Below are comments from the Interpreter Agencies of Minnesota (IAM), which contracts with thousands of language interpreters providing services in health care settings.

Bill HF 1904: The Interpreting Stakeholder Group (ISG) Report as Required by Minn. Stat. 214.001, Subd. 2
Legislative Questionnaire for New or Expanded Regulation of Health Occupations: Evidence in Support of Regulation – Minn Stat. 214.002, Subd. 2. Contents of report

(1) The harm to the public that is or could be posed by the unregulated practice of the occupation or by continued practice at its current degree of regulation;

Response: Because of the unregulated nature of spoken-language health care interpreting in Minnesota, many unqualified or inadequately qualified individuals have worked in the field over the years. They do not possess the language proficiency nor interpreting skills, knowledge of medical terminology nor the code of ethics, to enable accurate and clear communication between patients and providers. The result of this could include, but is not limited to: misdiagnosis and inappropriate treatments, misinterpreting information leading to harmful medication errors or failure to comply with treatment protocols. These errors result in increased healthcare costs which are paid with taxpayer money. In addition, untrained interpreters might engage in unethical practices, manipulating the system to create more work for themselves, engaging in fraudulent billing practices, giving untrained medical advice to patients, or violating patient privacy.

IAM comments: The proponents list multiple problems that "could" or "might" occur from the lack of regulation of language interpreters, but the bill does nothing to address them. See the proponent's answer to Question #7, in which they acknowledge that the bill will do nothing to change how interpreters are trained or educated. The reality is that health systems and health plans are setting education and training standards currently for language interpreters, standards which have become community norms. This legislation is an answer in search of a problem.

(2) any reason why existing civil or criminal laws or procedures are inadequate to prevent or remedy any harm to the public;

Response: Current laws related to spoken-language health care interpreting are Title VI of the Civil Rights Act of 1964, and Executive Order 13166 which require recipients of federal assistance to provide interpreters to person (patients) needing those services. Additionally, Minn Statutes 256B.0625 subd. 18a(d), requires that interpreters must be listed in the Minnesota Department of Health Interpreter Roster to be eligible to receive Medical Assistant and MinnesotaCare reimbursement. However, these laws have no requirements nor standards related to interpreter qualification or competency, which results in lower quality than is necessary to prevent harm to patients. In addition, there is no law or procedure to enforce disciplinary actions on interpreters who cause harm to patients.

IAM response: This legislation puts Minnesota at risk of violating Title VI and EO 13166 because "meaningful access to medical services" (line 3.33) will be put at risk if this bill is enacted. Rural hospitals and clinics will find it even more difficult to find interpreters because the new requirements for interpreters are expected to reduce the number of interpreters. This shortage will delay care. The reality is that there is no pattern of interpreters causing harm to patients any more than there is a pattern of harm due to actions by physicians, nurses or other health care staff. Interpreters are not exempt from criminal and/or civil penalties for their actions.

(3) why the proposed level of regulations is being proposed and why, if there is a lesser degree of regulation, it was not selected;

Response: Healthcare interpreting requires specialized knowledge and skills. The Interpreting Stakeholders Group (ISG) has actively worked to develop this registry legislative proposal over the past few years in collaboration with various stakeholders in the healthcare interpreting field (interpreters, interpreting agencies, hospital systems, health plans, educational institutes). ISG also conducted a survey in 2010 requesting Minnesota interpreters to list the requirements for the registry. Based on all the stakeholders inputs, ISG concluded that the registry needs to require interpreters to obtain training in medical terminology and the practice of interpreting, demonstrate language proficiency and interpreting skills through testing. These are the minimum requirements to ensure interpreters are competent to provide quality service and effective use of taxpayer money.

In December 2009, two national bodies began to offer national certification for healthcare interpreters. However, national certification is not yet available for the many languages served in Minnesota. Thus, our proposal consists of two pathways for interpreters to be listed on the registry; one is to become nationally certified, the other path is qualification through training and testing similar to the national certification.

This level of regulation is consistent with the requirements set forth in Minnesota Statutes 144.058(c).
Please note that interpreters who speak a rare language and are not working regularly can still choose to remain on the roster only.

