Interpreting and Advocacy

Patient Rights, Patient Safety, and Appropriate Advocacy

Felicity Ratway, MA, CMI

- Why advocacy?
- When and how do I advocate for a patient?
- What laws protect patients?
- What rights do patients have?

Considerations

Models of Interpreting & the Interpreter's Role

Interpreters have more than one role

Scholars have described different roles that interpreters take on in our practice...

Models of Interpreting (Beltran Avery)

1. **The interpreter as conduit**--the interpreter is “invisible,” merely relaying the message

2. **The interpreter as manager of the cross-cultural/cross language mediated clinical encounter**-- aside from conveying the message, the interpreter facilitates successful communication between the two parties“by actively assisting, when necessary, to overcome barriers to communication embedded in cultural, class, religious and other social differences.” This means managing the flow of communication and flagging cultural differences

3. **The incremental intervention model**--The interpreter steps out of the conduit role only as necessary to prevent a breakdown in communication

4. **The interpreter as embedded in her cultural-linguistic community**--the interpreter is an intermediary between two cultural-lingustic communities, and must take into account cultural considerations to promote a successful encounter. According to this model, “the interpreter has to have credibility as a member of the community in order to have credibility as an interpreter.”

Models of Interpreting (Roat and Creeze)

Conduit--“accurate rendering of meaning, maintaining tone and register.” This is the default for interpreters when things are going smoothly in the encounter

Clarifier--checking for understanding, providing clarification as needed

Cultural Broker--pointing out misunderstandings caused by cultural differences

Advocate--standing up for the patient when his/her health is at risk

Intrusiveness

-Which of these roles seem least intrusive?

-Which are more intrusive?

-Where do you operate most of the time?

Code of Ethics & Standards of Practice

Code of Ethics (NCIHC)

“ When the patient’s health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.”

Standards of Practice (NCIHC)

- The interpreter may speak out to protect an individual from serious harm. For example, an interpreter may intervene on behalf of a patient with a life-threatening allergy, if the condition has been overlooked.
- The interpreter may advocate on behalf of a party or group to correct mistreatment or abuse. For example, an interpreter may alert his or her supervisor to patterns of disrespect towards patients.

