



# THE NATIONAL BOARD OF CERTIFICATION FOR MEDICAL INTERPRETERS

## **Q&A of Meeting between National Board Representatives and the Health Disparities Working Group on Medical Interpreter Services from the Massachusetts Office of Health Equity on 11/18/09**

### **1. How does this Certification advance the industry and how will it affect those who have been interpreters for 20 years?**

- We consider the medical interpreter to be an integral part of the team of professionals caring for the patient, family, or community with LEP. The interpreter has critical tasks to perform, has a need for specific training, is as intimately involved as other professional team members in dealing with confidential and sensitive material, and thus needs a validated credential. Other team members expect all involved in these challenging tasks to have been trained, evaluated, and declared competent for the tasks at hand [e.g. the nurse, doctor, dietician, social worker, physical therapist, pastoral counselor, etc.]. Most team members are not concerned about the details of the “certification” process. We assume it to be a process widely accepted by experts and practitioners in the field and don’t generally expect it to be a controversial process. We see the certification process to be critical to mainstreaming the profession of medical interpretation. We see some resistance to this as having many origins, some part of which may be subconscious bias and stereotyping of the culturally/ethnically/racially diverse group of people performing this role.
- Medical interpreters who are working in the field will not be mandated to get certified. If their employer were to mandate it they would not be able to fire an interpreter who doesn’t pass but would have to come up with an improvement plan for that employee. Most important it is beneficial to patient safety for employers to know which interpreters are truly proficient and which are not. It is also beneficial to the interpreter to know what they need to do to keep up with new minimal professional standards for patient safety.

### **2. How will fees affect those trying to attain Certification?**

- Like many certification processes in medicine, new certification poses a potential threat to those who have been doing the work in a competent manner before certification was offered. Again by analogy with the medical profession, new certification typically begins with “grandfathering” procedures that allow those with expertise and competence demonstrated by experience in the field to sit for a certifying exam despite lack of formal training that will be the standard after an initial period. Exam fees are set at a level that just covers the expenses of testing and are not designed to produce profit. The field of medical interpretation was originally populated by many unpaid volunteers. This is a standard that seems out of date and potentially below our current standard of care. We expect the emerging profession to anticipate reasonable costs for training and certification. For example, interpreters are now investing in better and longer training in order to attain better work opportunities and be better prepared for this profession.

### **2. Who monitors those who are certified, how, and how often?**

- Again, by analogy with medical certification, periodic updates of some kind will be expected to maintain certification. This may ultimately require retesting. For now, we feel that proof of

ongoing activity and CEUs is the standard for recertification. We are following the Registry for Interpreters for the Deaf (RID) model which ASL certified interpreters use.

**3. What core competencies will the Certification measure?**

- Formal job analysis for the medical interpreter has been done. Certification testing has been specifically designed based on elements of understanding of medical terminology as well as more ethereal aspects of ethics, role definition, cultural competency, appreciation of expected standards, and demonstration of skills.

**4. Does the Certification apply specifically and solely to a particular set of standards? Which one(s)?**

- Several sets of standards have been developed over the years including early documents by the NCIHC [National Council on Interpretation in Health Care], CHIA [California Health Interpreters Association], and the IMIA [International Medical Interpreters Association]. There is considerable consensus and overlap as well as some evolution of standards. Through the job analysis, the certification process includes testing the knowledge and understanding of the points of view over these various sets of standards.

**5. Is it possible - or necessary - for a national Certification process to be monitored by a state government board?**

- We feel that state government can be very helpful in recognizing a national certification process, although we tend to recognize the function of a state typically as a licensing body that takes into account all background, training, and credentials before licensing a professional to work in their state. Recognition of national certification as a national competency standard will assist in it becoming the norm. It will also assist greatly with the standardization of language access at a national level. The Massachusetts Department of Health has been a known national leader in medical interpreter efforts and we hope that early adoption in this state will lead other states to follow. States may wish to pursue the process of licensing in the future and consider standards for reimbursement that relate to certification [e.g. separate Medicaid billing codes to be used when a covered patient is seen with the support of a professional, certified medical interpreter or inclusion of credentialed medical interpreters in accountable care organizations for global payments].
- We believe that a state government board should monitor that hospitals are compliant with minimal competency standards. Since hospitals engage with interpreters across states (remote interpreting) only a national competency standard can meet that need.

**6. What are the potential conflicts if a state Certification is also developed?**

- As noted above, we wish to mainstream the process of professionalization of the field of medical interpretation nationally due to the prevalence of remote interpreting. Ideally, one national standard and process for certification will emerge as it has for many other health-related professions. We feel that the appropriate role for the state is to support the independent process developed by practitioners and leaders in the field, to provide incentives for the certification process, and to validate the process of professionalization as it does for other disciplines whether by licensing standards, reimbursement requirements or differentials, or by other means. The National board is very interested in potential Board representation or support.

**7. How does this Certification process resolve tiering in quality of care across languages of lesser diffusion?**

- The debate over tiering and certification has been ongoing for over 20 years with particular concern about the potential for excluding competent interpreters, typically foreign-born, with limited formal education. The National Board kept the educational requirements as low as possible where the focus is on competency for patient safety reasons. There is also concern for quality assurance of minority languages, also called languages of lesser diffusion. The National Board has developed a program that categorizes three levels of language groups, each with a different credential and certification process. The first group represents the top 22 languages requested in the US based on language minority population. The second group incorporates the next 30 minority languages for which there are already existing national exams, and the third group are called new emerging languages and incorporate all languages and dialects not in the top 52 categories. The 3 tier system [CMI, QMI, and SMI] Certified, Qualified, and Screened Medical Interpreter, developed for the National Board of Certification for Medical Interpreters seems the best way to avoid exclusion while ensuring standards of competence. Interestingly, a very recently circulated review of standards for reimbursement in the profession has demonstrated fairly high educational levels for those now working in the field and responding to an IMIA survey.

#### **8. How do you suggest that reimbursement models reflect such tiers?**

- As noted above, reimbursement may eventually include an upgraded level and new billing codes used when a qualified interpreter has been used. It is not obvious that the level should be different for the different tiers of certification [CMI, QMI, and SMI]. While these are different credentials, they are all of equal value as these professionals will be receiving different credentials available to their language and yet will be credentialed by the same organization, the National Board. This process could promote standardized documentation of language minority status and accounting of methods used for addressing language barriers. This process in itself would be a powerful tool for documenting and addressing language-based disparities in our state and could serve as a national model for other locations and third party payers.
- Certification specifies only the 'Minimal' level of competency for the profession. The National Board is not promoting lower levels for non-clinical encounters, as that would not encompass medical interpreting. However, in the future advanced certification levels are planned for interpreters with higher skills such as mental health specializations or the ability to provide simultaneous interpreting skills. Reimbursement officials will have to decide if they would wish to reimburse non-certified medical interpreters.
- Medical interpreters interpret in the medical setting in clinical and sometimes non-clinical situations. The vast majority of interpretations are of a clinical nature in medical settings. The National Board is not an oversight body for non-medical interpreting.

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