STATE OF MAINE
131ST LEGISLATURE
TASK FORCE ON ACCESSIBILITY TO APPROPRIATE COMMUNICATION METHODS FOR DEAF AND HARD-OF-HEARING PATIENTS
MEETING #2: MONDAY, DECEMBER 11, 2023

START TIME: 10:00AM

AUDIO AND VIDEO LIVESTREAM AVAILABLE AT:
https://legislature.maine.gov/Audio/#211

10:00	**Welcome & Introductions** Senator Henry Ingwersen, Senate Chair Representative Colleen Madigan, House Chair
10:10	**Report outline review** Elena Roig & Steve Langlin, Legislative Analysts
11:30	**Presentation: Pine Tree Society medical interpreter** Polly Lawson, CI, CoreCHI
12:15	**BREAK**
12:45	**Presentation: Dr. Judy Shepard-Kegl**
1:30	**Presentation: USM Interpreter Training Program** Regan Thibodeau & Sandra Wood
2:30	**Report outline review** Elena Roig & Steve Langlin, Legislative Analysts
4:00	**Adjourn**

***Note: times are approximate and subject to change*

Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard of Hearing Patients
DRAFT Report Outline
December 2023

I. Introduction
- a. Study process, enacting legislation, & meeting summaries
- b. Timeline/time constraints

II. Background
- a. Problem identification
  - i. Hospitals/doctors' offices frequently rely on the use of VRI even if in-person services are requested; in-person services are frequently preferred by many patients
    1. VRI limitations: internet connection, visual accessibility, little transparency on the licensure/qualifications of the interpreter, interpreter may not be aware of cultural/regional signs and terminology, practitioners don't always know how to operate the technology
    2. The use of a friend or family member as an interpreter can be inappropriate – they are not a neutral party nor do they necessarily know medical terminology (especially younger people)
    3. Requests for in-person interpreters are often not arranged by hospitals until shortly before the appointment or upon arrival in an emergency situation, further limiting availability
  - ii. Patients may not be aware of their rights with regard to accessibility to communication methods
  - iii. Needs among the deaf and hard-of-hearing are varied, but this is not reflected in the number of services offered in healthcare settings
    1. Important information can be missed if the appropriate/desired communication method is not offered
    2. Hospitals make decisions on communication methods on behalf of patients; patients should be making those decisions for themselves
  - iv. Regional disparity – lack of services in rural parts of the state compared to populated areas (northern Maine vs. southern Maine)

III. Recommendations
- a. Develop a mechanism to track overall availability of interpreters, hours worked by interpreters, availability of qualified medical interpreters, gaps in access (particularly tracking gaps between north/south/rural/urban
- b. Require development and implementation of language access plans at hospitals statewide
- c. Improve wages of interpreters
- d. Mandate availability of in-person interpreters when requested
- e. Incentivize more trained interpreters to remain and work in the state
- f. Legislation to reconvene this task force in the next legislative interim (2024) and direct certain entities to gather data (?)

IV. Conclusion

TITLE XV
EDUCATION

Chapter 200-M
CART PROVIDER AND SIGN LANGUAGE INTERPRETER NET TUITION REPAYMENT PROGRAM

Section 200-M:1

200-M:1 Definitions. –
In this chapter:
I. "CART provider" means a person who provides computer-aided, realtime translation of spoken language into English text by using a stenotype machine, notebook computer, and real time software to display the spoken text on a computer monitor, or other display device for individuals who are deaf or hard of hearing.
II. "Net tuition" means tuition costs for postsecondary school education that was directed toward the completion of a degree or certificate in judicial reporting, broadcast captioning, real time transcription, or sign language interpretation, or any other degree or certificate that the department of education, division of workforce innovation deems acceptable for purposes of CART provider and sign language interpreter net tuition repayment.
III. "Sign language interpreter" means a person who provides American Sign-Language based interpreting, which is the process of conveying information between American Sign Language and English.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:137, eff. July 1, 2011. 2018, 315:27, eff. Aug. 24, 2018. 2019, 118:2, eff. July 1, 2019.

