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February 10, 2012

Doug Porter
Health Care Authority
MS 45330
Olympia, WA 98504

Subject: HCA Interpreter Services Screening Guidelines

Dear Mr. Porter,

We are writing with questions, concerns, and initial recommendations about HCA's draft Interpreter Services Screening Guidelines. WFSE/AFSCME Council 28 emailed several of their own questions to HCA on January 12, 2012, but has not received a response yet. The Washington State Coalition for Language Access (WASCLA), a non-profit organization whose mission is to promote language access to services for those with limited English proficiency, is joining Council 28 in seeking answers to the questions below, as well as to request a meeting to discuss our mutual concerns.

First, Council 28 and WASCLA wish to clarify that we are not opposed to interpreting via video and telephonic modalities. In fact, we look forward to increasing access to healthcare for limited English proficient Washingtonians by increasing options for Medicaid healthcare providers.

WFSE/AFSCME Council 28 and WASCLA are united in recommending that HCA's final guidelines include the following two components:

1.) In-person interpreting as the primary mode of delivery for interpreter services, with the option for healthcare providers and LEP patients to opt-in to remote interpreting modalities.

2.) Clear standards about necessary equipment and training in its use, as well as education requirements for Medicaid providers on utilization of telephonic or video interpreter services.

Both organizations have the following outstanding concerns about how HCA will implement the proposed changes:

1.) What, if any, is the default for non-medical appointment requests by DSHS employees?

2.) What, if any, are the equipment and training requirements for the 12-15,000 Medicaid providers in order to have a telephonic or video interpreter? As Council 28 detailed in their September 2011 report to HCA, there are serious consequences to the use of improper equipment to provide remote interpreter services. The State must define and mandate the use of specific equipment for each form of remote interpreting interaction. Equipment specifications must be detailed and

provided to all interpreters and providers. Vendor contractors providing phone or video interpreting for the State must also provide training and technical support for all interpreters, medical providers, and State employees to make use of any new technology successful.

3.) What are the exceptions HCA will recommend for when remote interpreting methods are acceptable for Medicaid medical providers to use, unless access to health care is at risk. We appreciate HCA's recognition of the unanimous suggestion by the hospitals, clinics, industry consultants, and interpreters represented in HCA's work group during the fall of 2011 to have such a basic list.

4.) What, if any, guidance about costs for each appointment type will be given to Washington's 12-15,000 Medicaid providers? There is a very real likelihood that the default use of a telephonic interpreter could cost more per appointment than an in-person interpreter. Given that the average appointment in 2011 in the HCA program was 1.1 hours, use of a telephonic interpreter at a per-minute rate for that duration is likely far greater than for an in-person interpreter. We don't believe the decision guiding modality determination should be primarily cost based, and the actual price-point at which a modality becomes more expensive comparatively is complex, and depends on the outcome of Council 28's collective bargaining negotiations for remote rates. However, we do hope that HCA is considering how to educate providers on the actual costs.

5.) What, if any, are the rights of Medicaid enrollee patients to request a preferred modality for an appointment? Todd Slettvet's December 2011 memo suggested that the feedback from the work group was to have medical providers alone select the mode of interpretation. Council 28 agreed that medical provider input was important, but that the input of patients and interpreters was also critical.

Many of these issues HCA is considering have already been studied at the national and international levels. For example, see:

- ASTM International's ASTM F2089 - 01(2007) Standard Guide for Language Interpretation Services, http://www.astm.org/Standards/F2089.htm

- Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members, by Cindy Roat for the California Academy of Family Physicians in 2005, http://www.medicalleadership.org/resources/continuing_education.shtml

We look forward to your response to our questions, and to discussing our concerns and recommendations with you in person before HCA's Request for Proposals is released in mid February.

Sincerely,

/s/

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