



Patient Safety, Professionalization, and Reimbursement as Primary Drivers for National Medical Interpreter Certification in the United States

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Abstract: In a medical setting, interpretation by unskilled bilingual individuals can have serious repercussions when it results in a lower standard of care for minority-language patients. In order to address the issue and to help ensure that competent interpreters are recognized and compensated for their skills, the National Board of Certification for Medical Interpreters launched a national certification program for medical interpreters in 2009. This article describes the process of development and deployment for national certification, its current state, and plans to expand certification to additional languages and locales.

Keywords: medical interpreting, healthcare interpreting, interpreter certification, National Board of Certification for Medical Interpreters, interpreter certification, health care

1. Introduction

Medical interpreting is a specialization of the interpreting profession, with a growing number of staff positions in hospitals worldwide, and an increasing number of professional associations dedicated to medical interpreting. The professionalization of the field has been a gradual process. It began with the first Code of Ethics in 1986 and [Standards of Practice](#) for the profession in 1995. This professionalization was later significantly marked by the development of national certification of medical interpreters in the United States in October 2009 by the National Board of Certification for Medical Interpreters (National Board). In this article, three aspects of certification will be covered: 1) the primary drivers for certification, 2) the development process for the initial certification exams and 3) expansion plans for the certification program.

2. Drivers for certification

In health care most practitioners are certified in order to maintain the primary ethical principle of protecting the patient from harm. The need to consider

and manage the safety of patients within healthcare has been widely recognized over the past decade. The concept and understanding of patient safety has grown, and healthcare institutions are constantly seeking to identify how and why things go wrong in patient care. This concern is entrenched in the medical ethical precept embodied by the phrase *primum non nocere* (Latin, “first, do no harm”). Many consider that this Latin phrase highlights the main or primary consideration (*primum*): in other words, it is *more* important not to harm your patient than to do them good. This emphasis is partly because patients are prone to accept treatments that are believed to be beneficial without first having evaluated them adequately to ensure they do no harm.

While the general public might not be aware of the intricacies of accurate interpretation, research on the effects of medical interpreting errors on patient health outcomes conducted by healthcare providers has found that medical interpreting is an activity that requires a high level of specialized skill. Several scientific studies have demonstrated that incompetent practice can cause serious negative health outcomes and bodily harm. Interpretation errors have even led to serious harm, as in the 1980 case of, eighteen-year-old Willie Ramirez. Due to an error of interpretation, doctors misunderstood the Cuban Spanish word *intoxicado* to mean that Ramirez had intentionally overdosed on drugs, rather than that his family thought he had eaten a spoiled hamburger and was “intoxicated” as a result. As a result of this misunderstanding, doctors failed to detect an intracranial hemorrhage for two days and Ramirez was left a quadriplegic. The resulting legal challenge awarded a \$71 million settlement to Ramirez (Price-White, 2008). This case showcases the importance of adequate skill elements for interpreters that inspired and obliged the International Medical Interpreters Association (IMIA) and colleagues in the field to promote national certification as a well-established and convenient method of self-regulation to protect patient safety.

The expectation of availability of language services to patients with limited English proficiency (LEP) has become a standard of adequate care throughout much of the United States. Federal law requires health care providers who receive federal funding to provide language interpretation services (LIS) to their LEP patients. However, despite the documented benefits of receiving LIS, finding the resources in an already financially constrained operating budget to pay for language programs can be challenging for providers: it is essentially an unfunded mandate. While the mandates and expectation of availability exist, adequate funding is not a reality in even the best hospitals in the country. Health care systems have to use their own administrative funds to cover LIS since only 13 states in the US even reimburse for interpretation services for Medicaid patients.

While Medicaid does reimburse for LIS in 13 states, insurance companies do not. For the most part, healthcare organizations pay for LIS out of pocket from the administrative funds in their departmental budgets, which are capped and even cut in difficult economic times. This pressure means that even the hospitals with the largest interpreter staffs provide LIS to only a small percentage of those patients that require interpreters, as budget allows. Payers and policymakers are also challenged to find ways to pay for LIS. Important questions concern what entity(s) should pay for services, to whom, and how, and whether LIS should be paid for directly. Current national payment reform discussions seem to favor a move from a fee-for-service model to one based on global services. This change of payment structure has already started in states such as Massachusetts, where the IMIA is headquartered. In July 2009, Massachusetts distinguished between episode-based payments (i.e., bundled payments) and “global payments,” which are

fixed-amount payments for the care that patients may receive in a given time period. In order for language minority patients to have access to a qualified interpreter each and every time they need one, *certified* medical interpreting services need to be bundled into these global payments, so that hospitals across the United States have a mechanism to be reimbursed for that service.