IAM Response: Major health care systems and as well as health plans already require language interpreters used in their facilities or with their enrollees to have completed at least a 40-hour training course. The existing education standard in the community is working. The 2010 survey referenced did not include the thousands of interpreters that work as independent contractors through interpreting agencies, so any conclusions reached from the "survey" are flawed. The people the ISG purports to seek to protect and promote have not been included in their process. The national certification bodies referenced are not appropriate standards for Minnesota because of the unique languages spoken here. For example, no national

certification body certifies proficiency in Somali or Hmong, two languages that are near the top in demand for interpreters.

(4) any associations, organizations, or other groups representing the occupations seeking regulation and the approximate number of members in each in Minnesota;

Response: The Minnesota-based Upper Midwest Translation and Interpreting Association (UMTIA), a chapter of the American Translators Association, advocates and supports regulation to ensure quality care. UMTIA has 83 members in Minnesota as of January 16, 2014. The U.S.-based International Medical Interpreters Association (IMIA) also advocates and supports regulation. The Minnesota Chapter of IMIA has 33 members. Both professional organizations have been actively participating in the legislative proposal project the last few years.

IAM Response: There are thousands of independent contractors that work as interpreters in Minnesota and they work primarily through interpreter agencies. Over 3,000 are on the existing roster. They were not provided an opportunity to participate in the ISG process and its conclusions and recommendations do not reflect their views. The few members of the UMTIA and IMIA largely represent the views of purchasers of interpreter services (hospitals and health plans) and not the views of the thousands of front-line independent contractors whose businesses would be harmed by this legislation.

(5) the functions typically performed by members of this occupational group and whether they are identical or similar to those performed by another occupational group or groups;

Response: Spoken-language healthcare interpreters are expected to provide complete, accurate interpretation of all information in medical encounters without addition or omission, and in an ethical manner. They facilitate communication between patients and health care teams, enabling the health care teams to have the information necessary to provide high quality care, and the patient to understand information in order to make informed health care decisions and follow treatment plans. In addition, healthcare interpreting requires a high level of cross-cultural competence.

On occasion, spoken-language healthcare interpreters may need to function as cultural brokers to appropriately address culture-based misunderstanding between providers and patients. On occasion, interpreters may also need to advocate appropriately on behalf of patients under certain circumstances.
Similar professions include the sign-language health care interpreting field, community interpreters and legal interpreters. However, advocacy cannot be part of the function of the legal interpreters.

(6) Whether any specialized training, education, or experience is required to engage in the occupation and, if so, how current practitioners have acquired that training, education, or experience;

Response: Spoken-language healthcare interpreting requires specialized training. However, Minnesota has no state-wide enforceable requirement nor standard for interpreter training/experience.

Individuals may obtain training through the 40-hours "Bridging The Gap Professional Medical Interpreter" or the "The Community Interpreter" training, 18 to 60 credit academic programs at the University of Minnesota, Century College, Riverland College, or Rochester Community and Technical College. The training program at the community colleges provide internship opportunity to gain experience.

Beginning in 2013, several large hospital systems in the metro area require current practitioners to complete a minimum of 40-hours basic healthcare interpreting training, as well as 8-hour of continuing education per year. However, these hospitals do not require current practitioners to pass standardized written or oral tests in medical terminology in English and/or the target languages, nor any interpreting skills test.

To fulfil the hospital systems training requirements, majority of current interpreters complete at least the 40 hour "Bridging The Gap Professional Medical Interpreter" or "The Community Interpreter" training.

IAM Response: Interpreters are already regulated by the PMAP contracts between the Department of Human Services and the health plans. Most hospitals currently require interpreters used to serve public program enrollees meet standards. These include: all agency interpreters used must have documented immunizations, orientation into interpreter functions and duties, 40-hours of classroom training on interpreter functions and ethics, a language skills test of medical terminology, criminal background checks, photo ID badges with the agency name and work order records that must provide detailed information of every interpreter job and the services provided which must be signed by a health care provider on-site. Health care providers and health plans routinely conduct audits to assure that interpreters used by them meet these standards. Hospitals and health plans currently provide the oversight of interpreters sought by the bill. As noted above, many purchasers of interpreter services already require 40-hours of training and continuing education. The market has responded to the needs for standards for interpreters and this bill is therefore not needed.

(7) Whether the proposed regulation would change the way practitioners of the occupation acquire any necessary specialized training, education, or experience and, if so, why;

Response: It will not necessarily change the way interpreters are currently acquiring training and education which is most often obtained through a 40-plus hours training program. However, some interpreters may need to obtain additional formal training to acquire language proficiency, knowledge of medical terminology and interpreting skills (e.g. attentive listening, comprehension, information retention, analytical thinking).