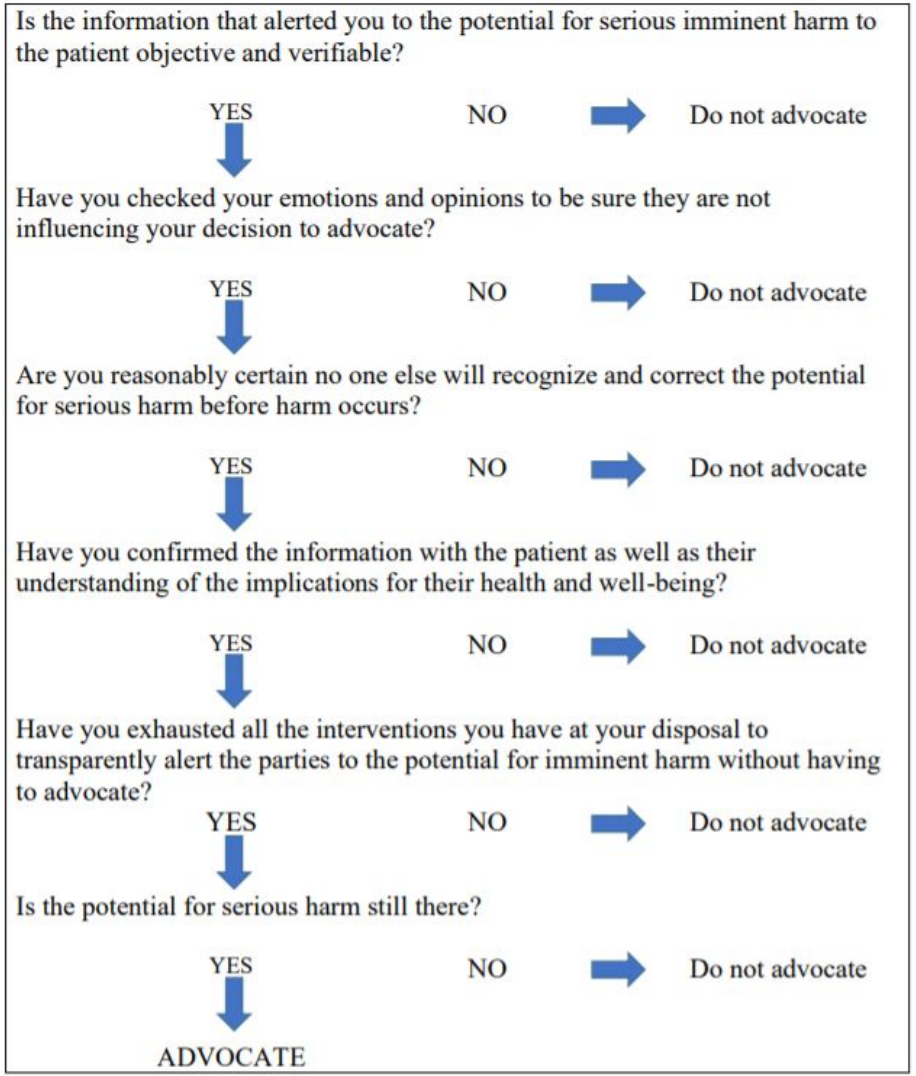
Why Advocate

- Per NCIHC
  - “OBJECTIVE: To prevent harm to parties that the interpreter serves.”
- To protect the patient’s well-being, safety, dignity

What Does Appropriate Advocacy Look Like?

- Least intrusive action--protecting patient autonomy
- Done to protect patient safety (keep in mind that patients have certain rights in order to protect their safety)
- Transparency (both parties are informed)
- No legal advice

Advocacy Flowchart (*from NCIHC)



Why is Advocacy Needed?

- Who are the communities we serve? What barriers do they face?
- Why should interpreters be familiar with legislation protecting patients?

Why is Advocacy Difficult?

- Balance of power
- Neutrality
- “Invisible” interpreter/conduit model as default

Language Access Legislation

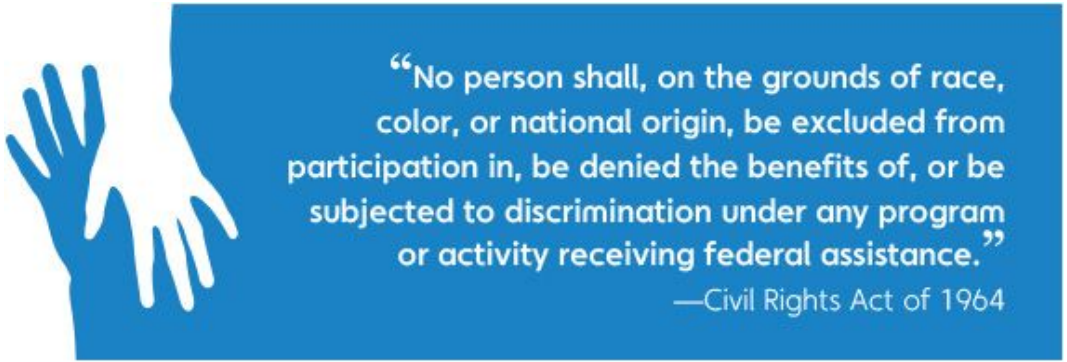
- Title VI
- Executive Order 13166
- Title VI Guidance (2001 and 2003)
- CLAS Standards
- ORS 413.550-413.560
- Section 1557 of the Affordable Care Act

Language Access Protections

TITLE VI

Title VI (1964)

- Part of the Civil Rights Act of 1964
- Governs nondiscrimination in federally assisted programs
- Prohibits discrimination based on race, color, or national origin
- Applies to any organization that receives federal funding
- LEP patients are covered by the protection against discrimination based on national origin



Scope

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq.* states:

"No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under **any program or activity receiving Federal financial assistance."**

Regulations for implementing Title VI, provided in part at 45 C.F.R. Section 80.3 (b), state that:

"(1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, or color, or national origin:

(i) **Deny an individual any service, financial aid, or other benefit provided under the program:**

(ii) **Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others in the program;"**

Executive Order 13166

Executive Order 13166 (2000)

- Set the stage for more comprehensive legislation on the implementation of Title VI
- Requires each federal agency to ensure that recipients of federal financial assistance are providing equal access; “each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice.” (in the medical world, the important agency is HHS)
- DOJ is tasked with providing LEP guidance to other federal agencies and ensuring consistency across agencies

Scope

- “**The obligations of Executive Order 13166 apply to all federal conducted and assisted programs.** In his Memorandum for Heads of Federal Agencies regarding the Federal Government’s Renewed Commitment to Language Access Obligations Under Executive Order 13166, the Attorney General **directed federal agencies that provide federal financial assistance to draft LEP guidance for agencies that are recipients of federal financial assistance (recipients)**. The term federal financial assistance includes, but is not limited to, grants and loans of federal funds; grants or donations of federal property; training; details of federal personnel; or any agreement, arrangement, or other contract which has as one of its purposes the provision of assistance.”

