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Homework assignment for September 19, 2023 meeting of the DSHS Language Access Workgroup.

Comments on SSB 5304 Sec. (3)

(b) Strategies for increasing access to language access providers in rural communities and for languages of lesser demand,

(c) Strategies for workforce resiliency including adequate workload and compensation, and

(d) Standards of ethics and professional responsibility.

Introduction:

WASCLA would like to see the state develop and activate a bold vision for carrying out the state's equity commitments to eliminate communication barriers to essential services, in both the short and long term. In order to provide meaningful comments about Sec.3 (b),(c), and (d) of SSB 5304/ RCW 74.04.025, WASCLA believes that considerations on these topics, just as for the prior topics assigned to the DSHS 5304 Workgroup, must be grounded in a well-informed and holistic approach. As mentioned in our prior comments for the Workgroup, without the necessary data, service planning and implementation cannot take place.

Assessment of the current status of adequacy of interpreter services on the basis of language and/or geographic location must be paired with assessment of the effectiveness of existing services, or about the lack thereof, in correlation with the specific care delivery settings. The issues are not just about rural areas and languages of lesser demand, as shortages of qualified interpreters also exist for commonly spoken languages including Spanish, and occur in all geographic areas of the state. Strategies must be carefully developed and evidence based, which the timeframe for the 5304 Workgroup has not permitted. As work progresses on improving communication access for healthcare services, including interpreter services, it must be part of overarching strategies to eliminate language barriers both across state government and in Washington's civil society as a whole. A piecemeal approach will not yield the necessary and durable results that we want and need.

WASCLA believes it would be misguided to focus only on healthcare in the limited sense of medical care, and instead the focus should be on the health of our state population in the broad and intersectional context of health, safety, and well-being, and across public and private sectors. The COVID-19 pandemic response, spearheaded by the Office of the Governor in conjunction with the State Department of Health, spurred an array of language access initiatives to meet population needs, and provides important lessons and examples of the coordinated approach which WASCLA believes is necessary for real change to occur. Currently, language access reform efforts are underway in several state agencies, including the work by OSPI to establish a system for training and credentialing of spoken and signed language interpreters to work with families at their students' schools, and Rulemaking by the Pharmacy Quality Assurance Commission of DOH to establish standards for accessibility of prescription drug

information and labeling. The HCA and partner WA Health Benefit Exchange, in addition to their routine operations which include language services, are now engaged in the massive task of Medicaid redeterminations following the end of the COVID Public Health Emergency, work which includes overcoming communication barriers faced by clients. Likewise, DOH which is engaged in language access through its multiple functions, as well as DCYF and the Department of Ecology, the Emergency Management Division of MIL, the Department of Natural Resources, the Office of the Insurance Commissioner, the Department of Enterprise Services, just to name a few agencies, which have or are now developing and/or arranging for communication services of their own. The need for coordinated language services is immense. WASCLA encourages the WA State Office of Equity to move forward with its plan to add the role of language access coordination for state government. It will be critical for the Office of Equity to become engaged in the assessment and planning of interpreter services in health and human services, to be able to guide the development and delivery of comprehensive language services across state government.

It's WASCLA's position that the workgroup needs more time to be able to learn from initiatives such as these, which can be helpful background for the considerations now underway regarding the medical interpreter testing program. We recommend the following resources, as well as those listed in our comments for item (d), which were specifically created for healthcare services by subject matter specialists in communications practices in health and health care delivery.

Selected References

US. Department of Health and Human Services, Office of Minority Health
National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

Governor's Interagency Council on Health Disparities

2014 Language Access Policy Paper

2014 State Action Plan to Eliminate Health Disparities

Governor's Interagency Council on Health Disparities and WA State Department of Health
CLAS Standards in Washington

WA State Commision on Hispanic Affairs
2013-2014 Washington State Latino/Hispanic Assessment Report, special issue on Health
The State of Language Access in Washington 2014, pp. 59-64

WASCLA Tools for Health provider education materials

Language Access in Healthcare: What Providers in Washington State Need to Know

Selected Resources for Medical Providers on Language Access in Healthcare

WASCLA's recommendations are based on our direct experiences from more than a decade of engaging with agencies and programs, such as information from the impacts of the COVID-19 pandemic, which highlight the vital importance of language services. We offer the following comments specifically on the elements of SSB 5304 Sec. (3) for which input on strategies has been requested of the Workgroup:

- (b) Increasing access to interpreter services, in rural communities and for languages of lesser demand.

  To develop appropriate strategies, first we need to understand the current status of language service provision, per language, in each community, through a public health lens. Information is needed as well as about unmet needs, and the existence , and implementation of, a Language Access Plan by each covered entity. Information from service providers in all care delivery settings in all areas, as well as from patients, community members, and advocates is equally important.

  At present, this data is not available in the public domain. While HCA maintains the Interpreter Services Data Dashboard, the information provided has limitations, and there is no overall tracking done of the provision of interpreter services for all patients and clients with LEP (i.e those for whom interpreter requests to HCA went unfilled as well as those for whom requests are not made to HCA), nor on the effectiveness of language services that are provided. WASCLA has previously made Public Disclosure Requests to HCA's data unit seeking this information, and thus learned about the limitations of the data that is available. Please see my written testimony for hearings on SSB 5304 where I discussed data needs and limitations of fill rate date for determining service needs.

