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To: Senator Josh Green, Chair
Senator Glenn Wakai, Vice Chair
Senate Committee on Health

From: Dominic Inocelda
Chair, Office of Language Access – Language Access Advisory Council

Date: February 6, 2015, 2:30p.m.
State Capitol, Room 414

Re: Testimony on S.B. 904
Relating to State Certification of Health Care Interpreters

The Office of Language Access ("OLA") appreciates the opportunity to testify on S.B. 904 Relating to the State Certification of Health Care Interpreters. My name is Dominic Inocelda, and I am the Chair of OLA's Language Access Advisory Council (LAAC), testifying on behalf of OLA in lieu of its Executive Director, as this position is currently vacant.

OLA was established by law in 2007 to address the language access needs of the state's limited English proficient (LEP) population by providing oversight, central coordination, and technical assistance to state and state-funded agencies in their implementation of the requirements of Hawaii's language access law under HRS Chapter 321C. Hawaii's statute mirrors federal civil rights law that prohibits discrimination by federal and federally-funded agencies against LEP persons, as this constitutes national origin discrimination.

OLA strongly supports the intent of S.B. 904 which would establish a health care interpreter certification system within the Department of Health, with standards and guidelines to be established by a board. After meeting with stakeholders to discuss concerns over the current language, OLA offers comments with suggested amendments which (1) add further interpreter representation to the board;

and (2) simplify the board's duties. These amendments are outlined below. We will also provide this committee with a Proposed SD1 that incorporates these amendments.

There is a tremendous need for competent health care interpreters within our multi-ethnic, multi-lingual state. This bill would create a framework patterned off of an existing program in the State of Oregon for a state certification system that would help ensure that the interpreters certified under it are competent and adequately trained to provide their services to government-funded health care providers.

Interpreter competency is of utmost importance in the life and death situations characteristic to the health care context. To illustrate this, attached to this testimony are a few "Untold Stories" in health care that we gathered from a project OLA has been engaged in over the last few years. These stories are disturbing because they are wholly unavoidable had timely, cost-efficient, competent interpreter services been provided.

As a civil rights compliance matter, hospitals and health care providers that receive federal funding have an obligation under Title VI of the Civil Rights Act of 1964; Executive Order 13166 and its related federal regulations; as well as federal case law, to provide language access to the limited English proficient (LEP) populations they serve. Failure to provide competent oral interpretation services may result in a determination by federal authorities or a court that the provider discriminated against the LEP patient based upon his or her national origin. This can, and has resulted in a program's debilitating loss of federal funding; in addition to significant costs associated with the time spent in compliance monitoring; cooperating with investigations; and negotiating consent agreements. OLA is aware of at least 4 major state departments within Hawaii that have been mired in such circumstances.

Another important factor this committee should consider is the cost to the state and our government-funded health care providers to litigate and pay damages. It's been reported that hospitals have settled language access lawsuits for millions of dollars. A health care provider's malpractice insurance typically does not pay for civil rights violations.

Furthermore, Congress enacted the Hospital Readmissions Reduction Program (HRRP) as part of the Patient Protection and Affordable Care Act (ACA), under which Medicare will penalize hospitals for higher-than-expected rates of readmissions. Studies have concluded the obvious - language barriers prevent patients and their families from understanding their diagnosis or discharge instructions; which logically leads to a greater risk of readmission.

This certification program will serve our health care providers by helping to ensure they are meeting their civil rights obligations by using oral interpreters that are vetted, trained, and certified under it. Like Oregon, this proposal is likely to be part of a growing trend among states to improve language access compliance.

SUMMARY OF SUGGESTED AMENDMENTS:

- Include on page 4, line 1 an additional board member representing the interpreter community as follows:

> **"One interpreter certified by the "Certification Commission of Healthcare Interpreters"; or "The National Board of Certification for**

Medical Interpreters"; and with expertise in these certification programs;

- Replace the language regarding Board duties on page 6, line 1 – page 8, line 7, as follows:

"§321C-C Board duties. The board shall work in cooperation with the office of language access and the department of health to establish guidelines and standards for state certification as a health care interpreter; and shall consider the requirements established for qualification or certification under the "Certification Commission of Healthcare Interpreters"; and "The National Board of Certification for Medical Interpreters." The guidelines and standards established by the board may include, but are not limited to, determining the qualifications required for certification as a health care interpreter; establishing various tiers of qualification and the credentialing for each tier; potential interstate reciprocity agreements on educational and testing programs for health care interpreters; and operational and funding issues.