Formal training also allows individuals to practice these various skills in internship or practicum program to gain experience under the supervision of experienced preceptors/mentors. Interpreters also need to develop critical thinking skills needed to make appropriate

IAM Response: The above acknowledgement that the bill will not change how interpreters are trained or educated undercuts the central argument for the bill – additional regulation is needed to enhance patient care. The bill will not improve patient care and promote patient safety and is not needed.

(8) whether any current practitioners of the occupation in Minnesota lack whatever specialized training, education, or experience might be required to engage in the occupation and, if so, how the proposed regulation would address that lack;

Response: Spoken-language healthcare interpreting is an unregulated health-related profession in Minnesota. Over the years, many individuals entered the field without specialized training and/or experience**.** At times, their services are provided at a sub-par level resulting in confusion, misinformation and medical errors. Hospital systems have regularly received complaints regarding interpreter performance issue and lack of language proficiency. Other complaints were related to non-adherence to the interpreter code of ethics and unfamiliarity with standards of practice. Also, some interpreters received unsolicited complaints from patients who were served by other interpreters with poor knowledge of medical terminology and unprofessional conducts.

The Minnesota Department of Health also recognizes a widespread lack of English language skills among interpreters, and has received increasing number of complaints regarding interpreters' lack of knowledge of medical terms.

The proposed legislation would address this lack of specialized training and experience as stated in response to question (3) and (7) above. The ways to obtain trainings and increase competency are also described in this bill.

IAM Response: The bill's proponents admit in their answer to question 7 above that the bill will have no impact on the training and education of language interpreters. Their contention that the bill will enhance patient care is undercut by this statement. Despite their statement that there are increasing complaints about interpreters, the agencies that comprise the Interpreter Agencies of Minnesota have not heard complaints from the Department of Health about the independent contractor interpreters dispatched by these agencies. As noted above in the proponent's answer to question 6, health care interpreters are subject to increasing regulation by hospital systems that have implemented education and training requirements on all interpreters used to serve their patients. The bill does nothing to provide education and training for interpreters.

(9) whether new entrants into the occupation would be required to provide evidence of any necessary training, education, or experience, or to pass an examination, or both;

Response: Yes, new entrants into the occupation with the intent to be eligible for Medical Assistance or MinnesotaCare reimbursement would be required to provide evidence of high school diploma or equivalent to be listed in the roster. In addition to this requirement, they would be required to provide evidence of national certification or evidence of training, interpreter skills and language proficiency testing to be listed in the registry.

IAM Response: Many interpreters fled homelands where opportunities for high school education did not exist and they never received a high school diploma. Nevertheless, as immigrants to America, they have learned English and are now fluent in both their native language and English. As noted above in the answer to question 3, national certification does not exist in Somali, Hmong and other major languages prevalent in Minnesota, so interpreters of these languages cannot receive the required national certification.

(10) whether current practitioners would be required to provide evidence of any necessary training, education, or experience, or to pass an examination, and, if not, why not;

Response: Yes, current practitioners with the intent to be eligible for Medical Assistance and MinnesotaCare reimbursement would be required to provide evidence of a high school diploma or equivalent to be listed in the roster. In addition to this requirement, they would be required to provide evidence of national certification or evidence of training, language proficiency and interpreter skills testing to be listed in the registry.

Please refer to response to question (6) and (8) above for the rationales.

IAM Response: Please see answer to question 9 above.

(11) the expected impact of the proposed regulation on the supply of practitioners of the occupation and on the cost of services or goods provided by the occupation.

Response: Some interpreters have already met the requirements set forth by the proposed legislation (e.g. training, language proficiency and interpreter skills testing, national certification). If this bill is signed into law, it is anticipated that providers would express a preference for registered interpreters, driving up participation in the registry and thus the supply of qualified practitioners.
Interpreters who speak a rare language and work infrequently can still choose to remain on the roster only.
Currently, there are over 3000 interpreters listed on the MDH interpreter roster, with the majority of them being independent contractors. It is possible that some interpreters would decide to leave the field because they choose not to obtain training and/or national certification. This would create more opportunities for the qualified interpreters and allow them to work full time. Ultimately, this would benefit the patients.

