ethics and National Standards of Practice for Interpreters in Health Care; experience in development of K-12 English Language Proficiency Standards and assessment instrument; developed college-level certificate program in health care interpreting; education consultant

Languages in which the test is currently offered

The prototype has been developed in English-Spanish.

For what purposes, if any, is this certification required?

While certification is not currently required of interpreters in Massachusetts, the impetus to develop this certification comes from several sources:

- 1) state legislation that requires the use of "qualified interpreters"
- 2) the need expressed by coordinators of interpreter services in major health care facilities
- 3) the need identified by MMIA as next step after development and history of use for training and supervision of the MMIA Standards of Practice in the state

Components of the certification process

The prototype consists of a series of test modules, both written and oral, that measure different aspects of knowledge and skill a competent entry-level interpreter should have. The MMIA is not currently considering other requirements except to strongly encourage that the candidate for certification has at least 40 hours of training. It is also likely that the final version of the test will have two tiers, one of which will serve as a screening tool.

Test development process

The prototype was developed by the certification committee of the MMIA. Feedback was received from professionals in the field (both national and international) through presentations at conferences, and from the National Council on Interpreting in Health Care (NCIHC) on the proposed content and methodologies used. The prototype is based on the MMIA standards of practice. Test modules measure the areas of knowledge and skills defined in the standards, which establish what a competent interpreter should know and be able to do.

The prototype was pre-piloted in Massachusetts with a small number of volunteer participants and revised on the basis of the results. The revised prototype was piloted more formally in 2003-2004 with volunteer interpreters from Massachusetts and California through funding from the U.S. Department of Health and Human Services Office of Minority Health, awarded through NCIHC.

Determination of validity

Content validity

The MMIA committee is made of experienced professional interpreters in both the medical and court settings. Members made an assessment of what needed to be measured based on their experience, the MMIA standards of practice and feedback received from other professionals in the field. The content of the test was judged to measure the knowledge and skills (concepts) it is meant to measure.

Construct validity

The MMIA has not as yet done a test of construct validity.

Concurrent validity

The MMIA has measured concurrent validity to some extent inasmuch as our prototype tests the accuracy and completeness of the oral conversion of messages from L1 to L2 and from L2 to L1.⁴ The statistical analysis of these two measurements was limited but a positive relationship was found between two measures – Spanish to English sentence conversion and performance on the role play section.

Predictive validity

Due to a lack of resources, the MMIA has not yet been able to test for predictive validity.

Criteria for recruiting test raters

For the piloting of this test, raters were required to have at least three years of experience as paid, professional interpreters and to be involved in training interpreters.

Training of test raters

For the piloting of this test, trainers were required to participate in two-day training. The MMIA did not screen at this time but in the future will do so. Screening will most likely consist of participation in training **and** having to meet some inter-rater reliability standard that has yet to be determined.

⁴ L1 refers to the first language in an interpreted language pair; L2 refers to the second language of the pair.

Inter-rater reliability, as measured by the agreement of scoring between coder pairs, varied by module. 62 percent of the coder pairs had inter-coder reliability of .80 or higher in the English to Spanish sentence conversion and 86 percent had inter-coder reliability of .80 or higher in the Spanish to English sentence conversion. A t-test disaggregated by rater's location showed that Massachusetts coders had significantly better inter-coder reliability than California coders on the sentence conversion.⁵ 76 percent of the coder pairs had inter-coder reliability of .80 or higher on Role Play 1 and 80 percent had inter-coder reliability of .80 or higher on Role Play 2. The same trend by rater's location was found with the Role Plays.

Test logistics

The pilot test was applied in person, taking about 2 - 2 1/2 hours for the written and lab sections together and about 1 to 1-1/2 hours for the role play section.

As this test is still in development, it is not being routinely offered. The experience referenced here was from a pilot of the test in 2003-2004. The MMIA has not yet decided on a fee for the test, but developers hope to price it so that it would not be unreasonable for the candidate to pay it him/herself. Protocols for allowing candidates to retake the test in case of failure the first time have not yet been established.

Strengths of the process

The greatest strength of this test is that it is based on principles of “authentic” assessment, i.e., it measures what candidates are expected to know and be able to do, not peripheral skills or requirements. The developers also tried to ensure that the methodologies used to measure the skills do not get in the way of direct demonstration of the knowledge and skills required.

Limitations of the process as it currently stands

Application of this test may be costly, and it is certainly labor intensive. Controlling the administration of the test, in particular the role play section, will require a great deal of training to achieve the requisite reliability in administration.

Content and how it is tested

This content list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate

| What is tested? | | If it is tested, how is it tested? |
|---|---|---|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | 1) conversion of spoken messages from L1 to L2 and from L2 to L1 through audiotapes controlled for length of time to convert 2) role plays |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | Same as above |

⁵ Massachusetts raters had additional training in which they examined candidate responses together to develop a common understanding before scoring tests independently. Such training was not offered to the California raters.

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | |
| Accuracy of oral conversion, non-English to English, simultaneous mode | No | |
| Sight translation, English to non-English | No | |
| Sight translation, non-English to English | No | |
| Medical terminology, English | • | 1) labeling of diagrams of the major body systems 2) matching terms and definitions 3) sentence conversions and role plays |
| Medical terminology non-English | • | 1) providing the appropriate non-English term or description for the labels in the diagrams 2) sentence conversions and role plays |
| Ability to comprehend and produce appropriate register | • | 1) sentence conversions 2) role plays |
| Medical concepts | • | 1) sentence conversions; 2) role plays |
| Understanding of interpreter role | • | 1) scenarios 2) role plays (use of rubric to score) |
| Understanding of interpreter ethics | • | 1) scenarios, some with multiple choice answers and explanation for choice 2) scenarios with open-ended question |
| Pre-session | No | |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Role plays (use of rubric to score) |
| Use of positioning to support the patient-provider relationship | No | |
| Use of the first person | No | This instrument doesn't really test for this apart from an expectation that the conversion will reflect the first person when that is used; should also be included in the explanation of the interpreter role to patient and provider, when appropriate, in first role play. This may change with other cultural-linguistic groups where use of first person may be inappropriate. |
| Knowledge of cultural practices | • | Scenarios |

| What is tested? | | If it is tested, how is it tested? |
|--------------------------------|----|--|
| Culture-brokering skills | | <ul style="list-style-type: none"> Minimal measurement through role play (use of rubric to score) |
| Understanding of advocacy role | | <ul style="list-style-type: none"> Scenarios |
| Advocacy skills | No | |
| Memory skills | No | Not measured separately from accuracy and completeness. |
| Note-taking skills | No | Only indirectly if candidate chooses to use in the role play (use of rubric to score) |
| Written translation | No | |
| Other (please specify) | No | |

NETWORKOMNI® MULTILINGUAL COMMUNICATIONS CERTIFICATION PROGRAM IN TELEPHONE INTERPRETING

Statement on Certification

In the interpreting profession at large, certification programs in the United States have traditionally centered on terminology and interpreting skills specific to a given industry (court, health care, etc.) and have not typically provided a sole focus on the comprehensive interpreting skills and terminology required of interpreters whose work may span an array of industries. The NetworkOmni® certification development team created a program to address this need as it applies to telephone interpreting. Additional goals include helping set standards for the field, educating practitioners and serving as a means of providing information about the importance of the program to the general public.

This internal certification was created to ensure that interpreters meet the specified program requirements for providing high-quality telephone interpreting services to NetworkOmni® clients. Indeed, calls are routed to interpreters according to their skill level, as identified by the certification process.

The certification program was initially developed to include one language from each of the three major language groups serviced by NetworkOmni® interpreters (Romance, Slavic and Asian). To this end, the program was first created for the most frequently requested language representative of each group: Spanish/English, Russian/English, and Mandarin/English (in development). By developing assessment tools separately for each language group, the test development team is able to identify trends across language groups, as well as note distinguishing characteristics. Both provide a basis for updates and improvements to the program, as well as expansion into additional languages.

In terms of program range, it is safe to estimate that the NetworkOmni® Certification Program covers 80 to 85 percent of the content addressed in all calls interpreted by NetworkOmni® interpreters. Since the client base and volume of business in individual industries is in a state of flux, as is the case in all corporate-sector enterprises, the content of the training and testing materials is reviewed on an on-going basis.

Certificates are granted to interpreters who meet each specific requirement of the program. The availability of specific certification program components varies from one language to the next; however, the majority of certification program components reach across all languages. Once all certification program components are available in additional languages, interpreters meeting those requirements will be eligible for certification as well. In summary, the quality control process in place for additional languages is a modified version of the certification program.

Contact:

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Nature of certifying organization

NetworkOmni® is a full-service interpretation and translation company.

Test developers

The program was developed by bringing together expertise from the areas of interpretation, language testing, curriculum development and intercultural communication to work with NetworkOmni® staff. Specifically, the core research and development team for the NetworkOmni® certification project included:

- David Sawyer, Ph.D., a conference interpreter who also serves as a consultant on language mediation issues and was, at the time, a professor of interpretation and translation affiliated with the Graduate School of Translation and Interpretation of the Monterey Institute of International Studies. This member of the team is currently a diplomatic interpreter and translator and the training officer at the Office of Language Services of the U.S. Department of State.
- Frances Butler, Ph.D., a senior research associate and language testing specialist affiliated with the Center for the Study of Evaluation at the University of California at Los Angeles
- Jean Turner, Ph.D., an expert in assessment and language testing who is a professor affiliated with the Graduate School of Language and Educational Linguistics of the Monterey Institute of International Studies.
- Irena Stone, Ph.D., an expert in language communication and applied linguistics, with broad experience in translating/interpreting, interpreter training, language and literature teaching, both domestically and internationally. Dr. Stone was, at the time, Director of Quality Assurance and On-going Education at NetworkOmni®.

Guidance and feedback on the program were provided by the NetworkOmni® Advisory Board, whose members are applied linguists with specializations in language testing, assessment, curriculum development and intercultural communication:

- Charles Stansfield, PhD, President, Second Language Testing, Inc.
- Thom Hudson, PhD, Associate Professor of Second Language Studies, the University of Hawaii;
- Elena Garate, PhD, Dean of International Students, Santa Monica Community College.

Languages and venues for which this certification is currently offered

Telephone Interpreting (TI), i.e., the call-center industry, which requires interpreting services in highly specific scenarios across a range of industries including health care.

For what purposes, if any, is this certification required?

This internal certification was created to ensure that interpreters meet the specified program requirements for providing high-quality telephone interpreting services to NetworkOmni® clients. Calls are routed to interpreters according to their skill level, as identified by the certification process.

Components of the certification process

The NetworkOmni® Certification Program in Telephone Interpreting is a proprietary training, testing and monitoring program for telephone interpreters. The program consists of a 20 to 30 minute screening test, two stages of training (15 hours total) with two 45 minute comprehensive interpreting skills tests, one after each training period. In addition, as part of the process, interpreters receive individual monitoring and feedback on at least five to eight live calls approximately once a month. The amount of monitoring is customized according to the interpreter's performance. All training and testing is delivered over the telephone. The training sessions are small group sessions with from two to seven participants.

Following resume review and identification of a potential candidate, there are three critical decision points in the process: (a) the screening test, (b) the initial interpretation test plus monitoring, and (c) the final interpretation test plus monitoring. First, the screening test confirms level of education, previous interpreting experience, and language proficiency in both English and the other language. The interviewees must demonstrate the ability to produce fluent speech in their working languages on a wide range of topics occurring in the context of telephone interpreting. Thus language proficiency is assessed through the use of questions derived from topics in the industries served by NetworkOmni®. Candidates must produce correct grammatical structures and use a wide range of vocabulary appropriately and accurately in the topic areas. Further, they must formulate ideas and concepts with precision and economy of expression.

Next, the initial training phase provides the basics of telephone interpreting and introduces interpreters to the nature of general customer service calls. Following this training, the initial interpretation test determines whether candidates continue in the process. If candidates successfully complete the initial test, they begin interpreting on general calls and proceed to the second training phase, which covers advanced telephone interpreting strategies and more challenging calls in a variety of industries. New telephone interpreters (TIs) are monitored frequently as soon as they begin taking calls and receive individual feedback on their performance as needed. When TIs have completed the second phase of training, they take the final interpretation test. If they pass the test, they begin taking specialized calls, including health care calls, and are monitored according to program requirements. They again receive feedback as needed, and once they have demonstrated performance that meets or exceeds the requirements, they receive NetworkOmni® certification. Monitoring continues on a regular basis as part of the internal quality assurance procedure at NetworkOmni®.

The process described here is being implemented and refined on an ongoing basis, particularly the sequencing of training and testing, so that it becomes more efficient over time. An important part of assuring the quality and effectiveness of a program such as NetworkOmni®'s Certification Program in Telephone Interpreting is systematic review of every aspect of the program and revision as necessary when new data become available. In many settings, training materials and tests are selected and used for long periods of time without review or change. This lack of scrutiny can lead to problems with test security and out-dated materials. Outdated materials can in turn undermine the authenticity and relevance of the training and testing as industries and the client base evolve.

Test development process

The development process consisted of the following basic steps:

- a. Extended review of existing processes to determine areas for modifications and refinements of assessment, curriculum materials, and monitoring and feedback procedures in order to offer internal certification of TIs.
- b. Rigorous analysis of the types of calls NetworkOmni® TIs were handling across the industries represented by NetworkOmni® clients, including transcription of calls to serve as a basis (models) for training materials and test content.
- c. Development/refinement of training materials and tests, including tryouts/piloting and revision leading to the final materials.
- d. Implementation of the certification process with NetworkOmni® TIs, and ongoing critiquing and refinement of the process. NetworkOmni® plans to expand the certification program, which will provide an opportunity for ongoing refinement as additional data become available. The Quality Assurance staff regards the development and implementation of the certification program as an iterative process given the dynamic nature of this operational setting.

Determination of validity

Validation evidence should be gathered in multiple ways from multiple sources. The validation procedures for the NetworkOmni® Certification Program include documentation on the empirical design of the testing and training regime, documentation of the program development history, and a series of case studies with clients in several industries to solicit their opinions on test appropriateness. Each type of validity is addressed specifically below. Follow-on activities include external evaluation of the entire program by representatives of a company that provides comprehensive interpreter services.

