Language Testing Options

2008

Robert Wood Johnson Foundation

Hablamos Juntos

We speak together.

Table of Contents

The list of testing and training options referenced in this document is for informational purposes only. This is a sampling, and not an exhaustive list of all testing options available. Inclusion in this resource list does not imply any endorsement, recommendation or approval by either the Robert Wood Johnson Foundation or Hablamos Juntos.

Introduction

The original *Hablamos Juntos Language Testing Options* report published in 2002 provided information on twelve resources available at the time to assess the foreign language proficiency of prospective interpreters. This small number of resources illustrates what little emphasis had been placed on language assessment just five years ago. One of the most notable changes since that time is the proliferation of language proficiency testing and interpreter training across the nation, with public and private entities offering a variety of language-related services (e.g. testing and training) in several fields including health care.

This update on language testing options includes a sample of 35 resources readily available on the Internet. Through a team effort, these resources were selected based on consultant and National Program Office knowledge of what programs exist around the country and are organized into four categories: 1) language proficiency testing; 2) proficiency testing required for interpreter training programs; 3) proprietary proficiency tests offered by commercial language agencies; and 4) testing options to assess interpreter skills beyond language proficiency. This report also discusses the conditions that promote the growing use of interpreters in health care, some of the scales being used to assess language proficiency, and various approaches to the assessment of interpreter competence.[1] In health care, the term "health interpreter" or "medical interpreter" are used interchangeable to describe any individual whose primary role is interpreting, but it may also be used to include those who do so only intermittently or ad hoc. Dual role interpreters is used to connote bilingual staff that interpret as part of regular assigned duties while ad hoc interpreting is used to distinguish those who interpret intermittently or ad hoc, generally family, friends or others recruited on the spot.

Definitions of Language Proficiency Vary

There is no nationally accepted definition, although organizations such as Teachers of English to Speakers of Other Languages (TESOL) have developed standards that are widely accepted, as have the Enhanced Assessment Consortia and individual states.

- Language proficiency, Kenji Hakuta, Ph.D., Stanford professor and leader in the field of bilingual acquisition, argues must include both social language skills and academic language skills; must include both productive (writing, speaking) and receptive (reading, listening) modes; and must include fluency as well as knowledge of specific components, such as grammar.[2] The construct of language proficiency is difficult to define.
- Language proficiency is described as the ability to function in a situation that is defined by specific cognitive and linguistic demands, to a level of performance indicated by either objective criteria or normative standards.[3]
- Language proficiency and terms of communicative competence is defined to include four basic components: 1) grammatical competence, 2) sociolinguistic competence, 3) discourse competence, and 4) strategic competence.[4]
- Language proficiency for interpreting, in the past decade, has been linked to knowledge of specific context (e.g., school, clinic, hospital) and integrative skills to achieve communicative competence.[5]

Language services in health care generally have advanced with the rapid increase of limited English proficiency (LEP) speakers in the United States, which is important because growing research evidence suggests that patients with communication barriers less often access preventive health care, such as cancer screenings, and instead use more expensive health services like emergency department care. In addition, the promotion of national interpreter standards of practice as well as language proficiency testing as a prerequisite for interpreter training have contributed to progress in the testing field. The next section summarizes the progress made in improving language services in health care on both national and international fronts, the emphasis on language proficiency testing that has emerged, and how the field of testing has evolved over the past five years. Special attention is paid to heritage speakers as interpreters and the tools available to assess their language proficiency. Individuals that learn the language of their family at home, often as infants and children, but receive their formal language education in English are considered heritage speakers. Over time, English often becomes their dominant language – resulting in a high variability of proficiency in their heritage language.

Hablamos Juntos
We speak together.

SECTION 1

Overview Of Progress

Twenty-first-century economic trends and borderless trade are associated with large-scale population shifts worldwide. Between 2000 and 2005, the number of people in the United States that speak a language other than English increased by more than seven million, bringing the total to 52 million. Over the same time period, the LEP population grew to 23 million, an increase of almost 4 million. In every industry (e.g. government, security, business, education, etc.) these demographic changes have increased the demand for interpreters. In health care in particular, cumulative and consistent research findings point to a causal relationship between limited English proficiency and poor health outcomes. Recommendations point to the use of trained and tested interpreters as standard practice for overcoming language barriers between health care providers and their LEP patients.[6] As a result, concerns about interpreting competence have gained prominence and prompted demand for better tools to assess language proficiency specifically, and interpreting competence more generally. Recent progress to address interpreting competence shows a progression of government and accrediting body responses, which frame advances in assuring interpreter quality.

At the national level, various private and public initiatives have brought attention to the pressing need of addressing language barriers. In 2001, the U.S. Department of Health and Human Services Office of Minority Health (OMH) released the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS).[7] Of the 14 standards recommended, four are rooted in regulatory requirements that impose responsibility on health care organizations to assure equal access to LEP patients. More specifically, CLAS standards include requirements to assess the language proficiency of interpreters, as well as other bilingual staff and providers who communicate directly with LEP patients (CLAS 5).

These early policy initiatives have been reinforced by a growing body of literature linking language barriers to disparities in health outcomes.

The Office for Civil Rights (OCR), charged with the enforcement of Title VI of the Civil Rights Act of 1964, offers technical assistance to organizations that serve LEP individuals. OCR recently implemented the *Effective Communication in Hospitals Initiative,* designed to provide hospitals with the information and resources needed to meet the challenges of communicating effectively with persons who speak limited or no English, or who are deaf or hard of hearing. OCR's national resources include materials and tools developed by various interpreter organizations and associations over the past few years.[8]

These early policy initiatives have been reinforced by a growing body of literature linking language barriers to disparities in health outcomes. In 2002, the pivotal Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Health Disparities,* stressed the importance of effective communication and the need to be patient-centered as a means of establishing equity in health outcomes.[6] According to the report, professional interpreter services should be the standard of care where language differences pose barriers to care. The implications of poor communication in health care were further emphasized two years later by another IOM report on health literacy – *Health Literacy: A Prescription to End Confusion.* This second report concluded that nearly 90 million American adults have difficulty understanding and acting upon health information. Even when language barriers are not present, health care communication is a challenge, underscoring the increased risks for patients dependent on interpreters for health-related communication.[9]

At the industry level, various efforts are underway to respond to the government and IOM recommendations. Health care organizations accredited by The Joint Commission (formerly Joint Commission on the Accreditation of Healthcare Organizations) already have several standards that together emphasize responsibility in meeting the language and cultural needs of patients and ensuring effective communication through the provision of

linguistic services, both oral and written.[10] In 2006, an additional requirement to collect language preference data was added. Further, with financial support from The California Endowment, a California-based foundation, the Joint Commission launched a national study to learn how hospitals are meeting existing standards related to the cultural and language needs of patients. The *Hospitals, Language and Culture* project has focused its initial work on language barriers specifically.