- Replace the language regarding "Application for qualification or certification; eligibility" with language relating to rule-making authority on page 8, line 8 – page 10, line 8, as follows:

"§321C-D Rules. The board may adopt rules pursuant to chapter 91, to implement this chapter."

As this bill makes an appropriation, OLA defers to the Governor's Executive Budget Request for fiscal priorities, but appreciates this committee for its commitment to language access and for the opportunity to provide this testimony.

UNTOLD STORIES OF LANGAUGE ACCESS

Background

On November 7, 2012, the State of Hawaii – Office of Language Access (OLA) held a retreat involving members of OLA's Language Access Advisory Council, OLA staff, State Language Access Coordinators, and interested members of the public. In discussing OLA's mission and vision of the future, those present shared multiple anecdotal stories on the ability of Hawaii's Limited English Proficient (LEP) population's to access essential government and government-funded services as mandated by our state's language access laws.

Everyone agreed that few LEP persons actually report non-compliance with the language access laws because (1) they may be unaware of our language access laws and their rights; (2) linguistic barriers make reporting the violation a challenge; (3) they fear exposure and/or prosecution for themselves or their family members if they happen to be in the United States illegally; and/or (4) there are various national, cultural, and/or personal factors that influence an LEP person's decision to report a violation.

In the group's collective desire to share these anecdotal stories and provide a forum for those who are effectively voiceless in asserting their rights to language access, it decided to engage in an alternative means of collecting and sharing these stories in a way that would preserve the confidentiality of those aggrieved; but also ensure that the public and our state agencies and state-funded entities become more aware of the challenges and successes we've faced in ensuring language access for all.

Note – these stories have not been verified or corroborated. They are not meant to serve as the basis of any specific complaint or legal action, but are merely illustrative.

This is an ongoing project. We are interested in gathering more stories of both language access success and language access denial. If you have additional stories to share, please email them to **rebecca.gardner@doh.hawaii.gov**; and **ola@doh.hawaii.gov.** All efforts will be made to keep these stories confidential.

. . . . [Stories about public safety, domestic violence, education, housing, and more have been removed.] . . .

HEALTH

MIS-DIAGNOSIS OF CHILD'S MENTAL HEALTH

The 2-year old son of a Spanish-speaking woman was referred by a doctor to an agency that assists developmentally-disabled children. The agency asked an interpreter to ask the mother if she would be interested in receiving free services to assist with her "developmentally delayed" child. The mother was shocked and embarrassed; and explained that the boy was fine, healthy, and bright, having met all developmental milestones at appropriate times.

At the boy's check-up with the doctor who made the referral, the doctor asked the mother several questions about the boy, which she could not understand because she was LEP. The mother had asked for an interpreter, but the doctor denied her request because he believed that either he knew enough Spanish to understand her, or that she knew enough English to get by.

Nevertheless, the doctor proceeded to use the 7-year old sister of the boy as an interpreter to ask questions about the boy. The mother is not sure what the daughter might have said about her son, but thinks her daughter may have said something about the child being 'slow'. Nevertheless, the mother understood nothing about what was conveyed between the doctor and her 7-year old daughter.

Other Spanish-speaking patients had similar problems with the same doctor who maintains that he does not need or use interpreters.

PATIENT AUTONOMY IN DISEASE TREATMENT/PREVENTION EFFORTS

Public Health officials determined that an older Marshallese student had Hansen's disease and referred the student to a specialist. Before seeing the specialist, the services of an interpreter were obtained for the exam. The interpreter met with the student and asked the student if he knew the reason for the visit with the specialist. The student did not know, nor was he ever aware or told that he had Hansen's disease. The student was never offered an interpreter - despite the seriousness of his health condition. (The specialist later determined that he did not have Hansen's disease.)