The cost of the services is not expected to increase for the state, unless the Minnesota legislature decides to increase the reimbursement rate.

Currently, spoken-language healthcare interpreters are paid between $15 to $35 per hour. It is likely that qualified and/or nationally certified interpreters would prefer to work with interpreter agencies paying higher hourly rates. The higher rates of compensation are comparable to other Minnesota healthcare positions requiring training and education. Please refer to the compensation guide researched and published in 2013 by the International Institute of Minnesota. http://www.iimn.org/wp-content/uploads/2013/07/Healthcare-Careers-Your-Guide-to-Colleges-and-Careers-in-Healthcare-in-the-Twin-Cities-Metro.pdf

IAM Response: As the proponents note in their answer above, the new requirements means that it is possible "some interpreters would decide to leave the field". The new criminal background checks, tests and other requirements will add costs. If these costs are borne by the interpreters, fewer interpreters are expected to be available, which can create backlogs for medical services and potential for patient harm. If these costs are borne by the State, these are costs the State is not currently paying. The State is already spending money to maintain and monitor the roster. Creation of a registry will add additional costs to the State. It should also be noted that the $15-$35 per hour rates paid to interpreters does not reflect that these interpreters do not typically work 40 hours a week, unless they are in-house. Many interpreters are just scraping by and living just above the poverty line.

Evidence in Support of Regulation - Minn Stat. 214.002, Subd. 3. Additional contents

(1) typical work settings and conditions for practitioners of the occupation;

Response: Typically, spoken-language healthcare interpreters provide interpreting services at hospitals medical and surgical units, trauma centers, out-patient clinics, mental health facilities, dental clinics, and at patients' homes when necessary.
Often, interpreters receive urgent requests to provide immediate services at hospital emergency departments and intensive care units, urgent care clinics, labor and delivery centers, mental health facilities or hospice care. Under these circumstances, interpreters are expected to report to duty within 40 minutes.

(2) whether practitioners of the occupation work without supervision or are supervised and monitored by a regulated institution or by regulated health professionals.

Response: Spoken-language healthcare interpreters work at the aforementioned settings without supervision.

IAM Response: All actions taken by interpreters are supervised by health care professionals in the clinical setting. They interact with patients and clinicians only at the direction of the health care professional managing the treatment or procedure.

Legislative Questionnaire for New or Expanded Regulation of Health Occupations - Additional Questions

(1) What other professions are likely to be impacted by the proposed regulatory changes?

Response: All healthcare professionals who care for or come into contact with limited-English-proficiency patients would be impacted in a positive way. In addition, it is reasonable to expect that trainers and educators of interpreting programs would also be impacted in a positive way.

IAM Response: There will be negative impacts to rural clinics and hospitals because there will be fewer interpreters available to assist non-English speaking patients. Only those interpreters that are on a state roster or registry are allowed to serve public program patients (page 4, lines 1-3). Many rural communities have challenges finding qualified interpreters. Limiting interpreting services to only those interpreters on a state roster or registry means some rural hospitals and clinics will not be able to find a qualified interpreter to serve their patient. This will put them in violation of Title VI of the Civil Rights Act and Executive Order 13166 (page 3, lines 31-35).

Further, the changes in requirements for interpreters may, as the proponents noted above, drive current interpreters from the profession. Forcing individuals operating an interpreter business to cease operations is not beneficial, either for them and their families, or for the State of Minnesota, which will lose tax revenues as independent contractors close their doors.

(2) What position, if any, have professional associations of the impacted professions taken with respect to your proposal?

Response: The U.S.-based International Medical Interpreters Association (IMIA) and its Minnesota Chapter support this proposal. The Minnesota-based Upper Midwest Translation and Interpreting Association (UMTIA), a chapter of the American Translators Association, does not oppose this proposal.

IAM Response: These two groups do not represent the thousands of independent contractor translators that will be harmed by this bill. IMIA, a Boston-based national organization, has only a few Minnesota members. UMTIA has less than 100 members and few are independent contractor interpreters. These low numbers compare to over 3,000 interpreters listed on the State roster.

IAM has concerns with the bill in its current form. It does not reflect input from independent contractor translators. IAM strongly supports enhancing the quality of interpreter services to assure patient care, but the legislation does nothing to do that. Moving to a state registry is premature given that existing problems with the state roster have not been addressed. IAM would be happy to share its views on how to enhance the roster and the current system.

