DEPARTMENT OF HEALTH

# Spoken Language Healthcare Interpreter Work Group

**DATE: NOVEMBER 25, 2025**
**MINUTES PREPARED BY: LEA BITTNER**
**LOCATION: VIA WEBEX**

## Attendance

- Daniel Monari – member
- Jama Dahir – member
- Jose Tori Maguina - member
- Lailee Tung – member
- Maikhou Vang - member
- Marc Sony Cadet - member
- Marisa Rueda – member
- Michele Reither – member
- Munna Yasiri – member
- Rachel Herring – member
- Rick Michals – member (Rachel Gacioch – delegate)
- Talee Vange – member
- Jia Vang - MDH
- Lea Bittner – Alliant Consulting
- Kelly Deering – Alliant Consulting
- Jessie Schuppe – Alliant Consulting
- Jill Freudenwald – Guest Speaker
- Chelsey Olson – community member
- Dan Endreson - community member
- Mohamad Anwar - community member

## Agenda

- 2:00 - 2:05 Welcome and Housekeeping
- 2:05- 2:15 Meeting Recap and Project Plan
- 2:15 - 2:40 Guest Speaker
- 2:40 – 3:20 Member Discussion
- 3:20 - 3:30 Future Meeting Topic Prep, Next Steps and Closing

## Business from Previous Meeting

- Polling results were shared with members.
  - Identify broad group of key stakeholders for survey: 73% full support, 27% support with minor reservations.
  - Form work group to develop survey questions; including stakeholders from recommendation #1: 90% full support, 10% support with minor reservations.

  - Create different versions of the surveys (provider, interpreter, agency, etc.) 56% full endorsement. 33% with minor reservations, 11% don't fully like but will support.
  - Surveys should be available in all common languages (translated and interpreted for those survey takers who may not read and who prefer spoken language interpretation): 64% full support, 36% support with minor reservations.
  - Set up outreach events that offer in-person (preferred) and remote interpreters (for non-bias) to help LEP individuals understand and fill out surveys (2 different roles): 60% full support, 30% support with minor, 10% don't fully support.
  - State should contract qualified spoken interpreters (rare and common languages) to help LEP groups with completing survey via events such as town hall meetings and focus groups: 70% full, 20% with minor reservations, 10% don't fully like but will support.
  - Follow generally accepted principles for the creation, piloting, and revision of scientifically sound survey research [including culturally responsive]: 89% full support, 11% support with minor reservations.
- Revised language for a recommendation was presented and voted on: promote survey through different media channels: emails, social media, website, mail, partnering with different community groups/associations etc. Collect survey responses online and in-person (78% full support, 22% support with minor reservations).
- More than 50% of support by voting members will move recommendation to MDH.

# Information Presented

Legislative Process – Jill Freudenwald, Agency Policy Specialist with MDH

## Purpose of the Work Group

- The Spoken Language Health Care Interpreter Work Group was created by legislative mandate to review issues related to interpreters and make formal recommendations to the Commissioner of Health for presentation to legislators in 2027.
- Only legislators can move recommendations forward into law; the group's role is to prepare and present them.

## Legislative Process Overview

- Current phase: *Agency Prep Work* (now through February).
  - This is when agencies gather information, develop recommendations, and prepare for the legislative session.
- Legislative Session begins in February:
  - Hundreds of bills are introduced.
  - The Office of the Revisor formats bill language correctly.

  - Bills only advance if they receive committee hearings.
  - Smaller bills often get combined into larger omnibus bills.
  - Passed bills go to a conference committee for alignment.
  - Final votes occur in the House and Senate.
  - If approved, the Governor signs the bill into law.
- This work group's recommendations will be relevant to the January 2027 session, when the next round of action is expected.

## Committee Hearings and Engagement

- Recommendations will be submitted for legislative committee hearings in 2027.
- Ways individuals can engage to support proposed legislation:
  - Contact legislators.
  - Attend hearings.
  - Provide public testimony.

## Legislative Timing & Difficulty

- A work group member asked: Will we have to go through the whole legislative cycle again for recommendations we make if we are aiming to see our recommendations turn into legislative changes? Answer: It often takes multiple sessions or years to move a proposal into law; progress depends on legislative interest, party makeup, and the state budget. Previous attempts for the Department of Health to make legislative recommendations on health care interpreters have not successfully made it through the process. The creation of this work group was MDH's attempt to try a different strategy.
- A work group member commented: Previous attempts to regulate interpreters failed not due to budget issues, but because of opposition from segments of the community/industry.
- One-party majority sessions can be challenging; sometimes little moves forward.

## Guidance for Developing Strong Recommendations

Jill provided several best practices:

1) Be clear and concise in recommendation language.
   a. State the problem and the outcome you want.
2) Identify supporters and opponents.
   a. Legislators introducing the bill must be able to defend it.
3) Be aware of costs.

   a. Recommendations may require funding.
   b. 2027 will be a budget year, which can help proposals that require fiscal analysis or new appropriations.
   c. The agency can prepare fiscal notes if needed.

4) Learn from history.
   a. Past bills have failed; understanding who opposed them can guide strategy.
   b. Stakeholders recommended contacting legislative aides from previous attempts.
   c. Having a short history of past efforts will help inform next steps.

