Comments to the SSB 5304 Workgroup regarding Healthcare Interpreter Certification

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Statement of potential conflict of interest

I am a national consultant on language access in health care with over 30 years of experience in this field. I am participating in this workgroup as a volunteer and have no vested financial interest in the outcome. I do, however, provide training for healthcare interpreters and could potentially benefit if more training were required of interpreters seeking certification.

Statement of purpose

These recommendations will address four basic questions posed to the workgroup under SSB 5304:

1. Recommendations regarding healthcare interpreter certification process.
2. Recommendations aimed at increasing the availability of language services in rural areas and for languages of lesser demand.
3. Recommendations regarding the retention of interpreters.
4. Recommendations regarding a Code of Ethics for interpreters.

Finally, I will offer some recommendations on a few broader issues that impact language services to recipients of state-funded services in Washington.

Healthcare Interpreter Certification

The Reyes Consent Decree of 1991 requires DSHS to "ensure that all interpreters and bilingual workers are fluent in English and a primary non-English language. DSHS shall develop standards of testing, oral and written, to ensure that all interpreters and bilingual workers meet the standards. Testing shall include evaluation of the language competence, interpreter skills, understanding of DSHS policies regarding confidentiality, DSHS forms and the role of interpreters."[1] The consent decree goes on to state, "As soon as the test is validated and approved, DSHS will being testing of contracted interpreters and translators and bilingual staff in the five primary languages of Spanish, Vietnamese, Cambodian, Laotian and Chinese."[2] It is not clear to me whether this language actually requires DSHS to test interpreters, or whether the spirit of the ruling is that DSHS make reasonable efforts to guarantee the quality of language services provided to recipients of state-funded services, such as healthcare paid for by Medicaid. For the sake of these recommendations, I will assume the latter.

At the time of Reyes, there was no valid and reliable test available to ascertain the skills of a healthcare interpreter, therefore, it made sense for DSHS to invest in developing its own certification process. When it was developed, the DSHS tests were shown to be valid and reliable. However, high stakes tests such as these must be maintained periodically in order to maintain their validity and reliability; this means that new items are continuously tested and substituted into the test, raters are tracked and periodically retrained to prevent rater drift. The DSHS healthcare interpreter certification tests have not been regularly maintained since they were designed in 1995 and so are no longer valid and reliable. Bringing these high stakes tests up to standard would cost hundreds of thousands of dollars. Please see my attached written testimony to the Ways and Means Committee for an estimate of the costs of continuing to provide interpreter testing as a service of DSHS.

[1] Consent Decree, page 16, Section 30.

[2] Consent Debree, page 17, Section 31.

In 1995, DSHS had no choice but to invest this money. Today there are two national certification processes for healthcare interpreters: one through the Certification Commission for Healthcare Interpreters (CCHI – a 501(c)5 non-profit organization) and the other through the National Board for Certification of Medical Interpreters (NBCMI – a division of the International Medical Interpreters Association). The money that the State of Washington would spend duplicating these testing processes could be better spent supporting candidates to become nationally certified. To that end, these are my recommendations:

1. Require interpreters serving Medicaid patients to be certified by CCHI.
   Both CCHI and NBCMI provide national certification testing for healthcare interpreters. CCHI is a national 501(c)6 non-profit organization specializing in healthcare interpreter testing. It currently provides language-specific testing for interpreters of English-Spanish, English-Arabic and English-Chinese. The recently implemented CoreCHI-P test, an oral test available to speakers of all other language pairs, tests cognitive skills shown to be statistically predictive of passing a language-specific interpreting test. With these tests, CCHI is prepared to certify interpreters of any language pair.

   NBCMI is a division of the International Medical Interpreter Association (IMIA). While the IMIA claims to be a federally recognized non-profit organization, an October 10 search of the IRS website could find no trace of this organization's non-profit status. NBCMI currently provides language-specific testing in English-Spanish, English-Cantonese, English-Mandarin, English-Russian, English-Korean and English-Vietnamese. It also provides a written test for interpreters of other language pairs (the CMI-HUB), with no oral section.