Hablamos Juntos, funded by the Robert Wood Johnson Foundation, was established to develop practical ways of increasing the availability and quality of language services. The first national initiative of its scale to work directly with health care organizations, the program invested $10 million – one million dollars each in ten demonstration sites around the country – that helped shine a light on the challenges of developing practical solutions to overcome language barriers. Health care organizations, health plans, hospitals, and health systems, as well as not-for-profit community organizations, participating in the two-year *Hablamos Juntos* demonstrations came to understand that clear communication is essential for patients to receive safe, high-quality health care services. However, the seemingly basic step of hiring interpreters meant improvising minimum qualifications and assessment tools. In the end, the challenges encountered by the demonstration helped to show that it would take more than money to assure quality language services in health care. They learned first-hand that the field of language services needed to be further developed, with *Hablamos Juntos* teams' adopting the metaphor that they were "building an airplane as they were flying it." The teams found that they had to build programs virtually from the ground up. They participated in a pilot project to assess language proficiency and created local programs to train their interpreters – relying on the experience of leaders in these fields.

The experience of the *Hablamos Juntos* demonstration sites contributed to an increased awareness of the challenges that health care organizations face, including the need for both staff and development investments to create practical solutions and grow response capacity. The work of the demonstration sites informed recommendations included in several "how-to" guidebooks published in recent years to help health organizations address language barriers.[11,12,13] These guidebooks speak to the importance of language access services and provide background information and guidance for assuring patient language needs, along with providing organizational support for planning and implementation. They also address translation, signage/way-finding and community involvement.

Together, these national and industry-level activities have raised the profile of language services, positioning them as essential to the effectiveness of health care communication for millions of patients unable to speak English well. Collectively, initiatives and resources developed through philanthropic funders such as The California Endowment, the Commonwealth Fund and the Robert Wood Johnson Foundation, have helped to bring attention to the link between language proficiency and interpreting quality, as well as the potential effects on health outcomes, which reinforces the importance of assessing the language proficiency of bilinguals in health care settings. The next section discusses the evolutionary factors contributing to the progress of language proficiency testing options.

Types of Foreign Language Speakers

Native Speakers – People, who grow up speaking the language of their society, obtain most of their education there and conduct most of their life-work in that language. In essence, it is their dominant language and the one in which they feel most comfortable speaking and/or writing.

Heritage Speakers – People who learn their ethnic language at home as children but raised in a country that has a different dominant language (e.g., Children of Spanish-speaking immigrants who are born and raised in the U.S. and learn Spanish at home but are taught via English in school). Typically, heritage speakers have little or no formal education in their ethnic language. Often, their second language (e.g., English) becomes their dominant language, and they demonstrate variable degrees of language ability in their first, heritage language. Heritage speakers can range from English-dominant individuals with no reading and writing ability in the heritage language, to those with some limited reading and writing skills in their heritage language.[14]

Interpreter Services – An Evolving Concept

SECTION 2

Interpreting in health is an emerging and evolving field. The International Medical Interpreter Association (IMIA), formerly known as the Massachusetts Medical Interpreters Association (MMIA), is a newly formed umbrella organization that promotes several standards documents that demonstrate a convergence on minimum standards for interpreters. MMIA adopted *Medical Interpreting Standards of Practice* in 1995, which suggested interpreters in health care must not only be fluent in both the source and target languages, but must also have the skills and subject knowledge to be able to comprehend and re-express the message at the pace of normal speech.

ASTM International (a volunteer international standards-setting agency) produced the *Standard Guide for Language Interpretation Services (Standards F2089-01)* in 2001, defining minimum qualifications for language interpreters in a variety of settings, including health care.[15] It is the second organization to identify oral fluency as an important skill for professional interpreters. The minimum qualifications for interpreters, updated in 2007, include excellent command of both languages, interpreting skills (e.g. attention, analytical thinking, memory, language transfer, note taking) and knowledge of the subject matter (e.g. medical terminology and constructs). Additional considerations include clearly-delineated responsibilities between the organization employing interpreters and the clients for whom they provide services, technological requirements, and elements common to all interpretation events (e.g. mode of interpretation, onsite or remote interpretation, and time considerations). The new standards also contain more than two dozen terms related to interpretation, with which everyone who interprets or oversees interpreting in a health care setting should be familiar.

NCIHC is now actively promoting a national certification process for interpreting in health settings, in collaboration with state and national associations representing working interpreters, field experts and language agencies.

In 2001, the National Council on Interpreting in Health Care (NCIHC) published *A Guide to Initial Assessment of Interpreter Qualifications,* echoing the need to assess the language proficiency of not only interpreters, but also bilingual health care staff and providers who communicate directly with patients.[16] The guide supports the position that "…ideally, proficiency [should be] verified with formal testing." Building on the pioneering work of state and regional organizations, specifically the *California Standards of Practice for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention* developed by the California Healthcare Interpreting Association (CHIA) and the IMIA standards mentioned earlier, NCIHC produced *A National Code of Ethics for Interpreters in Health Care* in 2004[17] and proposed *National Standards of Practice for Interpreters in Health Care* in 2005.[18] The former document includes guidelines for making judgments about acceptable and desirable behavior in a given context or in a particular relationship, while the latter deals with the practical concerns of an interpreter's duties. Neither address interpreter skills specifically, but these national and international efforts are part of a growing call for the development of national standards for interpreter services. In fact, NCIHC is now actively promoting a national certification process for interpreting in health settings, in collaboration with state and national associations representing working interpreters, field experts and language agencies.[19]

Prior to the launch of *Hablamos Juntos* in 2001, Wirthlin Worldwide administered two surveys to learn how language barriers affect the quality of health care given to Spanish-speaking patients with little or no English proficiency: one that targeted Spanish-speaking Latinos and the other that targeted health care providers

practicing in a variety of settings and medical specialties. One of the key findings resulting from the survey of Latinos is that while interpreters made communication easier, many patients were concerned about using interpreters with poor or limited Spanish language skills.

This question of varying language proficiency was also explored with leaders in the interpreting field via expert interviews conducted by *Hablamos Juntos*. Wide variability of interpreter quality was identified as a chief concern among those interviewed and thought to be the result of the common practice of drawing interpreters from immigrant communities, also referred to as heritage communities. Language experts in the demonstration locations as well as those doing research on interpreting in health settings confirmed a wide range of language proficiency characteristics of heritage language speakers.

Many health organizations struggle to determine whether their interpreter workforce is sufficiently skilled. While visiting health care organizations across the country to select demonstration sites for *Hablamos Juntos*, program leaders found health organizations used a variety of locally-devised means of assessing the language proficiency of interpreters, including informal measures such as soliciting the opinions of staff or trusted heritage community members. This of course is quite different from other fields like business and academia, where reliable, validated language proficiency tests developed for these settings are frequently used.