Section 200-M:2

200-M:2 CART Provider and Sign Language Interpreter Net Tuition Repayment Program Established. – The department of education, division of workforce innovation shall administer a program for the promotion, acquisition, and retention of CART providers and sign language interpreters in the state.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:138, eff. July 1, 2011. 2018, 315:28, eff. Aug. 24, 2018. 2019, 118:3, eff. July 1, 2019.

Section 200-M:3

200-M:3 Application; Repayment. – An individual who has completed eligible CART or sign language interpreter training in accordance with rules adopted pursuant to RSA 200-M:5, including internships and residencies, and agrees to work as a CART provider or a sign language interpreter in this state, may apply to the department of education, division of workforce innovation for repayment under the CART provider and sign language interpreter net tuition repayment program and become eligible to be reimbursed up to 100 percent of his or her qualifying tuition not to exceed the cost of 4 years of in-state tuition at the university of New Hampshire, during a 5-year period of working as a CART provider or sign language interpreter. A 10 percent net tuition repayment shall be made upon completion of the first year of employment in this state, with an additional 10 percent made after the second year of work, an additional 20 percent after the third year of work, an additional 30 percent after the fourth year of work, and an additional 30 percent after the fifth

year of work.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:138, eff. July 1, 2011. 2018, 315:29, eff. Aug. 24, 2018. 2019, 118:3, eff. July 1, 2019.

Section 200-M:4

200-M:4 Repealed by 2017, 195:17, eff. Sept. 3, 2017. –

Section 200-M:4-a

200-M:4-a CART Provider and Sign Language Interpreter Net Tuition Repayment Fund. – There is hereby established a fund to be known as the CART provider and sign language interpreter net tuition repayment fund. The fund shall include any sums appropriated for such purpose. In addition, the department of education, division of workforce innovation may accept public sector and private sector grants, gifts, or donations of any kind for the purpose of funding the provisions of this chapter. The moneys in this fund shall be nonlapsing and shall be continually appropriated to the department of education. The fund may be expended by the department of education to accomplish the purposes of this chapter.

Source. 2019, 118:1, eff. July 1, 2019.

Section 200-M:5

200-M:5 Administration; Rulemaking. – The department of education, division of workforce innovation shall adopt rules, pursuant to RSA 541-A, relative to procedures, eligibility, and qualifications for applicants, qualifying educational costs, criteria for terms of service by a CART provider and/or sign language interpreter, procedures for repayment of net tuition costs, and the administration of the program by the department of education, division of workforce innovation. The commissioner of the department of education shall annually report to the general court on the effectiveness of this program.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:140, eff. July 1, 2011. 2018, 315:30, eff. Aug. 24, 2018. 2019, 118:4, eff. July 1, 2019.

From: Jeffrey Austin <jaustin@themha.org>
Sent: Sunday, December 10, 2023 4:05 PM
To: Langlin, Steven
Subject: FW: Hospital Data

Sorry, I should have included you in the email as well.
Jeff

From: Jeffrey Austin
Sent: Sunday, December 10, 2023 4:02 PM
To: Roig, Elena <Elena.Roig@legislature.maine.gov>
Subject: Hospital Data

Hi,

I was able to get data from three hospitals on their volume of ASL needs.

Small rural hospital – 13 so far this year. Don't have a contract with in-person services and not sure if Pine Tree would cover them.
Medium southern Maine hospital – 28 in the past two months (projected out to maybe 170 for a year).
Large central Maine hospital – 491 so far this year. Contract with Pine Tree for in-person services. Not sure how often in-person is used.