SERIOUS HEALTH CONDITIONS, IMMIGRATION, TRAVEL SECURTITY & POSSIBLE RACIAL PROFILING

A 12-year old girl was traveling interisland with her mother so that she could be evaluated for a medical condition that required surgery. On one of her interisland medical trips, the girl and her mother were removed from the security line and taken to a small interrogation room.

During the entire detainment, the girl was required to interpret for her mother in Spanish. At no time was the family offered an interpreter, nor allowed to call anyone. They were never told they could request an interpreter. No reason nor justification was given to the mother and daughter as to why no interpreter was present.

They were told to sign papers, but the papers were in English. No Spanish translation was made available to them. Their fingerprints and mug shots were taken and they were given deportation papers, but later released on their own recognizance.

The girl's primary care physician wrote a clear, terse and direct letter to the government officials, stating that the child will likely die if returned to her homeland. State and county offices have assisted the family with interpreters, assistance, and guidance. Nevertheless, the family is in a holding pattern - hyper vigilant and perpetually fearful of being deported, which undoubtedly compounds the stress and uncertainty relating to the girl's grave health problems.

HOSPITAL CARE

An 81-year old LEP individual suffered from heart disease and high cholesterol. He was undergoing treatment with medications; an Automated Implant Cardio Converter; and placed on a special diet.

When in the hospital for gastrointestinal bleeding and dehydration, the man showed many signs of needing an interpreter and translated documents; but no service was offered or provided during his 10-day hospitalization.

While hospitalized, a number of medication errors were made. He had negative reactions to a blood transfusion, to which the staff was delayed in responding to. His discharge time was also delayed. Moreover, critical information was not provided and received in a timely manner. It was generally felt that competent services were not provided.

The man had adult bilingual children (both nurses) who were able to translate and interpret patient care services; however in their absence, it is believed that the patient's outcome would have been poor to near fatal.

For a follow-up appointment, the daughter requested an interpreter 2 days prior, but was told by the same hospital admission that the hospital generally had "Language Line" or phone interpretation, but the hospital's contract with the service had either ended, or the phone was not working. She was also told that since the bilingual daughter was going to be there, it was ok to have family translate. The hospital went on to tell the daughter "It will be okay, honey…no worries. I think we have a girl that speaks Filipino, but not sure what dialect she speaks."

Nevertheless, all information and instructions provided to the patient were in English. The daughter was again asked to interpret and do sight translation of the documents.

During the treatment, no translated documents were made available. "Language Line" phone interpreter services were not provided. Although the hospital had staff that spoke the patient's language, they were not utilized. Moreover, the nurses or aides that did speak the patient's language would not speak his language when interacting with him. The patient and family could not understand why the Nurses and Aides assigned to the patient did not speak to him in his native language, despite the family encouraging them to do so. The staff seemed hesitant - that perhaps some policy was preventing them from doing so.

Success: *However, at another follow-up appointment, an R.N. who spoke the patient's language was assigned and all instructions and patient education were provided in the patient's language. The R.N. did sight*

translation of the consent forms; lists of rights and responsibilities; confidentiality forms; intake forms; discharge instructions; etc. The outcome was excellent and service was extraordinary. When competent language services were provided, the patient left the facility feeling well taken care of; that he mattered and was respected.

EMERGENCY ROOM

An elderly LEP man had to go to the emergency room and was accompanied by his daughter. The daughter had called ahead and requested that an interpreter be present when they arrived so she would not have to interpret. None was provided when they arrived. She repeated her request and was told that "it is ok honey, we know you will do fine." During admissions, the daughter again requested and was denied an interpreter.

A hospital employee told the daughter that the hospital no longer had the "Language Line" interpreter service; but the daughter knew otherwise and told the employee that the hospital did, in fact, have the service.
All documents were in English, so she had to translate them for her father. The hospital staff did not see any reason to call anyone else in since the daughter was bi-lingual. The daughter did not want to do any of this. She just wanted to "be the daughter" and help her father get what he needed.