Nevertheless, with the availability of new testing tools, more and more health care organizations are beginning to administer language proficiency assessments for the new (and even existing) employees. In addition, many interpreter training programs now require some level of language assessment before admission. In line with this trend are a growing number of tests available to assess language proficiency in general; however, most of these tests are not standardized. In fact, none of the testing options found and included in this report specific to health settings has been formally validated or standardized nationally. Further, finding that someone demonstrates a high level of language proficiency does not mean (s)he will make a good interpreter because other skills are required beyond language proficiency. Without a reliable means of gauging interpreting competence, quality of care and patient safety are at risk for patients with LEP.

The Average Interpreter

Although published data is lacking, estimates vary that anywhere from 44 – 60 percent of the bilinguals employed in hospitals, clinics and medical offices across the nation are heritage speakers. From those tested during the pilot, the *Hablamos Juntos* team found that the average health interpreter in the demonstrations was a U.S.-born woman between the ages of 31 and 40 who had a relatively short tenure as a health interpreter. Nearly three in four, had worked as a health interpreter for five years or less. More than half reported having received no interpreter training, and nearly half reported learning their native language at home, not in school. The pilot project also showed that those working as interpreters were interested in being tested, and readily sought to know how well they were doing.

Hablamos Juntos
We speak together.

SECTION 3

Approaches to Language Testing

Measures of language proficiency tend to compare language learner progress against native speakers (those who grew up speaking the language of their society, obtaining most of their education there and conducted most of their life-work in that language). Moreover, most are designed to test an individual's proficiency in cases where the test-taker learned the language in a classroom setting. However, language learning among heritage speakers is different than that of classroom-trained language learners. For this reason, we recommend taking a close look at the *type* of language proficiency tests available and understanding for *whom* they were designed before choosing one right for your target audience.

Testing basic language skills can range from informal to formal. An informal approach could be an unstructured oral conversational interview between the candidate and a rater who speaks both of the candidate's languages. A more formal approach might involve a semi-structured interview between the candidate and rater with clear scoring criteria.[11] Most guidelines for oral language proficiency assessment can be traced back 40 years to U.S. government training programs using the Interagency Language Roundtable (ILR) and American Council for the Teaching of Foreign Languages (ACTFL) tests called *Oral Proficiency Interviews* (OPIs).

Using an internationally-recognized scale of language proficiency, these tests are used to measure progress in language learning and general speaking proficiency based on formal academic preparation for purposes

How is language tested?

The American Council on the Teaching of Foreign Languages (ACTFL) is a national organization dedicated to the improvement and expansion of the teaching and learning of foreign languages. The ACTFL guidelines for speaking have four main levels: Novice, Intermediate, Advanced and Superior – with low, mid and high subdivisions in each level, except Superior. The guidelines (most recently revised in 1999) are used to describe an individual's proficiency level. Listening, speaking, reading and writing are each scored and receive a rating from Novice at the low end to Superior at the high end. An official ACTFL oral proficiency certificate is issued with the identified proficiency level.

Oral Proficiency Interview (OPI) – The ACTFL OPI is a standardized procedure for the global assessment of functional speaking ability. The OPI test was initially designed for government agencies (e.g. Peace Corps, Foreign Service) but is now commonly used for student placement in language programs, academic entrance to institutions of higher learning, hiring and professional advancement in academic institutions and businesses; while Test of English as a Foreign Language (TOEFL) is used as an exit exam to determine progress after foreign language training.[20] Official ACTFL OPIs can currently be administered in the following languages: Albanian, Arabic, Cambodian, Cantonese, Croatian, Czech, Dutch, Egyptian, English, Farsi, Flemish, French, German, Greek, Haitian Creole, Hebrew, Hindi, Hmong, Indonesian, Italian, Japanese, Khmer, Korean, Lao, Malay, Mandarin Chinese, Norwegian, Polish, Portuguese, Punjabi, Russian, Serbian, Slovak, Spanish, Swahili, Tagalog, Thai, Ukrainian, Urdu and Vietnamese. Institution specific tests are also available for placement into ESL courses.

Simulated Oral Proficiency Interview (SOPI) – The ACTFL SOPI is a computerized version of the ACTFL OPI using a performance-based audio-taped speaking test similar in structure to the OPI. It is used to measure speaking proficiency and relies on a test booklet and audio-taped instructions, which makes it is easier to administer because it does not require a trained tester to conduct the interview in-person, yet still strives to be as similar to the OPI as possible. Different levels of the test can be produced by administering only the first part of the interview. This assessment is used by a variety of colleges and universities, and research has shown results to be consistent with the OPI. The SOPI is currently available in Arabic, Chinese, French, German, Hausa, Hebrew, Indonesian, Japanese, Portuguese, Russian and Spanish.[21]

NOTE: *Second language and health interpreting researchers have reported that the ACTFL OPI (both the face-to-face and audio-taped SOPI version) does not accurately measure the language proficiency of heritage-speaking bilinguals in health care settings because of their native-speaker-based norms.[22,23,24,26] Heritage speakers without the benefit of formal education in their heritage language may not use the proper forms of grammar or sentence structures that an educated native speaker would use, and thus, may be unfairly penalized by the format of these tests. Before they become accepted as a standard form of assessment in health care organizations and interpreter training programs additional research is needed to develop tests that do not disadvantage the heritage speakers.*

of student placement, academic entrance, hiring and professional advancement in academic institutions, government agencies (e.g. Foreign Service) and businesses. The tests measure a person's ability to perform language tasks in comparison to native speakers and are designed to be interactive, 20- to 30-minute, face-to-face or telephone interviews conducted by certified ACTFL interviewers. They are typically rated by two certified testers and follow a detailed protocol. In addition, a computerized (simulated) version of the oral proficiency exam is available.

Although the ACTFL guidelines are widely used to describe the oral performance of speakers in academic settings, questions have arisen about their validity, particularly for testing heritage speakers.[25] In addition, there is a lack of empirical evidence supporting the scale performance descriptions. Experts in both applied linguistics and interpretation are now challenging its validity, raising the concern that heritage speakers who lack formal education may be unfairly penalized by the format and nature of the OPI. As a result, its appropriateness for health care organizations and interpreter training programs is questionable because it typically does not measure communicative competence in the context of a health care setting nor is suitable for the typical heritage speaker.[26] It is possible for interviewers to tailor their interview and include role plays that relate to the medical field. However, this is typically not the case. Tests that use a task-based assessment would be more appropriate.[27]

In summary, most language proficiency tests, particularly those rooted in government foreign language training programs, are not designed to assess bilingual individuals who have not received formal language education in the two languages. Nor are they specifically designed for the unique nature of health care interpreting. Language testing options for native language speakers generally follow the ACTFL design, while those for heritage speakers may place emphasis on language assessment combined with language development options.

The next section includes a list of 35 resources (organized into four categories) available today that can assess interpreter qualifications.

Measuring Language Proficiency: What should be assessed?