Thanks,
Jeff

Maine Hospital Association

Langlin, Steven

From: McInerney, Mark <Mark.McInerney@maine.gov>
Sent: Tuesday, December 5, 2023 7:40 AM
To: Langlin, Steven
Cc: Roig, Elena; Murray, Dillon F; Dawson, Andrew
Subject: RE: ASL interpreter salary data
Attachments: Interpreters and Translators SOC code 273091 2022 OEWS by State.xlsx

Good morning Steve,

These data are from the Occupational Employment and Wage Statistics (OEWS) program which is a collaborative program between states and the BLS. In each state program, jobs are wage data are classified according to the Standard Occupational Classification System (SOC) which is a federal statistics standard and may not align perfectly with job titles, licensing requirements, ect. that are of interest for a research purpose. The most detailed occupation for which state estimates are produced groups Interpreters and Translators together.

Given the limitation of the coding structure however, we can provide data for states in the region. The attached spreadsheet contains detailed wage and employment data for Interpreters and Translators in New England states and NY. It does appear that in VT and RI due to the relatively small size of the occupation that there is not enough information to produce valid wage estimates. On average it does not appear that there is a substantially lower wage in ME relative to NH though wages are higher in CT and NY. These data were compiled using the BLS Occupational Employment and Wage Statistics Query System which can be used to collect data from multiple different areas at once.

Area name	Employment(1)	Hourly mean wage	Annual mean wage(2)
Connecticut	230	$36.53	$75,980
Maine	230	$28.35	$58,970
Massachusetts	2,470	$30.73	$63,920
New Hampshire	190	$25.88	$53,830
New York	2,500	$37.04	$77,030
Rhode Island	140	(8) -	(8) -
Vermont	60	(8) -	(8) -

Hope this helps, let me know if I can provide any additional information.

Mark McInerney
Director
Center for Workforce Research and Information

Area name	Employment(1)	Hourly mean wage	Annual mean wage(2)	Hourly 10th percentile wage	Hourly 25th percentile wage	Hourly median wage	Hourly 75th percentile wage	Hourly 90th percentile wage	Annual 10th percentile wage(2)	Annual 25th percentile wage(2)	Annual median wage(2)	Annual 75th percentile wage(2)	Annual 90th percentile wage(2)	Employment per 1,000 jobs	Location Quotient
Connecticut(0900000)	230	$ 36.53	$ 75,980	$ 21.06	$ 26.34	$ 34.74	$ 39.23	$ 46.08	$ 43,800	$ 54,790	$ 72,260	$ 81,610	$ 95,840	0.14	0.4
Maine(2300000)	230	$ 28.35	$ 58,970	$ 19.60	$ 19.60	$ 23.80	$ 25.79	$ 30.37	$ 40,760	$ 40,760	$ 49,500	$ 53,640	$ 63,160	0.379	1.08
Massachusetts(2500000)	2,470	$ 30.73	$ 63,920	$ 19.66	$ 23.05	$ 26.76	$ 34.55	$ 43.02	$ 40,880	$ 47,940	$ 55,650	$ 71,870	$ 89,480	0.691	1.96
New Hampshire(3300000)	190	$ 25.88	$ 53,830	$ 17.50	$ 21.44	$ 24.59	$ 27.56	$ 42.08	$ 36,400	$ 44,600	$ 51,160	$ 57,310	$ 87,520	0.292	0.83
New York(3600000)	2,500	$ 37.04	$ 77,030	$ 18.13	$ 23.01	$ 31.52	$ 43.82	$ 57.72	$ 37,710	$ 47,860	$ 65,570	$ 91,140	$ 120,050	0.274	0.78
Rhode Island(4400000)	140	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	0.289	0.82
Vermont(5000000)	60	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	(8) -	0.188	0.53

Langlin, Steven

From: Nancy Hudak <nehudak@hotmail.com>
Sent: Saturday, December 9, 2023 9:29 AM
To: Roig, Elena; Langlin, Steven
Subject: HoH/Deaf Task Force
Attachments: HoH Task Force, comments.pdf

Ms. Roig and Mr. Langlin:

I acknowledge that the Task Force has not invited public comment on their work, but having skimmed the materials from the December 4th meeting and the Agenda for December 11th, I hope they will accept my comments on behalf of Hard-of-Hearing Mainers as distinct from the Deaf community.