The IMIA (the only association of medical interpreters at a national and international level) and Language Line Services (LLS), the largest employer and tester of medical interpreters in the US, understood the urgency of *national* certification within the framework of the ongoing *national* health reform. (Formerly the Massachusetts Medical Interpreters Association, the IMIA is now a national and international non-profit professional association representing the interests of medical interpreters, with over 2,000 members.) Collaborative advocacy by the IMIA and LLS in Washington, D.C., for reimbursement of LIS was hampered by lack of a national certification process that defines which services and service providers should be reimbursed. Through national certification, these groups are now able to represent a *certified* body of interpreters¹ during payment reform discussions. In pursuit of this goal, the IMIA and LLS co-founded a separate organization, the [National Board of Certification for Medical Interpreters](#) (National Board), in early 2009 that was solely charged with overseeing national certification. The National Board launched national certification for medical interpreters on October 10, 2009. Professionalization, reimbursement, and patient safety were the drivers for this certification.

The mission of the National Board is to foster improved healthcare outcomes, patient safety, and patient/provider communication, by elevating the standards for and quality of medical interpreting through a nationally recognized and validated certification for medical interpreters. The organization is a regular member of the International Federation of Translators (FIT), a federation of translator and interpreter associations worldwide that has consultancy status with UNESCO.

The IMIA, as an umbrella organization for medical interpreters, is committed to act as the standard-setting body for the medical interpreting profession. Although many methods for interpreter assessment have existed, they have varied greatly, resulting in confusion about qualification and the best ways to assure quality care. In the U.S. federal legislation such as Title VI of the Civil Rights Act of 1964 against discrimination—including

¹ National certification should not be confused with licensure, which refers to the granting of a license that gives one the legal permission to practice a particular profession. Many privileges and professions require a license, generally from the government, in order to ensure that the public will not be harmed by (possibly incompetent) non-licensed practitioners. Such licenses are usually issued to regulate activities deemed to be dangerous or a threat to the person or the public or which involve a high level of specialized skill. Licensure often involves accredited training and certification examinations, but varies widely for different activities and in different countries. Some states in the United States already license Sign Language interpreters. Where licensing occurs, practicing such a profession without a license can bring about severe legal penalties. Until licensure is mandatory, national certification for medical interpreters will not be able to ensure that the public received services only from competent medical interpreters.

Historically licensing was an effective method to bar unqualified individuals from entry into the qualified professional group. Licensure was the preferred route of regulation for physicians, lawyers, teachers, accountants, and architects. However, in many cases licensing has given way to certification and/or membership in professional bodies as a means of excluding the unqualified.

discrimination based on national origin—and national guidelines such as the National Standards on Culturally and Linguistically Appropriate Services (CLAS), effectively require hospitals to train and test those performing medical interpreting if they are to ensure compliance with legal requirements. The IMIA has worked toward medical interpreting certification since its inception in 1986, and piloted an exam, first in 2001 and then later in 2003 in collaboration with the California Healthcare Interpreters Association (CHIA) and the National Council of Interpreting in Health Care (NCIHC). Later there were attempts to collaborate, the failure of which resulted in two national certifications in the United States: the National Board of Certification for Medical Interpreters, which started testing in late 2009, and the Certification Commission for Healthcare Interpreters (CCHI), which followed soon after.

While most assessments vary in quality, scientifically validated exams are in a completely different category from other assessments because they are legally defensible in a court of law. Since the 1980s, qualified medical interpreters had become frustrated with the use of unqualified individuals who are not adequately trained or tested. Since hospitals, employers, and even patients are not always able to judge the quality of an individual's language proficiency or interpretation, this problem has become prevalent in the field, one well documented in the discourse analysis studies that record interpretation errors (see, e.g., Downing, 1991).

The IMIA's charter mandated it to develop educational and skill requirements for interpreters, and had been working for over 26 years on developing a certification program for medical interpreters. This program is the organization's most important project to date. By helping to form the National Board, it established an independent certifying body to oversee the national certification project according to accreditation guidelines. Most successful professionalization processes have included a certification process and the recognition of this fact was an important driver of this process.