ASTM International has defined the spectrum of speaking and language proficiency along a five-point scale, with 0 being the lowest (Survival Proficiency) and 5 being the highest (Educated Native Proficiency). Whether a staff person is functioning at a minimal level, a limited level, or a fully functional level is not as important as knowing whether or not this level of functioning is appropriate in light of his/her duties (e.g., an individual's use of minimal skills for basic conversational interpreting versus using that same person to inform and guide a complex medical procedure requiring informed consent). In other words, functioning at a minimal level of proficiency may be enough for a staff person whose main duties involve greeting patients or scheduling appointments. On the contrary, a medical assistant who is proficient at the General Functional Proficiency level will be able to not only interpret patient-provider communication accurately, but also clarify points made, understand intended meaning, and make sense of any challenges presented.

Language Testing Options – Resource List

SECTION 4

Knowing the type of bilingual speaker a staff person may be (native, non-native or heritage) and assessing their language proficiency are essential in determining the level of interpreting the person is capable of and the responsibility they can be assigned. Several language proficiency tests have been developed and validated for use as a screening tool for heritage speakers. They are most often used to determine admissions into interpreter training programs or prior to employment as an interpreter. The prevalence of specific types of language testing options is much greater today than five years ago. Thirty-five testing options are catalogued into the following four sections:

- **Section A:** Includes a list of six organizations whose language proficiency testing options are geared toward different types of speakers (e.g. non-native vs. heritage). The first five options in this section are based on the ACTFL guidelines (appropriate for non-native speakers), and the last one is based on the Language and Interpreter Skills Assessment (L&ISA) work, which targets heritage speakers.
- **Section B:** Includes 17 options linked to interpreter training of some kind; they may have been referenced in various publications, presented at conferences or identified online. Community not-for-profit organizations and university programs are also listed here.
- **Section C:** Includes six commercial testing options, all of which are proprietary and available to the public with limited information (unless you are a subscriber to their services).
- **Section D:** Includes six tests to assess interpreter readiness – specifically skills testing.

This resource list was complied to assist health care providers identify language proficiency testing options for their interpreting staff with an emphasis on heritage speakers. It may also serve as a starting point for further inquiry about tests offered. Information provided for all resources include: the name of the organization, the city and state of the main office, general testing information, testing fees, the time it takes to complete the identified assessments and contact information (name, phone, email and website address, when available). Even though all of these organizations are available to health care organizations, most test administration is onsite. The programs listed do not repre-

Seeking Language Testing Options - What should I ask?

1. Can the test be taken from any **location** or over the telephone? *Tests can be administered in-person, over the telephone or via internet/computer.*
2. How much does the test **cost**? *Costs range from as low as free to as high as hundreds of dollars.*
3. What is the **objective of the test** or why was the test developed? *Test objectives may focus on linguistic competency, training program readiness and/or academic performance.*
4. What **skills** are assessed or what does the test attempt to determine? *Tests can assess linguistic and cognitive processing skills such as listening, understanding, retaining and interpreting information.*
5. How much **time** does the assessment take? *Times may vary 10 minutes up to half a day.*
6. What is the **process** the test taker will experience? *Tests may consist of paper/pencil processes, be computer-based, conducted in person or by phone, may involve surveys or questionnaires, may be tape recorded, etc.*
7. How are proficiency testing **results** reported? *Results may be reported in various forms (e.g. certificate, email confirmation, letter, etc.). It is important to understand what a certificate means – is it a measure of time completion, program requirement fulfillment, etc. It is important to understand what a final score means – is it an average, is it measured against a scale, does it correspond to a "level" of some kind. Caution: regardless of what form results may come in - certificates and scores may not be measures or designations of competency and skill.*
8. **Who** can receive test results? *Some test scores/results are only shared with the employer and not the test taker; others only give results to the test taker and not to the employer.*

sent an exhaustive list of resources, but rather a national sampling illustrating the significant increase in the number of language proficiency tests compared to *Hablamos Juntos'* initial 2002 report. As before, but to a greater extent, the biggest limitations to this update were due to a growing number of proprietary tests offered by language services companies, available only to health care organizations under contract.

Note: *Those language companies contacted for this update but would not share information about the development or validation of tests used were not included in this report.*

A. Language Testing Options

Organization:	Center for Applied Linguistics (CAL)		> Washington, DC
Test Information:	ACTFL Oral Proficiency Interview & Telephone Assessment		
Fee:	$110.00	**Time:**	45 minutes
Contact:	1.800.551.3709		> www.cal.org
Organization:	Center for Applied Linguistics (CAL)		> Washington, DC
Test Information:	ACTFL Simulated Oral Proficiency Interview (SOPI) & Telephone Assessment		
Fee:	$134.00	**Time:**	45 minutes
Contact:	1.800.551.3709		> www.cal.org
Organization:	Language Testing International (LTI)		> White Plains, NY
Test Information:	ACTFL Oral Language Proficiency Interview, Telephone or Face-to-Face Assessments Online applications accepted		
Fee:	$134.00	**Time:**	10 – 30 minutes
Contact:	Helen Hamlyn – 1.800.486.8444		> www.languagetesting.com
Organization:	Language Learning Enterprises, Inc.		> Washington, DC
Test Information:	ACTFL Oral Language Proficiency Interview Online applications accepted		
Fee:	$99.00	**Time:**	30 minutes
Contact:	1.888.464.8553		> www.lle-inc.com/assessment.html
Organization:	Bilingual Services Program, State Personnel Board		> Sacramento, CA
Test Information:	ACTFL Oral Language Proficiency (written English and Cantonese, Japanese, Korean, Vietnamese, or Spanish multiple choice) – for Medical Interpreters		
Fee:	$325.00	**Time:**	4 hours
Contact:	1.916.653.7625		> bilingual@spbca.gov
Organization:	Healthy House Within a MATCH Coalition		> Merced, CA
Test Information:	Language Proficiency Test in Spanish, English and Hmong. Literacy component included.		
Fee:	$50.00	**Time:**	25 minutes
Contact:	Tatiana Vizcaíno-Stewart – 209.724.0102		> tatiana@healthyhousemerced.org