I have attached a PDF version of my comments as well as copying them below.

Thanks you for your assistance,
Nancy

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Comments for the TASK FORCE ON ACCESSIBILITY TO APPROPRIATE COMMUNICATION METHODS FOR DEAF AND HARD-OF-HEARING PATIENTS (LD976)

December 11, 2023

Senator Henry Ingwersen, Senate Chair
Representative Colleen Madigan, House Chair, and
Members of the Committee:

My name is Nancy Hudak and I am a resident of Standish. I am submitting these comments to emphasize that Hard-of-Hearing (HoH) Mainers face different challenges from the Deaf community.

I am the parent of a hearing-impaired child (now 46, but HoH since age four following a bout of meningitis) and as the spouse of a severely HoH individual (it is a familial condition, so several of his close relatives are also HoH). My husband wears a Cochlear Implant and a linked hearing aid. Both my husband and daughter are fully capable of interacting with the world in almost all situations, but medical emergencies are not the norm.

There are just a few points to make specifically around HoH patients:

- Hearing impaired, but not Deaf, people do not generally make social connections based on the disability. Their capacity to become informed and lobby, therefore, is limited.
- There are many HoH people who have gotten there progressively or later in life, either from medical problems or simple aging. They may or may not be in contact with other HoH people.
- Some HoH people do not acknowledge their impairment.
- Many HoH people have good speech so may not be easily identifiable by listening to them speak.
- HoH people do not necessarily know American Sign Language (ASL), so the emphasis in most guidance on providing ASL intepreters is not useful. The December 11 Agenda is a case in point.

- In my experience in both Aroostook and Cumberland Counties, medical providers - including hospitals - do not generally make an effort to determine if a patient is hearing impaired. Once they do know, their accommodations are not as good they can be: *using masks with windows, taking care to face the patient, using slower speech, assuring a quiet room without fans or noise-cancelling devices*, for a few examples.

- Fortunately, I have almost always been able to accompany my husband to appointments, including Emergency Room visits, so can do his hearing for him. I have worried many times about patients, particularly older ones, I have seen there with no one.

- HoH patients need access to medical facilities and providers at times other than in emergencies like the tragedy in Lewiston. I cannot think of a medical provider with which I have interacted over the past years, even since the pandemic when technology (email, text, captioning, Zoom,"Contact Us" from a website, Chat, etc.) came to the forefront, has offered any way to communicate other than by phone, TTY, or Patient Portals.

- HoH patients may not easily be able to use a phone; they (particularly late-deafened) likely do not have a TTY since it is somewhat outdated; and Patient Portals permit access only to direct providers and billing departments, no one else.

Two final points about this Task Force itself:
1. Had the Portland Press Herald not reported on it, I (for one) would never have known.

2. It is unfortunate that a transcript of the December 4th meeting was not provided as another means of access. Watching several hours of video is certainly not optimal for anyone not directly involved. However, it was closed captioned, so that text could have been transcribed into a document.

Polly B. Lawson, CI, Core CHI
Gblpbl@aol.com

Resume:
Freelance ASL/English Interpreter with approx. 30 years experience
1979 began learning ASL (non-native, ASL is my 2nd language)
1982, graduated from Merrimack Valley Community College, 2 year ITP in Manchester, NH
1991 Certified by RID
1997 to 2006 stopped freelance work to raise children (continued interpreting at my church)
2007 returned to full-time freelance work
2012 graduated from University of Southern Maine with a BA in Linguistics and ASL/English Interpreting
2018 took an intensive course in Medical Interpreting at USM
2018 earned Core Certificate in Healthcare Interpreting (Core CHI) from the Certification Commission for Healthcare Interpreters
2018 to present: In order to keep my Certificate in Healthcare Interpreting valid, I must complete, on a 4 year cycle, 32 hours of medical interpreter training and show proof of at least 40 hours of work in medical settings. (I work hundreds of hours per year interpreting in medical settings.) NOTE: The Registry of Interpreters for the Deaf does not and has never offered a specialist certificate in healthcare interpreting.