The IMIA has taken steps to recognize and unify all certified interpreters. The IMIA recognizes all national certification programs and promotes the hiring of certified interpreters. To this end the IMIA created the Certified Interpreter Division, which admits IMIA members who are certified by any of the national certifying entities, to promote the benefits of employment of certified interpreters. It includes medical interpreters certified by both the National Board (with a CMI credential) and the CCHI (with a CHI credential), as well as interpreters certified nationally by the Registry of Interpreters for the Deaf (RID). The IMIA does not require membership of newly certified interpreters as a condition for certification or to maintain certification. On the contrary, the IMIA grants newly certified interpreters from all these entities a complimentary yearlong membership in the association as a gesture of recognition for their pioneering steps to professionalize this specialization.

3. Development of the Written and Oral Examinations

Once the decision to develop a credible, reliable, and vendor-neutral national certification was made, PSI Services LLC (PSI) was hired by Language Line University (LLU) and the International Medical Interpreters Association (IMIA) to construct an oral and written examination for medical interpreter certification. Reports produced in this process provide evidence of psychometric quality and validity in accordance with the Standards for Educational and Psychological Testing (See American Educational Research Association, American Psychological Association, & National Council on

Measurement in Education, 1999). The process included a national job analysis, creation of examination specifications, development of test items, pilot testing and psychometric analysis, and assembly of equivalent test forms. (All subsequent references to the details of this examination refer to PSI Services, 2010). The National Board certification examinations were developed based on a national job analysis conducted by PSI in January 2009. The job analysis study used a multiple-method approach, incorporating expert judgments of an advisory committee (augmented with consultation with focus groups from across the country), and a national survey of practicing professionals.

3.1. Advisory Committee

PSI worked to assemble a preliminary inventory of professional activities, job knowledge and skills. In accordance with PSI's instructions, LLU convened an advisory committee to review and define the list of professional activities performed and the knowledge and skills required for competent practice in the medical interpreter profession. The advisory committee consisted of 44 experienced medical interpreting professionals representing various regions of the United States. Qualifications of the advisory committee members included extensive experience in medical interpreter training and training development, medical interpreting skills assessment and test design, and degrees in medicine and practice in related healthcare fields. Furthermore, the advisory committee members had higher education in interpreting and/or translation and current work experience as active medical interpreters, coordinators of interpreter services, and language access advocates.

Based on their collaborative experience, members of the advisory committee reviewed and modified a preliminary list of 76 professional activities and 88 knowledge statements, along with 38 proposed demographic questions. Based on this list, they then reviewed and finalized the content to be included in the survey.

3.2. Survey

PSI next developed a survey instrument incorporating the professional activities and required knowledge identified by the expert advisory committee, in order to confirm the relevance and importance of the items to medical interpreters nationwide. A set of nine preliminary demographic items was added in the beginning of the survey and 29 additional background questions were added in the last section of the survey. The survey included three rating scales to be used by survey respondents to provide a quantitative estimate of the job relevance of each activity, knowledge, and skill.

The job analysis survey included three rating scales for each *activity*. The questions, response options, and numerical representations are presented below:

1. **Frequency:** Respondents were asked, "How often do you perform this activity or task?" Response options were: "Never" (0), "Less than Monthly" (1), "At Least Monthly" (2), "At Least Weekly" (3), and "Twice Weekly or More" (4).
2. **Importance:** Respondents were asked, "How important is it that you perform this activity competently?" Response options were: "Of no importance" (0), "Of little importance" (1), "Moderately important" (2), "Very important" (3), and "Critically Important" (4).
3. **Competence of Activity/Task Necessary for Certification:** Respondents were asked, "How much command in this activity/task should be required to become a Certified Medical Interpreter?"

Response options were: “No Competence” (0), “Some Competence” (1), and “Full Competence” (2).

The job analysis survey also included three rating scales that respondents used to assign ratings to each *knowledge area*:

1. **Frequency:** Respondents were asked, “How often do you use this knowledge in performing your job?” Response options were: “Never” (0), “Rarely” (1), “Sometimes” (2), “Frequently” (3), and “Very frequently” (4).
2. **Importance:** Respondents were asked, “How essential is this knowledge to overall competent performance of your job?” Response options were: “Not important at all” (0), “Somewhat important” (1), “Moderately important” (2), “Very important” (3), and “Critically important” (4).
3. **Command of Knowledge Necessary for Certification:** Respondents were asked, “How much command of this knowledge should be required to become a Certified Medical Interpreter?” Response options were: “No command” (0), “Some command” (1), and “Full command” (2).

