

The New Joint Commission Standards for Patient-Centered Communication

Hospitals Remain Unprepared As The Joint Commission Standards Go Into Effect



EXECUTIVE SUMMARY

The number of patients with limited-English proficiency seeking treatment from U.S. healthcare institutions is rapidly on the rise. Hospitals and other healthcare facilities are already struggling to ensure that these patients receive the same standard of care as those who speak English. Now, new Joint Commission standards that have been implemented in 2011 as part of a pilot phase to prepare the field, will require healthcare organizations to provide all patients, regardless of language, patient-centered communication. Beginning no earlier than January 2012 organizations that fail to comply may risk jeopardizing their accreditation. This paper discusses the challenges ahead as healthcare organizations struggle to provide necessary language access services and integrate these new standards into their day-to-day operations.

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

INTRODUCTION

Language challenges impact healthcare

Immigration in the U.S. continues to reshape our demographics from one decade to the next. Due to generations of immigration, more U.S. residents speak languages other than English than at any previous time in our country's history. In fact, more than 50 million people — or approximately one in five residents — speak a language other than English at home.¹ Over 176 different languages and dialects are spoken across the nation, and languages once considered uncommon are now more frequently encountered.

For several decades, this growing linguistic diversity has had considerable impact on our medical institutions' ability to deliver equal and adequate healthcare services for all. Every day, thousands of limited-English proficient (LEP) patients face language barriers when visiting hospitals, urgent care clinics, private medical practices, when receiving exams and lab tests, and when receiving medications. Many LEP patients have difficulty communicating their medical histories and understanding healthcare instructions. Their questions are often misunderstood, and medical decisions are sometimes made without their knowledge, understanding, and consent. Providers also have difficulty understanding cultural observances that may affect the treatment they provide to LEP patients. In short, one can say LEP patients are in one of the highest at-risk categories of patients today.

Over the years, hospitals have endeavored to facilitate better communication by adding bilingual staff, hiring interpreters and utilizing over-the-phone and video interpretation services. As a result, hospitals have made great strides in providing LEP patients with better access to care through a variety of language services. The progress, however, has not been enough as we continue to see hospitals struggle to keep pace with the growing needs of an increasingly diverse community of patients.

¹ U.S. Census Bureau, 2008 American Community Survey 3-Year Estimates

Why language services are critical

Poor communication leads to poor care. According to The Joint Commission, communication breakdowns are responsible for the nearly 3,000 unexpected deaths, catastrophic injuries, and other sentinel events reported each year.² Whenever sentinel events occur, the potential for costly litigation is always present. The commission's findings go on to reveal that LEP patients suffer a greater percentage of adverse events as a result of such language breakdowns in 52% of reported cases, in comparison to English-speaking patients' 36%.³

Clearly, without access to professionally trained medical interpreters patient language barriers impact the cost and quality of healthcare. Caring for LEP patients without the aid of language access services takes a financial toll on virtually every healthcare organization. In a study of pediatric patients, for example, those experiencing language barriers recorded longer stays and higher charges than patients who spoke English.⁴ Another study concluded that LEP patients with no access to language services return to the ER more frequently than patients who do have access to interpreters and other services.⁵

Finally, healthcare institutions have a legal obligation to provide language services if they are recipients of government funding. To qualify for public funds, Medicaid, Medicare, and other government-financed programs hospitals must comply with federal and state regulations that mandate the provision of language services. Needless to say, these programs represent valuable financial support many hospitals simply can't afford to lose.

The unfortunate truth: most hospitals are not compliant

There is a distressing gap between the current language access regulations and the services now provided by most hospitals.

Even though federally funded hospitals and other facilities are required by law to provide access to competent language services, the regulations are often loosely followed. Many organizations are uninformed, and their support staff is ill prepared to access the appropriate services. Some hospitals continue to assist LEP patients by relying on patient family members, untrained bilingual staff, unmonitored contract interpreters, poorly tested language service providers, or some combination of them all.

To meet the standards, medical interpreters—whether they work full time, part time, or through a service provider—must have a formal education and be trained

¹ U.S. Census Bureau, 2008 American Community Survey 3-Year Estimates

² Joint Commission 2007 Sentinel Event Data “What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety”

³ Joint Commission, Language proficiency and adverse events in US hospitals: a pilot study, December 2006

⁴ Pediatrics Louis C. Hampers et al. (Peds 1999; 103(6): 1253-1256.)