(3) Please describe what efforts you have undertaken to minimize or resolve any conflict or disagreement described above.

Response: Board members of the UMTIA and IMIA were members of the ISG Legislative/Advocacy Committee during the development of the legislative proposal. In addition to working with the two professional associations, ISG actively engaged individual interpreters by sending out survey questionnaire, writing to encourage them to voice their opinion, hosting meetings to present the registry proposal draft, and publishing the proposed requirements in the legislative draft.

We would also like to mention that the ISG Legislative/Advocacy Committee included all other stakeholders (i.e. interpreters, interpreting agencies, hospital systems, health plans, interpreting educators) in the discussions and development of this legislative proposal over the past few years. Conflicts and disagreements were resolved at these committee meetings and monthly ISG membership meetings, and via additional written correspondence.

IAM Response: The ISG notes in its answer to question 3 that it last surveyed interpreters in 2010, but fails to indicate how many responded or what their responses were. ISG held a "town hall" meeting several years ago to discuss this proposal and another one recently. The majority of the interpreters present at both session opposed the plan. There are thousands of interpreters on the state roster. Their views are different than the views of interpreters employed in-house by health care systems and their views should be solicited and incorporated into any reform proposal.

ISG failed to get the support of the thousands of independent contractor interpreters to their plan. The bill directly impacts the ability of these interpreters to continue to work in their current positions. Changes which affect that many households need to be carefully considered before moving forward.

Concluding comments:

IAM members contract with many independent contractor language interpreters that serve thousands of Minnesota patients each week. It supports the provision of timely and accurate interpretation services to health care consumers. Proficient interpreters enable patients and their treating health care professionals communicate clearly and simultaneously, assuring better care for consumers and better use of public dollars.

IAM does have additional concerns with the bill. These include:

- There are hundreds of dialects and languages spoken in Minnesota hospitals and clinics. The bill includes so many exceptions that interpreters for most of these languages would not be covered.
- The bill also does not provide any incentives for interpreters to acquire the new training and education required to be on the registry. Interpreters who incur the expenses of

these new requirements will not be paid any more, even though their costs have gone up, which is not fair to these individuals.

- There is a large loophole in the bill as it relates to electronic interpreter services. The bill is silent on whether the same requirements for interpreters will apply to non-Minnesota interpreters utilized via video teleconferences. It should be clear that standards that apply to interpreters serving Minnesota patients apply to <u>all</u> interpreters, not just some. Further, the State should consider the merits of enabling non-Minnesotans to provide interpreter services via video teleconferences at the expense of Minnesotans who will lose their jobs as a result.
- The Advisory Council for spoken language interpreters is not balanced in the bill (9.26). It includes one explicit ISG member in addition to members representing insurers and hospitals, who lead ISG. Of the nine members, only three are actual interpreters. A "Council for spoken language interpreters" should have a majority of spoken language interpreters.
- The Commissioner is granted significant authority in the bill, but is exempted from the rulemaking requirements of Chapter 14 in several significant areas (6.28). Those affected by the Commissioner's actions that directly affect their business should have the opportunity to comment through the rulemaking process.
- Also, the Commissioner is authorized to use the funds collected from the current roster for implementation of the registry (7.7). This is unfair to those individuals who paid their roster fee but may not join the registry. If the registry moves forward, it should be funded by those who will benefit from its creation – not by taking money dedicated to another purpose. The bill itself notes the inappropriateness of using funds collected for the roster for other purposes (7.24).
- The current roster fee of $50 has generated a large surplus. IAM believes these funds should be used to enhance education opportunities for the interpreters that paid the fees that created the fund. The fee should also be changed from an annual fee to a one-time fee since the state has failed to use the fees collected. The fee is a tax on independent contractors that does nothing to enhance the profession.
- The current practice by many health systems is that interpreter payments can be made only to persons on the roster. This has delayed patient care in emergency situations when an interpreter cannot be dispatched to the ER to serve a patient until prior approval by the hospital system. While this is an issue between interpreter agencies and providers, it is an example of how relying on the current roster (or a future registry) can limit timely access to interpreter services.
- This proposal was expected to be cost-neutral, but as noted above, the additional education, testing and background checks will add costs to interpreter services. Who will bear these costs?

IAM would be happy to talk with the bill's proponents to address these concerns and questions.

Thank you.