**The New Joint Commission Standards for Patient-Centered Communication White Paper**

**(Excerpts reprinted from White paper for educational tool for LSU SOM Clerkship Ethics)**

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**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. 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.

**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. 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%.

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. 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.

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.

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**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.)

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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 the1990’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 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.

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**The New Joint Commission Standards….**

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

necessary and to provide information in a manner tailored to the patient’s age,

language, and ability to understand.

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