July 19, 2022

My name is Cameron Coval. I am the Executive Director of Pueblo Unido PDX. I am writing to provide testimony on behalf of Pueblo Unido PDX, a non-profit organization that connects communities with vulnerable immigration status to legal, social, and Indigenous language interpretation services.

I'll begin with a snapshot of the need:

The American Immigration Council estimates that 110,000 undocumented immigrants reside in Oregon. Data from the Equity Corps of Oregon free legal aid program shows that of over 1,000 service users currently in removal proceedings in Oregon, roughly 20% speak Indigenous languages from present-day Mexico or Guatemala. If that 20% estimate is projected across all 110,000 undocumented immigrants in Oregon (including those who are not currently in removal proceedings at the immigration court), then a conservative estimate suggests that there are at least 22,000 undocumented Oregonians who speak Indigenous languages as their primary language. Of course, this estimate does not include those who have obtained a stable immigration status and are no longer undocumented, so the actual number of Indigenous language speakers in Oregon is likely much higher than 22,000, and still growing. Indeed, in HB2359, the State Legislature recognized that there is "a growing demand for health care interpreters in rural communities in this state, especially for interpreters capable of interpreting languages of limited diffusion."

The Oregon Judicial Department's (OJD) Language Access Plan shows that the Indigenous language Mam was one of the top 10 languages requested across the state in 2019. In 2020, top languages requested in OJD districts include: Mam (Lane, Marion, Lincoln, Tillamook, Umatilla & Morrow), Mixteco (Clackamas, Linn), Q'anjob'al (Umatilla & Morrow), K'iche' (Columbia, Umatilla & Morrow), and Purépecha (Deschutes). To my knowledge, comparable data does not exist or is not available in healthcare settings in Oregon.

There are over 70 recognized Indigenous languages in Mexico, with over 360 variations, and 24 recognized Indigenous languages in Guatemala, many with their own variations as well. Members of the Collective of Indigenous Interpreters of Oregon (CIIO)—a program of Pueblo Unido PDX–speak the following languages: Akateko, Chuj, Ixil, K'iche', Mam, Mixteco Bajo and Alto, Purépecha, Q'anjob'al, Q'eqchi', Zapoteco Alto.

As of July 19, 2022, of the 995 qualified or certified healthcare interpreters in Oregon, there is 1 qualified Mam healthcare interpreter, 1 qualified Purépecha interpreter (who is a member of CIIO) and 0 qualified or certified healthcare interpreters for any of the other top languages identified by OJD or represented in the Collective of Indigenous Interpreters of Oregon. To say

that there is a significant gap in language access for Indigenous language speakers in Oregon would be an understatement.

Language access in healthcare settings is an equity issue with life or death consequences. In HB2359, the Oregon State Legislature found that persons with limited English proficiency are "often unable to interact effectively with health care providers," and are "often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information." The Legislature also found that, without an interpreter, communication between health care providers and patients is impeded, which "negatively impact[s] health outcomes and prevent[s] clear and accurate communication and the development of empathy, confidence and mutual trust that is essential for an effective relationship between health care provider and patient."

Health care providers at Legacy Health and Virginia Garcia Women's Clinic concurred with the State Legislature's findings in testimony submitted to the Oregon Health Authority during public comment on OHA's proposed administrative rule changes. In their testimony submitted April 7, 2022, Legacy Health's Language Access Program Coordinator stated,

> "In serving and providing care for the communities of Silverton and Woodburn, we are experiencing an increased need for Mam interpreters in that region. There are multiple dialects of Mam and finding an interpreter from the small pool of individuals who speak the right regional dialect has been challenging, especially when patients come to our Urgent and Emergency Care settings.
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> Legacy Health contracts with many agencies, some of whom have only a few interpreters for onsite or phone interpretation. Since Mam interpreters cannot get 40 hours of work each week for their language skills, they must take other jobs to support their families, which makes them less available on-demand in urgent and emergent situations. Despite our best intentions, this could delay care to Mam-speaking patients while we locate an interpreter. This is a frightening situation for everyone involved. We strive to provide timely care to <u>all</u> patients regardless of their language."