To ensure that the job analysis survey included a representative sample of medical interpreters and medical interpreter supervisors in the United States, LLS contacted relevant stake-holder groups, including professional interpreter associations at both national and state/regional levels, hospitals and other healthcare organizations, colleges and universities that offer healthcare interpreter training programs, healthcare interpreting advocacy groups, medical interpreters (both staff interpreters and freelancers), and members of the LLU Global Advisory Council. The primary goal was to obtain a sample of respondents from each state. A total of 5,654 e-mail invitations to participate in the survey were sent to practicing professionals in the medical interpreting field, some of whom forwarded the survey on to colleagues, association members, and students, further boosting the number of recipients. A total of 1,506 individuals completed at least part of the survey. Prior to the last section (additional demographic questions), 1,108 participants had completed the task (activity) and knowledge statement sections in their entirety. In the last section of the survey (additional demographic information), 157 participants indicated that they were not currently practicing medical interpreters, and these responses subtracted from the total, resulting in 939 complete surveys. The respondents to the current job analysis survey demonstrated acceptable regional distribution for the proportion of states in each census region of the United States and were representative in terms of professional profiles (see PSI Services, 2010, particularly Tables 1 and 2, and Appendix A for more information).

The job analysis ratings were analyzed to identify professional activities that should be represented in the examination. Professional activities were determined to qualify for inclusion in the examination if they met each of the following criteria:

1. Performed by more than 50% of respondents;
2. Mean importance rating was 2.0 or greater (at least moderately important); and
3. Mean competence rating was 1.0 or greater (at least some competence required at the time of certification).

Applying the criteria described above to the activity data resulted in the identification of 49 (of 73) qualifying professional activities.

The job analysis ratings were also analyzed to identify knowledge areas that should be represented in the examination. Knowledge statements were judged to be qualifying for inclusion on the examination if they met all of the following criteria:

1. Mean importance rating was 2.0 or greater (at least moderately important)
2. Mean command rating was 1.0 or greater (at least some command required); and
3. Required for the performance of at least one qualifying professional activity, as determined during a subsequent linkage process, in which participants linked knowledge statements to task statements.

PSI conducted statistical analyses of the responses to the job analysis survey to determine which of the professional activities and knowledge statements to test in the medical interpreter certification exam. LLS convened an expert panel to review the survey results and confirm that the qualifying activities and knowledge statements were represented in the examination content.

3.3. Creation of exam specifications and test examples

Based on the results of the survey and utilizing a template and process provided by PSI, the panel developed examination content specifications from the job analysis data through a combination of empirical and rational methods and provided their recommendations. Content specifications were developed for both the oral and written exams.

Working with PSI, LLS next convened a panel of experts to write, review, and formally evaluate test items measuring sight-translation and consecutive-interpreting skills for the Spanish-English version. In addition, IMIA and PSI convened a panel of experts to write, review, and formally evaluate written exam items after reviewing and confirming previously developed content specifications. Following a rigorous training process on test item writing and standard setting, each panel of experts began the test item writing process, based on the test specifications established by the job analysis. Subject Matter Experts (SMEs) evaluated each item for relevance to occupational requirements and need for competence upon certification. They also estimated the difficulty for practicing professional interpreters.

A recommended minimum passing score (cut score) was established through a standard-setting study for each of the oral and written exams. Subject matter experts rated each item using a modified Angoff procedure, a widely used standard-setting approach that test developers use to determine the passing percentage (cut score) for a test. PSI then analyzed the resulting item bank to derive a recommended cut score for the oral and written exams, designed to ensure safe and competent practice as a medical interpreter,

Appropriate test content specifications are critical elements of effective certification examinations to ensure that tests proportionately reflect the medical interpreting domain. For the oral and written examinations, the specifications were developed through a combination of statistical analyses of the responses to the 2009 job analysis survey and through the expert judgment of the job analysis advisory committee. As noted by Morgeson and Campion (1997), the validity of job analysis findings is enhanced when multiple methods are employed and the findings converge. The present study relied on both empirical analyses of the job analysis data and expert judgments to produce the content specifications. Tannenbaum and Wesley (1993) have reported that the two methods tend to produce similar results,

and the committee and survey results were found to be consistent in the present study.

