My name is Alejandro Rivas. I am qualified through OHA, and I have been working as a health care interpreter in Oregon since 2008. I am writing to urge your support of HB 2359 because this bill would allow for the enforcement of existing law protecting patients' right to access credentialed, Certified and Qualified interpreters on the Oregon Health Authority registry and keep interpreters and the patients we serve safe during public health crisis like the one we are going through now.

Limited English Proficient (LEP) individuals make up 8.7% of the US population, and that number is growing[2,5]. People with limited English proficiency experience significant health disparities. They are less likely to access the medical care they need[1,6], and when they do access care, they are more likely to have communication issues, less likely to receive quality care, and less likely to be satisfied with their care[2,4,10]. They experience poorer health, and are more likely to have uncontrolled chronic conditions[6,11-13].

The CCO 2.0 contract, ORS 413.552, ORS 414.625, Title VI of the Civil Rights Act, the federal Culturally and Linguistically Appropriate Services (CLAS) Standards, Section 1557 of the Affordable Care Act, Title III of the Americans with Disabilities Act, and many other state and federal protections guarantee LEP individuals and individuals with disabilities the right to trained interpreters in a timely manner at all points of contact in the health care setting. Nonetheless, patients in Oregon continue to face language access barriers. In 2020, OHA finally began to verify in whether CCOs are meeting their legal and contractual obligation to ensure that patients have access to Certified and Qualified interpreters. With this data, what interpreters and patients saw on the ground is supported by evidence: Certified and Qualified interpreters have not been prioritized for appointments, even when we were lacking work in the midst of the COVID-19 pandemic, the agencies we work with were reporting significant decreases in work[15] .

When health care providers meet their obligations to provide trained interpreters, it makes a difference. Patients who work with trained healthcare interpreters have higher satisfaction[1, 3, 6], better understanding[6-9], better care[2, 8], and better health outcomes[2, 3, 6-9] compared to those who rely on ad hoc interpreters, such as family, friends, and bilingual staff who are not trained as interpreters. Patients who have access to interpreters are less likely to resort to emergency services, and more likely to access preventive care[1, 8, 14].

This legislature already knows that the consequences of failing to provide access to trained interpreters can be dire. That's why we have Certification and Qualification credentials that require 60 hours of training and ongoing continuing education, a statutory requirement to work with interpreters that hold those credentials, and a statutory requirement that CCOs provide their members with access to Certified and Qualified interpreters under ORS 414.625. HB 2359 would allow those requirements that are already on the books to actually be enforced, with accountability for CCOs, providers, and language companies--so that the burden doesn't fall on one stakeholder alone.

Aside from the quality of language access services, I want to mention health and safety issues. The disparate impact of the COVID-19 pandemic reflects pre-existing inequalities in our

communities. Access to information during these chaotic times is crucial, especially for the communities most gravely impacted. Health outcomes of people of color, people with disabilities, immigrants, indigenous peoples and refugees depend on the quality and availability of language access services. When the pandemic hit, no one seemed prepared. Health disparities were exacerbated because vulnerable populations were not sufficiently protected by health policy measures. Individuals and community-based organizations wrestled with issues that I'd expected state or county officials to address. There were shortfalls in integrating language access services into platforms used for remote visits, providing patients access to credentialed interpreters, and ensuring interpreters had access to and were trained to use PPE.

A colleague addressed members of the Oregon Senate regarding the issue of interpreters' access to PPE. The Oregon Health Authority published a recommendation that interpreters be provided PPE, but the recommendation was not consistently followed. Felicity Ratway personally connected with counties across the state to ask them to provide PPE and recruited volunteers to help distribute to hundreds of interpreters as safely as possible through contactless home deliveries and staggered pickup times in parks.

Language minorities, who are predominantly immigrants and people of color, have a higher risk of developing COVID-19. Working with interpreters who don't have PPE exacerbates that risk. Because contract interpreters travel between different hospitals and clinics, one interpreter without PPE could potentially spread COVID-19 to many different locations.

When interpreters don’t know about such exposures and continue working, it puts vulnerable patients at risk. I grew weary each time I was informed of the type of appointments I would interpret days which were held in a conference room with a team of doctors and technicians giving family members their options of their relative infected with Covid19 on a respirator. I’ve done less of those in 2021. I felt relief when I knew I wouldn’t be exposed even with hospital PPE in short supply. Those phone calls aren’t onsite with patients. Terminal calls aren’t easy.

HB 2359 would give interpreters access to PPE, require them to be informed of exposures, and require that they receive CDC-recommended job-specific trainings, which many of us have not received as contract workers.

This bill is the next step forward to make sure that existing legal requirements are actually enforced and protecting interpreters and the patients we serve. Please vote “aye” on HB 2359.

Sources

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