Members of the Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard of Hearing Patients:

You have asked me here to describe my work as a medical interpreter and to share my perspective on how I think access to healthcare for Deaf, HH, DeafBlind and Late Deafened patients can be improved.

In a perfect world, healthcare services would always be rendered directly by providers who can converse fluently and directly with their Deaf/HH/DB or Late Deafened patients, and these providers would be fully aware of health care disparities experienced by the Deaf community over the centuries. No interpreters would be necessary. As more Deaf/HH individuals become healthcare providers, this standard of care has actually become a reality for some.

In lieu of that gold standard, qualified healthcare interpreters are essential. I begin by describing what I believe are the elements that must be considered for healthcare interpreting to be successful. These elements are:
1. patient preference for language and access is primary consideration
2. the healthcare provider recognizes their need for full access to their patient
3. the interpreter(s) committed to ethical practice and ongoing training
4. the interpreter referral agency is local and well connected in the Deaf and Interpreter communities

Definition: A healthcare interpreter's work is to provide communication access between a patient and a healthcare provider in such a way as to allow both parties to understand each other and to communicate effectively. The interpreter(s) provides not only a bridge in terms of language, but also in terms of the cultural differences that may exist between provider and patient. When this process happens successfully, the provider has the opportunity to understand their patient's needs and to provide the necessary care, *and* the patient has the opportunity to fully express their healthcare concerns and to receive the care they need.

1. The Patient: varied in preferences for interpreter use: gender, situation, level of trust for certain interpreters, VRI never, occasionally, always

2. The Provider: varies also in terms of experience with Deaf patients and with interpreters, comfort with one or two interpreters in the room, willing to take the time needed to allow for the interpretation process to happen effectively, aware of issues such as healthcare disparities…

3. The Interpreter(s)
It is a given that, in order to work as an interpreter, one must have fluency or near fluency in ASL and English and have a working knowledge of the cultures inherent to both languages. Attaining and retaining language fluency for interpreters like me who started learning ASL in my 20s is a continuous endeavor. Medical interpreting requires additional focus and training, in fact a healthcare interpreter's career should be infused with trainings on the various systems of the human body along with plenty of practice discussing these systems in ASL. Interpreters who are themselves Deaf and who use ASL as their native language, while still needing ongoing training in medical knowledge, bring their ASL fluency to bare in describing body features and systems in a rich and visual way. When teaming with a DI, I have deeply admired, appreciated, and learned from the commitment to the visual. Training on how to find resources for preparing for an assignment, and how to use resources *during* an assignment is also key. For example, if I am interpreting and I recognize that the Deaf patient is not fully understanding the anatomy of his knee injury based on *my* description in ASL, I might ask the Dr. to demonstrate the injury using the 3 dimensional model of the knee that I see on the office shelf. Healthcare interpreters should have a working knowledge of common medications and their uses, and have the ability to describe medical diagnostic tools. It is also important to understand the various goals and protocols of healthcare settings, for example: the goal of an emergency room vs. the goal of an outpatient well-child check; the protocols in play for an MRI vs. those of an operating room. Medical interpreting is necessary in every medical setting, from labor and delivery to end of life/hospice care. This incredibly diverse type of interpreting work is at times uplifting and at times traumatic, but it always involves the most personal details of people's lives. Thus, healthcare interpreters need to be deeply committed to honest and ethical practice that is based on a deep respect for the patient's right to privacy as well as to the provider and patient's confidence in an honest and transparent interpreting process.

3. The interpreter referral agency

But even with all this training in place, a successful healthcare interpreting assignment also depends on a well informed interpreter referral agency. Most healthcare assignments begin well before day of the healthcare appointment (barring emergency and last minute requests…of which there are many! But we are focusing, right now, on what works best.)

Here is a typical scenario: An interpreter referral agency receives a call from a healthcare provider for interpreter services for a patient who will be undergoing surgery. The goal of the appointment will be to explain the type of surgery, the preparation the patient must follow prior to the surgery, the date, arrival time, expected length of hospital stay, etc.