Similarly, in testimony submitted to OHA on April 2, 2022, the Site Medical Director of Virginia Garcia Women's Clinic stated,

> "Access to interpretation services has been expanding and improving through my years as a health care provider. I can access hundreds of languages at the touch of an Ipad screen, on demand and not cause delays in my day to day work. But our access to indigenous languages from Mexico and Central America continues to be a problem.

> Local language banks have no access to interpreters in these languages, and national banks do not either.
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> I work at a federally qualified health center whose mission is to serve those with barriers to care. The most vulnerable patients I encounter daily are those that speak very little or no Spanish and speak an indigenous language from Mexico and Central America. Our state is not actively looking for specific data to guide their recommendations on these vulnerable populations. We don't even know which languages are present and at which volumes so that we can adequately respond."

Their testimony concluded with two examples of recent patient interactions, which they stated are interactions that are encountered daily throughout Oregon's healthcare system. These interactions are not the exception to the rule, they said, rather the norm for patients that speak an Indigenous language from Mexico or Central America:

> "At this time we have a 16 year old who came to her first prenatal appointment about one month ago. She speaks Q'eqchi, and on her phone visit with our RN the day before, said that she spoke a little Spanish but it made her embarrassed. We were not able to find this language in our Epic system so we put her as a Spanish speaker into our system. She presented to her visit 45 minutes late, and I was not able to do a complete intake and examination as I often do at my first visit. She was very quiet and shy. I was not able to ask her if this pregnancy was even planned. She reported she had arrived from Guatemala 2 weeks ago, and I asked her if she had been safe as she travelled *[sic]* here, but she didn't understand my question. We drew her prenatal initial labs, did a gonorrhea/chlamydia
> test and a urine culture like we do on every first visit. Her chlamydia and her urine culture were both positive. We had our RNs reach out to the patient to get her to pick up prescriptions for these infections. When she came in 2 weeks later, she was not sure what antibiotics she had taken. She was not able to understand the instructions at the pharmacy. Here is a direct quote from a provider in our clinic that saw her that day " It is not clear to me if she's taken the medications or not. We weren't able to get an interpreter, we called two local agencies and a national agency and no luck. I tried explaining but not sure if she really understands or if she's just saying yes because of the shame of me repeatedly asking to better understand what's going on. So she may still have chlamydia and UTI…". For this patient it has taken three Spanish speaking providers (two midwives and an RN) to thoroughly embarrass and confuse this patient, that deserves the adequate interpretation just like any other person that walks in our door."

> "I attended a delivery a few months ago, a patient that had had all of her deliveries at a rural hospital in Guatemala. She spoke Mam and a little bit of Spanish, and throughout her pregnancy had not been able to find a Mam interpreter consistently to get a good patient history. She had had a CS in Guatemala, and then had had a vaginal birth afterwards, the plan was to have a VBAC this time, as she had a really high chance of success given she had delivered vaginally once after her CS. She declined pain medications. She had signed consents for trial of labor after cesarean in clinic with a Mam telephone interpreter, and we had reviewed the consent again at the hospital in Spanish. She was progressing well in her labor and when she got to the most intense stage in labor, transition at 7 cm, she completely shut off communication with everyone. I felt like she had an out of body experience, she looked away from all of us, and stopped interacting with us. She got to 10 cm, and she needed to start pushing to deliver the baby. Despite the fact that she was ready to start pushing, her mind was not with us, and she would not push. There was clearly some trauma that was coming up for her at that time, maybe a bad experience at the hospital in Guatemala, maybe some PTSD that was coming back to haunt her at that time, but we were unable to reach her for four hours. Her baby was stable, and she was stable, but she would not push her baby to get the baby delivered. I sat with her and reassured her in Spanish to my best of my abilities, that she was safe, that we were here to support her, that her baby was fine, and that if she pushed with her contractions, she would have this baby and she would be done with her labor pain. She would not look at me or at anyone in the room. We waited for four hours, and remained as a calming force in the room, despite the language barrier and the lack of information about her history or what may have caused this trauma response. At one point though, she finally came back to the room, and looked at me in the eye and said she was ready. She pushed three times and out came the baby. I will never forget this birth. And I will never forget the feeling of not being able to give this patient enough space and safety because of a language and cultural barrier, that I was not able to access an interpreter."

Having established that there is a fatal gap in language access for Indigenous language speakers, and that such a gap relegates a growing number of Oregonians to, at best, substandard health care, and at worst, denial of life-saving services, I'll now turn to discussing why such a gap exists, and what actions the State could consider to address it.