Test development was conducted using the following process:

1. Training on item writing and standard-setting (modified Angoff rating) processes by PSI
2. Development of oral exam items
3. Development of written exam items
4. Review of exam items
5. Standard setting
6. Analysis of ratings

Experimental forms of the oral and written exams were assembled and pilot tested separately. PSI analyzed the test item response data to cast equivalent alternate forms of the oral and written examinations. Further details regarding the methodology are described below.

3.4. Pilot testing and development of alternative forms

Pilot testing was administered remotely to at least 100 medical interpreters for each of three experimental forms. Raters were selected and trained. The pilot written examination was administered to over 250 medical interpreters. For more information on the pilot see the Technical report (PSI Services, 2010).

The oral test forms (Spanish-English) were pilot tested with 300 interpreters and the written test forms (in English) were pilot tested with 257 interpreters. The test responses were analyzed statistically to ensure that the test items had acceptable psychometric properties and to assemble statistically equivalent alternate exam forms. For the oral examination, three equivalent final test forms were assembled based on the examination specifications and the analysis of the pilot test data. For the written exam, equivalent alternate forms were assembled to meet the test specifications using FormCast™, PSI's proprietary automated test generation system.

On the basis of the mean Angoff ratings for the selected items, an overall cut score of 70% was established for the medical interpreter certification oral examination and 75% for the written medical interpreter examination.

3.5. Summary of the development of the National Board Exams

The medical interpreter certification oral and written examination development project involved a national job analysis with representation from across the US that included a wide range of medical and interpreting settings. Per established protocol for test development, exam content specifications were based on the statistical data from the job analysis survey and input from subject matter experts, which then served to guide test item development and standard setting. An extensive pilot test phase and rigorous psychometric analysis provided the basis for assembling statistically equivalent oral and written examination forms, which met rigorous psychometric criteria for content validity and high measurement quality.

Overall, this process presents strong evidence for the psychometric quality and validity of the oral and written examinations for medical interpreter certification through a combination of a nationally representative occupational analysis survey and expert panels, expert-developed test items, pilot testing and statistical analysis, and professionally sound test-form assembly. However, while a sound and scientifically validated examination development process is essential for a credible national certification program, it is only one needed element. Rigorous and secure registration,

administration, and recertification processes are equally important. Access to the examinations and support for multiple language combinations must also be assured. These additional issues will be discussed below.

4. The National Board Exams

After the exam development process was completed, certification testing (Spanish-English) began in December 2009. This section describes the certification process as it has developed since that time. It discusses exam prerequisites, test administration, recertification requirements, the expansion of testing to new languages, and accreditation of the certification process.

4.1. Prerequisites

The prerequisites to be eligible to sit for the exams are designed to screen individuals before they start the process. If untrained or non-bilingual individuals take the certification exams, passing rates will prevail that are not indicative of what is possible by individuals who have a standing chance to pass these exams. Prerequisites protect the process as well as the candidates so that they only take the exams if they have a chance of passing them. The Joint Commission and CLAS Standards require medical interpreters to be both trained and tested, so testing alone is not sufficient. Therefore individuals must provide documentation of interpreter training as a prerequisite in order to meet these pre-established standards. Each application and supporting documentation is reviewed by a National Board committee for authenticity and eligibility, and is either approved or the candidate is asked to send in further documentation. The following requirements are used to determine eligibility:

- 1) **Age.** The minimum age required of an individual is 18 years of age. Copies of a driver's license, birth certificate, or passport are acceptable proofs of age.
- 2) **General Education.** The minimum educational requirement is a high school diploma. A high school or GED (high-school equivalency) diploma is acceptable proof of general education. (This requirement might change in the future, as has happened with ASL Sign Language interpreter certification, which raised the educational requirement to a bachelor's degree as of July 1, 2012.)
- 3) **Medical Interpreter Education.** Successful completion of a registered medical interpreter educational program (only graduation from medical interpreter educational programs with a minimum 40 hours duration will be accepted). A certificate of completion from such a program is the only acceptable proof of medical interpreter education. (This requirement might become more stringent when national IMIA accreditation for medical interpreter educational programs becomes available.)
- 4) **Oral proficiency in English.** English-language proficiency may be demonstrated by any one of the following:
 - Bachelor's, Master's, PhD, or any other degree from any US institution of higher education.
 - Graduation from any high school from an English-language country or from an American high school abroad.
 - One of the following tests (subject to change)
 - **TOEFL** (Test of English as a Foreign Language): 570+ on paper; 230+ on computer version; 90+ on iBT.