Content validity

Content validity refers to the appropriateness of test content for a given purpose. The testing and training conducted by NetworkOmni® is based on the content of actual client calls. Thus, the tests and training materials reflect the nature of calls across client industries. In this way, empirical data serve as the underlying basis for design of the testing and training materials. Since NetworkOmni® interpreters receive calls from a wide variety of industries and the tests reflects this, the content validity of the tests is high. If the tests were to focus specifically on one type of call, such as health care, they would not be as valid a representation of the type of work NetworkOmni® interpreters do on a daily basis.

Construct validity

Construct validity refers to effectiveness of a test in representing the underlying construct/s being assessed by the instrument – in this case, the ability to interpret the range of exchanges that occur in client telephone calls. Scenarios used in training and on tests include examples from health care calls, insurance calls, emergency calls, etc.

Through representative tasks based on such scenarios, the tests allow for documentation of the candidate's telephone interpreting skills and abilities in the depth and breadth necessary for handling client calls.

As part of the development process, a validation study with NetworkOmni® clients was conducted. Development team members met with client representatives in various industries, including health care. At each meeting, several staff members, typically from the company's training and development area, listened to a presentation about NetworkOmni® Training and Testing Program for Telephone Interpreters. The session included recorded examples of TI's responses to the certification tests. Client staff was asked to provide feedback in terms of appropriateness of test content including difficulty level for their interpreting needs. They were asked if the scenarios on the tests were representative of the types of calls TIs would be handling for them. Feedback from clients led to both verification of the appropriateness of the training and testing materials and to some modifications.

Concurrent validity

Concurrent validity indicates a comparison of performance across tests that measure the same construct. At this time, the development team is aware of no other comprehensive certification programs in the interpreting community that focus on skill-based assessment, as opposed to knowledge-based assessment. Therefore, there are no comparable instruments available to NetworkOmni® to allow for a concurrent validity study.

Predictive validity

In this case, predictive validity refers to the results of a test/s indicating that an interpreter who passes the test/s will be able to perform acceptably on related tasks at later times. Monitoring data from an in-house certification study provide evidence of predictive validity. An additional study of predictive validity is planned.

Criteria for recruiting test raters

All test raters are in-house Quality Assurance interpreter trainers who are also active telephone interpreters. Required qualifications include: demonstrated bilingual skills, experience in intercultural communication, advanced studies of foreign languages and/or linguistics.

Training of test raters

Trained by the Quality Assurance staff, the test raters have a thorough knowledge of all the developmental stages, the testing and training materials specifically designed for each, and the interpreter profile and rating criteria being used. The program is designed to incorporate feedback from raters on an on-going basis in order to refine and modify the rating criteria. The rating criteria are also used for the monitoring process. This additional use of the criteria helps assure consistency and familiarity of the criteria throughout all program components.

Studies are currently being designed to establish operational inter-rater reliability.

Test logistics

This test is applied over the telephone. The screening test takes about 20 to 30 minutes; the initial test, 45 minutes; and the final test, 45 minutes. The entire process takes four to eight weeks, including monitoring.

All of the components of certification are critical to the total quality assurance process. The tests are not currently offered separately, but only as part of the process.

If the candidate is scored as a *Retake* (as opposed to a *Reject*), he or she will be provided with feedback and allowed to retake the test once.

Strengths of the process

- Involvement of language testing experts, combined with interpreting expertise.
- Continual oversight and review by an advisory board.
- Comprehensive skill-based assessment versus knowledge-based assessment.
- Use of empirical data to generate testing and training content, as well as to help ensure that the program reflects proportionately NetworkOmni®'s client base which, given the company's size, is representative of the interpreting needs of the call center industry

Limitations of the process as it currently stands

One limitation to the program is the limited number of languages for which all components of the program are currently available. However, the most important components – monitoring and training – are provided to interpreters of all languages available through NetworkOmni®.

Another limitation, for health care interpreting in general, is the test's specificity, both to telephonic interpreting and to the types of calls received by NetworkOmni®. This specificity means that this certification process is highly appropriate for NetworkOmni® interpreters but less so for health care interpreters in general.

Content and how it is tested

This content list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | Discussed in the section about screening test: The interviewee must demonstrate the ability to produce fluent speech in his or her working languages on a wide range of topics occurring in the context of telephone interpreting. |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | Same as above. |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | Not applicable. |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | Not applicable. |
| Sight translation, English to non-English | No | Not applicable. |
| Sight translation, non-English to English | No | Not applicable. |
| Medical terminology, English | No | While some test calls do contain medical terminology, the focus is on comprehensive interpreter skills. |
| Medical terminology non-English | No | While some test calls do contain medical terminology, the focus is on comprehensive interpreter skills. |
| Ability to comprehend and produce appropriate register | • | Tested as a component skill in the composite skill of interpreting; that is, the test taker will demonstrate ability to use language that is appropriate to the sectors served by NetworkOmni® particularly with regard to syntax, vocabulary and register. |

| What is tested? | | If it is tested, how is it tested? |
|---|----|---|
| Medical concepts | • | Although the certification is not a health care interpreting certification and medical concepts are not tested directly, advanced training and testing content includes medical calls that are typical of those interpreted for NetworkOmni®'s health care industry clients. NetworkOmni®'s clients have stated in formal focus group settings that they believe the calls are representative of their calls. |
| Understanding of interpreter role | • | Concepts are covered in training sessions on content. Appropriate conduct is verified in testing and monitoring. |
| Understanding of interpreter ethics | • | Concepts are covered in training sessions on content. Appropriate conduct is verified in testing and monitoring. |
| Pre-session | • | Concepts are covered in training sessions on content. Appropriate conduct is verified in monitoring. |
| Use of compensation techniques to maximize accuracy (e.g., asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Concepts are covered in training sessions on content. Appropriate use is verified in testing and monitoring. |
| Use of positioning to support the patient-provider relationship | No | |
| Use of the first person | • | Concepts are covered in training sessions on content. Appropriate conduct is verified in testing and monitoring. All NetworkOmni® calls are interpreted in first person. |
| Knowledge of cultural practices | • | Some knowledge of cultural practices must be demonstrated in the screening; however, it is not tested as it relates to health care specifically. |
| Culture-brokering skills | No | Not applicable. |
| Understanding of advocacy role | No | Not applicable. |
| Advocacy skills | No | Not applicable. |

| What is tested? | | If it is tested, how is it tested? |
|------------------------|----|---|
| Memory skills | | <ul style="list-style-type: none"> • Concepts are covered in training sessions on content. Tested as a component skill in the composite skill of interpreting. Not measured directly. |
| Note-taking skills | | <ul style="list-style-type: none"> • Concepts are covered in training sessions on content. Tested as a component skill in the composite skill of interpreting. Not measured directly. |
| Written translation | No | Not applicable. |
| Other (please specify) | | <ul style="list-style-type: none"> • Fundamental stress management techniques, call center protocols and customer service etiquette are covered in training sessions on content. Ability to apply knowledge is verified in testing and monitoring. |

OKLAHOMA STATE UNIVERSITY WITH THE OKLAHOMA STATE DEPARTMENT OF HEALTH HEALTH SERVICES INTERPRETER CERTIFICATION

Contact:

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Institute for Issue Management and Alternate Dispute Resolution
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Nature of certifying organization

The Institute for Issue Management and Alternative Dispute Resolution, which developed and implements the certification, was set up by statute within Oklahoma State University.

Test developers

Demetrio (JR) Gutierrez, Director of Minority Health, Oklahoma State Department of Health
Jorge Cure, M.D.

Languages and venues for which this certification is currently offered

This certification is for interpreters serving in health care and social service venues. It is offered for any language, but to date has been applied principally in Spanish.

For what purposes, if any, is this certification required?

At this time, certification for health care interpreters in Oklahoma is voluntary.

Components of the certification process

The certification includes a 20-hour training/review in health care interpreting, followed by a written and oral test of interpreting knowledge and skills.

The written exam is comprised of 196 items that cover medical terminology, interpreter role and ethics, cultural issues, the U.S. Department of Health and Human Services Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) guidelines and regulatory issues. These items are principally multiple-choice. There is one section in which candidates are asked to translate into English dosification notation. Candidates pass with 70 percent correct responses.

In the oral exam, the candidate watches a videotape/DVD of a medical interview between a patient and provider. The candidate provides the interpretation, which is tape-recorded and evaluated for accuracy and the consistent use of the first person. Candidates pass with 70 percent correct.

Test development process

A committee of Subject Matter Experts (SMEs) was formed to identify skills sets; this committee included M.D.s, language agency owners, interpreters, public health practitioners and academics. The committee wrote a Standards of Practice for interpreters. The committee

was reduced to the principal test designers (listed above), and a written certification test was designed based on the Standards of Practice. When this was beta-tested, very few interpreters could pass it, making clear the need for prior training. A 20-hour training program was developed based on concepts taught in other health care interpreter trainings around the country. After taking this training, candidates did significantly better on the written certification test. The committee then went on to develop a test of oral interpreting skills.

Determination of validity

Content validity

Content validity was established through consensus of the SMEs on the committee.

Construct validity

Not established.

Item analysis is done on each training/testing cadre. Any item that is answered incorrectly by 40 percent or more of candidates is re-evaluated to see why candidates are getting it wrong.

Concurrent validity

Not established.

Predictive validity

Not established.

Criteria for recruiting test raters

The test raters were initially limited to the people that had developed the test. Primary trainers in addition to recently Health Service Certified Interpreters are being used to rate the oral exams.

Training of test raters

Two to three raters are used to rate each test. These raters observe the candidate's test recording and reach consensus on the rating.

Raters are involved in the training during the role play sessions, in order to give them an idea of the skills being taught. Then they are individually coached by the test developers regarding rating. Some guidelines have been developed by the Spanish raters, which are shared with the raters of the other languages. For example, candidates are expected to use English words for any English utterance with no linguistic equivalence in the target language; use of paraphrases or word pictures is considered inaccurate.

At the moment, the question of inter-rater reliability is moot, as the Spanish language tests are being rated jointly by two to three raters, and the non-Spanish tests are being rated by one single rater per language.

Test logistics

This test is applied in person on the campus of Oklahoma State University in Stillwater. The written portion takes three hours to complete, while the oral portion takes about ten

minutes. Testing is available only after completion of training, which is offered every three months. The test costs \$120 for both written and oral portions, which is usually paid by the employer or candidate. Candidates who fail the test can retake it any time within six months following training.

Strengths of the process

The principal strength of this certification process is that it represents a first step toward assuring quality in health care interpreting in Oklahoma. The test is still being improved, based on experience and candidate scores; the current written test is the second revision, while the oral test is in its third revision.

Limitations of the process as it currently stands

The principal limitation of this process lies in the current lack of established validity and reliability. In addition, the test was originally developed for Spanish language interpreters; additional language versions are translated from the Spanish. The test is mostly in English; only specific portions are in native tongues.

Content and how it is tested

This skills list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

Please note: Only limited information on how the content is tested was submitted for this test.

| What is tested? | | If it is tested, how is it tested? |
|--|----|--|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | Not tested, but not discounted if they use it. |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | |
| Sight translation, English to non-English | No | |
| Sight translation, non-English to English | No | |
| Medical terminology, English | • | |
| Medical terminology, non-English | • | |

| What is tested? | | If it is tested, how is it tested? |
|---|----|---|
| Ability to comprehend and produce appropriate register | No | |
| Medical concepts | • | |
| Understanding of interpreter role | • | |
| Understanding of interpreter ethics | • | |
| Pre-session | • | |
| Use of compensation techniques to maximize accuracy (e.g., asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | |
| Use of positioning to support the patient-provider relationship | • | |
| Use of the first person | • | |
| Knowledge of cultural practices | • | |
| Culture-brokering skills | • | |
| Understanding of advocacy role | • | |
| Advocacy skills | No | |
| Memory skills | • | Imbedded in oral exam. |
| Note-taking skills | • | |
| Written translation | • | From English into a language other than English |
| Other (please specify): CLAS mandates, Title VI (Civil Rights enforcement) | | CLAS guidelines and regulatory issues |

REGISTRY OF INTERPRETERS FOR THE DEAF, INC. (RID) NATIONAL INTERPRETER CERTIFICATION (NIC)

Contact:

Lori Frison
National Testing System Coordinator
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nts@rid.org,

Nature of certifying organization

The Registry of Interpreters for the Deaf, Inc., (RID) is a national membership organization of professionals who provide sign language interpreting/transliterating services for Deaf and Hard of Hearing persons. Established in 1964 and incorporated in 1972, RID is a tax-exempt 501(c)(3) nonprofit organization.

RID advocates for the increased quality, qualifications and quantity of interpreters through three main services:

- Professional certification through the National Testing System
- Professional development through the Certification Maintenance Program and Associate Continuing Education Tracking
- Promoting the RID Code of Ethics through the Ethical Practices⁶

RID hopes in the future to establish an autonomous testing body to administer the certification process.

Test developers

RID contracted with CASTLE Worldwide Inc for the development of this certification test; CASTLE in turn assigned the task to Scott Bublitz, Ph.D., James Penny, Ph.D., and James P. Henderson, Ph.D., who worked with a test development committee from within RID.

(The following is taken from the RID Web site at www.rid.org.)

CASTLE Worldwide, Inc. is a testing company formed by a group of nationally respected test developers/psychometricians. The members of the CASTLE team come from some of the largest testing companies in America, bringing with them extensive experience in the development and administration of virtually every type of certification and licensure examination on state, national, and international levels.

For several years, Dr. Scott Bublitz and Dr. James Penny have worked closely with NAD (the National Association of the Deaf) and RID to develop several testing instruments and administer a number of rater trainings. Dr. James P. Henderson is Executive Vice President\ of CASTLE and has served as chair of the National Commission for Certifying Agencies (NCCA), which is the accreditation body of the National Organization for Competency Assurance (NOCA). Dr. Henderson also serves as psychometrician to the NCCA. Under Dr. Henderson's leadership, CASTLE has conducted numerous job analyses and role

⁶ From the Home Page of the RID Web site at www.rid.org

delineation studies for clients of both national and international scope. Dr. Henderson also has extensive experience in the administration of credentialing programs.