The man was later admitted and his family went home. The father again requested an interpretation of what the nurses said when they came to see him, but the hospital failed to provide it.
While his family was gone, he needed a blood transfusion, to which he had a reaction. The man tried to explain to staff that something was wrong, but no one understood. Fortunately the daughter returned in time to see what was happening.

Both of the man's daughters are nurses. Had they not been, they believe the outcome would not have been good.

The father explained to the daughters, and on his hospital release survey that he only received attention when the family was present. All physician visits were conducted in English, and included directions and information in English. No interpreter was provided when no family was present. The telephone interpreter service was not used even when the daughters requested that it be used; which was especially problematic when they were not there.

When follow-up treatment was required, the hospital asked the daughter to accompany the man for the purpose of interpreting. Based upon their experience, she felt she had no choice for the sake of her father's health and safety.

(This story may concern the same individual as the story above; but came from a different source.)

MIS-NAMED BABY

An expecting mother and her husband, both LEP, went to the hospital when the woman went into labor. They were accompanied by their own interpreter who helped them fill out the admittance forms. The baby's first name was left blank because they did not know the gender yet. The interpreter had to leave to go to work.

During labor, the couple was asked to sign more forms. No interpreter was provided and all documents were in English. The mother signed a form she thought was for an injection. This form was actually another form asking for the baby's name. She signed her own name.

That form was later used to put the child's name on the birth certificate. The child is male, but the birth certificate reflects his mother's name as his own. When the birth certificate arrived a month or so later the parents were shocked, shamed and dismayed that their son carried the mother's name and not the father's as intended.

No interpreter service was provided to the woman, including Language Line, during intake, pre-labor, delivery or recovery.

The couple spent untold hours and expense to officially correct the name; apply for Med-Quest; get a new birth certificate; and pay fees for legal and other related services.

. . . .

HAWAII INTERPRETER ACTION NETWORK
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hawaii.interpreters@gmail.com

To: Sen. Josh Green, M.A., Chair; Sen. Glenn Wakai, Vice-Chair;
All members, Senate Committee on Health

FROM: M. Alohalani Boido, M. A., Hawaii Judiciary Certified Court Interpreter;
Chair, Legislative Action Committee, Hawaii Interpreter Action Network
Affiliate, Pacific Media Workers Guild, Local 39521

HEARING: Feb. 6, 2015; 2:30 p.m., CR 414

RE: **SUPPORT with amendments, SB 904,**
Relating to state certification of health care interpreters

Chair, Vice-chair, and all members of this Committee, thank you for hearing this bill. I am Marcella Alohalani Boido, a founding member of Hawaii Interpreter Action Network (HIAN), an affiliate of the Pacific Media Workers Guild, Local 39521. We represent the interests of Hawaii's professional interpreters and translators. We are deeply concerned with issues related to language access, such as appropriate standards for interpreters. Hawaii needs appropriate, state-approved credentials for healthcare/medical interpreters.

I apologize for not being present, but I am working for the Judiciary today. Please feel free to contact me with your questions and concerns.

Probably most people still believe that any bilingual can interpret, and that it is OK for family and friends to interpret for a patient. However, both of these beliefs are false. A number of tragic events, and very expensive law suits, as well as federal government and Joint Commission guidance, have settled these issues.

The nationwide movement to standards for health care interpreters is therefore gathering strength. The health consequences for patients (and the legal consequences for health care providers) of missing or poor quality interpreter services can be severe. HIAN strongly advises all relevant parties to join this movement. Sooner is better than later. The effective delivery of medical services and the maintenance of accreditation for our hospitals and ambulatory care facilities depends on it.

In 2012, the Joint Commission, the body that accredits hospitals and ambulatory care facilities, published standards on language access, including interpreter services.[1]

Patient-Centered Communication Standards for Hospitals

"The patient-centered communication standards were developed as part of a larger initiative to advance the issues of effective communication, cultural competence, and patient- and family-centered care. The patient-centered communication standards for hospitals were fully implemented in July 2012 and are published in the *Comprehensive Accreditation Manual for Hospitals (CAMH).* The standards address issues such as qualifications for language interpreters and translators…"[2]

Ensure the competency of individuals providing language services.[3]

Language services that meet patient communication needs promote quality and safety. **Hospitals must ensure the competency of their language interpreters and translators.*** (Emphasis added.)