   All of CCHI's tests are currently valid and reliable. Its test development process has been accredited by the National Commission of Certifying Agencies, and it is actively involved in constantly updating and maintaining its tests. IMIA did have NCCA accreditation but has allowed it to lapse.

   Both CCHI and NBCMI have prerequisites for testing. Candidates must prove that they are over 18 years old, that they have at least a high-school education from any country, that they are fluent in both English and in the non-English language of certification, and that they have received at least 40 hours of basic training. These requirements, while adding cost to the certification process, will guarantee a higher skill level among the interpreters serving Washington's LEP population and Medicaid providers than is currently the case.

   Both CCHI and NBCMI have registration processes done over the internet and test remotely through a professional testing organization called Prometric, which has multiple testing locations throughout Washington State. The tests can also be set up to be done from home with an online proctor.

   Both CCHI and NBCMI require continuing education to maintain their credentials. CCHI requires 32 hours of CE every four years, 4 credits of which must be performance-based, as well as 40 hours of actual interpreting. NBCMI requires 30 contact hours of CE every five years.

   With a valid and reliable national certification option available, there is no need to duplicate the effort by running a parallel program at the state level.

Please note that there seems to be some question as to whether Washington State could legally contract with either of these organizations for their services, considering that they are not based in this state. However, this model does not require the State to contract with CCHI or NBCMI; it simply requires that the State require national certification to provide services to Medicaid patients.

2. Partner with state and local non-profit organizations such as NOTIS to provide scholarships for candidates who need financial assistance to pay for training and certification costs.
   There is one major drawback to the national certifications compared to the program previously being implemented by the Language Testing and Certification Division of DSHS, and that is cost. Both national certification programs charge a candidate around $530, in addition to the cost of basic training. The LTC program used to cost under $100 with no meaningful training required. While many here in Washington State will be able to afford this fee in order to get certified, others may find these fees a real barrier to entering the interpreting profession. Therefore, it would behoove Washington State to dedicate some funds to assisting interpreter candidates who have financial need in meeting these expenses. This could be done through partnership with local interpreter associations such as the Northwest Translators and Interpreters Society, which already provides some level of scholarships for members to attend basic trainings or conferences.

3. Partner with community colleges to provide in-person or online basic training for healthcare interpreters.
   As mentioned, the national certification both require at least 40 hours of basic training. All those who train interpreters will testify that quality interpreting requires knowledge and skills that can only be acquired through training and practice. As a provider of continuing education to DSHS-certified interpreters, I have been frequently chagrined at the general ignorance and high level of inaccuracy in the interpreting of students who are already certified by DSHS. Requiring training before testing will lead to a higher pass rate among those who test and better service being provided to LEP Washingtonians and the providers who serve them.

   Developing out of the 2020 Pandemic, there are now many online basic training programs for healthcare interpreters, include those of ALTA Language Services, Liberty Interpreting Academy, InterpreterEd.com, Americans Against Language Barriers, Blue Horizon, and many others. Some of these classes take place synchronously (that is, at a set time with everyone online together) and some are asynchronous (self-study classes in which the student proceeds at their own rate). In addition, Washington's Community College system could be an appropriate partner in helping to provide in-person or online basic training for healthcare interpreters. The potential drawback with Community College classes is that they must pay for themselves, so classes are often cancelled the day before starting because not enough students have registered. The State could help subsidize these programs, or the colleges could work together to run online classes open to their students anywhere in the state.

4. Task LTC with verifying the pre-requisites for national certification.
   Another way to ameliorate the cost of national certification would be to task LTC with the verification of the pre-requisites for the national certification test. This would allow CCHI and NBCMI to lower their fee to the test candidate.