The interpreter referral agency, which is local to the area, records all this information, and then proceeds to consider the patient's preferences for certain interpreters. Since this patient typically benefits from a Deaf/Hearing interpreter team, the agency will consider both deaf and hearing interpreters who have had experience working with this patient, and, if possible, check on their availability for this date and time. Job offers will be emailed via a HIPAA compliant scheduling system and the Deaf and Hearing interpreters will respond that they are available, The agency will then confirm with the healthcare provider that a Deaf/Hearing interpreter team has been confirmed for the appointment.

The agency will have provided the interpreters with a brief description of the type of surgery being performed so the interpreters will have time, prior to the assignment, to do any necessary research on this surgery…so as to develop a visual understanding of the procedure. This will prove essential in providing a clear and accurate interpretation when the surgeon describes the procedure to the patient.

In short, an effective referral agency for medical interpreters is local, knows the Deaf community well, is familiar and honors (whenever possible) patient preferences for interpreters, recognizes the need for and regularly uses Deaf interpreters, knows the interpreter pool in terms of abilities, training, etc., and provides the interpreters with the necessary information to prepare for the job.

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When all of these elements are recognized and honored, the chances of quality healthcare are good. Example: Asylee patient and vaccinations vs. flu shots (DI, Dr.'s time, understanding)

When even one of these elements is not in place, breakdowns occur:
Examples:

Patient preference ignored: ER patient accepts the use of VRI for triage…asks for in person interpreter to be called in, but since VRI is in play, providers do not bother to call for in person interpreter, patient is unaware that no in person interpreter was called, but constantly waiting for interpreter to arrive...sometimes for DAYS if admitted.

Provider does not recognize the need: Rounding without ensuring interpreter is on site. OR: Deaf consumer has intelligible speaking voice and so is presumed "hearing enough" when actually, consumer is profoundly Deaf and is forced to lipread the providers

Interpreter not committed to ethical practice: Misunderstandings are not clarified, medication lists are not clear so interpreter guesses at medication name based in consumer providing the 1st letter

Agency unable to provide due to shortages: Happening often. Last Thursday, 7 unfilled appointments. OR: agency is *not* local, sends interpreter requests for patients they do not know to interpreters whose credentials they do not know. This can be an issue with VRI…since interpreters are frequently not local.

Suggestions:
Keep 4 elements at the forefront of policy making:

Deaf patient language and access preference: establish clear and well defined DEAF COMMUNITY LEAD protocols on the use if VRI in healthcare facilities. These should include when VRI is NOT access, connectivity/internet standards, size of screen, proper use and location if IOW. In person interpreters a generally the better approach to access (except when a Deaf consumer does not want an in person interpreter) VRI appropriate uses can be outlined and discussed by Deaf consumer groups.

Training for incoming healthcare workers on what access to healthcare really means for BOTH provider and patient. Provision of Deaf lead training on providing accessible healthcare for Deaf/HH/DB and Late deafened communities. Explore via training provider bias and attitudes about Deaf patients. Become aware of documented healthcare disparities. Training on use of interpreters. (Resource: Deaf and Hard of Hearing Experiences in Healthcare Summit for healthcare professional and healthcare administrators aimed at improving communication access and creating systemic change that will improve the patient experience for Deaf, HH, DB and late deafened individuals. FMI: 2axend.com)

Healthcare Interpreters
Establish healthcare interpreter training standards for medical interpreters in Maine.
We need many more interpreters in Maine to fill the constantly growing need. Recruit? Train? Pay incentive? (Maine pays interpreters less than other New England states)
The Maine Sign Language Interpreting Committee (a subcommittee of the Maine Association of the Deaf) is beginning to create a list of training needs for Maine's interpreters. Healthcare interpreting will be a priority.
(Resource: Deaf in Healthcare Summit for Interpreters, an annual 3 day online conference coordinated by Corey Axelrod, Founder and CEO of 2axend, a Deaf owned Deaf run company devoted to bringing a Deaf perspective on what is truly effective and equitable access to Healthcare settings for Deaf, Hard of Hearing, late deafened, and Deaf-Blind patients and their families. Many of the trainers in this Summit are healthcare providers who are Deaf. FMI: 2axend.com. Also: Saint Catherine University (Catie Center) Advancing ASL English Healthcare Interpreters provides a wealth of online medical and mental health interpreter training)FMI: healthcareinterpreting.org)