- **ELPT** (English Language Proficiency Test): 950+
 - **MELAB** (Michigan English Language Assessment Battery) 80+
 - **ECPE** (Examination for the Certificate of Proficiency in English): PASS
 - **FCE** (First Certificate in English, Level 3): A
 - **CAE** (Certificate in Advanced English, Level 4): B
 - **CPE** (Certificate of Proficiency in English, Level 5): B
 - **IELTS** (International English Language Testing System) 7.0+
- 5) **Oral proficiency in the other language(s) (referred to here as “L2”).** L2 proficiency may be demonstrated by one of the following:
- Bachelor’s, Master’s, PhD, or any other degree from an institution of higher education where L2 is spoken
 - Graduation from a high school of the country where L2 is spoken
 - 24 semester credit hours of L2 or university major in L2
 - ACTFL Oral Exams (American Council on the Teaching of Foreign Languages): /Advanced Mid Level (see www.actfl.org)
 - ILR 3.5 + (see www.govtilr.org)

4.2. Test administration

The National Board written exam is administered by PSI and offered on demand in hundreds of secure testing centers located around the country. Candidates may schedule their exam online. The exam is administered by computer in a quiet, secure, and proctored environment. Candidates know immediately at the end of the exam whether they have passed or failed. If they pass, they are given instructions on how to schedule the oral performance exam.

The oral examination is administered by a testing company (ISO-Quality Testing) in similar secure testing centers at sites maintained by other testing companies. Because oral examinations are not common in most fields, it is challenging to find locations that either have a separate room or that are willing to set up specific days/times of the week to serve a single candidate.

The exam was initially given at some 300 sites, but as it was a pioneering computerized oral exam, there were technical difficulties. In 2011 the National Board halted exams for two months to work out these problems and then resumed with just seven sites. National Board personnel worked with these sites, visiting several, and provided orientation and guidelines to the proctors. In addition, the National Board now provides technical support for each and every exam. With the problems resolved, the number of sites has expanded to 30 as of February 2013. These sites are spread across the U.S., with more being added as additional sites become able to deliver an oral exam.

In addition, the exams are delivered on site at health care facilities that wish to certify their interpreter staff, using a secure setting and impartial proctors who sign non-disclosure agreements. Duke Medical Center in Durham, North Carolina was the first site where examinations were delivered on site. The National Board gave a webinar to the Center’s staff to orient them on how the certification exams were developed, what categories are covered, and what the expectations are. The webinar training also explained the particularities of a computerized exam and how it functioned from a technical perspective. Then twelve of the staff’s Spanish-language interpreters who had passed the written exam took the National Board oral exam on a Saturday in a secure, proctored location on their campus that met the same set of requirements that apply to the testing centers. Duke Medical

Center then set up another testing session to certify the remainder of their interpreters. When all interpreters are certified, there will be a special ceremony at the hospital where they will be recognized and presented with their certificates.

Because of increased demand for on-site testing in addition to on-demand testing, the National Board now offers on-site testing at several other sites, and there are plans at other health care entities to offer the exam on site for staff interpreters. In addition, the National Board makes special arrangements for interpreters in areas far from the established network of testing centers. For example, the National Board welcomed the first Certified Medical Interpreter (CMI) in Alaska in January 2012 after the candidate and the Board made special arrangements with a testing center in Anchorage.

Testing sites are also set up to handle interpreters with special needs, and to date there are two blind candidates have been able to complete the two exams and become CMIs.

4.3. Recertification

To maintain certification all Certified Medical Interpreters must recertify every five years (as is the case with sign language interpreters) by participating in education directly related to medical interpretation. CMIs must recertify by completing three CEUs (Continuing Education Units)—equivalent to 30 contact hours of approved training—before the credential's expiration date (five years from initial CMI date of certification). All continuing education must be related to interpreting skills, ability, and medical knowledge. The National Board accepts International Medical Interpreter Association (IMIA), American Translators Association (ATA), and Registry of Interpreters for the Deaf (RID) CEUs. The ATA and RID CEUs must be for workshops, conferences, and events that are related to medical interpreting knowledge and skills enhancement. Certificants can post their documentation, such as a copy of their National Board certificate and educational certificates, on their online profiles in the IMIA National Public Registry of Medical Interpreters.