5. Partner with state and local organizations to help support candidates through the online process. For students who are even moderately tech-savvy, the tasks of registering, training, and testing online will present no challenge. However, experience has shown that interpreters with more limited experience with technology may need support in walking through these online processes. Organizations such as Interpreters United, NOTIS, the Community Colleges or Language Testing and Certification could provide this sort of support.

6. Suspend the accreditation of continuing education programs.
   Both national credentials already require continuing education in order to be maintained, and both national certifying bodies require the continuing education classes they accept to meet certain standards. LTC could, therefore, suspend its current work in accrediting CE programs and tracking CE credits, limiting itself to maintaining the online Gateway in order to track certification revalidation every 4 years. LTC would need to continue to track CE for those interpreters already certified by DSHS, so that they could maintain their credentials without having to retest.

Comments on the Options offered the work group

In my opinion, none of the options created by the Work Group are sufficient in themselves. I believe that the recommendations I make above would provide a better system overall than any of the options we were presented.

I do believe that having a centralized office to manage language access for all of the state services would be a great step forward, however, I find it hard to believe that the legislature would fund such an office. In addition, that office would need to be headed by someone with a great deal of expertise in language access across many domains: healthcare, social services, legal services, mental health services, educational services, etc., as each of these domains encompasses different role definitions, different standards of practice, and different national resources.

Comments on comments submitted by Interpreters United

There are significant factual errors in the comments submitted by Interpreters United. I believe that Natalya Mytareva of CCHI and Eliana Lobo, representing the Community Colleges, have addressed many of those inaccuracies; I refer you to their comments.

Availability of language services in rural areas and for languages of lesser demand.

Providing sufficient interpreters in rural areas, and providing sufficient interpreters in languages of lesser demand, has always been a struggle. National best practices recognize the use of remote interpreting, especially video-interpreting, as the best means to provide language access in areas where the cost of paying for an interpreter to travel (especially for a short appointment) is unsustainable. In addition, working remotely allows interpreters in languages of lesser demand to provide services across many cities and states, increasing the probability that they will have sufficient work to stay in the profession and sufficient practice to become skilled.

Recommendations regarding the retention of interpreters.

There are three major components that influence retention of interpreters:

1. Sufficient remuneration.
2. Acceptable working conditions.
3. Respect.

I believe that Interpreters United is better positioned than I to comment on the degree to which the current system remunerates interpreters fairly, provides acceptable working conditions, and affords respect to interpreters as language professionals.

Recommendations regarding a Code of Ethics for interpreters.
A National Code of Ethics for Interpreters in Health Care already exists, developed through a 2-year national consensus-building process by the National Council on Interpreting in Health Care. It is counterproductive for Washington State to develop and maintain a separate Code of Ethics for healthcare interpreters here. While certain parties express concerns about the National Code's inclusion of advocacy, a close review will show that this Code supports advocacy only in cases in which the "patient's health and well-being are in jeopardy." Such advocacy would be, in fact, required by any healthcare institution of anyone working on its premises, including interpreters.

Comments on workgroup process
There are significant concerns around the process of this "Advisory" Group. The extremely short time frame afforded this process allowed us only six 90-minute meetings, one of which was spent entirely on introductions. Many participants had no expertise in interpreting, language access systems or high stakes test development/maintenance/implementation. The group was so large that, even in small group sessions, there was no time for real discussion, only for each individual to state a view in 2-3 minutes. The report-outs to the larger group were often highly inaccurate, largely, I believe, because the facilitators had no background in the subject matter and so did not really understand what they were hearing. Nuance was lost and many ideas were simply not reported. While it was possible to go back and listen to all the recordings later, I do not think that any participants had the time to do that. In the end, it would be a mistake to believe that any "recommendation" from this group represents anything close to consensus; in fact, it is a pity that we were not allowed the time to really discuss the issues and come to some general agreements. Perhaps if the group were reconvened, or reconfigured, and allowed a longer time frame in which to work, true recommendations could be made.