Interpreter referral agencies: Local is preferred due to knowledge of Deaf and Interpreter Communities. Local Interpreter Agency healthcare contract holders provide regular input on protocols for requesting interpreter services (lead time if possible, Deaf/Hearing team information rational, work with inpatient settings on improving best practice for interpreter presence for inpatients)

Deaf community leaders, healthcare administrators and Interpreter referral agency directors work together to establish realistic protocols for healthcare interpreting in various medical settings.

Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard of Hearing Patients
DRAFT Report Outline
December 2023

I. Introduction
   a. Study process, enacting legislation, & meeting summaries
   b. Timeline/time constraints
II. Background
   a. Problem identification
      i. Issues arise in all types of medical settings – providers frequently rely on the use of VRI even if in-person services are requested; in-person services are frequently preferred by many patients
         1. VRI limitations: internet connection, visual accessibility, little transparency on the licensure/qualifications of the interpreter, interpreter may not be aware of cultural/regional signs and terminology, practitioners don't always know how to operate the technology, VRI interpreter can make mistakes, little accountability, VRI delays can eat into appointment time
         2. The use of a friend or family member as an interpreter can be inappropriate – they are not a neutral party nor do they necessarily know medical terminology (especially younger people)
         3. Requests for in-person interpreters are often not arranged by providers until shortly before the appointment or upon arrival in an emergency situation, further limiting availability
      ii. Patients may not be aware of their rights with regard to accessibility to communication methods
      iii. Needs among the Deaf, hard-of-hearing, Late Deafened, Deaf blind communities -- as well as Deaf individuals with other disabilities -- vary among these groups and among individuals, but this is not reflected in the number of services offered in healthcare settings
         1. Important information can be missed if the appropriate/desired communication method is not offered
         2. Providers make decisions on communication methods on behalf of patients; patients should be making those decisions for themselves – these assumptions about communication methods can lead to misunderstandings
         3. In many instances ASL is one's first language and should be treated as such when services are offered and implemented
      iv. Regional disparity – lack of services in rural parts of the state compared to populated areas (northern Maine vs. southern Maine)
III. Recommendations
   a. Develop a mechanism to track overall availability of interpreters, hours worked by interpreters, availability of qualified medical interpreters, gaps in access (particularly tracking gaps between north/south/rural/urban)

i. Track complaints made to hospitals and providers, requests made for communication methods, and whether those requests are honored or something else is offered in place of the communication method requested

b. Require development and implementation of language access plans in healthcare settings statewide
    i. Require that language access plans are publicly available or available upon request
    ii. Implement accountability/monitoring system to ensure that language access plans are being followed – not just monitoring or investigating when complaints arise
        1. Ensure that federal law is being followed
    iii. Require that language access plans are reported on annually (to the Legislature?)
    iv. DHHS (?) create statewide guidelines for best practices? Mandate best practices?
c. Improve wages of interpreters
    i. Wages commensurate with credentialing/training
d. Require training of staff in healthcare settings and informing of patients
    i. ADA/Disability coordinators and frontline staff should be better trained on the specifics of each communication method offered and their suitability for the needs of patients – specifically the suitability of VRI
    ii. Patients should be informed on their rights and how the healthcare system works generally, how to make a complaint at that particular provider, how to access the available services, and how to proceed when their requests are not honored
        1. Knowing how to file a complaint will lead to better/more accurate tracking of data on complaints
e. Mandate availability of in-person interpreters when requested
f. Ensure better access to written materials (i.e. discharge plans, brochures) in different formats (i.e. an option to have in video format in ASL)
g. Incentivize more trained interpreters to remain and work in the state
    i. DOL/DHHS/DOE study barriers to licensure, landscape of where someone can access training/workforce development opportunities to be a licensed ASL interpreter
h. Legislation to reconvene this task force in the next legislative interim (2024) and direct certain entities to gather data (data mentioned above?)