• Define qualifications for language interpreters and translators to comprise a combination of language proficiency assessment, education, training, and experience.

The Joint Commission also has language access standards for ambulatory health care.

HIAN suggests several amendments. Some are substantive. Others are intended to correct what appear to be errors of understanding, omission, or terminology. Departures from standard terminology in the field will be noted and corrected the first time only. For brevity's sake, some of the scholarship and details will be in footnotes.

P.1, line 16.

The purpose of this Act is for the department of health to oversee ~~to establish~~ a health care interpreter qualification and certification system ~~within the department of health~~, with

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[1] http://www.jointcommission.org/Advancing_Effective_Communication/. Accessed 2/4/2015.
[2] *Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Joint Commission Hospital Accreditation Standards*. http://www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf. Accessed 2/4/2015.
[3] *The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. P. 38. http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf. Accessed 2/4/2015.

standards to be established by a board of health care interpreters. [4]

Saying that the credentialing system will be *within* the department of health could be understood to mean that the certification program has to be in the department, and imply that the department can't just approve external certification programs. The truth is mostly like the opposite of this: the program will be approving already existing credentials from outside.

Currently there are two major, national credentialing organizations. They are the Certification Commission for Healthcare Interpreters ("CCHI") and the National Board for the Certification of Medical Interpreters ("NBCMI").[5] Both have a written test in English, as well as oral examinations in several languages, with more in development. The oral tests for both organizations have been accredited by the National Commission for Certifying Agencies ("NCCA").[6] Both require a minimum of 40 hours of training specifically for healthcare interpreters to be eligible to take the written and oral tests. Both are non-profits, but NBCMI is affiliated with LanguageLine, a for-profit company.[7]

Oregon recognizes both of these tests, with some additional requirements. Washington State has its own tests. California has its own test for Spanish, but this is not being administered currently.[8] In 2013 and 2014, bills were presented to the California legislature with provisions to recognize the CCHI and NBCMI credentials.[9] The National Center for Interpretation("NCI") at the University of Arizona has a Spanish/English credentialing test for students who have completed the NCI's 40-hour medical interpreter training.[10] More testing entities will probably arise, offering tests with varying degrees of scientific validity.

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[4] Some folks say "health care interpreters," others say "healthcare interpreters." See http://www.cchicertification.org/healthcare-interpreters/healthcare-interpreters. Accessed 2/3/2015.

[5] CCHI: http://www.cchicertification.org/. NBCMI: http://www.certifiedmedicalinterpreters.org/. Accessed 2/4/2015.

[6] NCCA: http://www.credentialingexcellence.org/ncca. Accessed 2/4/2015.

[7] This connection with LanguageLine is very controversial.

[8] That is unfortunate. It is probably the most rigorous test in existance. Test takers were allowed four hours and fifteen minutes to complete the written test, which had hundreds of test items, and tested for both Spanish and English. In contrast, the current written tests are much shorter and only in English. The California medical interpreter test was created as a credential for workmens compensation medical interview and treatment purposes. California certified court interpreters are now also certified as medical interpreters. That followed the inclusion of medical terminology in the court interpreter written test. That written test was discontinued a few years ago.

[9] 2013: AB 1263. 2014: AB 2325.

[10] This organization had the first federal contract for court interpreter test creation and administration, and has a lot of test creation and administration expertise. http://nci.arizona.edu/. Accessed 2/4/2015.

P. 3, line 3.

> "Health care" means medical, surgical, or hospital care or any other evaluative or remedial care recognized by state law, including dental and mental health care, as well as medical interviews and treatment for workmens compensation purposes.

Does the legislature want to cover alternative therapies such as acupuncture, massage, or homeopathic or chiropractic treatment? We leave it to you to create the appropriate text.