The agency (MDH) can assist in drafting recommendations, ensuring alignment with statutes, packaging recommendations for clarity and compatibility with legislative processes.

## Work Group Early Recommendations Discussion

1) Definition and meaning of "Certified":
   - Member asked what "certified" means.
   - Lea: Certification refers to people who are formally certified to provide interpreter services.
   - Member: Minnesota does not have its own certification for healthcare interpreters. There is no certification requirement to be on the MDH interpreter roster. Two national bodies offer certification:
     - CCHI – Certification Commission for Healthcare Interpreters
     - NBCMI – National Board of Certification for Medical Interpreters
2) Current Situation in Minnesota:
   - The roster of interpreters does not verify interpreter skills or qualifications.
   - Requires only adherence to the code of ethics and a $50 fee.
   - Many people on the roster have varying or minimal training.
   - Originally, the roster was intended as a first step toward a skills-verified registry, but this hasn't been implemented.
   - Minnesota has no minimum standard for healthcare interpreter qualifications.
3) Types of Credentials:
   - Certificate/Training (e.g., 40-hour courses).
   - Courses like Community Interpreting or Bridging the Gap.
   - Provide knowledge of protocols, ethics, and standards—not currently validating interpreting skill.

- Certification: A skills-based process that includes written and oral exams, proven skill, not just attendance, requires ongoing renewal and professional development.
- A certificate shows you completed a course; certification proves your ability through testing and ongoing requirements.
- Important distinction emphasized by several members.

4) National & State Context.
   - Washington, Oregon and Maryland have certification programs which are models MN could consider.
   - Court interpreters do have a state certification system—healthcare interpreters do not.
5) Concerns About Quality and Patient Safety.
   - Lack of minimum standards leads to:
     - Inconsistent training and skills.
     - Errors in medical interpretation (e.g. wrong terminology like "yellow blood" for platelets).
     - Negative impacts on patient outcomes and health equity.
   - Members commented about quality assurance being critical.
   - Providers acknowledge current internal language tests often lack medical accuracy.
   - Hospitals test language proficiency, but agencies don't. Some hospital's tests do not include medical terms and anatomy.
   - Without minimum qualifications, payers (insurers) resist higher reimbursement for interpreter services.
6) Need for Standardization and Regulatory Structure - Member discussion included:
   - Creating a minimum requirement for medical interpreter training and testing in Minnesota.
   - Using certification as a benchmark or establishing tiers: Past proposals: Tier 1 certification, Tier 2 higher education.
   - Setting statewide expectations under ACA 1557 / Title VI.
   - Developing a framework for hospitals and clinics to follow.
7) Oversight, Accountability, and Ongoing Competence.
   - Member: Certification provides ongoing oversight and ensures updated knowledge. The registry could help MDH track interpreter competence, complaints, or negligence.
8) Virtual Interpreting and Vendor Issues

    - Large volume of MN interpreting is remote to people outside of MN. Current environment is reducing the pool of high-quality in-person interpreters.
    - Many remote interpreting vendors:
        - Have no standard training or certification requirements.
        - May use interpreters located outside MN or outside the U.S.
    - Consensus that vendors should be held to the same standards as in-person interpreters.

9) General Consensus Emerging.
    - Quality, training, and regulation of healthcare interpreters are critically important. Minnesota should consider:
        - Defining "certified" clearly.
        - Establishing minimum training/qualification standards.
        - Moving from a roster to a verified registry.
        - Aligning state policy with national certification bodies.
        - Ensuring consistency across in-person and remote interpreting providers.
        - Test for language proficiency, interpreting skills and medical terminology/anatomy.
    - Goal: Protect LEP patients, improve equity, and strengthen the interpreter workforce.

## Decisions Made

- Recommendations discussed at the last meeting were revisited; MDH will consider 50% or more support of a recommendation to move forward with.
- Revised Recommendation 8 (regarding promotion of survey via various channels) was presented and voted on resulting in 78% fully endorsed, 22% support with minor reservations.

## Next Steps

- Draft recommendations are due 12/4; the Thursday before the next meeting [SLHCIWG.MDH@state.mn.us](mailto:SLHCIWG.MDH@state.mn.us).

## Reminders

- Work group members are requested to share topic information or suggested subject matter experts (SMEs) to speak to the group on the designated topics ASAP via the new email box:

SLHCIWG.MDH@state.mn.us so that they can be scheduled in advance to address the Work Group.

- Members are expected to RSVP to the meeting invites and notify the SLHCIWG email box for any meeting which will be missed. Members can send a delegate in their absence. Contact MDH asap if you cannot fulfill your member responsibilities.
- Members are expected to refer to the meeting summary prior to engaging in any subsequent conversation to ensure timeliness of effort.
- Members are asked to submit Expense Forms after each meeting if they are not being compensated through their organizations.

Minnesota Department of Health
Spoken Language Health Care Interpreter Roster
PO Box 64900
St. Paul, MN 55164-0900
651-201-4200
health.hci@state.mn.us
www.health.state.mn.us

05/05/2026

*To obtain this information in a different format, call: 651-201-4200.*