Test Development Committees

National Interpreter Certification Content Experts - Original Group

Original group – Jason Burnley (CA), Jerry Conner (FL), Rita Dennis (FL), Reggie Egnatovitch (DE), Sheryl Emery, Tom Galey (CA), Suzanne Garcia-Lightbourn (CA), Gino Gouby (AZ), Shirley Herald (AR), Sally Koziar (IL), Dan Langholtz (CA), John Lewis (DC), Cathy Mcleod (CA), Pasch McCombs (CA), Annette Miner (CA), Marilyn Mitchell (NY), Mary Mooney (TX), Geri Mu (CA), Rachel Naiman (CO), Wanda Newman (DC), Jan Nishimura (VA), Debbie Peterson (WA), Rico Peterson (NY), David Quinto-Pozos (IL), Linda Ross (OH), Robert Sanderson (CA), Ellie Savidge (WA), Sue Scott (AL), Deb Stebbins (MD), Bruce Sofinski (VA), Gwen Trujillo (OH), Kevin Williams (NE) and James Womack (NV).

National Interpreter Certification Content Experts - Test Completion Group

Test Completion Group – Suzanne Garcia-Lightbourn (CA), Gino Gouby (AZ), Dan Langholtz (CA), Pasch McCombs (CA), Marilyn Mitchell (NY), Geri Mu (CA), Rachel, Naiman (CO), Wanda Newman (DC), Debbie Peterson (WA), David Quinto-Pozos (IL), Linda Ross (OH), Ellie Savidge (WA) and Gwen Trujillo (OH).

Languages and venues for which this certification is currently offered

RID's generalist certification and the National Interpreter Certification are recommended for a broad range of interpretation assignments. The languages tested are English and American Sign Language (ASL) (interpretation and transliteration).

For what purposes, if any, is this certification required?

Requirements for certification vary by state.

Components of the certification process

- I. Written test: 150 multiple choice questions covering the following tasks:
 - Assess each interpreting situation to determine if qualified for the assignment.
 - Prepare for assignment by assessing logistics/purpose of interaction for all parties.
 - Maintain competence in the field of interpreting (e.g., attending workshops and classes, reading professional literature, working with a mentor).
 - Apply the Code of Ethics for the interpreting profession.
 - Provide interpreting services that reflect awareness and sensitivity to culturally and ethnically diverse groups.
 - Facilitate the flow of communication during the interpreting process.
 - Apply the appropriate communicative mode and language register.
 - Construct equivalent discourse in the target language while monitoring message comprehension and feedback to modify interpretation accordingly.
 - Use ASL proficiently within expressive interpreting tasks, including choice of sign vocabulary, use of sign modification to show variation in meaning and grammatical function, and appropriate use of space, facial expression and body movement.

- Comprehend ASL proficiently during the interpreting task, including sign vocabulary choice and sign modification to show variation in meaning and grammatical functions.
 - Use English proficiently to construct an equivalent message in the target language, including appropriate vocabulary choice, tone, grammar and syntax, with appropriate use of register, pausing, rhythm, intonation, pitch, and other supra-segmental features.
 - Comprehend English proficiently to construct an equivalent message in the target language, including appropriate vocabulary choice, tone, grammar, syntax, appropriate
2. Interview and Performance test
 - Five ethical questions that are answered to a video camera. They may be answered in ASL, Transliteration or Total Communication modes, but not voice only.
 - Five, 20-minute scenarios to interpret, testing both interpreting and transliterating.
 - Rating
 - NIC Certified means standard on interview and performance.
 - NIC Advanced means standard on interview and high on performance.
 - NIC Master means high on interview and performance.
 3. Certification maintenance
 4. Ethical practices

Test development process

RID began working on the certification of sign-language interpreters around 1972. After a number of years, concerns about the validity and reliability of their test prompted RID to suspend certification for a time. The National Association for the Deaf (NAD) then developed their own test in order to provide a continuous supply of certified ASL interpreters to the market. In 1994, NAD and RID formed the *National Council on Interpreting (NCI)* to, among other things, develop a joint National Interpreter Certification (NIC) test. This new test has replaced the NAD certification and the RID generalist test and is being administered under the auspices of RID for the time being.

The development of the NIC cost more than \$1 million. Annual maintenance costs are about \$200,000-\$300,000. In 2004, a total of 1500 performance tests were given.

Determination of validity

Content validity

In order to establish the validity of the content to be tested, individual RID members, both interpreters and deaf consumers were surveyed about what criteria were needed for a professional interpreter, what knowledge and skills were involved. Subject Matter Experts (SMEs) reviewed the survey results and determined which content should be included in the test. The group of SMEs included deaf consumers, deaf interpreters and hearing interpreters, all with a great deal of experience in the field.

In order to maintain content validity over time, an addition version of the written test has been developed and two more are in process.

Construct validity

Since SMEs determined that knowledge of written English was an important skill to test, the use of written protocol for the test was not a concern.

Interestingly, candidates may choose to take the written test by computer. This option is a bit more expensive. While testing by computer could be seen as a challenge to the construct validity of the test, that fact that this mode is optional and that there is actually a higher pass rate among those who take the test by computer supports the construct validity of this mode of testing.

Predictive validity

The predictive validity of this test can be measured by market forces; certified interpreters are hired more often and are paid more than non-certified interpreters. Were their skills not superior, there would be no difference in rates of pay and hire.

Test rating

There are three types of raters of the NIC. Deaf/hard-of-hearing raters rate the sign language portions for transliterating and interpreting skills. Hearing interpreter raters rate the overall performance of the candidate. Hearing (non-interpreter) raters rate the voicing aspects of the performance section. The candidate's test tape is simultaneously sent to one rater in each rater category. In the case of rater disagreement, the test tape is sent to a fourth rater.

Criteria for test raters

To become a rater of the RID test, candidates must meet at least the following criteria:

- commit to spending 45 minutes to one hour to evaluate each candidate's tape.
- commit to rating and returning tapes within a maximum of two weeks from the date of receipt.
- have no involvement or conflict of interests with any other testing system.
- commit to following the RID code of ethics and the RID Ethical Practices System guidelines.
- submit a cover letter addressing why the candidate wants to become a rater.

In addition, interpreter raters must be certified themselves and have at least five years experience working in a variety of community interpreting settings. They must present a letter of reference from a deaf consumer, a certified member of RID, an employer, or other professional attesting to their ability to remain neutral and unbiased.

Deaf raters must be consumers of a variety of interpreting/transliterating services. They must have experience evaluating interpreters and present a letter from a deaf consumer, a certified member of RID, an employer or other professional attesting to their ability to remain neutral and unbiased.

Hearing raters must have a verifiable knowledge of proper spoken English grammar and articulation and present a letter from a deaf consumer, a certified member of RID, an employer or other professional attesting to their ability to remain neutral and unbiased.

Training of test raters

Raters for the RID test undergo 3-1/2 days of initial training, after which they are given a packet of test tapes to rate. If their ratings fall within acceptable limits, they are confirmed as official raters, and RID starts to send them actual candidate tapes to rate.

The psychometricians who monitor administration of this testing process employ several methods to ensure inter-rater reliability. The first is the process of having rater candidates, before they are allowed to work for RID, actually rate tapes that have been previously rated to check how closely they agree with established rating protocols. The other is to have the master raters (the individuals who trained the raters) rate a tape from time to time. That tape is then included in the midst of a full shipment of tapes to a given rater to be rated over a designated period of time. The raters do not know which is the test tape. The ratings of each individual rater are then reviewed vis-à-vis the master rater ratings. If the individual rater's score is within a designated range, no additional action is taken. If it is not, other activities are undertaken, including but not limited to, a second verification test rating, notification of areas where the rater is beyond the designated ranges, remedial training, probationary status, and ultimately, if results remain unsatisfactory, suspension from additional rating.

Test logistics

The test is given in person, and takes about three hours each for the knowledge test and the interview and performance tests. The written paper-and-pencil test is given periodically across the nation; for example, it was offered in June and December 2005 at 51 sites in the U.S. The computer-based version is delivered at several hundred sites nationwide and is available year round. For this version, the candidate may choose the date, time and place of testing from the listing provided by CASTLE Worldwide, Inc. Information regarding the specific sites and dates is made available to candidates after their applications are processed.

The total cost for the certification process is \$500 or \$550. The introductory member price for the new knowledge portion of the test, which includes the cost of computer-based testing, is set at \$225, including a nonrefundable application fee. Candidates who do not wish to take advantage of computer-based testing can deduct \$50 from the cost. The introductory member price for the combined Interview and Performance Test is \$325, which includes the nonrefundable application fee.

Candidates who fail the test may retake it as many times as they wish, with a waiting period of six months between tests.

At this time, there are no prerequisites to either the written or the oral test. In 2008, hearing candidates for the Interview and Performance Test must have a minimum of an associate's degree. In 2012, the minimum requirement will be raised to a bachelor's. Also in 2012, deaf candidates for the Interview and Performance Test must have a minimum of an associate's degree, and, in 2016, the minimum requirement will be raised to a bachelor's degree.

Strengths of the process

The principal strength of this certification process is the scientific rigor applied to the development and maintenance of the tests. In addition, as this certification process is 34 years old, any inherent limitations have been resolved.

Limitations of the process as it currently stands

The principal limitation of this test for the purposes of interpreting in health care is that the test does not focus on health care content.

Content and how it is tested

This skills list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

NOTE: A comprehensive test outline is available at <http://www.rid.org/nicoutline.pdf>. No information was available, however, on how each skill set is tested.

| What is tested? | | If it is tested, how is it tested? |
|--|----|------------------------------------|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | . |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | |
| Accuracy of oral conversion, English to non-English, simultaneous mode | • | |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | • | |
| Sight translation, English to non-English | No | |
| Sight translation, non-English to English | No | |
| Medical terminology, English | No | |
| Medical terminology, non-English | No | |

| What is tested? | | If it is tested, how is it tested? |
|--|----|------------------------------------|
| Understanding of interpreter ethics | • | . |
| Pre-session | • | |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | |
| Use of positioning to support the patient-provider relationship | • | |
| Use of the first person | • | |
| Knowledge of cultural practices | • | |
| Culture-brokering skills | • | |
| Understanding of advocacy role | No | |
| Advocacy skills | No | |
| Memory skills | No | |
| Note-taking skills | No | |
| Written translation | No | |
| Other (please specify) Additional knowledge and skill sets are described in the NIC Tasks, Knowledge and Skill Statement, available for review at http://www.rid.org/nicoutline.pdf | • | |
| Ability to comprehend and produce appropriate register | • | |
| Medical concepts | No | |
| Understanding of interpreter role | • | |

**UNIVERSITY OF ARIZONA
NATIONAL CENTER FOR INTERPRETATION TESTING, RESEARCH AND POLICY
THE MEDICAL INTERPRETER COMPETENCY EXAMINATION**

Statement on Certification

The National Center for Interpretation Testing, Research and Policy (NCITRP) does not consider the Medical Interpreter Competency Examination (MICE) a certification, as it lacks the legal contracts or government/organizational backing to call it that. However, the *purpose* of this examination is to measure minimal competency in health care interpretation for hospital or clinical settings and the scientific rigor involved in its development suggest that it could be used as a certification tool.

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Nature of the testing organization

University of Arizona's National Center for Interpretation Testing, Research and Policy (NCITRP) is an institution dedicated to language policy development, interpreter testing, training, validation analysis and curriculum development. In addition to the assessment for health care interpreters, NCITRP also has developed assessment instruments for judicial interpreters for state and municipal courts in Spanish, Navajo and Haitian Creole. They are also developing tests of language proficiency for first responders (firefighters) and social service workers.

Test developer

The assessment tests at the NCITRP were developed by Roseann D. Gonzalez, Ph.D. Dr. Gonzalez has 30 years of varied testing experience in traditional testing such as SAT, GRE and LSAT and is considered a pioneer in the development of interpreter performance testing. Her research in the courtroom register in 1976 became the foundation of the Federal Court Interpreter Certification exam. She was the primary consultant to the Administrative Office of the U.S. Courts from 1979 until 2000. The format and scoring mechanism she devised for testing federal court interpreters has become the standard model for testing interpreter performance, successfully withstanding even legal challenge (Selzter v. Foley, 1980).

Dr. Gonzalez started performing research in the medical area at Phoenix Children's Hospital where she transcribed patient-doctor speech and the interpretation of that speech in interpreted events. She has also examined patient-doctor/nurse speech of recorded events of a major telephone interpreting service. In addition to her own expertise, Dr. Gonzalez led a team of experts in the development of the health care interpreter assessment process.

Languages in which the test is offered

Spanish-English

For what purposes, if any, is this certification required?

Certain closed contracts require the certification of an agency's employees; these are private, municipal and state organizations.

Components of the certification process

The Medical Interpretation Competency Examination includes an oral performance assessment consisting of three parts:

1) Consecutive:

A 30-minute interchange between a doctor and a patient that is to be consecutively interpreted. The length of the exercise is important, in that it allows the sampling of language that commonly occurs in symptom elicitation, diagnosis and treatment, all in one situation.

2) Sight Translation:

- a) Report written in technical medical Spanish to be sight translated into English.
- b) Report written in technical medical English to be sight translated into Spanish.

3) Medical Terminology and Patient Talk

This part is divided into 2 sections:

- a) a section that tests comprehension of colloquial patient speech in Spanish to be interpreted into English, and
- b) a section that requires candidates to consecutively interpret medical terminology presented in the context of a sentence from English into Spanish. This section tests breadth and depth of comprehension of colloquial Spanish of patients and technical medical "doctor" talk. By embedding vocabulary in sentences, raters can also test a candidate's knowledge of proper syntactical, semantic and grammatical collocation of the word

Additionally, there is a 10-item written, multiple-choice test of health care interpreter ethics. Although tests of ethics are generally suspect in terms of truly gauging the application of knowledge, this one has a high correlation with interpreter performance on the oral test.

Even though the medical examination only includes two modes, additional testing in terminology (oral), medical concepts (written) and ethics (written) are included.