4.4. Expansion to new languages

In December, 2010, the National Board was awarded a grant by the Oregon Office of Multicultural Health & Services for the development of oral certification exams in five additional languages: Cantonese, Mandarin, Korean, Vietnamese, and Russian. The State of Oregon currently recognizes the independent board's testing and credentialing in Spanish as meeting the requirements for certification of Oregon interpreters and will extend approval to the CMI credentialing in the additional languages upon implementation of the new oral exams. Oregon, one of just a handful of states that have any formalized standards for medical interpreter certification, has long been a pioneer in the area of language access for limited English speaking patients. The State's adoption of the certification exams and credentialing process established by the National Board is an important validation of their historic initiative to bring a national standard to the profession.

In 2001, the 71st Oregon Legislative Assembly passed Senate Bill 790, which called for the provision of healthcare interpreters for persons with limited English proficiency (LEP). Oregon's Health Care Interpreter Council was then charged with developing and implementing the administrative rules that would govern the registry, qualification, and certification of interpreters for six languages.

David Cardona, Coordinator of the Health Care Interpreter Program and Language Access Services Program for the Oregon Office of Equity and

Inclusion, Oregon Health Authority, led this effort. The Oregon Health Authority recognized that the state of Oregon would save considerable time and resources in achieving their goal of ensuring the safety of LEP patients. Oregon is a state like many others where the LEP population has rapidly increased since 1990. Washington, California, Texas, and Utah are among the states considering recognizing national medical interpreter certification via pending legislation. In addition, the State of New York now reimburses Medicaid LEP patients, and has recommended that National Board-certified interpreters be utilized.

The development of these exams is now complete: the pilot examination process is done,² the exams have been validated, and these five exams are currently in the process of being rolled out (during the first three months of 2013).

4.5. Accreditation

The National Board's medical certification program for Spanish was accredited in December 2012 by the *National Commission for Certifying Agencies (NCCA)*, a division of the Institute for Credentialing Excellence. Certification programs that receive NCCA Accreditation demonstrate compliance with the NCCA's *Standards for the Accreditation of Certification Programs*.³ NCCA-accredited programs certify individuals in a wide range of professions and occupations, including nurses, automotive professionals, respiratory therapists, counselors, emergency technicians, and crane operators, among others. To date, NCCA has accredited over 200 programs from more than 100 organizations in the United States and abroad.

NCCA accreditation should not be confused with national accreditation for Medical Interpreter Educational Programs. Just as NCCA Accreditation demonstrates compliance with NCCA standards for certification programs, the IMIA offers an IMIA accreditation for training programs that demonstrate compliance with the IMIA standards for medical interpreter educational programs. It is important for the public and future interpreters to know that there will soon be measurable minimal benchmarks that medical interpreter programs have to follow in order to be accredited. IMIA accreditation will be voluntary (like the NCCA and others) and will allow educational programs to distinguish themselves from non-accredited programs. IMIA accreditation will accredit only on-site or online medical interpreter educational programs (not courses) or community educational programs that incorporate medical or healthcare interpreting in their curriculum.

The National Board certification program has done everything possible to be as rigorous and as accessible to interpreters as it can be. It does not give out credentials to interpreters who do not prove they possess the knowledge and skills required to interpret competently. The National Board also does not grant credentials to those who participate in pilot exams. It requires the verification of all prerequisites at registration; it is not done on the "honor system" with intermittent auditing. (Audit-based assessment could lead to scenarios where individuals pass certification exams but are later discovered in an audit not to have undergone the appropriate interpreter training.) The National Board exams are as accessible as possible since candidates can schedule written and/or oral exams at third-party testing sites

² The National Board does not grant participants in pilot programs credentials since the data from the pilots is being used to finalize the actual exams.

³ See <http://www.credentialingexcellence.org/ncca/>

in multiple cities in the country at their convenience or can participate in on-site testing at hospitals and other institutions upon request. The imminent expansion of the National Board into other credentials and languages demonstrates its strong commitment to providing providers and patients a mechanism of credentialing for all languages in all cities, regardless of how minor a particular language is in a region.

5. Future plans and expansion

There is strong commitment to include all interpreters who wish to be certified, not just those who speak those languages most commonly spoken in the U.S. The National Board is now in the process of offering the Qualified Medical Interpreter (QMI) and Screened Medical Interpreter (SMI) credentials. These credentials are for interpreters who interpret in languages other than the six languages for which the National Board has developed an oral certification exam.