P. 3, line 6. Health care interpreters perform sight translation, which is spoken or oral work. They do not do document translation, which is written work. "Sight translation is a hybrid type of interpreting/translating whereby the interpreter reads a document written in one language while translating it orally into another language."[11]

> "Health care interpreter" means a person who is readily able to communicate in a language other than English with a person whose primary language is a language other than English and who has ~~with~~ limited English proficiency, accurately sight translate the written statements or interpret the oral statements of the person with limited English proficiency into English, and sight translate the written statements or interpret the oral statements of other persons into the language of the person with limited English proficiency.
>
> Patients with limited English proficiency should be provided with health care interpreter services.

Page 3, line 3. **HIAN is troubled by the proposed composition of the proposed board.** We think there should be more interpreters on the board, especially certified interpreters. They are the people with the necessary expertise. The proposed board seems to be composed largely of non-interpreter interest group representatives, and is short on needed expertise. There should be more expertise, and less interest group representation. At this point, however, we are not going to make many specific suggestions. We may do that if this bill moves forward, or in our testimony for the companion bill, HB 845. Currently we are short on time.

Page 4, line 1. A person who teaches interpreters has relevant expertise. Healthcare interpreting is a very specialized field.

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[11] **Court Interpretation: Model Guides for Policy and Practice in the State Courts**, p. 32. Chap. 2, "interpreting terminology." Accessed from http://www.ncsc.org/Topics/Access-and-Fairness/Language-Access/Resource-Guide.aspx on 2/4/2015.

(2) One educator who teaches interpreters ~~or persons in related educational fields, or who trains recent immigrants and persons with limited English proficiency~~;

Page 5, line 1. All of the counties except Honolulu City and County—the county with the largest population— have a representative on the proposed board. This appears to be an error of omission. We propose inserting (and then appropriately renumbering paragraphs which follow):

(10) One representative residing in the city and county of Honolulu who has shown interest in language access in health care;

P. 7, line 4. Interpreter interpret. Translators translate. Current, available health care interpreter tests do not test the ability to translate.[12] (Wash, rinse, repeat…legislative staff will need to make these corrections.)

(B) Oral ~~and written~~ language skills in English and in the language other than English for which health care interpreter qualification or certification is granted;

Page 9, line 1. Here again is the confusion about the work of health care interpreters. They interpret. They do not generally perform document translation, unless they are also medical translators (translation is a different profession).[13]

(b) A person may be qualified as a health care interpreter under this section only if the person:

(1) Is able to fluently interpret ~~or translate~~ between English and the language, dialect, slang or specialized vocabulary of the language other than English ~~non-English language~~ for which the qualification is sought;[14]

(2) Has had at least sixty hours of health care interpreter training that includes anatomy, physiology, and concepts of healthcare interpreting standards of practice and ethics ~~medical interpretation; and~~.[15]

[12] If I recall correctly, the California workmens compensation interpreter test had two short sections on translation, of perhaps two or three sentences. These texts dealt with very simple medical instructions. For reasons of test confidentiality, I cannot say more. This test is not currently available.

[13] American Translators Association, https://www.atanet.org/. Accessed on 2/4/2015.

[14] I'd like to quibble about "fluency," which has to do with ease in speaking a language. A person can speak a language fluently, but in a very broken and limited way, with poor grammar and limited vocabulary.

[15] There are three major Standards of Practice ("SOP") documents. National Council on Interpreting in Health Care ("NCIHC"): http://www.ncihc.org/ethics-and-standards-of-practice. PowerPoint:

~~(3) Has had practical experience as an intern with a practicing health care interpreter;~~

"Twenty years of doing something the wrong way does not constitute experience."[16] The internship requirement is one of those things that sounds wonderful in theory, but would currently probably be a disaster in practice. A person who has made it through the credentialing process to this point will most likely have had far more training, testing, and study than the vast majority of "practicing health care interpreters." Placing such a person under the supervision of a far less qualified person is a recipe for problems. The more established interpreter may be very motivated to push out the newbie, or may try to influence or force the newbie to do things the wrong way—the same way the more "experienced" person is doing them.

It will probably take at least ten years, and more likely, twenty years, before we have enough certified and qualified health care interpreters who are working and who can take on an intern. Even then, we won't have them in every language needed, on every island.