IV. Conclusion

DISABILITY RIGHTS MAINE

MEMORANDUM

TO: Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard of Hearing Patients
FROM: Disability Rights Maine
SUBJECT: Draft Report Outline Comments
DATE: December 11, 2023

I. Introduction

a. Study process, enacting legislation and meeting summaries
b. Timeline/time constraints

II. Background

a. Problem Identification
    i. Deaf, Hard of Hearing, Late Deafened, and Deaf Blind individuals are diverse and have varied communication needs. A variety of communication tools, services, and technology are available to facilitate effective communication for these patients.

    ii. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability

    iii. Medical providers (hospitals, doctors' offices, paramedics, etc) are not always prepared to provide the auxiliary aids and services, or other accommodations, that may be needed for communication with Deaf, Hard of hearing, Late Deafened or Deaf Blind patients. Examples of auxiliary

aids and services include captioning, ASL interpreters, pro-tactile interpreters, assistive listening devices, clear masks, and others.

iv. Patients may not be aware of their rights with regard to accessibility to communication methods.

    1. Needs among the deaf and hard-of-hearing are varied, but this is not reflected in the number of communication services offered in healthcare settings.

    2. Important information can be missed if the appropriate/desired communication method is not offered.

    3. Patients often lack information on communication aids and services available from their medical provider, and where and how to request them.

v. Front line staff and providers at hospitals/doctors' office may not be aware of patient rights with regard to accessibility and effective communication.

vi. Regional disparity – lack of services in rural parts of the state compared to populated areas (northern Maine vs. southern Maine)

vii. Communication with Deaf and Hard of Hearing patients during emergency medical transportation is a particular need that is often overlooked.

viii. Hospitals/doctors' offices frequently rely on the use of VRI even if in-person ASL interpreting services are requested; in-person interpreting services are frequently needed and requested by many Deaf patients for various reasons.

    1. VRI limitations: internet connection, visual accessibility, size of screen, little transparency on the licensure/qualifications of the interpreter, interpreter may not be aware of cultural/regional signs and terminology, practitioners don't always know how to operate the technology, patient may not be able to attend to a screen for communication due to body position/effects of sedation/health conditions/other factors.

    2. The use of a friend or family member as an interpreter is generally inappropriate except in certain situations; entities cannot require a person to bring someone to interpret for them. Even if a patient requests to use friend or family as interpreters, they are not a neutral party nor do they necessarily know medical terminology (especially younger people).

3. Requests for in-person interpreters are often not arranged by medical providers until shortly before the appointment or upon arrival in an emergency situation, further limiting availability.

iv. Recommendations

a. Require development and implementation of language access plans that include the needs of patients who are Deaf, Hard of Hearing, Deaf-Blind or have other communication disabilities, at hospitals statewide.

b. Require inclusion of communication accommodation information in Patient Rights information, including: a list of communication aids and services available to all patients, a brief description of services, and information on how to request the aid or service needed.

c. Develop training and technical assistance resources available to medical providers on communicating with Deaf, Hard of Hearing, and Deaf-Blind patients

d. Develop state-level regulations to guide the appropriate use of Video Remote Interpreting in medical settings; Mandate that hospitals/providers attempt to provide in-person interpreters when requested.

e. Develop a mechanism to track overall availability of ASL interpreters, hours worked by interpreters, availability of qualified medical interpreters, gaps in access (particularly tracking gaps between north/south/rural/urban

f. Improve wages of interpreters

g. Incentivize more trained interpreters to remain and work in the state

h. Legislation to reconvene this task force in the next legislative interim (2024) and direct certain entities to gather data (?)

v. Conclusion