⁵ Boston University School of Public Health, Bernstein J, et al. J Immigrant Health 2002; 171-176

and assessed specifically in medical interpretation. In addition, human resources departments are expected to maintain files for all medical interpreters, regardless of their employee status. As part of The Joint Commission tracer reviews, hospitals are expected to provide surveyors with documentation proving that each interpreter has undergone competency assessment. This same level of documentation must be included in all remote language service provider contracts. Contracts must also provide assurance that the service providers' competency standards are consistent with the hospital's internal requirements. Consistent with existing federal, state and local laws The Joint Commission standards also require written translations for vital documents such as informed consent documentation, complaint forms, and information on the availability of free language assistance programs. Signage may also need to be translated into several languages. Making sure everything falls into place involves the kind of system-wide language service program that few hospitals are able to sustain.

THE HISTORY OF HEALTHCARE LANGUAGE ACCESS SERVICES

In order to understand what healthcare organizations must do to elevate their current language access programs to the level of regulatory compliance, it helps to realize just how the healthcare industry has arrived at this particular crossroads. With that in mind, let's take a brief look at how language access has evolved in the past few decades.

The origins of medical interpreting

Language programs can be traced back to 1964 and Title VI of the Civil Rights Act. Title VI ensures that no person, regardless of race, color, or national origin, can be denied the benefits of any program receiving federal financial assistance. (The Office of Civil Rights, with support from the Department of Justice considers it a violation of Title VI when LEP patients are denied "meaningful access" to care due to language barriers.) Four years later, in 1968, Boston City Hospital hired the country's first two full-time interpreters, and the profession of medical interpreting in the U.S. was born.

Understanding and acceptance

The 1980's brought the first significant studies to measure medical interpreting's tangible value and its influence on patient outcomes. Given the absence of interpreter training and educational programs for this new profession, these studies were critical. Early studies evaluated interpreting errors and their clinical consequences. Later surveys compared the varying results of using bilingual staff, vocational interpreters, or no interpreters at all. In 1986, the nation's first medical interpreter trade association, the Massachusetts Medical Interpreter Association (MMIA), was founded. A year later, the first medical interpreter code of ethics was adopted.

The MMIA championed the professional status of the medical interpreter throughout the 1990's by joining forces with providers and making several

appearances at the Massachusetts State House to promote legislation requiring medical interpreters in all healthcare institutions. In 1995, the association established the medical interpreting profession's first standards of practice. The standards recognized the complexities of interpretation in a medical encounter and the importance of establishing a therapeutic connection between a provider and patient. In 2007, the MMIA became the International Medical Interpreter Association (IMIA).

The notion that effective patient-physician communication is essential to quality medical care for non-English speaking patients was finally beginning to take hold.

Mandates for training and the birth of certification

The turn of the century was also a turning point in the progress of medical interpreting. Massachusetts again led the way by enacting the first state law, in April of 2000, requiring acute care hospitals to provide LEP patients with interpreters. Later that year in August, President Clinton signed Executive Order 13166, directing federal agencies to establish language access policies for all programs that receive federal funds. The order also clarified and strengthened the language access implications of Title VI of the Civil Rights Act.

In 2001, the Office of Minority Health issued its Culturally and Linguistically Appropriate Services (CLAS) standards. These standards were undertaken to correct certain inequities in health services and to be more responsive to the individual needs of all patients, regardless of race, culture, and language preference. The field of medical interpreting gained further credibility in 2009 when the 23-year effort to launch a national medical interpreter certification process was realized by the National Board of Certification for Medical Interpreters.

The Joint Commission takes center stage

Beginning in 2005 The Joint Commission began to exercise its influence. Also in 2006 the "Certification of Health Care Interpreters in The United States: A Primer, a Status Report, and Considerations for National Certification" was published by the California Endowment to underline the importance of national certification for medical interpreters.

At the same time, The Joint Commission began surveying hospitals on the provision of language services. In the years to follow, it would evaluate the broad variety and quality of language access services being provided throughout our nation's health centers with the intent of publishing new regulations. Those regulations would ultimately become the "Joint Commission's 2010 New & Revised Standards & Elements of Performance for Patient-Centered Communication."