The medical profession and medically-related professions are subject to frequent upward changes in standards. For example, when my father came here to do his internship and residency at St. Francis Hospital, nurses had two years of training (and he himself trained quite a few). Now they have four. We used to have general practitioners. Now we have four "primary care" specialties.[17] So, the internship requirement for health care interpreters will have to wait until we have the conditions to support and implement this change.

We also have languages in Hawaii where it would be very difficult to find a person who could supervise an intern, because few or no speakers of that language work as health care interpreters.

Page 8, line 8. Some people may have current and valid qualification(s) or certification(s) from another state or from a nationally recognized testing entity. In fact, these credentials will probably form the basis for Hawaii state department of health approved credentials.

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http://www.slideshare.net/NCIHC/ncihc. California Health Care Interpreters Association ("CHIA"): http://c.ymcdn.com/sites/www.chiaonline.org/resource/resmgr/docs/standards_chia.pdf. International Medical Interpreters Association ("IMIA"), previously the Massachusetts Medical Interpreters Association. IMIA is an affiliate of NBCMI. http://www.imiaweb.org/uploads/pages/102.pdf. Accessed 2/4/2015.

[16] One of my father's medical school professors used to say this, albeit in Spanish.

[17] Some people are surprised when I tell them that my father(and other general practitioners) used to set bones and deliver babies. Now these actions are the province of specialists: orthopods and OB-GYNS, respectively. My father was a founding member of the American Academy of Family Practitioners, so he also lived through and supported one of these step-ups in standards.

§321C-D Application for Hawaii state department of health qualification or certification; eligibility. (a) Any person seeking Hawaii state department of health qualification or certification as a health care interpreter shall submit an application to the board…

Page 9, line 11. Same issue.

provided that the person shall not use the title "Hawaii state department of health qualified health care interpreter" unless the person has met the requirements for qualification established in this section and by rule, and has been issued a valid certificate of qualification by the board.

Page 9, line 16. Same issue.

(c) In addition to the requirements for certification established in this section, a person may be certified as a Hawaii state department of health health care interpreter only if the person:

Page 10, lines 1-4:

(2) Has passed written ~~and oral~~ examinations required by the board in English, including medical terminology, and a scientifically valid, criterion-referenced[18] oral examination of interpreting skills between English and a ~~in the~~ language other than English[19] ~~non-English language that the person wishes to interpret or translate, and in medical terminology~~;

If this bill moves forward, HIAN will be suggesting further and more detailed changes. We hope that the current proposed amendments will enable all of us to focus on more of the substantive issues in the future. Right now, we are short on time, and still consulting with national level experts.

We hope our testimony has been helpful to you in your thinking, and provides you with reference materials to consult.

Respectfully, we ask you to **please support SB 904, with these amendments**. Thank you.

[18] "Scientifically valid" tests are created according to the test creation standards of the American Psychological Association. "Criterion referenced" tests are objective. They are not graded on a curve.
[19] "Language other than English" is the standard term, sometimes abbreviated to "LOTE."

From: Terrina Wong
To: HTHTestimony
Subject: S.B. 904 Relating to State Certification of Health Care Interpreters
Date: Thursday, February 05, 2015 2:00:33 PM

To: Senator Josh Green, Chair
Senator Glenn Wakai, Vice Chair
Senate Committee on Health

From: Terrina Wong, Deputy Director, Pacific Gateway Center
Member, Language Access Advisory Council

Date: February 6, 2015 at 2:30 PM
State Capitol, Room 414

As a member of the Advisory Council to the Office of Language Access and as Deputy Director of Pacific Gateway Center, I appreciate the opportunity to offer this testimony on behalf of S.B. 904 Relating to State Certification on Health Care Interpreters.

Pacific Gateway Center is a non-profit organization, founded in 1973, whose mission is to empower immigrants, refugees and low income through programs that build skills that help to better access opportunities that lead to self-sufficiency. Therefore, we deeply understand first-hand the critical importance of language access to limited English proficient persons.