Test development process

NCITRP developed this examination because of the lack of instruments that establish competency for health care interpreters. The development process follows the established conventions of valid test development. It began with the convening of an expert panel which identified the knowledge, skills, abilities and tools (KSATs) required for a health care interpreter in the clinical setting; the most important KSATs; and how they would be measured. The most representative content was identified, and then the scripts were written

to incorporate the content that the experts thought best represented the body of linguistic and interpretation knowledge and abilities the interpreter had to display. Members of the expert panel along with other consultants and staff members wrote the first draft of the exam, piloted it with several persons and then, based on pilot data, refined the tool. Then the tool was presented to the expert panel again for further comment and revision. Finally, the tool was piloted with a group of 17 candidates in the summer of 2004.

Additional attention was paid to enforcing the standards of practice produced by organizations such as the National Council on Interpreting in Health, the California Health Care Interpreting Association and the Massachusetts Medical Interpreting Association. A panel of experts that included test developers, raters, interpreters, faculty, medical doctors, linguists and nurses collaborated in the development process.

The passing standard was set empirically through a criterion validity study during piloting in conjunction with expert panel recommendation.

Determination of validity

Content validity

Content validity was established through the careful, empirically based development process, taking into consideration the many years of experience of the expert panel in performing, teaching and testing health care interpretation. The research conducted by Dr. Gonzalez in patient – doctor/nurse interaction at the Phoenix Children’s Hospital, as well as hundreds of recorded events submitted for analysis from a major telephone interpreting company, added to the resident knowledge that went into this test.

Construct validity

Construct validity refers to the degree to which inferences can legitimately be made from the operationalizations of the tool and the degree to which the instrument measures the actual construct of interpreting in a medical setting. Construct validity is related to generalizing from performance as measured by the test to the actual job of health care interpreting. Although construct validity is difficult to prove, this test piggybacks on the construct validity of the Federal Court Certification instrument, also developed by NCITRP. The particular “construct” (consecutive interpretation and sight translation in the medical setting) was identified, as well as how best to isolate that construct and measure it.

Criterion (concurrent) validity

In piloting this instrument, NCITRP also did a criterion validity study in which instructors of the Medical Interpreting Institute were asked to rate their students in terms of interpreting proficiency *before* the students took the pilot examination. The teachers rated the students as low/intermediate/high. These were confidential ratings. The students were

tested by independent raters (not their teachers). There was a high correlation (0.9) between the teachers' independent ratings of their students' abilities and the students' actual performance on the examination. This is evidence that the test is accurately measuring ability as set by an outside criterion (in this case, teacher judgment). There was also a high correlation between the MICE and the post-testing instrument used at the University of Arizona Medical Interpreter Institute, where the students attended.

Predictive validity

Because the test has shown evidence of construct validity, its developers believe that the tool may also have a high degree of predictive validity, which means that the test can actually predict performance on the job. Of course, as with any performance test, there are many confounding variables such as personality, stress or fatigue that may actually interfere with performance.

Criteria for recruiting test raters

Raters were chosen on the basis of qualifications, including federal certification, experience in testing and training and experience in health care interpreting. All were faculty members in the Agnese Haury Institute for Interpretation (legal and medical). Criteria for becoming a rater include a complete analysis of credentials and experience as well as a comprehensive rater-training session (unique to the NCIRTP).

Training of test raters

MICE has an objective scoring system, allowing all candidates' performances to be judged fairly using the same standard of evaluation. The same scoring mechanism developed for the Federal Court Interpreter Certification test was applied to this test, as it has proven effective in ensuring uniformity of rating, consistency of scoring across raters, times and candidates, which then assures reliability of the test and contributes significantly to overall validity. In addition, there is a subjective scoring mechanism that captures the delivery features and adaptability (resourcefulness) of a candidate's performance. These subject assessments can "trigger" a pass if the candidate's objective scores fall within a certain range of the criterion. This is also a feature of the Federal Court Interpreter Examination that has been empirically tested and validated.

Inter-rater reliability was 0.87, calculated on the basis of three pilot tests with two raters. Later, the developers switched to using single raters only.

Test logistics

This test is applied in person, but it could, with adequate technology, be adapted to be applied over the telephone or over the internet if necessary.

The oral performance test takes about one hour and the ethics written portion one-half hour.

The test is offered at three training sites (Sacramento, Miami, Tucson) in the spring, summer and fall. It can also be conducted in any city for 15 or more candidates by special arrangement. The cost for the test is \$225, paid by the candidate or by the sponsoring organization.

In the case of failure, the candidate may retake the test every six months, provided that the candidate has followed the raters' recommendations for improvement which might include self-study, shadowing, formal training, etc.

Strengths of this process

- 1) The testing of terminology and medical concepts within a dialogue/context, not just in a written exam.
- 2) A challenging consecutive section that tests technique (memory and note taking), terminology, concepts, colloquial patient talk, doctor's medical register, across several tasks, elicitation of symptoms, examination, diagnosis and treatment. Because of the consecutive exercise's length (30 minutes) and length of utterances (up to 40 words), it also tests stamina.
- 3) Challenging, authentic sight translations in Spanish and English with excellent scoring items (sights are 200 words in length).
- 4) Most distinctively, a medical terminology/patient speech section that tests vocabulary language in the context of whole sentences (15 minutes). This section affords the opportunity to assess lexical depth and breadth across semantic/topical medical domains. This is a very comprehensive test that validly, fairly and reliably measures general interpreter competency in the medical setting.

Limitations of the process as it currently stands

The NCITRP considers that the principal drawback to this testing process is the lack of resources to make it broadly available to hospitals and other service providers. The test designers hope to build buy-in to make this a national certification instrument, based on its validity as a measure of accurate interpreting that does not underestimate or overestimate the kind of linguistic and interpreting proficiency required for general health care interpretation.

Content and how it is tested

This skills list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

| What is tested? | | If it is tested, how is it tested? |
|--|----|--|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | <p>Accuracy of both English and Spanish (doctor talk and patient talk) is tested through the 30-minute consecutive exercise. Medical topics, vocabulary, register in both Spanish and English, medical terminology and register have been carefully developed to simulate authentic discourse with sufficient interpreter stumbling blocks built into the scoring units.</p> <p>The passing criterion was set at 78 percent. Candidates have to conserve the meaning and register of 78 percent of the scoring units that were identified in the three parts of the oral performance test.</p> |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | See above. |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | It was determined by the subject-matter experts that although simultaneous is sometimes used, it is not an absolute requirement for minimal competency in health care interpretation and that it could be learned and practiced if required. |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | See above. |
| Sight translation, English to non-English | • | Sight translation of an English medical report of a procedure 200 words; rigorous exercise requiring knowledge of specialized medical terminology. Candidate is instructed to read and study document and then given x minutes to render. |
| Sight translation, non-English to English | • | Sight translation of a medical report written in technical medical Spanish simulating an authentic document from Mexico (without “Mexicanisms,” but certainly stylistically Mexican medical register). Candidate is instructed to read and study document and then is given a certain number of minutes to render the sight translation. |

| What is tested? | | If it is tested, how is it tested? |
|--|----|--|
| Medical terminology, English | • | 24 authentic English medical register doctor statements and questions spanning several medical domains, medical terminology. Candidate listens to statement or question and provides a consecutive interpretation of those statements questions just after hearing the stimulus. This format tests listening comp in the stimulus language and then consecutive interpretation into the target language, but focuses on medical terminology. |
| Medical terminology non-English | • | 22 authentic Spanish patient speech involving several medical domains and topics. Candidate listens to statement or question and then provides a consecutive interpretation just after hearing the stimulus. This tests candidate's ability to understand colloquial Spanish patient talk, cultural references, symptomatic, behavioral and clinical histories. |
| Ability to comprehend and produce appropriate register | • | Yes, strewn throughout all exercises. Certain scoring units are assessing register. |
| Medical concepts | • | Yes, strewn throughout all exercises. |
| Understanding of interpreter role | • | Yes, throughout consecutive doctor-patient interchange and tested directly through written ethics-scenarios test. |
| Understanding of interpreter ethics | • | Yes, ethics scenarios test |
| Pre-session | No | Not applicable. |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Taking notes, asking for repetition, throughout consecutive exercise and medical terminology exercise. Although, test is limited in time, so asking for too many repetitions or clarifications works against candidate. This is also another check on competence. Does the interpreter have enough language and resourcefulness on hand to complete the exercise in a timely manner, as would be the requirement in the actual setting. |

| What is tested? | | If it is tested, how is it tested? |
|---|----|--|
| Use of positioning to support the patient-provider relationship | No | Not applicable. |
| Use of the first person | • | Implicit in all |
| Knowledge of cultural practices | • | Yes, built into Consecutive and Medical Terminology/patient talk portion |
| Culture-brokering skills | • | Built into Consecutive |
| Understanding of advocacy role | • | Built into Ethics test |
| Advocacy skills | • | Built into Ethics test, not in performance |
| Memory skills | • | Significantly built into Consecutive and Medical Terminology portion |
| Note-taking skills | • | Built into Consecutive and Medical Terminology/ Patient Talk portion |
| Written translation | No | Not applicable. |
| Other (please specify) | • | Accurate, concept-by-concept rendition Conservation of register |

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES MEDICAL INTERPRETER CERTIFICATION EXAMINATION

Contact:

Language Testing and Certification Program
PO Box 45820
Olympia, WA 98504-5820
360-664-6111

Nature of certifying organization

State government

Test developer

Hungling Fu, Ph.D.

Languages and venues for which this certification is currently offered

Certified languages: Spanish, Russian, Vietnamese, Cambodian, Laotian, Mandarin Chinese, Cantonese Chinese, Korean

Screened languages: All languages and all dialects for which certification is not available.

Venues: Medical.

Social Service, Licensed Agency Personnel, Department Bilingual Employees and translators are certified by the Language Translation and Certification office through other tests. **The description that follows describes the medical interpreter certification test only.**

For what purposes, if any, is this certification required?

Certification is required in Washington state of any interpreter whose services are to be reimbursed by the state.

Components of the certification process

There are no prerequisites to take either the certification test (for speakers of eight languages) or the screening test (for speakers of all other languages). Health care interpreters must take both a written test and an oral test. The interpreter must pass the written test before proceeding to the oral test.⁷

The written test has five sections, all in multiple-choice format.

- Section one covers the professional code of ethics, in English, with true and false questions.
- Section two covers medical terminology (symptoms, diseases, treatments, etc.), with the stem term in English and multiple-choice options in the non-English language.
- Section three covers clinical/medical procedures, with both question and answer in English only.

⁷ The information in this section is taken from DSHS's Language Testing and Certification website at <http://www1.dshs.wa.gov/msa/ltc/itsvcs.html>.

- Section four is a brief test in the English language on syntax and grammar, with the candidate choosing an option that best completes each unfinished sentence.
- Section five is the same as section four, except that all items are in the non-English target language.

The oral test has two parts: one tests sight translation skills and the other, consecutive interpretation skills. In the sight translation test, the candidate has six minutes to orally render an English text into the target language, and another six minutes to render a non-English text into English. In the consecutive interpretation test, the candidate plays the role of the interpreter, using prerecorded audio materials with built-in pauses to perform the interpretation. The entire oral test is audio-recorded and then scored by independent graders retained by the Language Testing and Certification Department (LTC).

In response to concerns about the quality of interpretation in languages other than the certified ones, LTC developed a non-language-specific test. Interpreters who speak languages other than the eight listed previously must go through a screening process that consists of a written test and an oral test. Candidates who pass both tests are considered *qualified* or *screened*, not *certified*.

The written screening test is entirely in English, with four multiple-choice sections: professional code of ethics, medical terminology, clinical/medical procedures and indirect writing test in the English language. The oral screening test has three parts that are audio-recorded. The first part is a sight translation exercise of 10 unrelated sentences from English into the target language. This part of the test is not graded. The second part is a memory retention test, conducted entirely in English. During the third part of the test, the candidate is asked to listen to his or her own recorded sight translation and to interpret the tape from the non-English language back into English. The resulting English interpretation is then compared by raters to the original English text for accuracy and completeness. In this way, the candidate's interpreting skills can be screened without the need for language-specific raters to be located and trained for the multitude of languages being tested.

Test development

- 1) Consultations with related professional groups
- 2) Development of test guidelines
- 3) Development of proficiency guidelines
- 4) Development of test specifications
- 5) Research of related literature
- 6) Item writing
- 7) Review of items by various expert panels
- 8) Revision of items
- 9) Pilot testing
- 10) Benchmark setting
- 11) Finalizing test
- 12) On-going adjustments if necessary

Determination of validity

Content validity

Content validity was established through the development of test guidelines, proficiency guidelines, test specifications and the use of expert panels.

Construct validity

No information was available on how or whether the test's construct validity has been established.

Criterion (concurrent)

No information was available on how or whether the test's concurrent validity has been established.

Predictive

No information was available on how or whether the test's predictive validity has been established.

Criteria for recruiting test raters

At a minimum, raters must be themselves certified with high scores in all the tests offered by this program.

Training of test raters

Raters receive group and individual training to follow rating rubrics. They then work in pairs to maintain consistency. Inter-rater reliability was measured at 0.97.

Test logistics

This test is applied in person. Candidates are allowed up to 90 minutes for the written test and 20 minutes for the oral test. The entire certification process takes 3-6 months, depending on the volume of applications.

The test is offered once a month at six locations in Washington state, every month except December and January. It costs \$75 for both tests, a fee that is paid by test candidates.

Candidates who fail the test may retake the test up to three times. After the third attempt, the candidate must wait for six months before an additional attempt.

Strengths of this certification process

High reliability; cost-effectiveness; unique and flexible oral test procedures for the screening test, which allows the state to test candidates in any language pair.

Limitations of the process as it currently stands

When this test was developed, there was little expertise in health care interpreting in the state, making the identification of subject matter experts difficult. In addition, the test was developed and validated for English-Spanish and then simply translated into the other seven certifiable languages; this calls into question the validity of the test in these languages. The lack of a training component linked to this test, and the relative simplicity of the test make the predictive validity of the test questionable as well. Finally, no formal requirements have been established to maintain certification status once certified.