B. Language Testing Options linked to Training

Organization:	Asian Health Services		> Oakland, CA
Test Information:	Oral Interpreting Skills Test – Available with or without training program. Pre-screening required for training. English and Spanish		
Fee:	$125.00	**Time:**	45 minutes
Contact:	1.510.986.1153		> www.ahschc.org
Organization:	Boston University *Interpreter Programs*		> Boston, MA
Test Information:	Audio screening tool – listening to short bilingual statements and repeating the same text into an audiotape. English and Spanish		
Fee:	$50.00* (Applied to training if passing score)	**Time:**	Varies
Contact:	Karen Murphy – 1.866.633.9370		> http://profesional.bu.edu
Organization:	Cross Cultural Communication Systems, Inc. *Art of Medical Interpretation*		> Wobrun, ME
Test Information:	Pre-screening examination for training. Available in English and Spanish		
Fee:	$30.00	**Time:**	30 – 45 minutes
Contact:	Aida Cases – 1.888.678.2227 Ext. 121		> www.cccsorg.com
Organization:	Cross Cultural Health Care Program *Bridging the Gap*		> Seattle, WA
Test Information:	Telephonic language proficiency assessment done by Pacific Interpreters.		
Fee:	$70.00* (Applied to training if passing score)	**Time:**	15 – 20 minutes
Contact:	Jennifer Calhoun – 1.206.860.0329		> Jennifer@xculture.org
Organization:	CultureSmart		> Quincy, NH
Test Information:	Language proficiency and fluency test. Training pre-assessment test required. Competencies assessed: ability to carry on a conversation in both languages, ability to interpret specific terms from one language to another and understanding of medical terms and specialized topics (if applicable). Available in 20 languages.		
Fee:	$50.00 - $100.00** (Depends on language and contracted training services)	**Time:**	20 – 25 minutes
Contact:	Greg Figaro – 1.617.890.1111		> greg@culturesmart.org
Organization:	Du Page Federation on Human Services Reform Language Access Resource Center		> Villa Park, IL
Test Information:	Language screening assessment. Written assessment (essay and sight translation). Oral proficiency test – open-ended questions/dialogue. English and Spanish		
Fee:	$125.00	**Time:**	2 hours
Contact:	Linda Coronado – 1.630.782.7544		> lcoronado@dupagefederation.org

Organization:	Healthcare Interpreter Certificate Program Georgia Perimeter College		> Clarkston, GA
Test Information:	Mandatory language proficiency assessment prior to training course. English and Spanish		
Fee:	$75.00	**Time:**	2 hours
Contact:	Fran Mohr – 1.678.891.3016		> www.gpc.edu
Organization:	Interpreters and Translators, Inc.		> Manchester, CT
Test Information:	Language assessments evaluate the language skills of staff interpreters. Specially designed and pre-recorded medical statements and questions. Tests are designed to help administrators assess whether staff interpreters command of both English and their native language to interpret in a medical setting. Online written and oral assessments		
Fee:	Varies	**Time:**	45 – 75 minutes
Contact:	Francesco Pagano – 1.800.648.0686		> info@ititranslates.com
Organization:	Massachusetts Area Health Education Center		> Brockton, MA
Test Information:	Language Assessment – Oral proficiency in English and target language. Assesses ability to read and write at a basic level in target language.		
Fee:	$50.00	**Time:**	2 hours
Contact:	Pierre Jerome – 1.508.583.2250		> apierrejerome@hcsm.com
Organization:	New York University – School of Medicine		> New York, NY
Test Information:	Assessment of bilingual and interpreting aptitude mandatory. Literacy assessment - Basic 8th grade reading comprehension. Oral bilingual interview. Demonstrate ability to understand and speak the target language in a colloquial register. Assessment of basic medical terminology.		
Fee:	$100.00	**Time:**	30 minutes
Contact:	Javier González – 1.202.263.8242		> gonzac05@med.nyu.edu
Organization:	Northern Virginia Area Health Education Center		> Alexandria, VA
Test Information:	Internally developed and copyrighted language proficiency test – currently being validated. Reading ability assessed. Offers express phone language proficiency test. English and Spanish		
Fee:	$50.00	**Time:**	2 hours
Contact:	Adelya Carlson – 1.703.549.7060		> acarlson@nvahec.org
Organization:	Northern Virginia Area Health Education Center *Interpreting in Health and Community Settings*		> Alexandria, VA
Test Information:	Language Proficiency Test. Oral and written components. English, Spanish, Vietnamese, Arabic		
Fee:	$50.00	**Time:**	2 hours
Contact:	Rosemary Rodriguez – 1.804.355.4559		> rrodriguez@richmonddiocese.org
Organization:	PALS for Health		> Los Angeles, CA
Test Information:	Language proficiency test. General knowledge, grammar, vocabulary, medical terminology, translation and interpretation. Training based on “Connecting Worlds Curriculum”. English, Spanish, Cantonese, Mandarin, Korean, Vietnamese, Khmer, Armenian.		
Fee:	$60.00	**Time:**	2.5 hours
Contact:	Susan K. Choi – 1.213.553.1827		> susanc@palsforhealth.org

Organization:	Southern New Hampshire Area Health Education Center		> Raymond, NH
Test Information:	Language Assessments – oral and written. This language assessment consists of: brief dictation in English; translation of English dictation into target language. Brief conversation in English and Interpretation from English to target language.		
Fee:	$75.00	**Time:**	30 minutes
Contact:	Florentina Dinu – 1.603.895.1514		> fgdinu@snhahec.org
Organization:	University of Arizona – National Center for Interpretation		> Tucson, AZ
Test Information:	Medical Interpreter Competency Exam. Participant self-assessment of Spanish skills. Those with less proficient language skills are advised not to register. Two-part testing process. English and Spanish		
Fee:	$225.00	**Time:**	60 minutes
Contact:	Roseann Dueñas González – 1.520.621.3615		> ncitrp@u.arizona.edu
Organization:	University of Arkansas		> Little Rock, AR
Test Information:	Language screening assessment or medical interpreting assessment. Written and oral proficiency assessment		
Fee:	$10.00 – $15.00	**Time:**	30 – 60 minutes
Contact:	Angelina Levitskaya – 1.501.686.6556		> levitskayaangelinag@uama.edu
Organization:	University of Minnesota *Certificate Program in Translation and Interpreting*		> Minneapolis, MN
Test Information:	LTI Oral Proficiency Interview *(Must achieve a certain level before certificate is provided after training)*		
Fee:	$140.00	**Time:**	30 minutes
Contact:	Bruce Downing, PhD – 1.612.624.4055		> www.cce.umn.edu

C. Commercial Testing Options

Organization:	Berlitz		> Princeton, NJ
Test Information:	Provides customized tests for language assessments conducted by phone. Tests are standardized to the Common European Framework of Reference (CEF). Assess oral proficiency only (speaking and listening) or be combined with literacy assessment (reading and writing). Several of the tests are available online, and others are conducted by trained Berlitz raters by telephone.		
Fee:	Varies	**Time:**	20 – 45 minutes
Contact:	Kim Dillon-Williams – 1.601.497.6571		> kim.dillan-williams@berlitz.us
Organization:	CyraCom		> Tucson, AZ
Test Information:	Uses two different language proficiency assessments – internally and externally. The tools are proprietary and informed by experiences and expertise, (from tools such as ACTFL), and draw from industry standards from groups such as IMIA, CHIA and NCIHC. The test does not assess literacy.		
Fee:	Available upon request	**Time:**	(external test) varies
Contact:	Bill Prenzno – 1.800.713.4950 Ext. 1698		> www.cyracom.com