William J. Clinton
Executive Order 13166—Improving Access to Services for Persons With Limited English Proficiency

HHS Plan

- HHS creates a language access plan which “establishes a strategy for ensuring meaningful access by individuals with LEP to HHS administered programs and activities in accordance with Executive Order 13166 (EO 13166), Improving Access to Services For Persons With Limited English Proficiency, issued August 11, 2000.”

- However, many elements of this plan apply to HHS agencies (ie CDC, NIH, etc) not general clinics/hospitals

Title VI Guidance 1

Title VI Guidance (2001)

- Full title : 65 FR 52762 Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency
- Policy guidance--sets guidelines explaining how to be in compliance with Title VI

Title VI Guidance 2

Title VI Guidance (2003)

- Full title: 68 FR 47311 - Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
- Updates original Title VI Guidance after public commentary

CLAS Standards

CLAS Standards (2003)

- Divided into 3 levels of enforcement
  - Mandates (4-7)--currently required for all recipients of federal funds
  - Guidelines (1-3, 8-13)--recommended by OMH (Office of Minority Health) to be adopted as mandates
  - Recommendations (14)--voluntary compliance only
- Themes
  - Culturally Competent Care (Standards 1-3)
  - Language Access Services (Standards 4-7)
  - Organizational Supports for Cultural Competence (Standards 8-14).

CLAS Standards (2003)

- Culturally Competent Care (Guidelines)
  - **Standard 1:** Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
  - **Standard 2:** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
  - **Standard 3:** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

CLAS Standards (2003)

- Language Access Services (Mandates)
  - **Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
  - **Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them o f their right to receive language assistance services.
  - **Standard 6.** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
  - **Standard 7.** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

CLAS Standards (2003)

- Organizational Supports for Cultural Competence (Guidelines)
  - **Standard 8.** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
  - **Standard 9.** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
  - **Standard 10.** Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

CLAS Standards (2003)

- Organizational Supports for Cultural Competence (Guidelines)
  - **Standard 11.** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
  - **Standard 12.** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
  - **Standard 13.** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable o f identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

CLAS Standards (2003)

- Organizational Supports for Cultural Competence (Recommendations)
  - **Standard 14.** Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Section 1557 of the ACA

Section 1557 of the Affordable Care Act (2016)

- Part of the Affordable Care Act
- Applies to any organization that receives funding from HHS
- Reinforces many ideas from HHS Guidance. Recipients must:
    - Post notice of patient rights
    - Post taglines in top 15 languages
    - Develop and implement a language access plan
    - Unqualified staff and untrained individuals may not serve as interpreters
- Prohibits the use of low-quality VRI

Oregon Statute

ORS 413.550-413.560 (2003)

- " 'Certified health care interpreter' means an individual who has been approved and certified by the Oregon Health Authority...
- 'Qualified health care interpreter' means an individual who has received a valid letter of qualification from the authority...
- It is the policy of the Legislative Assembly **to require the use of certified health care interpreters or qualified health care interpreters whenever possible** to ensure the accurate and adequate provision of health care to persons with limited English proficiency and to persons who communicate in sign language.
- It is the policy of the Legislative Assembly that health care for persons with Limited English proficiency be provided according to the guidelines established under the policy statement issued August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights, entitled, 'Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency,' and the 1978 Patient's Bill of Rights."

State of Oregon

ORS 413.550-ORS 413.558

HB 2359 (2021)

- New bill this legislative session
- Would provide an enforcement mechanism for existing requirements

BREAK!