Content and how it is tested

This skills list was based on the content of many introductory trainings for health care interpreters. Please note that the inclusion of a particular skill on this list is not meant to insinuate that such a skill should necessarily be included in any given certification process.

| What is tested? | | If it is tested, how is it tested? |
|--|----|---|
| Accuracy of oral conversion, English to non-English, consecutive mode | • | Audiotaped oral interpretation of an audiotaped patient-provider interaction. |
| Accuracy of oral conversion, non-English to English, consecutive mode | • | Audiotaped oral interpretation of an audiotaped patient-provider interaction. |
| Accuracy of oral conversion, English to non-English, simultaneous mode | No | |
| Accuracy of oral conversion, Non-English to English, simultaneous mode | No | |
| Sight translation, English to non-English | • | Audiotaped oral interpretation of an audiotaped patient-provider interaction. |
| Sight translation, non-English to English | • | Audiotaped oral interpretation of an audiotaped patient-provider interaction. |
| Medical terminology, English | • | Written test, multiple-choice. |
| Medical terminology, non-English | • | Written test, multiple-choice. |
| Ability to comprehend and produce appropriate register | • | Written test, multiple-choice. |
| Medical concepts | • | Written test, multiple-choice. |
| Understanding of interpreter role | No | |
| Understanding of interpreter ethics | • | Written test, multiple-choice. |
| Pre-session | No | Pre-test study guide/practice materials provided. |
| Use of compensation techniques to maximize accuracy (e.g. asking for a pause, asking for a repeat, asking for clarification, taking notes, etc.) | • | Two repeats are allowed on the oral test. Note taking is allowed. |
| Use of positioning to support the patient-provider relationship | No | |

| What is tested? | | If it is tested, how is it tested? |
|---------------------------------|----|---|
| Use of the first person | • | Built-in through consecutive interpretation test. |
| Knowledge of cultural practices | No | |
| Culture-brokering skills | No | |
| Understanding of advocacy role | No | |
| Advocacy skills | No | |
| Memory skills | • | Built-in through oral testing. |
| Note-taking skills | • | Built-in through consecutive interpretation test. |
| Written translation | No | |

PART THREE

INITIATIVES TO ESTABLISH STATE CERTIFICATION

As mentioned in the previous section, as of September 2005 Washington state was unique in offering a certification for clinical health care interpreters through a state entity: in this case, the State Department of Social and Health Services. In October, Oklahoma became the second state to offer a health care interpreter certification process through a state agency. There are also efforts ongoing in other states to establish statewide certification for interpreters in health care. The states listed below, which are profiled in this section, were at the following stages of development as of January 2006:

| | |
|------------------|---|
| Washington State | The Washington State Department of Social and Health Services Certification/Screening process for health care interpreters has been in use continually since 1994. |
| Oklahoma | The Oklahoma State Department of Health and Oklahoma State University are certifying their third group of interpreters. |
| Oregon | The State plans to start qualifying interpreters based on training in Fall 2006. |
| Indiana | A state commission is seeking funding to establish a training program that will lead to certification in the future. |
| Iowa | The State Office of Latino Affairs plans to start qualifying interpreters based on training in Summer 2006. |
| Massachusetts | The Massachusetts Medical Interpreter Association is seeking funding to undertake the development of a test blueprint based on the first test that has been successfully piloted. |
| North Carolina | A test is currently being piloted at the University of North Carolina at Greenboro. |
| Texas | Legislation to establish state certification for health care interpreters was defeated in 2005. |

While the information included in each state profile is current as of January 2006, it will no doubt become quickly outdated. Readers who are interested in tracking how a given state's process is progressing are encouraged to contact directly the leaders mentioned in each section.

Washington State

History

Unlike other state certification initiatives that are described here, certification in Washington state came about as a result of legal action. The Washington State Department of Social and Health Services (DSHS) had originally agreed to test interpreter skills in a 1983 agreement with Region X of the U.S. Department of Health and Human Services Office of Civil Rights and again in a 1987 agreement with the same office. However as of 1990, no testing program had been developed. Frustrated with the state's lack of compliance and chagrined at the number of welfare recipients who were losing benefits due to poor or absent interpreting, Evergreen Legal Services, a legal aid association, brought a class action suit on behalf of Limited English Proficient applicants and recipients of DSHS services. The resulting negotiation led to a consent decree, filed in 1991, stipulating the state's responsibility to assure the quality of the interpreting provided to recipients of state-funded services.⁸

The consent decree led to the establishment of the Language Interpreter Services and Translation Office (LIST) at DSHS. LIST developed first a language proficiency test for DSHS bilingual staff and a certification test for social service interpreters in the six most common languages among DSHS beneficiaries; these tests were implemented in late 1991. The process of interpreter testing included a written multiple-choice test and an oral test of sight translation, consecutive interpreting and simultaneous interpreting (often needed at administrative hearings). Interpreters had to be certified in order for the State to pay for their services. Since Washington was using public funds to pay for interpreter services for all Medicaid patients, this was a serious matter.

The social service interpreter test, as its name suggests, was developed for interpreters working in social service settings, however it was not appropriate for health care interpreters, who use a different set of vocabulary and skills in their work. At the request of DSHS medical service programs, LIST developed a second battery of tests leading to certification specifically for health care interpreters. These tests were implemented in 1995. Assessment for DSHS translators was also created and implemented in the same year.

Although LIST was now administering a wide variety of certification tests, the certification was still available only for eight language pairs: Spanish, Russian, Vietnamese, Cantonese, Mandarin, Cambodian, Korean and Laotian (Russian and Korean were added in 1994). In response to pressure to provide some sort of skills testing for interpreters of other languages, LIST adopted a novel testing approach that was applicable to interpreters of any language pair: "Screening" became required of interpreters in non-certifiable languages in 1995.

⁸ Consent decree between the Washington Department of Social and Health Services and Luisa Reyes and Salvador Penado on behalf of themselves and others similarly situated, No. C91-303, March 4, 1991, filed in U.S. District Court in Seattle, WA. For more information, contact Gillian Dutton at Northwest Justice Project, JillD@nwjustice.org.

Altogether, DSHS spent about \$50-60,000 (exclusive of staff time) to develop the tests. As of 2004, the agency continued to spend about \$325,000 per year in implementing the test, a bit over half of which was being recuperated in fees.⁹

As of January 2006, certification continues. Between 1995 and 2003, the attempt and pass rates stayed fairly constant; between 140-185 candidates attempted the test each month, and about 36-38 percent (50-70/month) were successfully certified. Strangely enough, agencies and health care institutions reported (and continue to report) a continuing shortage of certified interpreters in certain language groups and in certain regions of the state. What was happening? Although it has not been possible to track what happens to interpreters who become certified, there are several possibilities. In areas where there is, at some point, a surplus of interpreters in certain languages, individual interpreters may not be getting enough work and so may leave the field, until there is suddenly a shortage. Or it may be that interpreters are becoming certified as a requirement for dual-role interpreter positions, contributing to the impression that more interpreters are being certified than are actually available as freelancers to meet the need. It also seems possible that working conditions and remuneration for health care interpreters are such that many interpreters work only a short time before moving on to other jobs. In any case, the certification program continues to function, but the scarcity of interpreters for certain languages and regions persists.

The Language Testing and Certification office (the successor to LIST) has implemented a number of measures to respond to this shortage. Temporary “provisional authorization” has been extended to some interpreters who meet certain testing standards. LTC has also offered to accept other validated tests in lieu of the DSHS certification. So far the only other tests accepted are the federal and state court interpreter certifications and the Language Line Medical Interpreter Certification. Neither of these measures has significantly impacted the problem. As a result, the Interpreter Recruitment Subcommittee at the Health Resources and Services Administration (which oversees the state Medicaid program) has proposed a major review of the entire certification process, including a potential overhaul of the test itself. Interestingly, this proposal coincides with an initiative by the CHOICE Health Network in Southwestern Washington (funded by a grant from the Robert Wood Johnson Foundation) whose goal is to stimulate public discussion and develop options regarding quality assurance in interpreting.

What the certification process involves

The Washington State Medical Interpreter Certification process is described in the previous section.

Key lessons

1. The system of service delivery needs to be set up in a way that encourages the retention of valuable language resources.
2. Coordination between state agencies that certify and those providing interpreting is critical in minimizing competition for limited resources.

⁹ Hungling Fu, Language Testing and Certification Office, WA State DSHS, May 2004, personal communication.

¹⁰ Hungling Fu, Language Testing and Certification Office, WA State DSHS, May 2004, personal communication.

3. The certification tool needs constant revision to address changes in languages, demographics, programs and the expertise in the industry; it must evolve to meet the continually changing needs of the interpreters and the populations they serve.
4. Certification options must be flexible to assure that interpreters of rare languages are not excluded by an inflexible testing system.

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Oklahoma

History

Oklahoma's health care interpreter certification program is jointly sponsored by the State Department of Health and the University of Oklahoma's Institute for Issue Management and Alternative Dispute Resolution (IIMADR). The latter institution was formed by state statute in 2002, with a mandate to provide training, certification for mediators, research and mediation services as well as other forms of dispute resolution. When the state legislature later formed a task force on minority health disparities, the IIMADR joined the Cultural Competence Sub-committee, due to the experience the Institute had with cultural and linguistic issues in their dispute resolution work. The Chief of the Minority Division of the State Health Department, who also sat on this sub-committee, was concerned about the quality of interpreting in the state. Since IIMADR had a mandate to train and certify mediators, it was felt that training and certifying interpreters could be folded into their work under the same statute. With support from both the Department of Health and private language companies, IIMADR began the work of designing a certification test.

The test was developed by a committee and beta tested on a group of interpreters. It became clear that training would be necessary in order to prepare people to pass the test. A 20-hour training was developed based on the key concepts of other health care interpreter trainings being taught around the country. The training/testing process was initiated in fall of 2005. To date, the training and testing combination has been offered twice.

What the qualification and certification processes will involve

The certification process involves a 20-hour training in health care interpreting, followed by a written and oral test of interpreting knowledge and skills. For details about this test, see the profile in Part II.

Certification for health care interpreters in Oklahoma is voluntary at this time. It is hoped that entities that contract with interpreters will begin to require it as more interpreters are certified.

Key lessons

1. In states where it is unlikely that a bill directly setting up interpreter certification would pass the legislature, interpreter certification can sometimes be established through other mechanisms.
2. Oklahoma's certification process was developed relatively quickly, and currently lacks the proof of scientific validity and reliability of other certification programs. However, plans to measure validity and reliability are being considered. In the meanwhile, certification is upgrading the skills of health care interpreters in the state. Had a longer, more painstaking process been used from the beginning, this upgrading of skills might still be years away.

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Oregon

History

Efforts to establish certification for health care interpreters in Oregon started as far back as 1997, when Maria Michalczyk (then at Oregon Health Sciences University Medical Center) and Robin Lawson (of Passport to Languages) worked to introduce a bill into the state legislature that would require certification for interpreters in health care venues. A previous bill that would have required certification in all settings was narrowed to deal with health care only. Unfortunately, limited awareness among the legislators about the issues of language access in health care led to the bill being defeated.

In 2000, another legislator, state Sen. Avril Gordly (Democrat, District 10), who had previously worked on issues around certifying judicial interpreters, introduced a new bill requiring certification of health care interpreters. After many iterations, public hearings and testimony in the legislature, Senate Bill 790 finally passed on the very last day of the 2001 legislative session and was signed into law by Gov. John Kitzhaber, an emergency physician as well as governor.

The 2001 Senate Bill 790 authorized and funded the formation of the Oregon Council on Health Care Interpreters and endorsed a two-phase process for assuring interpreter skills. The first phase provided for qualification of interpreters based on education only, while the second phase provided for certification based on both education and testing.

The first task was to configure the Council, whose composition was specified by the legislation. The Governor was to appoint representatives from the following groups:

- educators
- policy makers
- health care providers

- safety-net clinics
- hospitals, health systems, health plans
- The Commission on Asian Affairs
- The Commission on Hispanic Affairs
- The Commission on Black Affairs
- Indian Services
- The International Refugee Center of Oregon
- The Oregon Judicial Department Certified Court Interpreter Program
- The Commission for Women
- The Institute for Health Professionals at Portland Community College
- The following departments within the State Department of Human Services (DHS): the Office of Medical Assistance Program, Mental Health and Disability Services, and Senior and Disability Services (Health Division).

Interestingly enough, the final version of the legislation that passed neglected to include working interpreters among the represented groups. Fortunately, there was enough flexibility with the composition of the group that in fact working interpreters were added to the group and were included in additional meetings.

By February 2002, the Council was convened. In the end, some groups, feeling that language access was not a priority for their constituency, chose not to participate. It also proved difficult to achieve participation by health care providers. Nonetheless, the Council began its deliberations. The group began to meet regularly to better understand the issues involved in certifying interpreters and to write administrative rules specifying just how the law would be implemented.

Then, in 2003, the certification effort received a setback, when the \$50,000 budget originally assigned to this work was revoked due to a state budget crisis. These funds, allotted from the Emergency Fund, were to have served only as seed money, as the cost of the actual implementation and administration would come from the budget of the Office of Multicultural Health. Loss of this seed funding severely hampered the pace of development of the certification process, resulting in a decision to focus principally on the qualification phase of the plan and leave certification for a future time. The Council continued with its work to draft administrative rules.

In early 2005, public hearings were held in Portland to review the draft administrative rules. As the time allotted for public input drew to a close, complaints were tendered from rural areas where stakeholders felt that they had not been given a chance to comment. The Council responded by conducting another round of public hearings, this time at six sites throughout Oregon. When the hearings were completed in October 2005, the Council considered all comments and, together with the Office of Multicultural Health, made the final changes to the administrative rules.

The registry of qualified health care interpreters, based on compliance with training requirements, is now scheduled to begin in fall 2006 under the direction of the Director

of the Office of Multicultural Health. The certification phase will be put on hold for the moment, due to limited financial and human resources.

What the qualification and certification processes will involve

Under this new law, applicants for qualification or certification must:

- be at least 18 years of age.
- demonstrate fluency in both English and the language in which certification is sought by passing an exam offered or approved by DHS.
- have at least 60 hours of formal training as a health care interpreter, including medical terminology, anatomy, physiology, concepts and modes of interpreting, and ethics. The training can be acquired through formal academic settings, seminars, in-service trainings, distance learning, or on-the-job training.
- complete an orientation provided by DHS or its designee.
- sign a specific Code of Professional Responsibility.
- provide proof of at least 20 hours of work as a professional health care interpreter.