THE NEW JOINT COMMISSION STANDARDS

The Joint Commission is an independent, non-profit organization that surveys and accredits hospitals and other healthcare institutions across the country. Its mission (see page 3) is to advance healthcare for the public, and one of its projects is to promote safe, high quality care for every patient by improving communication and

cultural competence throughout the industry.

In January 2010, The Joint Commission released a set of new and revised standards for patient-centered communication as part of this project. During the pilot phase of the implementation, the surveyors will evaluate healthcare organizations' compliance for their medical interpreters in the areas of language proficiency assessment, educational background and training. It also calls for written translation of signage and vital documents for frequently encountered languages to meet patient communication needs.

The Joint Commission expects that healthcare organizations will comply with the new standards by ensuring that organizations can provide documentation that all their interpreters, both staff and contract interpreters, meet the requirements.

The standards that apply to language access services

The language-specific sections of the new Joint Commission standards also require healthcare providers to develop a system of identifying a patient's preferred language, to certify the competency of individuals who provide language services, to develop a method or program for delivering language services, to document each interpreting session, and to translate written documents and signage for frequently encountered languages.

Standard HR.01.02.01 instructs hospitals and healthcare organizations to define and confirm staff qualifications. Organizations will be expected to maintain documented evidence proving language proficiency assessment, education, training, and experience for all interpreters that work full time, part time, through an agency, or through a remote telephone or video interpreter service provider.

Standard PC.02.01.21 requires healthcare providers to identify each patient's communication needs, both oral and written, including the patient's preferred language for discussing healthcare. It also requires providers to communicate with the patient in that language during care and treatment.

Standard RC.02.01.01 calls for organizations to keep medical records that contain information documenting each patient's care, treatment, and services. The records must contain demographic information including a patient's race, ethnicity, communication needs, and preferred language.

Standard RI.01.01.01 involves the respect, protection, and promotion of patient rights. It dictates that hospitals must have written policies on patient rights, that hospitals inform patients of those rights, that written translations of those rights be made available in common languages, and that staff treat patients accordingly. It instructs hospitals to be respectful of patients' cultural and personal values, religious and spiritual beliefs, and right to privacy.

Standard RI.01.01.03 mandates that hospitals must respect each patient's right to receive information in a manner he or she understands. The standard directs healthcare providers to make interpreting and translation services available as

The new patient-centered communication standards expect that individuals who provide language services for the hospital meet the qualifications defined by the organization. The new note to existing standard HR.01.02.01, EP 1 includes several examples of qualifications, such as language proficiency assessment, education, training, or experience. The hospital has the flexibility to define the qualifications for their interpreters and translators, and they would be expected to demonstrate that their interpreters/translators meet the hospital's qualifications.

necessary and to provide information in a manner tailored to the patient's age, language, and ability to understand.

It is important to note that these Joint Commission standards also apply to patients that are deaf or hard of hearing. The standards grant the same rights and access to patients who require American or other Sign Languages as they do to patients who require a spoken language interpreter.

The consequences of non-compliance

The Joint Commission reviews hospitals for compliance on an ongoing basis as part of their accreditation process. Unscheduled accreditation surveys take place, on average, every three years. Hospitals that fail to meet the standards risk jeopardizing the accreditation process, incurring unexpected costs, and taxing limited resources. Non-compliance could also potentially limit its access to government assistance and attract further scrutiny.

The greatest consequence of non-compliance with the new standards, as The Joint Commission itself would tell you, is the potential delivery of substandard care that could lead to irreversible harm caused solely by the inability to communicate with LEP patients.

Non-compliance may also result in negative findings that would require follow-up activities on the part of the hospital and more rigorous and additional examinations by The Joint Commission. Such events are disclosed to the public and can result in unwanted public attention to the hospital's operations, particularly when a large LEP population is involved. This could have a negative impact in the local community, who may lose confidence in the healthcare organization's ability to provide quality care for its LEP patients.

If an organization does not comply with the standards, it can jeopardize its accreditation. Hospitals are typically afforded the opportunity to remedy compliance failures and the process can take months to resolve.

Non-compliance can also cost a hospital a significant amount of money. Re-establishing compliance can be an expensive, time consuming proposition. New protocols and policies must be implemented, new documentation must be created, and qualified personnel must be trained or hired. All of that can take months to implement.