Organization:	Fluency, Inc.		> Sacramento, CA
Test Information:	Collaborated with Avant Assessment of Eugene, OR, to develop an Internet-based language assessment (MITI) for Spanish-English interpreters to evaluate the linguistic abilities of prospective and practicing interpreters. The test is being piloted and is projected to be available by Spring 2008.		
Fee:	Available upon request	**Time:**	30 minutes
Contact:	Bill Glasser – 1.916.473.0100		> www.gofluently.com
Organization:	Language Line University		> Oakland, CA
Test Information:	Language assessments were internally developed after researching proficiency tests, ACTFL, TOEFL and others, as well as a well-documented test development process. Basic grammar, vocabulary and syntax, to determine an individual's linguistic skill. Designed to evaluate the level of proficiency in the test language.		
Fee:	Not available	**Time:**	20 – 30 minutes
Contact:	Janet Johnson – 1.877.351.6636		> jejohnson@languageline.com
Organization:	NetworkOmni Multilingual Communications		> West Lake Village, CA
Test Information:	Language screening test		
Fee:	Available upon request	**Time:**	20 – 30 minutes
Contact:	Irene Wei – 1.800.543.4244		> iwei@networkomni.com
Organization:	Pacific Interpreters		> Oakland, CA
Test Information:	Phone assessment that measures basic grammar and syntax, pronunciation, level of understanding, ability to maintain speaker's meaning, use of medical terminology and number of additions and repetitions. It also consists of a consecutive interpretation. The current test is in the process of revision. Measures oral fluency.		
Fee:	$85.00	**Time:**	20 – 30 minutes
Contact:	Tess McKenzie – 1.800.311.1232		> tessm@pacificinterpreters.com

D. Interpreter Skills Testing Options

Organization:	Healthy House		> Merced, CA
Test Information:	The Connecting Worlds - Interpreter Readiness Test measures ability to integrate interpreting skills in three of the six skill areas: linguistic, cognitive processing and setting-specific skills. Include interpreter skills pre-training assessment. Based on real-life interpreting encounters. Requires participant to accurately listen, understand, retain and interpret more complex information. The interactions between the health provider and patient are longer, and the medical terms are more challenging. The candidate must concentrate on processing and converting complex information for different kinds of speakers under pressure. The tests were developed in California by Claudia Angelelli, Ph.D., and a team of language and testing experts. Spanish, Hmong and Cantonese.		
Fee:	Available upon request.	**Time:**	25 – 45 minutes
Contact:	Tatiana Vizcaíno-Stewart – 209.724.0102		> tatiana@healthyhousemerced.org

Organization:	CyraCom Interpreting Skill Assessment > Tucson, AZ		
Test Information:	Reports that they have developed a method to assess the ability to integrate interpreting skills. The test measures a candidate's ability to interpret clinical encounters, knowledge of medical vocabulary and ability to convert messages from one language to another. 20 languages.		
Fee:	Available upon request.	**Time:**	20 – 40 minutes
Contact:	Bill Prenzno – 1.800.713.4950 Ext. 1698 > www.cyracom.com		
Organization:	Language Line University – Interpreter Skills Test > Oakland, CA		
Test Information:	Reports that they have developed an interpreter skill test to help determine if bilingual candidates have the professional skills and expertise needed to adequately serve the multilingual market. The interpreter skills test evaluates interpreter's competence with regard to language fluency in English and test language, interpreting skills, interpreting protocols, industry terminology and professionalism required for specific settings.		
Fee:	Available upon request.	**Time:**	
Contact:	1.877.351.6636 > LLU@languageline.com		
Organization:	Pacific Interpreters Interpreter Skills Assessment > Oakland, CA		
Test Information:	Reports that they have developed a Language and Interpreter Skills Assessment. Measures interpreter competency by assessing listening comprehension and ability to accurately interpret, ability to maintain register, number of additions/omissions made, proper intervention techniques, use of medical terminology, first-person interpreting, rules of conduct and interpreter ethics. An optional sight translation assessment is also available. The assessment consists of a consecutive interpretation of a medical role-playing scenario.		
Fee:	$165: assessment, $185: sight translation	**Time:**	30 – 45 minutes
Contact:	Gene Tonrey – 1.800.445.5684 > genet@pacificinterpreters.com		
Organization:	CultureSmart > Quincy, NH		
Test Information:	Reports that they have developed an Interpreting Skills Assessment to evaluate interpreted medical encounter in English and a second language between a health provider and a non-English- speaking patient. A written test evaluates knowledge in medical vocabulary; knowledge of common conditions, including symptoms; patient culture; ethics and standards of practice; medical procedures and specialties; knowledge of basic anatomy and translation of simple instructions.		
Fee:	Available upon request.	**Time:**	30 – 45 minutes
Contact:	Greg Figaro – 1.617.890.1111 > greg@culturesmart.org		
Organization:	University of Arizona National Center for Interpretation > Tucson, AZ		
Test Information:	Reports that a team of experts developed a medical interpreter competency examination. The test is based on authentic materials and patient/provider encounters. It assesses linguistic, socio-cultural, setting-specific and professional skills with consecutive interpreting and sight translation.		
Fee:	Available upon request.	**Time:**	25 minutes
Contact:	Roseann Dueñas González – 520.621.3615 > rgonzale@u.arizona.edu		

Hablamos Juntos
We speak together.

SECTION 5

Interpreter Readinesss: Testing, Training, and Skills Challenges

Interpreting in health care settings is a multifaceted process requiring a variety of skills to ensure that the intent and meaning of health care discussions are interpreted as accurately and completely as possible. The fundamental means of ensuring effective communication and quality health care for patients unable to speak English well is the improvement of the language proficiency assessment and training of health care interpreters. Language proficiency testing is becoming synonymous with interpreter services – one of the significant changes that has emerged over the past five years. Preparing and qualifying interpreters has evolved to encompass a combination of language proficiency testing, interpreter training followed by competency assessment, ongoing skill development, and annual performance evaluations. Consequently, interpreter training programs have proliferated nationwide, with many now requiring some form of language assessment prior to program admission.

Although increased attention to assessing interpreting competencies is generally a positive trend, there is a risk of invalid testing if the tasks interpreters perform in their jobs are not considered. Progress in interpreter assessment calls into question the importance of assessing the skills of anyone stepping into the role of interpreter – specifically dual role interpreters who are often used intermittently to interpret when trained interpreters are not available. The difference between full-time and dual role interpreters, those who interpret as part of other regularly assigned duties, have left open for debate whether the same training requirement should apply to both. Some experts in the field contend that holding bilingual employees who only occasionally interpret to the same standards as those who are full-time interpreters may be unreasonable, particularly depending upon the information to be interpreted. For example, basic language proficiency and improvised interpreting skills may be adequate for scheduling appointments or helping patients and their family's complete forms. That said, few would argue that those same basic skills are adequate for interpreting a discussion about a diagnosis or obtaining informed consent for a medical procedure.