Applicants for certification, when it is implemented, will be required to pass an oral and written examination offered by DHS or its designee in English and a non-English language.

The law also allows DHS to accept certificates from entities outside of Oregon in lieu of testing, if the candidate can demonstrate that the other test's criteria is equal to or exceeds the Oregon criteria.

Qualified or certified interpreters will need to renew their credentials every year by showing proof of:

- having received at least 8.5 hours of continuing education per year.
- having provided at least 25 hours of paid or volunteer health care interpreting per year.
- having re-signed the Code of Professional Responsibility.

Under the Administrative Rules set up to implement the 2001 Senate Bill 790, qualification and certification will be voluntary, though state organizations, such as the Oregon Medical Assistance Program will require interpreters to be qualified or certified. Due to the education done during the past years, as well as to national trends, health care organizations are starting to require training and some sort of evaluation from their interpreters. It is the hope of the Council that all health care organizations will require qualification/certification when it is available and that professional interpreters will seek it in order to stand out from their competitors.

Key lessons

There are key lessons to be learned from Oregon's experience in legislating certification.

- Community input is absolutely necessary during all phases of the process: writing legislation; drafting administrative rules; building public buy-in and final implementation.
- Having an ally in the legislature who both understands interpreting issues and knows how to craft legislation is essential.

- The inclusion in the bill of participation by representatives from state commissions helps significantly in building buy-in, even though many of those commissions may not in the end participate.
- State commissions should be of a workable size. The Council set up in Oregon had 24 members, which was much too big for effective action.
- While the Oregon Council sought to include a limited-English-proficient health care consumer in its membership, the logistics of providing transportation, child care and interpreting/translation of all materials was overwhelming.
- Including funding in the bill is important; planning for a budget early on is equally important so that funds cannot be rescinded.
- It is crucial to administratively “place” a body like the Council under the aegis of a department that can support its work.
- Advocates should be prepared for short turnaround times in reviewing draft legislation, but should take great care to review each draft for unintended changes.
- Advocates should plan for a long timeline. In Oregon, it took almost two years to really educate legislators and key constituencies about the importance of this issue.
- In trying to establish a program like this statewide, it is important to have champions and allies who have deep roots in and links to rural communities. There is a natural suspicion among rural communities of major policy changes originating in the large cities, and building trust and buy-in across the urban/rural divide is imperative.

In the end, the Oregon Council on Health Care Interpreters made a decision to proceed with qualification based on training, while waiting a while to take on certification based on testing. The reason for this is simple: cost. As more states around the country seem to be taking up this issue, it is the hope of the Council that in several years, a core group of states may be ready to form a national consortium and work on building a testing mechanism that can be paid for and administered jointly over many states. Since just such a consortium provides certification for state courts, this hope seems a reasonable approach to a complex and costly endeavor.

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Indiana

History

In 2003, the Indiana Minority Health Coalition (IMHC) decided to write a bill introducing state certification for interpreters out of concern for the growing number of linguistic minorities in the state. The IMHC had close working relationships with members of the Indiana state legislature, including the Indiana Black Legislative Caucus. Representative John Aguilera (12th District), a Hispanic and Chair of the Governor's Commission on Latino Affairs, was also involved from the early stages of development of the bill and introduced it into the state legislature.

Drafted with limited input from professionals in the interpreting or translation communities, the original bill had some problems. The bill called for the formation of a 15-member commission “to implement certification for health care interpreters and translators.” The system was to be up and running within one year under the supervision of IMHC, which had no experience either in testing or in language services. Based on concerns expressed in testimony before the House, the legislature chose to limit the scope of the bill to setting up a Commission to study the issue and devise a plan for implementation.

The bill passed and was signed into law by Gov. Joseph E. Kernan in March 2004, officially forming the Indiana Commission on Health Care Interpreters and Translators. The State Health Commissioner was given the charge of making the appointments to the newly formed Commission, which was to be housed in the Indiana State Department of Health and responsible to the State Health Commissioner. The legislation called for representation from the following sectors:

- one member representing the state department
- one member representing local health departments
- one member representing the medical profession
- one member representing institutions of higher education in Indiana
- two members representing patient advocacy groups
- one member representing community organizations
- one member representing interpreter professional associations
- one member representing translator professional associations
- one member representing hospitals
- one member representing the interagency council on black and minority health
- one member representing the department of corrections
- one member representing the department of education
- one member representing the office of Medicaid
- the executive director of the health professions bureau or designee.

State Health Commissioner Gregory Wilson sent out a call to the designated sectors for nominations and selected members based on the names submitted. The Commission started meeting in May of 2004 to begin writing its own by-laws.

Upon completion of the by-laws, the group turned to its charge of developing a plan by which a certification process might be implemented. They decided to divide into four sub-committees, each with its own mandate, reflecting the four charges set forth in the bill.

- The Education and Training Committee was to decide the level and type of training necessary to perform the job of health care interpreter and health care translator.
- The Regulatory Oversight Committee was to review and determine the proper level of regulation or oversight that state government should have over health care interpreters and health care translators practicing in the state of Indiana.
- The Definitions Committee was to define the terms *health care interpreter* and *health care provider*. However, in order to understand the terminology that was used in other committees and in the final report that was due to the State Health Commissioner, the definitions committee compiled a list of more than 70 terms used commonly in the language fields and in testing.

- The Standards Committee was to set the standards of practice for health care interpreters and translators in the state of Indiana.

The Commission's final report was submitted to the legislature on Oct. 28, 2004. In January 2005 a new Republican governor took office. In addition to significantly cutting the budget for education and human services, Gov. Mitch Daniels asked all Democrats on boards and commissions to resign. Most refused, and the Democrats walked out of the legislature in protest. As a result, 130 bills died on the House floor, including the bill to fund the certification program.

Subsequently, again with the help of the Indiana Minority Health Coalition, new legislation was appended to a Senate bill that would have extended the commission's charter, by putting it directly under the Indiana Health Professions Bureau and switching the selection of commission members from the Indiana State Department of Health to the governor's office. The Indiana State Medical Association (ISMA) lobbied heavily against this bill, and the bill subsequently failed. Fortunately, previous legislation authorized the commission to continue functioning until further legislation was passed. The Indiana State Department of Health agreed to support the commission financially until that time.

Meanwhile, the commission started a series of town hall meetings throughout the state of Indiana with the specific purposes of educating interpreters and translators about this move toward certification and of informing health care providers of requirements they should look for when hiring interpreters and/or translators. To date, the initiative has been successful, and the commission has received significant support from the Area Health Education Centers which has offered facilities free to the Commission to continue the town hall meetings. In addition, in late April 2005, the Governor's Senior Advisor on Latino Affairs and the Executive Director of the Commission on Latino Affairs began to take a more active role in supporting the certification effort.

As of January 2006, the commission is working on legislation regarding the implementation of the proposed qualification/certification process and waiting for funding from the legislature. However, since the goal of Phase I of the process was to work towards having *qualified interpreters*, the commission has made a priority of working on a health care interpreting course that will be one of the components required for qualified interpreter status. The commission will also make recommendations on the other competencies that will be required for individuals to acquire qualified interpreter status. The commission will then work on a complete health care interpreting curriculum to help prepare interpreters for the certification process.

What the qualification and certification processes will involve

Like the Oregon model, after which the commission patterned its plan, the first phase of Indiana's process will focus on a *qualification* for interpreters, based on:

- a language proficiency test (testing in all language pairs)
The Education and Training Committee has prepared a list of available language proficiency tests, such as the testing done by the American Council on Teaching of Foreign Languages (ACTFL) and Language Line Services. The list also

- includes educational institutions in Indiana that have language proficiency testing in English as well as some of the more commonly interpreted languages.
- a test on medical terminology and anatomy
The Education and Training Committee has prepared a list of courses in medical terminology and anatomy that are available in Indiana through both traditional and Web based courses. Interpreters and translators who complete one course in each area will be eligible for qualified status in this area. The committee is working on a test for those with significant work experience who feel that they do not need to take a course, but the commission has indicated that in Phase II they will consider moving closer to the Oregon model of required education and/or training in all areas mentioned.
 - a minimum of 40 hours of training in health care interpreting
The Education and Training Committee has surveyed training programs in Indiana and will publish a compendium by early 2006. For example, there are several places in Indiana that offer the *Bridging the Gap* curriculum, and successful completion of this training will meet the criteria for qualified interpreter status.
 - a test on the National Code of Ethics for Interpreters in Health Care.
The commission has been given authorization to adopt the NCIHC National Code of Ethics for Interpreters in Health Care. The Education and Training Committee will develop an exam on this Code.

Successful completion of language proficiency testing, completion of a medical terminology and medical anatomy class, completion of the *Bridging the Gap* or other similar health care interpreting curriculum and passing the test on the National Code of Ethics will constitute compliance with Phase I, that of “qualified health care interpreter.” Qualified health care interpreters and translators will be listed in a registry that will be available through the Commission’s Web site.

Translators will also be required to complete all but the language proficiency testing. However, translators who are not certified by the American Translators Association will have to take a written translation exam based on a medical topic that will be scored by three specialists and will be required to receive two passing scores out of three. Those translators who meet the above criteria will receive *Qualified Health Care Translator* status.

This process will be overseen by the Office of Minority Health in the State Department of Health. The goal is to have all working interpreters tested and entered in registry by end of 2006. Those who are currently working as health care interpreters or translators who do not pass the language proficiency exam or the written translation exam will not be entered into the registry of qualified interpreters. Those who are working as health care interpreters and translators who pass the language proficiency exam have a period of one year to meet the other requirements to receive *Qualified* status. Any individual who does not meet *Qualified* status by the end of 2006 will not be entered into the registry of *Qualified Health Care Interpreters and Translators* and employers will be encouraged to follow the legislation to use only *Qualified* status employees until certification is implemented. *Qualified* status will be available for all languages. Eventual certification will be available only in Spanish, while other languages must achieve *Qualified* status for employment.

The second phase of the process will be certification based on an oral test of interpreting skills. The Commission hopes to begin work on the implementation of Phase II starting in 2007. Clearly, adopting a pre-developed test is preferable for budgetary reasons, but if necessary the state will develop its own assessment tool. The Commission would like to have certification required of all interpreters once it is available, but this would require passage of additional legislation.

Key Lessons

1. The participation of people knowledgeable about interpreting, translation and testing is absolutely essential in the process of developing certification.
2. Building political support for a certification process should be done before the bill gets to the legislature.
3. A budget with which to conduct this work must be established.
4. It is important to have a backup plan in case of political setbacks.

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Iowa

History

In 2004, the Iowa State Legislature passed section 216A.15(9) of the Iowa Administrative Code, awarding the Iowa Division of Latino Affairs (IDLA) the power to develop a program to qualify Spanish language interpreters in the state. The IDLA developed a draft program, with the following purposes:

1. Comply with Iowa Code Section 216A.15(9).
2. Develop a mechanism for establishing the qualifications for Spanish-English interpreters, thus creating a pool of qualified professional interpreters.
3. Develop a system that improves the quality of interpretation but is still cost-effective for providers, interpreters, and clients.
4. Professionalize interpreters by providing professional standards and a code of ethics.
5. Develop an evaluation system for organizations to assess the language skills of employees and applicants.
6. Develop an interpreter qualification system that is replicable and expandable into other languages.
7. Develop a qualification process that focuses on training the interpreters rather than on a single certification test.
8. Encourage Iowa's interpreters to become nationally certified.

The first public hearing on the Administrative Rules for Spanish Interpreters was held on March 24, 2005, in order to get public feedback on the plan to develop a Certification Program for Spanish Interpreters. Opposition was expressed over the term *certified*

interpreters because of the common understanding that certification implies a vigorous, valid and reliable skill testing. Additional concerns were expressed about whether the law would **require** interpreters to be credentialed, citing the lack of professional interpreters in rural areas of the state. IDLA assured those with concerns that the credentialing would be voluntary.

The timeframe to submit the rules with the respective changes expired. In January 2006, a new rulemaking process was initiated, this time using the language *Qualification of Interpreters* instead *Certification of Interpreters*. Commissioners of the IDLA approved the new Administrative Rules in February 2006. IDLA hopes to have the qualification process up and running by summer of 2006.

In the second quarter of 2005, the IDLA applied to the U.S. Department of Labor Employment and Training Administration for a two-year grant to fund the interpreter program. A final revision of the proposal was submitted in December 2005. At the time of this writing, IDLA is waiting for a response.

What the qualification process will involve

The interpreter program's goal is to establish a process to qualify Spanish-English interpreters for work in specific contexts. A reliable training and testing process will be established to serve individuals working in health care, social services and the courts. This system will improve the quality of interpretation while paying attention to the cost-effectiveness for providers, interpreters, and clients. It will provide standards and a code of ethics, develop an evaluation system and implement an interpreter qualification system that is replicable and expandable into other languages. Through the development of the mechanism for establishing qualifications for Spanish-English interpreters, an statewide roster of available, qualified professional interpreters will be created. The program will also encourage interpreters in Iowa to become nationally certified, where such certification exists.

As a prerequisite to entrance into the Qualified General Interpreters Training Program (QGITP), candidates in Iowa will have to be at least 18 years of age, pass a criminal background check, have a high school diploma or its equivalent, and be bilingual in English and Spanish. The candidates must then pass an approved language proficiency test as well as completing the QGITP in order to be called a Qualified General Interpreter.

For entry into the Qualified Specialization Interpreters Training Program, an interpreter must be a Qualified General Interpreter in good standing and complete a specialized 150-hour training program in their specific field of interest: health care interpreting, judicial interpreting or social service interpreting. IDLA's goal is to institutionalize at the state level the curricula that will be developed and/or offered through independent training institutions chosen and vetted by IDLA.

In order to maintain either qualified status, candidates must show 30 contact hours of continuing education per year and maintain themselves in good standing regarding the Code of Professional and Ethical Conduct for Interpreters.

IDLA hopes that the resulting screening and training paradigm can then be used as a framework to develop qualification for interpreters of other languages.

Qualification in Iowa will be voluntary for the general interpretation and the three specializations. However, it is hoped that interpreters who make it onto the statewide roster of Qualified Spanish Interpreters of IDLA will be given preference in contracting and hiring.