IMPROVING HOSPITAL LANGUAGE SERVICES

The Institute of Medicine report, "Unequal Treatment (2002)," demonstrated alarming results tied to language barriers. The report cites that minorities, when compared to Caucasian Americans, receive lower quality of medical care resulting in overall poorer health. The report also indicated that language barriers — which result in miscommunication, poor decision-making, and ethical compromises — are a root cause of the findings.

An independent, not-for-profit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. To earn and maintain The Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years.

Language barriers commonly lead to fewer physician visits, missed appointments, prescription medicine mistakes, repeat emergency room visits, and the reduced use of preventive services among LEP patients.⁶ On the other hand, when professional interpretation services are available, the proper use of clinical and preventive services increases among LEP patients.

So, what steps can hospitals take to level the playing field for LEP patients, ensure greater care, and comply with the new Joint Commission standards? The following four suggestions serve a basic foundation for moving forward.

Develop a system-wide language services program

Healthcare organizations should implement a language plan that establishes access at every patient point of contact. Interpreting services are necessary throughout an institution, whether a patient is asking questions at the information desk, in an exam room, visiting an outpatient clinic, having blood drawn at a lab, getting financial assistance, working with social services, or anywhere else. Any facility seeking to comply with regulations will be able to accommodate LEP patients in such ways by utilizing a combination of on-site staff interpreters and contract interpreters as well as over-the-phone and video interpreters, all professionally trained for healthcare environments and medical interpreting.

Implement ongoing training and education

Due to changing state and federal regulations and constant staff turnover, it is critical for language service programs to include ongoing training and education for all staff throughout the entire hospital system. Hospital personnel must clearly understand when to call for interpreter services, how to access them, and which type of service to request (in person, by phone, through video). Similarly, the interpreters themselves must be tested and trained on a regular basis. Keeping pace with new regulations, medical advances, and hospital policies and procedures is a vital part of their jobs.

Align policies and procedures with current standards

Policies and procedures validate the existence of a hospital's language access program. They provide the necessary guidelines that enable staff to administer services in an effective way. They also help determine when language services programs are adhering to regulatory requirements. Therefore, it is imperative that hospital administrators carefully include all necessary protocols when developing policies and procedures. It is equally important that each staff member know these services are available, understand them, know where to find them when needed, and put them into regular practice.

Gain executive endorsement

To be an effective language services advocate, one must articulate the urgency for

⁶ Office of Minority Health U.S. Department of Health and Human Services, March 2002

language services and compliance standards to senior leaders of the organization clearly and simply. That may require a discussion on mitigating patient risk and the ever-present threat of litigation. It may require putting faces to the patient's stories so that hospital administrators understand the human impact from decisions about funding its language services. It might mean calculating a tangible return on investment. Or it could involve a grave reminder about the costly consequences of doing nothing or not enough. One way or another, it is crucial that an organization's leadership recognize the many benefits involved in raising the level of language services to the standards required by The Joint Commission. This needs to be addressed as a patient safety and risk management issue.

A SUMMARY OF THE SITUATION

For an LEP patient, communicating with a healthcare provider, receiving proper treatment, and navigating the complex web of people and procedures that a hospital presents is a daunting challenge. Relying on bilingual staff, family members, or untrained interpreters whose misunderstandings, omissions, biases, and impatience often get in the way, is a risky way to bridge the language gap. It takes an organized set of policies, trained hospital staff, and professionally trained medical interpreters to ensure that LEP patients get the care and assistance they require.

This reality is a driving force behind the new Joint Commission standards implemented January 2011. The Joint Commission expects that hospitals demonstrate a greater commitment to language services and cultural competency for all its LEP and deaf patients. And it is giving hospitals one year to prepare.

Many hospitals aren't ready

The problem is that few hospitals have taken the necessary steps to comply. Some still don't see the link between language services, patient rights and patient safety.

Other healthcare facilities may believe they are compliant because they already have bilingual staff, contract interpreters, and over-the-phone or video interpreters. However, The Joint Commission standards outline some detailed requirements that entail more specific responsibility for these organizations.

In addition, there are many hospitals across the country that genuinely appreciate the urgency to adopt the new standards but simply don't know how to get started and don't know where to turn for help.

The Joint Commission is serious

The Joint Commission has invested years of study and significant resources in creating these standards. It has every intention of ensuring that healthcare organizations understand and are in compliance with the patient-centered communication standards.