Testing Challenges

Pressed by the immediate reality of a growing number of patients in the U.S. with limited English proficiency yet speaking a wide variety of languages, hospital systems and health care organizations around the country have begun using new approaches for interpreting services. The introduction of video health interpreting (VMI) as a more efficient means of providing language services has raised interest in assessing skills for the various forms in which interpreting takes place: in person, by telephone and now via videoconferencing. All three of these formats require interpreter skills and competencies unique to the communication venue, conditions that have yet to be explored. Some, frustrated by the lack of consistency and generic approach to testing, resort to developing their own assessment tests using a smorgasbord approach (i.e., taking bits and pieces from different sources). The result is unreliable and invalid tests, making it difficult to compare test results among organizations, identify inconsistencies and locate gaps. Testing can vary from a 20-minute informal conversation in Spanish (or in a variety of other non-English languages) to an extreme example that includes a five-page screening application requiring an essay in English and Spanish. Assessment is often followed by variable training that takes place over several hours, days or even months. Further, most tests listed in this resource have not been validated and/or tested for reliability.

Another challenge is test security. To be effective over time, the integrity of tests used to determine entry into a profession or domain of work must be vigorously protected to ensure their dependability. Similar tests required of other allied health professionals (e.g., Basic and Advanced Cardiac Life Support, or BCLS and ACLS) are often covered by test security agreements to ensure content is protected from unauthorized internal or external access and damage. Agreements between organizations can often be negotiated to facilitate ease of administration at multiple sites.

Training Challenges

Without national training standards to guide the field of health interpreting, programs will continue to differ considerably (e.g., required prerequisites, length of program, required competencies). Many interpreter training programs today focus on the development of only a few skill areas such as those that are setting-specific (e.g., medical terminology, health care system) or involve a particular set of professional skills (e.g., standards of

Notes from the Field

Hablamos Juntos – Lessons Learned: Pilot-testing the Language and Interpreter Skills Assessment (L&ISA) tools on a national scale.

In 2003, *Hablamos Juntos* demonstration sites set out to determine whether their interpreter workforce was sufficiently skilled by participating in a pilot project using computerized tests that assessed high, medium and low competency levels of Spanish.[28] In partnership with The California Endowment, *Hablamos Juntos* was able to establish 37 test centers in 10 states where these Language and Interpreting Skills Assessments could be administered via computer. There were several benefits to this approach, including: 1) it eliminated the need for printed test materials, 2) it allowed test security to be maintained, and 3) bilingual individuals from across the nation were able to access the assessments. Test center computers were registered with a central server and test results were automatically sent to the central server when completed. Trained raters working for the *Hablamos Juntos* scored each test result, as did trained raters at the local pilot sites.

Pilot Results

A total of 195 advanced and 267 Intermediate tests were administered during the pilot. Participants scored lowest using the advanced Language Proficiency tool, scoring on average 53 percent. Participants scored 50 percent or below in three of the five skill sets tested by this tool: listening comprehension, speaking and speaking with special emphasize on register (which is a skill not tested by the intermediate tool). For the advanced language proficiency test, the scores ranged from five to 30 (out of a possible 30). The distribution resembled a bell curve, with the majority of scores falling between 15 and 20. The mode (peak frequency) was a score of 15, where 64 of the participants scored.

Intermediate and AdvanceTests

The intermediate and advanced tests used activities typically performed by health interpreters drawn from an extensive collection of authentic data (392 interpreter-mediated medical encounters, 2001). Analysis of the authentic data found five Spanish language components essential to interpreting skills: 1) literacy, 2) reading comprehension, 3) listening comprehension, 4) language production, and 5) understanding of idiomatic and colloquial language. Each test measures a set of skills at different levels. The intermediate test assessed listening and reading comprehension, literacy in Spanish and speaking abilities, while the advanced proficiency test measured speaking using different registers (complexity of language used), as well as the skills listed above. Both of these tests focus on a variety of elements including: detail and sequences, social and cultural appropriateness, and general language ability. These tests were developed by Dr. Claudia Angelleli for the "Connecting Worlds Interpreter Training Curriculum," and pilot tested by Hablamos Juntos as part of the L&ISA pilot study.

Pilot results and training tools are available on the *Hablamos Juntos* website – www.hablamosjuntos.org or http://www.hablamosjuntos.org/resource_guide_portal/pdf/11LISA_Profile_Final.pdf.

practice, interpreting protocols, ethics). Consequently, training opportunities that develop essential cognitive and interpersonal skills are needed to develop core interpreting competencies. Additionally, data reported by several training organizations contacted during the development of this report indicate that even after training, participants struggled to competently demonstrate integrated interpreting skills. Clearly, a certificate program does not equal certification and a program may not necessarily be focused on developing the skills that can lead to interpreting competency and may not be an indicator of graduates' qualifications. Without national standards and a consensus on certification to delineate what is considered adequate for interpreter training as a floor, there is greater likelihood of interpreters with varying ability and skills; making it difficult to assess the quality of care LEP patients receive.

Interpreter Skills Challenges

Integrated interpreting skill tests simulate real-life interpreting situations in health care settings. A few of these tests have already been developed (see Section D of the Resource List), some of which are based on discourse analyses of authentic interpreted health care encounters. These assessments are designed for test takers to demonstrate their capabilities in six skill areas that form the set of skills used by competent interpreters: *linguistic, cognitive, interpersonal, socio-cultural, setting-specific and professional*. Each of these six areas consists of a variety of distinct sub-skills. For example, some of the skills in the *cognitive* area include listening ability, speed of comprehension, anticipation, analytical skills, memory, coherence, speed and clarity of expression, and ability to restate and convert messages. Areas such as *setting-specific and professional skill development* are more adequately supported by current training programs. However, the interpersonal and cognitive processing skills are less-developed areas in the health care interpreting field today, so they are among the areas most needing attention.

SECTION 6

Next Steps for Health Care Leaders

Health care communication is dynamic and challenging, even when all parties speak English fluently. In the case of LEP patients, interpreters serve as a bridge between health care professionals responsible for applying a highly technical, science based-field and a patient unable to speak English well. This distance between the two can often be worlds apart. Interpreters must have a foot in each world to comprehend and convey what one party needs to say to the other. Health care and its outcomes – pain and suffering, or health and wellness – hang in the balance.

This report provides an overview of the emerging field of health interpreting and an introduction to a sample of language testing options. Much progress has been made since the initial *Language Testing Options* report was published in 2002. The pivotal role of language proficiency in interpreting has become well known and increasingly valued, resulting in the enterprising business nature of Americans to kick in; evidenced by the number of testing options included in this report. Activism in this area has successfully led to the development of many resources for assessing the language and interpreting skills of health interpreters. Health care providers now have many more commercial and non-commercial language testing options than ever before. This is both a blessing and a curse, because the challenge now is in making a decision about which test to use.