Key lessons

1. This process has demanded a permanent and fluent communication with diverse population sectors such as educational institutions, media, Latino organizations, interpreters and translators associations, and the general public, in order to avoid misconceptions and misunderstandings that have at times slowed the process.
2. For a program to be successful, it is important that it be inclusive so that all individuals will have the same opportunities to either start the training program or apply for transferability.
3. In order to avoid reinventing the wheel, it is important for the program to embrace all existing courses of interpreter training that have already been established.
4. Candidates who have met the minimum requirements and live in rural areas should have a special preference because of the lack of professional interpreters there and indeed the limited bilingual services provided to the increased number of Latinos.

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Massachusetts

History

Massachusetts is home to the oldest association of health care interpreters in the country: the Massachusetts Medical Interpreter Association (MMIA). This influential organization has long been a leader in the field of health care interpreting, starting in 1995 with its Medical Interpreting Standards of Practice.

Soon after publishing the Standards of Practice, the MMIA began work on developing a certification tool for health care interpreters. They decided to start with a test for Spanish-language interpreters, as Spanish is by far the most commonly interpreted language in the state. The development of a prototype went slowly, since all the members of the Certification Committee were volunteering their time. In 2001, the MMIA conducted a pilot test of their first prototype, however, due to a lack of funding, the pilot did not attract the number of participants necessary to generate significant results.

The following year, the National Council on Interpreting in Health Care (NCIHC) approached MMIA about piloting the test both in Massachusetts and in California (in collaboration with the California Health care Interpreting Association – CHIA). With funding from the U.S. Department of Health and Human Services Office of Minority Health, NCIHC was able to facilitate this collaboration so that MMIA might obtain a large enough sample to pilot the test effectively. The instrument was revised, administrators and raters trained and the test piloted in 2003.

At this time, MMIA is searching for funding in order to take the next steps toward implementing the test in Massachusetts. They are particularly interested in creating materials that would support other users in developing comparable tests in other languages: i.e. specifications for item writing, how to calibrate the items, etc.

What the qualification and certification processes will involve

Although the test is not currently being offered to the public, the specifics of the MMIA test itself are described in the previous section of this report. At this time, the MMIA is not engaged in a political process to legislate certification for interpreters in Massachusetts, so it is difficult to say what a formal process would involve there. However, based on the success that the MMIA has had in implementing standards and ethics through outreach, training and consumer education, it is likely that any certification process implemented in the state would be widely accepted once it is available.

Key lessons

There are some key lessons that can be learned from the MMIA's experience in writing certification tests.

- Creating a certification instrument is costly and time consuming.
- Intensive screening and training of test administrators and raters is crucial to achieving reliability on the test. When a lack of linguistic or conceptual equivalency exists between English and the non-English language, it is extremely difficult to provide raters with guidelines as to what the “correct” answer might be. Judgment must be used, making the scoring more subjective.
- Using role plays to simulate actual interpreting conditions is theoretically a more valid testing mode than a tape-based test, however consistency of administration is required.
- While reading and writing may not figure among the skills to be tested, some material may need to be tested this way, if only for logistical ease. Options should be included, however, for taking the test in an exclusively oral mode if necessary.

As MMIA continues to work on the Spanish version of the test, it is to be hoped that other states may use the blueprint they are developing to write comparable versions of the test in other languages. It may be that a future consortium could adopt these instruments for use across states, if the model is ultimately found to be valid and reliable.

For more information

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North Carolina

History

A certification test for health care interpreters in North Carolina is currently being developed at the Center for New North Carolinians (CNNC) at the Social Work Department of the University of North Carolina at Greensboro (UNCG). The Center began in 2000 to train health care interpreters, using a 40-hour curriculum developed by the CNNC and led by Raleigh Bailey, Ph.D. In 2003, a contract was signed with the North Carolina Area Health Education Centers (AHEC) to train interpreters throughout the state with a curriculum developed by Eta Trabing, Jazmin Metivier, the North Carolina Interpreter Task Force of the Office of Minority Health with revisions by CNNC. After having trained approximately 5,000 candidates in a variety of languages, Arelys Chevalier, the coordinator of the program at CNNC decided that the time had come to develop a certification process based on the training.

After consulting with testing experts at UNCG and with the creator of the Washington State certification exam (Hungling Fu, Ph.D.), Ms. Chevalier decided to start with a certification process for medical and social service Spanish-language interpreters, based on the content of the 40-hour training being offered through the state of North Carolina.

What the qualification and certification processes will involve

The certification is based on training and testing. Candidates will be required to show proof of training before taking the test. Training programs equivalent to that of UNCG will be accepted.

The test itself consists of a written and an oral section. The written section, which takes about 3-1/2 hours to complete, is largely multiple choice and covers role, ethics, Title VI of the 1964 Civil Rights Act and regulatory issues, anatomy and physiology, diagnostic tests, common diseases and positioning. There are two parts to the oral section. The first is conducted through a series of videotaped role plays. These are used to check interpreter skills in cultural interventions, clarification, advocacy, positioning, transparency, pre-session, and, of course, accuracy and completeness. The other part of the verbal test is listening comprehension. A candidate listens to three paragraphs, in both Spanish and English, each longer than the first, that are either read by a test administrator or played on an audiotape. After each paragraph is read, the candidate is recorded while describing, in whatever language the paragraph was read in, the main idea of the paragraph.

Current status of test

As of January 2006, this test is in the process of being piloted with the help of the North Carolina Association of Professional Interpreters (NCAPI) so that its validity and reliability can be measured. Once that is completed, the certification process will be implemented through UNCG/CNNC. For the moment, certification will be entirely voluntary. There is some concern in the state that if certification were required by all human service and health care institutions, the pool of interpreters would be reduced and that many currently working as interpreters would lose their jobs. Nonetheless, NCAPI is standing by to help promote the test across the state, so there is the expectation that the process will be widely supported.

While the test currently being developed is for Spanish-speakers only, it is interesting to note that there is significant interest among leaders of the Hmong community in North Carolina to establish a parallel certification in Hmong. To this end, the leaders have formed a language committee to provide linguistic expertise to UNCG in developing such a test.

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Texas

History

As in other states, the certification efforts in Texas have been led by a champion – or, in this case, two champions. Patricia Yacovone, an aspiring health care interpreter, met Esther Díaz, long-time interpreter trainer and advocate, at a meeting of the Austin Area Translators and Interpreters Association (AATIA) in September 2003. Ms. Yacovone sought advice on how to prepare herself for a career in health care interpreting and was surprised to discover that Texas had no certification option.

After taking a course in health care interpreting, Ms. Yacovone was determined to take on the issue of certification. She founded a statewide organization, the Texas Association of Healthcare Interpreters and Translators and surveyed its members about their opinions regarding interpreter qualifications and certification. The members overwhelmingly agreed that the use of qualified interpreters was the most important issue on which the organization should direct its focus. A meeting was arranged with newly elected state representative Mark Strama (D-Austin) and Sen. Kyle Janek, M.D., (R-Houston), the Vice Chair of the Senate Health and Human Services Committee.

Ms. Yacovone and Ms. Díaz prepared a presentation outlining the current laws affecting health care interpretation around the country at the state and federal levels, which they shared with Rep. Strama, who agreed to sponsor a health care interpreter bill using the Oregon legislation as a prototype. Ms. Yacovone and Ms. Díaz also gave their presentation to an aide to Sen. Janek. Unfortunately, Sen. Janek expressed concern over the cost of implementation and declined to sponsor an interpreter bill in the Senate.

On February 22, 2005, Rep. Strama filed HB 1341, which called for the establishment of an advisory committee on qualifications for health care interpreters and translators. Within days, Rep. Rafael Anchia (D-Dallas) and Hubert Vo (D-Houston) also signed onto the bill. After the first reading on the floor of the House, the bill was sent to the House Public Health Committee, chaired by Rep. Dianne White-Delisi (R-Temple). Although Representative Strama had requested a hearing early on, HB 1341 was not heard in the Public Health Committee meeting until 2 a.m. in the morning on the last possible day for hearings. Despite the efforts of advocates who remained at the State House from 2 p.m. the previous afternoon (the appointed time for the hearing) and testified before a rather unwelcoming committee, the bill was tabled and eventually abandoned by the chair, who refused to call for a vote. A bright spot of the marathon committee meeting however was the wholehearted support given to the bill by committee member Rep. Jim McReynolds (D-Lufkin).

Other details

The bill proposed the creation of a 10 member Advisory Committee to be placed under the aegis of the Health and Human Services Commission (HHSC), the agency that also oversees the state's social service agencies and the state health department. It was felt that the responsibility for the bill's implementation would fall on the Department of State Health Services (DSHS). However, there was some reluctance expressed on the part of DSHS about accepting that charge.

An initial response was that the responsibility for testing might better lie with the Texas Department of Licensing and Regulation (TDLR), the entity which oversaw the certification of court interpreters. Backers, however, felt that TDLR's handling of the court interpreter certification had not been optimal and pressed DSHS to accept responsibility for the health care interpreter certification process because the department already had experience with creating a process for certifying *promotoras*, and had a registry for certain other health care professionals. Furthermore, the fiscal cost would be minimal because the costs for testing, training and registration would be covered by the interpreters themselves.

What the qualification and certification processes would have involved

Like Oregon and Indiana, the Texas bill contemplated a multistage process:

- Years 1 and 2: Advisory Committee to identify language assessment resources
Formal language assessment required of health care interpreters
Identification of required content for training
Formal training of health care interpreters
- Years 3 and 4: Identification of acceptable certification tests
Formal certification of health care interpreters

Key Lessons

1. Finding the right legislative backer is important. It helps to have as a sponsor for the bill someone who is enthusiastic about the bill AND a member of the Committee where the bill will be heard.
2. Seek bipartisan, bicameral support.
3. File a companion bill in the other chamber as soon as possible.
4. Build support in the department of state government that will oversee the certification program.
5. Minimize or eliminate the fiscal impact.
6. Build support for the next legislative session so that the acceptance of the bill will be smoother next time.
7. Emphasize that any certification established would be voluntary on the part of the interpreters.
8. Identify **local** cases of undesirable consequences that occurred after the use of ad-hoc or untrained interpreters in the medical setting.

Strategies for the future

The House and Senate passed companion bills this past legislative session that allow for the use of Medicaid funds to pay for health care interpreting services at several hospital districts around the state. It is hoped that input from supporters of HB 1341, or at least of the philosophy behind it, will be able to influence the implementation of that law by stressing the importance of using trained and qualified health care interpreters in the hospitals.

The process of dialogue among stakeholders and increasing the awareness about the tragic consequences the use of unqualified interpreters may have, remains a significant focus of the efforts in Texas after the failure of HB 1341.

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PART FOUR

THE ROAD TO NATIONAL CERTIFICATION OF HEALTH CARE INTERPRETERS

Introduction

From the previous section, it is clear that both public and private entities are experimenting with certification, and that efforts are being made in some states to implement statewide testing. It is equally clear that so far none of these processes represents national certification. Is this a concern? There seems to be a great deal of interest in establishing a national certification instead of a series of localized certifications; why is that?

The state, academic, and corporate certification initiatives are all very valuable in raising the standard for health care interpreters for particular groups in particular parts of the country. Each can be tailored to the unique needs of a certain target group of interpreters (e.g. telephonic interpreters) or to the specific political climate of a particular state. In addition, these initial experiments in health care interpreter skills assessment have created a body of experience and knowledge that can inform the development of other tests. However, a national certification process, if done well, could proffer a number of unique benefits.

- The process of developing a national certification will require a vital nationwide discussion about a number of key implementation issues, such as the impact of requiring certification, the implications of tiered interpreting systems and the ramifications of the professionalization of the field. The more widespread these discussions, the more standardized the advance of the field.
- Pooling resources to develop one national certification process instead of 50 state processes will result in tremendous cost savings that could be translated into the development of testing in a larger number of languages.
- A national certification, if done well, would command increased credibility for both the credential and for the field of health care interpreting in general. This credibility may help in building buy-in among health care administrators, without whose acceptance the credential will have little actual impact.
- Federal legislators are more likely to allocate funding to pay for interpreter services if there is a national certification process that embodies a single agreed-upon quality standard for health care interpreters.
- A single, national certification makes it easier for consumers of interpreter services to understand what the credential represents. With multiple certifications available, it is difficult for consumers to compare credentials or to understand the strengths and limitations of each.
- The existence of a national certification process circumvents the need for each state to set up reciprocity agreements with the certifying bodies of other states.

- A national certification process is more likely to attract funding for test development. This may seem a mercenary consideration; however, while considering the cost of development of a valid and reliable testing instrument, the issue of funding should not be dismissed.

Finally, it is unlikely that every state in the country is going to dedicate the time, effort and resources to develop certification. The creation of a national certification process can make certification available to all interpreters, uniting the field and creating one single standard for all.

What would it take, then, to develop a national certification for health care interpreters?

Developing a National Certification Process

The following steps for developing national certification are based on interviews with test developers, interpreter advocates and those involved with developing certification on the state level. While not definitive, they may provide a starting place for further discussion.

I. Find a home.

Much of the value of a certification process lies with the credibility of the certifying body. What would be a logical “home” for a national certification for health care interpreters?

One possibility is a professional association. Physicians are certified by State Medical Boards and translators by the American Translators Association. Sign language interpreters are certified by the Registry of Interpreters for the Deaf (RID). One professional health care interpreter organization, the Massachusetts Medical Interpreters Association, is already working on certification, as described in the previous section. However, there is no national professional association as yet that really represents the interests of health care interpreters. While the ATA does have an Interpreters Division, it does not yet have general credibility among health care interpreters.

Another possibility would be government. Federal judicial interpreters are certified by the State Department, and the state health care interpreter certifications existing or under development in Washington, Oregon, and Indiana are all under the control of state entities. Would a federal agency be a logical home for a national health care interpreter certification? Such an organization might be able to access federal funding for such a venture, and it would surely have a great deal of credibility. On the other hand, government entities are political bodies and, as such, their programs often shift with the political exigencies of changing administrations. A quick review of the experiences related to developing state certification in Indiana, Oregon and Texas argue that a government entity might not be the most stable platform from which to launch a long-term project such as this.