First, until recently the Oregon Health Authority required interpreters to provide proof of GED or educational equivalency, pass a background check, and demonstrate language proficiency in order to become a qualified or certified healthcare interpreter. These requirements constituted significant barriers for Indigenous language interpreters seeking to obtain qualification or certification. Thankfully, due to advocacy efforts by CIIO and Pueblo Unido, and collaboration with OHA's Office of Equity and Inclusion, the educational equivalency and

background check barriers have been eliminated as of July 1, 2022, and an alternative method to demonstrate language proficiency has been implemented. Admittedly, the latter should only be considered a short-term solution while more robust language proficiency evaluation mechanisms are devised, but in the meantime, the absence of formal language proficiency evaluation mechanisms for Indigenous languages no longer serves as a barrier to healthcare interpreter qualification or certification. The remaining step that OHA needs to take is to offer its required trainings in languages besides English (e.g. Spanish), so that interpreters who, for example, provide interpretation from an Indigenous language into Spanish and collaborate with a Spanish-English relay interpreter, are able to obtain credentialing.

While progress has and continues to be made to open up more avenues for Indigenous interpreters to enter the healthcare interpreting profession, a second issue is that of living wages and incentives to remain in the profession. Presently, Indigenous language interpreters find it difficult to obtain full time work through healthcare interpretation, and the base pay rate of $60/hr is well below what Indigenous interpreters need to offset the investment in training and equipment, what they deserve for their unique and imperative skills, and what they can charge in legal, community, and other interpretation settings. For example, the Collective of Indigenous Interpreters of Oregon have established a base rate of $115/hr with a two hour minimum for virtual interpretation between English and an Indigenous language, and $85/hr with a two hour minimum for virtual interpretation between Spanish and an Indigenous language. Rates and hourly minimums are even higher for in-person interpretation. The Collective's rates are likely to increase further in the coming months due to rising inflation and cost of living. If the base rate for interpretation in healthcare settings does not increase accordingly, Indigenous interpreters will have no incentive to apply their skills in healthcare settings; they may opt, instead, to provide their services in other settings, or pursue other professions, such as management roles in agriculture or small business, where their language skills are valued and where they can be hired and earn full time wages. This would create a death spiral for language access, in which qualified healthcare interpreters will remain in dangerously short supply, and service providers will have to continue pressing untrained and unqualified family and friends to provide interpretation for their patients, or will have to try to "get by" and provide health care services without any interpreter at all. In either case, health outcomes for patients who speak Indigenous languages will be further prejudiced, and the State will fail in its commitment to uphold Title VI of the Civil Rights Act of 1964 and the 1978 Patient's Bill of Rights.

In addition to establishing accessible pathways for Indigenous language healthcare interpreters to obtain credentialing and earn living wages for their services, a third action the State may consider is offering incentives to CCOs that follow through on their commitment to language justice–the right to understand and be understood in one's own language. If CCOs are incentivized to make Indigenous language interpretation widely available, providers will be able

to offer better care, patient health outcomes will improve, and Indigenous language interpreters will have more opportunities and incentives to remain in the healthcare interpreting profession. The result is a win-win for patients, providers, and interpreters.

In conclusion, the level of need for Indigenous language interpretation is already high and far surpasses the availability of qualified Indigenous language interpreters, due at least in part to barriers to formal credentialing and insufficient wages for healthcare interpreters. This widening language access gap results in disparate and inequitable health outcomes for Indigenous language speaking patients, and compromises the State's ability to guarantee patient rights. It is imperative that the State gather more robust data to better understand and address this issue, and take necessary measures that incentivize Indigenous interpreters to enter and remain in the healthcare interpretation field. The State must also incentivize and hold accountable coordinated care organizations and other healthcare providers for delivering on their commitment to equal access and equity for all patients. Finally, although my testimony has focused specifically on the needs of Indigenous language-speaking patients and interpreters, the same lessons may apply more broadly to patients and interpreters of other languages of lesser diffusion. It would be prudent for the State to engage with organizations and stakeholders of these other lesser diffusion language groups to identify their specific needs and develop solutions accordingly.

Thank you for your consideration of this testimony. Please do not hesitate to contact me if you have any questions.

Sincerely,

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