  To be able to develop plans for increasing interpreter services by locale and language, we first need to know exactly what happens at the client level (for clients with any insurance status including the uninsured) when requests for interpreters go unfilled in lesser-demand languages, as well as when interpreters are not requested. While WASCLA regularly receives anecdotal information about communication service gaps, we need data to make informed decisions.

  The data may identify the need for DSHS or another state agency to engage in additional supports to increase the interpreter pool in a given region of the state and/or in a given language. In that way, the state could target their efforts to reduce gaps in healthcare access while gaining efficiency.

  Regarding services in rural areas, Washington has long been involved in healthcare initiatives, multidisciplinary healthcare provider training, and continuing education programs, which focus on providing and improving services in rural and underserved areas of our state and regionally. It will be vital to connect with these programs and agencies, as well counterparts nationwide, to learn first hand about current practices and challenges, to seek recommendations on enhancing language services, and to build community engagement for language services.

It is pertinent to note that the use of technology as a way to increase the availability of interpreters is appealing in these times. However, technology and related access gaps must be addressed before we can promote the use of a remote interpreter services technology as sole or primary solutions. For example, before a medical provider can rely on video remote interpreting as a solution, they first must ensure that the necessary equipment and broadband service are consistently available and adequate to transmit a smooth, clear image and sound quality. What we know from prior experience is that systems designed for one population are often used for other populations, even when the system is not built to adequately serve the latter. For example, the bandwidth needed to transmit spoken language interpreter services over a video remote interpreter platform is less than the bandwidth needed for quality sign language interpreter services due to the visual nature of sign language. Therefore, systems designed by and for spoken language interpreters may have unintended consequences if applied to sign language users. To avoid harm, any technology solutions being considered must be thoroughly reviewed for such unintended consequences.

- (c) Increasing workforce resiliency including adequate workload and compensation

Once again, these issues highlight the urgent need for comprehensive planning, which begins with data on the current status of language services not only to serve state government programs, but for the healthcare sector as a whole. With a few notable exceptions, little is known about language services provision by all of Washington's provider entities. Investments must be made in communication services as part of the routine standards of care.

This question necessarily brings up the issue of state agency bilingual employees, as the section of the RCW that talks about workload relates only to bilingual employees at the department (DSHS). However, this Workgroup has been limited to focusing feedback on medical interpreter testing and credentialing of contracted interpreters and has not been provided with the necessary foundational information to provide informed insights into this topic.

WASCLA's position is that this topic should be set out for a future workgroup, for considerations informed by data about the current bilingual employee numbers and caseloads, etc. That work would necessarily include a review of the bilingual fluency exams, developed around the same time as the DSHS medical interpreter exams and in need of modernization as well. (The same considerations apply to the other LTC programs of social services interpreter testing, document translator testing, and continuing education functions.)

An additional Washington resource that can be helpful for further planning of language services in state government is: Washington State Office of Financial Management, Report to the Legislature STUDY OF PROCUREMENT OF INTERPRETER SERVICES, 2013.

- (d) Standards of ethics and professional responsibility

Establishing standards of practice specifically for healthcare interpreting, including ethics and professional responsibilities, have been a high priority of specialist groups in the field, and it is important that Washington standards of today reflect these best practices.

The DSHS Interpreter's Code of Professional Conduct, as outlined in WAC 388-03-050, contains many of the necessary aspects of the standards of ethics for interpreters working in healthcare settings. In addition to reviewing its current usage in the field of healthcare, it is important that the code fits the sector of practice that an interpreter is engaged in. In other words, before the DSHS code could be contemplated for use in other sectors, attention must be given to the guiding principles and service structure of each field. For example, in healthcare , human services, and education, the interpreter can be a team member essential to the delivery of linguistically and culturally appropriate services which center the well-being of the client. Court interpreting , in contrast, is based on an adversarial service model.

WASCLA recommends that this issue also be addressed in a follow up workgroup /advisory body , as there has been insufficient time and information provided for this Workgroup's members to be informed by best practices, some of which are outlined below.

Key references include:

California Healthcare Interpreting Association (CHIA)
California Standards for Healthcare Interpreters - Ethical Principles, Protocols, and Guidance on Roles & Interventions, 2002

International Medical Interpreter Association (IMIA)
IMIA Standards of Practice, 2007, 1998, 1997, 1996

National Council on Interpreting in Healthcare

A National Code of Ethics for Interpreters in Healthcare, 2004

National Standards of Practice for Interpreters in Healthcare, 2005

National Standards for Healthcare Interpreter Training Programs, 2011
Interpreter Advocacy in Healthcare Encounters: A Closer Look . 2021

US Agency for Healthcare Quality and Research (AHRQ)

Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide For Hospitals. AHRQ Publication No. 12-0041, 2012

Improving Patient Safety Systems for Patients With Limited English Proficiency. Figure 5. Overview of Medical Interpreter Standards of Practice, 2020

American Hospital Association
Team STEPPS, establishes role of interpreters as members of the healthcare team.
Enhancing Safety for Patients With LEP Module

Beyond knowledge of federal and state laws and rules governing language access and interpreter services, it is important to become familiar with the specific communication services requirements of the accrediting bodies for healthcare facilities. The principal accreditation organizations are:

Joint Commission
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Road Map for Hospitals
Language Access and Interpreter Services – Understanding The Requirements
Standards Overview: New Requirements to Reduce Health Care Disparities
Health Care Equity Certification

DNV
PR.4 LANGUAGE AND COMMUNICATION