Would an academic center be a logical place to house an interpreter certification program? There are a number of universities in the United States that offer degrees in translation and interpretation. Some – such as the University of Massachusetts at Amherst, the National Center for Interpretation Testing, Research and Policy at the University of Arizona and the National Foreign Language Center at the University of Maryland have demonstrated

a particular interest in health care interpreting and might be a credible base for a certification program. It would be important, however, for any university that took this on to be willing to work with experts in the field who might not carry advanced academic credentials.

A fourth possible home for a national health care interpreter certification program is a national non-profit organization. For many years, sign language interpreters could be certified by the National Association for the Deaf, an organization that advocated for the rights of the hearing impaired. In that vein, the National Council on Interpreting in Health Care (NCIHC) might be a logical home for this certification program. The NCIHC has been active in helping develop national consensus around health care interpreter ethics and standards of practice and so has significant expertise and credibility in the field. Its multidisciplinary approach to its work would also assure a broad basis for development of any certification test. And as the NCIHC does not hire interpreters, it has no conflict of interest in certifying them. As an all-volunteer organization, however, the NCIHC would need to consider carefully its capacity to undertake such a large and long-term project.

A final possibility for a home for certification is the formation of a consortium of organizations, joined for the express purpose of creating a certification process. In July, 1995, four states (Minnesota, New Jersey, Oregon and Washington) joined with the National Center for State Courts to develop proficiency testing for state court interpreters. The resulting organization, the Consortium for State Court Interpreter Certification is “a voluntary program in which member states c[an] pool financial resources and professional expertise to eliminate duplication of expense and effort, and lower the cost of interpreter test development and administration for all of the member states.”¹¹ With a growing number of states interested in implementing certification, but hesitant to invest the resources necessary to do so in a wide number of languages, this consortium could be a useful model for health care interpreter certification.

2. Build public support

One clear drawback of national certification is that, unless national or state legislation is passed, or a federal agency establishes official policy (all difficult and time-consuming efforts), any national certification will be voluntary. Therefore, it is essential to make a concerted effort to build widespread support for a national certification process. As discussed in the introduction, interpreters, providers, health care institutions, language agencies, insurance companies and limited-English-proficient communities all have something to gain from a quality certification process. Efforts must be made to include and mobilize these groups to support – politically if necessary – the establishment of a national certification for health care interpreters. The relationships fundamental to accruing this support must be established early and nurtured assiduously over time.

¹¹ From the Consortium for State Court Interpreter Certification Web site at http://www.ncsconline.org/D_Research/CourtInterp/Res_CtInte_ConsortCertFAQ.pdf

3. Secure funding for test development.

Whatever organization emerges as the appropriate home for a certification process, test development cannot begin without funding. Developing and implementing a valid and reliable certification process can be an expensive undertaking. Three sources of potential funding are immediately apparent.

- a. Grant funding could be sought for the initial development of the first test. There are a number of major foundations and federal government agencies that have demonstrated an ongoing interest in advancing the cause of language access. Any or all of these could be approached.
- b. Once one test is available, it is likely that at least some states will be willing to pay a fee for access to the test, providing funding for implementation and further test development.
- c. A reasonable fee charged to certification candidates can help offset the cost of implementation.

4. Choose professional test developers to work with the organization to design the test.

Developing valid and reliable assessments is the work of professional test designers. Just as being bilingual does not qualify one to work as an interpreter, even experts in interpreting are not necessarily qualified to develop interpreting tests. Therefore, it will be important early in this process to retain the services of a team of individuals who are competent and experienced in designing certification tests, preferably in language-related fields.

5. Develop criteria for candidates to be allowed to take the test.

No assessment can test everything. For this reason, there are often prerequisites to taking a certification exam, each of which is really a proxy for something we cannot, or do not intend to test. We may apply age criteria partially as a proxy for emotional maturity and life experience. We may apply basic educational criteria, as we cannot test the broad general knowledge that interpreters need. In reviewing the certifications being developed in Oregon, Indiana and North Carolina, it is interesting to note that all have included a training requirement. This stands as a proxy for the many interpreting skills that cannot be included on a test. As we add criteria, however, we should constantly be asking ourselves whether they will exclude candidates who could be doing the job well, or at least well enough.

6. Decide what knowledge, attitudes and skills to test.

One of the first tasks facing test developers is to decide what exactly to test. Most psychometricians, experienced in test design but not in the topic to be tested, convene a group of Subject Matter Experts (SMEs) to make these decisions. The Registry of Interpreters for the Deaf also conducted surveys of working sign language interpreters to inform their process. Luckily for health care interpreting, the National Council on Interpreting in Health Care (NCIHC) has, with great foresight, already developed some national consensus through their development of the National Standards of Practice for Interpreters in Health Care (see www.ncihc.org). This document will be invaluable in informing the work of the SMEs called upon to specify the content of a national certification test.

An additional decision relates to which language pair to test. While Spanish/English may be the obvious choice, simply due to the overwhelming demand for interpreters in that language pair, it could be argued that adequate resources already exist to assure quality in interpreting in Spanish. Several commercial-language screening tests exist for Spanish, there are many Spanish training materials and assessments where they exist, are almost always in Spanish. Would the country be better served by starting with a language other than Spanish? NetworkOmni has adopted an interesting approach by dividing languages into three main groups (Romance, Slavic and Asian) and simultaneously developing tests for one in each group (e.g. Spanish, Russian and Cantonese). Clearly, the language(s) of testing is a basic choice that must be made consciously, early in the process.

7. Decide how to test.

How will we test the content we decide needs to be tested? Standardized multiple choice tests are objective, easy to grade and cheaper to administer. However this same testing methodology penalizes those who do not read English easily or who are unfamiliar with the psychology of the multiple-choice test (which is an uncommon testing method outside of the United States). Observing an interpreter actually interpreting in a real-life situation is a much more valid testing method, but one that is impractical. What to do? A decision will have to be made as to which testing methodologies will be used, striking a balance between construct validity and practicality. In this, the experiences of those organizations that have actually constructed and implemented health care interpreter certification tests will be exceedingly valuable.

8. Design a draft test.

This is the nitty-gritty work of the test designer: to construct test items based, if possible, on real interpreted encounters. More items must be created than will be used, as some will be discarded during pilot testing.

9. Pilot test items, first with a small group, then with large group.

After writing the test items, they must first be piloted with a small group of candidates. This gives the designers information about which questions were too easy, or too hard, or written in a confusing way. For example, if everyone gets a particular item right, then it has no predictive value; it does not differentiate between candidates of different skill levels. The ideal ratio is 50 percent of candidates getting the item right and 50 percent getting it wrong. On multiple choice tests with four possible answers, 25 percent getting an item right is the level of pure chance; therefore, the optimal ratio is 62.5 percent (halfway between 25 percent and 100 percent).

10. Revise the draft test.

Based on the piloting of test items, the items must be revised and a draft test assembled.

11. Develop different versions of the test.

It is important to have different but equivalent versions of the test, both for test security and to accommodate those who may need to retake it. Usually different versions of a test are made by choosing a different set of questions from the pool of test items. The different versions are then included in the pilot and statistical methods are used to test to what

12. Set standards for grading.

In multiple-choice tests, indicating the right answers may seem like a simple task. Many interpreter skills, however, cannot be assessed through these objective testing methodologies. In parts of the test that require more subjective grading, it is not so simple to determine what qualifies as a correct answer. For example, accuracy in linguistic conversion is certainly a skill that any certification process must test. However, in cases in which there is no direct linguistic equivalent in the target language for a statement or an idea expressed in the source language, interpreters must paraphrase, or create “word pictures.” It may be difficult, then, to decide if a particular paraphrase is close enough to be acceptable. In addition, test designers will have to decide how to deal with regional differences, small changes in register, older forms of a language as compared with more modern forms, etc. Considering the scope of linguistic variation, it is not surprising that setting standards for grading becomes very difficult at times.

13. Write a guide for candidates.

One of the hallmarks of a credible certification test is that candidates are sent preparatory information about what skills will be assessed and what sort of questions will be on the test. Often sample questions are included and study materials recommended. This process both allows candidates to practice and reduces test anxiety, a common underlying cause of poor test performance.

14. Develop training materials for test administrators and raters.

Test reliability depends entirely on a consistent administration and rating of the test. Those who give the test and those who rate it, must receive uniform training and ample practice in order to avoid invalidating the test. The careful development of training materials will support consistency in training over subsequent groups of administrators and raters.

15. Choose and train test administrators and raters.

Criteria for who will administer and who will rate the tests must be developed, as well as policies for choosing, retaining, paying and dismissing raters. Once the first administrators and raters have been contracted, they must receive the training designed above. The training must include evaluation of raters’ performance to maximize the potential for inter-rater reliability.

16. Pilot the test.

In piloting the test, it is useful to have a statistician recommend a target number of candidates in order to assure that the universe of test scores is large enough to lead to statistically significant results regarding inter-rater reliability. In addition, if it is possible to include candidates whose skill level is already known, it will be possible to judge to what degree the test has predictive validity.

17. Analyze the results.

Analysis of the pilot results will require the assistance of a statistician.

18. Revise the test and all support materials.

Based on the results of administrator/rater training and the test pilot, all materials should be reviewed and potentially revised.

19. Set cut score.

One of the hallmarks of a certification test is that it compares candidate performance to a pre-set standard. This is called “criterion-based testing.” Setting the standard is a subjective process. One method for doing this is the Angoff method, in which stakeholders are brought together to act as judges. Each stakeholder then rates each item on the test based on an estimation of the probability that a minimally qualified person would get a particular item right. The average of all the scores becomes the passing grade. This grade is then reviewed by the certifying organization and may be moved up or down based on the projected gravity of false positives and false negatives.

20. Implement the certification process.

Finally, we are ready to launch our certification process. Timelines and localities for testing must be determined, a registration process developed, publicity done and test preparation packets sent out. Clearly, certification will require a full-time staff to implement.

21. Using the first test as a blueprint, start over with different languages.

At the conclusion of this work, the result is a certification process for health care interpreters in one language pair. However, there are hundreds of languages being interpreted on a regular basis in the United States. To develop certification in other language pairs, new tests must be developed. Simple translation of a test validated for Spanish does not render a valid test in, for example, Vietnamese. However, the test content and basic format can be retained, and the lessons learned from the initial testing experience will inform future development efforts.

Additional questions

A few additional questions regarding remain to be considered.

- How can interpreters in the less common languages be evaluated?
Traditionally, materials and testing in language access always start with Spanish, because of its overwhelming prevalence in the country. However, there is also need to certify interpreters in other languages. Some of these will never reach the critical mass necessary to justify the expenditure to develop specific tests for them. Should they be ignored, or is there another option?
- Washington state initiated a very interesting process to “qualify” interpreters in languages it does not certify. The qualification test involves a multiple-choice test in English addressing ethics, medical terminology and English grammar. The candidate then is given an English document to sight translate into a tape recorder. The tape recorder is removed, and the candidate is given an English-English shadowing exercise. Then the candidate is asked to listen to the recorded sight translation and to do a consecutive interpretation back into English. The resulting interpretation is rated by comparing it to the original English script for meaning. While this is not a perfect technique for evaluating a candidate’s interpreting

skills, and one with questionable face validity, it does represent one creative way to assess the abilities of interpreters in multiple different languages.

- Could there be an alternative route to certification that doesn't involve testing?
Is it possible to be a good interpreter and not read English well? Is it possible to be a good interpreter and a terrible test-taker? Should we make any allowances for people who are the false negatives – those who really do have the skills but whose skills are not measured well by the test we develop? Should we make allowances in certain language groups but not others? All these questions must be discussed and a national consensus reached at some point.
- Should certification be required?
Once certification is available, the next question is whether certification should be mandatory. Clearly, requiring certification raises issues of how to provide services if there exists a dearth of certified interpreters. Not requiring it however, raises issues of motivation; what motivates an interpreter to get certified if certification is not required? What motivates a health care organization to use certified interpreters if it is not compulsory? What does it say about the importance of certification if, in the end, it is optional? As with the previous question, this is one that will require careful consideration, public debate and consensus building.

First Steps

There is, actually, one step that comes before all the rest listed above. That is to begin the national dialogue on certification for spoken-language health care interpreters. Many of the issues discussed above are thorny problems. They will not be easily resolved; indeed, any response will be but an informed choice, with full awareness of all potential consequences. Without a general consensus on how to address these issues we run the risk of either developing a certification that lacks national credibility and is therefore irrelevant, or developing a certification that actually does harm.

How can we begin? One approach is to convene a series of small meetings with leaders in the field of health care interpreting. These first meetings would serve to identify the questions that need answering and the research that must be done, to establish a baseline for discussion of the certification issue and to suggest a process through which the foundation for a national certification could be established. Such meetings would not produce answers to the tough questions, but they would create an action plan for how the answers would be generated. Who then will take the initiative to start this national process? It lies in the hands of those committed to the development of health care interpreting as a field to reach out and begin.

SUMMARY AND CONCLUSION

There can be no doubt that there is increasing interest in the United States in certifying health care interpreters. States, language agencies and academic institutions are all making valuable headway in developing assessment instruments. Perhaps the time has come to begin the long process of creating a national certification process.

We must not forget, however, the overall context of certification for health care interpreters: quality assurance. The goal of certifying interpreters is to guarantee a certain minimum skill level in the people tasked with facilitating communication between patients and providers who speak different languages, with the larger goal of improving access to and quality of the health care received by limited-English-proficient populations. Testing is only one step toward that goal: it will not replace appropriate recruiting, language screening, testing, monitoring and continuing education. In addition, testing can only tell us so much about a candidate. The following, found on the website of the Registry of Interpreters for the Deaf, is a crucial reminder as to what we are about:

It should be noted that, as with all things in life, there are limitations to what testing can and cannot do. Tests are but one of many tools to assist people in making informed decisions about job-related skills, and test scores should not be viewed outside the context of other measures of competence. Thus, it is important for all concerned to know that . . . current and future tests judge skills for the job - they do not and cannot judge the character of the individual. The burden for judging the character of an interpreter is carried by agencies and consumers who must screen for such areas.

<http://www.rid.org/nic.html>

A testing process is just a tool, and one of many, but it can be a useful tool. The time has come to seriously begin the process of developing a national tool that will serve interpreters, and benefit all whom they serve, across the country.

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