To qualify for any of these credentials, interpreters must first submit the documentation needed to meet the prerequisites for certification by the National Board. After the applicant passes the written test, which is in English, the National Board will have a process in place for them to either take an equivalent third-party oral exam accredited by the National Board in their language, and receive the QMI credential, or go through an oral screening process to achieve the SMI credential. After passing the written examination, the screening process will include a portfolio review of information about the candidates' education, training, testing, and experience in interpreting in languages other than those covered under the CMI and QMI designations, as well as an oral interview. The National Board will ensure the rigor of this process in order to ensure the equivalence of all National Board credentials. The National Board will maintain the job analysis findings and scientific standards when reviewing third-party exams for possible inclusion in their QMI credentialing program.

As tests are reviewed by a sub-committee of the National Board for accreditation as part of the QMI designation, the National Board will also initiate work on the Screened Medical Interpreter (SMI) designation. Languages not covered under the CMI and QMI designation will be considered for the SMI credential. Facilities can be assured that interpreters with either of these credentials are certified to possess the minimal knowledge and skills recognized for that language pair for safe communication and interpretation for patients and providers. These will be the highest credentials achievable in these language pairs for medical interpreting.

6. Conclusion

While the National Board and IMIA are very proud of the work done to date, it is only a means to achieve three primary objectives: protecting the health and safety of language minority patients, expanding access to language minority patients by reimbursing hospitals for certified interpreting services, and professionalizing medical interpreting.

Development of national certification has not been without controversy. One concern the National Board encountered was that certification may actually be counterproductive by restricting the number of active professionals able to practice and that it inhibits the working of a free

economy. This objection raises real concerns that need to be addressed in medical interpreting. In the nineties and through 2009, there was much controversy and objection from all stakeholders to national certification over the concern of how it would affect the already limited pool of bilingual professionals willing to do interpretation work at low wages. This concern was further augmented by the lack of access to adequate training and job opportunities for individuals proficient in many minority languages and for those who live and work in rural areas.

There was also the concern that certification would limit those that were practicing at the time who might not qualify under the new rigid qualification guidelines. Concern for these social consequences was soon overridden by concerns for patient safety and language minority patient access to qualified interpreters. As demonstrated by the adoption and expansion of national certification for medical interpreters, and also by ever-increasing remote technologies and service delivery models, most have come to realize that the benefits of certification outweigh the disadvantages.

National certification works to achieve the first objective of providing safe communication, ensuring patient safety and the promise to do no harm to language minority patients. In order for a reimbursement program to be effective, the payer needs to know who is qualified to receive reimbursement. National certification answers the question of which service providers should be reimbursed. For example, New York State Medicaid Reimbursement recommends that providers seek National Board Certified Interpreters. National certification thus helps establish the field of medical interpreting as a profession.

However, national certification by itself does not fully protect the public from unqualified individuals who could make serious errors in highly technical communication in health encounters between qualified healthcare providers and language minority patients. Only licensure will achieve this goal and is something the interpreting community will have to consider in the future, although serious issues concerning less-common languages and emergency situations would have to be addressed.

The National Board and the IMIA are working collaboratively to expand testing sites and ensure that as many languages as possible have a credentialing process. This will first and foremost benefit minority language patients, including those who speak indigenous languages. The National Board continues to seek ways to improve its exams, the testing platform, and the testing experience. The IMIA and the National Board plan to increase access to the exams by using a more accessible and technically advanced means to deliver the oral performance exam through virtual proctoring.

The IMIA will also continue its work to internationalize the certification process for the benefit of minority language patients worldwide. The National Board is now testing in Toronto, making Canada the first non-U.S. country to offer medical interpreter certification. There is great interest in other countries to establish or adopt an international certification program for medical interpreters. The globalization of health care has heightened awareness of the need for quality language access. As training programs increase, the need for competency exams follows. Because language service delivery systems increasingly cross international borders, an international quality control process to ensure safe communication becomes paramount.

ISO/ICE 17024, the international standard that sets out criteria for certification of individual professionals, was designed to harmonize certification programs worldwide. There is discussion and consensus among many experts in our field that it would benefit from a standard that is specific for the certification of translators, interpreters, and terminologists, and some

believe that the International Federation of Interpreters (www.ift-fit.org) would be the right home for such a project. The IMIA supports this goal and is interested in obtaining international accreditation as soon as the process becomes international.

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