Patient Protections

-Needs and Capacity Assessment

-Access and Quality Assessment

-Oral Language Assistance Services

-Written Translation

-Staff Training

-Development of Policies and Procedures

-Documentation of Patient Refusal of Language Access Services

-Notification of Language Access Services

-Stakeholder Consultation

-Digital Information

-Assessing Competence of Bilingual Staff, Interpreters, and Translators

What do these laws require?

Needs & Capacity Assessment

Who in the area is eligible for our services, and can we meet their needs?

Access & Quality Assessment

Were LEPs able to access our services? How effective were our strategies for providing language access?

Oral Language Assistance Services

That's us, folks!

Written Translation

Do all patients have meaningful access to vital documents?

Staff Training

Does our staff know how to work with LEP patients?
Do they know what rights LEP patients have?

Policies & Procedures

Do we have a documented plan for providing language access services? Do staff members know and follow it?

Documenting Patient Refusals

What if a patient doesn't want to use our services?

Notification of Language Access Services

How must patients be informed of their rights?

Stakeholder Consultation

How can we seek input from the community?

Digital Information

What language access requirements apply to digital information?

Assessing Competence

How can we evaluate bilingual staff, interpreters, and translators to ensure competence?

Scenarios

Goals for Practice Scenarios

- For each scenario, talk with your group to come up with an idea of how to intervene and at what point in the encounter
- Write down how you would intervene
- Explain your reasoning
- Which legislation might protect the patient?
- More than one possible answer--but think about the Code of Ethics & Standards of Practice when making your decision.

Break-out rooms: Real-life scenario

- What was a time you could have advocated for a patient (whether you actually did or not)?
- How did you handle the situation at the time?
- How would you handle it now?

Example Scenario: "Stop Interpreting"

You are interpreting for a 12-year-old patient at a pre-op appointment. The patient speaks English, but his mother does not. The provider asks you to stop interpreting because it is distracting. She says she will ask you to interpret when she needs to communicate with the patient's mother, but since the child speaks English it will be easier if they talk without interpretation. The mother doesn't say anything to the provider, but in your pre-session she said she was worried that her child might need surgery, and was glad you were there to interpret everything in this appointment.

Scenario 2:
"Bring a Family member"

You are interpreting at a home visit. The nurse thanks you for being there, but then asks the patient if there is a family member to interpret for future visits so she doesn't have to request an interpreter. The patient says that the only person in her family who speaks English is her son, but he works full-time. The nurse then asks if the patient's son can take time off from work to come interpret. The patient hesitantly agrees to ask him.

Scenario 3:
"Pay more attention"

You are interpreting for a primary care appointment. The PCP asks the patient about her visit with the cardiologist he referred her to. He asks questions about her EKG results, the medications she was prescribed, and what the cardiologist told her about her diagnosis. After the patient fails to answer several questions, her PCP tells her she needs to take her health more seriously and pay more attention at her appointments. The patient apologizes, explaining that she wasn't provided with an interpreter when she went to the cardiologist and didn't understand most of what was said.

Scenario 4:

"Find a chiropractor"

You are interpreting for a patient who suffers from back pain. His PCP wants to write him a referral. The provider says that the chiropractor she usually refers patients to does not provide interpreters, so the patient will have to bring a family member to interpret. When the patient says he doesn't have anyone who can go with him to the chiropractor, she recommends finding a Russian-speaking chiropractor that accepts his insurance, so she can refer him to that provider. She tells the patient to call her back once he's found someone.

Scenario 5:
"Come Back Tomorrow"

You are in the lobby waiting for your patient to be called back. The clinic has 3 receptionists, but only one speaks Vietnamese, and she works only a few days a week. A Vietnamese-speaking patient asks a receptionist to get an interpreter on the phone to schedule an appointment. The receptionist tells the patient to come back in the morning to schedule the appointment when his Vietnamese-speaking co-worker will be able to help. The patient asks you if you speak Vietnamese and can help, because she doesn't want to have to come back the next day to schedule.

Scenario 6:

"They wouldn't see me"

You are interpreting for a patient at a primary care clinic. During your pre-session, the patient thanks you for coming to the appointment. She explains that her last 2 appointments were canceled and rescheduled; the clinic could not find an on-site interpreter and refused to use a phone interpreter. She states that she has had a UTI for a while now, and is worried it has gotten worse because she was unable to be seen earlier.

Preferred Language Cards

- Bilingual
- Lists the language a patient speaks
- States their right to language access

Brief note on OCR

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