Joint Commission surveyors will visit healthcare organizations, unannounced,

on a regular basis. They will be speaking directly with hospital management, administrative staff, medical personnel, on-site interpreters, and with contract language service providers. Through their “tracer” methodology process, they will have direct contact with LEP patients and will ensure that all interpreter-assisted communication has been documented appropriately.

The Joint Commission will also examine the relationships with each independent contractor or remote language service provider a hospital contracts with to verify credentialing and compliance. Therefore, hospitals must also make sure that each of their language service providers have contracts and documentation in place to satisfy Joint Commission surveyors.

Non-compliance threatens patient safety, reputations, and budgets

Substandard language services, or lack of access, can lead to poor LEP patient outcomes. Study after study verifies this conclusion. If surveyors find compliance issues, the industry and public backlash could be overwhelming. The potential costs associated with non-compliance may be difficult to calculate, but its significance is certain.

Now is the time to implement changes

Meeting The Joint Commission standards won't be easy. Hospitals will need to assess their patients' language assistance needs and their own current interpreter service programs. Existing resources will have to be vetted. Services will need to be improved or established. Staff will require adequate training. Personnel files with proper assessment and credentialing for all staff, contract, and service interpreters will need to be made available. Signage and vital documents will have to be translated. New policies and procedures will need to be implemented to ensure compliance throughout the entire hospital system. These measures require immediate attention in order to comply with The Joint Commission when fully implemented.

Hospitals can prepare themselves

As outlined previously, complying with the new standards will require hospitals to develop a system-wide language access program, to implement regular training and education, to establish new policies and procedures, and get senior leadership involved. The most ambitious healthcare organizations may wish to embark on their own. However, many have neither the resources nor experience to accomplish such goals without help.

These institutions can turn to their current language access programs managers, but are also encouraged to consult with industry experts, such as their language access vendors. These vendors likely have greater industry knowledge, a variety of solutions and training programs that can be tailored to the organization, and some may even have Joint Commission survey experience. A hospital with a carefully developed language access program, based on recommendations from expert consultants, will

The new patient-centered communication standards expect that services provided by contracted agencies that provide language services for the hospital also meet the qualifications defined by the organization. In this case, the hospital would be expected to demonstrate that their contracted interpreters/translators meet the hospital's qualifications. The contractor would be required to use the same process followed by the hospital if that was part of the hospital's defined qualifications.

be in the best position to weather a Joint Commission survey and comply with the new 2011 standards.

A NOTE FROM THE AUTHORS

When you consider that our immigrant and refugee populations are already over 50 million people and today's ethnic minority will become the majority by 2042, it's impossible to ignore the significant influence they are certain to have on our healthcare system.⁷ These ethnic groups already have a dramatic impact on healthcare service delivery, patient safety, and quality of care. Fortunately, The Joint Commission's new standards for patient-centered communication will advance effective communication, cultural competence, and patient care for these growing populations.

This paper is intended to help hospitals prepare themselves for the new Joint Commission accreditation standards beginning in January 2011. The Joint Commission has reviewed the paper and their comments are incorporated in the blue sidebar comments throughout the document. While some recommendations provided might be considered above and beyond The Joint Commission's publication "A Roadmap for Hospitals" based on our years of experience as hospital administrators we believe they will provide great guidance to healthcare organizations. Healthcare organizations must now gear up for the new standards by carefully choosing a language service provider that can help put them on an expeditious and efficient path to compliance.

To serve in this capacity, Language Line Services is currently offering a comprehensive Customer Regulatory Readiness Program, much of which is free and includes consultation, support, and instructional materials. For more information regarding Language Line Services' Customer Regulatory Readiness Program — Support for The Joint Commission Requirements for Language Access, please call (800) 752-6096 or visit www.language.com/industry_healthcare.

⁷ Population Reference Bureau, May 2009

ABOUT THE AUTHORS



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Center has become the epicenter for advances in the delivery of interpreter services. As a national and international language access advocate, Mr. Arocha has presented at numerous conferences and been sought out as a consultant. In 2006, he was invited by the Robert Wood Johnson Foundation to be part of the National Advisory Committee (NAC) in their Speaking Together initiative. He was called again in 2008 to serve on the NAC of Aligning Forces for Quality initiative. Mr. Arocha has lived in Venezuela, Italy, Egypt, Iran, Spain, Japan, Austria, and Brazil. He holds an MA in Healthcare Management from Cambridge College, Massachusetts, and is fluent in French, Spanish, and Portuguese.



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