An integral part of the operations of Pacific Gateway Center is its Hawaii Language Bank (HLB) that offers qualified interpreters to the community. In 2014, HLB received close to 900 requests specifically for medical interpretation. SB 904 would establish a health care interpreter certification system and many HLB interpreters would be keenly interested pursuing certification.

I fully support the need to acknowledge interpreters who seek the opportunity to be certified and that validates their knowledge, qualifications and competencies in medical interpretation. This bill will also reassure the community in need of health care interpreters, particularly consumers, hospitals and medical practitioners, of the existence of certified medical interpreters who have demonstrated their knowledge and skills before a professional board.

As a member of the Advisory Council of the Office of Language Access, we believe S.B. 904 ensures competent language access that will avert inaccurate or incomplete information and promote meaningful interaction between the health care provider and the patient.

As a bilingual individual who works daily with limited English proficient persons and who teaches ESL to immigrants, I believe that S.B. 904 promotes the importance of qualified language access in a field that requires accuracy in transmission of critical information and messaging related to a person's health.

Thank you for this opportunity to provide this testimony.

Terrina Wong

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From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: mfsm819@hotmail.com
Subject: Submitted testimony for SB904 on Feb 6, 2015 14:30PM
Date: Thursday, February 05, 2015 12:56:39 PM

SB904
Submitted on: 2/5/2015
Testimony for HTH on Feb 6, 2015 14:30PM in Conference Room 414

Submitted By	Organization	Testifier Position	Present at Hearing
mary santa maria	Individual	Support	No

Comments: Lives depend upon accurate oral interpretation in many critical areas in the medical field. Daily in Hawaii crucial, often fatal errors are made due to mis-communication or no communication. Informed consent forms are meaningless if they are not understood. Standards must be made and met for those interpreting in medical setting. Children won't do, providers with minimal language skills won't do, trained, certified interpreters will do. Pass the bill please. cordially Mary Santa Maria Maui

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

College of Professional and Global Education

Re: SB904, Committee Hearing (HTH 414, Feb 6, 2015 2:30 PM)

Dear Committee members,

I write from California in general support of the Bill, with a few notes re a few issues.

I am the Director of a new Medical Interpreting Certificate Program (Spanish-English), in its first year.
Across the country, many persons, institutions inside and outside the medical interpreting industry are attentive to certification issues and the role of legislation. As you will know, the California legislature passed major bills in 2014 for certification and funding which were vetoed by the Governor but will likely re-appear later.

In terms of the professionalization of the industry through certification and state registration and funding, then, by virtue of this bill Hawaii is at the forefront of prospective changes which will likely be incrementally adopted elsewhere. As a result, decisions should not be made simply in response to the local immediate situation, but rather by a conscious calibration to the academic and professional consensus (to the extent that that exists) at the national level.

An example of how this plays is whether certification should be managed directly within the Department of Health, or whether, rather, various external and nationally administered certification systems should be used. The Bill's current articulation, which indicates in-house management, has advantages and disadvantages, but is only reasonable if the provision of significant and adequate funding for the establishment and maintenance of a HA certification system is incorporated into the Bill. The use of externally administered national certification systems would also have advantages of convenience and some possible disadvantages; if the Bill is modified in this sense, it would be appropriate to stipulate the responsibility of the HA Board of Health Care Interpreters to periodically scientifically (i.e., academically) verify the national certification systems in use at that time, together with new candidates for use. To this end, in addition to medical interpreting industry professionals and government administrators, the HA Board of Health Care Interpreters would need to include academics whose expertise is in psychometric testing (that is, without special knowledge of medical interpreting).

Without going into any detail here, it should be noted that the national record (both federally and in miscellaneous states) regarding the composition of Boards and oversight bodies in medical and in legal interpreting has been notoriously susceptible to structural flaws leading to many enduring situations which are patently damaging.

In short, the Bill must aim for a management design which either fiscally underwrites substantive in-house responsibilities, or, rather, has recourse to external certification systems but does so in a way that creates substantive oversight responsibilities for the Board so that the Board does not simply farm out certification and the verification of the validity of the certification system. In both instances, the composition of the Board of Health Care Interpreters is a delicate business and must be thoroughly thought through.

Thank you for your attention.

Piers Armstrong

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