Understanding how the field of testing is evolving may help in evaluating the various approaches now available., However, without consistency and standardization, the testing options included here merely represent a range of approaches to assessing language proficiency, with wide differences in testing goals and rating scales used. Hence, results are likely to be inconsistent and incomparable. That is why it is critical to ask questions about the expertise and background of the test developers, the testing objectives and the criteria used to assess language proficiency. A lack of test standards also calls into question the validity and reliability of these tests, which raises liability concerns when these tools are used to assess bilingual workers and the results form the basis for making employment decisions.

Even though independent innovation is critical in pioneering different ways to address this unmet need, a cautionary note remains – substantial work is still needed to lessen variability among testing options and to standardize these tools. Further unchecked test development may simply add unnecessary complexity. There is now a need to balance innovation with practical necessities driven by real-time needs. It is time for health care industry leaders to develop a neutral impartial body, akin to the National Quality Forum, to harvest advances in this area and to focus further development.

We are pleased to see this level of progress in the area of language proficiency testing, both in recognizing its importance and its development. In keeping with this momentum, our hope is that five years from now, standards for assuring the skills of interpreters exist across the industry and the promise of effective communication and safe quality health care for LEP patients is realized.

Hablamos Juntos
We speak together.

References

[1] Kalina S. (2000). "Interpreting Competence as a Basis and Goal for Teaching." *The Interpreters' Newsletter* 10, p. 3–32.

[2] Hakuta, K. (1985). "The relationship between degree of bilingualism and cognitive ability: A critical discussion of some new longitudinal data." In E. Nelson, ed. Children's Language v5. Hillsdale, N.J.: Erlbaum.

[3] Bialystok, E. (2001) "Bilingualism in Development: Language, Literacy and Cognition." Cambridge University Press. Cambridge, England.

[4] Canale, M., & Swain, M. (1980) "Theoretical bases of communicative approaches to second language teaching and testing." *Applied Linguistics,1, 1–47.*

[5] Canale, M. (1981) "On some theoretical frameworks for language proficiency." In C.Rivera (Ed.). *Language Proficiency and Academic Achievement*. Avon, England: Multilingual Matters, Ltd.

[6] Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson, Editors. (2003) "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. The National Academies Press.

[7] US Department of Health and Human Service Office of Minority Health (2001) "National Standards for Culturally and Linguistically Appropriate Services (CLAS)." Retrieved July 10, 2007 from Web site: http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

[8] US Office of Civil Rights (2008) "Hospital and Effective Communication Initiative" Web site: http://www.hhs.gov/ocr/hospitalcommunication.html

[9] Nielsen-Bohlman, L., Panzer AM, & Kindig DA., Editors (2004). "Health Literacy - A Prescription to End Confusion." Committee on Health Literacy, Board on Neuroscience and Behavioral Health, Institute of Medicine of The National Academies Press.

[10] The Joint Commission (2007). "Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care" The Division of Standards and Survey Methods.

[11] US Department of Health and Human Service Office of Minority Health (2005). "A Patient-Centered Guide to Implementing Language Access Services in Health Care Organizations." Retrieved January 10, 2008 from Web site: http://www.omhrc.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107

[12] America's Health Insurance Plans (2006). "Tools to Address Disparities in Health: Communications Resources to Close the Gap" Retrieved January 10, 2008 Web site: http://www.hiaa.org/content/default.aspx?bc=38|10760

[13] National Health Law Program (2006). "Language Services Resource Guide" Retrieved January 10, 2008 Web site: http://www.healthlaw.org/library/item.118835-Language_Services_Resource_Guide_for_Health_Care_Providers_Oct_06

[14] Valdès, G., Chàvez, C., Angelelli, C., Gonzalez, M., Garcìa, D., & Enright, K. (2000) "Bilingualism from another perspective: The case of young interpreters from immigrant communities." In A. Roca (Ed.), "Research on Spanish in the United States: Linguistic issues and challenges." pp42–81. Somerville, MA: Cascadilla Press.

[15] ASTM International (2007) "Standard Guide for Language Interpretation Services – F2089-01" Annual Book of ASTM Standards. West Conshohocken, Pennsylvania.

[16] National Council on Interpreting in Health Care (2001) "Guide to Initial Assessment of Interpreter Qualifications" Retrieved July 17, 2007 Web site: http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc

[17] National Council on Interpreting in Health Care (2004) "National Code of Ethics for Interpreters in Health Care" Retrieved July 17, 2007 Web site: http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc

[18] National Council on Interpreting in Health Care (2005) "National Standards of Practice for Interpreters in Health Care" Retrieved July 17, 2007 Web site: http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc

[19] National Council on Interpreting in Health Care (2007) "Are We Ready for National Certification of Health Care Interpreters? A Summary of NCIHC Open Forums" Retrieved February 17, 2008 Web site: http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc

[20] *Test of English as a Foreign Language(TOEFL) is the most common English proficiency exam for North American universities and colleges, also accepted by some British universities and employers as proof of English proficiency. http://esl.about.com/cs/teachertraining/a/a_abbr.htm*

[21] American Council on the Teaching of Foreign Languages (1999) "The ACTFL Proficiency Guidelines C Speaking (1986) – Reprinted 1999." ACTFL, Inc

[22] Savignon, S. (1985). "Evaluation of communicative competence: the ACTFL provisional proficiency guidelines." Modern Language Journal 69, 129–34.

[23] Valdes, G. (1998). "The construct of the near-native speaker in the foreign language profession: Perspectives on ideologies about language." ADFL Bulletin v29 n3, 4-8.

[24] Johnson, M. (2001) "The Art of Non-Conversation. A Reexamination of the Validity of the Oral Proficiency Interview." Yale University Press, New Haven, CT and London

[25] Valdes, G. & Figueroa, R (1994). "Bilingualism and Testing: A Special Case of Bias." Norwood, New Jersey: Ablex

[26] Lantolf, J. & Frawley, W. (1985) "Oral proficiency testing: A critical analysis," *Modern Language Journal* v69 n4: 337–45

[27] Brown, J., Hudson, T., Norris, J. & Bonk, W. (2002). "An Investigation of Second Language Task-Based Performance Assessments." NFLRC Monographs Distributed for the National Foreign Language Resource Center

[28] These language proficiency assessments were developed by Claudia Angelelli, Ph.D. and a team of experts. The panel of experts brought a wealth of knowledge and expertise including that of Dr. Angelelli (field of health care interpreting, assessment of interpreters' abilities and heritage speakers), Dr. Guadalupe Valdèz (Heritage speakers, Bilingualism and Testing); Dr. Edward Haertel (Design of Measurement Instruments, Item Analysis, Statistics); Dr. Mary Ann Lyman-Hager, (Language Testing, Testing and Technology); Professor Christian Degueldre (Translation and Interpreting; and Dr. Jean Turner (Language and Educational Linguistics- Language Testing Theory). All contributed to the development of the tests.

This Report was Produced by *Hablamos Juntos*

Hablamos Juntos (We Speak Together) is a national program of the Robert Wood Johnson Foundation (RWJF) whose main goal is reducing language barriers to health care for patients who speak or understand little or no English.


Hablamos
Juntos
We speak together.